Government of Canada 2002 Report to the Secretary General of the United Nations on the UNGASS Declaration of Commitment on HIV/AIDS

The State of the Epidemic in Canada

An estimated 49,800 people were living with HIV/AIDS in Canada at the end of 1999, an increase of 24% increase from the estimated 40,100 at the end in 1996. The number of new HIV infections in 1999 was estimated at about 4,200 – essentially unchanged since 1996. Significant changes in infection rates have occurred within population subgroups, as substantiated by several studies across Canada and by national HIV/AIDS surveillance data.

Sexual behaviour continues to be the principal means of transmitting HIV. New infections occurred primarily among men who have sex with men (38% of new infections) and injection drug users (34%), but the proportion of new infections among heterosexuals who do not inject drugs is also significant at 21%. Research studies in Toronto and Vancouver confirm these findings. In 2000, for the first time since the mid-1980s, an increased number of newly diagnosed HIV cases among men who have sex with men was reported to Health Canada's HIV surveillance system.

Recent surveillance data show that the HIV epidemic is far from over in Canada. In 2001, the number of new HIV-positive test reports increased for the first time since 1995. In addition, the proportion of new test reports attributed to heterosexual exposure has increased steadily over time, from 8% before 1996 to 33% in 2001. Correspondingly, women now account for 25% of new positive test reports, up from 11% before 1996.

Shifts in the epidemic are also occurring among other populations. The estimated number of new infections among injection drug users declined by 27% between 1996 and 1999. The annual number of newly diagnosed HIV cases in this population also declined in the national surveillance data. However, targeted studies across Canada have found that HIV infection rates among injection drug users are not declining in all areas of the country.

An estimated 370 Aboriginal people become infected with HIV each year, an average of more than one each day. The facts are equally stark in the correctional environment. The HIV prevalence rate in federal prisons is an estimated 1.6% of inmates tested.

National surveillance data provide a picture of those who come forward for testing and are found to be HIV-positive. At the same time, an estimated 15,000 Canadians who are infected with HIV have not been diagnosed and are unaware that they are HIV-positive. These individuals represent a significant challenge for prevention, care and treatment.

Realities and Challenges

Knowledge has been gained and progress achieved in the fight against HIV/AIDS, but the epidemic remains uncontrolled, and many challenges lie ahead.

- **HIV/AIDS continues to spread in Canada.**

People with HIV/AIDS are living longer, mainly because of the availability of highly active antiretroviral therapy (HAART). At the same time, new infections continue to occur, placing greater demands on Canada's health care and social service systems, workers in the HIV/AIDS community, and society in general. Clearly, new prevention efforts are needed to reach those living with HIV/AIDS and those vulnerable to infection.

- **An estimated one-third of people living with HIV/AIDS in Canada are not aware that they are infected.**

Canada must remain vigilant in monitoring the epidemic. Innovative ways of encouraging people to come forward for HIV testing must be found so that those who are HIV-positive can have access to care, treatment, support and prevention programs as soon as possible after they have become infected.

- **The epidemic is a moving target.**

The face of the HIV/AIDS epidemic continues to change. After some successful prevention work in the early 1990s, HIV infection is once again increasing among men who have sex with men. Users of injection drugs, women and Aboriginal people have become increasingly vulnerable to HIV infection. Canada's response must be flexible enough to address changes in the epidemic while not jeopardizing earlier gains.

- **HIV/AIDS treatments are failing.**

As many as 4,000 HIV-positive Canadians are believed to be in need of an alternative to HAART because of drug intolerance or ineffectiveness, and this number is growing. New treatments are needed to avoid an increase in AIDS-related deaths. The appearance of multi-drug-resistant HIV intensifies these challenges.

Action on HIV/AIDS in Canada

Canada's response to the HIV/AIDS epidemic has evolved significantly over the past two decades. As the threat of HIV/AIDS grew, governments, the health care system and other sectors of society have responded. From the initial mobilization of the gay community into small, volunteer-based community organizations in the early 1980s, involvement expanded to include the medical community, professional associations, researchers and the private sector, along with hemophiliacs and others infected through the blood system.

The national response to HIV/AIDS is based on early development of national standards (including standards for condoms and other products and devices) and practices (including testing procedures) and an established and operational infrastructure to support action and dialogue.

As well, the development and dissemination of information by local and national organizations on topics ranging from treatment options to palliative care to pregnancy characterized Canada's response from the earliest days of the epidemic.

In 1990, the federal government established the National AIDS Strategy (NAS) to help organize the various players into a more formal, interconnected approach. In 1993, the NAS was renewed for five years, with an increase in annual funding from $37.3 million to $42.2 million.[1]

Following extensive consultations with stakeholders in 1997, the Canadian Strategy on HIV/AIDS (CSHA) was launched in 1998 with permanent funding for a continuing, co-ordinated national response. The CSHA represents a shift from a disease-oriented approach under the NAS to one that looks at root causes, determinants of health, and other dimensions of the HIV epidemic. People living with HIV/AIDS and those at risk of HIV infection are the focus of efforts under the CSHA.

The Canadian Strategy on HIV/AIDS

The CSHA opened a new era in HIV/AIDS programming. Given its system of government, which divides or shares responsibilities in areas such as health and social services between federal, provincial and territorial governments,[2] Canada has a complex network of community-based, institutional and governmental systems that strive for an appropriate and effective response to HIV/AIDS. All major stakeholders are considered full partners in this response, linked by multiple working relationships and a shared determination to win the fight against HIV/AIDS.

The CSHA provides a framework for unprecedented collaboration among these partners and for innovation and engagement in addressing the epidemic. CSHA partners have set a challenging

1. Unless otherwise stated, all figures are in Canadian dollars.
2. See Annex A, A Note on Canada's Health Care System.

agenda. Efforts need to be intensified, and more sectors of society need to join the campaign. CSHA partners are committed to:

- keeping HIV/AIDS on the public agenda,
- positioning HIV/AIDS within a broad social justice context,
- expanding the pan-Canadian approach by establishing new partnerships with essential stakeholders and sectors,
- fulfilling Canada's obligations under the UNGASS Declaration of Commitment, with its focus on intensifying regional, national and international responses to HIV/AIDS,
- continuing to improve surveillance systems,
- revitalizing prevention efforts that integrate prevention and care, treatment and support programs for Canadians living with or at risk of HIV/AIDS,
- engaging vulnerable populations in developing and implementing unique approaches to addressing the needs of people living with or vulnerable to HIV/AIDS,
- setting HIV/AIDS research priorities and increasingly linking Canadian efforts to international research activities, with the goal of finding effective vaccines, drugs and therapies and, ultimately, a cure for HIV/AIDS, and
- reviewing CSHA funding priorities to maximize the impact of financial resources.

In pursuing these goals, three policy directions guide the CSHA:

- enhanced sustainability and integration,
- increased focus on those most at risk, and
- increased public accountability.

Health Canada, as the lead federal department for issues related to HIV/AIDS, co-ordinates the CSHA nationally with an annual budget of $42.2 million, allocated as follows.

CSHA Strategic Areas and Funding Allocations
($ millions)

Prevention	3.90
Community development and support to non-governmental organizations	10.00
Care, treatment and support	4.75
Research	13.15
Surveillance	4.30
International collaboration	0.30
Legal, ethical and human rights	0.70
Aboriginal health and community development	2.60
Correctional Service Canada	0.60
Consultation, evaluation, monitoring and reporting	1.90

Total **42.20**

Several responsibility centres within Health Canada contribute to the work of co-ordinating the CSHA:

- The Centre for Infectious Disease Prevention and Control, including its the HIV/AIDS Policy, Coordination and Programs Division, conducts national surveillance and research on the epidemiology and laboratory science related to HIV/AIDS, sexually transmitted disease and tuberculosis and develops recommendations for their control. The CSHA is co-ordinated through the Centre.
- The departmental Program Evaluation Division is responsible for assessing program effectiveness.
- The First Nations and Inuit Health Branch provides HIV/AIDS education and prevention programming and related health care services to First Nations and Inuit communities. The Branch also commits $2.5 million in non-CSHA moneys to meet the needs of First Nations people living on reserves and Inuit people living in Inuit communities.
- The regional offices of Health Canada provide a focus for co-ordination and input across the country.
- The International Affairs Directorate in the Department's Policy Branch, implements the international collaboration component of the CSHA, focusing on increasing the effectiveness of existing collaboration among voluntary organizations, the private sector, and federal government departments.

The other federal government partners in the CSHA are the Canadian Institutes of Health Research and Correctional Service Canada:

- The Canadian Institutes of Health Research (CIHR) is Canada's major federal funding agency for health research and administers most of the research funds for the CSHA. The CIHR supports all aspects of health research, including biomedical, clinical science, health systems and services, and the social, cultural and other factors influencing population health. The CIHR manages most of the CSHA's extramural research program and also provided $4.8 million from its own budget for HIV/AIDS research in 2001-2002.
- Correctional Service Canada, an agency of the Ministry of the Solicitor General, is responsible for the health of inmates in federal correctional facilities and plays an important national leadership role in contributing to the understanding of HIV/AIDS in the correctional environment. Correctional Service Canada invests $3 million annually, over and above the funding provided by the CSHA, in HIV/AIDS programming in federal penitentiaries.

In addition to federal initiatives and funding, provincial and territorial governments provide major financial contributions to delivering HIV/AIDS-related health care services, research and prevention activities. The provinces in particular account for significant, and in some cases rising, expenditures on HIV/AIDS, not least because of the cost of treating and caring for people living with HIV/AIDS.

The Government of Canada has emerged as a strong partner in the global response to the HIV/AIDS epidemic:

- The Canadian International Development Agency (CIDA) identified HIV/AIDS was one of its four social development priorities in September 2000. CIDA funding for HIV/AIDS initiatives is projected to increase incrementally from $23 million in 2000-2001 to $80 million by 2004-2005, for a total five-year investment of $270 million.
- The International Development Research Centre
- In addition, in July 2001 the Government of Canada announced that it would contribute $150 million over four years to the Global Fund to Fight AIDS, Tuberculosis, and Malaria.

National Advisory Committees

At the national level, committees representing a broad range of views and perspectives provide strategic advice and policy directions that influence the CSHA.

The **Ministerial Council on HIV/AIDS** provides advice to the federal Minister of Health on aspects of HIV/AIDS that are national in scope. Its membership reflects a broad range of experience and knowledge and includes five seats designated for Canadians living with HIV/AIDS. The Council has focused on evaluating and monitoring the CSHA, championing current and emerging issues, and offering a vision for the long term. In 2000-2001, the Council helped shape Health Canada's policy recommendations to Citizenship and Immigration Canada on the screening of migrants for HIV and to Correctional Service Canada on the provision of HIV/AIDS prevention, care and support services to inmates in federal prisons. The Council's paper, "Taking Stock: Assessing the Adequacy of the Government of Canada Investment in the Canadian Strategy on HIV/AIDS", released in January 2001, advised on the need for additional public funding for the CSHA. The Council has also brought attention to the need for more community-based research and to the spread of HIV among vulnerable populations, including injection drug users, women and Aboriginal people.

The **Federal/Provincial/Territorial Advisory Committee on AIDS** (FPT AIDS) provides policy advice to the Conference of Deputy Ministers of Health, based on gathering, analyzing and sharing information on emerging issues. FPT AIDS participated in a collaborative effort with four other federal/provincial/territorial committees to examine injection drug use as a health issue. The resulting report provides a framework for multi-level strategies to reduce the harms associated with injection drug use and promotes increased co-ordination and collaboration across jurisdictions and sectors. The Conference of Deputy Ministers subsequently released the report for broader consultation. In addition, FPT AIDS has dealt with a broad range of issues related to Aboriginal people and with legal issues concerning individuals who are unwilling or unable to prevent HIV transmission.

The **International HIV/AIDS Working Group** guides the international collaboration element of the CSHA. Composed of national and international community-based organizations and

various federal government departments, the Working Group advises Health Canada's International Affairs Directorate on relevant collaborative international efforts.

Setting Strategic Direction under the CSHA

Changes in the epidemic and emerging challenges are limiting Canada's ability to sustain gains and make new progress. In October 2000, at the first CSHA direction-setting meeting, more than 125 individuals representing the full range of CSHA multisectoral partners established 10 national strategic directions to guide the CSHA over the next two to three years:

- Mobilize governments at all levels, Aboriginal governments and community leaders to take co-ordinated action on HIV/AIDS.
- In collaboration with Aboriginal people, build a national HIV/AIDS strategy for all Aboriginal people and their chosen communities within the CSHA.
- Build an information strategy to identify, obtain, analyze, validate, communicate and facilitate the use of a broad base of information required to achieve the goals of the CSHA.
- Build public awareness of the impact of the HIV epidemic in Canada and globally; encourage political leadership that advances Canada's response to the epidemic; and mobilize politicians, bureaucrats and community leaders.
- Build a prevention strategy that sets specific goals, is based on principles, develops appropriate strategies, and includes culturally specific programs. This strategy must be co-ordinated nationally, developed collaboratively and implemented locally.
- Build a strategic approach to care, treatment and support to ensure that people living with HIV/AIDS have equal and seamless access to care, treatment and support.
- Renew and sustain pan-Canadian expertise and develop broad-based intersectoral knowledge of HIV/AIDS.
- Engage vulnerable individuals in Canada in an inclusive and empowering way in order to build unique approaches that are flexible, innovative, measurable and accountable.
- Move to a social justice framework that is based on the determinants of health in order to address the vulnerabilities of people living with and at risk of HIV/AIDS.
- Develop a five-year operational/strategic plan for the CSHA that builds SMARTER (specific, measurable, attainable, realistic, time-limited, effective, relevant) objectives for each CSHA component. Develop annual workplans based on these objectives.

A second direction-setting meeting was held in April 2002; the results of that meeting are in the process of being prepared.

Progress to Date

Although the challenges ahead are great, considerable work has been done to address the epidemic. CSHA partners have identified key areas where results in the short term will contribute to achieving the goals of the CSHA. The CSHA's progress in each of these areas and the contribution of Canadian partners to the global challenge are set out below.

- *Shaping a Co-ordinated Canadian Response*. Many organizations are engaged in addressing HIV/AIDS. Co-ordination and collaboration strengthen policy and programming efforts.
- *Building a Pan-Canadian Response to HIV/AIDS*. The CSHA is promoting new partnerships, both within the traditional HIV/AIDS community and with non-traditional stakeholders.
- *Engaging in the Global Response to HIV/AIDS*. Canada is committed to halting the global spread of HIV and to helping developing countries strengthen their response.
- *Strengthening the Canadian Response Through Science*. Research in biomedical, clinical and social sciences is strengthening the future response.
- *Increasing the Use of Reliable Information*. Resources are being developed and disseminated for use by persons living with or at risk of HIV/AIDS and by others involved in the Canadian response.
- *Increasing Capacity Across the HIV/AIDS Spectrum*. The CSHA is strengthening the capacity of individuals and groups to respond to a complex and widespread epidemic that has significant health, socio-economic and human rights implications for society.

How this Report was Prepared

As described earlier and in Annex A, the organization of Canada's health system gives rise to multiple interlocking responsibilities for HIV/AIDS programs and services. As the federal government had lead responsibility for preparing this report, and given the time constraints involved, it was decided to use the CSHA as the focus for the report. As a result, many HIV/AIDS activities and initiatives in other federal departments and agencies, provincial and territorial governments, and non-governmental organizations are not covered here.

The report was compiled by Health Canada's International Affairs Directorate (IAD), which began by asking for input from its CSHA partners and from the Canadian International Development Agency. The following federal departments and agencies responded to the questionnaire and provided other input for the draft report.

- Health Canada, including
  - Centre for Infectious Disease Prevention and Control
  - First Nations and Inuit Health Branch
  - International Affairs Directorate
- Canadian Institutes of Health Research
- Correctional Service Canada
- Canadian International Development Agency

The IAD then circulated a draft report for review and comments by the following partners and collaborators:

- the CSHA partners who had provided input and by CIDA,
- the Federal/Provincial/Territorial Advisory Committee on AIDS, and
- the IAD's International HIV/AIDS Working Group, composed of representatives from five key national non-governmental organizations:
  - Canadian Aids Society
  - Canadian Public Health Association
  - Canadian HIV/AIDS Legal Network
  - Interagency Coalition on AIDS and Development
  - International Council of AIDS Service Organizations

The IAD received feedback from reviewers, incorporated it in the draft report, and again circulated the revised report to CSHA partners for a final review. The report was also reviewed by the federal Department of Foreign Affairs and International Trade.

Responses to the Questionnaire

1. Leadership-Strategy Development (2003 Target)

1.1 Does the country have a multisectoral National Strategic Plan on HIV/AIDS?

Yes. Multisectoral partnerships are fundamental to the Canadian Strategy on HIV/AIDS. At every stage of planning and delivery, the CSHA involves governments, national and regional organizations advocating on behalf of persons living with HIV and AIDS (PHAs), and professional associations representing persons working in care, treatment and support, as well as PHAs.

The April 2002 national direction-setting meeting for the CSHA agreed to develop a five-year strategic and operational plan. Many provinces also have strategies and programs on HIV/AIDS.

Health Canada's First Nations and Inuit Health Branch, along with the Centre for Infectious Disease Prevention and Control, is supporting development of a National Aboriginal Strategy for HIV/AIDS. The strategy, now in its developmental stage, is directed by a working group made up of representatives from Aboriginal organizations involved in HIV/AIDS issues and programming. In the absence of a national Aboriginal strategy until now, the First Nations and Inuit Health Branch is providing support for HIV/AIDS programs in seven regions and one territory. All these regions have regionally based strategies involving collaboration with provinces, Health Canada's Population and Public Health Branch, and other departments. Their strategies will support and be supported by the National Aboriginal Strategy.

1.2 Has HIV/AIDS been integrated into the overall national development plan including poverty-reduction strategies?

Yes. The process of integrating determinants of health, including poverty, is under way through key directions now set for the CSHA. Among these are commitments for mobilizing integrated action on HIV/AIDS and for putting in place a social justice framework to guide the Strategy. This includes the strategic integration of HIV/AIDS into the work of other governmental departments and non-governmental sectors.

1.3 Have national policies/strategies been developed to strengthen health, education and legal systems to support an effective response to HIV/AIDS?

These are in the process of being developed. The goals and the national directions of the CSHA are oriented toward broad sectoral involvement. Examples of activities are as follows:

- The development of a strategic workplan now being undertaken by the Federal/Provincial/ Territorial Advisory Committee on AIDS aimed at improved health policies and strategies.
- Funding to the Council of Ministers of Education of Canada to conduct the Youth, Sexual Health and HIV/AIDS Study to determine the relationship between the determinants of

health, HIV and sexual health. This is potentially a precursor to a national strategy for integrating HIV/AIDS into education systems and programs.
- Funding for operations and policy development to the Canadian HIV/AIDS Legal Network.

Additional support is required for initiatives such as an advocates' manual on HIV/AIDS, human rights education, the reorientation of Canada's drug laws and policies and prison policies from the perspective of harm reduction (including preventing spread of HIV and improving access to care, treatment and support), expanding coverage of medically necessary pharmaceuticals in public health insurance plans, and assessing the health and human rights impacts of international trade laws, especially with respect to HIV.

In the corrections field, Correctional Service Canada has developed a national peer education and counselling program with specific components to address vulnerable populations, specifically Aboriginal and women offenders. This program provides education about HIV transmission, risk factors and prevention messages delivered by peers who have been trained by local experts.

In addition, all inmates entering federal facilities receive the Reception Awareness Program, giving an overview of harm reduction initiatives and of the programs, testing and treatment opportunities available to them. CSC recognizes the varied learning capabilities of offenders and has developed information materials about harm reduction in various formats.

CSC also provides condoms, dental dams, bleach, and methadone as harm reduction tools to decrease the spread of infectious diseases within prison and into the community.

CSC provides voluntary testing with informed consent for HIV, Hepatitis C and sexually transmitted diseases in all federal institutions, accompanied by pre- and post-test counselling, and provides voluntary treatment to all those infected with HIV. All federal offenders have access to a specialist in HIV care and to legal assistance within the system.

1.4 Please note any problems or constraints encountered in developing national strategies on HIV/AIDS and integrating them in multisectoral development national plans.

The increase and prevalence of HIV in vulnerable individuals and populations present vexing policy challenges. HIV/AIDS is just one of the social and health challenges facing those living in environments and with histories that predispose them to infection and illness, for example, homeless persons and injection drug users. Responsibility for addressing broad systemic and historical determinants of health, which cut across multiple jurisdictions and mandates, is fragmented but has been identified as an area for improvement and engagement. Development of a co-ordinated national approach is under way.

Both the CSHA and the National Aboriginal Strategy processes require efforts to engage all key stakeholders. This can be identified as a constraint, as it takes time, effort, and will, especially when resources are limited.

Additional support to develop and implement additional programs would further assist in the development of multisectoral national plans.

2. Prevention

2.1 Has the country established time-bound national targets to achieve the internationally agreed prevention goal to reduce HIV prevalence amongst young people aged 15-24 by 25% by 2005?

Development of these is under way and will inform national strategic planning. All key players have agreed that Canada should adopt a strategic approach to HIV prevention.

2.2 Has the country established national prevention targets for groups that are particularly vulnerable?

No. Although national prevention targets have not been established, the CSHA focuses on those most at risk. The CSHA has recently established the importance of addressing vulnerability. A strategic approach to this is under way.

The First Nations and Inuit Health Branch, working together with Aboriginal peoples, has focused on community-based initiatives. While communities vary in their needs and set different priorities, many communities have youth as a target group for their prevention and promotion activities.

In prison settings, Correctional Service Canada has developed specific prevention messages for particular target populations – specifically Aboriginal populations, injection drug users, and women – in peer education programs.

2.3 Are there prevention programmes in place that address HIV/AIDS in the workplace?

Yes. Canada implemented AIDS-in-the-workplace programs beginning in 1990. This work has subsequently been expanded upon in communities and workplaces. Publications and guidelines on needle-stick injuries are widely available, as are occupational post-exposure prophylactics.

Correctional Service Canada staff are given continuing education on harm reduction, the transmission of infectious diseases, and prevention, including universal precautions. CSC has a policy to provide and pay for post-exposure prophylaxis for any staff member assessed by a physician as having had a significant exposure.

2.4 Please note any problems or constraints encountered in developing prevention programmes and setting targets.

Canada's constitutional division of responsibilities means that target-setting and prevention programs may vary from province to province. Thus, we have the challenge of developing effective mechanisms and increasing the effectiveness of existing mechanisms (e.g., the Federal/Provincial/Territorial Advisory Committee on AIDS), with respect to both policy and directed funding, to ensure that national programs and targets are established.

There are also legal and policy constraints with respect to providing safe injection equipment and sites and methadone treatment in prison.

2.5 Do programmes exist to prevent mother-to-child transmission of HIV?

Yes. Voluntary provincial and territorial HIV testing programs are available for pregnant women; however, the uptake is still not sufficient to prevent some HIV infections in newborn babies. Treatments are available in all provinces and territories to prevent mother-to-child transmission of HIV.

For the First Nations and Inuit Health Branch, lack of long-term resource and program commitments are constraints on setting targets. The lack of surveillance and of resources for surveillance also restricts the setting of targets.

Regional strategies vary for preventing mother-to-child transmission among Aboriginal people. All regions provide awareness/educational programs, and most distribute condoms, with some providing female condoms. One region has a prenatal surveillance project that has received support from the region's First Nations leadership. Some have family support programs that would address this area. However there is no uniform program or strategy across the country specifically for this area. The National Aboriginal Strategy for HIV/AIDS is still in its development phase but offers the potential to highlight this issue.

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

The Federal/Provincial/Territorial Advisory Committee on AIDS has *Guiding Principles for HIV Testing of Women during Pregnancy*, which reinforce the application of the widely supported principles of voluntarism, confidentiality and informed consent in the refinement and development of relevant policy.

3. Care, Support and Treatment (Targets by 2003 and 2005)

3.1 Does the country have a national policy/strategy to address the factors affecting the provision of HIV-related drugs?

Yes. The *Canada Health Act* sets the standard for all provinces and territories to provide all medically necessary physician and hospital services to eligible residents. The direct provision of HIV-related drugs is the responsibility of provinces and territories through their respective drug access policies and programs. While the majority of people living with HIV/AIDS have access to necessary drugs, instances do occur where access is limited. Drug access and cost reimbursement programs sometimes result in drug interruptions. For people living in Canada without legal status, provision of drugs and receipt of health care is tenuous.

As with the other HIV/AIDS program areas, there is no formal national Aboriginal strategy related to the provision of HIV-related drugs at present. The National Aboriginal Strategy now under development has identified this as an area to be addressed. However, existing regional strategies support care and community-based activities for Aboriginal populations. These include Family Support Programs, teen/youth support groups, culturally appropriate counselling, care and support for Inuit, and grief workshops. Unfortunately, most communities hesitate to provide treatment at this time because of lack of capacity in terms of resources and training. Treatment is generally provided through provincial medicare programs, and prescription medication is provided to 'registered Indians' (First Nations people with status under the *Indian Act*) and to Inuit under a program known as the Non-Insured Benefits Program.

All inmates in the federal correctional system have access to HIV/AIDS medication should they choose to commence treatment. Consultation with institutional physicians and HIV/AIDS medical specialists determines the most appropriate treatment.

3.2 Does the country have a national policy/strategy on drugs, intellectual property rights and related practices?

Yes. Canada is a signatory to the Trade Related Aspects of Intellectual Property Agreement and has legislation in place protecting drug patent rights, including those for HIV/AIDS.

The First Nations and Inuit Health Branch has a policy of providing 'registered Indians' and recognized Inuit and Innu with prescription drugs not covered by provincial, territorial or third-party health insurance plans. This includes any HIV/AIDS medication that on the Drug Benefit List approved by the Non-Insured Benefits Program.

3.3 Does the national plan provide for the progressive implementation of comprehensive care strategies?

Yes. Given that many people living with HIV/AIDS who have multiple needs are now challenging the ability of service providers to meet a standard of comprehensiveness, the CSHA recently agreed to develop a strategic approach to comprehensive care. Most provinces and territories have strategies that include an approach to care. Some of these are currently under review, and some jurisdictions are considering a determinants-of-health approach.

The Federal/Provincial/Territorial Advisory Committee on AIDS addresses cross-cutting issues affecting the provision of progressive implementation of comprehensive care.

HIV/AIDS treatment guidelines and modules have been developed using a multidisciplinary and multisectoral approach that included people living with HIV/AIDS. Guidelines have also been established to assist the work of social workers, nurses and physicians.

Correctional Service Canada follows community standards regarding comprehensive care strategies, on the advice of community specialists. Strategies to increase the number of inmates accessing testing and treatment have been developed within CSC national and regional headquarters.

3.4 Does the country have a national policy/strategy to provide psycho-social care for those affected by HIV/AIDS?

Yes. A new strategic approach to care, treatment and support, including psycho-social care, is under way. The goals of the CSHA guide the national approach to addressing socio-economic factors and the impact of the epidemic. This includes psycho-social care.

Considerable work has been completed on best practices in this field. Funding from the federal government and from some provinces and territories is provided to community organizations and to national non-governmental organizations to implement responses that include these activities.

An example is the Canadian Working Group on HIV/AIDS and Rehabilitation, which advises on and funds short-term projects in rehabilitation, disability, income maintenance and work issues.

All federal offenders have access to the services of professional psychologists and psychiatrists. Discharge planning is used to connect the HIV-positive offender to services in the community upon release from jail.

3.5 Please note any problems or constraints encountered in developing policies and plans on care and support.

Delivery of care and support is the responsibility of provinces and territories, with the exception of certain populations, such as First Nations people living on reserves and Inuit people living in Inuit communities, for whom medical and health services are a federal responsibility.

As a result, policies may vary from one jurisdiction to another; the federal government may have influence, but no control. Some people have moved from one part of the country to another to improve their care.

Canada's geography and population distribution sometimes result in a disparity of services for those not close to HIV/AIDS resources. Canada is also struggling with shortages of human resources in some parts of the country, and this has an impact on the delivery of HIV/AIDS services.

For the First Nations and Inuit Health Branch, constraints encountered in developing policies and plans on care and support probably have a lot to do with diversity in geography, culture and capacity. Developing appropriate and relevant policies and plans requires consultation, time and resources. Limited resources area also a general constraint, affecting everything from capacity building and training to operational resources for programming.

4. HIV/AIDS and Human Rights

4.1 Does the country have legislation, regulations and/or other measures in place to eliminate all forms of discrimination against people living with HIV/AIDS?

Yes. Canadian courts have confirmed that HIV seropositivity and AIDS, and suspicion of these conditions, constitute a disability. Human rights legislation exists at the federal level and in each province and territory, protecting, among other things, the rights of people with a disability and imposing a duty on service providers to accommodate their special needs. In addition, the *Canadian Charter of Rights and Freedoms* has been invoked successfully to protect people living with HIV/AIDS in several contexts.

In recognition of First Nations and Inuit rights and their need to develop culturally relevant programs, the First Nations and Inuit Health Branch takes a community-based approach to program development, and most of the HIV/AIDS resources available through the Branch are directed to community-based initiatives. In all regions, collaborative strategies and program development involve voices from the various sectors, including people living with HIV/AIDS.

4.2 Does the country have a national policy/strategy for the promotion and realization of the rights of women who are affected or at-risk of HIV infection?

No. However, the human rights and constitutional provisions cited earlier provide protection from gender discrimination and from adverse-effect discrimination.

The National Aboriginal Strategy for HIV/AIDS will also address gender-specific issues.

4.3 Does the policy/strategy assess dimensions that place women and girls at particular risk of HIV infection?

Specific initiatives to address women and HIV issues have been implemented across Canada, including a national conference on women and HIV and the development of gender specific resources and programs.

The National Aboriginal Strategy for HIV/AIDS will address factors that place women and girls at risk of HIV infection.

Correctional Service Canada is obliged by law to provide programming that is gender-specific and Aboriginal-specific. CSC has developed a draft national strategy to address gender-specific issues around women and infectious diseases, especially HIV. The strategy considers issues such as later diagnosis among women, women as caregivers, sex-trade work, disempowerment, position in society, self-esteem, and abuse.

4.4 Are HIV/AIDS programmes and strategies gender sensitive?

Where gender is seen as a determinant of health, as in the cases of gay men or women, then gender considerations are incorporated. Further, Canada's broad equality laws and policies in place address gender issues.

Correctional Service Canada has developed a gender-sensitive peer counselling program for women and HIV/AIDS. Women offenders are housed in institutions separate from male offenders, and all programs account for gender. For the last seven years, female inmates have been housed in institutions closer to their homes to encourage support from families and keep open links with children. In addition, a gender- and culturally appropriate Aboriginal healing lodge has been established for Aboriginal women.

4.5 Have steps been taken to develop or strengthen monitoring and evaluation mechanisms to track progress in implementation, and in the promotion and protection of human rights of people living with HIV/AIDS?

The Canadian Strategy on HIV/AIDS has a monitoring and evaluation component for all activities, including legal, ethical and human rights commitments and activities.

The human and constitutional rights of all Canadians, described earlier, assert the rights of people living with HIV/AIDS and provide remedies when rights are violated. Further, government and civil society partners agreed in April 2002 on establishing a social justice framework to guide the CSHA, based on the following principles: a rights-based approach, operating across the determinants of health, and integrative approach, and an approach that considers the lens of social inclusion.

Correctional Service Canada has several mechanisms in place to ensure human rights issues are addressed, including the legislation governing its mandate. A unit within CSC deals with human rights issues, and a grievance process is in place for inmates who believe their human rights have been infringed. Due process is followed until there is resolution of the issue. CSC has established

Citizen Advisory Committees with access to all federal institutions to determine that human rights issues are addressed. Inmates have access to a committee any time during their incarceration. In addition, CSC meets regularly with community-based AIDS service organizations to discuss issues identified in the treatment of offenders living with HIV/AIDS. CSC offers human rights seminars for staff on a regular basis.

4.6 Please note any problems or constraints encountered in developing human rights policies.

Those most vulnerable to HIV/AIDS are often also those most socially and economically marginalized, and these groups tend to lack social cohesion, organization, and a credible public voice for the assertion of rights.

5. Reducing Vulnerability (Targets by 2003)

5.1 Does the country have strategies and programmes that address factors that make individuals particularly vulnerable to HIV infection including risky and unsafe sexual behaviour, injection drug use and population movements?

The CSHA focuses on those most at risk. All programs must satisfy this requirement. This includes all determinants of the epidemic. Through the AIDS Community Action Plan (a funding program to support the NGO sector) of the CSHA, and with the support and collaboration of the provinces, territories and AIDS service organizations, the CSHA has supported the development of a community-based response to HIV/AIDS and ensured the inclusion of vulnerable populations in this response.

Strategies to address the causes and effects of addiction are one part of efforts to promote health and prevent illness. In September 2001, federal and provincial Ministers of Health released *Reducing the Harm Associated with Injection Drug Use*, with recommendations on how prevention, outreach, treatment and rehabilitation, research and national leadership can reduce the problems that injection drug use causes for individuals, their families and their communities.

To address risky sexual and injection-drug use behaviours, we are attempting to understand where they occur geographically, the extent to which they occur, and in which population groups they occur. This information will be used to design, guide and evaluate effective prevention programs. To obtain this information, a regular program of standardized data collection has been established; this is the behavioural surveillance component of second-generation surveillance.

Injection Drug Users, Men Who Have Sex with Men, STIs, Youth

The Centre for Infectious Disease Prevention and Control is involved in a wide range of prevention and behavioural and other second-generation surveillance activities. The following are some examples of work under way:

Risk behaviour surveillance among injecting drug users
Plans are under way to establish several sentinel sites across Canada where standardized information on injecting and sexual behaviours of injecting drug users (IDUs) can be collected annually to monitor behaviours and help evaluate prevention programs.

Risk behaviour surveillance among men who have sex with men
A similar program is being developed for this population, establishing goals and mechanisms for collecting baseline and ongoing data on key sexual behaviours as a means of second-generation surveillance.

Since the beginning of the HIV/AIDS crisis, researchers have noted an epidemiological link between HIV/AIDS and other sexually transmitted diseases. With the interrelationship of HIV and STDs becoming more recognized, focusing on STD prevention can be considered a second-generation approach to HIV prevention. Early detection and treatment of sexually transmitted infections (STIs) is an important strategy in HIV prevention.

Enhanced surveillance of Canadian street youth
Through surveillance of sexual risk behaviour, HIV and other STIs in street youth, targeted interventions and harm reduction programs are being developed.

STIs in Aboriginal populations
A plan of action has been developed involving the provinces and territories to address the high rates of STIs in this disadvantaged population.

Aboriginal Peoples

Given their status with respect to a range of determinants of health, Aboriginal people have been identified as a population with greater vulnerability to HIV. In addition, some recent studies have shown that among the injection drug users in urban areas, a large proportion are Aboriginal people. Many Aboriginal people move back and forth from cities to their home communities or to other cities. Risky behaviours such as unsafe sexual practices increase their vulnerability.

As described throughout this report, no one jurisdiction has responsibility for all health programming for all Aboriginal people. Provinces provide health services for Metis and non-status First Nations persons living off reserves and Inuit who live away from their communities. Health Canada provides health promotion for all Canadians, including these groups. The First Nations and Inuit Health Branch mandate is to provide health services and health promotion for First Nations people living on reserves and for Inuit living in their communities.

The jurisdictional situation can be a barrier to reaching vulnerable people among these populations. However, most regional Aboriginal HIV/AIDS strategies are finding ways to address this issue by involving the relevant jurisdictions in their strategy development. The National Aboriginal Strategy will also be identifying the roles and responsibilities of each jurisdiction to ensure gaps and duplication are reduced.

Inmates in Federal Correctional Facilities

Correctional Service Canada provides education to offenders on HIV/AIDS and has a harm-reduction approach to dealing with high-risk behaviour (provision of condoms, dental dams, lubricants, and bleach for cleaning injection-drug paraphernalia). CSC provides methadone to opioid-addicted offenders who can benefit from the methadone program, thus decreasing sharing and injecting behaviours and reducing the transmission of blood-borne pathogens. CSC participates in discharge planning for inmates on any complex medical regime such as methadone or anti-retroviral treatment to ensure there are no breaks in the treatment program. Referrals for support in the community are arranged before release.

5.2 Do existing strategies, policies and programmes recognize the importance of:
(a) The family in reducing vulnerability?
(b) Youth-friendly information, sexual education and counselling services?
(c) Cultural, religious and ethical factors?

Yes. The CSHA, through its policy directions, goals and more recently established national directions, addresses vulnerability and is in the process of translating this into national strategic action. Canada has a long history of community-driven definitions of vulnerability. This has resulted in programs designed specifically by and for members of various ethnic communities, youth and those with families, no matter how defined.

5.2.a The family in reducing vulnerability

Health Canada has worked with government and non-governmental partners to develop family-oriented resources, such as workshops where parents can learn to talk with their children about healthy sexuality, including STI prevention, contraception and healthy relationships.

Programs at Correctional Service Canada are developed with family in mind, knowing that most offenders, upon release, will return to their support structure, whether formal family or not. Offenders are encouraged to maintain family ties during incarceration especially.

5.2.b Youth-friendly information, sexual education and counselling services

Health Canada is one of several partners responsible for producing internet-based sexual education materials. The *Sexual Education Gateway* provides quick and easy access for educators to reliable resources through a catalogue with links to more than 400 educational resources and lesson plans for sexual health education. The information is presented by topic and organized by grade level and resource type. *WebQuests* are guided assignments that introduce students to learning concepts while linking with reliable, factual and responsible Internet sites.

Health Canada published the *Canadian Guidelines for Sexual Health Education* in 1994 to guide individuals, professionals and agencies working in this area; it also offers direction on developing policy and programs. The Guidelines are being updated in 2002.

Health Canada recently consulted with NGO representatives and other experts on future directions in the area of sexual health education. One of the early outcomes of this consultation was a research document that supports the need for sexual education in schools.

5.2.c Cultural, religious and ethical factors

The *Canadian Guidelines for Sexual Health Education* articulate a set of common principles that encompass and respect diversity in society.

The *Sexual Education Gateway* described earlier provides guidance to educators on how to teach sexual health education with sensitivity to and respect for differing cultural and religious backgrounds.

Some research is under way in Canada on the specific HIV issues related to populations from endemic countries.

The First Nations and Inuit Health Branch supports a community-based approach to health programs and services that allows for culturally relevant initiatives. First Nations and Inuit communities value family and youth. Hence community-based programs recognize the importance of family and youth when dealing with health issues such as HIV/AIDS. Community-based HIV/AIDS initiatives include family support groups, youth groups, involvement of youth and elders in broadcasting healthy lifestyle choices, development of youth- and culturally appropriate teaching tools, and peer education.

With respect to the corrections system, offenders are encouraged to maintain ties with a religious community during incarceration. Correctional Service Canada employs Aboriginal elders to provide religious/cultural guidance to Aboriginal offenders. In addition, representatives of religious organizations have access to the institutions through a range of programs. CSC includes a chaplaincy division and employs chaplains serving all institutions.

5.3 Please note any problems or constraints encountered in developing strategies and programmes to reduce vulnerability.

The current challenge is to develop a national approach to issues of vulnerability. The CSHA is now defining this national perspective, although many issues of vulnerability, including homophobia, strategies for Aboriginal peoples, and programs for injection drug users have been addressed.

Constraints encountered in developing strategies and programs to reduce vulnerability among Aboriginal peoples include lack of training and capacity; limited resources; and lack of relevant

research for these populations, including research to look at vulnerable segments within the so-called vulnerable populations, as not all Aboriginal people are necessarily vulnerable.

6. Children Orphaned and Made Vulnerable by HIV/AIDS (Targets by 2003)

6.1 Does the country have a national policy and strategy to provide a supportive social environment for orphans or children infected and affected by HIV/AIDS in order to ensure enrolment in school, access to shelter, nutrition, health and social services?

Yes. All children are entitled to school, shelter, nutrition, health and social services. Discrimination against children with HIV/AIDS appears to have abated, and access to all programs and services appears to be in place.

The federal Department of Indian Affairs and Northern Development and the provinces have responsibility for social services for Aboriginal populations, including the provision of supportive environments for orphaned children irrespective of the reason they are orphaned.

6.2 Please note any problems or constraints encountered in developing a national policy for orphans.

Canada does not appear to have a significant number of orphans as a result of AIDS.

7. Alleviating Social and Economic Impact (Targets by 2003)

7.1 Has the economic and social impact of the HIV/AIDS epidemic in the country been evaluated and multisectoral strategies developed that address the impact at individual, family, community and national level?

Yes. The last assessment of the economic burden of HIV/AIDS was completed in 1997. A new one will be prepared beginning in 2002. This will feed all existing strategies and mechanisms.

However, the economic and social impact of the HIV/AIDS epidemic among First Nations and Inuit specifically has not been evaluated. Constraints include lack of resources, both human and financial.

7.2 Is a national legal and policy framework that protects the rights of people living with and affected by HIV/AIDS in the workplace in place?

Yes. The human and constitutional rights described earlier (question 4.1) apply to the rights of people living with HIV/AIDS in the workplace.

7.3 Please note any problems or constraints encountered with respect to undertaking social and economic analysis and developing a policy framework for AIDS in the workplace.

A national AIDS-in-the-workplace policy has not been seen as necessary. Legislation is already in place to deal with discrimination in the workplace, including discrimination related to HIV/AIDS.

8. Research and Development

8.1 Has there been an increase in national investment in HIV/AIDS related research and development?

Yes. Since the initiation of the CSHA in May 1998 there has been an increase in the national investment in HIV/AIDS-related research. Fostering scientific advancements is a priority under the CSHA, which provides annual funding of $13.15 million for research within Health Canada and for extramural research at universities, hospitals and other research institutions. These funds, along with the additional investments they leverage from other stakeholders, are an integral part of Canada's response to HIV/AIDS. Although the contribution to research from the CSHA has not increased since 1998-99, research investments have increased from national funding sources such as the Canadian Institutes of Health Research and with the creation of new national research funding programs, including the Canada Foundation for Innovation, Genome Canada and Canada Research Chairs. The accompanying table shows total financial commitment to HIV/AIDS research in Canada since the CSHA was established, including national funding programs that operate independently of the CSHA.

Federal HIV/AIDS Research Investment
Commitments as of April 30, 2002 ($ thousands)

	1998-99	1999-00	2000-01	2001-02	2002-03[1]	Total
Biomedical / Clinical Stream[3]	5,300	4,600	4,600	4,600	4,600	23,700
Health Services / Population Health Stream[3]	2,425	2,425	2,425	2,425	2,425	12,125
Canadian HIV Trials Network[3]	3,200	3,200	3,200	3,200	3,200	16,000
Community-Based Research	1,000	1,000	1,000	1,000	1,000	5,000
Aboriginal Research Program	800	800	800	800	800	4,000
Health Canada	1,125	1,125	1,125	1,125	1,125	5,625
CSHA Total	**13,850**	**13,150**	**13,150**	**13,150**	**13,150**	**66,450**
Canadian Institutes of Health Research[2]	896	2,798	3,740	4,800	5,000	17,234
Canada Research Chairs Program	na	Na	400	1,175	1,400	2,975
Canadian Network for Vaccines and Immunotherapeutics[4]	na	Na	1,432	1,378	1,369	4,179
Canada Foundation for Innovation[5]	896	3,655	373	1,927	0	6,851
Grand Total	**15,642**	**19,603**	**18,895**	**22,430**	**20,919**	**97,489**

na = Not applicable.

1. Amounts in 2002-2003 are estimates and are subject to change depending on amounts actually spent by end of fiscal year.
2. The Medical Research Council's commitment (inherited by CIHR) was at least $10 million over 5 years beginning in 1998-99. CIHR's commitment is at least $3.5 million per year for five years beginning in 2001-2002.
3. CSHA funding administered by Canadian Institutes of Health Research.
4. Approximate figures on how much CANVAC is spending on HIV vaccine research (provided by CANVAC).
5. The amounts in this table reflect CFI's contribution to total eligible project costs. On average, the CFI contributes 40%. The institutions secure the remaining 60% from funding partners in the public, private and voluntary sectors. The amounts in each fiscal year reflect the fiscal year in which the award was approved. Amounts do *not* reflect funds disbursed in each fiscal year.

8.2 Have efforts been made to encourage the development of:

(a) National research infrastructure?

(b) Laboratory capacity?

(c) Improved surveillance systems?

(d) Data collection, processing and dissemination?

(e) Training of basic and clinical research, social scientists, health-care providers and technicians?

(f) Human resources?

8.2.a National research infrastructure

Yes. Please see (b), below.

8.2.b Laboratory capacity

Yes. Health Canada's National HIV and Retrovirology Laboratories provide national and international resource and reference services in clinical HIV laboratory sciences for the purpose of improving the health of individuals living with HIV/AIDS. This is accomplished through the provision of national and international quality assurance programs for HIV immunology, serology and viral load testing and as well as through the development, evaluation and transfer of technologies for HIV diagnosis and clinical monitoring to national and international partners.

The National HIV and Retrovirology Laboratories in collaboration with Canadian HIV Strain and Drug Resistance Surveillance Program carry out the molecular analysis of HIV-strain and drug-resistant variants in Canada as well as the development of bioinformatic software required for molecular epidemiological analysis of the HIV epidemic.

The National HIV and Retrovirology Laboratories also provide reference-service testing, expertise and guidance to provincial public health, hospital and blood-screening laboratories as well as to international partners for the correct and timely diagnosis of HIV infections.

The National HIV and Retrovirology Laboratories provide laboratory support for HIV and STD surveillance programs in the estimation of national incidence and prevalence rates.

National stakeholders include the Health Canada's Population and Public Health Branch, provincial public health laboratories, the Canadian HIV Clinical Trials Network, hospitals and academic laboratories. International stakeholders include the World Health Organization, Pan American Health Organization, the U.S. National Institutes of Health, the U.S. Centers for Disease Control and Prevention, UNAIDS, and various national health ministries in developing countries. Funding for National HIV and Retrovirology Laboratory programs is provided in part through the CSHA and the Health Canada Blood Safety Program.

In addition, research infrastructure and laboratory capacity have been developed through the Canada Foundation for Innovation, the Networks of Centres of Excellence, the Canadian HIV Trials Network, and Canadian Institutes of Health Research projects.

The **Canadian Institutes of Health Research** (CIHR) was established in June 2000 with a mandate to create an integrated health-research agenda that reflects the emerging needs of Canadians. CIHR is Canada's premier funding agency for health research. On behalf of the

CSHA, CIHR administers $10.2 million to fund meritorious research grants and research personnel awards across the entire spectrum of HIV/AIDS research, including biomedical, clinical sciences, and health system and services, as well as research into the social, cultural and other factors that affect the health of populations. CIHR will continue to contribute at least an additional $3.5 million per year to HIV/AIDS research until 2006-07. In 2001-02, CIHR committed an additional $4.8 million.

CIHR has several programs that contribute to the development of infrastructure and laboratory capacity, such as operating grants to support research projects by an individual or small group of investigators; equipment/maintenance grants to fund the purchase of specific items or the maintenance of instruments required for ongoing research; and group grants to support teams of three or more investigators undertaking collaborative multidisciplinary health research in Canadian research institutions or communities. In 2001-02, CIHR supported 25 new HIV/AIDS research projects and had a total of 91 ongoing HIV/AIDS research projects. Among the 91 research projects, CIHR funded 77 operating grants, 3 clinical trials, 5 industry partnership grants, 1 project under the regional partnerships program, 1 equipment/maintenance grant, 3 group grants, and 1 tri-national clinical trial.

The CIHR administers funding for the **Canadian HIV Trials Network** (CTN) to conduct scientifically and ethically sound clinical trials. The CTN is a partnership of researchers and research institutes committed to developing treatments, vaccines and a cure for HIV and AIDS.

The **Canada Foundation for Innovation** (CFI) is an independent corporation established by the Government of Canada in 1997. The CFI's goal is to strengthen the capability of Canadian universities, colleges, research hospitals, and other not-for-profit institutions to carry out world-class research and technology development. By investing in research infrastructure projects, the CFI supports research excellence and helps strengthen research training at institutions across Canada. CFI has invested more than $6 million in HIV/AIDS research infrastructure.

Networks of Centres of Excellence are unique partnerships among universities, industry, government and non-governmental organizations aimed at turning Canadian research and entrepreneurial talent into economic and social benefits for all Canadians. An integral part of the federal government's Innovation Strategy, these nation-wide, multidisciplinary and multisectoral research partnerships connect excellent research with industrial know-how and strategic investment.

The **Canadian Network for Vaccines and Immunotherapeutics** (CANVAC) is one of 22 funded Networks of Centres of Excellence. CANVAC is a network of leading Canadian scientists specializing in the fields of immunology, virology and molecular biology. CANVAC's researchers, along with their partners from the private, public and government sectors, are developing vaccines to prevent and treat chronic diseases such as cancer, HIV/AIDS, and hepatitis C. They hope to trigger the body's immune system to protect against these life-threatening diseases.

Genome Canada is the primary funding and information resource relating to genomics in Canada. It is a not-for-profit corporation dedicated to developing and implementing a national strategy in genomics research for the benefit of Canadians. Genome Canada has received $300 million from the federal government to establish five research centres across the country. To date Genome Canada has approved two large-scale research projects related to HIV/AIDS for a total contribution of approximately $10.3 million.

8.2.c Improved surveillance systems

Yes. The Division of HIV/AIDS Epidemiology and Surveillance in at the Centre for Infectious Disease Prevention and Control has an HIV/AIDS Surveillance Unit responsible for publishing semi-annual reports and for conducting specific analyses on the changing aspects of the HIV epidemic. As well, in collaboration with the Centre's Division of Retrovirus Surveillance in the Centre, the HIV/AIDS Surveillance Unit works to improve the quality and completeness of surveillance data. For example:

National HIV/AIDS surveillance meetings
In March 2001 a national surveillance meeting addressed data transfer and quality issues for the national HIV/AIDS surveillance system. The meeting was attended by provincial and territorial representatives and community groups, in addition to staff of the Centre for Infectious Disease Prevention and Control. Issues were identified and working groups were struck to develop solutions and to improve the system.

Collaboration with surveillance experts from other developed countries
The Division of HIV/AIDS Epidemiology and Surveillance participates regularly in meetings and workshops on surveillance with officials from other developed countries, including the Unite States (CDC), United Kingdom (Public Health Laboratory Service), Australia, and a number of European countries. These are good opportunities to share findings and explore ideas for system improvements.

Canadian HIV Strain and Drug Resistance Surveillance Program
This relatively new program collects blood samples from all individuals newly diagnosed with HIV across Canada and analyzes them for HIV strain type and genetic characteristics of primary antiretroviral drug resistance.

8.2.d Data collection, processing and dissemination

The Division of HIV/AIDS Epidemiology and Surveillance provides technical and financial support for targeted studies on HIV epidemiology in areas where there are data gaps not filled by existing surveillance systems or by externally funded academic research projects. Data on HIV in Canada are also synthesized from a variety of sources, analyzed, published in reports and scientific journals, and presented at national and international conferences. For example:

HIV/AIDS Epi Updates
This annual publication comprises a series of 15 short Epi Updates, each of which describes a certain aspect of the HIV epidemic in Canada.

Inventory of HIV incidence and prevalence studies in Canada
This publication lists all studies that report any HIV incidence or prevalence data pertaining to Canada. Concise descriptions of sample size, study methods and data interpretation are included.

Guide to HIV/AIDS epidemiology and surveillance terms
This publication, produced in collaboration with the Canadian AIDS Society, is intended to help community members better understand epidemiology and surveillance terms. As a result, communities will be better able to use epidemiology and surveillance data for programming and policy making and to advise the Division on how to make surveillance data more relevant to their needs.

8.2.e Training of basic and clinical research, social scientists, health-care providers and technicians

Training opportunities have been established through **CIHR Research Personnel Awards**, the CSHA Community-Based Research Capacity-Building Program, and the Aboriginal Capacity-Building Program.

CIHR administers funds for meritorious research personnel awards across the entire spectrum of HIV/AIDS research, including biomedical, clinical sciences, health systems and services, and the social, cultural and other factors that affect the health of populations. To maintain a leadership role, attract bright new people to the field, and advance the science of HIV/AIDS, CIHR invests continuously in research capacity, for example, through research training and salary awards. In 2001-02, 37 HIV/AIDS researchers received training awards from CIHR.

In addition, across Canada, an estimated 210 graduate students and 70 post-doctoral fellows are training as HIV/AIDS researchers through support from CIHR research grants.

Special efforts are also under way to build Canada's capacity for community-based HIV/AIDS research. The **Community-Based Research Capacity-Building Program** and the **Aboriginal Capacity-Building Program for Community-Based Research** are four-year initiatives funded through the CSHA that offer scholarships and other skills-building opportunities. Scholarships are available to graduate students in master's and doctoral programs who conduct community-based research on HIV/AIDS as part of their degree requirements. As of July 2001, a total of six scholarships – four for community-based capacity building and two for Aboriginal research capacity building – had been awarded.

8.2.f Human resources

Health Canada has a study under way to evaluate the state of human resources in the sector. Further work to address problems and deficiencies will be undertaken once study results are clear. Addressing human resource issues is one of the strategic directions of the CSHA.

Human resources for the conduct of HIV/AIDS research in Canada are supported by CIHR salary awards, the Canada Research Chairs program, and support for technicians and research assistants from research grants.

CIHR salary awards are provided to independent investigators who have made outstanding contributions and have demonstrated leadership in their field. In 2001-02, 16 investigators received salary awards from CIHR that allowed them to devote more of their time to HIV/AIDS research projects.

The Government of Canada established the **Canada Research Chairs** Program in 2000. Its key objective is to enable Canadian universities, together with their affiliated research institutes and hospitals, to achieve the highest levels of research excellence, to become world-class research centres in the global knowledge-based economy. The secondary objectives of the Program are to:

- strengthen research excellence in Canada and increase Canada's research capacity by attracting and retaining excellent researchers in Canadian universities;
- strengthen the training of highly qualified personnel through research;
- improve universities' capacity to generate and apply new knowledge; and
- optimize the use of research resources through institutional strategic planning and inter-institutional and intersectoral collaboration.

Eight HIV/AIDS researchers are supported by the Canada Research Chairs program at present.

8.3 What measures have been taken to ensure that research protocols for the investigation of HIV-related treatment are ethical and includes antiretroviral therapies and vaccines are evaluated by independent committees of ethics?

In signing an application to the Canadian Institutes of Health Research, applicants and administrators give an undertaking that any research carried out with funds from CIHR will respect all CIHR requirements for the ethical conduct of research as expressed in policy documents.

In general, the following policy statements place primary responsibility on researchers and require the institutions in which research is conducted to have in place the monitoring and review committees defined in the guidelines. CIHR reserves the right to deny or withdraw funding if the investigator or the institution does not comply with the following guidelines.

(a) Research involving human beings
Any research involving human subjects must be approved by the appropriate local review committee, established and operating in accordance with the relevant CIHR statements of policy

– including the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* and CIHR's recently released guidelines for stem cell research, *Human Pluripotent Stem Cell Research: Guidelines for CIHR-Funded Research* – before research begins. The institution is responsible for withholding CIHR funds from the researcher(s) until the required approvals have been given.

(b) Research involving animals
Any research involving animals must be approved by the appropriate local review committee, established and operating in accordance with the relevant *Care and Use of Experimental Animals* and *Canadian Council of Animal Care* statements of policy before the research is started. The institution is responsible for withholding CIHR funds from the researcher(s) until the required approvals have been given.

8.4 Please note any problems or constraints in increasing investments in research.

The total budget for the CSHA has not increased since it was launched in 1998. Conflicting demands on the budget have not allowed research funding from the CSHA budget to increase.

9. HIV/AIDS in Conflict and Disaster Affected Regions

9.1 Does the country have a national policy/strategy that incorporate HIV/AIDS prevention, care and treatment into programmes that respond to emergency situations?

No. However the CSHA has mechanisms to identify new and emerging issues and the capacity to respond in any emergencies. The Federal/Provincial/Territorial Advisory Committee on AIDS and the Ministerial Council on HIV/AIDS have a mandate to identify issues of concern, including any emergency situations. The Centre for Infectious Disease Prevention and Control would identify emergencies and develop a plan of response.

9.2 Please note any problems or constraints encountered in increasing investments in research.

None noted.

10. Resources

10.1 Have national budgetary allocations for HIV/AIDS programmes been increased and adequate allocations, including a line budget for HIV/AIDS, made by all ministries and other relevant stakeholders*?*

Absolute figures for HIV/AIDS spending from all departments, agencies and relevant stakeholders are not available for this report. Nor does this report include expenditures by provincial or territorial governments.

Some federal departments and agencies, such as the Canadian International Development Agency, the International Development Research Centre, and the Canadian Institutes of Health Research, have increased funding for HIV/AIDS.

The budget for the CSHA has remained constant for 10 years.

Some provinces have increased expenditures for HIV/AIDS over the last 10 years, especially in response to increased prevalence, while other provinces have not made specific budget allocations for HIV/AIDS.

The international collaboration component of the CSHA includes a commitment to develop new strategies to ensure the appropriation of increased resources for HIV/AIDS globally. Much of this work is done through a multisectoral working group coordinated through Health Canada's International Affairs Directorate (IAD).

The IAD conducted a survey of Canadian government departments/agencies, non-governmental organizations and universities to determine the level of Canada's involvement in the global response to the HIV/AIDS pandemic. The results indicated that Canadian organizations are actively involved in numerous HIV/AIDS projects throughout the world. These projects covered a wide range of issues, including prevention, policy development, counselling, training, epidemiology, evaluation, research and comprehensive care, among others. The research showed that the international involvement of Canadian organizations and agencies has led to a strengthening of the domestic response to HIV/AIDS. Thus collaboration between the IAD and non-governmental organizations on projects to promote and facilitate international action in HIV/AIDS has the corollary effect of increasing application of resources to HIV/AIDS domestically.

10.2 For donor countries: Have steps been taken towards meeting the agreed international target of 0.7% of Gross National Product as Official Development Assistance?

Yes. Canada remains committed to reaching the 0.7% of GNP target. In the most recent federal budget (December 2001), international assistance was increased by $1 billion over three years. Canada's Prime Minister announced in Monterrey, that Canadian international assistance will increase by at least 8% per year in the years to come, which should result in doubling our current aid performance in eight or nine years. This demonstrates Canada's commitment to increasing our Official Development Assistance budget as our fiscal situation permits. Canada has also committed to quadrupling Official Development Assistance spending on HIV/AIDS between 2000 and 2005, from $20 million to $80 million per year.

10.3 For donor countries: Have steps been taken towards meeting the target of 0.15 - 0.20% of Gross National Product as Official Development Assistance for least developed countries?

Yes. Through Official Development Assistance, Canada is committed to working with the poorest of the poor by focusing on four social development priorities: health and nutrition; HIV/AIDS; basic education; and child protection. Canada is increasing its international assistance to Africa. The December 2001 budget provided an additional $500 million in international assistance toward the G8's response to Africa's plan to lift itself out of poverty; this will be a main focus of discussion at the G8 Summit in Canada in June 2002. Canada is also working to mainstream the four social development priorities in all international assistance efforts in Africa.

11. Follow-up

11.1 Have national mechanisms for follow-up been established, such as scheduling of national reviews and establishing monitoring systems?

Yes. A national direction-setting and work-planning process involving multisectoral partners has been established for the CSHA. As well, the CSHA has a clear monitoring and accountability process with an evaluation cycle. Planning for implementation of the strategy is undertaken by all multisectoral partners, consumers and professions.

The First Nations and Inuit Health Branch does not have its own national review but is included in the CSHA's national review. However, all community projects provide reports and workplans to their respective regions. The regions in turn submit their reports to the national office.

The Canadian Institutes of Health Research, led by the Institute of Infection and Immunity, is developing a research priority-setting mechanism that will include CIHR, Health Canada, HIV researchers and other stakeholders. This mechanism will monitor current research priorities for HIV/AIDS research and will develop strategic initiatives to respond to these priorities.

12. Recommendations

12.1 Please make recommendations on actions needed to make rapid progress in implementing the UNGASS Declaration of Commitment on HIV/AIDS.

- Produce a report outlining the status of countries' responses to the foregoing questions to enable inter-country communication on policy and program development and implementation.

- Develop an evaluation model that could be used to enhance national action and the ability of countries to provide data.

- As the country reports are not confidential, ask UNAIDS post all country reports in a dedicated section of its website. This would give all countries access to relevant detail that

cannot be included in the Secretary General's overall report and would serve to encourage us all in our efforts to bring about change and to report on them comprehensively.

- Consider producing country reports in a way that allows countries to share not only basic information about their HIV/AIDS initiatives and activities but also to share best practices and experiences with various approaches.

- Where the Declaration of Commitment has established target dates, consider asking countries to submit information in a form that would allow assessments of whether countries were meeting targets within established timeframes.

Annex A
A Note on Canada's Health Care System

A brief overview of Canada's health care system may be helpful in understanding Canada's domestic response to HIV/AIDS. For the most part the system is a publicly financed and privately delivered system that is best described as an interlocking set of ten provincial and three territorial health insurance plans. Known to Canadians as Medicare, the system provides access to universal coverage for medically necessary hospital, in-patient and out-patient physician services.

This structure results from the constitutional assignment of jurisdiction over most aspects of health care, including management and delivery of health services, to the provincial order of government. The system is referred to as a 'national' health insurance system in that all provincial and territorial hospital and medical insurance plans are linked through adherence to national principles set at the federal level.

Like other health care, programs and services related to HIV/AIDS care and treatment are managed and delivered within each jurisdiction as appropriate under this constitutional division of responsibilities.

Provinces and territories plan, finance and evaluate the provision of hospital care, physician and allied health-care services, some aspects of prescription drug care and public health.

The federal government's role involves setting and administering national principles or standards for the health care system; assisting in the financing of provincial health care services through fiscal transfers; and fulfilling functions for which it is constitutionally responsible, such as providing direct health service delivery to specific groups, including veterans, First Nations people living on reserves, and Inuit living in Inuit communities.

Health Canada is the federal department responsible for helping the people of Canada maintain and improve their health. The department is also active in health protection, disease prevention and health promotion. In partnership with provincial and territorial governments, non-governmental organizations and health stakeholders, Health Canada provides national leadership to develop health policy, promote disease prevention, reduce health and safety risks, and enhance healthy living for all Canadians. Actions in these areas include HIV prevention programs such as HIV testing and counselling, needle-exchange programs, promotion of condom use, and programs aimed at reducing vulnerability to HIV.

There is important interplay between the health services delivery system and the health promotion and protection functions; both are supported at the national, provincial, territorial and local level.