STD/AIDS Control

2005 ANNUAL REPORT

BC Centre for Disease Control
AN AGENCY OF THE PROVINCIAL HEALTH SERVICES AUTHORITY

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std/aids 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 STD/AIDS 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, treatment 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 remain our foremost concern.
- We provide STI/AIDS related education and training resources to 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 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.
- We participate in STI/AIDS related research and teaching as a university affiliated organization, helping us 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 STD/AIDS 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 Resource Centre at 604-660-2090.

2005

director's letter

Dr. Michael Rekart, Director

A Message from the Director

2005 marked a year with many changes at STD/AIDS Control. We saw changes to our clerical/administrative team; there was a small but significant change in the syphilis epidemic trend; and we changed the clinic sign, at the urging of clients, from "Sexually Transmitted Disease Clinic" to simply "Clinic".

Some sexually transmitted infections, including chlamydia and gonorrhea, continued to increase. The chlamydia rate increased by 16 per cent to 28/100,000: 9043 new cases were reported in 2005. Gonorrhea reports increased from 1013 in 2004 to 1187 cases in 2005 (17 per cent increase). As well, hospital and day surgery diagnoses of ectopic pregnancy increased from 523 in 2003 to 562 in 2004 (Due to data transfer, ectopic pregnancy rates are reported through 2004 only.)

Some STIs, on the other hand, decreased in 2005. New diagnoses of HIV this year declined from 444 to 420; new AIDS cases decreased from 115 in 2003 to 99 in 2004; and infectious syphilis cases declined from 305 in 2004 (rate of 7.3/100,000) to 290 (6.8/100,000). Hospital and day surgery reports of pelvic inflammatory disease (PID) and tubal infertility went down from 705 to 626 and from 264 to 251, respectively.

Some trends identified in previous years remained the same:

- an over-representation of Aboriginals, especially for syphilis and HIV infections among females;
- a high proportion of gonorrhea, HIV, AIDS and syphilis cases in gay men;
- the highest chlamydia rates among 15 to 19-year-old girls; and
- the highest rates for STIs in the Vancouver Health Service Delivery Area (HSDA).

In spite of the slight decrease in HIV for 2005, our HIV primary prevention efforts have stalled, with annual rates fairly steady at approximately 10/100,000 over the last seven years. As a result, AIDS cases since 2001 have also been relatively stable. While we could celebrate the fact that HIV and AIDS have not rebounded, it is probably more important to ask ourselves why we have not been able to prevent new HIV and AIDS cases in a significant way. It is clear that we need new tactics. Social networking and mathematical modeling have proven useful and will continue to be applied, however the most promising new strategies include: (1) early diagnosis and intervention for acute and recent HIV and Hepatitis C Virus (HCV) infections, (2) STI vaccines, especially for Human Papilloma Virus (HPV) and herpes, and (3) more aggressive diagnosis and treatment of Herpes Simplex Virus 2 (HSV2) to decrease HIV viral load and prevent HSV-enhanced HIV susceptibility.

In 2006, we embarked on an initiative to delineate best practices in HIV and STI primary prevention, to initiate innovative strategies not previously available or accessible, and to support the Health Authorities in implementing basic and enhanced prevention interventions. We know that concerted and coordinated efforts lead to better control of HIV, AIDS and STIs. All those working in prevention look forward to 2006 as a landmark year.

Michael L. Rekart

Dr. Michael Rekart
Director, STD/AIDS Control

the year in review

Clinical Activities

Street Nurse Program

Chee Mamuk Program

Education and Communications

Research Program

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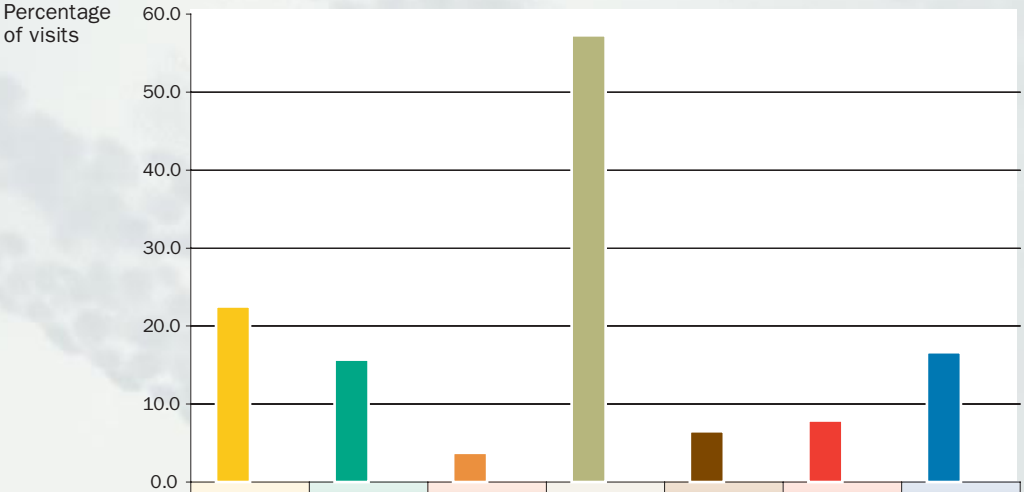
clinical activities

STD Clinic and Street Nurses

The division's patient services are delivered through two principal channels: the STD 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 • 2005



	STD Screening	STD Symptoms	Contact to STD	HIV Testing	Hepatitis	Wart Treatment	Other
Percentage	22.5	15.7	3.8	57.3	6.5	7.9	16.7
Number	3,967	2,767	663	10,093	1,151	1,394	2,937

In 2005, the STD Clinic and Street Nurse Program recorded 17,625 visits. The breakdown of clinic visits is consistent from year to year, with 2005 being very similar to previous years. HIV testing was a reason for visit for 10,093 (or 57.3 per cent) of clinic visits. Reasons related to other STIs accounted for 8,971 visits (or 49.9 per cent) of total clinic visits. Hepatitis continues to be the reason for 1,151 (or 6.5 per cent) of clinic visits.

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

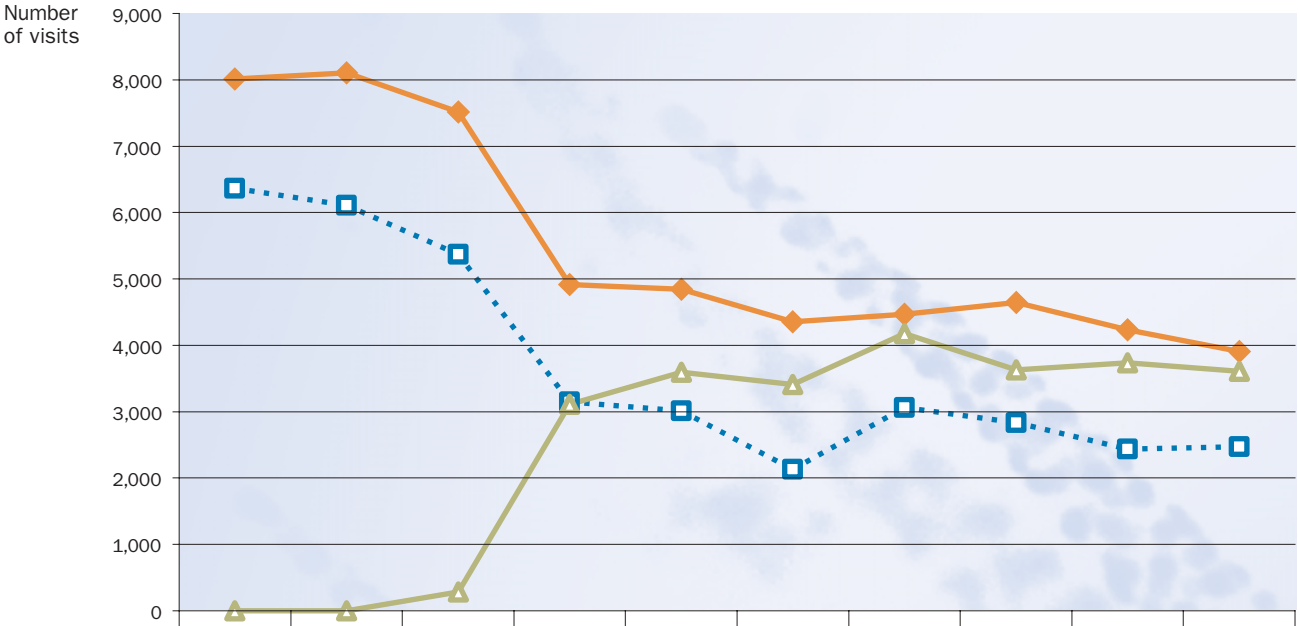
Note: Percentages do not equal 100% because one client may have several reasons for visit (e.g. HIV testing, symptoms and STI screening).

west 12th std clinic

The STD Clinic on 12th Avenue is centrally located, easily accessible to 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 STD/AIDS information phone line.
- Operate partner notification services.
- Maintain an STI/AIDS education resource centre for province-wide use.
- Provide administration of all division operations.

1.2 West 12th STD Clinic Visits • 1996 to 2005



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
STD	8,013	8,105	7,513	4,916	4,847	4,355	4,465	4,649	4,237	3,905
HIV	6,368	6,108	5,372	3,145	3,012	2,134	3,064	2,837	2,440	2,473
STD & HIV	0	0	285	3,110	3,591	3,412	4,177	3,629	3,736	3,608
Total	14,381	14,213	13,180	11,172	11,450	9,901	11,706	11,115	10,414	9,987

AIDS prevention street nurse program

The AIDS Prevention Street Nurse Program (SNP) is the outreach program for STD/AIDS Control. The mandate of the SNP is STI/HIV prevention in at-risk, hard to access and marginalized populations in British Columbia.

Embracing a harm reduction, health promotion and population health framework the SNP works collaboratively with a wide range of partners to develop innovative and responsive STI/HIV prevention programming. Flexible and focused initiatives in service delivery, education, project work and research are guided by frontline experiences of the outreach team and changing health and social environments.

Service delivery:

STI/HIV counselling, testing, diagnosis, treatment, follow-up and referrals are provided by nurses in both clinical and non-clinical settings. Harm reduction education and distribution and collection of needles and other supplies are integrated as health practice on and off-site. There were 33,350 direct client encounters in 2005.

- **Bute Street Clinic –** The largest outreach clinical site is in The Centre, the lesbian, gay, bisexual and transgendered community center in Vancouver's West End. Bute Street Clinic, a busy two nurse site, provided service to 6,853 clients in 2005.
- **Other Clinical Sites –** Clinical services are offered at other small sites housed in Pender Community Health Clinic (PCHC), Surrey Pretrial Centre, Vancouver Detox and Seymour Street Youth Services Site. In November 2005 youth services were moved from the Seymour Street Site to Directions, the new integrated youth site run by Family Services of Greater Vancouver.
- **Mobile Clinics/Services –** Outreach nurses provided service at Youth Action Centre (YAC), Women's Information Safe House (WISH), Downtown Eastside Women's Centre, Dusk to Dawn, and at hotels, strolls, parks, the race track, massage parlors, health fairs and others sites as needed.

Education programs:

Education programs ranging from one-hour presentations to three-day workshops are offered for client, community and professional groups and students locally, provincially and internationally. Field experiences are provided for health professionals and university and college students.

Key workshops in 2005:

- Partnered with Chee Mamuk to provide workshops on reserves throughout British Columbia.
- Provided partner counselling and referral services (PCRS) and outreach training to public health nurses in the Northern Health Authority in Smithers and the Queen Charlotte Islands.
- Partnered with the British Columbia Multicultural Society to provide peer education workshops.
- Conducted workshops at Fraser Valley University, the University of British Columbia and Langara College.
- Participated in projects that provided training courses in Vietnam, Bosnia and Argentina.

Innovative projects:

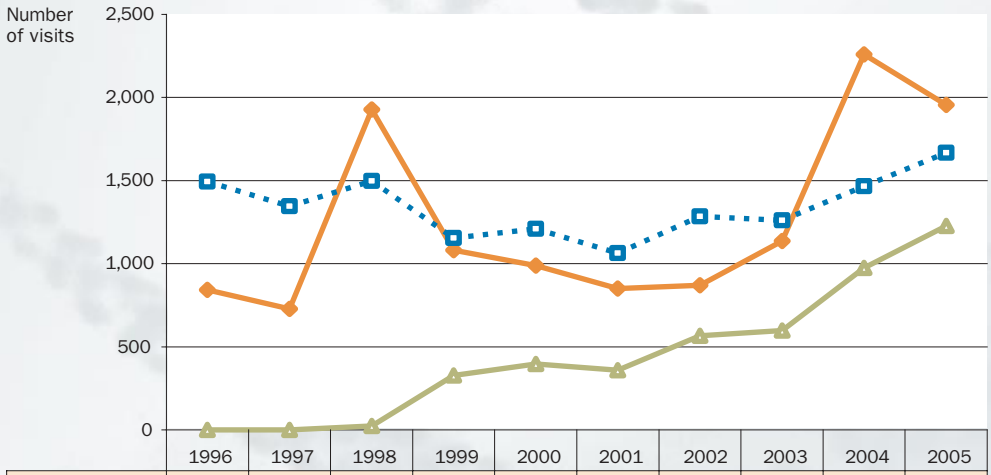
Key projects in 2005

- **Cyber Outreach project –** A three phase project which began in January 2004 and was completed in November 2005. The goal was to provide an online of STI/HIV sexual health information and referral service on a gay internet site. A total of 14,044 hits were recorded on the site, and 341 site users interacted with nurses through e-mail and instant messaging. Internet programming is continuing as an outreach initiative into 2006.
- **Massage parlor outreach –** Street nurses worked with peers from Sex Workers Action Network (SWAN) to access sex workers in massage parlors. A questionnaire about health risks and access to services was administered and will be continued in 2006.
- **Patron of Sex Workers project –** Focus groups with patrons of sex workers were conducted.
- **Papalooza –** Pap (papanicolaou, or pap smear) and STI testing was given at festive events in several venues in the Downtown Eastside for women who do not access services.
- **"Engaging Problematic Substance Users – Taking Health to the Streets i.e. Nurses Teaching Nurses"–** Funding was received from Health Canada's Drug Strategy Fund to produce an educational DVD to teach nurses across Canada engagement strategies. Production started in the fall of 2005 and will be completed by March 2007.

Research:

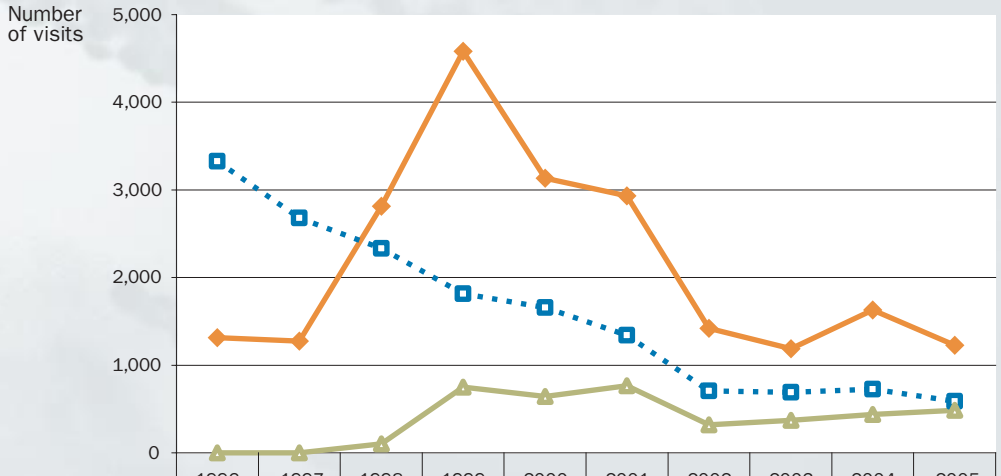
- **"Impact of self sampling for human papilloma virus and targeted recruitment on the uptake of pap testing in street involved women" –** Gina Ogilvie, principal investigator. Data and specimen collection for the pilot phase was finished in December 2005.
- **Health Canada Street Youth Study –** commenced in late 2005.

1.3 Bute Street Clinic Visits • 1996 to 2005



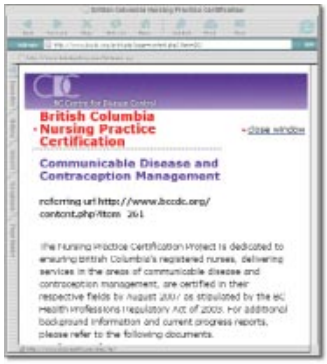
	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
STD	843	729	1,927	1,082	988	850	870	1,136	2,259	1,955
HIV	1,494	1,345	1,498	1,154	1,209	1,063	1,285	1,260	1,466	1,667
STD & HIV	-	-	23	328	396	359	566	597	974	1,228
Total	2,337	2,074	3,448	2,564	2,593	2,272	2,721	2,993	4,699	4,850

1.4 Agency/Outreach Visits • 1996 to 2005



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
STD	1,316	1,273	2,814	4,580	3,134	2,931	1,421	1,187	1,628	1,227
HIV	3,325	2,681	2,331	1,815	1,656	1,340	707	689	727	587
STD & HIV	-	1	101	750	642	766	319	372	437	487
Total	4,641	3,955	5,246	7,145	5,432	5,037	2,447	2,248	2,792	2,302

education and communication: meeting new challenges



Certificate in STI/HIV Clinical Nursing Practice

In response to the pending Provincial Scope of Practice legislation, STI Education, in partnership with Provincial Health Authorities, the University of British Columbia and the College of Registered Nurses of British Columbia developed a distance learning program in STI/HIV Clinical Nursing Practice.

The overall goal of the Certificate in STI/HIV Clinical Nursing Practice is to educate and support registered nurses working in settings that require STI/HIV knowledge, expertise and skill. The course is delivered mostly online, but includes clinical face-to-face practicum experience. The online approach was chosen so that STD/AIDS Control could most effectively reach health care workers throughout the province, given scarce educational resources. The online program is in the pilot testing phase while we collect the feedback of experienced STI nurses.

Soul Access

The Soul Access project was initiated in 2002 to meet the STI/HIV/AIDS data needs of our clients by providing them with secured access to the data in a web-based cube format. Clients include medical health officers, public health nurses, BCCDC staff, the Ministry of Health and Health Canada. The STI cubes provide better accessibility and presentation of surveillance data. Data is more accurate and up-to-date than presentations in the annual and semi-annual reports.

The cubes present the number of STI/HIV/AIDS cases and rates in seven to eight dimensions (e.g. date of test, gender, age, ethnicity, health authority and risk group). The numbers are displayed in two or more selected dimensions and can be filtered in any number of the dimensions. In order to protect confidentiality, the cubes do not contain any personal identifiers and have no links to the original databases.

In March 2005, the STI cubes became available on the intranet for authorized users across the province. One to three designates in each Health Authority and the Ministry of Health have accessed the cubes between March 2005 and March 2006. The cubes for the STIs (chlamydia, gonorrhea and syphilis) and HIV are updated monthly, and the cube for AIDS is updated every six months. For more information on the cubes, visit BCCDC's PartnerNet at: **www.bccdc.org** or e-mail: **linda.knowles@bccdc.ca**.

research program

The goal of the STD/AIDS Control Research Program is to engage in significant research activities (design, implementation, analysis and dissemination) that result in evidenced-based strategies to prevent, control or eliminate sexually transmitted infections and HIV/AIDS. Teams of researchers are created among the staff within the division and collaborators external to the division are routinely involved.

In 2005, STD/AIDS Control designed and took the lead role in conducting research studies, including:

1 Antenatal Seroprevalence of Hepatitis C and HIV in BC

2 Evaluation of Mandatory HIV Reportability in British Columbia

3 A Focus Group to Assist in the Development of a Sexual Health Survey For Patrons of Sex Workers

4 Assessment of Sexual Health Risk Behaviours Among Indoor Sex Workers in Greater Vancouver

5 An On-Line HIV/STI Information and Referral Service: A Pilot Project

6 Impact of Self Sampling for HPV

7 Recent HIV Seroconversion at Time of First Positive Test: A Comparison Before and After HIV Reportability

8 Master's thesis completed by Lucy Barney, from the University of British Columbia's School of Nursing: "What is a culturally Relevant Prevention Program for First Nation Youth?"

In addition, staff within the division has collaborated on numerous external research projects such as:

- The ORCHID Project: Outreach and Research in Community Health Initiatives and Development
- The Cedar Project
- Stigma, Risk and Protective Factors for Vulnerable Youth
- Rural and Northern Youth Sexual Health
- A Randomized Controlled Evaluation of HPV Testing for Cervical Cancer Screening
- Improving the Health of Drug-dependant Prison Inmates

Research findings were presented at the following conferences:

1 14th Annual Canadian Conference on HIV/AIDS Research, May 12-15, 2005 (5 staff attended; 11 posters presented)

2 16th Biennial Meeting of the International Society for Sexually Transmitted Diseases Research; July 10-13, 2005 Amsterdam (8 staff attended; 8 posters presented)

3 The 4th International Conference on Urban Health, October 26 – 28, 2005 (2 staff attended; 1 poster presented)

4 17th International Conference on the Reduction of Drug Related Harm, Vancouver.

Gina Ogilvie and Lucy Barney participated on advisory boards reviewing abstract submissions to Canadian Aids Research Society (CAHR) and the International Human Papilloma Virus Conference, both held in Vancouver this year. Of special note, Melanie Rivers (Chee Mamuk) has assumed the responsibility of peer reviewer for the Canadian Journal for Aboriginal Community Based Research, a publication of the Canadian Aboriginal AIDS Network. Lucy Barney has also participated in a peer review for the Canadian Institute for Health Research for the Community Based Research Capacity-building component.

publications

1 Rekart ML, Wong T, Wong E, Hutchinson K, Ogilvie G. The impact of syphilis mass treatment one year later: self-reported behaviour change among participants. *International Journal of STD & AIDS* 2005; 16: 571-578(8).

2 Ogilvie GS, Knowles L, Wong E, Taylor D, Tigchelaar J, Brunt C, James L, Maginley J, Jones H, and Rekart ML. Incorporating a social networking approach to enhance contact tracing in a heterosexual outbreak of syphilis. *Sexually Transmitted Infections* 2005; 81: 124-127.

3 Jones HD, Taylor D, Montgomery CA, Patrick DM, Money D, Vipond JCF, Morshed MG, Ruissard DA, Rekart ML. Prenatal and Congenital Syphilis in British Columbia. *Journal of Obstetrics and Gynaecology Canada* 2005; 27(5): 467-472.

4 Brunham CR, Pourbohloul B, Mak S, White R, Rekart ML. The Unexpected Impact of Chlamydia trachomatis Infection Control Program on Susceptibility to Reinfection. *The Journal of Infectious Diseases* 2005; 192: 1836-1844.

5 Lampinen TM, Ogilvie GS, Chan K, Cook D, Miller ML, Hogg RS. Sustained increase in HIV-1 incidence since 2000 among men who have sex with men in British Columbia, Canada. *J AIDS* 2005; 40(2): 242-4.

6 Kropp RY, Wong T. Canadian LGV Working Group. Emergence of Lymphogranuloma venereum in Canada. *Can Med Assoc J* 2005; 172: 1674-1676.

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Jones E, Redekop L, Chakraborty B, MacMillan C, Sanstra I, Taylor D, Maginley J, Ogilvie GS, and Rekart ML. Acceptability of a Designated Youth Supervised Injection Facility for Homeless Youth in Vancouver, British Columbia. Canadian Association of HIV Researchers Conference, May 2005, Vancouver, BC.

Marra F, Woolcott J, Ogilvie GS, and Brisson M. Resource Utilization and the Burden of Cost from Genital Wart Surveillance and Treatment. 22nd International Pappillomavirus Conference and Clinical Workshop, April 30-May 6, 2005, Vancouver, BC.

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Ogilvie GS, Maan E, Palepu A, Remple V, Heath K, Macdonald G, Christilaw J, Berkowitz J, Fisher WA, and Burdge DR. Fertility History and Intentions of HIV Positive Women of Reproductive Age. 16th International Society of STD Researchers, July 2005, Amsterdam, Netherlands.

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Ogilvie GS. Organizing Committee, International Human Papillomavirus Conference, Vancouver, April 2005.

Ogilvie GS. Plenary Speaker, Sexually Transmitted Infections in Canada, Guelph Sexuality Conference, June 2005.

Ogilvie GS. Reviewer, Epidemiology and Public Health Track, Canadian Association of HIV Researchers, May 2005.

Ogilvie GS. Reviewer, International Human Papillomavirus Conference, Vancouver, April 2005.

Rivers M. National Native Addictions Partnership Foundation Training Conference, Richmond, BC.

Rivers M. Paths to Healing: Healing Our Spirit's 9th Annual Conference.

Rivers M. The Gathering Tree: A children's book on HIV with a First Nations storyline, October 10, 2005.

Rivers M. Travel the Four Directions of Community Development, April 11, 2005.

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presentations

Barney L. Around the Kitchen Table Project: Provincial Services Health Association Board, September 27, 2005.

Barney L. Chee Mamuk Activities, Projects and Framework: First Nations and Inuit Health Branch, June 28, 2005.

Barney L. First Nations Youth Perspectives on Risk Behavior and Prevention of HIV and HCV: British Columbia Centre for Excellence on HIV/AIDS, June 8, 2005.

Barney L. Prevention of HCV in First Nation Youth: BCCDC Grand Rounds, September 9, 2005.

Barney L. The Gathering Tree and TB not TV: Special presentation on Aboriginal Youth Projects for BCCDC, September 13, 2005.

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Chee Mamuk program

The mandate of Chee Mamuk is to provide culturally appropriate, on-site and community-based HIV/AIDS and STI education and training to Aboriginal communities, organizations and professionals within BC. The program was formed in 1989 to address the increasing rates of HIV/AIDS in the Aboriginal community.

With a focus on spiritual, mental, emotional and physical health, Chee Mamuk creates awareness of HIV/AIDS using culture, community involvement and scientific information to educate Aboriginal communities.

There are currently four full-time employees providing services to the 194 First Nations bands and Aboriginal organizations of British Columbia. The program offers referrals and consultations, and is continuously upgrading educational materials on HIV and Hepatitis C through such innovations as Women's kits, condom key chain holders, female condom cover packaging and HIV testing handouts with First Nation art work and cultural teachings.

Chee Mamuk developed and published the children's book *The Gathering Tree* in 2005. 1,900 copies of the book were distributed throughout the province to schools, First Nations band offices, health centres and community-based organizations. The book is now being printed in paperback as well as hardcover.

Around the Kitchen Table is a new project for Chee Mamuk. The project is funded by the Protection, Prevention and Promotion Branch of the Provincial Health Authority. The project's objective is to assist Aboriginal women to return to their traditional roles as natural helpers, givers of life and keepers of the culture. With this in mind, the goals are to decrease the spread of HIV/AIDs in Aboriginal women and to support those who are infected or affected by HIV/AIDS. This is a collaborative effort with the Children and Woman's Oak Tree Clinic, BC Centre for Excellence in HIV/AIDs - Treatment, Outreach Street Nurse Program, Positive Women's Network and all communities with which we work. This year's focus communities include the Cowichan, Haida Gwai, Kelowna and Aboriginal Health and Safety Workers.

Since its inception, Chee Mamuk staff has provided workshops and training (on HIV/AIDs) to six thousand people in British Columbia. We have discovered that Aboriginal communities are at different levels of learning about HIV/AIDS, therefore we have adapted a model that will help us present prevention in a culturally appropriate way consistent with an individual community's needs in HIV/AIDS education.

The Community Readiness Model we have adapted was developed by TriEthnic Center of Colorado, and is similar to the Change Behavior Model. We will be implementing it this year for presenting education and training at levels appropriate for each community.

As outlined in the table below, each stage of the model uses different interventions to move the community to the next stage of readiness, until eventually initiation and maintenance of HIV/AIDs programs and policies are achieved.

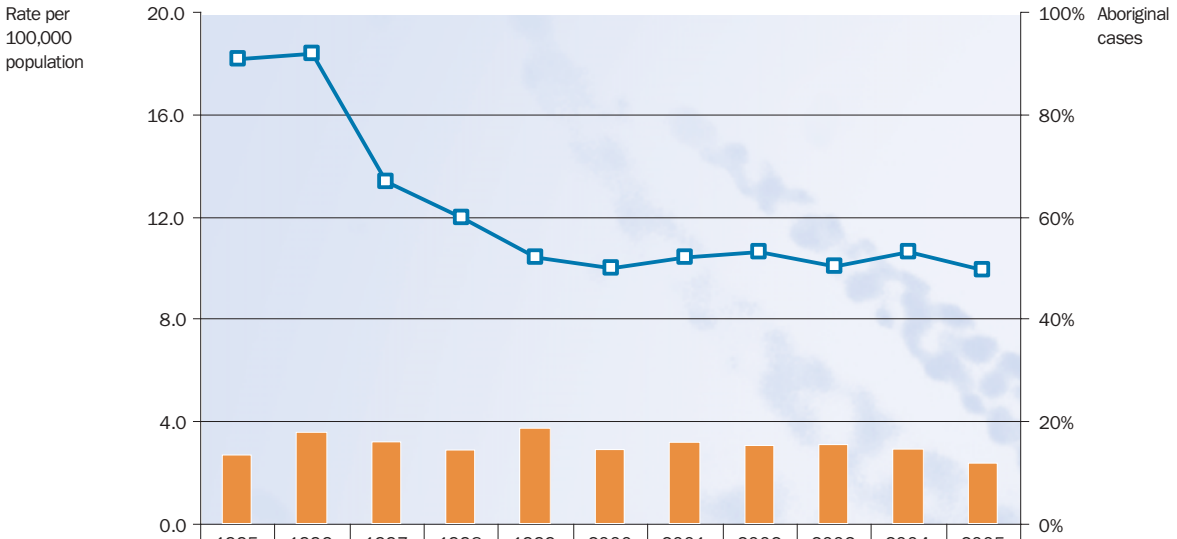
The assessment and/or evaluation of community readiness to deal with HIV/AIDS includes six dimensions:	**Community readiness stage:**
1. Community efforts	1. No awareness
2. Community knowledge of the efforts	2. Denial/resistance
3. Leadership	3. Vague awareness
4. Community climate	4. Pre-planning
5. Community knowledge about the issue	5. Preparing
6. Resources related to the issue	6. Initiation
	7. Stabilization
	8. Confirmation/expansion
	9. High level of community ownership

special report: HIV, AIDS and STI's in aboriginal people in british columbia

HIV

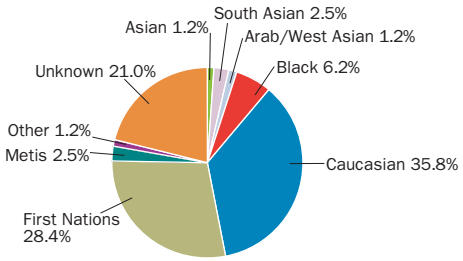
Aboriginal people make up 5 per cent of the population in BC, however, 12 per cent of new HIV positive tests in 2005 were among this population. Aboriginal women made up 30.9 per cent of the HIV positive tests among women in BC in 2005. Aboriginal men made up 6.8 per cent of the newly positive. The highest risk factor for Aboriginal people is Injection Drug Use at 38.8 per cent.

2.1 Persons testing newly positive for HIV in BC with proportion of Aboriginal cases • 1995 to 2005

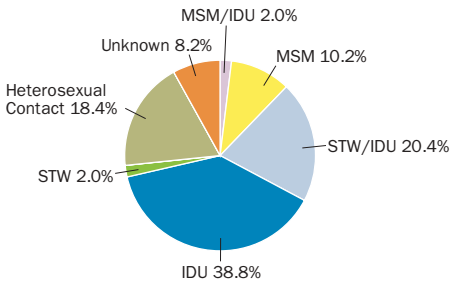


	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
% Aboriginal	13.3%	17.7%	15.9%	14.3%	18.5%	14.4%	15.7%	15.1%	15.3%	14.4%	11.7%
Total BC Rate	18.2	18.4	13.4	12.0	10.4	10.0	10.4	10.6	10.1	10.6	9.9

2.2 Females testing newly positive for HIV in BC by ETHNICITY • 2005



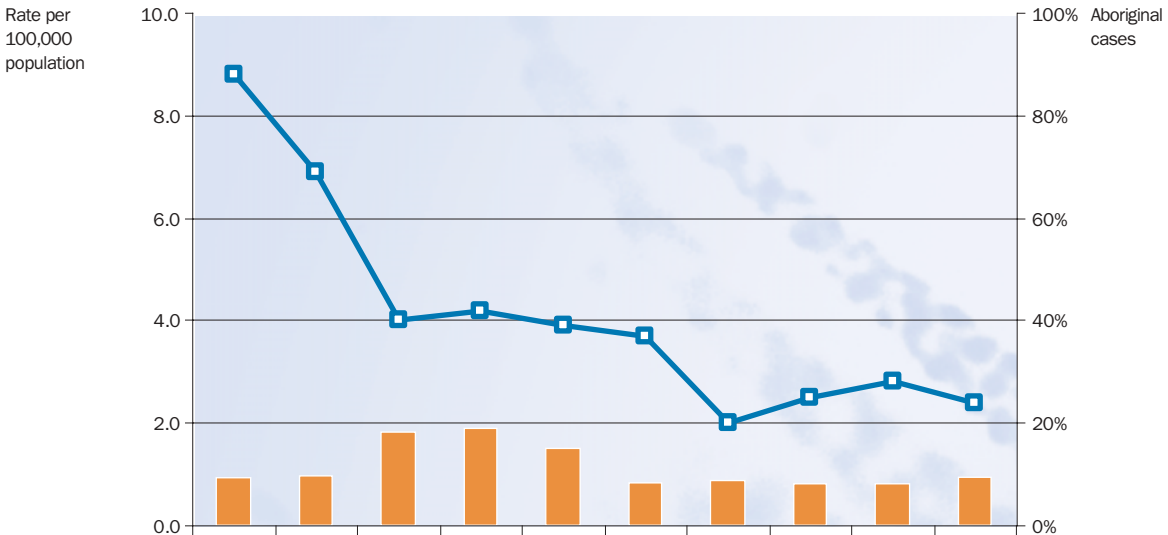
2.3 Aboriginal persons testing newly positive for HIV in BC by RISK FACTOR • 2005



AIDS

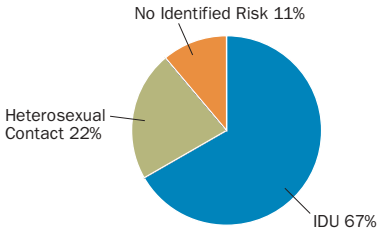
The highest risk factor for Aboriginal AIDS in 2004 was Injection Drug Use. Seventy-eight per cent of AIDS cases in Aboriginal people was among males.

3.1 AIDS rates in BC with proportion of Aboriginal cases • 1995 to 2004

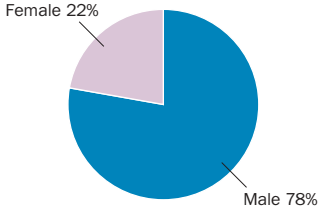


	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
% Aboriginal	9.0%	9.3%	17.6%	18.3%	14.6%	8.0%	8.4%	7.8%	7.8%	9.1%
Total BC Rate	8.8	6.9	4.0	4.2	3.9	3.7	2.0	2.5	2.8	2.4

3.2 Aboriginal AIDS case reports in BC by RISK FACTOR • 2004



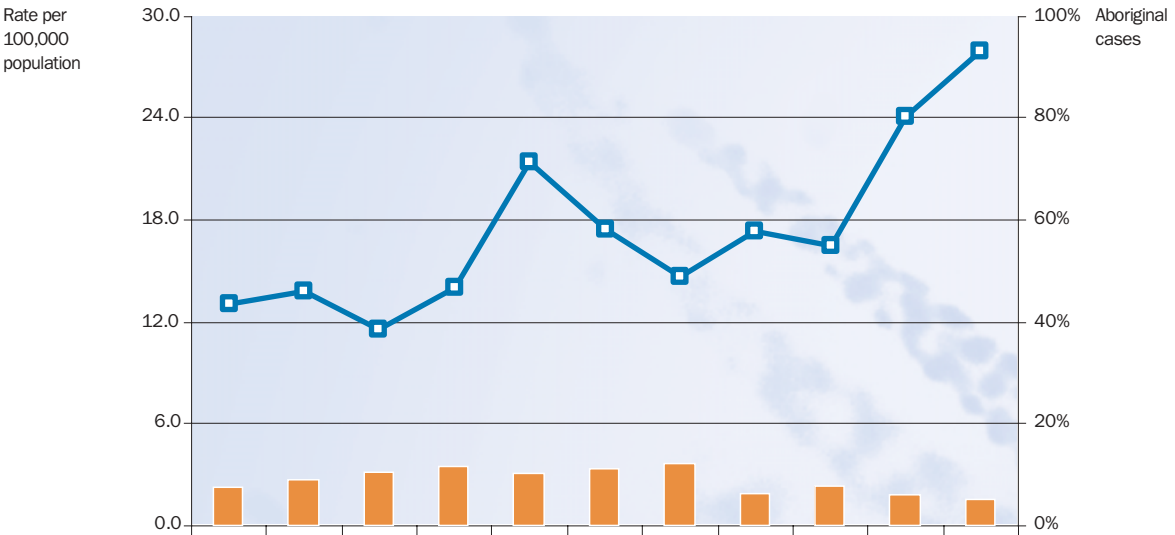
3.3 Aboriginal AIDS case reports in BC by GENDER • 2004



gonorrhea

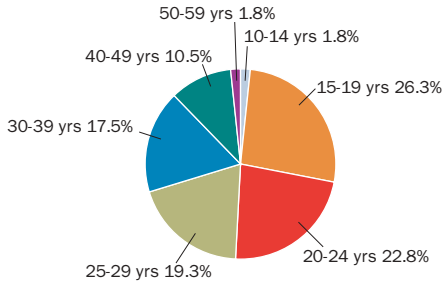
Among Aboriginal people with gonorrhea, 70 per cent were heterosexual, and 15 – 29 was the age group with the largest burden of disease.

4.1 Gonorrhea rates in BC with proportion of Aboriginal cases • 1995 to 2005

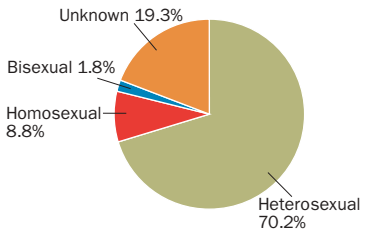


	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
%Aboriginal	7.1%	8.4%	9.9%	10.9%	9.7%	10.5%	11.5%	5.9%	7.3%	5.6%	4.8%
Total BC Rate	13.0	13.8	11.5	14.0	21.4	17.5	14.7	17.3	16.5	24.1	28.0

4.2 Aboriginal Gonorrhea case reports in BC by AGE • 2005



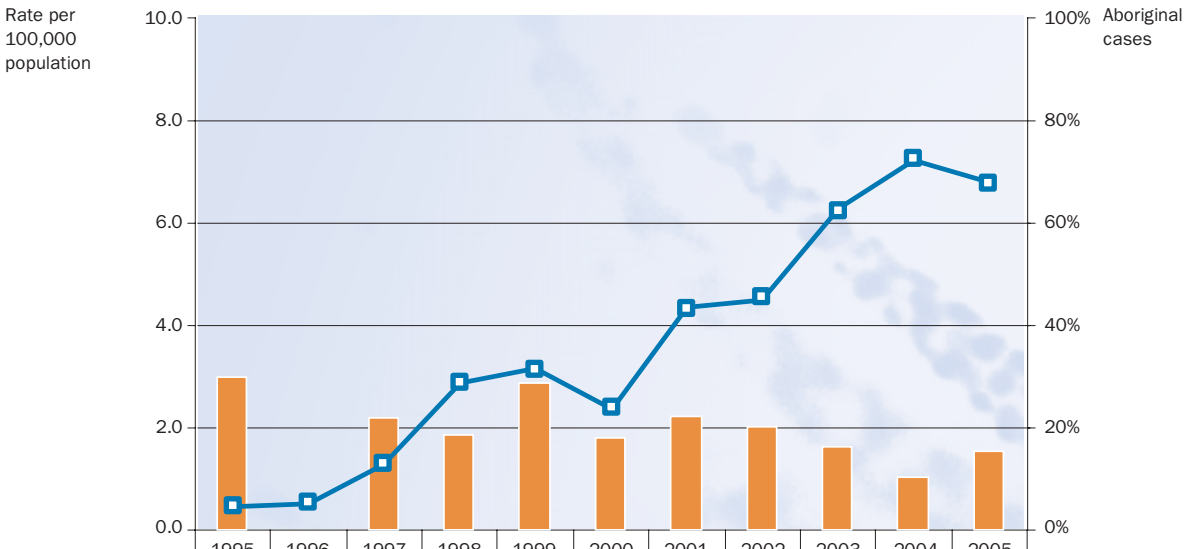
4.3 Aboriginal Gonorrhea case reports in BC by SEXUAL PREFERENCE • 2005



infectious syphilis

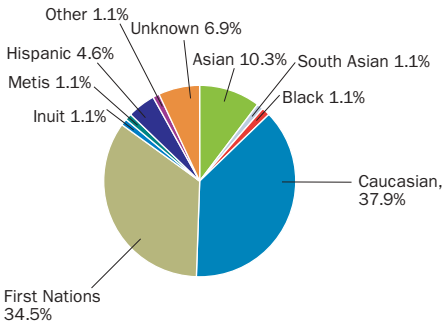
Aboriginal people accounted for 15.2 per cent of infectious syphilis cases in BC in 2005. Aboriginal females accounted for 36.7 per cent of all females with syphilis. Almost three-quarters of syphilis cases among Aboriginal people affected are women, and 88.6 were heterosexual.

5.1 Infectious syphilis rates in BC with proportion of Aboriginal cases • 1995 to 2005

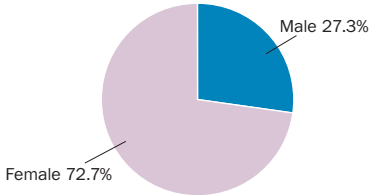


	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
%Aboriginal	29.4%	0.0%	21.6%	18.3%	28.3%	17.7%	21.9%	19.9%	16.0%	10.2%	15.2%
Total BC Rate	0.5	0.5	1.3	2.9	3.2	2.4	4.4	4.5	6.3	7.3	6.8

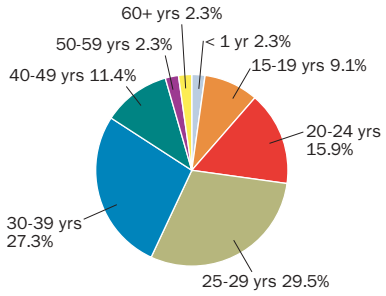
5.2 Female Infectious syphilis case reports in BC by ETHNICITY • 2005



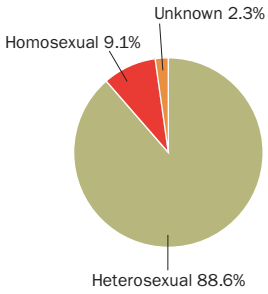
5.3 Aboriginal infectious syphilis case reports in BC by GENDER • 2005



5.4 Aboriginal infectious syphilis case reports in BC by AGE • 2005



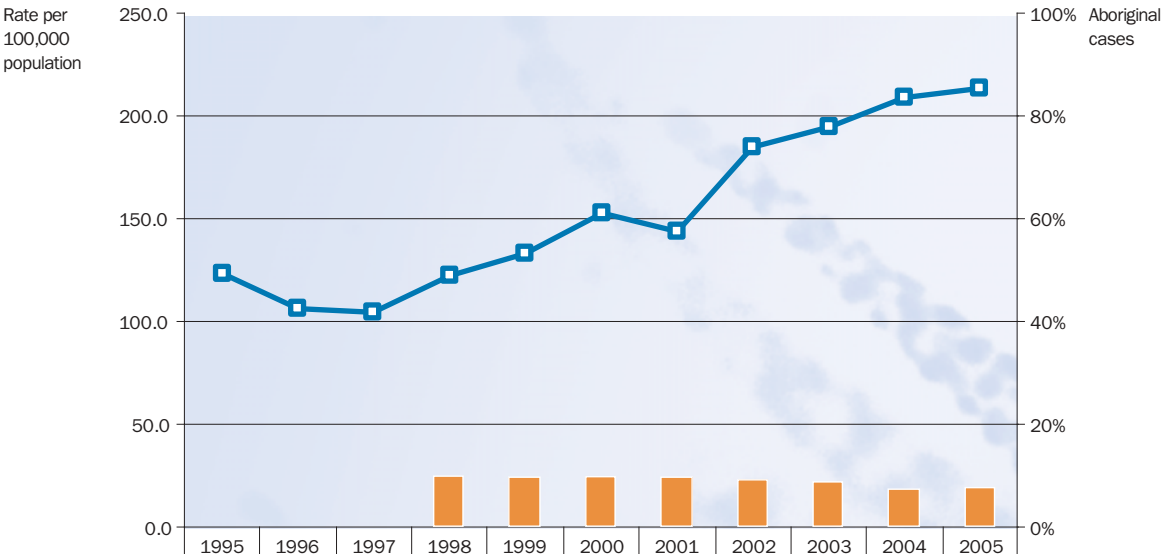
5.5 Aboriginal infectious syphilis case reports in BC by SEXUAL PREFERENCE • 2005



chlamydia

Of 2005 chlamydia cases, 6.6 per cent were reported from Aboriginals, with 81 per cent of these occurring in Aboriginal females. Again, 15 – 29 year olds had the largest burden of disease. Three- quarters of chlamydia infections in Aboriginal people occurred in heterosexuals.

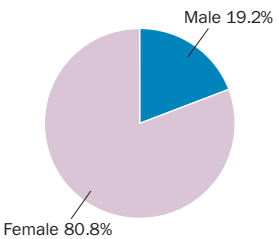
6.1 Chlamydia rates in BC with proportion of Aboriginal cases • 1995 to 2005



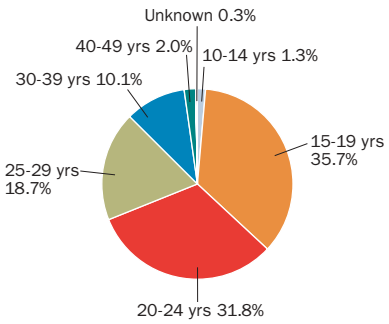
	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
% Aboriginal*	-	-	-	8.5%	8.4%	8.5%	8.4%	8.0%	7.6%	6.3%	6.6%
Total BC Rate	123.4	106.2	104.2	122.5	133.4	152.5	143.8	185.1	194.6	208.6	213.3

*Pre-1998 numbers are not available.

6.2 Aboriginal Chlamydia case reports in BC by GENDER • 2005



6.3 Aboriginal Chlamydia case reports in BC by AGE • 2005



The following table outlines some of the trends in STIs comparing Aboriginal and non-Aboriginal British Columbians for 2005.

TREND	Aboriginal	All British Columbia
HIV trend	↓	↓
AIDS trend	↑	↓
Gonorrhea trend	↓	↑
Syphilis	↑	↓
Chlamydia	↑	↑
Major HIV risk factor	IDU	MSM
Age group most affected by STIs	15-29	15-29

The burden of disease in recent years for HIV/AIDS and most reportable STIs was greater for Aboriginal than non-Aboriginal people in the province. Although they comprise just 5 per cent of the British Columbia population, in 2005 Aboriginals accounted for 12 per cent of new HIV infections, 9 per cent of new AIDS cases, 15 per cent of incident infectious syphilis and 6.6 per cent of chlamydia reports. This over-presentation was more pronounced for Aboriginal women who accounted for 31 per cent and 37 per cent of new HIV and syphilis cases, respectively.

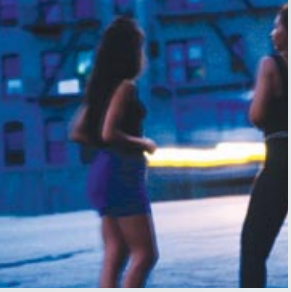
These numbers are based on an assumption of equal access to HIV, AIDS and STI screening and care. In fact, equal access to testing for Aboriginal people is unlikely, and therefore the real picture may actually be worse. There could be many additional Aboriginal people living with HIV or other STIs who have not been tested and are not aware of their status. This situation offers an important reminder, and guides the work of programs such as Chee Mamuk, that knowledge is key in prevention, support and treatment.

highlights of 2005

Sex Work Harm Reduction

Book Launch of The Gathering Tree*,*
a children's HIV/AIDS educational book

05



Sex Work Harm Reduction

Dr. Michael Rekart, Director of the STD/AIDS Control Division, published a landmark article in the Lancet in December of 2005 proposing a new paradigm for prevention, care and support: sex work harm reduction.

This hypothesis is based on the reality that sex work is an extremely dangerous profession that can be made safer by applying the same harm reduction principles that have successfully reduced HIV spread and improved lives among drug users.

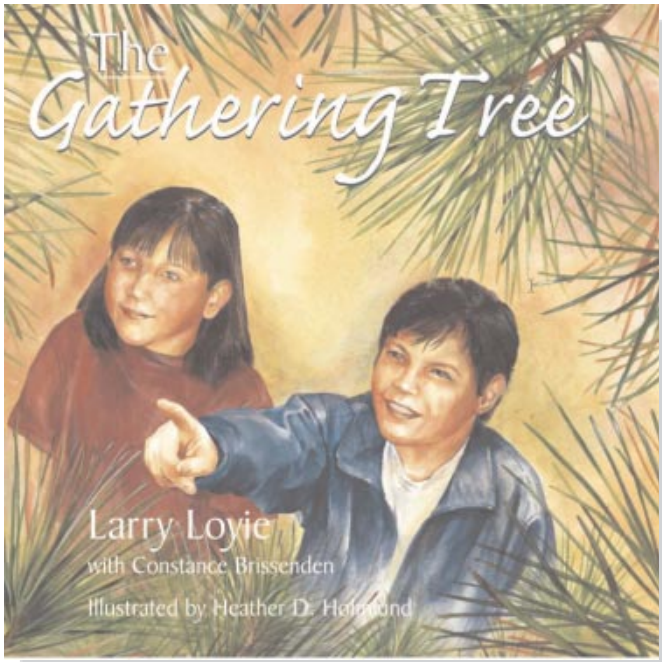
Sex workers around the world are exposed to serious harm that can be summarized in seven overarching themes: drug use, disease, violence, discrimination, debt, criminalization and exploitation (including child prostitution, trafficking and exploiting migrants).

Likewise, successful and promising harm reduction strategies are categorized under seven general headings: education, empowerment, prevention, care, occupational health and safety (OHS), decriminalizing sex workers and a human rights-based approach.

Successful interventions include peer education, condom negotiating skills training, safety tips for street-based sex workers, male and female condoms, the prevention-care synergy, OHS guidelines for Australian brothels, self-help organizations and community-based child protection networks.

Initiatives are already available in many places, including Vancouver, to improve the day-to-day lives of sex workers while they continue to work. Considering sex work harm reduction as a new and central paradigm can hasten benefits to these workers.

Book Launch of *The Gathering Tree*, a children's HIV/AIDS educational book



As more families and children were affected by HIV/AIDS, a gap in culturally appropriate resources for Aboriginal children became apparent. This year, Chee Mamuk developed a children's book, *The Gathering Tree*, to teach young people about HIV from a First Nations' perspective. Chee Mamuk contracted Larry Loyie, an award-winning Cree author, and co-author Constance Brissenden, to write a story to introduce the topic to children.

The Gathering Tree is a unique educational resource for parents, teachers, health educators, students and the community. Chee Mamuk believes that it is important to start educating children at a young age and develop ways to use this resource to raise awareness of HIV/AIDS.

The Gathering Tree is a gentle, positive story of a rural First Nations family facing the illness of their favorite cousin, Robert. As the children, 11-year-old Tyler and younger sister Shay-Lyn, learn more about HIV, they discover that illness brings understanding and self-awareness. Supported by the elders, Robert speaks to the community at the annual traditional gathering, encouraging them to learn more about HIV. The sensitive story brings the characters to life and includes aspects of traditional life and ways of learning.

Chee Mamuk focus tested with children, conducted a scientific review and worked with an advisory committee comprising an Aboriginal educator, an HIV-positive individual, a sexual health author/educator, a teacher, a nurse and a worker from an Ontario-based children's HIV organization.

Books were disseminated free to the First Nations and Inuit Health Branch nurses at their annual conference in February to use in their 194 communities. Up to 1300 copies were mailed out to schools, AIDS Service Organizations, Aboriginal health organizations, day care centres, friendship centres and libraries. They were given to those who have family members with HIV/AIDs.

The package included a lesson plan for teaching, discussion questions, bookmarks, and brochures with ideas for how to use the book in communities.

2005

Left to Right: Dr. Gina Ogilvie, Associate Director, STD/AIDS Control, BCCDC; Denise Turner, PHSA Board Representative; Melanie Rivers, Educator; and Lucy Barney, Program Manager

Book Launch

A traditional West Coast Witness Ceremony took place on Squamish Nation territory on September 26, 2005 to launch the book. One hundred and twenty community members attended to celebrate this exciting new resource: three elementary schools, government agencies, community leaders and members. The authors were on hand to sign the book and the news media televised the event.

Comments from recipients of *The Gathering Tree:*

"First, many many thanks for the complimentary copies of the newly published book "The Gathering Tree." It was not only beautifully illustrated, but made the necessary connection to speaking openly within the family and then the essential elements associated with tradition."

"I wanted to take a moment to acknowledge receipt of the excellent resource book "The Gathering Tree". Thank-you so much for the two complimentary copies. They are excellent and will be an asset in our work with children within our transition house and second-stage housing facilities where we work with victims of family violence. We feel honored to be the recipients of such excellent work."

How to order: *The Gathering Tree* features more than 20 dynamic full-colour illustrations by award-winning artist Heather D. Holmlund, ensuring the book is enjoyed by all ages. The book is designed for 9-year-olds and up. It is a 48-page hardcover book (ISBN 1-894778-28-6. Price: CDN $19.95; US $18.95) and is published by Theytus Books of British Columbia, an Aboriginal publisher for more than 25 years.

The Gathering Tree can be ordered from Theytus Books at 1•877•493•0188 or **www.theytusbooks.ca** (ISBN 1-894778-28-6, HC 10X 10, 48pp, $19.95 CDN)

incidence trends

New reports of gonorrhea increased in 2005 to 1187 from 1013 in 2004. This meant a rate increase to 28.0/100,000 from 24.1 (normal value test, p< 0.01). Cases and rates increased significantly for both genders, however males continued to be more affected than females (42.6/100,000 versus 13.6/100,000). Gonorrhea rates in most Health Service Delivery Areas (HSDAs) increased with Vancouver experiencing by far the highest gonorrhea rate at 87.3/100,000. Nearly all age groups in both genders recorded increases, with the 20-24-year-old age group showing the highest rates. A BC laboratory survey completed in 2005 confirmed that the gonorrhea increase between 2003 and 2004 represented a 'true' increase in incidence, combined with an increase in male screening volumes subsequent to the introduction of nucleic acid amplification testing (NAAT) for male urines. Gonorrhea is increasing in many western jurisdictions, but no specific cause has been identified other than more risky sexual behavior.

Chlamydia continued to climb in 2005 recording a rate increase from 208.6/100,000 in 2004 to 213.3/100,000 in 2005 (normal value test, p=0.07). Females had twice the chlamydia rate of males, possibly reflecting higher rates of screening and testing among women. HSDA rates were stable in 2005 compared to 2004, with the exception of areas in the Vancouver Island and Northern Heath Authorities. Females 15-19 and 20-24 years-old and males 20-24 years-old showed the highest age group rates once again.

This year, BCCDC proposed a new hypothesis to explain increasing chlamydia rates throughout the developed world: Early treatment may suppress the natural immune response and place patients at increased risk of re-infection. Annual increases in re-infection rates in BC support this theory.

The long-standing epidemic of infectious syphilis in BC showed signs of improvement with the year-over-year case rate decreasing for the first time since 2000. The 2005 rate was 6.8/100,000, compared to the 2004 rate of 7.3/100,000 (normal value test, p=0.221). Both the sex work and the gay male-related outbreaks seem to have stabilized. Resource intensive prevention and control efforts by the BC public health community may at last be paying dividends.

Males continue to be much more affected by syphilis than females. There were no significant 2005 trends by age or geography; however, Aboriginal females accounted for over one-third of new infectious syphilis cases, whereas they make up only 5 per cent of the total female population in BC.

New HIV cases decreased slightly from 2004 (444 reports) to 2005 (420 reports). This corresponds to a rate decrease from 10.6/100,000 to 9.9/100,000 (normal value test, P=0.161). There were small decreases for both genders, but the male rate continued to be several times higher than the female rate (16.0 versus 3.8, respectively). The HIV rate nearly doubled for the Northern Interior HSDA (7.8 compared to 14.2 a year ago) and there were 5 new cases in the Kootenay-Boundary HSDA in 2005 compared to none in 2004. The number of new HIV diagnoses in men who have sex with men (MSM) dropped from 186 in 2004 to 160 in 2005. Otherwise, there were no significant trends by risk category but, as further information is received on 2005 cases currently classified as 'unknown risk', that picture may change. There were no notable age group trends and Aboriginals continued to be over-represented, especially females who accounted for 28.4 per cent of new diagnoses.

The AIDS rate and new case reports declined slightly from 115 in 2003 to 99 cases in 2004 and from 2.8/100,000 to 2.4/ 200,000 (normal value test, p=0.109). Due to delays associated with AIDS case reports, this 2005 report includes cases through 2004 only. The male AIDS rate (4.0/100,000) was several times higher than the female AIDS rate (0.7/100,000).

Pelvic inflammatory disease (PID) cases reported from hospitals and day surgeries decreased from 705 in 2003 to 626 in 2004, corresponding to a rate decrease from 78.4/100,000 to 69.5 (normal value test, $p<0.05$). Ectopic pregnancy reports increased from 523 to 562 over the same period, a rate increase from 58.2/100,000 to 62.4 (normal value test, p=0.16). Hospital and day surgery diagnoses of tubal infertility declined from 264 cases (rate 29.4) to 251 cases (rate 27.9). The correlation between these data sets and the Medical Services Plan (MSP) database will be explored in future years. The data received by STD Control on PID, ectopic pregnancy and tubal infertility is one year behind due to delays in reporting, collation and data transfer.

epidemiology

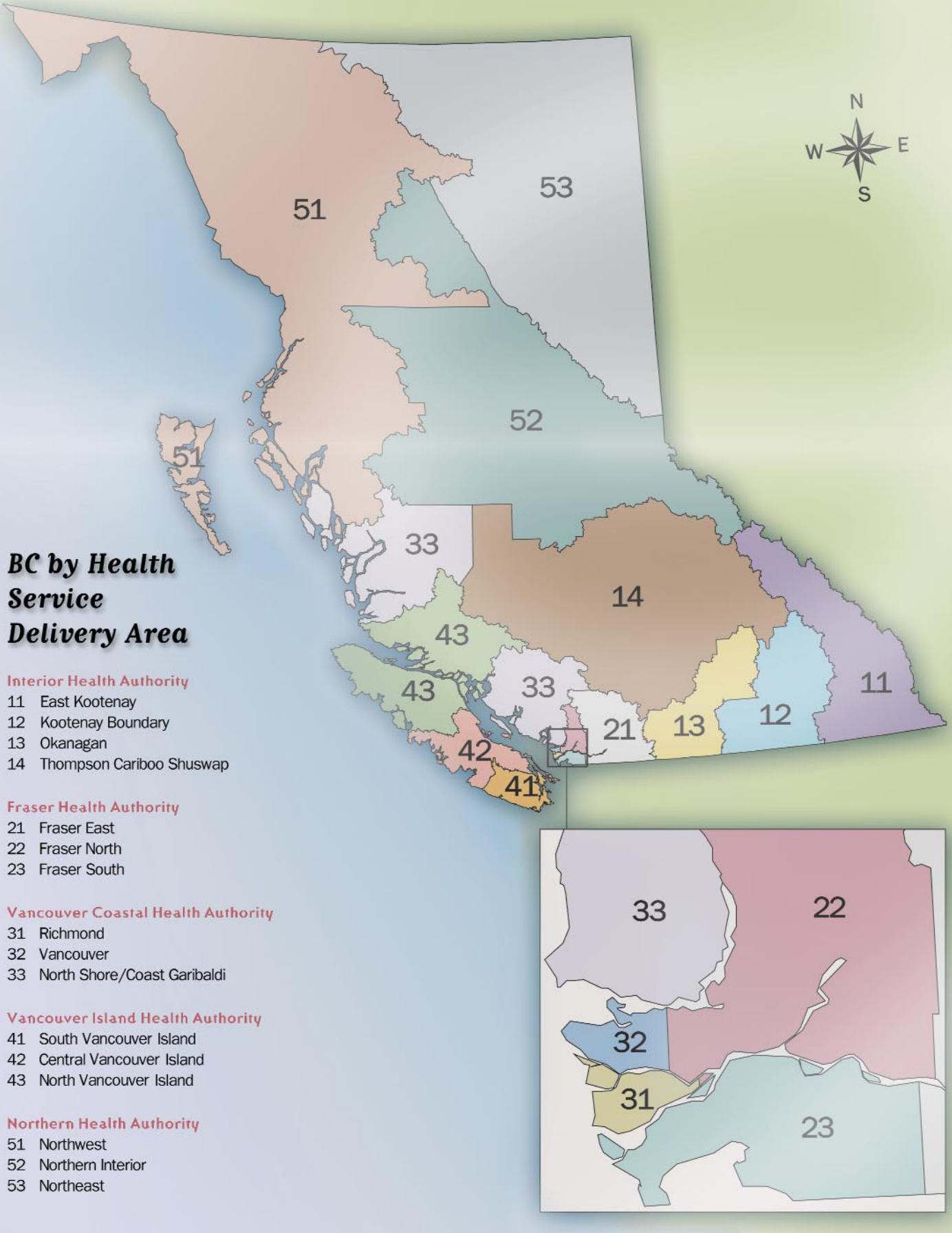
In British Columbia, provincial law requires that certain communicable infections be reported to the Medical Health Officer of the region by health care providers and laboratories. The reportable STIs are gonorrhea, chlamydia, syphilis, HIV and AIDS. HIV infection became reportable on May 1, 2003.

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 56.



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

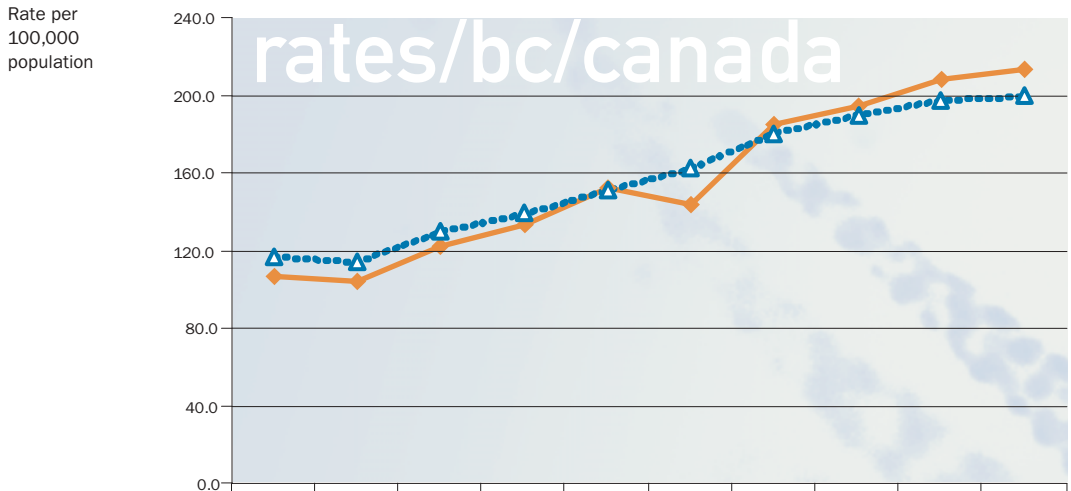
Vancouver Island Health Authority
41 South Vancouver Island
42 Central Vancouver Island
43 North Vancouver Island

Northern Health Authority
51 Northwest
52 Northern Interior
53 Northeast

chlamydia

The chlamydia rate in BC was 213.3 in 2005, up from 208.6 in 2004. This reflects an increase in case reports from 8752 to 9043. Several HSDAs saw increases in the chlamydia rate. By age, women aged 15-19 and 20-24 continue to have the highest chlamydia rates at 1430.1 and 1517.0, respectively. Chlamydia cases and rates have been climbing since 1997.

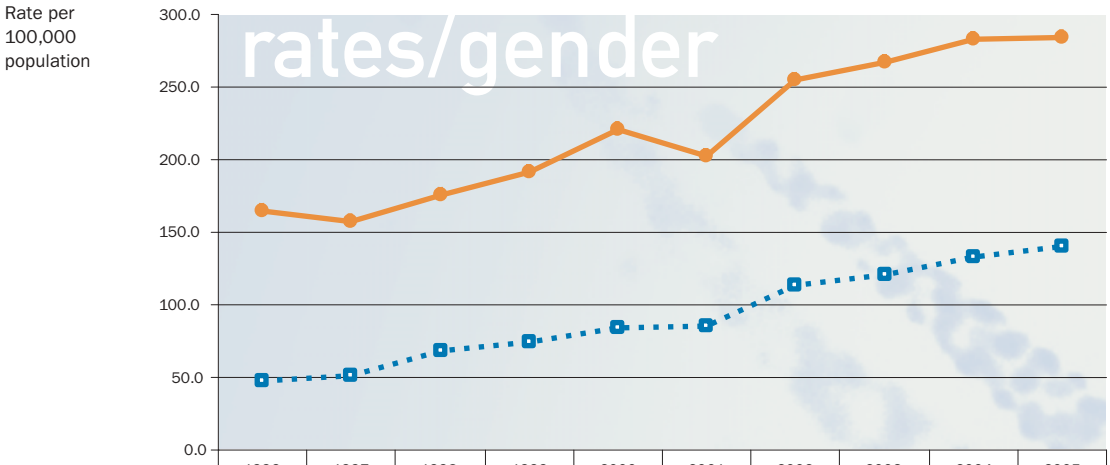
7.1 Chlamydia case reports and rates in BC • 1996 to 2005



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005*
BC Reports	4,116	4,116	4,880	5,353	6,160	5,863	7,616	8,080	8,752	9,043
BC Rate	106.2	104.2	122.5	133.4	152.5	143.8	185.1	194.6	208.6	213.3
Canadian Rate	115.9	113.9	129.0	138.2	150.9	161.4	179.4	189.4	197.1	198.5

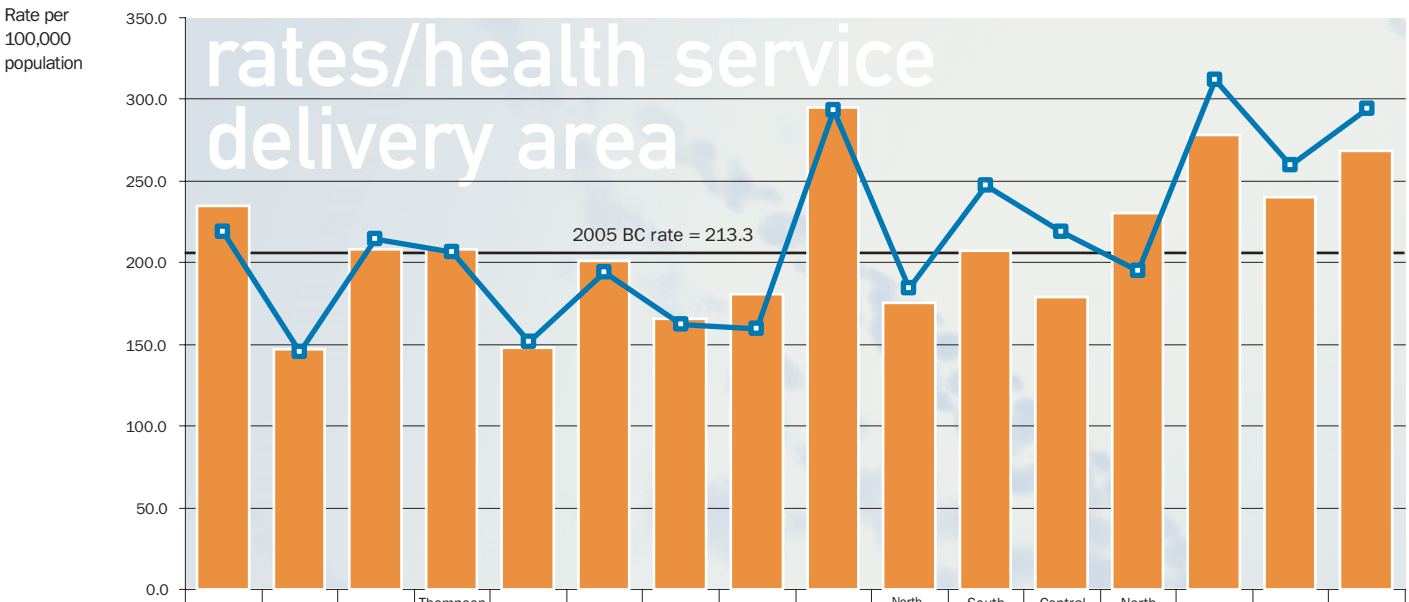
*2005 Canadian Rate is projected (Public Health Agency of Canada, April 2006)

7.2 Chlamydia case reports and rates in BC by gender • 1996 to 2005



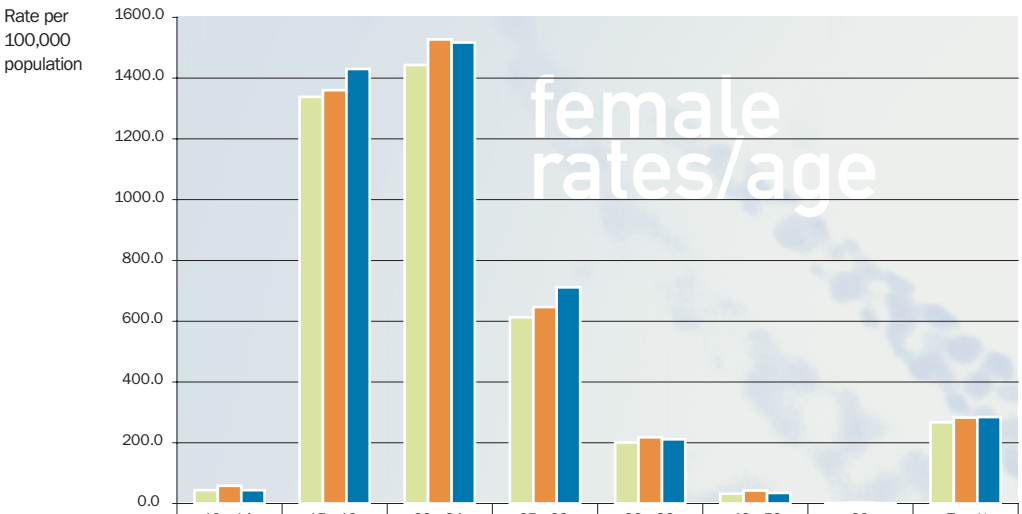
	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Reports - Female	3,191	3,110	3,518	3,868	4,476	4,147	5,293	5,590	5,986	6,090
Reports - Male	917	1,002	1,361	1,484	1,681	1,716	2,322	2,489	2,764	2,952
Rate - Female	164.1	156.8	175.7	191.7	220.1	201.9	255.1	267.0	282.8	284.7
Rate - Male	47.5	51.0	68.7	74.4	83.8	84.8	113.8	120.9	132.9	140.6

7.3 Chlamydia 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	180	116	701	457	401	1087	1031	277	1755	504	860	546	229	264	403	198
Rate 2004	234.7	146.8	208.1	208.2	148.0	200.9	165.3	180.6	295.0	175.6	207.8	179.4	230.7	278.5	240.0	268.8
Rate 2005	219.3	145.4	214.2	206.2	151.3	193.7	162.6	159.2	293.6	184.5	246.9	218.5	194.7	311.5	259.3	294.6

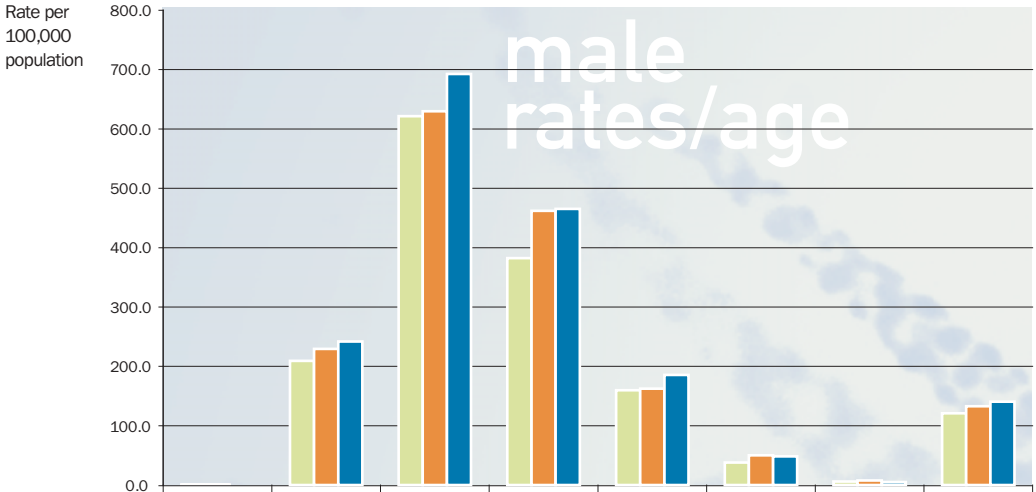
7.4 Female chlamydia rates in BC by age • 2003 / 2004 / 2005



	10 - 14	15 - 19	20 - 24	25 - 29	30 - 39	40 - 59	60+	Total*
2003 Rate - Female	44.0	1,338.1	1,443.4	612.9	200.5	32.5	1.5	267.0
2004 Rate - Female	58.4	1,360.2	1,527.6	646.8	217.7	42.7	2.9	282.8
2005 Rate - Female	43.9	1,430.1	1,517.0	711.4	211.2	34.9	1.2	284.7

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

7.5 Male chlamydia rates in BC by age • 2003 / 2004 / 2005



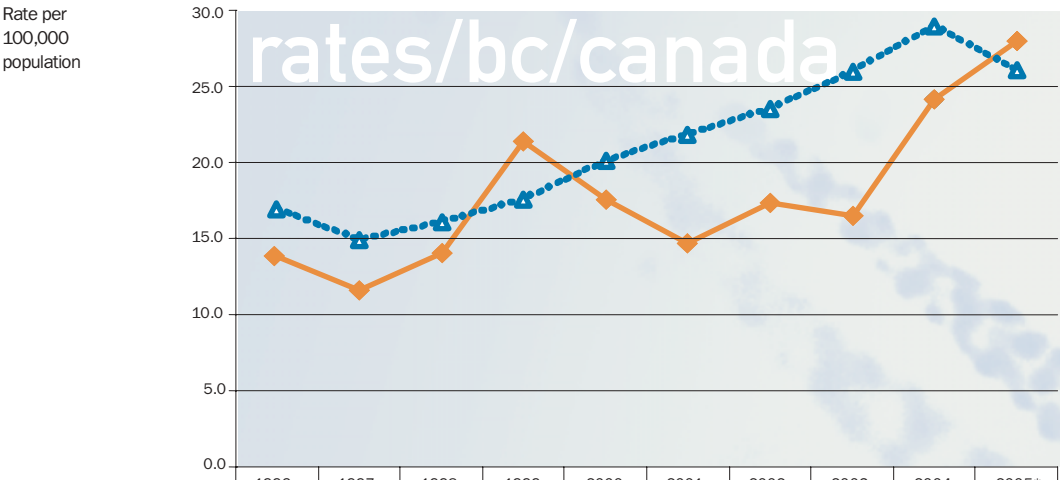
	10 - 14	15 - 19	20 - 24	25 - 29	30 - 39	40 - 59	60+	Total*
2003 Rate - Male	0.7	209.1	621.6	382.3	159.6	38.1	6.1	120.9
2004 Rate - Male	0.7	229.5	629.8	462.2	162.3	50.0	7.8	132.9
2005 Rate - Male	-	241.9	692.7	465.4	185.5	48.5	4.9	140.6

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

gonorrhea

The 2005 gonorrhea rate for BC (28.0) was significantly higher than 2004 (24.1), reflecting an increase in case reports from 1013 to 1187. The major increases involved males across all age groups and Health Authorities. Gonorrhea was concentrated in 20-39 year-old males and 15-24 year-old females. This continuing rise in gonorrhea over the last 2 years reflects a 'true' increase in incidence as well as increased testing in males following the introduction of nucleic acid amplification testing (NAAT) of urine in men.

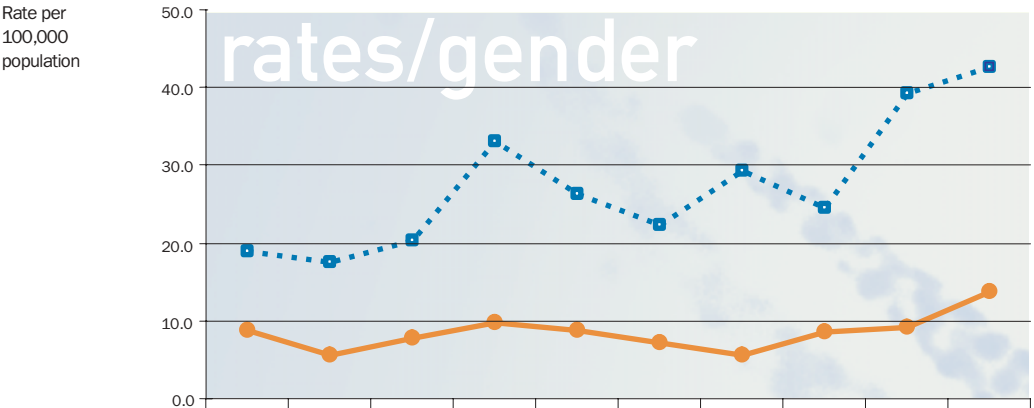
8.1 Gonorrhea case reports and rates in BC • 1996 to 2005



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005*
BC Reports	534	456	558	859	707	600	714	684	1013	1187
BC Rate	13.8	11.5	14.0	21.4	17.5	14.7	17.3	16.5	24.1	28.0
Canadian Rate	16.9	14.9	16.1	17.6	20.1	21.8	23.5	26.0	28.9	26.1

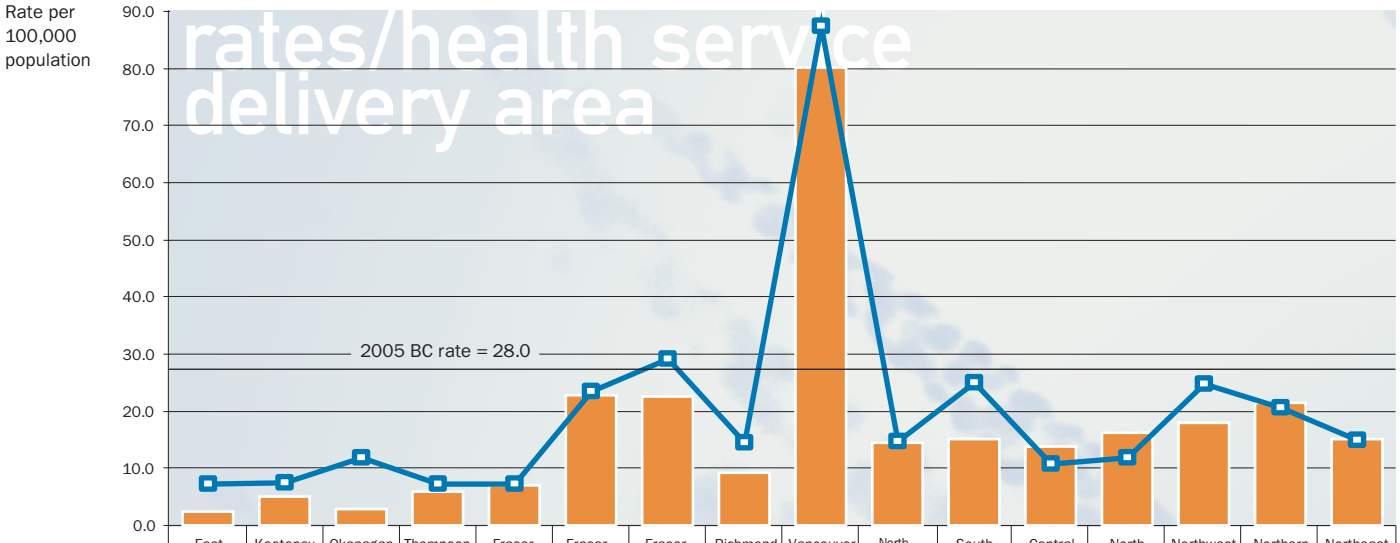
*2005 Canadian Rate is projected (Public Health Agency of Canada, April 2006)

8.2 Gonorrhea case reports and rates in BC by gender • 1996 to 2005



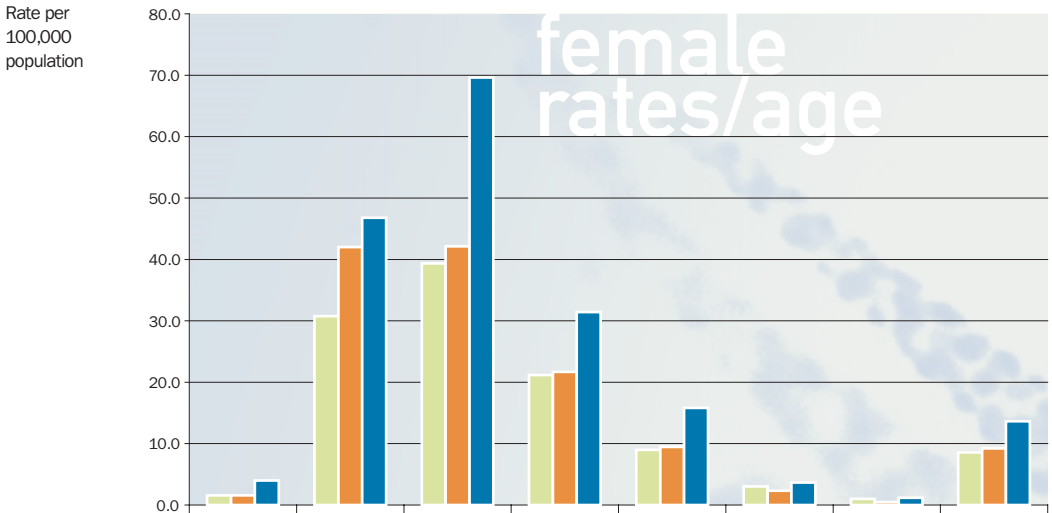
	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Reports - Male	364	343	402	661	529	451	599	504	818	895
Reports - Female	170	112	155	197	177	149	115	179	195	292
Rate - Male	18.9	17.5	20.3	33.2	26.4	22.3	29.3	24.5	39.3	42.6
Rate - Female	8.7	5.6	7.7	9.8	8.7	7.3	5.5	8.5	9.2	13.6

8.3 Gonorrhea 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	6	6	39	16	19	132	184	25	522	40	87	27	14	21	32	10
Rate 2004	2.5	5.0	2.8	5.9	6.9	22.7	22.5	9.3	80.2	14.4	15.0	13.7	16.3	17.9	21.5	15.1
Rate 2005	7.3	7.5	11.9	7.2	7.2	23.5	29.0	14.4	87.3	14.6	25.0	10.8	11.9	24.8	20.6	14.9

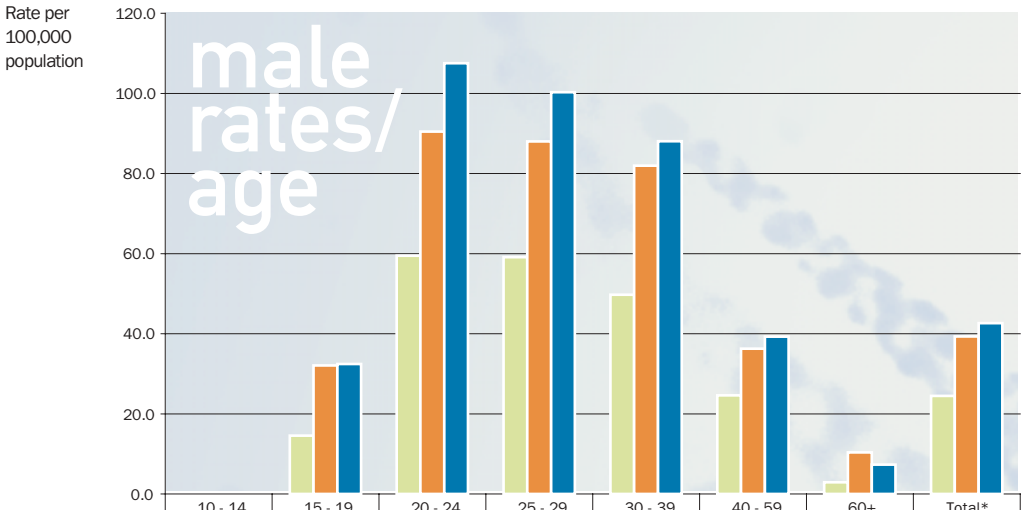
8.4 Female gonorrhea rates in BC by age • 2003 / 2004 / 2005



	10 - 14	15 - 19	20 - 24	25 - 29	30 - 39	40 - 59	60+	Total*
2003 Rate - Female	1.6	30.8	39.3	21.2	9.0	3.0	1.0	8.5
2004 Rate - Female	1.6	42.0	42.1	21.7	9.5	2.3	0.5	9.2
2005 Rate - Female	4.0	46.8	69.6	31.4	15.8	3.7	1.2	13.6

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

8.5 Male gonorrhea rates in BC by age • 2003 / 2004 / 2005



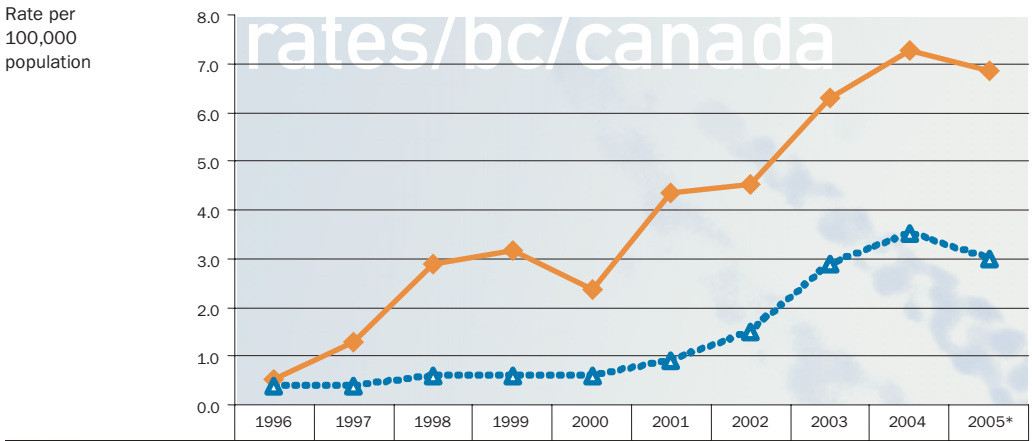
	10 - 14	15 - 19	20 - 24	25 - 29	30 - 39	40 - 59	60+	Total*
2003 Rate - Male	-	14.5	59.5	59.1	49.7	24.6	2.9	24.5
2004 Rate - Male	-	32.1	90.4	88.0	82.0	36.3	10.4	39.3
2005 Rate - Male	-	32.4	107.5	100.3	88.1	39.3	7.3	42.6

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

infectious syphilis

The rate per 100,000 population of infectious syphilis decreased from 7.3 in 2004 to 6.8 in 2005, reflecting a decrease in cases from 305 to 290. This is the first decrease in cases and rates since the current outbreak began in 1997. The majority of cases continue to be reported from the Lower Mainland. There were no significant trends across gender, age groups, sexual preference or geography. Aboriginal females continue to be over-represented in infectious syphilis, accounting for 34.5 per cent of new reports.

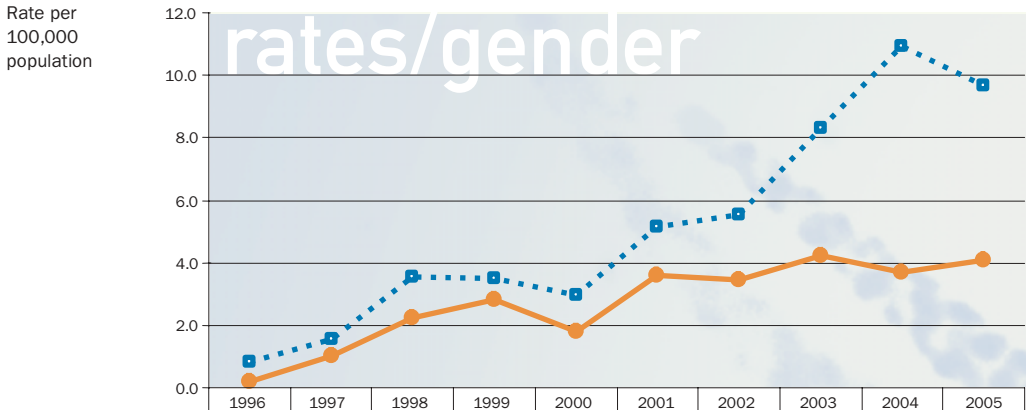
9.1 Infectious syphilis case reports and rates in BC • 1996 to 2005



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005*
BC Reports	20	51	115	127	96	178	186	262	305	290
BC Rate	0.5	1.3	2.9	3.2	2.4	4.4	4.5	6.3	7.3	6.8
Canadian Rate	0.4	0.4	0.6	0.6	0.6	0.9	1.5	2.9	3.5	3.0

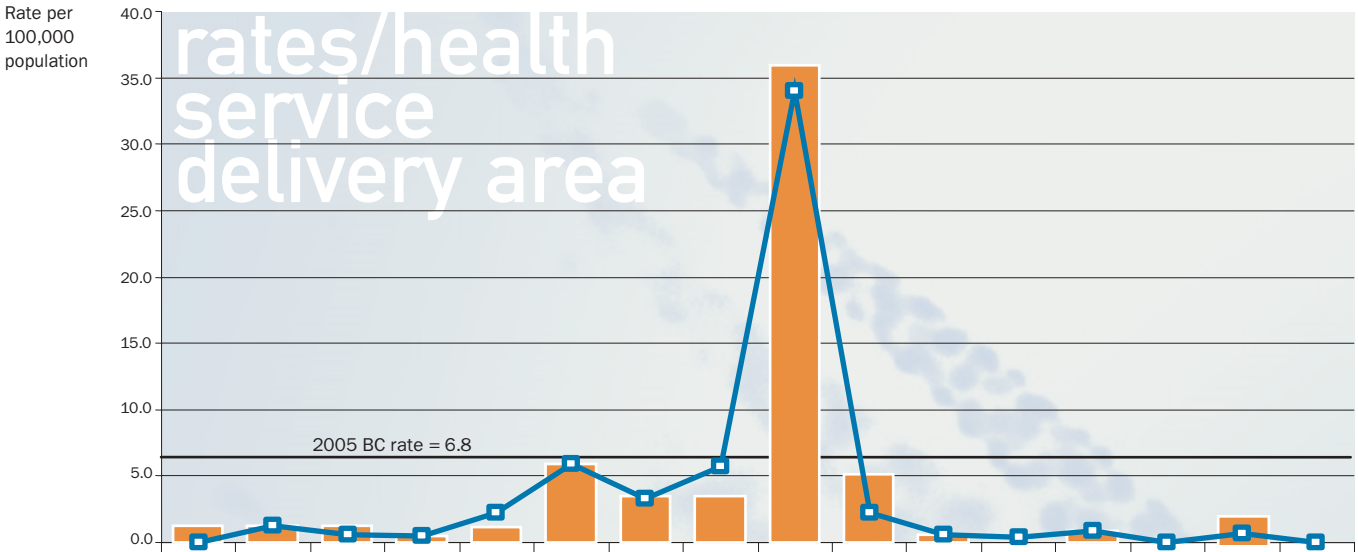
*2005 Canadian Rate is projected (Public Health Agency of Canada, April 2006)

9.2 Infectious syphilis case reports and rates in BC by gender • 1996 to 2005



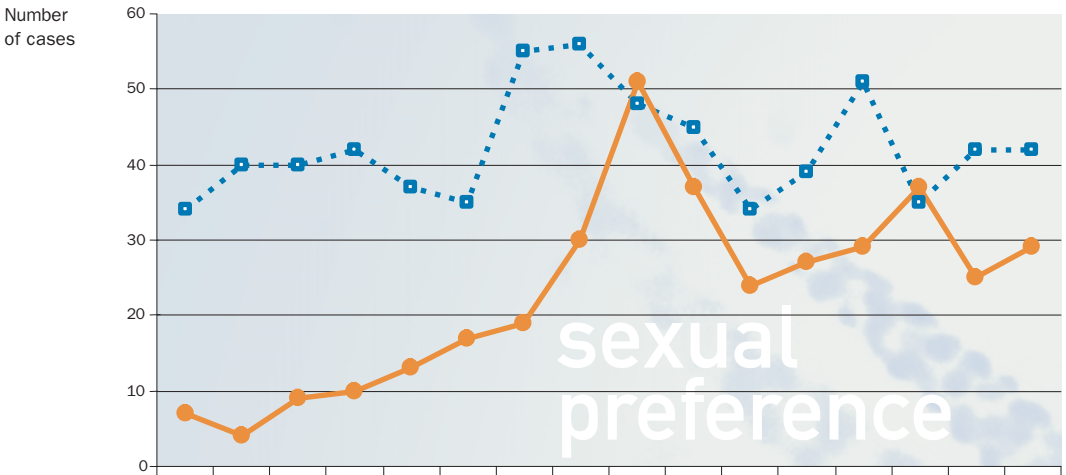
	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Reports - Male	16	31	70	70	59	104	113	171	227	203
Reports - Female	4	20	45	57	37	74	72	89	78	87
Rate - Male	0.8	1.6	3.5	3.5	2.9	5.1	5.5	8.3	10.9	9.7
Rate - Female	0.2	1.0	2.2	2.8	1.8	3.6	3.5	4.3	3.7	4.1

9.3 Infectious syphilis case reports and rates in BC by health service delivery area • 2004 and 2005



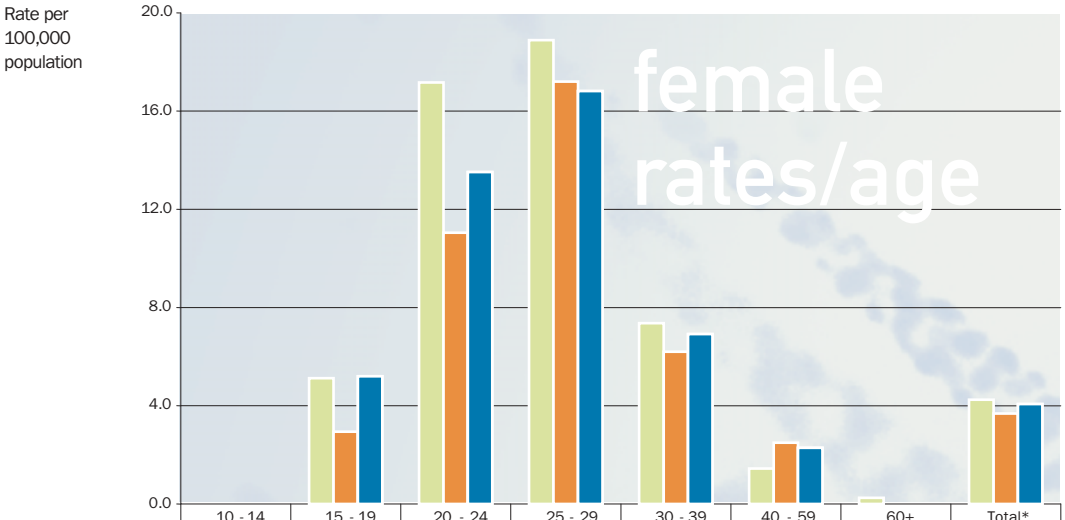
	East Kootenay	Kootenay Boundary	Okanagan	Thompson Cariboo Shuswap	Fraser East	Fraser North	Fraser South	Richmond	Vancouver	North Shore/Coast Garibaldi	South Vancouver Island	Central Vancouver Island	North Vancouver Island	Northwest	Northern Interior	Northeast
Reports 2005	0	1	2	1	6	33	21	10	203	6	2	1	1	0	1	0
Rate 2004	1.2	1.3	1.2	0.5	1.2	6.0	3.5	3.5	35.9	5.2	0.6	0.0	0.9	0.0	2.0	0.0
Rate 2005	0.0	1.3	0.6	0.5	2.3	5.9	3.3	5.7	34.0	2.2	0.6	0.4	0.9	0.0	0.6	0.0

9.4 Infectious syphilis case reports in BC by sexual preference • 2002 to 2005



	2002 Q 1	2002 Q 2	2002 Q 3	2002 Q 4	2003 Q 1	2003 Q 2	2003 Q 3	2003 Q 4	2004 Q 1	2004 Q 2	2004 Q 3	2004 Q 4	2005 Q 1	2005 Q 2	2005 Q 3	2005 Q 4
Non-MSM	34	40	40	42	37	35	55	56	48	45	34	39	51	35	42	42
MSM	7	4	9	10	13	17	19	30	51	37	24	27	29	37	25	29

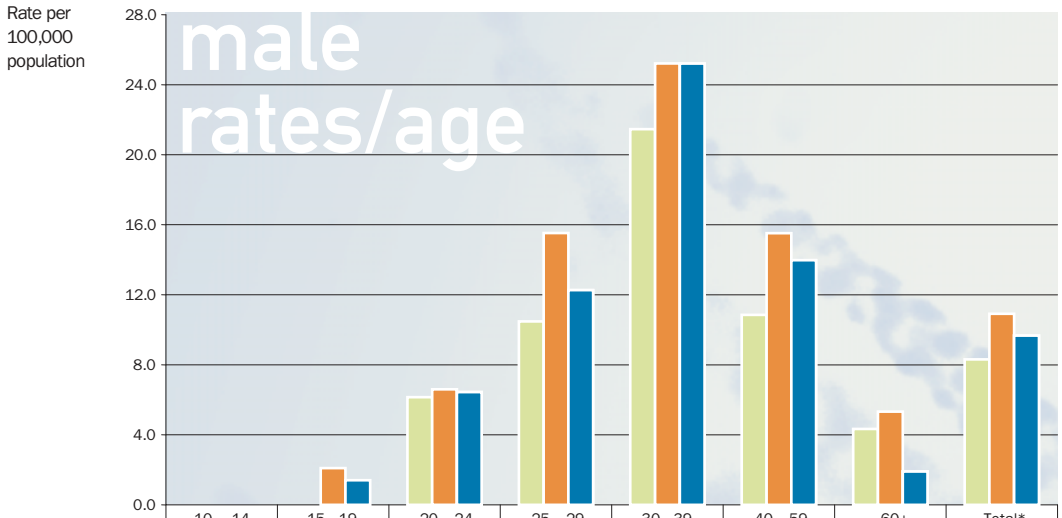
9.5 Female infectious syphilis rates in BC by age • 2003 / 2004 / 2005



	10 - 14	15 - 19	20 - 24	25 - 29	30 - 39	40 - 59	60+	Total*
2003 Rate Female	-	5.1	17.2	18.9	7.4	1.4	0.2	4.3
2004 Rate Female	-	2.9	11.0	17.2	6.2	2.5	-	3.7
2005 Rate Female	-	5.2	13.5	16.8	6.9	2.3	-	4.1

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

9.6 Male infectious syphilis rates in BC by age • 2003 / 2004 / 2005



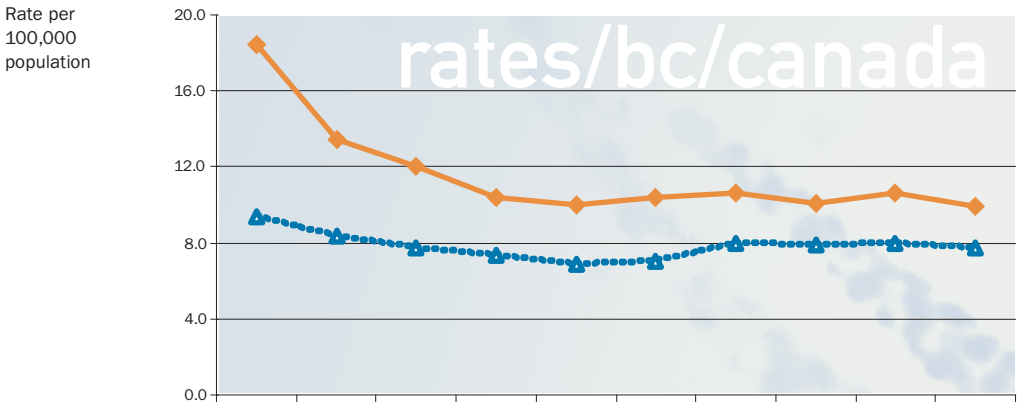
	10 - 14	15 - 19	20 - 24	25 - 29	30 - 39	40 - 59	60+	Total*
2003 Rate - Male	-	-	6.2	10.5	21.5	10.8	4.3	8.3
2004 Rate - Male	-	2.1	6.6	15.5	25.2	15.5	5.3	10.9
2005 Rate - Male	-	1.4	6.4	12.3	25.2	14.0	1.9	9.7

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

HIV

The HIV rate per 100,000 population decreased in 2005 to 9.9 from 10.6 in 2004. Cases continue to be distributed around the province, with the greatest concentration in the Lower Mainland. There were no significant trends for gender or age; however, the rate for the Northern Interior HSDA increased from 7.8 (12 cases) in 2004 to 14.2 (22 cases) in 2005. Aboriginals continue to be over-represented in new HIV reports, especially Aboriginal females who accounted for 28.4 per cent of new reports in 2005.

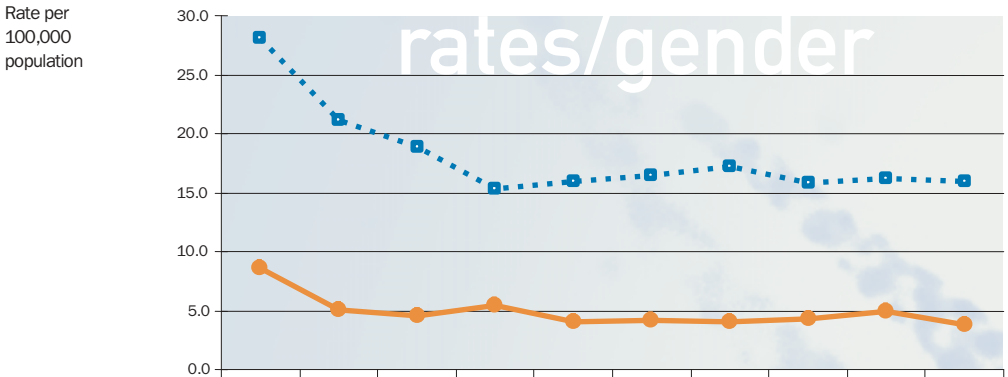
10.1 Persons testing newly positive for HIV in BC • 1996 to 2005



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005*
BC Reports	713	529	476	416	403	426	436	418	444	420
BC Rate	18.4	13.4	12.0	10.4	10.0	10.4	10.6	10.1	10.6	9.9
Canadian Rate	9.4	8.4	7.7	7.3	6.9	7.0	8.0	7.9	8.0	7.7

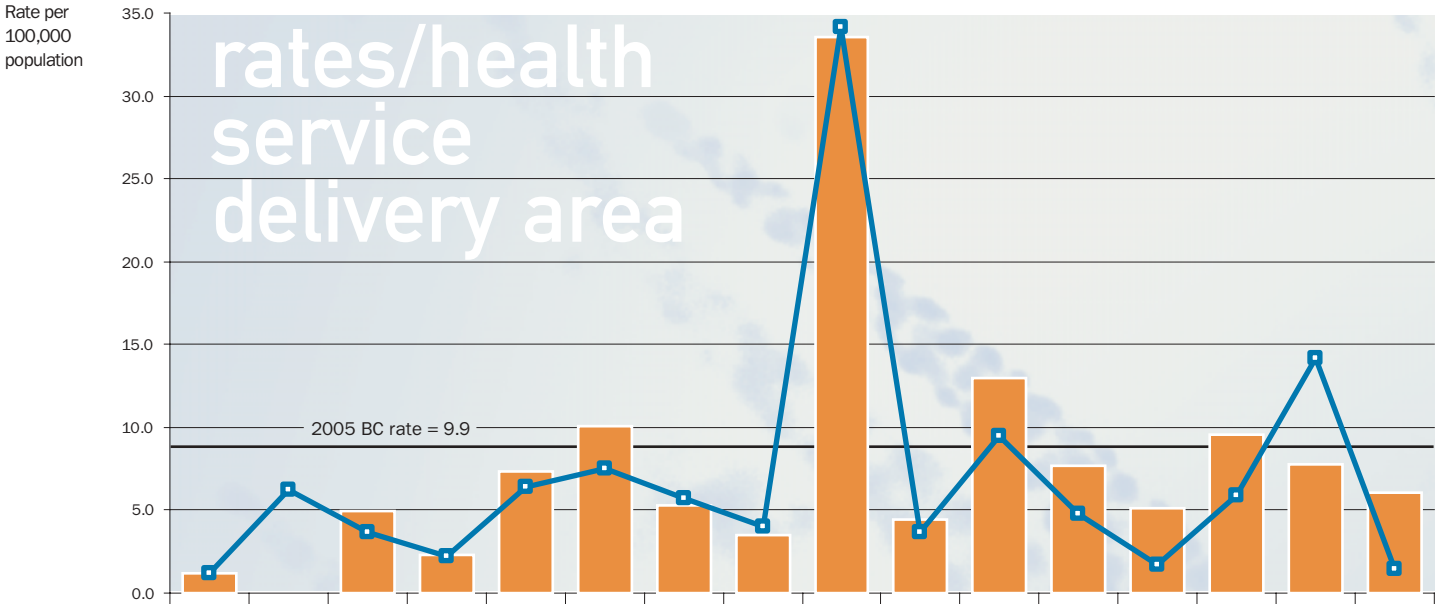
*2005 Canadian rate is preliminary (Public Health Agency of Canada, May 2006).

10.2 Persons testing newly positive for HIV in BC by gender • 1996 to 2005



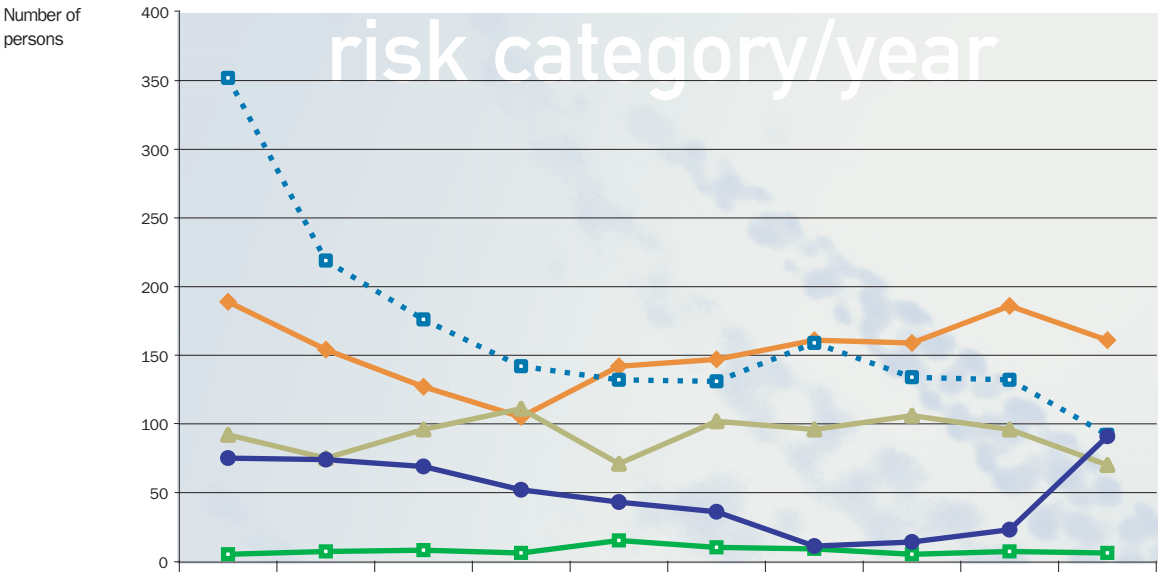
	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Reports - Female	167	102	92	110	83	87	85	91	106	81
Reports - Male	543	417	375	305	319	334	351	325	337	336
Rate - Female	8.6	5.1	4.6	5.5	4.1	4.2	4.1	4.3	5.0	3.8
Rate - Male	28.1	21.2	18.9	15.3	15.9	16.5	17.2	15.8	16.2	16.0

10.3 Persons testing newly positive for HIV 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	1	5	12	5	17	42	36	7	204	10	33	12	2	5	22	1
Rate 2004	1.2	0.0	4.9	2.3	7.3	10.1	5.3	3.5	33.5	4.4	13.0	7.7	5.1	9.5	7.8	6.0
Rate 2005	1.2	6.3	3.7	2.3	6.4	7.5	5.7	4.0	34.1	3.7	9.5	4.8	1.7	5.9	14.2	1.5

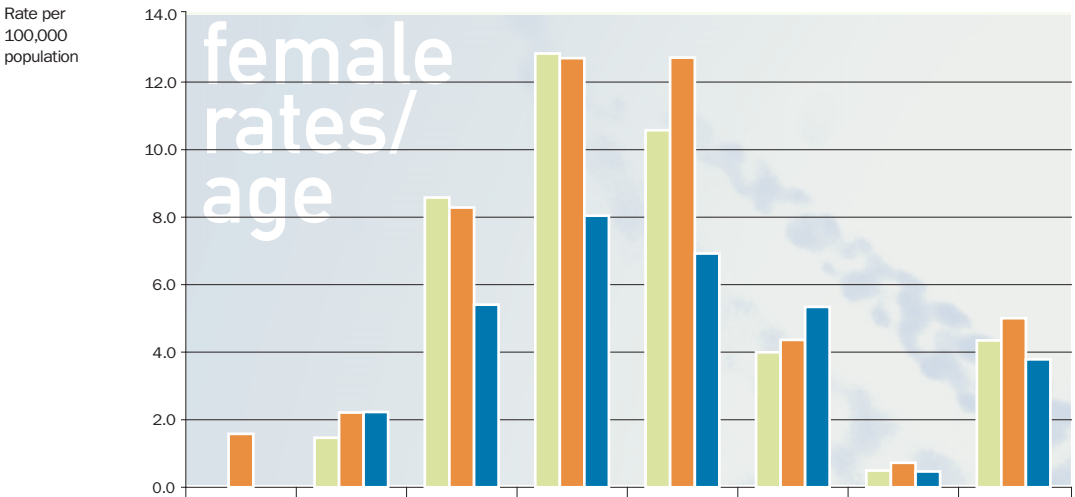
10.4 Persons testing newly positive for HIV in BC by risk category • 1996 to 2005



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005*
MSM	189	154	127	105	142	147	161	159	186	161
IDU	352	219	176	142	132	131	159	134	132	92
HET	92	75	96	111	71	102	96	106	96	70
Other	5	7	8	6	15	10	9	5	7	6
NIR/Unknown	75	74	69	52	43	36	11	14	23	91

MSM = Men having Sex with Men, IDU = Injection Drug Use, HET = HETerosexual contact, NIR = No Identified Risk
*The NIR/Unknown number for 2005 will decrease as more information is collected on the cases.

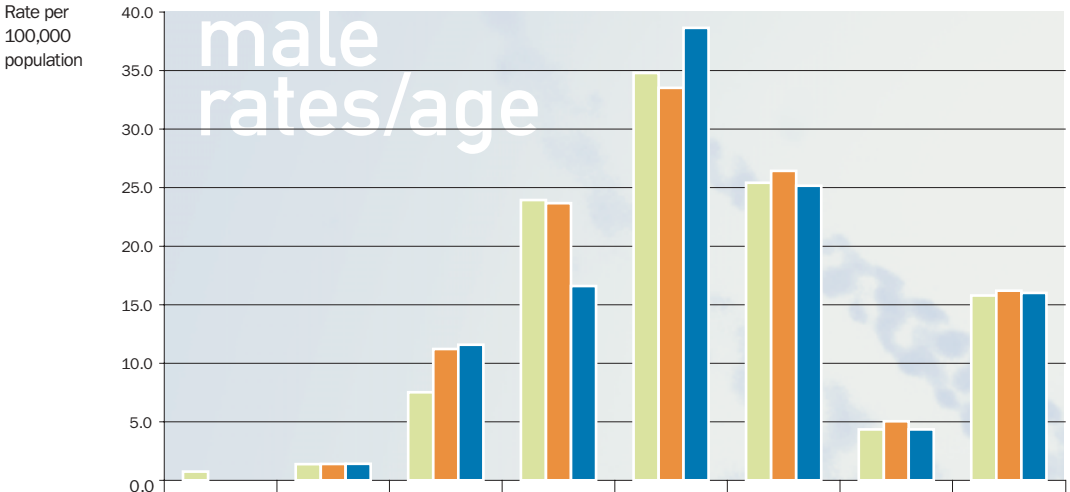
10.5 Females testing newly positive for HIV in BC by age • 2003 / 2004 / 2005



	10 - 14 yrs	15 - 19 yrs	20 - 24 yrs	25 - 29 yrs	30 - 39 yrs	40 - 59 yrs	60+ yrs	Total*
2003 Rate - Female	-	1.5	8.6	12.8	10.6	4.0	0.5	4.3
2004 Rate - Female	1.6	2.2	8.3	12.7	12.7	4.4	0.7	5.0
2005 Rate - Female	-	2.2	5.4	8.0	6.9	5.3	0.5	3.8

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

10.6 Males testing newly positive for HIV in BC by age • 2003 / 2004 / 2005



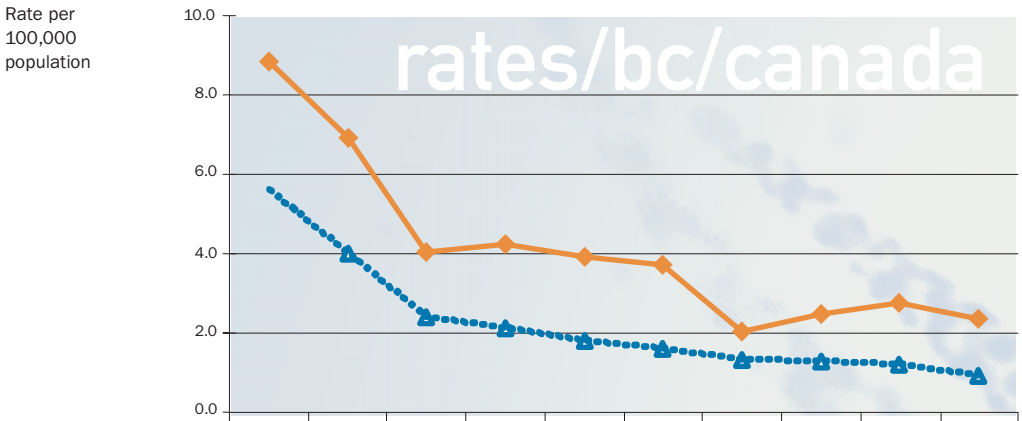
	10 - 14 yrs	15 - 19 yrs	20 - 24 yrs	25 - 29 yrs	30 - 39 yrs	40 - 59 yrs	60+ yrs	Total*
2003 Rate - Male	0.7	1.4	7.5	23.9	34.8	25.4	4.3	15.8
2004 Rate - Male	-	1.4	11.2	23.7	33.5	26.4	5.0	16.2
2005 Rate - Male	-	1.4	11.6	16.6	38.6	25.2	4.4	16.0

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

AIDS

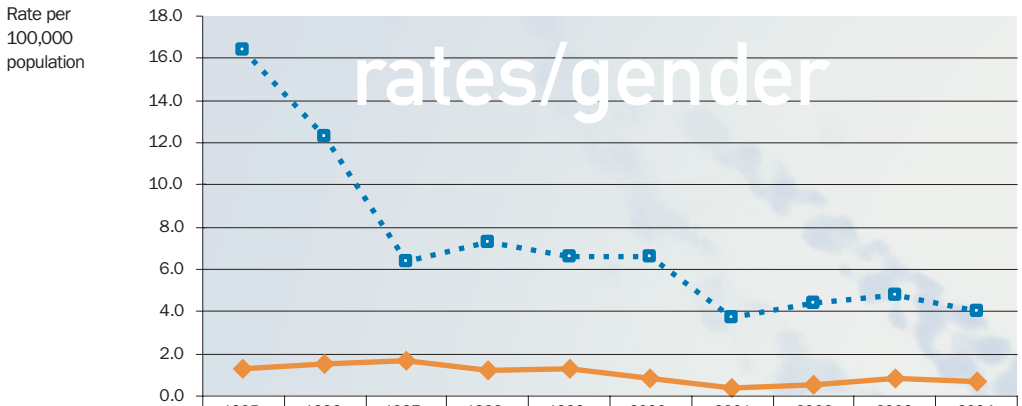
Due to the delays associated with AIDS reporting, this 2005 report includes data on AIDS through 2004 only. In 2004, the AIDS rate in BC decreased to 2.4 (99 cases) from 2.8 (115 cases) in 2003. AIDS cases in males continue to be concentrated in the 30-59 age group, whereas female cases were more evenly distributed over the range of 20-59 years. The highest rate was recorded in the Vancouver Health Service Delivery Area at 8.6 /100,000.

11.1 AIDS case reports and rates in BC • 1995 to 2004



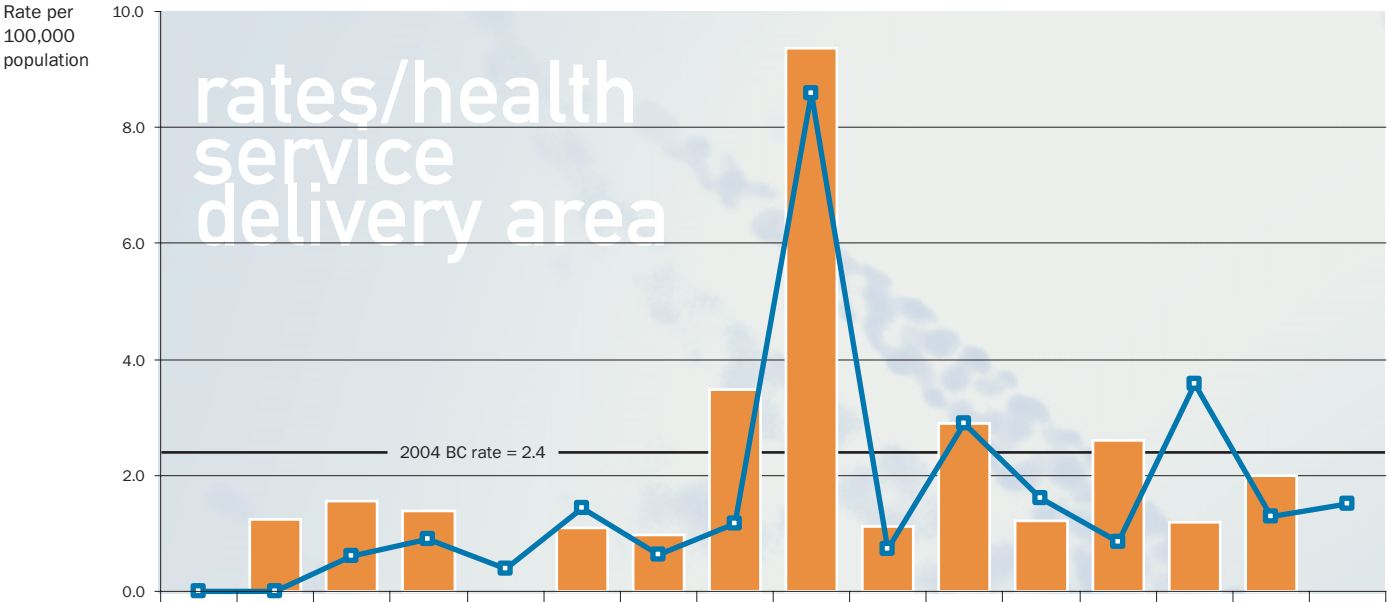
	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
BC Reports	334	268	159	169	158	150	83	102	115	99
BC Rate	8.8	6.9	4.0	4.2	3.9	3.7	2.0	2.5	2.8	2.4
Canadian Rate	5.6	4.0	2.4	2.1	1.8	1.6	1.3	1.3	1.2	0.9

11.2 AIDS Case Reports and Rates in BC by gender • 1995 to 2004



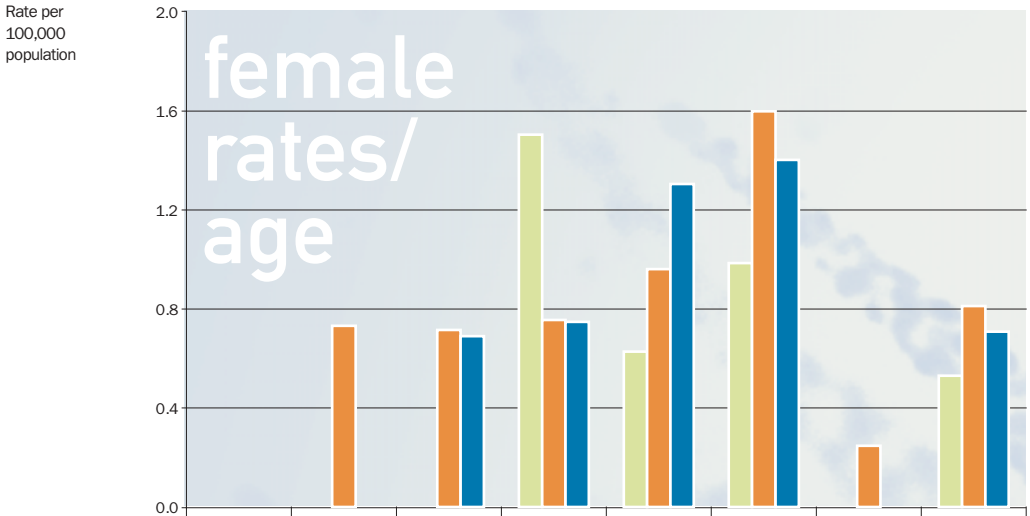
	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Reports - Male	309	238	125	145	131	132	75	90	98	84
Reports - Female	25	30	33	24	26	17	8	11	17	15
Rate - Male	16.4	12.3	6.4	7.3	6.6	6.6	3.7	4.4	4.8	4.0
Rate - Female	1.3	1.5	1.7	1.2	1.3	0.8	0.4	0.5	0.8	0.7

11.3 AIDS case reports and rates in BC by health service delivery area • 2003 to 2004



	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 2004	0	0	2	2	1	8	4	2	51	2	10	4	1	3	2	1
Rate 2003	0.0	1.2	1.6	1.4	0.0	1.1	1.0	3.5	9.4	1.1	2.9	1.2	2.6	1.2	2.0	0.0
Rate 2004	0.0	0.0	0.6	0.9	0.4	1.4	0.6	1.2	8.6	0.7	2.9	1.6	0.9	3.6	1.3	1.5

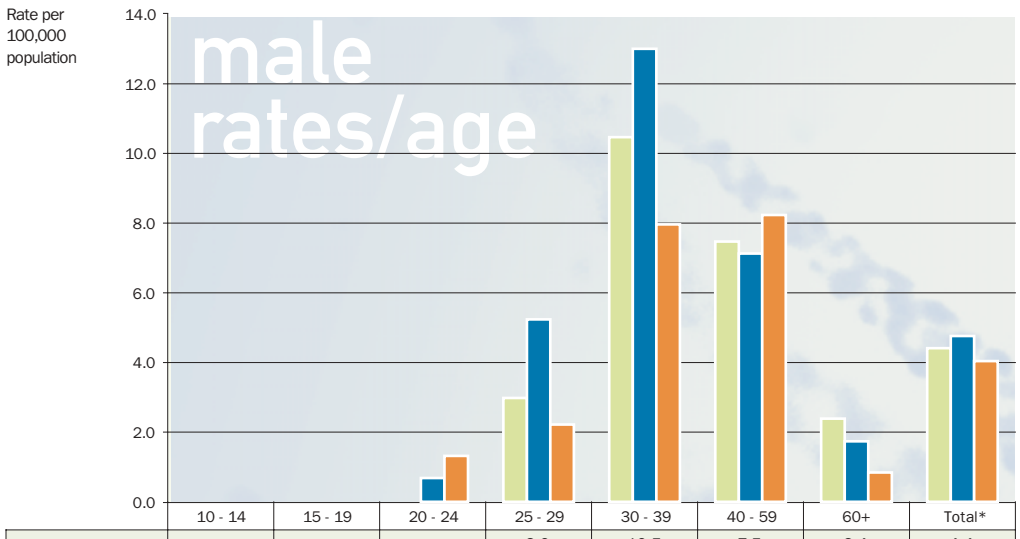
11.4 Female AIDS rates in BC by age • 2002 / 2003 / 2004



	10 - 14	15 - 19	20 - 24	25 - 29	30 - 39	40 - 59	60+	Total*
2002 Rate - Female	-	-	-	1.5	0.6	1.0	-	0.5
2003 Rate - Female	-	0.7	0.7	0.8	1.0	1.6	0.2	0.8
2004 Rate - Female	-	-	0.7	0.7	1.3	1.4	-	0.7

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

11.5 Male AIDS rates in BC by age • 2002 / 2003 / 2004



	10 - 14	15 - 19	20 - 24	25 - 29	30 - 39	40 - 59	60+	Total*
2002 Rate - Male	-	-	-	3.0	10.5	7.5	2.4	4.4
2003 Rate - Male	-	-	0.7	5.2	13.0	7.1	1.7	4.8
2004 Rate - Male	-	-	1.3	2.2	8.0	8.2	0.8	4.0

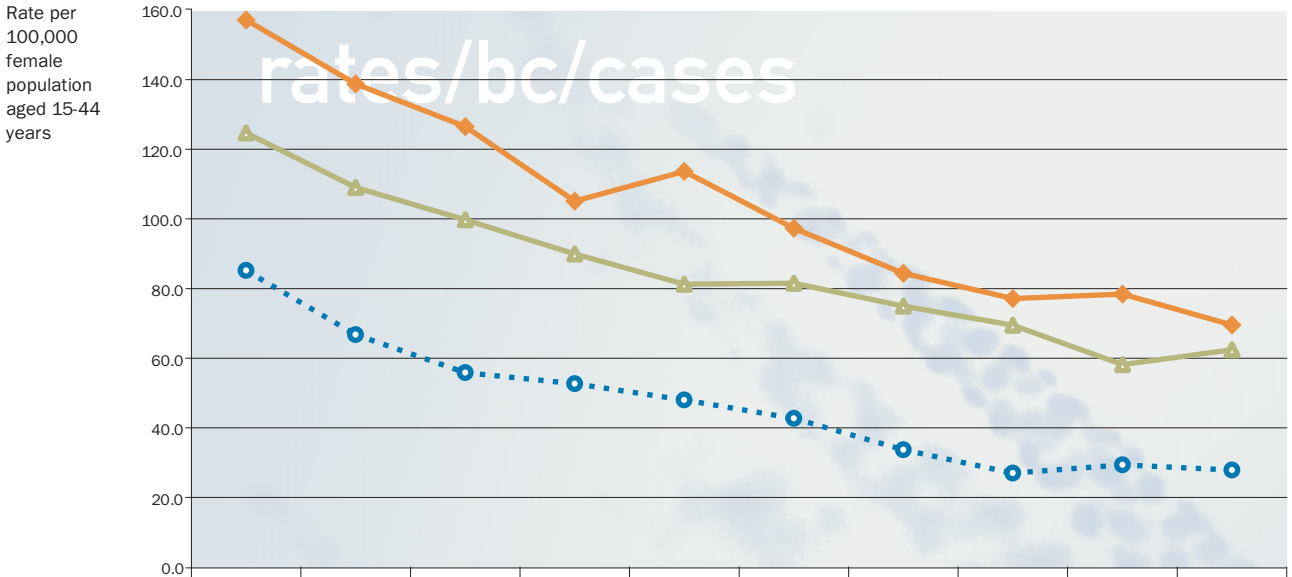
Total* - Rate includes ALL males (i.e. aged <1 to 60+ years and males with age not specified)

PID

Pelvic Inflammatory Disease (PID), ectopic pregnancy and tubal infertility:

Because of delays in reporting and data transfer, PID, ectopic pregnancy and tubal infertility rates are reported through 2004 only. The rates for tubal infertility and PID declined slightly from 2003 but the ectopic pregnancy rate rose from 58.2/100,000 to 62.4/100,000. The significance of this change is not clear.

12.1 Pelvic inflammatory disease, ectopic pregnancy and tubal infertility case reports and rates in BC • 1995 to 2004



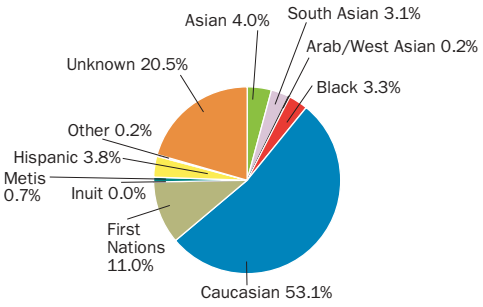
	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
PID Cases	1,361	1,235	1,142	948	1,024	875	760	695	705	626
Ectopic Cases	1,080	970	900	811	732	733	675	626	523	562
Tubal Cases	738	594	504	475	432	384	303	243	264	251
PID Rate	157.1	138.8	126.6	105.1	113.7	97.3	84.4	77.1	78.4	69.5
Ectopic Rate	124.7	109.0	99.7	89.9	81.3	81.5	75.0	69.5	58.2	62.4
Tubal Rate	85.2	66.8	55.9	52.7	48.0	42.7	33.6	27.0	29.4	27.9

ethnicity

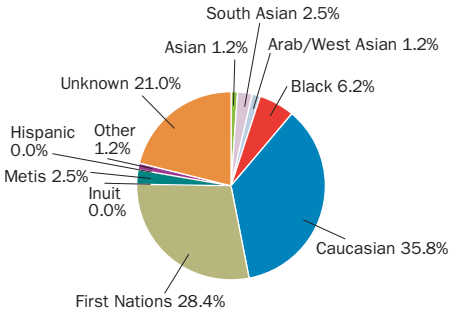
HIV and infectious syphilis continue to disproportionately affect First Nations, especially women.

13.1 Persons testing newly positive for HIV in BC by ethnicity • 2005

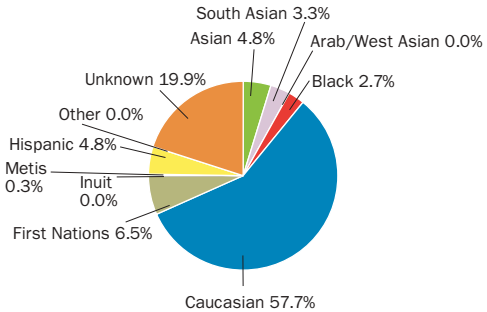
Total



Female

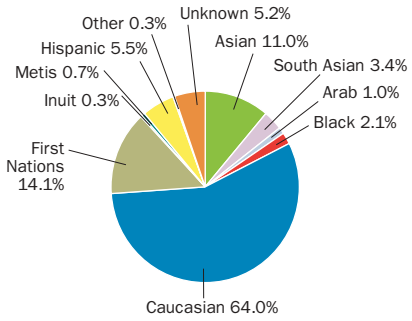


Male

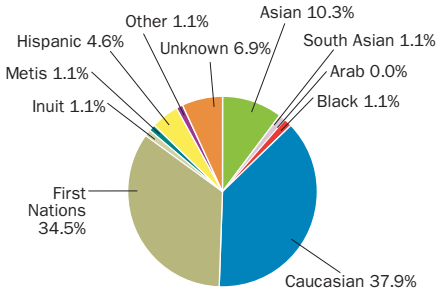


13.2 Infectious syphilis case reports in BC by ethnicity • 2005

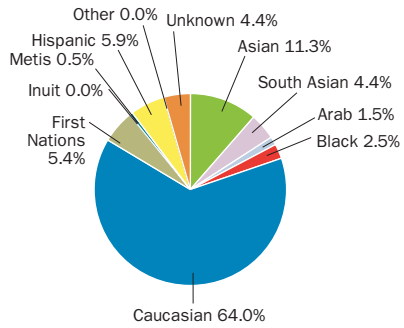
Total



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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