

Government of Canada
Report to the Secretary General
of the United Nations on the
United Nations General Assembly Special Session
on HIV/AIDS
Declaration of Commitment on HIV/AIDS
January 2003 – December 2005

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Foreword

Canada is pleased to submit its third report to the Secretary General of the United Nations on the UNGASS Declaration of Commitment on HIV/AIDS. Since the 2003 report, there has been significant progress made with the launch of *Leading Together: Canada Takes Action on HIV/AIDS, 2005-2010*. This blueprint for Canada-wide action calls for consolidated action on all fronts, including governments, community, researchers, individuals and others involved in Canada's response to HIV/AIDS. The *Federal Initiative to Address HIV/AIDS in Canada* (hereafter, the *Federal Initiative*) has also been launched, with an increase in ongoing federal HIV/AIDS funding of the domestic response from \$42.2 million per annum to \$84.4 million by 2008-09. Canada's provinces and territories are responsible for the delivery of health care and have made significant contributions to the response to HIV/AIDS both through the funding of medical services and the implementation of strategies to address HIV/AIDS. The Declaration has been an important tool for Canada to inform the development of these approaches, and we look forward to working with UNAIDS over the coming year as Canada continues to operationalize the Declaration domestically.

While this report focuses mainly on the domestic response, it is important to note that Canada is committed to helping global efforts to meet the UNGASS Commitments through our development assistance programs, contributions to global initiatives, and support given to policy development within global fora. In 2004-05, the Canadian International Development Agency contributed \$234 million to the global response as an example of our dedication to this international crisis.

The Canadian response is built on partnerships: between governments at all levels, non-governmental organizations, community groups, people living with and at-risk of HIV/AIDS, researchers and scientists. Community non-governmental organizations have been at the heart of the Canadian response to HIV/AIDS since the very beginning of the epidemic and continue to play a key role in guiding the response. Across the country, people have come together and organized to protect, inform, support and care for each other and their communities including Aboriginal peoples, the gay and lesbian community, women's groups, social service agencies, etc. Many have reached beyond their own communities to support the efforts of other groups. Networks have developed and true collaborations are increasingly common. Canada's approach is grounded in human rights and the determinants of health and seeks to address and overcome the stigma and discrimination faced by those living with HIV/AIDS and those at risk.

Building on our domestic and international work, Canada looks forward to hosting the XVI International AIDS Conference in Toronto in 2006 and to hosting the 17th International Conference on the Reduction of Drug Related Harm

in Vancouver. This will be the third time that Canada has hosted the International AIDS Conference, and it will be an opportunity for all participating countries to share their experience in responding to HIV/AIDS and to learn from the global response.

I. Status at a glance

Overview of the epidemic

Estimated number of Canadians living with HIV in 2002: 56,000

Estimated number of Canadians who have died of AIDS as of 2002: 13,000

Populations most-at-risk: Gay men, people who use injection drugs, Aboriginal people, prisoners, women, people from countries where HIV is endemic, and youth

Strategic Responses

Leading Together: Canada Takes Action on HIV/AIDS (2005-2010), a blueprint for Canada-wide action on HIV/AIDS, developed through a multi-stakeholder process, has been released. This plan calls for action from all sectors in the Canadian response to HIV/AIDS, including governments, communities, researchers and individuals, and lays out specific actions and targets to address the epidemic.

The *Federal Initiative to Address HIV/AIDS in Canada (Jan 2005)*: Evolving from the previous Canadian Strategy on HIV/AIDS, the *Federal Initiative* will focus on five federal areas of priority: program and policy interventions; knowledge development; communications and social marketing; coordination, planning, evaluation and reporting; and global engagement. This national priority was further supported with an increase in ongoing federal HIV/AIDS funding of the domestic response from \$42.2 million per annum to \$84.4 million by 2008-09.

Concurrent with these national directions, most provinces and territories have taken initiative by adopting or renewing HIV/AIDS strategies, whether as part of an integrated approach to bloodborne pathogens and/or sexually transmitted infections, or as stand-alone approaches.

II. Overview of the AIDS epidemic

It is estimated that, as of 2002, 13,000 Canadians have died of AIDS and 56,000 are currently infected with HIV. Of those infected, it is estimated that 17,000 are unaware of their infection and between 2800 and 5300 new infections occurred in 2002 despite prevention efforts.

Men who have sex with men continue to be the population most affected by HIV/AIDS, accounting for an estimated 58 percent of all HIV infections, followed by people who use injection drugs at about 20%. Aboriginal peoples (made up of First Nations, Inuit and Métis) represent a disproportionately high number of HIV infections -- making up only 3.3% of the overall population but an estimated 5% to 8% of all prevalent infections. Women accounted for an estimated 23 per cent of new infections in 2002; heterosexual contact and injection drug use are the two major risk factors for HIV infection in women. Disproportionate rates of infection (7% to 10% of prevalent infections in 2002) have also been noted among those living in Canada who were born in a country where HIV is endemic -- mainly countries of sub-Saharan Africa and the Caribbean, who make up approximately 1.5% of the Canadian population¹.

The burden of the epidemic in Canada has been concentrated in four provinces – Ontario, Quebec, British Columbia and Alberta – which account for 95% of all HIV positive test reports since 1985.

¹ Health Canada, *Estimates of HIV prevalence and incidence in Canada, 2002*. Canada Communicable Disease Report, Vol. 29, No. 3, December 2003.

III. National responses to the AIDS epidemic

Canada is responding to the epidemic on both domestic and global fronts. This response involves all levels of governments, the community as well as the scientific and medical sectors and necessitates coordination amongst these different jurisdictions and the various federal government players.

The pan-Canadian response

Canada is a federation, with responsibilities for health shared amongst the federal government and provinces and territories. Provinces and territories deliver health care and hospital services for the majority of the population. The Government of Canada is responsible for ensuring the availability of, and/or access to, health services for First Nations people living on reserve and the Inuit in northern Canada, federal prisoners and those in the armed services. In partnership with provincial and territorial governments, the Government of Canada works to develop health policy, fund the health system, enforce health regulations, and promote disease prevention and healthy living. These shared jurisdictional responsibilities mean that coordination among many levels of government is necessary to ensure the most consistent, effective and comprehensive response to HIV/AIDS within Canada.

Since the 2003 report, there has been significant progress made in outlining a pan-Canadian response to HIV/AIDS with the release of *Leading Together: Canada Takes Action on HIV/AIDS (2005-2010)*. The document was developed after a large-scale consultative process involving stakeholders from across the country, including community groups, people living with and/or at-risk of HIV/AIDS, health care providers, researchers, and governments across Canada. It calls for consolidated action on all fronts and lays out specific actions and targets to achieve its bold vision, namely that "the end of the epidemic is in sight." Currently, a multi-sectoral body is being formed to champion the widespread use of the document, to strengthen engagement and to monitor its use.

The federal response

In January 2005, the Government of Canada launched the *Federal Initiative to Address HIV/AIDS in Canada* and increased ongoing federal HIV/AIDS funding of the domestic response from \$42.2 million per annum to \$84.4 million by 2008-09. The *Federal Initiative* is a partnership between four federal departments and agencies: the Public Health Agency of Canada, Health Canada, Canadian Institutes of Health Research, and Correctional Service Canada. The *Federal Initiative* has the following goals:

- Prevent the acquisition and transmission of new infections;
- Slow the progress of the disease and improve quality of life;
- Reduce the social and economic impact of HIV/AIDS;
- Contribute to the global effort to reduce the spread of HIV and mitigate the impact of the diseases.

The *Federal Initiative* builds on the previous *Canadian Strategy on HIV/AIDS* (1998-2004) and reinforces the importance of partnership and engagement with players across governments, civil society, health care providers, researchers, and those living with or at risk from HIV. It is an approach grounded in human rights and the determinants of health. As part of its strategy, the *Federal Initiative* will develop population-specific approaches for the following groups: people living with HIV/AIDS, gay men, people who use injection drugs, Aboriginal people, federal inmates, youth and women at risk for HIV and people from countries where HIV is endemic. These specific approaches will address policies and programs affecting the lives of people from designated populations, with specific attention to integrated approaches involving people who fall within more than one population (e.g. women and people living with HIV/AIDS) and issues that cross populations. Specifically, the *Federal Initiative* policy direction of integration states that programs will address barriers to services for people living with, or vulnerable to, multiple infections and conditions that have an impact on their health.

The global response

Canada has contributed over \$600 million to the global effort to address HIV/AIDS since 2000. Canada's International Policy Statement identifies health, including HIV/AIDS, as a key priority for official development assistance with gender equality as a cross-cutting issue in all of the Canadian International Development Agency (CIDA)'s policies and programming. Foreign Affairs Canada has developed a strategy to effectively address the foreign policy dimensions of HIV/AIDS, including such issues as human security, human rights, multilateral and bilateral advocacy, workplace guidelines and complex humanitarian emergencies. CIDA is currently developing a Strategic Directions Paper for Health, including HIV/AIDS, which flows from CIDA's HIV/AIDS Action Plan (2000-2005).

A further contribution to the Global Fund to Fight AIDS, Tuberculosis and Malaria of \$250 million for 2006-07 was announced in September 2005, bringing Canada's total commitment to the Global Fund to \$550 million. In addition, Canada has made significant contributions to UNAIDS, the WHO "3X5" Initiative, the International AIDS Vaccine Initiative, the International Partnership for Microbicides, United Nations Population Fund (to ensure strong linkages with sexual and reproductive health and access to condoms and other reproductive health commodities), and a number of large bilateral and regional programs in Africa, Asia, Eastern Europe, Latin America and the Caribbean.

Partnerships across federal departments and agencies are a key component of the Government of Canada's approach in order to coordinate HIV/AIDS related activities and to address the determinants of health.

Provincial and territorial responses

Provinces and territories in Canada are responsible for the provision of health care. Treatment is available across Canada, and there are programs in place to

ensure that low-income does not prevent people from accessing antiretrovirals. Most provinces and territories have adopted or are developing strategies to address HIV/AIDS. In Quebec, Alberta, Saskatchewan, Northwest Territories, an integrated blood-borne pathogen and sexually transmitted infection approach has been adopted, recognizing that HIV/AIDS, hepatitis C and sexually transmitted infections affect similar population groups. In British Columbia, Manitoba, Ontario, Nova Scotia, Newfoundland, Nunavut Territory and the Yukon Territory, provinces and territories have focussed on HIV/AIDS. Most provinces and territories promote principles related to population health and respect for human rights in order to reduce vulnerability and address the epidemic in the long term.

The community response

From the very beginning of the epidemic, Canadian civil society mounted a vigorous response to the challenge of HIV/AIDS. With governmental and societal support, community organizations are playing a key role in designing and delivering front-line services and in helping to identify emerging policy issues and develop appropriate policy responses. Community organizations participate in national planning and expert panels, the development and championing of innovative approaches in prevention and support, and delivering programs. Canada endorsed the principle of greater involvement of people living with HIV/AIDS in developing a national response to the epidemic at the Paris AIDS Summit in 1994, and this principle continues to be a fundamental tenet of Canada's approach.

Key to the response in Canada are national non-governmental HIV/AIDS organizations:

- Canadian Aboriginal AIDS Network
- Canadian AIDS Society
- Canadian AIDS Treatment Information Exchange
- [Canadian Association for HIV Research](#)
- [Canadian Foundation for AIDS Research](#)
- Canadian HIV/AIDS Information Centre
- Canadian HIV/AIDS Legal Network
- Canadian HIV Trials Network
- Canadian Treatment Action Council
- Canadian Working Group on HIV and Rehabilitation
- Interagency Coalition on AIDS and Development
- International Council of AIDS Service Organizations

Under the *Federal Initiative*, the Government of Canada supports non-governmental organizations at the national, regional and community levels. Many provinces and larger municipalities also fund community organizations. National HIV/AIDS funds contribute to the goals of the *Federal Initiative* by supporting a strong voluntary sector response, supporting the engagement and meaningful involvement of those living with and at risk of HIV/AIDS, encouraging strategic collaboration and partnerships, enhancing capacity,

gathering and exchanging information and knowledge, enabling the development of policies and programme interventions, and enhancing a broader response to the HIV/AIDS epidemic and its underlying causes. For example, the AIDS Community Action Programme, a funding program under the *Federal Initiative*, supports community-based organizations across Canada to: create supportive environments to reduce or eliminate social barriers that prevent people living with or at risk of HIV/AIDS from accessing health care and/or social services; carry out health promotion for people living with HIV/AIDS; carry out prevention initiatives; and strengthen community based organizations. Funding in 2004-05 was targeted specifically to address populations most at risk of infection and those already living with the disease.

IV. Major challenges faced and actions needed to achieve the UNGASS goals/targets

Resources to support the response

In May 2004, an increase in federal funding was announced to support the Canadian response with an increase in ongoing federal HIV/AIDS funding from \$42.2 million per annum to \$84.4 million by 2008-09. The Government of Canada is working with a range of partners to address the challenge of ensuring the effective use of this funding and measuring the impact of the response. Many of the provinces and larger municipalities also make significant financial contributions to the response to the epidemic.

Developing discrete approaches to address the epidemic for populations most vulnerable to HIV/AIDS

The incidence of new infections within Canada has been rising in certain populations – gay men, people who use injection drugs, women, Aboriginal peoples, and people from countries where HIV is endemic. There are challenges in reaching these vulnerable groups as many are marginalized and do not access traditional prevention, care or treatment services. Reflecting lessons learned from the response to HIV/AIDS over the past two decades, the *Federal Initiative* has initiated the development of a population-specific framework which will result in evidence-based, culturally appropriate responses that are better able to address the realities that contribute to infection and poor health outcomes for the target groups. Population-specific approaches also allow people at risk of infection and those living with HIV/AIDS to directly shape policies and programs that affect them.

The hidden epidemic

Of the 56,000 people in Canada estimated to be infected with HIV in 2002, it is thought that about a third, or 17,000, are unaware of their infection². Policies and programmes that target this hidden epidemic include social marketing to increase awareness and the development of tailored population-specific approaches. For instance, the implementation of second generation surveillance which looks at trends in disease prevalence and risk behaviours amongst key population groups – gay men, people who use injection drugs and people from countries where HIV is endemic – will allow for more effective targeting and monitoring of the response within each distinct population, in turn allowing for more appropriate planning of future activities to best meet any remaining gaps.

Addressing the determinants of health

The HIV/AIDS epidemic is driven by social, cultural and economic determinants, and is fuelled by stigma and discrimination. Factors, such as poverty, homelessness, stigma, addiction, violence, untreated mental health problems, lack of employment opportunities, powerlessness, lack of choice, lack of legal

² Canada Communicable Disease Report, 2003.

status and lack of social support increase people's vulnerability to HIV, limiting their ability to protect themselves from HIV, and, for those living with HIV/AIDS, limiting their ability to access support and to maintain their health. Many of these factors lie outside the purview of health ministries. The Government of Canada is addressing this issue through actions across government that seek to improve the health status of all Canadians by improving the determinants of health. The Government of Canada will bring greater focus to these activities through the creation, in 2005, of the Government of Canada Assistant Deputy Minister Committee on HIV/AIDS. This is an interdepartmental committee which includes representation from 14 federal departments and agencies with mandates that have an impact on, or are related to, Canada's HIV/AIDS response. This committee provides a common platform to promote horizontal coordination and interdepartmental action across the Government of Canada and will promote linkages and alignment of policies and programs, particularly as they relate to HIV/AIDS and related determinants of health issues such as employment, affordable housing, disability, immigration and social justice. This increased government collaboration is a key element of the *Federal Initiative*.

Addressing non-disclosure

The issue of non-disclosure of HIV/AIDS by persons infected with the virus to sexual partners and persons with whom they share drugs remains a complex one, and one which presents challenges for AIDS service providers in reaching out to people living with HIV/AIDS. In *R vs Cuerrier* (1998), the Supreme Court of Canada outlined a criminal law approach to the issue. The case addressed whether non-disclosure of one's HIV status constitutes fraud, thereby vitiating consent to sexual acts and subjecting a person with HIV to the possibility of an assault conviction. The Court held that for fraud to exist, three factors must be established: (1) a reasonable person must consider the behaviour to be dishonest (non-disclosure of one's HIV status may constitute such misconduct); (2) the dishonesty must result in significant risk of bodily harm (it appears from the reasoning in *Cuerrier* that protected sex with condoms may not be considered to pose a significant risk of harm) and; (3) the person would not have consented to engage in sexual acts had the HIV positive person disclosed.

In 2005, the conclusions of a working group on the issue of persons who are unwilling or unable to disclose their status, organized by the Federal/Provincial/Territorial Advisory Committee on AIDS, were published. The experts – representing a diverse range of backgrounds including public health, physicians, mental health, legal, epidemiological, people living with HIV and AIDS, and community-based service organizations – endorsed an approach rooted in public health rather than a criminal law approach and which emphasized prevention as the primary objective, flexibility, risk assessment, counselling and respect of the Canadian Charter of Rights and Freedoms.³

³ Persons who fail to Disclose their HIV Status: Conclusions Reached by an Expert Working Group. *Canada Communicable Disease Report*. Vol. 31-05. March, 2005

Addressing stigma and discrimination

Stigma and discrimination continue to lead to increased vulnerability of people to HIV and isolation and marginalization of those who are living with or at risk for HIV/AIDS. For those in marginalized groups – such as gay men, people who use injection drugs, Aboriginal people, people from countries where HIV is endemic and sex workers – the stigma associated with HIV can be compounded by other forms of discrimination such as racism and homophobia. There are great challenges for health service providers in reaching these marginalized groups, particularly those engaged in illegal activities such as injection drug use or some forms of sex work. In these situations, public health approaches aimed at reducing the harms experienced by marginalized groups are the preferred interventions as they have demonstrated their ability to reduce the amount of harm experienced by marginal groups. Harm reduction measures -- such as needle exchange, safe drug use equipment and practices, and methadone maintenance -- are in place to varying degrees across the country. Reaching people who use injection drugs and sex workers remains a complex and shifting public policy issue with health, social, legal, ethical and human rights implications.

The Federal Initiative supports national and community-based organizations to carry out communications and social marketing activities to improve Canadians' knowledge of HIV, to address community and societal attitudes, and to reduce the stigma and discrimination that fuel the epidemic. For example, through funding from the *Federal Initiative*, in January 2005, the Canadian HIV/AIDS Legal Network launched *A Plan of Action for Canada to reduce HIV/AIDS-related stigma and discrimination*. The plan highlights the responsibility of governments at all levels to lead both by example and by rigorously applying anti-discrimination laws and measures to reduce stigma.

Linkages with other infectious diseases

Many people living with and vulnerable to HIV/AIDS have complex health needs and may be vulnerable to other infectious diseases such as those transmitted sexually or by injection drug use. The *Federal Initiative* addresses this possibility by linking with other health and social programs, where appropriate, to ensure an integrated approach to program implementation. These programs address barriers to services for people living with or vulnerable to multiple infections and conditions that have an impact on their health. Canada, for instance, has a significant population of individuals co-infected with HIV and hepatitis C. Separate federal programs that target hepatitis C and sexually transmitted infections operate in tandem with the *Federal Initiative* to address common risk factors. Some provinces and territories have adopted an integrated approach to addressing HIV along with other bloodborne pathogens and/or sexually transmitted infections.

The resurgence of syphilis in Canada

As recently as 1997, the elimination of syphilis in Canada seemed imminent. However, since that time, the rates of syphilis in Canada have increased dramatically with preliminary rates for 2004 showing a greater than 900 percent

increase when compared to 1997. These rapidly increasing rates are being fuelled by outbreaks across the country particularly affecting men who have sex with men and sex trade workers. Syphilis increases the risk of transmitting and acquiring HIV; thus, its resurgence in Canada can only negatively impact the HIV epidemic. However, evidence has shown that the early detection and treatment of sexually transmitted infections such as syphilis can have a major impact on reducing the sexual transmission of HIV. As such, the Public Health Agency of Canada continues to monitor the rates of syphilis in Canada and works closely with the provinces and territories to raise awareness of the resurgence of syphilis and the need to respond in a coordinated manner both rapidly and effectively to such a public health threat.

Strengthening the national response

Under Canada's federal system, different provinces and territories and the federal government each have their own role in the national response to HIV/AIDS. Different provinces and territories face different epidemics, both in the size of the epidemic and in the populations affected. While this facilitates a response that is tailored to the unique needs of each jurisdiction, differing priorities and implementation structures can present challenges in setting and tracking national goals and progress. To help address this challenge, the Federal/Provincial/Territorial Advisory Committee on AIDS promotes intergovernmental collaboration and public policy development. In addition, a national surveillance system is in place that collects data from provinces and territories to assist with developing national summaries and analyses. To facilitate collaborative action, *Leading Together*, a pan-Canadian approach to HIV/AIDS identifies common approaches and values in addressing HIV/AIDS at a national level.

Increasing global access to medication

In May 2004, the Government of Canada passed Bill C-9, the Jean Chrétien Pledge for Africa Act, legislation aimed at changing patent laws to allow for the manufacturing of lower-cost versions of patented medicines to least developed/developing countries in order to address public health problems such as HIV/AIDS, tuberculosis and malaria. Canadian civil society played a key mobilizing role in the advocating for this legislation, and the Government of Canada worked closely together to ensure inter-departmental policy coherence. The Government of Canada is committed to facilitating and encouraging participation in the Pledge for Africa regime and, through Health Canada and Foreign Affairs Canada, has been engaging in a number of outreach initiatives in order to increase the understanding of the potential benefits of the Pledge for Africa regime.

V. Support required from country's development partners

Not applicable.

VI. Monitoring and evaluation environment

Strengthened monitoring and evaluation, particularly at the national level, has been called for by Canadian civil society and by provincial and territorial governments as made evident by the growing emphasis on accountability and transparency. Canada's federal system presents a challenge as a result of independent evaluation procedures implemented at the provincial and territorial level, often including different targets and associated indicators to be used for performance measurement. *Leading Together seeks to address this challenge through the introduction of nation-wide targets, indicators and recommended areas for action related to key priorities, including: awareness; social factors driving the epidemic; prevention, diagnosis, care, treatment and support; leadership in global efforts; and the enhancement of frontline capacity.* This multi-sectoral initiative is supported by activity already being undertaken by the Government of Canada and several provincial governments to set clear targets for their own responses to the HIV/AIDS epidemic. Building on this, the Government of Canada's *Federal Initiative to Address HIV/AIDS in Canada* is supported by a performance management strategy that includes a data collection and evaluation plan, and a commitment to regular reporting. These tools, when they are fully developed, will provide a record of progress towards reaching the federal targets.

VII. Expenditures

Amount of National funds disbursed by governments in low and middle income countries

2004-05 figures (in millions of dollars)

Canadian International Development Agency	\$234.10
(\$45.6 million through bilateral channels, \$25 million through partnership channels, \$163.5 million through multilateral channels, including the Global Fund to Fight AIDS, Tuberculosis and Malaria), WHO 3x5, and UNAIDS.	

Amount of national funds spent by governments on HIV/AIDS on domestic initiatives

In May 2004, the Government of Canada announced that federal funding for the domestic response to HIV/AIDS would increase from \$42.2 million per annum to \$84.4 million by 2008-09.

Between April 2004 and March 2005, the first year of the *Federal Initiative*, the following national funds were spent on HIV/AIDS in Canada through the Public Health Agency of Canada, Health Canada, Canadian Institutes of Health Research, and Correctional Service Canada.

2004-05 Federal Initiative on HIV/AIDS funding (in millions of dollars)

Programme and Policy Intervention	\$23.0
Knowledge Development	\$16.7
Communications and Social Marketing	\$1.3
Coordination, Planning, Reporting and Evaluation	\$5.6
Global Engagement	\$0.6
Total	\$47.2

Other Federal Funds

First Nations Inuit Health Branch, Health Canada \$2.59 million

The Canadian Institutes of Health Research (CIHR) contributed an additional \$ 8.45 million to HIV/AIDS research in 2004-05⁴.

⁴ In addition to this contribution, CIHR also contributed \$6.76 million to indirect HIV/AIDS research funding for projects where there is an HIV/AIDS component of less than 50%.

Correctional Service Canada invests \$13 million annually from its own budget in infectious disease management -- including HIV/AIDS care, treatment and support -- in the correctional environment. In addition, Correctional Service Canada allocates \$7.8 million to its National Methadone Maintenance Programme.

Provincial and Territorial Funding

Provinces and territories in Canada are responsible for the delivery of health care and pay the costs of medical services and medications, including antiretroviral drugs, for those living with HIV/AIDS⁵. In addition several provinces – British Columbia, Alberta, Saskatchewan, Ontario and Quebec – have separate funding for community groups engaged in HIV/AIDS initiatives.

⁵ In some provinces, the payment of antiretrovirals is only for those on income support, other provinces pay the cost of antiretrovirals for anyone who is HIV positive, regardless of income.

ANNEX 1

Consultation/Preparation Process for the national report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

The Public Health Agency of Canada (PHAC) was the lead agency in preparing the 2006 UNGASS Report. The initial drafts of the Main Section, Part A of Annex 2 (the National Composite Policy Index), and Annex 3 were prepared by PHAC in consultation with other government departments participating in the federal response to the HIV/AIDS epidemic and with representatives of the provinces and territories. A draft was sent out for consultation in late November to key national partners, national non-governmental organizations, the Ministerial Council on HIV/AIDS, and the National Aboriginal Council on HIV/AIDS. Enhancements were made to the document based on the feedback received.

In a separate process, PHAC initiated a contract with an external consultant to prepare Part B of Annex 2 (the National Composite Policy Index) concerning human rights and civil society participation in consultation with national HIV/AIDS non-governmental organizations and human rights experts. This draft document was sent to national HIV/AIDS non-governmental organizations for feedback and input.

On January 10, 2006, a teleconference was held with representatives of key national partners and government departments to review and discuss the findings of the entire report (including both parts of Annex 2) in order to: address issues of consistency, accuracy and tone; ensure that the document as a whole provides an accurate picture of the Canadian response; and recommend a process for future UNGASS reporting. The teleconference ended with general agreement as to text of the combined report subject to suggested changes and modifications. The report was then submitted to the Chief Public Health Officer for approval. Part B of Annex 2, prepared in consultation with national HIV/AIDS non-governmental organizations, will not be subject to changes by government as it is to be an independent work and reflect the perspectives of external to government stakeholders.

ANNEX 2: Part A

National Composite Policy Index

I. Strategic Plan

I.1 Country has developed a national multi-sectoral strategy/action framework to combat HIV/AIDS.

The pan-Canadian response

Leading Together, Canada takes Action on HIV/AIDS (2005-2010), a blueprint for Canada-wide action on HIV/AIDS, was released in 2005. *Leading Together* calls for consolidated action on all fronts, including governments, community, researchers, health care providers, people living with and at-risk for HIV, individuals and others involved in Canada's response to HIV/AIDS. It lays out specific actions and targets necessary in order to achieve its bold vision that "the end of the epidemic is in sight." *Leading Together* includes the sectors of health, education, women, and youth. It is grounded in a human rights framework, strongly supports the engagement and leadership of people living with HIV/AIDS, and outlines concrete actions to increase awareness, address the social factors driving the epidemic, increase prevention, strengthen diagnosis, care, treatment and support, provide leadership in the global response, and enhance front-line efforts.

Canada's federal response

In May 2004, the Government of Canada announced an increase in federal HIV/AIDS funding, with an increase in ongoing federal HIV/AIDS funding of the domestic response from \$42.2 million per annum to \$84.4 million by 2008-09. In January 2005, the *Federal Initiative to Address HIV/AIDS in Canada* was launched, outlining how the federal government will support this funding increase. The Public Health Agency of Canada, Health Canada, Canadian Institutes of Health Research and Correctional Service Canada all receive funding from this initiative.

The Federal Initiative has the following goals:

- § Prevent the acquisition and transmission of new infections;
- § Slow the progress of the disease and improve quality of life;
- § Reduce the social and economic impact of HIV/AIDS;
- § Contribute to the global effort to reduce the spread of HIV and mitigate the impact of the diseases.

The *Federal Initiative* builds on the Canadian Strategy on HIV/AIDS (1998-2004), reinforcing the importance of partnership and engagement with players across governments, civil society, and researchers. Governments, national and regional non-governmental organizations working in HIV/AIDS, professional associations representing persons working in care, treatment and support, people living with or at risk for HIV/AIDS, researchers, epidemiologists and policy makers are actively engaged in the development and delivery of policy and programmes supported with federal funding. It is an approach grounded in human rights and the determinants of health.

Through the *Federal Initiative*, population-specific approaches are being developed for the following groups: people living with HIV/AIDS, gay men, people who use injection drugs, Aboriginal people, federal inmates, youth and women at risk for HIV and people coming from countries where HIV is endemic.

In April 2005, Canada's International Policy Statement was launched. This whole-of-government approach will help strengthen coherence among Canada's aid and non-aid policies and actions. The Statement sets out a new framework for development cooperation that will increase the effectiveness of Canadian development assistance, focusing Canadian efforts and resources in key sectors and countries. The Canadian International Development Agency's (CIDA) programming will be focused on five sectors - health (including HIV/AIDS), good governance, basic education, private-sector development and environmental sustainability. CIDA is currently developing a Strategic Directions Paper for Health including HIV/AIDS. A concept paper on HIV/AIDS was elaborated in consultation with other Government departments and non-governmental organizations.

Foreign Affairs Canada has developed a strategy to effectively address the foreign policy dimensions of HIV/AIDS, including such issues as human security, human rights, multilateral and bilateral advocacy, workplace guidelines and complex humanitarian emergencies.

Provincial and territorial responses

In Canada's federal system, provincial and territorial governments are responsible for the delivery of health care. Most provinces and territories have adopted or are developing strategies to address HIV/AIDS. In some provinces and territories, an integrated blood-borne pathogen and sexually transmitted infections approach has been adopted, recognizing that HIV/AIDS, hepatitis C and sexually transmitted infections affect similar population groups (Quebec, Alberta, Saskatchewan, Northwest Territories). Other provinces and territories have focussed on HIV/AIDS – British Columbia, Manitoba, Ontario, Nova Scotia, Newfoundland, Nunavut and the Yukon.

The efforts of different levels of government are linked through the Federal/Provincial/Territorial Advisory Committee on AIDS, which has as its goals the promotion of public policy development; the promotion of increased

inter-governmental, inter-jurisdictional and multilevel collaboration on issues related to HIV/AIDS and the promotion of the use of epidemiological data and community information in the development of policy, programs and services in Canada.

I. 2 Country has integrated HIV/AIDS into its general development plan.

HIV/AIDS is clearly positioned as an important domestic and international issue for the federal government. The *Federal Initiative* coordinates the domestic response and also seeks to bridge the domestic and international responses. It is a horizontal initiative, involving four federal departments and agencies – the Public Health Agency of Canada, Health Canada, the Canadian Institutes of Health Research, and Correctional Services Canada. The Canadian International Development Agency and Foreign Affairs Canada work together on the international response. The domestic and global responses are linked through various mechanisms to ensure policy coherence and shared learning.

I. 3 Country has evaluated the impact of HIV/AIDS on its economic development for planning purposes.

The total annual cost (direct and indirect) of HIV/AIDS was estimated to be approximately \$1 billion in 1998¹. While there are few definitive figures available, provinces and territories pay the costs of medical services for those living with HIV/AIDS, and pay for the cost of medications, including anti-retrovirals². In 2003, British Columbia's Provincial Health Officer estimated that the province spent approximately \$100 million on HIV-related services. In 2001-02, the Ontario government spent approximately \$50 million to support HIV-related services (not including physician costs, drug programmes, in-patient hospital services, and home care and palliative care services).

I. 4 Country has a strategy/action framework for addressing HIV/AIDS issues among its national uniformed services, military, peacekeepers and police.

The Treasury Board of Canada policy on HIV/AIDS applies to both the armed forces and the Royal Canadian Mounted Police. This policy outlines a number of requirements and guidelines with respect to the rights and benefits of employees living with HIV, the availability of voluntary testing and pre and post-test counselling, education and information, and precautions for employees with a potential risk of exposure.

¹ Albert, Terry and Gregory Williams, *The Economic Burden of HIV/AIDS in Canada*. Canadian Policy Research Network, 1998.

² In some provinces, the payment of anti-retrovirals is only for those on income support, other provinces pay the cost of anti-retrovirals for anyone who is HIV positive, regardless of income.

The Department of National Defence has an occupational health policy to enable people living with HIV/AIDS to work according to their health and ability. It is also intended to safeguard the confidentiality of the military member's personal health information. In addition, all Canadian Forces personnel scheduled for operational duty must complete pre-deployment training that includes a preventive medicine component. Sexually transmitted infections, including HIV/AIDS, are included in this training.

II. Political Support

II. 1 The head of government and/or other high officials speak publicly and favourably about AIDS efforts at least twice a year.

The Minister of Health, the Minister of State for Public Health and the Minister of International Cooperation make regular speeches or comments about the epidemic and responses to it. In 2004, significant funding increases to both the domestic and international responses were announced.

II. 2 Country has a functional national multi-sectoral HIV/AIDS management /coordination body recognized in law.

Several multi-sectoral coordination and advisory bodies are in place to coordinate the response to HIV/AIDS and to provide advice to the government from the community, medical, and research sectors.

The pan-Canadian context

HIV/AIDS is managed by multiple jurisdictions of governments at three levels; federal, provincial and territorial, and municipal. Each jurisdiction has authority for HIV/AIDS management within its mandate and all collaborate with civil society. The Federal/Provincial/Territorial Advisory Committee on AIDS established in 1988, provides policy advice on issues and priority initiatives, and promotes timely, effective and efficient inter-governmental and inter-jurisdictional collaboration on issues related to HIV/AIDS in Canada. The Federal/Provincial/Territorial Heads of Corrections Working Group on Health, made up of members from correctional services from federal, provincial, and territorial governments, works collaboratively: to promote program and policy development that is informed and sensitive to the complex issues surrounding inmate health; and to provide proactive leadership and advice to the Federal/Provincial/Territorial Heads of Corrections on trends and best practices as they relate to health in a correctional setting.

Government of Canada Assistant Deputy Minister Committee

In 2005, The Government of Canada Assistant Deputy Minister Committee on HIV/AIDS was established to promote greater linkages and alignment of federal government policies and programmes relating to HIV/AIDS. It is currently made up of the Assistant Deputy Ministers of fourteen departments and agencies with mandates that influence or are related to Canada's response to HIV/AIDS. The committee provides a common platform to promote horizontal coordination and programme coherence across federal departments and agencies.

Federal advisory bodies

The Ministerial Council on HIV/AIDS, established in 1988, provides advice to the Minister of Health on pan-Canadian aspects of HIV/AIDS. Council members are

appointed by the Minister of Health and are chosen for their experience and collective expertise, which span the disciplines that form the Canadian response to the epidemic, from the research community to front-line professional and non-professional workers involved with emerging at-risk groups. Five of its fifteen members are people living with HIV/AIDS.

The National Aboriginal Council on HIV/AIDS is an advisory body made up of Aboriginal peoples (First Nations, Inuit and Métis) who provide policy advice to Health Canada and the Public Health Agency of Canada and other relevant stakeholders about HIV/AIDS and related issues among all Aboriginal (Inuit, Métis and First Nations) peoples in Canada.

II. 3 Country has a functional national HIV/AIDS body that promotes interaction among government, the private sector and civil society for implementing HIV and AIDS strategies/programmes.

The *Federal Initiative* identifies partnership and engagement as a policy direction, bringing a wide range of sectors together to strengthen coordination and coherence of action. The experience of civil society is conveyed to the federal government through the advisory bodies mentioned above and through national multi-sectoral, multi-stakeholder meetings that have played a key role in setting directions for the Canadian response to the epidemic.

The federal government supports the Canadian Association of HIV/AIDS Researchers and the Clinical Trials Network, which brings together researchers, health care providers and the private sector.

The Consultative Group on Global HIV/AIDS Issues is made up of national NGOs, researchers, Health Canada, Public Health Agency of Canada, Canadian Institutes of Health Research, Canadian International Development Agency and Foreign Affairs Canada. It acts as a forum for government and civil society to engage in a dialogue on Canada's response to the global epidemic, including the provision of advice to participating government departments on the global HIV/AIDS epidemic; and of guidance and suggestions regarding collaboration and policy coherence to ensure a more effective response.

The Canadian Institutes of Health Research (CIHR) HIV/AIDS Research Advisory Committee is chaired by a member of the CIHR Institute of Infection and Immunity Advisory Board, and has members representing multiple CIHR Institutes, HIV/AIDS researchers, Health Canada, the Ministerial Council on HIV/AIDS and broader community organizations. This membership enables the Committee to be a voice for HIV/AIDS researchers within CIHR, and encourages good communication between stakeholders interested in HIV/AIDS research. The Committee has a mandate to make recommendations to CIHR regarding research priorities for HIV/AIDS.

II. 4 Country has a functional HIV/AIDS body that is supporting coordination of HIV-related service delivery by civil society organizations.

Service delivery is a provincial responsibility that is managed differently from province to province. Some provinces fund service delivery by community based organizations. In some provinces, the provincial government, the regional office of the federal government and NGOs work together to engage in planning, priority identification, and enhanced coordination of community based activities by the civil society. In addition, many projects are funded through the AIDS Community Action Programme, a Public Health Agency of Canada regional fund that supports frontline responses to HIV/AIDS in communities.

Civil society coordination is achieved through different mechanisms, including participation in government-led planning and consultation processes, and through national and regional umbrella organizations.

Political support for the HIV/AIDS programme

The federal government has consistently supported the response to HIV/AIDS in Canada. The Prime Minister has been active on the international scene, calling for an enhanced global response to HIV/AIDS. Significant budget increases to both the domestic and international responses were announced in 2004. The Standing Committee on Health monitors and reviews federal HIV/AIDS efforts to ensure that funding is used where it is most needed.

III. Prevention

III. 1 Country has a policy or strategy that promote information, education and communication (IEC) on HIV and AIDS to the general population.

There is currently no unifying strategy, but information, education and communication are provided through a variety of mechanisms which are described below. Under the *Federal Initiative*, The Public Health Agency of Canada administers an HIV/AIDS Information Services Initiative (HISI) Fund to support a national service whereby high quality HIV/AIDS information is identified, made meaningful, and available. The initiative currently supports the Canadian HIV/AIDS Information Centre, administered by the Canadian Public Health Association, and the Canadian AIDS Treatment Information Exchange: two services that have an international reputation for the provision of comprehensive HIV/AIDS prevention, care, treatment and support information. Following a national consultation, the HISI fund will undergo a redesign in 2006 to incorporate the principals of knowledge transfer and exchange.

The Public Health Agency of Canada supports national and front-line communications and social marketing activities to improve Canadians' knowledge of HIV, to address community and societal attitudes, and to reduce the stigma and discrimination that fuel the epidemic. National public awareness programmes are being developed to provide accurate information on HIV and to highlight the ways in which stigma and discrimination contribute to the epidemic.

III. 2 Country has a policy or strategy promoting HIV and AIDS-related reproductive and sexual health education for young people.

Sexual and reproductive health education is delivered within the school setting, under curricula set by provincial and territorial ministries of education within Canada. The type of HIV/AIDS information provided and the age at which it is provided varies across Canada.

The role of the federal government is in establishing guidelines, carrying out research and surveillance and funding social marketing campaigns. In 2003 Health Canada, together with governmental and nongovernmental organisations at the provincial, territorial and community levels, produced a revised edition of the Canadian Guidelines for Sexual Health Education. The Guidelines provide the framework for the development of comprehensive sexual health education programmes and services that meet the diverse needs of Canadians.

The 2002 Canadian Youth Sexual Health and HIV/AIDS Study, coordinated by the Council of Ministers of Education Canada, found that youth's feelings of susceptibility to HIV/AIDS have decreased since 1989; and that one –half of grade nine students did know that there is no cure for AIDS. The survey also found an increase in respect for the basic human rights of those living with HIV/AIDS, compared to 1989 results. This information is being used along with other sources to help shape an upcoming social marketing campaign.

III. 3 Country has a policy or strategy to promote information, education and communication and other preventive health interventions for most-at-risk populations.

The *Federal Initiative* will support specific community-based social marketing campaigns developed by and for specific populations, namely gay men, Aboriginal people, people who use injection drugs, federal inmates, women and youth at-risk, people from countries where HIV is endemic, and people living with HIV/AIDS. Some current projects include:

Gay men

Working with a National Advisory Team composed of partner organizations from across Canada, the Public Health Agency of Canada has funded AIDS Vancouver to develop and roll out two phases of a national social marketing campaign to reinvigorate HIV/AIDS prevention among gay men across Canada.

Aboriginal peoples

At the national level, the First Nations and Inuit Health Branch of Health Canada continued to support Aboriginal organizations in delivering HIV/AIDS awareness programmes. This included the expansion of Aboriginal AIDS Awareness Day to a week-long event beginning on World AIDS Day, with the Canadian Aboriginal AIDS Network as the main coordinator and implementer of activities; and supporting the work of Pauktuutit Inuit Women's Association with Inuit people.

The Aboriginal Strategy on HIV/AIDS in Canada supports regional and local levels to organize their efforts to respond to HIV/AIDS. It includes specific strategies on national coordination and technical support; community development and capacity building; prevention and awareness; sustainability, partnerships and collaboration; legal, ethical and human rights issues; engaging aboriginal

groups with specific needs; supporting harm reduction approaches; holistic care, treatment and support; and research and evaluation.

Federal inmates

Correctional Service Canada (CSC) recognizes that the management of infectious diseases such as HIV can only successively be achieved through the implementation of a range of prevention, treatment and harm reduction activities. CSC delivers several education programmes for inmates, such as the National HIV/AIDS Peer Education and Counselling Programme, Circles of Knowledge Keepers (an Aboriginal HIV/AIDS peer education and counselling programme), and the Choosing Health in Prisons Programme. CSC offers inmates voluntary testing for HIV/AIDS, sexually transmitted infections (STIs), hepatitis A, B and C and tuberculosis. All inmates are offered vaccinations for hepatitis A and B, and an annual influenza vaccination. CSC has an HIV Post Exposure Protocol for staff and inmates.

In partnership with the Public Health Agency of Canada, CSC health services staff received training on the prevention, diagnosis, treatment and management of STIs. This training was accompanied by an STI manual developed to summarize this information specifically for working with an incarcerated population. CSC also tracks infectious disease prevalence, and uptake for testing, treatment and participation in prevention education, through its Infectious Disease Surveillance System. The purpose of this work is to monitor trends and to inform the development of policies and prevention programs.

Inmates in CSC penitentiaries have access to the following harm reduction measures:

- Bleach for cleaning injecting, tattooing and piercing equipment;
- Condoms, dental dams and water-based lubricant;
- A methadone maintenance treatment programme;
- A safer tattooing practices pilot project that is now operating in six federal penitentiaries

Needle exchange programmes are not currently available in federal penitentiaries; however, CSC has sought the scientific and technical advice of the Public Health Agency of Canada on the risks and benefits of prison needle exchange programmes.

III. 4 Country has a policy or strategy to expand access, including among most-at-risk populations, to essential preventative commodities

Currently access to preventative commodities in Canada includes the following items:

Condoms, HIV testing (anonymous, nominal and non-nominal), syringes, sterile water, bleach, cookers, filters and sharps containers. Other preventative commodities include the hepatitis B, hepatitis A and flu vaccines, tuberculosis testing and treatment, hepatitis B and C testing, methadone programmes,

physician assisted narcotics programmes, drug rehabilitation programmes, post-exposure prophylaxis, health promotion and prevention information programmes, universal access to a primary health care physician and universal access to primary and secondary education. Programmes on social marketing for condoms, blood-safety, safe injections in health care settings, and antenatal syphilis screening are in place.

The availability of these preventative commodities and programmes varies across Canada and is dependant upon a number of factors including federal health transfers to provinces and territories, provincial, territorial and municipal allocations of resources to health, and approaches used by provincial and municipal health related agencies. Canada endorses the principle of universal access to HIV/AIDS education, prevention, diagnosis, care, treatment, support and rehabilitation services.

III. 5 Key prevention activities

Prevention activities vary across the country, depending on the nature of the epidemic in the jurisdiction, and the mode of delivery. For the most part, prevention activities are delivered by local AIDS service organizations, community based organizations, and public health units. These specific activities identified by UNAIDS are available in Canada – namely, social-marketing programmes for condoms; school-based AIDS education for youth; behaviour-change communications; voluntary counselling and testing; programmes for sex workers; programmes for men who have sex with men; programmes for injecting drug users; programmes for other most-at-risk populations; blood safety; programmes to prevent mother-to-child transmission of HIV; programmes to ensure universal precautions in health care settings. There is currently no formal programme to promote accurate HIV and AIDS reporting by the media. Availability to some prevention activities does vary across the country, and there are challenges in reaching marginalized people. Certain key activities are highlighted below.

HIV Testing

Nominal and non-nominal HIV testing is available in all provinces and territories, and many offer anonymous testing as well.

Prevention of Mother to Child Transmission

Voluntary HIV testing programmes are available in all provinces and territories for pregnant women. In 2002 The Federal/Provincial/Territorial Advisory Committee on AIDS released *Guiding Principles for HIV Testing of Women during Pregnancy*, which reinforce the application of the widely supported principles of voluntarism, confidentiality and informed consent in the refinement and development of relevant policy.

Treatments are available in all provinces and territories to prevent mother-to-child transmission of HIV, although this is not sufficient to prevent all HIV infections in newborn babies. In 2004, 163 cases of perinatal exposure to HIV were reported, of the 139 whose mothers received any perinatal ART prophylaxis, 108 of the perinatally exposed infants were confirmed not infected, 3 were confirmed to be infected, and the status of 28 was not confirmed³.

In federal penitentiaries, prenatal care is provided for all pregnant offenders. This includes voluntary testing for HIV. All women are encouraged to participate in testing and/or appropriate treatment to prevent transmission from mother to child. Opioid-dependent offenders who are pregnant are encouraged to undergo methadone treatment to decrease the risks associated with injection drug use and pregnancy.

Programmes for People who use Injection Drugs – Supervised Injection Site
In September 2003, Canada's first legal supervised injection site was opened, as part of a partnership between Vancouver Coastal Health Authority, the Portland Hotel Society and the British Columbia Ministry of Health. Health Canada granted the Vancouver Coastal Health Authority an exemption under current Canadian legislation to launch a supervised injection site pilot research project, and is providing up to \$1.5 million in funding to support the evaluation component of the project to determine whether supervised injection sites will improve the health of drug users and reduce the harm associated with illicit drug use. Funding for the establishment and administration of the pilot project, and the actual supervised injection site, is the responsibility of the Vancouver Coastal Health Authority.

While the one-year evaluation results were promising, the evaluation represents only an initial step in terms of assessing whether the supervised injection site in the Downtown Eastside of Vancouver is reducing the harm associated with injection drug use. Efforts to document the health outcomes of people who use injection drugs associated with the site will continue throughout a three-year evaluation period and beyond.

North American Opiate Medication Initiative (NAOMI)
NAOMI is a medical research study designed to determine whether medically prescribed heroin is more effective than methadone in treating people who have failed standard therapies for chronic opiate addictions. The study is funded by the Canadian Institutes of Health Research, and will be undertaken by the University of British Columbia, the University of Montreal and the University of Toronto. The Canadian Institutes of Health Research is providing \$8.1 million for the clinical trial to be conducted. In 2005, Health Canada granted approval to the clinical trial proposal and issued an exemption - for scientific purposes -

³ *HIV and AIDS in Canada, Surveillance Report to December 31, 2004*. Public Health Agency of Canada, 2005.

under current Canadian legislation, authorizing the use of heroin in the clinical trial. NAOMI commenced recruitment in February 2005.

IV. Care and support

IV. 1 Country has a policy or strategy to promote comprehensive HIV and AIDS care and support, with sufficient attention to barriers for women, children and most-at-risk populations.

The responsibility for the direct delivery of care is under provincial and territorial jurisdiction. Different jurisdictions take different approaches to HIV and AIDS care and support, but most have a policy or strategy to address this issue.

Leading Together has as one of six action areas: ‘Strengthen diagnosis, care, treatment and support services’.

I. IV. 2 Key care, treatment and support activities

The specific activities identified by UNAIDS – screening of blood transfusions, universal precautions; treatment of opportunistic infections; antiretroviral therapy; nutritional care; STI care; family planning services; psychosocial support for those living with HIV and their families; home-based care; palliative care; treatment of common HIV-related infections; and post exposure prophylaxis – are available in Canada. Medical services are delivered by provincial and territorial health systems, while civil society organizations play a key role in delivering psychosocial support, home-based and palliative care. Availability to some services does vary across the country, and marginalized people are less likely to be aware of and to access care and support services. Key activities are outlined below.

Access to HIV/AIDS related medicines

The *Canada Health Act* sets the standard for all provinces and territories to provide all medically necessary physician and hospital services to eligible residents. The cost of HIV-related drugs is covered either through public or private insurance plans, or for those on income assistance, through drug access programmes at the provincial or territorial level. While the majority of people living with HIV/AIDS have access to necessary drugs, instances do occur where access is limited. Drug access and cost reimbursement programmes can result in drug interruptions. A 2002 study found that one in three people who died of AIDS in British Columbia had never been treated with antiretroviral drugs; Aboriginal peoples, low-income people and women were over-represented in this group. This study demonstrates the ongoing challenge of reaching marginalized populations. For people living in Canada without legal status, provision of drugs and receipt of health care is tenuous.

Prescription medication and medical transportation is provided to ‘registered Indians’ (First Nations people with status under the *Indian Act*) and to Inuit

under a federal programme known as the Non-Insured Health Benefits Programme.

Access to medicines in federal penitentiaries

Upon receiving a positive diagnosis for HIV, a federal inmate is referred to the institutional physician and a community HIV/AIDS specialist. Treatment is directed by the community HIV/AIDS specialist, who also determines the treatment regime most appropriate for the individual. HIV medication is provided at no cost to the inmate. Prior to release from penitentiary, the inmate is connected with a community health provider, and is provided with an interim supply of medications.

IV. 3 Country has a policy or strategy to address the additional needs of orphans and other vulnerable children.

There is not a significant number of HIV/AIDS orphans in Canada, and children under 15 represent only 1.3% of total positive HIV test reports in Canada since 1985. (PHAC, 2004)

Youth, particularly those who are street involved, Aboriginal and/or gay, have been identified as one of the populations at risk for HIV/AIDS and the federal government is developing a population-specific approach for youth at risk. *A Canada Fit for Children: Canada's National Plan of Action*, released in 2004, is Canada's official response to its commitments made at the UNGASS on Children in 2002. Promoting healthy lives, including combating HIV/AIDS, is one of the priority areas of this plan.

The needs of vulnerable children are met through the delivery of provincial health and social services that include child protection services, adoption services, child and family counselling and social service agencies, welfare and disability income support programmes, publicly funded primary health services and subsidized housing. The delivery of these programmes varies across Canada and is dependent upon federal funding in the form of health transfers to provinces; provincial and municipal allocations of resources to health; and approaches used by provincial and municipal health and social service related agencies.

V. Monitoring and Evaluation

Different jurisdictions have different roles in Canada's health care system, and take different approaches to monitoring and evaluation of their own activities. At present, there is no single national plan, but *Leading Together*, lays out concrete actions outcomes and goals, and the shared responsibility of different actors in Canada's response to HIV/AIDS. A Championing Group for *Leading Together* will be examining ways to monitor progress.

The federal government has a detailed Results Based Management and Accountability Framework for the *Federal Initiative* that includes a data collection and analysis strategy, performance indicators and quantifiable goals, guidelines on tools for data collection, and data dissemination and reporting commitments.

Canada's Report on HIV/AIDS is published annually, providing an account of annual progress to the public. Civil society is involved in providing input into the report and commenting on draft reports. Semi-annual *Surveillance Reports*, and annual *HIV/AIDS Epi Updates* are published, providing a roll up of provincial and territorial HIV/AIDS surveillance data to the national level, and an overview of HIV epidemiology among various risk groups. These reports serve to monitor the state of epidemic, to help guide and evaluate HIV prevention, and to assist with ongoing risk assessment and management.

ANNEX 2: Part B

National Composite Policy Index

I. Human rights

- I. 1 Canada has laws and regulations that protect people living with HIV and AIDS against discrimination (such as general non-discrimination provisions or those that specifically mention HIV, that focus on schooling, housing, employment, etc.).

While Canada has enacted human rights legislation, and interpreted it in a way that it includes people living with HIV/AIDS under the umbrella of physical disability, enforcement of this legislation remains inadequate. In most cases, it is up to the individual who experiences discrimination to 1) know their rights, 2) recognize that they have been discriminated against, 3) have knowledge of the complaints mechanisms available for redress, and 4) be willing/able to lodge a complaint. These mechanisms for enforcement present many barriers for people living with HIV/AIDS and vulnerable populations. In order to access their basic rights, people must first have access to basic human rights information, rights-based education, and knowledgeable service providers to advocate and support self-advocacy. Given the nature of HIV/AIDS related stigma and the corresponding need for confidentiality, national and community-based AIDS service organizations have a key role to play in eliminating discrimination by bridging the enforcement gap through supporting such education and advocacy. The role of education and advocacy is not just the promotion of human rights, but also an integral part of ensuring the adequate enforcement of human rights legislation (particularly for vulnerable populations who might not otherwise have access to the information and resources they need).

Despite human rights protections being available in Canada, there remain significant challenges. Provided an individual has the fortitude to go forward with one of the redress mechanisms available to them, the process is often a daunting task, which requires resources that may not always be worth the effort. In some cases, a positive outcome in a formal remedial action may not necessarily result in positive change, and are at times compromised by various jurisdictional issues, as in the case of Aboriginal people who fall within both federal jurisdiction and provincial/territorial jurisdictions.

I. 2 Canada has non-discrimination laws or regulations which specify protections for certain groups of people identified as being especially vulnerable to HIV and AIDS discrimination (i.e., groups such as people who inject drugs, gay and other men who have sex with men, sex workers, youth, mobile populations, and prison inmates).

Section 15(1) of the Canadian Charter of Rights and Freedoms, which applies to all laws and other actions by governments in Canada, states:

Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

Under the Canadian Human Rights Act⁹, people living with HIV are protected from HIV-based discrimination in all jurisdictions because HIV is considered a disability in the context of anti-discrimination law with respect to any employment, goods, services, facilities or accommodation or access thereto or occupancy of any commercial premises or residential accommodation¹⁰. These protections apply to both the private and public sector. The Canadian Human Rights Commission Policy on HIV/AIDS states:

Everyone has the right to equality and to be treated with dignity and without discrimination, regardless of HIV/AIDS status.

The *Canadian Human Rights Act*¹¹ prohibits discrimination on the basis of disability. Individuals with HIV/AIDS may therefore seek protection under the *Canadian Human Rights Act*. People who are not HIV positive may also be subject to discrimination by virtue of their real or perceived membership in a risk group or their association with a person or people with HIV/AIDS. These individuals may also seek protection under the *Canadian Human Rights Act* on the basis of perceived disability. The Commission will expedite the investigation of complaints alleging HIV/AIDS related discrimination. There are problems associated with relying on the concept of disability for framing human rights obligations and prohibition of discrimination. Discrimination on the basis of HIV status alone, as

⁹ Canadian Human Rights Act: <http://www.cfc.ca/pages/law/canada/canada.H-6.head.html>

¹⁰ R. Elliott & J. Gold. Protection against discrimination based on HIV/AIDS status in Canada: the legal framework. *HIV/AIDS Policy & Law Review* 2005; 10(1): 20-31.

¹¹ Canadian Human Rights Commission pamphlet: *HIV/AIDS Discrimination: It's Against the Law*

well as discrimination against those who are vulnerable, should be prohibited in all circumstances, including those outside of issues of disability.

Discrimination on the basis of sexual orientation is also prohibited in all jurisdictions of Canada. Gender-based discrimination is prohibited, as with HIV status or sexual orientation. However, only one jurisdiction in Canada (the Northwest Territories) has explicit protection on the basis of gender identity. Discrimination on the basis of race or ethnicity is prohibited. Discrimination on the basis of age is prohibited for those between the ages of 18 and 65 (youth and the elderly are not generally covered). Discrimination on the basis of injecting drug use is not prohibited under anti-discrimination legislation in any jurisdiction. However, in the employment context, some courts and tribunals have considered drug addiction/dependence to constitute a disability (or “handicap”, depending on the wording of the applicable statute) under law and therefore there is a duty to accommodate that disability, short of “undue hardship.”

There is also no protection for sex workers against discrimination based on their involvement in sex work. If an individual is convicted of using a place for prostitution, the owner or landlord of that space must be notified and can face criminal charges and conviction if they do not take steps such as evicting the sex worker from his or her apartment which thereby persecutes the sex worker.

Anti-discrimination legislation needs improvement in terms of protecting youth, transgendered people, drug users and sex trade workers. According to an environmental scan conducted by the AIDS Calgary Equality Project, there is a dearth of information on HIV-related discrimination in Canada. It is unknown how frequently HIV-based discrimination occurs, in what contexts, the responses to HIV-based discrimination, and how individuals seek effective redress.¹² Human Rights Commissions are charged with providing redress for discrimination, and some have a fast-track process or special guidelines for HIV-based complaints. However, there are concerns about delays and hurdles in getting Commissions to adequately respond to HIV-related complaints, largely due to resource constraints.

Canada needs some additional research to gain a more thorough assessment of the extent of discrimination – in employment, housing, harassment, health care settings – on the basis of HIV status. Human Rights Commissions would be able to provide information about the number of complaints filed, which is generally believed to be a small proportion of actual incidents of discrimination.

¹² Canadian HIV/AIDS Legal Network (1998). *HIV/AIDS and Discrimination: A Discussion Paper*

The complexities of jurisdictional issues for the three Aboriginal groups in Canada (First Nations, Inuit and Métis) can result in lack of consistency in service delivery. There are parallel systems in Canada due to Treaty and Aboriginal rights which result in unique status for Aboriginal people. In many cases, Aboriginal people fall through the cracks, and they often face discrimination based on ethnicity, HIV status, and in some cases, discrimination based on risk behavior(s) such as injection drug use.

I. 3 Canada has some laws and regulations that present obstacles to effective HIV prevention and care for most-at-risk populations.

All HIV prevention tools (e.g., male and female condoms, lubricants, clean needles, methadone substitution therapy) are, in principle, available and accessible in communities across Canada. With respect to prisons, there is uneven access across correctional jurisdictions, which, in Canada, are divided into provincial/territorial (for those serving sentences of less than two years) and federal (for those serving sentences of two years or more). No correctional jurisdiction currently makes clean needles accessible.

A 2002 report¹³ noted that in the provincial/territorial jurisdictions of New Brunswick, Nunavut, Prince Edward Island, and some institutions in the Northwest Territories, condoms, dental dams and water-based lubricant were still not available to prisoners. The province of Québec provided condoms, but not dental dams or water-based lubricant. As well, based on the same 2002 findings, some of the provincial/territorial jurisdictions that provided safer sex materials in prisons did so primarily (or solely) through the medical units. This meant that prisoners who sought access to condoms had to make a request to staff, a clear barrier to prisoners who wanted to practice safer sex. In the case of provincial institutions in Ontario, provincial correctional policy specifically prohibited prisoners from accessing more than one condom at a time or having more than two in their possession. Correctional Service Canada (CSC), responsible for federal penitentiaries, has a national policy to make condoms, dental dams, bleach, lubricant and methadone continuation and initiation available to prisoners. It should also be noted that CSC has sought scientific and technical advice from the Public Health Agency of Canada on the risks and benefits of prison needle exchange programs.

The Canadian HIV/AIDS Legal Network has recommended that in order to remove barriers to the use of prevention tools in prisons, condoms, dental dams, bleach and water-based lubricant needed to be made more easily and discreetly accessible to inmates in all prisons, in different locations throughout the institutions, and without inmates having to ask for them.

In practice, even within community settings, most vulnerable populations (e.g., youth, Aboriginal communities, small rural communities, refugees, trafficked

¹³ Canadian HIV/AIDS Legal Network: *Action on HIV/AIDS in Prisons: Too Little, Too Late* (2002).

women and sex trade workers) have very spotty access to these prevention tools. For over a decade, it has been recommended that Canadian prison systems move ahead with implementing needle exchange programs in prisons.

Provision of these prevention tools and programs varies according to province/territory and between health regions, especially for female condoms, needles, methadone and bleach. For some small communities, even where these prevention tools are accessible, individuals may be reluctant to access them from health centres or stores due to lack of privacy. Refugees, immigrants and trafficked women may not be able to get prevention tools and programs due to language barriers or lack of availability. Vancouver (British Columbia) is piloting Canada's first official safe injection facility and a thorough evaluation is being conducted in order to assess the impacts of the program on drug use, overdose, infection, and crime rates.

- I. 4 The promotion and protection of human rights is explicitly mentioned, in varying degrees and with varying depth, in HIV and AIDS strategies.

Leading Together: Canada Takes Action on HIV/AIDS (2005-2010) is a pan-Canadian multi-stakeholder, multi-sectoral Action Plan, providing an opportunity for all parts of the country and all organizations involved in HIV/AIDS to come together as part of a larger, nation-wide effort. *Leading Together* explicitly bases its approach and recommended actions on the principles of human rights. Human rights is stated as one of the core values of *Leading Together*: "All people, regardless of their sexual orientation, race, culture, gender or risk behaviour, are important, and their human rights – including their economic, social, cultural, civil and political rights – should be recognized, respected and promoted. Not one life is expendable. We recognize the dignity and worth of each person."

Human rights is also mentioned in the description of the "Current State of the Epidemic: Why We Need to Step up Our Efforts" as Reason #4: "Stigma and discrimination continue to threaten people with HIV and communities at risk. Stigma can lead to violations of the human rights of people living with HIV, including unlawful discrimination in housing, employment and health and social services."

Under the Blueprint, "Commitment to Social Justice and Human Rights," *Leading Together* states that an effective response to HIV: "recognizes and addresses the broad determinants of health that make people vulnerable to HIV and to disease progression; understands those determinants in ethical terms and is committed to addressing the injustices that contribute to them; and is based on human rights and recognizes that protecting people's human rights – including the right to the highest attainable standard of health – is a means of achieving social justice and the goals of this document." *Leading Together* also states "Advocacy is an essential part of a commitment to social justice and to human rights. When the voices of a disadvantaged group are not heard or listened to, others must speak for them and advocate for their civil and political rights (e.g.,

freedom of expression and association, freedom from torture) and their economic, social and cultural rights (e.g., the right to shelter, food, a safe working environment). All those involved in HIV must champion the rights of people living with HIV and of communities at risk. The determinants of health will be addressed when social justice is achieved, and social justice is achieved when the human rights of every person are fully realized.”

Under “The Actions: What we will do between now and 2010”, Action #2 is to Address the Social Factors/Inequities Driving the Epidemic, with the rationale: “While the majority of Canadians are aware of how HIV is transmitted, fewer realize the impact of social determinants of health on risk or understand the need for a social justice and human rights approach to HIV.” Seventeen specific actions are recommended under Action #2. Human rights are also mentioned under Action #5, Under Action #5: Provide Leadership in Global Efforts, and specifically, the document instructs Canada to integrate human rights, including the right to the highest attainable standard of physical and mental health and the human rights of women, into Canada’s international relationships through a variety of methods and partnerships.

The *Federal Initiative to Address HIV/AIDS in Canada: Strengthening Federal Action in the Canadian Response to HIV/AIDS* replaces the Canadian Strategy on HIV/AIDS and is meant to contribute to a comprehensive and integrated Government of Canada response towards realizing *Leading Together*. However, the *Federal Initiative* is weak in its grounding in a human rights framework. Human rights are only mentioned briefly under Knowledge Development, stating that “Support will be provided for research on and analysis of the legal, ethical and human rights dimensions of Canada’s response to HIV/AIDS.” Under Global Engagement, the *Federal Initiative* states: “In collaboration with CIDA, Foreign Affairs Canada and others, technical support and policy guidance will be provided on global issues, such as gender risk factors, human rights, microbicides, vaccines and harm reduction. CIDA, Foreign Affairs Canada and Federal Initiative partners will cooperatively represent Canada in international HIV/AIDS and health fora.”

While the *Federal Initiative* states that the federal government will make a larger and more effective contribution to addressing the complex social, human rights, biological and community barriers that continue to fuel the epidemic, it does not commit to domestically address human rights issues faced by those living with or vulnerable to HIV/AIDS beyond providing support for research on human rights issues. The Government of Canada should be taking much more active steps to reduce human rights barriers within all five of its Areas of Action and human rights should be core principles and explicit activities within program and policy interventions, communications and social marketing; and coordination, planning, evaluation and reporting (as well as in knowledge development and global engagement).

- I. 5 The Canadian Government, through political and financial support, has involved vulnerable populations in governmental HIV-policy design and program implementation.

Leading Together: An HIV/AIDS Action Plan for All Canada was developed by a broad cross-section of organizations and individuals involved in the Canadian response, including organizations representing vulnerable populations and people living with HIV. Starting in 2000, civil society was involved in a series of consultations and committees to develop the Action Plan. Key experts assisted in identifying strategic directions and specific objectives to answer the question: "What do we need to do to optimize the Canadian Response to HIV/AIDS over the next five years?" The results were used to begin drafting the Strategic Plan. The draft strategic plan then underwent a wide consultation in the Fall of 2003. Two consultation processes were developed. The first was a broad consultation of Canadian participants in the HIV/AIDS response from as many sectors as possible. The second process aimed to consult directly with PHAs and vulnerable populations. The consultation of PHAs and vulnerable populations required particularly innovative mechanisms to allow for the strongest possible voice and input. To assist in guiding the development of that consultation, an advisory group of PHAs, vulnerable Canadians and others was assembled and provided advice and parameters to frame those particular consultations. All of this work culminated in the finalization of a Strategic Plan, announced and launched on World AIDS Day of 2003.

The *Federal Initiative to Address HIV/AIDS in Canada* facilitates increased engagement by, and improved collaboration among, all levels of government, communities, non-governmental organizations, professional groups, institutions and the private sector. Most of the following national organizations are supported by funding through the *Federal Initiative*:

- Canadian Aboriginal AIDS Network
- Canadian AIDS Society
- Canadian AIDS Treatment Information Exchange
- [Canadian Association for HIV Research](#)
- [Canadian Foundation for AIDS Research](#)
- Canadian HIV/AIDS Information Centre
- Canadian HIV/AIDS Legal Network
- Canadian HIV Trials Network
- Canadian Treatment Action Council
- Canadian Working Group on HIV and Rehabilitation
- Interagency Coalition on AIDS and Development
- International Council of AIDS Service Organizations

The AIDS Community Action Program (ACAP) is one component of the *Federal Initiative to Address HIV/AIDS in Canada*. ACAP is a federal funding program that supports local, regional, and provincial/territorial community-based organizations addressing HIV/AIDS issues across the seven regions of Canada: Atlantic provinces, Quebec, Ontario, Manitoba/Saskatchewan, Alberta, British

Columbia, and the Northern Secretariat (Northwest Territories, Nunavut Territory and Yukon Territory).

ACAP programming reflects the principles of community development; health promotion; partnerships and collaboration; population health; and planning and evaluation. These principles are in alignment with the policy direction of the *Federal Initiative*: partnership and engagement; integration and accountability. ACAP funding supports programming in the following areas:

- Prevention Initiatives to prevent HIV in populations known to be vulnerable to HIV.
- Health Promotion for People Living with HIV/AIDS to increase the capacity of people living with HIV to manage their condition (services, treatment, support, work, learning), and support for people affected by HIV.
- Creating Supportive Environments to reduce social barriers that prevent people living with HIV, those at risk, and those affected from accessing health care and social services. Targeted environments include (but are not limited to): prisons, addiction treatment, professional groups (nurses, educators, pharmacists, physicians, etc.), workplaces, other non-profits, general public.
- Strengthening Community Based Organizations to increase the skills and abilities of the people who work at all levels of the community-based HIV movement: board, staff and volunteers.

ACAP resources are available for operational funding (available to AIDS Service Organizations) and for time limited project funding (available to community organizations that deal with HIV/AIDS as part of their wider programming). ACAP plays a key role in influencing the development and implementation of provincial and territorial programs designed to support community-based HIV/AIDS work. Previous evaluation reports of the National AIDS Strategy clearly indicate that continued federal support for ACAP is integral to any success the federal government hopes to have in preventing the spread of HIV and in creating supportive social environments for people living with HIV/AIDS¹⁴. ACAP is also an invaluable funding program in furthering multi-sectoral participation in the population health framework.¹⁵

It is important to note that inclusion and involvement of community-based organizations does not necessarily mean that there is meaningful involvement of vulnerable populations. Sex trade workers are not even named as a vulnerable population in the *Federal Initiative*, and prisoners and people who inject drugs traditionally have not been well-represented by community-based HIV/AIDS organizations or national NGOs.

I. 6 Canada does not have a specific policy to ensure equal access, between men and women, to prevention and care.

¹⁴ Health Canada. *ACAP Allocations for Regional HIV/AIDS Programming - A discussion paper*. September 1999.

¹⁵ Susan Dann & Associates. *The PPHB Regional Office Role in HIV/AIDS*. May 2003.

Health care is a provincial jurisdiction in Canada but the Canada Health Act mandates that all Canadians have the right to access essential health care services. Although there is officially universal access to health care in Canada, people living with HIV or vulnerable to HIV still experience barriers to accessing health care services and realizing the right to health. Canada does not have specific policies for men and women with respect to HIV prevention and care, but there is a legal framework that governs equal access to care in general.

Recently, the Public Health Agency of Canada has been working with the coalition called “Blueprint for Action on Women and HIV/AIDS” in order to discuss the draft Framework on Population Specific Approaches for the *Federal Initiative* and to identify priority actions/issues for consideration for women in each of the priority vulnerable populations listed in the *Federal Initiative*. *Blueprint for Action on Women and HIV in Canada: Towards 2006* (referred to as *The Coalition*) was created by civil society to bring together individuals and organizations addressing the needs of women living with, and affected by, HIV/AIDS in Canada to act as a united voice on policy issues. The coalition seeks to advocate on these issues and influence national, provincial and municipal governments to provide services and funding programs aimed specifically at services for women living with HIV/AIDS and women affected and vulnerable to HIV/AIDS.

The aim of the coalition is to develop a set of demands addressed to governments, the pharmaceutical industry and other stakeholders addressing all aspects of HIV/AIDS including prevention, care, treatment and support, research and policy initiatives that would stop the alarming infection rate and lack of gender-based treatment information and research. The Blueprint has defined a group of demands with one overarching demand: All demands must have adequate and sustained resources, including financial and human resources; must be culturally and linguistically appropriate and must include women with HIV as an integral part of the solution making and decision making process.

With respect to HIV prevention and education, the coalition calls for a comprehensive approach to sexual and reproductive health and prevention programming, including enhanced support and adequate resources for the research and development of microbicides and creation of a microbicide implementation plan that will ensure affordable, free and unlimited access. Also, the coalition calls for sustainable and culturally and linguistically sensitive services for women who experience violence and their families, and for culturally and linguistically appropriate prevention and education strategies and programs for First Nations, Métis and Inuit, developed by Aboriginal peoples with resources provided by all levels of governments.

Further work needs to be done by appropriate stakeholders, including governments, healthcare institutions, healthcare providers and HIV-positive women, to develop responsive models for health care and support delivery that acknowledge and affirm the multiple roles that women play and the importance of including these in care and support plans. With respect to women’s care,

treatment and support issues, the Blueprint Coalition makes the following recommendations:¹⁶

- Ensure that informed choice and option of treatments (e.g., complementary and alternative medicine) be available and specific to women.
- Ensure that there is a systemic post-approval surveillance system on drugs for women (and their treatment). This does not currently exist.
- Investigate and research how stigma and discrimination are barriers for getting and receiving support and care. The collected data should be segregated by sex and age.
- Gather and provide gender specific treatment information to: (a) ensure that treatment options are just as good for women as men, and that women are treated as women (not just mothers), and (b) provide health care professions with gender-specific information.
- Across the country, establish standards of care, improve access to treatment (add treatment to formularies quickly).
- Coordination of treatment information across Canada.

Women tend to receive HIV-positive test results later in the course of the disease (often finding out during pregnancy) because many doctors and women still believe women are at low risk of contracting HIV. Women therefore are discouraged from receiving early detection and treatment, receiving both can maintain health over a longer period of time¹⁷.

Diagnosis is one important part of the continuum of services to address HIV/AIDS, along with prevention, care, treatment and support. There is a need for more anonymous testing sites and population-specific testing sites, particularly for women. Physicians need better training on how to recognize and respond to signs and symptoms that women are in abusive relationships. Partner notification and disclosure in the context of violence against women is not well addressed in Canada.

Discrimination against women and failure by the medical community to understand the disease in women also prevent women from receiving effective treatment. Many HIV-positive women feel intimidated by doctors and may not ask as many questions as their HIV-positive male counterparts.

Pharmaceutical companies and the medical community must remove barriers preventing women from joining drug studies. Governments must remove the social and economic barriers preventing women from gaining access to treatment. Women need greater social and economic support if they are to receive effective treatment.

¹⁶ *Blueprint for Action on Women and HIV/AIDS in Canada: Towards 2006*, April 1-2 2005 Meeting, Minutes

¹⁷ Canadian AIDS Society. www.cdnaids.ca

Poverty is another barrier to treatment because anti-HIV drugs are very expensive, and although the majority of costs are often covered by provincial plans, deductibles, co-payments and dispensing fees may prove prohibitive for people on low-income. Women earn less than men; many women work part time, and are often excluded from health plans; many mothers place the financial needs of their children and families above their own. Complementary and alternative therapies are typically not covered by provincial health plans, placing such therapies out of reach for many women.

Clinical Trials: despite increasing rates of HIV among women, they are woefully under-represented in clinical trials, which require a substantial time commitment, and may result in unpaid time away from work. Pharmaceutical companies and hospitals do not provide child-care services or compensatory money, making it difficult for women to participate in studies. Taking time off work may raise disclosure issues, as some women may not want to disclose their HIV status to employers. Women are often excluded from drug trials because of their biological potential for pregnancy. Many women lack support in the home, which can hinder their ability to participate in studies.

Barriers to drug adherence: as with barriers to treatment, social and economic factors prevent HIV-positive women from keeping to a drug regimen. However, women are faced with an additional burden: as traditional family caregivers, they give much of their time and energy to the care of others. Skipping medications, or taking drugs later than recommended, can reduce the overall level of health in HIV-positive women. Women need a family-centred approach to care and treatment.

It should be noted that there is very little attention given to the role of men and boys and there is no gender-focused policy on men and boys (e.g., to mitigate the epidemic amongst heterosexual men). There is also no analysis in the *Federal Initiative* of the differential impact of the HIV/AIDS epidemic on men, women, girls and boys.

I. 7 Canada does not have an explicit policy to ensure equal access to prevention and care for most-at-risk populations.

The *Federal Initiative* states that new programs will be developed along the prevention-care continuum with and for people living with HIV/AIDS, gay men, people who inject drugs, Aboriginal people, federal inmates, youth and women at risk for HIV and people coming from countries where HIV is endemic. The *Federal Initiative* does not, however, directly address measure to ensure equal access and care for most at-risk populations. With respect to prisons, there is uneven access across correctional jurisdictions, which, in Canada, are divided into provincial/territorial (for those serving sentences of less than two years), and

federal (for those serving sentences of two years or more). No correctional jurisdiction currently makes clean needles accessible.

A 2002 report¹⁸ noted that in the provincial/territorial jurisdictions of New Brunswick, Nunavut, Prince Edward Island, and some institutions in the Northwest Territories, condoms, dental dams and water-based lubricant were still not available to prisoners. The province of Québec provided condoms, but not dental dams or water-based lubricant. As well, based on the same 2002 findings, some of the provincial/territorial jurisdictions that provided safer sex materials in prisons did so primarily (or solely) through the medical units. This meant that prisoners who sought access to condoms had to make a request to staff, a clear barrier to prisoners who wanted to practice safer sex. In the case of provincial institutions in Ontario, provincial correctional policy specifically prohibited prisoners from accessing more than one condom at a time or having more than two in their possession. Correctional Service Canada (CSC), responsible for federal penitentiaries, has a national policy to make condoms, dental dams, bleach, lubricant and methadone continuation and initiation available to prisoners. It should also be noted that CSC has sought scientific and technical advice from the Public Health Agency of Canada on the risks and benefits of prison needle exchange programs.

The Canadian HIV/AIDS Legal Network has recommended that in order to remove barriers to the use of prevention tools in prisons, condoms, dental dams, bleach and water-based lubricant needed to be made more easily and discreetly accessible to inmates in all prisons, in different locations throughout the institutions, and without inmates having to ask for them.

In practice, even within community settings, most vulnerable populations (e.g., youth, Aboriginal communities, small rural communities, refugees, trafficked women and sex trade workers) have very spotty access to these prevention tools. For over a decade, it has been recommended that Canadian prison systems move ahead with implementing needle exchange programs in prisons.

Provision of these prevention tools and programs varies according to province and between health regions, especially for female condoms, needles, methadone and bleach. For some small communities, even where these prevention tools are accessible, individuals may be reluctant to access them from health centres or stores due to lack of privacy. Refugees, immigrants and trafficked women may not be able to get prevention tools and programs due to language barriers or lack of availability. Vancouver (British Columbia) is piloting Canada's first official safe injection facility and a thorough evaluation is being conducted in order to assess the impacts of the program on drug use, overdose, infection, and crime rates.

There are a limited number of First Nations, Métis and Inuit prevention messages and programs being offered to Aboriginal youth¹⁹. Of the messages that are available, a pan-Aboriginal approach is sometimes being taken that is often

¹⁸ Canadian HIV/AIDS Legal Network: *Action on HIV/AIDS in Prisons: Too Little, Too Late* (2002).

¹⁹ Canadian Aboriginal AIDS Network: *HIV Prevention Messages for Canadian Aboriginal Youth*, March 2004. http://www.caan.ca/english/grfx/resources/publications/youth_prevent.pdf

ineffective. In particular, Inuit youth are being lost in this approach. Aboriginal youth under the age of 15 and people who inject drugs are the groups most in need of HIV prevention messages but they are among the least likely to be receiving them. Prevention education must begin before youth become sexually active, and it must address injection drug use.

There are now efforts underway by the African and Caribbean Council on HIV/AIDS in Ontario to develop a National HIV/AIDS Strategy for Black Canadian, African and Caribbean Communities. Generally speaking, targeted prevention programs are well designed and well-targeted but grossly under-resourced (due to one-time project funding). Prevention initiatives are largely led by community organizations working directly with the vulnerable populations. Most prevention messages in Canada have targeted MSM and gay men, people who inject drugs, and youth. Limited messages have been targeted to women, migrants and mobile populations; as well, very few prevention initiatives have been implemented for prisoners, transgendered people, and sex workers.

I. 8 Canada has policies prohibiting HIV screening for general employment purposes (appointment, promotion, training, benefits).

The Canadian Human Rights Commission (CHRC) originally issued a policy statement on AIDS in 1988. In June 1996, the Commission released a revised version of the statement, based on current medical, scientific and legal information. The CHRC's policies are mirrored in numerous other Canadian legislation and policies²⁰.

Commission will not accept being free from HIV/AIDS as a *bona fide occupational requirement* (BFOR) or a *bona fide justification* (BFJ) unless it can be proven that such a requirement is essential to the safe, efficient and reliable performance of the essential functions of a job or is a justified requirement for receiving programs or services.

HIV positive persons pose virtually no risk to those with whom they interact in the workplace. The Commission, therefore, does not support pre- or post-employment testing for HIV. Such testing could result in unjustified discrimination against people who are HIV positive.

As a result of new drugs and forms of intervention, people with HIV infection are now able to continue productive lives for many years. If individuals with the requisite workplace accommodation are able to continue to work, they should be allowed to do so. Any decision made by an organization relying on health and safety considerations to exclude a person must be based on an individual assessment supported by authoritative and up-to-date medical and scientific information.

²⁰ Canada Labour Code, Part II; Canadian Human Rights Act; Constitution Act, 1982 (*Canadian Charter of Rights and Freedoms*); Government Employees Compensation Act; Privacy Act; Public Service Employment Act; Public Service Staff Relations Act

Regarding health care workers, the Canadian Medical Association Policy on HIV/AIDS states that:

The routine testing of health care workers for the HIV antibody is not justified. The CMA supports the application of universal precautions that enhance the protection of health care workers against potential infection from patients and vice versa.

The Canadian Human Rights Commission supports this view.

The *Public Service Staff Relations Act*, which applies to all federal government departments and other portions of the Public Service, states that employees are not required to undergo mandatory tests for HIV infection. Human rights regulations in Canada recognize that in most work environments in the public and private sector, employees with HIV infection or AIDS do not pose a health risk to others. As with other serious illnesses and disabilities, these employees are encouraged to remain productive as long as they are able. They must not be subject to discriminatory practices. The *Public Service Staff Relations Act* also states that departments must ensure that: the rights and benefits of employees with HIV infection or AIDS are respected; the occupational safety and health of employees with a potential risk of exposure to HIV is protected; employees are informed of existing information, education, counseling and evaluation services in the Public Service with respect to HIV infection and AIDS.

However, other issues relating to workforce participation for people living with HIV require further policy development in Canada. As the nature and impact of HIV/AIDS have shifted in recent years, many people living with HIV in Canada are living longer but also with impairments, activity limitations and participation restrictions. Many community-based AIDS organizations in Canada are initiating work to address workplace issues for people living with HIV, such as the Canadian AIDS Society, the Canadian Aboriginal AIDS Network, COCQ-sida, British Columbia Persons with AIDS Society, AIDS Committee of Toronto, the British Columbia Coalition of People With Disabilities, the Interagency Coalition on AIDS and Development (ICAD), AIDS Calgary, and the Canadian Working Group on HIV and Rehabilitation (CWGHR). People living with HIV face numerous barriers with respect to remaining in employment or returning to employment after taking disability or sick leave. There are many issues faced by people living with episodic disabilities, such as HIV, in Canada. Two priority issues identified by the participants of the Episodic Disabilities Network are income security and labour force participation. The unpredictability of living with HIV, as with other episodic disabilities, can have a significant impact on income support.

ICAD is working to apply a rights-based approach to policy development and the practical considerations for implementing employee rights and employer obligations in the workplace. ICAD is developing training materials and workshops for both employers and employees regarding human rights and employment related legislation in Canada and how this relates specifically to HIV/AIDS as well as other life threatening, chronic and/or episodic disabilities. CWGHR is leading the "Labour Force Participation and Social Inclusion for

People Living with HIV and Other Episodic Disabilities" project. This project is building on a network of episodic disability groups to identify and analyse policies, programs and practices of public and private disability income support and workplace issues to determine strengths, gaps and barriers. This knowledge will then be transferred to policymakers, employers, human resource professionals, labour representatives, insurance providers and other relevant stakeholders. Finally, the project will facilitate labour force participation by testing and evaluating new models for flexible employment and income support to accommodate people with episodic disabilities.

One area for improvement in Canada is for the private sector (particularly Canadian corporations working internationally) to adopt the International Labour Organization's Code of Practice on HIV/AIDS. Currently, the government of Canada does not institute any incentives for Canadian firms working internationally to abide by the ILO Code of Practice on HIV/AIDS, nor penalties for those who do not.

I. 9 Canada has policies to ensure that HIV and AIDS research protocols involving human subjects are reviewed and approved by a national/local ethical review committee.

Organizations that can apply for HIV/AIDS research funding to bodies such as the Canadian Institutes of Health Research (CIHR), the Canadian Foundation for AIDS Research, or provincial health research funding bodies (e.g., Ontario HIV Treatment Network), must be able to administer a process for ethical review that is consistent with the Tri-Council Policy Statement on *Ethical Conduct for Research Involving Humans*, which articulates national standards for Canadian researchers²¹. The general principles articulated in the Canadian Tri-Council Policy Statement include: respect for human dignity; respect for free and informed consent; respect for vulnerable persons; respect for justice and inclusiveness; balancing harms and benefits; minimizing harm; and maximizing benefit.

Although research ethics committees are common features of academic and clinical research institutions, they usually provide services only to their own members, so non-affiliated community-based researchers are usually ineligible. Most community-based HIV/AIDS organizations, however, don't have mechanisms for research ethics review. Only a few community-based research

²¹ Medical Research Council, Natural Sciences and Engineering Research Council, and Social Sciences and Humanities Research Council, August 1998. The full text is available at <http://ncehr.medical.org/english/mstr_frm.html>.

ethics review boards exist in Canada: Aboriginal Ethics Review Boards, the Community-Based Research Centre, the Community Research Ethics Board of Alberta, the University of Toronto's HIV/AIDS Research Ethics Board. Canada generally lacks HIV/AIDS-focused research ethics boards that communities or clinical/academic researchers across Canada can access.

Consequently, community-based researchers experience difficulties to access ethical review which diminishes opportunities to access the annual allocation of community-based research (CBR) funding for HIV/AIDS. To overcome this barrier, the current strategy of community-based researchers is to rely on partnerships with academic researchers.

Ultimately, this has implications for the completion of important research projects and the ethical soundness of community-based research projects. In such academic-community partnerships, however, the process of applying for ethical review is left to the dominion of the academic's institutional guidelines. These institutional guidelines and the members of academic ethics committees are not necessarily sensitive to ethical issues arising from CBR methodologies, do not necessarily include civil society representatives or people living with HIV, nor do they provide a forum for ethical guidance and consultation for community-based researchers. Additionally, researchers submitting protocols to academic ethics committees experience lengthy delays in the review process, have concerns about legal liability superseding ethical responsibility, and dominant scientific-research values are imposed on community-based researchers²². In AIDS prevention research, there is often a very close relationship between the affected communities and behavioural researchers. These complex relationships present challenges for institutional guidelines, which often do not understand or recognize collaborative research relationships. For that matter, members of institutional ethics committees are likely to come from research backgrounds that have placed them in control of the research process, because of scientific and funding criteria. In the context of CBR, an ethics committee needs to be aware of the distribution of power between community-based researchers and the organizations in which they work.

Access to ethical review continues to be a programmatic concern for CBR. Community-based organizations and investigators recognize and respect the need for ethical conduct in research. However, obtaining ethical review for CBR projects from traditional institutional committees requires partnerships that they feel are not necessarily helpful to, or understanding of, community research goals. One way to resolve the existing systemic barrier to ethical review for CBR would be through the establishment of competent and impartial community ethics committees. They should be understanding of the sensitive issues that often accompany HIV/AIDS projects as well as the multidisciplinary nature of CBR. The development of a community-based research ethics infrastructure

²² HIV/AIDS Policy and Law Newsletter. Ethical Review in Community-Based HIV/AIDS Research. Volume 5, Number 1, Fall/Winter 1999

would also promote increased independence for non-academic researchers and improve their awareness of ethical issues. Other potential benefits of CBR ethics committees would be:

- Community ownership of the ethics review process would promote independence in CBR. It would also help develop expertise essential to more balanced relationships with academic partners in research.
- Expedited ethics review at the community level would facilitate timely completion of research.
- Community-based ethics committees would provide direct guidance and consultation to community-based researchers and research populations.
- Community members would become more receptive to CBR as a result of increased peer involvement in the ethics review process.
- The autonomy of community-based ethics review would promote understanding of less traditional research methodologies. The ethics review process undertaken by community ethics committees can be expected to be less rigid and formulaic, and would prioritize different ethical aspects than academic or clinically based ethics committees.

Community-based researchers have been asking for a CBR ethics committee at least since 1999 to remove the systemic barrier facing community-based researchers. The committee should be recognized as having the authority to review, approve, or reject research proposals as well as perform a positive function by providing ethical guidance to researchers and organizations. The CBR ethics committee would promote principles of fairness and access, so that any CBR project in Canada could benefit from ethical review and guidance. Finally, the existence of any CBR ethics committee should be made known to researchers and community-based organizations. This could be achieved by including contact information in the CIHR's CBR grant applications.

I. 10 Does your country have the following monitoring and enforcement mechanisms?

Collection of information on human rights and HIV and AIDS issues and use of this information in policy and program development reform. There are no formal and standardized mechanisms for provincial, regional, or national-level monitoring of human rights issues relating to HIV/AIDS.	Yes	No
Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions and ombudspersons which consider HIV- and AIDS-related issues within their work	Yes	No
Establishment of focal points within governmental health and other departments to monitor HIV-related human rights abuses	Yes	No
Development of performance indicators or benchmarks for compliance with human rights standards in the context of HIV and AIDS efforts	Yes	No

I. 11 Members of the judiciary have not been trained/sensitized to HIV and AIDS and human rights issues that may come up in the context of their work.

The National Judicial Institute is an independent, non-profit organization that serves the Canadian judiciary, by planning, coordinating and delivering judicial education dealing with the law, the craft of judging and social context. The NJI also partners with and promotes the education offered by many other organizations, both Canadian and international. According to the National Judicial Institute, there are no courses offered to judges to provide them with sensitivity training in issues of HIV/AIDS as it relates to human rights or other legal issues.

I. 12 Are the following legal support services available in your country?

Legal aid systems for HIV and AIDS casework There are only a few legal aid organizations targeted to HIV/AIDS casework (the HIV & AIDS Legal Clinic of Ontario, University of Ottawa Community Legal Clinic, Comité des personnes atteintes du VIH du Québec), but otherwise there are only general legal aid systems which do not specialize in HIV/AIDS.	Yes	No
State support to private sector laws firms or university based centers to provide free pro bono legal services to people living with HIV and AIDS in areas such as discrimination	Yes	No
Programs to educate, raise awareness among people living with HIV and AIDS concerning their rights Many community-based AIDS organizations in Canada provide services for people living with HIV to understand their rights (e.g., Canadian HIV/AIDS Legal Network, Canadian Aboriginal AIDS Network, Canadian AIDS Society, COCQ-sida, British Columbia Persons with AIDS Society, AIDS Committee of Toronto, the Interagency Coalition on AIDS and Development, AIDS Calgary, and the Canadian Working Group on HIV and Rehabilitation).	Yes	No

I. 13 There are programs led by the Government of Canada which are designed to change societal attitudes of discrimination and

stigmatization associated with HIV and AIDS to understanding and acceptance.

Most information, education or communication initiatives aiming to change societal attitudes of discrimination and stigmatization are local or regional, sporadic, and time-constrained (mostly around AIDS Awareness Week, Aboriginal AIDS Awareness Week, and World AIDS Day). The Canadian HIV/AIDS Information Centre (a program of the Canadian Public Health Association) has produced resources for their “Change the World” social marketing campaign that focuses on reducing the stigma and discrimination faced by those infected or affected by HIV/AIDS, funded by the Public Health Agency of Canada. This campaign was developed for Canadian HIV/AIDS Awareness Week and World AIDS Day (2005). The Canadian Aboriginal AIDS Network is also implementing an Aboriginal HIV/AIDS Anti-Discrimination project, also supported by the Public Health Agency of Canada. The HIV/AIDS Division has also been working for the past year with stakeholders on the development of a PHAC-led national social marketing strategy to address HIV/AIDS related stigma and discrimination, as identified in the *Federal Initiative*.

II. Civil society participation

II. 1 Civil society has made a significant contribution to strengthening the political commitment of top leaders and national policy formulation.

Leading Together: An HIV/AIDS Action Plan for All Canada was developed by a broad cross-section of organizations and individuals involved in the Canadian response, including organizations representing vulnerable populations and people living with HIV. Starting in 2000, civil society was involved in a series of consultations and committees to develop the Action Plan. Key experts assisted in identifying strategic directions and specific objectives to answer the question: "What do we need to do to optimize the Canadian Response to HIV/AIDS over the next five years?" The results were used to begin drafting the Strategic Plan. The draft strategic plan then underwent a wide consultation in the fall of 2003. Two consultation processes were developed. The first was a broad consultation of Canadian participants in the HIV/AIDS response from as many sectors as possible. The second process aimed to consult directly with PHAs and vulnerable populations. The consultation of PHAs and vulnerable populations required particularly innovative mechanisms to allow for the strongest possible voice and input. To assist in guiding the development of that consultation, an advisory group of PHAs, vulnerable Canadians and others was assembled and provided advice and parameters to frame those particular consultations. All of this work culminated in the finalization of a Strategic Plan, announced and launched on World AIDS Day of 2003.

Civil society – led primarily by national HIV/AIDS non-governmental organizations, community-based AIDS service organizations, and regional coalitions – is very active in analyzing and influencing Canadian policies relating to, and affecting, those vulnerable to or living with HIV/AIDS. Many civil society organizations are very active in policy analysis, education, advocacy, and community mobilization. Civil society organizations use a variety of advocacy strategies (such as letter-writing campaigns, petitions, demonstrations, lobbying and in person-meetings) to challenge politicians, government and other decision makers to address critical issues relating to HIV/AIDS, increasingly from a rights-based approach. Canadian civil society consistently insists on its inclusion in government policy formulation processes, either formally as members of advisory committees and steering groups, or through consultation with civil society stakeholders.

II. 2 Civil society representatives have had very limited involvement in the planning and budgeting process for the National Strategic Plan on HIV and AIDS and for the current activity plan.

Civil society organizations working in the area of HIV/AIDS have very little input into the allocation of *Federal Initiative* funding between and within the areas of 1) program and policy interventions; 2)

knowledge development; 3) communications and social marketing; 4) coordination, planning, evaluation and reporting; and 5) global engagement. There has generally been less than optimal transparency about how funding is allocated within these areas of federal action; NGOs have very little information, for example, on the full plan for requests for proposals and their respective focus areas. There has also been tension between the government and NGOs with respect to the slow pace at which the Federal Initiative funding has been released to organizations and not enough of the funding is reaching vulnerable populations. The doubling of the *Federal Initiative* funding levels between 2003-04 and 2008-09 so far has not been reflected in the funding programs being offered to civil society.

One of the criticisms from the civil society HIV/AIDS sector is that a significant proportion of the new *Federal Initiative* funding for HIV/AIDS will be allocated to the overhead and administration costs of the Public Health Agency of Canada and the other government departments administering the *Federal Initiative*. A request has been sent to the Government of Canada for the exact amounts of Operations and Management funds allocated within the government departments so that civil society can ensure that the amounts are reasonable in relation the funds allocated to actual Grants and Contributions for non-governmental HIV/AIDS programming and research. Civil society is concerned that the increases in *Federal Initiative* funding for HIV/AIDS will not proportionally benefit national NGOs, community-based organizations, and the vulnerable communities that the serve, due to high administration costs associated with the newly established Public Health Agency of Canada, as well as the increasing complexity of the HIV epidemic in Canada.

II. 3 The complimentary services provided by civil society to areas of prevention and care are well recognized in both the National Strategic plans and reports.

The *Federal Initiative to Address HIV/AIDS in Canada* facilitates increased engagement by, and improved collaboration among, all levels of government, communities, non-governmental organizations, professional groups, institutions and the private sector. Community development is the cornerstone of an effective response to HIV/AIDS. Much of the progress made so far in reducing the spread of HIV, and in caring for and supporting infected individuals, has been accomplished by non-profit, voluntary organizations and community groups. Federal support has been essential in helping to build and maintain this nation-wide community-based network.

Funding enables new and innovative programs that further engage the volunteer, health care and research communities in programs to prevent HIV infection and to care, treat and support people living with HIV/AIDS. These programs result in

decreased infections, scientific advances in new treatment therapies, reliable diagnostic testing, effective health care practices, a strong community support system and a national knowledge base on how the epidemic is moving and changing.

Most of the following national organizations are supported by funding through the *Federal Initiative*:

- Canadian Aboriginal AIDS Network
- Canadian AIDS Society
- Canadian AIDS Treatment Information Exchange
- [Canadian Association for HIV Research](#)
- [Canadian Foundation for AIDS Research](#)
- Canadian HIV/AIDS Information Centre
- Canadian HIV/AIDS Legal Network
- Canadian HIV Trials Network
- Canadian Treatment Action Council
- Canadian Working Group on HIV and Rehabilitation
- Interagency Coalition on AIDS and Development
- International Council of AIDS Service Organizations

The AIDS Community Action Program (ACAP) is one component of the *Federal Initiative to Address HIV/AIDS in Canada*. ACAP is a federal funding program that supports local, regional, and provincial/territorial community-based organizations addressing HIV/AIDS issues across the seven regions of Canada: Atlantic provinces, Quebec, Ontario, Manitoba/Saskatchewan, Alberta, British Columbia, and the Northern Secretariat (Northwest Territories, Nunavut and Yukon).

ACAP programming reflects the principles of community development; health promotion; partnerships and collaboration; population health; and planning and evaluation. These principles are in alignment with the policy direction of the *Federal Initiative*: partnership and engagement; integration and accountability. ACAP funding supports programming in the following areas:

- Prevention Initiatives to prevent HIV in populations known to be vulnerable to HIV
- Health Promotion for People Living with HIV/AIDS to increase the capacity of people living with HIV to manage their condition (services, treatment, support, work, learning), and support for people affected by HIV
- Creating Supportive Environments to reduce social barriers that prevent people living with HIV, those at risk, and those affected from accessing health care and social services. Targeted environments include (but are not limited to): prisons, addiction treatment, professional groups (nurses, educators, pharmacists, physicians, etc.), workplaces, other non-profits, general public

- **Strengthening Community Based Organizations** to increase the skills and abilities of the people who work at all levels of the community-based HIV movement: board, staff and volunteers.

ACAP resources are available for operational funding (available to AIDS Service Organizations) and for time limited project funding (available to community organizations that deal with HIV/AIDS as part of their wider programming). ACAP plays a key role in influencing the development and implementation of provincial and territorial programs designed to support community-based HIV/AIDS work. Previous evaluation reports of the National AIDS Strategy clearly indicate that continued federal support for ACAP is integral to any success the federal government hopes to have in preventing the spread of HIV and in creating supportive social environments for people living with HIV/AIDS²³. ACAP is also an invaluable funding program in furthering multi-sectoral participation in the population health framework.²⁴

II. 4 Civil society expects to be prominently involved in a National Periodic review of the Strategic Plan.

Each organization that receives funding from the *Federal Initiative* must submit funding proposals and progress reports to the government department administering the funding. Additionally, there are departmental workplans within each government department, with funded evaluation components in each department, and regular reports are provided to the Ministerial Council regarding the status of *Federal Initiative* spending.

A monitoring plan has not yet been established for Canada's Action Plan. The *Federal Initiative* states that coordination, planning, evaluation and reporting will be enhanced to optimize both the federal and pan-Canadian responses to the epidemic and the use of resources. The focus will be on supporting the implementation of *Leading Together* and the development of issue-specific plans (for example, vaccines, population-specific approaches) and an evaluation strategy for the *Federal Initiative*. Integral to this will be mechanisms that enhance the engagement of people living with and vulnerable to HIV/AIDS. The following activities were outlined for coordination, planning, evaluation and monitoring of the *Federal Initiative*:

- A body will be established to coordinate and align the work of departments and agencies participating in the *Federal Initiative*.
- A multi-jurisdictional and multi-sectoral model will be developed to support the implementation of *Leading Together*.
- National and regional plans consistent with *Leading Together* will be developed and implemented.

²³ Health Canada. *ACAP Allocations for Regional HIV/AIDS Programming - A discussion paper*. September 1999.

²⁴ Susan Dann & Associates. *The PPHB Regional Office Role in HIV/AIDS*. May 2003.

- A performance measurement and evaluation strategy will be developed and implemented. Progress toward the goals of the *Federal Initiative* will be monitored on an ongoing basis.
- An annual report will be published each year on World AIDS Day as a key component of the performance measurement strategy.

The success of *Leading Together* depends on a voluntary nation-wide partnership, the responsibility for steering and monitoring it is to be shared among all the partners. The process for monitoring will likely involve five stages:

1. Commitment. Identifying the partners who should be part of the collective plan, and receiving from them a commitment to participate.
2. Roles and Responsibilities. Encouraging each partner to define its roles and responsibilities in implementing the Action Plan, based on its mission, skills and resources (i.e., what can each organization bring to our collective effort?)
3. Operational Plans. Asking each partner to identify the steps it will take over the next five years to implement the Action Plan, and reviewing all the operational plans against the Action Plan to identify any gaps (i.e., are there any outcomes or actions in the Action Plan that are not addressed by at least one partner?).
4. Monitoring Progress. Identifying the measures we will use to assess our progress and the information that partners will provide to support monitoring.
5. Steering the Plan. Using the monitoring information to develop progress reports, share effective strategies, and identify the need for new outcomes or actions, or to make changes in the Action Plan to respond to changing needs and knowledge.

II. 5 To what extent your country have a policy to ensure that HIV and AIDS research protocols involving human subjects are reviewed and approved by an independent national/local ethical review committee *in which people living with HIV and caregivers participate?*

Individuals representing community perspective, including AIDS service organization representatives, care providers, and PHAs make up 50% of the membership of the Canadian Institute for Health Research review committee for Community-Based Research. However, community representatives are not necessarily members of other research review committees (e.g., for basic or clinical HIV/AIDS research). Civil society strongly recommends that inclusion of community representatives be instituted on other research review committees.

III. Prevention

III. 1 Which of the following prevention activities have been implemented in 2003 and 2005 in support of the HIV-prevention policy/strategy?

<i>(Check all programs that are implemented beyond the pilot stage to a significant portion of both the urban and rural populations).</i>	2005
a. A program to promote accurate HIV and AIDS reporting by the media.	NO
b. A social-marketing program for condoms With the exception of World AIDS Day campaigns led by the Global AIDS Campaign, there are no standardized prevention (or condom promotion) messages in Canada. Any information, education or communication initiatives on prevention are local or regional, sporadic, and time-constrained (mostly around AIDS Awareness Week and World AIDS Day – e.g., the Assumptions Campaign, Gay Men Play Safe, and Condom Country Campaign). Communities generally develop and deliver their own targeted messages, due to restraints from school boards and the need to deliver population-specific messages. Most community-based prevention messages are based on sex-positive and harm reduction approaches, as opposed to abstinence-based models, recognizing that most people are sexually active and/or use drugs, while also providing them with information and prevention messages that will assist them to protect their health.	YES/ NO
c. School-based AIDS education for youth The curriculum in schools varies by province and school board with respect to condoms and needle use messages. There is currently no standardized curriculum across Canada mandating HIV/AIDS education in all jurisdictions.	YES/ NO
d. Behaviour-change communications (see b above)	YES/ NO
e. Voluntary counseling and testing Canadians choosing to be tested for the presence of HIV infection have three different testing options, depending on the province or territory in which testing takes place: Nominal, Non-Nominal, or Anonymous. To varying degrees, depending on provincial or territorial health regulations, women are routinely tested during their prenatal care. However, in practice of prenatal HIV testing, specific informed consent is still inconsistently obtained.	YES
f. Programs for sex workers Prevention programs for sex workers vary between communities, with very few organizations specializing in HIV/AIDS prevention for this population. Sex workers are not listed as a vulnerable population in the <i>Federal Initiative</i> .	YES/ NO
g. Programs for men who have sex with men Prevention programs for gay men and other men who have sex with men vary between communities, although they are listed as one of the vulnerable populations in the <i>Federal Initiative</i> .	YES
h. Programs for people who inject drugs, if applicable	YES

<p>Prevention programs for people who inject drugs varies between communities, although they are listed as one of the vulnerable populations in the <i>Federal Initiative</i>. In theory, needle exchange programs are available across Canada, except in prisons where institutional policies prohibit access to clean needles. For over a decade, it has been recommended that Canadian prison systems move ahead with implementing needle exchange programs in prisons.²⁵ Correctional Service Canada has sought scientific and technical advice from the Public Health Agency of Canada on the risks and benefits of prison needle exchange programs. Vancouver (British Columbia) is piloting Canada's first official safe injection facility and thorough evaluation is being conducted in order to assess the impacts of the program on drug use, overdose, infection, and crime rates.</p>	
<p>i. Programs for other most-at-risk populations ¹²</p> <p>In theory, all HIV prevention tools (e.g., male and female condoms, lubricants, clean needles, methadone substitution therapy) are available and accessible across Canada. In practice, even outside of prisons, most vulnerable populations (e.g., youth, Aboriginal communities, small rural communities, refugees, trafficked women and sex trade workers) have very spotty access to these prevention tools.</p> <p>Provision of these prevention tools and programs varies according to province and between health regions, especially for female condoms, needles, methadone and bleach. For some small communities, even where these prevention tools are accessible, individuals may be reluctant to access them from health centres or stores due to lack of privacy. Refugees, immigrants and trafficked women may not be able to get prevention tools and programs due to language barriers or lack of availability.</p>	<p>YES/ NO</p>
<p>j. Blood safety</p> <p>Canadian Blood Services carefully screens all prospective donors to minimize the potential for transmission of infectious diseases. Donated blood undergoes extensive testing for infectious diseases, and blood groups and compatibility.</p>	<p>YES</p>
<p>k. Programs to prevent mother-to-child transmission of HIV</p>	<p>YES</p>
<p>l. Programs to ensure safe injections in health care settings</p>	<p>YES</p>

²⁵ Canadian HIV/AIDS Legal Network: *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience* (2004).

IV. Care and support

IV. 1 Which of the following activities have been implemented under the care and treatment of HIV and AIDS programs?

<i>(Check all programs that are implemented beyond the pilot stage to a significant portion of both the urban and rural populations).</i>	2005
<p>a. HIV screening of blood transfusion Canadian Blood Services carefully screens all prospective donors to minimize the potential for transmission of infectious diseases. Donated blood undergoes extensive testing for infectious diseases, and blood groups and compatibility.</p>	YES
<p>b. Universal precautions</p>	YES
<p>c. Treatment of opportunistic infections (OI)</p>	YES
<p>d. Antiretroviral therapy (ART)</p> <p>The current standard of HIV treatment includes the use of a combination of at least 3 different anti-HIV medications from at least two different classes. Currently there are two major classes of anti-HIV medications available in Canada:</p> <ul style="list-style-type: none"> ○ reverse transcriptase inhibitors or RT inhibitors (RTIs) ○ protease inhibitors (PIs) <p>Drug coverage formularies through public drug reimbursement plans vary by province as health care is a provincial jurisdiction. There are also 19 federal drug formularies that operate outside of provincial health formularies (e.g., for Veterans, on-reserve Aboriginals or refugees). Generally, while admitted to a hospital, patients will receive drugs free of charge as they are considered medically necessary.</p> <p><i>While Canada has the right principles in place to provide access to treatment, the difficulty is putting those principles into practice. There are significant inconsistencies in access to treatment based on geography and sub-populations through marginalization of certain vulnerable groups. The Canada Health Act only requires that public health insurance plans in the provinces/territories cover medically necessary hospital and physician services; this includes those prescription drugs that are supplied to patients while in hospital or sometimes upon discharge from hospital if they are sent home with a supply of medication. Other than that, there is no universal requirement to include coverage for medications in the public health insurance plans. Provinces provide drug coverage for (a) the elderly, and (b) social assistance recipients (including people with disabilities); but even though the province pays the cost, individuals often have to pay the pharmacist's dispensing fee or some small "co-payment". Only some provinces (e.g., British Columbia, Québec) provide a more extensive pharma-care program that isn't just limited to the elderly or recipients of social assistance, but is available to all residents. Finally, there are "catastrophic drug plans" for people (who are not elderly nor on social assistance) who face catastrophically high drug costs.</i></p>	YES

<i>(Check all programs that are implemented beyond the pilot stage to a significant portion of both the urban and rural populations).</i>	2005
<p><i>These programs (e.g., Ontario's Trillium Drug Program) are income-based – that is, there is a deductible based on the person's annual income; the person pays out of pocket for their medications up to that deductible amount, and the catastrophic drug program covers the remainder of the costs.</i></p> <p>Generally, ARVs are covered by provincial health formularies. Some ARV medications are restricted by limited use or can be accessed through exceptions to drug formulary rules, however it requires a lot of paper work and cost for physicians to prove that their patients meet the exceptions. For example, in Ontario with Tenofovir, doctors were asked to provide a genotype test and a full medical history of the patient's file; many doctors find this very daunting and expensive. There are also inconsistencies in the formularies between provincial health jurisdictions; each province re-evaluates their formularies based on recommendations from the national Common Drug Review. In some cases, they disregard the recommendations (e.g., Atavanavir is not on the Manitoba formulary and not on Aboriginal on-reserve formulary).</p> <p>There are also inequities in access to treatment for specific populations. In urban settings, the ability to access treatment in a confidential way is much greater than in a rural setting. The First Nations and Inuit Health Branch (FNIHB) has its own drug formulary system for on-reserve Aboriginals; however, there is no jurisdictional responsibility for ensuring access to treatment for off-reserve Aboriginal people. Canadian NGOs report that women, immigrants/refugees and people who use illicit drugs have less access to ARV therapies. There are also rural-urban differences in access to treatment. Rural settings don't get access to as many clinical trials, and women are not enrolled in trials to an equitable degree to their male counterparts.</p>	
<p>e. Nutritional care There are no formal nutritional care programs for people living with HIV within the health care system. Food supports are provided by some community-based HIV/AIDS organizations or through food banks.</p>	NO
<p>f. Sexually transmitted infection care</p>	YES
<p>g. Family planning services</p>	YES
<p>h. Psychosocial support for people living with HIV and their families People living with HIV and their families primarily receive psychosocial support through local community-based HIV/AIDS organizations.</p>	YES
<p>i. Home-based care Home-based care is a provincial health jurisdiction and varies by health authority within provinces. Generally, there are inadequate home-care services across all disease and health conditions and HIV/AIDS care is no exception.</p>	YES/ NO
<p>j. Palliative care and treatment of common HIV-related infections: pneumonia, oral thrush, vaginal candidiasis and pulmonary TB (DOTS)</p>	YES

<p>(Check all programs that are implemented beyond the pilot stage to a significant portion of both the urban and rural populations).</p>	<p>2005</p>
<p>k. Cotrimoxazole prophylaxis among HIV-infected people A wide variety of antibiotic and antiprotozoal treatments for <i>Pneumocystis carinii</i> pneumonia, urinary tract infections, bronchitis, middle ear infection, and diarrhea are available through the various provincial/territorial health jurisdictions. In Canada, Cotrimoxazole is available through all of the provincial/territorial public health drug formularies through one or more of the following brand names: Apo-Sulfatrim, Bactrim, Coptin, Novo-Trimel, Nu-Cotrimox, Roubac and Septra. Cotrimoxazole has been available in Canada for over 20 years.</p>	<p>YES</p>
<p>l. Post exposure prophylaxis (e.g., occupational exposures to HIV, rape) Standards for PEP vary by health jurisdiction.</p>	<p>YES</p>
<p>m. Rehabilitation services for people with HIV/AIDS In Canada, the profile of HIV disease is changing, with new drugs delaying disease progression and helping people to live longer. People living with HIV disease, their families, caregivers and those involved in treatment, education and policy face many challenges. Living longer with HIV often means dealing with problems in body functions or structures, activity limitations, and participation restrictions that range from moderate and inconvenient to severe and debilitating. Impairment refers to loss of physiological or psychological functions, such as weakness or impaired cognition. Activity limitation refers to lack of ability to perform activities such as walking or bathing. Participation restriction refers to a disadvantage that limits fulfillment of a role that is considered normal for a person, such as the inability to return to work. These challenges are manifest in physical, psychological, and social forms. They require a series of concerted and collaborative efforts for rehabilitation. Rehabilitation services such as physiotherapy, occupational therapy, and speech-language support are not widely available for people living with HIV/AIDS, nor are the costs for these services covered by many provincial health plans on out-patient basis. Awareness, access and quality of knowledge/service vary by jurisdiction and amongst both service providers and people living with HIV/AIDS.</p>	<p>NO</p>

ANNEX 3

National Programme Behaviour and Impact Indicators

Canada does not currently collect much of the data outlined in the new core indicators for concentrated/low-prevalence epidemics. Work is underway to determine what mechanisms and resources will be required to collect these data and to determine priorities/coherence amongst the indicators for the *UNGASS Report, the Federal Initiative to Address HIV/AIDS in Canada and Leading Together: Canada Takes Action on HIV/AIDS*.

In 2002, PHAC -- in collaboration with provincial, regional and local health authorities, community stakeholders and researchers -- established I-Track which is an HIV and Hepatitis C-associated risk behaviour surveillance system for people who use injection drugs and has been implemented at sentinel sites across Canada. I-Track will provide data for the UNGASS indicators as well as other types of indicators. A similar approach has been taken for gay men with the establishment of M-Track, a second generation surveillance system looking at trends in diseases prevalence and risk behaviour among men who have sex with men in Canada. The establishment of E-Track, which will address risk behaviour among people from countries where HIV is endemic, is currently underway. These systems will provide important data for Canada to tailor and monitor its responses for each vulnerable population and will provide improved information for the next UNGASS report.

Core Indicators for Concentrated / Low-Prevalence Epidemics	
II. UNGASS Indicator	III. Canada's Data
Percentage of [most-at-risk population(s)] who received HIV testing in the last 12 months and know the results.	<ul style="list-style-type: none"> • No national data is available for men who have sex with men. • In the Ontario Men' Survey a cross-sectional study which recruited 5,080 self-identified gay and bisexual men, 77.7% of men indicated that they had even had an HIV test²⁶. • In the M-Track ARGUS studies among MSM in Montreal, the proportion of MSM who reported getting tested within the last 12 months was found to be 39.04%. • In the I-Track studies conducted in 2003-04 at Regina, Winnipeg, Toronto, Sudbury, Victoria and Edmonton, the proportion of IDUs tested within last 12 months was found to be 57.8%.

²⁶ Myers, Allman et al, *Ontario Men's Survey*, 2004. p. 57.

<p>Percentage of [most-at-risk population(s)] reached with HIV/AIDS prevention programmes.</p>	<p>Canada does not collect these data.</p>
<p>Percentage of [most-at-risk population(s)] who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.</p> <p>FOR MSM</p> <p>People can protect themselves from HIV by avoiding anal sex</p> <p>People can protect themselves from HIV, the virus that causes AIDS, by using a condom correctly every time they have anal sex</p>	<p>No National level data available.</p> <p>However, data on two of the questions was collected from MSM as part of M-Track-ARGUS studies in Montreal:</p> <p>83.6%</p> <p>51.1%</p>
<p>Percentage of female and male sex workers reporting the use of a condom with their most recent client.</p>	<ul style="list-style-type: none"> 80.6% of female and male sex workers aged 15-24 reported using a condom with their most recent client in 2003²⁷.
<p>Percentage of men reporting use of a condom the last time they had anal sex with a male partner.</p>	<ul style="list-style-type: none"> In the M-Track ARGUS studies among MSM in Montreal, the proportion of MSM who reported using a condom during last anal sex out of those who had anal sex in the last 6 months was found to be 64.6%.
<p>Percentage of injecting drug users who have adopted behaviours that reduce transmission of HIV, i.e., who avoid using non-sterile injecting equipment and use condoms, in the last month.</p>	<ul style="list-style-type: none"> In the I-Track studies conducted in 2003-04 in Regina, Winnipeg, Toronto, Sudbury, Victoria and Edmonton, the proportion of IDU who adopted safe behaviours out of those who had sex in the last month and who injected in the last month was found to be 27.7%.
<p>Percentage of [most-at-risk population(s)] who are HIV infected.</p>	<ul style="list-style-type: none"> The Ontario Men's Survey asked men to provide a saliva sample. Of all the men in the survey, 6.4% tested HIV positive, but 28.4% of men refused to provide a sample. Of those who provided a sample, 9.4% tested HIV positive²⁸. In the M-Track ARGUS studies among MSM in Montreal, the HIV prevalence

²⁷ Public Health Agency of Canada. *Street Youth in Canada. Findings from Enhanced Surveillance of Canadian Street Youth, 1999-2003*. Unpublished report. November 2005.

²⁸ Myers, Allman et al, *Ontario Men's Survey*, 2004. p. 62.

	<p>was found to be 12.4%.</p> <ul style="list-style-type: none"> • In the I-Track studies conducted in 2003-04 in Regina, Winnipeg, Toronto, Sudbury, Victoria and Edmonton, the proportion of IDUs infected with HIV was found to be 12.5%.
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Other UNGASS Indicators for which Canada collects data	
Percentage of HIV-infected pregnant women receiving a complete course of anti-retro viral prophylaxis to reduce the risk of MTCT	<ul style="list-style-type: none"> • Out of 145 perinatally HIV-exposed infants born in 2004, 139(96%) received any perinatal ART prophylaxis²⁹.
Percentage of young people aged 15–24 reporting the use of a condom during sexual intercourse with a non regular sexual partner	<ul style="list-style-type: none"> • 62.2%³⁰ (2003 CCHS) -- N.B. only unmarried people were asked this question • In the Canadian Youth, Sexual Health and HIV/AIDS Study³¹ (2002), 67.1% of survey respondents reported condom use at last sexual intercourse. The survey focused on school-based youth between 12 and 21 years of age.
Percentage of HIV-infected infants born to HIV-infected mothers. Target: 20% reduction by 2005; 50% reduction by 2010	<ul style="list-style-type: none"> • Out of 145 perinatally HIV-exposed infants born in 2004, 3 (2%) were confirmed to be infected with HIV³².
Percentage of population aged 15-24 with comprehensive correct knowledge of HIV/AIDS.	<ul style="list-style-type: none"> • In the HIV/AIDS Attitudinal Survey (2003) of those 15 years of age and above, 84% responded that unsafe sex can transmit HIV. • In the same survey, 25% thought HIV could be transmitted by kissing; but only 17% of those under 25 years old thought this.

²⁹ Public Health Agency of Canada, *HIV and AIDS in Canada: Surveillance Report to December 31, 2004*. p.28.

³⁰ Canadian Community Health Survey 2.1, 2003.

³¹ Boyce, William et al. Canadian Youth, Sexual Health and HIV/AIDS Study, 2003.

³² Public Health Agency of Canada, *HIV and AIDS in Canada: Surveillance Report to December 31, 2004*. p.28.