Survey of Canadian HIV/AIDS Prevention Policy and Program Priorities

Canadian Public Health Association
June 2000

Overview of CPHA

- Incorporated in 1912
- National not-for-profit health association
- Represents over 25 health disciplines and the general public
- Governed by a 24-member Board of Directors
- Management board is 8-member Executive Board
- Conducts and supports health and social programs nationally and internationally
- Stresses partnership role with national and international NGOs, federal/provincial governments and private sector corporations
- Provides a "special" health resource at national and international levels of both professionals and non-professionals

Mission Statement

The Canadian Public Health Association (CPHA) is a national, independent, not-for-profit, voluntary association representing public health in Canada with links to the international public health community. CPHA's members believe in universal and equitable access to the basic conditions which are necessary to achieve health for all Canadians.

CPHA's mission is to constitute a special national resource in Canada that advocates for the improvement and maintenance of personal and community health according to the public health principles of disease prevention, health promotion and protection and healthy public policy.

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Overview

In February, 2000, the Canadian Public Health Association (CPHA) with the support of Health Canada initiated a national survey of public health practitioners, AIDS service organizations (ASOs), governments, and others with experience and interest in HIV/AIDS prevention.

The purpose of the survey was to determine the current state of prevention activity in Canada as one component in determining the ongoing role of CPHA in the development of public health policy relating to HIV/AIDS prevention.

The survey included three components:

- A fax questionnaire that was distributed to approximately 500 contacts in March, 2000, and which generated 118 replies by early April;

- A series of telephone interviews with 33 key informants, reflecting the geographic and sectoral mix in the overall target group for the survey;

- Three roundtable discussions convened in early May in Vancouver, Ottawa, and Montréal. Each of these locations a cross-section of participants representing public health agencies, ASOs and governments were invited.

We are very grateful to the many HIV/AIDS prevention practitioners and policy-makers who gave freely and eagerly of their limited time, to help make this report a useful, living document.

We also express our appreciation to InfoLink Consultants Inc. who undertook this survey on behalf of CPHA and to the HIV/AIDS Prevention & Community Action Programs, Health Canada for their financial support of this project.

The Context: A Continuum of Roles

Among front-line HIV/AIDS prevention workers, CPHA is best known and respected as manager of the Canadian HIV/AIDS Clearinghouse. Many prevention practitioners identify the Association primarily with the Clearinghouse's mandate to "provide information on HIV/AIDS prevention, care and support to health professionals, schools, community-based organizations and to a broad audience of individuals and other groups."† This response is understandable – particularly with respondents whose jobs include little or no responsibility for policy.

In the broader context, CPHA's mandate is to serve as an advocate "for the improvement and maintenance of personal and community health according to the public health principles of disease prevention, health promotion and protection, and healthy public policy."

The more restricted perception of CPHA as the Clearinghouse base proved to be a very useful starting point for engaging some of the participants in a broader discussion of current challenges and priorities in HIV/AIDS prevention, as a means of exploring policy issues that CPHA might wish to address within its larger mandate.

The following "Principles for Policy Development" and "Specific Recommendations" synthesize the results of the survey as related to CPHA's ongoing role in developing and supporting public health policy in HIV/AIDS prevention.

† Canadian HIV/AIDS Clearinghouse, *Annual Work Plan and Budget, Fiscal Year 2000/2001*, April 1, 2000.

Emerging Principles for Policy Development within the CPHA Context

1. Strategic partnerships, including those with affected communities, should be used as key resources in the research, planning and development of policies. (Implementation of this principle could mean the reconstitution of the advisory committee that was previously in place to help guide its HIV/AIDS program.)

2. Policy development should focus on attainable goals, increased funding, adaptable content, evaluation and accountability, action, "less politics", and development of inclusive processes.

3. Policy development should take into account the broader context in which HIV/AIDS exists as a disease (it is not the only Sexually Transmitted Infection, or the only blood- borne pathogen), the broader reality of the populations most vulnerable to infection (HIV is not the only health/life issue facing most populations at risk), and the requirements for a broader continuum of prevention messages and reinforcement (support for behaviour change should be consistent wherever a person goes, and different populations need very different approaches to accomplish that).

4. Policies should be forward looking, not just focusing on the situation as defined by current statistics and situations, but identifying appropriate responses to emerging trends and populations as can be responsibly projected.

5. CPHA should ensure that information on its policy development activity is distributed as widely and frequently as possible – both to ensure that partners at all levels are aware of the work that is going on, and to generate broader support for that work.

Specific Recommendations

1.0 Recommendations on Policy Directions

1.1 Target future policy development related to HIV/AIDS prevention that will especially benefit priority populations such as:

- youth
- injection drug users
- street populations
- Aboriginal communities (both on-reserve and off-reserve)
- women
- prison populations
- remote, isolated and otherwise inaccessible populations

Policies will need to acknowledge and reflect the considerable overlap that often exists between some of these priority populations.

While these may be the current priority populations, attention should also be paid to the specific needs of other at-risk populations that may not currently rate high in the statistics.

1.2 Direct policy work at the national level, and through CPHA regional affiliates, toward removing barriers, combating HIV/AIDS discrimination and stigmatization, and creating opportunities for effective prevention work at the local level.

1.3 Position HIV/AIDS prevention policies in the broader context of;

- Sexually Transmitted Infections;
- Blood-borne Pathogens;
- Harm Reduction;
- Determinants of Health.

Promote Harm Reduction as a cornerstone of HIV/AIDS prevention policies at all levels of government and within the public health community.

Promote policies at all levels of government and society that acknowledge the decisive impact that housing, employment, self-esteem and other determinants of health can have on the likelihood of HIV transmission.

1.4 Generate policy support from local, provincial/territorial and federal governments to encourage curriculum development and delivery in elementary and secondary schools.

Prevention education should begin in the early elementary years, with broad messages related to self-esteem, mutual respect, conflict resolution and problem-solving. This would set the stage for a full range of more focused health promotion messages, including healthy sexuality and HIV/AIDS prevention, as students move into older grades.

1.5 Encourage governments at all levels and private sector organizations to develop policy and funding frameworks that support and facilitate HIV/AIDS prevention efforts undertaken by front-line organizations.

This support would be especially important for the development and dissemination of prevention strategies that successfully target specific groups and cultures. (Eg., Aboriginal communities, injection drug users, prison populations, etc.)

1.6 Examine current prevention policies regarding their overall effectiveness and consider reframing "prevention" from a "risk education" perspective.

2.0 Recommendations on National Activities

2.1 Reconstitute the advisory committee that was previously in place to help guide the Association's HIV/AIDS program.

2.2 Along with CPHA members and partners, undertake an aggressive public awareness campaign that emphasizes harm reduction, healthy sexuality, and a broad focus on the determinants of health as critical supports for successful HIV/AIDS prevention.

This campaign would have the general public as a key target audience as well as public institutions that so far resist harm reduction as an approach to HIV/AIDS prevention. The understanding and support of both these audiences will enable appropriate, targeted prevention programs to function effectively.

2.3 Build on existing partnerships, and develop new ones to:

- establish the link between HIV/AIDS and other Sexually Transmitted Infections;
- position HIV within an integrated strategy to deal with blood-borne pathogens;
- fully address the determinants of health that underlie any HIV/AIDS prevention effort;
- maintain and expand existing prevention program and policy collaborations;
- increase the scope and effectiveness of school-based programs (education associations, Canadian Council of Ministers of Education);
- extend the involvement of the private sector in prevention education (insurance and pharmaceutical industries).

2.4 Assemble a coalition of CPHA members and partners to discuss and promote the successes and benefits of Harm Reduction in general, and to advocate for its broad use as a means of HIV/AIDS prevention.

3.0 Recommendations on National Programming and Front-Line Support

3.1 Continue the work of the Canadian HIV/AIDS Clearinghouse.

3.2 Promote those prevention approaches that are flexible, participatory, based on a community development approach to health, and adaptable to the best practices that are most readily suited to a particular context or target audience.

3.3 Expand the Clearinghouse role to include a place/forum where front-line practitioners can share program ideas, concerns, best practices and examples of educational materials that have worked with different audience groups.

3.4 Assemble or produce research results that will help make the case for prevention programming at the local level.

3.5 Work with front-line practitioners and affected communities to plan, develop, deliver and evaluate HIV/AIDS prevention materials and campaigns, and urge governments to work in the same way.

3.6 Promote peer-based training for audiences as diverse as youth, prison populations, women and Aboriginal people.

3.7 In collaboration with education partners, develop school-based curriculum to support broad-based prevention messages for early elementary school children, and more targeted prevention messages for older students.

3.8 Identify or develop and disseminate effective approaches to incorporating “AIDS 101”- type messages within the broader Harm Reduction or Determinants of Health framework.

The following sections of this report provide details of the fax survey responses, telephone interviews and roundtable discussions.

The Fax Survey

Overview

- The fax survey generated 64 responses from public health offices or CLSCs, 26 from AIDS service organizations (ASOs), and 22 from local, provincial/territorial or federal governments.

- Six respondents were from communities or service areas with populations of more than one million, nine were in communities with populations of 500,000 to one million, 38 were in communities of 100,000 to 500,000, and 43 were in areas with fewer than 100,000 residents.

- Exactly half of the respondents – 59 – were spending less than $50,000 on HIV/AIDS prevention initiatives in 2000. While there was relatively little change in spending levels between 1995 and 2000, based on the ranges used in the survey questionnaire, the comparative figures suggested a slight to moderate increase in overall funding.

- Similarly, HIV/AIDS prevention programs showed a moderate increase in the number of paid staff between 1995 and 2000. On a percentage basis, this trend was most dramatic among AIDS service organizations, largely because ASOs started out with the lowest staffing levels. The largest increase in total numbers occurred in a relatively small number of government programs. Volunteer effort related to HIV/AIDS prevention was located primarily in AIDS service organizations.

- Survey participants identified secondary school students, injection drug users, the general public, men who have sex with men, pregnant women, street-involved youth, and rural populations as the top target audiences for their current HIV/AIDS prevention initiatives. For the immediate future, injection drug users emerged as a key focal point, receiving a point rating of 4.21 on a one-to-five scale. The rest of the priority list showed a gradual shift in emphasis among the audience groups, with street-involved youth and women receiving somewhat higher priority and the general public receiving somewhat less. Secondary school students placed second, followed by street-involved youth, men who have sex with men, women as a general audience, the general public, and pregnant women.

- The report provides detailed breakdowns of the relative priority attached to different target audiences by public health organizations, ASOs and governments, and by respondents in larger and smaller communities. The analysis by community size showed some difference in priorities – while respondents in larger communities identified injection drug users and men who have sex with men as their top two target audiences for current prevention programming, their counterparts in smaller settings listed secondary school audiences, followed by rural populations. Asked to identify their emerging priorities, the larger communities focussed on IDUs, street youth, and men who have sex with men; the smaller communities listed secondary school students and women.

- Across all organization types and geographic areas, the target audiences listed in the survey questionnaire consistently received higher point ratings based on the need for future prevention activity than they did when the question related solely to current programming. This result suggested considerable unmet need for HIV/AIDS prevention services – a conclusion that was certainly reinforced by the telephone interviews and roundtable discussions. And while the statistical results captured the priorities expressed by respondents as a whole, it was clear that there are strong, committed practitioners and advocates delivering HIV/AIDS prevention programming to virtually every target audience imaginable – including many that were not listed in the survey questionnaire. This suggests fertile ground for the development of a wide range of local prevention partnerships.

- Respondents identified targeted prevention education, sexuality education, condom distribution, general prevention education, professional education and training, public education, high school outreach/curriculum development, and public booths/displays as the most important HIV/AIDS prevention strategies. While these priorities are generally reflected in current programming, a number of respondents cited limits in their ability to deliver professional education and training, high school outreach/curriculum development, and public education. Assertiveness training/self-esteem, anti- discrimination education, and street outreach emerged as key priorities for future prevention programming.

- Respondents identified sexuality education and STDs, as well as the prevention of emerging communicable diseases (e.g. Hepatitis C), as "related or underlying issues" that received emphasis in their organizations. This result was reinforced in the telephone surveys and roundtable discussions, where many participants stressed the importance of placing HIV/AIDS prevention initiatives in a broader context.

- Asked to identify the top three prevention programs in their own jurisdictions, more than half of the fax survey respondents listed a variety of education, information and awareness initiatives. Testing, specifically anonymous testing, emerged as the second- most common prevention strategy. About 25% of respondents indicated that they were involved with various harm reduction strategies.

- Funding, interagency coordination, negative attitudes, and a lack of awareness emerged as the most common gaps in current HIV/AIDS prevention programming. A number of participants reported difficulties delivering prevention messages within the school system, and organizing effective harm reduction programs for injection drug users. Women, Aboriginal communities, ethnocultural populations, commercial sex workers, and rural communities were identified as target audiences for which current prevention programming is inadequate or inappropriate.

- Respondents said policy initiatives should support curriculum development and delivery in elementary and secondary schools, as well as broader educational efforts aimed at post-secondary students, politicians, law enforcement personnel, educators, and health care professionals.

Injection drug users, women, street youth, prison populations, and refugees were identified as specific target audiences that could benefit from the policy development process.

- Policy intervention is also required to build stronger support for harm reduction as a basis for prevention programming, and to encourage wider understanding of the social and economic determinants that underlie any public health initiative.

- A large proportion of respondents identified materials for low-literacy populations and fact sheets on specific issues as resources that would help them maintain or strengthen their HIV/AIDS prevention programs. Videos, peer training/counselling materials, and training manuals generated moderate interest, while general brochures, posters and multilingual materials were less popular.

- Relatively large proportions of fax survey respondents were involved in care, treatment and support or policy activities, in addition to their work in HIV/AIDS prevention. Relatively few were working in correctional settings or addressing legal, ethical or human rights issues.

- Human resources and funding emerged as by far the most common barriers to effective HIV/AIDS programming.

- Respondents saw a role for CPHA in developing and distributing information resources, providing coordination among organizations and jurisdictions, and serving as an advocate for HIV/AIDS prevention at the federal level. Program support and policy development received slightly less emphasis. Only about 20% of participants felt the Association should be involved in direct program coordination.

General Profile

Organization type

Of the 118 individuals who replied to the survey, 64 worked in public health offices or CLSCs, 26 with ASOs, and 22 with local, provincial/territorial or federal governments. Two were from local or regional associations, one was from a national association, and three described themselves as "other".

Size of community or service area

Six respondents were working in communities or service areas with populations of more than one million. Nine reported populations of 500,000 to one million, 38 were in communities of 100,000 to 500,000, and 43 were in areas with fewer than 100,000 residents.

Annual spending on HIV/AIDS prevention

Seven respondents reported HIV/AIDS prevention budgets above $500,000, four reported totals between $250,000 and $500,000, 19 were spending between $100,000 and $250,000, another 19 were in the $50,000-$100,000 range, and 10 chose not to answer the question. Exactly half of the participant group – 59 respondents – were spending less than $50,000. This result, and several others that follow, will be broken out by organization type and community size in the more detailed project report.

Looking back to March, 1995, four respondents recalled HIV prevention budgets above $500,000, five had spent between $250,000 and $500,000, 10 reported totals between $100,000 and $250,000, 17 were in the $50,000-$100,000 range, 15 declined to answer, and 67 were below $50,000. Respondents were not asked to disclose specific budget figures, but a comparison between 1995 and 2000 for the 102 who answered both questions shows that 22 organizations moved *up* at least one expenditure category, six moved down, and 74 – almost all of them in the lowest spending range – remained unchanged.

Staffing levels

Of the 103 respondents who provided information on the number of paid staff in their organization whose time was devoted to HIV prevention, 11 reported staffing levels of zero or less than one, 67 were in programs with one to five staff, 17 had six to 15 staff, three had 16 to 25 staff, and five had more than 25. In March, 1995, with 100 respondents reporting historical data, 11 organizations had zero staff or fewer than one, 71 had one to five, 13 had six to 15, one had 16 to 25, and four had more than 25. Overall, average staffing levels for HIV prevention activities in responding organizations *increased* between March, 1995 and March, 2000, from 7.75 to 9.5.

Volunteer support

Of the 31 organizations that reported any volunteer involvement in HIV prevention programming, 13 had one to six volunteers involved, eight had seven to 15, four had 16 to 25, and 6 had more than 25. In 1995, out of 29 with volunteers involved, 11 had one to six, 12 had seven to 15, three had 16 to 25, and three had more than 25. Average volunteer participation increased from 10.8 to 18.1 in organizations with any volunteer program at all.

General Findings

Target audiences

Based on a 1-5 scale, respondents were asked to rate the importance of different target audiences for HIV/AIDS prevention messages – based on their current program activity, and according to the programming needs in their communities or service areas. The distinction between the two questions was intended to capture unmet service needs that organizations would want to address, given sufficient resources. While the phrasing of the second question – "based on the level of need in your jurisdiction" – was purposely kept neutral, *each target audience received a higher average priority rating based on the need for prevention activity than it did when the question related solely to current programming.*

Target Audiences for HIV Prevention Programming

	Current Priorities		Emerging Priorities	
1	Education: secondary	3.22	Injection drug users	4.21
2	Youth: in school	3.12	Youth: in school	4.06
3	Injection drug users	3.05	Education: secondary	3.97
4	General public	3.04	Youth: street-involved	3.91
5	Men who have sex with men	2.77	Men who have sex with men	3.81
6	Women: pregnant	2.56	Women: not pregnant	3.7
7	Youth: street-involved	2.55	General public	3.64
8	Rural populations	2.54	Women: pregnant	3.55
9	Women: not pregnant	2.49	Education: college/univ.	3.51
10	Homeless populations	2.42	Homeless populations	3.47
11	Education: college/univ.	2.32	Prison pop'ns: men	3.43
12	Prison pop'ns: men	2.27	Rural populations	3.38
13	Aboriginal pop'ns: urban	2.12	Education: adult	3.3
14	Prison pop'ns: women	2.09	Commercial sex workers	3.24
15	Education: adult	2.07	Prison pop'ns: women	3.04
16	Commercial sex workers	2.06	Aboriginal pop'ns: urban	3.01
17	Work force groups	1.88	Work force groups	2.9
18	Ethnocultural communities	1.78	Aboriginal pop'ns: on-reserve	2.65
19	Aboriginal pop'ns: on-reserve	1.77	Ethnocultural communities	2.65

- Secondary school audiences emerged as the highest-priority focus for current prevention activities, followed by youth in school (essentially a rephrasing of the same target), injection drug users, the general public, men who have sex with men, pregnant women, street-involved youth, and rural populations. Rankings for all target audiences ranged from 1.77 to 3.22 on a scale of one to five; the top eight choices fell within a range of 2.54 to 3.22.

- Based on the level of need in respondents' jurisdictions, injection drug users were identified as the most important target audience, followed by youth in school, secondary school audiences, street-involved youth, men who have sex with men, women who are not pregnant, the general public, and pregnant women. Rankings for all target audiences ranged from 2.60 to 4.36 on a scale of one to five; the top eight choices fell within a range of 3.55 to 4.36.

- Work force groups, ethnocultural communities, and on-reserve Aboriginal populations consistently placed last, based both on current program activities and perceived levels of community need.

The question on target audiences generated the following write-in responses:

- Detox centre clients/adults in addiction treatment
- Women who are abused
- Residents with special needs e.g. deaf community
- Family, friends & lovers of HIV-positive men
- Parents
- Care providers
- Metis settlements
- Gay and bisexual youth
- Lesbian women
- Young prostitutes
- Health professionals (mentioned three times)
- Police
- Community HIV/AIDS workers
- People living with HIV/AIDS
- Mental health population
- Targeted, relevant professional training
- Aboriginal people in small communities
- Community researchers and program coordinators
- One-on-one STD screening
- Cross-cultural awareness in relation to the Aboriginal population
- African families
- Migrant workers
- Heterosexuals
- Grade 7 & 8 students in school/senior elementary
- Public education: elementary schools (mentioned twice)

- Travellers
- Tattoo parlours/other invasive services
- Youth in correctional facilities
- Community professionals who work with youth (clergy, social workers, recreational workers).

Prevention Strategies

Respondents were asked to identify the types of prevention services they currently offered, as well as the services they would like to offer.

Based on the totals in *both* categories, targeted prevention education, sexuality education, condom distribution, general prevention education, professional education and training, public education, high school outreach/curriculum development, and public booths/ displays received highest priority. Rankings ranged from 88 to 115 out of a total sample of 118, indicating that a large proportion of respondents attached a high degree of importance to these services.

Among these eight priority areas, professional education and training, high school outreach/curriculum development, and public education had the highest proportion of respondents who would have liked to offer related services, but were not doing so at the time of the survey. The responses did suggest, however, that key priorities are being met by current programming: The proportion of respondents who wanted to but were *not* offering one of the eight top-priority services ranged from 13.1% to 33.3%.

In raw numbers, the services that respondents were most interested in adding to their prevention repertoires were assertiveness training/self-esteem, anti-discrimination education, street outreach, professional education and training, media outreach, and targeted prevention education. Based on the percentage of respondents who expressed interest in a particular service but could not offer it, the top choices were assertiveness training/self-esteem, methadone therapy, workplace outreach, street outreach, anti- discrimination education, and college/university outreach. (It is worth noting, however, that only 50% of respondents or fewer expressed any interest at all in college/university outreach, methadone therapy, or workplace outreach.)

HIV Prevention Strategies

Current Offerings and Gaps

	Offer	Would Offer	Total	% gap
Anti-discrimination education	45	37	82	0.45
Assertiveness/self-esteem	35	44	79	0.56
College/university outreach	27	22	49	0.45
Condom distribution	86	13	99	0.13
High school outreach/curriculum development	64	25	89	0.28
HIV testing: anonymous	54	20	74	0.27
HIV testing: nominal/non-nominal	53	16	69	0.23
Media outreach	47	28	75	0.37
Methadone therapy	20	25	45	0.56
Needle exchange/bleach distribution	51	25	76	0.33
Non-nominal case reporting	43	7	50	0.14
Partner notification	55	17	72	0.24
Prevention: general	79	20	99	0.20
Prevention: targeted	87	28	115	0.24
Professional education/training	62	31	93	0.33
Public booths/displays	69	18	87	0.21
Public education	65	25	90	0.28
Sexuality education	79	22	101	0.22
Street outreach	38	37	75	0.49
Workplace outreach	27	27	54	0.50

The following table lists the most important gaps in current HIV prevention services, based on the proportion of organizations that would offer a particular service if they could. The table shows the percentage of respondents who wanted to offer the service but could not, as well as the total number who expressed interest in each service.

HIV Prevention Strategies

Current Service Gaps: Top Priorities

	Service	%	n
1	Assertiveness/self-esteem	0.56	79
2	Methadone therapy	0.56	45
3	Workplace outreach	0.50	54
4	Street outreach	0.49	75
5	Anti-discrimination education	0.45	82
6	College/university outreach	0.45	49
7	Media outreach	0.37	75
8	Professional education/training	0.33	93

The question on prevention strategies generated the following write-in responses:

- Policy advocacy
- Conference planning
- Mobile HIV clinic
- Interactive electronic education and student support
- Community research
- Integrating harm reduction into more programs
- Fem ale condom distribution
- Youth outreach/mentoring
- Parent education
- Consumer education
- Caller-anonymous website
- Sexual ethics education
- Sexual comfort training for a variety of community professionals
- Sexual health workshops.

Related Issues

Asked to rate a series of nine "related or underlying issues" according to the emphasis they receive from their organizations, participants assigned highest priority to sexuality education and STDs, with a score of 4.11 out of five, followed by prevention of emerging communicable diseases (e.g. Hepatitis C), with a score of 3.76. Full results for this question are shown in the following table.

Importance of Issues Related to HIV Prevention

	Issue	Ran k
1	Sexuality education and STDs	4.11
2	Prevention of emerging communicable diseases (e.g. Hepatitis C)	3.76
3	Linkages to other health/social issues	3.44
4	Culturally-appropriate messages	3.3
5	Substance abuse	3.27
6	HIV/AIDS-related discrimination	3.24
7	HIV/AIDS policy	3.21
8	HIV/AIDS care & support	3.14
9	Family violence	2.85

In write-in responses, participants added the following related and underlying issues to the list:

- Racial discrimination
- Homosexuality
- Needle exchange
- Mental health issues
- Sexual violence
- Community discomfort with any sexual issue.

Programming Priorities

In the first of several questions that invited write-in responses, respondents were asked to list the three top priorities for HIV/AIDS prevention programming in their own jurisdictions. Identification of trends in response to an open-ended question is necessarily a somewhat arbitrary task, but careful analysis showed that:

- Education, information and awareness was the most common prevention programming priority, mentioned by more than half of respondents. This broad category included several types of initiatives, most frequently including efforts to educate youth about healthy sexuality and lifestyle, both in schools and elsewhere. Other strategies involved information outreach to the general public, people in the workplace, and communities that were seen to be at high risk for HIV transmission. A number of participants also highlighted the need for culturally-appropriate information.

- Testing emerged as the second-most common prevention strategy. About half of the respondents who mentioned this item specified anonymous testing, and many of them linked it very specifically with counselling.

- Harm reduction strategies, specifically needle exchange programs and condom distribution, were mentioned by about 25% of respondents.

Many respondents replied to this question by identifying specific target audiences for HIV/AIDS prevention programming.

- Youth were clearly a top-priority target population for a large proportion of respondents. Youth in school were identified as the main target for education and information programming, but a number of survey participants made specific reference to street- involved youth, young women, young offenders, and gay youth.

- Injection drug users were the second-most common target audience. Once again, respondents expressed specific support for harm reduction programs, including needle exchange and condom distribution.

- A number of respondents identified women, sometimes specifying pregnant women, as a priority audience.

- Smaller numbers of survey participants identified the gay and lesbian community, the street-involved population, correctional populations, Aboriginal people, and ethnocultural communities as specific targets for prevention programming.

Coordination of services, elimination of HIV/AIDS discrimination, and funding issues were also mentioned in response to this question.

Current Gaps in Prevention Programming

Respondents were asked to list three gaps in current HIV/AIDS prevention programming in their jurisdictions. Common themes included limited financial and human resources, as well as strong emphasis on harm reduction programs, educational programs targeted to specific communities, continuing efforts to combat discrimination and break down taboos, and coordination with other communicable disease and STD programs.

- Money, or lack of it, was the most frequent problem. Funding shortfalls were mentioned in about half of the responses, either as a standalone concern or in relation to limited time or staffing.

- About 25% of survey participants expressed concern about a lack of coordination among organizations involved in HIV/AIDS prevention. Some respondents explained that the difficulty had to do with differences of attitude and focus, while others attributed it to a lack of overall policy orientation toward working together.

- About 20% of respondents cited negative attitudes or a lack of awareness of HIV/AIDS and related issues. This problem usually emerged in relation to general population attitudes, but a few responses described attitudinal problems involving the professionals whose support is required to run successful programs.

- A few respondents described policy gaps at the provincial level, or in the education system, that hindered prevention activities in their jurisdictions.

- A small number of respondents expressed concern about a lack of HIV/AIDS prevention training among service providers and educators.

This question also generated a number of responses dealing with specific gaps in HIV/AIDS prevention programming.

- The most dramatic programming gap exists in the education system – primarily at the elementary and secondary levels. A number of participants reported that teachers are uncomfortable with topics related to HIV/AIDS prevention, and that the curriculum needs work.

- The second-most frequent programming gap had to do with harm reduction efforts for injection drug users. The majority of respondents who mentioned IDUs stated said that needle exchange programs are either inadequate or non-existent.

- Prevention programming for women emerged as an area where a more comprehensive effort is required.

- A number of respondents expressed concern about a lack of culturally appropriate prevention materials designed for Aboriginal communities and ethnocultural populations.

- Several participants expressed concern about the inadequacy of current prevention programming for sex trade workers.

- Some respondents noted that HIV/AIDS prevention services are often unavailable in rural areas. Information must be tailored more carefully for rural residents, and a greater effort is needed to overcome the barriers posed by distance.

- In several jurisdictions, an overall lack of medical services has limited public access to HIV testing, methadone programs, sexual health clinics, and programs addressing co- infection with tuberculosis, STDs and other diseases.

- Hard-to-reach groups include youth who are not already in contact with other programs, street-involved populations (particularly youth), and the gay population.

- A few respondents stressed the need for HIV/AIDS education and risk reduction programs in correctional settings.

Policy Development Priorities

Respondents were asked to identify the top three policy development priorities for HIV/AIDS prevention programming at the local, provincial/territorial or national level. Their replies addressed overall policy directions, target populations, and a number of specific needs.

In general, respondents said policy development should focus on attainable goals, increased funding, adaptable content, evaluation and accountability, action, “less politics”, and development of planning processes that include people who are affected by HIV/AIDS, as well as front-line workers.

Survey participants also identified a number of specific areas where policy development is required:

- In education, policy support from local, provincial/territorial and federal governments is required to encourage curriculum development and delivery in elementary and secondary schools. Some respondents also called for policy support for educational efforts targeting post-secondary students, politicians, law enforcement personnel, educators, and health care professionals.

- Policy development can also play an important role in relation to linkages and integration of services. Noting that HIV/AIDS "not a separate issue from the rest of health", respondents suggested linkages with social services, education and justice. Several also supported the development of inter-regional strategies.

- Confidentiality, disclosure and the duty to warn emerged as one specific area where policy guidance is needed. Some respondents recommended that HIV/AIDS be defined as a reportable disease, and asked for clarification of the legal issues surrounding partner notification and the establishment of a comprehensive provincial database.

- A number of respondents suggested continuing and strengthening existing policies related to prevention and harm reduction.

A number of respondents called for policy development in support of specific target populations for HIV/AIDS prevention programs.

- For injection drug users, emerging policy issues include decriminalization of injection drug use, policy support for methadone and needle exchange programs, support for a national network of drug user groups, and the issue of therapeutic abandonment of this population due to lack of resources.

- Respondents raised a number of policy issues related to women and HIV/AIDS. Pregnancy and vertical transmission emerged as the most frequent concern, followed by family violence and the sex trade.

- Policy measures related to youth and HIV/AIDS could include safe havens for street youth and tougher consequences for anyone found guilty of engaging youth in the sex trade.

- A few respondents expressed concern about the lack of harm reduction programs in correctional institutions.

- Policy support is required for refugees who do not have access to provincial health plans.

Resource Materials

Given a list of eight types of resource materials that might be most useful in maintaining or strengthening their HIV/AIDS prevention programs, respondents attached highest priority to materials for low-literacy populations, followed by targeted fact sheets on specific prevention issues. General brochures, posters, and multilingual materials received relatively little emphasis.

Useful Resource Materials

	Resource	n
1	Materials for low-literacy populations	84
2	Fact sheets on specific issues	75
3	Videos	69
4	Peer training/counselling materials	67
5	Training manuals	58
6	General brochures	47
7	Posters	45
8	Multilingual materials	38

A number of survey participants responded to this question with their own suggestions for resource materials. In particular, a half-dozen respondents expressed interest in Internet resources. The complete list follows:

- Aggressive publicity and media campaign
- Resources to support school curriculum
- Print resources which address blood borne infections together, e.g. Hepatitis B & C and HIV
- Media spots with targeted messages
- Website/CDs of HIV/AIDS educational material; web addresses (mentioned at least five times)
- Funding more staff!!!
- Financial resources
- Skills development/skill-building resources
- No suitable resources for collaboration/coordination
- Rigourous evaluation of effective methods of affecting youth behaviours
- Money to do our own thing
- Videos targeted to rural/Aboriginal youth addressing healthy relationships
- Videos for the general public on risk behaviours
- Material on evaluation done by other health units
- “How to” re: peer counselling programs
- Age-appropriate resources for grades 1-10, presented from the perspective of public safety rather than human sexuality
- Culture-specific materials
- Gender-specific materials
- Policy documents to support advocacy/action for provincial policies
- Displays
- Budget for full-time staff
- Money
- Inuit specific materials
- Training/resources for workers working with low-literacy populations
- Training manuals for all health and social service providers dealing with counselling PLHAs

- *We Need to Know About AIDS* by Health Canada was an excellent resource for parents, and should be reproduced
- Pamphlets move better than fact sheets
- Materials for law enforcement, religious and political target groups
- Food, shelter, nutritional supplements
- Peer training/counselling materials for high school groups
- comic book for teens, and another for low-literacy adults but with less complicated story lines: integrate safe sex rather than making HIV the "end all and be all" of the story
- condom ads in national magazines and on television.

Related Program Activities

Respondents were asked to identify the "other program activities" in which they were involved in areas related to HIV/AIDS. Based on a list of five options, HIV care, treatment and support emerged as the most frequent activity, followed closely b policy development. At the other end of the spectrum, only about one-quarter of respondents indicated any involvement in legal, ethical and human rights issues, or in corrections.

Related Program Activities

	Activity	n
1	Care, treatment and support	54
2	Policy	52
3	Epidemiology	41
4	Corrections	30
5	Legal, ethical and human rights	29

The question generated the following write-in responses:

- Preventive health/public health
- Health promotion/information campaign
- Health promotion
- Prevention!!
- Intersectoral collaboration with other departments
- Crisis intervention/referral
- Community development
- Advocacy (mentioned three times)
- Social reintegration
- Research (mentioned twice)
- Professional development as an individual
- National/regional mentoring program for physicians and nurses in HIV/AIDS care
- AIDS in the workplace
- Community-based research
- Funding

- Women's health project
- Regional network/services
- National network
- Aboriginal population
- Local projects (mentioned at least twice)
- Testing
- Follow-up with cases and contacts
- Contact tracing
- Case management
- Facilitation and advocacy as opportunity arises
- Community coordinating committee
- Community desensitization
- Professional education
- Accountability framework
- International development
- Needle exchange.

Barriers to HIV/AIDS Prevention Programming

Human resources and funding emerged as by far the most common barriers to effective HIV/AIDS prevention programming in the organizations that responded to the fax survey: 87 out of 118 (73.7%) identified human resources/sufficient staffing as a problem, while 86 (72.9%) listed funding. For the most part, respondents appeared to have few difficulties obtaining information, establishing links with similar organizations (e.g. between adjacent public health offices), or connecting with national organizations.

Barriers to Effective Programming

	Resource	n
1	Human resources/sufficient staffing	87
2	Funding	86
3	Training	42
4	Links to other organizations with similar interests (e.g. between a public health office and an AIDS service organization)	30
5	Information	23
6	Links to similar organizations (e.g. between adjacent public health offices)	22
7	Links to national organizations	13

Participants identified the following specific barriers through their write-in responses:

- Links between physicians, street workers, social workers
- Lack of research to support evidence-based prevention activities
- Links to First Nations providers
- Skills development for staff, volunteers and Board members

- Links with teaching institutions
- Lack of knowledge of ways of affecting behaviour over the long term
- Competing against other pressing issues (housing, employment, land claims)
- Regionalization of health and social services – no standard across the jurisdiction
- Links to international organizations/organizations in other countries
- Links across the new local jurisdiction
- Lack of sufficient drug treatment programs
- Safe houses for street youth
- General public misconceptions regarding services
- Lack of political will to support creative, progressive programming
- Poor provincial support and resources to assist local officials with surveillance, prevention, management or control
- Meaningful involvement of the AIDS community itself and their families in rural areas
- Regional Board support
- HIV/AIDS is still not seen as a problem in many areas, especially rural communities
- Public perception
- Attitudes: “Not a problem in our community”, and “HIV is appropriate fate for IDU scum”
- Attitude that “it won’t happen to me”
- Misinterpretation of information
- Negative political climate
- National/provincial leadership that’s out in the field rallying the troops, not circulating information
- Community discomfort with any sexual issue
- Lack of national media saturation on safe sex (any STD, not just HIV).

CPHA’s Role

Given a list of six possible policy and program development roles for the Canadian Public Health Association in relation to HIV/AIDS prevention, respondents placed the greatest emphasis on development and distribution of information resources, followed by coordination among organizations at different jurisdictional levels. Just over half of the group saw a role for the Association in policy development. Out of the list of roles in the survey questionnaire, only program coordination failed to garner substantial support.

Role of the Canadian Public Health Association

	Role	n
1	Development and distribution of information resources	78
2	Coordination among federal, provincial/territorial, local, and non-government organizations	70
3	Advocacy at the federal level	68
4	Program support	61
5	Policy development	60
6	Program coordination	24

In write-in responses, survey participants added a number of specific suggestions:

- Transfer of knowledge between research and program
- Evaluation and distribution of knowledge on effective interventions for changing behaviour
- Development of prevention tools
- Work with other agencies as *equal*, not as *coordinator*
- Watchdog/advocacy to ensure that money is spent on evidence-based approaches, not just traditional "awareness"
- Comprehensive school health programming, with input from local jurisdictions to ensure curriculum fit and usability
- Lobbying for adequate financial resources
- Inuit/cultural specific materials
- Coordination with municipal, police, church, economic policy, etc.
- Provincial/regional advocacy
- Address media reluctance to advertise safe sex
- Any chance you could apply yourself to the moral issues that tend to dilute community programming?
- Can you lobby to offer financial incentives (or disincentives re: lack of grants) to the TV and film industries if safe sex is promoted in shows and movies produced in Canada?

CPHA Membership

Out of 118 respondents, 46 (39%) were CPHA members.

Analysis

The following conclusions can be drawn from the aggregate responses to the fax survey.

Target Audiences

- Overall, there is considerable unmet need for HIV prevention programming, as indicated by the point ratings that respondents assigned to different priority audiences. As noted above, *every* target audience received a higher rating as an emerging priority than as a focal point for current prevention activities, indicating that respondents would like to be doing more to prevent HIV/AIDS transmission if they could. Indeed, the extent of this service gap can be measured by the fact that the *highest*-rated target audience based on current prevention programming scored lower than the *lowest* of eight audiences that were identified as emerging priorities. This result was essentially consistent across all major organization types in the survey, and across larger and smaller communities.

- Teenagers in school emerged as a key target audience for HIV/AIDS prevention messages. Two overlapping targets – "public education: secondary schools" and "youth: in school" scored first/second as current priorities, and third/second as emerging priorities.

- A growing emphasis on harm reduction was particularly evident in the identification of injection drug users and street-involved youth as key priority audiences. IDUs moved up from third to first rank as an emerging priority, while street-involved youth rose from seventh to fourth.

- Men who have sex with men remained steady as a target audience, placing fifth as a current priority and fifth as an emerging priority. However, the increase in point rating from 2.77 to 3.81 on a scale of one to five indicated that many respondents see the need for renewed prevention efforts involving this group. Based on comments gathered in the course of the telephone surveys, it may be that respondents involved a shift in emphasis toward a younger generation of gay men, who would not remember the early days of the epidemic or the full-scale prevention campaigns that took place at that time.

- The general public fell from fourth rank as a current priority to seventh rank as an emerging priority, although the overall point rating for this target increased from 3.04 to 3.64. In the course of the telephone surveys, and in at least one discussion group, participants suggested that anti-discrimination and broader prevention messages aimed at the general public provide essential context and support for targeted campaigns involving focussed audiences.

- Pregnant women slipped from sixth rank as a current priority to eighth rank as an emerging priority, but the overall point rating increased from 2.56 to 3.55. Women who are not pregnant scored slightly higher than pregnant women as an emerging priority audience – a marginal but noteworthy difference, given some comments in the course of the project that women are only considered important in HIV/AIDS prevention work when they are carrying a child whose needs are then seen to come first.

- While the priority rankings provide useful guidance, it would be dangerously superficial to simply exclude all audiences below a given threshold from future consideration. Ethnocultural communities, Aboriginal populations on- and off-reserve, and work force groups consistently scored low as target audiences, while prison populations, commercial sex workers, and homeless populations scored around the low middle. But each of these is an important piece of the HIV/AIDS prevention puzzle and, just as important, each is a focal point for a number of organizations that might serve as program partners for future HIV/AIDS prevention initiatives. This will become clear in the analysis of priority audiences according to organization type and community size.

Prevention Strategies

- As suggested above, the responses to this question indicated that respondents are already pursuing the most immediate or urgent HIV/AIDS prevention strategies. While 115 respondents – virtually everyone taking part in the survey – identified targeted prevention as a needed service, only 24% saw it as a gap in their current programming. Similarly, 101 listed sexuality education as an important element of an HIV/AIDS prevention program, but only 22% reported it as a gap.

Condom distribution and general prevention also emerged as popular choices, with 99 out of 118 respondents (83.9%) indicating either that they currently offered the service or would like to. But neither of these activities emerged as a major service gap – only 13% of interested respondents were unable to offer condom distribution, while 20% of interested respondents were unable to deliver general prevention programs.

- At the other end of the spectrum, 56% of the 79 respondents who expressed interest in offering assertiveness training/self-esteem programs were unable to do so, as were 56% of the 45 respondents who identified methadone as a useful strategy. The same response came back from 50% of the 54 respondents interested in workplace outreach, and 49% of the 75 respondents interested in street outreach.

- One way of identifying the next tier of HIV/AIDS prevention strategies is to combine the most important approaches, based on the total number of "hits" from respondents, with the percentage of interested respondents who identified each option as a service gap. On this basis, the following priorities emerge:
  - Assertiveness training/self-esteem (79 interested/56% gap);
  - Street outreach (75 interested/49% gap);
  - Anti-discrimination education (82 interested/45% gap);
  - Professional education and training (93 interested/33% gap).

Once again, it will be important to avoid the temptation to rule out *any* prevention strategy based on its overall score in response to this survey question. Different prevention approaches are best suited to specific target audiences, and respondents represented a wide range of organizations with different capacities and community needs. This could mean, for example, that an organization that already offers assertiveness training for street-involved youth has yet to establish a condom distribution program. While the responses to this question are indicative of future directions, they should not be taken as a general rule for all organizations or communities.

Related or Underlying Issues

Survey participants' responses on issues related to HIV/AIDS prevention suggested possible ground for program partnerships or overlaps. On a one-to-five scale, sexuality education and STDs (4.11), prevention of emerging communicable diseases (3.76), and linkages to other health and social issues (3.44) emerged as top priorities. But the other six issues on the list scored high enough – between 2.85 and 3.30 – that significant program opportunities could be lost if any topic is ruled out. The results suggest, for example, that there may be significant opportunities for HIV/AIDS prevention programs to:

- Combine efforts with outreach services that present a harm reduction message in relation to other communicable diseases like Hepatitis C;

- Join with immigrant service organizations to adapt standard messages for specific audience groups; or

- Help arrange resources to enable women's shelters to make the connection between family violence, negotiating skills, and HIV/AIDS transmission.

The question on related and underlying issues was presented in multiple-choice format, so none of these specific options originated with survey respondents. They are simply intended to illustrate the range of creative, front-line solutions that could emerge as part of a renewed program or policy development function related to HIV/AIDS prevention.

Findings by Organization Type

As indicated earlier in this report, the decisive majority of fax survey respondents identified themselves with one of three sectors – public health (64), AIDS service organizations (24), or governments (22). Separate analysis of these groups reveals differences in priorities and approach that could ultimately be very useful in the development of a comprehensive HIV/AIDS prevention strategy.

Size of community or service area

The largest proportion of respondents were located in communities or service areas with populations below 100,000. The breakdown appears in the following table.

Size of Community by Organization Type

	Public Health	ASOs	Gov'ts
1 million or more	1	2	2
500,000-1 million	1	7	1
100,000-500,000	25	11	2
<100,000	34	4	3
Not applicable	3	2	14

Annual spending on HIV/AIDS prevention

Not surprisingly, of the seven survey respondents who reported HIV/AIDS prevention budgets above $500,000, all but two were located in government. Of the four whose organizations were spending between $250,000 and $500,000, two worked with public health offices and the other two with ASOs. Details appear in the following table.

Annual Spending by Organization Type

	Public Health	ASOs	Gov'ts
>$500,000	1	1	5
$250,001-$500,000	2	2	0
$100,001-$250,000	11	7	1
$50,000-$100,000	11	4	2
<$50,000	36	11	0
Not applicable	3	1	14

Consistent with the general survey results, as shown in the table on the following page, respondents' budget information indicated moderate improvements in funding levels for all organization types.

Annual Spending by Organization Type

March 1995 and March 2000

	Full Survey		Public Health		ASOs		Gov'ts	
	2000	**1995**	**2000**	**1995**	**2000**	**1995**	**2000**	**1995**
>$500,000	7	4	1	0	1	0	5	4
$250,001-$500,000	4	5	2	3	2	0	0	2
$100,001-$250,000	19	10	11	5	7	5	1	0
$50,000-$100,000	19	17	11	7	4	9	2	1
<$50,000	59	67	36	44	11	11	0	8
Not applicable	10	15	3	5	1	1	14	7

Staffing levels

While individual responses on staffing levels showed little movement among categories between 1995 and 2000, the category averages showed that:

- Staffing levels increased between 1995 and 2000 in all organization types;
- The percentage increase was most dramatic in ASOs, but largely because ASOs started out with the lowest staffing levels;
- Relatively high staffing levels within a small number of federal and provincial government programs gave a skewed sense of the average staff time available for front- line HIV/AIDS prevention programs. While it is important to recognize the importance of central programs, this statistical shift helps reconcile what turns out to be a small rise in staffing levels with the very apparent demand for increased HIV/AIDS prevention resources.

Paid Staff by Organization Type

March 1995 and March 2000

	Full Survey		Public Health		ASOs		Gov'ts	
	2000	**1995**	**2000**	**1995**	**2000**	**1995**	**2000**	**1995**
<1	11	11	7	7	3	2	1	2
1-5	67	71	34	37	20	23	10	9
6-15	17	13	13	11	2	0	1	1
16-25	3	1	3	1	0	0	2	1
>25	5	4	2	2	0	0	2	1
Not applicable			5	6	1	1	8	9
Category average	9.5	7.75	6.6	5.9	3.34	1.96	31.6	24.7

Volunteer support

To a large extent in 1995, and even more significantly in 2000, volunteer effort related to HIV/AIDS prevention was located primarily in AIDS service organizations. While ASOs and public health organizations both showed increases in average volunteer strength between 1995 and 2000, ASOs also reported a larger number of volunteer programs and a small shift toward larger programs.

Volunteers by Organization Type

March 1995 and March 2000

	Full Survey		Public Health		ASOs		Gov'ts	
	2000	**1995**	**2000**	**1995**	**2000**	**1995**	**2000**	**1995**
1-6	13	11	3	5	8	6	1	0
7-15	8	12	2	3	6	9	0	0
16-25	4	3	0	1	3	2	0	0
>25	6	3	1	0	5	3	0	0
Total with volunteers	31	29	6	9	22	20	1	0
Category average	18.1	10.8	10.3	6.7	21.4	12.9	4	0

Target Audiences

The chart on the next two pages presents current and emerging target audiences for HIV/AIDS prevention programming, broken down by organization type.

As measured by *current* programming priorities, teenagers in school were the top priority for public health organizations, and across the entire sample.

ASOs and governments assigned very high priority to injection drug users and men who have sex with men; public health organizations placed IDUs fourth and MSM eighth.

Aboriginal populations in urban settings emerged as the top priority for prevention efforts organized by government, but placed 13th out of 19 options across the entire sample.

Public health and AIDS service organizations both ranked the general public as their third most important target audience.

For future prevention programming, injection drug users emerged as an overwhelming priority for ASOs and governments, and as a significant priority for public health practitioners, sufficient to move this group up from third to first in the overall priority rankings. Teenagers in school remained a high priority – particularly for public health, but for governments and ASOs as well.

Target Audiences for HIV Prevention Programming

Priorities by Organization Type

	Full Survey		Public Health		ASOs		Governments	
Current Priorities								
1	Education: secondary	3.22	Education: secondary	3.37	Injection drug users	3.6 1	Aboriginal pop'ns: urban	3.27
2	Youth: in school	3.12	Youth: in school	3.14	Men who have sex with men	3.5 5	Injection drug users	3.24
3	Injection drug users	3.05	General public	3.07	General public	3.5 2	Men who have sex with men	3.19
4	General public	3.04	Injection drug users	2.79	Education: secondary	3.4 3	Youth: in school	2.95
5	Men who have sex with men	2.77	Rural populations	2.72	Youth: street-involved	3.3 6	Prison pop'ns: men	2.81
6	Women: pregnant	2.56	Women: pregnant	2.56	Homeless populations	3.2 6	Aboriginal pop'ns: on-reserve	2.75
7	Youth: street-involved	2.55	Women: not pregnant	2.36	Youth: in school	3.2 6	Education: secondary	2.70
8	Rural populations	2.54	Men who have sex with men	2.35	Commercial sex workers	3.0 5	Youth: street-involved	2.53
9	Women: not pregnant	2.49	Youth: street-involved	2.29	Education: college/univ.	3.0 5	Prison pop'ns: women	2.50
10	Homeless populations	2.42	Education: college/univ.	2.21	Women: not pregnant	2.7 7	Women: pregnant	2.44
11	Education: college/univ.	2.32	Homeless populations	2.19	Prison pop'ns: women	2.6 4	Women: not pregnant	2.44
12	Prison pop'ns: men	2.27	Education: adult	2.11	Prison pop'ns: men	2.62	General public	2.24
13	Aboriginal pop'ns: urban	2.12	Prison pop'ns: men	1.96	Women: pregnant	2.57	Homeless populations	2.20
14	Prison pop'ns: women	2.09	Commercial sex workers	1.83	Ethnocultural communities	2.5 5	Rural populations	2.06
15	Education: adult	2.07	Work force groups	1.75	Aboriginal pop'ns: urban	2.3 5	Ethnocultural communities	1.88
16	Commercial sex workers	2.06	Prison pop'ns: women	1.71	Work force groups	2.33	Education: college/univ.	1.80
17	Work force groups	1.88	Aboriginal pop'ns: urban	1.64	Education: adult	2.29	Education: adult	1.77
18	Ethnocultural communities	1.78	Ethnocultural communities	1.45	Rural populations	2.27	Work force groups	1.69
19	Aboriginal pop'ns: on-reserve	1.77	Aboriginal pop'ns: on reserve	1.38	Aboriginal pop'ns: on-reserve	1.86	Commercial sex workers	1.63

Target Audiences for HIV Prevention Programming

Priorities by Organization Type

	Full Survey		Public Health		ASOs		Governments	
Emerging Priorities								
1	Injection drug users	4.21	Education: secondary	4.28	Injection drug users	4.6 8	Injection drug users	4.0 0
2	Youth: in school	4.06	Youth: in school	4.15	Men who have sex with men	4.2 9	Youth: in school	3.7 2
3	Education: secondary	3.97	Injection drug users	4.09	Youth: street-involved	4.14	Aboriginal pop'ns: urban	3.65
4	Youth: street-involved	3.91	Youth: street-involved	4.02	Youth: in school	4.10	Aboriginal pop'ns: on- reserve	3.56
5	Men who have sex with men	3.81	Women: not pregnant	3.96	Commercial sex workers	3.91	Men who have sex with men	3.56
6	Women: not pregnant	3.70	Women: pregnant	3.82	Homeless populations	3.91	Youth: street-involved	3.56
7	General public	3.64	General public	3.76	Ethnocultural communities	3.81	Prison pop'ns: men	3.53
8	Women: pregnant	3.55	Education: college/univ.	3.73	General public	3.70	Prison pop'ns: women	3.29
9	Education: college/univ.	3.51	Men who have sex with men	3.71	Prison pop'ns: men	3.70	Homeless populations	3.27
10	Homeless populations	3.47	Rural populations	3.54	Education: secondary	3.70	Education: secondary	3.22
11	Prison pop'ns: men	3.43	Education: adult	3.46	Education: college/univ.	3.68	Women: not pregnant	3.13
12	Rural populations	3.38	Homeless populations	3.40	Education: adult	3.57	General public	3.12
13	Education: adult	3.30	Prison pop'ns: men	3.31	Women: not pregnant	3.57	Women: pregnant	3.06
14	Commercial sex workers	3.24	Commercial sex workers	3.17	Prison pop'ns: women	3.45	Rural populations	2.88
15	Prison pop'ns: women	3.04	Work force groups	2.92	Rural populations	3.37	Work force groups	2.67
16	Aboriginal pop'ns: urban	3.01	Prison pop'ns: women	2.78	Aboriginal pop'ns: urban	3.33	Commercial sex workers	2.62
17	Work force groups	2.90	Aboriginal pop'ns: urban	2.69	Women: pregnant	3.33	Education: college/univ.	2.50
18	Aboriginal pop'ns: on-reserve	2.65	Ethnocultural communities	2.13	Aboriginal pop'ns: on-reserve	3.16	Education: adult	2.47
19	Ethnocultural communities	2.65	Aboriginal pop'ns: on-reserve	2.02	Work force groups	3.11	Ethnocultural communities	2.46

- Based on the top eight rankings for the three organization types, all but two of the 19 target audiences identified in the survey questionnaire have at least one champion as a current or emerging priority. The following lists present the target audiences according to the number of top rankings they received from one or more of the organizational groupings.

Current Priorities

- Public education: secondary (public health, ASOs, governments);
- Injection drug users (ASOs, governments, public health);
- Aboriginal populations: urban (governments);
- Youth: in school (public health, governments, ASOs);
- Men who have sex with men (ASOs, governments, public health);
- General public (public health, ASOs);
- Rural populations (public health);
- Youth: street-involved (ASOs, governments);
- Prison populations: men (governments);
- Women: pregnant (public health);
- Homeless populations (ASOs);
- Aboriginal populations: on-reserve (governments);
- Women: not pregnant (public health);
- Commercial sex workers (ASOs).

Emerging Priorities

- Injection drug users (ASOs, governments, public health);
- Public education: secondary (public health);
- Youth: in school (public health, governments, ASOs);
- Men who have sex with men (ASOs, governments);
- Youth: street-involved (ASOs, public health, governments);
- Aboriginal populations: urban (governments);
- Aboriginal populations: on-reserve (governments);
- Women: not pregnant (public health);
- Commercial sex workers (ASOs);
- Women: pregnant (public health);
- Homeless populations (ASOs);
- General public (public health, ASOs);
- Ethnocultural communities (ASOs);
- Prison populations: men (governments);
- Public education: colleges/universities (public health);
- Prison populations: women (governments).

The following tables show current and emerging priority audiences for each of the three organization types.

Target Audiences for HIV Prevention Programming

Current and Emerging Priorities: Public Health

	Full Survey				Public Health			
	Current Priority		**Emerging Priority**		**Current Priority**		**Emerging Priority**	
1	Education: secondary	3.22	Injection drug users	4.21	Education: secondary	3.37	Education: secondary	4.28
2	Youth: in school	3.12	Youth: in school	4.06	Youth: in school	3.14	Youth: in school	4.15
3	Injection drug users	3.05	Education: secondary	3.97	General public	3.07	Injection drug users	4.09
4	General public	3.04	Youth: street-involved	3.91	Injection drug users	2.79	Youth: street-involved	4.02
5	Men who have sex with men	2.77	Men who have sex with men	3.81	Rural populations	2.72	Women: not pregnant	3.96
6	Women: pregnant	2.56	Women: not pregnant	3.7	Women: pregnant	2.56	Women: pregnant	3.82
7	Youth: street-involved	2.55	General public	3.64	Women:	2.36	General public	3.76
8	Rural populations	2.54	Women: pregnant	3.55	Men who have sex with men	2.35	Education: college/univ.	3.73
							Men who have sex with men	3.71

Target Audiences for HIV Prevention Programming

Current and Emerging Priorities: AIDS Service Organizations

	Full Survey				ASOs			
	Current Priority		**Emerging Priority**		**Current Priority**		**Emerging Priority**	
1	Education: secondary	3.2 2	Injection drug users	4.2 1	Injection drug users	3.6 1	Injection drug users	4.6 8
2	Youth: in school	3.1 2	Youth: in school	4.0 6	Men who have sex with men	3.5 5	Men who have sex with men	4.2 9
3	Injection drug users	3.0 5	Education: secondary	3.9 7	General public	3.5 2	Youth: street-involved	4.1 4
4	General public	3.0 4	Youth: street-involved	3.9 1	Education: secondary	3.4 3	Youth: in school	4.1
5	Men who have sex with men	2.7 7	Men who have sex with men	3.8 1	Youth: street-involved	3.3 6	Commercial sex workers	3.9 1
6	Women: pregnant	2.5 6	Women: not pregnant	3.7	Homeless populations	3.2 6	Homeless populations	3.9 1
7	Youth: street-involved	2.5 5	General public	3.6 4	Youth: in school	3.2 6	Ethnocultural communities	3.8 1
8	Rural populations	2.5 4	Women: pregnant	3.5 5	Commercial sex workers	3.0 5	General public	3.7
					Education: college/univ.		Prison pop'ns: men	

Target Audiences for HIV Prevention Programming

Current and Emerging Priorities: Governments

	Full Survey				Governments			
	Current Priority		**Emerging Priority**		**Current Priority**		**Emerging Priority**	
1	Education: secondary	3.22	Injection drug users	4.21	Aboriginal pop'ns: urban	3.27	Injection drug users	4
2	Youth: in school	3.12	Youth: in school	4.06	Injection drug users	3.24	Youth: in school	3.72
3	Injection drug users	3.05	Education: secondary	3.97	Men who have sex with men	3.19	Aboriginal pop'ns: urban	3.65
4	General public	3.04	Youth: street-involved	3.91	Youth: in school	2.95	Aboriginal pop'ns: on-reserve	3.56
5	Men who have sex with men	2.77	Men who have sex with men	3.81	Prison pop'ns: men	2.81	Men who have sex with men	3.56
6	Women: pregnant	2.56	Women: not pregnant	3.7	Aboriginal pop'ns: on-reserve	2.75	Youth: street-involved	3.56
7	Youth: street-involved	2.55	General public	3.64	Education: secondary	2.7	Prison pop'ns: men	3.53
8	Rural populations	2.54	Women: pregnant	3.55	Youth: Street-involved	2.53	Prison pop'ns: women	3.29

Prevention Strategies

The table on the following page presents data on HIV/AIDS prevention strategies that respondents have adopted or would like to adopt, broken down by organization type. Carrying on the analysis presented earlier in this report, the table includes information on the gaps that respondents identified in their current programming.

The table also holds good news for practitioners who might like to learn new prevention strategies from their colleagues or peers: For virtually every strategy, and in each of the sectors, at least a handful of respondents indicated pertinent experience. This indicates that practitioners themselves can serve as a vitally important resource in extending the range of HIV/AIDS prevention approaches in Canadian communities.

HIV Prevention Strategies

Current Offerings and Gaps by Organization Type

	Full Survey				Public Health				ASOs				Governments			
	Offer	Would offer	Total	% gap	Offer	Would offer	Total	% gap	Offer	Would offer	Total	% gap	Offer	Would offer	Total	% gap
Anti-discrimination education	45	37	82	0.45	19	18	37	0.49	14	8	22	0.36	12	11	23	0.48
Assertiveness/ self-esteem	35	44	79	0.56	17	21	38	0.55	7	12	19	0.63	10	11	21	0.52
College/university outreach	27	22	49	0.45	13	17	30	0.57	12	3	15	0.20	2	2	4	0.50
Condom distribution	86	13	99	0.13	55	8	63	0.13	19	3	22	0.14	11	2	13	0.15
High school outreach/ curriculum development	64	25	89	0.28	39	13	52	0.25	11	9	20	0.45	14	3	17	0.18
HIV testing: anonymous	54	20	74	0.27	41	11	52	0.21	4	7	11	0.64	7	1	8	0.13
HIV testing: nominal/ non-nominal	53	16	69	0.23	41	9	50	0.18	3	4	7	0.57	8	3	11	0.27
Media outreach	47	28	75	0.37	26	16	42	0.38	14	7	21	0.33	5	5	10	0.50
Methadone therapy	20	25	45	0.56	12	14	26	0.54	2	6	8	0.75	6	5	11	0.45
Needle exchange/ bleach distribution	51	25	76	0.33	31	16	47	0.34	12	6	18	0.33	8	3	11	0.27
Non-nominal case reporting	43	7	50	0.14	37	4	41	0.10	0	3	3	1.00	5	0	5	0.00
Partner notification	55	17	72	0.24	43	11	54	0.20	1	3	4	0.75	9	3	12	0.25
Prevention: general	79	20	99	0.20	44	14	58	0.24	19	3	22	0.14	13	3	16	0.19
Prevention: targeted	87	28	115	0.24	49	22	71	0.31	20	5	25	0.20	16	1	17	0.06
Professional education/ training	62	31	93	0.33	35	17	52	0.33	15	8	23	0.35	11	5	16	0.31
Public booths/displays	69	18	87	0.21	42	11	53	0.21	21	3	24	0.13	3	4	7	0.57
Public education	65	25	90	0.28	37	16	53	0.30	15	4	19	0.21	11	4	15	0.27
Sexuality education	79	22	101	0.22	48	11	59	0.19	16	4	20	0.20	14	6	20	0.30
Street outreach	38	37	75	0.49	22	23	45	0.51	10	11	21	0.52	5	3	8	0.38
Workplace outreach	27	27	54	0.50	14	17	31	0.55	9	7	16	0.44	3	2	5	0.40

Using the raw data, it was possible once again to identify key gaps in current HIV/AIDS prevention activities, based on the number of respondents who expressed interest in a particular strategy and the proportion who wanted to offer a service but could not. The following table indicates that:

- Of the top emerging programming priorities identified by public health practitioners, all were of interest to the majority or a near-majority within the category, and were identified as gaps by 33% to 57% of respondents.

- Among ASOs, street outreach and assertiveness training/self-esteem emerged as top priorities, followed by workplace outreach and anonymous HIV testing. Other high- priority prevention strategies were of interest to only a limited number of respondents.

- Among governments, the top two programming gaps were anti-discrimination education and assertiveness training/self-esteem, followed by methadone therapy, media outreach, and street outreach. Once again, other strategies received high percentage ratings as programming gaps, but were only of interest to a limited number of respondents.

- Priority gaps identified by respondents in all three organizational groupings included assertiveness training/ self-esteem, workplace outreach, and street outreach. College/university outreach, anti-discrimination education, media outreach, and methadone therapy emerged as important gaps for two out of the three groupings.

HIV Prevention Strategies

Programming Gaps by Organization Type

	Full Survey		Public Health		ASOs		Governments	
1	Assertiveness/ self-esteem	0.56 (79)	College/university outreach	0.57 (30)	Non-nominal case reporting	1.00 (3)	Public booths/ displays	0.57 (7)
2	Methadone therapy	0.56 (45)	Assertiveness/ self-esteem	0.55 (38)	Methadone therapy	0.75 (8)	Assertiveness/ self-esteem	0.52 (21)
3	Workplace outreach	0.50 (54)	Workplace outreach	0.55 (31)	Partner notification	0.75 (4)	Media outreach	0.50 (10)
4	Street outreach	0.49 (75)	Street outreach	0.51 (45)	HIV testing: anonymous	0.64 (11)	College/university outreach	0.50 (4)
5	Anti-discrimination education	0.45 (82)	Anti-discrimination education	0.49 (37)	Assertiveness/ self-esteem	0.63 (19)	Anti-discrimination education	0.48 (23)
6	College/university outreach	0.45 (49)	Media outreach	0.38 (42)	HIV testing: nominal/non-nominal	0.57 (7)	Methadone therapy	0.45 (11)
7	Media outreach	0.37 (75)	Needle exchange/ bleach distribution	0.34 (47)	Street outreach	0.52 (21)	Workplace outreach	0.40 (5)
8	Professional education/training	0.33 (93)	Professional education/training	0.33 (52)	Workplace outreach	0.44 (16)	Street outreach	0.38 (8)

Related Issues

Identification of related issues by organization type was largely consistent with the aggregate survey results. Sexuality education and STDs, prevention of emerging communicable diseases, and linkages to other health and social issues emerged as the top three priorities for public health organizations and governments, though not for ASOs. Development of culturally- appropriate messages placed fourth for ASOs and governments, though not for public health organizations. It may be noteworthy that, of the three respondent groups, public health practitioners assigned the lowest point rating to HIV/AIDS policy, and the lowest point ratings for related issues overall.

Related Issues by Organization Type

	Full Survey		Public Health		ASOs		Governments	
1	Sexuality education & STDs	4.11	Sexuality education & STDs	4.25	HIV/AIDS discrimination	4.33	Sexuality education & STDs	4.29
2	Prevention of emerging communicable diseases	3.76	Prevention of emerging communicable diseases	3.77	HIV/AIDS care & support	4.13	Prevention of emerging communicable diseases	3.8
3	Linkages to other health/social issues	3.44	Linkages to other health/social issues	3.21	Sexuality education & STDs	4	Linkages to other health/social issues	3.27
4	Culturally-appropriate messages	3.3	Substance abuse	3.09	Culturally-appropriate messages	3.91	Culturally-appropriate messages	3.06
5	Substance abuse	3.27	HIV/AIDS policy	3.03	Linkages to other health/social issues	3.91	HIV/AIDS policy	3.06
6	HIV/AIDS-related discrimination	3.24	Culturally-appropriate messages	2.87	Prevention of emerging communicable diseases	3.83	Substance abuse	3.06
7	HIV/AIDS policy	3.21	HIV/AIDS discrimination	2.77	Substance abuse	3.48	Family violence	2.97
8	HIV/AIDS care & support	3.14	Family violence	2.75	HIV/AIDS policy	3.38	HIV/AIDS care & support	2.89
9	Family violence	2.85	HIV/AIDS care & support	2.71	Family violence	2.71	HIV/AIDS-related discrimination	2.75

Resource Materials

Consistent with the aggregate results, respondents in all three organizational groupings expressed strong interest in receiving resource materials for populations with low literacy skills, as well as fact sheets on specific issues or concerns related to HIV/AIDS prevention. Governments expressed stronger support for videos as a prevention education tool, while public health and AIDS service organizations saw greater value in peer training and counselling materials. General brochures and posters received consistently low ratings across the three groupings.

Useful Resource Materials by Organization Type

	Full Survey		Public Health		ASOs		Governments	
1	Materials for low-literacy populations	84	Materials for low-literacy populations	48	Materials for low-literacy populations	18	Videos	16
2	Fact sheets on specific issues	75	Peer training/ counselling materials	43	Fact sheets on specific issues	18	Materials for low-literacy populations	15
3	Videos	69	Fact sheets on specific issues	40	Peer training/ counselling materials	15	Fact sheets on specific issues	14
4	Peer training/ counselling materials	67	Videos	37	Videos	14	Training manuals	10
5	Training manuals	58	Training manuals	33	Training manuals	12	Multilingual materials	9
6	General brochures	47	General brochures	29	Multilingual materials	12	Peer training/ counselling materials	8
7	Posters	45	Posters	27	Posters	10	General brochures	7
8	Multilingual materials	38	Multilingual materials	29	General brochures	8	Posters	7

Related Program Activities

Responses on related program activities reflected the different profile that each organization type brings to its work on HIV/AIDS: Public health practitioners identified epidemiology and policy as their most frequent related activities, ASOs listed care, treatment and support, and governments listed policy and epidemiology. Despite a relatively lukewarm response on an earlier survey question, policy emerged as the most frequent related function for government, and a close second for public health organizations.

Related Program Activities by Organization Type

	Full Survey		Public Health		ASOs		Governments	
1	Care, treatment & support	54	Epidemiology	28	Care, treatment & support	22	Policy	13
2	Policy	52	Policy	27	Corrections	11	Epidemiology	9
3	Epidemiology	41	Care, treatment & support	22	Legal, ethical & human rights	10	Corrections	9
4	Corrections	30	Corrections	11	Policy	7	Care, treatment & support	7
5	Legal, ethical & human rights	29	Legal, ethical & human rights	10	Epidemiology	3	Legal, ethical & human rights	7

Barriers to HIV/AIDS Prevention Programming

Given the sheer weight of aggregate support for human resources and funding as the key barriers to HIV/AIDS prevention programming, it came as no surprise that respondents representing the three organization types expressed virtually identical viewpoints in this area. The two top priorities were reversed in the responses from government officials, but only by a margin of 11 replies to 10. Other responses to this question were very similar across organizational categories.

Barriers to Effective Programming by Organization Type

	Full Survey		Public Health		ASOs		Governments	
1	Human resources/ sufficient staffing	87	Human resources/ sufficient staffing	54	Human resources/ sufficient staffing	21	Funding	11
2	Funding	86	Funding	52	Funding	20	Human resources/ sufficient staffing	10
3	Training	42	Training	20	Training	11	Training	10
4	Links to other organizations with similar interests	30	Links to other organizations with similar interests	17	Links to other organizations with similar interests	5	Links to other organizations with similar interests	6
5	Information	23	Information	13	Links to similar organizations	5	Links to similar organizations	6
6	Links to similar organizations	22	Links to similar organizations	10	Information	2	Information	5
7	Links to national organizations	13	Links to national organizations	8	Links to national organizations	1	Links to national organizations	2

CPHA's Role

Despite minor differences across organization types in the advice CPHA received related to its own role in HIV/AIDS prevention initiatives, development/distribution of information resources and coordination among organizations and jurisdictions emerged as consistent favourites. Of the three groupings, public health organizations placed the highest priority on federal advocacy and policy development. Direct program coordination received the lowest priority across the board.

CPHA Role by Organization Type

	Full Survey		Public Health		ASOs		Governments	
1	Develop/distribute info resources	78	Develop/distribute info resources	46	Develop/distribute info resources	16	Coordination among orgs/ jurisdictions	14
2	Coordination among orgs/ jurisdictions	70	Advocacy at the federal level	43	Coordination among orgs/ jurisdictions	14	Develop/distribute info resources	13
3	Advocacy at the federal level	68	Policy development	41	Advocacy at the federal level	13	Program support	12
4	Program support	61	Coordination among orgs/ jurisdictions	39	Program support	12	Policy development	8
5	Policy development	60	Program support	37	Policy development	8	Advocacy at the federal level	7
6	Program coordination	24	Program coordination	18	Program coordination	2	Program coordination	4

Findings by Community Size

Completed surveys were received from 53 respondents in communities or service areas with populations of 100,000 or more, and 43 respondents in areas with populations below 100,000. The differences in focus between these two groups might suggest tailored approaches to HIV/AIDS prevention that should be reflected and accommodated within a broader national strategy.

Annual spending on HIV/AIDS prevention

Although communities in both size categories had prevention programs operating on low budgets, there was a strong relationship between community size and annual spending on HIV/AIDS prevention. Unfortunately, the survey questionnaire was not sufficiently detailed to permit analysis of per capita spending in communities of different sizes or profiles.

Annual Spending by Community Size

	>100,000	<100,000
>$500,000	5	1
$250,001-$500,000	4	0
$100,001-$250,000	14	2
$50,000-$100,000	9	8
<$50,000	18	31
Not applicable	3	1

Consistent with the general survey results, respondents' budget information generally indicated moderate improvements in funding levels in communities of all sizes.

Annual Spending by Community Size

March 1995 and March 2000

	Full Survey		>100,000		<100,000	
	2000	1995	2000	1995	2000	1995
>$500,000	7	4	5	3	1	0
$250,001-$500,000	4	5	4	2	0	0
$100,001-$250,000	19	10	14	8	2	1
$50,000-$100,000	19	17	9	12	8	5
<$50,000	59	67	18	24	31	34
not applicable	10	15	3	4	1	3

Staffing levels

While individual responses on staffing levels showed little movement among categories between 1995 and 2000, the category averages showed moderate increases in communities of all sizes, and indicated that staffing levels are consistently lower in areas with populations below 100,000.

Paid Staff by Community Size

March 1995 and March 2000

	Full Survey		>100,000		<100,000	
	2000	**1995**	**2000**	**1995**	**2000**	**1995**
<1	11	11	4	5	5	5
1-5	67	71	33	33	26	29
6-15	17	13	10	9	5	2
16-25	3	1	0	0	2	1
>25	5	4	2	2	3	2
Not applicable			4	4	2	4
Category average	9.5	7.75	11.4	9.5	8.8	6.7

Volunteer support

Based once again on a relatively small part of the overall sample, voluntarism related to HIV/AIDS prevention appeared to be largely an urban experience. More urban HIV/AIDS organizations had more volunteers in 1995 than their rural counterparts, and by 2000 this gap had widened, with fewer rural organizations reporting a smaller average number of volunteers.

Volunteers by Community Size

March 1995 and March 2000

	Full Survey		>100,000		<100,000	
	2000	**1995**	**2000**	**1995**	**2000**	**1995**
1-6	13	11	6	4	4	7
7-15	8	12	6	9	2	3
16-25	4	3	4	2	0	1
>25	6	3	4	2	2	1
Total with volunteers	31	29	20	17	8	12
Category average	18.1	10.8	22.2	13.2	6.9	8.3

Target Audiences

The chart on the next two pages presents current and emerging target audiences for HIV/AIDS prevention programming, broken down by community size. Responses within the two categories largely reflect the differences in the face of the HIV epidemic between large urban areas and other parts of the country.

- Based on current service delivery, communities and service areas with populations above 100,000 identified injection drug users and men who have sex with men as their two top priority audiences, followed by youth in school, the general public, and secondary school audiences.

- In contrast, secondary school audiences were the top priority in communities under 100,000, followed by rural populations, the general public, and pregnant women. Injection drug users placed sixth with a point rating of 2.38 on a one-to-five scale, compared to 3.61 in larger communities and service areas.

- Prison populations consistently scored lower in smaller communities than in larger ones. Men in prison scored 2.73 on a one-to-five scale in communities over 100,000, compared to 1.67 in communities under 100,000. Women in prison scored 2.34 in larger communities and 1.71 in smaller ones.

- Communities in both size categories consistently placed Aboriginal populations in the lower third of their priority lists for current and future programming – and just as consistently listed ethnocultural communities last or second-last. While it is a given that some group will come last in any priority-setting exercise, this result may well have been a reflection of the mix of individuals who chose to respond to the survey – since HIV/ AIDS prevention is clearly a priority in Aboriginal communities, and in many ethnocultural groupings.

Target Audiences for HIV Prevention Programming

Priorities by Community Size

	Full Survey		>100,000		<100,000	
Current Priorities						
1	Education: secondary	3.22	Injection drug users	3.61	Education: secondary	3.49
2	Youth: in school	3.12	Men who have sex with men	3.17	Rural populations	3.11
3	Injection drug users	3.05	Youth: in school	3.13	General public	3.05
4	General public	3.04	General public	3.08	Youth: in school	3.00
5	Men who have sex with men	2.77	Education: secondary	3.04	Women: pregnant	2.68
6	Women: pregnant	2.56	Youth: street-involved	2.94	Injection drug users	2.38
7	Youth: street-involved	2.55	Homeless populations	2.88	Women: not pregnant	2.26
8	Rural populations	2.54	Prison pop'ns: men	2.73	Men who have sex with men	2.24
9	Women: not pregnant	2.49	Women: not pregnant	2.68	Education: adult	2.23
10	Homeless populations	2.42	Commercial sex workers	2.60	Education: college/univ.	2.14
11	Education: college/univ.	2.32	Women: pregnant	2.52	Work force groups	2.03
12	Prison pop'ns: men	2.27	Education: college/univ.	2.50	Aboriginal pop'ns: urban	1.94
13	Aboriginal pop'ns: urban	2.12	Prison pop'ns: women	2.34	Youth: street-involved	1.90
14	Prison pop'ns: women	2.09	Rural populations	2.28	Homeless populations	1.77
15	Education: adult	2.07	Education: adult	2.04	Prison pop'ns: women	1.71
16	Commercial sex workers	2.06	Aboriginal pop'ns: Urban	1.94	Prison pop'ns: men	1.67
17	Work force groups	1.88	Work force groups	1.88	Aboriginal pop'ns: on-reserve	1.67
18	Ethnocultural communities	1.78	Ethnocultural communities	1.85	Ethnocultural communities	1.55
19	Aboriginal pop'ns: on-reserve	1.77	Aboriginal pop'ns: on-reserve	1.67	Commercial sex workers	1.49

Target Audiences for HIV Prevention Programming

Priorities by Community Size

	Full Survey		>100,000		<100,000	
Emerging Priorities						
1	Injection drug users	4.21	Injection drug users	4.47	Education: secondary	4.44
2	Youth: in school	4.06	Youth: street-involved	4.19	Youth: in school	4.13
3	Education: secondary	3.97	Men who have sex with men	4.04	Women: not pregnant	4.00
4	Youth: street-involved	3.91	Prison pop'ns: men	3.98	Injection drug users	3.89
5	Men who have sex with men	3.81	Youth: in school	3.98	General public	3.85
6	Women: not pregnant	3.70	Education: secondary	3.82	Rural populations	3.79
7	General public	3.64	Homeless populations	3.79	Women: pregnant	3.69
8	Women: pregnant	3.55	Commercial sex workers	3.77	Men who have sex with men	3.67
9	Education: college/univ.	3.51	Education: college/univ.	3.62	Education: adult	3.58
10	Homeless populations	3.47	Women: not pregnant	3.58	Education: college/univ.	3.52
11	Prison pop'ns: men	3.43	Women: pregnant	3.53	Youth: street-involved	3.49
12	Rural populations	3.38	General public	3.49	Work force groups	3.31
13	Education: adult	3.30	Prison pop'ns: women	3.39	Aboriginal pop'ns: urban	3.12
14	Commercial sex workers	3.24	Education: adult	3.24	Homeless populations	2.93
15	Prison pop'ns: women	3.04	Rural populations	3.19	Prison pop'ns: men	2.73
16	Aboriginal pop'ns: urban	3.01	Aboriginal pop'ns: urban	2.76	Aboriginal pop'ns: on-reserve	2.52
17	Work force groups	2.90	Work force groups	2.73	Commercial sex workers	2.52
18	Aboriginal pop'ns: on-reserve	2.65	Ethnocultural communities	2.67	Prison pop'ns: women	2.32
19	Ethnocultural communities	2.65	Aboriginal pop'ns: on-reserve	2.44	Ethnocultural communities	2.27

- Based on the top eight priorities for larger and smaller communities, 12 of the 19 target audiences identified in the survey questionnaire have at least one champion as a current or emerging priority. Once again, target audiences according to the number of top rankings they received, with organization types listed according to the relative importance they assigned to each group (for example, under current priorities, public health organizations ranked 'public education: secondary' highest, followed by ASOs and governments).

Current Priorities

- Injection drug users (larger, smaller);
- Public education: secondary (smaller, larger);
- Men who have sex with men (larger, smaller);
- Youth: in school (larger, smaller);
- Rural populations (smaller);
- General public (larger, smaller);
- Youth: street-involved (larger);
- Homeless populations (larger);
- Prison populations: men (larger);
- Women: pregnant (smaller);
- Women: not pregnant (smaller).

Emerging Priorities

- Injection drug users (larger, smaller);
- Public education: secondary (smaller, larger);
- Youth: street-involved (larger);
- Youth: in school (smaller, larger);
- Men who have sex with men (larger, smaller);
- Women: not pregnant (smaller);
- Prison populations: men (larger);
- General public (smaller);
- Rural populations (smaller);
- Homeless populations (larger);
- Commercial sex workers (larger);
- Women: pregnant (smaller).

The following tables show current and emerging priority audiences for larger and smaller communities.

Target Audiences for HIV Prevention Programming

Current and Emerging Priorities: Communities >100,000

	Full Survey				Communities >100,000			
	Current Priority		**Emerging Priority**		**Current Priority**		**Emerging Priority**	
1	Education: secondary	3.22	Injection drug users	4.21	Injection drug users	3.61	Injection drug users	4.47
2	Youth: in school	3.12	Youth: in school	4.06	Men who have sex with men	3.17	Youth: street-involved	4.19
3	Injection drug users	3.05	Education: secondary	3.97	Youth: in school	3.13	Men who have sex with men	4.04
4	General public	3.04	Youth: street-involved	3.91	General public	3.08	Prison pop'ns: men	3.98
5	Men who have sex with men	2.77	Men who have sex with men	3.81	Education: secondary	3.04	Youth: in school	3.98
6	Women: pregnant	2.56	Women: not pregnant	3.7	Youth: street-involved	2.94	Education: secondary	3.82
7	Youth: street-involved	2.55	General public	3.64	Homeless populations	2.88	Homeless populations	3.79
8	Rural populations	2.54	Women: pregnant	3.55	Prison pop'ns: men	2.73	Commercial sex workers	3.77

Target Audiences for HIV Prevention Programming

Current and Emerging Priorities: Communities <100,000

	Full Survey				Communities >100,000			
	Current Priority		**Emerging Priority**		**Current Priority**		**Emerging Priority**	
1	Education: secondary	3.2	Injection drug users	4.2	Education: secondary	3.5	Education: secondary	4.4
2	Youth: in school	3.1	Youth: in school	4.1	Rural populations	3.1	Youth: in school	4.1
3	Injection drug users	3.1	Education: secondary	4	General public	3.1	Women: not pregnant	4
4	General public	3	Youth: street-involved	3.9	Youth: in school	3	Injection drug users	3.9
5	Men who have sex with men	2.8	Men who have sex with men	3.8	Women: pregnant	2.7	General public	3.9
6	Women: pregnant	2.6	Women: not pregnant	3.7	Injection drug users	2.4	Rural populations	3.8
7	Youth: street-involved	2.6	General public	3.6	Women: not pregnant	2.3	Women: pregnant	3.7
8	Rural populations	2.5	Women: pregnant	3.6	Men who have sex with men	2.2 4	Men who have sex with men	3.7

Prevention Strategies

The following table presents data on HIV/AIDS prevention strategies that respondents have adopted or would like to adopt, broken down by community size. The table includes information on the gaps that respondents identified in their current programming.

HIV Prevention Strategies

Current Offerings and Gaps by Community Size

	Full Survey				Public Health				ASOs				Governments			
	Offer	Would offer	Total	% gap	Offer	Would offer	Total	% gap	Offer	Would offer	Total	% gap	Offer	Would offer	Total	% gap
Assertiveness/self-esteem	35	44	79	0.56	12	22	34	0.65	15	13	28	0.46				
College/university outreach	27	22	49	0.45	20	9	29	0.31	5	10	15	0.67				
Condom distribution	86	13	99	0.13	42	5	47	0.11	35	5	40	0.13				
High school outreach/ curriculum development	64	25	89	0.28	30	13	43	0.30	23	10	33	0.30				
HIV testing: anonymous	54	20	74	0.27	26	8	34	0.24	23	10	33	0.30				
HIV testing: nominal/ non-nominal	53	16	69	0.23	27	5	32	0.16	20	8	28	0.29				
Media outreach	47	28	75	0.37	29	11	40	0.28	14	13	27	0.48				
Methadone therapy	20	25	45	0.56	10	14	24	0.58	5	6	11	0.55				
Needle exchange /bleach distribution	51	25	76	0.33	27	10	37	0.27	19	12	31	0.39				
Non-nominal case reporting	43	7	50	0.14	25	2	27	0.07	13	3	16	0.19				
Partner notification	55	17	72	0.24	27	5	32	0.16	21	8	29	0.28				
Prevention: general	79	20	99	0.20	41	8	49	0.16	29	8	37	0.22				
Prevention: targeted	87	28	115	0.24	52	10	62	0.16	23	15	38	0.39				
Professional education/ training	62	31	93	0.33	37	13	50	0.26	17	13	30	0.43				
Public booths/displays	69	18	87	0.21	39	6	45	0.13	23	9	32	0.28				
Public education	65	25	90	0.28	39	8	47	0.17	18	13	31	0.42				
Sexuality education	79	22	101	0.22	38	9	47	0.19	30	8	38	0.21				
Street outreach	38	37	75	0.49	27	14	41	0.34	6	20	26	0.77				
Workplace outreach	27	27	54	0.50	17	15	32	0.47	9	10	19	0.53				

Using the raw data, it was possible once again to identify key gaps in current HIV/AIDS prevention activities, based on the number of respondents who expressed interest in a particular strategy and the proportion who wanted to offer a service but could not. The following table indicates that:

- Respondents from communities and service areas with populations above 100,000 were largely in agreement with the prevention gaps identified by the broader survey group – their top three gaps were exactly the same, and seven of the eight priority items corresponded to the original list. Based on the number of respondents who expressed interest in a particular strategy and the percentage who saw it as a gap, top priorities for larger communities included assertiveness training/self-esteem, street outreach, anti- discrimination education, high school outreach/curriculum development, and methadone therapy.

- Street outreach emerged as the most significant programming gap in smaller communities. Based on the data, the remaining seven priority items appeared to be more or less equal in importance, given that some (college/university outreach, methadone therapy, workplace outreach, anti-discrimination education) were likely to be unavailable in settings where they were needed, while others (anti-discrimination education, media outreach, assertiveness training/self-esteem, professional education and training) generated more widespread interest on the part of responding organizations.

HIV Prevention Strategies

Programming Gaps by Community Size

	Full Survey		**>100,000**		**<100,000**	
1	Assertiveness/self- esteem	0.56 (79)	Assertiveness/self- esteem	0.65 (34)	Street outreach	0.77 (26)
2	Methadone therapy	0.56 (45)	Methadone therapy	0.58 (24)	College/university outreach	0.67 (15)
3	Workplace outreach	0.50 (54)	Workplace outreach	0.47 (32)	Methadone therapy	0.55 (11)
4	Street outreach	0.49 (75)	Anti-discrimination education	0.41 (39)	Workplace outreach	0.53 (19)
5	Anti-discrimination education	0.45 (82)	Street outreach	0.39 (41)	Anti-discrimination education	0.52 (27)
6	College/university outreach	0.45 (49)	College/university outreach	0.31 (29)	Media outreach	0.48 (27)
7	Media outreach	0.37 (75)	High school outreach/ curriculum development	0.30 (43)	Assertiveness/ self-esteem	0.46 (28)
8	Professional education/ training	0.33 (93)	Media outreach	0.28 (40)	Professional education/ training	0.43 (30)

Related Issues

Identification of related issues by community size was largely consistent with the aggregate survey results. Sexuality education and STDs and prevention of emerging communicable diseases emerged as the top two priorities in both size groupings. Respondents in larger communities placed higher priority on HIV/AIDS discrimination, while their counterparts in smaller communities were marginally more concerned about family violence.

A cluster of high point ratings (between 3.19 and 3.52 on a one-to-five scale) meant that the eighth-ranked item for larger communities received a higher score than the fourth-ranked item for smaller jurisdictions, indicating that respondents in larger communities may be more concerned about underlying and related issues.

Related Issues by Community Size

	Full Survey		>100,000		<100,000	
1	Sexuality education & STDs	4.11	Sexuality education & STDs	4.02	Sexuality education & STDs	4.29
2	Prevention of emerging communicable diseases	3.76	Prevention of emerging communicable diseases	3.8	Prevention of emerging communicable diseases	3.8
3	Linkages to other health/social issues	3.44	HIV/AIDS discrimination	3.52	Linkages to other health/social issues	3.27
4	Culturally-appropriate messages	3.3	Linkages to other health/social issues	3.5	Culturally-appropriate messages	3.06
5	Substance abuse	3.27	Substance abuse	3.38	Substance abuse	3.06
6	HIV/AIDS-related discrimination	3.24	Culturally-appropriate messages	3.36	HIV/AIDS policy	3.06
7	HIV/AIDS policy	3.21	HIV/AIDS care & support	3.3	Family violence	2.97
8	HIV/AIDS care & support	3.14	HIV/AIDS policy	3.19	HIV/AIDS care & support	2.89
9	Family violence	2.85	Family violence	2.69	HIV/AIDS discrimination	2.75

Resource Materials

There were no significant differences in the need for specific types of resource materials in larger and smaller communities. The top four choices corresponded precisely to the aggregate data, except that smaller communities placed somewhat more emphasis on peer training and counselling materials and somewhat less on fact sheets dealing with specific issues. Multilingual materials took on somewhat more importance in larger communities, while posters and general brochures received somewhat less emphasis.

Useful Resource Materials by Community Size

	Full Survey		>100,000		<100,000	
1	Materials for low-literacy populations	84	Materials for low-literacy populations	39	Materials for low- literacy populations	32
2	Fact sheets on specific issues	75	Fact sheets on specific issues	35	Peer training/counselling materials	32
3	Videos	69	Videos	29	Videos	27
4	Peer training/counselling materials	67	Peer training/counselling materials	27	Fact sheets on specific issues	27
5	Training manuals	58	Training manuals	21	Training manuals	25
6	General brochures	47	Multilingual materials	18	General brochures	23
7	Posters	45	General brochures	17	Posters	21
8	Multilingual materials	38	Posters	17	Multilingual materials	13

Related Program Activities

Here, again, responses by community size were virtually indistinguishable from the aggregate results, with the exception that smaller communities placed slightly more emphasis on legal, ethical and human rights issues and slightly less on corrections.

Related Program Activities by Community Size

	Full Survey		>100,000		<100,000	
1	Care, treatment & support	54	Care, treatment & support	28	Care, treatment & support	18
2	Policy	52	Policy	23	Policy	16
3	Epidemiology	41	Epidemiology	20	Epidemiology	13
4	Corrections	30	Corrections	20	Legal, ethical & human rights	6
5	Legal, ethical & human rights	29	Legal, ethical & human rights	17	Corrections	4

Barriers to HIV/AIDS Prevention Programming

For both larger and smaller communities, the ranking of barriers to HIV/AIDS prevention programming was identical with the aggregate data – with the curious exception that funding outscored human resources as the top priority for respondents who identified themselves with either a larger or a smaller service area. This discrepancy was made up by respondents who chose not to answer the question on community size.

Barriers to Effective Programming by Community Size

	Full Survey		>100,000		<100,000	
1	Human resources/ sufficient staffing	87	Funding	41	Human resources/ sufficient staffing	36
2	Funding	86	Human resources/ sufficient staffing	40	Funding	36
3	Training	42	Training	15	Training	18
4	Links to other organizations with similar interests	30	Links to other organizations with similar interests	9	Links to other organizations with similar interests	13
5	Information	23	Information	8	Information	12
6	Links to similar organizations	22	Links to similar organizations	7	Links to similar organizations	10
7	Links to national organizations	13	Links to national organizations	5	Links to national organizations	5

CPHA's Role

In communities of all sizes, there was strong support for CPHA's role in the development and distribution of information resources. Larger communities placed more emphasis on federal advocacy and policy development, while smaller communities expressed stronger interest in coordination among organizations and jurisdictions, and in program support. Consistent with the results based on organization type, direct program coordination received the lowest priority across the board.

CPHA Role by Community Size

	Full Survey		>100,000		<100,000	
1	Develop/distribute info resources	78	Develop/distribute info resources	33	Develop/distribute info resources	30
2	Coordination among orgs/jurisdictions	70	Advocacy at the federal level	30	Coordination among orgs/jurisdictions	28
3	Advocacy at the federal level	68	Policy development	29	Program support	27
4	Program support	61	Coordination among orgs/jurisdictions	26	Advocacy at the federal level	26
5	Policy development	60	Program support	22	Policy development	22
6	Program coordination	24	Program coordination	8	Program coordination	12

Best Practices

Asked to identify best practices in HIV/AIDS prevention, a number of participants responded with very brief references, including: research, AIDS in the workplace, "money to do our own thing", community-based research and advocacy, funding, program information, prevention programming, a women's health project, regional and national networks, contact training and case management, a community coordinating committee, testing and follow-up with cases and contacts, contact training and case management, "community desensitization" and professional education, accountability frameworks, international development, needle exchanges, intersectoral collaboration with other departments and governments, crisis intervention/referral, community development, advocacy, social reintegration, health promotion, closer collaboration and coordination, training for school personnel, and a national mentoring program for physicians and nurses involved in HIV/AIDS care. Specific references included:

- An Opening Doors Project involving a local AIDS committee and three other jurisdictions in its province;

- Development of a three-year regional plan for community-based services related to HIV/AIDS;

- Development of prevention materials for law enforcement, religious and political target groups; along with the provision of food, shelter and nutritional supplements;

- Closer attention to legal, ethical and human rights issues, especially in relation to recalcitrance – in an era of HIV notification and the "complete lack of legal process", one participant stressed the importance of legal counsel for public health officials, and appropriate facilities for short- and long-term management.

The Telephone Survey

Delivering the Message: What Works and What Doesn't

In the telephone interviews, participants identified the main target audiences for their HIV/AIDS prevention activities, and talked about the most and least effective strategies for delivering a prevention message.

General Comments

A provincial official stressed the importance of prevention programs that are developed in close collaboration with members of specific target audiences. In general, "programs that work for marginalized people are programs that take the data out to them, and involve them in preparing and disseminating the data," he said. The approach is very practical, hands-on and attuned to the cultural language or ethnography of the group. Examples of those types of programs are needle exchanges and Aboriginal-based education programs that are devised and put together by community members in a way that incorporates their culture.

The least effective programs, he said, are those that are "top-down, don't involve people, talk at them, use fear and scare-mongering techniques, are one-shot, and don't continue."

A similar perspective emerged from a discussion with an AIDS service organization in a mid- sized community, who stressed his organization's reputation for being client-friendly. The organization's guiding theme is harm reduction, he said: "We don't say, 'Don't do it'". Instead, the organization meets people "where they're at", and tries to encourage them to move towards more healthy and less risky lifestyles. Audience outreach is based on peer information, advertising in a local gay magazine and college newspapers, a speakers' bureau, and production of resource materials that feature a local information line with a toll-free number for people outside the city.

One provincial official had had positive experience with partnerships between public health and other agencies and non-government organizations, including:

A collaborative effort between a provincial public health program and the Laboratory Centre for Disease Control;
A partnership between the public health program and local needle exchanges;
Prison programs in which public health staff work with correctional officials on specific issues, such as blood-borne pathogens;
Epidemiological research linked with front-line services like anonymous and non- nominal testing and HIV/AIDS counselling.

The official stressed the importance of fitting HIV/AIDS into an overall prevention strategy for blood-borne pathogens, adding that the least effective and efficient programs have been those that

focussed solely on HIV – in particular, he singled out the early "fiascos" that treated injection drug use as a risk factor for HIV, but not for other blood-borne diseases. Ultimately, he said the approach overwhelmed all blood issues and triggered the stigmatization of people living with HIV/AIDS while ignoring the larger picture. Now, the same scenario is being played out around Hepatitis C. In a similar vein, he said HIV should be placed within a broader strategy dealing with the full range of sexually transmitted diseases.

Youth

Consistent with the results of the fax survey, youth emerged as a key target audience for HIV/AIDS prevention programming. But for a number of telephone survey participants, the distinction among groups of youth – by age group, or by lifestyle – was a bit superficial.

A representative of one of Canada's leading youth service organizations stressed that the group makes no distinction between street-involved youth or youth in school. "We don't have a higher priority. We're trying to reach as many youth as we can. We do want to reach youth who are most at-risk, but we usually generally tend to do that through our support and outreach rather than prevention education." Outreach programming includes one-on-one support that incorporates HIV/AIDS prevention messages.

The organization's prevention services include public education in secondary schools, colleges and learning centres, a project in rural communities, work with street-involved youth, programs for youth in prisons, and a project for young sex trade workers. The most effective activities are those that involve "peer-for-peer, youth-driven, youth-directed prevention education." This approach is reflected in everything the organization does – its services are directed to youth between the ages of 15 and 29, while all of its board members and most of its volunteers are in the same age range. Older volunteers may help out as trainers, but do not usually work in front- line prevention.

"The programs that we run are really directed by our youth volunteers, so if they would like to do something [such as create a radio program], we provide administrative support to give them the training they might need," the respondent said. "Peers understand their peers..We just recognize that when you're talking to young people, having another young person talking to them can be more effective than having an authority figure, especially in a school situation."

The one limitation in this peer-for-peer approach is the breadth of the target audience. Youth reflect a full cross-section of society, and if the organization lacks volunteers within a particular group, it becomes difficult to create materials that are accessible to all. The answer to this problem is reflected in a rural outreach program, in which local youth are trained to be the resource people. "We can go in there and do presentations, but we're coming from an urban setting. When we train local youth, they know the politics, they know what's going on in their communities, and they can talk to the other youth."

A public health official in a mid-sized service area agreed that a peer approach is the best way to reach youth in school, in both urban and rural settings. The key is to build partnerships with youth, schools, parents, and communities, because "we can't do it alone. Intersectoral work is what really works with youth."

The organization sponsors peer-aged educational teams that work within the school system, with public health acting as a resource group and providing teachers and students with materials on safer sex and healthy lifestyles. School surveys suggest the approach is working: after peer education programs are delivered, sexual activity declines among participating youth, and safer sex practices become more popular. Provincial statistics also show a reduction in teen pregnancy rates since 1991.

The organization has also set up a network of teen wellness centres, including two community-based facilities and a half-dozen located in schools. The centres are developed in consultation with local youth to deal with a range of issues, including sexuality, healthy eating and eating disorders, bullying, and relationships. Depending on the needs identified by students, the centres may be staffed with nurses, social workers, nutritionists, or other practitioners.

The respondent said the least effective prevention method has been "going into the schools and doing a one-time, educational 'blitz' thing". Experience with this type of work demonstrates that sexuality and healthy living must be built into the curriculum throughout the school year. Other survey participants agreed that one-on-one approaches are best for HIV screening, prevention education and counselling, and that awareness campaign and open houses have limited impact. One public health official in a small service area commented that youth "seem pretty invulnerable to education", but that one-on-one contact is most effective. Presentations dealing with relationships and healthy dates can be a good jumping-off point for HIV/AIDS prevention messages, and persons living with HIV/AIDS can generate a lot of interest as speakers – but, in general, public lectures are a poor prevention tool.

Youth in Secondary Schools

The Regional Health Authority in one smaller service area has had considerable past experience with educational presentations, in which public health nurses or representatives of ASOs speak to an entire school population or to a smaller group of students who have chosen a particular topic. From this background, one of the most effective ways of reaching high school students is to involve them in planning and facilitating the event. The respondent also reported positive feedback on speaking engagements featuring persons living with HIV/AIDS. The main focus for curriculum development should be communication skills and self-esteem – and material on self-esteem, in particular, should be introduced at an earlier age.

Another public health organization echoed the Regional Health representative's comment on the value of involving PLWHAs in public speaking engagements. And an ASO in a larger community

reported positive experience with "speaks" featuring a PLWHA and his sister. The pair attend about five high school sessions per year.

One ASO in a smaller service area has had considerable success with health fairs and classroom presentations, but still found that peer education train-the-trainer sessions are the best approach to HIV/AIDS prevention outreach. Students have helped public health nurses design "youth- relevant" displays, and have also developed programs for university residences. The least effective strategy was a targeted 1-800 line devoted to youth and peer education, which operated for two hours, one evening per week, for a year. Even after extensive promotion, the line averaged less than one call per month. Continuing calls to the organization's regular 1-800 line showed that youth "need immediate, on-the-spot counselling, rather than waiting until next Tuesday night."
The organization recently introduced a youth advisory committee, to develop new mechanisms for delivering a prevention message to younger audiences.

A more integrated approach is to build HIV/AIDS prevention messages into a broader curriculum module on career and personal planning. One public health agency found this to be an easier way of working with local school districts to reach students in grades 10 and 11.

"We used to have a lot of difficulty getting into schools with this information, but we've put a process in place around that now," the respondent said. Students' evaluations of the prevention presentations has demonstrated that "it's important information, and it's effective" – though a key objective is to reach students at a younger age, before they begin to make choices that might expose them to HIV.

Culturally appropriate school curriculum was a major focus for one official from a provincial/territorial education department. Speaking from a community with a large Indigenous population, the respondent stressed the value of an integrated approach that delivers a broad-ranging HIV/AIDS prevention and health promotion message to students and the broader community. The high school curriculum addresses all aspects of healthy relationships, in a way that enables students to design their own community research projects and address issues of concern to them. A K-6 curriculum, due to be released next year, will focus on social and emotional wellness, community roles and responsibilities, healthy choices, problem-solving skills, traditional values and beliefs, and development of a positive cultural identity.

Elementary school populations will need different approaches, like posters and story-writing contests, but the common denominator is the importance of involving youth directly rather than simply making presentations to them. "Learning usually happens best if they have the information, but also get to work with the information in some way," one public health respondent said. "We'd probably be looking at trying to incorporate that kind of strategy in whatever we do in the elementary schools, but it will depend very much on how we're able to negotiate this with the school districts. And all of that takes resources."

Another health unit spends at least three hours with each grade nine class in the public school system, to inform students on issues related to HIV/AIDS and other STDs. The students are already quite well informed, probably because the unit also has a program aimed at grades 7 and 8 – the purpose of the grade 9 sessions is to repeat key prevention messages, while delving more into the issues involved in being sexually active. The most effective presentation formats are those that get students involved and encourage them to interact with each other, and with health unit staff. The message is that "sex is wonderful if it is the right time, and as long as you are protected," the respondent stressed. "Don't tell them not to have sex – it doesn't work." A major challenge is that the sessions cannot be extended to Catholic schools, where discussion of condoms is not permitted.

College and University Students

Once again, the most basic principle for HIV/AIDS prevention education is to involve members of the target audience in developing and delivering the message. But on one mid-sized campus, the biggest challenge is to capture students' attention. "There are a lot of parties going on," a public health respondent said. "The kids are busy, so you can't just call a meeting." But in Québec, one CLSC organized an open house at a local community college (CEGEP), and actively encouraged students to stop and talk about HIV prevention and risk behaviours. "They didn't have much choice," recalled the respondent. "We grabbed them as they went by!" One social service agency in a major urban centre has had the most success talking with students one- on-one at information tables and booths. Panel discussions and large-group sessions are less successful, since there is no opportunity for questions or direct interaction.

College and university campaigns are also an opportunity to reach out to future health and social service professionals, to reinforce or augment any curriculum content they may be receiving on HIV prevention. A key priority is to ensure that medical students "aren't in the dark" in relation to HIV/AIDS, one respondent said, "because a lot of our physicians are."

Young Seasonal Staff

The ASO in one small resort community has identified young adults working as seasonal staff as a key audience for peer-based prevention activities. The organization recruits and trains volunteers from different workplaces to help organize educational pub nights as well as a range of recreational activities – from mountaineering for women, to kayaking, to barbecues – to which a prevention message can be added. A key objective is to bolster self-esteem and self- confidence, with messages along the lines of: "If you can safely summit an 11,000-foot mountain, you can safely negotiate safer sex." Informal activities have been much more effective than formal presentations, and flexible timing has been extremely important in accommodating participants' work schedules.

Street-Involved Youth

A public health respondent reinforced the view that street youth can be very hard to reach, noting that it was only after many months of perseverance that a visiting public health nurse was able to disseminate information among youth at an underground meeting place.

Another successful initiative resulted from placing a health unit's street health centre next door to a facility run by the school board, in which youth are encouraged to drop in and work on homework. The proximity of the street health centre means that youth can be invited into the centre for a number of services, and can be exposed to HIV/AIDS information while they are there.

A similar piggy-backing of services worked particularly well for a public health agency that organized a campaign after a Hepatitis A epidemic. Approximately 125 very high-risk youths were tested for HIV/AIDS in conjunction with their Hep A tests, a considerable success given the challenges involved in reaching this population.

A spokesperson for an ASO stated that their outreach service had been very effective, until funding was cut. Outreach consisted of street level workers walking the streets and visiting bars, making contact with street youth and distributing condoms, resource materials, and the clinic's phone number.

Another respondent stated that a six-month pilot project aimed at reaching street youth failed, since the target group moved according to the weather. Ultimately, the information was given to front-line workers dealing primarily with street youths, in hopes that they would have better success

Street youth can be referred from other youth programs such as Employment Insurance, school re-entry programs, and youth correction facilities, according to a public health official. Youth in private school and vocational schools, and those who have left school, are hard to reach, an official pointed out, adding that even in public schools, school nurses are often no longer available. Another public health official stated that there is considerable overlap among injection drug users, sex trade workers and youth, all of whom are hard to reach.

Better outreach to street youth might be attained through the use of mobile clinics, such as those currently available in Vancouver, said one respondent. Another stated that at their agency, the flyers currently in use are not really reaching street-involved youth. The agency is now working on a new flyer design which they hope will be more appealing to this population, and plan to distribute the new flyers in places frequented by street youth.

Men who have Sex with Men

One public health official stated that a local community organization dealing primarily with gay men has had very good success in reaching men who have sex with men. They distribute information and condoms in local parks and bars, "meet(ing) gay men on their ground, and it works."

An effective activity is to "provide a safe environment for people to explore and become comfortable with who they are," according to an ASO representative. This does not necessarily include direct discussion of HIV/AIDS prevention. "When you're working with marginalized communities, until they feel safe and accepted as who they are, they're not going to be receptive to prevention messages," he said. While his organization does make prevention information available, "we don't break it out as a separate piece."

Examples of activities in this area include peer support groups for men, youth and Aboriginal people, along with a spirituality group. The organization also does one-on-one work. The representative said, "one of the most important roles we play is that we're here. We have a lot of people, especially young street kids, who come up on a regular basis to get a hug, some words of encouragement, that type of stuff, which I think is in some ways maybe more effective than the peer support groups. But the two work hand-in-hand."

A respondent from a gay/lesbian health organization agreed. "I think the issues are much the same. It's providing an opportunity, a place for gay people to feel good about themselves. If you live in a homophobic environment that continually gives you negative messages, you adopt the position that, 'I'm not worthy anyway, so why the hell should I bother protecting myself?'"

Peer programming is by far the most effective outreach method, according to a federal health official, who stressed that "AIDS, or any other healthy lifestyle education needs to come from the target group!" However, she also noted that one must be careful in defining who is a 'peer'. Peer here means someone from the target community, not merely someone of the same age, race, and sex.

A respondent from an ASO pointed out that certain approaches are destined for failure. "I think what doesn't work so well is sitting people down and giving them lectures about safer sex. I find that tunes people out. Whereas if you talk to people about respecting themselves and feeling good about themselves and allow them to work towards that, then I think information about safer sex is more readily accepted and integrated." Integrating prevention messages is the key, he said. "I think that sex is only one small part of people's lives. To separate it out, I don't know how effective it is."

A public health official noted that one of the least effective strategies has been attempting to get gay men to attend local health care organizations. "It is much easier to meet them on their own ground," this respondent said. "It does not work to try and make them come to the centre. They just don't come."

One ASO did offer a "man-to-man" targeted phone line, but received too few calls to be worthwhile. However, she pointed out that a 1-800 line has been quite successful in reaching men who have sex with men.

A good way to reach men who have sex with men would be to incorporate their interests into the already-running sexual wellness programs, a public health officer said. The programs should be developed with sensitivity to the needs of men who have sex with men.

While a provincial health department reported a good rapport when talking with the gay community, the approach has been very piecemeal. While the ideal would be to talk to young gay men in schools before they engage in high-risk activity, this is a very difficult task, the respondent said.

Another ASO representative pointed out that the survey questionnaire did not really cover the mandate of his organization. "This talks about targeted programming," he said. "It doesn't talk about communities, and we tend to work more at the community level than in a targeted area." The differences between the two approaches is that while some organizations only receive funding to work with a specific audience, such as commercial sex workers, his organization reaches this audience as part of its general program.

Injection Drug Users

A federal official in a large urban community commented that the most effective services come out of the target community – in this case, injection drug users themselves. The official stated that most needle exchange programs don't work particularly well, unless they are based on partnerships between AIDS organizations and the target audience and are peer-run.

Availability is an important consideration. One AIDS service organization had good success with a pilot needle exchange program, pointing to a reduction in the number of needles found on streets and in wading pools as one measure of its success. But the drawback is that IDUs from other parts of the province can only take part if they travel to a central location to exchange their needles.

One health board in a major urban centre has addressed this challenge with three street vans that move from area to area – one as part of a street nurse program, one in connection with a needle exchange program, and one as a general health van. The health board has also introduced needle exchange in all its sites since 1995, and set up about 15 designated needle exchange locations. This integrated approach makes it possible to expand the program and connect it with a range of other health services, without adding a large number of extra staff.

Trust, confidentiality, and discretion are crucial as well. The needle exchange in one urban/rural region was cited as an example of a program whose success depends largely on being "out of the public eye" and "right under the radar of the community at large". The program runs about 80

connected drop-off sites across the region, and volunteers – some of whom are users themselves – act as liaisons with program coordinators. "This initiative has made great strides in making inroads into a community that is normally very distrustful," a respondent noted.

A public health organization in an urban area stressed that injection drug users can best be reached by going to the places where they are, and by doing things on their terms. Here, as well, needle exchanges have done a good job hiring people who can communicate with their target groups and educate their peers. The attitude of people in the health care system is often not helpful, and injection drug users do not like the treatment they receive. It would be helpful to pause and examine what works, but there does not seem to be the time to do this. Drug users want to learn and are actually becoming quite knowledgeable, but have not taken the next step and put their knowledge into their behaviour. On the other side, many prevention workers may find it difficult to understand a culture in which saying "don't do it" does not work.

But the sole staff member for a local government agency in a small town took a different view, suggesting that program activities should be related to the drug problem itself, not to the disease. He suggested that a needle exchange program in his community was not well-used because people were afraid everyone would know they were drug users (even though they already do). "Needles are found all over the place," he said. "A safety awareness campaign would be a good idea, to teach them to be responsible, to at least protect others. Programs are necessary to make this group understand how irresponsible it is. Safe sex programs would not work. The spread of HIV will never stop in this group unless the drug use stops."

A health unit in one urban area offers a number of successful programs and services for injection drug users including a needle exchange, a methadone clinic, an outreach worker, and a street health centre that recently added a nurse practitioner to address primary health care issues. The unit is also involved with a program called *Creating A Better Life*, funded through Health Canada, and has established a research relationship with a major university, looking into issues surrounding the children of injection drug users. The unit still operates an outreach van, but wonders if it is really necessary given that it now has a street health centre.

A federal government official described a population health approach focussed on the determinants of health as a key factor in reaching target audiences. "We need to address their basic needs, like housing and food before you can get to the education piece." But while outreach workers play an important role, and peer support groups for IDUs can provide important social supports, there is only so much that a health program can do in isolation."The problem is there aren't enough services ... once the outreach workers reach these individuals, where do they take them?" One health board in a large urban area bought two downtown hotels and converted them into "good, safe living places" for homeless people. The hotels accept people who inject drugs, and people living with HIV. "What we've been working on, with us and other partners, is furthering a housing

policy and recognizing that housing is a major contributor to improvements in health,:" the respondent noted.

Within the IDU population, the same health board stressed the importance of focussing on youth. "Older people who are injection drug users or are gay have had all the education, and their (HIV infection) rates have dropped. But as long as you're feeding new people into the pipeline, your numbers continue to go up."

Activities that aren't effective include "literature-based prevention initiatives" focussed on distributing pamphlets. "It's hard to get people's attention" when they are worried about basic needs.

Aboriginal Populations

An AIDS service organization in an urban setting stressed the importance of prevention programs that are geared closely to the needs of the target audience and conducted by people who are familiar with Aboriginal traditions. "Each workshop is tailored to the audience. It depends on what the community is looking for." Participants have included both urban and rural audiences, ranging from community members to health professionals to prisoners. The workshops, conducted by Aboriginal educators, cover the basics of prevention – what HIV/AIDS is, and how to protect oneself. Workshops can also include information on the services available in different communities, how to negotiate safer sex, and self-esteem issues.

The educators also make themselves available for one-on-one work. "It's for people who either need more information or aren't comfortable in a group setting."

For urban populations, there is an emphasis on harm reduction, as more people are street-involved with injection drug use and the sex trade. With on-reserve and rural populations, "there has to be a lot more sensitivity to sexual abuse issues, because the communities are small and there are varying degrees of dealing with it openly ... you have to be really sensitive about how you talk about it, because it comes up when you discuss sexuality."

The same ASO also targets Aboriginal community health providers, along with its own members and volunteers. One important function is to provide basic HIV/AIDS information to health care providers on-reserve, many of whom are practically-trained nurses and drug and alcohol counsellors who don't hold professional degrees. "Professional education for them is very important. They are the first line of health care for many communities, so it's really important for them to be sensitized and knowledgeable about HIV/AIDS."

Following an in-house strategic planning process, the Board of one mid-sized public health agency opened discussion process in relation to Aboriginal communities, by establishing a collaborative committee with Aboriginal representation. "We're still talking about how we can do this to be the

most effective," a respondent reported, "and there are some resource issues because the Aboriginal community doesn't have any direct money for HIV/AIDS."

Based on consultations conducted during the strategic planning process, the respondent expressed doubts about the effectiveness of prevention programs that "parachute things in" and are not sustainable. While one-shot programs deliver information to individuals, "it isn't effective in terms of the community being left to try to deal with whatever issues arise from that education."

One federal official stressed the value of activities based on Aboriginal culture and tradition, including potlatches, sweat lodges and community events. Many people in Aboriginal communities still assume that HIV/AIDS is a gay mens' disease that is limited to urban areas. But "when you incorporate cultural and traditional factors, it becomes more relevant."

In a comment that echoed other health promotion and mental health programs in Aboriginal communities, the official also gave high marks to "youth-based" programs involving Aboriginal audiences, particularly recreational activities that enhance social support networks. "It's one way to bring youth in."

In one rural setting where 80% of the population is Aboriginal, the local public health agency developed two sexual wellness programs and involved youth in their design and delivery. While the project is too new to have been evaluated, the pre-launch discussions turned out to be productive in their own right. The agency also found it useful to hold workshops and discussions with Aboriginal youth and community leaders, focussing on teen pregnancy, STDs and HIV/AIDS. A volunteer training program was less effective – while the trainees became more aware, there was insufficient program support to allow them to reach out effectively to a wider population.

An urban AIDS organization expressed interest in extending its prevention efforts to Aboriginal women, given sufficient resources to do so. "There's more of a safe atmosphere when you have an all-women's group and they can talk about issues of sexual abuse, sexuality or being in an abusive relationship and negotiating safer sex." The organization already does some work with Aboriginal families, but would like to expand this activity to include more intervention with youth. Workshops currently under way include a two-page survey, in which participants are asked at what age they started having sex. "Most of the time, prevention education doesn't reach them until after they've become sexually active or started experimenting with drugs. If it's not going to be everywhere in the school system for a while, we need to talk to families about how to talk to their children."

The least effective prevention initiatives are those that simply say "don't do it", a respondent said. "If you tell people not to do things, they usually just walk away." A "top-down" approach isn't useful, either. "A lot of our education is grassroots. When you're doing the education, it's with the people, where the people are at, instead of throwing a lot of medical jargon at them and then expecting them to feel empowered to protect themselves afterwards."

The same organization expressed interest in targeting Aboriginal leadership. “Once they acknowledge what an important issue this is, a lot of other community groups will fall into line. But it’s a scenario that needs quite a bit more work.”

A public health official in a mid-sized community said it had been difficult to get “buy-in” from Aboriginal communities for even the most basic HIV/AIDS surveillance programs, if the surveys included any information on ethnocultural background. While that level of precision may not be essential, she said, it would make it easier to deliver targeted programs.

Women

One ASO has found that it reaches women most effectively through its general 1-800 line. The line offers a link to counselling, sympathetic medical practitioners, anonymous testing sites across the province, and a network of nine sexual health centres established by the provincial government over the past 10 years. Of the 3,500 calls that the 1-800 line received in its first year (in a province with a population below 750,000), half were from women. This year, the number of calls appears to be doubling, to a rate of about 600 per month.

The sexual health centres themselves are a valuable resource, providing integrated access to information on sexuality issues, general education, anonymous HIV testing, counselling, assistance to parents with sex education, sex education programs in schools and communities, and pregnancy services.

A number of respondents said not enough has been done to reach out to women as an audience for HIV/AIDS prevention messages. While some respondents were critical of approaches that place higher priority on women who are pregnant, A public health official in a mid-sized community said it’s easier to reach pregnant women with prevention messages. “They’re so ready to do anything that will help the baby,” she said, “and they’re so much more accessible.”

Homeless Populations

A handful of public health respondents reported limited success delivering HIV/AIDS prevention message to homeless populations.

One agency hosts two-hour prevention workshops at a local detoxification centre, in the hope that people will carry new knowledge with them when they leave. A respondent described these events as “really just a captured session”, since participants have no control over whether to take part. But the workshops generate good dialogue and a lot of questions. The agency has also left HIV prevention information with the staff at a local street drop-in centre and distributed pamphlets at a pool hall and adult education centres, in an attempt to reach youth who are out of school. It also

organizes information sessions for youth upon request. In the near future, the agency will be airing a television special on sexual health, HIV and STDs, produced by youth at the drop-in centre.

One CLSC sent workers to talk with homeless people at a local shelter, but found that the workers outnumbered the participants – in that instance, the biggest gain was the opportunity to share information with social workers at the shelter. Another agency has been using a "train the trainer" approach, in which different organizations identify volunteers to receive and then disseminate prevention information. But the program is about to be cancelled, due to a lack of funds. "The difficulty is going to be how to sustain it over time, and that's where the resource issue comes."

Prison Populations

A federal official passed on a suggestion from a recent gathering of prison outreach workers, who agreed that prevention messages should be delivered when people first enter the correctional system, as part of a general orientation on safety issues. The group identified peer- based programs and support groups led by prisoners as the best way of countering the main challenge in this environment: "How do you make prisoners feel that they can trust someone in the system around this issue?"

A provincial official said HIV screening, information and awareness programs are best carried out by fieldworker with specific background in prevention issues. The official added that harm reduction programs work best with a minimum of structure: "When clients have to formally request condoms or bleach, demand is very low. It works better if these things are offered, and they don't have to make a formal request."

A respondent expressed interest in intensifying the public health connection with prison populations, through counselling and other forms of one-on-one contact. Another public health official reported good success in reaching this population – the men tend to be very honest, and ask a lot of questions – though it is difficult to measure long-term impact. More recently, prevention programs have become less consistent, possibly due to staffing difficulties at the local prison that make it difficult to accommodate educational sessions.

The provincial official said prevention services should also be extended to offenders in open custody. These people are often linked to high-risk behaviours, but are not covered by current programs and activities. Additional resources would make it possible to provide them with the HIV/AIDS prevention education and coaching they need.

A university social work program has identified institutionalized populations, parolees, and inmates on day release as priority audiences, and regularly assigns students to training placements in correctional settings. The program has found support for HIV/AIDS prevention efforts on the part of senior correctional officials, but noted that programming is frequently blocked by correctional officers, guards, middle management, and – most significantly – their unions. The respondent cited

inmates in transition back to the general society as a distinct audience for which sufficient program funding has not been available, noting that people who are just returning to the street face a special set of risks that could be mitigated if there were a broadly-based prevention program waiting to greet them upon their release.

Commercial Sex Workers

A public health organization in a mid-sized community provides access to information, condoms and anonymous HIV testing for commercial sex workers, as part of a broader prevention program. But the health unit has had mixed results going directly to houses where sex trade workers are employed to offer HIV testing and education. When an employer imposes testing and education on the workers, there tends to be distrust and resistance. "It works well if the needle exchange workers pave the way for the nurses."

A social work student in Ottawa has undertaken a field placement with commercial sex workers, to help them empower themselves around HIV/AIDS prevention issues and improve their capacity to do their jobs more safely and increase their self-esteem.

The health unit is more concerned about sex trade workers who are only periodically on the street, since those who are employed at houses are often well-covered by programs and services. Employers often come to the health unit and pick up two or three gross of condoms, which has the added benefit of establishing links between the health unit and owners and making the workers easier to reach for testing and education.

This particular health unit would also like to target sex trade clients, given adequate resources to do so. Since it does not seem possible to stop HIV-positive sex trade workers from continuing their business, their clients need to be better informed.

General Public

A number of respondents stressed the importance of delivering accurate, effective HIV/AIDS prevention messages to the general public, as a means of clearing the way for prevention and harm reduction campaigns aimed at specific target audiences. In one mid-sized urban area, a public health official recalled general awareness campaigns in the earliest days of the epidemic that had generated public support – and, as a result, political backing – for some of the best targeted prevention programs in the country.

Different organizations working with the general public said they would seize any opportunity to promote HIV/AIDS awareness and prevention. A public health unit in an urban area found it could reach the general public most effectively with an annual campaign in conjunction with World AIDS Day. Working closely with a local AIDS organization, it uses an AIDS quilt to help publicize the issue. An AIDS service organization working in a larger urban area holds a memorial vigil on World AIDS Day. A small public health organization working in a rural area and another public health

department working in a mid-sized urban area similarly felt that a remembrance service is a good way of reaching the general public and giving the epidemic a human face.

Many organizations have found that it is effective to use forums such as AIDS Day and AIDS Week to promote their message. A public health agency in a mid-sized community noted that during World AIDS Day and Week, a number of activities happen that receive media profile. Working with the media has been important to help create a larger community awareness about HIV/AIDS. A public health organization in a rural area helped to publish a series of 8 articles on different AIDS prevention topics in local papers. "It was a good way to reach the general public." In addition to being better informed, people in the community now know where they can go there for help and information. A local organization in a large metropolitan area found that the most effective activities have been provincial awareness campaigns with the mass- media. "These do reach a wide audience."

A mid-sized public health agency found that what does not work is generalized information with which people do not identify. On the one hand it is important to keep the information out there, but on the other, "people get worn out hearing it". It is difficult to get people to remember that AIDS has not gone away without boring them. The media have lost interest because they cannot find a new angle on it. It is hard to find a balance. People should not be allowed to think that everything is okay now. The slogan "AIDS can affect you" is not useful any more. The AIDS prevention community should think of a kind of message that will be effective. Perhaps the anti- smoking campaign should be imitated. But how to reach young gay men before they get into a situation is particularly difficult. It is hard to reach them when people do not even want to hear the word "gay". The least successful activity for one other organization was an advertising campaign for which ads had been planned in four Québec monthly magazines. " It turned out to be a complete failure as two of the magazines refused to published the ads as they were targeted at gay men."

A public health agency in a mid-sized community has staffed a number of fairs and outreach activities in which they meet the public. Another public health organization in a smaller community noted that their most successful activity was an information kiosk that was set up at the local shopping mall. " We are not sure if people were there because of us of because it was pay day, but we did get to talk to lots of people who stopped."

A smaller public health unit found that it was difficult to reach the general public, that a high percentage still think that HIV is not its concern. It did have good feedback on Talk Backs _ radio interviews after which listeners were invited to phone in. People did not actually phone in that day in great numbers, but the Department had positive feedback afterwards. A successful approach for the agency in the larger community has been to go to the work place and other groups to talk about issues other than AIDS/HIV. "Nobody wants to start out talking about AIDS, but the subject of AIDS can evolve from a discussion of another subject. For example, perhaps an incident at a work place where there was blood on the floor can result in a call to the Health Department for a

presentation on industrial safety." Health units are constantly doing public education and are known as places to call for information.

One health unit in a mid-sized community is encouraging new mothers to have HIV testing, either pre-pregnancy or prenatally. Their goal is to have 100% of pregnant women tested prior to giving birth. Currently the area prenatal testing rate is at about 50%. The unit does have some concerns about the quality of counselling around testing which may be done in physicians offices.

An AIDS service organization is planning an educational forum which the public and the medical community have been invited to. It is working with a drug company to provide a HIV primary care physician as a speaker for the event.

Another AIDS service organization in a small community obtained funding to put together six "train-the trainer" modules, which have been offered to a large variety of agencies. The modules cover "the whole range of things associated with education for HIV/AIDS and were built on best practices. Literature was reviewed before the modules were developed." People such as health care workers, RCMP officers, school personnel, and alcohol and drug workers have gone through the training. "That's created a much greater level of awareness in the community then what there was previously."

Rural Populations

The sole staff member for a rural public health organization reported that there are not many resources available to reach rural populations. Because there is not an identifiable gay or street population and the area is spread out, there are no visible pockets of high-risk groups and finding suitable prevention strategies is difficult. The organization held a remembrance service for people who have died of AIDS; this had never been done before and was seen as a good awareness and prevention activity.

The same organization reported that any opportunity to network with other rural service providers was welcomed. They sponsored a workshop for other rural groups who have an interest in HIV. Representatives of three or four rural groups came together for a day to share their history and structure, their types of activities, and to brainstorm about objectives and about ways to increase community support. As part of the session, they did an exchange of resources, which they found quite useful. Some of these people had never met before. Rural groups are often left out of central meetings and it is not just money that stands in the way of their attendance. The time and money needed for travel and for overnight stays often makes it impossible.

An AIDS service organization in one urban area runs a Saturday walk-in clinic that is used by many people from rural parts of the province who come to it for anonymity. The staff would like to be able to provide these people with resource materials but finds that it is unable to do so; the cost of getting together to create and produce materials has been downloaded onto the community

without a corresponding increase in funding. The organization, which has both salaried staff and a number of volunteers, has lost outreach staff and now has to buy materials which used to be provided to it for free.

A public health organization servicing a dispersed population mentioned the huge stigma around HIV in their area. “The Health Unit regards AIDS as a chronic illness, but the population treat it as a plague.” HIV has had bad press and people are frightened of it. The population is elderly; the area is losing its young people. There is fear associated with the older attitudes towards the sort of behaviour which helps HIV spread. The people feel that people bring on AIDS themselves through their behaviour and that “homosexuality is an abomination”. It is hard to know how to approach this mind set.

Another public health organization has a particular concern about gay/lesbian rural youth, as they may be more socially isolated. A very popular youth education tool over the past two years is a federally-produced kit called “Just Loosen Up and Keep Talking”. This briefing kit is used when talking to CHBs, municipal governments, parents, and youth groups about the supports needed to create a friendly environment to promote healthy lifestyles and sexuality to youth. Based on its reception and demand, it has been very successful, and so far Public Health has run six sessions in one year using the kit, mainly to youth educators (about 180 people).

Given sufficient resources, one gay/lesbian health organization would add rural populations to its priority list. Activities for these populations would involve “building supportive environments” for people. That would include an 800 line, which the organization has, but doesn’t advertise because of insufficient funds to pay for heavy usage; establishing peer support groups; and “working in communities with professionals such as teachers to educate them more about working with gays and lesbians.” The key issue is safety. “If you’re gay or lesbian you don’t feel very safe in this world often ... If people don’t feel safe, they’re not going to practice good health ... So it’s finding places where people can feel safe to explore who they are and thereby enabling them to make healthy decisions about their lives.”

Another public health organization would also like to reach more gay, lesbian and bisexual youth, and provide safer environments for them in what can be a very homophobic climate, especially in the rural areas. Teen Wellness Centres would be a good place to start to reach out to them. Most programs at the centres are youth-driven, with student advisors. There are peer education seminars and workshops. TWCs do not necessarily provide treatment, but are safe resource and information centres. “TWCs are starting to crop up in rural schools,” and there is now a Planned Parenthood office in a town of 30,000.

Parents

A public health agency in a smaller community would like to target parents, giving them the important message that they should start at an early age to teach their children themselves about healthy sexuality. They should not depend on the school system to give their children all the answers. This message works well for parents who have strong religious beliefs and values as it allows them to teach their own beliefs. Many parents think they are not adequately equipped for this role but given the confidence and tools most will do well. Parents need to be given the self-esteem and belief in themselves to do this for their children. This message should be incorporated into prenatal and parenting courses. The difficulty arises from the fact that the more motivated parents who are interested in their children's health will be most likely to respond; those who are less interested will not. Most parents are very busy, so a strategy would be to put the information in the workplace rather than ask people to commit to an evening course. An example of a least effective method of reaching parents would be a 10-week course, because of the time factor. The message has to be integrated into what already exists.

People in the 35 to 40 Age Group

A public health agency in a mid-sized community would like to specifically target people in the 35 to 40 age group, the age when the most screening is done. "It would be good to have prevention activities targeting this age group, as there is a real need."

Prevention Workers

One association described a successful program that consists of a two-day workshop, in which the results of research on HIV/AIDS and prevention activities are presented to AIDS prevention workers. The format allows time for participants to explore ways of integrating research results in their day-to-day practice.

Deinstitutionalized Populations

The director of a university social work program with significant involvement in front-line HIV/AIDS prevention activities described group homes and other community support facilities as "fancy foster homes", and expressed concern that residents are "extremely vulnerable for a dozen reasons". While efforts are being made to get people with developmental disabilities out of hospitals and help them find the basics of life, the respondent said, "health is only receiving scant attention".

Ethnocultural Communities

Four different organizations in different parts of the country stated that they would like to specifically target ethnocultural communities for HIV/AIDS prevention programs. A large federal organization noted that "culturally appropriate" activities go beyond language. They include having persons with HIV speak about their experiences, and making sexual health education culturally appropriate, which is a challenge, "because in some communities that's not discussed at all...The tradition we have of going in and talking about AIDS 101 may not work."

Two different AIDS service organizations, one with several paid staff and the other operating with volunteers, both expressed a wish to specifically target the South Asian populations in their communities. One suggested that a way to work "might be through literature"while the other proposed offering a "capacity-building" project.

Another federal organization in a rural area struggled with the challenge of providing services given how few ethnocultural organizations and communities were present in their region. "I'd like to see some culturally specific programs for AIDS prevention developed that are particular to our regional situation", the spokesperson said, citing rural populations, small town attitudes toward different ethnic groups, and differing cultural perspectives on drug use, pre-marital sex, and related issues.

In one large urban area, a community service agency expressed concern about the HIV-related taboos that exist in a large, well-established religious community. Too many people still see the epidemic as a god's punishment for homosexuality, or simply believe that the virus will never reach their own community – an attitude that places them at higher risk for transmission.

Persons Living with HIV/AIDS

For one association of persons living with HIV/AIDS, questions about prevention programming led into a discussion of different "tertiary prevention" efforts, aimed at helping PLWHAs to maintain and improve their health.

Effective prevention measures include a treatment information newsletter for members that includes material on health improvement, lifestyle improvement, and quality of life. Articles are factual, and "more scientific than not". The focus is broad, covering topics like diet, income generation, and empowerment, all of which are factors in improving health and decreasing the likelihood of disease. This connection has important implications for prevention, "because people make better choices when they're less sick. There's also a large body of evidence now that if you're less sick you have lower viral load, so you're actually less communicable."

In addition to delivering up-to-date treatment information to every PLWHA in the province who wants to receive it, the publication "helps doctors and health care professionals throughout the province deliver better health care to HIV-positive people. If that helps them be healthier, then they're also less communicable."

The organization also organizes workshops across the province, dealing with healthy lifestyle choices.

Work Force Groups

A federal government regional office noted that various new treatments have greatly increased lifespan and lowered morbidity rates for people living with HIV, but that little has been done in the

workforce to accommodate these people and their coworkers. "More specific work needs to be done to adjust to this phenomenon, as more and more HIV infected people return to work."

New Singles

A public health organization in a small community observed that it is more difficult for recently separated, divorced or widowed people to get the information or the preservatives they need than it is for young people. "Suddenly, they are back 'on the market' and they have not had to worry about protecting themselves for years. Those who were in really long-lasting relationships did not even have to worry about AIDS before." Information nights and media advertising were suggested as possible means of getting the message across.

Gaps in Resources and Supports

Funding

Although some organizations cited funding constraints as a constant challenge, others focussed more on effective use of available resources. "It's not so much additional money that we need, but a different organization of the medical services we offer," said one respondent. "More money would be interesting only if there was a total restructuring of the way services are delivered." Another survey participant agreed that better communication and closer collaboration would make it easier to coordinate the efforts of governments, health institutions, and community groups.

But one ASO expressed concern that prevention is consistently underfunded relative to care, treatment and support, to the extent that it must sometimes ask groups to help cover the cost of prevention workshops. A public health official stressed the need for core funding for a network of youth wellness centres that currently depend on short-term grants. While "we don't need a beefing up of public health services in general", she said targeted funding is required for programs that have been proven to work.

A public health respondent in a mid-sized rural community provided a detailed list of new projects that would depend on adequate funding, including an outreach effort targeting nearby Aboriginal communities, closer links between local practitioners and a nearby centre of excellence in HIV/AIDS, educational materials for elementary school classes, a video, and a regional conference for the general public, physicians, women, and agencies with an interest in HIV/AIDS. One ASO said it could use additional funding to reinstate a successful outreach service, produce resource materials, and pay for a prison outreach program, including travel costs. (Some of these cost items, but not all of them, could be minimized by adopting or adapting existing resources from elsewhere.)

Human Resources

Understaffing emerged as a major concern, with a large proportion of respondents expressing concern about their capacity to reach out across large geographic areas, provide suitable support services, or adequately coordinate volunteers.

In many cases, respondents identified funding shortfalls as a human resource issue. "The major resource we need is adequate staffing, because the work we do is very personal and labour intensive," said a representative of a gay/lesbian health organization that works with an estimated 2,000 contacts per month. "We're stretched to the limit." Sufficient staffing would require an increase in core funding, from the current $102,000 per year to $250,000. Another $50,000 per year would cover the cost of launching a rural outreach project.

One public health respondent framed this issue as a need for more time, noting that an effective approach to prevention would require at least two full days of uninterrupted staff time per week. Most recently, the organization's sexual health program received increased funding for abortion-related services, but not for other activities. A provincial official said a funding increase would make it possible to hire more specialized staff.

Human resources can be a qualitative as well as a quantitative issue. One ASO said its programming calls for "multi-talented" prevention workers who are trained speakers, can work with groups and individuals, and bring cultural sensitivity, awareness of community issues, and medical knowledge to their work. And a public health official stressed the need for training and capacity-building as well as funding for new staff positions, to support stronger prevention programs aimed at injection drug users, men in correctional settings, and men who have sex with men.

Collaboration and Partnerships

An ASO dealing primarily with youth audiences called for "more interministerial communication" between provincial health and education departments, to help standardize secondary school curricula dealing with career and personal planning issues. An association in a large service area added that "nobody knows what other people are doing," and suggested assigning one employee to promote partnerships among the various organizations with a mandate for HIV/AIDS prevention. This activity may have to begin at a fairly basic level, however: "The fundamental problem is that few people realize the importance of prevention."

A federal official stressed the importance of intersectoral partnerships to address broader issues like housing and poverty, and also to deliver a prevention message through the school system. He noted that the government can often "make more inroads in the educational sector than community groups can," and also has a stronger capacity to interpret epidemiological data and studies.

Access and Attitudes

For one public health official in a mid-sized community, effective prevention programming comes down to access and attitudes. In schools, a "politically sensitive" environment makes it difficult to reach young gay men – or even to put up posters that include the word "gay". Access to prison populations depends on building a good rapport, while university populations need to be convinced to take part in the discussion: "At that age, they're so cynical that they fall asleep in front of you."

A Broader Focus

A provincial official stressed the need to address the issues of marginalization and socio- economic deprivation that underlie the HIV epidemic. "For homeless street kids, urban Aboriginals, sex trade workers and injection drug users, having stable, affordable housing is really important if they're actually going to limit their risk behaviour," the official noted. "Vancouver flooded the streets with outreach social workers, but it's questionable how much good they could do because they weren't able to give people adequate incomes or places to sleep." The ideal would be to conduct ethnographic research in local, high-risk situations, to develop the most appropriate and timely interventions. "Whether those skills are negotiating sexual relationships if you're in the sex trade, or whether they're skills in cleaning your needle if you're an injection drug user, they'd be very specific."

Leadership

In smaller communities, senior health officials may need to be reminded that HIV/AIDS is a local issue. "Here, it is not like in large cities," said a respondent from a small CLSC. "AIDS is not very visible, and therefore it is not a priority." Other survey participants noted that tobacco programming appears to receive higher priority than HIV/AIDS prevention.

From a larger community, a public health respondent called for more aggressive leadership at the national level. There should be "somebody speaking out from a national platform so it's not just a local issue, as it is very much now," a respondent stated. "That's one of the things that have been lost. If you talk to the provincial coordinators across the country, they've all been cut back. People have gotten comfortable with the disease. So one of the things we have to do is to remount the charge." He added that "a substantial new influx of money" is needed at the local, provincial and national levels – not to add staff per se, but to contract people to carry out specific activities like peer counsellor training.

Information Resources and Supports

Different respondents expressed the need for plain language prevention materials, video and multimedia materials, and Internet-based tools. A public health official expressed concern that a provincial government had cut funding for prevention pamphlets, noting that "37 health units all doing the same thing is a horrendous waste of time".

A public health official said small, rural communities lack targeted resources for people living with HIV/AIDS, and for their family members. Support groups are difficult to organize without requiring people to travel to a larger centre. A "telelink" would be one effective way of breaking down the barriers posed by geography and distance.

Research and Evaluation

A federal official stressed the growing importance of research that is both community- and evidence-based, adding that Health Canada sometimes provides guidance to community groups that are involved in prevention research. He said his office could also use more resources to support the development of a regional evaluation strategy for funded programs.

Barriers to HIV/AIDS Prevention Programming

Funding

A number of respondents identified funding as the most important barrier to effective HIV/AIDS prevention programming. One ASO began operations just after its provincial AIDS bureau cut off core funding, with the result that volunteer energy is devoted exclusively to fundraising to pay for an office and answering machine – without start-up funding to build critical mass, there are simply no resources for programming or permanent staff. Of the four unfunded AIDS committees in this province, one has already folded. The same respondent complained of a "downtown" vision of HIV/AIDS care in communities surrounding one of the major geographic centres of the epidemic in Canada.

A provincial official expressed a similar concern about funding levels. "We spend a lot of money on AIDS prevention," but "there isn't sufficient funding to address some of these basic issues."

Availability of Services

A public health official in a mid-sized community noted that some agencies refused to participate in HIV/AIDS education programs. "Agencies don't always see the importance of [prevention] if they're not an AIDS-serving organization. It's not necessarily at the top of their priority list." This problem can be compounded by local health practitioners "who feel that they have all the information already, and don't need more knowledge or information in the area."

For one respondent from Manitoba, the lack of a well-planned, province-wide public awareness campaign emerged as a key gap in prevention programming. In a province where half the population lives in one city, there are dramatic service gaps in surrounding areas – all the specialists and testing facilities are in Winnipeg, standards of care vary, and practitioners in smaller communities lack up-to-date information on HIV/AIDS.

In correctional facilities, the high mobility of inmates is seen as a major obstacle to effective prevention programming. Another barrier is the reluctance or outright resistance of some staff in relation to even the most basic prevention programs, such as the provision of condoms and bleach. “As for needle exchange programs, they are hardly thinkable at this stage,” said one provincial official.

Attitude, Stigma and Apathy

A key attitudinal barrier is people’s belief that HIV/AIDS is a not a problem for them. “They just don’t see that it could impact on their families _ not like heart disease,” said a public health official in a smaller rural service area. And in rural areas, though the situation has improved, funding is limited because HIV is not as visible as more common diseases like diabetes.

Another facet of this attitudinal problem is the tendency to blame people who are at higher risk for HIV transmission. One public health official noted that the public is often tired of hearing about AIDS, and too quick to blame people with addictions. According to another public health respondent, this low level of tolerance can also take the form of a lack of support in relation to family strife, unemployment, addictions, and other social health issues.

A respondent from a gay/lesbian health organization focussed in on homophobia, in the general community and within the gay community, as a barrier to HIV/AIDS prevention. This relates to a tendency toward “compartmentalizing HIV/AIDS and looking at people like they don’t belong to systems or communities and they don’t live in environments.” Studies have shown that gay men are becoming infected because of substance abuse and self-esteem issues, he said, “so it’s dealing with those issues to enable people to make healthy choices...we have to work with people to deal with the issues in their lives that cause them to take risks” More broadly, “we need to create environments where people feel safe to explore their issues and their lives. We’ve gotten too targeted around HIV/AIDS. We look at penises and vaginas and we don’t look at whole people and whole communities...If you feel worthless as a human being, why bother protecting yourself? Who cares whether you live or die. I’ve had people say that to me.”

A respondent from an ASO in a mid-sized service area said stigmatization can often block prevention messages in Aboriginal communities, where HIV is still seen as a gay white man’s disease . “That initial period is difficult because you’re trying to win people over,” the respondent noted. “When you’re going into sometimes hostile situations, you have to be really innovative about getting the prevention message out.”

Another respondent, speaking from a major metropolitan area, added that societal stigmas around sexuality represent a fundamental obstacle. Prevention workers are not free to discuss this topic, and often cannot go into schools to raise students’ awareness about HIV/AIDS prevention. “You can’t get into school to talk to children. Even in youth centres, it’s difficult. Our society is too prudish to allow a frank discussion of sexual issues.”

An ASO working with youth in a major metropolitan area faces similar challenges. When peer educators are brought in to speak to high school classes, the arrangement is often intended to fulfill a mandated curriculum requirement, so the time slot is typically limited to an hour. "If we're lucky, if I can convince the teacher, we get more than that," the respondent said. But if not, an hour is "not enough. When you're talking about HIV/AIDS and sexual health you can't really cover everything in an hour." Follow-up is also crucial, but "some teachers don't do it because they're uncomfortable." And peer educators can also face an uphill battle attempting to convince school officials that youth are qualified to deliver content in this area. By contrast, peer educators are given considerably more speaking time at alternate programs, where the target audience often includes youth who are most at-risk for HIV.

An ASO in a mid-sized service area stressed that women face additional barriers in attempting to protect themselves from HIV/AIDS. "Many women fear violence or abuse when negotiating safer sex," a respondent noted. "Women in the sex trade are particularly financially and physically vulnerable."

A local government official in one small community expressed concern about the assumption that people won't adopt prevention practices that run counter to their cultural beliefs. When campaigns aimed at specific ethnocultural groups are ruled out, the only available alternative is to target different groups based on risk behaviours.

A federal official identified "AIDS fatigue" is a huge barrier to effective prevention work. "People just don't want to hear about it anymore," she said. "There is the misconception out there in the public that the new HIV/AIDS therapies are as good as a cure…and they don't have to worry about it anymore." She also noted that social justice issues are generally not as high a priority as they used to be. "The plain fact is," she said, "that AIDS is just not an issue any more in the minds of the public at large." A public health official in a small community agreed that there can be a lack of public and political will to focus on HIV/AIDS as a concern, particularly in comparison with other health challenges like tobacco use. In this respect, the biggest barrier to effective prevention programming is the limited extent to which the community identifies with it.

Rethinking 'AIDS 101'

One federal official identified the "AIDS 101" mentality as a barrier to effective prevention. "You go into a school, you do your AIDS 101 talk, and you leave," he said. "That doesn't necessarily mean the individual is going to be less at risk. Because there are other things that put that individual at risk besides knowledge level." With young gay men, for example, there are issues of self-esteem and isolation, meaning that "prevention has to be more than education- based".

A public health official in a small community said prevention strategies must be completely rethought. "After 15 years of experience in the field, it is clear that a major barrier is the way

prevention activities are designed," the official said. "Behaviour changes must come from the clients, not from the prevention workers, and we have a hard time integrating this notion into our work." But when people are constantly told what to do, there comes a time when the message no longer goes through.

At a deeper level, the official said, the main obstacle is the lack of self-esteem in most people. "We must start in elementary schools and help children develop the self-esteem they will need to have a healthy and safe sexuality. If these kids don't like who they are, they are not going to take care of themselves properly. We must set up programs in elementary schools to foster self- esteem in children, then move on to secondary schools. Then we can try to reach those who fell through the cracks to teach them how they can reduce the risks."

Human Resources

Limited staffing arose as an issue in a range of settings – from public health offices, to correctional facilities, to an ASO struggling to deliver a state-of-the-art peer education program. "With more doctors, we could broaden our medical services, but its not going to happen tomorrow," said an official with a CLSC in a mid-sized community. "We're working on it, but things move slowly, very slowly."

A federal official cited a lack of trained staff as a major problem. When injection drug users became a major focus for HIV prevention efforts, he recalled, "a lot of mainstream agencies had to suddenly get their volunteers and staff on board, having to attend to these populations."

The Need for Partnerships

A federal official stressed the need for intersectoral partnerships to promote HIV prevention. "If you're looking at trying to really address the root causes or problems that put people at risk," he said, "you need to bring in other systems like the education system and housing that go beyond health." But a public health official in a small community noted that prospective partners often lack the time to take on one more issue. "Other agencies, particularly schools, are bombarded from all directions as to what they should include (in their curricula)." A provincial official agreed that prevention education in the school system is inconsistent at best. "Sex education in schools is pretty hit and miss generally."

Another federal program officer stressed the need for greater federal-provincial collaboration. "We need to have the provinces at the table," she said, particularly in regions and provinces that have never seen the full force of the epidemic and, therefore, may never have fully embraced the issue. "When your funding is based on ten in need, instead of a hundred, it's harder to get the point across in rural areas and small towns," she said. "The numbers game gets played – even if the proportion of people in need is the same, it's much smaller in absolute terms."

Lack of Context

Some of these barriers could be addressed by placing HIV/AIDS prevention within a broader policy context. "What we've been struggling with is the lack of a population health framework around AIDS," said one federal official. "If we are really serious about HIV/AIDS and other disease prevention, we need to start focussing on the risk factors that put people at risk for HIV infection in the first place – those socioeconomic factors that cause them to turn to drugs and other unhealthy practices." This would mean paying more attention to unemployment, poverty, and other social determinants that lead drug users to shoot up in the first place, rather than asking only whether they have a source of clean needles to avoid becoming infected with HIV and other blood-borne diseases."

A provincial official added that HIV/AIDS prevention is still fraught with political sensitivities because the virus has still not been "normalized" as a diagnosis or a disease. He suggested this stigma could be countered by linking HIV with other blood-borne pathogens, rather than continuing with prevention strategies that single HIV out.

But in at least one CLSC, this segmenting of health concerns extends beyond HIV/AIDS. Physicians are attached to specific programs dealing with 12- to 25-year-olds, home care, or mental health, and cannot intervene outside their assigned areas. "There is no such thing as general medical service at the moment."

This issue can be particularly pertinent for specific at-risk communities, said one provincial official. In the Aboriginal community, "there's a huge inheritance from post-colonialism and the abuse of the residential school system, which makes people vulnerable. Moving harm reduction into the Aboriginal community is going to be a challenge." Similar problems arise with street kids, sex trade workers, homeless people, injection drug users, and other "people living on the margins," for whom the pressures of day-to-day living represent a barrier to thinking about the long-term.

In part, this issue reflects a lack of services that would make youth or injection drug users feel welcome. "There are problems in the community here, but no one is taking steps to eliminate them," said a public health official in a mid-sized service area, who stressed the need for more supports to keep people from getting into the situations that can create problems like HIV infection in the first place. She added that "youth do not trust going into the public medical system," due to issues of confidentiality and accessibility.

How a National Association can Help

Respondents indicated that a national association like CPHA could help address their problems with prevention programming by:

Policy Development

- Acting as an advocate with federal decision-makers, in order to create a receptive climate for the front-line work that must be done and ensure that resources are directed to the targeted programs that are needed;

- Putting its considerable credibility behind national promotional/awareness campaigns to support effective prevention initiatives and counter inaccurate public perceptions – such as the belief that it's strange to hand out needles to injection drug users;

- Encouraging prevention approaches that position HIV/AIDS as one of a series of blood- borne pathogens that call for continued vigilance and public education;

- Extending greater recognition to youth-run programming;

- Encouraging broader HIV/AIDS prevention partnerships – for example, between the health and education sectors;

- Broadening the focus of its work on HIV/AIDS prevention, and encouraging other organizations to do the same, to include a focus on homophobia, self-esteem, safe communities, safe environments, and other determinants of health;

- Supporting policy development in specific communities, in partnership with front-line community resource workers;

- Involving itself in discussions of how pharmaceutical companies and governments arrive it a reasonable price for HIV/AIDS treatments.

Information Dissemination and Training

- Maintaining the AIDS Clearinghouse as a distribution point for prevention information – especially readable, plain-language materials in printed form, posters, and videos, since the Internet is inaccessible to many of the people who are at highest risk for HIV/AIDS;

- Avoiding the overkill and information overload that can result from constant bombardment with print materials, while encouraging local speakers to meet with youth, IDUs, or other target audiences on a regular basis;

- Supporting the development of standardized prevention modules for schools, reflecting the need to "start young and involve the whole community";

- Supporting skills development for front-line workers and policy-makers, particularly in rural and remote settings;

- Developing a web-based workshop, a set of pamphlets, and a standard conference presentation package to deliver the "prevention programming ABCs" to first-time HIV/AIDS educators.

Direct Support to Front-Line Prevention

- Helping to connect front-line practitioners with government core funding and other potential funding sources, possibly by maintaining a list of granting organizations;

- Encouraging greater coordination among front-line workers and governments in different organizations, and at different levels of activity. "I know it is somewhat suicidal on my part to say so, but one major obstacle is the fact that there are separate resource envelopes. As a result, mental health is competing with AIDS, AIDS is competing with drug use, and so on," a respondent said. "It's time to realize that AIDS is more than a virus – it encompasses other issues such as drug use, poverty and social isolation. Budgets should be based not on types of problems, but on people."

- An official from a provincial/territorial education department urged CPHA to support local community support efforts that take a more holistic, culturally appropriate approach to HIV/AIDS prevention for specific audiences, like Indigenous populations. "People have heard the information, and they're not acting on it. Their idea is that it can't happen here – it won't happen to me," she said. "We're destined to be the next Africa unless we do something."

Evaluation and Research

- Supporting evaluation of HIV/AIDS prevention strategies and dissemination of research findings, case studies, and project templates, to help front-line workers figure out what works and adapt it to fit local needs and circumstances;

- Conducting or encouraging more thorough research on prevention needs in rural communities.

- A handful of respondents were unable to answer the question because they had never heard of CPHA. This issue is explored in the report of the Montreal roundtable discussion.

CPHA's Role in Policy and Program Development

Respondents said CPHA's policy and program development role could include:

Policy Development

- Continuing the practice of distributing policy statements that reflect the consensus of the public health community;

- Working to change mindsets on new approaches and models, such as harm reduction as a basis for prevention programming with injection drug users;

- Encouraging "various public health sectors" to focus on living conditions and other determinants of health, rather than disease as such;;

- Addressing the current lack of a population health framework for HIV/AIDS prevention programming;

- Encouraging policy-makers to recognize the common roots that HIV shares with other health and social issues, such as teen pregnancy, addictions and injection drug use, and Hepatitis C;

- Entering the debate on specific policy issues, such as the discussion of accreditation and incentives for foreign physicians to practice in rural Manitoba;

- Fostering partnerships and collaboration among the different organizations involved in HIV/AIDS prevention, to replace the competition that now takes place between different disease areas;

- Developing policy and/or programming to address the impact of HIV/AIDS in correctional settings, Aboriginal communities, and street-involved populations, and among women, sex trade workers, and men who have sex with men;

- Recognizing and promoting Aboriginal approaches to HIV/AIDS prevention;

- Encouraging policies and funding frameworks that support front-line prevention organizations;

- Developing policy on fair access to treatment programs and provision of user-friendly services to all target groups;

- Developing templates for healthy public policy, to ensure that positive, effective approaches to prevention are not lost in the decentralization of health policy and service delivery;

- Making policy development information available to front-line prevention programs when they are starting up.

Information Dissemination and Research

- Continuing to act as a clearinghouse for prevention information and best practice guides;
- Providing some continuity in the distribution of educational resources;
- Distributing publications like *Canadian AIDS News* that help tie the country together and make it easier for front-line practitioners to avoid reinventing the wheel;
- Coordinating awareness campaigns that include national television advertising;
- Developing a national HIV/AIDS prevention curriculum that can be adapted by provincial/ territorial education ministries;
- Assembling research findings and best practice models and distributing them widely, with hard-hitting advice on the long-run financial savings attributable to prevention programs and the costs of inaction.

Other Forms of Support

Most replies to this question focussed on the development and coordination of educational messages and materials. Respondents called on the CPHA to:

- Serve as a central clearinghouse for educational materials from different AIDS committees;
- Develop materials in partnership with local communities, in a way that recognizes the good work that is already being done on the front lines;
- Identify or develop prevention materials that are specific to persons living with HIV/AIDS, and to different cultures, income groups, and sexual identities;
- Develop an accessible database and distribute regular listings of prevention studies, successes, failures and best practices, to help front-line practitioners sort through the available material and determine what works and what doesn't;
- Distribute interpretations of current epidemiological data, to help inform local programming;

- Ensure that prevention messages reflect underlying issues like self-esteem, substance abuse, and other factors that fall outside a strictly clinical context;

- Develop or provide training materials for different professional groupings;

- Provide an ongoing forum where prevention issues can be addressed;

- Develop a national media campaign to build public awareness and support for harm reduction as a disease prevention strategy;

- Support local activities around World AIDS Day.

Some respondents urged the Association to help raise awareness of HIV/AIDS prevention as a policy priority among senior decision-makers, and to promote partnerships that extend beyond health practices that focus primarily on treatment. “If we do not go this route, no progress will be made until a vaccine comes along,” one respondent stated. “In Canada, and in North America in general, if there is a pill that can be taken, we do not deal with the problem.”

One public health official said CPHA should review the HIV/AIDS Strategy for Nova Scotia, recently completed by the provincial AIDS coalition, and identify areas where its expertise can be used to support local efforts. Other public health respondents said CPHA could assist with capacity-building and policy development in smaller communities, and serve as a behind-the- scenes advocate for appropriate prevention policy and programming.

Once again, a couple of participants said CPHA will have to raise its profile in Québec if it hopes to have any impact on prevention policies or practices.

One public health official said CPHA has done good work to combat the stigma that is often associated with HIV/AIDS, but still has a long way to go. It’s encouraging that the Supreme Court has taken a strong, positive stand in this area, and that the issue has been redefined as the right to a life partner, to good health and to feel good about oneself. But “gays and needle users are still maligned groups, and they are at risk for HIV. Unless we can change structures and ways of thinking, then we can’t make the messages really do anything.”

A couple of participants stressed the value of communication and information-sharing among front-line practitioners, noting that resources are needed for computer networks and “telelinks” to support groups. In this context, they called on CPHA to provide funding, professional training, and support visits to isolated medical outposts. One ASO asked whether CPHA could provide financial support to CANNET, a national network of HIV/AIDS resource libraries whose funding was recently cut off.

Best Practices

Participants identified a range of best practices in HIV/AIDS prevention, including:

- Cost-effective collaborative processes, in which "people all come together around the table that are involved in the issue, together with people who are actually living with HIV/AIDS, and discuss the issue and work out their values, beliefs, fears, things that they think need to done in the community";

- Train-the-trainer programs that build up the expertise within an agency, to increase the likelihood that knowledge and information will continue to circulate beyond the time limits posed by project funding;

- Local partnerships that involve multiple organizations working together and sharing resources, so that more people can be reached, as well as a post-secondary research component for evaluation purposes;

- Culturally appropriate prevention models and curriculum resources that are tailored specifically to Aboriginal communities;

- Closer networking among physicians, nurses, and other health practitioners who share an interest in HIV/AIDS prevention;

- Small group and one-on-one interventions that make it possible to "refocus people on themselves";

- Use of videoconferencing to link 30 or more rural communities involved in training programs;

- Remembrance services and meetings of HIV/AIDS educators rural communities;

- Prevention programs in the Netherlands (Amsterdam, Rotterdam), Australia, the United Kingdom (Merseyside), Switzerland and Germany (Frankfurt), all of which combine harm reduction programs with enhanced social housing, social services, outreach education, and diversion from the criminal justice system for members of at-risk populations;

- Peer education and teen wellness centres, as well as mobile needle exchanges and clinics for urban street youth, to provide "*safe*, youth-friendly environments for young people to access the supports they need";

- Street outreach programs in Toronto and Kingston;

- A protocol for a low-maintenance methadone treatment produced by the Kingston Health Unit, entitled *Methadone Maintenance: A Guide to Establishing a Clinic-Based Program*;

- Needle exchange programs, like the 24-hour centre at Toronto's Wellesley Hospital, that are accessible and convenient for injection drug uses and include a major peer involvement component;

- A prevention manual produced in Winnipeg, entitled *Taking Care of Each Other*;

- A Winnipeg street outreach program;

- Street outreach programs in parks, on the streets, in "shooting galleries", and in other settings where members of key target populations feel at home;

- Policy development related to institutionalized populations, conducted by the Batshaw Centre in Montreal;

- *Project Ten*, a network of local groups for gay, lesbian and bisexual youth, designed to create a safe place where young people who were previously marginalized can find mutual support;

- As a reference point, recent reports developed in partnership with gay, lesbian and bisexual youth, including *Safe Spaces*, *Make Noise*, and *Bright Red Hair and Sliced Bread*;

- Establishment of a home for active drug users that succeeded in stabilizing 80% of its residents, as a necessary first step in delivering prevention messages and programs (the home was eventually deemed too expensive and shut down);

- A partnership between public health officials and corrections staff at a federal penitentiary to curb the transmission of blood-borne pathogens;

- Development of an interdepartmental, interjurisdictional secretariat to deal with a full range of child and youth issues, including HIV/AIDS prevention;

- Use of the Internet to link Aboriginal communities and other remote settings, with local interfaces that allow sufficient privacy for users who want to ask questions or download information. (Internet access skills will still limit the reach and value of this particular approach.)

- Some respondents stressed the importance of evaluation in demonstrating to funders and others that a program has established itself as a best practice model. "The critical thing from a funder's perspective," said one respondent, "is evidence that the program is answering a real need, and is working to fulfill that need." One participant said it would be useful to receive additional detail on ACAP-funded projects, to get a sense of what worked in communities and why.

The Roundtables

Roundtable discussions were held in early May in three communities – Vancouver, Montreal and Ottawa. Despite two attempts, the project team was unable to find a suitable time for a roundtable session in Halifax. One key participant, in particular, explained that his time was very limited because of the effort required to deal with health program cutbacks at the provincial level.

While the three roundtables were based on a common discussion guide, the summaries demonstrate the extent to which each group established its own focus and direction. Comments and insights from the roundtables have been incorporated in the observations and recommendations at the beginning of this report.

Vancouver Roundtable - May 2, 2000

Participants

- Margaret Birrell, Executive Director, BC Coalition for People with Disabilities
- Brian O'Connor, Regional Medical Health Officer, North Shore Health Region
- Heather Pattullo, President, Public Health Association of BC; community developer, Vancouver/Richmond Health Board
- Paul Perchal, Director of Programs and Services, AIDS Vancouver
- Chris Wong (moderator)

Moderator Chris Wong reviewed the highlights from the fax survey and asked whether participants had any comments. A participant said large urban areas appeared to have been under-represented in the survey, and noted that the list of target audiences did not conform to those that appear in standard epidemiology reports. He also expressed surprise that the list of prevention strategies did not include the use of new drugs that slow the progression of AIDS, as this is an important component of his organization's prevention program. He expressed concern that, in BC at least, public health policy is slipping back towards old ways of doing things, citing partner notification as an example.

What target audiences for HIV/AIDS prevention activities do you think will be most important over the next two to five years?

A participant predicted that the audiences who "will be" targeted are different from those whom he believes "should be" targeted. Those who should be targeted are straight men, women, youth, Aboriginal people and gay men. Women have had the fastest rate of infection in recent years, he noted, yet relatively few resources are being allocated to prevention efforts for this group.

A group member said intravenous drug users should also be targeted. The previous speaker agreed, but noted that the rate of infection for this group has levelled off in recent years. He said

advocacy and lobbying will be needed to close the gap between the most likely and the most necessary target audiences for prevention efforts.

People with disabilities were identified as another important target audience, with a participant noting that the problem of HIV/AIDS in this group can only be addressed by tackling broader issues such as poverty and the overall determinants of health. Since deinstitutionalization, many people with disabilities are living vulnerable lifestyles on the fringes of society. The participant said her organization supports deinstitutionalization, but deplores the lack of supports that has led many people with disabilities to places such as the Downtown Eastside. She also cited the problem of hidden HIV/AIDS infections within institutions and group homes – a problem that no one wants to discuss, since it opens up the Pandora's Box of sexual abuse in institutions.

A group member said the bulk of new incidences of HIV infection are occurring among groups who live in poverty, with few or no social supports. These include IV drug users, Aboriginal people, street youth, straight men and women, and people with mental illness or developmental disabilities. Prevention efforts should focus on these vulnerable groups. However, he added, this does not detract from the need for other strategies, such as using drugs to halt the progression of the disease.

A participant said prevention needs to address the societal and underlying factors that influence the transmission of HIV/AIDS. Behavioural approaches are not enough, although most prevention strategies are still biased towards them.

What types of prevention activities will be most important over the next two to five years, and why?

A participant said a truly comprehensive prevention strategy would look at personal factors, interpersonal factors, societal factors and structural factors. This would mean understanding socio-cultural aspects of how individuals deal with risk, and how an individual's immediate surroundings can affect the way they respond to risks. It also includes providing the necessary health services and supports, ensuring they are culturally-appropriate and providing other basics, such as housing.

The next speaker referred to a radio interview she had heard that morning, in which a City of Vancouver official discussed the success of other cities, such as Liverpool and Amsterdam, in addressing these problems. In the case of Vancouver, a regional approach would be needed, including all the health boards in the Lower Mainland.

Another group member said the radio discussion had stressed the value of using the harm reduction model: "You accept that no matter what you do, there will be IV drug users, so you try to make it as safe as possible," he said. While certain authorities, like the Vancouver police, support decriminalization, needle exchanges and other harm-reduction strategies, the RCMP and others remain staunchly opposed. The CPHA could therefore play an important national role in changing

attitudes. "If IV use is a significant contributing factor, then the only model that will work is harm reduction," the group member said. "Enforcement won't work."

"In prevention, we try to communicate to people that they need to behave safely," added another participant. "But often, we don't provide them with safe alternatives." Condoms are an important harm-reduction tool, but they are still not universally available in Canada and many people in vulnerable populations have to buy them. "Access to safe harm-reduction services is essential," the participant said.

A group member described the North Shore community as very conservative and moralistic, suggesting that a proposal to install condom machines in schools would prompt a huge outcry. Community mores represent an important barrier, and dialogue is needed to overcome them. These attitudes send IV drug users from the North Shore to the Downtown Eastside, and gay men with HIV feel more comfortable seeking services in downtown Vancouver – all of which allows the North Shore and other similar communities to continue pretending that they don't have a problem.

Several participants said an important factor noted in the radio interview was decentralization of services in urban areas, with one speaker noting that the city of Frankfurt had established services in suburban areas before authorities tackled the downtown core. The same approach is needed in Greater Vancouver, she said, but it won't be easy – even establishing the HIV clinic in Richmond was a challenge.

A participant said the CPHA can help to change attitudes through a national awareness campaign on intravenous drug use (IDU) and sexual transmission. Universal condom distribution would be another valuable strategy, he added.

What gaps do you foresee in program delivery? Are there populations at risk that are not being served? What can be done to fill these gaps?

A participant said strategies that address youth are very incidental, and there is no provincially-mandated systematic program that targets youth. He acknowledged, though, that such programs would face opposition from conservative parents, school boards, and others. Another speaker agreed, noting that any sex education curriculum can raise fears, even though there have been proven results in places that implemented sex education programs with an STD component.

A group member wondered what prevention programs are being provided in colleges and universities. Another participant cited anecdotal reports that little or no HIV/AIDS prevention was being done at one North Shore college.

A participant said her organization is the only cross-disability group in Canada with an HIV/AIDS prevention program. The group has had more success in getting people to access information since it launched a website about a year ago, providing "wellness information" that people can

seek out in a private way. Care providers and associations need to be more courageous is addressing these issues, she added. Even staff who make the effort are sometimes "shut down."

Other gaps include inconsistency in pre- and post-test counselling and how this affects individuals' ability to have safer sex, a participant said. Displacement is another problem that results from using a crisis approach to HIV prevention: As new populations are identified, resources are shifted, leaving older populations with insufficient resources. The participant stressed that health professionals need more training, not just on HIV but on the social and cultural factors that affect people's ability to access services.

A group member said problems can be exacerbated by changes within the public health authorities. Some services are doing well and others have no resources, she said.

What forms of support can national non-government organizations provide to help you achieve your HIV/AIDS prevention goals at the local or regional level?

A participant said organizations like CPHA can use a national approach to address the problem of societal attitudes. CPHA can also target decision-makers, from school trustees and municipal officials to MLAs, through their national organizations, helping them to understand that HIV/AIDS prevention is much broader than simply a health issue and that their decisions have a significant impact. Another group member agreed that change will come when the issue is no longer just in the hands of health officials and advocates, and when national decision-makers acknowledge it and start putting it on their agendas.

Other participants stressed the need for an intersectoral approach, and underscored the role of a strong public spokesperson in promoting information flow and keeping the issue "in the foreground." In times of restricted health spending, there is also a need for a national voice to balance other associations, like the BC Medical Association, when they take positions that would undermine HIV/AIDS prevention efforts.

Citing international studies indicating that money spent on prevention reduces transmission, which saves health dollars in the long run, a participant said CPHA should advocate for more resources for prevention and capacity-building. He also proposed two-way information-sharing with less developed countries, noting that different societies have much to learn from each other.

What role(s) can CPHA play as the national voice of Canada's public health community?

A participant called on CPHA to help create awareness among public figures and the general public, by serving as a voice for a public health system that is being eroded across the country. As public health is reorganized, with new health regions and limited budgets, he said acute issues will naturally receive priority. A strong voice is needed to ensure that community health and health promotion are not forgotten.

Another group member agreed that CPHA has a valuable leadership role to play, especially in relation to intersectoral collaboration, information-sharing, and capacity-building. CPHA could also serve as the "national face" for a campaign for universal access to harm reduction services. He added that CPHA's role as an information clearinghouse should be re-examined, given recent questions about its effectiveness. A participant stressed the importance of linking national campaigns to the strong grassroots organization required to make them effective.

One speaker said CPHA could be far more effective as a strong policy advocate than as a supporter of programs. However, he acknowledged that an advocacy role might create difficulties when it brings the CPHA into conflict with the same government that funds it.

Where should CPHA be looking for partners to help support this activity?

There was some concern that CPHA would have to stretch its resources too thinly if it tried to work with organizations at the local, provincial and national levels. The focus should therefore be on working with federal departments, and with national umbrella organizations that represent teachers, municipal staff and others who work at the community level. A participant said she was pleased that CPHA already works with the umbrella body that represents non-governmental organizations. Another group member encouraged the Association to work with organizations that represent the different HIV/AIDS populations, and with provincial AIDS networks and coalitions, to ensure that issues specific to each target audience are considered. A participant said CPHA should also work with the Canadian Healthcare Association and with equivalent provincial bodies, since HIV/AIDS prevention is more than a public health issue.

More broadly, which players, inside and outside government, should be involved in HIV prevention policy and program development?

Participants reiterated that since the CPHA is funded by the federal government, an advocacy role may occasionally bring the organization into conflict with its funder.

The moderator asked whether other federal departments should be involved in prevention policies. In the context of the determinants of health and harm reduction, a participant replied that income, social security, police and RCMP, housing, and many provincial departments have roles to play. Participants agreed that the "cause" of HIV/AIDS prevention needs a highly visible, vocal advocate who can "lead the charge" and keep the issue in the public spotlight and on the government agenda. The environmental tobacco smoke lobby was cited as an example.

How would you prioritize the list of roles?

"If we are going to maintain a public health system, the advocacy role is key," said one participant. However, she cautioned that once an organization takes on an advocacy role, "there is no going back, because then you have weakened your ability to perform all your other roles." But another speaker agreed that the role of providing a strong public voice is both the most effective and the least costly one for CPHA to take on.

A group member said CPHA should seek to provide leadership in advocacy, information-sharing and capacity-building, adding that capacity building includes expanding the issue into the different sectors that need to become involved and getting buy-in from decision-makers. He questioned whether CPHA has the capacity to effectively mount a national campaign, suggesting that this should be a lower priority unless the organization gets more resources. He said a shortage of resources had made it difficult to get information from the HIV/AIDS Clearinghouse in a timely fashion.

What are the top five HIV/AIDS prevention goals for the next three to five years, and how would you measure progress towards those goals?

A participant said the top goal is obviously to decrease the incidence of HIV/AIDS in target populations. Progress would be measured by monitoring the relevant statistics. Another group member said prevention programs should also aim to reduce the progress of the illness among identified target groups, continue to increase the capacity of groups working in HIV/AIDS prevention, strengthen intersectoral co-operation, increase the amount of HIV research being carried out in Canada, and improve evaluation of prevention efforts.

Evaluation could fall under the category of research, the group member said. Some very successful work is being done in Canada, and is well worth studying. Most of the research now being done in Canada focusses on behavioural approaches to prevention, and is being done in a very academic fashion, yet community-based research can result in very effective and innovative programs. However, very little of the funding allocated for this type of work has been spent in the past two years, because organizations find it very hard to meet all the protocols and requirements. Capacity-building could help to bridge this gap, he added.

Concern was also expressed that the public health approach to HIV prevention has been shifting back to old public health models, such as partner notification. “That approach hasn’t worked,” a participant stressed. “Embracing harm reduction and working with other sectors has worked.” Based on experience in a number of countries, “we have to stop responding in a crisis fashion and come up with a more comprehensive and coordinated way of dealing with it.” Another group member explained that partner notification is not a matter of returning to old models of public health, or of penalizing or singling out individuals with HIV/AIDS. The reasoning was that many of the partners belong to marginalized groups, and would be unlikely to get support otherwise. Another consideration was the availability of effective treatments that could slow the progression of the disease if used early enough.

Based on these goals, are there areas where existing HIV prevention policies should be reviewed, or where new policies should be developed?

A public health participant stressed the need to focus on harm reduction instead of enforcement, which is not only very costly, but ineffective. Another group member said drug policies should be reviewed, citing difficulties for IV drug users seeking access to methadone or heroin. Post-exposure

prophylaxis also needs to be examined, as there is no policy for its use in cases of non-occupational exposure. Rapid HIV tests are being tried out in certain areas, and they should also be discussed before becoming widely available.

For groups with disabilities, a participant said problems such as poverty and ghettoization must be addressed before transmission of HIV can be controlled. But another group member said that, despite the talk about population health, little has been done to move beyond a focus on acute services. In some respects, it appears that government may be moving away from a population health approach, and if this is the case, it should be debated.

A participant said policy discussions should include some consideration of where to draw the line between prevention and treatment/support. This should include a look at complementary therapies, especially where they increase an individual's ability to cope. Another group member reiterated the importance of advocacy, noting that the Insurance Corporation of BC is considering cutting out many complementary therapies. The same has happened under other programs, she noted. "Until we have really strong advocates and groups with very strong leverage, we're just playing in the sandbox," she said.

Wong asked participants if they had any further comments to add. Several commented that this had been a very good discussion and thanked the moderator, who thanked them in turn for their valuable input.

Montreal Roundtable - May 4, 2000

Participants

- Élise Bénard, Centre d'action sida Montréal - femmes (CASM)
- René Lavoie, Séro Zéro
- Joanne Leroux, CPA-VIH
- Ken Monteith, ACCM
- Anne-Marie Racine, Les enfants de Béthanie
- Denise Byrnes (moderator)

Moderator's Comments

(The moderator provided the following observations shortly after the roundtable took place.)

First of all, the participants were all from community organizations involved in direct intervention work, so the discussion does not reflect a variety of organizations. The reps from Health Canada could not attend at the last minute. This was seen by the other participants as a lack of interest in participating, and we had to clear the air first. Their feeling was that they are always the ones who take the time to come, while government health reps don't view this kind of exchange/consultation as a priority.

The other major difficulty was the lack of knowledge and/or familiarity that the participants had with the CPHA. They stated clearly that they have very little contact with them, are unsure of their mandate or role, don't know what their resources or objectives are. Therefore they felt unable to identify a role for the CPHA in regards to the work they do on the front lines. They suggested that the CPHA should distribute information about who they are, their mandate and scope before consulting them. One cannot ignore either that in Quebec, national organizations are less "welcome", less "known", and tend to provoke a certain suspicion. This is a reality that is very present at the community group level...

After several attempts to get them to identify a role or a place for CPHA, be it in policy development or support to programs, it became obvious that the discussion would go nowhere. I tried to orient things towards priorities for prevention work and gaps in actual programming. After a certain refusal to collaborate by some participants (we've done this before, what will come out of it, the people who should be here aren't, CPHA is not here...) we managed to get the discussion going and to identify a few key areas that they saw as important focusses for the next few years. This led into some discussion of a possible role or focus for CPHA (to fill the gaps), but again, they felt they could not really be clear without more information.

On the whole, the exchange was interesting and productive...I had expected this kind of dynamic, knowing the community groups in Quebec and the relationship to national groups as well as government. In any case, I hope that the information I was able to collect will be useful and that perhaps CPHA will take note that they are a bit unknown in the Quebec HIV/AIDS community – this alone may be very useful!

Discussion Notes

After inviting participants to introduce themselves, the moderator asked them for their comments on the preliminary survey results that were sent to them prior to the roundtable. Comments dealt mostly with the consultation process.

A participant said that he had recently been to another meeting where CPHA had a prominent role and that he wondered what the Association's role was in the prevention field. "What's their mandate and who gave it to them? How do they fit into the Canadian AIDS Strategy? It is not clear." He wondered what caused CPHA to suddenly show interest in AIDS prevention: "They were nowhere to be seen for the last ten years. Why are they making their presence felt now?"

Another participant felt that CPHA was "mixing oranges, potatoes, and apples" in its survey, mixing together partners, questions, types of organizations..."I have no idea what these preliminary results are about", she added, as they do not help people understand who does what, or in what perspective. The numbers quoted, she felt, would be more meaningful if only comparable things were put together and if terms were more rigorously defined. Another group member agreed.

The budget numbers were seen as being of little use, since support and prevention usually share the same budget. The use of the words "prevention", "awareness", "education", and "training" was also questioned: "It is all mixed together here." Education, a participant noted, is "AIDS 101", training for AIDS workers, to help them intervene in a more effective way. Awareness was more accurate to designate information booths in schools, social marketing, broader interventions. As for prevention, he felt that this term designated interventions and programs aimed at targeted audiences. It includes counseling and needle exchange programs, for example.

Another participant noted that only community organizations were represented at the roundtable and expressed a certain skepticism as to the usefulness of the meeting. "Are we here so that decision makers can say later that community organizations were consulted while they decide single-handedly what is going to be done?" She wondered how such a meeting could be useful when there was nobody from the Quebec government or from Health Canada. She wanted to make it clear that they did not come as "Yes Men" and wanted to know what their role would be in the final results.

Participants also noted the absence around the table of CLSCs and intravenous drug users: "The round table is far from round," they unanimously commented, adding that this gap would not help CPHA to be taken seriously.

The moderator asked the group what their expectations were with regards to the consultation. Alluding to the introduction to the report on the preliminary survey results, she suggested that it might be difficult for them to help CPHA define the role it should play in the development of HIV prevention policies when they do know anything about the Association. Other group members

agreed that the Association is not well known in the HIV/AIDS field in Quebec. One participant had heard of it because his background was in youth services, where it is better known, partly through its newsletter. "CPHA needs to work on its PR," he said. Why didn't they, for example, send the last issue of their newsletter with the invitation to the roundtable?"

It was also pointed out that the AIDS field is already well organized and that networks are already in place. "Maybe the need for an association such as CPHA to get involved is lesser than in other sectors...".

Participants felt it was difficult to say when nobody in the group knew the Association and its work. People also wondered to what extent it could be trusted, and felt uncomfortable pushing their own agenda when so many sectors were not represented at the table. "All the people living with AIDS are important. We cannot push one group." There was also concern about the usefulness of such a consultation when so few organizations and sectors were represented. "All the groups mentioned in the survey should be around the table, otherwise we will have to start all over again, as usual," said one participant. "Today's meeting cannot give a sense of the situation in Quebec," another speaker agreed. In response the moderator's explanation that CPHA was hoping to get information from these roundtables to better direct its policies and identify existing gaps, a participant suggested that identifying gaps was a dangerous approach: "Every year, a few priority groups are identified and then, the next year, it has changed."

More willing to "play the game" and contribute, one group member talked about what she would like to see done in her field. She stressed the need for universal health precautions to be applied in all organizations and institutions. Very often, for example, child care centres do not take these precautions and are not even aware of them. Another participant agreed, noting that she regularly receives calls from martial arts centres asking to have students tested. What they really want, she said, is to be able to get rid of whoever is HIV-positive, when universal health precautions would be enough to protect all involved. Several people felt that education was badly needed, as shown by people's belief that walking barefoot on a karate mat where an HIV-positive individual has been, and maybe bled, is dangerous. Another group member recalled that the Canadian Police Association had tried to promote a Private Member's Bill that would have made it compulsory for anyone arrested or wounded to be tested for HIV. "It is frivolous to think that people are informed when it comes to HIV," a group member commented.

Education must be combined with universal health precautions, stated a participant. "We should act as if everyone had AIDS instead of trying to figure out who does. This would lead to better treatment of HIV-positive individuals." Many children are still being refused by day care centres, she added, when there wouldn't be any problem if all staff practiced universal precautions. Someone else suggested that what was needed was a demystification of the modes of HIV transmission. This is an "awareness" more than a "prevention" issue, she added.

Participants also identified the need for counselling and education for blended families. Issues such as partners telling each other about their HIV status, and how to live with a person who is HIV-positive, are not being adequately addressed.

A group member suggested that HIV/AIDS prevention programs targeting youth are the latest fad. "This tells me what to put in my next funding application", a participant commented. Although they did not deny the importance of this population, participants felt it was misleading to think of HIV/AIDS as a disease that can only be contracted by young people. Someone noted that 40- to 50-year-old newly single women constitute a high-risk group which is often forgotten. These women grew up before sex education became common, never bought condoms, and can end up behaving like teenagers and taking risks. In addition, they often feel that they are not in a position to impose safe sexual practices on their partners.

Another forgotten group is infected straight men who are not sufficiently targeted by prevention activities. A major problem is their fear of being mistaken for gays, which prevents them from getting help.

The group agreed that these issues all come back to the lack of work on sexuality in schools. "Young people are not made to feel secure in their sexuality", a participant noted. "You see young gay boys committing suicide or engaging in high-risk behaviours, but schools do not want to do anything to make young gays more comfortable with their sexuality". The first step to protect young people would be to make condoms available in schools, but this is not about to happen, someone else commented. But it's also important to work on a longer-term basis with groups to help develop their self-esteem and their social skills.

"It is not enough to teach AIDS 101 in school," the participant said. "We must also teach assertiveness to children and young people." This could be achieved by building notions of prevention and awareness into more general discussion groups.

Interventions designed to raise awareness in the workplace and in women's centres would also be useful as a means of reaching adults over the age of 30 or 40, a participant suggested. The difficulty in these settings is that health workers may not believe that HIV/AIDS is truly a problem for their client population.

It was suggested that a different approach might be helpful: "If we used personal testimonies, young people might listen better. We have preached for too long, and they've stopped listening." Testimonies of people who did not think they were at risk and still contracted HIV would have more impact. Another participant added that young people want to hear about love, not about sex or condoms. "We must talk to them about love if we want them to listen." Another challenge is to make them aware of the risks. Often, she explained, they feel that they are safe because they are in a "stable relationship"and, once they have been with the same partner for a while, they feel that

it is no longer necessary to protect themselves. The problem is that a stable relationship, at their age, means staying with the same person for a couple of weeks, she added. She also pointed out that old mentalities are still alive: a girl who has not gone out with many boys is still seen as a "slut", whereas a boy who has had many girlfriends is just a cool, popular guy. "The problem is as much the mentalities as it is the condoms. Since we have not found the way to do a condom or a brain graft yet, we must find another method to convince young people", she added.

Another suggestion was to emphasize the positive, by presenting condoms as part of a healthy relationship, rather than as a barrier.

Participants agreed that prevention efforts should be built on the example of what the gay population did when AIDS appeared. "They became mobilized, they worked on raising awareness, and this is why they went and got tested. The fear is not the same in other groups, and this why it is more difficult to promote prevention." Another person added that a high proportion of gay men were tested in Quebec, higher than in other places. Since testing is not compulsory, though, it is difficult to know the true extent of the epidemic.

"We must make a distinction between the real epidemic and the fictitious one," a group member commented. "It is not true that all young people are equally at risk. Prevalence is at 0.5% in the communities where 40-year-old women live, which is considerably lower than the 17% prevalence rate among intravenous drug users. However, he continued, awareness campaigns should remain very broad. Low-risk populations should not be ignored, just because they are less at risk. The danger is that the various groups will end up being pitted against each other.

Another concern is that HIV/AIDS no longer sees the serious media attention that it received in the 1980s. "How do we compensate for the fact that it is no longer discussed in the media?" a participant asked. From this starting point, a participant suggested that CPHA could the federal government to make prevention a top priority. There was general agreement on the need for political work, to get the government to finally invest in prevention after talking about it for 20 years.

A participant suggested that it might be effective to reverse the message that has been sent so far. Instead of having injection drug users, gay men and commercial sex workers talk about their experience and encourage people to take precautions, it might be more effective to have high- risk youth who avoided HIV through appropriate precautions, talking about their low-risk parents who failed to protect themselves because they felt a distance from the epidemic. A group member pointed out that, in reality, injection drug users are still more at risk than a 40-year-old woman who is not taking drugs or working in the sex trade, but another participant replied that something is not working because people continue to become infected.

A participant suggested changing laws that run counter to prevention efforts, such as measures that forbid needles in jail. “Harm reduction does not carry much weight against laws and societal rules,” she said.

The moderator asked the group what role they thought CPHA should play in the health field. Participants identified feedback on this consultation as one of the first things they wanted from the Association. They added that CPHA could act as an information broker, to help front-line workers keep track of the many groups and organizations in the field. Although they repeated that it was difficult to answer the question without knowing more about the Association’s mandate, budget, and political role, they suggested that it work to harmonize federal health policies and laws with harm reduction principles, and coordinate efforts with the Association québécoise de santé publique.

The moderator thanked the participants, who reminded her that they would like to receive feedback from CPHA and be informed of the results of the survey.

Ottawa Roundtable - May 4, 2000

Participants

- Neil Burke, Canadian Public Health Association
- Ron de Burger, Health Canada
- Danielle Dorschner, Ottawa-Carleton Regional Public Health
- Angela Favretto, HIV/AIDS Prevention and Community Action Programs, Health Canada
- Alain Houde, Canadian AIDS Society
- Lise Ladouceur, AIDS Committee of Ottawa-Carleton
- Mitchell Beer, InfoLink Consultants (moderator)

In response to participants' initial questions, it was explained that:

- The results of the environmental scan will have implications for the HIV/AIDS Clearinghouse's specific role in support of the front-line community, but that some of the results would focus more broadly.

- While traditional HIV/AIDS service providers were contacted for the fax and telephone surveys that took place earlier in the project, some federal, provincial and local governments were involved as well. Pharmaceutical companies were not contacted.

- The survey report will be based on the questionnaires, interviews and roundtable discussions, and not on a review of past literature.

What are the most important target audiences for HIV/AIDS prevention activities over the next two to five years?

From a public health perspective, injection drug users are the biggest target audience, followed by women. Studies indicate that it is important to intervene in that definite period of time between "snorting" and turning to injection drugs. These people can be found by focussing on substance use in general, by looking at the youth in the street and at the colleges and universities.

One participant felt that since men who have sex with men are still the most affected population, they should be identified as a priority audience alongside injection drug users. As far as youth are concerned, focus should be maintained on marginalized youth rather than youth in general – overall, the priority should be to reach the more vulnerable members of specific populations. Prevention messages should be supported by a general public awareness campaign, so that the public will not become an obstacle. Many other components of society need to be addressed for prevention programs to be effective – for example, if clean needles are needed but the mood of the population will not allow for it, then it will hard to get those clean needles.

A participant provided an historical perspective on the public health response to the HIV epidemic. Since the CPHA program was established in 1986, its focus has shifted from general awareness,

to specific targets, back to a holistic approach that incorporates elements of both. There needs to be a receptive climate in society at large, particularly among decision-makers. For example, the province must be involved for a program to be successful, but a good provincial program will go nowhere if the ground is not prepared for it.

For example, participants noted that the needle exchange program in Ottawa-Carleton was controversial at first, because the harm reduction approach was not understood. The program did receive support from Regional Council, unlike its counterparts in some other communities.

More broadly, a "War on Drugs" atmosphere influences the way prevention is done. And if the surrounding climate were more receptive to homosexuality, gay men would feel more included.

Participants agreed that CPHA can play an important role because it has a broad reach and can work at the policy level, in addition to preparing and disseminating materials. Supportive regional councils can be influenced by CPHA through provincial affiliates, though this process takes time. CPHA's policy process has also had a considerable impact on members' and affiliates' approach to HIV/AIDS prevention.

What gaps need to be addressed within the next two to five years?

Drug laws need to be reviewed. Participants stated that the "War on Drugs" is not helpful; rather, there needs to be a war on the War.

In relation to women and HIV, it can be too easy to forget about links to sexual violence, family violence, and issues of control. Women's shelters tend not to focus on HIV, even though many of their clients come from endemic countries. Participants generally felt that women receive the strongest HIV prevention messages when they have "bad habits", or when they are pregnant. They stressed the importance of focussing on young women with no skills to negotiate healthy relationships, or women who are newly divorced who have never had to think about safer sex. One part of the solution would be to advocate for wider use of microbicides, which can be easily used by women without their partners' knowledge.

Participants also stressed the importance of strengthening the "basic social health care system". Determinants of health, including housing, social security, and employment, are all linked to HIV prevention _ for example, a homeless person with no job may well end up in jail, where there is no safe way of injecting drugs. In large part, a determinants of health approach would mean seeing people as human beings, rather than as vectors or victims.

The group also suggested that CPHA attempt to form working partnerships with non-AIDS groups at the national level, in the same way that local public health offices and ASOs have formed community partnerships.

Youth programming requires considerable support. Some jurisdictions have healthy sexuality programs in the schools, but they need to be supported by awareness campaigns for parents. At the other extreme, school computer systems in one province are monitored so closely that they shut down completely if a student types the word “sex” into the search box. In Europe, HIV transmission is primarily related to drug use, rather than sex, probably because the culture is much more comfortable with sex.

The group identified curriculum development officers and departments of education as an underserviced community. There is a tremendous competition for curriculum space, so officials must be convinced that one topic is more important than others. An easier and more appropriate approach may be to adapt existing health curricula to address HIV prevention more thoroughly, along with other issues related to healthy sexuality.

One participant suggested a sharp distinction between prevention and risk reduction as policy and program goals. Where prevention implies an “all or nothing” attitude, risk reduction has more to do with empowering people, by providing them with the information, skills and motivation to make their own decisions.

The group also acknowledged that new HIV treatments have taken some of the apparent urgency out of prevention and harm reduction messages. In the 1980s, when AIDS was rampant, there were a lot of funerals. Diagnosis came late, with a life expectancy of 22 months, leading many older gay men to change their behaviour. With the new perception of HIV as a manageable disease, prevention becomes a harder sell with younger audiences.

What supports can a national organization like CPHA provide?

Participants identified several policy gaps:

- Other diseases such as tuberculosis, sexually transmitted diseases and Hepatitis C are active co-factors for HIV. The literature shows that the combined effect of these diseases with HIV is greater than the sum of their parts.

- Secondary and post-secondary schools are an important area where there has been little effort, and no formalized initiatives. Students at these institutions are at the age when they begin risky behaviours.

- CPHA should explore opportunities to work with private and public sector partners, to extend the reach of prevention initiatives and bring new resources to the table. There is an opportunity to develop prevention campaigns through unions and human resource departments.

The Canadian AIDS Society sees more national organizations focussing on awareness, preparing the ground and bringing down barriers so that prevention programs will be more effective. But a multi-faceted approach will be needed for awareness to take hold. An example would be an awareness campaign to show the effects of the War on Drugs on people in the street, to break down resistance to needle exchange and methadone programs. An awareness campaign could also take the form of a series of television ads, showing that drug users are people, too, but have to have a box to put their used needles in, in order to reduce the danger to others.

Awareness campaigns can be passive or aggressive. Posters are an example of the passive type. A more aggressive approach is to take every opportunity to get the message out by:

- Writing editorials and letters to the editor;
- Appearing on talk shows;
- Addressing Parliamentary committees;
- Speaking to policy-makers;
- Observing theme dates such as World AIDS Day;
- Speaking to school boards;
- Capitalizing on opportunities, such as an uproar in the community about a particular event or program.

Participants stressed the value of being able to call on CPHA for support on local issues, noting that the organization enjoys a high level of respect across the country. Public health units are the local network responsible for preventing disease, and the moral support they receive from CPHA can come in handy in reinforcing the public positions they take at town council meetings.

The moderator asked whether town council meetings or other local "uproars" might represent a "teachable moment" for HIV prevention, and whether CPHA could assist either by producing an issues management guide or having qualified speakers available to support local health units in different parts of the country. Participants said expert speakers had been used informally to some extent, but noted that a more organized speakers' list would require more knowledgeable people who are available and have the right personality for the assignment. A "how-to" guide was a less popular option: the group agreed that it's easier to seek advice from a colleague than to look up printed material, and suggested CPHA's role could be to bring people together – by telephone or via the Internet – to discuss common issues and similar challenges. Even then, the designated contacts would have to set aside time to share their expertise – although a participant pointed out that the sharing process would be part of the sharer's learning, too.

A key responsibility for CPHA is to put HIV/AIDS back on the national agenda, as a means of reinforcing the work that is already being done by some health units and enabling others to get back on track. The challenge is that, beyond the three major clusters in Toronto, Montreal and Vancouver, HIV/AIDS is "not high up on the radar screen" and health departments do not see it. So while some areas require more support, others need to be reminded that AIDS has not gone away.

This difference in focus underscores the need to tailor prevention messages to people at different levels of awareness, knowledge and involvement, with different community dynamics and norms.

At the policy level, what are the gaps and priorities?

A participant noted that CPHA's membership has always been one of its strengths. Members hold senior positions in health departments, for example, and are often influential in their communities. As a result, the Association has access to community mechanisms, and is in a strong position to affect what happens at the local level. In many jurisdictions, the Medical Officer of Health is also the school health officer by law, and can influence school board decisions. Ultimately, members tend both to be influenced by CPHA policy, and to exert their own influence upon it.

Participants noted that CPHA's HIV/AIDS policy manual stops in 1998, even though new issues are emerging all the time. At this time, specific issues include:

- The impact of co-factors on HIV/AIDS transmission and prevention;
- The need for a strong federal program on family violence;
- Marginalization of many at-risk populations, including the role of social services in furthering this marginalization;
- The role of the legal system in placing people at risk.

The group agreed that CPHA should become an active partner in the federal government's HIV/AIDS strategy, and that the prevention practitioners who replied to the fax survey should have a voice in policy development. As it stands, participants expressed concern that prevention is always "at the back of the bus" in relation to HIV diagnosis, treatment and support.

There is also a need to continue the policy shift that is already under way in some communities. Historically, public health agencies were seen as planning agencies with an obligation to prevent the spread of disease. Many health units are moving away from a legalistic interpretation of this mandate, but they are still guided by legislation. Participants agreed that CPHA should encourage this transition by encouraging partnerships at the community level and sharing best practice models when they are identified.

With whom should the CPHA be working?

At present, CPHA works in partnership with a variety of national organizations, such as the Canadian Mental Health Association and the College of Family Physicians. Depending on the policy area, it may be appropriate to make contact with the Canadian Council of Ministers of Education, the Association of Community Colleges of Canada, or the Association of Canadian Medical Colleges. Some participants also stressed the value of making contact with private sector partners, noting that insurance companies have had an interest in HIV/AIDS prevention for many years.

Is there any demand for a review of existing policy?

Participants asked for copies of CPHA's current policy book in order to consider this question.

Appendix: Survey Questionnaires

Fax Survey

Canadian Public Health Association
HIV/AIDS Prevention and Public Health Policy Survey • March 2000

The Canadian Public Health Association is conducting an environmental scan to capture the current state of activity in HIV/AIDS prevention across the country, and to identify emerging priorities for further policy development and program activity. ***Please take a few moments to complete this survey and return it by fax to (613) 235-0155 by March 31, 2000.*** We estimate that the entire survey will take about 10 to 15 minutes of your time. Many thanks in advance for your help and interest!

General Information

1. What kind of organization do you represent?
   - ❑ Public health agency or CLSC
   - ❑ AIDS Service Organization
   - ❑ Local government
   - ❑ Provincial/territorial department or agency
   - ❑ Federal department or agency
   - ❑ Local or regional association
   - ❑ National association
   - ❑ Other

2. If you are involved in delivering front-line public health or health promotion services, what is the size of your community or service area?
   - ❑ 1 million or more
   - ❑ 500,000 to 1 million
   - ❑ 100,000 to 500,000
   - ❑ fewer than 100,000
   - ❑ not applicable

3. What is your current annual budget for HIV/AIDS prevention activities?
   - ❑ $500,001 or more
   - ❑ $250,001 to $500,000
   - ❑ $100,001 to $250,000
   - ❑ $50,001 to $100,000
   - ❑ under $50,000

4. What was your annual budget for HIV/AIDS prevention activities as of March 1995?
   - ❑ $500,001 or more
   - ❑ $250,001 to $500,000
   - ❑ $100,001 to $250,000
   - ❑ $50,001 to $100,000
   - ❑ under $50,000

5. How many people in your organization are currently involved in HIV/AIDS prevention activities?
   _____Staff _____Volunteers

6. How many people in your organization were involved in HIV/AIDS prevention activities as of March 1995?
   _____Staff _____Volunteers

HIV/AIDS Prevention Programming

7. *In your current programming*, how much emphasis is placed on HIV/AIDS prevention activities involving the following target audiences?

	Low				**High**
Aboriginal people in urban settings	1	2	3	4	5
Aboriginal people on-reserve	1	2	3	4	5
Commercial sex workers	1	2	3	4	5
Ethnocultural communities	1	2	3	4	5
General public	1	2	3	4	5
Homeless/street populations	1	2	3	4	5
Injection drug users	1	2	3	4	5
Men who have sex with men	1	2	3	4	5
Prison populations: men	1	2	3	4	5
Prison populations: women	1	2	3	4	5
Public education: Secondary schools	1	2	3	4	5
Public education: College/university	1	2	3	4	5
Public education: Adult learning centres	1	2	3	4	5
Rural populations	1	2	3	4	5
Women: pregnant	1	2	3	4	5
Women: not pregnant	1	2	3	4	5
Work force groups	1	2	3	4	5
Youth: street-involved	1	2	3	4	5
Youth: in school	1	2	3	4	5
_____ *(other)*	1	2	3	4	5
_____ *(other)*	1	2	3	4	5

8. *Based on the level of need in your jurisdiction*, how much emphasis would you *like to place* on HIV/AIDS prevention activities involving the following target audiences?

	Low				**High**
Aboriginal people in urban settings	1	2	3	4	5
Aboriginal people on-reserve	1	2	3	4	5
Commercial sex workers	1	2	3	4	5
Ethnocultural communities	1	2	3	4	5
General public	1	2	3	4	5
Homeless/street populations	1	2	3	4	5
Injection drug users	1	2	3	4	5
Men who have sex with men	1	2	3	4	5
Prison populations: men	1	2	3	4	5
Prison populations: women	1	2	3	4	5
Public education: Secondary schools	1	2	3	4	5
Public education: College/university	1	2	3	4	5
Public education: Adult learning centres	1	2	3	4	5
Rural populations	1	2	3	4	5
Women: pregnant	1	2	3	4	5
Women: not pregnant	1	2	3	4	5
Work force groups	1	2	3	4	5
Youth: street-involved	1	2	3	4	5
Youth: in school	1	2	3	4	5
_____ *(other)*	1	2	3	4	5
_____ *(other)*	1	2	3	4	5

9. What types of HIV/AIDS prevention programs does your organization offer at the present time, and what types of programs would you *like to* offer?

	Offer Now	**Would Like to Offer**
Anti-discrimination education	❑	❑
Assertiveness training/self-esteem	❑	❑
College/university outreach	❑	❑
Condom distribution	❑	❑
High school outreach/curriculum development	❑	❑
HIV testing: anonymous	❑	❑
HIV testing: nominal/non-nominal	❑	❑
Media outreach	❑	❑
Methadone therapy	❑	❑
Needle exchange/bleach distribution	❑	❑
Non-nominal case reporting	❑	❑
Partner notification	❑	❑
Prevention education: general	❑	❑
Prevention education: targeted	❑	❑
Professional education and training	❑	❑
Public booths/displays	❑	❑
Public education	❑	❑
Sexuality education	❑	❑
Street outreach	❑	❑
Workplace outreach	❑	❑
_____ *(other)*	❑	❑
_____ *(other)*	❑	❑

10. In its HIV/AIDS prevention activities, what degree of emphasis does your organization place on the following related or underlying issues:

	Low				**High**
Sexuality education and STDs	1	2	3	4	5
HIV/AIDS-related discrimination	1	2	3	4	5
Culturally-appropriate messages that are tailored to different target audiences	1	2	3	4	5
Linkages to other health and social issues	1	2	3	4	5
HIV/AIDS policy	1	2	3	4	5
HIV/AIDS care and support	1	2	3	4	5
Prevention of emerging communicable diseases (e.g. Hepatitis C)	1	2	3	4	5
Substance abuse	1	2	3	4	5
Family violence	1	2	3	4	5
_____ *(other)*	1	2	3	4	5

11. In your own words, please list the three top priorities for HIV/AIDS prevention programming in your jurisdiction.

    1._____

    2._____

    3._____

12. What are the top three gaps in current HIV/AIDS prevention programming in your jurisdiction?

    1._____

    2._____

    3._____

13. What are the top three policy development priorities for HIV/AIDS prevention programming at the local, provincial/territorial or national level?

    1._____

    2._____

    3._____

14. What types of resource materials would be most useful to you in maintaining or strengthening your organization's HIV/AIDS prevention effort?
    - ❑ fact sheets on specific issues/concerns
    - ❑ general brochures
    - ❑ materials for low-literacy populations
    - ❑ multilingual materials
    - ❑ peer training/counselling materials
    - ❑ posters
    - ❑ training manuals
    - ❑ videos
    - ❑ _____ *(other)*
    - ❑ _____ *(other)*

15. Are you involved in other program activities related to HIV/AIDS?
    - ❑ policy
    - ❑ care, treatment and support
    - ❑ epidemiology
    - ❑ corrections
    - ❑ legal, ethical and human rights
    - ❑ _____ *(other)*
    - ❑ _____ *(other)*

16. What do you see as the most important barriers to effective HIV/AIDS prevention programming in your jurisdiction?
    - ❑ funding
    - ❑ human resources/sufficient staffing
    - ❑ information
    - ❑ links to similar organizations (e.g. between adjacent public health offices)
    - ❑ links to other organizations with similar interests (e.g. between a public health office and an AIDS Service Organization)
    - ❑ links to national organizations
    - ❑ training
    - ❑ _____ *(other)*
    - ❑ _____ *(other)*

17. What role(s) should the CPHA play in policy and program development related to HIV/AIDS prevention?
    - ❑ policy development
    - ❑ program support
    - ❑ program coordination
    - ❑ development and distribution of information resources
    - ❑ advocacy at the federal level
    - ❑ coordination among federal, provincial/territorial, local, and non-government organizations
    - ❑ _____ *(other)*
    - ❑ _____ *(other)*

18. Please list any best practice models for HIV/AIDS prevention that you work with, or would like to work with. If possible, please provide follow-up information (where the model was developed or implemented, where details can be found).

    _____
    _____
    _____
    _____

19. Are there specific HIV/AIDS prevention issues about which you would like more information?

    _____
    _____
    _____
    _____

20. Are you a member of the Canadian Public Health Association?
    ❑ Yes ❑ No *(for statistical purposes only)*

Please return this survey by fax to (613) 235-0155 by March 31, 2000.
Many thanks once again for your help!

Telephone Survey

Canadian Public Health Association
HIV/AIDS Prevention and Public Health Policy Telephone Survey • March 2000

Name & Title _____

Organization _____

City/Province _____

Introduction: As you may know, the Canadian Public Health Association is conducting an environmental scan to capture the current state of activity in HIV/AIDS prevention across the country, and to identify emerging priorities for further policy development and program activity. You've been selected as one of about 35 respondents to take part in a telephone survey to supplement a more general questionnaire that we distributed by fax earlier in March. Would you have about 30 minutes to help us out with this survey?

1. Which of the following categories best describes your organization?
   - ❑ Public health agency or CLSC
   - ❑ AIDS Service Organization
   - ❑ Local government
   - ❑ Provincial/territorial department or agency
   - ❑ Federal department or agency
   - ❑ Local or regional association
   - ❑ National association
   - ❑ Other

2. (Front-line organizations only:) What is the size of your community or service area?
   - ❑ 1 million or more
   - ❑ 500,000 to 1 million
   - ❑ 100,000 to 500,000
   - ❑ fewer than 100,000

3. What is your current annual budget for HIV/AIDS prevention initiatives?
   - ❑ $50,001 to $100,000
   - ❑ $25,001 to $50,000?
   - ❑ under $25,000

4. What was your annual budget for HIV/AIDS prevention initiatives as of March 1995?
   - ❑ $50,001 to $100,000
   - ❑ $25,001 to $50,000?
   - ❑ under $25,000

5. How many people in your organization are currently involved in HIV/AIDS prevention activities?
   _____Staff _____Volunteers

6. How many people in your organization were involved in HIV/AIDS prevention activities as of March 1995?
   _____Staff _____Volunteers

HIV/AIDS Prevention Programming

7. Please list the three most important target audiences for your current HIV/AIDS prevention activities, in order of priority. *(Interviewer: Where list suggests multiple options within a larger target group, prompt for details.)*
   - ❑ Aboriginal people in urban settings
   - ❑ Aboriginal people on-reserve
   - ❑ Commercial sex workers
   - ❑ Ethnocultural communities
   - ❑ General public
   - ❑ Homeless/street populations
   - ❑ Injection drug users
   - ❑ Men who have sex with men
   - ❑ Prison populations: men
   - ❑ Prison populations: women
   - ❑ Public education: Secondary schools
   - ❑ Public education: College/university
   - ❑ Public education: Adult learning centres
   - ❑ Rural populations
   - ❑ Women: pregnant
   - ❑ Women: not pregnant
   - ❑ Work force groups
   - ❑ Youth: street-involved
   - ❑ Youth: in school
   - ❑ _____*(other)*
   - ❑ _____*(other)*

8. What program activities have been most effective in reaching each of these target audiences? Least effective? Based on what evidence? *(Interviewer: Please use separate sheets as needed to record longer answers.)*

   Target Audience #1: _____
   _____
   _____
   _____

   Target Audience #2: _____
   _____
   _____
   _____

   Target Audience #3: _____
   _____
   _____
   _____

9. Given sufficient resources, what audience groups would you want to add to your priority list, and what program activities would likely be most effective in reaching them? Least effective? Why?

   Target Audience #4: _____
   _____
   _____
   _____

   Target Audience #5: _____
   _____
   _____
   _____

   Target Audience #6: _____
   _____
   _____
   _____

10. What resources or supports would you need to fully meet these priorities? *(Interviewer: Prompt for specific dollar amounts and types of human resources, e.g. social workers, public health staff, etc.)*
    _____
    _____
    _____

11. What do you see as the most important barriers to effective HIV/AIDS prevention programming? *(Interviewers: Prompt for specific examples.)*
    _____
    _____
    _____

12. How can a national association like CPHA help address this/these problem(s)?
    _____
    _____
    _____

13. What role(s) should the CPHA play in policy and program development related to HIV/AIDS prevention?
    _____
    _____
    _____

14. How can CPHA support your own activities related to HIV/AIDS prevention?
    _____
    _____
    _____

15. Can you identify any best practice models for HIV/AIDS prevention that you work with, or would like to work with? *(Interviewer: Prompt for follow-up information, indicating where the model was developed or implemented, or where details can be found.)*
    _____
    _____
    _____