Health Canada Santé Canada

Record of Proceedings

Canadian Strategy on HIV/AIDS Direction-Setting Follow-up Meeting

April 14 – 16, 2002

Canadian Strategy on HIV/AIDS
La Stratégie canadienne sur le VIH/sida

Canada

Our mission is to help the people of Canada
maintain and improve their health.

Health Canada

Additional copies of this document are available from

Canadian HIV/AIDS Clearinghouse
400 – 1565 Carling Avenue
Ottawa, Ontario
K1Z 8R1

Tel.: (613) 725-3424
Fax: (613) 725-1205
E-mail: aidssida@cpha.ca

This publication can be made available in/on computer diskette/
large print/audio cassette/braille, upon request.

Cat. N° H39-592/2002E
ISBN 0-662-32684-9

Record of Proceedings

Canadian Strategy on HIV/AIDS
Direction-Setting Follow-up Meeting

April 14-16, 2002

Montréal, Quebec

Canadian Strategy on HIV/AIDS
La Stratégie canadienne sur le VIH/sida

Disclaimer

This record of proceedings is based on presentations made at the Direction-Setting Follow-up Meeting. The opinions expressed are those of the people who made the presentations and do not necessarily reflect the views or policies of other participants, the organizers of the meeting, Health Canada, or the Minister of Health.

Table of Contents

Canadian Strategy on HIV/AIDS
Direction-Setting Follow-up Meeting

April 14-16, 2002
Montréal, Quebec

Executive Summary

Executive Summary

Since its inception in 1998, the Canadian Strategy on HIV/AIDS (CSHA) has been building a pan-Canadian response to HIV/AIDS through numerous consultative mechanisms, including a collaborative planning and direction-setting process for the CSHA.

The First CSHA Direction-Setting Meeting (Gray Rocks)

The collaborative planning and direction-setting process was launched in the fall of 2000 with the first CSHA Direction-Setting Meeting, held at Gray Rocks Inn, Quebec. The meeting identified 10 broad, long-term directions for the CSHA:

1. Mobilize integrated action on HIV/AIDS globally and in Canada
2. Build unique approaches for Aboriginal peoples within the CSHA
3. Build a broad information strategy
4. Get public commitment, political leadership, and funding
5. Build a strategic approach to prevention
6. Build a strategic approach to care, treatment, and support
7. Renew and develop human resources
8. Engage vulnerable Canadians
9. Move to a social justice framework
10. Develop a five-year operational/strategic plan

The Direction-Setting Follow-up Meeting (Montréal)

In April 2002, Health Canada convened a meeting in Montréal to continue the work begun at the Gray Rocks meeting. The objectives of the Montréal meeting were to

- update CSHA partners on recent developments and ensure that there is a common understanding of HIV/AIDS and of the Canadian and international responses;

- further the implementation of the 10 directions established at Gray Rocks in 2000; and
- enhance and sustain the national capacity for planning and action under the CSHA.

The expected outcomes of the Montréal meeting were as follows:

- a current environmental scan of Canada's response to the HIV/AIDS epidemic, incorporating information introduced at the meeting by participants from many sectors;
- identification of actions that would advance the implementation of the 10 directions; and
- time lines for the actions, to be used to promote and evaluate their implementation.

The Process

The Montréal meeting began with an environmental scan, which set the stage for the meeting and gave participants the necessary tools to move the CSHA forward. After the environmental scan, the meeting broke into small groups to develop actions that would make the 10 directions identified at the Gray Rocks meeting a reality. The proposed actions were presented in a plenary session and then developed further in a second small group session. The meeting concluded with a forum in which a plan was presented for each action, setting out the components of the action, a time line, the lead, and expected outcomes. If participants chose to, they could offer suggestions about the action plans and indicate their interest in participating in them.

The Action Plans

The following action plans were presented (listed according to the 10 directions):

1. *Mobilize integrated action on HIV/AIDS globally and in Canada*

   Action #1: Broad-Based, Issue-Specific Coalitions

   Action #2: Federal Interdepartmental Committee on HIV/AIDS

2. *Build unique approaches for Aboriginal peoples within the CSHA*

   Action #1: Study of Aboriginal Health Determinants and HIV/AIDS as a Goal of the Aboriginal Strategy on HIV/AIDS in Canada

Action #2: Build Social Capital in Aboriginal Communities as It Relates to HIV/AIDS

Action #3: Coordinated Aboriginal-Specific HIV Research Processes

3. *Build a broad information strategy*

Action #1: Develop a Dynamic Information Process

4. *Get public commitment, political leadership, and funding*

Action #1: Broad-Based Communications Strategy to Engage Public Commitment

Action #2: Engage Political Leadership Across Government

Action #3: Increase Funding for HIV/AIDS Programs

5. *Build a strategic approach to prevention*

Action #1: Develop a Flexible, Coordinated, and Measurable Prevention Strategy

Action #2: Summit on HIV/AIDS Prevention

6. *Build a strategic approach to care, treatment, and support*

Action #1: Post-Approval Surveillance System and Treatment Information Providers

Action #2: Model for Holistic Approach to Care, Treatment, and Support

7. *Renew and develop human resources*

Action #1: CSHA Multidisciplinary Human Resources Task Force

Action #2: Canadian HIV/AIDS Directory

8. *Engage vulnerable Canadians*

Action #1: Engaging Vulnerable Canadians

9. *Move to a social justice framework*

    Action #1: Develop Social Justice Values and Principles

    Action #2: Advocate a National Housing Policy/Strategy

    Action #3: Capacity Building

10. *Develop a five-year operational/strategic plan*

    Action #1: Develop a Five-Year Operational/Strategic Plan

Details of the action plans, along with comments and expressions of interest from the participants, are presented in Part Two of the Record of Proceedings.

Next Steps

Health Canada will work with the CSHA Direction-Setting Process Task Group to follow up on the outcomes of the Montréal meeting. Between May and September 2002, they will

- produce a record of proceedings of the Montréal meeting;
- convene teleconference meetings on Directions 1 to 9 to review the proposed actions and plan next steps (each teleconference will include the participants in the small group who worked on the direction, as well as individuals who expressed an interest in the actions proposed for that direction);
- convene a working group to design a process for Direction #10;
- provide regular updates on the follow-up activities.

Further steps toward implementing the proposed actions of the Montréal meeting will emerge from the meetings convened for each of the directions. The CSHA Direction-Setting Process Task Group will be active in this ongoing work as part of its role in monitoring the follow-up to the Montréal meeting.

Canadian Strategy on HIV/AIDS
Direction-Setting Follow-up Meeting

April 14-16, 2002
Montréal, Quebec

Part One: Summary of the Meeting

1 Building a Pan-Canadian Response to HIV/AIDS

The Canadian Strategy on HIV/AIDS (CSHA), launched in 1998, introduced a new era in Canada's response to HIV/AIDS. Not only does the CSHA receive permanent funding for an ongoing, coordinated response to HIV/AIDS, it also involves people with HIV/AIDS and their communities, community-based and multisectoral organizations, governments, and other stakeholders as full partners in the development of the response—a pan-Canadian response—to HIV/AIDS.

Building this pan-Canadian response is an ongoing process that began with the consultations that led to the establishment of the CSHA. It continues through the mechanisms put in place to provide advice to governments on HIV/AIDS, such as the Ministerial Council on HIV/AIDS, the Federal/Provincial/Territorial Advisory Committee on AIDS, the National Aboriginal Council on HIV/AIDS, and similar bodies.

The First CSHA Direction-Setting Meeting

A major step in the process of building the CSHA was taken when Health Canada convened the first CSHA Direction-Setting Meeting, known as the Gray Rocks meeting, in the fall of 2000. The meeting was attended by 125 people representing the full range of partners in the CSHA.

The purpose of the meeting was to launch a collaborative planning and direction-setting process for the CSHA and to identify broad strategic directions to guide it. Ten broad, long-term directions were identified:

1. Mobilize integrated action on HIV/AIDS globally and in Canada
2. Build unique approaches for Aboriginal peoples within the CSHA
3. Build a broad information strategy
4. Get public commitment, political leadership, and funding

Goals of the CSHA

- **prevent the spread of HIV infection in Canada;**
- **find a cure;**
- **find and provide effective vaccines, drugs and therapies;**
- **ensure care, treatment and support for Canadians living with HIV/AIDS, and their families, friends and caregivers;**
- **minimize the adverse impact of HIV/AIDS on individuals and communities;**
- **minimize the impact of social and economic factors that increase individual and collective risk for HIV.**

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

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

5. Build a strategic approach to prevention
6. Build a strategic approach to care, treatment, and support
7. Renew and develop human resources
8. Engage vulnerable Canadians
9. Move to a social justice framework
10. Develop a five-year operational/strategic plan

The CSHA Direction-Setting Follow-up Meeting

The CSHA Direction-Setting Follow-up Meeting, convened by Health Canada in Montréal in April 2002, continued the work begun at the Gray Rocks meeting. It is yet another step in building a collaborative and coordinated response to HIV/AIDS in Canada and will provide direction, along with other consultative processes, for the ongoing development of the CSHA.

The objectives of the Montréal meeting were to

- update CSHA partners on recent developments and ensure that there is a common understanding of HIV/AIDS and the Canadian and international responses;
- further the implementation of the 10 directions established at Gray Rocks in 2000; and
- enhance and sustain the national capacity for planning and action under the CSHA.

The expected outcomes of the Montréal meeting were

- a current environmental scan of Canada's response to the HIV/AIDS epidemic, incorporating information introduced at the meeting by participants from many sectors;
- identification of actions that would advance the implementation of the 10 directions; and
- time lines for the actions, to promote and evaluate their implementation.

The meeting was guided by the CSHA Direction-Setting Process Task Group, comprising representatives from a broad range of governmental and non-governmental partners (see Appendix A) and organized by staff at Health Canada.

2 Environmental Scan

The environmental scan set the stage for the meeting and gave participants the necessary tools to move the CSHA forward. It consisted of four parts. A printed report, *From Direction to Action*, prepared by Glen Brown & Associates Consulting,[1] was distributed to all participants before the meeting. Dr. Michael Rachlis, an independent consultant in policy analysis, epidemiology and program evaluation, addressed the plenary meeting on the subject of "Saving Medicare." Six panellists presented current information on aspects of the HIV/AIDS epidemic and Canada's response: trends in the epidemic in Canada, the view from the community, issues for people with HIV/AIDS, a researcher's perspective, collaborating on the Aboriginal HIV/AIDS Strategy, and collaborating on international issues. The environmental scan was rounded out by responses from participants, who identified gaps, brought new information, and added context to the discussion.

From Direction to Action

The report prepared by Glen Brown & Associates, *From Direction to Action*, highlighted the following key points about Canada's response to the HIV/AIDS epidemic:

- *The HIV/AIDS epidemic is wider and deeper than ever*. The scope—that is, the people and communities affected—and the complexity—that is, the issues—continue to expand.

- *Preventing new HIV infections continues to be a major challenge*. There has been a resurgence of sexual transmission among gay men. There is continuing vulnerability among Aboriginal people, injection drug users, and women. There is increased awareness of vulnerability among gay youth, women of Caribbean and African descent, and Aboriginal women.

- *HIV treatment is a mixed blessing*. Although many people with HIV/AIDS continue to benefit from advances in treatment, they face health, economic, social, and personal disadvantages related to their HIV status. In addition, they are facing new health crises from the side effects and toxic effects of anti-HIV drugs and from the consequences when these drugs fail.

- *The complexity of issues facing people with HIV/AIDS has grown*. People with HIV/AIDS battle issues of poverty, homelessness, mental health problems, and other conditions that challenge their health. At the same time, the health, social

1 Glen Brown & Associates Consulting. *From Direction to Action: Environmental Scan Report for the Montreal Direction-Setting Follow-Up Meeting on the Canadian Strategy on HIV/AIDS*. March 2002.

service and economic supports available to them have been eroded by government cutbacks.

- *There is a continuing need for research on a broad range of topics and disciplines*. Although the Canadian HIV/AIDS research community has grown stronger, it is hard to keep up with the scope and complexity of the epidemic.

- *There has been failure in "healthy public policy." Policy is not addressing the determinants of health: inadequate housing, poverty, decline in education, erosion in health care, barriers to access to treatment.*

- *There is a renewed emphasis on integrated health promotion*. Gay men and Aboriginal people are placing HIV health promotion within the wider context of health promotion for their communities. HIV health promotion is being approached as a continuum that includes prevention, care, treatment, support, and community development.

- *There is a significant surge in interest and activity in international HIV/AIDS issues*. There is increasing recognition of the global nature of the HIV/AIDS epidemic and the need for a global response.

- *There is considerable evidence of the willingness of partners in the CSHA to collaborate*. This is evident both in expressed desires and in recent or planned collaborative activities.

- *The Gray Rocks meeting showed great promise, but follow-through has been disappointing*. Although there has been progress on a few of the directions—the Aboriginal Strategy on HIV/AIDS in Canada, international collaboration—in most areas work is still in draft form and preliminary.

- *The funding of the CSHA is not at all sufficient for the tasks*. Organizations are struggling with greater and more complex demands while the funding of the CSHA has not increased. Lack of funding is a major barrier to making progress on the goals of the CSHA and the directions from the Gray Rocks meeting.

Response from participants

Participants drew attention to other gaps in the CSHA that were not addressed in the environmental scan report.

- The scan does not clearly and forcefully condemn the failure to provide needle exchanges in prisons and safe injecting facilities in the community. This is tantamount to genocide of Aboriginal peoples and injection drug users.

- The global dimension of the HIV/AIDS epidemic and Canada's response are part of the CSHA. For countries where HIV/AIDS is endemic, the epidemic is a crisis of enormous proportions. Canada must increase its advocacy of a global response to

the epidemic and must increase its funding for the international component of the CSHA.

- The CSHA does not have a specific strategy for working with people of Caribbean and African descent. It needs to develop a specific initiative for this population, such as the Endemic Task Force in Ontario.

- In addition to the Aboriginal Strategy on HIV/AIDS in Canada, there are Aboriginal HIV/AIDS strategies developed by Aboriginal leaders (such as the Inuit HIV/AIDS Plan of Action prepared by the Canadian Inuit HIV/AIDS Network) and by provincial/territorial governments. There should be coordination between these strategies and the CSHA.

- In relation to the trend to set the response to HIV/AIDS within a broader sexual health strategy or health promotion strategy, it would be helpful to have information about best practices in dealing with mental health problems and HIV/AIDS, or with sexually transmitted diseases and HIV/AIDS.

- Only one of 30 people consulted in the environmental scan was Aboriginal. None of the people consulted in the environmental scan had hemophilia.

Saving Medicare

The future of health care is one of the top political issues in Canada. It is the subject of no less than seven commissions and reports. Governments are facing—and making—decisions about how health care should be organized, where and how services should be delivered, and what services should be insured. These decisions will have an impact on the care of people with HIV/AIDS.

Dr. Michael Rachlis offered his assessment of health care in Canada—where we have been, what our challenges are, and where we need to go:

- *Medicare has sheltered Canadians well, but it needs remodelling*. Medicare has reduced administrative overheads for health care, enhanced equity of access to health care, and enhanced Canada's business competitiveness.

- *Money isn't the main issue*. We are spending neither too much nor too little. We should not be spending our next dollar on health care; we should be spending it to address the determinants of health. But funding for health care has been erratic; we need stable funding.

- *The health care system is out of date*. It was designed to address infectious diseases, acute illnesses, and accidents and injuries. But now most illnesses are chronic—heart disease, diabetes, HIV—and these are poorly handled.
  - Too many patients who do not need to be there are in hospital beds and emergency rooms. They need some care, but not hospital care.
  - Too many patients with chronic illnesses develop complications that could have been prevented with better community care.
  - Too many people develop illnesses that could have been prevented either through public health measures or by having their condition attended to at an early stage by the health care system.
  - The quality of health care is uneven, and too often patients face long, unnecessary delays for care.
- *Through innovation we can redesign the health care system to address current and future needs*.
  - Edmonton's palliative care program, if implemented across Canada, would free up 1,800 acute care beds.
  - Sault Ste. Marie Group Health Centre reduced the number of hospital readmissions after congestive heart failure from 25% to 10% in 6 months.
  - Calgary, Edmonton, and Saskatoon have comprehensive influenza prevention programs that helped prevent gridlock in their hospitals in 2000.
  - Sault Ste. Marie reduced the median time from mammography to breast cancer surgery from 108 days to 17 days by planning in advance for services.
  - The high cost of pharmaceuticals can be managed by using non-drug therapies for some conditions, improving prescribing practices with doctors and pharmacists working in teams, and purchasing drugs in bulk.

If there is a crisis in the country, it is in public health. We are one epidemic away from meltdown.

"The real problem is how do we reorganize the health delivery system. We have a health delivery system that is lamentably out of date." – Tommy Douglas (1982)

Between 70% and 80% of Canadians with high blood pressure, and more than 60% of those with diabetes, do not have their condition properly controlled.

Over 8% of coronary heart disease and adult-onset diabetes could be prevented with diet, exercise, and stress management.

- *Private financing and for-profit health care are not the solution*.
  - "For decades, studies have shown that for-profit hospitals are 3 to 11 percent more expensive than not-for-profit hospitals; no peer-reviewed study has found that for-profit hospitals are less expensive."[2]
  - "Schemes [to use private money to pay for health infrastructure development] produce more problems than solutions, partly for the simple reason that private capital is always more expensive than public capital."[3]
- *We need to address the barriers to health care reform*.
  - One of the barriers is the discrepancy between a federal government with a surplus but without direct responsibility for health care and provincial/ territorial governments worried about deficits and able to squander federal transfers if they are not targeted by the federal government.
  - There is a conflict in values between the people of Canada (who support medicare) and elites in Canada (who are questioning it).
  - Providers in the health care delivery system may be resistant to working differently.
  - Consumers are disorganized and weak.
- *What can the HIV/AIDS community do to help save medicare*?
  - Work with like-minded groups to influence Mr. Romanow's report.
  - Continue provincial advocacy of a reformed public health care system.
  - Educate the public, media and decision makers about the tremendous benefits of a reformed medicare.

2 S Woolhandler and DU Himmelstein. When Money is the Mission – The High Costs of Investor-Owned Care. *New England Journal of Medicine* 1999; 341(6).

3 R Smith. PFI: perfidious financial idiocy. *British Medical Journal* 1999; 319(7201): 2-3.

Trends in the Epidemic in Canada

Dr. Chris Archibald summarized the current data on HIV and AIDS in Canada.[4] In brief, there is evidence of a resurgence of infections among gay men in at least some cities in Canada, and the number of infections among injection drug users remains high. There have been increases in infections among Aboriginal people, people from countries in which HIV is endemic, and women.

- At the end of 1999, an estimated 49,800 people in Canada were living with HIV and AIDS.
- There were an estimated 4,190 new infections in 1999 (essentially unchanged from the estimate of 4,200 new infections in 1996).
- The largest number of HIV infections is among men who have sex with men. They accounted for an estimated 59% of people with HIV in Canada in 1999. The rate of infection has increased in recent years, rising from an estimated 30% of new infections in 1996 to an estimated 38% of new infections in 1999. HIV incidence in a Vancouver cohort of men who have sex with men was 3.7% in 2000, up from less than 2% in earlier years.
- Injection drug users accounted for an estimated 20% of people with HIV in Canada in 1999, and an estimated 34% of new infections in that year. HIV incidence in a Vancouver cohort of injection drug users is about 2% to 3%, with rates significantly higher among women than men.
- Aboriginal people account for about 9% of new infections but only 2.8% of Canada's population.
- People from countries in which HIV is endemic are making up an increasing percentage of AIDS cases in Canada (from 5.5% in 1995 to 15.3% in 2001). In Ontario, the estimated prevalence of HIV in this group is 0.5% to 0.9%.
- The proportion of new infections among women has risen steadily over the last two decades. Women now account for 45% of new infections diagnosed in people aged 15 to 29 years.

There is much that we would like to know but do not. For the year 2001, nearly all reports of new HIV diagnoses included information on age and gender, but only 54% had information on exposure category, 31% had information on ethnic background, and most had no information on geographic region. Staff from the Centre for Infectious Disease

4 C Archibald and J Geduld. Trends in HIV/AIDS in Canada. Division of HIV/AIDS Epidemiology and Surveillance, Centre for Infectious Disease Prevention and Control, Health Canada. April 2002.

Prevention and Control are working with provincial/territorial health authorities to improve data quality in routine HIV surveillance and are using sentinel studies and other sources of information (including community networks) to monitor determinants and indicators of HIV infection in vulnerable populations.

Response from participants

Participants noted that categories and statistics can obscure important realities in the epidemic. We need to know exactly *who* is vulnerable to HIV infection, *why* they are vulnerable, and *what* to do to prevent HIV infection among them.

- Among the people with HIV classified as being from endemic countries are many women of Caribbean and African descent. The Centre for Infectious Disease Prevention and Control must work with this population to gather more complete data about them and delineate their determinants of health–including gender roles and racial discrimination. It would be helpful to have a regular *Epi Update* on this population. The Centre should also develop plans for targeted HIV studies in this population.

- Gender as a determinant of health is obscured by gender-neutral categories, such as "heterosexual," "Aboriginal," or "injection drug user." For example, among heterosexual people with HIV, there are many women who were infected by their male partners. We need categories such as "heterosexual women," "Aboriginal women," "women who inject drugs." We need research on gender as a determinant of health in the HIV/AIDS epidemic.

- Socioeconomic determinants of health are not addressed through categories based on gender, ethnicity, or behaviour, such as "heterosexual," "Aboriginal," or "injection drug user." For example, lack of housing among injection drug users increases their vulnerability to HIV, and lack of subsidized housing for people with HIV means that they will go without adequate food or even become homeless, which in turn will affect their health. We need research on the socioeconomic determinants of health in the HIV/AIDS epidemic.

- The high prevalence of HIV among injection drug users in certain locales is obscured by overall national statistics on the proportion of people with HIV who are injection drug users. In some cities in Canada the prevalence of HIV among injection drug users is over 20%.

- Men who have sex with men—mostly (but not exclusively) gay men—accounted for an estimated 38% of new infections in 1999, although gay men make up only 5% of Canada's population. There appears to be a reluctance to recognize the impact of the HIV/AIDS epidemic on gay men. For example, the life expectancy of gay men is estimated to be about 58 years.

The View From the Community

Paul Lapierre, Executive Director of the Canadian AIDS Society, confirmed that, by and large, the environmental scan reflects the reality that community organizations are dealing with. He summed up the view from the community as follows:

- *The fact that new organizations are becoming involved in Canada's response*, many of which were represented at the Montréal meeting, shows that the epidemic is getting wider and more complex.
- T*he goals of the CSHA are our goals: they set the standard for our work*. How effective are we in moving toward them?
- T*here have been some successes in working toward the goals of the CSHA*, and many good ideas. But organizations do not have the time or the funding to carry out the work they need to do.
- *We need a complete response to the HIV/AIDS epidemic in Canada from governments*. This requires policies that promote health in a broad range of areas (health, housing, income support, drugs, racism), research and evaluation, funding, and political commitment and leadership.
- *We are learning more and more about different kinds of partnerships*—funding partnerships, consultative partnerships, collaborative partnerships. We are also learning what makes partnership work: trust, respect, common vision, shared goals, common activities, shared workload.
- *The lack of progress after the Gray Rocks meeting is a great disappointment*. Since that meeting there has been little action, only more documents, and most of those are draft documents. We all need to get to work; the responsibility does not lie with Health Canada alone. Community members need to assume their role in leading this work—in organizations of people with HIV/AIDS, in AIDS services organizations, in regional coalitions, in national organizations.
- *Will we have the resources to do the work*? We do not have the resources we need to develop the directions and work toward the goals of the CSHA. We in the community have a unique opportunity and responsibility to advocate for the resources that Canada needs to fight the HIV/AIDS epidemic.

Response from participants

There was concern about a loss of momentum in community advocacy on HIV/AIDS issues. It was easier to mobilize the community in the past, because people were dying. Since then there have been advances in treatment, research, and partnerships with government departments. Now the issues are more complex and it is, in fact, necessary to "inform" policy in a much wider range of areas. The next step for the community is to focus its advocacy on politicians at all levels of government and in many areas of government.

Participants were critical of Health Canada for its responsibility for the lack of progress since the Gray Rocks meeting, but they also recognized that other sectors, including the community, have a role and a responsibility in moving forward with specific actions. From the rhetoric of a "pan-Canadian" approach it is not clear who exactly is responsible for providing leadership on the directions. *If we are to move forward on the directions, we need to be specific and explicit about roles and responsibilities.*

Issues for People with HIV/AIDS

Louise Binder, a person with HIV/AIDS and Co-Chair of the Ministerial Council on HIV/AIDS, described a few of the most pressing realities and needs of people with HIV/AIDS.

- *HIV is infecting the marginalized and the vulnerable*. The HIV/AIDS epidemic has spread into many diverse populations in Canada. Today HIV is infecting primarily those who are marginalized and vulnerable in society. The populations most affected are marginalized either ethnically/culturally/religiously or socioeconomically or, most likely, in all of these ways. The first type of marginalization is experienced by people of Caribbean and African descent, Aboriginal people, people who do not categorize themselves as "white Anglo-Saxon Christians." The second type of marginalization is experienced by women; poor, unemployed or underemployed people; young people; prisoners and ex-prisoners; and drug users.

- *These populations do not have access to the basic requirements for good health*. For many of these people, their daily lives are focussed on survival. They need food, shelter, a job, welfare, clothing, basics for their family, their next fix or drink, and basic health care. These factors have a direct impact on the ability of people with HIV to stay healthy. They are concerned about such factors before they even begin to tackle HIV directly. But the social safety net they rely on to meet their basic needs has either been torn beyond repair or was never adequate to begin with.

- *Organizations need resources to help people meet their basic needs*. It is not the role of the CSHA to fund social services directly; this is a far larger responsibility of governments of Canada to Canadians. It is the role of the CSHA to ensure that there is an adequate network (including AIDS service organizations and non-governmental organizations) to help people with HIV/AIDS deal with these issues and to refer them to appropriate services outside the HIV community. There is not enough money to do even this, especially considering that diverse communities require discrete processes and approaches.

- *People with HIV/AIDS need ongoing, individualized treatment counselling*. One of the main issues people with HIV/AIDS face is decisions about treatment. Today, decisions must be highly individualized, but people with HIV/AIDS themselves cannot be expected to keep up with all the new information. They need excellent,

ongoing, individualized support in gaining access to treatment information. Doctors, pharmacists, and other health care providers are good sources of information but cannot be expected to devote time to thorough counselling sessions on treatment with each individual. There are fewer and fewer community members able to provide information, and the issues they are dealing with are increasingly complex.

- *People with HIV/AIDS need seamless, accessible, affordable health care*. People with HIV/AIDS need access to expert physicians, enough hospital beds, home care, and pharmacare. They need timely approval of experimental drugs. They need access to required treatments regardless of their economic status.

- *Co-infection and other diseases are increasingly becoming a problem*. Co-infection with hepatitis or herpes, as well as diseases brought on by the toxic effects of HIV drugs, are adding to the complexity for people with HIV/AIDS. Half of HIV deaths are now due to diseases caused by the toxic effects of drugs.

Response from participants

- Some participants questioned the use of the term "marginalization" or its application to only certain groups. The presentation did not include gay men in the list of marginalized populations. Although they may not be economically marginalized, they are socially marginalized by their sexual orientation because of homophobia in society. It was suggested that "vulnerable populations" always be used instead of "marginalized populations."

- There was a concern about how to invigorate the participation of people with HIV/AIDS in the response to the epidemic, particularly those from "marginalized" or "vulnerable" populations. It was suggested that mentoring between communities of people with HIV/AIDS can help people take power into their own hands and become involved in advocacy.

A Researcher's Perspective

Dr. Liviana Calzavara, President-Elect of the Canadian Association for HIV Research, discussed the challenges facing HIV researchers, particularly those in the social sciences.

- *The increasing complexity of the epidemic in Canada and internationally has increased the demands on researchers*. A greater number of vulnerable communities means that a greater number of targeted research studies is needed. As the management of HIV changes, so does the agenda for research: we now need research on re-integrating people with HIV/AIDS into the work force as well as on preventing HIV infection. With increasing demand for Canadian expertise in HIV research internationally, human resources at the national level are stretched.

- *It is a challenge to expand research beyond the medical paradigm to address the broader issues of the epidemic*. The response to the epidemic encompasses not

just medical care but also health promotion, social justice, the determinants of health, community action, and interdisciplinary research. But the medical paradigm is still dominant in our society and in the Canadian Institutes of Health Research (CIHR).

- *The transition to the CIHR is disrupting certain aspects of HIV research*. HIV researchers worked hard over the past 15 years to create a holistic, participatory funding mechanism. With the transition to the CIHR, which funds mostly investigator-initiated research, there is no mechanism to ensure that HIV research is consistent with the goals and principles of the CSHA. Some types of research that are necessary to direct the response to the HIV/AIDS epidemic (such as cohort studies or recurring behavioural studies) may not be funded because they may be seen as less innovative, of lower relevance to broader health issues, or more costly to conduct. Multidisciplinary, community-involved, social scientific research seems to be overlooked: in the latest CIHR funding competition, the success rate for HIV biomedical research proposals was 55%, whereas the success rate for HIV research proposals in the areas of the health system and services and population health was 11%.

- *There is no mechanism to coordinate HIV research among the institutes of the CIHR and to monitor whether research is meeting the goals of the CSHA*. Although the Canadian Association for HIV Research and the Ministerial Council on HIV/AIDS supported the formation of the CIHR, they also lobbied for an Office of AIDS Research. An Office of AIDS Research would provide the required mechanism for coordination and monitoring.

- *Changes in the policy and structure of health care have an impact on research as well as on prevention, care, treatment, and service delivery*. For example, the new policy of HIV testing of immigrants has made it very difficult to conduct HIV prevalence and behavioural research among people from countries in which HIV is endemic.

- *Researchers are vulnerable to lack of resources, funding, and institutional support*. Research funding, particularly in non-medical research, has not kept pace with the scope and the complexity of the epidemic. Non-medical researchers are particularly vulnerable because they do not have access to income from clinical practice, and the institutions that pay their salaries generally do not value applied research, community engagement, and policy-related work.

Dr. Calzavara concluded by stressing that Direction #10—the development of a five-year operational/strategic plan—is essential. We need to move quickly to establish "time-bound targets" for the CSHA, as suggested by the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) and implemented by the USA and the UK.

Response from participants

Participants provided further information and identified gaps with regard to research:

- The presentation did not discuss the CSHA's community-based research program—$1 million per year for community-based research and $800,000 per year for Aboriginal community-based research. It was observed that this is minuscule compared with the $570 million for investigator-initiated research under the CIHR.

- People with HIV/AIDS are sought out as "subjects" of research and as "experts" on prevention, care, treatment, and support. But they are not involved in the direction and design of research. People with HIV/AIDS need to take ownership and control of research.

- The institutes of the CIHR have begun a process to identify focussed areas of research and send out a request for proposals for research in those areas. The CIHR also has a priority-setting committee across all the institutes. It will be important to use these mechanisms and monitor how effectively they direct HIV/AIDS research.

- Is there an annual overview of HIV/AIDS research being conducted in Canada? Are there plans to initiate studies among women and youth of Caribbean and African descent? Are there plans to initiate studies of the socioeconomic determinants of health among vulnerable populations? How do researchers reconcile approaches that focus on the role of behaviours in the epidemic with approaches that focus on the role of socioeconomic determinants?

Collaborating on the Aboriginal Strategy on HIV/AIDS in Canada

Art Zoccole, Co-chair of the National Aboriginal Council on HIV/AIDS (NACHA) and Executive Director of the Canadian Aboriginal AIDS Network, described the achievements since the Gray Rocks meeting in developing the Aboriginal Strategy on HIV/AIDS in Canada, as well as the challenges that are still ahead.

NACHA was established in May 2001. It is composed of 24 members in four groups of six members each, representing First Nations, Inuit, Métis, and the community (community-based AIDS organizations and Aboriginal people with HIV/AIDS). NACHA will

- advise Health Canada and other stakeholders on all matters under the CSHA as they relate to Aboriginal peoples;

- ensure effective collaboration and communication between governments and Aboriginal peoples in Canada; and

- examine and advise on key issues to ensure that there is equal access to high standards of HIV/AIDS care and treatment, prevention, and education for all Aboriginal peoples in Canada.

Guidelines for the development of the Aboriginal Strategy on HIV/AIDS in Canada were completed in August 2001. The guidelines outline the roles and responsibilities of the various arms involved in the development of the Strategy and provide a framework to guide its development by a working group. This framework includes the following:

- a mandate for each party involved in the project;
- the body to whom each party is directly accountable;
- methods and means for reporting progress/findings;
- the composition of each party involved in the project;
- a breakdown of roles and responsibilities for the project;
- guiding principles for the working group and the Strategy;
- a commitments pledge for the working group;
- a list of key stakeholders to be involved in the Strategy;
- terms of reference for each committee; and
- an evaluation of the framework development process.

There are a number of concerns, however, for the partners in the Aboriginal Strategy on HIV/AIDS in Canada as they move forward.

- *Loss of corporate memory*. The collective memory of people working on HIV/AIDS is an invaluable source of knowledge and direction. The recent turnover in staff at Health Canada is a concern in this regard.

- *Incomplete data on HIV and AIDS among Aboriginal peoples*. The collection of epidemiologic data is not complete and consistent across the country. Ontario, for instance, does not collect data on ethnicity. Consequently, the prevalence and incidence of HIV/AIDS is under-reported, especially since many Aboriginal people with HIV/AIDS migrate to Ontario because of the services and support groups available there. Complete data on ethnicity are needed to direct priorities and programs.

- *Program funding not controlled by or directed to Aboriginal peoples*. There has been a call to release funding for services for Aboriginal peoples off-reserve, but so far this call has not been heeded. This prevents a great deal of work on HIV/AIDS from being done with Aboriginal peoples. In addition, although there has been success with the Aboriginal Community-Based Research Program in fostering skill and building capacity among Aboriginal peoples, there is a need to re-examine the eligibility criteria for the program to ensure that it meets the purpose of building unique approaches for and by Aboriginal people.

Collaborating on International Issues

Michael O'Connor, Executive Director of the Interagency Coalition on AIDS and Development, spoke of the growing involvement of Canadians in international HIV/AIDS issues.

- *There is increased momentum on international issues*. There has always been interest in international issues in the Canadian HIV/AIDS community—witness, for example, the leadership of Richard Burzynski within the International Council of AIDS Service Organizations. Now the Canadian public has awakened to the fact that 40 million people in the world are living with HIV/AIDS. Western governments are concerned about the implications of the epidemic for economic and security reasons.

- *How can we maintain the momentum*? We need to build and expand on the linkages we have established. We need to use the UNGASS Declaration of Commitment to hold governments accountable for their response to the epidemic. (It is hard to see how Canada can set and meet targets without increasing funding.) We must continue to learn from best practices. For example, best practices with children and orphans in developing countries are equally applicable in Canada.

- *What have we learned about collaboration*? The benefits of collaboration are mutual and often unexpected. For example, collaboration between AIDS Vancouver and organizations in Mexico enabled AIDS Vancouver to work with the Latin American community in Vancouver. Likewise, collaboration between the AIDS Committee of Toronto (ACT) and organizations in Brazil created better links between ACT and Portuguese-speaking people in Toronto. These are only a few examples of how funding from the Canadian International Development Agency (CIDA) for collaborative projects is having an impact on Canadian partners.

- *What are the implications for the CSHA*?

  - It is important to document and disseminate the lessons learned from international collaboration and how collaboration is improving HIV/AIDS prevention, care, treatment, and support in Canada.
  - The connection to international issues is implicit in many of the directions identified at Gray Rocks and is in fact explicit in the original and complete text of Direction #1. Health Canada should ensure that this connection remains explicit and should highlight the connection as it moves forward on the directions.
  - Health Canada should encourage CIDA to fund a second round of small grants for international collaborative projects and increase the funding for the program (only 17 of 90 applications were funded in the last round).
  - Funding for the international component of the CSHA should be increased.

Response from participants

Participants of Caribbean and African descent stressed that community organizations working with their populations in Canada should be involved in twinning projects between Canada and their countries or regions of origin. Expertise and experience from community organizations in these countries or regions can help community organizations in Canada in their work with these populations.

Reference Group on African/Black Communities

Participants in the meeting from Caribbean and African communities stressed the need to investigate, understand, and address the determinants of health of their communities with regard to HIV/AIDS. Among these determinants are racism and discrimination. They affect these communities' access to health care, the quality of health care they receive, and their reception into Canada (institutionalized in Canada's immigration and refugee policies).

Participants from these communities also underscored the fact that the global epidemic is as much a reality for them as the epidemic in Canada. The response to the global epidemic is as important as the response to the epidemic in Canada, and the two must be linked.

In order to strengthen Canada's response to the epidemic among people of Caribbean and African descent, participants from these communities put forward the following proposal in plenary:

- We, as African/black Canadians who work with African/black communities, propose that Health Canada strike a national reference group that is inclusive of black communities, organizations working with them, and Health Canada (multisectoral). The reference group would ensure that the issues raised in the environmental scan and in the 10 directions are addressed by the provision of resources and support for specific strategies/actions developed by African/black communities. This reference group should work in collaboration with already existing provincial and territorial initiatives, such as a) the HIV Endemic Task Force, and b) other community-based organizations or groups that provide services to this population.

    - Proposed by Esther Tharao, Ministerial Council on HIV/AIDS/Women's Health in Women's Hands; Floydeen Charles-Fridal, HIV Endemic Task Force/Youth Clinical Services, Inc.; Eunadie Johnson, Women's Health in Women's Hands; and Vuyiswa Keyi, African Community Health Services.

The proposal was welcomed with applause in the plenary.

Ƒ Turning Directions Into Actions

After hearing the environmental scan and the comments from participants, the meeting broke into small groups to identify specific actions that would make the 10 directions a reality. There was a small group for each direction. Participants brainstormed possible actions. They selected three that were most important, explained what each involved, and why each was important. Each group then presented its three most important actions to the meeting in a plenary session. All the participants then provided written feedback on forms provided for this purpose.

Participants returned to their small groups to consider the feedback and re-evaluate the actions they had proposed. They refined the actions and developed implementation plans for them. The implementation plans identified the components of the action, a time line, the lead, and expected outcomes. These plans were then displayed in a forum—a "marketplace" or "bazaar"—in which all participants could, if they chose to, offer suggestions about the action plans and indicate their interest in participating in them.

The following actions plans were presented (listed according to the 10 directions):

1. *Mobilize integrated action on HIV/AIDS globally and in Canada*

    Action #1: Broad-Based, Issue-Specific Coalitions

    Action #2: Federal Interdepartmental Committee on HIV/AIDS

2. *Build unique approaches for Aboriginal peoples within the CSHA*

    Action #1: Study of Aboriginal Health Determinants and HIV/AIDS as a Goal of the Aboriginal Strategy on HIV/AIDS in Canada

    Action #2: Build Social Capital in Aboriginal Communities as It Relates to HIV/AIDS

    Action #3: Coordinated Aboriginal-Specific HIV Research Processes

3. *Build a broad information strategy*

    Action #1: Develop a Dynamic Information Process

4. *Get public commitment, political leadership, and funding*

    Action #1: Broad-Based Communications Strategy to Engage Public Commitment

    Action #2: Engage Political Leadership Across Government

    Action #3: Increase Funding for HIV/AIDS Programs

5. *Build a strategic approach to prevention*

    Action #1: Develop a Flexible, Coordinated, and Measurable Prevention Strategy

    Action #2: Summit on HIV/AIDS Prevention

6. *Build a strategic approach to care, treatment, and support*

    Action #1: Post-Approval Surveillance System and Treatment Information Providers

    Action #2: Model for Holistic Approach to Care, Treatment, and Support

7. *Renew and develop human resources*

    Action #1: CSHA Multidisciplinary Human Resources Task Force

    Action #2: Canadian HIV/AIDS Directory

8. *Engage vulnerable Canadians*

    Action #1: Engaging Vulnerable Canadians

9. *Move to a social justice framework*

    Action #1: Develop Social Justice Values and Principles

    Action #2: Advocate a National Housing Policy/Strategy

    Action #3: Capacity Building

10. *Develop a five-year operational/strategic plan*

    Action #1: Develop a Five-Year Operational/Strategic Plan

4 Making Actions a Reality

Health Canada will work with the CSHA Direction-Setting Process Task Group to follow up on the outcomes of the Montréal meeting. Between May and September 2002, they will

- produce a record of proceedings of the Montréal meeting;
- convene teleconference meetings on Directions #1 to #9 to review the proposed actions and plan next steps (each teleconference will include the participants in the small group who worked on the direction, as well as individuals who expressed an interest in the actions proposed for that direction);
- convene a working group to design a process for Direction #10;
- provide regular updates on the follow-up activities.

Further steps toward implementing the proposed actions of the Montréal meeting will emerge from the meetings convened with regard to each of the directions. The CSHA Direction-Setting Process Task Group will be active in this ongoing work as part of its role in monitoring the follow-up to the Montréal meeting.

Canadian Strategy on HIV/AIDS
Direction-Setting Follow-up Meeting

April 14-16, 2002
Montréal, Quebec

Part Two: Proposed Action Plans

Direction #1:
Mobilize Integrated Action on HIV/AIDS Globally and in Canada

From the Gray Rocks Meeting Report[5]

Statement of the Direction

The Canadian Strategy on HIV/AIDS (CSHA) will mobilize government departments at all levels, Aboriginal governments, and community leaders to take coordinated, integrated, and efficient action on HIV/AIDS, focussing on the determinants of health and on equal access to health care. This action will centre on people living with and vulnerable to HIV/AIDS and will be driven by those most vulnerable to the epidemic. The action will be linked to and informed by the global response to the epidemic and will create an understanding among Canadians of their roles and responsibilities in addressing the epidemic, both globally and in Canada.

Explanation of the Direction

Reducing vulnerability to HIV/AIDS in Canada requires coordinated, integrated, and efficient action on determinants of health and inequities in health care that contribute to vulnerability. To be effective, such action must be supported by all governments, multiple departments, a broad range of political leaders, and the Canadian public. The goal would be action that is consistent across jurisdictions, sustained over time, and coordinated and integrated at the level of service provision, as required by people living with and vulnerable to HIV/AIDS.

The CSHA must

- educate other departments or units (besides Health departments or units) at all levels of government (federal, provincial/territorial, municipal, Aboriginal) on the impact of HIV/AIDS in Canada and globally so that they will understand how they can contribute to addressing HIV/AIDS;
- link the CSHA to other strategies and programs that address the determinants of health;

5 The statement and explanation of each direction are taken from the Gray Rocks meeting report*: Meeting Report: Canadian Strategy on HIV/AIDS Annual Direction-Setting Meeting, October 29-November 1, 2000, Gray Rocks Inn, Mont Tremblant, Quebec.* Ottawa: Minister of Public Works and Government Services Canada, 2001.

- work to reduce inequities between jurisdictions and within jurisdictions in the resources available for HIV/AIDS programs, health care, and social services;
- help Canadian planners and service providers learn from the experiences of other countries about taking integrated action to reduce vulnerability to HIV/AIDS;
- educate the Canadian public about the kind of responses required to reduce vulnerability to HIV/AIDS in Canada and globally so that they support a sustained and strategic approach to the HIV/AIDS epidemic;
- encourage broad-based political leadership that advances a more complete multisectoral response to the HIV/AIDS epidemic in Canada and globally.

Action #1: Broad-Based, Issue-Specific Coalitions

Preamble

In a determinants-of-health approach, broad-based coalitions are needed to address specific issues in the HIV/AIDS epidemic, e.g., a rainbow coalition; provincial AIDS coalitions; endemic populations coalition; First Nations, Inuit, and Métis coalitions, etc.:

- Integration starts at the grass roots.
- Diversity is important (and should not be viewed as duplication).
- Communication is key to integration.
- Accountability must be reciprocal.
- Ongoing evaluation or self-critical reflection should be part of the effort.
- Sustainability is essential.

Existing coalitions include the following:

- Canadian AIDS Society
- Pacific AIDS Network
- British Columbia Persons With AIDS Society
- Alberta Consortium
- Saskatchewan AIDS Network
- Manitoba AIDS Cooperative
- Ontario AIDS Network
- Coalition des organismes communautaires québécois de lutte contre le sida
- Canadian Working Group on HIV and Rehabilitation
- Winnipeg Harm Reduction Group
- Canadian Association for HIV Research

Objective

Develop mechanisms to bring coalitions of stakeholders together on HIV/AIDS-related issues to

- identify and work on collective issues;
- mobilize integrated action on HIV/AIDS;
- inform policy and program development.

Description

The coalitions have several characteristics.

- They could be both time-limited and ongoing.
- They should involve a broad base of stakeholders (e.g., the community, all levels of government, the private sector).
- They could be both community-driven and government-driven.
- They should be accountable to specific constituencies.
- They could develop new mechanisms to represent populations/groups that do not have current structures in place (e.g., endemic populations, gay men, rural areas).

Be a part of our six-point plan!

- Identify players in your jurisdiction.
- Get to know them.
- Understand their work and help them understand yours.
- Identify joint initiatives.
- Develop common tools.
- Implement action!

Outcomes (three years)

- HIV/AIDS-specific coalition(s) in all provinces and territories.
- Panel discussions at skills-building meetings and at other regional and national meetings.

Lead

- Individual jurisdictions or sectors.

Comments and expressions of interest

- This is a great way to realize the value of coalitions and give some real commitment to the idea.
- What is the problem with what currently exists?

  1) We need to involve players from outside HIV/AIDS more.
  2) We need to work together in better ways.

  We do not need new coalitions or to move to a different model of coalition, but we need to address the above problems. The Canadian HIV/AIDS Legal Network as an existing coalition is interested in being part of addressing these problems.
- Link to associated development of a social justice framework.
- Contact the Canadian Public Health Association (CPHA) to review past and present activity.
- Healing Our Nations is committed to this approach in the Atlantic First Nations and broader Aboriginal community.
- AIDS New Brunswick, in conjunction with the New Brunswick partnership, would take the lead in New Brunswick.
- The AIDS Coalition of Nova Scotia will take the lead in Nova Scotia.
- The Canadian AIDS Treatment Information Exchange (CATIE) continues its collaborative initiatives both within the traditional HIV/AIDS sector (e.g., Canadian AIDS Society, CPHA, Canadian Aboriginal AIDS Network, Canadian Treatment Advocates Council, etc.) and with related organizations from the broader community (e.g., Kids Help Phone, community health centres, testing centres).
- CATIE continues to assume national leadership in coordinating treatment information, as per the Health Canada treatment information environmental scan.

Action #2: Federal Interdepartmental Committee on HIV/AIDS

Preamble

We need to broaden the response to the HIV/AIDS epidemic to address the determinants of health. This requires clear accountability for deputy ministers of numerous departments and a mechanism for reciprocal accountability among departments. This should increase access to funding and other resources.

Objectives

Establish a federal mechanism for shared ownership and accountability of the CSHA to ensure that:

- the CSHA is "owned" by other departments and is part of the work of deputy ministers;
- there is access to resources (human, financial, and other).

Outcomes (three years)

- Engage the following departments and agencies:
  - Human Resources Development Canada, Canadian Heritage, Department of Indian Affairs and Northern Development, Justice Canada, Canadian Institutes of Health Research (CIHR), Canadian International Development Agency, Treasury Board Secretariat, Privy Council Office, Department of Foreign Affairs and International Trade, Industry Canada, Correctional Service of Canada, Secretaries of State for the Status of Women and Youth.

  These departments and agencies will

  - review mandates to ensure that HIV/AIDS is included in their work;
  - share relevant work plans;
  - identify specific resources they could contribute to the CSHA.
- Link with the Ministerial Council on HIV/AIDS and other regional bodies.

Lead

- Health Canada will provide incentives for engaging other departments.

JOIN US

Comments and expressions of interest

- Correctional Service of Canada would participate in the process.
- The CIHR will be happy to be part of this.
- We from Direction #6—Care, Treatment and Support Direction—need this to happen to support our vision of a consumer-centred approach.
- Next step—engage other governments.
- We need political commitment.
- Ministerial Council representatives are appointed by the Minister. Are they accountable to the community?
- I hope that the National Aboriginal Council on HIV/AIDS will assist and lead in this area.
- The Interdepartmental Committee should integrate HIV/AIDS, TB, STDs. It would increase deputy ministers' commitment.

Direction #2:
Build Unique Approaches for Aboriginal Peoples Within the Canadian Strategy on HIV/AIDS

From the Gray Rocks Meeting Report

Statement of the Direction

The Canadian Strategy on HIV/AIDS (CSHA), in collaboration with Aboriginal peoples, will build a National Aboriginal HIV/AIDS Strategy for all Aboriginal peoples and their chosen communities that is adequately funded, advances unique needs, and is acknowledged and accepted by Aboriginal and non-Aboriginal funders and all other stakeholders. This strategy will be the vision that moulds future directions for initiatives developed by and for Aboriginal peoples with HIV/AIDS and those affected by it.

Explanation of the Direction

Aboriginal peoples need to build an Aboriginal HIV/AIDS strategy that is integrated with the CSHA and provincial/territorial HIV/AIDS strategies. The strategy must be designed, owned, and controlled by Aboriginal peoples in partnership with other governments and organizations. It must

- focus on those most vulnerable;
- address vulnerable groups with specific, culturally appropriate strategies;
- create a safe space to address the HIV/AIDS epidemic within Aboriginal communities;
- be understandable to all Aboriginal peoples, including those whose language is neither English nor French;
- be inclusive of diversity within Aboriginal communities;
- be intergenerational in approach;
- build the capacity of communities to address the HIV/AIDS epidemic through partnerships;
- build internal leaders and external partnerships at all levels (local, provincial/territorial, national, international);
- support Aboriginal participation in HIV/AIDS planning at all levels;
- be supported and funded by the federal government and Aboriginal governments and leaders.

Running throughout the vision of this strategy are the notions that it is inclusive, respectful, action-driven, owned, controlled by and accessible to Aboriginal peoples.

Action #1: Study of Aboriginal Health Determinants and HIV/AIDS as a Goal of the Aboriginal Strategy on HIV/AIDS in Canada

Preamble

We, as Aboriginal people, need to know more about how determinants of health among Aboriginal people affect HIV transmission and the health of Aboriginal people living with HIV/AIDS. We need to integrate this knowledge into what is being done with regard to Aboriginal health as a whole, into the traditional values and actions of our communities, into what is being done with regard to gay men's health, etc. We can share the results of our knowledge internationally, for example with Native Americans and indigenous groups in other regions.

Values

- Aboriginal world view.
- The guiding principles of the Aboriginal Strategy on HIV/AIDS in Canada (ASHAC).
- The "Cinderella" principle: one shoe does not fit everyone. We need a new shoe or a tailored shoe.

Goals

As a goal of ASHAC, a study should be developed on Aboriginal health determinants as they affect HIV/AIDS-related issues in order to identify

- which Aboriginal health determinants affect HIV transmission among Aboriginal people and the health of Aboriginal people living with HIV/AIDS;
- how to integrate HIV/AIDS into overall policy on Aboriginal health as a specialty.

Objectives

- Identify what is being done on the determinants of Aboriginal health—the broad picture.
- Undertake intersectoral consultation at all levels.
- Develop a body of knowledge on Aboriginal health to effectively address HIV/AIDS.

Benefits for all CSHA stakeholders

- Specific culture-based programs/services will decrease HIV transmission and improve the health of Aboriginal people with HIV/AIDS.

- Social capital in Aboriginal communities will be increased, which will free up other resources.

- There will be a contribution to the broader picture on HIV/AIDS, and resources will be freed up that can be redirected to other areas of the Canadian HIV epidemic.

Comments and expressions of interest

- What about using the white chiefs to help?
- Great! Will really add to the knowledge base on this issue.
- This has links to issues in the development of a social justice framework; links to related legal, ethical, and human rights; and links to policy, movements, and emerging issues (Michael R. Smith, telephone 613-946-6675).
- The Canadian Public Health Association (CPHA) has traditionally supported the development of capacity of First Nations public health workers and has addressed the needs of the HIV-infected community (confirmation of further commitment is required).
- Planned Parenthood has developed a sourcebook on *Sexual Health Education* in Aboriginal communities. We did this in partnership with the Aboriginal Nurses Association (Julie Pentick, jpentick@ppfc.ca).
- The Canadian AIDS Society would like to play a role. Please let's talk and define our partnership agreement.
- Manitoba AIDS Cooperative would help with research and has access to participants (subject to board/member approval).
- This is an opportunity to move forward to the Canadian Aboriginal AIDS Network (CAAN) /Canadian HIV/AIDS Legal Network Memorandum of Understanding. There is full support from the Legal Network to address this work (Renée Masching, Canadian HIV/AIDS Legal Network board member).
- Saskatchewan Health is interested in healthy Aboriginal communities.
- Healing our Nations will lead the Atlantic First Nations communities in this work.
- Correctional Service of Canada is interested in advancing overall Aboriginal health issues.
- CAAN will do a project on Aboriginal HIV/AIDS, health determinants, and human rights initiatives in Canada.

Action #2: Build Social Capital in Aboriginal Communities as It Relates to HIV/AIDS

Preamble

Social capital is the recognition that the most important and valuable attributes of organizations are the expertise, enthusiasm, and support of all people, including volunteers, elders, clients, and front-line workers. A major force of organizations and funders must be to support the building and maintenance of the human capacity of each group to respond to organizational needs.

Values

Aboriginal concept of the sacredness of personhood:

- recognizing that all people are equally important;
- changing attitude—valuing humans;
- building the infrastructure to support and sustain human capacity in communities;
- recognizing and valuing existing social capital;
- nurturing relations and building trust.

Description

Plan, develop, and initiate a health policy process that will help to build social capital in Aboriginal communities as it relates to HIV:

- building of capacity in communities;
- recognizing the capacity already there.

Time line

- One year to refine the definition of social capital.

Comments and expressions of interest

- Yes (James Froh).
- Yes (Ken Clement, Healing Our Spirit).
- Connect to the 2-Spirit community in Vancouver and British Columbia. They are out of the loop (jeffa@parc.org).
- This is a great concept. I am interested in doing more learning about this as I begin my academic work (Renée Masching).

- Vancouver Area Network of Drug Users has 500 Aboriginal members. We'd love to be part of the Social Capital Project (VANDU, 50 East Hastings Street, Vancouver, BC, V6A 1N1, telephone (604) 683-8595, Vandu@vandu.org).

Action #3: Coordinated Aboriginal-Specific HIV Research Processes

Preamble

Unique problems may lead to unique research methods or approaches, which in turn lead to unique solutions. The purpose of the project would be to effectively address the HIV/AIDS epidemic among Aboriginal people within a context of valid research methods.

Values

- Health-outcomes-based research (i.e., aimed at improving health).
- Community relevance and involvement (i.e., community-based research, participatory research).
- Community ownership, control, access, and possession of the research process and products.
- Dedicated resources to sustain the research.
  - This is cost-effective (at the individual level) and cost-beneficial (at the population level).

Description

Develop coordinated Aboriginal-specific research processes involving the following steps:

1. Analyse gaps
   - knowledge, attitudes, beliefs/behaviours;
   - environment scan.
2. Identify and prioritize HIV research needs.
3. *Engage* existing researchers.
4. Identify and create research opportunities.

5. Generate *new* knowledge vis-a-vis research.

6. *Translate* knowledge to improve health (i.e., knowledge influences policy, which influences practices, which influence research, which in turn influences knowledge).

    - All this requires culture-based capacity building, ethics, and peer review.

Comments and expressions of interest

- Undertake community-based research and best practices on innovative approaches that produce positive outcomes.
- Expand best practices.
- Renee Masching personally and Healing Our Nations are interested in exploring, learning, and outlining how to conduct community-based research initiatives with the Aboriginal community in Canada and in the Atlantic region specifically.
- The Canadian Association for HIV Research could support priority-setting activities and assist with knowledge transfer.

Direction #3:
Build a Broad Information Strategy

From the Gray Rocks Meeting Report

Statement of the Direction

The Canadian Strategy on HIV/AIDS (CSHA) will build an information strategy to identify, obtain, analyse, validate, communicate, and facilitate the use of a broad base of information required to achieve the goals of the CSHA. The strategy will develop processes, build capacities, and leverage resources in a way that is consistent with the policy directions of the CSHA (e.g., inclusive, empowering, participatory, and collaborative). The strategy will include mechanisms to enable CSHA partners to learn from the experience, information, and research of other countries.

Explanation of the Direction

The CSHA needs a broad base of information to inform decisions on CSHA policy and program activities. This broad base of information includes quantitative and qualitative research; national, provincial/territorial, and local data; health care and social service statistics; post-approval surveillance of therapies; community-based studies; evaluation results; project reports; anecdotal information; etc.

In a broad-based information strategy, information needs are determined and met through a regular, collaborative, and inclusive process. The process

- depends on a comprehensive capacity-building program that enables participation at all levels;
- defines relevant questions with input from all concerned, according to the various kinds of evidence under consideration;
- assists in finding, allocating, advocating for, and leveraging resources as well as forming partnerships to enable the information gathering to be carried out;
- analyses and disseminates the results at all levels in a timely fashion without compromising the need for peer review or validation;
- facilitates the use of information by the group(s) that defined the need.

Action #1: Develop a Dynamic Information Process

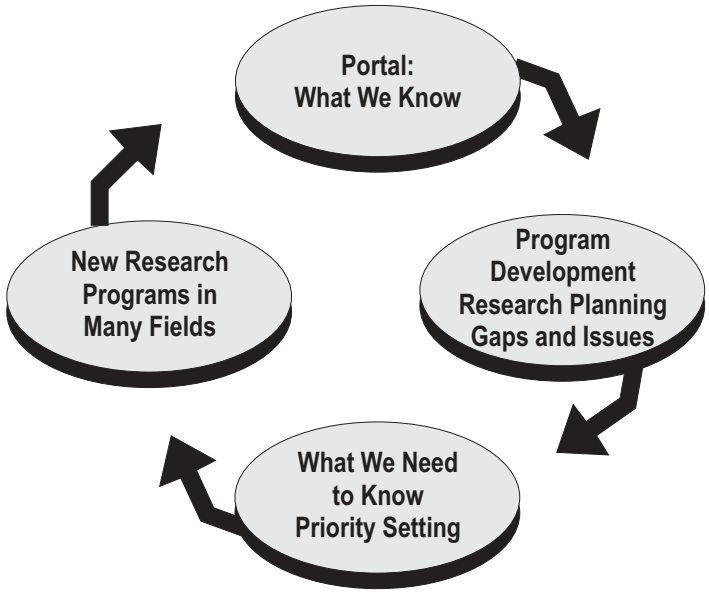
Preamble

Gathering, sharing, applying, and developing information and identifying gaps are part of a continuous cycle:

- From inventories of research, community-based research, epidemiology, and programs we identify *what we know*.
- What we know provides *information* for program development, research planning, and the identification of gaps and emerging issues.
- This information is fed into priority-setting activities that identify *what we need to know*.
- What we need to know helps to create *new knowledge*—new programs and new research.
- New knowledge becomes part of *what we know*.

The dynamic information process starts with providing CSHA partners with access to the knowledge accumulated from *research, community-based research, epidemiology, and programs.* Through this process we can apply what we know, learn from it, identify what we need to know, and create new knowledge.

Research Inventory — CBR Inventory —
Epidemiology Inventory — Programs Inventory



Objective

To develop a dynamic information process to provide information to

- support programs and research;
- identify gaps and emerging issues;
- set priorities.

Description (one-year plan)

The following should be accomplished within one year:

- Form a task group to develop guiding principles (ownership, control, access), set out an implementation strategy, and establish a steering committee.
- Establish portal and connections to existing inventories.
- Determine longer-term funding commitment.
- Initiate federal/provincial/territorial (F/P/T) Memorandum of Understanding on epidemiologic data.

Requirements for success

An initial task group is needed with the following skills:

- information and knowledge management;
- coordination;
- network to AIDS service organizations, researchers (academic, community-based), funding;
- knowledge of technology (e.g., web technologies).

Financial commitment is necessary to develop the concept.

Comments and expressions of interest

- Sustainable infrastructure crucial.
- Financial commitment not only for concept development but also for purchase of equipment and database.
- Need to include population-specific, women's health member on the Steering Committee, to help in identifying needs and gaps in the black community and link to our web site (Women's Health in Women's Hands).

- The Canadian AIDS Treatment Information Exchange's research strategy, called for by Health Canada's comprehensive review, involves an effective cross-section of health science professionals and knowledge management professionals relevant to secondary research in treatment information as well as to primary research in best models for service provision. (This process might be a possible model for the large over-arching process.)

- The F/P/T Advisory Committee on AIDS will put on the agenda a higher priority for gathering relevant epidemiologic data and development of bilateral memoranda of understanding between provinces/territories and Health Canada to ensure timely forwarding of data with appropriate recognition of ownership, etc. (Bryce Larke).

- LinkUp-Connexion—a project of the Canadian Aboriginal AIDS Network—could be involved (www.linkup-connexion.ca).

- The Canadian Association for HIV Research should be involved, given appropriate resources, both in the initial task group and in the Steering Committee.

- The Canadian Public Health Association/HIV/AIDS Clearinghouse is willing to be in the initial development group.

- The Canadian Working Group on HIV and Rehabilitation will look forward to contributing ideas about our experience with both developing knowledge (i.e., research) and disseminating knowledge (e.g., HIV and rehabilitation awareness and education) (tel. 416-324-4182).

- Red Road HIV/AIDS Network is in the process of building a GIS mapping program for the province of British Columbia. We would be interested in working in partnership on this larger scale information strategy.

- The Interagency Coalition on AIDS and Development would help develop the international component of this direction/activity.

- The Canadian Institutes of Health Research can partner in

  - research information source being developed with other funding agencies;
  - knowledge translation—part of mandate with dedicated staff;
  - regular research funding programs—project grants and personnel awards.

- The Centre for Infectious Disease Prevention and Control, HIV/AIDS Policy, Coordination and Programs Division.

Direction #4:
Get Public Commitment, Political Leadership, and Funding

From the Gray Rocks Meeting Report

Statement of the Direction

The Canadian Strategy on HIV/AIDS (CSHA) will build public awareness of the personal and economic impact of the HIV epidemic in Canada and globally, and will encourage and support political leadership that advances Canada's response to the epidemic. The CSHA will mobilize politicians, bureaucrats, and community leaders in all sectors and at all levels to obtain significantly increased, broader, coordinated, and efficient funding for the CSHA, provincial/territorial and Aboriginal HIV/AIDS strategies, and health care.

Explanation of the Direction

There is a need for significantly more funding at all levels—federal, provincial/territorial, municipal—for efforts to stop the HIV/AIDS epidemic. Although the annual incidence of HIV infection in recent years is estimated to be 4,200, federal funding for the CSHA has remained at the level it was in 1993 ($42.2 million). New challenges, such as the epidemics among Aboriginal peoples and injection drug users, require additional resources.

The need for resources extends beyond HIV/AIDS-specific programs. People with HIV/AIDS and their caregivers attest to the need for adequate and equitable funding for health care services across the country (including pharmacare, home care, and palliative care). There is also a need for adequate resources to address the determinants of health among people vulnerable to HIV/AIDS.

Obtaining significantly increased resources for HIV/AIDS programs, health care, and social services requires broad public support, commitment within government departments, and strong political leadership. The public must be made aware of the impact of the HIV/AIDS epidemic in Canada and globally. The case must be made for the role and responsibility of government departments in health, employment, housing, international development, justice, and other areas. Political leaders must be cultivated and supported in federal, provincial/territorial, municipal, and Aboriginal circles.

Political leadership is essential for much more than funding. It is crucial to establishing the environment in which prevention programs can work, reducing the stigma associated with HIV/AIDS or vulnerability, mobilizing a coordinated response to the epidemic across departments and jurisdictions, and building public awareness and responsibility with regard to the epidemic in Canada and the world.

Action #1: Broad-Based Communications Strategy to Engage Public Commitment

Preamble

We need to work collaboratively within a strategic communications framework to reach diverse audiences and engage them in the response to the HIV/AIDS epidemic.

Objective

Develop a strategic communications plan that

- outlines a framework that organizations can adapt to their work;
- provides generic tools, materials, and data (including many languages and diversity).

Audiences

- General public
- Specific groups
- Political leaders
- Media
- Who else?

Tactics

- National Testing Day
- World AIDS Day
- AIDS Awareness Week
- Conferences
- Provision of free condoms
- Link to existing resources/initiatives/campaigns
- What else?

Comments and expressions of interest

- Be open and creative, leaving room for regional differences.
- National Testing Day raises many ethical/legal/policy issues that need to be thought through.
- Is there a link to conferences on persons with HIV/AIDS (jeffa@parc.org)?
- Link to possibilities (mechanisms) defined in Direction #1.
- Link to Direction #3.
- The Canadian AIDS Society (CAS) has a role to play.
- The Manitoba AIDS Cooperative would support and be involved with National Testing Day (subject to member approval).
- Saskatchewan Health will consult within the Department on strategic communications, especially on World AIDS Day and National Testing Day.
- Healing Our Nations will be involved in working with and mobilizing Atlantic First Nations leaders and outreach in the broader Aboriginal community.
- I may be prepared to get involved with the work (Daniella R. Boulay-Coppens, Centre for AIDS Services of Montreal, 514-495-0990).

Action #2: Engage Political Leadership Across Government

Preamble

We need to make political leaders at all levels and in different areas of responsibility aware of the impact of the HIV/AIDS epidemic in social and economic terms, and we need to engage them in leading a response that extends across government departments. We should focus on those ministries that have a direct impact on the HIV/AIDS epidemic, building on a determinants-of-health approach and linking to health care reform.

Objective

To obtain commitment and endorsement from all levels of government for the implementation of the CSHA across government departments.

Action

1. Identify, encourage, and support "champions" in and out of government to put the objective on the political agenda.

   Who should do this:

   - public health;
   - community-based organizations;
   - national HIV/AIDS organizations;
   - the public;
   - Health Canada - HIV/AIDS Policy, Coordination and Programs Division and regional offices;
   - other government departments;
   - people with HIV/AIDS.

   Time line: within six months

2. Presentation of HIV/AIDS issues within the context of population health.

   Who should do this:

   - community-based organizations;
   - government departments and ministries dealing with housing, health, justice, corrections, social services, education, etc.

   Time line: ongoing

3. Incorporate the determinants of health as they relate to HIV/AIDS concerns into health care reform.

   Who should do this:

   - Health Canada - HIV/AIDS Policy, Coordination and Programs Division and regional offices;
   - provincial/territorial governments;
   - federal government;
   - national HIV/AIDS organizations.

   Time line: ongoing

Comments and expressions of interest

- Link with Directions #1 and #10.
- Promote the development of a minister of state for HIV/AIDS based on the British Columbia model.
- A potential agenda for more dollars.
- Necessary to move HIV out of AIDS service organizations in isolation and into all community-based organizations.
- CAS has a role to play.
- The Canadian Public Health Association would likely continue to advocate with national leaders relative to addressing HIV/AIDS issues in Canada.

Action #3: Increase Funding for HIV/AIDS Programs

Preamble

There is an urgent need for more funding for HIV/AIDS programs. To obtain the necessary resources, we need to

- get more funding for the CSHA. This involves building a case within Health Canada, getting provincial/territorial support through the Federal/Provincial/ Territorial Advisory Committee on AIDS, and holding Canadian governments accountable to their international commitments. There is already work under way in this regard: the Canadian Coalition of Organizations Responding to AIDS, efforts within the Centre for Infectious Disease Prevention and Control to make the case for increased funding for the CSHA, and efforts by the Ministerial Council on HIV/AIDS. The community needs to explore how it can support Health Canada in moving this effort forward.
- get funding from new sources. This involves working with the private sector and foundations and with other areas of government (e.g., housing, nutrition, Aboriginal issues, reproductive health).

The actions described below are intended to engage government and community organizations at the regional and local level in efforts to increase funding for the CSHA and to broaden the base of funding for HIV/AIDS work.

Objective

To increase funding for HIV/AIDS programs at the federal/provincial/territorial level across all sectors.

Action

- In the regions, the AIDS Community Action Program and Health Canada will seek out and develop project partnerships with other governmental regional coalitions, community-based organizations, and AIDS service organizations.
- A national organization (e.g., CAS) will develop a tool kit on how to access large corporate funders and foundations (e.g., sample query letters, proposals).

Comments and expressions of interest

- Planned Parenthood Federation of Canada has lots of information on this. A "tool kit" will be online in June 2002 (Julie Pentick, jpentick@ppfc.ca).
- The Manitoba AIDS Cooperative would work with others on a coordinated advocacy plan for CSHA dollars.
- CAS is willing to coordinate this action (look at what is already in existence, organize workshop at next Skills-Building Conference, identify partners, etc.).

Direction #5:
Build a Strategic Approach to Prevention

From the Gray Rocks Meeting Report

Statement of the Direction

The Canadian Strategy on HIV/AIDS (CSHA) will build a prevention strategy that sets specific **goals**, is based on **principles**, develops appropriate **strategies**, and includes culturally specific **programs**. This strategy must be coordinated nationally, developed collaboratively, and implemented locally.

Explanation of the Direction

The CSHA needs to become more strategic in its prevention efforts. It needs to establish specific goals and work toward those goals in a step-by-step fashion, laying the groundwork for innovative and risk-taking initiatives in accordance with fundamental principles and a deliberate strategy.

Suggested **goals** include

- a 50% reduction in HIV transmission;
- a decrease in the number of people in vulnerable situations;
- surveillance information in "real time" (not a year or more after the fact);
- wide public knowledge about how to prevent HIV transmission.

Suggested **principles** include the following:

- Preventing HIV transmission should be a priority.
- Harm reduction/risk reduction should be incorporated across the board (e.g., in alcohol and drug education programs and sexual health programs).
- Innovation and risk taking are necessary for effective prevention.
- Group-specific programs must be designed and implemented in collaboration with the communities for which they are intended.
- HIV prevention should be situated in the context of healthy sexuality.
- HIV prevention should be linked to the prevention of other infectious diseases (sexually transmitted diseases, hepatitis C).
- Primary prevention (prevention of HIV transmission) and secondary prevention (prevention of illness and transmission after infection) must be linked to HIV/AIDS care, treatment, and support.

Suggested **strategies** include

- a national Aboriginal HIV/AIDS strategy to reduce HIV transmission among Aboriginal peoples;
- a national prevention strategy for men who have sex with men, including gay men's wellness centres and aggressive anti-homophobia, anti-heterosexism campaigns;
- minimum national standards for an HIV/AIDS curriculum for educators;
- unambiguous sexual health education that starts early with adolescents;
- mechanisms to share expertise nationally on successful comprehensive programs that address vulnerability to HIV/AIDS;
- a continuous evaluation plan to ensure that programs are effective.

Suggested culturally specific **programs** include

- health rooms for vulnerable youth and drug users (safe injecting, referral to other services);
- peer education in prisons and with young offenders;
- specific HIV-prevention programs for women.

Action #1: Develop a Flexible, Coordinated, and Measurable Prevention Strategy

Preamble

The CSHA needs a prevention strategy with measurable targets to reduce HIV transmission, incorporating flexibility for regional variations. The strategy would

- reaffirm the principles set out in the Gray Rocks meeting;
- have a clearly defined purpose that recognizes the strategy's direct role within the federal government and its indirect role within provincial/territorial governments and other organizations;
- be transparent as to how decisions are made, so that activities are sustainable;
- build on existing work and merge with existing processes;
- take stakeholder roles and realities into account;
- recognize regional realities and "centres" in the HIV/AIDS epidemic, while also establishing standards available across the country;
- promote further analysis with regard to the shift from an individual approach to an individual and population health approach, the shift from harm elimination to harm

reduction, and the shift from isolation of HIV/AIDS work to integration of HIV/AIDS work;

- develop links and comparisons between surveillance data, research findings, and other ways of knowing.

The action outlined below describes the prevention strategy more fully and sets out a process for its development.

Objectives

- To incorporate a prevention strategy into the overall CSHA strategy.
- To achieve a reduction in HIV transmission, setting targets and markers to this end.

Description

The process to develop and implement a prevention strategy will

- build on existing frameworks;
- include specific activities for specific vulnerable populations;
- recognize regional diversity and government roles;
- integrate sexual health and hepatitis C;
- link with
  - research
  - surveillance
  - psychosocial knowledge
  - vaccine development;
- link with efforts to increase overall awareness of HIV/AIDS (Direction #1).

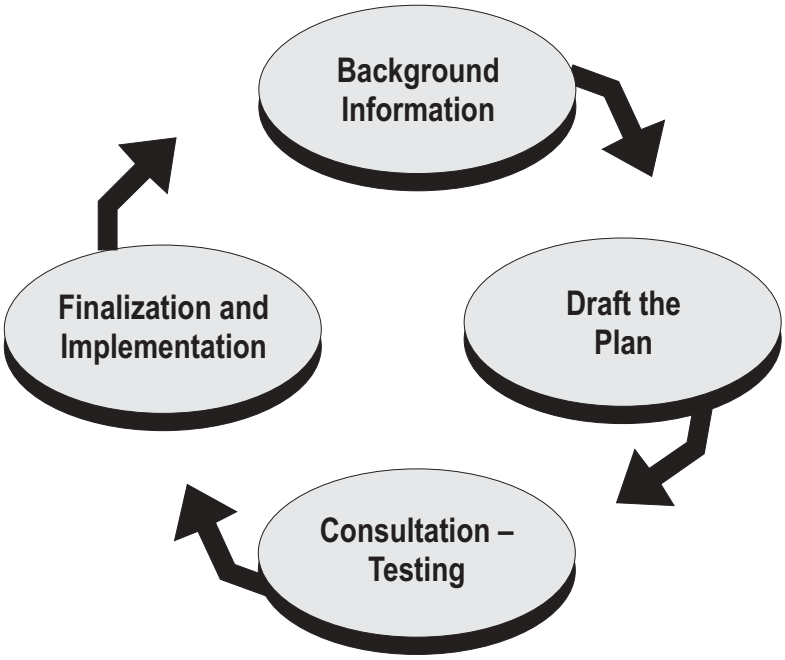
There are several steps in the process:

- research and analysis in collaboration with the CIHR;
- preparation of a draft strategy, drawing on
  - a national committee
  - specific subgroups
    - Health Canada matrix
    - other
  - national reference groups;

- consultation on the draft strategy;
- finalization of the strategy, including
  - implementation plan (March 2003)
  - evaluation/accountability plan (March 2003).

Lead

HIV/AIDS Policy, Coordination and Programs Division, Health Canada.



Commitments

Do you agree in principle with developing a prevention strategy?

- Robert Allen
- Neil Burke
- Phillip Haines
- Paul Hasselback, Canadian Public Health Association
- Annette Johns
- Ralf Jürgens (but it needs to be part of the five-year operational/strategic plan)
- Vuyiswa B. Keyi
- Beth McGinnis

- Stephanie Nixon (But don't lose sight of the interdependent and mutually reinforcing nature of *prevention* and *care*; and don't forget about secondary prevention, i.e. preventing complications in people already HIV-infected. This is a concern of the Canadian Working Group on HIV and Rehabilitation.)
- Marguerite Paiement

Do you want to be involved?

a) research and analysis

- The Canadian AIDS Society (CAS)
- The Canadian Association for HIV Research (CAHR) could help link organizers to appropriate research input.
- The Canadian HIV/AIDS Legal Network (for policy/legal/human rights analysis)
- Stephanie Nixon (with respect to vaccines)

b) developing draft strategy (working group, specific vulnerable subgroup)

- Barry Deeprose
- Annette Johns
- Vuyiswa B. Keyi
- Jane Oram
- CAS
- The CPHA

c) consultation

- Marguerite Paiement (Coordinator, STD/HIV/Hepatitis C Program, Montreal Public Health Department)
- CAS
- The CPHA
- The Canadian Working Group on HIV and Rehabilitation (can speak to secondary and tertiary prevention)
- The Manitoba AIDS Cooperative
- The Rainbow Health Coalition

d) communication (spread the word)

- CAS
- The CPHA could be contacted to act as a conduit.

e) be kept informed

- Phillip Haines
- Annette Johns
- Beth McGinnis
- Ken Mews, CAHR
- Marguerite Paiement
- CAS
- The CPHA
- Positive Women's Network (pwn@pwn.bc.ca)

Comments and expressions of interest

- Prevention of AIDS illness in HIV-positive people through effective treatment information and side-effects information (Canadian AIDS Treatment Information Exchange).
- Markers cannot be universal.
- Prevention in early emerging populations would not/could not be measured by a decrease in numbers.
- Promotion of self-esteem through cultural identity/engagement, sharing.
- Ensure you conduct community-based research in prevention, versus medical research.
- Gender issues missing.
- Vaccines and microbicides.
- Look at the United Nations General Assembly Special Session on HIV/AIDS Declaration of Commitment on HIV/AIDS for targets (Interagency Coalition on AIDS and Development [ICAD]).
- Vaccine strategy.
- Healing Our Nations is committed to prevention and is supportive of this work. Flexibility and variety to allow for *relevant* information and delivery to unique populations is imperative.
- The CPHA HIV/AIDS Clearinghouse to be on the Task Group.

Action #2: Summit on HIV/AIDS Prevention

Preamble

HIV/AIDS prevention involves many sectors: public health, addictions, education, community-based organizations, non-governmental organizations, health service providers, city officials, researchers, Health Canada, Correctional Service of Canada, etc. The Summit on HIV/AIDS Prevention would bring these sectors together to review the evidence for prevention—disease prevention, risk behaviour prevention, vulnerability prevention, economic burden of HIV/AIDS—and to exchange best practices in prevention.

Objectives

The purposes of the Summit would be to

- examine evidence for prevention;
- exchange best practices.

Description

The Summit would

- bring together key people who can have an impact on the prevention of HIV/AIDS and other diseases, such as hepatitis C and hepatitis B;
- review the most current evidence on prevention to identify gaps;
- provide a forum for sharing the strategies that work for different populations.

Outcomes

Participants would come away with

- increased knowledge of the evidence that supports prevention;
- a collection of proven ideas for programs, educational materials, projects *and other things that work!*

Time lines

- Planning committee established by June 30, 2002.
- Input from stakeholders June 30 to September 30, 2002.
- Summit date April 2003.

Commitments

Do you want to be part of the Summit?

- David Allison (St. John's)
- Cathy Eales
- Annette Johns (St. John's)
- Cindy MacIsaac (Halifax)
- Frank McGee (Ontario Ministry of Health)
- Beth McGinnis (New Brunswick)
- Heather Murray (Saskatchewan)
- Boyd Pelley (Council of Ministers of Education, Canada)
- Dianne Vaughan (Nova Scotia)

Comments and expressions of interest

- Bring international participants to this summit.
- Too soon.
- We need dollars.
- ICAD can advise on how to get dollars from the Canadian International Development Agency Conference Bureau on this.
- How would this be linked with development of five-year operational/strategic plan, existing (planned) conferences, and development of strategic prevention plan?
- A few—two? three? four?—years ago, Health Canada funded a one-day workshop/gathering around prevention, and it was added to a CAS Annual General Meeting. Look at the information from that in the planning of this. No need to reinvent the wheel.

Direction #6:
Build a Strategic Approach to Care, Treatment, and Support

From the Gray Rocks Meeting Report

Statement of the Direction

The Canadian Strategy on HIV/AIDS (CSHA) will build a strategic approach to care, treatment, and support to ensure that people with HIV/AIDS, including those co-infected with hepatitis C, have equal and seamless systemic access to care, treatment, and support; that the models and tools are available for individualized treatment; that treatment strategies are centred on quality of life as well as survival; and that all people with HIV/AIDS and co-infected have access to trials of treatments in Canada. This strategy will work to remove systemic barriers to access to care, treatment, and support, including barriers for prisoners and drug users. The criminalization of drug use is a major barrier and must be eliminated. The strategy will require a coordinated research strategy and adequate funding for research.

Explanation of the Direction

People with HIV/AIDS and those co-infected with hepatitis C should have **equal and seamless** access to care, treatment, and support across the health care system. Barriers to such access should be removed. These might include delays in the approval of drugs for use in Canada; delays in listing approved therapies in provincial/territorial formularies; barriers that result when the priorities of the pharmaceutical industry do not correspond to the needs of consumers; and lack of public insurance for components of the health care system. In addition, barriers specific to prisoners and drug users must be removed. Above all, the criminalization of drug use, a major barrier to care and treatment for drug users, must be eliminated.

Currently, people with HIV/AIDS confront many treatment decisions: when to start anti-retroviral therapies, whether to modify or switch therapeutic regimens, what to do in the event of successive treatment failure, and so on. They need access to the tools that will provide them and their physicians with individualized, specific, and reliable information in real time (CD4 testing, viral load testing, genotype testing, phenotype testing, therapeutic drug monitoring). There is also a need for population-based treatment models that can be customized for individual use.

Although people with HIV/AIDS are living longer as a result of anti-retroviral and other therapies, they are also experiencing numerous debilitating side effects. They need care, treatment, and support that will maintain or improve their quality of life as well as ensure their survival. Post-approval drug surveillance is essential to anticipating and managing the side effects of anti-retroviral treatment. Psycho-social research can assist in developing models of long-term care that centre on quality of life as well as survival.

There is a continuing need for access in Canada to trials of new experimental therapies for people with HIV/AIDS. These include not only industry-sponsored trials but also trials that industry will not sponsor. Canada is in a good position to mount niche trials, providing funding is secured.

Preamble to the Action Plans

People with HIV/AIDS and their caregivers require holistic care, treatment, and support. There are numerous issues that need to be addressed in this regard.

With regard to care, people with HIV/AIDS need access to

- affordable housing;
- legal services;
- a national pharmacare program;
- community health centres;
- alternative therapies, including medical marijuana;
- care for vicarious trauma of support workers.

With regard to treatment, people with HIV/AIDS need access to

- intersectoral qualitative and quantitative research;
- national treatment standards;
- drug monitoring (post-approval surveillance of toxicities and side effects);
- treatment in prisons;
- treatment for illegal immigrants or people admitted to Canada on a Ministerial Permit.

With regard to support, people with HIV/AIDS need access to

- peer support;
- support relevant to specific populations (gay men, people of African descent, women of racial diversity);
- research and support for HIV mental health issues.

The action plans below address three specific needs

- post-approval surveillance system;
- treatment information providers;
- a model for a holistic approach to care, treatment, and support.

Action #1: Post-Approval Surveillance System and Treatment Information Providers

1. Establish a post-approval surveillance system (PASS) for drug monitoring for anyone exposed to HIV drugs (including *in utero*).

Description

People with HIV/AIDS need a PASS that

- is an active system (not passive);
- is consumer-driven;
- includes reporting for *all* adverse events (side effects, toxicities) and benefits;
- obtains reports from anyone who comes in contact with the event, not just pharmaceutical companies.

Development of PASS will require

- resources;
- political will;
- methods of collection and analysis that are population-specific (including all relevant demographic information).

Time lines/milestones

- Political commitment (championing PASS).
- Once championed, have PASS in place by 2003-2004.

2. Treatment information providers

Description

People with HIV/AIDS need treatment information providers who are

- individual;
- locally based;
- population-specific;
- providers of ongoing support;
- located within communities.

The program should

- be peer-driven;
- recruit, train, retain, support, and compensate providers;
- provide individualized sessions with ongoing case management referrals;
- provide research for individuals as required;
- incorporate a community-based qualitative research model.

Time lines/milestones

- Private and public sector commitment and resources by 2003.

Signatories

- Todd Armstrong, Canadian Inuit HIV/AIDS Network
- Daryn Bond, Manitoba AIDS Cooperative
- Geoffrey Cole, Departmental Program Evaluation Division, Health Canada
- Barry Deeprose, deeprose@cyberus.ca
- Dionne A. Falconer/Michael O'Connor, Interagency Coalition on AIDS and Development (ICAD)
- James Froh, jfroh@health.gov.sk.ca
- Paul Hasselback (I will be willing to contact the Canadian Public Health Association to participate.)
- Gens Hellquist, Gay & Lesbian Health Services of Saskatoon
- Randy Jackson, Canadian Aboriginal AIDS Network APHA Co-ordination Program
- Vuyiswa B. Keyi, Toronto, vuyiswa@colosseum.com
- Myrna Majano, Myrna_Majano@hc-sc.gc.ca
- Laverne Monette, Ontario Aboriginal HIV/AIDS Strategy
- Stephanie Nixon, Canadian Working Group on HIV and Rehabilitation (regarding vaccines and secondary and tertiary prevention)

- Jane Oram, Health Canada
- Marilyn Sloane, Manitoba Corrections
- Steve Squibb, Ontario AIDS Network
- John Stinson, Manitoba AIDS Cooperative and Nine Circles Community Health Centre
- Canadian AIDS Society (CAS)
- HIV/AIDS Clearinghouse to be on planning committee

Comments and expressions of interest

- The HIV Therapies Enhanced Surveillance Project includes a number of HIV therapy monitoring projects (Health Canada, Marketed Health Products Directorate).

- Marketed Health Products Directorate coordinates a national post-approval surveillance and assessment system.

- Canadian Treatment Action Council (CTAC) PASS Community-Based Research Program in progress.

- Canadian AIDS Treatment Information Exchange (CATIE) and HIV/AIDS Clearinghouse Information Dissemination.

- CATIE provides national coordination role as called for in Health Canada's treatment information environmental scan.

- CATIE develops tools, training and models for building treatment information capacity in communities (geographic and "of interest").

- Mining of CATIE's data from treatment inquiry services: CATIE develops national templates for use by regional/local inquiry services in contributing on coordinated basis.

- Canadian Association for HIV/AIDS Research member input into CATIE Research Strategy, which could support this development.

- Canadian Working Group on HIV and Rehabilitation is committed to advancing education, awareness, and research with all stakeholders in rehabilitation in the control of HIV/AIDS and will look forward to participating in this initiative as appropriate (Stephanie Nixon, tel. 416-324-4182).

- ICAD can bring international best practices into this direction.

Action #2: Model for Holistic Approach to Care, Treatment, and Support

Objective

Develop a model to ensure that a holistic approach to care, treatment, and support is in place, including

- individual service plan and provision;
- community-based research;
- intersectoral collaboration.

(Words used to describe individual service plans include principles; values; choices; peer-driven; person-centred; continuum of care, support, treatment, prevention.)

Description and time line

- National criteria for service plans—developed by 2003
  - Identify multiple access points to care, treatment and support (e.g., population-specific agencies, clinics, etc.).
- Identify best practices in holistic approach to care, treatment, and support—mental, emotional, spiritual, physical—completed by January 2003.
- Educate, inform, and engage other sectors with regard to their links to HIV/AIDS and to the determinants of health—started by December 2002
  - Identify where resources and collaboration currently exist—completed by June 2003;
  - Policy document regarding who's doing what and who should be doing what—completed by March 2003.
- Model in place by 2004.

Comments and expressions of interest

- Hospice/palliative care.
- End-of-life issues missing—mentorship, training.
- Caregiving support.
- Vaccines and microbicides.
- See Action #1 for some of the links into making care, treatment, and support more seamless.
- Ensure linkages and consistency with developing social justice framework (Michael R. Smith, telephone 613-946-6675).
- CTAC recognizes treatment as a broad concept, including complementary/ alternative medicine and need for holistic care.
- CATIE coordination of training in community capacity-building for treatment information.
- CATIE coordination of health science professionals and community representatives in development of a national treatment information research strategy (as per recommendation of the Health Canada comprehensive review).
- ICAD can bring best practices as identified in other parts of the world.
- CAS would like to be a partner (e.g., policy document).
- Canadian Working Group on HIV and Rehabilitation is mandated to advance care, treatment, and support under the rubric of rehabilitation (broadly defined) in Canada and will look forward to participating in this initiative as appropriate (Stephanie Nixon, telephone 416-324-4182).
- Youth Clinical Services Inc. will provide expertise in this initiative around youth populations (Floydeen Charles-Fridal, Youth Clinical Services Inc., telephone 416-742-2514).
- Women's Health in Women's Hands best practice model can provide expertise related to black women and women of colour.

Direction #7:
Renew and Develop Human Resources

From the Gray Rocks Meeting Report

Statement of the Direction

The Canadian Strategy on HIV/AIDS (CSHA) will renew and sustain pan-Canadian human resources with **expertise** in HIV/AIDS and develop broad-based intersectoral human resources with **knowledge** of HIV/AIDS. Human resources are required in community-based staff, volunteers, health care providers, social service providers, and other sectors.

Explanation of the Direction

The CSHA has to create a strategy for renewal and development of human resources to deal with the complexity of the HIV/AIDS epidemic.

Three broad groups of human resources need to be addressed:

- community-based workers: HIV-specific workers (AIDS service organizations, AIDS consumer groups, health educators, clergy) and other community workers (dealing with the homeless, drug users, poverty, housing, other health issues);
- service providers: health care and social service providers, community health representatives, traditional healers, etc.;
- other: those working in justice, education, Aboriginal government, heritage, insurance, labour, immigration, etc.

The overall objectives of a human resources strategy should be

- to renew and sustain human resources with **expertise** in HIV/AIDS across Canada (HIV/AIDS health care providers, staff and volunteers in HIV/AIDS community-based organizations, etc.). The emphasis here should be on developing and renewing the expertise that Canada requires to deal with the increasing complexity of the HIV/AIDS epidemic.
- to develop a broad base of integrated human resources with **knowledge** of HIV/AIDS across all relevant sectors, both in government and in non-governmental organizations. The emphasis here should be on developing the range of competence that Canada requires to deal with all aspects of the HIV/AIDS epidemic in an integrated, intersectoral fashion.

Action #1: CSHA Multidisciplinary Human Resources Task Force

Preamble

The role of the task force would be to provide leadership and coordination for the development of a human resources action plan for the CSHA. Its work could include such things as

- a human resources needs assessment, integrated into the CSHA five-year operational/strategic plan;
- recruitment and retention through
  - mentoring
  - scholars-in-residence
  - research trainees
  - organizational development/bereavement project;
- education/training programs
  - comprehensive, multidisciplinary, multi-level HIV/AIDS curriculum
  - skills building
  - leadership program
  - treatment information training
  - cross-pollination between professional and community sectors.

The expected outcome would be larger, better-trained, more-involved, more secure, better-supported, longer-term human resources in all areas relevant to the CSHA in government, professional occupations, and community-based organizations.

Objective

To ensure better-trained, supported human resources in all areas relevant to the CSHA.

Description

A small, representative task force will examine human resources gaps and needs and develop strategies to address them.

It will include key stakeholders (i.e., people with HIV/AIDS, Health Canada, the Canadian Institutes of Health Research [CIHR], the Canadian Association for HIV Research [CAHR], the Canadian AIDS Society [CAS], the Canadian Aboriginal AIDS Network [CAAN], Human Resources Development Canada, professional associations, educators).

It could incorporate working committees that draw on a wider range of stakeholders in such areas as research, education, recruitment/retention.

Lead

Health Canada.

Time line

September 2002:	Task force identified and first meeting; Mandate and committee structure.
November 2002:	Committees meet.
April 2002:	Needs assessment completed.
September 2003:	National Forum on Human Resources in HIV/AIDS (to further a comprehensive human resources action plan).

Comments and expressions of interest

- The Ontario AIDS Network: Skill Building Program, Persons with HIV/AIDS Program, Community-based Research Capacity Building.
- The Canadian Skills Building Symposium, November 2003: workshops, tools.
- The injection drug users' networks included in membership!
- Facilitation training also needed. Community organizers and training for community organizers needed to engage vulnerable Canadians in HIV/AIDS prevention, etc.
- How do we train Aboriginal health care workers when Aboriginal people seem to have different challenges in life?
- Make resources available to people working on degrees part-time.
- Variable standards—not necessarily university-based (Canadian Inuit HIV/AIDS Network).
- The Canadian Treatment Action Council mandate includes membership and skills development.

- The Canadian Working Group on HIV and Rehabilitation already working on multiple initiatives to develop human resources regarding rehabilitation (broadly defined) in the context of HIV, e.g.:
  - persons with HIV/AIDS membership on our board;
  - HIV and rehabilitation workshops (great model!);
  - the list is endless!
- Initiative will be supported if membership of key stakeholders is expanded (Floydeen Charles-Fridal, Youth Clinical Services Inc., telephone 416-742-2514).
- Membership of the task force needs to be inclusive. Women's Health in Women's Hands will support this and would like to be included as a key stakeholder (telephone 416-593-7655).
- Regarding mentorship, the Interagency Coalition on AIDS and Development (ICAD) can help bring international experts to Canada in areas where they can help through (1) twinning and (2) exchanges.
- The Canadian AIDS Treatment Information Exchange (CATIE) to support training in treatment information.
- Roy Cain willing to work on education or research committee.
- CAAN: task force member and on one or two committees.
- National Secretariat on Homelessness, Human Resources Development Canada (telephone 1-819-956-9647).
- CAS is interested in development participation.
- The Planned Parenthood Federation of Canada (PPFC) may be interested in supporting this initiative (Julie Pentick, jpentick@ppfc.ca).
- We need to develop human resources in international issues and legal, ethical, human rights as well. There are some initiatives already, but this needs to be included. The Canadian HIV/AIDS Legal Network needs to participate in this initiative.
- CAHR can help with coordination of research input, given adequate resources.

Action #2: Canadian HIV/AIDS Directory

Preamble

We need to provide a way for *everyone* to identify who is working on HIV/AIDS in Canada.

Objective

To develop a web-based database of all people and organizations involved in the CSHA—a Canadian HIV/AIDS Directory.

Description

The directory is to be built upon existing initiatives (e.g., the CIHR, the Canadian Public Health Association, CAS, etc.).

It should be inclusive of community-based organizations other than AIDS service organizations and Canadians and organizations working on HIV/AIDS initiatives in Canada and internationally.

It should be searchable by name, area of interest, organization, geographic area, etc.

It should include job postings.

It should be funded through the CSHA.

It would provide a comprehensive inventory of people and organizations involved in the strategy.

Lead

- HIV/AIDS Clearinghouse, the Canadian Public Health Association.

Partners

- The CIHR;
- CAS;
- Others (see comments).

Time line

June 2002: Steering committee struck

- address information technology staffing as soon as possible;
- three full-time staff for the first year;
- one full-time staff to maintain the database.

December 2002: Complete inventory;
Identify gaps.

March 2003: Directory developed.

April 2003: Directory launched!

Comments and expressions of interest

- Can Industry Canada fund this project?
- Identify population-specific needs to include community health centres.
- Should be linked to initiative under Direction #3.
- Can this be linked to objective #3? It should be!
- Make-work project for CAS? *Let's not*.
- Good idea—Saskatchewan AIDS Network.
- Database should include people/organizations who can work internationally. ICAD would provide the input on this.
- CAAN: LinkUp-Connexion (telephone 1-888-285-2226, www.caan.ca).
- AIDS Committee of Newfoundland and Labrador.
- Manitoba AIDS Cooperative willing to share member group resource list.
- Cathey Earles, HIV/AIDS Project, Labrador, P.O. Box 767, Stn. B, Happy Valley, Labrador, A0P 1E0, cearles@nf.aibn.com.

- CATIE can share its database and provide advice as appropriate.
- The Canadian Working Group on HIV and Rehabilitation prepared to share its database and provide advice as appropriate.
- We are doing a web-based database at PPFC. It will list all our affiliates and the resources/programs they provide. We just finished developing it and can provide guidance and support to this process. We should be a partner here. Please contact us. Julie Pentick jpentick@ppfc.ca, telephone 613-241-4474, ext. 230.
- This doesn't have to be so complicated! It could be very simple and completed much sooner! I'd be happy to give you some ideas. I think this could be launched much sooner! (Julie Pentick, jpentick@ppfc.ca)

Direction #8:
Engage Vulnerable Canadians

From the Gray Rocks Meeting Report

Statement of the Direction

The Canadian Strategy on HIV/AIDS (CSHA) will meaningfully engage vulnerable individuals in Canada in an inclusive and empowering manner in order to build unique approaches that are flexible, innovative, measurable, and accountable. These approaches will be grounded in the determinants of health, will be community- and/or peer-driven, and will build the capacity of individuals and their communities to respond to the HIV epidemic.

Explanation of the Direction

The greatest increases and most dramatic shifts in the HIV/AIDS epidemic in Canada have been among Canadians who are vulnerable as a result of personal trauma, social marginalization, economic deprivation, and discrimination. These include people who use drugs, gay men, people born in countries where HIV/AIDS is endemic, women, Aboriginal peoples, prisoners. The CSHA must develop unique approaches to reduce the vulnerability of these individuals. These approaches must

- be developed together with these individuals through meaningful collaboration;
- be driven and delivered by vulnerable individuals and their communities;
- be comprehensive in their response;
- build the capacity of individuals and communities to address the factors that contribute to their vulnerability to the epidemic.

Three general themes should characterize the CSHA's efforts to build unique approaches for vulnerable individuals and their communities. The CSHA must

- recognize, confront, and work to eliminate systemic marginalization and oppression that result in vulnerability;
- be flexible and able to respond to changes in the epidemic at the local, community level;
- recognize that the situation is urgent because vulnerable groups have been ignored, and must take action immediately.

Action #1: Engaging Vulnerable Canadians

Preamble

Vulnerable Canadians must be engaged in an inclusive and empowering manner in order to build unique approaches that are flexible, innovative, and measurable.

To be vulnerable in the context of HIV/AIDS means

> to have little or no control over one's risk of acquiring HIV infection or, for those already infected with or affected by HIV, to have little or no access to appropriate care or support. Vulnerability is the net result of the interplay among many factors, both personal (including biological) and societal; it can be increased by a range of racial, religious, cultural, demographic, legal, economic and political factors. (Adapted from the Joint United Nations Programme on HIV/AIDS)

Description

Design a consumer-driven working group involving people from vulnerable populations to determine the initiatives, strategies, funding, etc., to

a) increase capacity for voice;
b) increase access to service;
c) increase education and knowledge.

This consumer-driven design is founded on inclusiveness, empowerment, flexibility, innovation, and the determinants of health, where they apply.

Comments and expressions of interest

- See initiative in Direction #1 for more concrete ways to have the voices heard.
- Initiatives must be designed by and for vulnerable populations.
- Everyone with HIV is a vulnerable person.
- The Canadian AIDS Society is interested in the development of this initiative—to be a partner, not the leader.
- Healing Our Nations is interested in supporting and developing unique and relevant programs, messages, and services.

- Youth Clinical Services Inc. will support outcomes from this initiative by way of expertise in working with youth (Floydeen Charles-Fridal, telephone 416-742-2514).

- The Correctional Service of Canada will give funding to inmate committees to engage this group in relevant access to services, increase knowledge and education, and give voice.

- The Canadian AIDS Treatment Information Exchange will support the treatment information needs of this initiative, e.g., through working in partnership with AIDS service organizations for specific target communities; reflecting vulnerable populations in research and publications.

- Laverne Monette, Ontario Aboriginal HIV/AIDS Strategy.

- The Interagency Coalition on AIDS and Development will support Direction #8 through

  - links to lessons learned from twinning;
  - helping to put effort into other twinning possibilities;
  - and more . . .

- The Canadian Aboriginal AIDS Network will participate and contribute Aboriginal expertise.

- Women's Health in Women's Hands Committee is interested in giving time and expertise to any initiatives coming out of this on behalf of the black communities from endemic countries.

- The Canadian Rainbow Health Coalition supports this and will participate concerning gay men (Barry Deeprose, deeprose@cyberus.ca).

- The Canadian HIV/AIDS Inuit Network will provide strategic leadership on this issue.

- Vuyiswa B. Keyi, vuyiswa@colosseum.com.

- Myrna_Majano@hc-sc.gc.ca, telephone 204-984-4258.

Direction #9:
Move to a Social Justice Framework

From the Gray Rocks Meeting Report

Statement of the Direction

The Canadian Strategy on HIV/AIDS (CSHA) will move to a social justice framework based on the determinants of health in order to address the vulnerabilities of people living with and vulnerable to HIV/AIDS. This framework will engage all sectors and levels of government and involve vulnerable populations in policy and program development, implementation, and evaluation.

Explanation of the Direction

The goals of the CSHA are to

- prevent the spread of HIV infection in Canada;
- find a cure;
- find and provide effective vaccines, drugs, and therapies;
- ensure care, treatment, and support for Canadians living with HIV/AIDS, their families, friends, and caregivers;
- minimize the adverse impact of HIV/AIDS on individuals and communities;
- minimize the impact of social and economic factors that increase individual and collective vulnerability to HIV.

If the CSHA is to make progress on the last three goals—if it is to reduce vulnerability to HIV/AIDS both before infection with HIV (primary prevention) and after infection (secondary prevention)—it must "reframe" the strategy in terms of social justice. Social justice places a primacy on such concepts as equity, accessibility, affordability, and respect for human rights in the provision of health care and social services. These and other values, based on the determinants of health, would guide policy and program development, implementation, and evaluation. The CSHA would be judged to have made progress when policies and programs meet the fundamental human needs and human rights of vulnerable Canadians.

Preamble to the Action Plans

We believe that social justice should guide the development of **all** Canadian public policy across **all** jurisdictions—**equity, fairness, and inclusion of all Canadians**—reflecting broad determinants of health and the broadest definition of health.

As stated in Direction #9, the CSHA will move to a social justice framework based on the determinants of health in order to address the vulnerabilities of people living with and vulnerable to HIV/AIDS. This framework will engage all sectors and levels of government and involve vulnerable populations in policy and program development, implementation, and evaluation.

Guiding principles for a social justice approach:

- an **integrative** approach;
- an approach that operates **across the determinants of health**;
- a rights-based approach that **respects, promotes, and fulfils rights**;
- an approach that presents a lens of **social inclusion** for policy design, program development, evaluation, etc.

Action #1: Develop Social Justice Values and Principles

Objective

The purpose of this action is to

- articulate social justice values and principles and develop concrete tools (for use by policy makers, in program design, evaluation, etc.);
- ensure that equity, fairness, and inclusion guide this work and assist in priority setting.

Description

Steps in the process are as follows:

- develop and clarify social justice values and principles;
- determine Health Canada's role;
- collaborate with other groups and sectors regarding current thinking about social justice;
- explore community building.

The action should look at existing tools that translate values into concrete actions. In this regard, it should consider

- who needs or wants to be involved;
- the role of Health Canada working across jurisdictions;
- the establishment of a task group of community group representatives to advise or work with Health Canada and "create clamour" (with funding) throughout the HIV/AIDS movement.

Comments and expressions of interest

- Vuyiswa Keyi, African Community Health Services (telephone 416-856-9145, vuyiswa@colosseum.com).

- Laverne Monette, Ontario Aboriginal HIV/AIDS Strategy, 2-Spirited People from the First Nations.

- Josephine Muxlow, Correctional Service of Canada (telephone 613-943-1919).

- Shannon Nix, Research – National Secretariat on Homelessness, Human Resources Development Canada, telephone 819-956-9647.

- Jane Oram, Health Canada, telephone 902-426-2701, Jane_Oram@hc-sc.gc.ca.

- Kathleen Stephenson, kstephenson@sympatico.ca—very interested; some experience in developing tools like this; could contribute if there is some appropriate role.

- The Canadian AIDS Treatment Information Exchange (CATIE) works with communities of culturally specific origins to meet the treatment information needs of those communities; always willing to continue this involvement.

- The Canadian AIDS Society (CAS) would like to be an active partner.

Action #2: Advocate a National Housing Policy/Strategy

Preamble

The CSHA needs to recognize housing as a key determinant of health and reinforce the link between housing and the needs of people with and vulnerable to HIV/AIDS.

The CSHA should partner with others who are advocating housing as a right.

Objective

The purpose of the action is to advocate a national housing policy/strategy that reflects the housing and support needs of vulnerable populations, e.g., people with HIV/AIDS and their families, drug users and their families.

Description

- Pull together research that establishes the links between vulnerability, disease, and housing.
- Identify models or types of housing and supports that are needed and work to meet immediate or projected needs.
- Prepare and disseminate reports and fact sheets.
- Connect with other groups advocating housing to share information and get support.
- Coordinate efforts of all housing advocacy groups.
- Advocate specific responses for people with HIV/AIDS (i.e., housed within 24 hours; Portland Hotel's no eviction policy).

Comments and expressions of interest

- Beric German, Street Health and Toronto Disaster Relief Committee (TDRC), telephone 416-921-8668. To get information about housing networks, contact Ms. Musond Kidd, telephone 416-599-TDRC (8372).
- Yes, this is good. Nunavut is in the process of drafting a new Human Rights Act. Inuit Tapiriit Kanatami supports the inclusion of housing as a right in the new Act (John MacDougall, johnmac@nunanet.com).

- Positive Women's Network: "Listen Up!" – Women's Health Research Project (pwn@pwn.bc.ca).
- Shannon Nix, Research – National Secretariat on Homelessness, Human Resources Development Canada, telephone 819-956-9647.
- CAS members will be partners.

Action #3: Capacity Building

Preamble

Within a social justice framework, the CSHA helps all sectors develop the capacity to address the broader determinants of health that underline vulnerability to HIV/AIDS through

- capacity building;
- learning;
- skills development;
- working across sectors, including correctional services.

The capacity building is for communities, groups, organizations, and individuals.

Description

- Develop communications tools to help people explain the link between determinants of health and disease.
- Combat injustice and inequality.
- Re-invigorate and re-energize at all levels to work with vulnerable groups in development of policies.
- Self-advocacy: skills and information.

Comments and expressions of interest

- CATIE is developing a model for community capacity building in treatment information.
- Use links with existing Canadian HIV/AIDS Legal Network projects (such as projects on HIV/AIDS and discrimination and projects on a rights-based approach).
- The Interagency Coalition on AIDS and Development could help bring international examples.
- The Canadian Public Health Association to provide public health and population health background information support.
- CAS is interested in the development of this initiative.
- Positive Women's Network: "Listen up!" – Women's Health Research Project (Valerie Van Clieaf, Coordinator, telephone 604-692-3000, pwn@pwn.bc.ca).
- ASIA – Asian Society for the Intervention of AIDS (telephone 604-669-5567, asia.bc.ca).
- Myrna_Majano@hc-sc.gc.ca.

Direction #10:
Develop a Five-Year Operational/Strategic Plan

From the Gray Rocks Meeting Report

Statement of the Direction

The Canadian Strategy on HIV/AIDS (CSHA) will develop a five-year operational/strategic plan that builds S.M.A.R.T.E.R. (Specific, Measurable, Attainable, Realistic, Time-limited, Effective, Relevant) objectives for each of the strategic areas derived from the goals of the CSHA. Work plans will be developed from these objectives and will include the following components: objectives, activities, time lines, outcomes, indicators, and data measurement methods. Both the S.M.A.R.T.E.R. objectives and the work plans will be informed by and account for the determinants of health and the CSHA's policy directions. Both the objectives and the work plans will be evaluated.

Explanation of the Direction

The CSHA needs to develop an operational/strategic plan that is

- long-term (five years);
- detailed (identifying specific interventions, such as syringe exchanges in prisons, and the steps required to achieve them);
- measurable (with outcomes that can be measured and evaluated);
- flexible and nimble (capable of changing quickly when the epidemic shifts).

This operational/strategic plan would

- be built on the goals and components of the CSHA;
- be based on the principles of the CSHA and the determinants of health;
- incorporate S.M.A.R.T.E.R. objectives for each area of activity;
- develop work plans that include objectives, activities, time lines, outcomes, indicators, and data measurement methods;
- adopt an evaluation process that aims at reciprocal accountability among the partners and stakeholders in the CSHA.

Action #1: Develop a Five-Year Operational/Strategic Plan

Preamble

The purpose of this action is to move forward on Direction #10 of the Gray Rocks meeting and, in fact, develop a five-year operational/strategic plan. The statement and explanation of Direction #10 in the report from that meeting, as well as the challenges that were identified then, continue to be valid.

The operational/strategic plan should be based on the goals of the CSHA—which continue to be sound—and develop objectives for each of those goals. In addition, the plan should

- be based on the determinants of health;
- include existing commitments (e.g., the United Nations General Assembly Special Session on HIV/AIDS Declaration of Commitment on HIV/AIDS);
- be bold;
- be strategic (in recognition of the fact that we cannot do everything and that tough choices will have to be made);
- be flexible, allowing organizations to agree to the objectives while still giving them options with respect to activities;
- identify best practices;
- include a statement of roles and responsibilities;
- include a monitoring and evaluation component; and
- include the outcomes from the work done on the other nine directions.

Description

Two groups should be established to move forward on this action:

- a small group (4-6 people), whose members have expertise in planning processes and expert knowledge of the CSHA (membership should also include people with HIV/AIDS), to design the strategic planning process (a process design group);

- a larger group (10-12 people) to develop the five-year operational strategic plan (an operational/strategic planning group).

The role of the process design group will be to design the strategic planning process. It should also develop criteria for membership in the second group and a draft Terms of Reference to guide the work of the second group.

The role of the operational/strategic planning group will be to develop a draft five-year operational/strategic plan, consult on the draft plan, and complete a final plan incorporating revisions from the consultations.

To assist these two groups, there should be some research to identify what is done in Canada and internationally in strategic planning. This research should consider

- background information on strategic plans in HIV/AIDS and other areas of health, such as tobacco and cancer;
- differences in the contexts and approaches of the provinces;
- Canada's national and international commitments on HIV/AIDS;
- the outcomes of the National Reference Groups;
- Treasury Board Secretariat submission requirements regarding extension of the CSHA.

Communications will be an ongoing and essential part of the process. It is necessary for the credibility of the process, buy-in, and meaningful consultations. A communications plan should be developed and implemented alongside the planning process, with the advice of experts in communications.

Time line

	Action	End Date
1.	Budget commitment	April 22, 2002
2.	Research/background information	August 31, 2002
3.	Set up of the process design group	June 1, 2002
4.	Completed process design	September 3, 2002
5.	Establishment of the operational/strategic planning group	September 30, 2002
6.	Five-year operational plan	
	• first draft	February 2003
	• consultations	June 2003
	• revisions	August 2003
	• plan completed	December 1, 2003
7.	Communications plan	Ongoing

Comments and expressions of interest

Discussion in plenary

When a preliminary version of the action plan was presented in plenary, there were a number of comments and questions that should be noted:

- How will the other nine directions fit into the five-year operational/strategic plan? What level of priority will the other nine directions have in relation to each other and within the five-year operational/strategic plan?
- How will the outcomes of the National Reference Groups be incorporated into the five-year operational/strategic plan?
- There are many barriers that inhibit us from achieving targets in HIV/AIDS work. These barriers are complex and difficult to overcome. One view in the plenary was that specific targets are bound to fail and that failure will be used in arguments against HIV/AIDS work. Another view in the plenary was that the five-year operational/strategic plan would have to identify not only the targets but also what is needed to achieve the targets, in clear and specific terms.
- Strategic planning is not a linear process. This is especially the case in HIV/AIDS work, where there is tremendous diversity, many working groups, numerous constituencies with specific needs, and political dynamics. What planning process will work in this context?

Suggested background documents

- Check with Swiss government and non-governmental experience on strategic planning.
- Provincial strategies and documents (i.e., Ontario is developing a similar operational plan).
- Documents from task forces.
- Experiences of other disease/health strategies.
- HIV/AIDS Clearinghouse/CSHA archives.
- There is a plan for action on legal, ethical, and human rights issues from 1998 to 2003.
- Check with Direction #1 for some of the ways to make connections within community, within government, and between community and government.

- Manitoba AIDS Cooperative: (1) Standards of Care Report; (2) Integrated Model of Service Delivery document; (3) others (Daryn Bond, John Stinson).

- The Canadian AIDS Society (CAS) can also provide background information.

What would turn you on about this plan?

- Providing clearer direction to work on the front line so that scarce resources are used most efficiently.

- Ensure that the working group is consumer-driven.

- That it takes an information-based/learning-based approach that understands the CSHA from a systems perspective (for example, see the work of Peter Senge, Margaret Wheatley).

- Coordination with Direction #5.

- Funding, and the commitment to get more funds.

- Make the plan time- and cost-effective. Hire someone to bring together what is known, including material from this conference. Put it out as a draft for consultation and feedback. The greater levels of depth come from encouraging alignment "with" and "of" the strategic plans of the various collaborative organizations.

Other comments

- Existing coalitions—provincial/territorial, national—should be brought together or asked to inform some of the outcomes here. They have a lobbying role to play.

- Consider making room for regional input, consultations, and discussion. Perhaps Directions #3 - #6 should occur regionally, and then the national, overall plan would be developed (add six months).

- The Canadian HIV/AIDS Legal Network is committed to this plan and will assist as much as possible, particularly on legal, ethical, and human rights components, but also on other components for which legal/policy analysis is required (prevention; care, treatment, and support, etc.).

- CAS would like to be part of an advisory committee.

- Vaccine strategy would like to be part of this.

- Include me in the working group meeting (Jeff Anderson, British Columbia Persons With AIDS Society).

Appendix A: Membership of the Direction-Setting Process Task Group, Canadian Strategy on HIV/AIDS

Members	Organization/Committee
Todd Armstrong	National Aboriginal Council on HIV/AIDS
Nina Arron (Chair)	Centre for Infectious Disease Prevention and Control, Health Canada
Louise Binder	Ministerial Council on HIV/AIDS, Canadian Treatment Action Council
Jennifer Hebert	Ministerial Council on HIV/AIDS
Glen Hillson	British Columbia Persons With AIDS Society, Canadian Treatment Action Council
David Hoe	Centre for Infectious Disease Prevention and Control, Health Canada
Stephen James	British Columbia - Yukon Regional Office, Health Canada
Paul Laybolt	AIDS Coalition of Nova Scotia
Frank McGee	Federal/Provincial/Territorial Advisory Committee on AIDS
Bruce Moor	Canadian Institutes of Health Research
Michael O'Connor	Interagency Coalition on AIDS and Development
Donald Sutherland	Centre for Infectious Disease Prevention and Control, Health Canada
Nancy Sutton	Correctional Service of Canada
Karl Tibelius	Canadian Institutes of Health Research
Art Zoccole	National Aboriginal Council on HIV/AIDS, Canadian Aboriginal AIDS Network

Appendix B: Participant List

Group	Organizations	Representatives
HIV/AIDS-specific organizations, coalitions and networks	**National**	
	Canadian Aboriginal AIDS Network	Ken Clement, Trevor Stratton
	Canadian AIDS Society	Paul Lapierre, Michael Yoder
	Canadian Association for HIV Research	Eleanor Maticka-Tyndale, Ken Mews
	Canadian HIV/AIDS Legal Network	Ralf Jürgens
	Canadian HIV/AIDS Clearinghouse, Canadian Public Health Association	Paul Kenney
	Canadian HIV Trials Network	Martin Schechter
	Canadian Treatment Action Council	Daryn Bond, Tony Di Pede
	Canadian AIDS Treatment Information Exchange	Patrick Cupido, Anne Swarbrick
	Interagency Coalition on AIDS and Development	Dionne Falconer, Michael O'Connor
	Canadian Coalition of Organizations Responding to AIDS	Phil Rauch
	Provincial	
	AIDS Coalition of Nova Scotia	Robert Allan
	AIDS New Brunswick	Margaret Dykeman
	AIDS PEI	Barbara Gibson
	Alberta Community Council on HIV	Kevin Midbo
	COCQ-SIDA	Lyse Pinault
	Manitoba AIDS Cooperative	John Stinson
	AIDS Committee of Newfoundland and Labrador	Bill Downer
	Canadian HIV/AIDS Inuit Network (Nunavut)	Franco Buscemi
	Ontario AIDS Network	Steve Squibb
	Pacific AIDS Network	Phillip Haines
	Saskatchewan AIDS Network	Tamara Shoup
	Driven by people living with HIV/AIDS	
	British Columbia Persons With AIDS Society	Jeff Anderson
	Comité de personnes atteintes du VIH/sida	Guy Germaine
	Living Positive	Margaret McGinn
	Toronto Persons With AIDS Foundation	Laurie Edmiston
	Victoria Persons With AIDS Society	Penny Bradford
	Population-specific	
	Endemic/Ethnocultural	
	Endemic Task Force	Floydeen Charles-Fridal
	Asian Society for Intervention in AIDS	Caitlin Johnston
	GAP-VIES	Joseph Jean-Gilles
	African Community Health Services	Vuyiswa Keyi

Group	Organizations	Representatives
HIV/AIDS-specific organizations, coalitions and networks (continued)	***Prisoners***	
	Prisoners' HIV/AIDS Support Action Network	Koshala Nallanayagam
	Children/Families	
	Teresa Group	Karen Vance-Wallace
	The Centre for AIDS Services of Montreal (Women)	Daniella Boulay-Coppens
	Youth	
	Youthco AIDS Society	Jennifer Evin-Jones
	Positive Youth Outreach	Alex McClelland
	Aboriginal	
	Healing our Nations	Renée Masching
	Manitoba First Nations HIV/AIDS Working Group	Larry Starr
	Ontario Aboriginal HIV/AIDS Strategy	LaVerne Monette
	Red Road Society	Bernice Doucet-Ryan
	IDU	
	Vancouver Area Network of Drug Users	Ann Livingston, Dean Wilson
	Mainline Needle Exchange	Cindy MacIsaac
	Street Health Community Nursing Foundation	Beric German
	Gay Men	
	Rainbow Health Coalition	Barry Deeprose
	Gay & Lesbian Health Services of Saskatoon	Gens Hellquist
	Action Séro Zéro	René Lavoie
	Seniors	
	AIDS Committee of Toronto	Ed Argo
	Women	
	Positive Women's Network	Marcie Summers
	Voices of Positive Women	Janet Rowe
	Women's Health in Women's Hands Community Health Centre	Eunadie Johnson
	Sex Trade Workers	
	Stella	Sylvie Gendron/Claire Thiboutot
Public health and other health care organizations	Vancouver Native Health Society	Leonard Laplante
	Canadian Centre on Substance Abuse	Nina Frey
	Canadian Public Health Association	Paul Hasselback
	Medical Officers of Health/Public Health Departments	David Allison, John Blatherwick, Marguerite Paiement
	Planned Parenthood Federation of Canada	Julie Pentick
	Canadian Hospice Palliative Care Association	Sharon Baxter

Group	Organizations	Representatives
Professional associations	Canadian Association of Social Workers	Antoinette Lambert
	Canadian Working Group on HIV Rehabilitation	Stephanie Nixon
Aboriginal organizations	Assembly of First Nations	Anita Stevens
	Congress of Aboriginal Peoples	Debra Wright
	Inuit Tapiriit Kanatami	John MacDougall
	Métis National Council	Don Fiddler
	National Indian and Inuit Community Health Representatives Organization	Aleda Morris
	National Association of Friendship Centres	Alfred Gay
	National Aboriginal Health Association	Harry Adams
	Pauktuutit Inuit Women's Association	Todd Armstrong
Researchers and research organizations	CANFAR	Joan Bosworth
	Ontario HIV Treatment Network	Patricia Balogh
	Community-Based Research Program	Roy Cain, Francisco Ibanez-Carrasco
	Aboriginal Research Program	Randy Jackson, Mac Saulis
	McGill AIDS Centre	Bluma Brenner
	Université de Montréal	Aline Rinfret, Rafick-Pierre Sékaly
	University of Toronto	Liviana M. Calzavara
	Université Laval	Léonard Mukenge-Tshibaka
	University of Ottawa	Judy Mill
Government departments	**Federal**	
	Canadian Institutes of Health Research	Jennifer Gunning, Bruce Moor, Earl Nowgesic, Karl Tibelius
	Canadian International Development Agency	Chris Armstrong
	Correctional Service of Canada	Josephine Muxlow, Nancy Sutton
	Health Canada	
	1. Centre for Infectious Disease Prevention and Control	Chris Archibald, Nina Arron, Howard Njoo, Paul Sandstrom, Grafton Spooner, Donald Sutherland, Susan Tolton, Tom Wong, Ping Yan
	2. Communications, Marketing and Consultation Directorate	Roslyn Tremblay
	3. Regional Offices, Population and Public Health Branch (PPHB)	Brenda Cantin, Hélène Chalifoux, Stephen James, Len Lopez, Myrna Majano, Jane Oram
	4. First Nations and Inuit Health Branch and Regional Offices	Lucie Dessureault, Marion Perrin, May Toulouse

Group	Organizations	Representatives
Government departments (continued)	**Federal (continued)**	
	Health Canada (continued)	
	5. International Affairs Directorate	Reeta Bhatia, Suzy McDonald
	6. Program Evaluation Division	Geoffrey Cole, Karen Gittens
	7. Therapeutic Products Directorate	Brian Foster, Susanne Reid
	8. Office of Canada's Drug Strategy	Joanne Lacroix
	9. Strategic Policy Directorate, PPHB	Etienne-René Massie
	10. Women's Health Bureau	Jacqueline Gahagan
	Human Resources Development Canada	Shannon Nix
	Indian Affairs and Northern Development	Janice Birney
	Status of Women Canada	Duy Ai Kien
	Treasury Board Secretariat	Marie-Hélène Legaré
	Provincial	
	British Columbia	Elena Kanigan, Gerrit van der Leer
	Newfoundland and Labrador	Cathey Earles, Annette Johns
	New Brunswick	Beth McGinnis, Leslie Reid
	Nova Scotia	Mahnaz Farhangmehr, Dianne Vaughan
	Ontario	Frank McGee
	Prince Edward Island	Jean Fallis, Anne Neatby
	Quebec	Horacio Arruda
	Saskatchewan	James Froh, Heather Murray
	Yukon	Bryce Larke
	Other	
	Council of Ministers of Education, Canada	Boyd Pelley
CSHA committees/ working groups	CSHA Direction-Setting Process Task Group	Louise Binder, Jennifer Hebert, Paul Laybolt
	F/P/T Advisory Committee on AIDS	Bryce Larke
	F/P/T Heads of Corrections Working Group on HIV/AIDS	Marilyn Sloane
	Community-Based Research Steering Committee	Jean Beauchemin, Lynne Leonard
	International Working Group on HIV/AIDS	Shaun Mellors
	Ministerial Council on HIV/AIDS	Don Kilby, Esther Tharao
	National Aboriginal Council on HIV/AIDS	Todd Armstrong, Renée Masching, Art Zoccole

Group	Organizations	Representatives
Organizers	Health Canada.....	Fernand Comeau, Ross Hammond, Marsha Hay Snyder, David Hoe, Kathy Rice, Sue Rivoire, Lori-Ann Smith, Steven Sternthal
	Facilitator - Leap Corporation	Alan Sobel
	Breakout facilitators	Alain Houde, Nathalie Lévesque, Patti Murphy, Carmen Paquette, Kathleen Stephenson, Douglas Stewart, Cynthia Taylor, Ingrid Wellmeier, Gerard Yetman, Arlo Yuzicapi Fayant
	Breakout resource people	Neil Burke, David Garmaise, Louise Hanvey, Michael Smith
	Recorder	Theodore de Bruyn
	Presenters	Louise Binder, Glen Brown, Liviana Calzavara, Paul Lapierre, Michael O'Connor, Michael Rachlis, Art Zoccole

Regrets

Marion André, Health Canada
Lucille Auffrey, Canadian Nurses Association
Raven Bowen, PACE
Lori Crozier, Blood Ties Four Direction (Yukon)
Joss Dewit, Canadian HIV Mentorship Program
Linda Findlay, Government of Alberta
Claudine Gaye, Wabano Centre for Aboriginal Health
Sheila Genaille, Métis National Council of Women
Neil Heywood, Citizenship and Immigration Canada
Glen Hillson, Direction-Setting Process Task Group
John Hiscott, McGill AIDS Centre
Andrew Johnson, Canadian Association of Nurses in AIDS Care
Debra Keays-White, Health Canada
Dawn Krahn, Government of Manitoba
Lisette Lafontaine, Justice Canada
Paulette Lefebvre, Canada Customs and Revenue Agency
Karine Lévesque, University of Montreal
Isra Levy, Canadian Medical Association
Michael Linhart, Canadian HIV/AIDS Legal Network
Ian Matheson, Privy Council Office
Michael McCulloch, Health Canada
Judith McIntyre, Government of Yukon
Susan Murdock, Heritage Canada
Nena Nera, Health Canada
Geraldine Osbourne, Government of Nunavut
Frank Plummer, University of Manitoba
Morgan Pond, Government of Newfoundland and Labrador
Donald Reed, Health Canada
Jonathan Roy, Finance Canada
Jeff Scott, Council of Provincial Medical Officers of Health
Sheila Sears, Government of Northwest Territories
Peter Taylor, Foreign Affairs and International Trade Canada
Marianne Tonnelier, CACTUS
Sara Urowitz, University of Toronto
Mark Wainberg, McGill AIDS Centre
Jim Zamparelli, Canada Mortgage and Housing Corporation
Christina Zarowski, International Development Research Centre