



# Seek and Treat for Optimal Prevention (STOP) of HIV Progress Report

Prepared by:  
HIV and Hepatitis C Care Team  
Northern Health  
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# STOP HIV: The Northern Experience

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## Introduction and Background

Northern British Columbia (BC) is a diverse region. It includes communities that range in size, accessibility and culture: from urban centres to small villages, from those that are remote to those that are easily accessible and from those with vibrant cultures rooted in the past to others that have recently grown around industry. Providing health care in the North requires creative and innovative programs guided by current information and tailored to its distinct populations and environments.

This report summarizes the progress in Northern BC related to the STOP HIV/AIDS (Seek and Treat for the Optimal Prevention of HIV/AIDS) program and the goals set out in the provincial strategy From Hope to Health: Towards an AIDS-free Generation (BC Ministry of Health [BC MOH], 2012).

## The STOP HIV/AIDS Project

STOP HIV/AIDS (also known as STOP) began as a four-year pilot project running from 2009 to 2013. The British Columbia Ministry of Health (BC MOH) and the BC Centre for Excellence in HIV/AIDS (BCCfE) initiated the STOP pilot to enhance the reach and engagement of British Columbians in HIV testing, treatment and care. STOP sought to normalize testing by expanding it beyond identified high-risk groups and making it a routine aspect of medical care. The STOP pilot focused on two communities in BC with high rates of HIV and HIV-related mortality: the Downtown East Side in Vancouver and the Northern community of Prince George.

In Northern BC, the STOP pilot built on existing HIV prevention work and enabled Northern Health (NH) to increase engagement with community organizations and create the NH Blood Borne Pathogens team, now called the HIV and Hepatitis C Care team. The BC MOH provided strategic policy guidance for health authorities to implement lessons learned from the pilot across the province.

Human Immunodeficiency Virus (HIV), a virus that attacks the immune system, was first identified as a public health concern in the 1980's. If HIV infection is left untreated it will overwhelm and weaken the immune system, leaving the body vulnerable to other infections. It is these other infections that are usually the cause of death in HIV. Acquired Immunodeficiency Syndrome (AIDS) is the final stage of HIV where the immune system is at its weakest and unable to provide any resistance to infections.

Transmission of HIV is usually associated with sex and intravenous (IV) drug use. As such, efforts to reduce the spread of HIV have led to programs that provide access to sterile needles and promote condom use.

In the 1980's and 90's HIV was widely viewed as a death sentence. Improvements in testing and treatment have made HIV a manageable chronic disease. A person who is diagnosed early and takes their medication every day can now expect to live almost as long as a person who does not have HIV.

The BC MOH policy framework, entitled *From Hope to Health: Towards an AIDS-free Generation*, started in April of 2013 and builds on the goals of the STOP pilot. There are five interrelated goals outlined in the framework (BC MOH, 2012):

1. Reduce the number of new HIV infections in BC.
2. Improve the quality, effectiveness and reach of HIV prevention services.
3. Diagnose those living with HIV as early as possible in the course of their infection.
4. Improve the quality and reach of HIV support services for those living with and vulnerable to HIV.
5. Reduce the burden of advanced HIV infection on the health-care system.

## *Background on the Northern HIV/AIDS response*

Services to respond to HIV/AIDS have developed over many years. For example, access to sterile needles, condoms and HIV/AIDS education has been available in many northern communities for over 15 years. HIV/AIDS services are provided by NH and a number of community agencies such as [Positive Living North](#), [Central Interior Native Health Society](#), the [Northern BC First Nations HIV/AIDS Coalition](#), [Northern HIV and Health Education Society](#) and other First Nations Health Organizations.

The HIV Monitoring Quarterly Reports (British Columbia Centre for Excellence in HIV/AIDS [BCCfE], 2015a) provide HIV data for NH and BC. Table 1 shows how the HIV/AIDS epidemic has evolved differently in Northern BC than it has in the province overall. For example, the main source of new HIV infections in BC (57.74%) is in men who have sex with men (MSM). In the North, however, transmission associated with MSM covers only 13.16% of newly diagnosed infections. Heterosexual transmission is 39.47% in Northern BC compared to 25.63% provincially. Another noteworthy trend is that injection drug use is one of the primary routes of transmission of HIV in the North and accounts for 36.84% of cases, compared to only 11.63% of cases in the province.

Table 1

<i>Newly diagnosed HIV infections by route of transmission (2010 Q2 - 2014 Q3)</i>				
Route	Number of newly diagnosed infections in Northern Health	Northern Health %	Number of newly diagnosed infections in BC	BC Provincial %
Heterosexual transmission	30	39.47%	313	25.63%
Intravenous (IV) drug use	28	36.84%	142	11.63%
Men who have sex with men (MSM)	10	13.16%	705	57.74%
Other	4	5.26%	24	1.97%
Unknown	4	5.26%	37	3.03%

Source: "HIV Monitoring Quarterly Report for Northern Health First Quarter 2015," by British Columbia Centre for Excellence in HIV/AIDS [BCCfE], 2015a and "HIV Monitoring Quarterly Report for Northern Health First Quarter 2015," by British Columbia Centre for Excellence in HIV/AIDS [BCCfE], 2015b.

There are also differences in how testing and services reach people in the North because of the small size of many communities, the distances between service centres and the compounding impacts of poverty, stigma and systemic discrimination (Northern Health, 2014a; BC MOH, 2015). In some areas, people living with HIV are isolated and marginalized; experiences which are exacerbated by the fact that HIV related services may be unwelcome by the wider community.

Advances in testing and treatment have transformed HIV into a life-long but manageable chronic disease. However, people still die from HIV. There are many reasons for this but among them are the facts that many people don't know they are living with HIV because they have never been tested and some people don't get tested because they have no identifiable risk factors (Champenois et al, 2013; Read, Armstrong-James, Tong, and Fox, 2011; Sudarshi et al, 2008).

Dedicated individuals and health care providers in NH and community organizations, with support from Provincial agencies like the BCCfE and the BC Centre for Disease Control (BCCDC), are working toward a future where no one dies from HIV. Emphasis over the past five years has been on early diagnosis and treatment of HIV. Medications now require fewer pills and have fewer side effects. Together, early diagnosis and more effective treatment can suppress the virus that causes HIV to a point where it does no further harm to the immune system.

Expanded testing and treatment of HIV has three obvious benefits for society. First, HIV is most infectious during early stages of infection. Identifying and treating people early in HIV infection reduces the amount of HIV virus circulating in the population (Johnston et al, 2010; British Columbia Centre for Disease Control [BCCDC], 2013a). Less virus in the population means less chance people will be exposed to HIV. Second, once people know they are infected with HIV they often adjust behaviour to avoid transmitting the infection to others. Finally, the costs associated with treating HIV are greatest in the advanced stages of infection. Expanded testing and treatment of HIV reduces the financial burden of HIV infection on society (Johnston et al, 2010).

## *Progress Towards “From Hope to Health” Goals*

The following sections outline how NH has progressed towards the five goals outlined in the BC MOH's “From Hope to Health” strategic guide.

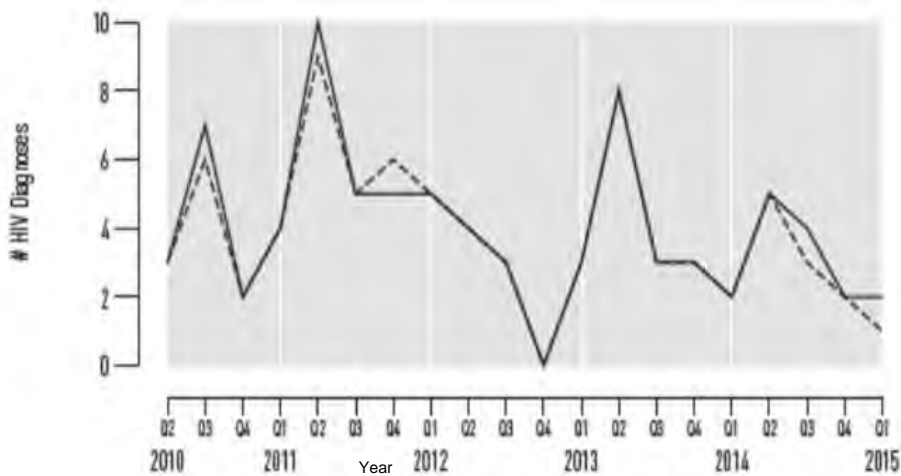
### *Goal 1: Reduce the number of new HIV infections in British Columbia.*

This is the ultimate long-term objective of the Northern response to HIV/AIDS. Improved access to harm reduction supplies, early diagnosis and engagement with treatment are important factors in achieving this objective. Success in the other four goals assists in reducing the number of new HIV infections.

#### *Indicator of Success: New HIV Diagnoses*

The HIV epidemic in NH peaked in 2004 with 33 new HIV diagnoses. Results vary from year to year but the overall trend in new diagnoses of HIV since then has been one of decline (BCCDC, 2013a; BCCfE, 2015b). Figure 1 shows new diagnoses of HIV in NH since 2010.

Figure 1. Number of new HIV Diagnoses in NH by Year from 2010 to 2015



Source: "HIV Monitoring Quarterly Report for Northern Health First Quarter 2015," by British Columbia Centre for Excellence in HIV/AIDS [BCCFE], 2015b.

Reports of new diagnoses do not reflect the true incidence (the actual rate of new cases) of the disease, because rates of new diagnoses are dependent on testing. Despite improvements, rates of HIV testing remain low in Northern communities. As a result, many people remain unaware they have HIV which increases their risk of poor health outcomes and dying unnecessarily from advanced HIV infection.

## Goal 2: Improve the quality, effectiveness and reach of HIV prevention services

Actions for this goal focus on ensuring everyone has access to harm reduction supplies. Safer sex and/or safer drug use supplies are available in more places across the North than ever before, including a range of NH facilities, programs, and community services. Visit <http://towardtheheart.com/site-locator> to find out more information.

Major progress in NH since 2009 also includes improved access to education and resources by:

- Initiation of a broad-based public education and awareness campaign in Prince George and across the North.
- The creation of the [HIV101](#) website, which provides accurate and easy to read information on HIV and links to free resources.
- Enhancements in HIV education, prevention and services for persons living with HIV through IMAGINE Grants and contracts with community organizations such as Positive Living North, Northern BC HIV Education Society, and the Northern BC First Nations HIV/AIDS Coalition.

IMAGINE provides funding for local initiatives in small communities to address issues related to HIV. A total of 22 projects were supported in 2014 (Northern Health, 2014b).

### Safer Sex and Safer Drug Use Supply Distribution Highlights

- Public Preventive Health (PPH) offers safer sex, inhalation and injection supplies through health units.
- In Prince George - the PPH Needle Exchange Program offers a range of harm reduction supplies and services through its downtown office, a van that provides evening street-outreach and other forms of outreach to agencies in Prince George.
- In Burns Lake - the Lakes District Hospital offers safer sex and safer drug use supplies.
- In Fort Nelson - Mental Health and Addictions, the Health Unit and Fort Nelson Friendship Society offer safer sex and safer drug use supplies.

### *Goal 3: Diagnose those living with HIV as early as possible in the course of their infection*

There are still many people living with HIV who are not getting tested until they have a serious HIV related illness. NH has made significant progress in expanding the offer of HIV testing to Northern British Columbians and reach people as early in their infection as possible.

#### *Indicator of Success: HIV Testing Episodes*

HIV testing episodes refer to the total number of HIV tests conducted in a community through acute care, physicians' offices and public health. This information is important because you cannot know the actual prevalence of HIV in an area unless you test. Where there is a low rate of HIV testing, reported rates of HIV tend to be low which may mislead the public and health providers into thinking HIV is not a significant concern.

Northern Health has seen a consistent increase in HIV testing episodes from 2010 to 2014 (BCCfE, 2015b). From 2013 to 2014 alone, total of 17 communities in Northern Health reported at least a 10% increase in the number of HIV tests conducted from all facilities. In spring 2014, acute care facilities in Fort St. James, Fraser Lake and Vanderhoof introduced the routine offer of HIV testing.

While the number of people tested for HIV is increasing each year there are inequities embedded in this. Based on data collected from the first quarter of 2010 to the first quarter of 2015, more men tested positive for HIV than women but women were two times more likely to be tested (BCCfE, 2015b).

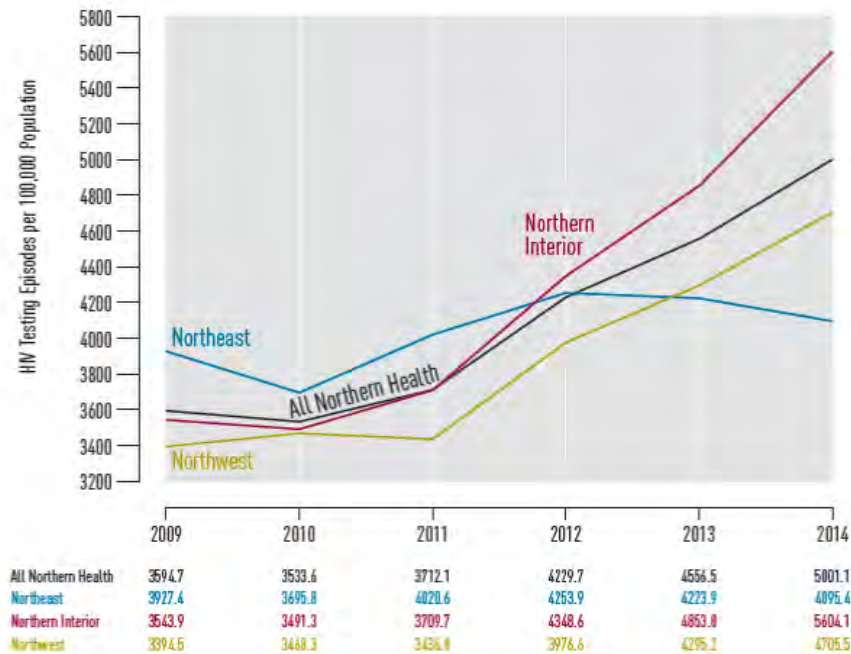
Routine prenatal screening for HIV accounts for part of the disparity between men and women, but even without prenatal screening women are more likely to be tested for HIV than men in NH and the province overall (BCCfE, 2015a).

#### *Indicator of Success: HIV Testing Rates*

HIV testing rates refer to the proportion of all people in particular areas or health care facilities that get tested for HIV. Figure 1 shows the rate of HIV testing for NH and health service delivery areas for 2009 to 2014 (BCCfE, 2015b). Rates of testing for Northern Health increased by 39.1% from 2009 to 2014 (from 3594.7 per 100,000 in 2009 to 5001.1 per 100,000 at the end of 2014;

BCCfE, 2015b). Across the North the highest rates of testing are in the Northern Interior and the lowest rates are in the North East (BCCfE, 2015b). Focused attention is needed to create an equitable reach of testing across the North.

Figure 2. Rate of HIV Testing for Northern Health and Health Service Delivery Areas



Source: "HIV monitoring quarterly report for Northern Health first quarter 2015," by British Columbia Centre for Excellence in HIV/AIDS [BCCfE], 2015b.

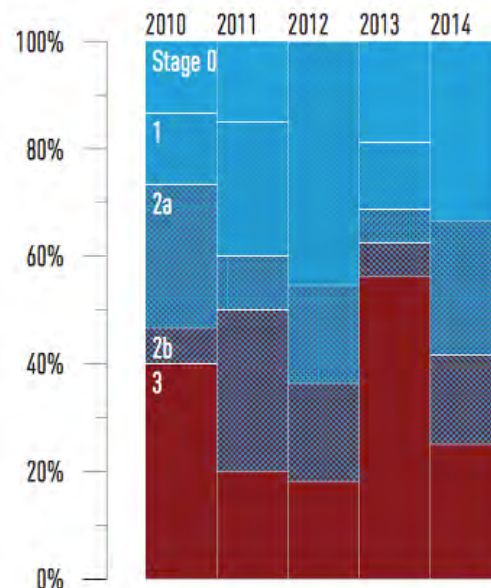
**Indicator of Success: HIV Progression of Disease at Time of Diagnosis**

An individual's chance of living a long and healthy life with HIV is influenced by how long they have been living with HIV at the time of diagnosis. One of the key factors to indicate the stage of HIV at diagnosis is the CD4 count. Many people with HIV in the North are diagnosed with advanced HIV infection, which is identified by a CD4 count below 500. A CD4 count below 500, means that a person has been living with HIV for many years and is at risk for developing HIV related infections. Increasing the routine offer of HIV testing to people in the North will help diagnose those with HIV earlier in the course of their infection.

Figure 3 shows what proportions of people were diagnosed with HIV at early to late stages of HIV infection each year from 2010 to 2014 (BCCfE, 2015b). Stage 0 (light blue bar) indicates a diagnosis at a very early stage of infection and stage 3 (red bar) indicates a diagnosis at an advanced stage of HIV infection. In 2010, approximately 40% of all new cases in the North were diagnosed at stage 3 (i.e., advanced HIV infection; BCCfE, 2015b). By 2014, just over 20% of new cases were diagnosed at a stage 3 (BCCfE, 2015b). This means that in 2014 most people were diagnosed at earlier stages of HIV infection and indicates an improvement in HIV testing practices. The intervening years, 2012 and 2013, show that the corresponding trend toward early diagnosis and testing practices is not linear. This indicates a need for sustained work to promote and improve HIV testing among providers across the North.



Figure 3. Stage of HIV Infection at the Time of Diagnosis in NH by Year (2000 to 2014)



Source: "HIV monitoring quarterly report for Northern Health first quarter 2015," by British Columbia Centre for Excellence in HIV/AIDS [BCCfE], 2015b.

### Point of Care Testing

NH began promoting point of care (POC) testing in designated centres in 2010. POC testing can be a valuable tool to reach and engage people regarding their HIV status. POC testing in the North increased each year from 2011 to 2013 (174, 282 and 521 tests per year, respectively) and slightly decreased in 2014 (470 tests; BCCfE, 2015b). These numbers show that POC testing in the North has more than doubled since 2011.

**Point of Care Testing (POC):**

- Screens for HIV antibodies.
- Is fast and simple.
- Requires a small amount of blood taken from a fingertip.
- Can be provided on-site with results available in minutes.

NH currently supports eight active POC testing sites. Plans are underway to increase the number of sites over the next year to improve access to HIV testing across the North.

### Goal 4: Improve the quality and reach of HIV support services for those living with and vulnerable to HIV

Supporting people living with HIV involves several things including:

- Helping people make informed choices about their health so they can live healthier lives.
- Engaging people effectively in services so they can be supported to follow care plans.
- Raising awareness of HIV and challenging misconceptions among providers, the community and those at risk for HIV.

Improvements made to NH HIV support services:

- A Medication Adherence Support Program coordinated by Central Interior Native Health Society.
- A Clinical Pharmacy Specialist.
- HIV treatment improvements within the Prince George Regional Corrections Centre to prevent treatment interruptions when people enter or are released from the facilities.
- Regional access to specialized services through a centralized clinic (Dr. Hamour’s office).
- Access to education and resources (see Goal 2).

NH’s Clinical Pharmacy Specialist supports people living with HIV, clinicians, other service providers and patients. Services include advising on treatment, offering adherence support, offering education and maintaining supplies of HIV medications.

The Clinical Pharmacy Specialist supports <i>patients</i> with:	The Clinical Pharmacy Specialist supports <i>clinicians and service providers</i> with:
<ul style="list-style-type: none"> <li>• Readiness to start treatment.</li> <li>• Adherence support strategies.</li> <li>• Management of side effects.</li> <li>• Benefits of treatment and consequences of non-adherence (i.e., not continuing treatment or not following their treatment plan).</li> </ul>	<ul style="list-style-type: none"> <li>• Medication adherence monitoring.</li> <li>• Drug information and interaction management.</li> <li>• Addressing challenges with medication, medication ordering and obtaining contingency supplies.</li> <li>• Providing medication supply information and medication contact information to patients who are moving out of province.</li> </ul>

An important aspect of medication services includes maintaining the contingency supplies of antiretroviral therapy medications (ARVs). Contingency supplies avoid treatment interruptions associated with delayed transport of medications from Vancouver and when patients are admitted to hospital without their medications. A contingency supply of ARVs was established in Prince George during STOP and contingency supplies were established in Terrace and Fort St. John shortly following the end of STOP. Work is ongoing to ensure acute and primary care providers know how to access contingency supplies when needed and that they reorder medications before patients are released from hospital.

Dr. Hamour’s clinic in Prince George provides specialized services and supports for HIV and hepatitis C (HCV) patients. These services are also available to physicians and patients across the North through various tele-medicine services.

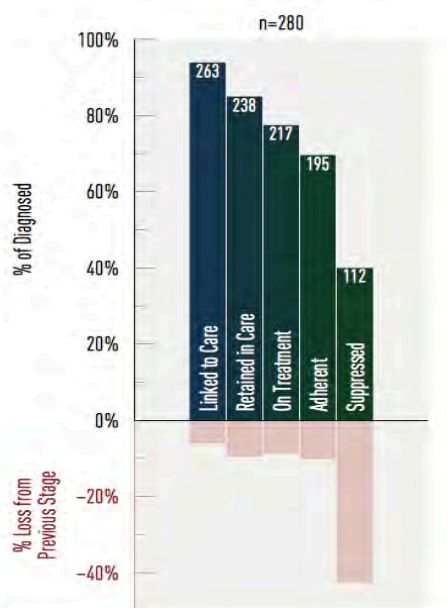
The Medication Adherence Support Program coordinated by CINHS offers assistance to people living with HIV who need increased support with adherence to achieve the maximum benefit from treatment.

**Adherence** is a common term used in health care that means continuing with the treatment and following the treatment instructions. For example, taking HIV medications every day as instructed.

### Indicator of Success: HIV Cascade of Care

Early diagnosis and treatment increases the likelihood of people with HIV living longer and healthier lives (BC MOH, 2012). There are many steps between diagnosis of HIV and having no detectable HIV in the blood. Ideally, there would be the same number of people at each step. As shown in Figure 4, the number of people at each step declines when people move through the continuum of HIV care in the North. The progressive decline is described as the cascade of care for HIV. Although it only reflects one point of time, the cascade of care shows where people become disconnected from care along the continuum from diagnosis to the suppression of HIV. This information shows providers where they need to target strategies to help people re-engage with care.

Figure 4. Estimated Cascade of Care for Northern Health, 2015.



Source: "HIV Monitoring Quarterly Report for Northern Health First Quarter 2015," by British Columbia Centre for Excellence in HIV/AIDS [BCCfE], 2015a.

Providing accurate data for the cascade of care for HIV can be challenging. One factor that can influence the accuracy of data reported by the province is whether or not patients remain in one region. Some Northern residents move between Northern and Southern communities but are statistically reported as living in the North. BCCfE is currently clarifying the number of people living with HIV who currently reside in the North and are not engaged with care.

Figure 4 shows the cascade of care for NH in 20a5 based on provincial health data (BCCfE, 2015b). Of the 280 identified cases in the NH region:

- 93.93% (263) were linked to some form of HIV care.
- 85.00% (238) were retained in HIV care.
- 77.50% (217) were on HIV treatment.
- 69.64% (195) were adhering to their treatment regimen.
- 40.00% (112) showed a suppressed viral load<sup>1</sup>.

**CD4 Count** refers to the strength of one's immune system by measuring how many CD4 immune cells there are. A CD4 count above 500 (copies /ml) usually means people living with HIV are healthy.

**Viral load (VL)** measures how much of the virus is circulating in someone's blood. Clinically, a viral load less than 200-250 usually means medications are controlling the HIV infection.

The aim of HIV treatment is to completely suppress the virus, which means that the virus is virtually undetectable when the blood is tested.

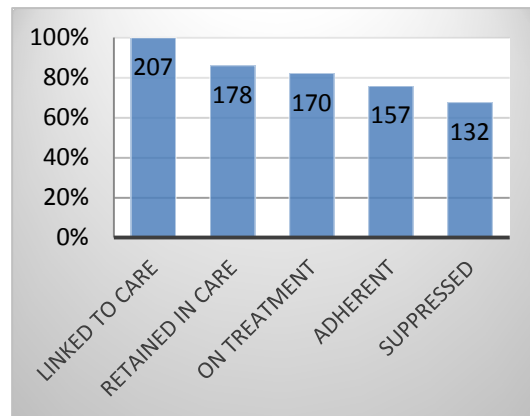
<sup>1</sup> Criteria for viral suppression vary (Nosyk et al, 2014). BCCfE criteria of viral suppression, reflected in data for Figure 4, are based on two consecutive lab reports with a viral load (VL) of less than 50 copies/ml (BCCfE & BCCDC, 2015). The laboratory definition of viral suppression is determined by what current technology is able to measure. Clinical definitions of viral suppression are *determined by* the VL that would require changes in treatment. Sources vary, but the clinical definition of viral suppression tends to be a VL of < 200-250 (J. Hawkes, Personal communication, June 24, 2015).

While the precise number of people who are not engaged with care is not yet known, the vast majority of people living with HIV in NH receive specialty services or consultation from Dr. Hamour.

The cascade of care for people seen through Dr. Hamour’s clinic in PG, based on unpublished data collected May 2015, was as follows<sup>2</sup>:

- 100% (207) were linked to HIV care in his office but had not been seen in over 1 year.
- 86% (178) were retained in HIV care.
- 82% (170) were on HIV treatment.
- 76% (157) were adhering to their treatment regimen.
- 64% (132) showed a suppressed viral load (< 50 copies/mL).
- 79 patients had deceased, moved or gone elsewhere and are not included in the above numbers.

Figure 5. Estimated Cascade of Care for Dr. Hamour’s Clinic, 2015.



Source: Unpublished data, Dr. Hamour’s clinic, 2015.

Additional Northern epidemiological research on the cascade of care is anticipated in late 2015 and may help to clarify the data for the North.

### **Goal 5: Reduce the burden of advanced HIV infection on the health-care system.**

#### **Indicator of Success: New Anti-Retroviral Therapy Starts**

Various initiatives aim to support all people living with HIV to begin treatment as soon as possible and sustain their engagement with HIV care. This includes efforts to encourage people who have stopped treatment to re-engage with care. One important strategy is offering adherence support through specialty clinical services in NH and contracts with several community organizations. During STOP, for example, NH partnered with CINHS to establish a Medication Adherence Support Program in Prince George which helps people stay on track with medications and care plans. A second strategy is offering peer informed services which were established prior to STOP and continue to be delivered through Positive Living North (PLN) in Prince George, Dawson Creek and Smithers.

<sup>2</sup>Data for the cascade of care for Dr. Hamour’s clinic is drawn from clinical chart reviews and is based on one VL report of <50 copies / ml. Since there are often long intervals between laboratory tests, the most recent VL is deemed to be the most accurate and reflective of current realities in NH. Differences in how viral load is reported by BCCDC and Dr. Hamour is one of several factors that results in the BCCDC reporting lower rates of viral suppression than is observed in clinical practice.

### NH projects and initiatives to promote HIV testing, engagement with care and adherence support:

- The NH HIV and Hepatitis C Care team continues to work in partnership with health providers and community agencies by promoting HIV care and treatment in the North and by providing training and education sessions.
- NH initiated and completed a process of HIV patient journey mapping to better understand and address the barriers to care. This project involved 19 people living with HIV in the North (Northern Health, 2014a).
- Various research projects are underway through partnerships between NH, external researchers and graduate students from various academic institutions.
- Plans to increase HIV point of care testing sites in the North are under way to reach those who have difficulty accessing existing HIV testing services.

### *Indicator of Success: HIV-Related Mortality*

Given the advancements in HIV therapy, no one should die from HIV. Unfortunately, this is still the case but things have improved. The number of people whose HIV infections progressed to AIDS has decreased in recent years from a high of 16 in 2009 to less than 5 in 2014 (BCCfE, 2015b).

## *Challenges*

NH, in collaboration with community partners and with funding and support from the STOP initiative, has improved the response to HIV in recent years. However, significant challenges still remain.

Some health care challenges are more prevalent in Northern communities and can lead to poorer health outcomes for all Northern residents than those living in other regions in BC (Statistics Canada, 2013; BC MOH, 2015). These challenges can

make living with and treating HIV more difficult. For example, living in the North can make it harder to access health care and HIV services. Many areas have chronic shortages and transitions in health providers. As a result, it may be difficult for residents to access HIV testing and care locally. In many communities residents must travel long distances to obtain general and/or specialized health services. Public transportation is limited in the North and travel in winter conditions is often treacherous. Some isolated communities have infrequent transport of blood specimens to testing facilities in Vancouver or Prince George.

Northern youth face additional challenges for HIV care. One study found that a history of trauma and exposure to sexual abuse increased the risk of HIV infection among youth in Prince George (Pearce et al, 2008). Engaging young people living with HIV is another challenge. For persons

Examples of Health and Health Care Challenges in the North (Statistics Canada, 2013):

- Increased rates of heart and lung disease, cancers, and intentional and preventable injuries.
- Lower high-school completion rates.
- Less access to fresh fruits and vegetables.
- Less access to medical care.

under 30 living with HIV, 76% (16/21) are linked to care compared to 95.3% (247/259) for people over 30 living with HIV (BCCfE, 2015b).

Consistency of care and relationships with providers are important to promote better health outcomes for socially marginalized people living with HIV (Schneider, Kaplan, Greenfield, Li, & Wilson, 2004; Pearce et al, 2008). Yet, in many health care settings in the North, services are provided on a satellite basis from other communities and there are frequent transitions of staff. These issues make it difficult to build connections and consistency in relationships.

Mistrust of health services, fears of providers' judgement and breeches in confidentiality are additional obstacles to obtaining HIV care for many people (Northern Health, 2014a). These challenges highlight that more work is needed to design services that better reach and sustain the engagement of those whose lives have been exposed to multiple harms, such as poverty, inadequate shelter, discrimination and violence (Pearce et al, 2008). These harms are intensified

"The fear of being outcast and shunned by my people was terrifying. I could think of nothing worse..."

- Anonymous (Northern Health, 2014a, p.11)

for Aboriginal peoples and compound the ongoing impacts of systemic social inequities. Together, these factors result in a higher burden of HIV for Aboriginal peoples (Pearce et al, 2008; BCCDC, 2013b).

Additional work is also needed to address other complexities of living with HIV. The fact that injection drug use is the most common cause of HIV infection in the North highlights the need to improve access to harm reduction services to reduce the transmission of HIV. Improved testing of and treatment for HCV is also important because most cases of HCV are transmitted by injection drug-use and high rates of HCV can be predictive of risk for HIV. Canadian statistics estimate that 54 - 70% of those infected with HIV are co-infected with HCV (Tanner, Matsukura, Ivkov, Amlani, & Buxton, 2014). HCV is also more infectious and easier to transmit than HIV. Rates of HCV in the North are among the highest in the province (Tanner et al., 2014).

## *Conclusion – Meeting the Challenge*

There are still many people who do not know that they are living with HIV. Routinely offering testing and improving linkages to care can lead to earlier diagnosis, initiation of treatment and better outcomes (BC MOH, 2012). Those living with HIV need to be better reached and engaged by the services provided by NH, its partner agencies and organizations. Given the impacts of discrimination and inequities for Aboriginal peoples, the NH HIV and Hepatitis C Care team (HHC) will continue to work closely with First Nations Health Authority (FNHA), Aboriginal agencies and communities to ensure HIV services are accessible, appropriate and respect Aboriginal peoples social realities and health care needs.

In collaboration with all stakeholders, NH is committed to addressing these challenges and to expanding and strengthening HIV services by:

- Providing safer drug use supplies, safer sex supplies and opioid substitution therapy (methadone).

- Continuing the public awareness campaign (e.g., HIV101).
- Promoting routine HIV/HCV testing in health care settings.
- Improving adherence and related support services.
- Reducing community and health care provider discrimination.
- Enhancing peer informed support services.

Continued collaborative and dedicated action holds the promise of an AIDS-free generation.

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