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INTRODUCTION

In the fall of 2003, AIDS Vancouver's newly elected Board of Directors set in motion the process of developing a new three-year strategic plan. Confident that the agency's existing plan (2000-2003) was a well-developed, comprehensive document and was serving the agency well, the Board made the conscious decision to move forward slowly with the planning process. This decision was largely motivated by the fact that the Board was also in the process of recruiting a new Executive Director, as the Board wanted to ensure that the new ED played an instrumental role in the development of the strategic plan that they would be responsible for implementing.

As such, the process of developing this strategic plan was a slow and deliberate one, often requiring patience and determination. There were delays, due to extenuating circumstances, however, throughout its development, the Board of Directors remained committed to providing AIDS Vancouver's staff, clients, members, and partners with a document that would communicate both an overall framework for the important work being done by the organization and a renewed vision for the future. The following strategic plan is the epitome of the term "living document" and will continue to grow and change to meet the needs of AIDS Vancouver and its clients.

MISSION, VALUES and GUIDING PRINCIPLES

Mission Statement

AIDS Vancouver acts to alleviate individual and collective vulnerability to HIV and AIDS through support, public education and community based research.

Definition of Vulnerability

The United Nations Joint Programme on HIV/AIDS best defines our understanding of vulnerability:

To be vulnerable in the context of HIV/AIDS means to have little or no control over one's risk of acquiring HIV infection or, for those already infected with or affected by HIV, to have little or no access to appropriate care and support. Vulnerability is the net result of the interplay among many factors, both personal (including biological) and societal; it can be increased by a range of cultural, demographic, legal, economic and political factors.

Core Values

- We believe people should be treated with dignity and respect at every stage of their life.
- We believe that people living with HIV/AIDS have the right to determine the direction of their own lives.
- We respect diversity, privacy, and confidentiality.
- We believe in fostering the development of relationships that mutually benefit AIDS Vancouver and its partners.
- We believe the participation of individuals and communities infected with and affected by HIV/AIDS are critical to all aspects of a humane and ethical response to the epidemic.
- We believe that reducing vulnerability to HIV infection and AIDS requires societal and structural change to the causes of political, social, and economic inequality.

Guiding Principles

The following principles guide and direct the planning, implementation and evaluation of our programs and services at AIDS Vancouver:

Health Promotion is the process of enabling people to increase control over and to improve their health. It involves actions that build healthy public policy, create supportive environments, strengthen community action, develop personal skills and reorient health services.

Harm Reduction is an approach which, for example, tries to reduce the harmful effects of using alcohol or drugs rather than exclusively promoting abstinence.

Community Based Research is an approach to research inquiry and method that involves the subject and/or benefactor of a study at all stages of the research process.

Community Development is a commitment to develop and sustain capacities within individuals and communities to address HIV/AIDS vulnerability. It involves fostering the development of supportive relationships that contribute to building capacity.

EXECUTIVE SUMMARY

AIDS Vancouver, one of Canada's oldest and largest AIDS service organizations, works *locally* to prevent new HIV infections and to assist people with HIV/AIDS in accessing the resources necessary to achieve and maintain sound health. In addition, AIDS Vancouver works *globally* in the fight against HIV/AIDS through mentorship, knowledge exchange and partnerships.

Unlike many AIDS service organizations (ASO's), which focus on a particular target population (i.e. women, Aboriginal peoples, injection drug users, etc.), AIDS Vancouver (AV) offers services to any person infected with or affected by HIV/AIDS. In the next three years, AIDS Vancouver will work to leverage the knowledge gained serving such a diverse base to further develop integrated models for prevention and case management. It is intended that this goal of increased integration will serve as a benefit not only to AIDS Vancouver, but to other ASO's as well.

This document outlines key strategies identified by AIDS Vancouver to:

- Provide leadership in the effort to prevent the spread of new HIV infections;
- Inhibit the advancement of HIV disease in those who are HIV-positive;
- Enable an enhanced quality life for people infected with and affected by HIV/AIDS.

This 2006 to 2008 strategic plan will lead AIDS Vancouver into its 25th year. AIDS Vancouver is proud of its heritage. The following goals and objectives seek to position AIDS Vancouver to continue to respond effectively to the needs of those infected with and affected by HIV/AIDS. Like other AIDS service organizations worldwide, we continue to struggle to keep HIV/AIDS in the public discourse in a society that still holds many dangerous misconceptions about the reality of this disease.

Summary of Goals and Objectives

Goals	Objectives
To advance our leadership in the HIV/AIDS field	• Build productive relationships. • Influence the HIV/AIDS policy agenda. • Develop our leadership capacities.

Goals	Objectives
To increase our capacities for effective HIV/AIDS prevention.	• Enhance engagement with HIV affected populations. • Promote opportunities for learning and development. • Increase additional funding resources. • Improve the effectiveness of programs and interventions.
To meet the health needs of our HIV affected clients.	• Champion optimal health care, housing, income security and psychosocial support. • Improve access to health information.
To create a supportive environment for clients that promotes health and well being.	• Ensure physical safety. • Promote conditions that support emotional safety. • Improve accessibility to all programs and services.
To reduce HIV stigma and discrimination.	• Address the experience of stigma and discrimination. • Extend awareness and promote human rights.

HISTORICAL CONTEXT

The letters in "AIDS" stand for Acquired Immune-Deficiency Syndrome. AIDS is the final stage of a syndrome of illnesses caused by the infection of HIV (Human Immunodeficiency Virus). This virus harms the immune system, which protects against infections – there is no known cure. The immunodeficiency of people with HIV leaves them vulnerable to infections and illnesses that they would likely not otherwise get, known as opportunistic infections. In order to prolong the onset of AIDS, those with HIV frequently have to maintain a strict regime of medications, which may also lead to significant health problems due to their side effects.

The disease has killed more than 25 million people worldwide since the first person was diagnosed with AIDS, including 13,054 people in Canada and over 2,800 British Columbians (of whom the majority were from the Lower Mainland). The latest statistics indicate that there are an estimated 40.3 million children, women, and men infected with the HIV virus worldwide; 56,500 in Canada; and 11,500 in BC. [1]

It has been estimated up to one third of HIV infected people in Canada have not been tested, are unaware they are HIV positive, and have the potential to unwittingly spread the virus to others.

> *Despite decreases in the rate of infection in certain countries, the overall number of people living with HIV has continued to increase in all regions of the world except the Caribbean. There were an additional five million new*

[1] *Figures from UNAIDS to June 2004*.

> *infections in 2005. The number of people living with HIV globally has reached its highest level with an estimated 40.3 million people, up from an estimated 37.5 million in 2003. More than three million people died of AIDS-related illnesses in 2005; of these, more than 500,000 were children.*[2]

In our community, HIV infection is still prevalent in vulnerable populations: those living in poverty, groups facing discrimination such as the gay and transgendered communities, those struggling with drug addiction, those living with mental illness and people living in abusive situations. HIV continues to spread into other communities, affecting additional populations more than ever before.

In the past six years, new HIV infection rates in BC have remained relatively constant. However, the demographics of those infected are shifting, with one third of all new infections coming from the heterosexual population, with women being increasingly affected. Detailed statistical information from the BC Centre for Disease Control is included in Appendix A.

HOW OUR STRATEGY WAS DEVELOPED

The Process

This strategic plan was developed by the Board of Directors in collaboration with staff, volunteers and clients of AIDS Vancouver, and community partners. A review of relevant literature and documentation was also undertaken and is included.[3]

Because AIDS Vancouver did not have an Executive Director at the beginning of the strategic planning effort, the early stages of the process had two major goals:

1. To identify major strategic themes to serve as the foundation for the strategic plan. These themes would also be used to inform the hiring process of the new Executive Director.
2. To guide the Board of Directors, staff (including the new Executive Director), and volunteers through the activities necessary to develop the strategic plan.

The themes, which are summarized below, were developed in the first phase of the process. A systematic review of news clippings from the past 25 years and the HIV/AIDS strategies of several community-based AIDS service organizations and government agencies are also reflected in the themes.

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[2] *UNAIDS/WHO press release, Geneva, November 21, 2005*
[3] see Appendix B for a detailed list of participants

During the first phase a timeline was produced that compared AIDS related events and activities from 1979 to the present and includes AIDS Vancouver's activities and services from its formation in 1983[4].

Once the new Executive Director was engaged, the planning activities shifted to the Board of Directors, staff, volunteers and clients, and the new Executive Director. Two facilitated, full-day planning sessions were held in October 2005, where participants discussed their vision, refined the organization's mission and values, and began to develop specific goals and objectives for the plan.

This document serves as a guide to ensure that AIDS Vancouver's day-to-day operations are constantly moving the agency towards its stated goals. It will also be used to evaluate the agency's on-going strategic progress and success.

Trends and Themes

Summarized below, these trends and themes emerged in the development of this strategic plan.

Trends

- Gay men continue to be the largest group of people in Canada and BC contracting HIV, as can be seen in the data contained in Appendix A. Furthermore, AIDS Vancouver continues to be one of the primary agencies serving gay men in the Lower Mainland.

- Populations most at risk in the coming years include, among others: marginalized and impoverished people, people struggling with addictions, gay men, youth, women, Aboriginal populations, those without adequate housing and incarcerated persons.

- Increases in HIV infection are being seen in immigrants from endemic areas (i.e. Africa, India, China, etc.); heterosexual youth; middle-aged and recently divorced/widowed individuals; and couples where the husband is having sex with men.

- Co-infection, the presence of HIV infection along with a secondary infection such as Hepatitis C or a sexually transmitted infection, is a growing challenge in Vancouver and beyond. For example, nearly all HIV infected youth in Vancouver are co-infected with Hepatitis C. In Northern native communities, the dramatic increase in Hepatitis C infections is causing great concern that increases in HIV infection will

[4] see Appendix C

follow shortly. AIDS Vancouver's primary focus continues to be on those with HIV or AIDS and as such we will continue to work with co-infected individuals in the context of their HIV/AIDS status.

Themes

- The recent increase of crystal methamphetamine[5] use has the potential to increase HIV infection among certain populations such as youth, gay men, etc. Readily available, reasonably inexpensive and easy to use, crystal methamphetamine use can reduce inhibitions increasing high-risk activities.

- It has been estimated that only 30% of those eligible for antiretroviral (AVR) drugs in Vancouver are receiving them. To maintain the positive effects of ARV's, the treatment regime must be adhered to a minimum 90% of the time, creating a variety of treatment challenges for marginalized populations.

- As HIV-positive people begin to live longer, and older members of our communities become infected and begin treatment, age-related issues are becoming a significant part of the HIV arena.

- There continues to be a serious lack of knowledge and sense of apathy towards HIV and AIDS among the general public. In addition, there are many misconceptions about HIV, such as the belief that there is a cure or that HIV is simply a manageable chronic illness. For these reasons, it is critically important for AIDS Vancouver and all organizations and governments to work to combat these fallacies.

PURPOSE OF THE STRATEGIC PLAN

An important purpose of this strategic plan is to provide direction to AIDS Vancouver staff, volunteers, and the Board of Directors regarding the focus of their work. It may also serve additional purposes for other individuals or groups who may use the plan. For example:

- It may inform the community at large about the work of AIDS Vancouver and the HIV/AIDS environment in which that work takes place.
- The AIDS Vancouver Board of Directors, through its governance process, will use the measurement indicators identified for each strategic objective to evaluate the organization's overall success.

[5] also known simply as Meth or Crystal

- Other ASO's and health organizations may use this document to better understand AIDS Vancouver's intended contribution to the goals of the HIV/AIDS sector.
- Potential funding partners and donors may use this plan to understand the context within which AIDS Vancouver will use any funds provided or donated.

What This Plan Does Not Include

This is a strategic plan, not an operational plan. Operational plans developed by the staff will be guided by the strategic plan.

Due to AIDS Vancouver's strong infrastructure and administrative capabilities this plan focuses on broader local and global HIV/AIDS leadership issues. It is intended that annual agency plans be developed to identify the activities that will be undertaken to fulfill the objectives described in this document.

GOAL AND OBJECTIVES

Certain terms and concepts that may mean different things to different people are described in the following section in order to ensure consistency as it pertains to this particular document.

DEFINITIONS:

Leadership

Leadership means staying ahead of the issues and providing a cutting edge conduit to the broader community and the media to help keep them accurately informed. AIDS Vancouver is often seen as a leader in the HIV/AIDS community in Vancouver and across Canada. AIDS Vancouver wishes to enhance this leadership position by *leading through action* in areas where AIDS Vancouver is best positioned to lead.

Leadership also means being politically astute and able to balance responsiveness and action with sustainability. In this regard, being a leader includes building and strengthening collaborative relationships with other ASO's and ASO coalitions (such as the Pacific AIDS Network). These activities may include seeking and maintaining partnerships where AIDS Vancouver can help to build capacity, act as a catalyst, maintain information resources, assist with infrastructure or act as a mentor for volunteer training, case management or prevention activities.

Finally, leadership means being accountable. In this case accountability includes: maintaining strong, transparent internal systems; participating in

appropriate regional, provincial, and federal advocacy efforts; and engaging the greater community in our mission both as volunteers and as donors.

Prevention

HIV prevention at AIDS Vancouver is thought of in a much broader way today than it was 23 years ago. At AIDS Vancouver, HIV prevention is viewed as a comprehensive approach that addresses: 1) individual risk scenarios and issues that create vulnerability to HIV infections at a population level in order to prevent new infections among HIV negative individuals and re-infection among individuals living with HIV; 2) quality of life issues that may impact on an individual's ability to maintain practices that reduce the potential of transmitting HIV to others and that slow the progression of HIV disease for people living with HIV; 3) public policy and social issues that can contribute to reducing the impact of HIV and AIDS related stigma and discrimination for individuals and communities affected by HIV.

Quality of life for HIV/AIDS infected and affected people

Quality of life, as viewed by AIDS Vancouver, includes self-determination, self-care, and self-reliance. It covers all aspects of a person's life and the support that increases the individual's capacity to affect his or her own life.

To assist HIV/AIDS infected and affected people to achieve a quality life, AIDS Vancouver works to reduce the impact of HIV on the individual and on the communities most impacted by HIV/AIDS. This is accomplished by working to reduce prejudice, stigma and discrimination of those living with HIV/AIDS, while also working to reduce harm through the provision of accessible services and specific interventions designed to meet the unique needs of the individual.

AIDS Vancouver works through partnerships and relationships with other agencies on larger issues related to HIV/AIDS, such as problematic substance abuse, housing, harm reduction and the provision of protection and refuge for marginalized and vulnerable people. This work, like prevention, is done within a framework of social justice and support.

In addition, in order to ensure an appropriate quality life for AIDS Vancouver staff and volunteers, self-care is also focused on in order to reduce the potential for staff and volunteer burnout.

The plan which follows outlines the governance process to empower the Board of Directors to monitor the progress towards achieving the objectives for each goal. The indicators will provide the framework of accountability for the agency and will contribute to the future success of our work.

GOAL: To advance our leadership position in the HIV/AIDS field.

Objective		**Leadership**
Build productive relationships.		Board Chair, Executive Director
Indicators	**Measures and data sources**	**Governance**
We are perceived as a significant player.	• Annual accumulation of "working relationships". • Periodic satisfaction survey of key partners.	Timeline and measures of each indicator reported to the Board of Directors by the Executive Director semi-annually with the first report due April 01, 2007.
Our resources are perceived as desirable.	• Annual accumulation of AV success stories.	
Our brand is recognized and valued.	• Annual accumulation of "good press".	
Our volunteers are effective.	• Volunteer records of numbers and participation.	
We are a recipient of donations.	• Annual donation highlights: individual donors, fundraising activities, 3rd party fundraisers.	
Our clients build their capacities.	• Quarterly reports (numbers): requests for resources; information requests; info-resource distribution; library inquiries/attendance; telephone, in-person and internet contact data.	

Objective		**Leadership**
Influence the HIV/AIDS policy agenda.		Board Chair, Executive Director
Indicators	**Measures**	**Governance**

Media perceives us as a credible source.	• Annual compilation of media requests, consulting topics.	Timeline and measures of each indicator reported to the Board of Directors by the Executive Director semi-annually with the first report due April 01, 2007.
We are consulted on policy development.	• Annual participation in agenda-setting activities.	
We are a key participant in networks and coalitions.	• Annual description of network activities.	
Objective		**Leadership**
Develop our leadership capacities.		Board Chair, Executive Director
Indicators	**Measures**	**Governance**
We have a competent board of directors.	• Rotation of board chair and executive responsibilities. • Annual review of success: recruitment of new members; range of skills, quality of participation and attendance; and understanding of role and governance model.	Reviewed annually by the Board of Directors prior to the AGM.
We have an effective management team.	• Performance reviews.	Completion of annual performance evaluations of Management staff provided to Board of Directors by Executive Director.

GOAL: To increase our capacities for effective HIV/AIDS prevention.

<table>
<tr><td colspan="2">Objective</td><td>Leadership</td></tr>
<tr><td colspan="2">Enhance engagement with HIV affected populations.</td><td>Director, HIV Prevention and Awareness Programs and Board Director</td></tr>
<tr><td>Indicators</td><td>Measures</td><td rowspan="11">Governance
Monthly – ED Report to indicate “on schedule”, “completed”, or issues against milestones.
Variations reported quarterly.
Short presentations provided to Board when appropriate.
Work plans with concrete measurable milestone will be presented to Board.</td></tr>
<tr><td>We provide ample opportunities for involvement in initiatives.</td><td>Annual review of prevention initiatives by affected population.
Evaluation reports: programs, campaigns, interventions.</td></tr>
<tr><td colspan="2">Objective</td></tr>
<tr><td colspan="2">Promote opportunities for learning and development.</td></tr>
<tr><td>Indicators</td><td>Measures</td></tr>
<tr><td>We provide a variety of volunteer and staff training opportunities.</td><td rowspan="2">Compilation of annual training and development activity, participation.
Annual review of conference submissions and invited presentations.</td></tr>
<tr><td>We promote external learning and development opportunities.</td></tr>
<tr><td colspan="2">Objective</td></tr>
<tr><td colspan="2">Increase funding resources for prevention.</td></tr>
<tr><td>Indicators</td><td>Measures</td></tr>
</table>

We are successful grant recipients. Our prevention committed resources expand. We recover production and distribution costs. We receive prevention designated donations.	• Annual accumulation of grant submissions and funds received, compared with previous years. • Annual cost-recovery report. • Annual total prevention-designated donations.	
Objective		
Improve the effectiveness of programs and interventions.		
Indicators	**Measures**	
Affected populations value efforts and perceive them to be important. A sustainable prevention planning framework exists. Conditions actually change for affected populations.	• Evaluation reports: programs, campaigns, interventions. • Annual review of planning framework and success anecdotes. • Annual case stories of community benefit.	

GOAL: To meet the health needs of our HIV affected clients.

Objective		**Leadership**
Advocate for optimal health care, housing, income security and psychosocial support.		Director, Client Services and Board Director
Indicators	**Measures**	**Governance**

Our clients receive health care that meets their needs.	• Annual client satisfaction review/survey.	Time line and measures are reported to the Board semi-annually with first report due April 01, 2007.
Our clients get adequate housing.	• Annual accumulation of success stories.	
Our clients receive optimal income security.	• Quarterly reports: case management intervention; health care, housing, income and psychosocial support; service events; new admissions, drop-ins, scheduled sessions; grocery distribution.	
Our clients have access to the psycho-social support they require.		
We identify and address gaps in the HIV care system.		

Objective		**Leadership**
Improve access to health information.		Director, Client Services and Board Member
Indicators	**Measures**	**Governance**
Our clients perceive us as a reliable source of health information.	• Annual client satisfaction survey. • Quarterly reports; intake, reception, help-line, library and internet usage.	Time line and measures are reported to the Board semi-annually with first report due April 01, 2007.
Our clients are satisfied with our assistance in enabling access to health information.		

GOAL: To create a supportive environment for clients that promotes health and well being.

Objective	**Leadership**
Ensure physical safety.	Management Team and Board Director

Indicators	Measures	Governance
Health and safety policies are in place.	• Reports of infractions compared to previous years. • Annual client satisfaction survey.	Time line and measures are reported to the Board semi-annually with first report due April 01, 2007.
A Code of Conduct is observed.		
Our physical environment is perceived as comfortable, nurturing and inviting.		
Objective		**Leadership**
Promote conditions that support emotional safety.		Management Team and Board Director
Indicators	**Measures**	**Governance**
We are perceived to be a supportive workplace.	• Staff performance reviews.	Time line and measures are reported to the Board semi-annually with first report due April 01, 2007.
Personnel receive appropriate training.		
We are perceived as a "comfortable, nurturing and inviting" agency.	• Annual client satisfaction survey.	
Objective		**Leadership**
Improve accessibility to all programs and services.		Management Team and Board Director
Indicators	**Measures**	**Governance**
Barriers are identified, documented and removed.	• Annual client satisfaction survey.	Time line and measures are reported to the Board semi-annually with first report due April 01, 2007.
Assessments are conducted regularly.	• Annual review of client demographics compared to current HIV epidemiological data for BC.	

GOAL: To reduce HIV stigma and discrimination.

Objective		**Leadership**
Address the experience of stigma and discrimination.		Management Team and Board Director
Indicators	**Measures**	**Governance**
Our programs and services help to reduce stigma and discrimination.	• Annual client satisfaction survey. • Annual review of success stories.	Time line and measures are reported to the Board semi-annually with first report due April 01, 2007.

Objective		**Leadership**
Extend awareness and promote human rights.		Management Team and Board Director
Indicators	**Measures**	**Governance**
Our actions advance human rights.	• Annual review of success stories.	Time line and measures are reported to the Board semi-annually with first report due April 01, 2007.

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Human Rights And The AIDS Crisis: The Debate Over Resources, K. Roth
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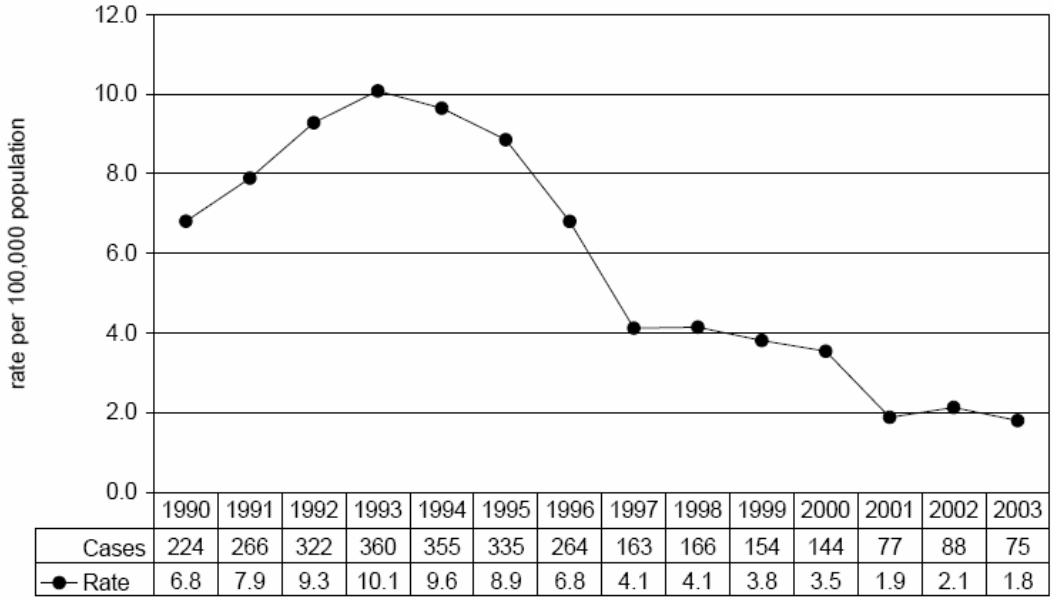
APPENDIX A – BC CDC Statistics on AIDS and HIV

It is important to remember that the future trends may be quite different from the historical ones. Therefore, the following information is offered more to set context than to inform specific future direction.

Section 1.0 - AIDS

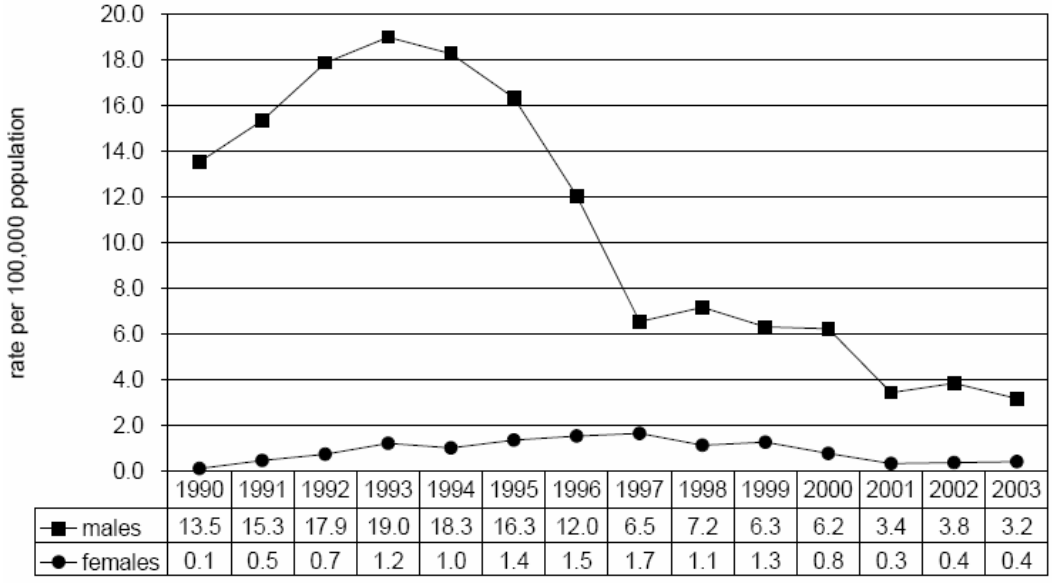
RATE is per 100,000 population.

Graph 1.1
AIDS Case Reports by YEAR OF DIAGNOSIS, 1990 to 2003



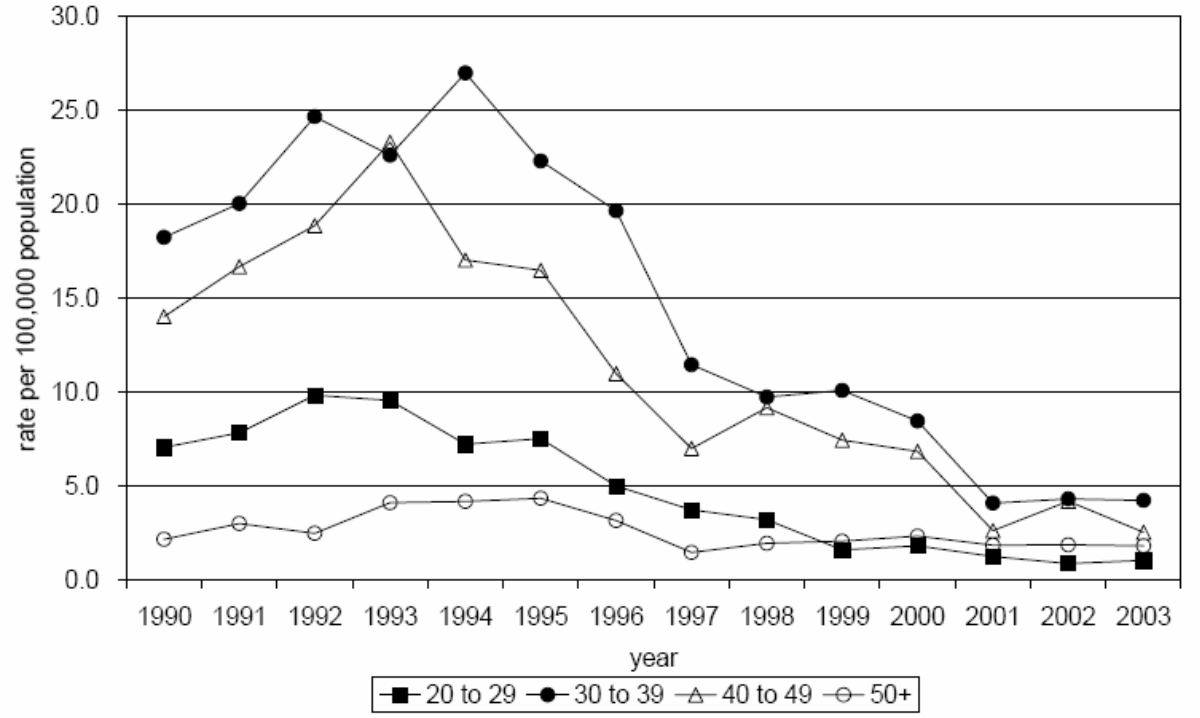
	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Cases	224	266	322	360	355	335	264	163	166	154	144	77	88	75
Rate	6.8	7.9	9.3	10.1	9.6	8.9	6.8	4.1	4.1	3.8	3.5	1.9	2.1	1.8

Graph 1.2
AIDS Case Reports by GENDER and YEAR OF DIAGNOSIS, 1990 to 2003



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
males	13.5	15.3	17.9	19.0	18.3	16.3	12.0	6.5	7.2	6.3	6.2	3.4	3.8	3.2
females	0.1	0.5	0.7	1.2	1.0	1.4	1.5	1.7	1.1	1.3	0.8	0.3	0.4	0.4

Graph 1.3
AIDS Case Reports by AGE and YEAR OF DIAGNOSIS, 1990 to 2003



Graph 1.4
AIDS Case Reports by RISK CATEGORY and YEAR OF DIAGNOSIS, 1990 to 2003

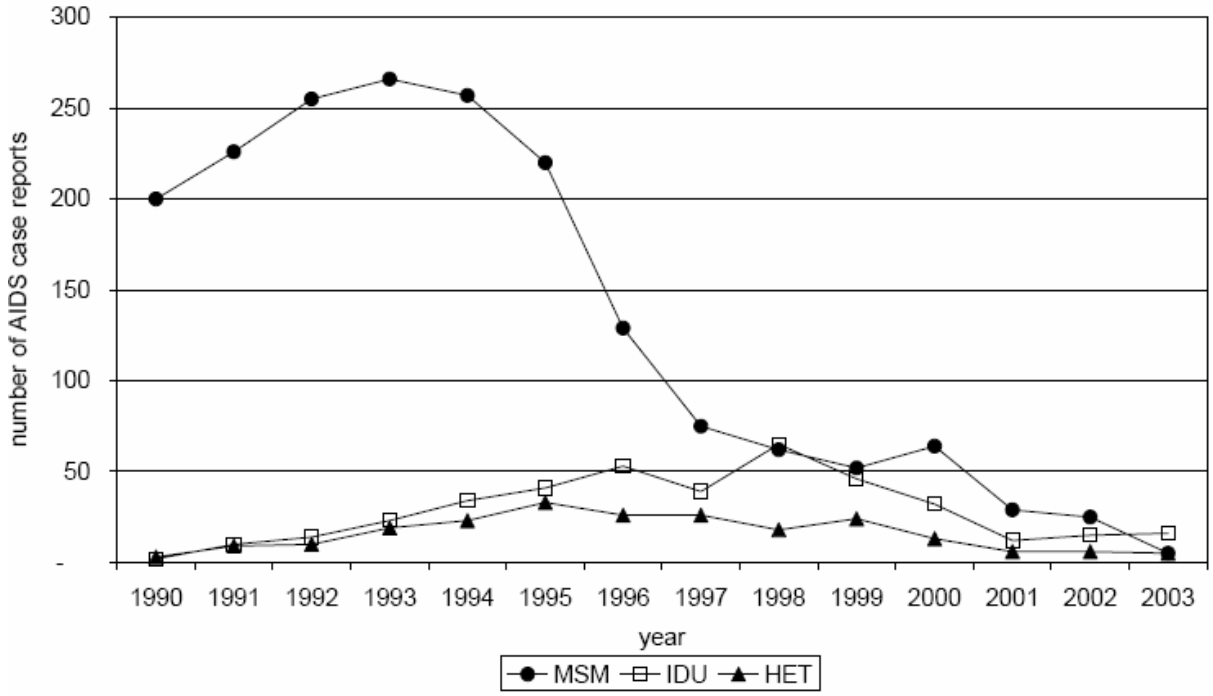


Table 1.5
AIDS Case Reports by RISK CATEGORY, GENDER and YEAR OF DIAGNOSIS, 1997 to 2003

Risk Category	AIDS	1997	1998	1999	2000	2001	2002	2003	TOTAL
MSM or WSW	males	75	62	52	64	29	25	5	2,524
	females	-	-	-	-	-	-	-	
	total	75	62	52	64	29	25	5	2,524
MSM/IDU or WSW/IDU	males	5	1	9	5	3	3	2	171
	females	-	-	-	-	-	-	-	
	total	67	1	9	5	3	3	2	233
IDU	males	22	47	34	24	10	13	13	295
	females	17	18	12	8	2	2	3	113
	total	39	65	46	32	12	15	16	408
heterosexual contact	males	16	15	14	9	3	5	2	139
	females	10	3	10	4	3	1	3	93
	total	26	18	24	13	6	6	5	232
hemophiliac	males	1	-	-	-	-	-	-	24
	females	-	-	-	-	-	-	-	2
	total	1							26
blood/BP recipient	males	-	-	-	1	-	-	-	11
	females	-	1	-	-	-	-	-	9
	total		1		1				20
perinatal	males	1	-	-	-	-	-	-	5
	females	1	-	-	-	-	-	-	5
	total	2							10
occupational exposure	males	-	1	-	-	-	-	-	1
	females	-	-	-	-	-	-	-	
	total		1						1
unknown	males	9	17	18	23	25	33	44	293
	females	5	1	4	4	2	5	3	37
	total	14	18	22	27	27	38	47	330
total*:	males	129	143	127	126	70	79	66	3,463
	females	33	23	26	16	7	8	9	259
	total	163	166	154	144	77	88	75	3,730

total* - Includes gender unknown.
TOTAL column to the far right is cumulative from 1983 to 2003 December 31.

MSM – men who have sex with men
WSW – women who have sex with women
IDU – injection drug user
HET – heterosexual contact
blood/BP recipient – blood or blood product recipient

Table 1.7
AIDS Case Reports by HEALTH SERVICE DELIVERY AREA*
and YEAR OF DIAGNOSIS, 1997 to 2003

HA	HSDA	AIDS	1997	1998	1999	2000	2001	2002	2003	TOTAL
Fraser	Fraser East	cases	5	4		1	1	3		52
		rate	2.11	1.67		0.41	0.40	1.18		
	Fraser North	cases	12	7	13	8	10	11	4	205
		rate	2.38	1.37	2.49	1.50	1.84	1.99	0.71	
	Fraser South	cases	11	6	12	9	4	9	6	161
		rate	1.96	1.05	2.06	1.52	0.66	1.46	0.96	
Interior	East Kootenay	cases					2			12
		rate					2.53			
	Kootenay Boundary	cases	3	1				2	1	24
		rate	3.68	1.23				2.51	1.26	
	Okanagan	cases	4	4	8	5	4	4	5	82
		rate	1.33	1.31	2.61	1.62	1.29	1.28	1.59	
	Thompson Cariboo Shuswap	cases	2	5	1	3	2	2	3	41
		rate	0.92	2.31	0.46	1.38	0.93	0.92	1.38	
Northern	Northeast	cases								8
		rate								
	Northern Interior	cases	6	4	2	1	4		3	36
		rate	3.83	2.57	1.30	0.65	2.65		1.97	
	Northwest	cases	1	1	2	1			1	14
		rate	1.11	1.13	2.28	1.19			1.18	
Vancouver Coastal	North Shore/Coast Garibaldi	cases	6	8	7	10	4	2	2	153
		rate	2.30	3.04	2.65	3.77	1.50	0.74	0.74	
	Richmond	cases		1	2	3	3	3	4	58
		rate		0.61	1.20	1.77	1.74	1.72	2.27	
	Vancouver	cases	96	102	84	83	31	44	35	2,433
		rate	17.25	18.10	14.72	14.36	5.28	7.44	5.86	
Vancouver Island	Central Vancouver Island	cases	5	7	2	5	3	2	3	76
		rate	2.11	2.94	0.84	2.10	1.25	0.83	1.24	
	North Vancouver Island	cases	1	2	1	2		1	2	21
		rate	0.85	1.70	0.86	1.75		0.87	1.75	
	South Vancouver Island	cases	11	10	19	8	8	5	5	292
		rate	3.28	2.97	5.62	2.36	2.34	1.47	1.46	
unknown	unknown	cases		4	1	5	1		1	62
		rate								
total:		cases	163	166	154	144	77	88	75	3,730
		rate	4.12	4.15	3.82	3.55	1.88	2.12	1.79	

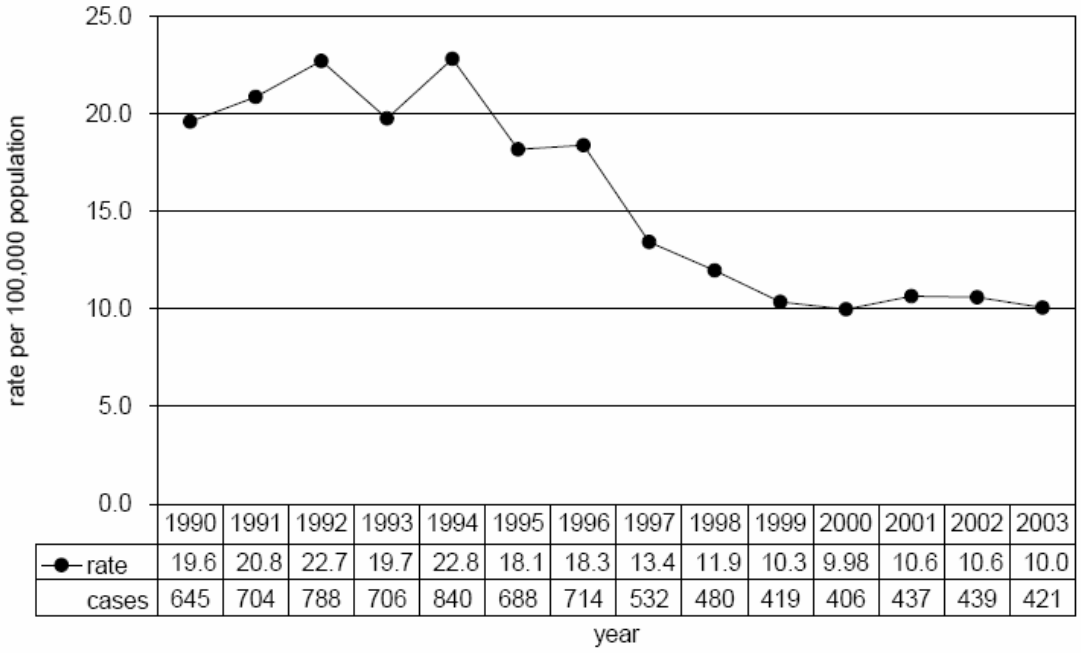
HSDA* - An AIDS case report, by year of diagnosis, is designated to the appropriate HSDA according to the patient's place of residence at the time of his/her diagnosis of AIDS (i.e. first disease indicative of AIDS).

HA – Health Authority
HSDA – Health Service Delivery Area

Rate is per 100,000 population.
TOTAL column to far right is cumulative from 1983 to 2003 December 31.

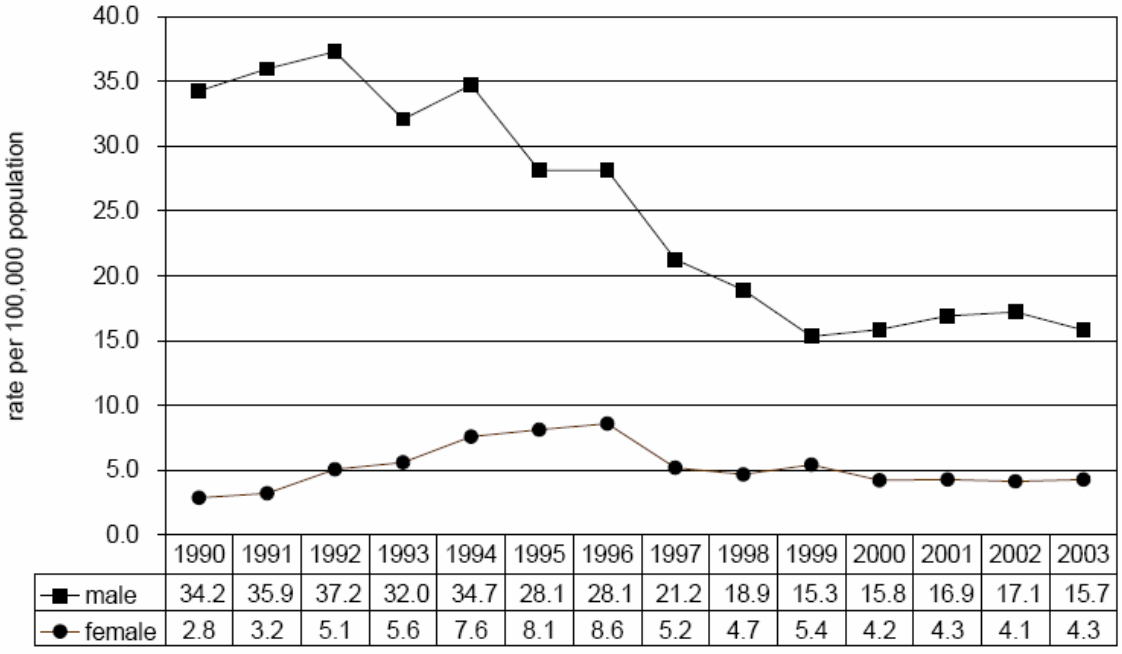
Section 2.0 - HIV

Graph 2.1
Persons Testing Newly Positive for HIV by YEAR OF TESTING, 1990 to 2003



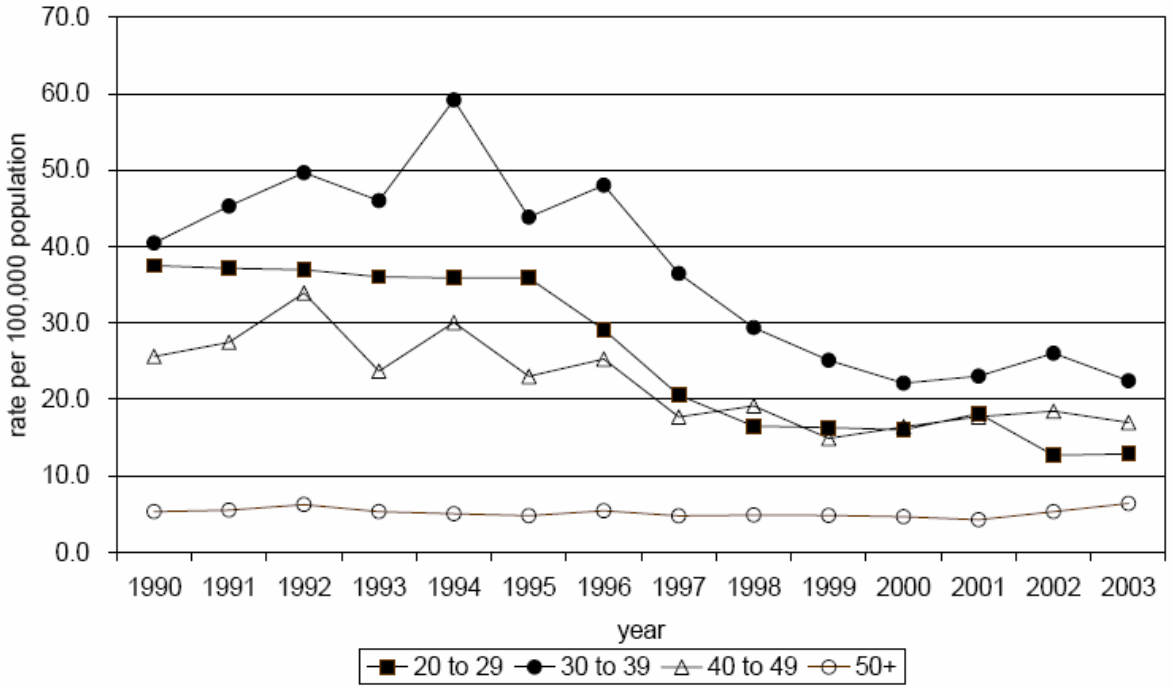
	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
rate	19.6	20.8	22.7	19.7	22.8	18.1	18.3	13.4	11.9	10.3	9.98	10.6	10.6	10.0
cases	645	704	788	706	840	688	714	532	480	419	406	437	439	421

Graph 2.2
Persons Testing Newly Positive by GENDER and YEAR OF TESTING, 1990 to 2003



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
male	34.2	35.9	37.2	32.0	34.7	28.1	28.1	21.2	18.9	15.3	15.8	16.9	17.1	15.7
female	2.8	3.2	5.1	5.6	7.6	8.1	8.6	5.2	4.7	5.4	4.2	4.3	4.1	4.3

Graph 2.3
HIV by AGE and YEAR OF TESTING, 1990 to 2003



Graph 2.4
Persons Testing Newly Positive for HIV by RISK CATEGORY and YEAR OF TESTING, 1990 to 2003

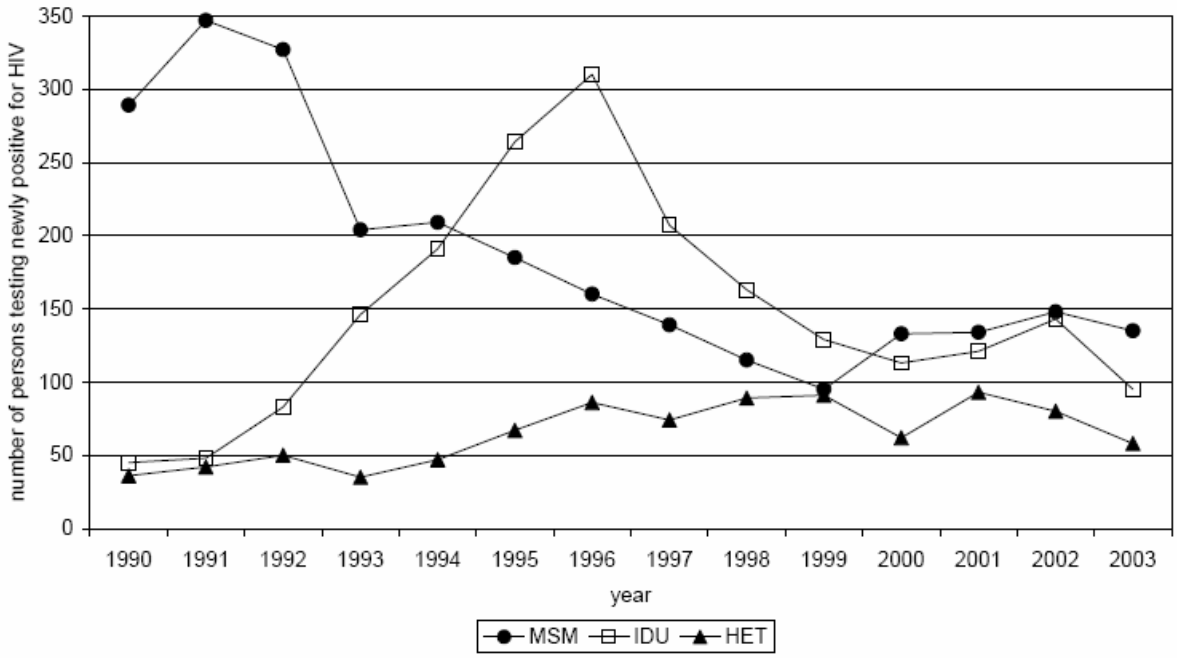


Table 2.15
Persons Testing Newly Positive for HIV by HEALTH SERVICE DELIVERY AREA* and YEAR OF TESTING, 1997 to 2003

HA	HSDA	HIV	1997	1998	1999	2000	2001	2002	2003	TOTAL
Fraser	Fraser East	persons	10	17	8	23	11	12	5	117
		rate	4.22	7.11	3.30	9.40	4.42	4.72	1.94	
		tests								-
	Fraser North	persons	50	27	29	47	38	47	43	407
		rate	9.93	5.27	5.55	8.82	6.99	8.51	7.66	
		tests								-
	Fraser South	persons	53	33	19	19	35	41	36	289
		rate	9.43	5.76	3.26	3.21	5.80	6.67	5.75	
		tests								-
Interior	East Kootenay	persons	1	2	3	1	1	1	3	17
		rate	1.26	2.54	3.81	1.27	1.26	1.25	3.73	
		tests								-
	Kootenay Boundary	persons	1	1	2	1	4	-	2	20
		rate	1.23	1.23	2.47	1.24	4.99		2.52	
		tests								-
	Okanagan	persons	9	14	6	16	11	11	15	113
		rate	2.99	4.60	1.96	5.19	3.54	3.53	4.78	
		tests								-
	Thompson Cariboo Shuswap	persons	5	10	3	8	13	8	12	72
		rate	2.31	4.62	1.39	3.69	6.06	3.69	5.53	
		tests								-
Northern	Northeast	persons	1	-	-	2	-	2	1	6
		rate	1.54			3.12		3.08	1.52	
		tests								-
	Northern Interior	persons	4	3	4	4	9	8	17	58
		rate	2.55	1.93	2.60	2.61	5.95	5.29	11.19	
		tests								-
	Northwest	persons	1	2	2	1	3	2	3	16
		rate	1.11	2.25	2.28	1.19	3.55	2.37	3.54	
		tests								-

HEALTH SERVICE DELIVERY AREA*- A person testing newly positive for HIV is designated to the appropriate HSDA according to the person's city of residence. If the person's city of residence is not available then the person is designated to the city of the clinic or physician where the person was tested.

HA – Health Authority
HSDA – Health Service Delivery Area

TESTS is number of HIV tests performed, both positive and negative, at the BCCDC Laboratory Services.
RATE is per 100,000 population.
TOTAL column to far right is cumulative from 1995 to 31 December 2003.

Table 2.15 (continued)
Persons Testing Newly Positive for HIV by HEALTH SERVICE DELIVERY AREA*
and YEAR OF TESTING, 1997 to 2003

HA	H S D A	HIV	1997	1998	1999	2000	2001	2002	2003	TOTAL
Vancouver Coastal	North Shore/Coast Garibaldi	persons	16	13	8	12	13	12	14	117
		rate	6.13	4.94	3.03	4.53	4.87	4.46	5.17	
		tests								-
	Richmond	persons	3	5	1	6	6	9	7	48
		rate	1.87	3.05	0.60	3.55	3.48	5.15	3.97	
		tests								-
	Vancouver	persons	332	310	303	221	241	228	212	2,733
		rate	59.64	55.00	53.08	38.23	41.06	38.54	35.50	
		tests								-
Vancouver Island	Central Vancouver Island	persons	17	10	11	12	13	10	9	106
		rate	7.17	4.20	4.61	5.03	5.42	4.15	3.72	
		tests								-
	North Vancouver Island	persons	2	4	2	2	1	6	3	31
		rate	1.70	3.40	1.72	1.75	0.88	5.25	2.62	
		tests								-
	South Vancouver Island	persons	24	28	17	30	35	40	38	297
		rate	7.16	8.32	5.03	8.86	10.25	11.74	11.13	
		tests								-
unknown	unknown	persons	3	1	1	-	-	-	-	82
		tests								
non-BC	non-BC	persons	-	-	-	1	3	2	1	7
total:	total:	persons	532	480	419	406	437	439	421	4,536
		rate	13.44	12.01	10.40	10.00	10.65	10.60	10.07	
		tests	-	-	-	-	-	-	-	-

HEALTH SERVICE DELIVERY AREA*- A person testing newly positive for HIV is designated to the appropriate HSDA according to the person's city of residence. If the person's city of residence is not available then the person is designated to the city of the clinic or physician where the person was tested.

HA – Health Authority
HSDA – Health Service Delivery Area

TESTS is number of HIV tests performed, both positive and negative, at the BCCDC Laboratory Services.
RATE is per 100,000 population.
TOTAL column to far right is cumulative from 1995 to 31 December 2003.

APPENDIX B – Strategic Plan Contributors

External Input Sources

- A Loving Spoonful
- ASIA
- BCPWA
- Canadian AIDS Society
- CDC
- BC Centre for Excellence in HIV/AIDS
- Dr. Peter Centre
- Friends for Life
- Healing Our Spirit
- Living Positive Resources Centre
- McLaren Housing
- Ministry of Health
- Provincial Health Services
- Public Health Agency of Canada
- St. Paul's Hospital
- The Portland Hotel
- Vancouver Costal Health
- Vancouver Native Health
- YouthCO AIDS Society

Board, Staff and Volunteer Participants

Board Participants

Tony Cave
Paul Harris
Matt Lovick
Gillian Maxwell
Warren Michelow
Jamie Myrah
Ken Werker

Staff & Volunteer Participants

Nancy Armitage
Phillip Banks
William Booth
Zdenky Burkhardt
Miranda Compton
John Dubé
Michael Mancinelli
Sonia Marnio
Richard O'Donnell
Kasandra Van Keith

Clients

Three focus groups were held: one gay men only, one women only and one mixed group (including men, women and trans-gendered). All participants are HIV positive. In total, approximately 20 clients participated. To protect their privacy, their names are not listed.

APPENDIX C – Comparative Timeline –
AIDS Vancouver Activities in the World AIDS Context

Year	What's Happening in the World	What's Happening at AV
1979	AIDS first acknowledged	
1981	US gay men start "experiencing unusual type of immune system failure" First recorded case of AIDS in the US	
1982	First reported case of AIDS in Canada	
1983	AIDS still not a recordable disease but alarm is growing; 24 known cases in Canada; people with AIDS asked to refrain from donating blood.	AIDS Vancouver Founded 6 known cases of AIDS in Vancouver; #1 priority – information dissemination Handbills, posters, newsletter and brochures main focus in awareness campaign; Forum held - topic(s) not clear - counselling sessions available; Government funding sought for organization - goal is a project to allow AV to screen the at-risk population; Monthly public meetings held at Lotus Hotel; City's Health dept has no plans to print AIDS material; SFU Criminology class interested in AIDS in prison, ask for speaker from AV; Hotline getting 4 to 6 calls per day.

1984	Discovery of the virus (HIV) that causes AIDS (HIV successfully cultured from patients with AIDS); Safe sex and condom use becomes focus of prevention campaigns; Provincial (BC) Committee on AIDS established by Health Minister.	AV established Emergency Assistance Fund for persons with AIDS; DARE (Dedicated AIDS Resource Effort) established to act a fundraising arm for ASOs; AV provides brochure to health professionals in the City; Support group established to help PWA get federal funding to help with medical coverage; Local Knowledge Network program produced, aired and re-aired; Awareness meeting with Bath owners; Brief given to Mayor and City Council.
1985	First test for HIV approved in the US; Testing of blood supplies for HIV start; National Advisory Committee on AIDS holds conference.	Poster campaign designed regarding blood donation and testing.
1986	Canadian AIDS Society hosts 2 day conference in Toronto	"Awareness Project" - focused on Provincial Minister of Health
1987	Agreed upon definition of AIDS – HIV infection and either at least one opportunistic infection from a list – pulmonary TB, pneumonia and invasive cervical cancer or a T-cells count of less than 200; AZT becomes first drug approved by FDA to treat AIDS.	$29,000 federal grant obtained for PWA Coalition; AV underwrites rental housing for palliative care; Workshops held for businesses, community clinics and city health street programs; Educational material and pamphlets major focus.
1988	AIDS is the third leading cause of death in US men aged 25-44; AIDS Clinical Trial Program started at the University Hospital (Stony Brook New York).	AV moves from Davie St to Richards St.; Educational assessment of Gay & Bisexual men in Vancouver completed from which program needs were determined and funding obtained to develop them; Client services expand lay and professional counseling services.
1990	U of T given federal funding for Treatment Information System for AIDS and HIV; WHO spends about $70 million (US) on AIDS programs; Canadian Clinical Trials Network established.	AV has 299 clients; Main areas: Helpline, Speakers Bureau & Print Resources; High demand for support groups; Buddy Program expanded to over 60 buddies; Man to Man program starts and first Safer Sex – Choices for Life campaign.

1991	Risky activities listed as unprotected sex and injection drug use; Safe activities listed as: living in the same apartment, sitting in a waiting room hugging, touching and other casual contact; AIDS listed as second leading cause of death in US men aged 25-44; Ottawa expands anonymous AIDS testing 9864 cases of HIV in Canada – 1377 have died of AIDS; Nova Scotia teacher diagnosed with HIV banned from classroom; US lifts ban on visitors with AIDS; Magic Johnson announces he has AIDS 3 people die of AIDS from transplanted organs from a donor who had AIDS; WHO Spends less than $50 million (US) on AIDS Programs; Average spending on prevention programs across North America is about $2.70 (US) per person; The first AIDS Awareness Week happens in Canada.	First full year for Man to Man focuses on education / prevention program print campaign, workshops, public sex education (operation Latex Shield), and special events; First year of AIDS in the Workplace program on Skytrain and buses; Speaker's Bureau continued, Helpline continued, also Food Bank program; AV has 681 clients.

1992	WHO estimates 30-40 million will be infected by 2000; DDC becomes the third drug approved by FDA; 1.7 million cases of HIV world wide: 69% are in Africa, US 16%, Canada not listed; AIDS is TIME magazine cover story; 1993 – WHO estimated AIDS cases would increase 9 time during the 1990's Worldwide there were 11 to 13 million infected with HIV with 1.5 million of those having AIDS; BC Social Credit government introduces Bill 34 which would allow those testing positive for HIV to be quarantined; Focus is on sex, injection drug use, breast milk of infected mothers to their babies (rare), but not shaking hands, hugging, kissing, coughing, sneezing, swimming pools, food, utensils, toilet seats. Treatment focuses on eating well, getting enough sleep, exercise and not smoking. Prevention focus is safe sex, condoms, avoiding injection drug use; Changing face of AIDS (beyond Gay men and intravenous drug users) gets wide press exposure.	AV and Vancouver Persons with AIDS Society join forces as AIDS Resource Centre; Man to Man education / prevention program print campaign, workshops, public sex education (operation Latex Shield), and special events; New programs: Health Promotion for people living with AIDS and HIV; Women's Education, Asian AIDS Education, and Provincial Outreach.

1993	Canadian AIDS Society argues for inclusion of 200 T-Cell criterion into the definition of AIDS; Videx used in Canada has fewer side-effects than AZT; People starting living longer with AIDS – news articles talk about "wonder drug" as "cure-like"; Recognition that people may live about 10 years with HIV before infections start showing up; Blacks and Hispanics start showing increases in HIV.	AV indicates that 6600 HIV infected people live in BC with over 30 people dying in Vancouver every month; AV issues research report "Taking Care of Each Other: health promotion in community" based AIDS work – a federally funded project; **Mission statement:** *AV is a non-profit volunteer and community-based organization serving the diverse needs of the communities affected by HIV and AIDS.* Case Management introduced to address client's long-term planning needs and to provide comprehensive care coordination; Project Sustain – health promotion, to assist people living with HIV in maintaining a healthy lifestyle; PARC Avenue Grocery has 250 clients weekly; **Services**: "intake, assessment, and referral", care teams, Pet Pal, advocacy and legal aid referral, emergency financial support and medical and treatment information. A collaborative model with Dr. Peter Day Case and others. **Programs:** Man to Man – take pride in yourself, take care of each other; Women's programs – print and distribution of information on HIV and AIDS; Asian support-Aids project (ASAP) – Asian hotline, print campaign in Chinese and Vietnamese, facilitating AIDS/HIV education in Asian community; Workplace project – helping businesses educate re HIV/AIDS; Speakers Bureau with ministry of social services to train their staff; Library – full integration of BCPWA and PARC Libraries into PARC Library Helpline; AV has over 400 volunteers.

1994	News articles focus attention towards HIV, away from AIDS in attempt to encourage hope; Reform Party tries to remove federal funding from 11th Annual AIDS Conference scheduled for Vancouver in 1996; Scientists encourage continued basic research into AIDS pathogenesis and host immune response and a focus on medical engineering to identify new treatment options; 10th Annual International AIDS Conference held in Yokohama Japan.	Shift in focus from traditional crisis intervention to pro-active outreach to target populations. More that 1500 people living in Vancouver with HIV/AIDS; Project Sustain is cornerstone of community services; Includes intake teams & Support programs volunteers, care teams home and hospital visits, buddies, counseling and therapy, medical equipment loans, grocery serves over 300 people a week; Prison outreach added to still ongoing programs; Man to Man work plan - promotes sexual health for gay and bi men and MSM by researching community needs, creating print materials and advertising campaigns for safer sex and self-esteem for gay and bisexual men; facilitating workshops, community forums and training addresses; and coordinating the distribution of materials throughout BC.
1995	UN reports that HIV in women is on the rise	Grocery serving 450 a week; Increasing numbers of women, injection drug users and immigrants getting services; 20% of new clients reside outside of City of Vancouver; Hospital intake expands beyond St. Paul's; 60,000 print items distributed; 30,000 condoms/lubes packages distributed; Community Outreach program added.

1996	Levels of infection rate in lymphatic tissues becomes indicator of rate of progress of HIV; News article states that not everyone who gets HIV will get AIDS; Doctors in San Francisco try using several drugs at once to treat terminal patient with great success (the cocktail is born); Vancouver hosts 11th International Conference on AIDS; "Study-Plan-Do" provincial and national workshops on theory, method and practice of community HIV health promotion.	**Mission Statement** *AV is dedicated to creating supportive environments for people living and affected by HIV and AIDS. We are guided by principles of health promotion and harm reduction, and affirm the voices of those living with HIV and AIDS. We provide support and education; enabling individuals to manage their own health. We are committed to developing collaborative community based response to HIV and AIDS throughout BC and beyond.* The year of "the cocktail" for drug therapy; Working to ensure Canada's National AIDS Strategy will be renewed for another 5 years; Collaborative venture with US AIDS groups on a bicycle tour fundraiser begins; HIV rates rise in injection drug users and young gay men; Women are now 1 in 4 of new clients; Grocery serving 625/wk.
1998	Articles in the press emphasize drug treatments and their effectiveness; UN releases figures show 1% of sexually active people have HIV; Number of teens infected is on the rise; New findings regarding how HIV enters cells; New research looks at protease inhibitors.	Nearly 16,000 clients served; Hep C emerges as major health issue on DTES; Help line getting around 4,600 calls; Print resources produces brochure for men who have sex with women.
1999	C-Section recommended to reduce HIV transmission from infected mothers to their babies; HIV drugs found effective in treating Hep B & C.	Reorganization sees prevention and support combine allowing staff better collaboration on issues; New logo is developed; Strategic plan for 2000 to 2003 developed; Little increases in funding over past 5 years, but case load is up 82%.

2001	AIDS in Africa and China becomes focus in the news; 20 years since AIDS took hold as a major issue; UN looks at the worldwide cost of fighting AIDS and governments won't step up to the reality. Bush says "It's too much".	Partnership with Mexican PWA from Mexico City – funded by CIDA – to exchange assistance and advocacy; New web site launched; New case management model started with 2 components: access – short-term and Intensive – long-term; Programs for women and gay men take a more holistic approach in working with community partners; Gay Men's Health program shifts from strict HIV prevention to broader concepts of health including physical, emotional and spiritual aspects; "Building Gay Men's Health: a Peer-Based Approach to Creating Community Change" was written; Goal of Women's Program – to help women manage their health options base on the ability to make informed decisions; Support Programs includes Care Team program, Home and Hospital Visitor program and Professional Counselling program.
2002	14th Annual Conference held in Barcelona; More that 10,000 US children have AIDS.	ED let go; Board resigns.
2003	Situation in China worsens; South African stock exchange requires all listed companies to make public their AIDS management policies.	New Davie street site for Gay Men's Health opens; **Mission Statement**: *AV exists to alleviate individual and collective vulnerability to HIV and AIDS through care, support, education, advocacy and research.*
2004	UN reports that ½ of known HIV infections are in women; AIDS surpasses Black Death as world's most devastating plague.	Organizational changes streamline administration and reduce overhead; Financially agency gets back into the black; Website is redesigned; Case management serves 1338 clients; Grocery serves 1385 clients.

2005	Concerns about crystal meth's impact on antiretoviral drugs voiced.	25 paid staff and 200 volunteers strive to provide a comprehensive and integrated range of health promotion, education, and support services. AIDS Vancouver delivers several key programs and services: Case Management; Grocery Program; PARC Library; Women's Programs; Gay Men's Health; Helpline; Support Programs.