UNAIDS

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Canada

COUNTRY:

Canada

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Date of submission:

1/30/2008

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:	Respondents to Part A [indicate which parts each respondent was queried on]	A.I / A.II / A.III / A.IV / A.V
:	Organisation	Canadian Institutes for Health Research
:	Name/Position	Jennifer Gunning - Team Lead, HIV/AIDS

:	Respondents to Part A [indicate which parts each respondent was queried on]	A.I / A.II / A.III / A.IV / A.V
:	Organisation	Canadian International Development Agency
:	Name/Position	Madani Thiam - Senior Advisor
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:	Name/Position	Christopher Armstrong - A/Team Leader
:	Respondents to Part A [indicate which parts each respondent was queried on]	A.II / A.III / A.IV
:	Organisation	Public Health Agency of Canada
:	Name/Position	Chris Archibald - Director Surveillance adn Risk Assessment
:	Respondents to Part A [indicate which parts each respondent was queried on]	A.I / A.III / A.V
:	Organisation	Public Health Agency of Canada
:	Name/Position	Stephen Sternthal - Manager CHVI Secretariat
:	Respondents to Part A [indicate which parts each respondent was queried on]	A.II / A.III / A.IV / A.V
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:	Name/Position	Grafton Spooner - Manager, External Government Relations
:	Respondents to Part A [indicate which parts each respondent was queried on]	A.I / A.II / A.III / A.IV / A.V
:	Organisation	Public Health Agency of Canada
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:	Respondents to Part A [indicate which parts each respondent was queried on]	A.I / A.II / A.III / A.IV / A.V
:	Organisation	Corrections Services Canada
:	Name/Position	Mary Beth Pongrac - Policy Officer HIV/AIDS
:	Respondents to Part A [indicate which parts each respondent was queried on]	A.I / A.II / A.III / A.IV / A.V
:	Organisation	Public Health Agency of Canada
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:	Organisation	Public Health Agency of Canada
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:	Respondents to Part A [indicate which parts each respondent was queried on]	A.II / A.III / A.IV / A.V
:	Organisation	Department of National Defense
:	Name/Position	Dr Tepper - Principal Medical Advisor
:	Respondents to Part A [indicate which parts each respondent was queried on]	A.I / A.II / A.III / A.IV
:	Organisation	Department of Foreign Affairs and International Trade
:	Name/Position	Michael McCulloch - Senior Advisor
:	Respondents to Part A [indicate which parts each respondent was queried on]	A.II / A.III / A.IV
:	Organisation	Health Canada - First Nations and Inuit Health Branch
:	Name/Position	Sonia Melo - Programme Coordinator
:	Respondents to Part A [indicate which parts each respondent was queried on]	A.I / A.II / A.III / A.IV / A.V
:	Organisation	Canadian Aboriginal AIDS Network
:	Name/Position	Kevin Barlow - Executive Director
:	Respondents to Part B [indicate which parts each respondent was queried on]	B.I / B.II / B.III / B.IV
:	Organisation	Canadian AIDS Society
:	Name/Position	Monique Dootlittle-Romas - Executive Director
:	Respondents to Part B [indicate which parts each respondent was queried on]	B.I / B.II / B.III / B.IV
:	Organisation	Canadian AIDS Treatment Information Exchange
:	Name/Position	Laurie Edmiston
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:	Organisation	Canadian Association for HIV Research
:	Name/Position	Darryl Perry - Executive Director
:	Respondents to Part B [indicate which parts each respondent was queried on]	B.I / B.II / B.III / B.IV

:	Organisation	Canadian HIV/AIDS Information Centre (Canadian Public Health Association)
:	Name/Position	Ian Culburt
:	Respondents to Part B [indicate which parts each respondent was queried on]	B.I / B.II / B.III / B.IV
:	Organisation	Canadian HIV/AIDS Legal Network
:	Name/Position	Richard Elliott - Executive Director
:	Respondents to Part B [indicate which parts each respondent was queried on]	B.I / B.II / B.III / B.IV
:	Organisation	Canadian HIV Trials Network
:	Name/Position	Julie Schneiderman - Communications Manager
:	Respondents to Part B [indicate which parts each respondent was queried on]	B.I / B.II / B.III / B.IV
:	Organisation	Canadian Treatment Action Council
:	Name/Position	Louise Binder - Board Chair
:	Respondents to Part B [indicate which parts each respondent was queried on]	B.I / B.II / B.III / B.IV
:	Organisation	Canadian Working Group on HIV Rehabilitation
:	Name/Position	Elisse Zack - Executive Director
:	Respondents to Part B [indicate which parts each respondent was queried on]	B.I / B.II / B.III / B.IV
:	Organisation	Interagency Coalition on AIDS and Development
:	Name/Position	Michael O'Connor - Executive Director
:	Respondents to Part B [indicate which parts each respondent was queried on]	B.I / B.II / B.III / B.IV
Position:		Manager
Position:	Full time/Part time	Full time
Position:	Since when?	2004
Position:		Senior Policy Analyst
Position:	Full time/Part time	Full time
Position:	Since when?	2006
Position:		Policy Analyst
Position:	Full time/Part time	Full time
Position:	Since when?	2005
Position:		Evaluation Analyst
Position:	Full time/Part time	Full time

Position:	Since when?	2007
Position:		Quality Assurance Junior Project Officer
Position:	Full time/Part time	Part time
Position:	Since when?	2007

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

Yes

IF YES, period covered:

2005-2010

IF NO or N/A, briefly explain

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

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

The Federal Initiative to Address HIV/AIDS in Canada is a partnership between four federal departments and agencies: the Public Health Agency of Canada, Health Canada, Canadian Institutes of Health Research, and Correctional Service Canada. The Federal Initiative has the following goals:

• Prevent the acquisition and transmission of new infections;
• Slow the progress of the disease and improve quality of life;
• Reduce the social and economic impact of HIV/AIDS;
• Contribute to the global effort to reduce the spread of HIV and mitigate the impact of the diseases.

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

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

17

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

Health:	Strategy/Action framework	Yes
Health:	Earmarked budget	Yes
Education:	Strategy/Action framework	Yes
Women:	Strategy/Action framework	Yes
Young people:	Strategy/Action framework	Yes

IF NO earmarked budget, how is the money allocated?

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

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

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

a. Women and girls:	Yes
b. Young women/young men:	Yes
c. Specific vulnerable sub-populations[3]:	Yes
e. Workplace:	No
f. Schools:	Yes
g. Prisons:	Yes
h. HIV, AIDS and poverty:	Yes
i. Human rights protection:	Yes
j. Involvement of people living with HIV:	Yes
k. Addressing stigma and discrimination:	Yes
l. Gender empowerment and/or gender equality:	Yes

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

Yes

IF NO, how were target populations identified?

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

Surveillance reports are published on a semi-annual basis.

1.5 What are the target populations in the country?

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

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

Yes

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

a. Formal programme goals? :	Yes
b. Clear targets and/or milestones? :	Yes
c. Detailed budget of costs per programmatic area? :	Yes
d. Indications of funding sources?:	Yes
e. Monitoring and Evaluation framework? :	Yes

1.8 Has the country ensured “full involvement and participation” of civil society[4] in the development of the multisectoral strategy/action framework?

Active involvement

IF active involvement, briefly explain how this was done:

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

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

No

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

No

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

N/A

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

Yes

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

4

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

Yes

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

Behavioural change communication:	Yes
Condom provision :	Yes
HIV testing and counselling(*):	Yes
STI services :	Yes
Treatment:	Yes
Care and support :	Yes

**(*)If HIV testing and counselling has been implemented for uniformed services beyond the pilot stage, what is the approach taken?
Is it voluntary or mandatory (e.g. at enrolment)? Briefly explain:**

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

The Treasury Board of Canada policy on HIV/AIDS applies to both National Defence and the Royal Canadian Mounted Police. This policy outlines a number of requirements and guidelines with respect to the rights and benefits of employees living with HIV, the availability of voluntary testing and pre and post-test counselling, education and information, and precautions for employees with a potential risk of exposure.

National Defence has an occupational health policy to enable people living with HIV/AIDS to work according to their health and ability. It is also intended to safeguard the confidentiality of the military member's personal health information. In addition, all Canadian Forces personnel scheduled for operational duty must complete pre-deployment training that includes a preventive medicine component. Sexually-transmitted diseases, including HIV/AIDS, are discussed in this briefing.

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

Yes

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

Yes

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

Estimates and projected needs

5.4 Is HIV and AIDS programme coverage being monitored?

Yes

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

Yes

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

Yes

IF YES, which population sub-groups?

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

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

Yes

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

Provincial

Comments on progress made in strategy planning efforts since 2005:

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

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

President/Head of government :	Yes
Other high officials :	Yes
Other officials in regions and/or districts :	Yes

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

Yes

IF NO, briefly explain:

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

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

The Government of Canada Assistant Deputy Minister Committee was established in 2005. Its mandate is to provide Government of Canada interdepartmental leadership, increased coordination and cooperation, and improved coherence of policies and programs, to more effectively address HIV/AIDS and related issues. 14 different departments are represented at the Assistant Deputy Minister level.

The Ministerial Council on HIV/AIDS was created in 1998 to provide advice to the Minister of Health on pan-Canadian aspects of HIV/AIDS. Its membership includes a cross-section of researchers, health care and front-line professionals involved with at-risk groups. Traditionally one-third of members are people living with HIV/AIDS. Representatives from the Public Health Agency of Canada and the Federal/Provincial/Territorial Advisory Committee on AIDS sit as ex officio members.

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

2.1 IF YES, when was it created? Year:

1998

2.2 IF YES, who is the Chair?

Name:	Co-chairs rotate on Advisory Councils established since 1998 (Ministerial Advisory Council and the Federal/Provincial/Territorial Advisory Committee on HIV/AIDS)
Title/Function:	Co-chair and rotating membership

2.3 IF YES, does it:

have terms of reference? :	Yes
have active Government leadership and participation? :	Yes
have a defined membership?:	Yes
include civil society representatives? (*):	Yes
include people living with HIV?:	Yes
include the private sector?:	Yes
have an action plan?:	Yes
have a functional Secretariat? :	Yes
meet at least quarterly?:	Yes
review actions on policy decisions regularly?:	Yes
actively promote policy decisions?:	Yes
provide opportunity for civil society to influence decision-making?:	Yes
strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?:	Yes

(*) If it does include civil society representatives, what percentage?

30

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

Yes

3.1 IF YES, does it include?

Terms of reference :	Yes
Defined membership :	Yes
Action plan :	Yes
Functional Secretariat :	Yes
Regular meetings (*):	Yes

(*)If it does include regular meetings, what is the frequency of the meetings:

quarterly, depending on the groups

IF YES, What are the main achievements?

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

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

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

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

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

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

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

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

50

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

Information on priority needs and services :	Yes
Technical guidance/materials:	Yes
Drugs/supplies procurement and distribution :	No
Coordination with other implementing partners :	Yes
Capacity-building :	Yes

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

No

Comments on progress made in political support since 2005:

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

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

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

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

Yes

1.1 IF YES, what key messages are explicitly promoted?

Be sexually abstinent:

Delay sexual debut:

Be faithful:

Use condoms consistently:

Engage in safe(r) sex:

Abstain from injecting drugs:

Use clean needles and syringes:

Fight against violence against women:

Greater acceptance and involvement of people living with HIV:

Other::

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

No

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

Yes

2.1 Is HIV education part of the curriculum in

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

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

Yes

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

No

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

Yes

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

Targeted information on risk reduction and HIV education:	IDU
Targeted information on risk reduction and HIV education:	MSM
Targeted information on risk reduction and HIV education:	Sex workers
Targeted information on risk reduction and HIV education:	Prison inmates
Targeted information on risk reduction and HIV education:	Other sub-populations (*)
Stigma & discrimination reduction:	MSM
Stigma & discrimination reduction:	Other sub-populations (*)
Condom promotion:	IDU
Condom promotion:	MSM
Condom promotion:	Sex workers
Condom promotion:	Prison inmates
Condom promotion:	Other sub-populations (*)
HIV testing & counselling:	IDU
HIV testing & counselling:	MSM
HIV testing & counselling:	Sex workers
HIV testing & counselling:	Prison inmates
HIV testing & counselling:	Other sub-populations (*)
Reproductive health, including STI prevention & treatment:	IDU
Reproductive health, including STI prevention & treatment:	MSM
Reproductive health, including STI prevention & treatment:	Sex workers
Reproductive health, including STI prevention & treatment:	Prison inmates
Reproductive health, including STI prevention & treatment:	Other sub-populations (*)
Vulnerability reduction (e.g. income generation):	IDU
Vulnerability reduction (e.g. income generation):	Sex workers
Vulnerability reduction (e.g. income generation):	Other sub-populations (*)
Drug substitution therapy:	IDU
Needle & syringe exchange:	IDU

(*)If Other sub-populations, indicate which sub-populations

Aboriginal populations, persons from countries where HIV/AIDS is endemic, women at risk, persons living with HIV/AIDS (PHAs), youth at risk.
Varying degrees of support in the area of stigma and discrimination and vulnerability reduction. Fullsome support for targted information on risk reduction, condom promotion, HIV testing aand counselling.
Some areas are not applicable.
Services vary across the country, depending on the specific population at risk. Services are delivered by a range of providers, including community organizations, government organizations and health services.

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

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

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

Yes

IF NO, how are HIV prevention programmes being scaled-up?:

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

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

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

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

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

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

Yes

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

Yes

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

Yes

IF NO, how are HIV and AIDS treatment, care and support services being scaled-up?

Yes - addendum
The responsibility for the direct delivery of care and treatment is under provincial and territorial jurisdiction. Different jurisdictions take different approaches to HIV and AIDS care and support, but most have a policy or strategy to address this issue. The voluntary sector is key in delivering psychosocial care and home and community-based care.
Yes, however, it is estimated that 27% of people in Canada who are HIV positive are unaware of their infection, and this presents an obvious barrier in accessing treatment in a timely manner. In order to increase the number of Canadians aware of their sero- status, the Public Health Agency of Canada has undertaken collaborative work with other levels of government, primary care providers, experts and community to develop a policy framework on HIV testing and counselling. The framework will inform HIV testing and counselling decision-making, based on the best available evidence, evolving and emerging issues and take into account diverse approaches and points of view, as well as specific considerations for particular populations most affected by HIV/AIDS.
Each jurisdiction determines where best to focus their HIV and AIDS treatment, care and support programmes. Provinces and territories conduct their own epidemiological and surveillance studies and know where to focus their efforts. People living in rural and remote areas, including First Nations reserves, are less likely to be able to access HIV treatment, care and support services.

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

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

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

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

No

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

Yes

4.1 IF YES, for which commodities?:

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

Comments on progress made since 2005:

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

N/A

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

Yes

IF YES, Years covered:

Not national but Federal since 2005 and ongoing

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

Yes

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

Yes

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

Yes, but only some partners

2. Does the Monitoring and Evaluation plan include?

a data collection and analysis strategy :	Yes
behavioural surveillance :	Yes
HIV surveillance :	Yes
a well-defined standardized set of indicators :	Yes
guidelines on tools for data collection :	Yes
a strategy for assessing quality and accuracy of data :	Yes
a data dissemination and use strategy :	Yes

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

Yes

3.1 IF YES, has funding been secured?

Yes

4. Is there a functional M&E Unit or Department?

Yes

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

in the NAC (or equivalent)? :	No
in the Ministry of Health? :	Yes

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

**
Number of permanent staff:

6

Number of temporary staff:

0

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

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

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

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

Yes, meets regularly

IF YES, Date last meeting:

2007

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

No

IF YES, describe the role of civil society representatives and people living with HIV in the working group

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

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

No

6.1 IF YES, what type is it?

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

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

Yes

6.3 Is there a functional Health Information System (HIS)?

National level :	Yes
Sub-national level (*):	Yes

(*)If there is a functional sub-national HIS, at what level(s) does it function?

Municipal and provincial/territorial

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

Yes

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

5

What are examples of data use?

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

What are the main challenges to data use?

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

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

At national level? :	Yes
At sub-national level? :	No

Comments on progress made in M&E since 2005:

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

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

Yes

1.1 IF YES, specify:

Section 15(1) of the Canadian Charter of Rights and Freedoms, which is part of the country's Constitution and which applies to all laws and other actions by governments and other state actors in Canada, states:
Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.
In addition, Canada has enacted anti-discrimination legislation at both the federal and provincial/territorial levels which prohibits discrimination based on "disability" or "handicap" by both public and private actors. The provisions in both the Charter and in anti-discrimination statutes which prohibit discrimination based on disability have been interpreted in a way that it includes people living with HIV/AIDS under the umbrella of physical disability.
For example, under the Canadian Human Rights Act, people living with HIV are protected from HIV-based discrimination in the federal jurisdiction because HIV is considered a disability in the context of anti-discrimination law with respect to any employment, goods, services, facilities or accommodation or access thereto or occupancy of any commercial premises or residential accommodation. These protections apply to both the private and public sector. The Canadian Human Rights Commission Policy on HIV/AIDS states:
Everyone has the right to equality and to be treated with dignity and without discrimination, regardless of HIV/AIDS status.
However, enforcement of these anti-discrimination statutes remains inadequate. In most cases, it is up to the individual who experiences discrimination to 1) know their rights, 2) recognize that they have been discriminated against, 3) have knowledge of the complaints mechanisms available for redress, and 4) be willing/able to lodge a complaint with the relevant human rights commission or initiate legal proceedings against the government alleging unconstitutional discrimination contrary to the Charter. Some anti-discrimination commissions, such as the Canadian Human Rights Commission, will expedite the investigation of complaints alleging HIV/AIDS related discrimination.
However, these mechanisms for enforcement present many barriers for people living with HIV/AIDS and vulnerable populations. In order to access their basic rights, people must first have access to basic human rights information, rights-based education, and knowledgeable service providers to advocate and support self-advocacy. Given the nature of HIV/AIDS-related stigma and the corresponding need for confidentiality, national and community-based AIDS service organizations have a key role to play in eliminating discrimination by bridging the enforcement gap through supporting such education and advocacy. The role of education and advocacy is not just the promotion of the human right to freedom from discrimination, but also an integral part of ensuring the adequate enforcement of anti-discrimination legislation (particularly for vulnerable populations who might not otherwise have access to the information and resources they need).
Despite human rights protections being available in Canada, there remain significant challenges. Provided an individual has the fortitude to go forward with one of the redress mechanisms available to them, the process is often a daunting task, which requires resources that may not always be worth the effort. In some cases, a positive outcome in a formal remedial action may not necessarily result in positive change, and are at times compromised by various jurisdictional issues, as in the case of Aboriginal people who fall within both federal jurisdiction and provincial/territorial jurisdictions.

2. Does the country have non-discrimination laws or regulations which specify protections for vulnerable sub-populations?

Yes

2.1 IF YES, for which sub-populations?

Women:	Yes
Young people :	No
IDU:	No
MSM:	Yes
Sex Workers :	No
Prison inmates :	No
Migrants/mobile populations :	Yes

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

Section 15(1) of the Canadian Charter of Rights and Freedoms, which applies to all laws and other actions by governments in Canada, states:

Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.
As noted above, federal and provincial/territorial legislation prohibits discrimination on the basis of disability. Individuals with HIV/AIDS may therefore seek protection under these laws. People who are not HIV positive may also be subject to discrimination by virtue of their real or perceived membership in a risk group or their association with a person or people with HIV/AIDS. These individuals may also seek protection under such laws on the basis of perceived disability. There are problems associated with relying on the concept of disability for framing human rights obligations and prohibition of discrimination. There is a need for the prohibition of discrimination in all circumstances, including those outside of issues of disability, on the basis of HIV status alone, as well as discrimination against those who are vulnerable.
The Charter and the federal and provincial/territorial anti-discrimination laws extend to prohibiting discrimination based on a number of grounds that provide protection to some – but only some – of the groups of people who are especially vulnerable to HIV/AIDS.
For example, discrimination on the basis of sexual orientation is prohibited in all jurisdictions of Canada, as is discrimination based on sex, race, ethnicity, national origin, etc.. However, only one jurisdiction in Canada (the Northwest Territories) has explicit protection on the basis of gender identity. Discrimination on the basis of age is prohibited for those between the ages of 18 and 65 (youth and the elderly are not generally covered). Discrimination on the basis of injecting drug use is not prohibited under anti-discrimination legislation in any jurisdiction. However, some courts and tribunals have considered drug addiction/dependence to constitute a disability (or "handicap", depending on the wording of the applicable statute) under law and therefore there is a duty to accommodate that disability, short of "undue hardship"; this interpretation and application of these statutes has been seen primarily in the employment context.
There is also no protection for sex workers against discrimination based on their involvement in sex work. If an individual is convicted of using a place for prostitution, the owner or landlord of that space must be notified and can face criminal charges and conviction if they do not take steps such as evicting the sex worker from his or her apartment which thereby persecutes the sex worker.
Discrimination on the basis of incarcerated status (i.e. against prisoners) has not been recognized in the law, even though prisoners regularly suffer discrimination in various areas, including access to HIV-related health services.
There is a need for improvement in anti-discrimination legislation in terms of protecting youth, transgendered people, people who use illegal drugs, sex trade workers, and prisoners. According to the Canadian HIV/AIDS Legal Network and an environmental scan conducted by the AIDS Calgary Equality Project, there is a dearth of information on HIV-related discrimination in Canada. It is unknown how frequently HIV-based discrimination occurs, in what contexts, the responses to HIV-based discrimination, and how individuals seek effective redress. Human rights commissions are charged with providing redress for discrimination, and some have a fast-track process or special guidelines for HIV-based complaints. However, there are concerns about delays and hurdles in getting commissions to adequately respond to HIV-related complaints, largely due to resource constraints.
Canada needs some additional research to gain a more thorough assessment of the extent of discrimination - in employment, housing, harassment, health care settings - on the basis of HIV status. Human rights commissions would be able to provide information about the number of complaints filed, which is generally believed to be a small proportion of actual incidents of discrimination.
The complexities of jurisdictional issues for the three Aboriginal populations in Canada (First Nations, Inuit and Métis) can result in lack of consistency in service delivery. There are parallel systems in Canada due to treaty and Aboriginal rights which result in unique status for Aboriginal people. In many cases, Aboriginal people fall through the cracks, and they often face discrimination based on ethnicity, HIV status, and in some cases, discrimination based on risk behaviour (s) such as injection drug use.
Until 2006, a Court Challenges Programme provided some funding to support test-case litigation under the equality rights section of the Canadian Charter of Rights and Freedoms. Such a program helped support some of the most important equality rights litigation in Canadian legal history. The federal government abolished the Court Challenges Program in late 2006.
A person who has experienced discrimination, from either a state action/actor (e.g., a law, government decision, or action by any organ of the state) or a private actor (e.g., a landlord, employer, service-provider, private sector organization) on a ground that is prohibited by the applicable federal or provincial/territorial anti-discrimination law may file a complaint with the relevant federal or provincial human rights commission or tribunal. In most jurisdictions, the complaint must be filed with the commission, which carries out investigative and conciliation functions, but also acts as a “gatekeeper” in the sense of having the decision over whether the complaint warrants being taken before a tribunal (in which case the commission also has carriage of the complaint, and acts as the complainant’s advocate before the tribunal during the hearing with no expense to the complainant). In a few jurisdictions (e.g., British Columbia and, more recently, Ontario), this gatekeeper/representative function has been abolished, and complainants have direct access to the tribunal (although they lack the representation previously provided by the commission). Ostensibly, measures are being put in place in these jurisdictions to ensure that complainants who have experienced discrimination will have access to legal counsel and representation so that this direct access model in fact offers access to the tribunal.

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

Yes

3.1 IF YES, for which sub-populations?

IDU:	Yes
Sex Workers:	Yes
Prison inmates :	Yes
Other::	Yes

IF YES, briefly describe the content of these laws, regulations or policies and how they pose barriers:

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

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

Prisoners

All HIV prevention tools (e.g., male and female condoms, lubricants, clean needles, methadone substitution therapy) are, in principle, available and accessible in communities across Canada. However, with respect to prisons, there is uneven access across correctional jurisdictions, which, in Canada, are divided into provincial/territorial (for those serving sentences of less than two years) and the federal Correctional Services Canada (CSC) (for those serving sentences of two years or more).

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

(1) Prison-based sterile syringe programs

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

(2) Safer tattooing programs

CSC's Safer Tattooing Initiative Pilot project, which operated safer tattooing rooms in 6 different federal institutions, was the only initiative in Canadian prisons that significantly addressed the potential transmission of HIV and HCV through tattooing. The project was terminated by the federal government in early December 2006, before a final evaluation was complete or the results made public. (As of early November 2007, almost a year later, the final evaluation report has yet

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

(3) Condoms and other safer sex materials

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

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

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

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

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

The Canadian HIV/AIDS Legal Network has recommended that in order to remove barriers to the use of prevention tools in prisons, condoms, dental dams, bleach and water-based lubricant needed to be made more easily and discreetly accessible to inmates in all prisons, in different locations throughout the institutions, and without inmates having to ask for them.

(4) Opiate substitution therapy (e.g., methadone)

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.

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

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

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

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

People who inject illegal drugs

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

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

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

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

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

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

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

The new National Anti-Drug Strategy contains no mention of harm reduction and provides no funding for harm reduction. This represents a significant step backward in the response to HIV (and hepatitis C virus) in Canada. The national AIDS strategy, the Federal Initiative to Address HIV/AIDS in Canada, espouses the importance of human rights and the use of evidence to inform programs and policies. Harm reduction services of various sorts are well-supported by extensive scientific evidence. Harm reduction as a policy “pillar” is central to a human rights-based response to HIV/AIDS, as a concrete manifestation of the right of people who use drugs to comprehensive HIV/AIDS prevention, treatment and care services, consistent with Canada’s legal obligations under international human rights treaties to take measures to protect,

promote and fulfil the right of all persons in Canada to the highest attainable standard of health. By abandoning harm reduction, the federal government's strategy on drugs is at odds with both the available scientific evidence and human rights principles.

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

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

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

• Similarly, Canada's criminal law prohibiting the distribution of drug paraphernalia ("instruments for illicit drug use") also raises the potential for criminal liability for NSP workers. Given the wording of Canada's law, and the fact that many NSPs operate with funding primarily from provincial/territorial or municipal governments as public health programs, it may be possible to argue that sterile needles and syringes themselves do not fall within the definition of prohibited paraphernalia (although this has never been tested in court). However, the law has made some NSPs reluctant to distribute other injection-related equipment (e.g. cookers, filters) for fear of running afoul of paraphernalia laws. Indeed, the potential for this legal liability has been a caution issued to public health officials by the provincial Ministry of Health in the Province of Ontario in February 2003.

• Police law enforcement practices have also been demonstrated to undermine access to harm reduction services such as NSPs, including in Canada, and to exacerbate the HIV risk of people who use drugs. Police practices of summarily confiscating or destroying drug use equipment found in the possession of those stopped on the street, which has been reported anecdotally on many occasions by people who use drugs and by those working in NSPs or providing other services, and even openly in the media, represent an obvious example of practice that is likely not only illegal but undermines public health initiatives such as NSPs. Police "crackdowns" and increased arrests related to drug activity have been shown to have a marked effect in the efficacy of NSPs' operations and ability to reach clients. Even where syringe possession is legal, and even where police may support NSP activities, the fear of law enforcement leaves some people reluctant to access NSPs.

• Judicially-created barriers to health services also exist. In some cases, judges have imposed probation, parole and bail conditions that prohibit a person accused or convicted of a crime from entering a particular area of a city (a 'red zone' or 'no-go zone'). These tend to be areas where drugs can be obtained, and also tend to be areas where NSPs operate. Judicially-imposed conditions may also include the requirement not to possess drug paraphernalia. In some cases, local police have informed persons who are clients of NSPs that they would be in breach of these conditions even if found in possession of sterile, unused syringes. Such restrictions work at cross-purposes with public health-oriented measures of ensuring access to sterile drug-use equipment (or other services) for those with drug dependence. In at least one case, a provincial court refused to impose such a condition that would prohibit an accused person from entering the downtown of his city, in part because it would hinder his access to necessary health services.

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

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

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

Insite was first established, with this legal exemption, in 2003. Since that time, it has been the subject of extensive

evaluation on numerous counts; the data generated by the research team have been published in more than 23 articles in the world's leading peer-reviewed medical journals and demonstrated multiple benefits for the health and well-being of individual service-users and for the broader community at large. Other Canadian municipalities (e.g., Toronto, Ottawa, Victoria) have begun to explore the feasibility of establishing similar facilities as public health initiatives aimed at protecting some of the most marginalized and vulnerable members of their communities.

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

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

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

Sex workers

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

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

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

It has been argued that, given the adverse consequences for the health and human rights of sex workers, and the fact that these adverse consequences are disproportionately borne by women sex workers, the current provisions of Canadian criminal law related to sex work are in violation of sex workers' human rights to freedom of expression, freedom of association, liberty, security of the person, and equality, in contravention of both the Canadian Charter of Rights and Freedoms (part of Canada's Constitution) and of international human rights norms. In 2007, two court proceedings challenging the constitutionality of various aspects of Canada's laws on prostitution were launched by sex workers' rights advocates; those cases are pending before the courts at the time of this writing.

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

Yes

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

No

IF YES, briefly describe this mechanism

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

6. Has the Government, through political and financial support, involved most-at-risk populations in governmental HIV-policy design and programme implementation?

Yes

IF YES, describe some examples

The federal government has involved most-at-risk populations in the development of governmental HIV policies and programs, although the level of involvement has diminished in the past two years.
Aboriginal people are disproportionately affected by HIV and are a stated target population in The Federal Initiative to Address HIV/AIDS. There is also a National Aboriginal Council on HIV/AIDS that offers policy advice to the Public Health Agency of Canada and Health Canada on HIV/AIDS issues. The concerns of other most-at-risk populations are represented by a variety of national organizations that were involved in consultations and discussions which led to the development of the pan-Canadian multi-sectoral policy document, Leading Together, and to The Federal Initiative to Address HIV/AIDS, which defines the federal government's response to HIV/AIDS.
Other most-at-risk groups which have been involved in the past in policy design and program implementation include gay men, women and communities from countries with generalized and high prevalence of HIV (Africa and the Caribbean). In the course of national consultations leading to the development of the national strategy, most sub-populations had some input into the process.
Despite this past involvement of civil society, most organizations consulted for this report expressed strong concern about more recent federal government actions which limit the participation of vulnerable sub-populations in policy and program development (see section II - Civil Society Participation).

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

HIV prevention services :	No
Anti-retroviral treatment :	No
HIV-related care and support interventions :	Yes

IF YES, given resource constraints, briefly describe what steps are in place to implement these policies:

The federal government does not provide free services for HIV prevention and treatment, care and support, because these fall under provincial/territorial jurisdiction, except for some Aboriginal populations (First Nations and Inuit) which receive services from the Government of Canada.
In general, prevention information resources are available free of charge to the public because production of the resources is supported by national or provincial/territorial funding. Access to HIV treatment and health services varies depending on the policies of the province or territory. Outreach and referral services provided by national non-governmental organizations are free of charge to service users, as are most services provided by local non-governmental organizations; these organizations are supported by government funding and/or private donations.

8. Does the country have a policy to ensure equal access for women and men, to prevention, treatment, care and support? In particular, to ensure access for women outside the context of pregnancy and childbirth?

Yes

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

Yes

9.1 Are there differences in approaches for different most-at-risk populations?

Yes

IF YES, briefly explain the differences:

Under the Canadian Charter of Rights and Freedoms, as discussed in Section I.2 (question 2), discrimination is prohibited on the basis of gender but socioeconomic factors such as poverty, lack of education, fear of stigma and discrimination, or lack of power in relationships may inhibit women from having full access to services.
Civil society is involved in the Blueprint for Action on Women and HIV/AIDS, a multi-sectoral coalition of HIV-positive women, Canadian and international HIV/AIDS organizations, and a variety of women's and reproductive rights groups advocating for better prevention, services and supports for women and girls infected and affected by HIV/AIDS. The coalition focuses on: law and ethics; human rights; research; stigma and discrimination; diagnosis, treatment, care and support; and prevention and education. The activities of the coalition were reported in detail in the 2006 non-governmental appendix to Canada's report to UNGASS. Since then, the coalition developed a report card on women and HIV/AIDS for AIDS 2006 – XVI International AIDS Conference in Toronto. The report card gave Canada an overall grade of D (poor) with highest grades in human rights (B-) and lowest in human resources (F). The coalition is preparing a report card for AIDS 2008 in Mexico City.

Canada does not have a specific policy to ensure equal access for most-at-risk populations to prevention, treatment, care and support. Most aspects of education and health care delivery fall within provincial or territorial jurisdiction and are not subject to national standards.
The Federal Initiative to Address HIV/AIDS specifies that specific national communications campaigns will be developed by and for gay men, injection drug users, Aboriginal people, and people from countries with generalized and high prevalence of HIV.
In the case of Aboriginal peoples, a variety of things must be taken into account in policy and program development, including language and literacy, historical trauma, culturally competent services and other variables such as risk behaviour, especially for people using injection drugs.
Many national non-governmental organizations stated that although the Federal Initiative specifies targeted programs for specific most-at-risk populations, funding of such initiatives was considerably delayed by a federal government review of approval processes. This delay jeopardizes the ability of funded organizations to produce the required deliverables in the time remaining to develop the projects. It is regrettable that no projects addressing HIV/AIDS among prisoners or injection drug users have been funded under the Specific Populations Fund of The Federal Initiative to Address HIV/AIDS in Canada. The federal government plans to develop population-specific status reports which aim to inform strategic policy and program design and delivery modes that target the eight most-at-risk populations that are identified in the Federal Initiative. At the time of this writing, only four status reports are moving ahead: communities from countries with high prevalence and generalized epidemics; Aboriginal peoples; gay men/MSM; and women. There is no clear timeline for status reports on the other populations (persons living with HIV/AIDS, prison inmates, people who use injection drugs and youth).

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

Yes

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

Yes

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

Yes

IF YES, describe the effectiveness of this review committee

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

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

- 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
- Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment:	No
- Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts:	No
- Performance indicators or benchmarks for reduction of HIV-related stigma and discrimination:	No

IF YES, on any of the above questions, describe some examples:

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

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

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

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

No

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

Legal aid systems for HIV and AIDS casework:	Yes
Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV:	Yes
Programmes to educate, raise awareness among people living with HIV concerning their rights:	Yes

15. Are there programmes designed to change societal attitudes of stigmatization associated with HIV and AIDS to understanding and acceptance?

Yes

IF YES, what types of programmes?

Media :	Yes
School education :	Yes
Personalities regularly speaking out :	Yes

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS in 2007 and in 2005?

2007:	7

Overall, how would you rate the effort to enforce the existing policies, laws and regulations in relation to human rights and HIV and AIDS in 2007 and in 2005?

2007:	6

Comments on progress made in enforcing existing policies, laws and regulations in relation to human rights and HIV and AIDS since 2005:

concern exists over legal actions against people living with HIV/AIDS who are deemed to expose sexual partners to the virus without informing them and noted that media coverage creates potential backlash against other people living with HIV/AIDS who do not expose sexual partners to the virus without informing them of their HIV status. This criminalization of HIV transmission has repercussions on prevention and treatment (see sections III on Prevention and IV on Treatment, Care and Support

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

4

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

1

3. To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included

a. in both the National Strategic plans and national reports?:	2
b. in the national budget?:	1

4. Has the country included civil society in a National Review of the National Strategic Plan?

No

5. To what extent is the civil society sector representation in HIV-related efforts inclusive of its diversity?

4

List the types of organizations representing civil society in HIV and AIDS efforts:

Canadian Aboriginal AIDS Network; Canadian AIDS Society; Canadian HIV/AIDS Legal Network; Canadian Treatment Action Council; Canadian Working Group on HIV Rehabilitation; Canadian Association for HIV Research; Canadian HIV Trials Network; Canadian HIV/AIDS Information Centre; Canadian Treatment Information Exchange; and the Inter-agency Coalition on AIDS and Development

6. To what extent 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 on progress made in increasing civil society participation since 2005:

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

1. Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV prevention programmes?

Yes

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

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

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2007 and in 2005?

2007:	5
2005:	7

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

Yes

IF NO, how are HIV and AIDS treatment, care and support services being scaled-up?:

At the national level, Canada has identified most-at-risk populations in need of treatment, care and support programs, rather than geographical districts. These populations may live anywhere in Canada, although some are concentrated in large cities and towns, such as communities from countries with generalized and high prevalence of HIV, while others may live in rural and remote areas, such as some on-reserve First Nations and Inuit communities.
The availability of HIV treatment, care and support varies across Canada because health care delivery and education fall within provincial/territorial jurisdiction. There are no national standards in health care or access to treatment, care and support. Each sub-national jurisdiction has a public health insurance plan that covers "medically necessary" physician and hospital services for all residents of the jurisdiction, as a pre-condition of receiving federal funding contributions under the Canada Health Act. The coverage of other health goods and services under public health insurance plans varies from province/territory to province/territory. There is no nation-wide pharmacare plan providing insurance covering the costs of prescription medications, although this has been recommended by numerous bodies, including the 2002 federal Commission on the Future of Health Care in Canada (the Romanow Commission). The lack of national standards, and of a national pharmacare program, creates inequality of access which needs to be addressed at the national level.
A view generally shared by national NGOs is that Canada needs more research into treatments for diverse affected populations. Some NGOs are concerned that the present federal government is less committed to treatment research than in the past. The Canadian government could play a role in coordinating Canadian-based HIV research as well as Canadian participation in international research efforts. Each research entity in Canada currently pursues its own research agenda, with little coordination. Some promising work is occurring within the federal government to establish a national research plan, including knowledge translation and exchange.

Comments on progress made in the implementation of HIV treatment, care and support services since 2005:

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

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

Prevention for youth :	51-75%
Prevention for IDU :	51-75%
Prevention for MSM :	51-75%
Prevention for sex workers :	51-75%
Counselling and Testing :	51-75%
Clinical services (OI/ART)* :	51-75%
Home-based care :	51-75%
Programmes for OVC** :	51-75%

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

N/A

Comments on progress made since 2005:

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

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

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

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