

# **UNGASS Country Progress Report**

**– CANADA –**

**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 2006 – December 2007**

## Foreword

Canada is pleased to submit its fourth report to the Secretary General of the United Nations on the UNGASS Declaration of Commitment on HIV/AIDS. Canada's domestic and international response to the HIV/AIDS epidemic is comprehensive, grounded in human rights and the determinants of health and further seeks to overcome the stigma and discrimination faced by those living with and at risk of HIV/AIDS.

Canada's approach is built on partnerships, strengthened capacity and knowledge generation and transfer, to effectively support policy and program development to best address the issues. Partnerships and collaborations with governments at all levels, non-governmental organizations, people living with and at-risk of HIV/AIDS, public health and medical practitioners, researchers and scientists remain fundamental to the Canadian response. 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 specific to the needs of their populations. Communities continue to play a significant role by providing their expertise, resources and involvement in the design and delivery of essential services.

Since the 2006 report, Canada has pressed forward to further operationalize the Declaration of Commitment on HIV/AIDS within its borders, as well as through its global contributions. Several key initiatives have been developed, piloted and launched, demonstrating Canada's commitment to action. In August 2006, Canada was proud to host the International AIDS Conference, for the third time, an event which enabled countries from around the world to share and learn from experiences in responding to HIV/AIDS. Canada's Access to Medicines Regime (CAMR) is an initiative that is but one part of Canada's support to increasing action to provide much needed medicines in the fight against HIV/AIDS, tuberculosis, malaria and other epidemics in the developing world. On September 19, 2007, Canada's Commissioner of Patents granted the first-ever authorization under the terms of the World Trade Organization (WTO) waiver to a Canadian generic drug manufacturer to export an HIV/AIDS drug to Rwanda.

The *Federal Initiative to Address HIV/AIDS in Canada (Federal Initiative)*, launched in 2005, continues to show progress towards its objectives by establishing a national social marketing campaign, a prevention policy framework, testing and counselling guidelines, a strengthened performance and evaluation system and a variety of funding mechanisms and research programs to support community partners in their contributions to the HIV/AIDS response. A population-specific framework is also under development, which will inform evidence-based, culturally appropriate strategies to address the particular needs of those populations most impacted or at risk of HIV/AIDS. Each of these objectives were designed in collaboration and consultation with governments,

civil society and the Canadian public, and further promoted the involvement of individuals most impacted by HIV/AIDS.

The Declaration remains to be an important tool for Canada, to help guide and inform the development of its strategies. Canada will continue to support key global partners such as UNAIDS, UNFPA, the World Health Organization, PAHO, and the Global Fund to Fight AIDS, TB and Malaria. Canada looks forward to working with UNAIDS and its global partners into the future, to further the effectiveness of the global response to HIV/AIDS.

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## **I Status at a glance**

### **(a) Inclusiveness of stakeholders in the report writing process**

The Public Health Agency of Canada (PHAC) was the lead agency in preparing the 2008 submission of the 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, provincial and territorial government representatives and national non-governmental organizations. 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 in late November, followed by a teleconference, in order to review and discuss the findings of both reports as an assessment of the consistency and tone, the accuracy of the Canadian response and to recommend future UNGASS reporting processes.

The report was submitted to the Chief Public Health Officer of PHAC 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.

### **(b) The status of the epidemic**

Estimated number of Canadians living with HIV at the end of 2005: 58,000 (48,000-68,000)

Estimated number of Canadians who have died of AIDS as of 2005: 13,300

Populations most-at-risk: gay men and men who have sex with men, people who use injection drugs, Aboriginal peoples, prisoners, women, people from countries where HIV is endemic, and youth at risk.

### **(c) The policy and programmatic response**

The federal government has consistently supported the response to HIV/AIDS in Canada. Since 2005, the federal government continues to call for an enhanced global response to HIV/AIDS, further announcing additional budget commitments to support domestic and international initiatives. The Standing Committee on Health monitors and reviews federal HIV/AIDS

efforts to ensure that funding is used where it is most needed. In addition, as per its commitment to Treasury Board, planning for a review of the Federal Initiative has begun which will assess the performance, progress, continued relevance and priorities of the strategy.

The Canadian approach is grounded in human rights and social justice, aiming to protect the most vulnerable populations. A population-focused lens has been fundamental to assessing the needs and priorities in terms of research, policy development, monitoring and evaluation measures. Further, the Canadian approach is evidence-based and continues to invest in knowledge transfer and capacity building initiatives, to support strategic and effective policy and program development.

The federal response also acknowledges prevention as a key measure to mitigate the epidemic. All levels of government support prevention efforts, from social marketing initiatives, to the distribution of condoms and needle exchange programs. There has been increased emphasis to support new prevention technologies and strategies, evidenced by setting research priorities and by distinct investments in prevention interventions and program funds, such as screening initiatives that aim to reach the undiagnosed, the development of testing and counselling guidelines and collaborations and contributions to the Canadian HIV Vaccines Initiative.

#### d) UNGASS National Level Core Indicators – 2008

#	National Programmes	Detailed Comments and References
3	Percentage of donated blood units screened for HIV in a quality assured manner	100% <sup>1</sup> .
4	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	Greater than 80% of those with advanced disease are on ART. <sup>2</sup>
5	Percentage of HIV-positive pregnant women who received	Out of 192 perinatally HIV-exposed infants born in 2006, 171 (89%) received any perinatal ART

<sup>1</sup>In Canada, it is mandatory that each donation is tested for HIV using two screening assays: 1) anti-HIV and 2) HIV RNA. Canadian Blood Services performs this testing using the Abbott PRISM anti-HIV 1/2 O plus assay and the Roche Ampliscreen HIV RNA assay using documented standardized work instructions in three GMP laboratories that are licensed by Health Canada. All three laboratories participate in external quality assessment schemes for all assays tested including the two HIV assays. *Haemoquebec* (responsible for blood services in the province of Quebec) follows the same protocols. There are of course situations where the samples from the donation are either not available or are unsuitable for testing. In this case the components manufactured from the donation are destroyed. Therefore 100% of donations released for transfusion have been tested (1) following documented standard operating procedures and (2) in laboratories that participated in an external quality assurance scheme.

<sup>2</sup> Public Health Agency of Canada - unpublished estimate, 2007.

#	National Programmes	Detailed Comments and References
	antiretrovirals to reduce the risk of mother-to-child transmission	prophylaxis <sup>3</sup> .
6	Percentage of estimate HIV-positive incident TB cases that received treatment for TB and HIV	Canada does not track this type of information. However, the most recent WHO global TB report has estimated HIV prevalence in adult incident TB cases in Canada in 2005 to be 8.3% <sup>4</sup> .
7	Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	<b>32%</b> of Canadians over the age of 15 years report having been tested for HIV (excluding testing for insurance, blood donation and participation in research) <sup>5</sup>
8	Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results	In Phase I of I-Track surveys conducted in Victoria, Edmonton, Regina, Winnipeg, Toronto, Sudbury, and the Quebec SurvUDI network, the proportion of injection drug users ( <b>IDUs</b> ) who were both eligible for testing (i.e. those who had already tested positive were excluded) in the last year and got tested was <b>59%</b> <sup>6</sup> .  In the M-Track ARGUS survey among men having sex with men ( <b>MSM</b> ) in Montreal in 2005, the proportion of MSM who reported getting tested within the last 12 months was found to be <b>42.6%</b> . This percentage excludes respondents who had been HIV or HCV seropositive for more than 12 months <sup>7</sup> .
9	Percentage of most-at-risk populations reached with HIV prevention programmes	In Phase I of I-Track surveys, the proportion of <b>IDUs</b> who ever used any needle exchange program services was <b>84.7%</b> ; the proportion of <b>IDUs</b> under the care of a doctor for HIV was

<sup>3</sup> Public Health Agency of Canada. *HIV and AIDS in Canada: Surveillance Report to December 31, 2006*. Table 10.

<sup>4</sup> *Global tuberculosis control: surveillance, planning, financing, WHO report 2006*. Geneva, World Health Organization (WHO/HTM/TB/2006.362).

<sup>5</sup> *HIV/AIDS Attitudinal Tracking Survey 2006, Final Report*. EKOS Research Associates, 2006

<sup>6</sup> *I-Track: Enhanced Surveillance of Risk Behaviours among People who Inject Drugs. Phase I Report, August 2006*. Surveillance and Risk Assessment Division, Centre for Infectious Disease Prevention and Control, Public Health Agency of Canada, 2006

<sup>7</sup> G Lambert, J Cox, F Tremblay, MA-Gadoury, LR Frigault, C Tremblay, M Alary, J Otis, R Lavoie, R Remis, J Vincelette, C Archibald, P Sandstrom. *ARGUS 2005: Summary of the survey on HIV, viral hepatitis and sexually transmitted and blood-borne infections (STBI) as well as on the associated risk behaviours among Montreal men who have sex with men (MSM)*. Montreal Public Health Department, Institut national de santé publique du Québec and the Public Health Agency of Canada. August 2006.

#	National Programmes	Detailed Comments and References
		82.3%; and the proportion taking medication for HIV was 58.4% <sup>8</sup> .
10	Percentage of orphaned and vulnerable children aged 0-17 whose households receive free basic external support in caring for the child	Not applicable.
11	Percentage of schools that provided life skills-based HIV education in the last academic year	Canada does not collect this data

	UNGASS: Knowledge and Behaviour	Detailed Comments and References
12	Current school attendance among orphans and among non-orphans aged 10-14	Not applicable.
13	Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	<p><b>84%</b> of Canadians <b>over the age of 15 years</b> were able to correctly identify how HIV is transmitted. Some Canadians incorrectly believe that HIV can be transmitted through kissing (32%), from mosquito bites (29%), from a sneeze or cough (11%), contact with objects such as drinking fountains or toilets (10%), or from casual contact (5%).</p> <p><b>82%</b> of Canadians <b>over the age of 15 years</b> were found to have medium to high levels of HIV/AIDS knowledge. Knowledge was measured via an index that included knowledge of HIV transmission methods, methods of detecting HIV, natural history of HIV and prognosis<sup>9</sup>. Young people ages 15-24, however, score lower on overall knowledge of HIV, including transmission methods, than those who are in between the ages of 25 and 64.</p>
14	Percentage of most-at-risk populations who both correctly identify ways of preventing the	Canada does not collect these data.

<sup>8</sup> *I-Track: Enhanced Surveillance of Risk Behaviours among People who Inject Drugs. Phase I Report, August 2006.* Surveillance and Risk Assessment Division, Centre for Infectious Disease Prevention and Control, Public Health Agency of Canada, 2006.

<sup>9</sup> *HIV/AIDS Attitudinal Tracking Survey 2006, Final Report.* EKOS Research Associates, 2006



	<b>UNGASS: Knowledge and Behaviour</b>	<b>Detailed Comments and References</b>
	sexual transmission of HIV and who reject major misconceptions about HIV transmission	
15	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Among respondents <b>15-24, 61.3%</b> reported that they had ever had sexual intercourse. Among respondents <b>15-17</b> only, <b>27.9%</b> reported that they had ever had sexual intercourse <sup>10</sup> .
16	Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	<b>13%</b> of Canadians over the age of 15 years who were sexually active engaged in sexual activity with more than one partner in the last 12 months <sup>11</sup> .
17	Percentage of women and men aged 15-49 who had more than one partner in the last 12 months reporting the use of a condom during their last sexual intercourse	Two different surveys have asked the question of condom usage to those who were sexually active. Neither asked this question specifically to those who had more than one partner in the last 12 months.  In the <i>HIV/AIDS Attitudinal Tracking Survey 2006</i> : 23% of Canadians over the age of 15 years who were sexually active used a condom the last time they had sex <sup>12</sup> .  In the <i>Canadian Community Health Survey</i> : Among respondents <b>15-49, 74.8%</b> indicated that they had sex in the past 12 months (*question asked of those who responded that they had ever had sex, incl. don't know/ refusal) Among those who were sexually active in the past 12 months, <b>19.4%</b> indicated that they used a condom the last time they had intercourse ( <b>22.5%</b> of males, <b>16.3%</b> of females) <sup>13</sup> .
18	Percentage of female and male sex workers reporting the use of a condom with their most recent client	Canada does not collect these data, however we do have data for IDUs engaged in sex work:  Among <b>female IDU participants with male client sex partners, 79.6%</b> reported always having used a condom during vaginal sex in the previous 6 months.

<sup>10</sup> *Canadian Community Health Survey 3.1, 2005.*

<sup>11</sup> *HIV/AIDS Attitudinal Tracking Survey 2006, Final Report.* EKOS Research Associates, 2006

<sup>12</sup> *HIV/AIDS Attitudinal Tracking Survey 2006, Final Report.* EKOS Research Associates, 2006

<sup>13</sup> *Canadian Community Health Survey 3.1 (2005)*

	<b>UNGASS: Knowledge and Behaviour</b>	<b>Detailed Comments and References</b>
		Among <b>male IDU participants with female client sex partners</b> , <b>60.5%</b> reported always having used a condom during vaginal sex in the previous 6 months <sup>14</sup> .
19	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	In the M-Track ARGUS survey among MSM in Montreal in 2005, the proportion of <b>MSM</b> 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 <b>64.6%</b> <sup>15</sup> .
20	Percentage of injecting drug users reporting the use of a condom the last time they sexual intercourse	Phase 1 I-Track (2003-2005): <b>43.4%</b> of <b>IDUs</b> used a condom the last time they had sex <sup>16</sup> .
21	Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	Phase 1 I-Track (2003-2005): <b>67.7%</b> of <b>IDUs</b> reported injecting <u>without</u> used equipment in the previous 6 months <sup>17</sup> .

	<b>UNGASS: Impact</b>	<b>Detailed Comments and References</b>
22	Percentage of young women and men aged 15–24 who are HIV infected	The percentage of young men and women aged <b>15-24</b> who are HIV infected is estimated to be <b>0.24%</b> or 15,824 people <sup>18</sup> .
23	Percentage of most-at-risk populations who are HIV infected	Phase 1 I-Track (2003-2005): <b>13.2%</b> of all participants in this <b>IDU</b> study were HIV positive (average of seven sites) <sup>19</sup> .  In Ontario, the HIV prevalence among <b>IDUs</b> was estimated to be <b>4.9%</b> in 2005 <sup>20</sup> .

<sup>14</sup> *I-Track: Enhanced Surveillance of Risk Behaviours among People who Inject Drugs. Phase I Report, August 2006.* Surveillance and Risk Assessment Division, Centre for Infectious Disease Prevention and Control, Public Health Agency of Canada, 2006.

<sup>15</sup> Public Health Agency of Canada, Centre for Infectious Disease Prevention and Control, Surveillance and Risk Assessment Division, Unpublished data. 2006.

<sup>16</sup> Public Health Agency of Canada. *I-Track: Enhanced Surveillance of Risk Behaviours among People who Inject Drugs. Phase I Report, August 2006.* Surveillance and Risk Assessment Division, Centre for Infectious Disease Prevention and Control, Public Health Agency of Canada, 2006.

<sup>17</sup> *I-Track: Enhanced Surveillance of Risk Behaviours among People who Inject Drugs. Phase I Report, August 2006.* Surveillance and Risk Assessment Division, Centre for Infectious Disease Prevention and Control, Public Health Agency of Canada, 2006.

<sup>18</sup> Public Health Agency of Canada, 2007.

<sup>19</sup> *I-Track: Enhanced Surveillance of Risk Behaviours among People who Inject Drugs. Phase I Report, August 2006.* Surveillance and Risk Assessment Division, Centre for Infectious Disease Prevention and Control, Public Health Agency of Canada, 2006.

<sup>20</sup> Remis RS, Swantee C, Schiedel L, Fikre M, Liu J. [Report on HIV/AIDS in Ontario 2005](#). Ontario

	UNGASS: Impact	Detailed Comments and References
		<p>In the M-Track ARGUS survey among <b>MSM</b> in Montreal in 2005, the HIV prevalence was found to be <b>12.5%</b><sup>21</sup>.</p> <p>In <b>Ontario</b>, the HIV prevalence among <b>MSM</b> was estimated to be <b>16.8%</b> in 2005<sup>22</sup>.</p> <p>In <b>Ontario</b>, the HIV prevalence among persons from endemic countries was estimated to be <b>0.87%</b> in 2005<sup>23</sup>.</p> <p>Among <b>inmates in federal prisons</b>, the prevalence rate was <b>1.67%</b> in 2005<sup>24</sup>.</p> <p>Enhanced <b>Street Youth</b> Study (1999-2003) <b>0.6%</b> of all participants who were tested for HIV (N=3449) were HIV positive (among seven sites)<sup>25</sup>.</p> <p>In federal correctional facilities, the point prevalence of HIV infection amongst <b>inmates</b> in 2005 was estimated to be <b>1.66%</b><sup>26</sup>.</p>
24	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Canada does not collect this data.
25	Percentage of infants born to HIV-infected mothers who are infected	Out of 169 perinatally HIV-exposed infants born in 2006 with confirmed HIV status, 5 ( <b>3.0%</b> ) were confirmed to be infected with HIV <sup>27</sup> .

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Ministry of Health and Long-Term Care, March 2007.

<sup>21</sup> G Lambert, J Cox, F Tremblay, MA-Gadoury, LR Frigault, C Tremblay, M Alary, J Otis, R Lavoie, R Remis, J Vincelette, C Archibald, P Sandstrom. *ARGUS 2005: Summary of the survey on HIV, viral hepatitis and sexually transmitted and blood-borne infections as well as on the associated risk behaviours among Montreal men who have sex with men*. Montreal Public Health Department, Institut national de santé publique du Québec and the Public Health Agency of Canada. August 2006.

<sup>22</sup> Remis RS, Swantee C, Schiedel L, Fikre M, Liu J. [Report on HIV/AIDS in Ontario 2005](#). Ontario Ministry of Health and Long-Term Care, March 2007.

<sup>23</sup> Remis RS, Swantee C, Schiedel L, Fikre M, Liu J. [Report on HIV/AIDS in Ontario 2005](#). Ontario Ministry of Health and Long-Term Care, March 2007.

<sup>24</sup> Correctional Service Canada, internal data.

<sup>25</sup> Enhanced Street Youth Study (E-SYS). Community Acquired Infections Division. PHAC, 2007.

<sup>26</sup> Correctional Service Canada. Internal data.

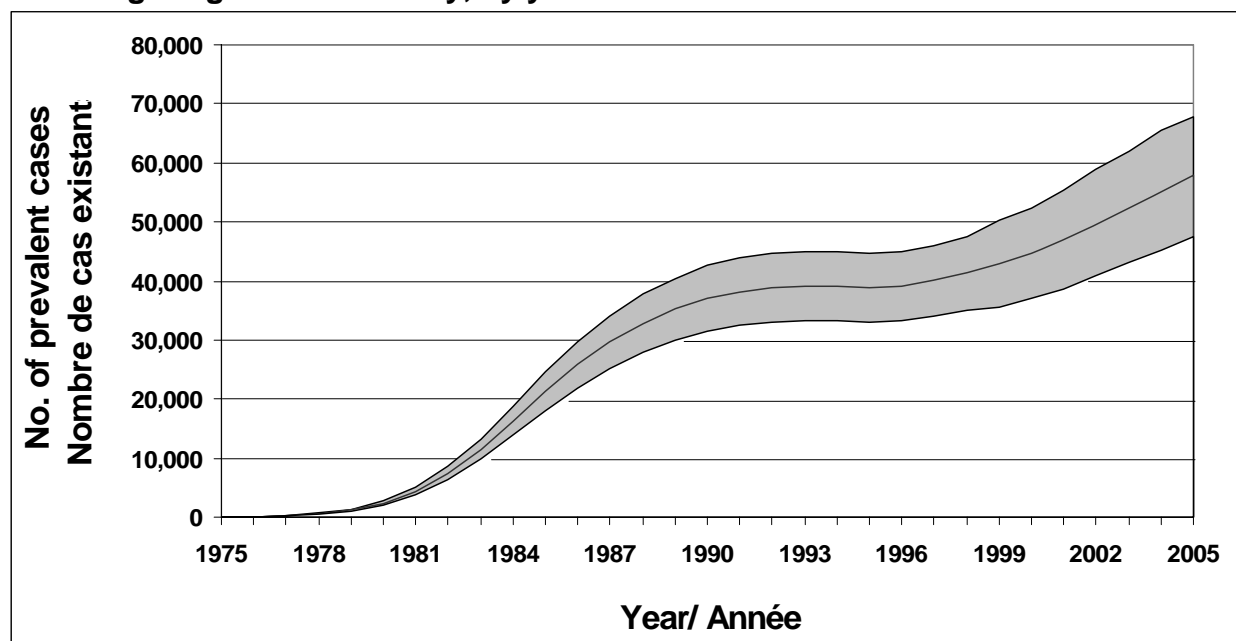
<sup>27</sup> Public Health Agency of Canada. *HIV and AIDS in Canada: Surveillance Report to December 31, 2006*. Table 10.

## II Overview of the AIDS epidemic

### *Overview of the epidemic*

At the end of 2005, 13,300 Canadians were reported to have died of AIDS and an estimated 58,000 (48,000-68,000) were living with HIV infection. Of these 58,000, an estimated 15,800 (11,500-19,500) were unaware of their infection. Approximately 2,300 to 4,500 new infections were estimated to have occurred in 2005 despite prevention efforts.

**Figure 1: Estimated number of prevalent HIV infections in Canada, including range of uncertainty, by year<sup>28</sup>**

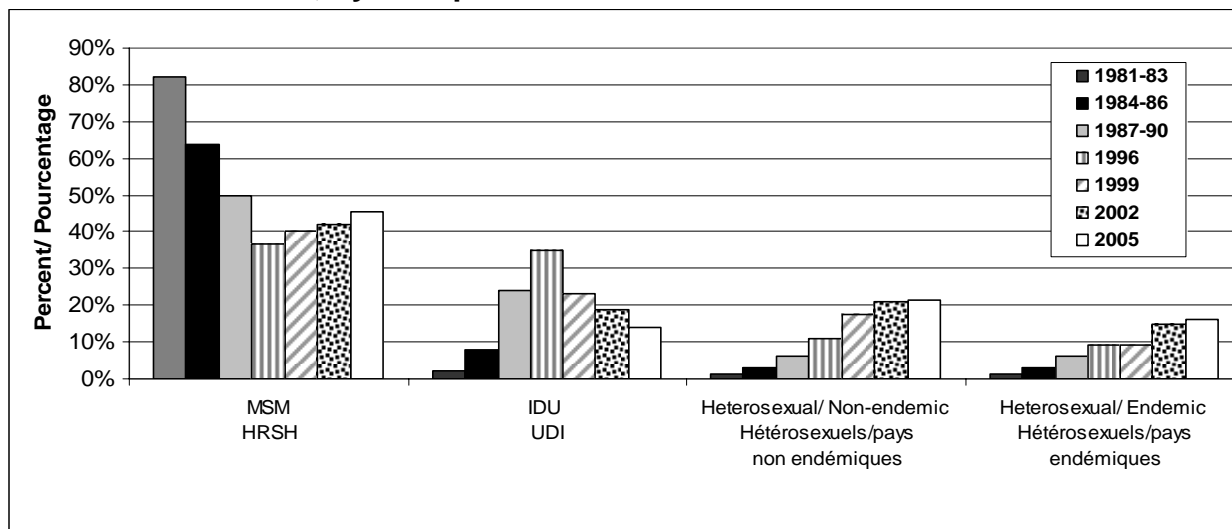


At the end of 2005, gay men and other men who have sex with men continue to be the population most affected by HIV/AIDS, accounting for an estimated 51% of all HIV infections. People who use injection drugs followed at 17%. Aboriginal peoples (composed of First Nations, Inuit and Métis), who make up only 3.3% of the overall population, represent a disproportionately high number of HIV infections, with an estimated 9% of new infections in 2005 and 7.5% of all prevalent infections at the end of 2005. Women accounted for an estimated 27 % of new HIV infections in 2005, where heterosexual contact and injection drug use were identified as the two main exposure categories. Disproportionate rates of infection have also been noted among people living in Canada who were born in a country where HIV is endemic. This population makes up approximately 1.5% of the Canadian population however, in 2005, accounted for an estimated 16% of

<sup>28</sup> Boulos D, Yan P, Schanzer D, Remis RS and Archibald C. Estimates of HIV prevalence and incidence in Canada, 2005. Canada Communicable Disease Report 2006; 32(15): 165-174. <http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/06vol32/dr3215ea.html>

new infections (via heterosexual contact) and 12% of prevalent infections at the end of 2005.<sup>29</sup>

**Figure 2: Estimated exposure category distributions (%) of new HIV infections in Canada, by time period<sup>30</sup>**



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.

<sup>29</sup> Ibid.

<sup>30</sup> Ibid.

### **III National response to the AIDS epidemic**

Canada's response to the AIDS epidemic involves all levels of government, the voluntary sector, the research community, the public health sector, clinicians and those living with or at risk of HIV/AIDS. This multi-sectoral response requires close coordination amongst these different actors.

#### *The pan-Canadian response*

Canada is a federation, with responsibilities for health shared across federal, provincial and territorial governments. Provinces and territories deliver health care and hospital services for the majority of the population, while the Government of Canada is responsible for ensuring the availability of, and/or access to, health services for First Nations people living on reserve, the Inuit in northern Canada, federal prisoners and the armed forces. In partnership with provincial and territorial governments, the Government of Canada develops health policy, funds the health system, develops and enforces health regulations, and promotes 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.

*Leading Together: Canada Takes Action on HIV/AIDS (2005-2010)* provides a national framework for the pan-Canadian response and was developed by a broad range of stakeholders - including AIDS service organizations, clinicians and other health care professionals, researchers, national HIV/AIDS organizations and governments at all levels. 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." The stakeholder-led document was developed after a large-scale consultative process involving community groups, people living with and/or at-risk of HIV/AIDS, health care providers, researchers, and governments across Canada.

#### *The federal response*

The Government of Canada has responded to the HIV/AIDS epidemic both domestically and internationally. Partnerships across the federal government facilitate the exchange of information, and aim to increase alignment, coordination and integration of a government-wide approach to address HIV/AIDS.

#### *The domestic response – The Federal Initiative to Address HIV/AIDS in Canada*

In January 2005, the Government of Canada launched the *Federal Initiative to Address HIV/AIDS in Canada* and committed further federal funding to support the evolution of the domestic response. The *Federal Initiative* is grounded in human rights and the determinants of health, and identifies 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 disease.

The *Federal Initiative* reinforces the importance of partnerships and engagement to effectively respond to the epidemic. The *Federal Initiative* was created through a partnership of four federal departments and agencies: the Public Health Agency of Canada, Health Canada, the Canadian Institutes of Health Research, and Correctional Service Canada. Partnership and engagement with players in governments, civil society, the health care system, the research community, and with those living with/at risk of HIV are also key elements of the strategy.

The *Federal Initiative* aims to develop population-specific approaches to formulate and improve upon policies and programs which affect the lives of people from the following designated populations: people living with HIV/AIDS; gay men and men who have sex with men; people who use injection drugs; Aboriginal peoples; inmates; youth at risk; women; and people from countries where HIV is endemic. In addition, federal HIV/AIDS programs will be integrated with other health and social programs, as appropriate, to promote comprehensive and effective implementation. These programs will strive to address barriers to essential services for people living with, or vulnerable to, multiple infections and conditions that impact their health status.

#### *The Canadian HIV Vaccine Initiative*

In February 2007, the Canadian HIV Vaccine Initiative (CHVI) was announced by the Prime Minister of Canada and Bill Gates. This initiative represents a collaborative Canadian contribution to the Global HIV Vaccine Enterprise that is dedicated to accelerating worldwide efforts towards the development of safe, effective, affordable, and globally accessible HIV vaccines, which are essential to ultimately overcome the HIV/AIDS pandemic. The Government of Canada is contributing up to \$111 million and the Bill & Melinda Gates Foundation is contributing up to \$28 million over five years to support this initiative.

This initiative builds on the Government of Canada's commitment to a comprehensive, long-term approach to address HIV/AIDS, globally and domestically, including the development of new HIV prevention technologies. Participating federal departments and agencies are the Public Health Agency of Canada, Industry Canada, Health Canada, the Canadian Institutes of Health Research, and the Canadian International Development Agency.

The CHVI's specific goals are to:

- strengthen HIV vaccine discovery and social research capacity
- strengthen clinical trial capacity and networks, particularly in low and middle income countries
- increase pilot scale manufacturing capacity for HIV vaccine clinical trial

- lots
- strengthen policy and regulatory approaches for HIV vaccines, particularly in low and middle income countries
  - promote the community and social aspects of HIV vaccine research and delivery
  - ensure horizontal collaboration within the CHVI and with domestic and international collaborators.

The CHVI is an inclusive, global collaboration involving developed and developing countries, researchers, non-governmental organizations, the private sector and governments, with the needs of developing countries at its core.

### *The global response*

On World AIDS Day, December 1, 2006, the Canadian International Development Agency (CIDA) committed to a long-term comprehensive approach to fighting HIV/AIDS globally, which will be multi-faceted, multi-sectoral and recognizes the importance of promoting and protecting human rights. The approach emphasizes action on four key areas:

- to advance effective, evidence-based HIV prevention, including linking HIV/AIDS with education and the development of new preventive technologies;
- to promote gender equality and women's empowerment to address the feminization of HIV/AIDS;
- to strengthen health systems in developing countries to ensure equitable access to essential care, treatment and support for all those who need it; and
- to promote the rights of children and to protect and support those children affected by HIV/AIDS.

As the first in a series of concrete commitments under this new strategy, CIDA announced \$120 million to combat the epidemic in developing countries. CIDA will build on existing programs and will continue to identify opportunities for increased investments in concrete, results-driven initiatives in each of the four priority areas. As an example, CIDA is a major contributor to the Canadian HIV Vaccine Initiative, demonstrating its commitment to invest in the development of new HIV prevention technologies,. This investment complements CIDA's ongoing support to the International AIDS Vaccine Initiative, the African AIDS Vaccine Programme and the International Partnership for Microbicides.

CIDA also supports several large bilateral and regional programs in Africa, Asia and the Caribbean. The Government of Canada, through CIDA, will continue to support key global partners such as: UNAIDS; UNFPA, to ensure strong linkages with sexual and reproductive health, access to condoms and other reproductive health commodities; the WHO, through their plan to scale up universal access to prevention, care, treatment and support; and the Global Fund to Fight AIDS, TB and Malaria, providing a total of almost \$530 million since its foundation.



Foreign Affairs Canada has implemented *Commitment and Action*, the Department of Foreign Affairs and International Trade Canada's HIV/AIDS strategy to address the foreign policy dimensions of HIV/AIDS on issues such as: human security; human rights; multilateral and bilateral advocacy; workplace guidelines; and complex humanitarian emergencies. The Department initiated a series of bilateral discussions on HIV and human rights and has advocated for stronger language in the areas of human rights, gender and the protection of vulnerable groups in multilateral settings such as the June 2006 UNGASS on HIV/AIDS, UNGA and the G8.

A series of research papers and workshops were commissioned exploring the foreign policy and human security dimensions of HIV/AIDS including research conducted by the AIDS, Security and Conflict Initiative which is examining HIV/AIDS in military forces, humanitarian operations, and HIV/AIDS as a cause of instability. The Department is also funding the development of a set of standards for the design, conduct and reporting of ethical research in fragile states and countries affected by armed conflict and a series of training sessions for policy makers and field workers to strengthen knowledge and capacity in infectious disease surveillance in countries affected by armed conflict.

In addition to utilizing the Canadian Missions abroad to promote awareness and the use of Canada's Access to Medicines Regime, a survey and assessment of HIV/AIDS policies at Canadian Missions was completed in order to provide recommendations on the next steps required to ensure Canadian Missions are in compliance with the International Labour Organization's code of practice on HIV/AIDS and the world of work. DFAIT has also been working to increase the number of Canadian companies who are effectively addressing HIV/AIDS in areas of high HIV/AIDS prevalence.

#### *Provincial and territorial responses*

Provinces and territories in Canada are responsible for the provision of health care. Treatment is available across Canada, and programs are in place to ensure that low income does not prevent people from accessing anti-retrovirals. The majority of provinces and territories have adopted some form of a strategy to address HIV/AIDS. For example, in Quebec, Alberta, Saskatchewan and the Northwest Territories, an integrated approach has been adopted. By incorporating issues relating to both blood-borne pathogens and sexually transmitted diseases, the approach recognizes that HIV/AIDS, hepatitis C and sexually transmitted infections affect similar population groups. In other situations, provinces and territories have developed specific HIV/AIDS initiatives, such as in British Columbia, Manitoba, Ontario, Nova Scotia, Newfoundland, Nunavut and the Yukon. Most provinces and territories promote principles related to population health and the respect for human rights as a means to reduce vulnerability to HIV and to 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 resource support from government and across society, community organizations continue to play a key role in designing and delivering front-line services, identifying emerging policy issues and developing appropriate policy responses. Community organizations participate in national planning and expert panels, the development and championing of innovative approaches in prevention and support, and the delivery of programs.

The following national non-governmental HIV/AIDS organizations are key to the HIV/AIDS response in Canada:

- 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 through a variety of funding programs. 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 by addressing the underlying causes.

For example, the Non-Reserve First Nations, Inuit and Métis Communities HIV/AIDS Project Fund, a funding program under the *Federal Initiative*, supports community-based organizations aiming to reduce HIV incidence and to facilitate access to quality diagnosis, care, treatment and social support for Canada's Aboriginal population.

As well, the AIDS Community Action Programme (ACAP), a regionally managed 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; to carry out health promotion for people living with HIV/AIDS; to carry out prevention initiatives; and to strengthen community based organizations. While regional differences exist, the ACAP-funded projects target populations most at risk and those already living with the disease, which is consistent with the approach outlined in the Federal Initiative

## **IV Best practices**

### ***Political leadership –the Canadian HIV Vaccine Initiative***

The \$139 million Canadian HIV Vaccine Initiative (CHVI) represents a collaborative Canadian contribution to the Global HIV Vaccine Enterprise that is dedicated to accelerating worldwide efforts towards the development of safe, effective, affordable, and globally accessible HIV vaccines, which are essential to ultimately overcome the HIV/AIDS pandemic. The CHVI is an inclusive, global collaboration involving developed and developing countries, researchers, non-governmental organizations, the private sector and governments.

The CHVI focuses on five priority areas: discovery and social research; clinical trial capacity building and networks; pilot scale manufacturing capacity for clinical trial lots; policy and regulatory issues, community and social dimensions; and planning, coordination and evaluation.

### ***Political leadership – XVI International AIDS Conference, Toronto 2006***

Canada was proud to host, for the third time, the International AIDS Conference which was held in Toronto in August 2006. The City of Toronto, the Government of Ontario and the Government of Canada worked in a coordinated manner, providing extensive political, programme and financial support to the conference organizers and the overall conference program. The event received significant funding from the Government of Canada, providing direct financial support for many initiatives such as satellite sessions, travel entry, the Global Village and the domestic and international scholarship programmes, the latter which allowed for increased event participation and attendance of civil society representatives and people living with HIV/AIDS.

The importance of partnerships was demonstrated through the success of the Canadian Exhibition Space, which visually depicted the relationship amongst Canadians who share responsibility to address HIV/AIDS in Canada. The exhibit was a highly collaborative initiative, involving representatives from the Government of Canada, the provinces and territories, Canadian non-governmental organizations, and the City of Toronto.

The federal Minister of Health, the federal Minister of International Cooperation, the Ontario Minister of Health and the Mayor of Toronto all contributed to the success of the event providing speeches and presentations throughout the Conference such as at the opening ceremonies, satellite sessions and affiliated events. The Governor General also participated in the opening ceremonies.

The conference received extensive media coverage, bringing increased attention to HIV/AIDS issues across Canada and around the world.

***The supportive policy environment – Collaboration to address the epidemic***

HIV/AIDS is a priority at all levels of government in Canada. To address the challenges of multi-jurisdictional coordination, a national blueprint for action on HIV/AIDS was developed, which acknowledges the different roles that partners contribute to as part of the Canadian response under a common framework for action.

*Leading Together, Canada Takes Action on HIV/AIDS (2005-2010)* sets out an ambitious, coordinated nationwide approach to address HIV/AIDS and the underlying health and social issues that contribute to the epidemic. To promote the multi-sectoral approach and vision outlined in this document, a Championing Committee was established in late 2006, comprising of representatives from the voluntary sector, the research sector, and government. The Committee's mandate is to promote and champion the widespread use of *Leading Together* throughout Canada so that the document guides all sectors of Canada's response in order to get ahead of the epidemic and to improve the lives of people at risk of and living with HIV/AIDS.

Other advisory and consultative mechanisms exist to facilitate collaboration across and between jurisdictions such as the Federal/Provincial/Territorial Advisory Committee on AIDS, which promotes inter-jurisdictional collaboration and provides public policy development. The Assistant Deputy Minister Committee on HIV/AIDS provides for government-wide, interdepartmental leadership, increased coordination and integration of policy and programs that address HIV/AIDS and its related issues. Different provinces and territories have various mechanisms to support interdepartmental work on HIV/AIDS.

The voluntary sector is also active in coordinating its efforts. For example, the Canadian AIDS Society is a national coalition of over 125 community-based AIDS service organizations dedicated both to strengthening the response to HIV/AIDS across all sectors of society, and to enriching the lives of people and communities living with HIV/AIDS. Another example is the Canadian Aboriginal AIDS Network, a non-profit coalition of individuals and organizations which provides leadership, support, and advocacy for Aboriginal peoples living with and affected by HIV/AIDS, regardless of where they reside (on or off reserve). Several provinces have umbrella groups representing the various community organizations involved in the response to the HIV/AIDS epidemic.

***Scale-up of effective prevention programmes***

Prevention is fundamental to bringing an end to the epidemic in Canada. Prevention has become a focus of renewed energy, with an emphasis on best practices in reaching at-risk populations, on encouraging partnerships, on knowledge transfer, on scientific evidence, and on specific interventions such as testing and vaccine development.

*Prevention: The HIV Prevention Forum*

The Public Health Agency of Canada, in partnership with the National Collaborating Centre for Infectious Diseases, held an HIV Prevention Forum in Ottawa on April 12-13, 2007. The forum brought together federal government officials, domestic and international experts, provincial and territorial government and public health delegates, HIV/AIDS national and frontline organization representatives, public health practitioners, people living with HIV/AIDS, researchers, and other stakeholders. Participants discussed and identified strategies for sustaining HIV prevention efforts over the next decade to prevent the acquisition and transmission of new HIV infections.

Outcomes of the forum included an improved awareness of the roles and responsibilities of the partners involved in HIV prevention and identified priorities and multi-stakeholder strategies for sustaining HIV prevention.

*Prevention: HIV testing*

Emerging issues and policy discussions related to HIV testing include healthcare-provider-initiated testing and counselling, point-of-care rapid testing, the availability of home test kits, as well as issues related to human rights, surveillance, research, training and delivery of testing and counselling programs. These evolving issues, and others, continue to raise several questions regarding who should administer tests as well as the potential impact of insufficient counselling and referral when considering treatment and support initiatives.

The federal government has responded to this changing environment on both the domestic and international front. The Public Health Agency of Canada (PHAC), the Canadian International Development Agency, Health Canada and Foreign Affairs Canada engaged in the WHO/UNAIDS discussion on approaches to provider-initiated testing and counselling in a number of international fora. By bringing forward the Canadian experiences to HIV testing, it reinforced the importance to include pre and post test counselling, confidentiality and informed consent issues in all situations where HIV testing is provided. The PHAC sponsored an international policy dialogue on HIV testing and counselling in 2006, which brought together leading human rights experts, public health ethicists, HIV testing and counselling specialists and public health practitioners to discuss the issues. A research paper prepared for this dialogue – *HIV Testing and Counselling: Policies in Transition (2006)*<sup>31</sup> – serves as an important resource on the history of testing and on emerging approaches adopted both domestically and internationally.

Many studies have demonstrated that the use of rapid testing technologies increase the uptake of HIV testing in most vulnerable populations. In support of the introduction of rapid tests, PHAC published revised guidelines: *Point of Care HIV Testing Using Rapid HIV Test Kits: Guidance for Health-Care Professionals*. These guidelines aim to ensure that health-care professionals, who are approved to perform HIV testing, can appropriately administer rapid

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<sup>31</sup> <http://www.phac-aspc.gc.ca/aids-sida/publication/hivtest/index-eng.html>

HIV testing in points-of-care sites. The guidelines highlight the need for pre- and post-test counselling and the adaptation of post-test counselling in the context of rapid HIV testing.

*Prevention: Targeted Research Initiatives*

The Canadian Institutes of Health Research (CIHR) identifies prevention as one of six priorities for their HIV/AIDS Research Initiative. To enhance research efforts and to build the capacity of Canadian investigators in the area of HIV prevention, CIHR designed a strategic research funding program, in consultation with a multi-sectoral working group, which was then launched in December 2006. The program supports research projects expected to contribute to the identification of new or improved HIV prevention strategies, ranging from novel technologies to innovative public health interventions.

***Scale-up of care/treatment/support***

As part of the *Federal Initiative*, the Public Health Agency of Canada realigned its national HIV/AIDS funding programs to strengthen the federal role in supporting communities to better address the epidemic. In 2006, the Specific Populations HIV/AIDS Initiatives Fund, one of five national funding programs under the *Federal Initiative*, was launched. This fund program supports national projects that: prevent HIV infection; increase access to appropriate diagnosis, care, treatment, and support; and increase healthy behaviours in populations most affected by HIV/AIDS and most vulnerable to infection.

***Capacity building - Developing a national framework for research planning and knowledge exchange***

Important components of both *Leading Together* and the *Federal Initiative* are initiatives that aim to strengthen research planning and knowledge transfer and exchange in order to increase the uptake and utilization of knowledge to further inform policy and program decisions. The Public Health Agency of Canada plays a lead role in the development of national initiatives. For example, work is underway to develop a national framework for research planning and knowledge exchange in Canada, in collaboration with governments, researchers, funders, community-based and national non-governmental organizations, public health practitioners, front-line service providers and people living with HIV/AIDS. The framework will identify ways in which to harness existing capacities and to strengthen systems so that information needs are identified in a timely manner, and knowledge is developed and transferred to meet these needs, resulting in evidence-informed policy, practice and decision-making.

The Canadian Institutes of Health Research (CIHR), Canada's leading funding agency for health research, has undertaken several initiatives to complement national research planning and knowledge exchange efforts. In February 2006, CIHR announced six research priorities which will help to guide the agency's HIV/AIDS research planning and investments to best address the key issues facing the epidemic in Canada. The priorities were identified through a consultative process which engaged researchers, government and community-

based organizations. The priorities encourage a population-specific approach, targeting high risk populations, and will support initiatives such as those that address the accessibility of essential services for those infected and at risk of HIV. CIHR is also undertaking the development of a strategic plan to better define the HIV/AIDS Research Initiative's mission and activities over the next five years. Both the strategic plan and priorities will help define the role of the agency in the national framework and will guide the development of a coordinated and collaborative approach with stakeholders.

***Capacity building –the National HIV/AIDS Knowledge Exchange Fund***

A new National HIV/AIDS Knowledge Exchange Fund was developed in 2006-07 after undertaking the following activities: a literature review of knowledge exchange models; a survey of front-line service providers; and consultations with national HIV/AIDS NGOs, health care providers, public health units, researchers, community-based AIDS service organizations and other federal government departments. In October 2007, the fund process was finalized. The National HIV/AIDS Knowledge Broker will act as the "one stop shop" providing relevant, current, and readily accessible knowledge and information in a timely manner in order to strengthen front-line HIV/AIDS prevention, diagnosis, care, treatment and support programs.

***Capacity building – the Development and Pilot of a Common Data Collection and Reporting Tool***

The Public Health Agency of Canada (PHAC) has established the Population Health Evaluators Network, whose membership consists of PHAC regional/national evaluators and program consultants from across population health programs. In 2005, the Network launched a pilot monitoring and evaluation initiative which saw the development of a Project Evaluation and Reporting Tool (PERT) and database to enable a more systematic assessment of evidence and improve results-based reporting across the Agency.

Funded organizations complete the PERT data collection questionnaire at various stages throughout their project life-cycle. The PERT can be completed online using an online data entry and analysis web application. A one-year pilot test of the PERT was initiated in October 2006 to assess the validity and reliability of the tool. The tool is currently being validated by external evaluation experts. Revisions will be made to the tool as a result of this process to support monitoring and evaluation activities of the Public Health Agency of Canada. Community organizations whose projects are funded through the AIDS Community Action Program and national HIV/AIDS funding programs, are participating in this pilot.

This initiative will strengthen PHAC's program monitoring and evaluation processes by supporting a streamlined, integrated, centralized, consistent and comparable approach to reporting.



## **V Major challenges and remedial actions**

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

The incidence of new infections within Canada continues to affect certain populations in disproportionate numbers. The unique nature of a sub-population's respective vulnerabilities and the shortcomings derived from using a uniform approach to address diverse prevention, care or treatment needs require a more tailored response in order to be more effective.

The Public Health Agency of Canada (PHAC) is developing population-specific HIV/AIDS status reports in collaboration with representatives from the eight populations identified under the *Federal Initiative*. The information generated aims to support work undertaken in the provinces and territories and by front line organizations, to more positively affect the health and well-being of individuals living with HIV/AIDS or at risk of infection. These reports will identify the current status of the epidemic in each population, look at the burden of and vulnerability to HIV/AIDS, provide a comprehensive overview of current research and responses, provide information on emerging issues and the lived experience of the population and identify opportunities to inform future policy and program development, research priorities and strategic action.

The PHAC has also created a Population Specific HIV/AIDS Initiatives Fund, which provides funding to community organizations to support relevant national policy, program and social marketing projects to prevent HIV infection, increase access to appropriate diagnosis, care, treatment, and support and increase healthy behaviours amongst populations most affected by HIV/AIDS and most vulnerable to HIV infection.

### ***Reaching the undiagnosed***

An estimated 58,000 Canadians are currently living with HIV, and an estimated 27% of them are unaware that they are infected. While the majority of these individuals fall under the vulnerable groups referenced above, they are not being reached by existing prevention programs and social marketing messages or are choosing not to get tested. Second generation surveillance which looks at trends in disease prevalence and risk behaviours amongst key population groups – gay men, people who use injection drugs, street-involved youth and people from countries where HIV is endemic – will allow for more effective targeting and monitoring of interventions within each distinct population, in turn allowing for more appropriate planning of future activities to best meet their needs.

The Public Health Agency of Canada is working in collaboration with provinces and territories and various experts and community groups, to develop an HIV testing and counselling policy framework that will aim to increase the number of HIV positive Canadians that are aware of their HIV status. This policy framework will be based on: the best evidence related to the HIV epidemic; medical, public health, legal, ethical and human rights considerations; and,

representative of major points of view and jurisdictional considerations and approaches.

***Addressing the determinants of health***

Evidence demonstrates a strong linkage of health inequities in populations and their vulnerability to HIV/AIDS. The Government of Canada integrates a determinants of health approach to address the root causes that drive the HIV/AIDS epidemic. In 2005, the Government of Canada Assistant Deputy Minister Committee on HIV/AIDS was created, whose members represent 13 federal departments and agencies, and whose respective mandates have an impact on Canada's HIV/AIDS response. This Committee provides a common platform to promote horizontal coordination, interdepartmental action and alignment of policies and programs, particularly as they relate to HIV/AIDS. Increased government collaboration is a key element of the *Federal Initiative*.

***Strengthening the national response***

Under Canada's federated system, each level of government has a role in the national response to HIV/AIDS. The epidemic varies depending on geographic location, both in size and in the populations it affects, requiring a tailored response to the unique needs of each jurisdiction. Differing priorities, approaches and implementation structures within jurisdictions limit the ability to set and track national goals and progress.

To help address these challenges to work across jurisdictions and to ramp up the resources necessary to meet an increasingly complex epidemic, several mechanisms have been put in place to promote intergovernmental collaboration and coordination. In 2005, the Pan-Canadian Public Health Network was established as one mechanism for different levels of government to work together to address public health issues. This Network builds on existing strengths in public health, and aims to strengthen public health infrastructure and capacity at the local, provincial, territorial and federal levels. The Federal / Provincial / Territorial Advisory Committee on AIDS (FPT-AIDS) has also been established to provide public health policy and program advice and to promote intergovernmental collaboration in the area of HIV/AIDS. FPT-AIDS has reported to the Network since 2006.

In addition, a national health surveillance system is in place to collect data from provinces and territories and to develop national summaries and analyses. FPT-AIDS is working to implement the *HIV/AIDS Surveillance and Targeted Epidemiological Studies Plan*, finalized in 2005, which emphasises enhanced surveillance, targeted epidemiological studies, and improved knowledge transfer of HIV/AIDS epidemiological and surveillance information. A series of sentinel behavioural surveillance studies were planned and implemented in 2006 and 2007. Future plans include maintaining the current surveillance projects and expanding to other vulnerable populations for 2008.

Twenty five years after the emergence of HIV/AIDS in Canada, significant progress has been achieved in building community and research capacity and strengthening inter-governmental collaboration. As the nature of the epidemic continues to evolve and treatments prolong the lives of people living with HIV/AIDS, new strategic partnerships, engaging a broader range of players, must be developed to prevent the acquisition and transmission of new infections and to improve the health outcomes of those living with or vulnerable to HIV.

### ***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. In *R v Cuerrier* (1998)<sup>32</sup>, the Supreme Court of Canada outlined a criminal law approach to the issue. The case determined that failure to disclose one's sero-status to sexual partners constitutes fraud, thereby vitiating consent to sexual acts and subjecting a person with HIV to the possibility of conviction of serious criminal offences.

A number of cases have been prosecuted in this vein, with the lower courts following the Supreme Court of Canada's jurisprudence. Distinct from some countries, Canada's convictions rest on the failure to disclose alone and do not require that transmission of HIV be proven. Concerns have been expressed about a possible disconnect between this criminal justice approach and community-based and public health prevention messages. A harmonized approach to address the common underlying social issues surrounding the failure to disclose HIV status to sexual partners should be encouraged.

In 2005, a working group was organized by the Federal/Provincial/Territorial Advisory Committee on AIDS to examine the issue of persons who are unwilling or unable to disclose their HIV status. Members represented public health, medical, mental health, legal and epidemiological experts, community-service organizations, in addition to people living with HIV/AIDS. The working group concluded that an approach rooted in public health should be adopted, rather than criminal law, emphasizing prevention as its primary objective, further emphasizing flexibility, individual risk assessment, counselling and respect for human rights<sup>33</sup>.

### ***Addressing stigma and discrimination***

A national public opinion survey conducted in 2006 revealed that people with and vulnerable to HIV/AIDS continue to face stigma and discrimination in Canada for several reasons including a general lack of knowledge regarding how HIV is transmitted. Stigma and discrimination surrounding HIV/AIDS inhibit people living with and at risk of HIV from accessing the information, prevention, diagnosis, care, treatment and support services they need.

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<sup>32</sup> *R. v. Cuerrier* 1998 CanLII (S.C.C), 1998-09-03

<sup>33</sup> Persons who fail to disclose their HIV Status: Conclusions Reached by an Expert Working Group. *Canada Communicable Disease Report*. Vol. 31-05. March, 2005

A National Social Marketing Campaign has been developed by the Public Health Agency of Canada (PHAC) to improve Canadians' knowledge of HIV, to address negative public attitudes, and to ultimately reduce stigma and discrimination. Created with input from an expert panel, and a national committee comprised of people living with HIV/AIDS, representatives from community-based and national AIDS Service Organizations, public health, and provincial/territorial governments, and based on extensive quantitative and qualitative research, the multi-year campaign proposes to use a range of marketing tools and tactics to target two primary audiences.

Two studies were commissioned by PHAC in support of the campaign's development – the HIV/AIDS Attitudinal Tracking Survey 2006 and the Aboriginal HIV/AIDS Attitudinal Survey 2006. Analysis indicated that the segment of both the general and aboriginal population most likely to have stigmatizing and discriminatory attitudes towards people living with HIV/AIDS, and be the most open to attitudinal and behaviour change, is men between the ages of 18-25 years old. The campaign will focus on two target audiences, the first will be 18-25 year old males, and the second will be focused in settings and environments where people living with HIV/AIDS experience stigma and discrimination, and may include health care or employment settings. Opinion leaders and the media will also be engaged and educated on HIV/AIDS-related stigma and discrimination issues.

### ***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.

The Public Health Agency of Canada has established an internal working group that is mandated to maximize synergies and identify opportunities for collaboration to address issues related to HIV, hepatitis C, tuberculosis and sexually transmitted infections including common risk factors, co-infections, and the co-morbidities associated to these infections. Some provinces and territories have adopted an integrated approach to addressing HIV in consideration of the linkages of HIV with other blood-borne pathogens and/or sexually transmitted infections.

***Increasing global access to medicine***

Access to affordable medicines has been a focus of international advocacy for years, with protests against patent regimes that make anti-retrovirals unaffordable to the vast majority of those living with HIV/AIDS in the developing world. To address this challenge, Canada developed the Canada Access to Medicines Regime (CAMR), which came into force on May 14, 2005. It implements a decision made by the General Council of the World Trade Organization (WTO) in 2003 that waived certain trade obligations thought to be a barrier to developing countries' access to lower-cost drugs. The goal of CAMR is to facilitate timely access to generic versions of patented drugs and medical devices, especially those needed by least-developed or developing countries to fight HIV/AIDS, malaria, tuberculosis and other diseases. CAMR enables Canadian generic manufacturers to apply to Canada's Commissioner of Patents for an authorization to manufacture and export lower-priced versions of patented drugs to countries unable to manufacture their own. Drugs exported under CAMR must also meet the same safety, efficacy and quality standards as those approved for sale in Canada. On September 19, 2007, Canada's Commissioner of Patents granted the first-ever authorization under the terms of the WTO waiver to a Canadian generic drug manufacturer to export an HIV/AIDS drug to Rwanda.

In addition to CAMR and the Canadian HIV Vaccine Initiative (CHVI), Canada introduced a new tax incentive in Budget 2007 for pharmaceutical companies who donate drugs to developing countries. Last January, the Government announced that it would double Canada's contribution, from \$100 million to \$200 million, to the Advance Market Commitment, a global effort to create a pneumococcal vaccine that will benefit the world's poorest nations. The government also recently committed \$111 million, with the Bill & Melinda Gates Foundation (\$28 million), to support the CHVI and accelerate the development of a HIV/AIDS vaccine. Canada is also chairing the World Health Organization Intergovernmental Working Group on Public Health, Innovation and Intellectual Property, whose mandate is to prepare a global strategy and plan of action on essential health research to address conditions affecting developing countries disproportionately.

## VI Monitoring and evaluation environment

The Government of Canada is committed to implement specific measures to strengthen accountability and increase transparency and oversight in government operations. Canadian civil society and governments are promoting strengthened monitoring and evaluation initiatives to demonstrate results for Canadians. The challenge in monitoring Canada's national response to HIV/AIDS is that each level of the response – national, provincial, territorial and community – has its own independent evaluation procedures, often including different targets and indicators to be used in performance measurement.

To guide national action, *Leading Together: Canada Takes Action on HIV/AIDS, 2005-2010*, introduced broad nation-wide desired outcomes, targets, and recommended actions 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. The mandate of the *Leading Together* Championing Committee is to encourage and monitor the use of the plan, not to measure progress.

The Government of Canada's *Federal Initiative to Address HIV/AIDS in Canada* includes a Results-Based Management and Accountability Framework, a common monitoring and evaluation plan for the federal investment in HIV/AIDS. The inter-departmental performance management strategy comprises a common data collection plan, evaluation plan, and regular reporting commitments. This framework, when fully implemented, will provide opportunities for shared priority setting, as well as a record of progress towards reaching the federal targets.

The *Canadian HIV Vaccine Initiative* has an integrated Results-Based Management and Accountability Framework and Risk-Based Audit Framework, developed in collaboration with participating departments/agencies, which provides the means to enhance monitoring, auditing, and reporting, and provide guidance for the evaluation-related activities. In addition to contributing to improvement in management practices and informing decision-making, this framework establishes a commitment to ongoing horizontal performance measurement that will ensure that program activities' key results contribute to the achievement of each participating department/agency strategic outcomes.

In order to communicate monitoring and evaluation results to civil society, *Canada's Report on HIV/AIDS* is published annually, providing an account of annual progress to the public. Semi-annual *Surveillance Reports*, annual *HIV/AIDS Epi Updates*, and reports from the *Enhanced Street Youth Surveillance Study* 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 1. Consultation process for the Country Progress Report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS**

### **1) Which institutions were responsible for filling out the indicator forms?**

- a) NAC or equivalent: Not applicable
- b) NAP: Yes, the Public Health Agency of Canada
- c) Others: Yes, a third party consultant developed UNGASS Appendix 7, Part B

### **2) With inputs from**

**Ministries:** Yes

Education - not applicable; Health - Yes; Labour - not applicable; Foreign Affairs – Yes; Others: Yes – Department of National Defence, Corrections Services Canada, Canadian International Development Agency, Provincial/Territorial government representatives.

**Civil society organizations:** Yes – national NGOs representing domestic and international

**People living with HIV:** No, not directly however may be within scope of consultations

**Private sector:** No

**United Nations organizations:** No, not applicable

**Bilaterals:** No, not applicable

**International NGOs:** No, not applicable

**Others:** No

**3) Was the report discussed in a large forum?** Yes – federal, provincial, territorial government jurisdictions, NGO community representatives.

**4) Are the survey results stored centrally?** Yes

**5) Are data available for public consultation?** Not applicable

**6) Who is the person responsible for submission of the report and for follow-up if there are questions on the Country Progress Report?**

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**United Nations General Assembly Special Session on  
HIV/AIDS  
Declaration of Commitment on HIV/AIDS**

**UNGASS Report  
January 2006 – December 2007**

**– CANADA –**

**Annex 2 - Part A  
National Composite Policy Index**

**Information provided by the Government of Canada**



## **Annex 2 - Part A**

### **National Composite Policy Index Questionnaire**

#### **I Strategic Plan**

##### **1. Has the country developed a national multisectoral strategy/action framework to combat AIDS?**

Yes **Period covered:** 2005- 2010

*Leading Together, Canada Takes Action on HIV/AIDS (2005-2010)* is a national blueprint for action for Canada's response to HIV/AIDS which was developed by a broad range of broad range of stakeholders - including AIDS service organizations, clinicians and other health care professionals, researchers, national HIV/AIDS organizations and governments at all levels. It is broken down into detailed actions covering six strategies:

- increase awareness of the impact of HIV/AIDS and increase the commitment to sustained funding of HIV/AIDS programs and services
- address the social factors/inequities driving the epidemic
- step up prevention efforts
- strengthen diagnosis, care, treatment and support services
- provide leadership in global efforts
- enhance the front-line capacity to act early and stay the course

The *Federal Initiative to Address HIV/AIDS in Canada* 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.

Many provinces and territories have multisectoral strategies and/or action frameworks.

##### **1.1 How long has the country had a multisectoral strategy/action framework?**

*Leading Together*, the national blueprint for action has been in effect for 3 years. The federal government has had an HIV/AIDS strategy for 17 years – the first federal strategy – the National AIDS Strategy was launched in 1990.

##### **1.2 Which sectors are included in the multisectoral strategy/action framework with a specific HIV budget for their activities?**

*Leading Together*, Canada's national blueprint does not have a budget. All partners in the Canadian response are asked to align their efforts with the overall goals and actions outlined in the document. The *Federal Initiative* and most provincial and territorial strategies have detailed accompanying budgets.

Sectors included	Strategy/Action framework	Earmarked budget
<b>Health</b>	Yes	Yes, at both federal and provincial/territorial levels
<b>Education</b>	Yes ( <i>Leading Together</i> ) No ( <i>Federal Initiative</i> )	No
<b>Labour</b>	No	No
<b>Transportation</b>	No	No
<b>Military/Police</b>	No	No
<b>Women</b>	Yes (both <i>Leading Together</i> and <i>Federal Initiative</i> )	No
<b>Young people</b>	Yes (both <i>Leading Together</i> and <i>Federal Initiative</i> )	No

***IF NO earmarked budget, how is the money allocated?***

Money is allocated by different jurisdictions according to their individual needs and strategic plans.

**1.3 Does the multisectoral strategy/action framework address the following target populations, settings and cross-cutting issues?**

Both *Leading Together* and the *Federal Initiative* address the following target populations, settings and cross-cutting issues.

<b><i>Target Populations</i></b>	
<b>a. Women and girls</b>	Yes
<b>b. Young women/young men</b>	Yes
<b>c. Specific vulnerable sub- populations</b>	Yes
<b>d. Orphans and other vulnerable children</b>	No (N/A)
<b><i>Settings</i></b>	
<b>e. Workplace</b>	No
<b>f. Schools</b>	Yes
<b>g. Prisons</b>	Yes
<b><i>Cross-cutting issues</i></b>	
<b>h. HIV, AIDS and poverty</b>	Yes
<b>i. Human rights protection</b>	Yes
<b>j. PLHIV involvement</b>	Yes
<b>k. Addressing stigma and discrimination</b>	Yes
<b>l. Gender empowerment and/or gender equality</b>	Yes

**1.4 Were target populations identified through a process of a needs assessment or needs analysis?**

Yes. The target populations were identified through national surveillance and through feedback from organizations working at the community level.

**IF YES, when was this needs assessment /analysis conducted?** Surveillance reports are published on a semi-annual basis.

**1.5 What are the target populations in the country?**

Gay men and men who have sex with men, people who use injection drugs, Aboriginal peoples, people from countries where HIV is endemic, people in correctional facilities, women, youth at risk, people living with HIV/AIDS.

**1.6 Does the multisectoral strategy/action framework include an operational plan?**

*Leading Together:* No. *Federal Initiative:* Yes

**1.7 Does the multisectoral strategy/action framework or operational plan include:**

	<b>Leading Together</b>	<b>Federal Initiative</b>
<b>a. Formal programme goals?</b>	Yes	Yes
<b>b. Clear targets and/or milestones?</b>	Yes	Yes
<b>c. Detailed budget of costs per programmatic area?</b>	No	Yes
<b>d. Indications of funding sources?</b>	No	Yes
<b>e. Monitoring and Evaluation framework?</b>	No	Yes

**1.8 Has the country ensured “full involvement and participation” of civil society in the development of the multisectoral strategy/action framework?**

For *Leading Together:* Active involvement

***IF active involvement, briefly explain how this was done:***

A small steering committee representing community members was set up to develop the document that became *Leading Together*. The draft document was shared widely, and face to face meetings were held across the country with civil society, clinicians and other health care professionals, researchers, and officials from various levels of governments. Special emphasis was placed on consulting people living with or at risk of HIV/AIDS, including gay men, people who use injection drugs, Aboriginal people, youth, women, people from countries where HIV is endemic and prisoners. A parallel on-line survey was also used to solicit feedback on the document.

**1.9 Has the multisectoral strategy/action framework been endorsed by most external Development Partners (bi-laterals; multi-laterals)?**

Not applicable.

**1.10 Have external Development Partners (bi-laterals; multi-laterals) aligned and harmonized their HIV and AIDS programmes to the national multisectoral strategy/action framework?**

Not applicable.

**2. Has the country integrated HIV and AIDS into its general development plans such as: a) National Development Plans, b) Common Country Assessments/ United Nations Development Assistance Framework, c) Poverty Reduction Strategy Papers, d) Sector Wide Approach?**

Not applicable.

### **3. Has the country evaluated the impact of HIV and AIDS on its socio-economic development for planning purposes?**

Yes. While there have been no recent Canadian evaluations of the socio-economic impact of HIV and AIDS, provincial and national studies released in 1998, 2001 and 2003 indicate that the economic costs associated with HIV and AIDS are considerable, continue to rise, and have serious economic consequences for the Canadian health system.

According to a 2003 study in the province of Alberta, the direct cost of HIV medical care per patient per month increased from about \$655 in 1995 to \$1,036 in 2001, primarily due to HAART. In 1995, antiretroviral drugs accounted for 30%, or \$198, of the cost per patient per month; while in 2001, they accounted for 69% or \$775. According to the study, the health care system is spending more on drugs for HIV; while, at the same time, and because of these drugs, it is spending less on in-patient, out-patient, and home care.<sup>1</sup>

In Canada, lifetime care and treatment costs were estimated in 1998 to total about \$160,000 per person with HIV, while the indirect costs associated with lost productivity and premature death may be as high as \$600,000 per person.<sup>2</sup> In addition, treatment costs varied depending on where people lived and where they were treated. For example, people who lived in rural or remote areas who travelled to receive care often had significantly higher costs.

According to a 2001 analysis, HIV/AIDS cost Canadians more than \$2 billion in 1999 in direct and indirect costs. Of this total, health care costs accounted for about \$560 million; prevention, research, and supports to people living with HIV/AIDS accounted for about \$40 million; and lost economic production due to premature death and disability accounted for nearly \$1.5 billion.<sup>3</sup>

#### **3.1 IF YES, to what extent has it informed resource allocation decisions?**

There is a widespread recognition that it is far cheaper to prevent new infections than to treat existing ones. All levels of government support prevention efforts, from social marketing to the distribution of condoms and clean needles. Provinces and territories all offer HIV screening for pregnant women and treatment for those women who are pregnant in order to try to stop the vertical transmission of the virus. There is a growing emphasis on prevention, including new initiatives aimed at prevention for positives, and reaching the undiagnosed. Canada has made significant contributions to the development of new prevention technologies, through the \$139 million Canadian HIV Vaccine Initiative and through contributions to the International AIDS Vaccine Initiative, the African AIDS Vaccine Programme and the International Partnership for Microbicides.

### **4. Does the country have a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services such as military, police, peacekeepers, prison staff, etc?**

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<sup>1</sup>Krentz HB, Auld MC, Gill MJ. *The changing direct costs of medical care for patients with HIV/AIDS, 1995--2001*. Canadian Medical Association Journal. 2003 July 22; Vol. 169, No 2: 106--110.

<sup>2</sup>Albert, Terry and Gregory Williams, *The Economic Burden of HIV/AIDS in Canada*. Canadian Policy Research Network, 1998.

<sup>3</sup>GPI Atlantic. *The Cost of HIV/AIDS in Canada*. June 2001.

The Treasury Board of Canada policy on HIV/AIDS applies to both National Defence 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.

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 diseases, including HIV/AIDS, are discussed in this briefing.

**4.1 IF YES, which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of one or more uniformed services?**

Behavioural change communication Yes

Condom provision Yes

HIV testing and counselling\* Yes

STI services Yes

Treatment Yes

Care and support Yes

Others: *[write in]* No

**\* What is the approach taken to HIV testing and counselling**

The approach is voluntary testing with pre-and post-test counselling, mirroring the civilian approach to such testing and counselling.

**5. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?**

Canada's publicly funded health care system is best described as an interlocking set of ten provincial and three territorial health insurance plans. The system provides universal coverage for medically necessary health care services provided on the basis of need, rather than the ability to pay. Under the Canada Health Act, all necessary drug therapy administered within a Canadian hospital setting is insured and publicly funded. Outside of the hospital setting, provincial and territorial governments are responsible for the administration of their own publicly-funded prescription drug benefit programs. Most Canadians have access to insurance coverage for prescription medicines through public and/or private insurance plans. The federal, provincial and territorial governments offer varying levels of coverage, with different eligibility requirements, premiums and deductibles. The publicly-funded drug programs generally provide insurance coverage for those most in need, based on age, income, and medical condition.

**5.1 Has the National Strategic Plan/operational plan and national AIDS budget been revised accordingly?**

Not applicable.

**5.2 Have the estimates of the size of the main target population sub-groups been updated?**

Yes. The estimates of prevalence and incidence were last revised in 2006, to reflect 2005 data. These addressed the trends in the disease among women, Aboriginal persons, and

looked at exposure categories of men having sex with men, injecting drug users, heterosexuals from a country where HIV is endemic, and heterosexual/non-endemic (heterosexual contact with a person who is either HIV-infected or at risk for HIV or heterosexual as the only identified risk).

**5.3 Are there reliable estimates and projected future needs of the number of adults and children requiring antiretroviral therapy?**

Estimates and projected needs	Estimates only	No
<b>x</b>		

**5.4 Is HIV and AIDS programme coverage being monitored?**

Yes

(a) **IF YES**, is coverage monitored by sex (male, female)?

Yes

(b) **IF YES**, is coverage monitored by population sub-groups?

Yes

**IF YES**, which population sub-groups?

The populations vary from jurisdiction to jurisdiction, but the main groups covered are: gay men, injection drug users, Aboriginal peoples, people from countries where HIV is endemic, people in correctional facilities, women, youth at risk

(c) **IF YES**, is coverage monitored by geographical area?

Yes

**IF YES**, at which levels (provincial, district, other)?

Provincial

**5.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?**

N/A

**Comments on progress in strategy planning efforts made since 2005:**

In the past two years, Canada has been in a position to build upon past work to better coordinate the planning and response to the epidemic.

## II Political support

### 1. Do high officials speak publicly and favourably about AIDS efforts in major domestic fora at least twice a year?

**President/Head of government** Yes

**Other high officials** Yes

**Other officials in regions and/or districts** Yes

The Prime Minister of Canada held a national press conference in February 2007 with Bill Gates to announce the collaboration between the Bill & Melinda Gates Foundation and the Canadian HIV Vaccine Initiative. The federal Minister of Health spoke at the AIDS Vaccine 2007 Conference, in Seattle, Washington. The Minister reaffirmed the Government of Canada's commitment and expressed enthusiasm about its collaboration with the Bill & Melinda Gates Foundation, and indicated the collaboration is being seen internationally as a model for other countries to follow in order to contribute to the overarching goal of accelerating global efforts to discover HIV vaccines.

At the XVI International AIDS Conference, the federal Minister of Health, the federal Minister of International Cooperation and the Ontario Minister of Health made various speeches at the conference including at the opening ceremonies, satellite sessions and affiliated events.

### 2. Does the country have an officially recognized national multisectoral AIDS management/coordination body? (National AIDS Council or equivalent)?

Yes. Canada has several bodies that act to coordinate and advise on the response to HIV/AIDS.

The Leading Together Championing Committee was created in 2006 to promote and champion the widespread use of *Leading Together* throughout Canada, so that the document influences and guides all sectors of Canada's response to get ahead of the epidemic and improve the lives of people at risk of and living with HIV/AIDS. Its membership includes those from nongovernmental organizations, researchers, people living with HIV/AIDS, and government.

The Federal/Provincial/Territorial Advisory Committee on AIDS, created in 1988 provides policy advice on issues and priority initiatives related to HIV/AIDS in Canada, and promotes timely, effective and efficient inter-governmental and inter-jurisdictional collaboration on issues related to HIV/AIDS in Canada. Its membership includes representatives from Canada's ten provinces and three territories, and from the federal government.

The Government of Canada Assistant Deputy Minister Committee was established in 2005. Its mandate is to provide Government of Canada interdepartmental leadership, increased coordination and cooperation, and improved coherence of policies and programs, to more effectively address HIV/AIDS and related issues. Fourteen different departments are represented at the Assistant Deputy Minister level.

The Ministerial Council on HIV/AIDS was created in 1998 to provide advice to the Minister of Health on pan-Canadian aspects of HIV/AIDS. Its membership includes a cross-section of researchers, health care and front-line professionals involved with at-

risk groups. Traditionally one-third of members are people living with HIV/AIDS. Representatives from the Public Health Agency of Canada and the Federal/Provincial/Territorial Advisory Committee on AIDS sit as *ex officio* members.

The National Aboriginal Council on HIV/AIDS was established in 2001 to act as an advisory mechanism providing 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. It is divided into four cauci, representing Inuit, Métis, First Nations and Community (representing Aboriginal HIV/AIDS organizations and community-based Aboriginal organizations involved in HIV/AIDS). Representatives from the Public Health Agency of Canada and from Health Canada's First Nations and Inuit Health Branch sit as *ex officio* members.

### 2.3 IF YES, does it:

	Leading Together Championing Committee	FPT Advisory Committee on AIDS	Ministerial Council on HIV/AIDS	Assistant Deputy Minister on HIV/AIDS	National Aboriginal Council on HIV/AIDS
have terms of reference?	Y	Y	Y	Y	Y
have active Government leadership and participation?	Y	Y	Y	Y	Y
have a defined membership?	Y	Y	Y	Y	Y
include civil society representatives?	Y	N	Y	N	Y
<b>IF YES, what percentage? [write in]</b>	70%		30%		100%
include people living with HIV?	Y	N	Y	N	Y
include the private sector?	N	N	30%	N	N
have an action plan?	Y	Y	Y	Y	Y
have a functional Secretariat?	Y	Y	Y	Y	Y
meet at least quarterly?	Y	Y	Y	N	Y
review actions on policy decisions regularly?	Y	Y	Y	Y	Y
actively promote policy decisions?	Y	Y	Y	Y	Y
provide opportunity for civil society to influence decision- making?	Y	Y	Y	N	Y
strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	N/A	N/A	N/A	N/A	N/A



**3. Does the country have a national AIDS body or other mechanism that promotes interaction between government, people living with HIV, civil society and the private sector for implementing HIV and AIDS strategies/programmes?**

Consultation and coordination between governments, people living with HIV/AIDS, civil society and the private sector are fundamental to the Canadian response to HIV/AIDS in both developing and implementing strategies and programmes.

Under the *Federal Initiative*, several groups serve as mechanisms to consult and coordinate on specific issues.

The Consultative Group on Global HIV/AIDS Issues is a forum for NGOs to advise federal departments and agencies on the global epidemic and for all parties to discuss issues of collaboration and policy coherence to ensure a more effective Canadian response.

Individual status reports are being prepared on each of the key populations under the *Federal Initiative*. These reports will comprise comprehensive factual information to depict the current picture of each population. A working group made up of members of the affected population, researchers, experts in the field, community organizations and government guide the development of each report.

The National Partners Group, made up of national non-governmental organizations meets bi-annually with the management team of the HIV/AIDS Policy, Coordination and Programs Division of the Public Health Agency of Canada to share information, discuss emerging issues and engage in policy discussion.

A National HIV/AIDS Social Marketing Action Committee comprised of people living with HIV/AIDS, representatives from community-based and national AIDS Service Organizations and provincial/territorial governments has been guiding the development of a national social marketing campaign.

A CIHR HIV/AIDS Research Advisory Committee, made up of researchers, community representatives (including people living with HIV/AIDS), health research institutes, PHAC and the Ministerial Council, provides leadership and advice regarding research priorities and strategic HIV/AIDS research programs.

**4. What percentage of the national HIV and AIDS budget was spent on activities implemented by civil society in the past year?**

In 2006-07, over half of the federal HIV/AIDS budget was spent on activities implemented by community and research organizations.

**5. What kind of support does the NAC (or equivalent) provide to implementing partners of the national programme, particularly to civil society organizations?**

<b>Information on priority needs and services</b>	Yes
<b>Technical guidance/materials</b>	Yes
<b>Drugs/supplies procurement and distribution</b>	No, this is a provincial/territorial role

<b>Coordination with other implementing</b>	Yes
<b>Capacity-building</b>	Yes

**6. Has the country reviewed national policies and legislation to determine which, if any, are inconsistent with the National AIDS Control policies?**

HIV and AIDS have been confirmed to constitute disability by Canadian courts and human rights tribunals. Every jurisdiction in Canada has human rights legislation which protects the rights of people with a disability.

While the *Federal Initiative to Address HIV/AIDS in Canada* (FI) does not include a "National AIDS Control Policy" for review of legislation or practices, the FI is a rights-based approach. All related legislation, policy, and practices must be in harmony with the *Canadian Charter of Rights and Freedoms*, the *Canadian Human Rights Act*, provincial and territorial human rights legislation, as well as the principles of administrative law.

### III Prevention

#### 1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population?

Yes. The *Federal Initiative to Address HIV/AIDS* will support national public awareness campaigns to raise awareness in the general population and to address stigma and discrimination.

##### 1.1 IF YES, what key messages are explicitly promoted?

The focus of messages varies across Canada, and by the agency promoting the message.

<b>Be sexually abstinent</b>	Y
<b>Delay sexual debut</b>	Y
<b>Be faithful</b>	Y
<b>Reduce the number of sexual partners</b>	
<b>Use condoms consistently</b>	Y
<b>Engage in safe(r) sex</b>	Y
<b>Avoid commercial sex</b>	
<b>Abstain from injecting drugs</b>	Y
<b>Use clean needles and syringes</b>	Y
<b>Fight against violence against women</b>	Y
<b>Greater acceptance and involvement of people living with HIV</b>	Y
<b>Greater involvement of men in reproductive health programmes</b>	
<b>Other: Fight stigma and discrimination</b>	Y

##### 1.2 In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

No.

#### 2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?

Yes. Education is under provincial jurisdiction, and curricula vary across the country. Reproductive and sexual health education, including HIV, is covered in each province or territory, however, it does vary in the timing of its delivery - either early or late in secondary school, depending on the province or territory.

**2.1 Is HIV education part of the curriculum in**  
**primary schools?** Yes, in some jurisdictions  
**secondary schools?** Yes, in most jurisdictions  
**teacher training?** Yes, in most jurisdictions

##### 2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

Yes.

##### 2.3 Does the country have an HIV education strategy for out-of-school young people?

No, although some organizations targeted at street-involved youth are active in HIV prevention education.



### Comments on progress made in policy efforts in support of HIV prevention since 2005:

Since 2005, focused policy efforts for vulnerable populations have been further developed at the federal level and in the provinces most affected by HIV/AIDS. The federal government is playing a leadership role in coordinating efforts on prevention across a wide range of sectors.

### 4. Has the country identified the districts (or equivalent geographical/de-centralized level) in need of HIV prevention programmes?

Each jurisdiction determines where best to focus their prevention programmes. Provinces and territories conduct their own epidemiological and surveillance studies and know where to focus their efforts. People living in rural and remote areas, including First Nations reserves, are less likely to be able to access HIV education and prevention services.

### IF YES, to what extent have the following HIV prevention programmes been implemented in identified districts\* in need?

HIV prevention programmes	The activity is available in		
	<i>all districts* in need</i>	<i>most districts* in need</i>	<i>some districts* in need</i>
Blood safety	x		
Universal precautions in health care settings	x		
Prevention of mother-to-child transmission of HIV	x		
IEC on risk reduction		x	
IEC on stigma and discrimination reduction			x
Condom promotion	x		
HIV testing & counselling		x	
Harm reduction for injecting drug users		x	
Risk reduction for men who have sex with men		x	
Risk reduction for sex workers			x
Programmes for other vulnerable subpopulations			x
Reproductive health services including STI prevention & treatment	x		
School-based AIDS education for young people	x		
Programmes for out-of-school young people		x	
HIV prevention in the workplace			x

\*For Canada, 'districts' has been interpreted to mean provinces and territories.

### Comments on progress made in the implementation of HIV prevention since 2005:

Since 2005 there has been increased funding to programmatic responses, and increased sharing of information on best practices. The voluntary sector has been key to the successful implementation of these programmes.

## IV Treatment, care and support

### 1. Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care, and home and community-based care).

The responsibility for the direct delivery of care and treatment 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. The voluntary sector is key in delivering psychosocial care and home and community-based care.

#### 1.1 *IF YES*, does it give sufficient attention to barriers for women, children and most-at-risk populations?

Yes, however, it is estimated that 27% of people in Canada who are HIV positive are unaware of their infection, and this presents an obvious barrier in accessing treatment in a timely manner. In order to increase the number of Canadians aware of their sero-status, the Public Health Agency of Canada has undertaken collaborative work with other levels of government, primary care providers, experts and community to develop a policy framework on HIV testing and counselling. The framework will inform HIV testing and counselling decision-making, based on the best available evidence, evolving and emerging issues and take into account diverse approaches and points of view, as well as specific considerations for particular populations most affected by HIV/AIDS.

### 2. Has the country identified the districts (or equivalent geographical/ decentralized level) in need of HIV and AIDS treatment, care and support services?

Each jurisdiction determines where best to focus their HIV and AIDS treatment, care and support programmes. Provinces and territories conduct their own epidemiological and surveillance studies and know where to focus their efforts. People living in rural and remote areas, including First Nations reserves, are less likely to be able to access HIV treatment, care and support services.

#### *IF YES*, to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts\* in need?

HIV treatment, care and support services	The service is available in		
	<i>all districts* in need</i>	<i>most districts* in need</i>	<i>some districts* in need</i>
Antiretroviral therapy	x		
Nutritional care	x		
Paediatric AIDS treatment	x		
Sexually transmitted infection management	x		
Psychosocial support for people living with HIV and their families		x	
Home-based care		x	
Palliative care and treatment of common HIV-related infections	x		
HIV testing and counselling for TB patients	x		
TB screening for HIV-infected people	x		
TB preventive therapy for HIV-infected people	x		

HIV treatment, care and support services	The service is available in		
	<i>all</i> districts* in need	<i>most</i> districts* in need	<i>some</i> districts* in need
TB infection control in HIV treatment and care facilities	x		
Cotrimoxazole prophylaxis in HIV infected people	x		
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	x		
HIV treatment services in the workplace or treatment referral systems through the workplace	N/A	N/A	N/A
HIV care and support in the workplace (including alternative working arrangements)			x

\*For Canada, 'districts' has been interpreted to mean provinces and territories.

**3. Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?**

Not applicable.

**4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral drugs, condoms, and substitution drugs?**

Yes

**4.1 IF YES, for which commodities?:**

Anti-retrovirals, medicines for HIV-related conditions, condoms and substitution drugs are available in every jurisdiction, but there are challenges for some to access these commodities.

**5. Does the country have a policy or strategy to address the additional HIV- or AIDS-related needs of orphans and other vulnerable children (OVC)?**

Not applicable

## V Monitoring and evaluation

Different levels of government have their own monitoring and evaluation plans. There is no single national plan. *Leading Together* lays out concrete actions, targets and desired outcomes, and describes the shared responsibility for the response to HIV. It does not have a monitoring and evaluation plan with specific tasks, responsible organizations, and budgets identified.

The federal government does have a Monitoring and Evaluation Plan, which will inform the rest of this section.

### 1. Does the country have *one* national Monitoring and Evaluation (M&E) plan?

Yes (for the federal investment only) **Years covered:** 2005- ongoing

**In progress** Yes

#### 1.1. *IF YES*, was the M&E plan endorsed by key partners in M&E?

Yes. The M&E plan was endorsed by all four federal government departments participating in the *Federal Initiative*.

#### 1.2. *IF YES*, was the M&E plan developed in consultation with civil society, including people living with HIV?

Yes. The federal investment M&E plan was developed as part of an internal-to-government process. Civil society was involved in the consultation that established funding priorities.

#### 1.3. *IF YES*, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, but only those organizations funded through the federal investment.

### 2. Does the Monitoring and Evaluation plan (for the federal investment) include?

a data collection and analysis strategy	Yes
behavioural surveillance	Yes
HIV surveillance	Yes
a well-defined standardized set of indicators to monitor performance for the federal investment	under development (validation)
a well-defined standardized set of quantitative indicators to monitor the epidemic	Yes
guidelines on tools for data collection	under development
a strategy for assessing quality and accuracy of data	under development
a data dissemination and use strategy	Yes. evaluation and reporting commitments

**3. Is there a budget for the M&E plan?** Yes. **Years covered:** 2005-ongoing for the federal investment.

**3.1 *IF YES*, has funding been secured?** Yes



**4. Is there a functional M&E Unit or Department?** Yes (federal investment)

**4.1 IF YES, is the M&E Unit/Department based:**

**in the NAC (or equivalent)?** No

**in the Ministry of Health?** Yes (Public Health Agency of Canada)  
**elsewhere?**

**4.2 IF YES, how many and what type of permanent and temporary professional staff are working in the M&E Unit/Department?** 7

**Number of permanent staff:** 6

<b>Position</b>	<b>Full time/Part time</b>	<b>Since when?</b>
Manager	Full time	2004
Senior Policy Analyst	Full time	2006
Policy Analyst	Full time	2005
Evaluation Analyst	Full time	2007
Quality Assurance Junior Project Officer	Part time	2007
Administrative Assistant	Part time	2004

In addition, there is a Surveillance and Risk Assessment Division which provides overall strategic direction and coordination for HIV/AIDS surveillance and epidemiological work. Their mandate is to describe the epidemiology of HIV infection in Canada and to monitor and assess the temporal geographic and demographic trends in the HIV epidemic in Canada. This division has some 20 fulltime permanent staff.

**Number of temporary staff:** Zero, although external consultants are contracted to do specific pieces of work.

**4.3 IF YES, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit/Department for review and consideration in the country's national reports?**

Yes. Monitoring, evaluation and reporting commitments and roles are identified in the funding authority documents.

**IF YES, does this mechanism work? What are the major challenges?**

Yes. Federal government partners submit their M&E data and reports to Public Health Agency, HIV/AIDS Policy, Programs and Coordination Division, Accountability and Evaluation Section. These are included in the annual report on the *Federal Initiative to Address HIV/AIDS in Canada*, evaluation reports, and Federal Government annual performance reports.

Challenges include the fact that each federal department has its own accountability and evaluation structure, which may include different approaches, timelines, indicators and reporting formats, resulting in multiple reporting efforts.

**4.4 IF YES, to what degree do UN, bi-laterals, and other institutions share their M&E results?**

Not applicable.

**5. Is there a M&E Committee or Working Group that meets regularly to coordinate M&E activities?**

Yes, meets regularly

*IF YES*, Date last meeting: The *Federal Initiative* co-ordinating body meets 3 times a year. The Accountability Working Group meets as needed and works by e-mail.

**5.1 Does it include representation from civil society, including people living with HIV?**

No, but the Ministerial Council on HIV/AIDS, whose mandate it is to provide advice to the Minister of Health on pan-Canadian aspects of HIV/AIDS, does review and provide advice on issues related to the implementation of the *Federal Initiative*, including monitoring and evaluation. At least one-third of the members of the Council are people living with HIV.

**6. Does the M&E Unit/Department manage a central national database?**

Not yet – plans are being made to develop a centralized data storage system. There is a central national data base for surveillance information. There is a grants and contributions database, covering all funded projects in the Public Health Agency and Health Canada. The Canadian Institutes of Health Research also manages a database with information on all research grants and awards.

**6.1 If yes, what type is it?**

Lotus Notes database, shared jointly with Health Canada and the Public Health Agency. The Canadian Institutes for Health Research (CIHR) also hosts an internal database and an publicly accessible on-line database so that the public may access information regarding research projects funded by CIHR.

**6.2 If yes, does it include information about the content, target populations and geographical coverage of programmatic activities, as well as their implementing organizations?**

Yes. (PHAC/HC). The CIHR database does not contain standardized information on target populations.

**6.3 Is there a functional\* Health Information System?**

**National level** Yes

**Sub-national level** Yes

*IF YES*, at what level(s)? Municipal and provincial/territorial

**6.4 Does the country publish at least once a year an M&E report on HIV, including HIV surveillance data?**

Yes. The federal government publishes an annual progress report on the *Federal Initiative*. It also collects HIV/AIDS data from provincial and territorial governments and from population-specific track studies, and publishes various reports, including a semi-annual report on surveillance, epidemiology updates, and estimates of HIV prevalence and incidence. In addition, several provincial governments publish annual reports on their surveillance data.

**7. To what extent is M&E data used in planning and implementation?**

Monitoring and evaluation data is used extensively to help guide planning and implementation of policy and programming.

**What are examples of data use?**

A wide range of information is being used in the development of population specific approaches; recent surveys have informed the federal government's work on stigma and discrimination; and there is a growing emphasis on the development of various tools and approaches to knowledge exchange.

**What are the main challenges to data use?**

Different jurisdictions do not always use the same indicators. For surveillance data, data completeness varies by jurisdiction, and data sharing agreements must be negotiated in detail. Personnel in frontline organizations have a varying capacity to analyze and synthesize data. There is currently no centralized data storage system designed to collect information relevant to program and policy development needs, although such a system is under development.

**8. In the last year, was training in M&E conducted**

**At national level?** Yes. Training is provided as needed (logic model development, data collection).

**IF YES, Number of individuals trained:** Data not collected

**At sub-national level?** Not applicable

**Comments on progress made in monitoring and evaluation efforts of the**

**AIDS programme since 2005:** In 2005 reporting requirements were met and a logic model defined. Since that time, indicators have been improved, and regular data collection initiated, and a refined program theory has been developed and applied.

**United Nations General Assembly Special Session on  
HIV/AIDS  
Declaration of Commitment on HIV/AIDS**

**UNGASS Report  
January 2006 – December 2007**

**– CANADA –**

**Annex 2 – Part B  
National Composite Policy Index**

**Information provided by national non-governmental organizations**

December 19, 2007

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## Foreword

### Disclaimer

*This Appendix contains information provided by national non-governmental organizations. It is not a Government of Canada document. The information and perspectives in this Appendix were provided by 10 national non-governmental organizations working on HIV/AIDS issues. The views presented in this document are not endorsed by and do not necessarily reflect the views held by the Government of Canada.*

The following report was compiled from information provided by Canadian national non-governmental organizations using the *UNAIDS Guidelines on Construction of Core Indicators* for Appendix 7 – National Composite Policy Index, Part B, to be administered to representatives from non-governmental organizations. The *Guidelines* are less suited to Canada's federated system of government than they are to highly centralized governments with unified approaches to health and education. For this reason, many of the questions asked in the *Guidelines* had to be modified to reflect the Canadian situation in which primary responsibility for health care delivery and education fall within provincial and territorial, rather than national, jurisdiction. Many provinces and territories devolve responsibility for health care delivery to relatively autonomous regional health authorities, which further increases variability in quality and access to services across Canada.

National non-governmental organizations provided information from the national perspective and focused on areas falling within the jurisdiction of the Government of Canada. (Note: the Government of Canada is usually referred to in this Appendix as the *federal government*.)

The following national non-governmental organizations provided information for this Appendix through telephone interviews or written responses to the *Guidelines*:

- Canadian Aboriginal AIDS Network
- Canadian AIDS Society
- Canadian AIDS Treatment Information Exchange
- Canadian Association for HIV Research
- Canadian HIV/AIDS Information Centre (Canadian Public Health Association)
- Canadian HIV/AIDS Legal Network
- Canadian HIV Trials Network
- Canadian Treatment Action Council
- Canadian Working Group on HIV Rehabilitation
- Interagency Coalition on AIDS and Development

The national non-governmental organizations have been given the opportunity to review this Appendix to ensure that it accurately reflects the information and perspectives which they provided.

## 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.)**

Section 15(1) of the Canadian Charter of Rights and Freedoms, which is part of the country's Constitution and which applies to all laws and other actions by governments and other state actors 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.*

In addition, Canada has enacted anti-discrimination legislation at both the federal and provincial/territorial levels which prohibits discrimination based on “disability” or “handicap” by both public and private actors. The provisions in both the Charter and in anti-discrimination statutes which prohibit discrimination based on disability have been interpreted in a way that it includes people living with HIV/AIDS under the umbrella of physical disability.

For example, under the *Canadian Human Rights Act*, people living with HIV are protected from HIV-based discrimination in the federal jurisdiction 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 accommodation. 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.*

However, enforcement of these anti-discrimination statutes 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 with the relevant human rights commission or initiate legal proceedings against the government alleging unconstitutional discrimination contrary to the Charter. Some anti-discrimination commissions, such as the Canadian Human Rights Commission, will expedite the investigation of complaints alleging HIV/AIDS related discrimination.

However, 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 the human right to freedom from discrimination, but also an integral part of ensuring the adequate enforcement of anti-discrimination 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.*

As noted above, federal and provincial/territorial legislation prohibits discrimination on the basis of disability. Individuals with HIV/AIDS may therefore seek protection under these laws. 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 such laws on the basis of perceived disability. There are problems associated with relying on the concept of disability for framing human rights obligations and prohibition of discrimination. There is a need for the prohibition of discrimination in all circumstances, including those outside of issues of disability, on the basis of HIV status alone, as well as discrimination against those who are vulnerable.

The Charter and the federal and provincial/territorial anti-discrimination laws extend to prohibiting discrimination based on a number of grounds that provide protection to some – but only some – of the groups of people who are especially vulnerable to HIV/AIDS.

For example, discrimination on the basis of sexual orientation is prohibited in all jurisdictions of Canada, as is discrimination based on sex, race, ethnicity, national origin, etc.. However, only one jurisdiction in Canada (the Northwest Territories) has explicit protection on the basis of gender identity. 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, 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"; this interpretation and application of these statutes has been seen primarily in the employment context.

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.

Discrimination on the basis of incarcerated status (i.e. against prisoners) has not been recognized in the law, even though prisoners regularly suffer discrimination in various areas, including access to HIV-related health services.

There is a need for improvement in anti-discrimination legislation in terms of protecting youth, transgendered people, people who use illegal drugs, sex trade workers, and prisoners. According to the Canadian HIV/AIDS Legal Network and 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. 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.

The complexities of jurisdictional issues for the three Aboriginal populations 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 behaviour(s) such as injection drug use.

Until 2006, a Court Challenges Programme provided some funding to support test-case litigation under the equality rights section of the Canadian Charter of Rights and Freedoms. Such a program helped support some of the most important equality rights litigation in Canadian legal history. The federal government abolished the Court Challenges Program in late 2006.

A person who has experienced discrimination, from either a state action/actor (e.g., a law, government decision, or action by any organ of the state) or a private actor (e.g., a landlord, employer, service-provider, private sector organization) on a ground that is prohibited by the applicable federal or provincial/territorial anti-discrimination law may file a complaint with the relevant federal or provincial human rights commission or

tribunal. In most jurisdictions, the complaint must be filed with the commission, which carries out investigative and conciliation functions, but also acts as a “gatekeeper” in the sense of having the decision over whether the complaint warrants being taken before a tribunal (in which case the commission also has carriage of the complaint, and acts as the complainant’s advocate before the tribunal during the hearing with no expense to the complainant). In a few jurisdictions (e.g., British Columbia and, more recently, Ontario), this gatekeeper/representative function has been abolished, and complainants have direct access to the tribunal (although they lack the representation previously provided by the commission). Ostensibly, measures are being put in place in these jurisdictions to ensure that complainants who have experienced discrimination will have access to legal counsel and representation so that this direct access model in fact offers access to the tribunal.

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

Legal obstacles exist to effective HIV prevention and treatment for sub-populations. In particular, the Métis, which are an Aboriginal sub-population, do not have access to paid medications because they are covered by provincial/territorial health plans whereas First Nations and Inuit populations have drug coverage under a national health benefits program. National criminal legislation impedes free access to prevention and treatment for sex workers and often for people who use illegal drugs. NGOs working with communities from countries with generalized and high prevalence of HIV highlight that these communities, and individuals from and in these communities, experience denial of human rights in multiple ways, including HIV-based stigma and discrimination, racism, gender inequality and discrimination related to sexual orientation. Canada could more effectively respond to these forms of oppression through addressing them as multi-dimensional stigma, rather than tackling them in isolation.

Although there are barriers to HIV prevention, care, treatment and support for many of the populations named in the questionnaire, we limit ourselves here to more detailed commentary with respect to just three of these populations: prisoners, injection drug users, and sex workers.

#### **Prisoners**

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. However, 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 the federal Correctional Services Canada (CSC) (for those serving sentences of two years or more).

Over 2006-2007, the Canadian HIV/AIDS Legal Network and the Prisoners’ HIV/AIDS Support Action Network (PASAN), researched policies and programming related to HIV and hepatitis C prevention in prison systems across Canada. Based on that research, a forthcoming report (to be released in December 2007) indicates that, as a matter of sound public health policy and of protecting prisoners’ human rights, several critical areas have been identified where changes are needed in the policies of correctional systems. Even

where sound policy is in place, there are frequent gaps between policy and practice, undermining effective HIV and HCV prevention.<sup>34</sup>

*(1) Prison-based sterile syringe programs*

No correctional jurisdiction in Canada currently makes clean needles accessible, hindering HIV and HCV prevention amongst prisoners who inject drugs. This policy deficit persists even though there is ample evidence from more than a decade of research and from correctional systems' own data that a significant percentage of percentage of prisoners inject illegal drugs while incarcerated (and a significant percentage of prisoners have addictions), and HIV and HCV prevalence among populations is many times higher than in the Canadian population as a whole,<sup>35</sup> and despite (a) the positive experience of numerous countries that have implemented sterile syringe programs in prisons,<sup>36</sup> and (b) repeated expert recommendations not only from NGOs,<sup>37</sup> but from a Parliamentary special committee,<sup>38</sup> the Correctional Investigator of Canada, medical associations,<sup>39</sup> UN agencies<sup>40</sup> and the government's own Public Health Agency of Canada (which last recommendation was provided by the Public Health Agency at the request of Correctional Services Canada).<sup>41</sup> In December 2006, the federal Minister of Public Safety, under whose department federal correctional system falls, reiterated the government had a "zero tolerance" approach toward illicit drugs in prisons and would not be introducing programs to make sterile syringes accessible in federal prisons.<sup>42</sup> No provincial correctional system has yet responded to the recommendations for implementing prison-based sterile syringe programs.

*(2) Safer tattooing programs*

CSC's Safer Tattooing Initiative Pilot project, which operated safer tattooing rooms in 6 different federal institutions, was the only initiative in Canadian prisons that significantly addressed the potential transmission of HIV and HCV through tattooing. The project was terminated by the federal government in early December 2006, before a final evaluation

<sup>34</sup> G. Betteridge & G. Dias. *Hard Time: HIV and Hepatitis C Prevention Programming for Prisoners in Canada*. Toronto: Canadian HIV/AIDS Legal Network & Prisoners' HIV/AIDS Support Action Network, 2007, online via [www.aidslaw.ca/prisons](http://www.aidslaw.ca/prisons). See also: R. Elliott. Deadly disregard: government refusal to implement evidence-based measures to prevent HIV and hepatitis C virus infections in prisons. *Canadian Medical Association Journal* 2007; 177: 262-264.

<sup>35</sup> For the most recent of such studies, and references to earlier studies, see: L. Calzavara et al. Prevalence of HIV and hepatitis C virus infections among inmates of Ontario remand facilities. *Canadian Medical Association Journal* 2007; 177:257-61; C. Poulin et al. Prevalence of HIV and hepatitis C virus infections among inmates of Quebec provincial prisons. *Canadian Medical Association Journal* 2007; 177: 252-6; and Betteridge & Dias, *Hard Time*, supra note 1.

<sup>36</sup> R Lines et al. *Prison needle exchange: lessons from a comprehensive review of international evidence and experience*, 2<sup>nd</sup> ed. Toronto: Canadian HIV/AIDS Legal Network, 2006, online via [www.aidslaw.ca/prisons](http://www.aidslaw.ca/prisons).

<sup>37</sup> *Ibid.*

<sup>38</sup> Standing Senate Committee on Social Affairs, Science and Technology. *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*. Ottawa: Government of Canada, May 2006, online: <http://www.parl.gc.ca/39/1/parlbus/commbus/senate/com-e/soci-e/rep-e/rep02may06-e.htm>.

<sup>39</sup> Ontario Medical Association. *Improving our health: Why is Canada lagging behind in establishing needle exchange programs in prisons?* Toronto: The Association, 2004, online: [www.oma.org/phealth/omanep.pdf](http://www.oma.org/phealth/omanep.pdf).

<sup>40</sup> United Nations Office on Drugs and Crime, Joint United Nations Programme on HIV/AIDS, World Health Organization. *HIV/AIDS prevention, care, treatment and support in prison settings: a framework for an effective national response*. New York: United Nations, 2006, online: [www.unodc.org/pdf/HIV-AIDS\\_prisons\\_July06.pdf](http://www.unodc.org/pdf/HIV-AIDS_prisons_July06.pdf).

<sup>41</sup> Public Health Agency of Canada. *Prison needle exchange: review of the evidence*. Ottawa: The Agency, 2006.

<sup>42</sup> W Kondro. Conservative government scuttles needle exchange. *Canadian Medical Association Journal* 2007; 176: 308.

was complete or the results made public.<sup>43</sup> (As of early November 2007, almost a year later, the final evaluation report has yet to be made public despite repeated requests.) The Canadian government's Chief Public Health Officer indicated that the program made sense from a public health perspective and that the pilot project was not given enough time to operate in order to establish conclusively its effect in changing risk behaviour or, ultimately, the prevalence rate of HIV, hepatitis C or other infectious diseases.<sup>44</sup> The evaluations conducted by CSC indicated that the program may have reduced the risk of transmission and resulted in cost saving in the long run.<sup>45</sup> Prisoners and some community AIDS organizations expressed concerns with some aspects of the program and noted that many of the project sites started too late and did not have enough "buy-in" from correctional staff. However, this should not take away from the creative and innovative role that CSC played in initiating this project, and the useful co-operation between the Public Health Agency of Canada and CSC in developing the pilot program. There is a need for federal government leadership in reinstating the safer tattooing pilot project, allowing a thorough, independent evaluation and, if the evaluation is favourable (as initial early assessments suggested), expanding the project to other institutions.

### *(3) Condoms and other safer sex materials*<sup>46</sup>

As of the first half of 2006, the federal Correctional Services Canada and 6 of 13 provinces/territories in Canada had a stated policy on making condoms, dental dams and water-based lubricant available to adult prisoners in their correctional facilities. (Access to these safer sex materials may be provided in some other provincial/territorial correctional systems as a matter of operational practice, even if there is no stated policy on the matter, but clear policy direction supporting access to such materials is advisable.)

However, condom, dental dam and lubricant distribution was inconsistent in the federal and provincial prisons visited by PASAN in the course of preparing this report. In some prisons, condom distribution was required by policy but condoms were not available in practice. For example, in one prison where the policy stated that prisoners should be provided access to condoms without having to ask prison staff, condoms were kept in a staff member's desk drawer. Most provincial prisons visited had some form of condom distribution. However, many programs are not effective because prisoners must ask health care or other staff for condoms, dental dams and lubricant. All international guidelines and recommendations clearly outline that this is not an effective method of distribution. (Some provincial prison guards are still concerned that condoms are a security risk, such as clogging septic systems or jamming locks. There is a need for these concerns to be addressed by prison administration through increased information and education for, and discussion with, prison guards. These problems have not materialized in prison systems that have implemented condom distribution.)

Dental dam distribution in the prisons visited is even less consistent than condom distribution. The dental dams that are distributed tend to be the kind used by dentists,

<sup>43</sup> W. Kondro. Prison tattoo program wasn't given enough time. *Canadian Medical Association Journal* 2007; 176: 307.

<sup>44</sup> *Ibid.*

<sup>45</sup> Correctional Service Canada. *Draft Evaluation Report: Correctional Service Canada's Safer Tattooing Practices Pilot Initiative*. Ottawa: CSC, undated [obtained through an access-to-information request and on file].

<sup>46</sup> Information in this section adapted from Betteridge & Dias, *supra* note 1.

which some prisoners said are too thick to allow enough sensation during sex and, in most cases, are not sterile (unless individually wrapped). Some of the federal prisons visited made efforts to ensure that dental dams were individually wrapped, for sanitary reasons. There were often no printed instructions on how to use the dental dams, either posted near to where dental dams were distributed, or distributed with the dental dams. Based on interviews, it was clear that some prisoners do not know the function of dental dams or how to use them properly.

Prisoners' safer-sex needs do not stop the moment they are released. Some jurisdictions have recognized this and have responded. For example, Manitoba provincial prisons offer release kits for prisoners, as did some other prisons visited. These kits are one way of addressing prisoners' need for safer-sex information and condoms and lubricant after their release. The kit includes an information card with phone numbers for local representatives of regional health authorities, Aboriginal organizations and other health services. This is a quick, inexpensive and effective method of helping prisoners protect their health upon release.

A review of policy and program documentation revealed imprisoned youth are not provided with adequate access to condoms, dental dams or lubricant. Only three provinces/territories had stated policies on making these materials available to youth imprisoned in youth custody facilities. (Except in unusual cases, youth who receive a custodial sentence do not serve those sentences in federal prisons.)

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.

*(4) Opiate substitution therapy (e.g., methadone)<sup>47</sup>*

Methadone is a narcotic medication licensed for use in Canada to treat opiate addiction. Substitution therapy has been described by in a joint WHO, UNODC and UNAIDS report in the following terms:

Medicines used in substitution therapy can be prescribed either in decreasing doses over short periods of time (usually less than one month) for treatment of withdrawal or for detoxification, or in relatively stable doses over a long period of time (usually more than six months) for substitution maintenance therapy, which allows stabilization of brain functions and prevention of craving and withdrawal. Substitution maintenance therapy is one of the most effective types of pharmacological therapy of opioid dependence. There is consistent evidence from numerous controlled trials, large longitudinal studies and programme evaluations, that substitution maintenance treatment for opioid dependence is associated with generally substantial reductions in illicit opioid use, criminal activity, deaths due to overdose, and behaviours with a high risk of HIV transmission.<sup>48</sup>

<sup>47</sup> Information in this section is adapted from Betteridge & Dias, *supra* note 1.

<sup>48</sup> WHO, UNODC and UNAIDS. *Substitution Maintenance Therapy in the Management of Opioid Dependence and HIV/AIDS Prevention: Position Paper*. Geneva: WHO/UNODC/UNAIDS, 2004.

Prison is a challenging environment in which to provide drug treatment programs because of the zero tolerance of drug use and emphasis on drug interdiction. In the prison setting, many prisoners cannot ask for help from the same people who are responsible for imprisoning them. Prisoners cannot disclose struggles with their recovery from drug addiction because of the zero tolerance drug policy. Consequences for a drug-positive urine test can include: increased security, loss of escorted temporary absences (ETAs) and unescorted temporary absences (UTAs), loss of contact visits with family, not getting released on parole, etc.

Continuation of methadone maintenance therapy (MMT) for people imprisoned in Canada is becoming more common. In the federal correctional system, CSC policy provides both for the *continuation* of MMT for adult prisoners who were receiving it before incarceration and the *initiation* of MMT while incarcerated for those for whom it is medically indicated. In practice, difficulties accessing MMT can persist even in the face of good policy.

However, provincial policies vary: as of early 2006, at least seven provinces/territories had policies permitting the *continuation* by adult prisoners of MMT upon incarceration, but only three had policies regarding *initiation* while incarcerated. The Province of British Columbia has the most extensive methadone program of any provincial prison system. (Only one province, Saskatchewan, had a policy on continuation of MMT for incarcerated youth; no province had a policy on initiation of MMT by incarcerated youth with opiate dependence.)

A critical need exists for federal and provincial/territorial governments to address both policy and programmatic barriers to access to MMT for prisoners, as part of effective HIV and HCV prevention among prisoners who inject drugs.

### **People who inject illegal drugs**

The Public Health Agency of Canada has estimated that in the mid-1990s, over one-third of new HIV infections in Canada were among people who inject drugs; likely in part because of harm reduction initiatives, this has declined to an estimated 14 percent of new infections in 2005.<sup>49</sup> Health Canada has also advised that hepatitis C virus (HCV) is transmitted primarily through the sharing of needles and other drug equipment.<sup>50</sup> Hence the importance of harm reduction approaches, such as:

- access to methadone treatment for opioid addiction, which reduces the use of drugs such as heroin by injection
- needle exchange and similar programs that reduce the sharing of drug-use equipment
- supervised injection sites that not only ensure the use of sterile injection equipment but provide education to help HIV and HCV prevention, reduce harmful injecting in other ways, and connect some of the most marginalized people who use illegal drugs to other health services.

<sup>49</sup> Public Health Agency of Canada. "HIV/AIDS Among Injecting Drug Users in Canada", *HIV/AIDS Epi Update* (August 2006), p. 75, online: [www.phac-aspc.gc.ca/publicat/epi-aepi/epi-06/pdf/epi06\\_e.pdf](http://www.phac-aspc.gc.ca/publicat/epi-aepi/epi-06/pdf/epi06_e.pdf).

<sup>50</sup> Health Canada, "It's Your Health – Hepatitis C", online: [www.hc-sc.gc.ca/iyh-vsv/diseases-maladies/hepc\\_e.html](http://www.hc-sc.gc.ca/iyh-vsv/diseases-maladies/hepc_e.html).

However, harm reduction has never been a well-supported component of Canadian federal policy and funding, and in the past year steps have been taken by the federal government that further undermine harm reduction as an element of a comprehensive drug strategy.

*(1) Canada's approach to drugs: prohibition and law enforcement hinder HIV/HCV prevention and public health, while government abandons or undermines harm reduction measures*

The use of various narcotic and psychotropic drugs remains a criminal offence under Canada's *Controlled Drugs and Substances Act*. Until 2007, Canada's Drug Strategy (first adopted in 1987) was stated to consist of a "balanced approach" that complements prohibition-based law enforcement with three other "pillars" – prevention of drug use, treatment for drug addiction, and harm reduction (i.e., programs and services to reduce harms that can be associated with problematic substance use, such as HIV and HCV infection, overdose, etc.<sup>51</sup> However, a 2001 investigation by the Auditor-General of Canada concluded that 95 percent of government resources in the fight against drugs went to criminal law measures, including policing and incarceration.<sup>52</sup> Canada's Drug Strategy was renewed in 2003, but a recent analysis revealed that the great bulk of federal government spending on addressing controlled drugs continued to be spent on enforcing criminal prohibitions against drugs, with much smaller proportions spent on prevention of problematic substance use, addiction treatment services, and harm reduction programs and services.<sup>53</sup> There is a significant body of evidence indicating that criminalization of people who use drugs, and some police practices in enforcing such criminal laws, exacerbate the HIV/AIDS risk faced by people who use drugs and thereby harm public health.<sup>54</sup>

In February 2007, the federal government announced that it would be initiating a new National Anti-Drug Strategy, from which any reference to harm reduction was conspicuously absent, both as a matter of stated policy and in the allocation of new funding. In October 2007, the government announced the new National Anti-Drug Strategy, which the government has stated

*provides a focused approach involving three action plans to deliver on priorities aimed at reducing the supply of and demand for illicit drugs, as well as addressing the crime associated with illegal drugs. The new approach will lead to safer and healthier communities by taking action in three priority areas: preventing illicit drug use; treating illicit drug dependency; and combating the production and distribution of illicit drugs.*<sup>55</sup>

<sup>51</sup> Health Canada. *Canada's Drug Strategy*. Available until 2007 on the website of the Public Health Agency of Canada, but since removed and replaced in October 2007 with the *National Anti-Drug Strategy* at [www.nationalantidrugstrategy.gc.ca](http://www.nationalantidrugstrategy.gc.ca).

<sup>52</sup> Auditor General of Canada. *2001 Report of the Auditor General of Canada*. Chapter 11 – Illicit drugs: The federal government's role. Ottawa: Office of the Auditor General of Canada, 2001, online via [www.oag-bvg.gc.ca](http://www.oag-bvg.gc.ca).

<sup>53</sup> K DeBeck et al. Canada's 2003 renewed drug strategy – an evidence-based review. *HIV/AIDS Policy & Law Review* 2006; 11(2/3): 1, 5-12.

<sup>54</sup> For a recent review of the literature, see: J. Csete. *Do Not Cross: Policing and HIV Risk Faced by People Who Use Drugs*. Toronto: Canadian HIV/AIDS Legal Network, 2007, online via: [www.aidslaw.ca/drugpolicy](http://www.aidslaw.ca/drugpolicy).

<sup>55</sup> See [www.nationalantidrugstrategy.gc.ca/nads-sna.html](http://www.nationalantidrugstrategy.gc.ca/nads-sna.html) (accessed 11 November 2007).



The new National Anti-Drug Strategy contains no mention of harm reduction and provides no funding for harm reduction. This represents a significant step backward in the response to HIV (and hepatitis C virus) in Canada. The national AIDS strategy, the *Federal Initiative to Address HIV/AIDS in Canada*, espouses the importance of human rights and the use of evidence to inform programs and policies. Harm reduction services of various sorts are well-supported by extensive scientific evidence.<sup>56</sup> Harm reduction as a policy “pillar” is central to a human rights-based response to HIV/AIDS, as a concrete manifestation of the right of people who use drugs to comprehensive HIV/AIDS prevention, treatment and care services, consistent with Canada’s legal obligations under international human rights treaties to take measures to protect, promote and fulfil the right of all persons in Canada to the highest attainable standard of health.<sup>57</sup> By abandoning harm reduction, the federal government’s strategy on drugs is at odds with both the available scientific evidence and human rights principles.

*(2) Needle exchange programs: coverage of important HIV/HCV prevention services is far from comprehensive in Canada*<sup>58</sup>

Needle and syringe programs (NSPs) are a proven, cost-effective way of reducing the transmission of blood-borne viruses such as HIV and HCV. Scientific evidence has established that they do not result in increased crime in neighbourhoods, nor do they lead to drug use. However, barriers persist in Canada that prevent people who use drugs from free access to sufficient sterile injection equipment. Although there are limited data on the number of people who inject drugs in Canada, studies have estimated that NSPs currently distribute only about 5% of the number of syringes needed to ensure sterile equipment at every injection. A recent literature review and country-wide research drawing upon key informants in every Canadian jurisdiction — including government officials, NSP staff, researchers, and people who inject drugs — identified numerous barriers, including the following legal and policy barriers:

- Canada’s criminal laws prohibiting possession of controlled drugs and substances — which include prohibition on possessing anything that contains or has on it any amount of a prohibited drug or substance — leaves NSP clients vulnerable to police and other law enforcement actions. Evidence from some studies indicates that fear of arrest and prosecution for drug offences contributes to a reluctance to carry injection equipment (since such equipment could be used as evidence against them), which is linked to an increased risk of sharing injection equipment or other unsafe injection practices (e.g., hurried injection to avoid detection). In the case where possessing a needle containing traces of an illegal drug is itself the offence of drug possession, this creates an obvious incentive to discard used equipment immediately, and hence a disincentive to carry used equipment to the needle exchange site or other safe disposal locations if not easily accessible – particularly if there is a

<sup>56</sup> N. Hunt. A review of the evidence-base for harm reduction approaches to drug use. London: Forward Thinking on Drugs – A Release Initiative, 2003, online: [www.forward-thinking-on-drugs.org/review2-print.html](http://www.forward-thinking-on-drugs.org/review2-print.html).

<sup>57</sup> E.g., *International Covenant on Economic, Social and Cultural Rights*, Article 12.

<sup>58</sup> Information in this section adapted from: A. Klein. *Sticking Points: Barriers to Access to Needle and Syringe Programs in Canada*. Toronto: Canadian HIV/AIDS Legal Network, 2007, online: [www.aidslaw.ca/drugpolicy](http://www.aidslaw.ca/drugpolicy).



concern about police presence. Criminalizing the possession of used needles also casts a shadow of criminality over NSP staff.

- Similarly, Canada's criminal law prohibiting the distribution of drug paraphernalia ("instruments for illicit drug use") also raises the potential for criminal liability for NSP workers. Given the wording of Canada's law, and the fact that many NSPs operate with funding primarily from provincial/territorial or municipal governments as public health programs, it may be possible to argue that sterile needles and syringes themselves do not fall within the definition of prohibited paraphernalia (although this has never been tested in court). However, the law has made some NSPs reluctant to distribute other injection-related equipment (e.g. cookers, filters) for fear of running afoul of paraphernalia laws. Indeed, the potential for this legal liability has been a caution issued to public health officials by the provincial Ministry of Health in the Province of Ontario in February 2003.
- Police law enforcement practices have also been demonstrated to undermine access to harm reduction services such as NSPs, including in Canada, and to exacerbate the HIV risk of people who use drugs. Police practices of summarily confiscating or destroying drug use equipment found in the possession of those stopped on the street, which has been reported anecdotally on many occasions by people who use drugs and by those working in NSPs or providing other services, and even openly in the media, represent an obvious example of practice that is likely not only illegal but undermines public health initiatives such as NSPs. Police "crackdowns" and increased arrests related to drug activity have been shown to have a marked effect in the efficacy of NSPs' operations and ability to reach clients.<sup>59</sup> Even where syringe possession is legal, and even where police may support NSP activities, the fear of law enforcement leaves some people reluctant to access NSPs.
- Judicially-created barriers to health services also exist. In some cases, judges have imposed probation, parole and bail conditions that prohibit a person accused or convicted of a crime from entering a particular area of a city (a 'red zone' or 'no-go zone'). These tend to be areas where drugs can be obtained, and also tend to be areas where NSPs operate. Judicially-imposed conditions may also include the requirement not to possess drug paraphernalia. In some cases, local police have informed persons who are clients of NSPs that they would be in breach of these conditions even if found in possession of sterile, unused syringes. Such restrictions work at cross-purposes with public health-oriented measures of ensuring access to sterile drug-use equipment (or other services) for those with drug dependence. In at least one case, a provincial court refused to impose such a condition that would prohibit an accused person from entering the downtown of his city, in part because it would hinder his access to necessary health services.<sup>60</sup>

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<sup>59</sup> For a review of the available studies, including research in the Canadian context, see: A,

<sup>60</sup> *R. v. Reid*, [1999] B.C.J. No. 1603 (B.C. Prov. Ct.).

(3) *Supervised injection facilities: lack of government support and commitment*

Supervised injection facilities (SIFs) are legally-sanctioned health facilities that enable the consumption of otherwise-illegal drugs with sterile equipment under the supervision of health professionals. SIFs constitute a specialized health intervention within a wider network of health services for people who use drugs. They have been operating successfully for years in a number of jurisdictions in Europe, and in Australia and Canada.<sup>61</sup>

Insite, the first authorized SIF in North America, operates in Vancouver's Downtown Eastside. This facility currently operate under the protection of an exemption, granted by the federal Minister of Health, from the application of certain provisions of Canada's *Controlled Drugs and Substances Act* – specifically, the criminal prohibition on possession of controlled substances. Absent such an exemption, the users and staff of a SIF would be exposed to the risk of criminal prosecution for possession.

Insite was first established, with this legal exemption, in 2003. Since that time, it has been the subject of extensive evaluation on numerous counts; the data generated by the research team have been published in more than 23 articles in the world's leading peer-reviewed medical journals and demonstrated multiple benefits for the health and well-being of individual service-users and for the broader community at large.<sup>62</sup> Other Canadian municipalities (e.g., Toronto, Ottawa, Victoria) have begun to explore the feasibility of establishing similar facilities as public health initiatives aimed at protecting some of the most marginalized and vulnerable members of their communities.

However, the continued operation of the health facility has remained a matter of concern for service-providers, service-users, and those working in the areas of HIV/AIDS, hepatitis C, and addiction health services, given the federal government's continued reluctance to make permanent the legal exemption allowing Insite to operate without fear of criminal prosecution of service-users or staff, and its announced moratorium on the granting of any further exemptions to permit the establishment of SIFs elsewhere in the country. Insite's initial 3-year exemption was to run until September 2006. During the XVIth International AIDS Conference in August 2006 in Toronto, the fact that the government had still not indicated its support the ongoing operation of Insite received considerable international attention. A few weeks thereafter, days before the exemption was to expire, the federal government announced that the exemption would be renewed until December 2007, while it commissioned "additional research", including an assessment of whether Insite (a health facility aimed at attracting persons with addictions to services to protect their health) had any correlation with crime in the vicinity. While welcoming the temporary extension, this new approach was widely criticized by health researchers, service-providers and advocates as an inappropriate measure to apply to a health service. (And while indicating a need for "more research", the federal government discontinued the previous research funding that had been supporting the extensive and scientifically rigorous evaluation of Insite over three years.)

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<sup>61</sup> See studies cited in: E. Wood et al. Summary of findings from the evaluation of a pilot medically supervised safer injecting facility. *Canadian Medical Association Journal* 2006; 175: 1399-1404.

<sup>62</sup> For a summary of research findings, see E. Wood et al., *ibid.*

In early October 2007, the government granted an additional 6-month extension on the Insite exemption, until the end of June 2008. The decision was widely criticized as stalling, and calls were repeated for granting a permanent exemption for Insite and for entertaining applications for exemptions for other sites in Vancouver or in other municipalities where local decision-makers had identified the need and potential benefit for such services.

At this time, the future of Insite as a legally-sanctioned health facility is uncertain, and no other municipality is able to obtain an exemption from the federal law criminalizing drug possession, a significant barrier to establishing this health service for people who inject illegal drugs.

### **Sex workers**<sup>63</sup>

Recent research has explored the complex, multifaceted relationship between Canadian criminal law and sex workers' health and safety, including the risk of HIV infection. Sex workers are, unfortunately, not mentioned as a "specific population" of concern under the federal government's AIDS strategy, the *Federal Initiative to Address HIV/AIDS in Canada*, even though they are a population at risk and whose health and human rights — including HIV risk — are adversely affected by the current Canadian legal environment.

While prostitution (i.e., the exchange of sex for money or other valuable consideration) is not illegal *per se* in Canada, the federal *Criminal Code* (which applies throughout the country) contains numerous provisions that make it difficult – and even dangerous – for sex workers and their clients to engage legally in prostitution. Four sections of the *Criminal Code* make illegal virtually every activity related to prostitution and prohibit prostitution in almost every conceivable public or private place. In spite of these criminal prohibitions, there is every indication that thousands of people in Canada are involved in prostitution, including sex workers, customers and other people who profit from it.

The available evidence indicates that the criminal law reflects and reinforces the stigmatization and marginalization of sex workers, which has a concrete dimension and predictable outcomes. This criminalization limits sex workers' choices, often forcing them to work on the margins of society, thereby increasing the risks they face. The criminal law and its enforcement place sex workers in circumstances where they are vulnerable to high levels of violence and exploitation, as well as potential exposure to HIV. The preponderance of credible evidence points to the fact that the prostitution-related offences in the *Criminal Code* contribute, both directly and indirectly, to sex workers' risk of experience violence and other threats to their health and safety.

It has been argued that, given the adverse consequences for the health and human rights of sex workers, and the fact that these adverse consequences are disproportionately borne by women sex workers, the current provisions of Canadian criminal law related to sex work are in violation of sex workers' human rights to freedom of expression, freedom of

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<sup>63</sup> Information in this section is adapted from: G. Betteridge. *Sex, work, rights: reforming Canadian criminal laws on prostitution*. Toronto: Canadian HIV/AIDS Legal Network, 2005, online via [www.aidslaw.ca/sexwork](http://www.aidslaw.ca/sexwork). See also: Pivot Legal Society. *Voices of Dignity: A Call to End the Harms Caused by Canada's Sex Trade Laws*. Vancouver: The Society, 2004; and Pivot Legal Society. *Beyond Decriminalization: Sex Work, Human Rights and a New Framework for Law Reform*. Vancouver: The Society, 2006, both online via [www.pivotlegal.org](http://www.pivotlegal.org).

association, liberty, security of the person, and equality, in contravention of both the *Canadian Charter of Rights and Freedoms* (part of Canada's Constitution) and of international human rights norms.<sup>64</sup> In 2007, two court proceedings challenging the constitutionality of various aspects of Canada's laws on prostitution were launched by sex workers' rights advocates; those cases are pending before the courts at the time of this writing.

#### **I.4. The promotion and protection of human rights is explicitly mentioned in national HIV and AIDS strategies.**

The promotion and protection of human rights are explicitly mentioned in *The Federal Initiative to Address HIV/AIDS* which acknowledges that a comprehensive response to HIV/AIDS must include addressing human rights as part of an approach that is based on a social justice framework and the determinants of health.

*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. Respect for 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 are 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,*

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<sup>64</sup> Betteridge, *ibid.*

*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, and the implementation of the *Federal Initiative* has shown quite limited attention to, or support for, human rights.

- The Federal Initiative makes explicit reference to the success of "a human rights approach to addressing HIV/AIDS". However, following the launch of the Federal Initiative in early 2005, the federal government abolished the "Legal, Ethical and Human Rights Fund" that, under the previous Canadian Strategy on HIV/AIDS, had supported research, education, and policy development on human rights issues related to HIV/AIDS, and no similar fund with a clear focus on supporting such initiatives has been created to replace it. This risks rendering the explicit reference to human rights in the federal strategy an empty rhetorical gesture.
- Human rights are mentioned only 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." As of the date of writing, no such support has materialized under the newly-created "Knowledge Exchange Fund" that is to fund work in the area of Knowledge Development.
- 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." Funding for some human rights

work (e.g., developing model legislation aimed at protecting and fulfilling women's rights as an element of reducing their vulnerability to HIV and the impact of HIV/AIDS) has been important, but the Global Engagement Component of the Federal Initiative represents a small portion of the Initiative and of the attached funding. It is anticipated that additional support for work on the legal empowerment of women will soon be forthcoming from CIDA.

- 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 (which has not materialized to any significant degree). A critical need exists for the Government of Canada to take 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 does not have a national mechanism for recording, documenting and addressing cases of discrimination experienced by people living with HIV and/or most-at-risk populations**

There is no national governmental mechanism to record, document and address cases of discrimination experienced by people living with HIV or most-at-risk populations. Several national non-governmental organizations, however, do conduct research into cases of discrimination directly or by compiling information from their member groups.

**I.6. The Canadian Government, through political and financial support, has involved vulnerable populations in governmental HIV-policy design and program implementation.**

The federal government has involved most-at-risk populations in the development of governmental HIV policies and programs, although the level of involvement has diminished in the past two years.

Aboriginal people are disproportionately affected by HIV and are a stated target population in *The Federal Initiative to Address HIV/AIDS*. There is also a National Aboriginal Council on HIV/AIDS that offers policy advice to the Public Health Agency of Canada and Health Canada on HIV/AIDS issues. The concerns of other most-at-risk populations are represented by a variety of national organizations that were involved in consultations and discussions which led to the development of the pan-Canadian multi-sectoral policy document, *Leading Together*, and to *The Federal Initiative to Address HIV/AIDS*, which defines the federal government's response to HIV/AIDS.

Other most-at-risk groups which have been involved in the past in policy design and program implementation include gay men, women and communities from countries with generalized and high prevalence of HIV (Africa and the Caribbean). In the course of

national consultations leading to the development of the national strategy, most sub-populations had some input into the process.

Despite this past involvement of civil society, most organizations consulted for this report expressed strong concern about more recent federal government actions which limit the participation of vulnerable sub-populations in policy and program development (see section II below).

### **I.7 The Canadian government does not directly provide free prevention or treatment, care and support services**

The federal government does not provide free services for HIV prevention and treatment, care and support, because these fall under provincial/territorial jurisdiction, except for some Aboriginal populations (First Nations and Inuit) which receive services from the Government of Canada.

In general, prevention information resources are available free of charge to the public because production of the resources is supported by national or provincial/territorial funding. Access to HIV treatment and health services varies depending on the policies of the province or territory. Outreach and referral services provided by national non-governmental organizations are free of charge to service users, as are most services provided by local non-governmental organizations; these organizations are supported by government funding and/or private donations.

### **I.8 Canada does not have a specific policy to ensure equal access, between men and women, to HIV prevention, treatment, care and support.**

Under the Canadian Charter of Rights and Freedoms, as discussed in Section I.2, discrimination is prohibited on the basis of gender but socioeconomic factors such as poverty, lack of education, fear of stigma and discrimination, or lack of power in relationships may inhibit women from having full access to services.

Civil society is involved in the Blueprint for Action on Women and HIV/AIDS, a multi-sectoral coalition of HIV-positive women, Canadian and international HIV/AIDS organizations, and a variety of women's and reproductive rights groups advocating for better prevention, services and supports for women and girls infected and affected by HIV/AIDS. The coalition focuses on: law and ethics; human rights; research; stigma and discrimination; diagnosis, treatment, care and support; and prevention and education. The activities of the coalition were reported in detail in the 2006 non-governmental appendix to Canada's report to UNGASS. Since then, the coalition developed a report card on women and HIV/AIDS for AIDS 2006 – XVI International AIDS Conference in Toronto. The report card gave Canada an overall grade of D (poor) with highest grades in human rights (B-) and lowest in human resources (F).<sup>65</sup> The coalition is preparing a report card for AIDS 2008 in Mexico City.

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<sup>65</sup> The report card is available at <http://womensblueprint.org/UserFiles/File/Report%20cards/Report%20Card%20English%202006.pdf>

**I.9 Canada does not have an explicit policy to ensure equal access to prevention and care for most-at-risk populations. There are differences in approach for different most-at-risk populations.**

Canada does not have a specific policy to ensure equal access for most-at-risk populations to prevention, treatment, care and support. Most aspects of education and health care delivery fall within provincial or territorial jurisdiction and are not subject to national standards.

*The Federal Initiative to Address HIV/AIDS* specifies that specific national communications campaigns will be developed by and for gay men, injection drug users, Aboriginal people, and people from countries with generalized and high prevalence of HIV.

In the case of Aboriginal peoples, a variety of things must be taken into account in policy and program development, including language and literacy, historical trauma, culturally competent services and other variables such as risk behaviour, especially for people using injection drugs.

Many national non-governmental organizations stated that although the *Federal Initiative* specifies targeted programs for specific most-at-risk populations, funding of such initiatives was considerably delayed by a federal government review of approval processes. This delay jeopardizes the ability of funded organizations to produce the required deliverables in the time remaining to develop the projects. It is regrettable that no projects addressing HIV/AIDS among prisoners or injection drug users have been funded under the Specific Populations Fund of *The Federal Initiative to Address HIV/AIDS in Canada*. The federal government plans to develop population-specific status reports which aim to inform strategic policy and program design and delivery modes that target the eight most-at-risk populations that are identified in the *Federal Initiative*. At the time of this writing, only four status reports are moving ahead: communities from countries with high prevalence and generalized epidemics; Aboriginal peoples; gay men/MSM; and women. There is no clear timeline for status reports on the other populations (persons living with HIV/AIDS, prison inmates, people who use injection drugs and youth).

**I.10 Canada has policies prohibiting HIV screening for general employment purposes (appointment, promotion, training, benefits).**

The answer remains the same as in 2006:

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 policies.

The 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.

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, counselling and evaluation services in the Public Service with respect to HIV infection and AIDS.

**I.11. 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.**

All proposals for nationally-funded research involving human subjects must undergo ethics review by a recognized ethics review body which may be located in a university, health institution or other organization, although there is no national policy on HIV research protocols. Many ethical review bodies have members representing civil society, including those from the populations participating in the research. Organizations such as the Canadian Institutes of Health Research and the Canadian HIV Trials Network have mechanisms for consulting with and including representatives of civil society in policy/program decisions and ethics reviews. Not all clinical trials run by pharmaceutical companies have community input, however, but they would all undergo ethical review. As a result of pressure from civil society organizations, some pharmaceutical companies consult with community members. Most national non-governmental organizations that responded to this question stated that sustained efforts had been made by research bodies to involve civil society and no NGOs expressed strong concern about these issues.

Canada is currently creating national standards for research ethics review boards with the input of key stakeholders across the country, including civil society representatives.

### **I.12 Does Canada have the following monitoring and enforcement mechanisms?**

#### Independent national institutions for the promotion and protection of human rights

At the national level, Canada has a human rights commission, a human rights tribunal, a privacy commission, an ombudsperson and an auditor-general who often addresses health-related spending and effectiveness of national programs. None of these mechanisms have a specific mandate to address HIV-related issues, but may address these issues when they come to their attention as part of their general mandate.

#### Focal points within government departments to monitor HIV-related human rights abuses

There is no national focal point for monitoring HIV-related human rights abuses or HIV-related discrimination. The onus rests with individuals to bring cases of discrimination to the attention of monitoring bodies or the courts. Several national non-governmental organizations are partially supported by national funding and include such monitoring in their work. In particular, the Canadian HIV/AIDS Legal Network is active in monitoring court proceedings, but is limited in its capacity to intervene or to support individuals or groups in the use of such mechanisms.

#### Performance indicators for compliance with human rights standards/reduction of stigma

Canada does not have performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts but Canada has had initiatives for reducing HIV-related stigma and discrimination. A social marketing campaign is planned to reduce stigma and discrimination in the attitudes of young Canadian men, and representatives from some of the national non-governmental organizations and the community-based AIDS service organizations have been involved in an advisory capacity on the Social Marketing Action Committee.

### **I.13 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.**

Non-governmental organizations that answered this question reported that they were not aware that the judiciary in Canada has received any particular training on HIV/AIDS and human rights issues. It was noted that the legal profession in general receives little sensitization about HIV/AIDS and human rights issues as part of formal legal education. Some private bar lawyers have developed expertise on HIV/AIDS and some legal aid clinics provide services to HIV-positive clients dealing with a range of poverty law issues (e.g. housing, income support, etc.). The Canadian HIV/AIDS Legal Network has provided resources to the legal profession to help sensitize them about HIV/AIDS-related issues. For example, the *HIV/AIDS Policy & Law Review* is the only fully bilingual (English and French) international periodical on AIDS-related legal issues in the world. The *Review* is indexed in QuickLaw/Lexis-Nexis where it is consulted by legal professionals and on PubMed where it is consulted by a wider range of researchers, as well as being disseminated in hard copy around the world and free of charge online to a

global audience. Funding for this initiative under the *Federal Initiative to Address HIV/AIDS* has been discontinued, thereby jeopardizing the continued publication of the *Review*.

#### **I.14. The following legal services are available in Canada**

Legal aid systems are available for HIV/AIDS casework in the context of general legal aid programs. Some non-governmental organizations reported that private sector firms or university-based centres provide free or reduced-cost legal services to persons living with HIV. None of these programs, however, are national in scope or jurisdiction. There is only one free-standing legal aid clinic with a dedicated mandate of providing legal advice and services to (low-income) people living with HIV/AIDS, the HIV & AIDS Legal Clinic – Ontario whose mandate extends just to that province. Some non-governmental organizations educate persons living with HIV about their rights and provide some assistance locally in dealing with legal and human rights issues such as access to income security programs, housing issues, employment questions, etc. At the national level, the Canadian HIV/AIDS Legal Network is most active in this respect, but is not equipped to provide legal advice or services in individual cases. Non-governmental organizations working at the provincial/territorial or local level provide some education.

#### **I.15 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.**

There are programs designed to change societal attitudes of stigmatization associated with HIV/AIDS, consisting of media exposure, education in schools (see further comments in section III below) and personalities speaking out. Many national non-governmental organizations engage in this work, which may be partially funded by the federal government. Non-governmental organizations at the provincial/territorial and local levels also engage in efforts to reduce stigmatization.

#### **Rating progress since 2005**

Only one non-governmental organization provided a rating of policies, laws and regulations in 2005 and 2007, rating efforts in both years at 7 out of 10. The same organization was the only one to rate the effort to enforce existing policies, laws and regulations and rated this effort at 6 out of 10 for 2005 and 2007 with the comment that concern exists over legal actions against people living with HIV/AIDS who are deemed to expose sexual partners to the virus without informing them and noted that media coverage creates potential backlash against other people living with HIV/AIDS who do not expose sexual partners to the virus without informing them of their HIV status. This criminalization of HIV transmission has repercussions on prevention and treatment (see sections III and IV below).

## II. Civil society participation

Since the 2006 UNGASS report, there has been a dramatic decrease in the involvement of civil society representatives in the planning and budgeting process for the national strategic plan on AIDS, *The Federal Initiative to Address HIV/AIDS in Canada*. In May 2004, the federal government committed to increasing federal AIDS funding from C\$ 42.2 million annually to C\$84.4 million annually by the year 2008/09. However, the implementation of that increase in funds has been marred by an apparent decrease in the proportion overall of such funding that is available to support community-based responses to the epidemic. Furthermore, in the past 18 months, the federal government has made a number of decisions, without any input from civil society organizations working in the HIV/AIDS sector, to impose cuts on funding support for community-based organizations and to commit to a “new” Canadian HIV Vaccine Initiative (in collaboration with the Bill and Melinda Gates Foundation) that involves no commitment of new government funds; rather, it appears that this initiative will draw funds reallocated from existing areas in both the Federal Initiative and from the existing budget of the Canadian International Development Agency. While all stakeholders support greater Canadian support for HIV vaccine research and development, this “new” commitment to strengthen Canada’s response to HIV comes at the expense of existing programming and services. This is counter-intuitive because the community has supported vaccine research and preparedness for years, including vital role outline in the newly released *Canadian HIV Vaccines Plan*. Reducing the funding for community-based organizations will only weaken their ability to participate in the Canadian HIV Vaccine Initiative.

Some NGOs commented that the UNAIDS questionnaire should be broadened to include the activities and perspectives of the private sector (business and labour) as well as those of NGOs because the Canadian government could do more to engage the private sector in HIV-related workplace programs in Canada and in other countries where Canadian businesses operate.

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

Non-governmental organizations rate the involvement of civil society as high (range from 4 to 5) while stating that this involvement has not resulted in political commitment from the federal government to HIV/AIDS issues.

### **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.**

Non-governmental organizations rate civil society involvement in planning and budgeting low (range from 0 to 3).

### **II.3.a and b Civil society services are included in national strategic plans and reports, but to a lesser extent in the national budget**

Non-governmental organizations rate civil society involvement in national strategic plans and national reports from low to middle range (range from 1 to 4). NGOs rate involvement in the national budget as low (range from 0 to 2).

#### **II.4 Civil society has not been involved in a national review of the national strategic plan**

Many national non-governmental organizations stated that, as of this writing, civil society has not been involved in a national review of *The Federal Initiative to Address HIV/AIDS in Canada*. The federal Minister of Health has recently indicated a commitment to the national non-governmental organizations that they will be involved when the review is launched. The input of civil society is critical to the evidence required to fully review the *Federal Initiative*.

#### **II.5 The diversity of civil society in HIV-related efforts is inclusive to some extent**

Some national non-governmental organizations rated efforts to be inclusive of diversity at 4 out of 5, while others rated it as low as 1. The types of organizations representing civil society at the national level are: Canadian Aboriginal AIDS Network; Canadian AIDS Society; Canadian HIV/AIDS Legal Network; Canadian Treatment Action Council; Canadian Working Group on HIV Rehabilitation; Canadian Association for HIV Research; Canadian HIV Trials Network; Canadian HIV/AIDS Information Centre; Canadian Treatment Information Exchange; and the Inter-agency Coalition on AIDS and Development.

#### **II.6 Civil society is not able to access adequate financial or technical support to implement its HIV activities**

a. Currently, Canadian civil society does not have adequate financial support to implement its HIV activities – a situation that is all the more troubling given that federal AIDS funding is supposed to be increasing annually over the period 2004-2009, and the federal government continues to report record budget surpluses year after year. Recent budgetary figures released to the national non-governmental organizations by the federal government indicate that a commitment to increase total funding under the *Federal Initiative to Address HIV/AIDS* to an annual level of \$84.4 million will not be honoured. In addition, funding cuts are being applied to the budget of the Public Health Agency of Canada, including to AIDS programming under the *Federal Initiative*, and to civil society work supported in other areas of government funding that are relevant to HIV/AIDS (e.g. funding to support civil society-based research and advocacy on women's rights in Canada, funding to disability support programs and funding to support health programming for Aboriginal communities). Non-governmental organizations that provided ratings for adequate financial support rated support as low to middle (range of 1 to 3).

b. Some NGOs cited the existence of a national HIV/AIDS surveillance system consisting of a federal/provincial/territorial partnership as a technical support for their work, but stated that they sometimes had difficulty getting access to surveillance data. Non-governmental organizations that provided ratings for adequate technical support rated support as low to middle (range of 0 to 3).

### **Progress since 2005**

All national NGOs agreed that civil society participation has decreased greatly since 2005. At the federal level, civil society participation has worsened as a result of decision-making that is not transparent or consultative and that is less accountable to citizens than in the past. The government-civil society partnership model which prevailed in the past has been replaced by an adversarial model. While there is an international movement to recognize civil society as a core component of the response to HIV/AIDS, the Canadian government is moving away from this position and appears to regard civil society as an implementer of government projects rather than a partner. Several organizations cited rumours that the Canadian contribution to the HIV vaccine initiative will come from funds previously directed to community-based programs, further weakening the ability of civil society to participate in a national response to HIV/AIDS and to actively engage in prevention and treatment initiatives at the grass roots level. In general, NGOs mentioned increased political interference in HIV/AIDS initiatives and increased inertia in the bureaucracy with the result that funding for some programs has decreased despite a growth in the budget for the national strategy because approval of programs is stalled within government. Some NGOs cited a negative climate created by the perception that the Canadian government will punish organizations that engage in HIV/AIDS-related advocacy by reducing funds available to these organizations. NGOs cited as evidence of a lack of federal government transparency both the suppression of the 2006 World AIDS Day report and the possible lack of a 2007 World AIDS Day report.

## **III. Prevention**

### **III.1 Canada has identified most-at-risk populations rather than districts in need of HIV prevention programs**

At the national level, Canada has identified most-at-risk populations in need of prevention programs, rather than geographical districts. These populations may live anywhere in Canada, although some are concentrated in large cities and towns, such as communities from countries with generalized and high prevalence of HIV, while others may live in rural and remote areas, such as some on-reserve First Nations and Inuit communities. The availability of HIV prevention programs varies across Canada because health care delivery and education fall within provincial/territorial jurisdiction (except for First Nations and Inuit populations, among most-at-risk populations). A social marketing campaign is planned to reduce stigma and discrimination in the attitudes of young Canadian men, and representatives from some of the national non-governmental organizations and the community-based AIDS service organizations have been involved in an advisory capacity on the Social Marketing Action Committee.

Canada could do more to support Canadian participation in global clinical trials and research. A need has been identified for more research into prevention for most-at-risk populations. The national strategy needs to be more strongly focused on prevention and rooted in a population health approach that addresses the determinants of health. There is

a need to address the root causes of low self-esteem and poor body images, which requires stronger linkages to mental health policies and programs.

Blood safety and universal precautions are available across Canada.

Prevention of mother-to-child transmission is available in most parts of Canada.

Risk reduction: The availability of information, education and communication on risk reduction varies across Canada, depending on provincial/territorial policies and programs and on local resources.

Stigma and discrimination reduction: Information, education and communication on stigma and discrimination reduction also vary across Canada, for the reasons cited above. At the national level, public awareness campaigns to reduce stigma and discrimination were implemented in the past. Canada also communicated messages consistent with past World AIDS Day themes of reducing stigma and discrimination. A social marketing campaign is planned to reduce stigma and discrimination in the attitudes of young Canadian men, and representatives from some of the national non-governmental organizations and the community-based AIDS service organizations have been involved in an advisory capacity on the Social Marketing Action Committee. Many non-governmental organizations at the national and local levels work to reduce stigma and discrimination; some of this work may be supported by funds from the federal government.

Condom promotion is largely conducted at the local level. The availability of condoms depends on the resources of provincial/territorial/municipal public health programs and of local non-governmental organizations. Some NGOs observed that local and provincial funding cuts for public health have restricted the distribution of free condoms.

Testing and counselling: The Public Health Agency of Canada estimates that as many as 30% of those living with HIV in Canada have not been tested and remain unaware of their status. A policy framework for HIV testing and counselling is being developed at the national level with the participation of some non-governmental organizations. Testing and counselling occur at the local level, usually in health care settings, and thus fall under the jurisdiction of the provinces and territories. NGOs report that the quality of testing and counselling is variable. Some testing and counselling are offered by local non-governmental organizations. HIV testing for pregnant women is available in all jurisdictions on either an opt-in or opt-out basis, depending on the policy of the province or territory. Non-governmental organizations have concerns about respect for confidentiality, informed choice and access to pre-and post-test counselling, especially under opt-out models and under the new WHO guidelines which favour opt-out testing and may diminish the role of counselling and referral. NGOs are also concerned about lack of access to treatment for those with positive test results because of fears of stigma, discrimination and violence, especially against women.

The criminalization of HIV transmission can discourage testing because those who are ignorant of their serostatus are not liable to criminal prosecution. Greater support is needed for the development of messages that persons should be tested in order to better care for their health.

Harm reduction for people who use injection drugs was discussed in Section I, particularly with respect to clean needle programs. There is also a need to focus on other drug paraphernalia such as safer crack kits. Harm reduction is about more than needles and equipment; it also requires addressing the determinants of health as part of a broader harm reduction strategy, which would include issues such as housing, access to health care, counselling and support, to name just a few.

Various non-governmental organizations at the national, regional and local level are concerned that the present federal government's new drug strategy will eliminate harm reduction programs because the strategy emphasizes only abstinence and criminal prosecution and does not include harm reduction. NGOs are concerned that this approach will be ineffective in reducing HIV transmission and will lead to increased transmission. Most NGOs cite evidence that harm reduction can reduce HIV transmission and are concerned that the federal government has ignored this evidence in the interest of promoting a strategy based on ideology rather than evidence.

Risk reduction for MSM: Infections among MSM have risen in recent years, particularly among young MSM. Half of new infections still occur among MSM. The availability of prevention programs for MSM varies across Canada and tends to be greater in large cities and towns. NGOs sometimes find themselves facing the need to maintain links with clients by not condemning their risky practices while helping to educate them to adopt safer ones. There have been and continue to be nationally funded social marketing campaigns targeting gay men and other men who have sex with men. The challenge remains to have campaigns that adequately address issues faced by this population. There is a trend adopted by NGOs to move towards a broader based approach to gay men's health and wellness, taking into account the social determinants of health that may help put gay men more at risk for acquiring and transmitting HIV. A need exists for federal leadership in supporting the development of appropriate messages and interventions and in re-focusing prevention programs on MSM as well as looking at gay men and their health issues as more than just vectors of HIV transmission.

HIV prevention services for sex workers are provided in some major cities by community-based organizations but there is no national program targeted for sex workers. Some NGOs stated that sex workers are well informed and willing to adopt safe practices, but that pimps create problems that lead to violence and unsafe sex. In addition, some NGOs, at both the national and local levels, have highlighted that the ongoing *de facto* criminalization of sex workers puts their health and safety at greater risk, including HIV-related risk, and impedes efforts to connect sex workers to HIV prevention, care, treatment and support services. There is a need for more national peer-based programs.

Other most-at risk populations in Canada include Aboriginal peoples, communities from countries with generalized and high prevalence of HIV (Africa and Caribbean), women and youth.

### **Aboriginal peoples**

Aboriginal peoples in Canada include First Nations, Inuit and Métis. Aboriginal peoples are served by a national non-governmental organization, the Canadian Aboriginal AIDS Network (CAAN). Health care services are delivered directly to some First Nations and to Inuit by the federal government, while non-status First Nations and Métis receive



health care services from the provincial or territorial government where they reside. The availability of HIV prevention programs for Aboriginal peoples thus varies depending on their status and place of residence. National and local Aboriginal health organizations, including CAAN, provide prevention information and education within the limits of their resources. Some NGOs cited the need to engage Aboriginal political and community leaders and the need for this effort to be supported in order to ensure more equitable access to HIV-related programs for Aboriginal peoples.

### **Communities from countries where the HIV epidemic is generalized and the prevalence of HIV is high**

There is an emerging epidemic in developed countries, including Canada, among communities from countries where the HIV epidemic is generalized and the prevalence of HIV is high. Infection in women and mother-to-child transmission are disproportionately high in these communities. In Canada, the communities are concentrated in Toronto and Montreal and receive some HIV-specific services from local non-governmental organizations in addition to services they may receive from provincial health care programs. However, many new immigrants are being placed in smaller communities with little access to services that are able to address their cultural issues around healthcare and/or their immigration experience.

The government of the province of Ontario is particularly pro-active and has developed a strategy in partnership with community-based organizations. At the national level, there have been discussions and plans to create programs to build capacity in these communities, but no funding has come from the federal government and discussions are in abeyance at present. NGOs working with this population have asked for federal government support for capacity building but have been refused. NGOs hope that the federal government will be more receptive to funding these programs in future and that the federal government will play a role in bringing stakeholders together, helping affected communities to build linkages and working with provinces and territories to improve surveillance by collecting more precise data on HIV and ethnocultural communities.

### **Women**

HIV prevention for women is not a designated national program but may be included in programs for specific populations such as Aboriginal peoples and communities from countries with generalized and high prevalence of HIV. A national consultative body on women's issues was dissolved several years ago and has not been re-established. A coalition of HIV-positive women, Canadian and international HIV/AIDS organizations and a variety of women's and reproductive rights groups have developed a Blueprint for Action on Women and Girls and HIV/AIDS (see section I.8).

### **Youth**

Programs for youth are largely delivered at the local level by non-governmental organizations and by provincial/territorial public education systems. Government of Canada funding has supported some of these programs at the local level. Non-governmental organizations are concerned by funding cuts to the national AIDS Community Action Program which has supported community-based work in the past.

Reproductive health services, including STI prevention and treatment, are delivered at the local level by provincial/territorial public health services and community-based

organizations. Most national non-governmental organizations surveyed for this report have a major focus on HIV/AIDS rather than STIs, and were unable to provide detailed comments about them.

School-based programs for youth: The decline in awareness among young people in school is of great concern. A survey published in 2003 by the Council of Ministers of Education (Canada), the *Canadian Youth, Sexual Health and HIV/AIDS Study*, showed that middle and high school students (Grades 7, 9 and 11; approximately ages 12-16) were less aware of HIV/AIDS than they were in 1989. The survey has not been repeated since 2003. As was cited above, the reasons for the decline in awareness may lie in the assumption that HIV/AIDS is no longer a major public health threat and the cancellation of school-based HIV education programs in many provinces. A lack of sustained commitment to youth HIV education could result in a resurgence of infection among youth and young adults in the future. Many non-governmental organizations attribute this decline in knowledge to an erroneous assumption by education systems that HIV/AIDS is no longer a major public health threat and that the disease is chronic and manageable. This has resulted in fewer resources being invested in helping youth learn about HIV.

Out-of-school youth: Most non-governmental organizations stated that they are unaware of specific national programs for out-of-school young people, except for programs that may be aimed at other populations, such as young MSM, or youth-oriented programs that exist in local pockets across Canada. Street youth are particularly hard to reach. There is a need for more coordinated national programs.

HIV prevention in the workplace was deemed by some national non-governmental organizations to be non-existent, while others cited work-related support programs for those living with HIV (see Section IV below).

One national NGO has identified persons living with disabilities as a vulnerable population for HIV transmission because of disability-associated stigma and discrimination, low self-esteem and associated depression and drug use, vulnerability to physical and sexual abuse and unfavourable determinants of health. Targeted prevention programs could be developed at the national level but do not currently exist.

Other programs:

Positive Prevention, the role HIV positive persons play in prevention, remains highly unexplored in Canada. There are a few NGOs and provincial bodies working on defining positive prevention, but there exists no national framework in this area and thus no national funding dedicated to the development of positive prevention programming. There is a need for more research in the area of positive prevention with respect to social determinants and the role they play in the health and well being of HIV-positive individuals and the behavioural changes that can be affected when basic needs are met.

Other issues which could benefit from federal support include prevention of co-infections with HIV, Hepatitis C and/or tuberculosis.

**Progress since 2005**

Overall, most national non-governmental organizations stated that there has been a decline in HIV prevention efforts at the national level since 2005, although a minority

stated that additional funding has been made available to them for prevention programs, enabling them to hire more staff to deliver these programs. Canada may be doing well relative to the rest of the world, but with the country's level of wealth, it could do better. Some NGOs expect that the present government's policies will result in a measurable worsening of the epidemic in the next 1-3 years.

The few non-governmental organizations that provided numerical scores rated efforts in 2005 at 7 and those in 2007 at a range of 5 to 6.

### **Additional comments on HIV prevention**

The absence of questions dealing with prevention research was noted; an organization stated that the shape of the epidemic has changed and there is a need for more research into prevention for emerging epidemics in most-at-risk populations. Needs have also been identified for stronger links between biomedical and psychosocial research in order to enhance their effectiveness; links between these research streams also need to be made with policy developers. There is a need to improve knowledge translation and exchange and to enhance research capacity through training and mentoring new investigators.

A general comment from many NGOs was that the prevention policies spelled out in the national strategy are good and could be effective, but the present political climate results in policies and programs not being implemented.

Some NGOs commented that Canada's commitment to international efforts to address the HIV/AIDS epidemic (prevention and treatment) have shifted away from Africa and toward Latin America because of trade considerations rather than need. They are concerned that Canada is losing its leadership role in the international community and that, whereas Canada was once considered to be progressive and a counterbalance to the policies of the United States, Canada is now being increasingly perceived internationally as obstructionist and conservative. Some Canadian non-governmental organizations link with counterparts in other countries to strengthen civil society participation in those countries.

## **IV. Treatment, care and support**

### **IV.1 Canada has identified most-at-risk populations rather than districts in need of HIV treatment, care and support services**

At the national level, Canada has identified most-at-risk populations in need of treatment, care and support programs, rather than geographical districts. These populations may live anywhere in Canada, although some are concentrated in large cities and towns, such as communities from countries with generalized and high prevalence of HIV, while others may live in rural and remote areas, such as some on-reserve First Nations and Inuit communities.

The availability of HIV treatment, care and support varies across Canada because health care delivery and education fall within provincial/territorial jurisdiction. There are no national standards in health care or access to treatment, care and support. Each sub-

national jurisdiction has a public health insurance plan that covers “medically necessary” physician and hospital services for all residents of the jurisdiction, as a pre-condition of receiving federal funding contributions under the *Canada Health Act*. The coverage of other health goods and services under public health insurance plans varies from province/territory to province/territory. There is no nation-wide pharmacare plan providing insurance covering the costs of prescription medications, although this has been recommended by numerous bodies, including the 2002 federal Commission on the Future of Health Care in Canada (the *Romanow Commission*). The lack of national standards, and of a national pharmacare program, creates inequality of access which needs to be addressed at the national level.

A view generally shared by national NGOs is that Canada needs more research into treatments for diverse affected populations. Some NGOs are concerned that the present federal government is less committed to treatment research than in the past. The Canadian government could play a role in coordinating Canadian-based HIV research as well as Canadian participation in international research efforts. Each research entity in Canada currently pursues its own research agenda, with little coordination. Some promising work is occurring within the federal government to establish a national research plan, including knowledge translation and exchange.

### **Specific treatment issues**

Some national non-governmental organizations stated that none of the treatment, care and support issues identified in the UNAIDS questionnaire are available to all affected populations in all jurisdictions. While services may be available in most jurisdictions, those services identified as being available in only some jurisdictions include nutritional care, pediatric HIV care, psychosocial support, home-based care and services in the workplace.

Antiretroviral therapy is available in Canada but access to treatment may vary because of several factors. Public funding for drugs varies according to provincial/territorial drug formularies which results in drugs being provided at little or no cost in some jurisdictions and not in others. Lack of access to affordable drugs occurs particularly with newer, more expensive drugs. The approval process for new drugs in Canada is lengthy and involves reviews at the national level for authorization to sell the drug, followed by review at the provincial/territorial level to decide if the drug will be included on the provincial/territorial formulary and made available at little or no cost to persons living with HIV. NGOs observed that this process is slow and cumbersome and results in inequitable access to treatment across Canada. An encouraging development is the pending adoption by the federal government of a progressive licensing framework for drugs that will involve continuous monitoring of drugs throughout the lifetime of the product.

Stigma and discrimination may limit access to treatment if people fear their privacy and confidentiality will not be respected. Some marginalized populations, such as the unstably housed or homeless, have limited access to health care services and do not have adequate supports for adherence to treatment such as drug storage, drug schedule reminders and safe places to take medication. Some programs at the local level in large cities address these issues; these programs may be delivered by public health services and

non-governmental organizations, sometimes working in partnership. A portion of the funding for their programs may come from the national HIV/AIDS budget.

Nutritional care is not a priority in national policies. HIV-related nutritional expertise is concentrated in major cities. Some local non-governmental organizations provide programs such as communal kitchens and meals. Lack of adequate nutrition, or proper nutrition in relation to medication, is a problem for socio-economically disadvantaged persons living with HIV/AIDS.

Pediatric HIV/AIDS treatment is generally available in Canada but may require travel for those living outside cities where such care is available. This presents a barrier to access in other regions. Because there are few cases of pediatric HIV infection in Canada, treatment expertise is not widespread.

STI management is not a primary focus of HIV/AIDS programs in Canada, but may fall within the responsibility of provincial/territorial and local public health programs. There is a need to address Hepatitis C-HIV co-infection by recognizing that people tend to be infected with the viruses at different times. Better intervention after the first infection could reduce the number of infections with the second virus; this requires national coordination and support. A need exists for a separate strategy for Hepatitis C that could work collaboratively with HIV/AIDS but not strip funding from HIV programs. Research is also needed into HPV and its effects on HIV transmission and treatment.

Access to psychosocial support for people living with HIV and their families varies greatly across Canada, is most available to those living in large cities and towns and is largely delivered by community-based organizations. There is an unmet need for psychosocial support for marginalized populations. The federal government in the past has funded the creation of information resources to be used by health care providers, community-based organizations and persons affected by HIV. National non-governmental organizations rate current activity in this area by the federal government as low.

Home-based care falls within the jurisdiction of provinces and territories, except for First Nations and Inuit peoples. For unstably housed and homeless populations, home care is non-existent. Some local public health authorities and community-based organizations have responded by providing housing or advocating for stable housing. The possibility of a national program for housing and HIV is currently being discussed at the national level with NGO participation.

Palliative care: The need for palliative care for persons living with AIDS has declined since the advent of antiretroviral therapies, but continues to be a need for those diagnosed late and with rapid progression of HIV disease, such as unstably housed and homeless populations. In the past, national funding supported a number of projects related to HIV/AIDS palliative care but this is not a current national priority. At the local level in some large cities, hospice services exist for those living with HIV who are unstably housed. Most local hospice palliative care services in Canada accept patients living with HIV/AIDS and some cities have HIV-specific hospices run by non-governmental organizations which provide a high level of care. The level of HIV palliative care expertise is declining in Canada because of the lower death rates since the advent of ART.

Tuberculosis and HIV: Treatment of HIV-related infections is delivered by provincial/territorial and local public health care services. The occurrence of such infections continues to be a problem for marginalized populations with poor access to treatment.

Tuberculosis co-infection with HIV is a growing public health concern in Canada, particularly focused on multi-drug-resistant TB. There are currently no national programs to address this.

Cotrimoxazole prophylaxis in HIV-infected people: Opportunistic infections have declined in Canada because of the widespread availability of antiretroviral therapies. A wide variety of antibiotic and antiprotozoal treatments for *Pneumocystis carinii* pneumonia, urinary tract infections, bronchitis, middle ear infection and diarrhea are available in the provinces and territories. In Canada, Cotrimoxazole is available through all of the provincial/territorial public health drug formularies.

Post-exposure prophylaxis for occupational exposure is available in all Canadian jurisdictions and is provided by local health authorities. Post-exposure prophylaxis for non-occupational exposure (nPEP), however, varies according to the policies of individual provinces and territories. There is no national program dealing with nPEP. There is variability across Canada in access to nPEP, cost to the patient, and in the number of drugs used in combination (two or three); there is a need for some of the drugs currently in use to be replaced with less toxic drugs. Access to nPEP is not available for accidental condom breakage and, in some jurisdictions, may not be available to victims of sexual assault. There is a need for access to nPEP to be less judgemental because prevention of even one case of transmission is cost-effective.

Access to HIV treatment, care, support and accommodation in the workplace varies greatly, depending on the employer. One of the greatest challenges faced by persons living with HIV is confidentiality in the workplace, for example, being able to take their medication during the day at work without revealing their HIV status or deciding whether or when to disclose their HIV status to the employer. Most employers do not have HIV-specific services but many provide supplementary health care insurance that covers HIV treatment. Small companies may have self-administered insurance that runs the risk of lack of confidentiality. Small companies may also find that they cannot afford to keep employees who are living with HIV because of the high insurance premiums and other costs. Canada could develop a pooling approach to insurance with encouragement from the federal government.

Other treatment, care and support concerns: These include co-infection with Hepatitis C and HIV, rehabilitation and disability, challenges faced by most-at-risk populations, access to cannabis for medical purposes, research and making treatment drugs available to developing countries

### **Co-infection with Hepatitis C and HIV**

Co-infection with Hepatitis C and HIV is more common than co-infection with TB. National non-governmental organizations have identified a need for programs in this area, but are not currently involved in nationally-funded initiatives. Some NGOs are concerned that efforts to fight Hepatitis C infection may be funded from existing HIV/AIDS budgets, thereby diminishing capacity to respond to HIV/AIDS.

### **HIV, disability and rehabilitation**

Canada has recently signed the United Nations Convention on the Rights of Persons with Disabilities (2007). The Convention has yet to be ratified at the international level. Canada is the only country with a national non-governmental organization devoted to issues of HIV, disability and rehabilitation, the Canadian Working Group on HIV Rehabilitation (CWGHR), which receives some funding from the federal government. CWGHR's initiatives include work with employers and disability insurance programs to develop support and adaptations for persons living with HIV who wish to remain in, or return to, the workplace. There is a need for rehabilitation programs to be enhanced at the national level for those living with HIV as well as support to remain in, or return to, the workplace, as well as rehabilitation for those who may not be able to engage in the labour force at all. Another key component of CWGHR's work includes working with professional associations involved in rehabilitation to have them include HIV-related rehabilitation in their practice. Many provinces and territories no longer make the services of rehabilitation professionals, such as physiotherapists and occupational therapists, available at no cost to patients in need, which creates inequitable access to these critical services.

### **Challenges faced by most-at-risk populations**

Some of the challenges faced by communities from countries with generalized and high prevalence of HIV (Africa and the Caribbean) were mentioned in Section I – Human rights and Section III – Prevention. Non-governmental organizations stated the need for a national strategy for these communities because they currently have no voice at the national level. Ontario was cited as the only province with significant support for HIV/AIDS-related issues for these communities. Some national and local non-governmental organizations are collaborating on the development of a strategy in the absence of support from the federal government. Although NGOs have noted an increase in HIV-related policies and programs for this population since 2007, they noted that none of this progress can be attributed to the involvement of the federal government.

### **Access to cannabis for medical purposes**

Access to cannabis for medical purposes is still hindered by barriers such as high cost without reimbursement, lack of information transfer to physicians about the medical properties of cannabis, lack of information dissemination about Canada's federal medical cannabis program that enables people to obtain legal authorization to possess cannabis, lack of adequate research to support evidence-based policies, lack of adequate options for a safe and affordable supply of cannabis, and stigma associated with cannabis use to manage HIV/AIDS related symptoms.<sup>66, 67</sup> There is a critical need for Canada to make cannabis accessible to seriously and chronically ill Canadians. The government has not addressed the barriers that have been identified, and has eliminated the Stakeholder Advisory Committee on Medical Marijuana, where dialogue to address these issues was possible.

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<sup>66</sup> Canadian AIDS Society. Cannabis as Therapy for People Living with HIV/AIDS: "Our Right, Our Choice. June 2006.

<sup>67</sup> Belle-Isle, L; Hathaway, A. Barriers to Access to Medical Cannabis for Canadians Living with HIV/AIDS. AIDS Care, April 2007; 19(4):500-506.

## **Research**

There is a need for nationally-supported treatment research to include niche research related to Aboriginal peoples, communities from countries with generalized and high prevalence of HIV, and women. Although Canada is a relatively small country, it could contribute to international research which requires a large number of participants. The need for further research has been identified in the areas of: harm reduction and supervised injection sites including the impact of harm reduction on clinical and economic aspects of Hepatitis C vaccine and co-infection with HIV; reducing violence and its impact on treatment access and adherence, especially for women; drug-resistant tuberculosis; and alternatives to ritonavir as a booster.

## **Making treatment drugs available to developing countries**

Some NGOs cited Canada's role in making HIV treatment drugs available to developing countries and stated that current Canadian government policies favour pharmaceutical companies that export relatively expensive brand-name drugs rather than cheaper generic drugs. These policies tend to favour industry rather than assist in addressing the epidemic. The 2004 legislation that created Canada's Access to Medicines Regime (CAMR) has not yet, as of this writing, led to exports of any medicines, although the first steps toward using toward this end finally occurred in September 2007. Numerous national NGOs from a broad range of sectors have called for legislative reforms intended to simplify and streamline the legislation so as to increase its usability for developing countries and generic manufacturers.

## **Progress since 2005**

Some national non-governmental organizations stated that they saw progress from 2005 to 2007 because of increased national funding for NGOs, while others cited funding cutbacks. Most organizations did not provide numerical scores.

## **IV.2. Percentage of programs provided by civil society**

With the exception of clinical services and some rehabilitation services, which fall within provincial/territorial jurisdiction, most non-governmental organizations estimated that all other services mentioned in the UNAIDS questionnaire are provided by civil society at levels of either 50-75% or greater than 75%. Some NGOs stated that the high quality of effective service provided by civil society is delivered in a cost-effective way and that more service delivery could be devolved to civil society.

## **IV.3. Strategies to address the needs of orphans and vulnerable children**

With the exception of communities from countries with generalized and high prevalence of HIV, non-governmental organizations considered this question to be not applicable to Canada. More research is needed to determine the dimensions of this situation in communities from countries with generalized and high prevalence of HIV.



## **V. Suggestions to UNAIDS from Canadian civil society organizations regarding the UNGASS report questionnaire**

- Include the participation of the private sector (business and labour) as well as civil society. The private sector has a role to play with respect to workplace HIV prevention, treatment, care and support in Canada and abroad. Many Canadian companies, especially those involved in mining and resource extraction, are active in countries with high prevalence and could have an impact on the epidemic in these countries.
- Include questions to capture the perspective of non-governmental organizations regarding the country's commitment to international efforts to address the epidemic.
- Include research as a distinct category for both high-prevalence and low-prevalence countries. There is a global consensus on a renewed prevention thrust in research, including emerging areas such as microbicides and circumcision. This research needs to be done in both developed and developing countries.