Survey Response Details

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1) **Country**

Canada (0)

2) **Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any:**

Tanya Lary

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7) **Date of submission:**

Please enter in DD/MM/YYYY format

31/03/2010

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8) **Describe the process used for NCPI data gathering and validation:**

The Public Health Agency of Canada (PHAC) led the preparation of the 2010 submission of the UNGASS Report. PHAC prepared the initial drafts of the Main Section, Annex 1 and Part A of the National Composite Policy Index, in consultation with other government departments participating in the federal response to HIV and AIDS. A draft was sent out for consultation to provincial and

territorial government representatives, federal advisory and coordination committees, and national non-governmental organizations. Enhancements were made to the document based on the feedback received. In a separate process, PHAC initiated a contract with an external consultant to prepare Part B of the National Composite Policy Index – the 'NGO Annex' – in consultation with national HIV/AIDS non-governmental organizations. This process was followed by a teleconference with national non-governmental organizations to review and discuss the findings of the entire report.

9) Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:

Both Government and non-governmental organizations were given the opportunity to review the text of the entire report. The government of Canada reviewed the NGO Annex for errors of fact, and communicated comments through the external consultant.

10)

Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):

Many of the questions in the NCPI are difficult to answer given Canada's federal system of government where responsibilities for the response to HIV and AIDS are split among different levels of government. For many answers, an additional nuanced and detailed description was provided in addition to the answer to the NCPI questions. The full text of Canada's response is available at the Public Health Agency of Canada's website: http://www.phac-aspc.gc.ca/aids-sida/

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11)

NCPI - PART A [to be administered to government officials]

	Organization	Names/Positions	Respondents to Part A [Indicate which parts each respondent was queried on]
Respondent 1	PHAC, HIV/AIDS Policy, Coordination and Programs Division	Marsha Hay-Snyder, A/Director	A.I, A.II, A.III, A.IV, A.V

12)

	Organization	Names/Positions	Respondents to Part A [Indicate which parts each respondent was queried on]
Respondent 2	PHAC, HIV/AIDS Policy, Coordination and Programs Division	Tanya Lary, Senior Policy Advisor	A.I, A.II, A.III, A.IV, A.V
Respondent 3	PHAC, HIV/AIDS Policy, Coordination and Programs Division	Grafton Spooner, Manager	A.I, A.II
Respondent 4	PHAC, HIV/AIDS Policy, Coordination and Programs Division	Jackie Arthur, Manager	A.III, A.IV
Respondent 5	PHAC, HIV/AIDS Policy, Coordination and Programs Division	Militza Zencovich, Senior Evaluation Analyst	A.V
Respondent 6	PHAC, HIV/AIDS Policy, Coordination and Programs Division	Maxim, Trubnikov, Policy Analyst	A.III
Respondent 7	PHAC, HIV/AIDS Policy, Coordination and Programs Division	Alian Houde, Senior Policy Advisor	A.IV
Respondent	PHAC, HIV/AIDS Policy, Coordination	Stephanie Mehta,	A.V

8	and Programs Division	Senior Policy Analyst	A.V
Respondent 9	PHAC, Surveillance and Risk Assessment Division	Chris Archibald, Director	A.V
Respondent 10	Canadian Institutes of Health Research	Jennifer Gunning, Associate Director	A.III
Respondent 11	Communicable Disease Control, Dpeartment of National Defence		A.I
Respondent 12	Correctional Service Canada	Mary Beth Pongrac, Project Officer	A.III
Respondent 13	HIV/AIDS-STBBI Program, First Nations and Inuit Health Branch, Health Canada	Tihut Asfaw, A/Lead	A.I, A.III
Respondent 14			
Respondent 15			
Respondent 16			
Respondent 17			
Respondent 18			
Respondent 19			
Respondent 20			
Respondent 21			
Respondent 22			
Respondent 23			
Respondent 24			
Respondent 25			

13)

NCPI - PART B [to be administered to civil society organizations, bilateral agencies, and UN organizations]

	Organization	Names/Positions	Respondents to Part B [Indicate which parts each respondent was queried on]
Respondent 1	Canadian AIDS Society	Monique Doolittle-Romas, Executive Director	B.I, B.II

14)

	Organization	Names/Positions	Respondents to Part B [Indicate which parts each respondent was queried on]
Respondent 2	Canadian Aboriginal AIDS Network	Ken Clement, Executive Director	B.I, B.II, B.III, B.IV
Respondent	Canadian AIDS Treatment	Laurie Edmiston, Executive	

Respondent 3	Canadian AIDS Treatment Information Exchange	Laurie Edmiston, Executive Director	B.I, B.II, B.III, B.IV
Respondent 4	Canadian Association for HIV Research	Bill Cameron, President	B.I, B.II, B.III, B.IV
Respondent 5	CIHR Canadian HIV Trials Network	David Cox, Chief Adminstrative Officer	B.I, B.II, B.III, B.IV
Respondent 6	Canadian Public Health Association	Ian Culbert, Director, Corporate and Business Development	B.I, B.II, B.III, B.IV
Respondent 7	Canadian Treatment Action Council	Ron Rosenes, Board-Co-Chair	B.I, B.II, B.III, B.IV
Respondent 8	Canadian Working Group on HIV and Rehabilitation	Elisse Zack, Executive Director	B.I, B.II, B.III, B.IV
Respondent 9	Interagency Coalition on AIDS and Development	Nicci Stein, Executive Director	B.I, B.II, B.III, B.IV
Respondent 10	Canadian HIV/AIDS Legal Network	Richard Elliott, Executive Director	B.I, B.II
Respondent 11	Canadian AIDS Society	Bachir Sarr, Programs Consultant	B.III
Respondent 12	Canadian AIDS Society	Stephen Alexander, Programs Consultant	B.IV
Respondent 13	Canadian Aboriginal AIDS Network	Art Zoccole, Board Chair	B.I, B.II, B.III, B.IV
Respondent 14	Canadian Treatment Action Council	Louise Binder, Board Co-Chair	B.I, B.II, B.III, B.IV
Respondent 15	CIHR Canadian HIV Trials Network	Kevin Pendergraft, Communications Manager	B.I, B.II, B.III, B.IV
Respondent 16	Canadian Association of HIV Research	Robert O'Neill, Executive Director	B.I, B.II, B.III, B.IV
Respondent 17			
Respondent 18			
Respondent 19			
Respondent 20			
Respondent 21			
Respondent 22			
Respondent 23			
Respondent 24			
Respondent 25			

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15)

Part A, Section I: STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV?

(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)

Yes (0)

Page 7

16)

Part A, Section I: STRATEGIC PLAN

Question 1 (continued)
Period covered:

2005-ongoing

17)

1.1 How long has the country had a multisectoral strategy?

Number of Years

19

18)

1.2 Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

	Included in strategy	Earmarked budget
Health	Yes	Yes
Education	No	No
Labour	No	No
Transportation	No	No
Military/Police	No	No
Women	Yes	No
Young people	Yes	No
Other*		

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19)

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?

While there is not an earmarked budget for women and young people, there is funding available for HIV-specific activities targetted at these groups.

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20)

Part A, Section I: STRATEGIC PLAN

1.3 Does the multisectoral strategy address the following target populations, settings and crosscutting issues?

Target populations	
a. Women and girls	Yes
b. Young women/young men	Yes
c. Injecting drug users	Yes
d. Men who have sex with men	Yes
e. Sex workers	No
f. Orphans and other vulnerable children	No
g. Other specific vulnerable subpopulations*	Yes
Settings	
h. Workplace	Yes
i. Schools	Yes
j. Prisons	Yes
Cross-cutting issues	
k.HIV and poverty	Yes
l. Human rights protection	Yes
m. Involvement of people living with HIV	Yes
n. Addressing stigma and discrimination	Yes
o. Gender empowerment and/or gender equality	Yes

21)

1.4 Were target populations identified through a needs assessment?

Yes (0)

Page 10

22)

Part A, Section I: STRATEGIC PLAN

Question 1.4 (continued)
IF YES, when was this needs assessment conducted?

Please enter the year in yyyy format

2004

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23)

Part A, Section I: STRATEGIC PLAN

1.5 What are the identified target populations for HIV programmes in the country?

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

24)

1.6 Does the multisectoral strategy include an operational plan?

Yes (0)

25)

1.7 Does the multisectoral strategy or operational plan include:

a. Formal programme goals?	Yes
b. Clear targets or milestones?	Yes
c. Detailed costs for each programmatic area?	Yes
d. An indication of funding sources to support programme?	Yes
e. A monitoring and evaluation framework?	Yes

26)

1.8 Has the country ensured "full involvement and participation" of civil society* in the development of the multisectoral strategy?

No involvement (0)

Page 12

27)

IF NO or MODERATE involvement, briefly explain why this was the case:

The Federal Initiative was developed as part of an internal to government process, however, the federal government conducts regular consultations with civil society on a range of HIV/AIDS issues, and has formal advisory and coordination bodies with significant civil society participation (Ministerial Advisory Council on the Federal Initiative, the National Aboriginal Council on HIV/AIDS, the National Stakeholders Group). These bodies provide advice on current and emerging issues.

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28)

Part A, Section I: STRATEGIC PLAN

2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment / UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?

N/A (0)

Page 16

29)

Part A, Section I: STRATEGIC PLAN

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?

Yes (0)

Page 17

30)

Part A, Section I: STRATEGIC PLAN

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

5 (5)

31)

4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?

Yes (0)

Page 18

32)

Part A, Section I: STRATEGIC PLAN

4.1 *IF YES*, which of the following programmes have been implemented beyond the pilot stage to reach a signifi cant proportion of the uniformed services?

Behavioural change communication	Yes
Condom provision	Yes
HIV testing and counselling	Yes
Sexually transmitted infection services	Yes
Antiretroviral treatment	Yes
Care and support	Yes
Other: Please specify	

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33)

Part A, Section I: STRATEGIC PLAN

Question 4.1 (continued)
If HIV testing and counselling *is provided* to uniformed services, briefly describe the approach taken to HIV testing and counselling (e.g, indicate if HIV testing is voluntary or mandatory etc):

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

34)

5. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations or other vulnerable subpopulations?

Yes (0)

Page 20

35)

Part A, Section I: STRATEGIC PLAN

5.1 *IF YES,* for which subpopulations?

a. Women	Yes
b. Young people	Yes
c. Injecting drug users	Yes
d. Men who have sex with men	Yes
e. Sex Workers	Yes
f. Prison inmates	Yes
g. Migrants/mobile populations	Yes
Other: Please specify	Yes

36)

IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:

Section 15 of the Canadian Charter of Rights and Freedoms applies to any legislation or actions of the federal and provincial or territorial governments. It gives people equal benefit and equal protection of the law without being discriminated against because of race, national or ethnic origin, colour, religion, sex, age, mental or physical disability. It also protects people from being discriminated against due to sexual orientation, marital status and citizenship. The Canadian Human Rights Act and provincial and territorial human rights legislation prohibit discrimination based on characteristics such as race, national or ethnic origin, colour, religion, age, sex, sexual orientation, marital status, family status, and disability and conviction for which a pardon has been granted. All related legislation, policy, and practices must be in harmony with the Canadian Charter of Rights and Freedoms, as well as the principles of administrative law. Every province in Canada has a public legal education organization that can inform Canadians about their rights. Canada has anti-discrimination commissions, such as the Canadian Human Rights Commission, which are independent statutory bodies created by federal, provincial and territorial human rights legislation. They are generally mandated to mediate and investigate complaints of discrimination under the prohibited grounds in their respective legislation. Commissions also work to prevent discrimination by undertaking human rights education and promotional activities.

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37)

Part A, Section I: STRATEGIC PLAN

6. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations?

No (0)

Page 23

38)

Part A, Section I: STRATEGIC PLAN

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

Yes (0)

Page 24

39)

7.2 Have the estimates of the size of the main target populations been updated?

Yes (0)

Page 25

40)

Part A, Section I: STRATEGIC PLAN

7.3 Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?

Estimates of current and future needs (0)

41)

7.4 Is HIV programme coverage being monitored?

Yes (0)

Page 26

42)

Part A, Section I: STRATEGIC PLAN

Question 7.4 (continued)
(a) IF YES, is coverage monitored by sex (male, female)?

Yes (0)

43)

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

Yes (0)

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44)

Part A, Section I: STRATEGIC PLAN

Question 7.4 (b) (continued)
IF YES, for which population groups?

The populations vary from jurisdiction to jurisdiction, but the main groups covered are gay men and other men who have sex with men, people who use injection drugs, Aboriginal peoples, women, people from countries where HIV is endemic, people in prisons, youth at risk, people living with HIV/AIDS

45)

Briefly explain how this information is used:

This information is used to develop policies and programmes targeted to the needs and realities of specific populations.

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46)

Part A, Section I: STRATEGIC PLAN

Question 7.4 (continued)
(c) Is coverage monitored by geographical area?

Yes (0)

Page 29

47)

Part A, Section I: STRATEGIC PLAN

Question 7.4 (c) (continued)
IF YES, at which geographical levels (provincial, district, other)?

provincial/territorial

48)

Briefly explain how this information is used:

This information is used to develop policies and programmes targeted to the needs and realities of specific populations in the different provinces and territories.

Page 30

49)

Since 2007, what have been key achievements in this area:

• The Government of Canada has strengthened horizontal coordination and management in its response to HIV and AIDS • Detailed second generation surveillance studies have continued, with the addition of a new Track on Aboriginal peoples and the planning for another on people from countries where HIV is endemic.

50)

What are remaining challenges in this area:

• The collection of national data, particularly on treatment issues continues to be a challenge. • Canada's data on the socioeconomic impact of HIV need to be updated. • Many of the factors determining vulnerability and resilience to HIV and AIDS are beyond the scope of the health sector, including poverty, education, housing, stigma, and discrimination.

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51)

Part A, Section II: POLITICAL SUPPORT

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

President/Head of government	No
Other high officials	Yes
Other officials in regions and/or districts	Yes

52)

2. Does the country have an officially recognized national multisectoral AIDS coordination body (i.e., a National AIDS Council or equivalent)?

Yes (0)

Page 34

53)

Part A, Section II: POLITICAL SUPPORT

3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?

Yes (0)

Page 35

54)

Part A, Section II: POLITICAL SUPPORT

Question 3 (continued)
IF YES, briefly describe the main achievements:

Consultation and coordination among governments, people living with HIV/AIDS, civil society and the private sector are fundamental to the Canadian response to HIV and AIDS in both developing and implementing strategies and programmes. Under the Federal Initiative, several groups serve as mechanisms to consult and coordinate on specific issues. The Consultative Group on Global

HIV/AIDS Issues is a forum for non-governmental organizations to advise federal departments and agencies on the global epidemic and for all parties to discuss issues of collaboration and policy coherence to ensure a more effective Canadian response. Individual status reports are being prepared on the key populations identified in the Federal Initiative. These reports will comprise comprehensive factual information to depict the current picture of each population. A working group made up of members of the affected population, researchers, experts in the field, community organizations and government guide the development of each report. A CIHR HIV/AIDS Research Advisory Committee, made up of researchers, community representatives (including people living with HIV/AIDS), health research institutes, PHAC and the Ministerial Council, provides leadership and advice regarding research priorities and strategic HIV/AIDS research programs. Broad public consultations on key policy issues are also fundamental to the federal response to HIV and AIDS (e.g. in 2009, PHAC held large consultations on the development of a prevention framework and guidelines for testing and counselling)

55)

Briefly describe the main challenges:

While consultation and interaction with key stakeholders are key to the federal government response, final decision making and accountability relating to policy and program design and budget allocations rests with the government.

56)

5. What kind of support does the National AIDS Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

Information on priority needs	Yes
Technical guidance	Yes
Procurement and distribution of drugs or other supplies	No
Coordination with other implementing partners	Yes
Capacity-building	Yes
Other: Please specify	

57)

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

Yes (0)

Page 36

58)

Part A, Section II: POLITICAL SUPPORT

6.1 IF YES, were policies and laws amended to be consistent with the National AIDS Control policies?

No (0)

Page 38

59)

Since 2007, what have been key achievements in this area:

• PHAC has conducted a review of its advisory and coordinating committees to ensure that effective mechanisms are in place to meet the current and future needs of the Federal Initiative. In consultation with the advisory and coordinating committees, PHAC is developing a response to this review including revisions to Terms of Reference, improved efficiencies, and enhanced information sharing and exchange.

60)

What are remaining challenges in this area:

• Canada is a federation, and responsibilities for prevention, care, treatment and support are shared across different levels of government. While this allows for flexibility in developing approaches that are targeted to local needs and realities, it can also lead to challenges in tracking national level data.

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61)

Part A, Section III: PREVENTION

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

Yes (0)

Page 40

62)

Part A, Section III: PREVENTION

1.1 IF YES, what key messages are explicitly promoted?

Check for key message explicitly promoted (multiple options allowed)

a. Be sexually abstinent (0)
b. Delay sexual debut (0)
e. Use condoms consistently (0)
f. Engage in safe(r) sex (0)
h. Abstain from injecting drugs (0)
i. Use clean needles and syringes (0)
j. Fight against violence against women (0)
k. Greater acceptance and involvement of people living with HIV (0)

n. Know your HIV status (0)
o. Prevent mother-to-child transmission of HIV (0)

63) **In addition to the above mentioned, please specify other key messages explicitly promoted:**

Anti-stigma and discrimination

64)

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

No (0)

Page 41

65)

Part A, Section III: PREVENTION

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

Yes (0)

66)

2.1 Is HIV education part of the curriculum in:

primary schools?	Yes
secondary schools?	Yes
teacher training?	Yes

67)

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

Yes (0)

68)

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

No (0)

69)

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for most-at-risk or other vulnerable sub-populations?

Yes (0)

Page 42

70)

3.1 IF YES, which populations and what elements of HIV prevention do the policy/strategy address?

Check which specific populations and elements are included in the policy/strategy

Targeted information on risk reduction and HIV education	Injecting drug user, Men having sex with men, Sex workers, Prison inmates, Other populations
Stigma and discrimination reduction	Injecting drug user, Men having sex with men, Other populations
Condom promotion	Injecting drug user, Men having sex with men, Sex workers, Prison inmates, Other populations
HIV testing and counselling	Injecting drug user, Men having sex with men, Sex workers, Prison inmates, Other populations
Reproductive health, including sexually transmitted infections prevention and treatment	Injecting drug user, Men having sex with men, Sex workers, Prison inmates, Other populations
Vulnerability reduction (e.g. income generation)	Injecting drug user, Sex workers, Prison inmates, Other populations
Drug substitution therapy	Injecting drug user, Other populations
Needle & syringe exchange	Injecting drug user, Other populations

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71)

Part A, III. PREVENTION

Question 3.1 (continued)

You have checked one or more policy/strategy for "Other populations". Please specify what are "other populations".

Aboriginal peoples, people living with HIV/AIDS, women, youth at risk, People from countries where HIV/AIDS is endemic

Page 44

72)

Since 2007, what have been key achievements in this area:

• Since 2005, focused policy efforts for key populations have been further developed at the federal level and in the provinces most affected by HIV and AIDS. Status Reports include status of the epidemic; describe the profile of affected populations; present major factors affecting vulnerability and resiliency of key populations; and summarizes best practices for prevention, current research and program interventions in response to the ongoing transmission of HIV. The federal government is playing a leadership role in coordinating efforts on prevention across a wide range of sectors. • In 2009, the Government of Canada completed an online public consultation for the development of an HIV Prevention Framework. A number of key concepts and essential elements and approaches in HIV prevention have been validated. Valuable feedback was received which will be further used in the development of theHIV Prevention Framework and related guidelines.

73)

What are remaining challenges in this area:

• Many of the factors that influence vulnerability to HIV – such as mental health, self-esteem, drug addiction and risk-taking behaviours – are complex and far -reaching. These factors require a concerted whole-of-government approach to foster healthy child development, healthy parenting, employment and skills development.

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74)

Part A, III. PREVENTION

4. Has the country identified specific needs for HIV prevention programmes?

Yes (0)

Page 46

75)

4.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access
Blood safety	Agree
Universal precautions in health care settings	Agree
Prevention of mother-to-child transmission of HIV	Agree
IEC* on risk reduction	Agree
IEC* on stigma and discrimination reduction	Agree
Condom promotion	Agree
HIV testing and counselling	Agree
Harm reduction for injecting drug users	Agree
Risk reduction for men who have sex with men	Agree
Risk reduction for sex workers	Agree
Reproductive health services including sexually transmitted infections prevention and treatment	Agree
School-based HIV education for young people	Agree
HIV prevention for out-of-school young people	Agree
HIV prevention in the workplace	N/A
Other: please specify	

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76)

Since 2007, what have been key achievements in this area:

• Since 2007 there has been increased funding to programmatic responses, and increased sharing of information on best practices. The voluntary sector has been key to the successful

implementation of these programmes.

77)

What are remaining challenges in this area:

• An estimated 2,500 people still become infected each year, despite the widespread availability of information and prevention tools. • There is a growing contribution of Canadian scientists to international HIV and AIDS prevention research in a number of areas.

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78)

Part A, Section IV: TREATMENT, CARE AND SUPPORT

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

Yes (0)

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79)

Part A, Section IV: TREATMENT, CARE AND SUPPORT

1.1 IF YES, does it address barriers for women?

Yes (0)

80)

1.2 IF YES, does it address barriers for most-at-risk populations?

Yes (0)

81)

2. Has the country identified the specific needs for HIV treatment, care and support services?

Yes (0)

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82)

2.1 To what extent have the following HIV treatment, care and support services been implemented?

	The majority of people in need have access

HIV treatment, care and support service	
Antiretroviral therapy	Agree
Nutritional care	Agree
Paediatric AIDS treatment	Agree
Sexually transmitted infection management	Agree
Psychosocial support for people living with HIV and their families	Agree
Home-based care	Agree
Palliative care and treatment of common HIV-related infections	Agree
HIV testing and counselling for TB patients	Agree
TB screening for HIV-infected people	Agree
TB preventive therapy for HIV-infected people	Agree
TB infection control in HIV treatment and care facilities	Agree
Cotrimoxazole prophylaxis in HIV-infected people	Agree
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree
HIV treatment services in the workplace or treatment referral systems through the workplace	N/A
HIV care and support in the workplace (including alternative working arrangements)	Agree
Other: please specify	

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83)

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

Yes (0)

Page 52

84)

Part A, Section IV: TREATMENT, CARE AND SUPPORT

Question 4 (continued)
IF YES, for which commodities?:

Anti-retrovirals, medicines for HIV-related conditions, condoms and substitution drugs are available in all jurisdictions.

Page 53

85)

Since 2007, what have been key achievements in this area:

- Increased funding through regional funding programmes to community support

86)

What are remaining challenges in this area:

- An estimated 26% of people in Canada who are living with HIV are unaware of their status, and

therefore are not accessing care, treatment and support services. • Access to treatment remains a concern for people living with HIV and AIDS, especially for those living in rural settings or on reserves where concerns around confidentiality are paramount. • Drug coverage under provincial/territorial plans and private insurance plans differs across the country and may affect access to treatment. • While treatments have increased the life expectancy and have improved the quality of life of people living with HIV/AIDS, they have created workplace accommodation and rehabilitation challenges, and are still accompanied by side-effects (e.g. lipodistrophy, cardiovascular disease, diabetes, liver and neuropathy dysfunctions) • As the population of people living with HIV/AIDS grows older, new challenges associated with HIV and aging are emerging.

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87)

Part A, Section IV: TREATMENT, CARE AND SUPPORT

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

N/A (0)

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88)

Part A, Section V: MONITORING AND EVALUATION

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

Yes (0)

Page 58

89)

1.1 IF YES, years covered:
Please enter the start year in yyyy format below

1985

90)

1.2 IF YES, was the M&E plan endorsed by key partners in M&E?

Yes (0)

91)

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

No (0)

92)

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

Yes, all partners (0)

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93)

Part A, Section V: MONITORING AND EVALUATION

2. Does the national Monitoring and Evaluation plan include?

a data collection strategy	Yes
a well-defined standardised set of indicators	Yes
guidelines on tools for data collection	Yes
a strategy for assessing data quality (i.e., validity, reliability)	Yes
a data analysis strategy	Yes
a data dissemination and use strategy	Yes

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94)

Part A, Section V: MONITORING AND EVALUATION

Question 2 (continued)
If you check "YES" indicating the national M&E plan include a data collection strategy, then does this data collection strategy address:

routine programme monitoring	Yes
behavioural surveys	Yes
HIV surveillance	Yes
Evaluation / research studies	Yes

95)

3. Is there a budget for implementation of the M&E plan?

Yes (0)

Page 62

96)

Part A, Section V: MONITORING AND EVALUATION

3.1 IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities?

Please enter the rounded percentage (1-100). If the percentage is less than 1, please enter "1".

13

97)

3.2 IF YES, has full funding been secured?

Yes (0)

98)

3.3 IF YES, are M&E expenditures being monitored?

Yes (0)

Page 64

99)

4. Are M&E priorities determined through a national M&E system assessment?

Yes (0)

Page 65

100)

Part A, Section V: MONITORING AND EVALUATION

Question 4 (continued)
IF YES, briefly describe how often a national M&E assessment is conducted and what the assessment involves:

Federal investments are monitored on an ongoing basis. There are annual reports to the Parliament of Canada, and assessments against relevance, efficiency and effectiveness are required every five years.

101)

5. Is there a functional national M&E Unit?

Yes (0)

Page 66

102)

5.1 IF YES, is the national M&E Unit based

in the National AIDS Commission (or equivalent)?	No
in the Ministry of Health?	No
Public Health Agency of Canada	Yes

103) **Number of permanent staff:**

Please enter an integer greater than or equal to 0

26

104) **Number of temporary staff:**

Please enter an integer greater than or equal to 0

0

Page 68

105)

Part A, Section V: MONITORING AND EVALUATION

5.3 IF YES, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

Yes (0)

Page 69

106) **Part A, Section V: MONITORING AND EVALUATION**

Question 5.3 (continued)
IF YES, briefly describe the data-sharing mechanisms:

For surveillance data, memoranda of understanding are in place with provinces and territories to share data with the federal government. Canada produces many surveillance and epidemiological reports, including annual HIV/AIDS Epi Updates, and a semi-annual report entitled HIV and AIDS in Canada, Surveillance Report. These are accessible electronically on the PHAC website. For programme data, federal government partners submit their M&E data and reports to the HIV/AIDS Policy, Coordination and Programs Division, Accountability and Awareness Section.

107)

What are the major challenges?

There may be a delay between the time when a person tests positive for HIV or is given a diagnosis of AIDS and the time when the report is received by PHAC. PHAC is currently working on an improved process of estimating under and delayed reporting of AIDS diagnoses and expects to publish findings using these methods in upcoming reports. The number of reported AIDS cases and positive HIV test reports at any point in time is not necessarily a true reflection of the total number of people with a diagnosis of AIDS or HIV infection. This is because some individuals with a diagnosis of HIV infection or AIDS are never reported to PHAC. This may lead to underreporting of cases. Ethnicity data is not available for all the provinces and territories; which can lead to difficulties in tracking national level trends for subpopulations. For the Federal Initiative’s horizontal approach, challenges include the fact that each federal department has its own accountability and evaluation structure, which may include different approaches, timelines, indicators and reporting formats, resulting in multiple reporting efforts. The updating of the Results-Based Management Accountability Framework, with key results identified for each department in a common logical framework, should help address this challenge.

Page 70

108)

Part A, Section V: MONITORING AND EVALUATION

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

Yes, meets regularly (0)

109)

6.1 Does it include representation from civil society?

No (0)

Page 71

110)

7. Is there a central national database with HIV- related data?

Yes (0)

Page 72

111)

Part A, Section V: MONITORING AND EVALUATION

7.1 IF YES , briefly describe the national database and who manages it:

There is a central national data base for surveillance information, managed by the Surveillance and Risk Assessment Division, PHAC. There is a grants and contributions database, covering all funded projects in PHAC and Health Canada. The Canadian Institutes of Health Research (CIHR) also manages a database with information on all research grants and awards.

112)

7.2 IF YES, does it include information about the content, target populations and geographical coverage of HIV services, as well as their implementing organizations?

Yes, all of the above (0)

Page 73

113)

7.3 Is there a functional* Health Information System?

At national level	Yes
At subnational level	Yes

Page 74

114)

Part A, Section V: MONITORING AND EVALUATION

For Question 7.2, you have checked "Yes, but only some of the above", please specify what the central database has included.

For Question 7.3, you have indicated "Yes" to "subnational level", please specify at what level(s)?

Provincial/territorial and municipal

115)

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

Yes (0)

116)

9. To what extent are M&E data used

9.1 in developing / revising the national AIDS strategy?:

5 (5)

117)

Provide a specific example:

Surveillance and epidemiological data and results from funded projects are used to identify priorities for federal policy work. The current development of a Prevention Framework is informed by the data showing where and in what populations new infections are occurring.

Page 75

118) **Part A, Section V: MONITORING AND EVALUATION**

9.2 To what extent are M&E data used for resource allocation?

5 (5)

119)

Provide a specific example:

Surveillance and epidemiological data demonstrated the need to fund targeted work among specific populations. Combined with input from affected populations and program recipients, the information was used to increase knowledge, awareness, and collaboration among specific populations, such as Aboriginal peoples living off reserve.

Page 76

120)

Part A, Section V: MONITORING AND EVALUATION

9.3 To what extent are M&E data used for programme improvement?:

5 (5)

121)

Provide a specific example:

The Canadian Guidelines for Sexual Health Education were updated in 2008, based on a national evaluation. As a result, the language used in the guidelines was revised to reflect Canada's diverse populations.

122)

What are the main challenges, if any?

Personnel in frontline organizations have a varying capacity to analyze and synthesize data.

Page 77

123) **Part A, Section V: MONITORING AND EVALUATION**

10. Is there a plan for increasing human capacity in M&E at national, subnational and service-delivery levels?:

Yes, at all levels (0)

Page 78

124)

10.1 In the last year, was training in M&E conducted

At national level?	Yes
At subnational level?	
At service delivery level including civil society?	Yes

Page 80

125)

Part A, Section V: MONITORING AND EVALUATION

10.2 Were other M&E capacity-building activities conducted other than training?

Yes (0)

Page 81

126) **Part A, Section V: MONITORING AND EVALUATION**

Question 10.2 (continued)
IF YES, describe what types of activities:

In 2009, Federal Initiative departments and agencies participated in a revision of the Results-

Based Management and Accountability Framework, which required capacity-building on logical frameworks, performance monitoring and indicator development.

Page 82

127)

Since 2007, what have been key achievements in this area:

• The completion of an Implementation Evaluation, leading to recommendations to strengthen horizontal management and finalize the Performance Measurement System and the Information Management System. • The revision of the Results-Based Management and Accountability Framework is a key accomplishment in response to this evaluation. • An electronic performance measurement system is under development.

128)

What are remaining challenges in this area:

• Implementing the performance measurement system is challenging as participating departments and agencies have different approaches to monitoring.

Page 83

129)

Part B, Section I: HUMAN RIGHTS

1. Does the country have laws and regulations that protect people living with HIV against discrimination? (including both general non-discrimination provisions and provisions that specifi cally mention HIV, focus on schooling, housing, employment, health care etc.)

Yes (0)

Page 84

130)

Part B, Section I. HUMAN RIGHTS

1.1 IF YES, specify if HIV is specifically mentioned and how or if this is a general nondiscrimination provision:

Canada has general non-discrimination provisions but does not have provisions that specifically mention HIV. Section 15(1) of the Canadian Charter of Rights and Freedoms, which is part of the country’s Constitution and which applies to all laws and other actions by governments and other state actors in Canada, states: Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

131)

2. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations and other vulnerable subpopulations?

Yes (0)

Page 85

132)

Part B, Section I. HUMAN RIGHTS

2.1 *IF YES,* for which subpopulations?

a. Women	Yes
b. Young people	Yes
c. Injecting drug users	Yes
d. Men who have sex with men	Yes
e. Sex Workers	No
f. prison inmates	No
g. Migrants/mobile populations	Yes
Persons with disabilities	Yes

133)

IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:

Human rights commissions and/or tribunals exist at the national and provincial levels. Individuals and groups may seek redress through the courts, although this process can be lengthy and costly. Until its abolition by the federal government in 2006, the Court Challenges Programme provided some funding to support test-case litigation under the equality rights section of the Canadian Charter. This program helped support important equality rights litigation.

134)

Briefly describe the content of these laws:

Section 15(1) of the Canadian Charter of Rights and Freedoms, which applies to all laws and other actions by governments in Canada, states: Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability. All populations listed in I.2.1 can therefore be considered to be protected against discrimination, although some populations are not specifically mentioned in the Charter.

135)

Briefly comment on the degree to which they are currently implemented:

Canada has enacted anti-discrimination legislation at both the federal and provincial/territorial levels which prohibits discrimination based on “disability” or “handicap” by both public and private actors. Individuals with HIV/AIDS may therefore seek protection under these laws. Under the Canadian Human Rights Act, people living with HIV are protected from HIV-based discrimination in the federal jurisdiction because HIV is considered a disability in the context of anti-discrimination

law with respect to any employment, goods, services, facilities or accommodation or access thereto or occupancy of any commercial premises or residential accommodation. These protections apply to both the private and public sector. There is a need for the prohibition of discrimination in all circumstances, including those outside of issues of disability, on the basis of HIV status alone, as well as discrimination against those who are vulnerable. Enforcement of these anti-discrimination statutes requires constructive, innovative approaches and the combined efforts of civil society and all levels of government to promote and enhance compliance. The Government of Canada tabled a motion in Parliament in December 2009 to ratify the United Nations Convention on the Rights of Persons with Disabilities passed by the United Nations General Assembly in 2006. Several NGOs have collaborated on a study of the implications of the Convention for Canada. Challenges remain with respect to groups not currently specified in the Charter of Rights and Freedoms and other statutes, including persons who use drugs (drug addiction/dependence is recognized in some anti-discrimination statutes as a disability); sex workers and prisoners. While prisoners are not specifically named in the Charter, federal offenders living with HIV are protected under Correctional Service of Canada policy from discrimination on the basis of their HIV status (Commissioner's Directive 821). A collaborative approach to legal reforms is desirable – one that involves government and civil society, including representatives of affected groups.

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136)

Part B, Section I. HUMAN RIGHTS

3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable subpopulations?

Yes (0)

Page 87

137)

Part B, Section I. HUMAN RIGHTS

3.1 *IF YES,* for which subpopulations?

a. Women	No
b. Young people	No
c. Injecting drug users	Yes
d. Men who have sex with men	No
e. Sex Workers	Yes
f. prison inmates	Yes
g. Migrants/mobile populations	Yes
Persons living with HIV	Yes

138)

IF YES, briefly describe the content of these laws, regulations or policies:

Please see comments below.

139)

Briefly comment on how they pose barriers:

Criminalization of HIV transmission It is a criminal offence in Canada to transmit or expose another person to HIV through unprotected sex. In recent years, legislators and courts have decided that the criminal law requires people living with HIV to disclose their HIV status before engaging in behaviours that risk transmitting HIV. As a consequence, some people living with HIV have been convicted of serious criminal offences, such as aggravated sexual assault or grievous bodily harm, and sentenced to significant time in prison for failing to disclose their HIV status. Civil society organizations have taken the position that HIV transmission is a public health issue, rather than a criminal issue. Sub-populations that experience discrimination Legal obstacles exist to effective HIV prevention and treatment for several sub-populations. First Nations peoples, for example, experience differing applications of the law depending on whether they are on-reserve or off-reserve and may experience differing access to services. Although there are barriers to HIV prevention, care, treatment and support for many of the populations named in the questionnaire, we limit ourselves here to a brief summary with respect to just three of these populations: prisoners, injection drug users and sex workers. Prisoners There is uneven access to prevention programs in Canada's prisons. In particular, lack of access to prison-based sterile syringe programs or safe tattooing programs and uneven access to condoms and other safer sex materials adversely affect public health efforts to combat the spread of HIV among prison populations. There is also uneven access to treatment and the continuum of care, including in-prison and post-discharge services. The example of limited access to opiate substitution therapy (e.g. methadone) serves to illustrate the impact of restricted access to prevention on the prison population. Methadone is a narcotic medication licensed for use in Canada to treat opiate addiction. Substitution therapy has been described by in a joint WHO, UNODC and UNAIDS report in the following terms: Medicines used in substitution therapy can be prescribed either in decreasing doses over short periods of time (usually less than one month) for treatment of withdrawal or for detoxification, or in relatively stable doses over a long period of time (usually more than six months) for substitution maintenance therapy, which allows stabilization of brain functions and prevention of craving and withdrawal. Substitution maintenance therapy is one of the most effective types of pharmacological therapy of opioid dependence. There is consistent evidence from numerous controlled trials, large longitudinal studies and programme evaluations, that substitution maintenance treatment for opioid dependence is associated with generally substantial reductions in illicit opioid use, criminal activity, deaths due to overdose, and behaviours with a high risk of HIV transmission. Correctional Service of Canada (CSC) has substance abuse programs designed specifically for women, men and Aboriginal peoples. Barriers can exist, however, because in the prison setting, many prisoners may be reluctant to ask for help from the same people who are responsible for imprisoning them. Prisoners cannot disclose struggles with their recovery from drug addiction because of the zero-tolerance drug policy. Consequences for a drug-positive urine test can include increased security, loss of escorted temporary absences and unescorted temporary absences, loss of contact visits with family, not getting released on parole, etc. Continuation of methadone maintenance therapy (MMT) for people imprisoned in Canada is becoming more common. In the federal correctional system, CSC policy provides both for the continuation of MMT for adult prisoners who were receiving it before incarceration and the initiation of MMT while incarcerated for those for whom it is medically indicated. CSC also provides Suboxozone (buprenorphine). In practice, difficulties in accessing opioid substitution therapy can persist even in the face of good policy. There is a compelling case to be made for government and civil society to work together to consider adopting the most efficacious evidence-based public health prevention strategies appropriate to the issues of HIV and prisoners. People who inject illegal drugs The Public Health Agency of Canada estimates that 17% of new HIV infections in Canada are among people who inject drugs. In recent years steps have been taken by the federal government that reduce harm reduction as an element of a comprehensive drug strategy. The National Anti-Drug Strategy contains no mention of harm reduction and provides no funding for harm reduction. Federal funding has continued to expand for law enforcement initiatives, while funding for harm reduction initiatives has been discontinued in some cases. The example of the supervised injection facility in Vancouver serves to illustrate the situation. Supervised injection

facilities (SIFs) are legally-sanctioned health facilities that enable the consumption of otherwise illegal drugs with sterile equipment under the supervision of health professionals. SIFs constitute a specialized health intervention within a wider network of health services for people who use drugs. They have been operating successfully for years in a number of jurisdictions in Europe, Australia and Canada. Insite, the first authorized SIF in North America, operates in Vancouver's Downtown Eastside. This facility currently operates under the protection of an exemption from the application of certain provisions of Canada's Controlled Drugs and Substances. Insite has been the subject of extensive evaluation on numerous counts; the data generated by the research team have been published in more than 30 articles in the world's leading peer-reviewed medical journals and have demonstrated multiple benefits for the health and well-being of individual service-users and for the broader community at large. Other Canadian municipalities (e.g. Toronto, Ottawa, Victoria) have begun to explore the feasibility of establishing similar facilities as public health initiatives aimed at protecting some of the most marginalized and vulnerable members of their communities. In early October 2007, the government granted an additional 6-month extension on the Insite exemption, until the end of June 2008. In May 2008, the operators of Insite succeeded in obtaining a court decision that the application of Canada's criminal law prohibiting possession and trafficking of controlled substances was unconstitutionally overbroad, insofar as it impeded access to a health facility such as Insite, because it resulted in avoidable morbidity and mortality, thereby infringing the rights to life and to security of the person under the Canadian Charter of Rights and Freedoms. The court granted Insite's users and staff a constitutional exemption from the application of these parts of Canada's criminal law indefinitely and also declared that the unconstitutional aspects of Canada's Controlled Drugs and Substances Act were invalid and of no force; this latter declaration was suspended for a year to give the federal government time to re-draft its law. The federal government appealed that decision. At this time, a decision from the appellate court is pending and, whatever the outcome, that decision will likely be further appealed to the Supreme Court of Canada. The potential exists for constructive dialogue between government and civil society about Insite and, more broadly, about harm reduction. This could result in innovative, evidence-based approaches to this important public health issue. Sex workers Recent research has explored the complex, multifaceted relationship between Canadian criminal law and sex workers' health and safety, including the risk of HIV infection. Sex workers are not mentioned as a "specific population" of concern under the federal government's AIDS strategy, the Federal Initiative to Address HIV/AIDS in Canada, even though they are a population at risk. While prostitution (i.e. the exchange of sex for money or other valuable consideration) is not illegal per se in Canada, the federal Criminal Code (which applies throughout the country) contains numerous provisions that make it difficult and dangerous for sex workers and their clients to engage legally in prostitution. This criminalization limits sex workers' choices, often forcing them to work on the margins of society, thereby increasing the risks they face. In 2007, two court proceedings challenging the constitutionality of various aspects of Canada's laws on prostitution were launched by sex workers' rights advocates; one of those cases was dismissed at the outset on procedural grounds while the other has been argued before the courts, with a decision pending as of this writing. Here again, the opportunity exists for civil society to work collaboratively with government to find solutions to public health problems posed by the risky and criminalized nature of sex work.

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140) **Part B, Section I. HUMAN RIGHTS**

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

Yes (0)

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141)

Part B, Section I. HUMAN RIGHTS

Question 4 (continued)
IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:

The promotion and protection of human rights are explicitly mentioned in The Federal Initiative to Address HIV/AIDS in Canada which acknowledges that a comprehensive response to HIV/AIDS must include addressing human rights as part of an approach that is based on a social justice framework and the determinants of health. Leading Together: Canada Takes Action on HIV/AIDS (2005-2010) is a pan-Canadian multi-stakeholder, multi-sectoral action plan, providing an opportunity for all parts of the country and all organizations involved in HIV/AIDS to come together as part of a larger, nation-wide effort. Leading Together explicitly bases its approach and recommended actions on the principles of human rights. Respect for human rights is stated as one of the core values of Leading Together. Civil society would welcome an opportunity to work with government to address human rights issues faced by those living with, or vulnerable to, HIV/AIDS, in addition to taking active steps to reduce human rights barriers.

142)

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, most-at-risk populations and/or other vulnerable subpopulations?

Yes (0)

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143)

Part B, Section I. HUMAN RIGHTS

Question 5 (continued)
IF YES, briefly describe this mechanism:

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

144)

6. Has the Government, through political and fi nancial support, involved people living with HIV, most-at-risk populations and/or other vulnerable subpopulations in governmental HIV-policy design and programme implementation?

Yes (0)

Page 91

145)

Part B, Section I. HUMAN RIGHTS

Question 6 (continued)

IF YES, describe some examples:

The federal government has involved most-at-risk populations in the development of governmental HIV policies and programs. Aboriginal people are disproportionately affected by HIV and are a stated target population in The Federal Initiative to Address HIV/AIDS. The National Aboriginal Council on HIV/AIDS offers policy advice to the Public Health Agency of Canada and Health Canada on HIV/AIDS issues. The concerns of other most-at-risk populations are represented by a variety of national organizations that were involved in consultations and discussions which led to the development of the pan-Canadian multi-sectoral policy document, Leading Together, and to The Federal Initiative to Address HIV/AIDS, which defines the federal government's response to HIV/AIDS. Other most-at-risk groups which have been involved in policy design and program implementation include gay men, women and communities from countries with generalized and high prevalence of HIV (Africa and the Caribbean). The involvement of these populations in HIV policy design and program implementation needs to be reaffirmed and strengthened, in collaboration with civil society, through concrete engagement strategies. Several organizations stated that they welcome the openness to dialogue on these issues displayed by the federal Minister of Health.

146)

7. Does the country have a policy of free services for the following:

a. HIV prevention services	Yes
b. Antiretroviral treatment	Yes
c. HIV-related care and support interventions	Yes

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147)

Part B, Section I. HUMAN RIGHTS

Question 7 (continued)
IF YES, given resource constraints, briefly describe what steps are in place to implement these policies and include information on any restrictions or barriers to access for different populations:

The federal government does not provide free services for HIV prevention and treatment, care and support, because these fall under provincial/territorial jurisdiction, except for some Aboriginal populations (Inuit and on-reserve First Nations), federal prisoners and the armed forces, which receive health services from the Government of Canada. In general, prevention information resources are available free of charge to the public because production of the resources is supported by national or provincial/territorial funding, although prevention materials such as male and female condoms may not be available free of charge. Access to HIV treatment and health services varies, depending on the policies of the province or territory. Access also varies for those receiving health care services from the federal government, depending on the population served (e.g. prisoners, defence personnel, on-reserve First Nations and Inuit populations). Outreach and referral services provided by national non-governmental organizations are free of charge to service users, as are most services provided by local non-governmental organizations; these organizations are supported by government funding and/or private donations. Populations receiving health services from the federal government have variable access, depending on the population. Practice also varies between provinces and territories with respect to access to treatment and reimbursement for medications. There is a need for access to catastrophic drugs and a national pharmaceuticals strategy.

148)

8. Does the country have a policy to ensure equal access for women and men to HIV prevention, treatment, care and support?

Yes (0)

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149)

Part B, Section I. HUMAN RIGHTS

8.1 In particular, does the country have a policy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?

Yes (0)

150)

9. Does the country have a policy to ensure equal access for most-at-risk populations and/or other vulnerable subpopulations to HIV prevention, treatment, care and support?

Yes (0)

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151)

Part B, Section I. HUMAN RIGHTS

Question 9 (continued)
IF YES, briefly describe the content of this policy:

Responsibility for education and health care delivery fall within provincial or territorial jurisdiction and are not subject to specific HIV-related national standards. Ease of access to services depends on programs and conditions in provinces and territories. Policies may vary for populations receiving health care services from the federal government (e.g. prisoners, armed forces, Inuit and on-reserve First Nations populations).

152)

9.1 IF YES, does this policy include different types of approaches to ensure equal access for different most-at-risk populations and/or other vulnerable sub-populations?

Yes (0)

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153)

Part B, Section I. HUMAN RIGHTS

Question 9.1 (continued)

IF YES, briefly explain the different types of approaches to ensure equal access for different populations:

The Federal Initiative to Address HIV/AIDS in Canada specifies that specific national communications campaigns will be developed by and for gay men, injection drug users, Aboriginal people, and people from countries with generalized and high prevalence of HIV. In the case of Aboriginal peoples, a variety of things must be taken into account in policy and program development, including language and literacy, historical trauma, culturally competent services and other variables such as risk behaviour, especially for people using injection drugs. The federal government is developing population-specific status reports which aim to inform strategic policy and program design and delivery modes that target the eight most-at-risk populations that are identified in the Federal Initiative. Civil society is represented on status report working groups. The status report on communities from countries with high prevalence and generalized epidemics is completed. Work is progressing on status reports for Aboriginal peoples, gay men/MSM, women, persons living with HIV/AIDS and persons using injection drugs. Work will begin in 2010 on reports for prisoners and youth.

154)

10.Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

Yes (0)

155)

11.Does the country have a policy to ensure that HIV research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?

Yes (0)

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156)

Part B, Section I. HUMAN RIGHTS

11.1 IF YES, does the ethical review committee include representatives of civil society including people living with HIV?

Yes (0)

157)

IF YES, describe the approach and effectiveness of this review committee:

Many ethical review bodies have members representing civil society, including those from the populations participating in the research. Organizations such as the Canadian Institutes of Health Research (CIHR) and the CIHR Canadian HIV Trials Network have mechanisms for consulting with and including representatives of civil society in policy/program decisions and ethics reviews. Not all clinical trials run by pharmaceutical companies have community input, however, but all would undergo ethical review. There are some problems with ethical review committees. They may have lack of continuity and universality of rules. For example, all persons in clinical trials may not be able to stay on a medication after a trial is completed even though the medication may be appropriate for them. They may have to wait for long periods until the medication is made

accessible through a provincial/territorial formulary. Another problem is potential conflict of interest when ethics boards are hired by pharmaceutical companies for company-led clinical trials. There is a need for national ethical guidelines that apply to all human research subjects and all ethical review committees, including those based in hospitals. There is also a need for monitoring of adherence to guidelines by government, civil society and other relevant stakeholders. As a result of pressure from civil society organizations, some pharmaceutical companies consult with community members. Most national non-governmental organizations that responded to this question stated that sustained efforts had been made by research bodies to involve civil society.

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158)

– Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work

Yes (0)

159)

– Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment

No (0)

160)

– Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts

No (0)

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161)

Part B, Section I. HUMAN RIGHTS

Question 12 (continued)
IF YES on any of the above questions, describe some examples:

Independent national institutions for the promotion and protection of human rights At the national level, Canada has a human rights commission, a human rights tribunal, a privacy commission, an ombudsperson and an auditor-general who often addresses health-related spending and effectiveness of national programs. None of these mechanisms have a specific mandate to address HIV-related issues, but may address these issues when they come to their attention as part of their general mandate. Focal points within government departments to monitor HIV-related human rights abuses There is no national focal point for monitoring HIV-related human rights abuses or HIV-related discrimination. The onus rests with individuals to bring cases of discrimination to the attention of monitoring bodies or the courts. Several national non-governmental organizations are partially supported by national funding and include

such monitoring in their work. In particular, the Canadian HIV/AIDS Legal Network is active in monitoring court proceedings, but is limited in its capacity to intervene or to support individuals or groups in the use of such mechanisms. Performance indicators for compliance with human rights standards in the context of HIV efforts Canada does not have performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts but Canada has had initiatives for reducing HIV-related stigma and discrimination.

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162)

Part B, Section I. HUMAN RIGHTS

13. In the last 2 years, have members of the judiciary (including labour courts/ employment tribunals) been trained/sensitized to HIV and human rights issues that may come up in the context of their work?

No (0)

163)

– Legal aid systems for HIV casework

Yes (0)

164)

– Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV

Yes (0)

165)

– Programmes to educate, raise awareness among people living with HIV concerning their rights

Yes (0)

166)

15. Are there programmes in place to reduce HIV-related stigma and discrimination?

Yes (0)

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167)

Part B, Section I. HUMAN RIGHTS

Question 15 (continued)
IF YES, what types of programmes?

Media	**Yes**

School education	Yes
Personalities regularly speaking out	Yes
NGO programs	Yes

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168)

Part B, Section I. HUMAN RIGHTS

Question 15 (continued)
Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2009?

6 (6)

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169)

Part B, Section I. HUMAN RIGHTS

Question 15 (continued)
Overall, how would you rate the efforts to enforce the existing policies, laws and regulations in 2009?

6 (6)

170)

Since 2007, what have been key achievements in this area:

• Recognition by lower courts of the right of persons addicted to drugs to have access to safe injection facilities • Initiation of the process to ratify the United Nations Convention on the Rights of Persons with Disabilities

171)

What are remaining challenges in this area:

• Criminalization of HIV transmission, with repercussions on human rights, prevention and treatment; framing HIV transmission as a public health, rather than a criminal, issue • Restoring harm reduction to Canada's laws and policies concerning drug use • Continuing efforts to protect the human rights of persons living with HIV and most-at-risk populations.

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172)

Part B, Section II: CIVIL SOCIETY* PARTICIPATION

1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?

4 (4)

173)

Comments and examples:

Some non-governmental organizations have noted recent encouraging dialogue with the federal Minister of Health and with opposition parties. Aboriginal NGOs stated that they have been successful in engaging the support of some Aboriginal political leaders at the national level.

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174)

Part B, Section II. CIVIL SOCIETY PARTICIPATION

2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?

3 (3)

175)

Comments and examples:

In the interest of openness and transparency, civil society and the federal government should work toward strengthening communication on key issues of common concern, including funding for the Federal Initiative to Address HIV/AIDS in Canada. There is significant involvement of Aboriginal NGOs, researchers and treatment action representatives in planning. The National Aboriginal Council on HIV/AIDS provides advice to the federal government on a regular basis. The Canadian Aboriginal AIDS Network was involved in dialogue with the federal government that resulted in the renewal of the national Aboriginal HIV/AIDS Strategy to 2014. Researchers are represented by the Canadian Association for HIV Research and report being well represented on expert advisory committees and research advisory bodies. Treatment action representatives (led by the Canadian Treatment Action Council), including many persons living with HIV, participate in a number of expert advisory bodies concerned with drug review and licensing of pharmaceuticals. Some NGOs noted that there was good representation from civil society on advisory bodies and working groups, but that communication could be improved between the government and the community.

Page 105

176)

a. the national AIDS strategy?

2 (2)

177)

b. the national AIDS budget?

0

178)

c. national AIDS reports?

3 (3)

179)

Comments and examples:

Civil society representatives serve on advisory bodies and working groups which provide input to policies and reports developed by the federal government. In particular, NGOs noted the participation of civil society representatives on working groups to develop status reports on most-at-risk populations. On the other hand, there has been no Canadian World AIDS Day report since 2006 and no dialogue with civil society about why this is the case.

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180)

a. developing the national M&E plan?

1 (1)

181)

b. participating in the national M&E committee / working group responsible for coordination of M&E activities?

1 (1)

182)

c. M&E efforts at local level?

1 (1)

183)

Comments and examples:

Projects funded by the federal government and carried out by civil society organizations have evaluation components, but civil society organizations have little input to government monitoring and evaluation efforts at the local level. Civil society advisory bodies such as the Ministerial Advisory Council on the Federal Initiative to Address HIV/AIDS in Canada provide input and advice on monitoring and evaluation of activities encompassed by the Federal Initiative, but coordination of M&E activities is done within government.

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184)

Part B, Section II. CIVIL SOCIETY PARTICIPATION

5. To what extent is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. networks of people living with HIV, organizations of sex workers, faith-based organizations)?

4 (4)

185)

Comments and examples:

At the national level, the core principle of GIPA (Greater involvement of people living with or affected by HIV/AID) is respected. Persons living with HIV/AIDS serve on advisory bodies and working groups. The National Aboriginal Council on HIV/AIDS provides advice to the federal government. Representatives of some most-at-risk populations (e.g. from communities in Canada originating in countries where HIV is widespread and prevalence is high) sit on advisory bodies, but there is under-representation from affected populations on the issues of women, youth, sex workers, persons who use drugs, prisoners, persons with disabilities and street-involved persons.

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186)

a. adequate financial support to implement its HIV activities?

3 (3)

187)

b. adequate technical support to implement its HIV activities?

3 (3)

188)

Comments and examples:

Some NGOs cited the existence of a national HIV/AIDS surveillance system consisting of a federal/provincial/territorial partnership as a technical support for their work. NGOs report less sustainable funding for front-line service organizations than in the past because funding levels have not increased to keep pace with inflation. Most current funding is project-based, which results in the need to use short-term project budgets to cover staff salaries and overhead expenses. This results in instability for organizations and the inability to retain qualified staff. In addition, front-line organizations are being encouraged to provide integrated services for HIV, Hepatitis and sexually transmitted infections (STI) but are receiving funding primarily from HIV projects and little from other funding sources, resulting in an attempt to offer comprehensive services without adequate funding.

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189)

Part B, Section II. CIVIL SOCIETY PARTICIPATION

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

Prevention for youth	>75%
Prevention for most-at-risk-populations	
- Injecting drug users	>75%
- Men who have sex with men	>75%
- Sex workers	>75%
Testing and Counselling	>75%
Reduction of Stigma and Discrimination	>75%
Clinical services (ART/OI)*	<25%
Home-based care	<25%

Programmes for OVC**	<25%

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190)

Part B, Section II. CIVIL SOCIETY PARTICIPATION

Question 7 (continued)
Overall, how would you rate the efforts to increase civil society participation in 2009?

2 (2)

191)

Since 2007, what have been key achievements in this area:

• Continued voice and participation by civil society despite a perceived diminution of the role accorded to it by government. Civil society is encouraged by the apparent openness to dialogue of the current federal Minister of Health. • Broad consultation on the development of national HIV testing guidelines. Community feedback is being taken into account in the development of the guidelines and the Prevention Framework. • Participation by Aboriginal groups in policy and program discussions at the national level. Canada is seen as an international leader in the area of indigenous populations and HIV/AIDS. Support from the federal government has enabled Canadian Aboriginal organizations to play a leadership role at international conferences and working group meetings. • High level of civil society representation on research and treatment-related advisory bodies and on a variety of working groups.

192)

What are remaining challenges in this area:

• The need for both the federal government and civil society to work toward strengthening their partnership and working relationship in order to more effectively address the health care challenges posed by HIV. • The need for both the federal government and civil society to work together to ensure that the criteria for proposals and the related funding approval processes are refined and improved in support of program planning and service delivery. • Barriers to dialogue between civil society and government: the government has explicitly stated in announcements regarding funding opportunities that no advocacy activities can be supported with government funding. Government officials have repeatedly instructed organizations that even recommendations for policy makers should be avoided as outcomes of funded activities. • The need for stronger partnerships between government and civil society on the issue of criminalization of HIV transmission and public education about this issue; framing HIV transmission as a public health issue rather than a legal issue. • Aging of the current generation of civil society leaders and the need to mentor and support younger potential leaders. • The challenge of revitalizing NGO efforts to have a greater degree of participation within the context of a public climate of apathy which is based on the erroneous assumption that HIV/AIDS is no longer a serious public health risk.

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193)

Part B, Section III: PREVENTION

1. Has the country identified the specific needs for HIV prevention programmes?

Yes (0)

Page 112

194)

Part B, Section III: PREVENTION

Question 1 (continued)
IF YES, how were these specific needs determined?

In general terms, Canada identifies needs based on epidemiological data, research findings and dialogue with provincial and territorial health authorities, representatives of HIV/AIDS service organizations and representatives of most-at-risk populations. At the national level, Canada has identified most-at-risk populations in need of prevention programs. These populations may live anywhere in Canada, although some are concentrated in large cities and towns, such as communities from countries with generalized and high prevalence of HIV, while others may live in rural and remote areas, such as some Inuit and on-reserve First Nations communities.

195)

1.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access
Blood safety	Agree
Universal precautions in health care settings	Agree
Prevention of mother-to-child transmission of HIV	Agree
IEC* on risk reduction	Agree
IEC* on stigma and discrimination reduction	Don't agree
Condom promotion	Agree
HIV testing and counselling	Agree
Harm reduction for injecting drug users	Don't agree
Risk reduction for men who have sex with men	Agree
Risk reduction for sex workers	Don't agree
Reproductive health services including sexually transmitted infections prevention and treatment	Don't agree
School-based HIV education for young people	Don't agree
HIV prevention for out-of-school young people	Don't agree
HIV prevention in the workplace	Don't agree
Aboriginal peoples; communities from countries with high HIV prevalence; persons with disabilities; co-infections; positive prevention	Don't agree

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196)

Part B, Section III: PREVENTION

Question 1.1 (continued)
Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?

6 (6)

197)

Since 2007, what have been key achievements in this area:

• A pilot project to expand highly-active antiretroviral therapies to a most-at-risk population of street-involved people injecting drugs in the Downtown Eastside, Vancouver, British Columbia. • Harm reduction programs, such as the safe injection site (Insite) in Vancouver, which is provincially funded and has been the subject of rigorous scientific evaluation. Work is progressing at the national level with harm reduction programs targeted at Aboriginal communities, including youth, women, ex-prisoners and MSM. The Toronto private sector business community has expressed support for a possible supervised injection site in downtown Toronto. • Risk reduction programs for ethnocultural communities; most of this work occurs with provincial, rather than federal, funding • National database of evidence-based prevention programs being developed by CATIE in order to enhance learning and reduce duplication of efforts • Canadian leadership in international indigenous peoples' HIV initiatives • Progress on recognizing people with disabilities as an at-risk population and creation of partnerships between the worlds of disabilities and HIV • Initiation of ratification by Canada of the UN Convention on the Rights of Persons with Disabilities • Research: presence of HIV researchers on national advisory bodies; entry inhibitors; socio-behavioural observational research studies; pre-exposure prophylaxis; Canadian involvement in international vaccine development; harm reduction research; advances in knowledge translation. • Development of new prevention technologies: e.g. Canadian HIV Vaccine Initiative; government funding for a vaccine manufacturing facility; International Partnership for Microbicides; International AIDS Vaccine Initiative.

198)

What are remaining challenges in this area:

• Public apathy, based on a lack of understanding of HIV and the belief that HIV is just a chronic disease and no longer fatal. There is a need for continuing public education and awareness-raising. • Expansion of the criminalization of HIV transmission or exposure, encompassing a growing set of circumstances even where there is no significant risk of transmission; this contributes to HIV-related stigma, fear on the part of PHAs and inappropriately broad application of the criminal law. • Stigma and discrimination leading to risk behaviours and fear of being tested • Reduction in federal government support for harm reduction programs (especially for IDU), harm reduction services, (e.g. supervised injection sites) and research or policy work that relates to harm reduction among people who use drugs (including those in prison) • Continuing high infection rates in Aboriginal communities despite 10 years of targeted work • The need for greater government support and collaborative efforts with civil society on prevention for MSM and broader gay men's health issues • Lack of information sharing across provincial and territorial boundaries • Lack of capacity in public health systems and community-based organizations • Lack of inter-departmental dialogue within the federal government on issues such as HIV and disabilities • Need for stronger links between HIV/AIDS and mental health policies and programs, in light of research evidence about the root causes of low self-esteem and consequent risk behaviours • Inconsistencies in federal and provincial/territorial approaches. Federally-funded short-term projects (usually one year) address needs and reach designated populations, only to end and not be continued by provincial/territorial health services. In addition, approval of projects at the federal level can be slow. These factors can lead to reluctance on the part of front-line organizations to participate in future short-term projects. Projects need a 3-5 year time period in order to become sustainable. • Loss of federal government staff • Research: lack of research capacity; emphasis on knowledge translation at the possible expense of knowledge creation; need for greater and meaningful inclusion of affected communities in the research agenda (i.e. working with, not on, communities); need for more population-specific research (e.g. women, gay men, persons with disabilities) based on the determinants of health; need for more research on treatment as prevention; challenge of recruiting and retaining participants in clinical trials.

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199)

Part B, Section IV: TREATMENT, CARE AND SUPPORT

1. Has the country identified the specific needs for HIV treatment, care and support services?

Yes (0)

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200)

Part B, Section IV: TREATMENT, CARE AND SUPPORT

Question 1 (continued)
IF YES, how were these specific needs determined?

In general terms, Canada identifies needs based on epidemiological data, research findings and dialogue with provincial and territorial health authorities, representatives of HIV/AIDS service organizations and representatives of most-at-risk populations. At the national level, Canada has identified most-at-risk populations in need of treatment, care and support programs. These populations may live anywhere in Canada, although some are concentrated in large cities and towns, such as communities from countries with generalized and high prevalence of HIV, while others may live in rural and remote areas, such as some Inuit and on-reserve First Nations communities. The availability of HIV treatment, care and support varies across Canada because health care delivery and education fall within provincial/territorial jurisdiction. The federal government provides health services for federal prisoners, the armed forces, Inuit and on-reserve First Nations populations. Each sub-national jurisdiction has a public health insurance plan that covers “medically necessary” physician and hospital services for all residents of the jurisdiction, as a pre-condition of receiving federal funding contributions under the Canada Health Act. The coverage of other health goods and services under public health insurance plans varies from one jurisdiction to another. There is no nation-wide pharmacare plan to cover the costs of prescription medications.

201)

1.1 To what extent have the following HIV treatment, care and support services been implemented?

HIV treatment, care and support service	The majority of people in need have access
Antiretroviral therapy	Agree
Nutritional care	Don't agree
Paediatric AIDS treatment	Agree
Sexually transmitted infection management	Agree
Psychosocial support for people living with HIV and their families	Don't agree
Home-based care	Agree
Palliative care and treatment of common HIV-related infections	Agree

HIV testing and counselling for TB patients	Agree
TB screening for HIV-infected people	Agree
TB preventive therapy for HIV-infected people	Agree
TB infection control in HIV treatment and care facilities	Agree
Cotrimoxazole prophylaxis in HIV-infected people	Agree
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree
HIV treatment services in the workplace or treatment referral systems through the workplace	N/A
HIV care and support in the workplace (including alternative working arrangements)	N/A
solid organ transplants; dental care; disability and rehabilitation; most-at-risk populations; HIV and aging; access to medicinal cannabis; research; criminalization of HIV transmission; drugs for developing countries	Don't agree

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202)

Part B, Section IV: TREATMENT, CARE AND SUPPORT

Question 1.1 (continued)
Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009?

6 (6)

203)

Since 2007, what have been key achievements in this area:

• Promising research in some areas of treatment • New classes of therapies being developed • Improved drug review and approval processes • A more prominent role for Aboriginal-led and community-based HIV/AIDS research • Initiation of the ratification process by Canada of the UN Convention on the Rights of Persons with Disabilities

204)

What are remaining challenges in this area:

• Lack of a catastrophic drug plan linked to a national pharmaceutical strategy • Inadequate funding for non-governmental organizations providing care and support • The need to deal with basic survival issues of persons living with HIV, such as housing, income support and food, which taxes the ability of non-governmental organizations to provide services • Reluctance of HIV-positive persons to access antiretroviral treatment because of fear of community stigma and discrimination, especially among Aboriginal and cultural communities • Translating research results into practice • Inadequate results under Canada's Access to Medicines Regime to help developing countries with exports of lower-cost, generic ARVs and other medicines.

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205)

Part B, Section IV: TREATMENT, CARE AND SUPPORT

2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

No (0)