

The United Nations General Assembly Special Session on HIV/AIDS

Monitoring the Declaration of Commitment on HIV/AIDS

2010 Report from Canada: Appendix 4 – National Composite Policy Index, Part B

Information provided by national non-governmental organizations

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Table of contents

FOREWORD.....	3
I. HUMAN RIGHTS.....	5
II. CIVIL SOCIETY PARTICIPATION.....	23
III. PREVENTION.....	28
IV. TREATMENT, CARE AND SUPPORT.....	39
V. FURTHER SUGGESTIONS TO UNAIDS.....	51

Foreword

Disclaimer

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

The following report was compiled from information provided by Canadian national non-governmental organizations using the *UNAIDS Guidelines on Construction of Core Indicators, 2010 Reporting* for Appendix 4 – National Composite Policy Index, Part B, to be administered to representatives from non-governmental organizations.

The *Guidelines* are less suited to Canada's federated system of government than they are to highly centralized governments with unified approaches to health and education. In Canada, primary responsibility for health care delivery and education falls within provincial and territorial, rather than national, jurisdiction. Many provinces and territories devolve responsibility for health care delivery to relatively autonomous regional health authorities, which further increases variability in quality and access to services across Canada.

National non-governmental organizations provided information from the national perspective and focused on areas falling within the jurisdiction of the Government of Canada. (Note: the Government of Canada is usually referred to in this Appendix as the *federal government*.) References to "government" in this Annex are generally understood to include both elected representatives (politicians) and civil servants, since both are involved in policy development and implementation.

The following national non-governmental organizations provided information for this Appendix through telephone interviews or written responses to the *Guidelines*:

- Canadian Aboriginal AIDS Network
- Canadian AIDS Society
- Canadian AIDS Treatment Information Exchange
- Canadian Association for HIV Research
- Canadian HIV/AIDS Legal Network
- CIHR Canadian HIV Trials Network
- Canadian Public Health Association

- Canadian Treatment Action Council
- Canadian Working Group on HIV and Rehabilitation
- Interagency Coalition on AIDS and Development

The national non-governmental organizations have been given the opportunity to review this Appendix to ensure that it accurately reflects the information and perspectives which they provided.

Non-governmental organizations present this information in a spirit of willingness to dialogue and work collaboratively with the federal government on innovative and effective ways to respond to the HIV/AIDS epidemic.

I. Human rights

I.1 Does Canada have laws and regulations that protect people living with HIV against discrimination (including both general non-discrimination provisions and provisions that specifically mention HIV, focusing on schooling, housing, employment, health care, etc.)

Yes	X	No
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If Yes, specify if HIV is specifically mentioned and how or if this is a general non-discrimination provision:

Canada has general non-discrimination provisions but does not have provisions that specifically mention HIV.

Section 15(1) of the Canadian Charter of Rights and Freedoms, which is part of the country's Constitution and which applies to all laws and other actions by governments and other state actors in Canada, states:

Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

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

Yes	X	No
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I.2.1 If Yes, for which populations?

	Yes	No
Women	X	
Young people	X	
IDU	X	
MSM	X	
Sex workers		X
Migrants/mobile populations	X	
Prisoners		X
Other: Persons with disabilities	X	

If Yes, briefly explain what mechanisms are in place to ensure these laws are implemented.

Human rights commissions and/or tribunals exist at the national and provincial levels.

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

Briefly describe the content of these laws.

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

Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

All populations listed in I.2.1 can therefore be considered to be protected against discrimination, although some populations are not specifically mentioned in the Charter.

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

Canada has enacted anti-discrimination legislation at both the federal and provincial/territorial levels which prohibits discrimination based on “disability” or “handicap” by both public and private actors. Individuals with HIV/AIDS may therefore seek protection under these laws.

Under the *Canadian Human Rights Act*, people living with HIV are protected from HIV-based discrimination in the federal jurisdiction because HIV is considered a disability in the context of anti-discrimination law with respect to any employment, goods, services, facilities or accommodation or access thereto or occupancy of any commercial premises or residential accommodation. These protections apply to both the private and public sector.

There is a need for the prohibition of discrimination in all circumstances, including those outside of issues of disability, on the basis of HIV status alone, as well as discrimination against those who are vulnerable.

Enforcement of these anti-discrimination statutes requires constructive, innovative approaches and the combined efforts of civil society and all levels of government to promote and enhance compliance.

The Government of Canada tabled a motion in Parliament in December 2009 to ratify the United Nations Convention on the Rights of Persons with Disabilities passed by the United Nations General Assembly in 2006. Several NGOs have collaborated on a study of the implications of the Convention for Canada.

Challenges remain with respect to groups not currently specified in the Charter of Rights and Freedoms and other statutes, including persons who use drugs (drug addiction/dependence is recognized in some anti-discrimination statutes as a disability); sex workers and prisoners. While prisoners are not specifically named in the *Charter*, federal offenders living with HIV are protected under Correctional Service of Canada policy from discrimination on the basis of their HIV status (Commissioner's Directive 821).

A collaborative approach to legal reforms is desirable – one that involves government and civil society, including representatives of affected groups.

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

Yes X	No
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If Yes, for which subpopulations?

Note: some segments of the subpopulations of women, youth and MSM may experience obstacles, depending on whether they are also prisoners, IDU, etc.

	Yes	No
Women		X
Young people		X
Injecting drug users	X	
Men who have sex with men		X
Sex workers	X	
Prison inmates	X	
Migrants/mobile populations	X	
Aboriginal peoples:		
On reserve	X	
Off reserve	X	
Other:	X	
Persons living with HIV (criminalization of HIV transmission)		

If Yes, briefly describe the content of these laws, regulations or policies.

Please see comments below.

Briefly comment on how they pose barriers:

Criminalization of HIV transmission

It is a criminal offence in Canada to transmit or expose another person to HIV through unprotected sex. In recent years, legislators and courts have decided that the criminal law requires people living with HIV to disclose their HIV status before engaging in behaviours that risk transmitting HIV. As a consequence, some people living with HIV have been convicted of serious criminal offences, such as aggravated sexual assault or grievous bodily harm, and sentenced to significant time in prison for failing to disclose their HIV status.

Civil society organizations have taken the position that HIV transmission is a public health issue, rather than a criminal issue.

Sub-populations that experience discrimination

Legal obstacles exist to effective HIV prevention and treatment for several sub-populations. First Nations peoples, for example, experience differing applications of the law depending on whether they are on-reserve or off-reserve and may experience differing access to services.

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

Prisoners

There is uneven access to prevention programs in Canada's prisons. In particular, lack of access to prison-based sterile syringe programs or safe tattooing programs and uneven access to condoms and other safer sex materials adversely affect public health efforts to combat the spread of HIV among prison populations. There is also uneven access to treatment and the continuum of care, including in-prison and post-discharge services.

The example of limited access to opiate substitution therapy (e.g. methadone)¹ serves to illustrate the impact of restricted access to prevention on the prison population.

Methadone is a narcotic medication licensed for use in Canada to treat opiate addiction. Substitution therapy has been described by in a joint WHO, UNODC and UNAIDS report in the following terms:

Medicines used in substitution therapy can be prescribed either in decreasing doses over short periods of time (usually less than one month) for treatment of withdrawal or for detoxification, or in relatively stable doses over a long period of time (usually more than six months) for substitution maintenance therapy, which allows stabilization of brain functions and prevention of craving and withdrawal. Substitution maintenance therapy is one of the most effective types of pharmacological therapy of opioid dependence. There is consistent evidence from numerous controlled trials, large longitudinal studies and programme evaluations, that substitution maintenance treatment for opioid dependence is associated with generally substantial reductions in illicit opioid use, criminal activity, deaths due to overdose, and behaviours with a high risk of HIV transmission.²

Correctional Service of Canada (CSC) has substance abuse programs designed specifically for women, men and Aboriginal peoples. Barriers can exist, however,

¹ G. Betteridge & G. Dias. *Hard Time: HIV and Hepatitis C Prevention Programming for Prisoners in Canada*. Toronto: Canadian HIV/AIDS Legal Network & Prisoners' HIV/AIDS Support Action Network, 2007, online via www.aidslaw.ca/prisons. See also: R. Elliott. Deadly disregard: government refusal to implement evidence-based measures to prevent HIV and Hepatitis C virus infections in prisons. *Canadian Medical Association Journal* 2007; 177: 262-264.

² WHO, UNODC and UNAIDS. *Substitution Maintenance Therapy in the Management of Opioid Dependence and HIV/AIDS Prevention: Position Paper*. Geneva: WHO/UNODC/UNAIDS, 2004.

because in the prison setting, many prisoners may be reluctant to ask for help from the same people who are responsible for imprisoning them. Prisoners cannot disclose struggles with their recovery from drug addiction because of the zero-tolerance drug policy. Consequences for a drug-positive urine test can include increased security, loss of escorted temporary absences and unescorted temporary absences, loss of contact visits with family, not getting released on parole, etc.

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

There is a compelling case to be made for government and civil society to work together to consider adopting the most efficacious evidence-based public health prevention strategies appropriate to the issues of HIV and prisoners.

People who inject illegal drugs

The Public Health Agency of Canada estimates that 17% of new HIV infections in Canada are among people who inject drugs.³ In recent years steps have been taken by the federal government that reduce harm reduction as an element of a comprehensive drug strategy.

The National Anti-Drug Strategy contains no mention of harm reduction and provides no funding for harm reduction. Federal funding has continued to expand for law enforcement initiatives, while funding for harm reduction initiatives has been discontinued in some cases. The example of the supervised injection facility in Vancouver serves to illustrate the situation.

Supervised injection facilities (SIFs) are legally-sanctioned health facilities that enable the consumption of otherwise illegal drugs with sterile equipment under the supervision of health professionals. SIFs constitute a specialized health intervention within a wider network of health services for people who use drugs. They have been operating successfully for years in a number of jurisdictions in Europe, Australia and Canada.⁴

Insite, the first authorized SIF in North America, operates in Vancouver's Downtown Eastside. This facility currently operates under the protection of an exemption from the application of certain provisions of Canada's *Controlled Drugs and Substances*.

Insite has been the subject of extensive evaluation on numerous counts; the data generated by the research team have been published in more than 30 articles in the world's leading peer-reviewed medical journals and have demonstrated

³ www.phac-aspc.gc.ca/aids-sida/publication/survreport/estimato8-eng.php

⁴ See studies cited in: Urban Health Research Initiative, "Insight into Insite" (Vancouver: British Columbia Centre for Excellence in HIV/AIDS, 24 March 2009)

multiple benefits for the health and well-being of individual service-users and for the broader community at large.⁵ Other Canadian municipalities (e.g. Toronto, Ottawa, Victoria) have begun to explore the feasibility of establishing similar facilities as public health initiatives aimed at protecting some of the most marginalized and vulnerable members of their communities.

In early October 2007, the government granted an additional 6-month extension on the Insite exemption, until the end of June 2008. In May 2008, the operators of Insite succeeded in obtaining a court decision that the application of Canada's criminal law prohibiting possession and trafficking of controlled substances was unconstitutionally overbroad, insofar as it impeded access to a health facility such as Insite, because it resulted in avoidable morbidity and mortality, thereby infringing the rights to life and to security of the person under the Canadian Charter of Rights and Freedoms.

The court granted Insite's users and staff a constitutional exemption from the application of these parts of Canada's criminal law indefinitely and also declared that the unconstitutional aspects of Canada's *Controlled Drugs and Substances Act* were invalid and of no force; this latter declaration was suspended for a year to give the federal government time to re-draft its law. The federal government appealed that decision. At this time, a decision from the appellate court is pending and, whatever the outcome, that decision will likely be further appealed to the Supreme Court of Canada.

The potential exists for constructive dialogue between government and civil society about Insite and, more broadly, about harm reduction. This could result in innovative, evidence-based approaches to this important public health issue.

Sex workers⁶

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

While prostitution (i.e. the exchange of sex for money or other valuable consideration) is not illegal *per se* in Canada, the federal *Criminal Code* (which applies throughout the country) contains numerous provisions that make it difficult and dangerous for sex workers and their clients to engage legally in prostitution. This criminalization limits sex workers' choices, often forcing them to work on the margins of society, thereby increasing the risks they face. In 2007, two court proceedings challenging the constitutionality of various aspects of

⁵ For a summary of research findings, see E. Wood et al. 2005. *Safer injecting education for HIV prevention within a medically supervised safer injecting facility*. International Journal of Drug Policy 16: 281-284.

⁶ Information in this section is adapted from: G. Betteridge. *Sex, work, rights: reforming Canadian criminal laws on prostitution*. Toronto: Canadian HIV/AIDS Legal Network, 2005, online via www.aidslaw.ca/sexwork. See also: Pivot Legal Society. *Voices of Dignity: A Call to End the Harms Caused by Canada's Sex Trade Laws*. Vancouver: The Society, 2004; and Pivot Legal Society. *Beyond Decriminalization: Sex Work, Human Rights and a New Framework for Law Reform*. Vancouver: The Society, 2006, both online via www.pivotlegal.org.

Canada's laws on prostitution were launched by sex workers' rights advocates; one of those cases was dismissed at the outset on procedural grounds while the other has been argued before the courts, with a decision pending as of this writing.

Here again, the opportunity exists for civil society to work collaboratively with government to find solutions to public health problems posed by the risky and criminalized nature of sex work.

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

Yes	X	No
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If Yes, briefly describe how human rights are mentioned in this HIV policy or strategy:

The promotion and protection of human rights are explicitly mentioned in *The Federal Initiative to Address HIV/AIDS in Canada* which acknowledges that a comprehensive response to HIV/AIDS must include addressing human rights as part of an approach that is based on a social justice framework and the determinants of health.

Leading Together: Canada Takes Action on HIV/AIDS (2005-2010) is a pan-Canadian multi-stakeholder, multi-sectoral action plan, providing an opportunity for all parts of the country and all organizations involved in HIV/AIDS to come together as part of a larger, nation-wide effort. *Leading Together* explicitly bases its approach and recommended actions on the principles of human rights. Respect for human rights is stated as one of the core values of *Leading Together*.

Civil society would welcome an opportunity to work with government to address human rights issues faced by those living with, or vulnerable to, HIV/AIDS, in addition to taking active steps to reduce human rights barriers.

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

Yes	X	No
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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.

I.6. Has the Canadian Government, through political and financial support, involved most-at-risk and/or other vulnerable populations in governmental HIV-policy design and program implementation?

Yes	X	No
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If Yes, describe some examples:

The federal government has involved most-at-risk populations in the development of governmental HIV policies and programs.

Aboriginal people are disproportionately affected by HIV and are a stated target population in *The Federal Initiative to Address HIV/AIDS*. The National Aboriginal Council on HIV/AIDS offers policy advice to the Public Health Agency of Canada and Health Canada on HIV/AIDS issues.

The concerns of other most-at-risk populations are represented by a variety of national organizations that were involved in consultations and discussions which led to the development of the pan-Canadian multi-sectoral policy document, *Leading Together*, and to *The Federal Initiative to Address HIV/AIDS*, which defines the federal government’s response to HIV/AIDS. Other most-at-risk groups which have been involved in policy design and program implementation include gay men, women and communities from countries with generalized and high prevalence of HIV (Africa and the Caribbean).

The involvement of these populations in HIV policy design and program implementation needs to be reaffirmed and strengthened, in collaboration with civil society, through concrete engagement strategies. Several organizations stated that they welcome the openness to dialogue on these issues displayed by the federal Minister of Health.

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

	Yes	No
HIV prevention services	X	
Antiretroviral treatment	X (partial)	
HIV-related care and support interventions	X	

If Yes, given resource constraints, briefly describe what steps are in place to implement these policies and include information on any restrictions or barriers to access for different populations:

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

In general, prevention information resources are available free of charge to the public because production of the resources is supported by national or provincial/territorial funding, although prevention materials such as male and female condoms may not be available free of charge. Access to HIV treatment and health services varies, depending on the policies of the province or territory. Access also varies for those receiving health care services from the federal government, depending on the population served (e.g. prisoners, defence personnel, on-reserve First Nations and Inuit populations).

Outreach and referral services provided by national non-governmental organizations are free of charge to service users, as are most services provided by local non-governmental organizations; these organizations are supported by government funding and/or private donations. Populations receiving health services from the federal government have variable access, depending on the population. Practice also varies between provinces and territories with respect to access to treatment and reimbursement for medications. There is a need for access to catastrophic drugs and a national pharmaceuticals strategy.

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

Yes	X	No
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Under the Canadian Charter of Rights and Freedoms, as discussed in Section I.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 impede 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; prevention; and education. The coalition developed report cards on

women and HIV/AIDS for AIDS 2006 in Toronto and AIDS 2008 in Mexico City. The coalition is preparing a report card for AIDS 2010 in Vienna.

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

Yes	X	No
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Access to these support services depends on local public health services in each province or territory and on services provided by front-line non-governmental organizations. Access may be more challenging in rural and remote communities.

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

Yes	X	No
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If Yes, briefly describe the content of this policy:

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

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

Yes	X	No
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If Yes, briefly explain the different types of approaches to ensure equal access for different populations.

The Federal Initiative to Address HIV/AIDS in Canada specifies that specific national communications campaigns will be developed by and for gay men, injection drug users, Aboriginal people, and people from countries with generalized and high prevalence of HIV.

In the case of Aboriginal peoples, a variety of things must be taken into account in policy and program development, including language and literacy, historical

trauma, culturally competent services and other variables such as risk behaviour, especially for people using injection drugs.

The federal government is developing population-specific status reports which aim to inform strategic policy and program design and delivery modes that target the eight most-at-risk populations that are identified in the *Federal Initiative*. Civil society is represented on status report working groups. The status report on communities from countries with high prevalence and generalized epidemics is completed.⁷ Work is progressing on status reports for Aboriginal peoples, gay men/MSM, women, persons living with HIV/AIDS and persons using injection drugs. Work will begin in 2010 on reports for prisoners and youth.

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

Yes	X	No
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The Canadian Human Rights Commission (CHRC) Policy on HIV/AIDS states:

Everyone has the right to equality and to be treated with dignity and without discrimination, regardless of HIV/AIDS status.

The CHRC's policies are mirrored in numerous other Canadian legislation and policies.

The Commission will not accept being free from HIV/AIDS as a *bona fide occupational requirement* or a *bona fide justification* unless it can be proved that such a requirement is essential to the safe, efficient and reliable performance of the essential functions of a job or is a justified requirement for receiving programs or services.

HIV-positive persons pose virtually no risk to those with whom they interact in the workplace. The Commission, therefore, does not support pre- or post-employment testing for HIV. Such testing could result in unjustified discrimination against people who are HIV positive.

Employees living with HIV/AIDS are encouraged to remain productive as long as they are able and are entitled to arrangements for employment accommodations and workplace supports to facilitate opportunities to successfully participate and remain in the workforce. Any decision made by an organization relying on health and safety considerations to exclude a person must be based on an individual assessment supported by authoritative and up-to-date medical and scientific information.

⁷ Available at www.phac-aspc.gc.ca/aids-sida/publication/ps-pd/africacaribbe/index-eng.php

Regarding health care workers, the Canadian Medical Association Policy on HIV/AIDS states that:

The routine testing of health care workers for the HIV antibody is not justified. The CMA supports the application of universal precautions that enhance the protection of health care workers against potential infection from patients and vice versa.

The Canadian Human Rights Commission supports this view.

The *Public Service Staff Relations Act*, which applies to all federal government departments and other portions of the Public Service, states that employees are not required to undergo mandatory tests for HIV infection. The *Public Service Staff Relations Act* also states that departments must ensure that: the rights and benefits of employees with HIV infection or AIDS are respected; the occupational safety and health of employees with a potential risk of exposure to HIV is protected; and that employees are informed of existing information, education, counselling and evaluation services in the Public Service with respect to HIV infection and AIDS.

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

Yes	X	No
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All proposals for nationally-funded research involving human subjects must undergo ethics review by a recognized ethics review body which may be located in a university, health institution or other organization, although there is no national policy on HIV research protocols. Canada is currently creating national standards for research ethics review boards with the input of key stakeholders across the country.

I.11.1 If Yes, does the ethical review committee include representatives of civil society including people living with HIV?

Yes	X	No
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If Yes, describe the approach and effectiveness of this review committee:

Many ethical review bodies have members representing civil society, including those from the populations participating in the research. Organizations such as the Canadian Institutes of Health Research (CIHR) and the CIHR Canadian HIV Trials Network have mechanisms for consulting with and including representatives of civil society in policy/program decisions and ethics reviews.

Not all clinical trials run by pharmaceutical companies have community input, however, but all would undergo ethical review.

There are some problems with ethical review committees. They may have lack of continuity and universality of rules. For example, all persons in clinical trials may not be able to stay on a medication after a trial is completed even though the medication may be appropriate for them. They may have to wait for long periods until the medication is made accessible through a provincial/territorial formulary. Another problem is potential conflict of interest when ethics boards are hired by pharmaceutical companies for company-led clinical trials.

There is a need for national ethical guidelines that apply to all human research subjects and all ethical review committees, including those based in hospitals. There is also a need for monitoring of adherence to guidelines by government, civil society and other relevant stakeholders.

As a result of pressure from civil society organizations, some pharmaceutical companies consult with community members. Most national non-governmental organizations that responded to this question stated that sustained efforts had been made by research bodies to involve civil society.

I.12 Does Canada 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 X	No
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- **Focal points within governmental health and other departments to monitor HIV-related discrimination in areas such as housing and employment:**

Yes	No X
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- **Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts:**

Yes	No X
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If Yes on any of the above questions, describe some examples:

Independent national institutions for the promotion and protection of human rights

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

Focal points within government departments to monitor HIV-related human rights abuses

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

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

Canada does not have performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts but Canada has had initiatives for reducing HIV-related stigma and discrimination.

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

Yes	No X
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Non-governmental organizations are not aware that the judiciary in Canada has recently received any particular training on HIV/AIDS and human rights issues. It was noted that the legal profession in general receives little sensitization about HIV/AIDS and human rights issues as part of formal legal education. Some private bar lawyers have developed expertise on HIV/AIDS and some legal aid clinics provide services to HIV-positive clients dealing with a range of poverty law issues (housing, income support, etc.).

The Canadian HIV/AIDS Legal Network has provided resources to the legal profession to help sensitize them about HIV/AIDS-related issues.

In January 2008, the Canadian HIV/AIDS Legal Clinic and the HIV & AIDS Legal Clinic Ontario (HALCO) lodged a formal complaint with the appropriate judicial council regarding the conduct of a trial judge who ordered that a witness with HIV and HCV be masked before testifying in court and allowed court staff to don rubber gloves and to bag in plastic bags exhibits touched by the witness. On the basis of this complaint, these organizations also approached the National Judicial Institute and the provincial body responsible for education of provincial judges to propose that education on HIV/AIDS be incorporated into judicial training. While the provincial body declined to take action, the National Judicial Institute has been receptive to the proposal and, working with the Legal Network and HALCO, has developed a half-day training session, focusing on HIV and criminal law, for a number of judges from across the country, to be delivered in March 2010 as part of broader “social context” training program.

I.14. Are the following legal services available in Canada?

- Legal aid systems for HIV casework

Yes	X	No
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Legal aid systems are available for HIV/AIDS casework in the context of general legal aid programs. There is only one free-standing legal aid clinic with a dedicated mandate of providing legal advice and services to low-income people living with HIV/AIDS: the HIV & AIDS Legal Clinic – Ontario, whose mandate includes only that province.

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

Yes	X	No
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Some private sector firms or university-based centres provide free or reduced-cost legal services to persons living with HIV.

- Programs to educate, raise awareness among people living with HIV concerning their rights

Yes	X	No
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Some local non-governmental organizations educate persons living with HIV about their rights and provide some assistance in dealing with legal and human rights issues such as access to income security programs, housing issues, employment questions, etc. At the national level, the Canadian HIV/AIDS Legal Network is most active in this respect and handles several hundred inquiries

every year, but is not equipped to provide legal advice or services in individual cases. Non-governmental organizations working at the provincial/territorial or local level provide some education.

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

Yes X	No
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If Yes, what types of programs?

	Yes	No
Media	X	
School education	X	
Personalities regularly speaking out	X	
Other: NGO programs (see below)	X	

Many national non-governmental organizations engage in this work, which may be partially funded by the federal government. Non-governmental organizations at the provincial/territorial and local levels also engage in efforts to reduce stigmatization.

There is a need for federal government-led programs to change societal attitudes and high-level government leadership to publicly advance the agenda on HIV/AIDS issues, in collaboration with civil society.

Overall, how would you rate the effort to enforce the existing policies, laws and regulations in 2009?

Overall, organizations rated the effort to enforce existing policies law and regulations in 2009 at 6.

The organizations' assessment was that the situation has worsened since 2007, chiefly because: (a) additional provinces have enacted legislation authorizing forced HIV testing following certain occupational and non-occupational exposures, and another territory was considering the same; and (b) the application of the criminal law to HIV non-disclosure has been further expanded by prosecutors and courts to apply to situations posing even less risk of HIV transmission, accompanied by several instances of egregious media coverage of the issue.

Key achievements:

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

Remaining challenges:

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

II. Civil society participation

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

Non-governmental organizations rate the contribution of civil society to strengthening political commitment at 3-4.

Comments and examples:

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

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

Non-governmental organizations rate civil society involvement in planning and budgeting at 3.

Comments and examples:

In the interest of openness and transparency, civil society and the federal government should work toward strengthening communication on key issues of common concern, including funding for the *Federal Initiative to Address HIV/AIDS in Canada*.

There is significant involvement of Aboriginal NGOs, researchers and treatment action representatives in planning. The National Aboriginal Council on HIV/AIDS provides advice to the federal government on a regular basis. The Canadian Aboriginal AIDS Network was involved in dialogue with the federal government that resulted in the renewal of the national Aboriginal HIV/AIDS Strategy to 2014.

Researchers are represented by the Canadian Association for HIV Research and report being well represented on expert advisory committees and research advisory bodies. Treatment action representatives (led by the Canadian Treatment Action Council), including many persons living with HIV, participate in a number of expert advisory bodies concerned with drug review and licensing of pharmaceuticals. Some NGOs noted that there was good representation from civil society on advisory bodies and working groups, but that communication could be improved between the government and the community.

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

a) The National AIDS strategy?

Note: Non-governmental organizations do not provide treatment services; these are delivered by federal, provincial and territorial public health services. Non-governmental organizations do provide prevention, care and support services. The *Federal Initiative* provides support for the work of community-based and national organizations.

Non-governmental organizations rate civil society involvement in national strategic plans and national reports from low to middle range (1 - 3).

b) The national AIDS budget?

NGOs rate civil society involvement in the national budget at 1.

c) National AIDS reports?

Non-governmental organizations rate civil society involvement in national AIDS reports at 3.

Comments and examples:

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

II.4 To what extent is civil society included in the monitoring and evaluation (M&E) of the HIV response?

a. Developing the national M&E plan?

NGOs rate civil society participation at 1.

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

NGOs rate civil society participation at 1.

c. M&E efforts at local level?

NGOs rate civil society participation at 1.

Comments and examples:

Projects funded by the federal government and carried out by civil society organizations have evaluation components, but civil society organizations have little input to government monitoring and evaluation efforts at the local level.

Civil society advisory bodies such as the Ministerial Advisory Council on the Federal Initiative to Address HIV/AIDS in Canada provide input and advice on monitoring and evaluation of activities encompassed by the *Federal Initiative*, but coordination of M&E activities is done within government.

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

NGOs rated efforts to be inclusive of diversity at 4.

Comments and examples:

At the national level, the core principle of GIPA (Greater involvement of people living with or affected by HIV/AIDS) is respected. Persons living with HIV/AIDS serve on advisory bodies and working groups.

The National Aboriginal Council on HIV/AIDS provides advice to the federal government. Representatives of some most-at-risk populations (e.g. from communities in Canada originating in countries where HIV is widespread and prevalence is high) sit on advisory bodies, but there is under-representation from affected populations on the issues of women, youth, sex workers, persons who use drugs, prisoners, persons with disabilities and street-involved persons.

II.6 To what extent is civil society able to access:

a. Adequate financial support to implement its HIV activities?

NGOs rate the level of financial support at 3.

b. Adequate technical support to implement its HIV activities?

NGOs rate the level of technical support at 2-3.

Comments and examples:

Some NGOs cited the existence of a national HIV/AIDS surveillance system consisting of a federal/provincial/territorial partnership as a technical support for their work.

NGOs report less sustainable funding for front-line service organizations than in the past because funding levels have not increased to keep pace with inflation.

Most current funding is project-based, which results in the need to use short-term project budgets to cover staff salaries and overhead expenses. This results in instability for organizations and the inability to retain qualified staff. In addition, front-line organizations are being encouraged to provide integrated services for HIV, Hepatitis and sexually transmitted infections (STI) but are receiving funding primarily from HIV projects and little from other funding sources, resulting in an attempt to offer comprehensive services without adequate funding.

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

	<25%	25-50%	51-75%	>75%
Prevention for youth				X
Prevention for most-at-risk populations:				
Injecting drug users				X
MSM				X
Sex workers				X
Testing and counselling				X
Reduction of stigma and discrimination				X
Clinical services (ART/Opportunistic infections)	X			
Home-based care	X			
Programmes for orphans and other vulnerable children	X			

Overall, how would you rate the efforts to increase civil society participation in 2009?

Most NGOs rated efforts to increase civil society participation since 2007 at 2.

Key achievements:

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

- High level of civil society representation on research and treatment-related advisory bodies and on a variety of working groups.

Remaining challenges:

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

III. Prevention

III.1 Has Canada identified the specific needs for HIV prevention programs?

Yes X	No
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If Yes, how were these specific needs determined?

In general terms, Canada identifies needs based on epidemiological data, research findings and dialogue with provincial and territorial health authorities, representatives of HIV/AIDS service organizations and representatives of most-at-risk populations.

At the national level, Canada has identified most-at-risk populations in need of prevention programs. These populations may live anywhere in Canada, although some are concentrated in large cities and towns, such as communities from countries with generalized and high prevalence of HIV, while others may live in rural and remote areas, such as some Inuit and on-reserve First Nations communities.

III 1.1 To what extent has HIV prevention been implemented?

Most of the prevention components in the table below have been implemented in all or some regions of Canada, but their availability varies widely depending on provincial and territorial health care services or federally-provided health services to some populations, the resources available to community-based organizations and whether populations are rural or urban. Prevention efforts in many areas are community-driven and community-provided, often with federal or provincial funding.

Further details are given below the table.

HIV prevention component	The majority of people in need have access		
	<i>Agree</i>	<i>Don't Agree</i>	<i>Not applicable</i>
Blood safety	X		
Universal precautions in health care settings ⁸	X		
Prevention of mother-to-child (vertical) transmission of HIV	X		
Information, education and communication on risk reduction	X		
Information, education and communication on stigma and discrimination reduction		X	
Condom promotion	X		
HIV testing and counselling	X		
Harm reduction for injecting drug users		X	
Risk reduction for MSM	X		
Risk reduction for sex workers		X	
Reproductive health services including STI		X	

⁸ Policies may be in place but practices may not be consistently followed.

HIV prevention component	The majority of people in need have access		
	<i>Agree</i>	<i>Don't Agree</i>	<i>Not applicable</i>
prevention and treatment ⁹			
School-based HIV education for young people		X	
Programmes for out-of-school young people		X	
HIV prevention in the workplace		X	
Other: Aboriginal peoples; communities from countries with high HIV prevalence; women; persons with disabilities; co-infections; positive prevention		X (see notes below)	

Prevention of vertical transmission is available in most parts of Canada. Women may not access prevention and testing because of stigma and fear of repercussions in family relationships.

Risk reduction: The availability of information, education and communication on risk reduction varies across Canada, depending on provincial/territorial policies and programs and on local resources. Some most-at-risk populations are not receiving enough culturally appropriate information.

Stigma and discrimination reduction: Access to information, education and communication on stigma and discrimination reduction vary across Canada. Canada has communicated messages consistent with past World AIDS Day themes of reducing stigma and discrimination. Many non-governmental organizations at the national and local levels work to reduce stigma and discrimination; some of this work may be supported by funds from the federal government.

⁹ Access may be unequal between urban and rural or remote communities.

NGOs are disappointed by a federal government decision to cancel a planned social marketing campaign to reduce discriminatory attitudes among young heterosexual men, despite public opinion surveys showing that HIV stigma is still prevalent.

Condom promotion is largely conducted at the local level. The availability of condoms depends on the resources of provincial/territorial/municipal public health programs and of local non-governmental organizations. Some NGOs observed that local and provincial funding cuts for public health have restricted the distribution of free condoms. The female condom needs to be made cheaper, more accessible and better known in Canada. Access to condoms remains uncertain in provincial prison systems.

HIV testing and counselling: The Public Health Agency of Canada estimates that as many as 26% of those living with HIV in Canada at the end of 2005 have not been tested and remain unaware of their status.¹⁰ Testing and counselling occur at the local level, usually in health care settings, and thus fall under the jurisdiction of the provinces and territories, except for populations receiving health services from the federal government. NGOs report that the quality of testing and counselling is variable. Some testing and counselling are offered by local non-governmental organizations.

HIV testing for pregnant women is available in all jurisdictions on either an opt-in or opt-out basis, depending on the policy of the province or territory. Some NGOs raised concerns about opt-out testing and pointed out that opt-in testing can be highly effective. The province of Ontario, for example, has an opt-in policy and is consistently at the high range of uptake in Canada. In 2009, Ontario's uptake was 95% - 96%.¹¹

A policy framework for HIV testing and counselling is being developed at the national level with the participation of some civil society organizations. There is some concern about whether the framework will offer adequate protection for the "3 Cs" of HIV testing – counselling, informed consent and confidentiality – particularly since some provincial governments are in favour of routine opt-out testing. There is a need to ensure that anonymous testing is available.

The criminalization of HIV transmission is of great concern to NGOs. Criminalization can discourage testing because those who are unaware of their serostatus are not liable to criminal prosecution. Greater support is needed for the development of messages that persons should be tested in order to better care for their health. HIV transmission needs to be addressed as a public health issue rather than a legal/criminal issue.

NGOs are also concerned about lack of access to treatment for those with positive test results because of fears of stigma, discrimination and violence, especially against women. Confidentiality is a strong concern, especially in small communities, Aboriginal and ethnocultural communities.

¹⁰ www.phac-aspc.gc.ca/aids-sida/publication/survreport/estimato8-eng.php

¹¹ Source: Ontario AIDS Bureau.

Harm reduction for people who use injection drugs was discussed in Section I, particularly with respect to safe injection programs. There is a need to increase access to materials for safer drug use, such as safer crack kits and clean needles, which are currently only available in certain cities. The availability of crack kits lags behind that of clean needles. Harm reduction is about more than needles and equipment; it also requires addressing the determinants of health as part of a broader harm reduction approach, which would include issues such as housing, access to health care, counselling and support, to name just a few. Some research has shown that many drug users have suffered sexual and other forms of abuse and have low self-esteem. The links between addiction and mental health need more research.

Risk reduction for MSM: Infections among MSM have risen in recent years, particularly among young MSM. An estimated 44% of new infections in 2008 occurred among MSM.¹² The availability of prevention programs for MSM varies across Canada and tends to be greater in large cities and towns.

The challenge remains to have awareness-raising campaigns that adequately address issues faced by this population. There is a trend among NGOs to move toward a broader approach to gay men's health and wellness, taking into account the social determinants of health that may help put gay men at risk for acquiring and transmitting HIV. NGOs sometimes find themselves facing the need to maintain links with clients by not condemning their risky practices while helping to educate them to adopt safer ones. The role of personal responsibility can be difficult to integrate into messages.

A need exists for federal leadership in supporting the development of appropriate messages and interventions and in re-focusing prevention programs on MSM as well as looking at gay men and their health issues as more than just vectors of HIV transmission. Local projects in Toronto with MSM in bathhouses (interventions which deal with sexuality in a straightforward way) have had success in educating men to reduce transmission risks.

Risk reduction for sex workers is provided in some major cities by community-based organizations but there is no national program for sex workers. Some NGOs stated that most sex workers are well informed and willing to adopt safe practices, but that pimps create problems that lead to violence and unsafe sex. In addition, as discussed in section I, the legislative framework can create problems which lead to violence. A Vancouver-based project by the Asian Society for the Intervention of AIDS (ASIA) is working with inside sex workers, brothel owners and massage parlour owners to do prevention work. There is a need for more national peer-based programs.

Reproductive health services including STI prevention and treatment are provided by provincial and territorial public health services and may vary in quality and availability. Prevention services are provided by some non-governmental organizations. The federal government has a role in providing these services to populations for which it provides health services (e.g. prisoners,

¹² www.phac-aspc.gc.ca/aids-sida/publication/survreport/estimat08-eng.php

armed forces, Inuit and on-reserve First Nations). The federal government also has a role in developing guidelines for reproductive health services (e.g. screening for cervical and anal cancer).

School-based HIV education for young people may be provided by some provincial and territorial educational systems. The decline in awareness among young people in school is of concern. A survey published in 2003 by the Council of Ministers of Education (Canada), the *Canadian Youth, Sexual Health and HIV/AIDS Study*, showed that middle and high school students (Grades 7, 9 and 11; approximately ages 12-16) were less aware of HIV/AIDS than they were in 1989. The survey has not been repeated since 2003. A survey conducted in 2007 for the Canadian AIDS Society showed that most Canadians support adopting national standards for HIV/AIDS education programs in elementary and secondary schools. Efforts continue to encourage provincial and territorial departments of education to adopt this approach.

HIV prevention for out-of-school young people is not widely provided in Canada, but may be available in the context of general provincial and territorial health services. Out-of-school youth may be reached by programs aimed at young MSM, street youth or other young populations. There is a need for more coordinated national programs.

HIV prevention in the workplace is not common in Canada. There are some work-related support programs for those living with HIV (see Section IV below).

Other prevention concerns: Aboriginal peoples, communities from countries with generalized and high prevalence of HIV (Africa and Caribbean), women, persons with disabilities, co-infections, positive prevention and development of a testing framework.

Aboriginal peoples

Aboriginal peoples in Canada include First Nations, Inuit and Métis. At the national level, Aboriginal peoples have a voice through a non-governmental organization, the Canadian Aboriginal AIDS Network (CAAN). Health care services are delivered directly to some First Nations and to Inuit by the federal government, while non-status First Nations and Métis receive health care services from the provincial or territorial government where they reside. The availability of HIV prevention programs for Aboriginal peoples thus varies depending on their status and place of residence. No single approach will fit all Aboriginal peoples because of the diversity of cultures within the Aboriginal population and between urban and rural/reserve populations.

National and local Aboriginal health organizations, including CAAN, provide prevention information and education within the limits of their resources. Some NGOs cited progress in engaging Aboriginal political and community leaders and the need for this effort to be supported in order to ensure more equitable access to HIV-related programs for Aboriginal peoples. The high rate of infection among Aboriginal women and the increase in vertical transmission continue to be of

serious concern. A status report on HIV and Aboriginal communities is being developed by the federal government with input from civil society organizations.

Communities from countries where the HIV epidemic is generalized and the prevalence of HIV is high

There is an emerging epidemic in developed countries, including Canada, among communities from countries where the HIV epidemic is generalized and the prevalence of HIV is high. Infection in women and vertical transmission are disproportionately high in these communities. In Canada, the communities are concentrated in Toronto and Montreal and receive some HIV-specific services from local non-governmental organizations in addition to services they may receive from provincial health care programs. Many new immigrants, however, are being placed in smaller communities with little access to services that are able to address their cultural issues around healthcare and/or their immigration experience.

Women

HIV prevention for women is not a designated national program but may be included in programs for specific populations such as Aboriginal peoples and communities from countries with generalized and high prevalence of HIV. A national status report on women is being developed with the involvement of the federal government and women's organizations.

A coalition of HIV-positive women, Canadian and international HIV/AIDS organizations and a variety of women's and reproductive rights groups have developed a Blueprint for Action on Women and Girls and HIV/AIDS (see section I.8). This is being updated to include more information on young women, criminalization of HIV transmission, reproductive health and women's rights.

An issue of concern is the vulnerability of women in relationships where they have no control over safe sex practices and may be subject to violence. There are many other issues of concern, including lack of harm reduction services for women both in and out of prison, the safety of sex workers, and lack of gynaecological and anal cancer testing, to name only a few.

Persons living with disabilities

Persons living with disabilities are increasingly being recognized as a vulnerable population for HIV transmission because of disability-associated stigma and discrimination, low self-esteem and associated depression and drug use, vulnerability to physical and sexual abuse and unfavourable determinants of health. Information gathering and awareness-raising work is being done, but targeted prevention programs at the national level do not exist. A symposium on HIV and Disability occurred in 2009 with federal government support. Canada is in the process of ratifying the UN Convention on the Rights of Persons with Disabilities.

Co-infections

An issue which could benefit from collaborative efforts between the federal government and civil society is the prevention of co-infections with HIV, Hepatitis C and/or tuberculosis. Co-infections are neither HIV infections nor Hepatitis C infections; they are a discrete condition requiring specific guidelines and resources for treatment and care. At the federal level, funding for HIV and Hepatitis C come from separate budgets, which presents challenges for the development and coordination of comprehensive projects.

Positive prevention

Positive prevention is a term used when speaking of the role that persons living with HIV play in prevention and includes many things: primary prevention, stemming the transmission of HIV to non-positive persons by behavioural change or by speaking out publicly to reinforce prevention messages; secondary prevention, reducing the risk of re-infection; and tertiary prevention, ensuring that measures are in place for promoting quality of life while living with HIV to slow disease progression.

NGOs report that persons living with HIV/AIDS are generally responsive to employing safer sex and other reduction measures in their behaviours. Positive prevention is being explored by national and provincial bodies and civil society organizations. Some research is underway on positive prevention, but there is a need for more research with respect to social determinants and the role they play in the health and well being of HIV-positive individuals and the behavioural changes that could be affected once basic needs are met.

Development of a testing framework

A national working group is developing a national framework for HIV testing in order to reach the estimated 26% of infected persons who are unaware of their serostatus and who therefore do not seek treatment. Higher testing rates could lead to greater positive prevention.

Overall, how would you rate the efforts in the implementation of HIV prevention programs in 2009?

The non-governmental organizations that provided numerical scores rated efforts in 2009 at an average of 6.

Key achievements:

- A pilot project to expand highly-active antiretroviral therapies to a most-at-risk population of street-involved people injecting drugs in the Downtown Eastside, Vancouver, British Columbia.
- Harm reduction programs, such as the safe injection site (Insite) in Vancouver, which is provincially funded and has been the subject of rigorous scientific evaluation. Work is progressing at the national level with harm reduction programs targeted at Aboriginal communities,

including youth, women, ex-prisoners and MSM. The Toronto private sector business community has expressed support for a possible supervised injection site in downtown Toronto.

- Risk reduction programs for ethnocultural communities; most of this work occurs with provincial, rather than federal, funding
- National database of evidence-based prevention programs being developed by CATIE in order to enhance learning and reduce duplication of efforts
- Canadian leadership in international indigenous peoples' HIV initiatives
- Progress on recognizing people with disabilities as an at-risk population and creation of partnerships between the worlds of disabilities and HIV
- Initiation of ratification by Canada of the UN Convention on the Rights of Persons with Disabilities
- Research: presence of HIV researchers on national advisory bodies; entry inhibitors; socio-behavioural observational research studies; pre-exposure prophylaxis; Canadian involvement in international vaccine development; harm reduction research; advances in knowledge translation.
- Development of new prevention technologies: e.g. Canadian HIV Vaccine Initiative; government funding for a vaccine manufacturing facility; International Partnership for Microbicides; International AIDS Vaccine Initiative.

Remaining challenges:

- Public apathy, based on a lack of understanding of HIV and the belief that HIV is just a chronic disease and no longer fatal. There is a need for continuing public education and awareness-raising.
- Expansion of the criminalization of HIV transmission or exposure, encompassing a growing set of circumstances even where there is no significant risk of transmission; this contributes to HIV-related stigma, fear on the part of PHAs and inappropriately broad application of the criminal law.
- Stigma and discrimination leading to risk behaviours and fear of being tested
- Reduction in federal government support for harm reduction programs (especially for IDU), harm reduction services, (e.g. supervised injection sites) and research or policy work that relates to harm reduction among people who use drugs (including those in prison)

- Continuing high infection rates in Aboriginal communities despite 10 years of targeted work
- The need for greater government support and collaborative efforts with civil society on prevention for MSM and broader gay men's health issues
- Lack of information sharing across provincial and territorial boundaries
- Lack of capacity in public health systems and community-based organizations
- Lack of inter-departmental dialogue within the federal government on issues such as HIV and disabilities
- Need for stronger links between HIV/AIDS and mental health policies and programs, in light of research evidence about the root causes of low self-esteem and consequent risk behaviours
- Inconsistencies in federal and provincial/territorial approaches. Federally-funded short-term projects (usually one year) address needs and reach designated populations, only to end and not be continued by provincial/territorial health services. In addition, approval of projects at the federal level can be slow. These factors can lead to reluctance on the part of front-line organizations to participate in future short-term projects. Projects need a 3-5 year time period in order to become sustainable.
- Loss of federal government staff
- Research: lack of research capacity; emphasis on knowledge translation at the possible expense of knowledge creation; need for greater and meaningful inclusion of affected communities in the research agenda (i.e. working *with*, not *on*, communities); need for more population-specific research (e.g. women, gay men, persons with disabilities) based on the determinants of health; need for more research on treatment as prevention; challenge of recruiting and retaining participants in clinical trials.

Additional NGO comments on HIV prevention

Canadian research and international issues:

In order to address the need for building research capacity in resource-limited countries, the Canada-Africa Prevention Trials (CAPT) Network began in March 2007 as a partnership of leading HIV researchers, clinicians and NGOs in Canada and Africa who were interested in a new model of international HIV prevention research. Administered by the CIHR Canadian HIV Trials Network with funding from the Government of Canada through the Global Health Research Initiative (GHRI), the CAPT Network engaged South-South and South-North relationships to empower African leaders in developing and executing studies that responded

to local needs. Funding was allocated for two years until 2009 and currently the CAPT Network is reapplying for additional funding to continue prevention-based projects at eight African sites in Uganda, South Africa and Kenya.

IV. Treatment, care and support

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

Yes	X	No
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If Yes, how were these specific needs determined?

In general terms, Canada identifies needs based on epidemiological data, research findings and dialogue with provincial and territorial health authorities, representatives of HIV/AIDS service organizations and representatives of most-at-risk populations.

At the national level, Canada has identified most-at-risk populations in need of treatment, care and support programs. These populations may live anywhere in Canada, although some are concentrated in large cities and towns, such as communities from countries with generalized and high prevalence of HIV, while others may live in rural and remote areas, such as some Inuit and on-reserve First Nations communities.

The availability of HIV treatment, care and support varies across Canada because health care delivery and education fall within provincial/territorial jurisdiction. The federal government provides health services for federal prisoners, the armed forces, Inuit and on-reserve First Nations populations. Each sub-national jurisdiction has a public health insurance plan that covers “medically necessary” physician and hospital services for all residents of the jurisdiction, as a pre-condition of receiving federal funding contributions under the *Canada Health Act*. The coverage of other health goods and services under public health insurance plans varies from one jurisdiction to another. There is no nation-wide pharmacare plan to cover the costs of prescription medications.

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

Specific treatment issues

The services listed in Table 1.1 are available to most people in need but may not be readily available in all jurisdictions. In particular, there may be challenges with access to: nutritional care; paediatric HIV care; psychosocial support; home-based care; other rehabilitation services; and services in the workplace.

Details of treatment, care and support services appear below the table.

HIV and AIDS treatment, care and support services	Majority of people in need have access		
	<i>Agree</i>	<i>Don't agree</i>	<i>Not applicable</i>
Antiretroviral therapy	X		
Nutritional care		X	
Paediatric AIDS treatment	X		
Sexually transmitted infection management	X		
Psychosocial support for people living with HIV and their families		X	
Home-based medical care	X		
Palliative care	X		
Treatment of common HIV-related infections	X		
Treatment of HIV-related morbidities		X	
HIV testing and counselling for TB patients	X		
TB screening for HIV-infected people	X		
TB preventive therapy for HIV-infected people	X		
TB infection control in HIV treatment and care facilities	X		

HIV and AIDS treatment, care and support services	Majority of people in need have access		
	<i>Agree</i>	<i>Don't agree</i>	<i>Not applicable</i>
Cotrimoxazole prophylaxis in HIV-infected people	X		
Occupational post-exposure prophylaxis	X		
Non-occupational post-exposure prophylaxis (e.g. rape, sexual exposure)		X	
HIV treatment services in the workplace or treatment referral systems through the workplace			X
HIV care and support in the workplace (including alternative working arrangements)			X
Other programmes: Co-infections See notes below	X		
Other programmes: Solid organ transplants; dental care; disability and rehabilitation; most-at-risk populations; HIV and aging; access		X See notes below	

HIV and AIDS treatment, care and support services	Majority of people in need have access		
	<i>Agree</i>	<i>Don't agree</i>	<i>Not applicable</i>
to medicinal cannabis; research; criminalization of HIV transmission; drugs for developing countries.			

Antiretroviral therapy is available in Canada but access to treatment may vary, depending on provincial/territorial drug formularies and health coverage provisions for populations served directly by the federal government (e.g. prisoners, armed forces, Inuit and on-reserve First Nations populations). Lack of access to affordable drugs occurs particularly with newer, more expensive drugs. There is a critical need for a national catastrophic drug plan and a national pharmaceutical strategy, including rare disease coverage.

The review and approval process for new drugs in Canada is being enhanced at the federal level with the adoption of a progressive licensing framework for drugs, which involves continuous monitoring of drugs throughout the lifetime of the product. There is strong consumer involvement in every stage of this process. Biologics will be challenged with new issues such as subsequent entry inhibitors.

Stigma and discrimination may limit access to treatment if people fear that their privacy and confidentiality will not be respected. Some marginalized populations, such as the unstably housed or homeless, have limited access to health care services and do not have adequate supports for adherence to treatment such as drug storage, drug schedule reminders and safe places to take medication. Some programs at the local level in large cities address these issues; these programs may be delivered by public health services and non-governmental organizations, sometimes working in partnership. A portion of the funding for their programs may come from the national HIV/AIDS budget. Other populations (e.g. migratory populations and non-status Aboriginal peoples) may suffer from stigma discrimination, resulting in limited access to treatment.

Of great concern are co-morbidities such as cervical and anal cancer, heart disease, diabetes, bone loss, and liver and kidney diseases. Long-term treatment may result in side effects such as lipodystrophy. More research and greater access to therapies for co-morbidities and side effects are needed.

Nutritional care falls under provincial/territorial jurisdiction except for populations receiving health care services from the federal government. The federal government does work on broad issues which may include nutrition. HIV-related nutritional expertise is concentrated in major cities. Some local non-

governmental organizations provide programs such as communal kitchens and meals. Lack of adequate nutrition, or proper nutrition in relation to medication, can be a problem for socio-economically disadvantaged persons living with HIV/AIDS.

Paediatric HIV/AIDS treatment is available in Canada but may require travel for those living outside cities where such care is available. In 2008, only four infants were confirmed HIV-positive in Canada.¹³ Because there are few cases of paediatric HIV infection in Canada, treatment expertise is not widespread. Simplified fixed-dose combination paediatric formulations of ARVs are not generally available because access to generic products, the only likely source of most such combinations, is hindered by stringent patent protection.

In some at-risk populations, women may not seek testing because of stigma and fear of violence in relationships. They may become aware of their serostatus only when their baby tests positive. These women require greater support and help in getting access to treatment.

STI management is not a primary focus of HIV/AIDS programs in Canada, but may fall within the responsibility of provincial/territorial and local public health programs. The federal government may play a role in developing guidelines for STI management.

There has been some progress on HIV/HPV co-infection. A national study is examining the safety and efficacy of giving the HPV vaccine in HIV-positive girls and women.

The CIHR Canadian Clinical Trials Network has set up a working group on anal dysplasia in HIV. Currently, there is no clear diagnosis or clinical standard of care regarding anal dysplasia.

Access to psychosocial support for people living with HIV and their families varies greatly across Canada. Support is most available to those living in large cities and towns and is largely delivered by community-based organizations. There is an unmet need for psychosocial support for marginalized populations.

Home-based care falls within the jurisdiction of provinces and territories, except for Inuit and on-reserve First Nations peoples. For unstably housed and homeless populations, home care is non-existent. Some local public health authorities and community-based organizations have responded by providing housing or advocating for stable housing. For many populations, there is often inadequate home assistance for the tasks of daily living, cooking and shopping.

Palliative care: The need for palliative care for persons living with AIDS has declined since the advent of antiretroviral therapies, but continues to be a need for those diagnosed late and with rapid progression of HIV disease, such as

¹³ www.phac-aspc.gc.ca/aids-sida/publication/survreport/2008/dec/surveillance_2008_6-eng.php#Section_2_12

unstably housed populations. Most local hospice palliative care services in Canada accept patients living with HIV/AIDS and some cities have HIV-specific hospices run by non-governmental organizations which provide a high level of care. The level of HIV palliative care expertise is declining in Canada because of lower death rates since the advent of ART.

Treatment of HIV-related morbidities such as anal cancer, cervical cancer, heart disease and bone disease may not be readily available.

Tuberculosis and HIV: Tuberculosis co-infection with HIV is a growing public health concern in Canada, particularly focused on multi-drug-resistant TB. There are currently no national programs to address this.

Cotrimaxazole prophylaxis in HIV-infected people: Opportunistic infections have declined in Canada because of the widespread availability of antiretroviral therapies. A wide variety of antibiotic and antiprotozoal treatments for *Pneumocystis carinii* pneumonia, urinary tract infections, bronchitis, middle ear infection and diarrhoea are available. In Canada, cotrimoxazole is available through all of the provincial/territorial public health drug formularies.

Occupational post-exposure prophylaxis is available in all Canadian jurisdictions and is provided by local health authorities.

Non-occupational post-exposure prophylaxis varies according to the policies of individual provinces and territories. There is variability across Canada in access to nPEP, cost to the patient, and in the number of drugs used in combination (two or three); there is a need for some of the drugs currently in use to be replaced with less toxic drugs. Access to nPEP is not available for accidental condom breakage and, in some jurisdictions, may not be available to victims of sexual assault.

Access to HIV treatment, care, support and accommodation in the workplace varies greatly, depending on the employer. One of the greatest challenges faced by persons living with HIV is confidentiality in the workplace. Examples are the need to take medication during the day at work without revealing one's HIV status or deciding whether or when to disclose HIV status to the employer. Most employers do not have HIV-specific services but many provide supplementary health care insurance that covers HIV treatment. Small companies may have self-administered insurance that runs the risk of lack of confidentiality. Small companies may also find that they cannot afford to keep employees who are living with HIV because of the high insurance premiums and other costs. Canada could develop a pooling approach to insurance with encouragement from the federal government.

Other treatment, care and support concerns:

Co-infection with Hepatitis C and HIV

An estimated 30% of HIV-positive individuals are co-infected with Hepatitis C. The increasing numbers of co-infected individuals and the complexity of their

care require a full understanding of the interaction between HIV and Hepatitis C as a discrete condition requiring its own guidelines, treatment and care. National non-governmental organizations have identified a need for programs in this area, but are not currently involved in nationally-funded initiatives.

Research is progressing on Hepatitis C/HIV co-infection, with a national cohort study underway. The richness of the cohort's data and expertise of the investigators assembled will advance further studies focusing on many additional aspects of co-infection.

There is a need to address Hepatitis C/HIV co-infection by recognizing that people tend to be infected with the viruses at different times. Better intervention after the first infection could reduce the number of infections with the second virus; this requires national coordination and support. The need exists for greater collaboration between Canada's Hepatitis C strategy and its HIV/AIDS strategy in order to enhance collaboration without stripping funding from HIV programs.

A number of NGOs have expanded their mandates beyond HIV/AIDS to include Hepatitis and STIs, with a person-centered, rather than disease-centered, approach to care and support. Integration of services will require more coordination and collaboration by all levels of government with civil society organizations.

Access to solid organ transplants

Development work is being led by civil society organizations to create access to solid organ transplants for those living with co-infections, primarily HIV and Hepatitis C.

Access to dental care

Public health services in Canada do not cover the cost of dental services. Access to dental care has been identified as a need for persons living with HIV/AIDS because dental costs are prohibitively high for those without private insurance. NGOs are engaging in education and awareness-raising about this issue.

HIV, disability and rehabilitation

Canada is the only country with a national non-governmental organization devoted to issues of HIV, disability and rehabilitation, the Canadian Working Group on HIV and Rehabilitation (CWGHR), which receives some funding from the federal government. CWGHR's initiatives include work with employers and disability insurance programs to develop support and adaptations for persons living with HIV who wish to remain in, or return to, the workforce.

This work has resulted in partnerships with other health organizations and human resources organizations on the issue of income and other supports for those living with episodic-pattern conditions and on the broad issue of discrimination against those living with disabilities. Canadian organizations and the federal government have played leadership roles on these issues internationally.

There is a need for rehabilitation programs to be enhanced at the national level for those living with HIV as well as support to remain in, or return to, the workplace and engage in community activities. Many provinces and territories no longer make the services of rehabilitation professionals, such as physiotherapists and occupational therapists, available at no cost to patients in need, which creates inequitable access to these critical services.

CWGHR's work includes working with professional associations involved in rehabilitation to promote inclusion of HIV-related rehabilitation in their practice. CWGHR has developed online courses in HIV, disability and rehabilitation for rehabilitation professionals and other health care providers. These courses may be adapted for resource-poor countries.

There has been significant progress during the past two years in the development of partnerships between disability organizations and HIV organizations, resulting in a stronger voice in policy discussions with government. This work has shown the need for greater inter-departmental dialogue and collaboration within the federal government. Several NGOs collaborated both on a national forum in 2008 on HIV as a Disability and on the development of a discussion paper on HIV and disability. In 2009, HIV and disability organizations worked with Health Canada to hold an international policy dialogue on HIV and disability. Canadian organizations are working to promote international collaboration on this issue.¹⁴

An encouraging development is the Government of Canada's initiation in December 2009 of the ratification process for the UN Convention on the Rights of Persons with Disabilities. Several NGOs have collaborated on a study of the implications of the Convention for Canada.

Challenges faced by most-at-risk populations

Gay men still represent a significant proportion of all infections but are underserved. They may not be comfortable seeking services from community-based organizations that now serve a variety of other populations.

Some of the challenges faced by communities from countries with generalized and high prevalence of HIV (Africa and the Caribbean) were mentioned in Section I – Human rights and Section III – Prevention. The Interagency Coalition on AIDS and Development (ICAD) has led the development of a national network for organizations working with Black Canadian, African and Caribbean populations. The need for a national strategy remains. Ontario was cited as the only province with significant support for HIV/AIDS-related issues for these communities. In general, new immigrants and refugees need greater support in gaining access to treatment.

Aboriginal NGOs continue to face the challenge of lack of access to treatment because of the fear of lack of confidentiality, stigma and discrimination. The need

¹⁴ A report on the HIV and disability policy dialogue and related policy briefs are posted on the UNAIDS website and a 2009 issue of the *Journal of the International AIDS Society* focuses on the theme of HIV and disability, with several articles by Canadian HIV and disability groups.

for counselling and family support is great, but the resources of community-based organizations are limited. Progress has been made in services to urban Aboriginal populations through increased partnerships between Aboriginal and non-Aboriginal community-based organizations. The federal government increasingly recognizes the importance of Aboriginal involvement in the development of policies and programs.

The federal government has not yet released its status report on women and HIV, which hampers progress in this area. Women in prisons are of concern because they may have sub-optimal access to state-of-the-art medication, mental health and gynecological services and discharge planning.

Status reports on persons who use injection drugs, prisoners and persons living with HIV/AIDS have not yet been released by the federal government.

HIV and aging/HIV and living long-term with HIV medication

Antiretroviral treatments have prolonged lives to the point where many living with HIV are experiencing conditions associated with aging such as arthritis, diabetes, cardiovascular disease, neurocognitive impairment and osteoporosis. Research indicates that persons living with HIV may be subject to accelerated aging. More research is needed into prevention and treatment for accelerated aging. Several Canadian NGOs are working collaboratively on these issues to build bridges between the HIV community and gerontology and disease-specific organizations.

In addition to the issue of aging with HIV, and sometimes compounding it, is the issue of living long-term with HIV and medications. This arises with people aging with HIV and also with people diagnosed at birth or at a young age who have lived a long time and are growing up living with HIV and long-term medication use.

Access to cannabis for medical purposes

Access to cannabis for medical purposes is hindered by barriers such as high cost without reimbursement, lack of information transfer to physicians about the medical properties of cannabis, lack of information dissemination about Canada's federal medical cannabis program that enables people to obtain legal authorization to possess cannabis, lack of adequate Canadian research since 2003 to support evidence-based policies, lack of adequate options for a safe and affordable supply of cannabis, and stigma associated with cannabis use to manage HIV/AIDS related symptoms.^{15,16} NGOs have serious concerns about the federal government's recent decision to require advance payment from PHAs for medical cannabis when most cannot afford this.

¹⁵ Canadian AIDS Society. *Cannabis as Therapy for People Living with HIV/AIDS: "Our Right, Our Choice.* June 2006.

¹⁶ Belle-Isle, L; Hathaway, A. *Barriers to Access to Medical Cannabis for Canadians Living with HIV/AIDS.* AIDS Care, April 2007; 19(4):500-506.

Research

There is a need for nationally supported treatment research to include niche research related to Aboriginal peoples, communities from countries with generalized and high prevalence of HIV, and women. Some progress has been made in community-based Aboriginal research.

Canada continues to play a strong role in clinical trials. Promising research is underway in the area of immunotherapies to improve immune control of viral replication. The OPTIMA study of strategies for management of patients who have failed first- and second-line highly active retroviral therapy has been completed. OPTIMA addressed a highly controversial issue: whether an antiretroviral regimen using mega-ART, more than four antiretroviral drugs, was more effective than a regimen using standard ART, four drugs or less, in delaying the onset of AIDS or death. A major international approach was needed, and OPTIMA successfully proved that mega-ART had no effect on time to clinical outcomes.

A treatment-as-prevention pilot project is underway to expand the use of highly-active antiretroviral therapies in a most-at-risk population of street-involved people in Downtown Eastside, Vancouver, British Columbia. Over a six-year period, researchers will investigate whether expanded HAART among injection drug users will lead to a reduction in the number of new HIV infections and a decrease in adverse HIV/AIDS health outcomes among the target population.

Interdisciplinary research is growing, combining psychosocial, community-based and biomedical research. Research is ongoing in the areas of salvage therapy and treatment simplification, entry inhibitors, treatment as prevention, vaccine development,¹⁷ co-infections (especially HIV/Hepatitis C), and boosting of immunity and micronutrient supplementation, to name a few. Canadian pharmaceutical companies are competing for a government-funded vaccine production facility but this appears to be premature, since there is as yet no viable vaccine to produce.

Recruitment and retention of participants in clinical trials remains a concern because people living with HIV feel healthy and may be less focused on finding better treatments than in the past. Researchers report a trend toward more investigator-driven clinical trials rather than pharmaceutical industry-driven trials because there are few new drugs being developed. The positive side of this is the ability of researchers to compare the effectiveness of various drugs, rather than testing a single drug.

The need for further research has been identified in the areas of: harm reduction and supervised injection sites, including the impact of harm reduction on clinical and economic aspects of Hepatitis C vaccine and co-infection with HIV; reducing violence and its impact on treatment access and adherence, especially for women;

¹⁷ There is research at the basic science level for possible vaccine candidates, but no current clinical trial enrolling in Canada.

drug-resistant tuberculosis; alternatives to ritonavir as a booster; and aging and HIV.

There is a need for greater coordination and effectiveness of knowledge translation mechanisms from research to service organizations.

Making treatment drugs available to developing countries

Some NGOs cited Canada's role in making HIV treatment drugs available to developing countries and stated that current Canadian government policies favour pharmaceutical companies that export relatively expensive brand-name drugs rather than cheaper generic drugs. These policies tend to favour industry rather than assist in addressing the epidemic. The 2004 legislation that created Canada's Access to Medicines Regime (CAMR) has led to only one export of a single fixed-dose combination ARV to one country (Rwanda).

Several national NGOs from a broad range of sectors have called for legislative reforms intended to simplify and streamline the legislation so as to increase its usability for developing countries and generic manufacturers. In 2009, private members' bills to this effect passed second reading in both the Senate and House of Commons; at the time of writing, their final form and future was uncertain, given strong opposition by the brand-name pharmaceutical industry, the federal government and certain parliamentarians, but NGOs were continuing to encourage their enactment.

In addition to making treatment drugs available to developing countries, NGOs support the need for Canada to work toward provision of second- and third-line drugs, food, safe water and sound health systems infrastructures.

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programs in 2009?

Most national non-governmental organizations rated efforts in the implementation of HIV treatment, care and support programs in 2009 at 6.

Key achievements:

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

Remaining challenges:

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

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

Yes	No X	N/A
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More research is needed to determine the dimensions of this situation in communities from countries with generalized and high prevalence of HIV.

V. Further suggestions to UNAIDS

Canadian civil society organizations made the following suggestions 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.