Canada Report NCPI

NCPI Header

COUNTRY

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Describe the process used for NCPI data gathering and validation:
The Public Health Agency of Canada (PHAC) led the preparation of the 2012 submission of the UNGASS Report. PHAC prepared the initial drafts of the Main Section, Annex 1 and Part A of Annex 2 (the National Composite Policy Index), in consultation with other government departments participating in the federal response to HIV/AIDS, and provincial/territorial partners. The final report was approved was approved by the Minister of Health.
Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:
N/A
Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):
-

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

Organization	Names/Positions	A.I	A.II	A.III	A.IV	A.V	A.VI
-	-	No	No	No	No	No	No

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

Organization	Names/Positions	B.I	B.II	B.III	B.IV	B.V
-	-	No	No	No	No	No

A - 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
IF YES, what was the period covered:
2005-ongoing (the Federal Initiative), 2007 – 2016/17 (CHVI)
IF YES, briefly describe key developments/modifications between the current national strategy and the prior one. IF NO or NOT APPLICABLE, briefly explain why.:
In Canada, different levels of government are responsible for different aspects of health; however, all three levels of government collaborate to improve health for all Canadians. One of the key ways that federal, provincial and territorial governments share responsibility for public health is by collaborating to address public health issues and challenges through the Pan-Canadian Public Health Network (PHN). In addition, Canada has supported the development of Leading Together: Canada Takes Action on HIV/AIDS (Leading Together), which was developed collaboratively by Canadian HIV/AIDS stakeholders to identify approaches that can be taken by community groups, people living with, and/or at risk of HIV/AIDS, health care providers, researchers, and government jurisdictions across Canada. Leading Together describes activities that can be done individually or across sectors to to address the realities of the Canadian situation. The Federal Initiative is a partnership of the Public Health Agency of Canada, Health Canada, Canadian Institutes of Health Research, and Correctional Service Canada. It has the following goals: • Prevent the acquisition and transmission of new infections; • Slow the

progression of the disease and improve quality of life; • Reduce the social and economic impact of HIV/AIDS; and • Contribute to the global effort to reduce the spread of HIV and mitigate the impact of the disease. Many provinces and territories continue to revise and implement their own multi-sectoral strategies and/or action frameworks that align with federal policy, legislation and HIV/AIDS goals and objectives. The Federal Initiative supports and strengthens multi-sectoral partnerships to address the determinants of health; collaborative efforts to address factors that can increase the transmission and acquisition of HIV including sexually transmitted infections; and also addresses co-infection issues with other diseases (e.g., Hepatitis C and Tuberculosis) from the perspective of disease progression and morbidity in people living with HIV/AIDS. The performance measurement reporting has been strengthened. The Government of Canada and the Bill & Melinda Gates Foundation renewed their collaboration on the CHVI in July 2010. A key component of the renewed collaboration is the CHVI Research and Development Alliance. The Alliance is a Canadian network of researchers from the public and private sectors, as well as the international community, which aims to develop innovative solutions to the challenges facing HIV vaccine development. The Alliance Coordinating Office (ACO) will build and sustain the Alliance. An Advisory Board is providing governance and oversight to the Alliance, and recommendations to the Government of Canada and the Bill & Melinda Gates Foundation on projects to be funded. The Canadian HIV Vaccine Initiative (CHVI) is Canada's contribution to the Global HIV Vaccine Enterprise and represents a significant contribution to global efforts to develop a safe, effective, affordable, and globally accessible HIV vaccine. The CHVI is a collaborative agreement between the Government of Canada and the Bill & Melinda Gates Foundation. It brings together the Public Health Agency of Canada, the Canadian International Development Agency, Industry Canada, Health Canada, and the Canadian Institutes of Health Research. The CHVI builds on the Government of Canada's commitment to a comprehensive, long-term approach to address HIV/AIDS, globally and domestically, including the development of new HIV prevention technologies.

1.1 Which government ministries or agencies

Name of government ministries or agencies [write in]:
Through the Federal Initiative, the Public Health Agency of Canada, Health Canada, the Canadian Institutes of Health Research and Correctional Service Canada collaborate with other federal government departments, and provincial and territorial governments

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

SECTORS

Included in Strategy	Earmarked Budget
No	No
Yes	Yes
No	No
No	No
No	No
Yes	No
Yes	No

Other [write in]:
Aboriginal People
IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specifc activities?:
The Federal Initiative and provincial and territorial strategies have budgets. Money is allocated by different jurisdictions according to their individual needs and strategic plans.

1.3. Does the multisectoral strategy address the following key populations, settings and cross-cutting issues?

Men who have sex with men:
Yes
Migrants/mobile populations:
Yes
Orphans and other vulnerable children:
No
People with disabilities:
Yes
People who inject drugs:
Yes
Sex workers:
No
Transgendered people:
Yes
Women and girls:
Yes

Young women/young men:
Yes
Other specific vulnerable subpopulations:
Yes
Prisons:
Yes
Schools:
Yes
Workplace:
Yes
Addressing stigma and discrimination:
Yes
Gender empowerment and/or gender equality:
Yes
HIV and poverty:
Yes
Human rights protection:
Yes
Involvement of people living with HIV:
Yes

IF NO, explain how key populations were identifed?:
-
1.4. What are the identified key populations and vulnerable groups for HIV programmes in the country [write in]?:
Gay men and other men who have sex with men, people who use drugs, Aboriginal peoples, women, people from countries where HIV is endemic, people living in prisons, youth, and people living with HIV/AIDS.
1.5. Does the multisectoral strategy include an operational plan?: Yes

1.6. 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 implementation?:
Yes
e) A monitoring and evaluation framework?:
Yes

1.7

1.7. Has the country ensured "full involvement and participation" of civil society in the development of the multisectoral strategy?:
Active involvement
IF ACTIVE INVOLVEMENT, briefly explain how this was organised:
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 (e.g. 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. This advice was taken into account during the development of the Federal Initiative

1.8. Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?:
N/A

1.9

1.9. Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?:
N/A

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?:
Yes

2.1. IF YES, is support for HIV integrated in the following specifc development plans?

Common Country Assessment/UN Development Assistance Framework:

-
National Development Plan:
-
Poverty Reduction Strategy:
-
Sector-wide approach:
-
Other [write in]:
Canada is addressing the provisions of the International Labour Organization (ILO) Recommendation 200 on HIV/AIDS and the World of Work Recommendation. Many initiatives began well in advance of the adoption of the Recommendation in June 2010. This Recommendation is the first international labour standard for the protection of human rights at work for persons living with and affected by HIV/AIDS.

2.2. IF YES, are the following specifc HIV-related areas included in one or more of the development plans?
HIV impact alleviation:
Yes
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support:
-
Reduction of income inequalities as they relate to HIV prevention/treatment, care and/or support:
-
Reduction of stigma and discrimination:
Yes
Treatment, care, and support (including social security or other schemes):
-
Women's economic empowerment (e.g. access to credit, access to land, training):
-
Other[write in below]:
-

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?:
Yes
3.1. IF YES, on a scale of 0 to 5 (where 0 is "Low" and 5 is "High"), to what extent has the evaluation informed resource allocation decisions?:
5
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
5. Has the country followed up on commitments made in the 2011 Political Declaration on HIV/AIDS?:
Yes
5.1. Have the national strategy and national HIV budget been revised accordingly?:
No
5.2. 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
5.3. Is HIV programme coverage being monitored?:
Yes

5.3
(a) IF YES, is coverage monitored by sex (male, female)?:
Yes
(b) IF YES, is coverage monitored by population groups?:
Yes
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, women, people who use injection drugs, Aboriginal peoples, people from countries where HIV is endemic, people in prisons, and youth at risk.
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.
(c) Is coverage monitored by geographical area:
Yes
IF YES, at which geographical levels (provincial, district, other)?:
Provincial/territorial
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.

5.4. Has the country developed a plan to strengthen health systems?:

-

Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications:

N/A This is a provincial/territorial responsibility.

6. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate strategy planning efforts in the HIV programmes in 2011?:

-

Since 2009, what have been key achievements in this area:

N/A

What challenges remain in this area:

N/A

A - II. POLITICAL SUPPORT AND LEADERSHIP

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

A. Government ministers:

Yes

B. Other high offcials at sub-national level:

Yes

1.1

(For example, promised more resources to rectify identified weaknesses in the HIV response, spoke of HIV as a human rights issue in a major domestic/international forum, and such activities as visiting an HIV clinic, etc.):

Yes

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:

The federal Minister of Health the Honourable Leona Aglukkaq has met with the Ministerial Advisory Council on the Federal Initiative to Address HIV/AIDS, the National Aboriginal Council on HIV/AIDS, and with various national non-governmental organizations working on HIV/AIDS issues. Minister Aglukkaq has emphasized the importance of addressing the broader determinants of health leading to increased vulnerability to HIV/AIDS and poorer overall health status; she continues to emphasize integration of responses, effectiveness and enhanced efforts specific to Aboriginal peoples and the general population. Minister Aglukkaq was an active participant in the International AIDS Conference in Vienna in 2010. She participated in various bilateral meetings with other Ministers of Health and multilateral organizations, conference sessions and events. During the conference, Minister Aglukkaq announced the renewal of the Canadian HIV Vaccine Initiative to 2017, which resulted in the creation of the Research and Development Alliance, and the establishment of the Research and Development Alliance Coordinating Office. The response to Canada’s announcement on the renewed Canadian HIV Vaccine Initiative (CHVI) was supported by key multilateral partners including the Global Vaccine Enterprise, WHO and UNAIDS.

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

Yes

2.1. IF YES, does the national multisectoral HIV coordination body

Have terms of reference?:

Yes

Have active government leadership and participation?:

Yes

Have an official chair person?:

Yes

IF YES, what is his/her name and position title?:

Dr. Brian Conway, Mr. John Platter

Have a defined membership?:

Yes

IF YES, how many members?:

16

Include civil society representatives?:

Yes

IF YES, how many?:

12

Include people living with HIV?:

Yes

IF YES, how many?:

5

Include the private sector?:

No
Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?:
-

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
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/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 work with 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 most affected by HIV/AIDS and identified in the Federal Initiative. These reports will comprise comprehensive factual information of each population. A working group made up of members of the affected population, researchers, experts in the field, community organizations and governments 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. The Government of Canada Assistant Deputy Minister Committee on HIV/AIDS hosted the first Interdepartmental Policy Forum on the Determinants of Health and HIV/AIDS that included 14 federal government departments and agencies representing health and non-health sectors. Into 2010 and onwards, efforts are being explored to build an all-of-government approach to promote health and well-being for all Canadians by collaborating to address the broader social and economic determinants of health.
What challenges remain in this area:
While consultation and interaction with stakeholders are key to the Government of Canada response, final decision making and accountability relating to policy and program design and budget allocations rests with the government.
4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?:
50%

5.

Capacity-building:
Yes
Coordination with other implementing partners:
Yes
Information on priority needs:
Yes
Procurement and distribution of medications or other supplies:
No
Technical guidance:
Yes
Other [write in below]:
Procurement and distribution of druggs or other supplies is a provincial/territorial role

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National HIV Control policies?:
Yes
6.1. IF YES, were policies and laws amended to be consistent with the National HIV Control policies?:
-
7. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the political support for the HIV programme in 2011?:
-
Since 2009, what have been key achievements in this area:
Canada has supported and signed two critical global instruments: the Convention on Rights of Persons with a Disability, and the International Indigenous Human Rights Conventions. This will inform and guide our work for Aboriginal peoples and people living with a disability. At the United Nations High Level Meeting on HIV/AIDS in June 2011, Canada endorsed the Political Declaration on HIV/AIDS: Intensifying our efforts to eliminate HIV/AIDS.
What challenges remain in this area:
Canada is a federation, and responsibilities for prevention, care, treatment and support are shared across different levels of government. Each jurisdiction determines their priorities.

A - III. HUMAN RIGHTS

1.1

People living with HIV:
Yes
Men who have sex with men:
Yes
Migrants/mobile populations:
Yes
Orphans and other vulnerable children:
Yes
People with disabilities:
Yes
People who inject drugs:
Yes
Prison inmates:
Yes
Sex workers:
Yes
Transgendered people:
Yes
Women and girls:
Yes
Young women/young men:
Yes
Other specific vulnerable subpopulations [write in]:
Aboriginal peoples, visible minority groups, persons convicted of a crime for which a pardon has been granted

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?:
Yes
IF YES to Question 1.1. or 1.2., briefly describe the content of the/laws:
Section 15 of the Canadian Charter of Rights and Freedoms (Charter) applies to any government action, including legislation, regulations, policies and programs. It gives people equal protection and equal benefit of the law without being discriminated against based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability. Section 15 of the Charter has also been recognized to protect against discrimination based on such grounds as sexual orientation, marital status and citizenship. The Canadian Human Rights Act (CHRA) 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, disability and convictions from which a pardon has been granted. Human rights legislation prohibits discriminatory practices such as the denial of goods and services, as well as discrimination with respect to employment. It applies to both government and private entities. Canadian courts and human rights tribunals generally recognize HIV/AIDS as a disability. The Canadian Human Rights Tribunal Policy on HIV/AIDS states that a person with HIV/AIDS may seek protection under the CHRA.
Briefly explain what mechanisms are in place to ensure these laws are implemented:
Every province and territory in Canada has a public legal education organization that can inform Canadians about their rights. All legislation and government policies and practices must accord with the Charter and the principles of administrative law. The Charter is part of the Constitution Act, 1982, and any law that is considered inconsistent with section 15 of the Charter may be struck down or modified by the courts. Human rights commissions have been established at the federal level and in each province and territory. These 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.
Briefly comment on the degree to which they are currently implemented:
All legislation and government programs and policies must be compliant with the Charter. Government activities that may discriminate against a vulnerable group, either directly or indirectly may be struck down by the courts. Since the introduction of the Charter in 1982, there has been a significant amount of case law with respect to discrimination under section 15. Human rights tribunals currently operate at the federal level and in every province and territory. As a matter of business, these tribunals apply and interpret their respective human rights legislation during the investigation and mediation of complaints.
2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?:
No

IF YES, for which subpopulations?

People living with HIV:
-
Men who have sex with men:
-
Migrants/mobile populations:
-
Orphans and other vulnerable children:
-
People with disabilities:

-
People who inject drugs :
-
Prison inmates:
-
Sex workers:
-
Transgendered people:
-
Women and girls:
-
Young women/young men:
-
Other specific vulnerable subpopulations [write in below]:
Aboriginal peoples

Briefly describe the content of these laws, regulations or policies:
-
Briefly comment on how they pose barriers:
-

A - IV. PREVENTION

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

IF YES, what key messages are explicitly promoted?

Abstain from injecting drugs:
Yes
Avoid commercial sex:
Yes
Avoid inter-generational sex:
No
Be faithful:
Yes
Be sexually abstinent:
Yes
Delay sexual debut:
Yes
Engage in safe(r) sex:
Yes
Fight against violence against women:
Yes
Greater acceptance and involvement of people living with HIV:
Yes
Greater involvement of men in reproductive health programmes:
Yes
Know your HIV status:
Yes
Males to get circumcised under medical supervision:
Yes
Prevent mother-to-child transmission of HIV:
Yes
Promote greater equality between men and women:
Yes
Reduce the number of sexual partners:
Yes
Use clean needles and syringes:
Yes
Use condoms consistently:
Yes
Other [write in below]:
Anti stigma and discrimination

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

the media?:
No
2. Does the country have a policy or strategy to promote life-skills based HIV education for young people?:
Yes

2.1. Is HIV education part of the curriculum in

Primary schools?:
Yes
Secondary schools?:
Yes
Teacher training?:
Yes

2.2. Does the strategy include age-appropriate, gender-sensitive sexual and reproductive health elements?:
Yes
2.3. Does the country have an HIV education strategy for out-of-school young people?:
No
3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for key or other vulnerable sub-populations?:
Yes
Briefly describe the content of this policy or strategy:
Programming delivered by community-based organizations works with populations at risk of HIV to provide a wide range of prevention activities. Several jurisdictions have also developed targeted prevention approaches. The Federal Initiative calls for national community-led social marketing campaigns to reduce stigma and discrimination and/or risk-taking behaviours. These campaigns will be led by and for the populations identified in the Initiative as being most at risk of HIV/AIDS.

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

IDU	MSM	Sex workers	Customers of Sex Workers	Prison inmates	Other populations
Yes	Yes	Yes	Yes	Yes	Aboriginal, populations where HIV is endemic, women, PHA's yout at risk
Yes	No	No	No	No	Aboriginal
Yes	Yes	Yes	Yes	Yes	Aboriginal, populations where HIV is endemic, women, PHA's yout at risk
Yes	No	No	No	No	For specific populations under the federal mandate
Yes	Yes	Yes	Yes	Yes	Aboriginal, populations where HIV is endemic, women, PHA's yout at risk
Yes	Yes	Yes	Yes	Yes	Aboriginal, populations where HIV is endemic, women, PHA's yout at risk
Yes	Yes	Yes	Yes	Yes	-
Yes	Yes	Yes	Yes	Yes	Aboriginal, populations where HIV is endemic, women, PHA's yout at risk

3.2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate policy efforts in support of HIV prevention in 2011?:
-
Since 2009, what have been key achievements in this area:
•Focused policy efforts for key populations have been further developed at the federal level and in the provinces most affected by HIV/AIDS. The federal government is playing a leadership role in coordinating efforts on prevention across a wide range of sectors. •The federal government’s forthcoming HIV and Co-infections Prevention Policy Framework will articulate a set of shared principles; provide a high-level integrated prevention model, focused on at-risk populations, to allow governments and public health planners to situate and further develop their own prevention efforts; and support a more efficient and strategic use of prevention resources.
What challenges remain in this area:
Many of the factors that influence vulnerability to HIV (e.g. mental health, self-esteem, drug addiction and risk-taking behaviours, and socio-economic determinants of health) 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.
4. Has the country identified specifc needs for HIV prevention programmes?:
Yes
IF YES, how were these specific needs determined?:
Each jurisdiction determines where to best focus their prevention programmes, based on epidemiological and surveillance studies.

4.1. To what extent has HIV prevention been implemented?

Blood safety:
Agree
Condom promotion:
Agree
Harm reduction for people who inject drugs:
Agree
HIV prevention for out-of-school young people:
Agree
HIV prevention in the workplace:
Agree
HIV testing and counseling:
Agree
IEC on risk reduction:
Agree
IEC on stigma and discrimination reduction:
Agree
Prevention of mother-to-child transmission of HIV:
Agree
Prevention for people living with HIV:
Agree
Reproductive health services including sexually transmitted infections prevention and treatment:
Agree
Risk reduction for intimate partners of key populations:
Agree
Risk reduction for men who have sex with men:
Agree
Risk reduction for sex workers:
Agree
School-based HIV education for young people:
Agree
Universal precautions in health care settings:
Agree
Other[write in]:
-

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in implementation of HIV prevention programmes in 2011?:
-

A - V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?:
Yes
If YES, Briefly identify the elements and what has been prioritized:
All elements are addressed. The primary responsibility for direct delivery of health care and treatment for most Canadians is under provincial and territorial jurisdiction. The federal government is responsible for providing care and treatment for First Nations people living on reserves, the Inuit in northern Canada, federal prisoners and the armed forces. Jurisdictions take different approaches to HIV/AIDS care and support, but all have policies or strategies to address this issue. There is ongoing support to programmatic responses and increased sharing of information on best practices. The voluntary sector is key in delivering psychosocial, home and community-based care.
Briefly identify how HIV treatment, care and support services are being scaled-up?:
Through funding provided to community-based organizations, access is being improved in HIV/AIDS prevention, diagnosis, care, treatment and support for the populations most affected by HIV/AIDS in Canada. Through a determinants of health approach, a broader continuum of support is being promoted. For example, the Public Health Agency of Canada was a partner for the North American Housing and HIV/AIDS Research Summit 2010 and contributed again in 2011. The Summit promotes the exchange of knowledge to improve service delivery, health outcomes and reduce health inequalities of people living with, or at risk for HIV/AIDS as it related to housing and homelessness issues.

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

Antiretroviral therapy:
Agree
ART for TB patients:
Agree
Cotrimoxazole prophylaxis in people living with HIV:
Agree
Early infant diagnosis:

Agree
HIV care and support in the workplace (including alternative working arrangements):
Agree
HIV testing and counselling for people with TB:
Agree
HIV treatment services in the workplace or treatment referral systems through the workplace:
N/A
Nutritional care:
Agree
Paediatric AIDS treatment:
Agree
Post-delivery ART provision to women:
Agree
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault):
Agree
Post-exposure prophylaxis for occupational exposures to HIV:
Agree
Psychosocial support for people living with HIV and their families:
Agree
Sexually transmitted infection management:
Agree
TB infection control in HIV treatment and care facilities:
Agree
TB preventive therapy for people living with HIV:
Agree
TB screening for people living with HIV:
Agree
Treatment of common HIV-related infections:
Agree
Other [write in]:
-

2. Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?:
Yes
Please clarify which social and economic support is provided:
The primary responsibility for direct delivery of economic and social assistance services for most Canadians is under provincial and territorial jurisdiction. The federal government is responsible for providing economic support for First Nations people living on reserves, the Inuit in northern Canada, and federal prisoners. Jurisdictions take different approaches to HIV/AIDS care and support, but most have a policy or strategy to address this issue. Civil society also plays a significant role in the provision of social support.
3. Does the country have a policy or strategy for developing/using generic medications or parallel importing of medications for HIV?:
N/A
4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy medications, condoms, and substitution medications?:
Yes
IF YES, for which commodities?:
Antiretroviral drugs, condoms, and substitution drugs are available in all jurisdictions.
5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care, and support programmes in 2011?:
-
Since 2009, what have been key achievements in this area:
In an effort to expand the offer for HIV testing within the primary care setting, the federal government will be publishing new Guidelines for HIV Testing in spring 2012. The guidelines recommend that primary care physicians extend the offer of voluntary HIV testing as a part of routine health care using an approach that simplifies the testing process. This approach reflects the operational challenges facing health care providers. The goal of the guidelines is to further increase access to HIV testing, thereby decreasing the number of people unaware of their HIV status and ensuring that antiretroviral therapies are made
What challenges remain in this area:
•An estimated 26% of people in Canada who are living with HIV were unaware of their status in 2008, and therefore are not accessing care, treatment and support services . •Access to treatment remains a concern for people living with HIV/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 differ 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, workplace accommodation and rehabilitation challenges have emerged, and the combined complexities of long-term treatment and infection creates challenges for prevention, care, treatment, and support. As the population of people living with HIV/AIDS grows older, new challenges associated with HIV and aging are emerging.

6. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?:
N/A
7. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011?:
-
Since 2009, what have been key achievements in this area:
-
What challenges remain in this area:
-

A - VI. MONITORING AND EVALUATION

1. Does the country have one national Monitoring and Evaluation (M&E) plan for HIV?:
Yes
Briefly describe any challenges in development or implementation:
The federal government compiles and reports on national epidemiological and surveillance indicators in order to track HIV/AIDS at the national level. National level HIV/AIDS surveillance is possible as a result of all provinces and territories participating in, and setting directions for, HIV/AIDS surveillance. Provincial/territorial HIV/AIDS coordinators, public health units, laboratories, health care providers and reporting physicians provide non-nominal confidential data that enable the Public Health Agency of Canada (PHAC) to compile and analyze national data.
1.1 IF YES, years covered:
1985-ongoing
1.2 IF YES, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?:
Yes, all partners
Briefly describe what the issues are:
All provinces and territories have consistent indicators to track HIV incidence and prevalence in order to support national monitoring of HIV/AIDS. All 13 provinces and territories have endorsed and participate in national surveillance activities led by the federal government. The Federal Initiative M&E plan was endorsed by all four participating federal government departments and agencies. All civil society partners that are funded through the federal investment are aligned with the federal M&E plan.

2. Does the national Monitoring and Evaluation plan include?

A data collection strategy:
Yes
Behavioural surveys:
Yes
Evaluation / research studies:
Yes
HIV Drug resistance surveillance:
Yes
HIV surveillance:
Yes
Routine programme monitoring:
Yes
A data analysis strategy:
Yes
A data dissemination and use strategy:
Yes
A well-defined standardised set of indicators that includes sex and age disaggregation (where appropriate):
Yes
Guidelines on tools for data collection:
Yes

3. Is there a budget for implementation of the M&E plan?:
Yes
3.1. IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities? :
11%
4. Is there a functional national M&E Unit?:
Yes
Briefly describe any obstacles:
N/A

4.1. Where is the national M&E Unit based?

In the Ministry of Health?:
Yes

In the National HIV Commission (or equivalent)?:
No
Elsewhere [write in]?:
The Public Health Agency of Canada is the exact location of the M&E Unit

Permanent Staff [Add as many as needed]

POSITION [write in position titles in spaces below]	Fulltime	Part time	Since when?
Senior Policy Analyst	-	-	-
Policy Analyst	-	-	-
Evaluation Consultant	-	-	-

Temporary Staff [Add as many as needed]

POSITION [write in position titles in spaces below]	Fulltime	Part time	Since when?
Evaluation Consultant	-	-	-
Senior Program Consultant	-	-	-

4.3. Are there mechanisms in place to ensure that all key partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?:
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/AIDS in Canada, Surveillance Report. These are accessible electronically through the PHAC website. For programme data, federal government partners provide their M&E data and reports to the Public Health Agency of Canada which, as the lead federal partner, reports on Federal Initiative accomplishments to Canadians and international audiences.
What are the major challenges in this area:
The number of reported AIDS cases at any point in time is not necessarily a true reflection of the total number of people with a diagnosis of AIDS. This is because some individuals with diseases that are indicative of AIDS are not reported which, leads to underreporting of AIDS cases. Ethnicity data and exposure category information is not available for all the provinces and territories, which results in challenges 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 Performance Management Framework, with key results identified for each department in a common logical framework, should help address this challenge.
5. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?:
Yes
6. Is there a central national database with HIV- related data?:
Yes
IF YES, briefly describe the national database and who manages it.:
There is a central national data base for HIV/AIDS surveillance information, managed by 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.
6.1. IF YES, does it include information about the content, key populations and geographical coverage of HIV services, as well as their implementing organizations?:
Yes, all of the above

6.2. Is there a functional Health Information System?

At national level:
Yes
At subnational level:
Yes
IF YES, at what level(s)?:
Municipal, Provincial and Territorial levels

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

8. How are M&E data used?

For programme improvement?:
Yes
In developing / revising the national HIV response?:
Yes

Disclaimer

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

Avertissement

La présente annexe contient de l'information provenant d'organisations non gouvernementales canadiennes. Il ne s'agit pas d'un document du gouvernement du Canada. L'information et les perspectives contenues dans le présent document ont été fournies par des organisations non gouvernementales canadiennes actives dans le domaine de la lutte au VIH/sida. Les points de vue présentés ici ne sont pas cautionnés par le gouvernement du Canada et ne reflètent pas nécessairement les vues de ce dernier.

For resource allocation?:
Yes
Other [write in]:
-

Briefly provide specific examples of how M&E data are used, and the main challenges, if any:
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.

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

At national level?:
Yes
IF YES, what was the number trained:
Data not collected
At subnational level?:
-
At service delivery level including civil society?:
Yes
IF YES, how many?:
Data not collected

9.1. Were other M&E capacity-building activities conducted` other than training?:
No
10. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the HIV-related monitoring and evaluation (M&E) in 2011?:
-
Since 2009, what have been key achievements in this area:
• Key performance indicators have been developed • Improvements in performance measurement of funded organizations. • An electronic performance measurement system continues to be under development. • In October 2011, the AIDS Community Action Program (ACAP) initiated a pan-regional study to measure participant level changes in behaviour, knowledge and access. This will be the first time participant level data has been collected for ACAP funded interventions. • Participating federal departments have also improved monitoring and evaluation.
What challenges remain in this area:
• Implementing the performance measurement system is challenging as participating departments and agencies have different approaches to monitoring.

B - I. CIVIL SOCIETY INVOLVEMENT

1. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?:
2
Comments and examples:
With the exception of a brief meeting with the federal Minister of Health at the 2010 International AIDS Conference in Vienna, NGOs have had few occasions for dialogue with the federal Minister of Health. Aboriginal organisations have been successful in engaging the support of some Aboriginal political leaders at the national level. Civil society has attempted to secure government support for policies around harm reduction approaches and services at a federal level, but has not been successful; in fact, government policy has been openly and actively hostile to some evidenceǀbased harm reduction services aimed at, among other things, reducing HIV and hepatitis C virus (HCV) transmission among people who use drugs (e.g., supervised injection services). Funding for a federal AIDS strategy continues to be frozen well below the level unanimously recommended by all political parties in Parliament 8 years ago – and future funding levels remain uncertain in light of a governmentǀwide program of cuts to spending. (In early 2012, significant reductions from previous levels of federal funding under said strategy were imposed on several organizations, and numerous organizations addressing the health of vulnerable populations (e.g., Aboriginal communities, women's health). In the global arena, civil society has played a key role in maintaining political commitment for support to the Global Fund to Fight AIDS, Tuberculosis and Malaria, but overall official development assistance (ODA) has been frozen.
2. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") 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
Comments and examples:
The national strategy, known as the Federal Initiative to Address HIV/AIDS in Canada, is in place but the document only describes activities, funding and goals for the strategy up to 2009. It has not been reviewed or updated and civil society organisations do not know of any plans to review or update the strategy. External consultants were hired by the government to undertake some consultation with NGOs regarding revisions to the current funding structure for the Federal Initiative to Address HIV/AIDS so as to "align with government priorities." The government has stated that the consultants' report (released in May 2012) will be considered in the process of revising federal funding mechanisms, but that is the extent of the information

available to civil society. There has recently been restructuring within the HIV division at the Public Health Agency of Canada, streamlining and "integrating" work on HIV and other infectious diseases such as HCV. As communication between the federal government and civil society is poor, NGOs have little information about what is anticipated for the future of federal government attention to, and funding for, the response to HIV in Canada. Aboriginal organisations are also involved through the National Aboriginal Council on HIV/AIDS (NACHA) and provide advice to the federal government through that body. It parallels a similar body, with a similar function, called the Ministerial Advisory Council on HIV/AIDS. However, all such advisory bodies are currently under review by the government. Researchers are represented by the Canadian Association of HIV Research (CAHR) 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 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 community.

3.

a. The national HIV strategy?:

2

b. The national HIV budget?:

1

c. The national HIV reports?:

3

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, for example the development of various status reports on most‐at‐risk populations. However, it is noted that there has been no World AIDS Day report from Canada since 2006 and no dialogue with civil society about why this is the case, despite repeated inquiries and requests by civil society to be involved.

4.

a. Developing the national M&E plan?:

1

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

1

c. Participate in using data for decision-making?:

1

Comments and examples:

Civil society organisations have little input into government monitoring and evaluation efforts. Civil society bodies such as the Ministerial Advisory Council on HIV/AIDS provide input and advice, in very general terms, on monitoring and evaluation of activities encompassed by the Federal Initiative, but coordination of M&E activities is done by the government. In 2005, the Leading Together document was released to set out a country‐wide plan of action to address HIV. The report was developed over a few years through consultation and deliberation by civil society and government agencies (although was not ultimately produced as a Government of Canada document), and contained specific goals and targets. There has been no funding or infrastructure support to gather baseline data to measure and evaluate these goals and targets. Efforts to update this document have been stalled, partly due to conflict between civil society and government over issues such as including goals and targets (which the government has opposed including in an updated action plan).

5. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. organisations and networks of people living with HIV, of sex workers, and faith-based organizations)?:

4

Comments and examples:

At the national level the core principle of greater and meaningful involvement of people living with HIV is respected. Persons living with HIV serve on advisory bodies and working groups. There is good representation from Aboriginal peoples, and some most‐at‐risk populations but there is under‐representation from affected populations on the issues of women, youth, sex workers, people who use drugs, prisoners, persons with disabilities and street‐involved persons.

6. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society able to access

a. Adequate financial support to implement its HIV activities?:

2

b. Adequate technical support to implement its HIV activities?:

2

Comments and examples:

A national surveillance system is a form of technical support. However, data is not collected in a universal fashion across all provinces and territories which can weaken the data in some areas. In addition, the release of this data is always significantly delayed. For example, the most recent HIV/AIDS Epi Update from the Public Health Agency of Canada, released in July 2010, reports on and analyses data up until the end of 2008. The most recent national HIV/AIDS surveillance report only covers the period up to December 31, 2009, more than 2 years ago. Funding levels have not kept pace with inflation, which means the funding is less sustainable. In 2011 and 2012, funding to some national organisations increased while others experienced moderate to extreme cuts to funding. Information about the impact of a new round of

funding for local AIDS service organisations across the country is still unknown and under analysis. Funding has moved to become even more project‐based, which has increased the instability of organisations and increased the difficulty retaining qualified staff, particularly with significant delays in the processes of soliciting applications for funding and, for some organizations, in making decisions regarding funding support. Frontline organisations are increasingly expected to provide "integrated" services for HIV, hepatitis and other sexually transmitted infections but do not receive adequate resources.

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

People living with HIV:
>75%
Men who have sex with men:
>75%
People who inject drugs:
-
Sex workers:
>75%
Transgendered people:
>75%
Testing and Counselling:
>75%
Reduction of Stigma and Discrimination:
>75%
Clinical services (ART/OI)*:
<25%
Home-based care:
<25%
Programmes for OVC:**
<25%

8. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to increase civil society participation in 2011?:
2
Since 2009, what have been key achievements in this area:
Continued civil society voice and participation despite a reduction in transparency by government and a diminution of the role accorded to it by government. Participation by Aboriginal groups in policy and program discussions at the national level. Support from the federal government has enabled Canadian Aboriginal organisations to play a leadership role at international conferences and working group meetings, although this funding has recently been put on hold and is in jeopardy.
What challenges remain in this area:
The need for an improved working relationship between the federal government and civil society is more urgent than ever. NGOs feel increasingly disengaged and under threat from changes in funding mechanisms, policy directions and decisions (including an opposition to evidence‐based policy and programming in certain areas), and far less open and transparent communication. Despite the crucial role that civil society engagement with decision‐makers has played in the history of the HIV response in securing greater commitment to effective, evidence‐based measures for HIV prevention, care, treatment and support, the previous report mentioned that the government has explicitly stated that no "advocacy" activities can be supported with government funding. In the most recent call for funding, this criterion was maintained, but is apparently now interpreted even more expansively, further limiting the scope of effective activities by NGOs. Written and verbal feedback to NGOs indicated that funding is also now excluded for any "activity that could be interpreted as advocacy" or for any project producing materials that "could be used for advocacy". Some NGOs have been instructed not to use the term "harm reduction" in funding applications as this approach is not supported by the federal government, and have even been advised to avoid proposing activities that would result in "recommendations" for action. Some NGOs have also been instructed that activities such as capacity‐building workshops, or producing "know your rights" educational materials, may only address the rights of people living with HIV in certain contexts and that addressing the human rights of certain other vulnerable populations (including some of those named in the federal AIDS strategy as specific populations of concern) is not permissible under the terms of funding agreements. In prior years, civil society has always been included in the generation of this report. We have worked closely with the relevant civil servants and consultants. This year, civil society was excluded from the report process and had to petition the government to include this civil society report at the last minute. The narrative report was submitted by the Government of Canada without this Part B of the NCPI Questionnaire being administered to civil society organizations and without any consultation with or explanation to civil society of why this approach has changed, despite numerous inquiries over several months. This has sent a strong signal to civil society that the previous relationship with government is shifting and this is a cause for great concern.

B - II. POLITICAL SUPPORT AND LEADERSHIP

1. Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation?:
Yes

IF YES, describe some examples of when and how this has happened:
As noted above, the federal AIDS strategy includes some funding via grants for certain projects and activities by local or national organizations. Many of those organizations involve people living with HIV and/or members of key populations in the development and implementation of their programmes. Two civil society representatives were selected by civil society to be part of the official Canadian delegation to the UN High Level meeting on HIV and AIDS in June 2011. They were financially supported to attend and participate as equal members of the delegation. As noted above, a few advisory committees exist at the federal level in which people living with HIV and members of (some) key populations are included. In principle, those committees have some advisory input into federal government policy on HIVIrelated issues, although in practice it seems to be the rare occasion where that advice is accepted.

B - III. HUMAN RIGHTS

1.1.

People living with HIV:
Yes
Men who have sex with men:
Yes
Migrants/mobile populations:
Yes
Orphans and other vulnerable children:
Yes
People with disabilities:
Yes
People who inject drugs:
No
Prison inmates:
No
Sex workers:
No
Transgendered people:
Yes
Women and girls:
Yes
Young women/young men:
Yes
Other specific vulnerable subpopulations [write in]:
Young women/young men (above) in part

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?:
Yes
If YES to Question 1.1 or 1.2, briefly describe the contents of these laws:
Constitutional prohibition on discrimination based on certain grounds Section 15(1) of the Canadian Charter of Rights and Freedoms, which applies to all laws and other actions by all orders of government in Canada, states: Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability. As part of the constitution, which is the supreme law of the land, in theory this provision has overrides any other legislation or government action that is not in conformity with constitutional requirements; courts can and have struck down conflicting legislative provisions or government actions as being of no force and effect. Although some of the vulnerable populations listed above are not explicitly mentioned in the Charter, some of them are nonetheless protected because this constitutional provision prohibiting discriminatory legislation or actions by governments has been interpreted by the courts as being openIended and extending protection against discrimination based on grounds “analogous” to those listed. For example, “sexual orientation” has been “read in” to the Charter’s equality rights section above, meaning that discrimination by governments based on sexual orientation is constitutionally prohibited. Populations such as sex workers and prisoners, however, have not (yet) been recognized as protected against discrimination under the Charter based on their involvement in sex work or incarceration status. Federal and provincial/territorial antiIdiscrimination statutes In addition to the constitutional prohibition on discrimination, Canada has enacted antiIdiscrimination legislation at both the federal and provincial/territorial levels which prohibits discrimination based on various factors similar to those listed in the Charter (but usually with a broader list of explicit grounds on which discrimination is prohibited). These human rights statutes apply not just to government actors but also to private actors in specified contexts (e.g., employers, landlords, service providers, professional associations, etc.). One such ground on which discrimination is prohibited, which features in all such statutes, is “disability” or “handicap”. The provisions in both the Charter and in antiIdiscrimination statutes which prohibit discrimination based on disability have been interpreted in a way that it includes people living with HIV/AIDS under the umbrella of physical disability. For example, under the Canadian Human Rights Act, people living with HIV are protected from HIVIbased discrimination in the federal jurisdiction because Page 9 of 29 HIV is considered a disability in the context of antiIdiscrimination law with respect to any employment, goods, services, facilities or accommodation or access thereto or occupancy of any commercial premises or residential accommodation. These protections apply to both the private and public sector. The Canadian Human Rights Commission

Policy on HIV/AIDS states: Everyone has the right to equality and to be treated with dignity and without discrimination, regardless of HIV/AIDS status. The interpretation of the equivalent provincial statutes is the same. Limitations Protection against discrimination experienced by vulnerable populations remains inadequate, under both the constitutional prohibition on discrimination (Charter section 15) and anti-discrimination statutes. For example, discrimination on the basis of sexual orientation is prohibited in all jurisdictions of Canada, as is discrimination based on sex, race, ethnicity, national origin, etc. However, only one jurisdiction in Canada (the Northwest Territories) has explicit protection on the basis of gender identity. Discrimination on the basis of age is prohibited for those between the ages of 18 and 65 (youth and the elderly are not generally covered, even those are the populations most likely to face discrimination based on age). Discrimination on the basis of injecting drug use is not prohibited under anti-discrimination legislation in any jurisdiction, although it now well -established in Canadian law by various court and tribunal rulings that drug addiction/dependence to constitute a disability (or "handicap", depending on the wording of the applicable statute) under law and therefore there is a duty to accommodate that disability, short of "undue hardship"; this interpretation and application of these statutes has been seen primarily in the employment context. There is also no protection for sex workers against discrimination based on their involvement in sex work. If an individual is convicted of using a place for prostitution, the owner or landlord of that space must be notified and can face criminal charges and conviction if they do not take steps such as evicting the sex worker from his or her apartment which thereby persecutes the sex worker. (Some challenges to these criminal law provisions are currently before the courts.) Discrimination on the basis of incarcerated status (i.e. against prisoners) has not been recognized in the law, even though prisoners regularly suffer discrimination in various areas, including access to HIVrelated health services. There is a need for improvement in anti-discrimination legislation in terms of protecting youth, transgendered people, people who use drugs, sex trade workers, and prisoners. There is a dearth of information on HIV-related discrimination in Canada. It is unknown how frequently HIV-based discrimination occurs, in what contexts, the responses to HIV-based discrimination, and how individuals seek effective redress. Canada needs some additional research to gain a more thorough assessment of the extent of discrimination – in employment, housing, harassment, health care settings – on the basis of HIV status. Human rights commissions would be able to provide information about the number of complaints filed, which is generally believed to be a small proportion of actual incidents of discrimination.

Briefly explain what mechanisms are in place to ensure that these laws are implemented:

Human rights commissions and/or tribunals exist at the national and provincial levels. These are the only mechanisms by which to seek redress under the applicable anti-discrimination statute in the relevant jurisdiction. (Courts have ruled there is no independent civil cause of action for discrimination that can be brought before the courts.) In the case of unionized employees facing discrimination in the employment context, anti-discrimination statutes are incorporated by labour laws as minimum terms of collective agreements negotiated between unions and employers, meaning that a person seeking redress for discrimination (by an employer) in such a context must pursue a grievance under the collective agreement before a labour arbitrator. In claiming a violation by a government of the constitutionally protected right to non-discrimination, individuals and groups may seek redress via a civil proceeding in 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. Enforcement of these anti-discrimination protections remains inadequate. In most cases, it is up to the individual who experiences discrimination to 1) know their rights, 2) recognize that they have been discriminated against, 3) have knowledge of the complaints mechanisms available for redress, and 4) be willing/able to lodge a complaint with the relevant human rights commission or initiate legal proceedings against the government alleging unconstitutional discrimination contrary to the Charter. Some anti-discrimination commissions, such as the Canadian Human Rights Commission, will expedite the investigation of complaints alleging HIV/AIDS related discrimination. However, there are concerns about delays and hurdles in getting commissions or tribunals to adequately respond to HIV-related complaints, largely due to resource constraints. These mechanisms for enforcement present many barriers for people living with HIV/AIDS and vulnerable populations. In order to access their basic rights, people must first have access to basic human rights information, rights-based education, and knowledgeable service providers to advocate and support self-advocacy. Given the nature of HIV/AIDS-related stigma and the corresponding need for confidentiality, national and community-based AIDS service organizations have a key role to play in eliminating discrimination by bridging the enforcement gap through supporting such education and advocacy. The role of education and advocacy is not just the promotion of the human right to freedom from discrimination, but also an integral part of ensuring the adequate enforcement of antidiscrimination legislation (particularly for vulnerable populations who might not otherwise have access to the information and resources they need). Despite human rights protections being available in Canada, there remain significant challenges. Provided an individual has the fortitude to go forward with one of the redress mechanisms available to them, the process is often a daunting task, which requires resources that may not always be worth the effort. In some cases, a positive outcome in a formal remedial action may not necessarily result in positive change, and are at times compromised by various jurisdictional issues, as in the case of some Aboriginal people who fall within both federal jurisdiction and provincial/territorial jurisdictions depending on the context and nature of the discrimination.

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

-

2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?:

Yes

2.1. IF YES, for which sub-populations?

People living with HIV:

-

Men who have sex with men:

-

Migrants/mobile populations:

Yes

Orphans and other vulnerable children:
-
People with disabilities:
-
People who inject drugs:
Yes
Prison inmates:
Yes
Sex workers:
Yes
Transgendered people:
-
Women and girls:
-
Young women/young men:
-
Other specific vulnerable subpopulations [write in]:
-

Briefly describe the content of these laws, regulations or policies:
• Overly broad criminalization of people living with HIV for non‐disclosure of serostatus • Criminal law provisions creating risks to the health and safety of sex workers • Criminal laws on drugs impeding access to health services for people who use drugs • Laws and policies inhibiting access to HIV prevention and care for prisoners • Laws and policies undermining access to health care for certain migrants (e.g., refugee claimants)
Briefly comment on how they pose barriers:
Criminalization of HIV non‐disclosure Under Canadian criminal law as it currently stands, a person is guilty of the criminal offence of aggravated sexual assault in Canada if she or he does not disclose (known) HIV‐positive status before engaging in activity that poses a "significant risk" of transmission. In some cases, other criminal charges have also been laid. As of May 2012, at least 150 prosecutions had occurred for HIV non‐disclosure in the context of sexual encounters. (An unknown number of prosecutions have also been seen in cases of spitting, biting, etc., despite any significant risk of transmission.) As a consequence, some people living with HIV have been convicted of serious criminal offences, such as aggravated sexual assault, and sentenced to significant time in prison for failing to disclose their HIV status.4 Civil society organizations have taken the position that HIV transmission is primarily a public health issue, rather than a criminal issue and have been active in efforts to limit the scope of the criminal law – if not to the limited circumstances recommended by UNAIDS (as Canadian law has also gone well beyond those limits in ways that seem unlikely to be rolled back), then at least in some other ways by having a narrower, evidence‐based interpretation of the "significant risk" criterion that triggers a duty to disclose under pain of possible criminal prosecution. At this writing, decisions in two key cases are pending from the Supreme Court of Canada and from the Ontario Court of Appeal; these decisions will shape the parameters of Canadian law on this point for years to come. In those cases, several provincial prosecution services are arguing for a radically expanded use of the criminal law, some even going so far as to argue that disclosure of HIV‐positive status is required in all cases, and that without such disclosure, there can be no legally valid consent to sex – and hence the sexual encounter is equivalent in law to rape. Such an approach would dismiss entirely any consideration of the level of risk of transmission. In some provinces, civil society organizations have also been active in pursuing the development of prosecutorial guidelines that would, ideally, limit the application of the criminal law by police and prosecutors – again, in accordance with the evolving scientific evidence about risk and in light of other public policy concerns (including the adverse consequences for individual and public health of overly broad use of the criminal law to compel disclosure). 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 onreserve 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 inprison and post‐discharge services. The example of limited access to opiate substitution therapy (e.g. methadone)5 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.6 The 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 zerotolerance 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. Access to methadone maintenance therapy (MMT) for people imprisoned in Canada is becoming more common, although barriers persist. 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 Suboxone (buprenorphine). In some provincial systems, however, there is still no possibility of initiating MMT while incarcerated, even if continuing a pre-existing prescription is possible. In practice, difficulties in accessing opioid substitution therapy can persist even in the face of good policy. At this time, not a single prison in Canada provides or ensures that prisoners can get access to sterile injection equipment, despite a very high proportion of prisoners with a history of drug injection and a significant percentage reporting having injected while incarcerated. Extensive evidence has been provided repeatedly to government ministers and other officials responsible for prison systems, along with legal arguments and requests to initiate such programs in prisons or to permit community-based organizations delivering such services outside to introduce such services inside. To date, all such requests have been rejected. 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 use drugs In recent years steps have been taken by the federal government that reduce or eliminate harm reduction as an element of a comprehensive drug strategy. The National Anti-Drug Strategy introduced in 2007 contains no mention of harm reduction and provides no funding for harm reduction, contrary to years'-long, best practice about a comprehensive, "balanced" approach and extensive evidence of the benefits of harm reduction services. 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.7 Other Canadian municipalities (e.g., Toronto, Ottawa, Victoria, Montreal) 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. Anticipating that the federal government would not renew/extend its exemption from Canada's drug laws permitting its effective operation, 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 twice. In September 2011, the Supreme Court of Canada ruled in favour of Insite, granting it a constitutional exemption from the application of Canada's drug laws, and declaring that the federal Minister of Health must properly exercise his or her discretion on a case-by-case basis upon receiving applications for other, similar exemptions to operate supervised injection services. There is a need 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 workers8 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; a decision on appeal from the Supreme Court of Canada is pending and, if favourable on the question of standing, the matter will then proceed on the merits. In the meantime, the second case has proceeded before the courts in another province; in March 2012, the Ontario Court of Appeal issued a ruling in which it struck down certain provisions of the criminal law as unconstitutional, while upholding another provision. (Sex workers and other civil society organizations have been critical of the ruling for maintaining the prohibition that affects the greatest number of the most marginalized and at-risk sex workers. The matter is proceeding on appeal to the Supreme Court of Canada. Here again, the opportunity exists for civil society to work collaboratively with government to find solutions to the risks to individual health and the public health posed by the criminalization of sex workers. Migrants/mobile populations In early 2012, the federal government announced that it was planning changes to the Interim Federal Health Program, which provides supplemental medical coverage for refugee claimants in Canada (who are not eligible for full coverage under provincial public health insurance programs as non -residents). Civil society organizations have raised concerns about the impact of such cuts on the health of this population, including those living with HIV. The below footnotes correspond with references "(4)", "(5)", "(6)", "(7)", "(8)" cited above within this text box: 4 Tracking of cases is done by the Canadian HIV/AIDS Legal Network. For some analysis of documented cases between 1989 and 2010, see: E. Mykhalovskiy & G. Betteridge, "Who? What? Where? When? And with What Consequences? An Analysis of Criminal Cases of HIV Non-disclosure in Canada," Canadian Journal of Law and Society 2012; 27(1): 31-53. G. Betteridge & G. Dias. Hard Time: HIV and Hepatitis C Prevention Programming for Prisoners in Canada. Toronto: Canadian HIV/AIDS Legal Network & Prisoners' HIV/AIDS Support Action Network, 2007, online via

www.aidslaw.ca/prisons. See also: R. Elliott. Deadly disregard: government refusal to implement evidence-based measures to prevent HIV and Hepatitis C virus infections in prisons. Canadian Medical Association Journal 2007; 177: 262-264. 6 WHO, UNODC and UNAIDS. Substitution Maintenance Therapy in the Management of Opioid Dependence and HIV/AIDS Prevention: Position Paper. Geneva: WHO/UNODC/UNAIDS, 2004. 7 See studies cited in: Urban Health Research Initiative, "Insight into Insite" (Vancouver: British Columbia Centre for Excellence in HIV/AIDS, 24 March 2009) 8 Information in this section is adapted from: G. Betteridge. Sex, work, rights: reforming Canadian criminal laws on prostitution. Toronto: Canadian HIV/AIDS Legal Network, 2005, online via www.aidslaw.ca/sexwork. See also: Pivot Legal Society. Voices of Dignity: A Call to End the Harms Caused by Canada's Sex Trade Laws. Vancouver: The Society, 2004; and Pivot Legal Society. Beyond Decriminalization: Sex Work, Human Rights and a New Framework for Law Reform. Vancouver: The Society, 2006, both online via www.pivotlegal.org.

3. Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?:

Yes

Briefly describe the content of the policy, law or regulation and the populations included:

Canada's criminal laws include prohibitions on sexual assault and other forms of assault, including in the context of domestic violence.

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

Yes

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) was 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 was stated as one of the core values of Leading Together. As noted above, efforts to update this document have been stalled; at this time, no updated pan-Canadian action plan on HIV exists. 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.

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

Yes

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. The only quasi-governmental source of such data, which is only partial at best, consists of records held by the federal and provincial/territorial human rights commissions or tribunals about complaints actually formally lodged under applicable anti-discrimination laws regarding discrimination based on HIV status or on other grounds relevant to the most HIV-affected populations. This, of course, will significantly under-report the problem, since many instances of discrimination will not lead to a formal complaint being filed with a human rights commission or tribunal. (And, as noted above, some of the vulnerable populations are not protected against discrimination by existing Canadian laws, and so there is no basis for recording complaints of discrimination experienced by those populations on those grounds.) Several national non-governmental organizations, however, do conduct research into cases of discrimination directly or by compiling information from their member groups.

6. Does the country have a policy or strategy of free services for the following?

Provided free-of-charge to all people in the country	Provided free-of-charge to some people in the country	Provided, but only at a cost
-	Yes	-
Yes	-	-
-	Yes	-

If applicable, which populations have been identified as priority, and for which services?:

The federal government does not provide free services for HIV prevention and treatment, care and support, because these fall under provincial/territorial jurisdiction, with the exception of some Aboriginal populations (Inuit and on-reserve First Nations), federal prisoners and the armed forces, which receive health services funded by the Government of Canada. In general, HIV 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.

7. Does the country have a policy or strategy to ensure equal access for women and men to HIV prevention,

treatment, care and support?:

Yes

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

Yes

8. Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support?:

Yes

IF YES, Briefly describe the content of this policy/strategy and the populations included:

Gender equality in access to services Under the Canadian Charter of Rights and Freedoms, as discussed above, discrimination is prohibited on the basis of gender, but socioeconomic factors such as poverty, lack of education, fear of stigma and discrimination, or lack of power in relationships may impede women from having full access to services. Civil society is involved in the Blueprint for Action on Women and HIV/AIDS, a multiIsectoral coalition of HIVIpositive women, Canadian and international HIV/AIDS organizations, and a variety of women's and reproductive rights groups advocating for better prevention, services and supports for women and girls infected and affected by HIV/AIDS. The coalition focuses on: law and ethics; human rights; research; stigma and discrimination; diagnosis, treatment, care and support; prevention; and education. The coalition developed report cards on women and HIV/AIDS for AIDS 2006 in Toronto, AIDS 2008 in Mexico City and AIDS 2010 in Vienna. Access to services outside the context of pregnancy Access to these support services depends on local public health services in each province or territory and on services provided by frontIline nonIgovernmental organizations. Access may be more challenging in rural and remote communities. Equal access for other vulnerable populations Responsibility for education and health care delivery fall within provincial or territorial jurisdiction and are not subject to specific HIVIrelated 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 onIreserve First Nations populations).

8.1

8.1. IF YES, does this policy/strategy include different types of approaches to ensure equal access for different key populations and/or other vulnerable sub-populations?:

Yes

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 envisions specific national communications campaigns 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 populationIspecific status reports which aim to inform strategic policy and program design and delivery modes that target the eight mostIatIrisk populations that are identified in the Federal Initiative. Civil society is represented on status report working groups. As of this report, the status reports on women, Aboriginal peoples and people from countries where HIV is endemic have been completed.10 The below citation corresponsds with reference "(10)" cited above within this textbox: 10 Available at http://www.phac-aspc.gc.ca/aids-sida/publication/ps-pd/index-eng.php.

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

Yes

IF YES, briefly describe the content of the policy or law:

The Canadian Human Rights Commission (CHRC) Policy on HIV/AIDS states: Everyone has the right to equality and to be treated with dignity and without discrimination, regardless of HIV/AIDS status. The CHRC's policies are mirrored in numerous other Canadian legislation and policies. The Commission will not accept being free from HIV/AIDS as a bona fide occupational requirement or a bona fide justification unless it can be proved that such a requirement is essential to the safe, efficient and reliable performance of the essential functions of a job or is a justified requirement for receiving programs or services. HIVIpositive persons pose virtually no risk to those with whom they interact in the workplace. The Commission, therefore, does not support preI or postIemployment testing for HIV. Such testing could result in unjustified discrimination against people who are HIV positive. Employees living with HIV/AIDS are encouraged to remain productive as long as they are able and are entitled to arrangements for employment accommodations and workplace supports to facilitate opportunities to successfully participate and remain in the workforce. Any decision made by an organization relying on health and safety considerations to exclude a person must be based on an individual assessment supported by authoritative and upItoIdate medical and scientific information. Regarding health care workers, the Canadian Medical Association Policy on HIV/AIDS states that: The routine testing of health care workers for the HIV antibody is not justified. The CMA supports the application of universal precautions that enhance the protection of health care workers against potential infection from patients and vice versa. The Canadian Human Rights Commission supports this view. The Public Service Staff Relations Act, which applies to all federal government departments and other portions of the Public Service, states that employees are not required to undergo mandatory tests for HIV infection. The Public Service Staff Relations Act also states that departments must ensure that: the rights and benefits of employees with HIV infection or AIDS are respected; the occupational safety and health of employees with a potential risk of exposure to HIV is protected; and that employees are informed of existing information, education, counselling and evaluation services in the Public Service with respect to HIV infection and AIDS.

10. Does the country have the following human rights monitoring and enforcement mechanisms?

a. 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
b. Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts:
Yes
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 auditorIgeneral who often addresses healthIrelated spending and effectiveness of national programs. None of these mechanisms have a specific mandate to address HIVIrelated 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 HIVIrelated human rights abuses There is no national focal point for monitoring HIVIrelated human rights abuses or HIVIrelated discrimination. The onus rests with individuals to bring cases of discrimination to the attention of monitoring bodies or the courts. Several national non Igovernmental organizations include such monitoring in their work as permitted by available resources, but the capacity to document and respond is limited. In particular, the Canadian HIV/AIDS Legal Network is active in monitoring court proceedings, but has only limited 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.

11. In the last 2 years, have there been the following training and/or capacity-building activities

a. Programmes to educate, raise awareness among people living with HIV and key populations concerning their rights (in the context of HIV)?:
Yes
b. Programmes for members of the judiciary and law enforcement on HIV and human rights issues that may come up in the context of their work?:
Yes

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

a. Legal aid systems for HIV casework:
Yes
b. Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV:
Yes

13. Are there programmes in place to reduce HIV-related stigma and discrimination?:
Yes

IF YES, what types of programmes?

Programmes for health care workers:
Yes
Programmes for the media:
Yes
Programmes in the work place:
Yes
Other [write in]:
-

14. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2011?:
5
Since 2009, what have been key achievements in this area:
• Recognition by the country's highest court of the constitutional right of persons addicted to drugs to have access to supervised injection services • Ratification of the United Nations Convention on the Rights of Persons with Disabilities • First judicial training on HIV: In March 2010, in collaboration with the National Judicial Institute, the Legal Network and the HIV & AIDS Legal Clinic Ontario (HALCO) delivered a halfIday training session, focusing on HIV and criminal law, for a number of judges from across the country, as part of broader "social context" training program.
What challenges remain in this area:
• Overly broad criminalization of HIV nonIdisclosure • 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 mostIatIrisk populations.
15. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the effort to implement human rights related policies, laws and regulations in 2011?:
-
Since 2009, what have been key achievements in this area:
-
What challenges remain in this area:
-

B - IV. PREVENTION

1. Has the country identified the specific needs for HIV prevention programmes?:
Yes
IF YES, how were these specific needs determined?:
Seven priority populations have been identified in the Federal Initiative: people living with HIV, gay men, women, people who use drugs, prisoners, youth and people from endemic countries. The federal government has very slowly been releasing “status reports” on each of these priority populations, but it is unclear whether or how the focus on these priority populations impacts prevention programming. The federal government has developed a highllevel HIV Prevention Framework, but it is unclear whether civil society is aware of this document, and also unclear what impact it has on prevention programs. Prevention programmes are not being scaled up.

1.1 To what extent has HIV prevention been implemented?

Blood safety:
Strongly Agree
Condom promotion:
Agree
Harm reduction for people who inject drugs:
Agree
HIV prevention for out-of-school young people:
Disagree
HIV prevention in the workplace:
Strongly Disagree
HIV testing and counseling:
Agree
IEC on risk reduction:
Strongly Disagree
IEC on stigma and discrimination reduction:
Disagree
Prevention of mother-to-child transmission of HIV:
Agree
Prevention for people living with HIV:
Agree
Reproductive health services including sexually transmitted infections prevention and treatment:
Agree
Risk reduction for intimate partners of key populations:
Agree
Risk reduction for men who have sex with men:
Agree
Risk reduction for sex workers:
Agree
School-based HIV education for young people:
Agree
Universal precautions in health care settings:
Strongly Agree
Other [write in]:
-

2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in the implementation of HIV prevention programmes in 2011?:
6
Since 2009, what have been key achievements in this area:
There haven’t been any significant achievements in prevention programmes in Canada over the last few years. Epi data is collected in the provinces and forwarded to the federal government, and always years late. The most recent epi data is from 2008 estimates and indicates that the number of new HIV infections (incidence) may be increasing among Aboriginal people and in people who inject drugs. The number of new HIV infections (incidence) may be stable among gay men and other men who have sex with men (MSM), people exposed through heterosexual sex, MSMlIDU and women.
What challenges remain in this area:
The federal government actively doesn’t support harm reduction programs and efforts, while saying that they support evidence lbased programs. This contradiction is frustrating for researchers, programmers and those working on the frontlines, and impedes implementation of best practices for work with drugusing populations. Although there are educational programs and information, access remains an issue for specific populations, primarily aboriginal peoples, newcomers, and streetlinvolved populations. Recent research showing the important of undetectable viral load for reduced transmissions and other NPTs has not been adequately addressed by the federal government. They have commissioned reports on these topics but then don’t release these reports or alter them so they are “neutral” reports, absent of recommendations or potential actions.

B - V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV and AIDS treatment, care and support services?:
Yes
IF YES, Briefly identify the elements and what has been prioritized:
The Federal Initiative, designed to coordinate government efforts in HIV was developed in 2004 and has not been updated. Another document, Leading Together, funded by the federal government but written by civil society was developed after a comprehensive consultation process, was released in 2005 with goals and targets set for 2010. Funds were not available to gather baseline data to measure and evaluate the goals and targets. Efforts to update this document have been stalled by dissent between government control/funding and civil society lack of capacity to properly update this document.
Briefly identify how HIV treatment, care and support services are being scaled-up?:
Any efforts to scale up treatment services have been provincially led. For example, in 2 regions in BC there has been a pilot project to "test and treat", which has scaled up outreach, testing and treatment access and support.

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

Antiretroviral therapy:
Agree
ART for TB patients:
Agree
Cotrimoxazole prophylaxis in people living with HIV:
Agree
Early infant diagnosis:
Strongly Agree
HIV care and support in the workplace (including alternative working arrangements):
Disagree
HIV testing and counselling for people with TB:
Agree
HIV treatment services in the workplace or treatment referral systems through the workplace:
Disagree
Nutritional care:
Disagree
Paediatric AIDS treatment:
Agree
Post-delivery ART provision to women:
Agree
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault):
Strongly Agree
Post-exposure prophylaxis for occupational exposures to HIV:
Strongly Disagree
Psychosocial support for people living with HIV and their families:
Agree
Sexually transmitted infection management:
Agree
TB infection control in HIV treatment and care facilities:
Strongly Agree
TB preventive therapy for people living with HIV:
Strongly Agree
TB screening for people living with HIV:
Strongly Agree
Treatment of common HIV-related infections:
Strongly Agree
Other [write in]:
-

1.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2011?:
7
Since 2009, what have been key achievements in this area:
In some provinces HIV treatment, care and support programmes are strong and constant, in other less so.
What challenges remain in this area:
Health is a provincial responsibility and the federal government increasingly "hides behind" this role division. Whereas in earlier years the federal government provided guidelines (which informed and influenced provincial governments), they now only provide watered down "status reports" and technical reports.
2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?:
Yes

2.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?:
Yes
2.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children?:
Yes
2.3. IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?:
Yes
2.4. IF YES, what percentage of orphans and vulnerable children is being reached? :
-
3. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011?":
-
Since 2009, what have been key achievements in this area:
-
What challenges remain in this area:
-

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