A National Portrait

A Report on Governments' Responses to the HIV/AIDS Epidemic in Canada

Prepared for the Federal/Provincial/Territorial Advisory Committee on AIDS
November 2004

Territorial **Federal** Provincial Territorial
Federal **Provincial** Territorial Federal
Federal Provincial **Territorial** Federal

A National Portrait

A Report on Governments' Responses to the HIV/AIDS Epidemic in Canada

Prepared for the
Federal/Provincial/Territorial Advisory Committee on AIDS

November 2004

1. A National Portrait – A Report on Governments' Responses to the HIV/AIDS Epidemic in Canada.

H124-3/2004E-PDF
0-662-38828-3

COPYRIGHT:
© Her Majesty the Queen in Right of Canada, 2005

This report does not represent the official positions of the governments represented on the Federal/Provincial/Territorial Advisory Committee on AIDS (FPT AIDS).

FPT AIDS acknowledges the significant contribution of Martin Spigelman Research Associates in the preparation of this report.

Executive Summary

Introduction

Approximately 56,000 Canadians were living with HIV/AIDS at the end of 2002. The epidemic has been largely concentrated in four jurisdictions, with British Columbia, Alberta, Ontario and Quebec having 95% of all HIV positive test reports but only 85% of the Canadian population. Nevertheless, every jurisdiction has reported some cases and five jurisdictions reported more cases in 2003 than in 1995.

Overview by Jurisdiction**

Jurisdiction	Number of HIV+ Test Reports, 1985-2003	Number of HIV+ Test Reports, 2003	Number of HIV+ Reports/100,000 Population, 2003
Canada	55,180	2,482	8.27
British Columbia	11,552	436	11.16
Alberta	3,961	145	4.87
Saskatchewan	460	36	3.68
Manitoba	1,097	111	9.91
Ontario	24,408	1,104	9.68
Quebec	12,464	621	8.58
New Brunswick	313	9	1.23
Nova Scotia & PEI	626	4	0.38
Newfoundland & Labrador	221	19	3.70
Yukon, Nunavut and the NWT	78	6	6.47

** Data for the Number of HIV+ Test Reports 1985-2003 and the Number of HIV+ Test Reports 2003 are from Health Canada, Surveillance Report to December 31, 2003:23. Due to reporting delays and other factors, these data may differ from those provided by the provinces and territories in the jurisdiction-specific sections.

Governments across Canada – federal, provincial and territorial – are responding to the epidemic in a manner appropriate to their circumstances. In January 2004, the Federal/Provincial/Territorial Advisory Committee on AIDS (FPT AIDS) initiated this project in order:

- to summarize the different jurisdictions' responses to the epidemic;
- to analyze issues of common concern; and
- to identify means for strengthening the Canadian response to the epidemic.

Research for the project included a review of both surveillance data and of government publications relating to the epidemic, as well as interviews with approximately 50 key informants, including both non-governmental organizations and government officials involved in the response to HIV/AIDS.

A Sound Foundation

The HIV/AIDS epidemic remains a serious problem for all jurisdictions in Canada, if not at present then most certainly in the future. In some jurisdictions with few new reports of HIV infection, for example, the incidence of sexually transmitted infections speaks to unsafe sexual practices that place people at risk of HIV infection. It is by no means assured that the decade of declining incidence will continue into the future.

Nevertheless all jurisdictions have a sound foundation in place for addressing the current epidemic. Most have articulated a comprehensive, sound and well-considered strategy that provides direction to stakeholders. Some non-government HIV/AIDS stakeholders have identified lack of dedicated funding and measurable objectives or accountability requirements as challenges.

Invariably, jurisdictions are monitoring the epidemic and attempting to improve their surveillance and reporting systems. Public health delivery systems endeavour to ensure partner notification and are promoting awareness of HIV/AIDS and of sexual health in their schools and among their vulnerable populations. Jurisdictions include HIV testing as part of their prenatal screening programs – using either an opt-in or opt-out model – and may have nominal, non-nominal and sometimes anonymous testing available.

Additionally, all jurisdictions have some projects and organizations in place – some with federal rather than provincial or territorial funds – to reduce vulnerability and harm, and to provide care and support. In some jurisdictions, the different government and community stakeholders are working together to define priorities and allocate resources. In some jurisdictions also, stakeholders are endeavouring to find ways to transcend the boundaries that currently compromise efforts to bring a seamless array of services and supports to Aboriginal people.

Treatment is available everywhere in Canada and mechanisms are in place to ensure that physicians have access to the advice and support they need in order to provide quality care. The goal is to ensure that people – marginalized or mainstream – receive good care regardless of who they are and where they live. The key problems that have not been resolved anywhere are:

- the reluctance of many small communities to acknowledge there is a problem and to introduce measures to educate and prevent; and
- the challenge of reaching certain marginalized populations and effecting behavioural change.

Furthermore, after two decades of experience, there is a good understanding of what is needed to effectively address the epidemic, for example particular treatment regimens, community partnerships, culturally appropriate services, targeted prevention efforts sustained through the long term, a variety of harm reduction initiatives, a focus on vulnerable populations and efforts to overcome the stigma associated with HIV infection.

Most jurisdictions also understand the importance of a population health model and a human rights framework for effectively preventing HIV infection through the long term. This is not to say, however, that this model or framework is in place everywhere in Canada or that all jurisdictions are acting on the knowledge they have. Key informants highlighted the need for heightened public awareness, increased resources and re-energized leadership to address the epidemic.

Themes

A number of important themes emerge from the provincial and territorial pictures. The provincial and territorial pictures speak to the importance of each jurisdiction having the latitude to respond to the epidemic in a manner that reflects the local situation and local trends. These pictures illustrate that there is not one epidemic in Canada but rather several epidemics. First, there is one epidemic in the four largest provinces where a very significant number of people are living with HIV/AIDS. Here, governments have committed significant resources to support a broad range of prevention, harm reduction, care, treatment and support services, although key informants indicated that these were not adequate in all jurisdictions. In the other jurisdictions, the commitment of resources is much smaller and the range of services more limited.

Furthermore, the national portrait shows how the epidemic's character differs across jurisdictions. Men who have sex with men (MSM) remains the largest exposure category while the injection drug use (IDU) exposure category continues to be significant. Infections among people from HIV-endemic countries are more common in some jurisdictions than in others. The proportion of men to women who were diagnosed as HIV positive in 2003 differs from jurisdiction to jurisdiction. In one jurisdiction, for example, the ratio is 2:1 while in certain others it is 7:1.

Importantly, even within a single jurisdiction, there are distinct differences in the epidemic across regions. In Quebec and Manitoba, for example, the epidemic is largely concentrated in Montreal and Winnipeg respectively. In Alberta, the epidemic in Edmonton is largely in the IDU exposure category and involves Aboriginal people while in Calgary it is largely in the MSM category and involves non-Aboriginal people.

The regional differences in the epidemic speak to the role of regional or local health authorities that have the responsibility for planning the response to the epidemic and for providing services in most jurisdictions. These organizations are well positioned to identify and respond to local needs. There is, however, a perception that the epidemic may not be a priority for some health authorities, and that there is a need for strengthened accountability, enhanced coordination and integration at the regional level.

The provincial and territorial pictures also illustrate the importance of working in partnership, across departments, across governments and across government and community sectors. In some jurisdictions, there is a strong relationship and even a partnership between the provincial/territorial government, the regional offices of the Public Health Agency of Canada and Health Canada, and their community partners. There are similarly strong relationships between the Public Health Agency and provincial/territorial offices responsible for gathering and analyzing epidemiological data.

There appears to be a less strong relationship, however, among those agencies responsible for correctional services and those more directly responsible for health and HIV/AIDS, or among those agencies having responsibility for the health of Aboriginal people on and off reserve. Key informants also raised the issue of community partners needing additional resources to respond to an increasing number of people living with HIV/AIDS and to their enlarged realm of responsibility.

A recurring theme across the country was that there is a need to build public awareness of and to renew and further enhance political commitment to HIV/AIDS. In essence, HIV/AIDS risks falling off the policy map as a result of the declining number of new infections, the small number of people living with HIV/AIDS in certain jurisdictions, the misconception that HIV/AIDS is now curable, and the emergence of new priorities. These factors have been compounded by the epidemic affecting primarily marginalized populations and inner city neighbourhoods, neither of which elicit a great deal of public attention and public concern.

Strengthening the Canadian Effort

The provincial and territorial pictures, taken together, suggest means for building on the existing, sound foundation in order to strengthen the Canadian effort to address the HIV/AIDS epidemic.

First and foremost, efforts are needed to promote public awareness and concern, and "to put HIV/AIDS back on the public radar." Such efforts might include national awareness and education campaigns and the broader and more timely dissemination of surveillance and epidemiological information. They could also involve efforts to integrate HIV/AIDS with campaigns directed at other blood-borne pathogens and sexually transmitted infections. Integration may serve to place HIV/AIDS within a broader public health and perhaps population health context.

Second, it is important to continue to enhance political commitment as well as leadership that will champion efforts to address the epidemic in a vigorous and comprehensive manner. Political commitment and leadership are vital for:

- promoting public awareness, providing clear direction, dispelling stigma and preventing discrimination;
- providing the resources needed to build, disseminate and apply new knowledge, to effectively prevent the epidemic's spread, and to provide appropriate care, treatment and support; and
- ensuring that prevention, treatment, care and support efforts are available to all people everywhere in Canada.

Third, there is a need in Canada to shift public awareness and government spending from the treatment of disease to population health, and from short-term palliatives to long-term solutions. Efforts to promote population health – for example, by better protecting children from violence or through adequate housing – are the key to preventing HIV infection in the future. Controlling the epidemic requires efforts to address the very roots of HIV vulnerability.

Fourth, effectively managing the epidemic will require efforts to build greater cooperation and more effective partnerships across governments and across sectors, for the purpose of planning, delivering and funding programs. Inherent in this are efforts to strengthen and stabilize the community organizations that, at present, are struggling to cope with ever increasing needs and numbers, and with an increasingly broad range of issues and responsibilities. Inherent in this also are efforts to address the stigma still evident in small communities and to overcome the conservatism surrounding sexual health education and harm reduction.

HIV/AIDS is a complex disease and an ever-changing epidemic. Through the past decades, governments in Canada have built a strong foundation for addressing both the disease and the epidemic. But commitment to doing so has faded over time as other priorities emerged. A renewed commitment to action through cooperative partnerships is now needed, everywhere in Canada, if Canadians are to effectively address the epidemic.

Table of Contents

1. Introduction 1
1.1. Purpose and Objectives 1
1.2. Methodology 1
1.3. Report Organization 2

2. An Overview of HIV/AIDS Surveillance Data 3

3. HIV/AIDS by Jurisdiction 6
3.1. Canada 6
3.2. British Columbia 12
3.3. Alberta 17
3.4. Saskatchewan 23
3.5. Manitoba 27
3.6. Ontario 32
3.7. Quebec 40
3.8. New Brunswick 48
3.9. Nova Scotia 53
3.10. Prince Edward Island 57
3.11. Newfoundland and Labrador 61
3.12. Nunavut, the Northwest Territories and Yukon 65

4. A National Portrait 71
4.1. Different Epidemics in Different Jurisdictions 72
4.2. Articulating a Strategy 74
4.3. Organization 75
4.4. Cooperation and Coordination 76
4.5. Testing, Prevention, Care and Treatment 77
4.6. Knowledge 79

5. Conclusions 80
5.1. A Sound Foundation 80
5.2. Strengthening the Canadian Response 81

References 83

Appendices

A. FPT AIDS Advisory Committee Representatives 86

B. Project Overview 88

C. Surveillance Data Template 89

D. Key Informants and Interview Guide 91

Introduction 1

HIV/AIDS remains a significant threat to public health and to both individual and community well-being in Canada in spite of the many scientific, medical, social and human rights advances of the past decades. Since the mid-1980s, the epidemic has been responsible for approximately 18,000 deaths and Health Canada estimates that 56,000 Canadians are today living with HIV/AIDS.[1] Governments in Canada – federal, provincial and territorial – have each responded to the epidemic in a manner appropriate to their own jurisdiction's needs and circumstances.

1.1 Purpose and Objectives

In January 2004, the Federal/Provincial/Territorial Advisory Committee on AIDS (FPT AIDS) initiated this project – a National Portrait – in order:

- to summarize the different jurisdictions' policy and program responses to the epidemic;
- to identify and analyze issues of common concern; and
- to identify means for strengthening the effort to address the epidemic, everywhere in Canada.

FPT AIDS expects the National Portrait to fill an information gap and serve as a foundation for a strengthened, inter-governmental response to the epidemic.

1.2 Methodology

Research for the project took place between January and June 2004 and included a review of both surveillance data and of publications relating to each jurisdiction's efforts to address the epidemic. The methodology also included interviews with approximately 50 key informants associated with various government or community-based organizations involved in the response to HIV/AIDS. The interviews addressed issues pertaining to government organization, cooperation and coordination, prevention, care and treatment, knowledge and measures for strengthening each jurisdiction's response to the epidemic. The reports on the three northern territories were integrated in order to respect the confidentiality of the key informants' remarks. Members of the FPT AIDS Committee reviewed, commented upon and approved the draft and final reports.

[1] Canada, Health Canada, 2004(a):49 (deaths) and 1 (prevalence). With regard to the prevalence estimate, There is now a greater emphasis on ranges, and Health Canada estimated that between 46,000 and 66,000 people were living with HIV (including AIDS) at the end of 2002. N.B. The Public Health Agency of Canada, created on September 24, 2004 has taken over the responsibility for surveillance data, however, this report relies on Health Canada data produced prior to that date.

This project encountered certain challenges. One was to present similar surveillance data for each province and territory since different jurisdictions collect different levels of detail. Many jurisdictions, for example, do not identify the ethnic status of those diagnosed with HIV. The tables in Section 3 reflect these differences. Similarly, surveillance data published by the different jurisdictions and by Health Canada present certain discrepancies due to different reporting periods and the on-going effort to correct data from previous years.[2]

This report presents both HIV and AIDS surveillance data and estimates of HIV prevalence and incidence. Surveillance data include a description of positive HIV test reports (new HIV diagnoses) and AIDS diagnoses. Consequently, these data provide only a description of persons who have been diagnosed with HIV and AIDS and do not represent those who are infected but untested and undiagnosed. Other reasons that surveillance data understate the magnitude of the epidemic include the fact that surveillance data are subject to underreporting, delays in reporting and changing patterns of testing behaviour. Furthermore, as HIV is a chronic infection with a long latent period, many persons newly infected with HIV in a given year may not be diagnosed until later years.

As well, the project did not endeavour to document jurisdictions' HIV/AIDS-related expenditures since doing so would be meaningless without a full consideration of each government's policy priorities and fiscal circumstances. Furthermore, different jurisdictions report their HIV/AIDS-related expenditures in different ways or, indeed, not at all.

1.3 Report Organization

This report is organized in five Sections. Following this Introduction, Section 2 sets the context by providing a brief epidemiological overview of HIV/AIDS in Canada[3] while Section 3 describes the epidemic in each jurisdiction and each jurisdiction's policy and program response. Section 4 presents and analyzes the key issues that emerge from considering the provincial and territorial pictures and establishes the foundation for Section 5, Conclusions.

[2] For a description of data limitations, see Canada, Health Canada, 2004:69-71.

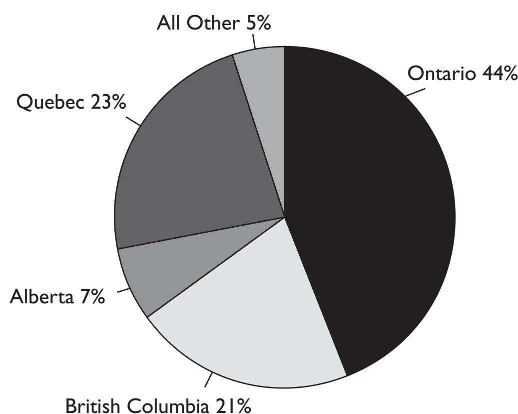
[3] This section relies upon the most recent Health Canada Surveillance Report, the Canada Communicable Disease Report and the HIV/AIDS *Epi Update* series. See Canada, Health Canada, 2004; Canada, Health Canada, 2003(a); and Canada, Health Canada, 2003(b), **http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/epiu-aepi/index.html**.

An Overview of HIV/AIDS Surveillance Data 2

The data presented below provide a context for the federal, provincial and territorial policy responses described in Section 3 and analyzed in Section 4. Those responses, for example, may be influenced by the number of new diagnoses in each jurisdiction, by incidence trends, by the total number of people living with HIV/AIDS and by the changing character of the epidemic.

According to Health Canada estimates, approximately 56,000 people in Canada were living with HIV infection (including AIDS) at the end of 2002, a 12.5% increase since 1999. **Figure 1**[4] shows data for cumulative HIV positive test reports from 1985 to 2003 and illustrates that the epidemic has been concentrated in four jurisdictions, with British Columbia, Alberta, Ontario and Quebec having 95% of all HIV positive test reports while having only 85% of the Canadian population. Nevertheless, as presented in **Table 1**, every jurisdiction has reported some cases.[5]

Figure 1, HIV+ Test Reports, 1985-2003



4 Canada, Health Canada, 2004(a).

5 Data for both Figure 1 and Table 1 are drawn from Canada, Health Canada, 2004:23. Data from Saskatchewan are preliminary only.

Table 1, Number of HIV+ Test Reports by Jurisdiction, 1985-2003

Jurisdiction	Total
British Columbia	11,552
Alberta	3,961
Saskatchewan	460
Manitoba	1,097
Ontario	24,408
Quebec	12,464
New Brunswick	313
Nova Scotia & PEI	626
Nfld. & Labrador	221
Yukon, Nunavut and the Northwest Territories	78
Total	55,180

From 1985 to 1994, there were almost 33,000 positive HIV test reports (all ages), an average of 3,300/year. **Figure 2** shows that the annual number of such reports declined steadily to 2000 and then increased in both 2001 and 2002 before remaining essentially unchanged in 2003.[6]

Figure 2, Number of positive HIV test reports, Canada 1995-2003

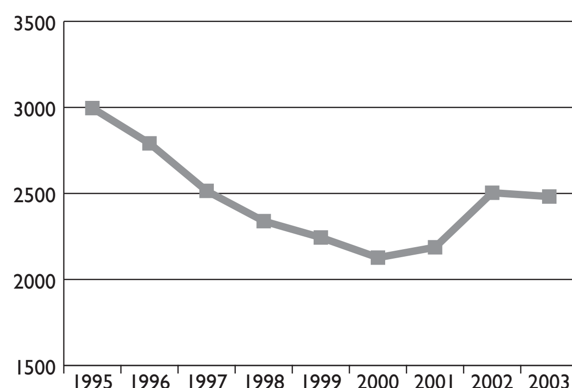


Figure 3 compares 1995 and 2003 and presents the change in the number of HIV positive reports by jurisdiction.[7] Five of the ten jurisdictions reported more new reports in 2003 than in 1995. Canada as a whole reported 514 fewer reports in 2003 than in 1995.

Figure 3, Change in Number of Cases Reported Between 1995 & 2003

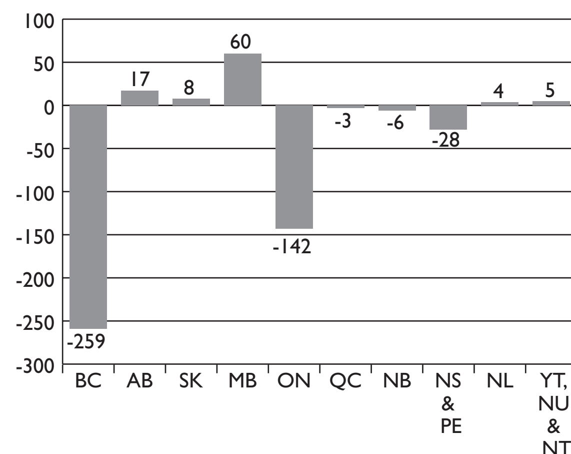


Figure 4 presents estimated HIV prevalence by exposure category for both 1999 and 2002.[8] The largest absolute increase (2,900 cases) during this time was in the men who have sex with men (MSM) exposure category while the largest relative increases were in the heterosexual (25%) and injection drug use (IDU) (13%) categories. In terms of incidence, MSM represented 40% of new HIV infections in 2002 while IDU represented 30% and the diverse heterosexual exposure category 24%.[9]

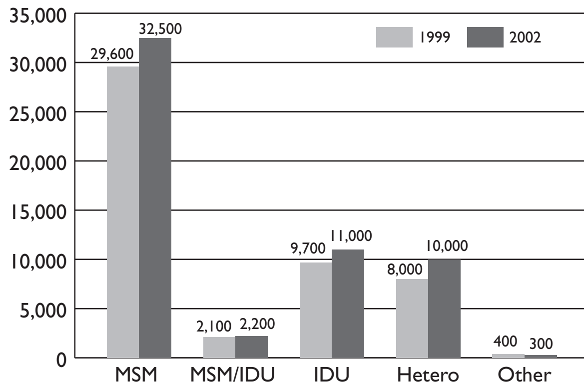
6 Canada, Health Canada, 2004:11.

7 The jurisdictional tables in Section 3 (below) provide the data for this Figure.

8 Canada, Health Canada, 2003(a):200.

9 Canada, Health Canada, 2004:24.

Figure 4, Estimated HIV Prevalence by Exposure Category, 1999 & 2002



At the end of 2002, there were an estimated 7,700 women in Canada living with HIV/AIDS representing 14% of the national total and an increase of 13% from 1999. Women represented 23% of new infections in Canada, a similar finding to 1999. HIV positive test reports (new diagnoses) among women have increased from 8.9% between 1985 and 1992 to 25.3% in 2003.[10]

The epidemic continues to be acute among Aboriginal people. While constituting approximately 3.3% of the Canadian population, Aboriginal people represented 13.4% of all AIDS diagnoses and 25.3% of all positive HIV test reports in those provinces that submitted ethnicity data in 2003.[11] Where data were available on ethnicity, approximately 63% of HIV positive reports among Aboriginal peoples were attributed to injection drug use compared to 30% among other Canadians.[12] People from countries in which HIV is endemic are also over-represented among those with HIV/AIDS in Canada. They represent 1.5% of the country's total population but 7%-10% of estimated prevalent cases and 6%-12% of estimated new infections.[13]

Although the number of young people (10-24 years) living with HIV/AIDS in Canada is small, their potential for spreading the virus is significant due to a variety of factors. Furthermore there have been 224 paediatric (children 0-14 years) AIDS cases in Canada of which 175 (78%) were attributed to perinatal transmission. Studies undertaken in Quebec, British Columbia, Alberta and elsewhere in the world, meanwhile, all show the effectiveness of treatments currently available to prevent perinatal transmission. [14]

Perhaps 30% of those living with HIV/AIDS in Canada today – approximately 17,000 people – are not aware of their condition and consequently are not accessing treatment and may unknowingly be transmitting the virus to others.

10 Canada, Health Canada, 2004:24,13.
11 Canada, Health Canada, 2004:25.
12 Canada, Health Canada, 2004 (a):48.
13 Canada, Health Canada, 2003(a):203-04.
14 Canada, Health Canada, 2003(a): 200.

3 HIV/AIDS by Jurisdiction

3.1 Canada

Surveillance Highlights

- the number of people living with HIV/AIDS may increase significantly through the coming years given the number of new infections combined with people living longer with HIV/AIDS because of the new treatment options available.
- there was approximately the same number of newly reported cases of HIV infection in 2003 as in 2002. However the number in 2003 (2,482) was higher than the number in either 2001 (2,187) or 2000 (2,127).
- unlike in the epidemic's early years, there is now a greater proportion of women, those using injection drugs and Aboriginal people who are being infected.
- the proportion of new HIV positive reports attributed to MSM has decreased from close to 75% between 1985-1994 to approximately 37% in the mid to late 1990's. There has been a slight increase in this category through the last three years, to 44%. The IDU exposure category represented 9% of positive HIV reports before 1994, increased to 33% in 1996 and 1997 and decreased to 12% in 2003. The diverse heterosexual exposure category[15] has steadily increased from 7.5% before 1995 to 36.9% in 2003. From 1998 to 2003, the proportion of positive HIV test reports attributed to the endemic country heterosexual subcategory has increased from 2.9% to 10.2%.
- females represent a growing proportion of positive HIV test reports. For the last three years females have accounted for approximately one quarter of positive HIV test reports in which sex is known. This represents a rise from 8.9% during the period between 1985 and 1992.

[15] This exposure category is made up of three subcategories: heterosexual contact with a person who is either HIV-infected or at increased risk of HIV infection; heterosexual as the only identified risk; and origin in a country where HIV is endemic.

Canada[16]

Indicator	Year				
	2003	2002	2001	2000	1995
Prevalence Estimate (HIV and AIDS)	>56,000	56,000		49,900[17]	40,100[18]
AIDS Cases					
Number of AIDS cases diagnosed by year	218	357	384	471	1,655
Cumulative number of AIDS cases reported	19,344	19,126	18,769	18,385	14,838
Newly reported adult AIDS cases by sex:					
male	163	300	321	405	1,496
female	52	52	59	56	130
Newly reported adult AIDS cases by exposure category					
MSM	71	117	151	218	1,091
MSM/IDU	5	6	14	15	74
IDU	36	50	48	92	130
Heterosexual contact[19]	12	24	21	25	101
HIV endemic country[20]	38	51	54	42	88
NIR – HET[21]	38	23	32	32	38
Blood/blood products	1	2	7	7	43
NIR[22]/Other	14	39	35	31	63
Newly reported AIDS cases by age					
<1-14	3	4	3	5	27
15-29	19	27	29	27	205
30-49	161	252	272	346	1,217
50+	35	74	80	84	206
AIDS-related deaths	93	103	187	263	1,500

16 Primary source is Canada, Health Canada, 2004. Selected data for 1995 drawn from the Health Canada Surveillance Report, December 2000.

17 To end of 1999.

18 Prevalence estimate for 1996. See Canada, Health Canada, 2000:197.

19 Sexual contact with a person at risk.

20 Origin from an HIV-endemic country.

21 NIR-HET: Heterosexual contact is the only risk factor reported and nothing is known about the HIV-related risk factors associated with the partner.

22 NIR: No Identified Risk.

Canada *(continued)*

Indicator	Year				
	2003	2002	2001	2000	1995
HIV Infection					
Number of positive HIV test reports	2,482	2,504	2,187	2,127	2,996
Positive HIV test reports by exposure category (Adult)					
MSM	361	506	401	469	684
MSM/IDU	12	19	33	27	58
IDU	96	302	279	288	452
Heterosexual contact	78	165	177	136	n/a
HIV-endemic countries	83	91	70	52	n/a
Heterosexual contact/ HIV-endemic countries[23]					114
NIR-Het	139	129	114	94	104
Blood/blood products	6	11	10	15	28
Other/NIR	94	91	91	97	186
Not reported	1,571	1,139	952	869	1,283
Positive HIV test reports by sex (Adults)					
Men	1,816	1,815	1,591	1,533	2,266
Women	615	620	524	484	534
<15 years	9	18	16	17	59
15-19 years	25	34	32	34	28
20-29 years	485	481	411	408	712
30-39 years	939	982	853	849	1,284
40-49 years	702	670	569	526	5,77
> 50 years	289	286	262	230	234
Age not reported	33	33	44	63	85

[23] Prior to 1997, it was not possible to separate the exposure categories "heterosexual contact with a person at risk" and "origin from an HIV-endemic country."

Organization

The federal efforts to address the epidemic began in the mid-1980s but were more fully coordinated after 1990 with the first and second National AIDS Strategies. In 1997 the Government of Canada announced a new Canadian Strategy on HIV/AIDS (CSHA) that was intended to be pan-Canadian in nature and to provide a coherent, national framework for addressing the epidemic. The CSHA is generally perceived as having been successful, for example in terms of developing community capacity, placing HIV/AIDS in a human rights context and encouraging both scientific and social research.[24]

The CSHA has 10 strategic areas, i.e.:

- research
- community development and support to national non-governmental organizations
- care, treatment and support
- surveillance
- prevention
- Aboriginal communities
- consultation, evaluation, monitoring and reporting
- legal, ethical and human rights
- Correctional Service Canada
- international collaboration

Management responsibility lies primarily with the HIV/AIDS Policy, Coordination and Programs Division within the Public Health Agency of Canada (PHAC), although important roles are also played by the regional PHAC offices responsible for the AIDS Community Action Program (ACAP), the Surveillance and Risk Assessment Division (PHAC), the National HIV and Retrovirology Laboratories (PHAC), the First Nations and Inuit Health Branch (Health Canada), International Affairs Directorate (Health Canada), Correctional Service Canada and the Canadian Institutes of Health Research[25]. Intergovernmental cooperation is facilitated by the PHAC and Health Canada regional offices and by both the FPT AIDS Committee and the FPT Heads of Corrections Working Group on Health. Both of these intergovernmental committees include representatives from all jurisdictions in Canada. The Minister of Health is advised by the Ministerial Council on HIV/AIDS, which has representatives of different types of expertise, including people living with HIV/AIDS. The National Aboriginal Council on HIV/AIDS advises the PHAC and Health Canada on HIV/AIDS issues that affect the Aboriginal peoples of Canada.

The CSHA's annual budget is $42.2 million with the largest proportions being directed to research ($13.2 million) and to community development/support to non-governmental organizations ($10 million). In 2003, additional amounts were committed by:

- the First Nations and Inuit Health Branch, Health Canada ($2.5 million); and
- the Canadian Institutes of Health Research ($4.7 million).[26]

Correctional Service Canada has also allocated $7.7 million for a National Methadone Maintenance program (of which $1 million comes from the Canadian Drug Strategy) and a total of $13 million for infectious disease prevention, screening, care, treatment and surveillance activities.

[24] For a review of the CSHA, see Spigelman, 2003.

[25] The Public Health Agency of Canada was created on September 24, 2004, and is largely comprised of the former Population and Public Health Branch (PPHB) of Health Canada. The HIV/AIDS Policy, Coordination and Programs Division, the Surveillance and Risk Assessment Division and the National HIV and Retrovirology Laboratories, and former regional PPHB offices are now part of the new Agency.

[26] Canada, Health Canada, 2003(d):5.

Canada has also made a significant contribution to the international effort to address HIV/AIDS. The Canadian International Development Agency has increased its annual funding for international HIV/AIDS programs from $22 million in 2000/01 to $80 million in 2004/05, for a total five-year investment of $270 million. In 2001, Canada also pledged $100M (USD) over four years to the Global Fund to Fight AIDS, Tuberculosis and Malaria while in 2004 it committed to effectively doubling its annual contribution. In May 2004, Canada announced a $100 million contribution to the World Health Organization (WHO) "3 by 5 Initiative." This represents over half of the current funding gap estimated by WHO for the years 2004 and 2005. Finally, Canada has committed $62 million from the Canada Fund for Africa towards the development of an AIDS vaccine and to support the work of a Canadian coalition on HIV/AIDS on the social impact of the disease, including children's education, labour and family structures. All in all, the country's five-year international investment will be more than $500 million.

Domestically, the federal government has recently announced its intention to increase the CSHA's budget to $84.4 million annually, to be phased in over five years. The Report of the Standing Committee on Health (*Strengthening the Canadian Strategy on HIV/AIDS*), the Five Year Review of the CSHA, *Leading Together: An HIV/AIDS Action Plan for all Canada*, PHAC research and input from stakeholders are guiding the development of a new policy framework for a renewed federal initiative.

Coordination and Cooperation

The CSHA incorporates a commitment to cooperation, multi-sectoral partnerships and consensus "[a]t every stage of planning and delivery…."[27] A series of direction setting meetings were held and ongoing advisory groups were established (for example the Ministerial Council on HIV/AIDS and the National Aboriginal Council on HIV/AIDS) to guide the development and implementation of the CSHA, and keep it responsive to emerging issues. The Working Group on International HIV/AIDS Issues brings together several government departments and non-governmental organizations to discuss international collaboration.

PHAC, both nationally and regionally, provides funding to non-governmental organizations in recognition of the vital partnership they bring to the response. These include national organizations such as the Canadian AIDS Society, the Canadian Aboriginal AIDS Network, the Canadian HIV/AIDS Legal Network, the Canadian AIDS Treatment Information Exchange, the Canadian Treatment Action Council, the Interagency Coalition on AIDS and Development, Canadian Public Health Association, and the Canadian Working Group on AIDS and Rehabilitation.

In a similar vein, the First Nations and Inuit Health Branch of Health Canada works with and funds a variety of national and regional organizations – for example, the Assembly of First Nations and the Canadian Aboriginal AIDS Network – to undertake health promotion and HIV/AIDS-related educational efforts among Aboriginal people and particularly among the Inuit and those First Nations people living on reserve. The Health Canada regional offices also work with and provide both operational and project funding to community organizations for similar purposes. This contribution is particularly significant in those jurisdictions where both the number of people living with HIV/AIDS and the provincial/territorial contribution are relatively small.

The government/community relationship is now characterized as being both strong and mature although the commitment to consultation has been described by some key informants as slowing the decision-making process. Nevertheless, coordination and collaboration are considered to be vital given the clear benefits associated with engaging community-level knowledge and experience.

[27] Canada, Health Canada, 2003(d):6.

Intergovernmental collaboration and cooperation are also vital given the country's federal structure wherein responsibility for health services lies primarily with the provinces and territories even while the Government of Canada has the ability to influence health policy through its roles in setting and administering national standards and enforcing the Canada Health Act, and through financial transfers. The federal government has endeavoured to provide leadership to the Canadian effort by assuming direct responsibility for certain activities and by enabling others to assume responsibility for other activities.[28]

Testing, Prevention, Care and Treatment

For the most part, the federal government is not directly involved in testing, care or treatment activities. Nevertheless it plays an active role in the effort to address HIV/AIDS at the community level, for example:

- its AIDS Community Action Program, with offices in each region, provides multi-year operational and project funding to a broad range of community organizations that are involved in a diverse array of community activities.
- it has a fiduciary responsibility for providing health care to the Inuit and to First Nations people living on reserve. The First Nations and Inuit Health Branch in Health Canada provides funding for health promotion efforts, medical treatment including HIV testing, certain drug treatments that are not covered by provincial programs and medical transportation for those having to travel for care or treatment.
- it has a direct responsibility for providing health care to those incarcerated in federal correctional institutions and to those serving in the military and the Royal Canadian Mounted Police.
- its efforts (since January, 2002) to ensure that all applicants for permanent residence in Canada older than fifteen years of age are tested for HIV.[29]
- its national community project funding for First Nations people living off reserve and for Inuit and Métis communities, as well as for capacity building, best practices models, information services, public information and legal, ethical and human rights.

The federal government has also played a major role in hosting national meetings and conferences, funding pilot projects, maintaining a national surveillance system and funding important research including cohort studies. Additionally, Health Canada and the Canadian Aboriginal AIDS Network have launched an educational campaign designed to enhance awareness and dialogue among First Nations, Inuit and Métis people.[30] The on reserve effort faces the challenge of preserving confidentiality while endeavouring to understand the size and scope of the epidemic in those communities.

Knowledge

The federal government and the CSHA have played an important role in creating, organizing, analyzing and disseminating epidemiological and other knowledge. The federal government is uniquely well placed to blend information and experiences from many different jurisdictions, and to promote efforts to embed this knowledge in practice through information exchanges such as those of the AIDS Community Action Program (ACAP).

Federal funding, most often through the Canadian Institutes of Health Research, has enabled Canadian researchers to contribute in a very significant way to the national and international effort to address the epidemic. These researchers are also playing an important role in certain clinical trials, in assessing treatment regimens and in the international effort

[28] See Spigelman, 2003:23.

[29] Canada, Health Canada, 2003(d):11.

[30] Canada, Health Canada, 2003(d):10.

to develop a vaccine. Canada has also promoted a health determinants approach to the epidemic, emphasizing the impact of discrimination, stigma and other social and economic factors on HIV vulnerability. Addressing these health determinants is seen as the key to reducing vulnerability and preventing the epidemic's spread, and has become embedded in the ACAP program.

Importantly the CSHA has endeavoured to address controversial issues such as harm reduction and to raise the tenor of public discussion by funding projects on topics such as building capacity among drug users and best practices in needle exchange. Given the importance of disseminating and applying new knowledge, PHAC also funds the Canadian HIV/AIDS Information Centre (formerly, the Canadian HIV/AIDS Clearinghouse) and the Canadian AIDS Treatment Information Exchange.

Finally, PHAC gathers surveillance data from each jurisdiction and provides national-level reports and analysis. It supports surveillance efforts in some jurisdictions through its Field Surveillance Officer (FSO) positions. Currently, these PHAC FSOs are working with their provincial counterparts in Vancouver, Calgary, Regina, Winnipeg, Toronto and Halifax. PHAC also supports surveillance efforts by partnering with the provinces and territories to standardize national definitions and data collection methods and, where required, by developing software applications.

Strengthening the Effort

The literature and key informants identified the following as means for strengthening the federal government's effort to address the HIV/AIDS epidemic:

- clarify priorities, goals and performance measures within the CSHA.
- provide the leadership necessary for building public support for controversial prevention and harm reduction programs.
- provide funds adequate to the many tasks associated with addressing the epidemic.
- effectively address the epidemic among certain particularly vulnerable groups, for example gay men, Aboriginal people living on and off reserve, those incarcerated in federal correctional institutions, women and those using injection drugs.[31]

3.2 British Columbia

Surveillance Highlights

- there are approximately 10,500 people in BC today living with HIV/AIDS, an increase of approximately 1,000 since 1999.
- the HIV incidence rate declined from 19.6 (/100,000 population) in 1990 to 18.2 in 1995 and 10.2 in 2000. The rate increased to 10.7 in 2001 and 2002 before declining again in 2003 to 10.1.[32]
- in 2003, MSM accounted for 36.5% of newly reported HIV+ cases for which the exposure category was known. The IDU exposure category accounted for 25.7% and heterosexual transmission for 24.9%. The equivalent proportions in 2000 were 37.4%, 32.0% and 19.7%. In other words, the proportion among MSM remained much the same while that for IDU declined and that for heterosexual transmission increased.
- women accounted for 21.5% of newly reported HIV cases in 2003 compared to 21.3% in 2000 and 22.4% in 1995.
- in 2003, Aboriginal people accounted for 16.0% of newly reported HIV cases for whom ethnicity was identified. Women accounted for almost 42% of these Aboriginal cases. In 1995, Aboriginal people accounted for 16.7% of newly reported HIV cases for whom ethnicity was identified.

[31] Spigelman, 2003:9.

[32] BC Centre for Disease Control (BCCDC), 2002:17.

British Columbia[33]

Indicator	Year				
	2003	**2002**	**2001**	**2000**	**1995**
Prevalence Estimate		10,500[34]		9,500[35]	
AIDS Cases					
Number of AIDS cases reported by year	75	88	77	144	335
Cumulative number of AIDS cases reported	3,730	3,655	3,567	3,490	2,599
Newly reported AIDS cases by sex					
male	66	79	70	126	308
female	9	8	7	16	26
Newly reported AIDS cases by exposure category					
MSM	5	25	29	64	220
MSM/IDU	2	3	3	5	15
IDU	16	15	12	32	41
Heterosexual contact	5	6	6	13	33
Other (haemophiliac, unknown, etc.)	47	39	27	30	26
Newly reported AIDS cases by age					
<15 year	0	1	2	2	3
15-29	6	5	7	10	42
30-49	45	57	45	102	245
50+	24	24	23	28	44
unknown	0	1	0	2	1
Newly reported AIDS cases by ethnicity					
Caucasian	30	37	50	99	250
Aboriginal	6	6	6	13	29
Asian	0	2	6	1	4
Other & unknown	39	43	15	31	52

[33] Division of STD/AIDS Control, BC Centre for Disease Control Society, July 2004. See also BCCDC, HIV/AIDS Update, Annual 2002.

[34] Estimated by the BCCDC to be between 8,000 and 13,000.

[35] BCCDC estimate for 1999.

British Columbia *(continued)*

Indicator	Year				
	2003	**2002**	**2001**	**2000**	**1995**
HIV Infection					
Total number of newly reported HIV+ cases	423	438	437	408	682
Newly reported HIV+ cases by exposure category					
MSM	135	148	134	133	185
MSM/IDU	24	12	20	10	28
IDU	95	145	121	114	267
Heterosexual contact	92	98	103	70	68
Sex Trade Worker/IDU	18	15	11	19	40
Sex Trade Worker	2	0	1	1	0
All other	4	9	10	9	10
Unknown	53	11	37	52	84
Newly reported HIV+ cases by sex					
Men	328	353	345	321	526
Women	90	85	87	87	152
Unknown	5	0	5	0	4
Newly reported HIV+ cases by ethnicity					
Caucasian	246	276	285	253	384
Aboriginal people	59	66	69	58	90
• men	34	39	38	36	55
• women	25	27	31	22	34
• unknown	0	0	0	0	1
Asian	28	47	28	25	30
Black	22	17	24	18	15
Hispanic	13	24	10	8	19
Unknown	55	8	21	46	144
Newly reported HIV+ cases by age					
Perinatal (<18 months)	1	0	1	2	1
<15 years	2	1	3	1	4
15-29	76	75	110	94	203
30-49	261	295	271	256	426
50+	82	66	50	54	41
Unknown	1	1	2	1	7

Organization

British Columbia has long been guided by a provincial strategy in its effort to address HIV/AIDS, first the 1998 *British Columbia's Framework for Action on HIV/AIDS* and subsequently a new *Priorities for Action in Managing the Epidemics, HIV/AIDS in British Columbia 2003-2007*. The latter's purpose is "to complement, guide and support community and health authority efforts to address what is one of the most serious public health challenges in B.C. today."[36] It is intended to serve as a blueprint, providing direction to the health authorities, community partners and provincial ministries as they each play their part in the provincial effort to address and manage the epidemic.

Priorities for Action recognizes that HIV/AIDS "is a complex disease that cannot yet be fully prevented." Its focus, therefore, is "on managing the epidemics through sustained effort in four key areas: prevention; care, treatment and support; capacity; and coordination and cooperation."[37] Importantly, it establishes ambitious and quantifiable goals for the period 2003 to 2007, i.e.:

- to reduce by 50% both the number of people becoming infected each year and the number of people who are HIV-positive but unaware of their infection;
- to increase by 25% the proportion of HIV-positive individuals who are linked to appropriate services;
- to enhance the province's capacity for monitoring the HIV epidemic; and
- to create and sustain broad-based support for *Priorities for Action*.

The document establishes measurable objectives and key strategies for each goal and includes a commitment to monitoring and accountability for the health authorities and other partners. These accountability measures have not yet been put in place, however, and may have to be considerably more specific and focused than what the government normally expects of the health authorities. Complementing *Priorities for Action* is a Chee Mamuk report on the epidemic among Aboriginal people and an older Aboriginal strategy prepared by the BC Aboriginal HIV/AIDS Task Force.[38]

The *Priorities* document has been well received by portions of the community and has been described as a useful tool for their own purposes. Some are particularly taken by the province assuming the risk of articulating such ambitious goals and express the hope that it will actively pursue these goals. Other community sources, meanwhile, raise concerns that they were not involved in developing *Priorities for Action* and that there are not new funds attached to it.

The Ministry of Health Services is responsible for managing and monitoring the province-wide efforts and plans to enhance its capacity to do so and to create mechanisms for encouraging coordination and cooperation among stakeholders. It is assisted by the BC Centre for Disease Control (BCCDC) particularly with regard to monitoring the epidemic and the Aboriginal aspect of the epidemic. The BC Centre for Excellence in HIV/AIDS is responsible for administering the province's anti-retroviral drug program.

The Provincial Health Officer estimated in 2003 that British Columbia spent approximately $100 million on HIV-related services.

[36] British Columbia, 2003:2.

[37] British Columbia, 2003:ii.

[38] See BCCDC, 2000 and BC Aboriginal AIDS Task Force, 1999.

Coordination and Cooperation

Coordination and cooperation constitute an important element in the BC effort. The province's platform for action on HIV/AIDS consists of six health authorities, five having regional responsibilities and one having responsibility for specialized, province-wide programs and services. Together, these health authorities and their community partners have been challenged by *Priorities for Action* to develop and deliver the range of programs and services needed to achieve the provincial goals. There is some concern among key informants, however, that the level of cooperation between AIDS Service Organizations and the health authorities will vary significantly from region to region, and that there will not be any central coordination or planning. However three of the Health Authorities have completed service plans and another three are in the process of developing their plans.

The provincial Ministry of Education has developed a sexual health component for its curricula. The Ministry of Health Planning is developing a relationship with the Solicitor General's department and, in concert with the health authorities, is attempting to develop protocols for addressing HIV/AIDS-related issues within the province's correctional centres.

British Columbia participates in the FPT AIDS Committee and in the FPT Heads of Corrections Working Group on Health. There is a strong working relationship with the regional PHAC office responsible for the AIDS Community Action Program although provincial and federal resources are managed separately. There is considerable concern in the province with the jurisdictional and service divide between Aboriginal people living on and off reserve, particularly in light of the epidemic's presence among Aboriginal people and their movement between communities.

British Columbia has not integrated its HIV/AIDS-related efforts with its other public health and blood borne pathogen efforts although certain Health Authorities are moving in that direction. Importantly, municipalities are playing a larger role in the effort to address the epidemic, for example in Vancouver with its "four pillar" approach and in Victoria where discussions are underway about enhancing harm reduction services.

Testing, Prevention, Care and Treatment

The province offers prenatal testing for HIV using an opt-in model that asks women whether they wish to be tested. Between October and December 2003, the provincial laboratory received 10,900 prenatal specimens and had permission to test 8,650 (79%) for HIV. As presented in **Table 2**, the total number of HIV tests performed has increased slowly over time and in 2002 totalled over 146,000.[39] In total 1.6 million tests have been performed since 1985.

Table 2, Number of HIV Tests Conducted in BC, 1995-2002

1995	1997	1999	2001	2002	2003
130,338	140,278	135,284	135,806	146,489	135,654

Some key informants expressed concern that the province's health care system focuses too heavily on acute care and devotes insufficient attention and resources to prevention, primary care and population health. They suggested that more vigorous leadership is required in this regard.

Knowledge

The BC Centre for Excellence in HIV/AIDS is a Canadian and international leader in terms of generating and disseminating new knowledge on all aspects of the epidemic. The BC Centre for Disease Control, meanwhile, has provided training

[39] BCCDC, 2002:17.

to different groups of professionals, hosts the Chee Mamuk Aboriginal program and partners with a variety of community-based AIDS-related organizations. Certain key informants suggested there is a need to improve the timeliness of the HIV/AIDS-related data disseminated by the BCCDC so they better inform community services.

It is also suggested that greater attention and emphasis needs to be placed on outcome-based evaluation in order to ensure that always limited resources are being spent in the most effective manner possible.

Strengthening the Effort

Key informants suggested a variety of means for strengthening the province's effort to address the epidemic:

- enhance public awareness and political commitment and leadership at all levels. There is a concern that HIV/AIDS has "fallen off the public radar" and consequently is no longer a priority.
- build a more effective sentinel surveillance system that better captures trends within the most vulnerable populations.
- place greater emphasis upon prevention and population health.
- commit additional financial resources to the epidemic and for both the Health Authorities and the community-based service organizations. Two key informants suggested that "everything is in place to address the epidemic except for the level of resources needed to do so."
- institute a system of tied federal transfers, with strict accountability requirements, in order to foster more effective intergovernmental cooperation and to ensure that federal dollars are used to achieve the province's public health goals.
- broaden membership on inter-sectoral committees addressing HIV/AIDS by including representatives of community organizations, the Health Authorities and other governments.
- establish a "champion" among the health authorities to assume leadership responsibility for HIV/AIDS.

3.3 Alberta

Surveillance Highlights[40]

- there are approximately 3,200 people living with HIV/AIDS in Alberta.
- in 2003, the rate for newly reported cases of HIV was much higher in Edmonton than in Calgary, at 7.0 and 5.4/100,000 respectively. Exposure category patterns vary significantly by region with IDU being most common in Edmonton and MSM in Calgary. In that year, however, there was a proportionate rise among MSM in both cities.
- provincially, in 2003, the most commonly reported exposure category was MSM (39% of all cases) followed by IDU (22%).
- between 1999 and 2003, 30% of all newly reported HIV cases were among Aboriginal people who account for approximately 5% of the province's total population. This varied by region however, and in 2003, 32% of new infections in the Edmonton area occurred among Aboriginal people compared to 5% in the Calgary area.

[40] Alberta Blood-borne Pathogens Surveillance Working Group, 2003:5-6; Communicable Disease Reporting System, May 4, 2004.

Alberta[41]

Indicator	Year				
	2003	2002	2001	2000	1999
Prevalence Estimate	N/A	N/A	N/A	N/A	3,200
AIDS Cases					
Number of AIDS cases reported by year	40	33	42	49	41
Cumulative number of AIDS cases reported	1,160	1,119	1,087	1,045	996
Newly reported AIDS cases by sex					
male	28	28	37	42	38
female	12	5	5	7	3
Newly reported AIDS cases by exposure category					
MSM	13	9	19	22	16
IDU	8	10	10	10	6
MSM and IDU	0	1	4	2	4
Hetero Endemic/Partner at Risk/NIR	18	10	8	15	14
Other	0	3	1	0	1
Unknown	1	0	0	0	0
Newly reported AIDS cases by age					
children & youth (0-19 yrs)	0	1	0	0	0
adults (20-59 yrs)	37	32	38	48	41
seniors (60+ yrs)	3	0	4	1	0
AIDS-related deaths	6	4	11	17	11

[41] Communicable Disease Reporting System, May 4, 2004. Prepared by Disease Control and Prevention, Alberta Health and Wellness. HIV data are available only from May 1998.

Alberta *(continued)*

Indicator	Year				
	2003	**2002**	**2001**	**2000**	**1999**
HIV Infection					
Total number of reported HIV cases	157	179	168	191	162
Newly reported cases of HIV infection by exposure category					
MSM	61	34	36	53	38
MSM/IDU	1	5	6	2	6
IDU	35	76	65	79	64
HIV/AIDS-endemic countries	15	18	18	14	18
Heterosexual contact – Partner at Risk	25	20	22	20	11
NIR – Heterosexual	19	18	19	21	22
NIR-Other	0	8	2	1	3
Perinatal	0	0	0	1	0
Unknown	1	0	0	0	0
Newly reported cases of HIV infection by sex					
Men	121	122	123	127	117
Women	36	57	45	64	45
Newly reported cases of HIV infection by ethnicity					
White	88	81	85	101	101
Black	17	20	20	16	18
Aboriginal	40	68	58	64	31
Asian	7	5	4	8	5
Other	4	4	1	1	5
Unknown Ethnicity	1	1	0	1	2
Newly reported cases of HIV infection by age					
0-14 yrs	0	0	0	1	0
15-24 yrs	19	13	16	22	24
25-59 yrs	131	165	146	165	136
60+ yrs	7	1	6	3	2

Notes:

1. Data extracted by Year of Reporting.
2. Age Groups constructed using Age at Report Date.
3. N/A = not available

Organization

In 1999, Alberta first articulated an HIV/AIDS Strategy encompassing the period 1998/99 to 2002. Although it did not have specific or quantifiable goals and objectives, it proved to be an important plan for addressing HIV/AIDS and, according to one key informant, for providing "permission to go forward with different initiatives." It was also useful for identifying different stakeholders' roles and responsibilities, including Alberta Health and Wellness, the Regional Health Authorities, community AIDS organizations and Health Canada.

Work is currently underway on a replacement strategy that will have measurable goals and accountability requirements, and will again identify the roles and responsibilities of key stakeholders in the prevention, treatment, care and support of people living with HIV/AIDS. It will be premised upon a population health perspective. The new Strategy will more fully integrate HIV/AIDS with other blood-borne pathogens and sexually transmitted infections (STIs) in the expectation that approach may:

- again raise the profile of HIV/AIDS and its interactions with other blood-borne pathogens and STIs;
- help overcome the "silos" that can compromise effective action and result in more support and resources given the promise of reduced duplication; and
- better reflect the community level reality where HIV/AIDS-related organizations have already incorporated hepatitis C and other STIs into their efforts.

Alberta Health and Wellness provides approximately $2.3 million to support community-based programming through the Alberta Community HIV Fund and an additional $70,000 for the Non-Prescription Needle Use Project.[42] The province also funds a community developer who provides blood-borne prevention programming primarily to off reserve Aboriginal groups. Other funding is provided through the Regional Health Authorities' global budgets.

Coordination and Cooperation

There is a strong working relationship with the regional PHAC office, and the provincial and federal governments have worked together to create an innovative model for funding. The Alberta Community HIV Fund (ACHF) is a joint community/provincial/federal funding disbursement model developed through consultation with representatives from community-based HIV/AIDS organizations, persons living with HIV/AIDS, the Regional Health Authorities, and provincial and federal health departments. The ACHF replaces both the PHAC guidelines for the AIDS Community Action Program and the Alberta Health and Wellness guidelines for community organization grants.

The fund provides for a simplified and transparent funding process that helps to prevent duplication and improve coordination. Through its operational and project-based funding,[43] the ACHF supports:

- efforts to create supportive environments and to provide care and support;
- prevention, harm reduction and health promotion initiatives; and
- measures to strengthen community-based organizations.

[42] The Health Canada contribution to the Alberta Community HIV Fund is approximately $683,000.

[43] Project funds range in size from $5,000 to $20,000.

This funding approach is seen by many as a best practice for joint work between federal and provincial governments.

Testing, Prevention, Care and Treatment

Alberta faces a significant challenge in that its epidemics are different from region to region. In Edmonton, for example, the epidemic is concentrated in the inner city with the exposure categories being primarily injection drug use and heterosexual transmission, and with Aboriginal people being the most vulnerable group. In Calgary, meanwhile, the epidemic is much more heavily concentrated in the MSM population.

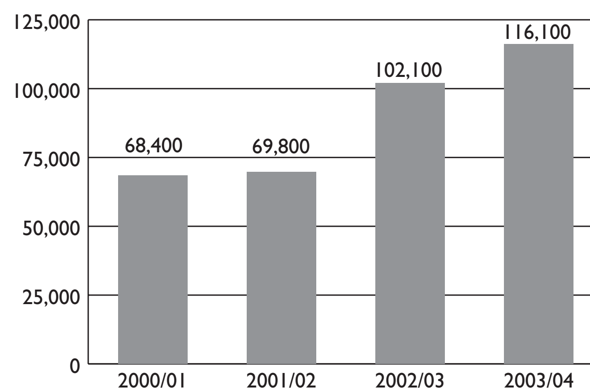
Regional Health Authorities undertake contact tracing on First Nations reserves but the federal/provincial realms of responsibility inhibit the development of comprehensive and seamless services for Aboriginal people. The high degree of movement between reserves or settlements and urban centres increases the challenges associated with locating Aboriginal people for follow-up services.

While some reserve communities are increasingly committed to tackle the issues of blood borne pathogens, a harm reduction approach (for example, providing sexual health education and condoms in schools) continues to be misunderstood or rejected in other communities. Concerns around confidentiality, especially in small reserve communities and Métis settlements, may also prevent some Aboriginal people from seeking testing. Additionally, awareness of and access to culturally appropriate information on how to prevent, manage and control disease may serve as barriers to some Aboriginal peoples.

In September 1998, Alberta introduced a prenatal HIV screening program that strongly recommends testing all pregnant women for HIV. This "opt-out model," recommended by the Canadian Medical Association,[44] offers women HIV testing during pregnancy with the option to decline. Informed consent remains a vital part of this initiative, however. This approach has resulted in approximately 95%-98% of all pregnant women in Alberta being tested for HIV.

Figure 5 illustrates the progressive increase in the total number of HIV serology tests conducted in Alberta each fiscal year since 2000/01.

Figure 5, Total Number of HIV Serology Tests by Year, in Alberta



Alberta also offers anonymous testing but only one of three sites in the province has been accessed by a small number of clients in the past two years.

[44] Alberta Blood-borne pathogens Surveillance Group, 2003:20.

HIV clinical services and antiretroviral costs are funded through a separate province-wide fund, with Edmonton coordinating the Northern Alberta HIV program and Calgary the Southern Alberta program. Several HIV physicians also conduct regular clinics in five provincial and federal correctional facilities. Furthermore, the province funds a toll free STI/HIV information line that provides both recorded information 24 hours a day and access to a nurse during business hours.

The Non Prescription Needle Use (NPNU) initiative, formed in 1995, is a coordinated response of 39 government departments, agencies, organizations and community groups to reduce the harms associated with injection drug use particularly as they relate to HIV and Hepatitis C. Field level staff work with policy makers to identify issues, develop programs and policies, and work collaboratively to improve the health of those who inject drugs.

The NPNU has worked to provide greater access to methadone in the province and the number of methadone clinics has increased from one, situated in Edmonton, to five across the province. There are now two clinics in Edmonton, one in Red Deer and two in Calgary. A provincial Opioid Dependency Treatment Coordinating Committee will set direction for the delivery of this treatment in Alberta.

Key informants suggested that the range of supports and services needed to address the HIV/AIDS epidemic in Alberta are largely in place. However they identified a need:

- for public education and for programs targeted to youth and to men who have sex with men;
- to focus greater attention on Aboriginal people and communities whether on or off reserve;
- to provide the range of social supports – such as housing – that can help to reduce HIV vulnerability; and
- to meet the needs of people living in small communities given the issue of confidentiality and the cost of medical travel.

Knowledge

The Government of Alberta invests in research through the Alberta Heritage Foundation for Medical Research. Importantly, the Foundation places considerable emphasis on disseminating and applying research. Its Research in Practice initiative and newsletter, for example, were "established to ensure that important research findings make their way into clinical practice and policy settings as quickly as possible."[45] Additionally the Alberta Community Council on HIV receives funding from PHAC to support a research coordinator who can assist agencies undertaking community-based research.

[45] See **http://www.ahfmr.ab.ca/publications/reports/hrip2000/from_to.html** and **http://www.ahfmr.ab.ca/publications.html**.

Strengthening the Effort

Key informants suggested a variety of means for strengthening the province's response to the epidemic:

- commit resources – although not necessarily new resources – to the emerging provincial strategy.
- respond to Aboriginal aspects of the epidemic by building relationships with First Nations and Inuit Health Branch in Health Canada, Aboriginal people and communities, Regional Health Authorities, HIV/AIDS-related agencies and other service organizations.
- enhance the ability to follow-up on identified cases particularly in rural areas.
- strengthen the prevention effort at the community, provincial and national level, and recognize that prevention campaigns must be consistent, aggressive and sustained through the long term.
- address the epidemic among populations coping with a variety of barriers such as addictions, mental health problems and housing issues.
- address the stigma and discrimination that are still associated with HIV/AIDS.

3.4 Saskatchewan

Surveillance Highlights

- the number of newly reported AIDS cases remains relatively small and stable.
- the number of newly reported cases of HIV infection was higher in 2003 than in 1995. The MSM exposure category was responsible for over 43% of newly reported cases in 1995 compared to 36% in 2003. IDU meanwhile was responsible for 25% of new cases in 1995 but only 19% in 2003. In 2002, however, IDU was the exposure category for 54% of newly reported cases. The sharpest increase has occurred among those in the heterosexual exposure category, i.e. 7% in 1995 and 17% in 2003.
- the percentage of new HIV+ cases involving Aboriginal people has increased from 32% in 1996 to almost 50% in recent years.
- 27% of all reported HIV cases, 1985-2003, involved women. This represents a 3:1 male/female ratio compared to a ratio of 6:1 for Canada as a whole.

Saskatchewan

Indicator	Year			
	2002	2001	2000	1995
AIDS Cases				
Number of AIDS cases reported by year	10	8	13	18
Cumulative number of AIDS cases reported	192	182	174	118
Newly reported AIDS cases by sex				
male	6	5	12	17
female	4	3	1	1
HIV Infection				
Total number of reported HIV cases	26	40	35	28
Newly-reported cases of HIV Infection by risk factor				
MSM	1	10	10	12
MSM/IDU	0	2	0	5
IDU	14	10	10	8
Heterosexual contact	7	8	10	2
HIV/AIDS-endemic countries	3	7	1	1
NIR/Perinatal/Occupational/Other	1	3	4	2
Newly-reported cases of HIV Infection by sex[46]	**1985-December 31, 2003**			
Men	330			
Women	120			
Newly-reported cases of HIV Infection by age (1998)[47]	**2002**	**2001**	**2000**	**1995**
Perinatal	0	0	1	1
1-19	1	0	1	1
20-29	6	9	7	11
30-39	5	15	13	12
40-49	10	12	7	4
50+	4	4	6	1

[46] 12 Saskatchewan, 2002:21; 19 Canada, 2003(c):19.

[47] 12 Saskatchewan, 2002:21.

Organization

The Saskatchewan Department of Health, Regional Health Authorities, community-based organizations and the Saskatchewan Advisory Committee on HIV/AIDS are together responsible for the province's response to the epidemic. The Department of Health has one person primarily responsible for coordination issues while the Advisory Committee has 16 regular and five liaison members. It includes representatives of different health professions, Aboriginal groups, government departments (Health, Learning, Community Resources and Employment, and Justice), the Saskatchewan Federation of Labour, needle exchange programs and AIDS Service Organizations.

The provincial Strategy Team developed the 2002 *At Risk* report that offered an extensive series of recommendations for prevention, care and treatment initiatives. It placed a heavy priority upon addressing injection drug use and, beyond that, recommended:

- providing education and outreach services;
- addressing the social determinants of health with respect to injection drug use;
- expanding harm reduction services;
- providing accessible and adequate addiction treatment services; and
- supporting research on injection drug use and addictions to enhance understanding of the issue.[48]

The *At Risk* report has not become a provincial strategy per se but it has served to build awareness and to provide direction. It is described as a "living document." Importantly, its two year developmental process itself enhanced awareness.

There are 13 Regional Health Authorities in Saskatchewan each having service responsibility for hospitals, health centres, wellness centres, social centres, supportive care, community health services, rehabilitation services and health promotion.

Additionally, there are five AIDS Service Organizations in the province funded both by the provincial government (approximately $325,000) and PHAC through its AIDS Community Action Program. One of these organizations, AIDS Programs South Saskatchewan, has been operating and providing information and support for 19 years.

Coordination and Cooperation

The Saskatchewan Advisory Committee on HIV/AIDS provides a forum for cooperation and coordination across agencies. The provincial Department of Health has a good working relationship with the PHAC regional office but few links to Correctional Service Canada.

There are community-based AIDS service organizations in Regina, Saskatoon and Prince Albert that serve both those communities and their surrounding areas. Ensuring a reasonable level of service consistency across the province's Regional Health Authorities is a challenge although this structure does enable local authorities to tailor their response, to HIV/AIDS and other conditions, to the needs and circumstances of their local area. Consistency is also an issue in the relationship between the community HIV/AIDS organizations and the Regional Health Authorities.

In Regina and Prince Albert, the community organizations, municipal authorities and two orders of government are said to work well together, responding quickly and effectively to new issues as they arise. This partnership is said to be less well developed with the Regional Health Authorities outside of the province's main centres, perhaps a reflection of the epidemic's geographic concentration. Certain key informants also suggested that the political organizations representing Aboriginal people in the province – unlike the Aboriginal community groups – are not significantly or sufficiently engaged in AIDS-related efforts.

[48] Saskatchewan, 2002:2.

Testing, Prevention, Care and Treatment

Saskatchewan tests pregnant women as part of their prenatal care regimen using an opt-in model for consent.

As of 2002, there were well-established needle exchange programs in Regina, Saskatoon and Prince Albert as well as new ones in Moose Jaw and Ile a la Crosse. The Saskatoon program had about 500 registered clients, 50% of whom were women, and provided its services through both a fixed site and a mobile unit. The Regina program had approximately 430 clients in 1999 while the Prince Albert program had slightly over 500 clients. In 1999, the programs distributed approximately 600,000 needles.[49] In response to the province's *At Risk* report, Saskatchewan recently expanded its methadone program with the number of prescribing doctors increasing from 6 in 1997 to 17 in 2000. The program's capacity expanded from 20 clients in 1996 to 550 in 2000.

In Regina, the Saskatchewan All Nations Hope AIDS Project – developed initially as part of AIDS Programs South Saskatchewan – now has an independent Board and operates autonomously. It has received both provincial and ACAP funding for local projects in Regina and Prince Albert as well as for projects that are provincial in scope. It has undertaken work related to both hepatitis C and HIV/AIDS in correctional institutions. The two Regina organizations are also participating, along with the Regina Health Region and the municipal government, in the South Saskatchewan Harm Reduction Initiative.

Knowledge

The Regina and Prince Albert Health Districts, along with Saskatchewan Health and PHAC, have undertaken studies "to define the burden of these public health problems [HIV and hepatitis C] in this risk group and to help guide the development and refinement of prevention policies and programs."[50] The studies provided some important insights into the group of people injecting drugs, finding for example that in Regina:

- only 30% of the subjects had completed high school or pursued higher education;
- 96% reported "fairly stable housing conditions;"
- 73% relied upon welfare as their primary source of income;
- 32% were currently supporting children;
- 37% had lived outside of Saskatchewan during the past five years; and
- 20% were using methadone at the time of the study.

About 44% of the sample reported using borrowed equipment and using condoms only infrequently when with regular or casual partners. A large percentage reported histories of family dysfunction, childhood abuse, learning disabilities and suicidal thoughts or attempts. Eighty percent reported alcohol abuse and most had engaged in some criminal activities. The Regina study led to important policy considerations, for example:

- programs must address the underlying determinants of health if they are to be successful;
- the Aboriginal population must be involved in planning and delivering new programs in order to ensure they are culturally appropriate;
- different program models are required for men and women, in part because of the latter's responsibility for their children and in part because of their greater incidence of abuse both as children and as adults; and
- needle exchange programs need to be expanded and decentralized.[51]

[49] Saskatchewan, 2002:31.

[50] Saskatchewan Health, 2000:4. See also Saskatchewan Health, 1998.

[51] Saskatchewan Health, 2000:5-6.

The Regina study also recommended efforts to move the community effort "upstream" in order to prevent drug use. This last conclusion was strongly supported by the Prince Albert study which found that 12% of IDUs had begun injecting between the ages of 10 and 14 years and another 41% between the ages of 15 and 19 years.[52]

Strengthening the Effort

Key informants and other sources suggested the following measures to strengthen the province's response to HIV/AIDS:

- adopt a "multifaceted, intersectoral approach … to build capacity and foster collaboration between communities and governments … The key to long-term prevention of blood-borne diseases is the willingness of all stakeholders to address the determinants of health underlying injection drug use."[53]
- more fully involve a broader range of Aboriginal organizations in the effort to address HIV/AIDS.
- shift "new health funding from acute care to prevention, from technology and salaries and wait lists to addressing the root causes of disease."
- rebuild public awareness and political will given that HIV is no longer "new or news."
- integrate HIV with other efforts to address blood-borne pathogens in order to raise its profile and since we are "past the time of treating it as a separate issue."

3.5 Manitoba

Surveillance Highlights

- in contrast to national trends, the number of newly reported cases of HIV infection has increased significantly over time, from 51 cases in 1995, to 70 in 2002 and 111 in 2003.
- in 2003, 81 of the 111 (73%) newly reported HIV+ cases were in Winnipeg. Similarly, six of the 12 new AIDS cases reported in Manitoba were in Winnipeg with the geographic location of the other six cases being unknown.
- in 2003, women represented 36% of all newly reported cases. Aboriginal people represented 27% of all cases for whom ethnicity was identified while African people represented 23% and Caucasians 19%.
- MSM represented only 11% of all newly reported HIV+ cases for whom the exposure category was known in 2003. IDU represented 17%, heterosexual contact 28% and endemic countries 20%.
- incidence among the Winnipeg IDU population has increased significantly, from 9% of all infections in the period 1986-1990 to 31% in both 1998 and 2002.
- there are nearly as many female as male injection drug users in Winnipeg and a disproportionate number are Aboriginal.[54]

[52] Saskatchewan Health, 1998:3.

[53] Saskatchewan, 2002:3.

[54] Elliott, 1999:iii.

Manitoba[55]

Indicator	Year				
	2003	2002	2001	2000	1995
AIDS Cases					
Number of AIDS cases reported by year	12	13	9	7	16
Cumulative number of AIDS cases reported	224	212	199	190	141
Newly reported AIDS cases by sex					
male	7	11	7	7	15
female	5	2	2	0	1
Newly reported AIDS cases by exposure category					
MSM	0	3	0	3	12
IDU	6	5	2	1	1
MSM/IDU	0	1	0	0	0
Heterosexual contact	3	4	5	3	1
Blood Products	1	0	0	0	1
Endemic	1	0	2	0	1
NIR	1	0	0	0	0
Newly reported AIDS cases by age					
0-19	0	0	0	0	0
20-39	8	8	4	2	14
40-49	3	4	3	3	0
50+	1	1	2	2	2
AIDS-related deaths	3	5	6	7	13

[55] Key source is Manitoba Health, 2003. Data provided by Manitoba Health, AIDS Case and HIV Case databases. Data extracted, July 9, 2004. AIDS cases are reported by date of diagnosis.

Manitoba *(continued)*

Indicator	Year				
	2003	**2002**	**2001**	**2000**	**1995**
HIV Infection					
Total number of newly reported HIV cases	111	70	65	57	51
Newly reported HIV cases by exposure category					
MSM	12	10	10	13	15
MSM/IDU	4	0	1	1	4
IDU	19	22	23	16	14
Heterosexual contact	31	21	19	21	13
HIV/AIDS-endemic countries	22	11	5	4	4
NIR	22	4	5	2	1
Recipient B/B products	1	2	2	0	0
Newly reported HIV cases by sex					
Men	71	41	39	38	42
Women	40	29	26	19	9
Newly reported HIV cases by ethnicity					
Aboriginal people	31	27	27	23	N/A
Asian	4	5	1	2	N/A
African	25	10	8	4	N/A
Caucasian	21	19	18	21	N/A
Other	3	1	0	1	N/A
Unknown/Missing	27	8	11	6	N/A
Newly reported HIV cases by age					
<15	4	1	0	0	0
15-19	0	3	0	2	1
20-29	27	14	13	19	21
30-39	48	30	30	20	21
40-49	25	12	9	10	6
50+	7	10	13	6	2

Organization

In 1996, the Government of Manitoba adopted a Provincial AIDS Strategy incorporating a population health philosophy and committing to "services that are readily accessible closer to home."[56] Communities were to be responsible for assessing need and determining who would provide what services while the provincial government would be responsible for integrating services, setting standards, developing policy and for monitoring outcomes. The Strategy's goals were:

- to reduce the spread of HIV infection;
- to provide a continuum of compassionate prevention, care, treatment and support programs for persons at risk of and infected/affected by HIV/AIDS; and
- to facilitate the planning, delivery and evaluation of all programs and efforts to ensure that they are guided by a population health philosophy.[57]

The Strategy also included a statement of principles that emphasized targeted efforts, reasonable accessibility, a continuum of services, coordination and integration, client centred services and confidentiality, human rights, community development and health promotion, and consistency with the Canadian Strategy on HIV/AIDS. Importantly it also recognized the special needs of Aboriginal people and prepared, in 2001, a harm reduction discussion paper to broaden the discussion around the epidemic.

Manitoba also has a Sexually Transmitted Diseases Control Strategy that can have "important implications for HIV prevention"[58] particularly since the province has some of the highest rates in the country for certain sexually transmitted infections. The chlamydia rate, for example, is 275 (/100,000) compared to a national average of 130 while for gonorrhoea it is 54.2 compared to 16.7. Manitoba intends to integrate its HIV/AIDS-related efforts with those relating to hepatitis C and other sexually transmitted infections. Some believe this approach will assist in bringing attention to this epidemic.

It has been suggested that the AIDS strategy has been limited in that there are not dollars specifically attached to it. Manitoba Health funds the eleven regional health authorities to provide direct service to their residents. The availability and accessibility of HIV/AIDS-related services varies greatly throughout the province with the majority of services available only in Winnipeg. Manitoba Health has a limited budget for special projects related to HIV/AIDS, STIs and hepatitis C.

Service delivery and planning for services is the responsibility of the regional health authorities. The Winnipeg Regional Health Authority has been most active, a reflection of the fact that over 80% of those living with HIV/AIDS live in that region. It has also been suggested that public awareness, interest and commitment – particularly outside of Winnipeg – has diminished over the years due to the relatively low number of HIV cases and competing priorities.

Coordination and Cooperation

In 2002, the Manitoba government acknowledged that to be effective, its HIV/AIDS-related efforts and issues have to become a "key component of not only health programming but also [of] the programs and policies of justice, education and social service organizations across the province."[59] In November 2003, Manitoba Health became co-chair of the Manitoba Harm Reduction Network (MHRN). The MHRN is supported by both provincial and federal funding sources.

[56] Manitoba Health 1995:8.

[57] Manitoba Health, 1995:13.

[58] Manitoba Health, 2001(a):3.

[59] Manitoba Health, 2002:2.

The MHRN is a diverse network of people involved in reducing the incidence of sexually transmitted infections and blood borne pathogens while its focus is to improve access to services for individuals and communities at elevated risk of infection. The MHRN has created specific task groups on Policy, Support and Basic Needs, Education and Outreach. It intends to meet annually to set priorities for action and to evaluate past initiatives.

Manitoba Health works closely with both the national and the regional offices of PHAC and Health Canada. PHAC, for example, funds a Field Surveillance Officer who works alongside provincial staff to enhance, compile and analyze surveillance and epidemiological data. Other cooperative initiatives include:

- the Manitoba Corrections Knowledge Attitude and Behaviour Study that is currently in the developmental stage; and
- a partnership between Manitoba Health and Manitoba Corrections to implement a Public Health Nurse Pilot Project in five of the province's correctional institutions.

At the community level, the Manitoba AIDS Cooperative brings together 15 AIDS Service Organizations to advocate for funding and for consistency across health regions.

Testing, Prevention, Care and Treatment

Between 1996 and 2002, almost 170,000 HIV tests were conducted in the province, ranging from 17,300 in 1996 to over 29,000 in 2002. The majority of both men and women being tested were between 20 and 39 years of age. Manitoba provides prenatal testing using an opt-out model. A working group is currently in the process of expanding testing options to include nominal and anonymous HIV testing.

The Regional Health Authorities and community-based organizations have undertaken a variety of prevention and harm reduction initiatives. One study, however, suggested that 30% of IDU respondents have difficulty obtaining needles at least some of the time because of their cost, the refusal of some pharmacies to sell them or the inaccessible location of needle exchange programs.[60]

There is also a broad range of services available to those living with HIV/AIDS, particularly in Winnipeg. These include a 12-unit housing complex, a series of educational workshops for social services and housing staff, a faith-based hospice targeted to those using injection drugs, various supports for street involved persons and a good network of services for street youth. The Nine Circles Community Health Centre, for example, may be unique in Canada in terms of the comprehensive array of clinical, advocacy and support, transportation, child care and other services it provides for those living with HIV/AIDS. Kali Shiva AIDS Services, the Ma Mawi Wi Chi Itata Centre, the Manitoba AIDS Hospice, the Northern AIDS Initiative and the Rainbow Resource Centre, among others, also provide an array of supports including non-medical home care, a women's program, a "kids club" and various activities for youth.[61]

Many HIV/AIDS-related drugs are covered by the provincial drug program although the deductible may be problematic for the working poor. Some respondents indicate that the process for placing new drugs on the formulary is very slow.

[60] Elliott, 1999:iv.

[61] See the Manitoba AIDS Cooperative at **http://www.mts.net/~aidscoop/MAC_members.html**.

Knowledge

It has been suggested that the academic research and epidemiological data being analyzed in Manitoba are useful for community purposes although very often they do "not drill down far enough" and are not available in a timely manner. Community agencies often witness trends a year or two before they are represented in the data and research. Key informants suggest that cohort and other such studies are needed to explore behavioural issues, and that community groups should be more fully engaged in the research process.

Strengthening the Effort

A variety of key informants have suggested that the following could strengthen the province's effort to address the epidemic:

- adopt a harm reduction philosophy to address the needs of those unable to abstain from injection drug use, and enhance the availability of injecting equipment.
- enhance the availability of additional treatment and support services.
- provide additional funding and resources to pursue the policies outlined in the provincial Strategy; include mechanisms to encourage cooperation and an accountability system that is not unduly onerous.
- place more emphasis on primary prevention including better links between education and health, and greater emphasis on marginalized populations everywhere in the province including Winnipeg.
- develop better accountability tools to ensure that funds are being used in the most effective manner possible.
- enhance public awareness and encourage political commitment.

3.6 Ontario

Surveillance Highlights

- over 22,000 persons were living with HIV/AIDS in Ontario in 2003. HIV prevalence has increased by 6% annually through the past five years.
- the number of newly diagnosed HIV-positive cases increased in 2002 and 2003 from an average of 1000 new diagnoses per year (1997-2001) to 1233 (2002) and 1217 (2003).
- 29% of new HIV diagnoses in 2003 were among women, a dramatic increase from the 2% observed after HIV testing began in 1985 and the 20% in the late 1990s. Men who have sex with men, however, remain the largest proportion of new diagnoses for which the exposure category has been identified, at 51%.
- since 1997, HIV prevalence rate has increased by 90% among persons from HIV-endemic countries.
- it is estimated that only 64% of the 22,100 HIV-infected persons in Ontario have been diagnosed, leaving about 7,950 who do not know they are infected.[62]
- it is suggested that some HIV/AIDS-related deaths are being attributed to other causes and hence not being identified in the epidemiological data.

[62] Ontario Advisory Committee on HIV/AIDS (OACHA), 2002:6.

Ontario[63]

Indicator	Year				
	2003	2002	2001	2000	1995
Prevalence Estimate[64]	22,100+	22,100	21,700	20,600	15,800
AIDS Cases					
Number of AIDS cases reported by year	119	123	157	132	608
Cumulative number of AIDS cases reported	7514	7395	7272	7115	5930
Newly reported AIDS cases by sex					
male	91	98	129	115	562
female	28	25	28	17	46
Newly reported AIDS cases by exposure category					
MSM	44	45	66	60	406
MSM/IDU	0	3	4	4	31
IDU	10	13	12	16	32
Heterosexual contact	26	29	23	22	65
HIV Endemic	31	31	30	18	27
Clotting Factor/Transfusion	1	0	3	3	20
NIR/occupational	6	8	12	5	20
Perinatal	1	3	1	3	7
Total number of AIDS cases by age	**1981-2003**	**2002**			
<15	77	2			
15-24	257	2			
25-44	5,467	76			
45-59	1,457	26			
60+	254	3			
Unknown	2	0			
AIDS-related deaths		21	46	50	

[63] Main sources are data provided by the Ontario HIV Epidemiologic Monitoring Unit, and Remis et al., Report on HIV/AIDS in Ontario, 2002, 2003.

[64] Estimates from Remis, 1998-2003.

Ontario *(continued)*

Indicator	Year				
	2003	**2002**	**2001**	**2000**	**1995**
HIV Infection					
Number of newly reported HIV cases	1217	1233	1017	938	1360
Newly reported HIV cases by exposure category					
MSM	266	316	222	251	359
MSM/IDU	5	4	8	13	19
IDU	36	39	36	42	75
Recipients of Blood	3	3	4	9	10
Recipient of clotting factor	2	0	2	2	10
HR/LR Heterosexual	131	135	121	95	108
HIV/AIDS-endemic countries	46	47	36	30	19
NIR/Other	700	655	558	466	736
Perinatal	28	34	30	30	25
Newly reported HIV cases by sex					
Men	852	878	733	686	1080
Women	346	325	253	203	221
Unknown	19	30	31	49	59
Newly reported HIV cases by Age	**1985-2003**				
<1 year	544	79	52		
1-14 years	191	9	7		
15-24 years	2,090	113	84		
25-39 year	13,357	625	517		
40-59 years	5,767	352	275		
60+	462	29	37		
Unknown	2,323	31	41		

Organization

The first Ontario HIV/AIDS Strategy was developed in 1994-1995 and was intended to serve until 2001. It proved useful as a touchstone for decision-making within government and for providing direction to community agencies.

In June 2002, the Ontario Advisory Committee on HIV/AIDS (OACHA) proposed a new strategy for the province covering the period to 2008. This strategy was an attempt to respond to the changes in "our ability to treat HIV, the course of the disease, the public and media attention given to HIV, and the spread of the virus."[65] It proposed two goals – namely, to prevent the spread of HIV and to improve the health and well-being of people living with HIV and their communities – as well as four policy directions:

- adopt a determinants of health approach and address social justice issues;
- focus on long-term, integrated, sustainable, targeted responses;
- develop a flexible provincial response to HIV that takes into account local/population needs; and
- improve Ontario's capacity to respond effectively through improved monitoring and accountability.[66]

The proposed Strategy also incorporates five elements. The first involves enhanced knowledge while the second emphasizes fostering leadership that will pursue an integrated approach to HIV prevention, support, care and treatment based on the determinants of health. A third endeavours to ensure access to prevention, support, care and treatment services. The remaining elements emphasize adequate resources and accountability.

In 2001-2002, the Ontario government spent approximately $50 million to support HIV-related services, not including physician costs, drug programs, in-patient hospital services, home care services and palliative care services. Many community-based AIDS organizations receive funding not only from the Ministry of Health and Long-Term Care but also from municipalities, the federal government and private sources.[67]

The province's AIDS Bureau is responsible for co-ordinating the Ministry's response to HIV. In many ways, it is the entry point to the Ministry and provides central coordination through its efforts to work bilaterally with the branches responsible for laboratories, public health, addictions and Aboriginal health. It also serves as the OACHA secretariat, provides funding for community groups and for research activities, monitors anonymous HIV testing, and helps to develop policy. There is not an interdepartmental committee on HIV/AIDS although ad hoc groups are established as required to address specific issues.

In addition to the AIDS Bureau, the Ministry's Public Health Branch, Central Public Health Laboratories Branch, OHIP, drug programs and others have some responsibility for funding HIV/AIDS-related services. OACHA suggests that while this approach promotes integration and the mainstreaming of HIV/AIDS-related services, it also means that:

- decisions about the funding and management of certain HIV programs are made by those for whom HIV may not be a priority.[68]

The OACHA report provides a useful assessment of the Ontario efforts to date. This assessment is presented in **Table 3**.

[65] Ontario Advisory Committee on HIV/AIDS (OACHA), 2002:Preface.

[66] OACHA, 2002:9-10.

[67] OACHA, 2002:61.

[68] OACHA, 2002:61.

Table 3, OACHA Summary of Perceived Strengths and Weaknesses

Type of Service	Strengths	Weakness
Prevention	• diversity, variety and comprehensiveness of prevention programs • availability of anonymous testing • community expertise	• fragmentation of services, lack of co-ordination among HIV/AIDS programs and between HIV programs and other services • lack of sustained, high-profile information campaign, lack of focus on the determinants of health, lack of services in rural areas, and lack of education for youth
Care and Treatment	• comprehensive care provided by HIV clinics; effective collaboration among clinics • Trillium and ODB willingness to cover new drugs • clinical care infrastructure	• lack of services in rural areas and for marginalized populations • impact of hospital restructuring • restrictions on CCAC services • lack of rehabilitation services • lack of co-ordination across services • timeliness within the Trillium Drug Program • lack of addiction/methadone services and mental health services, and of services for people in prisons
Support	• availability of comprehensive programs in urban centres • strong social safety net • support provided by the AIDS Bureau	• lack of services in rural areas, of affordable housing and focus on social determinants • lack of outreach services, workplace support, mental health services and other social services
Research	• strong research infrastructure • high calibre of research/teams • the public health laboratory system	• lack of collaboration among researchers • lack of research in key areas • lack of a global research strategy

The OACHA work is complemented by an Ontario Aboriginal HIV/AIDS Strategy covering the period from 2001 to 2006.

Public health services in Ontario are delivered through 37 local public health units that are overseen centrally. Monitoring allows for a degree of consistency in terms of services provided while still permitting the flexibility that is required to respond to local health needs.

Coordination and Cooperation

Ontario works closely with PHAC and Health Canada on HIV/AIDS-related efforts, at both the regional and national levels. The relationship is particularly close and effective at the regional level where the intergovernmental culture emphasizes that they are partners in a common effort. The two governments, for example, will make common visits to funded agencies, share information both formally and informally, and periodically fund projects jointly. They are currently working on a common reporting mechanism designed to reduce the administrative workload of community agencies while maintaining accountability requirements.

There is a sexual health component in the public school system but this is very much the responsibility of the Ministry of Education and local school boards, and was developed and is delivered without any significant involvement by the Ministry of Health and Long-Term Care.

Although the intra-governmental links with public health and the different pubic health units around the province are not strong, the latter play an important role through public education and contact tracing. Their obligations in this regard are outlined in a Mandatory Health Programs and Service Guidelines that includes goals and standards. It also links STIs with HIV/AIDS.[69]

The level of cooperation between community agencies and local health authorities can differ dramatically from location to location.

Testing, Prevention, Care and Treatment

Prenatal testing for HIV, using an opt-in model, is an important component of the provincial effort and the Ontario experience with this testing speaks to the importance and impact of careful follow-up with physicians. Ontario introduced prenatal testing in January 1999 and saw testing uptake increase from 41% to 48% in the first six months. This was followed by gradual improvement in the subsequent two years, to 60% in the second quarter of 2001. In September 2001, the HIV Laboratory began sending a memo with each prenatal test result for which an HIV test had not been ordered reminding the physician that an HIV test is recommended. This appears to have had a substantial impact, increasing HIV test uptake to 89% by the end of 2003. Other Ontario initiatives in this regard include the real-time monitoring of test uptake in pregnancy with updates to Medical Officers of Health and communication campaigns targeted to physicians and women. This prenatal testing has enabled Ontario to identify 186 HIV-infected pregnant women of whom 139 had not been previously diagnosed.[70]

Generally, there are public health and community-based HIV/AIDS services in most of the province's regions. At the same time, however, there is a lack of clinical services for people living with HIV/AIDS in the Northwest as well as in the Guelph/Kitchener/Waterloo and Peel regions. There is also a significant physician shortage in the province, and great concern that with retirements looming over the next five years, there may be a crisis in physician care for people living with HIV/AIDS.

[69] See Ontario, 1997.

[70] Correspondence with the Ontario office of the Chief Medical Officer of Health.

Nevertheless, a number of significant services have been developed through the past five to seven years, including:

- the Trillium Drug Program, an income-based program that provides drug coverage for people with disproportionately high drug costs;
- 25-30 needle exchange programs, some with mobile vans;
- 33 anonymous testing sites, prenatal testing for HIV and an infant formula program;
- both on and off-reserve agencies are funded to address HIV/AIDS issues within the Aboriginal community; and
- supportive housing and McEwan House.[71]

Ontario has had some success through the development of strategies for each of its high risk populations. These are as follows:

1. African and Caribbean Council on HIV/AIDS

The African and Caribbean Council on HIV/AIDS in Ontario (ACCHO) is in the final preparation stages before launching the *Strategy to Address Issues Related to HIV Faced by People in Ontario From Countries Where HIV is Endemic*. The ACCHO Strategy is a framework to coordinate and guide action to address issues related to HIV faced by people in Ontario from countries where HIV is endemic. It will result in coordination of agencies, institutions and policy makers working with these populations; community development initiatives to strengthen the capacity of these communities to address HIV/AIDS issues; and the identification of research priorities and opportunities.

2. Ontario Aboriginal HIV/AIDS Strategy

The Ontario Aboriginal HIV/AIDS Strategy (OAHAS) was developed in 1995 to direct HIV prevention, care, treatment and support work with off-reserve Aboriginal people in Ontario. The OAHAS was updated in 2000 as a strategic plan for the years 2001 to 2006. The OAHAS provides funding for a provincial coordinator and 7.5 HIV/AIDS workers located in strategic locations in the province. A reference group, composed of ministry and off-reserve Aboriginal representatives, oversees the implementation of recommendations contained within the OAHAS. The Strategy, controlled and implemented by Aboriginal people, has been successful at responding to the unique needs of Aboriginal people in a culturally appropriate way and raising the profile of HIV/AIDS in Aboriginal communities.

3. Injection Drug User Outreach Program

In 1996/1997, Ontario enhanced existing outreach to injection drug users by introducing 15 new IDU outreach workers throughout the province. This enhancement contributed to a significant reduction in new HIV infections in this population, with the rates never returning to the levels seen prior to the enhanced outreach program. In general, the IDU HIV epidemic in Ontario has been stabilized and is decreasing, a trend that began after the introduction of enhanced IDU HIV prevention strategies.

[71] OACHA, 2002:59.

4. Gay Men's HIV Prevention Summit and Working Group

In March 2003, Ontario hosted the Ontario Gay Men's Prevention Summit, which brought together over 100 HIV stakeholders from across the province. The Summit resulted in a consensus of the need to move forward with a more cooperative, province-wide, centrally coordinated response to the HIV prevention needs of gay and bisexual men. A provincial working group was struck to formulate a new HIV prevention strategy for gay and bisexual men. At the same time, Ontario contributed to a federal campaign to reduce the spread of HIV amongst gay and bisexual men entitled, "How do you know what you know?" The campaign was coordinated by the AIDS Committee of Toronto and implemented throughout Ontario, resulting in the distribution of prevention materials and messages throughout the province and establishing a precedent in the province for the utility of a single campaign of relevance to men across an extremely diverse province.

The ability of the broad array of community organizations to meet community needs has been compromised by the lack of funding increases from the province. Community organizations are operating with the same base funding they have had for 10-12 years in spite of many organizations seeing their caseloads double over the past five years.

Knowledge

The province has made significant investments in HIV research through the HIV Ontario Observational Database (HOOD), the AIDS Program Committee, the Ontario HIV Treatment Network (OHTN) and the AIDS Bureau funding for university-based research. The OHTN, for example, is a not-for-profit agency funded by the Ontario Ministry of Health and Long-Term Care. Its mission is "to optimize the quality of life of people living with HIV in Ontario and to promote excellence and innovation in treatment, research, education and prevention through a collaborative network of excellence representing consumers, providers, researchers and other stakeholders."[72] It is a collaborative network bringing together people living with HIV/AIDS, health care providers, consumers, researchers, community-based organizations and government.

In addition to advising government, the OHTN allocates $8 million annually for research and a provincial HIV Information Infrastructure Project (HIIP) that endeavours "to improve treatment and care for people living with HIV in Ontario, and increase the security and enhance the management of personal health information through the use of information technology."[73] Importantly, HIIP is also a valuable research database with the potential to dramatically improve research linked to patient care.

The province, OACHA and community organizations all understand the relationship between health for those living with HIV/AIDS and social determinants such as poverty and inadequate housing. It is suggested that governments are not adequately addressing these health determinants.

[72] See **http://www.ohtn.on.ca/**.

[73] See **http://www.ohtn.on.ca/index_hiip.html**.

Strengthening the Effort

Key informants and other sources suggested that the following would strengthen the provincial effort to address HIV/AIDS:

- commit additional attention and target efforts more fully to particularly vulnerable groups including Aboriginal people and people from countries in which HIV is endemic.
- address the complacency associated with HIV/AIDS that may be contributing to increasing HIV incidence. Enhance public awareness of and political commitment to HIV/AIDS particularly at the local level where efforts to address the epidemic must compete for local health funds.
- better integrate HIV/AIDS-related and other services while devoting greater attention to the social determinants and their contribution to HIV vulnerability.
- importantly, provide additional funding that will enable AIDS service organizations to catch up to increasing costs, to meet ever increasing need, to retain and adequately compensate their employees, and to achieve some measure of organizational stability.

Importantly key informants in Ontario suggested that the province should "strengthen what we are already doing."

3.7 Quebec

Surveillance Highlights

- there are 18,000 people currently living with HIV/AIDS in Quebec, an increase of 10% since 2000 and of 33% since 1996.
- the number of AIDS cases involving people from countries in which HIV is endemic is second only to the MSM exposure category. As of June 30, 2002, there were close to 700 AIDS cases with the endemic country exposure category.[74] The estimated number of pregnant women of African origin infected with HIV has increased continuously over time, from five in 1997 to 17 in 1999, 23 in 2000 and 32 in 2001.[75]
- there has recently been a significant increase (26%) in the number of newly reported HIV infections, from 493 in 2000 to 621 in 2003.[76]
- it is estimated that women represented 23% of newly reported HIV infections in 2002.
- the Island of Montreal remains the region most affected by HIV/AIDS with a cumulative incidence rate nine times higher than in the rest of the province.[77] It is estimated that there are more than 600 new cases of HIV infection each year in the Montreal region.[78]

[74] Quebec, Portrait, 2003:5.
[75] HIV was not a reportable condition in Quebec until 2002.
[76] Quebec, Sante et Services sociaux, 2003:17.
[77] Quebec, Portrait, 2003:9.
[78] "HIV/AIDS among Natives, an adapted training." FNQLHSSC/CSSSPNQL 2003.

Quebec[79]

Indicator	Year[80]				
	2003	2002	2001	2000	1995
Prevalence	N/A	18,000[81]		16,300 **(1999)**	13,500 **(1996)**
AIDS Cases					
Number of AIDS cases reported by year of diagnosis	37	99	91	113	534
Cumulative number of AIDS cases reported	6,098	6,001	5,936	5,859	4,830
Newly reported AIDS cases by sex and year of diagnosis					
male	26	83	75	98	473
female	11	13	16	15	61
Newly reported AIDS cases by exposure & year of diagnosis					**Total cases**
MSM	15	55	44	51	3,754
IDU	9	15	15	27	441
Heterosexual contact	5	9	8	10	411
MSM/IDU	0	2	4	5	282
Endemic country	6	15	16	13	674
NIR	2	2	3	5	180
Other	0	1	1	2	261
Newly reported AIDS cases by age and year of diagnosis					**Total cases**
children & youth (< 15 years)	0	0	0	0	101
adults	36	95	88	111	5745
seniors (> 60 years)	1	4	3	2	157
Reported AIDS-related deaths	56[82]	126	109	124	586

[79] See Québec, 2003; Québec, 2002; and Quebec, Portrait, 2003.

[80] As of December 31 2003. Surveillance des cas de syndrome d'immunodéficience acquise (sida) cas cumulatifs 1979-2003. Mise a jour No 2003-2 au 31 décembre 2003. Ministère de la Santé et des Services sociaux du Québec. Disponibles à : **http://www.msss.gouv.qc.ca/sujets/prob_sante/mts_vih_sida.html**.

[81] Estimated prevalence (14,000-22,000) in Quebec at the end of 2002, as estimated by the Division of HIV/AIDS Epidemiology, Health Canada. See also Québec, Portrait des infections transmissibles sexuellement et par le sang, de l'hépatite C, de l'infection par le VIH et du sida au Québec – décembre 2003. Available at **http://www.msss.gouv.qc.ca/sujets/prob_sante/mts_vih_sida.html**.

[82] First 6 months of 2003, as of February 2004. Institut national de la statistique du Quebec.

Quebec *(continued)*

Indicator	Year				
	2003	**2002**	**2001**	**2000**	**1995**
HIV Infection					
Minimum number of laboratory confirmed HIV cases[83]	621	619	526	493	624
	2002	**1999**			
Estimated Incidence of HIV[84] by exposure category					
MSM	250-450	300-500			
MSM/IDU	50-150	50-150			
IDU	350-650	450-800			
Endemic/Heterosexual contact	150-350	150-350			
Blood	<10	<10			
Estimated Incidence of HIV by sex					
Men	N/A	N/A			
Women	N/A	N/A			
Estimated Incidence of HIV by age					
<15 years	N/A	N/A			
15-29	N/A	N/A			
30-39	N/A	N/A			
40-49	N/A	N/A			
50-59	N/A	N/A			
60+	N/A	N/A			

83 Minimum number based upon confirmed laboratory results. The actual number of persons with a positive result is higher, but duplicates cannot be totally eliminated. The laboratory result does not include information relating to age group or risk exposure category.

84 Collection of epidemiological information on Laboratory confirmed HIV cases began in April 2002. To date, no official release of data on this subject has been made. The only available data to date on HIV prevalence and incidence are based on estimates produced for 2002 and 1999 by the Division of HIV/AIDS Epidemiology, Health Canada.

Organization

In Québec, the *Loi sur la santé publique* sets the context for the province's public health programs and strategies. In its broadest sense, this law aims to protect population health and to establish conditions favourable to maintaining and improving population health and well-being.[85] It also seeks:

- to establish measures that prevent diseases, trauma and social problems that impact on population health; and
- to have a positive influence on the main factors that determine health, notably by a concerted action involving various partners (government departments, Public Health services, regional and local agencies, community based agencies, etc.).[86]

The development of a National Public Health Program and its companion Regional and Local Action Plans on public health is a mandatory aspect of that law. The National Public Health Program provides the framework for all public health activities undertaken on a provincial, regional and local level.[87] It must include orientation statements, goals and priorities with regard to:

- monitoring population health and its determining factors;
- preventing the disease; trauma and social problems that can impact population health;
- promoting measures to enhance population health and well-being; and
- protecting and monitoring population health.[88]

The *Stratégie québécoise de lutte contre l'infection par le VIH et le Sida, l'infection par le VHC et les infections transmissibles sexuellement – Orientations 2003-2009* complements the National Public Health Program (2003-2012). The *Stratégie québécoise* encompasses HIV/AIDS, hepatitis C and other STIs given that they affect similar population groups. In addition to reaching vulnerable groups, the *Stratégie québécoise* also addresses the general population and those living with HIV/AIDS.

The *Stratégie québécoise* considers the current context of HIV/AIDS and the illusion that the epidemic is under control. The face and reality of people living with HIV/AIDS has also changed considerably with the advent of HIV medications and the increasing number of IDU, youth, women and members of ethno-cultural communities who are becoming infected. The *Stratégie québécoise* includes a variety of strategies to reach vulnerable groups, by renewing prevention messages, by adapting care and services to people living with HIV/AIDS and by engaging in partnerships that promote health.[89] More specifically, the strategy's goals are:

- to reduce the incidence of infections transmitted through sexual contact and blood;
- to ensure that quality care and services are readily accessible; and
- to create a social environment that supports prevention while respecting human rights.[90]

To achieve these goals, the Quebec strategy outlines eight policy statements:

1. Reinforce the individual's potential so that they change their behaviour.
2. Support the most vulnerable groups, for example by facilitating access to testing.
3. Encourage the use of clinical practices and measures that emphasize prevention.

[85] Loi sur la santé publique, Chap. 1, art. 1.

[86] Loi sur la santé publique, Chap.1, art. 3.

[87] Loi sur la santé publique, Chap.2, art.7.

[88] Loi sur la santé publique, Chap. 2, art. 8.

[89] Québec, 2004:27.

[90] Québec, 2004:11.

4. Develop specific prevention measures, for example through the collection of used syringes and by providing easy access to condoms.
5. Support the development of vulnerable communities and encourage their empowerment.
6. Ensure that adequate care is provided to people living with HIV/AIDS.
7. Participate and partner in concerted actions that favour health and well-being.
8. Consolidate surveillance and monitoring efforts as well as other support functions.[91]

Although provincial in scope, implementing these policy statements has to occur within regional and local realities. HIV/AIDS and hepatitis C, for example, are particularly concentrated in urban and semi-urban areas and within specific population groups, whereas STIs are more widespread among the general population. Consequently, regional and local public health offices and their community partners must adapt the policy statements according to the needs of their populations. Regional Action Plans on public health and Local Action Plans on public health have to reflect their own contexts and realities.[92]

The Strategy's budget is $21 million. The largest portion of this amount is distributed among the regional public health offices and community organizations. The remainder is directed towards knowledge and expertise development, information campaigns targeting the general population, research and evaluation, and surveillance. The National Program of Public Health for 2004-2005 has received supplementary funding and these funds will be allocated to regional agencies in order to enhance the Strategy's activities.

Coordination and Cooperation

There are many stakeholders and partners in the fight against HIV infection, including the Ministry of Health, other government departments, regional and local public health offices, health care professionals and administrators, community based organizations and researchers. The *Loi sur les services de santé et les services sociaux*, the *Loi sur l'Institut national de santé publique du Québec*, Quebec's Law on Public Health and its National Public Health Program, specify each stakeholder's responsibilities in this regard.[93]

Working from a provincial perspective, the Ministry of Health, for example, is responsible for:

- informing stakeholders about the National Public Health Program and the Strategy;
- putting in place the conditions necessary to implement the policy statements described in the Strategy;
- supporting regional agencies to apply the orientations, for example by developing specific tools;
- ensuring the evaluation of the strategies, approaches and interventions; and
- ensuring financial accountability.

The Institut National de Santé Publique du Québec, meanwhile, supports the Ministry of Health and regional agencies with their public health missions by:

- providing assistance in the form of advice, training, information, research, evaluation, specialized laboratory services and international cooperation;
- helping to develop knowledge and expertise;
- planning and coordinating national training programs; and
- overseeing the Strategy's evaluation process.

[91] Québec, 2004:31-42.

[92] Québec, 2004:30.

[93] Québec, 2004:46-48.

Other partners in this effort include:

- the regional public health departments who are responsible for carrying out the strategy within their jurisdictions. While considering their population's needs and realities as well as available resources, they develop Regional Action Plans based on the content of the National Public Health Program and the Strategy. With regard to HIV infection, they plan and coordinate programs, provide care and other services, and undertake health promotion, prevention, research and monitoring activities.
- hospitals, private specialized clinics and the *Unités Hospitalières de Recherche, d'Enseignement et de Soins Spécialisés sur le Sida* (UHRESS) provide care and services through multidisciplinary teams of specialists at the regional level and, on a supra-regional level, disseminate their expertise, notably through the *Programme national de mentorat* for doctors and nurses (ongoing training, mentoring, workshops, internships).
- at the local level, specialized clinics provide direct care to people living with HIV/AIDS. They share their expertise by training interns and by undertaking various research activities.
- at the local level, the Centres locaux de services communautaires (CLSC) provide front line care and services as well as undertaking primary prevention efforts targeted at youth and vulnerable populations. Their HIV/AIDS activities are integrated within the Local Action Plan on public health, all the while considering activities undertaken by community-based agencies.
- community-based agencies are autonomous in determining their missions and activities. In terms of HIV infection, they attend to many vulnerable population groups and offer a wide range of prevention, care, housing and other support services. They work in cooperation with the regional and local authorities and are partners in the effort to achieve the regional and local action plans.
- universities and other learning centres contribute to the Strategy through research, knowledge transfer, evaluation and other developmental activities.

Other partners participate in the effort to address HIV/AIDS, for example education and public safety agencies, municipalities, school boards, youth centres, detention facilities and transition houses.

Testing, Prevention, Care and Treatment

The Quebec strategy encourages individual responsibility with regard to safe behaviour as well as an attitude of tolerance, compassion and solidarity towards vulnerable groups. Prevention activities include:

- ongoing social marketing and communication campaigns to promote condom use, etc.;
- developing effective, evidence-based tools and materials;
- promoting sex education and drug use prevention programs in the educational system at every level; and
- special prevention and harm reduction efforts targeted to people living with HIV/AIDS and to vulnerable populations.

The number of HIV serology tests conducted in Quebec increased steadily from 1995 to 2001. This is illustrated in **Figure 6**. In the six months from January to June 30th 2002, 101,800 tests were conducted.[94] As elsewhere, testing is voluntary. Quebec also includes HIV testing, using the opt-out model, within the array of blood tests given pregnant women. In 2002, 58 pregnant women in Quebec tested positive for HIV. Of these, 31% were Caucasian, 43% were African, 19% were Haitian

[94] Quebec, Portrait, 2003:19.

and 3% were Latin American. In the first six months of 2003, there were 48 reported cases among pregnant women of whom 23% were Caucasian, 52% were African and 21% were Haitian. **Figure 7** illustrates the exposure categories associated with those pregnant women testing HIV positive in 2002.[95]

Figure 6, Number of HIV Serology Tests, Quebec by Year

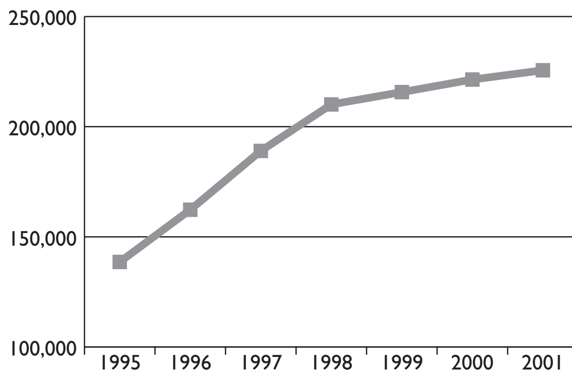
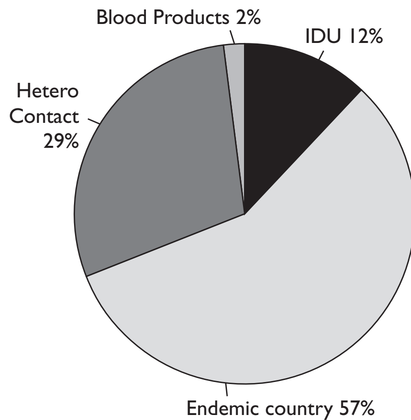


Figure 7, HIV+ Cases among Pregnant Women by Exposure Categories, 2002



In order to improve access to testing and to encourage testing, SIDEPs (*Services intégrés de dépistage et de prévention*) have been developed, most notably within the services provided at the CLSC level. These integrated services for testing and prevention offer counselling, testing and information both to the general population and to vulnerable groups. There are currently 70 SIDEPs in the province of Quebec and they are in the midst of expanding their services to STI and hepatitis testing and vaccination (HAV, HBV). They also encourage prevention among the partners of people living with HIV/AIDS. Importantly, the SIDEPs are encouraged to offer their services in places where vulnerable clients are located, for example in correctional centres or community organizations.

The Quebec Strategy emphasizes that every person living with HIV/AIDS must have access to quality care and services as well as the best available treatment. One component focuses on improving the integration of care and service networks, including UHRESS.[96] A variety of means have been implemented to support physicians who treat HIV positive clients, for example the *Programme national de mentorat*. There is also the *Comité consultatif sur la prise en charge clinique des personnes vivant avec le VIH* which brings together a panel of specialists from various fields to provide advice to the Department and publish guidelines for health care professionals on the use of HIV drug therapies.[97] Finally, the community-based housing for people living with HIV/AIDS model presently in use is considered to be unique anywhere.

[95] Québec, 2003:19.

[96] Québec, 2004:39.

[97] Québec, 2004:44.

Knowledge

Decision making, as well as the creation, planning and implementation of Strategy activities rely upon HIV surveillance and monitoring, research and evaluation. Many organizations are involved in the effort to build knowledge through research. The *Fonds de recherche en santé du Québec* (FRSQ) conducts epidemiological, clinical and basic research on public health. Recently, the FRSQ initiated a psychosocial research program on HIV and the *Réseau Sida et maladies infectieuses* of the FRSQ favours an integrated approach in regards to HIV research. Additional research is conducted by clinicians, universities or public health researchers, the INSPQ and UHRESS.

Moreover, a funding program jointly implemented by the Ministry of Health and the *Fonds québécois de la recherche sur la société et la culture* (FQRSC) for HIV research gave rise to a number of HIV research projects.

At the community level, research is being conducted by COCQ-sida on persons living with HIV/AIDS outside of urban centres, on adapting approaches for cultural groups, on assessing the quality of different interventions, and on developing training programs for pharmacists and counsellors. CPAVIH is working with pharmaceutical companies to assist clients with medications and the regimes they must follow, and to work towards combating the secondary effects caused by prolonged use of these medications.

Quebec also places considerable emphasis on evaluation as a means of improving program efficacy. The INSPQ is currently assessing prevention, care and services programs while the FQRSC is evaluating prevention initiatives as well as the impact of inter-sectoral actions.

Lastly, the province has encouraged skills development initiatives, including:

- Outillons-nous, by COCQ-Sida;
- seminars organized by the FRSQ HIV and STI prevention team;
- seminars organized for psychologists and social workers; and
- training for pharmacists in regards to methadone use.

Strengthening the Effort

The *Stratégie québécoise de lutte contre l'infection par le VIH et le SIDA, l'infection par le VHC et les Infections transmissibles sexuellement* is the Ministry of Health's position on strengthening the effort to address HIV/AIDS in Quebec.

Key informants outside of the Ministry of Health have proposed the following issues in order to strengthen the effort to address HIV/AIDS in Quebec, for example:

- expediting the process for adding new pharmaceuticals to the provincial formulary;
- increasing the level of funding committed to the epidemic and providing operational funding to community organizations;
- working together with other jurisdictions at the national level on common themes and encouraging increased partnerships;
- speaking more frankly with the general public in an effort to reduce the stigma and discrimination associated with HIV/AIDS;
- investing more heavily in research aimed at improving clinical practice;
- committing more effort to assisting persons with HIV/AIDS to re-enter the workplace;
- building a stronger human rights framework for persons living with HIV/AIDS; and
- getting the federal government to simplify the requirements of the AIDS Community Action Program, as the program's paper burden is onerous for community organizations in consideration of the funds available.

3.8 New Brunswick

Surveillance Highlights

- the number of newly diagnosed AIDS cases has declined significantly, from 17 in 1995 to two in 2002 and six in 2003. In total from 1979 to December 31, 2003, there have been 160 reported AIDS cases in New Brunswick, 90% of whom have been males. Fifty-seven percent of these cases have been attributed to the MSM exposure category, 6% to IDU, 17% to blood products and 8% to heterosexual contact with a person at risk.[98]
- the number of newly reported cases of HIV infection has also declined although not as dramatically, from 16 in 1995 to eight in 2002 and 10 in 2003. Since 1985 there have been 313 positive HIV reports of which 87% were among men.
- in 2001 there were five newly reported cases of HIV infection attributed to injection drug use, representing 50% of all new infections in that year. In 2003, there was one IDU case (10%) along with three attributed to MSM (30%), two attributed to endemic country (20%) and three to heterosexual contact (30%).[99]

[98] Canada, Health Canada, 2004:44.
[99] Canada, Health Canada, 2004:24.

New Brunswick[100]

Indicator			Year		
	2003	2002	2001	2000	1995
AIDS Cases					
Number of AIDS cases reported by year	6	2	3	4	17
Cumulative number of AIDS cases reported	160	154	152	149	116
Newly reported AIDS cases by sex					
Male	5	2	3	3	16
Female	1	0	0	1	1
Newly reported AIDS cases by exposure category					
MSM	2	2	3	3	9
IDU	1	0	0	0	3
Heterosexual contact	0	0	0	1	0
NIR-Het	1	0	0	0	2
Recipient of clotting factor	0	0	0	0	3
Newly reported AIDS cases by age					
0-19	1	0	0	0	1
20-59	5	2	3	4	16
60+	0	0	0	0	0
AIDS-related deaths	1	0	0	0	8

[100] Data provided by the Provincial Epidemiology Service, N.B. Department of Health and Wellness.

New Brunswick *(continued)*

Indicator	Year				
	2003	**2002**	**2001**	**2000**	**1995**
HIV Infection					
Total number of reported HIV cases	10	8	10	14	16
Newly Reported Cases of HIV Infection by exposure category					
MSM	3	1	3	9	8
MSM/IDU	0	1	0	0	1
IDU	1	0	5	2	3
Heterosexual contact	3	1	1	0	1
HIV/AIDS-endemic countries	2	4	0	1	0
NIR-Hetero	0	1	1	2	2
NIR	1	1	0	0	1
Newly Reported Cases of HIV Infection by gender					
Men	7	7	7	12	14
Women	3	2	3	2	2
Newly Reported Cases of HIV Infection by ethnicity					
Aboriginal people					
• men	0	0	0	1	2
• women	0	0	0	1	0
Asian	0	0	0	0	0
Black	2M/1F	2M/2F	0	1M	0
White	4M/2F	5M	7M/2F	9M/1F	11M/2F
Unspecified	1M	0	1F	1M	1M
Newly Reported Cases of HIV Infection by age					
Perinatal	0	0	0	0	0
1-14	0	1	0	0	0
15-24	2	2	0	1	1
25-39	6	5	6	8	11
40-59	2	1	4	5	4
60+	0	0	0	0	0

Organization

The Government of New Brunswick has chosen not to articulate a provincial strategy on HIV/AIDS although some work on such a strategy had been undertaken. It has been suggested that the province assigns a higher priority to hepatitis C given that it is affecting a larger number of people. In 2002, for example, there were 172 newly reported cases of hepatitis C and only 8 of HIV infection.[101] In the future, there may be interest in developing a strategy that addresses the full range of blood-borne pathogens.

The Department of Health and Wellness has one staff person, situated within the Project Management Section of the Public Health and Medical Services Division, who manages HIV/AIDS-related matters in addition to other responsibilities. The eight newly established Regional Health Authorities also have some role to play in addressing HIV/AIDS although their responsibilities in this regard are not yet defined and both access and consistency issues have not yet been addressed.

All regions of the province have established Sexual Health Programs with proactive Public Health nurses who involve themselves in community partnerships, including the Department of Education.

Coordination and Cooperation

The Department of Health and Wellness participates in a variety of activities that will have some influence on the epidemic's course. Its HIV/AIDS coordinator, for example, has a strong relationship with the Department of Education. As an example of this partnership's strength, two public health nurses – in their capacity with the Sexual Health Program and the Healthy Learner Program – recently participated with the Department of Education in revising and rewriting the Middle School Health Curriculum.

The provincial effort to address HIV/AIDS at the community level has benefited from the PHAC AIDS Community Action and Hepatitis C programs. The former provided some operational funding to AIDS service organizations in the province while the latter has funded a number of innovative projects in the federal and provincial correctional institutions located in New Brunswick. These projects addressed both hepatitis C and HIV vulnerability particularly with regard to injection drug use. Provincial organizations have also worked cooperatively with researchers at McGill University to establish a "Safe Spaces" project in Moncton to support gay youth, ages 15-24 years. This is one of four such pilot projects underway in Canada.

AIDS service organizations appear to have a limited relationship with the province but a strong relationship with regional public health staff. Public health nurses, for example, provide educational workshops for these organizations. The ASOs are also engaged in efforts to build partnerships at the community level to meet the full range of service needs, for example the Saint John Sex Trade Committee and the partnered but ultimately unsuccessful effort to introduce a methadone maintenance program in that city.

Certain key informants spoke highly of the PHAC regional office and in particular of its commitment to community development and population health. The federal office ensures that the ASOs are aware of funding opportunities as they arise through any federal department, and shares information and research as these become available. New Brunswick also participates in the FPT-AIDS Atlantic Regional Committee.

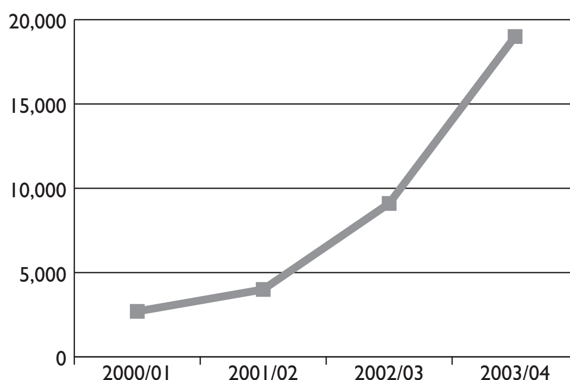
[101] Communicable Diseases Reported in New Brunswick by Health Region, 2002. **http://www.gnb.ca/0208/cd2002-e.asp**.

Testing, Prevention, Care and Treatment

The Government of New Brunswick is addressing the HIV/AIDS epidemic in a number of ways, for example by:

- funding a toll-free hotline managed by AIDS New Brunswick;
- maintaining anonymous testing centres in seven of the province's regions;
- providing some support, through its public health network, for needle exchange programs. The number of needles distributed has increased from 700 in 1999 to 80,000 in 2003, with 60,000 being distributed in Saint John and almost 20,000 in Fredericton. **Figure 8** illustrates this increase for the Fredericton program. The Department of Health and Wellness does not provide operational funding for this service but does supply all the needles, syringes and condoms for these community programs; and
- using its public health nurses for HIV testing in provincial correctional facilities and at one of the federal institutions for a pilot project offering anonymous testing.

Figure 8, Number of Needles Distributed, Fredericton



In 1998 the province introduced anonymous testing – in addition to non-nominal and nominal testing – through Sexual Health Centres in Moncton, Saint John, Fredericton, Edmundston, Campbellton, Bathurst and Miramichi. It is now considering a comprehensive prenatal HIV testing program for pregnant women. The New Brunswick Medical Society, in partnership with the Department of Health and Wellness, is proposing an "opt-out" but informed consent model.

The province also has what is described as a very strong prescription drug program that ensures these are widely accessible. Certain drugs can be obtained through the mail from the provincial office rather than through local pharmacies so as to ensure privacy and confidentiality in small communities. There are also two methadone programs in the province, one in Fredericton with 50 people enrolled and another 50 on a waiting list, and one in Moncton with 127 people enrolled and another 175 on a waiting list.

Knowledge

Little research is undertaken locally beyond project and accountability reporting.

Strengthening the Effort

Key informants identified the following measures as means for strengthening the provincial response to HIV/AIDS:

- recognize that HIV/AIDS poses a threat in New Brunswick as it does elsewhere, regardless of the relatively small number of people currently infected.
- commit additional resources to the epidemic and to support the province's ASOs.
- develop an HIV/AIDS strategy to enhance public awareness and to provide direction to the Regional Health Authorities.
- devote more attention to prevention and health promotion rather than focus so exclusively on the critical care system.

3.9 Nova Scotia

Surveillance Highlights

- in Prince Edward Island and Nova Scotia together,[102] the number of people diagnosed with HIV/AIDS is relatively small and considerably lower than in the mid-1990s. In 1995, for example, there were 32 newly reported cases of HIV infection compared to 16 in 2002 and four in 2003.
- for the entire period to December 31, 2003, MSM accounted for 74% of all AIDS cases. It also accounted for one of the four newly reported cases of HIV infection in 2003 and for nine of the sixteen cases in 2002.
- there were two newly reported cases of HIV infection in the IDU exposure category in 2003. There had not been any in this exposure category in 2002.

[102] Given the small number of people involved and the need to preserve confidentiality, data from Prince Edward Island and Nova Scotia are blended as a result of an agreement between the two governments. See Canada, Health Canada, 2004.

Nova Scotia and Prince Edward Island

Indicator	Year				
	2003	**2002**	**2001**	**2000**	**1995**
AIDS Cases					
Number of AIDS cases reported by year	2	5	3	7	32
Cumulative number of AIDS cases reported	300	298	293	290	
Newly reported AIDS cases by sex					
male	2	5	3	6	30
female	0	0	0	1	2
Total number of reported AIDS cases by exposure category	**To Dec. 31, 2003**				
MSM	223				
MSM/IDU	8				
IDU	14				
Blood/Blood products	20				
Endemic country	9				
Heterosexual contact/NIR	24				
NIR	2				
HIV Infection					
Total number of reported HIV cases	4	16	15	16	32
Reported HIV cases, by gender	**To Dec. 31, 2003**				
Male	534				
Female	80				
Newly-reported cases of HIV Infection by exposure category					
MSM	1	9	2	4	
MSM/IDU	0	0	0	1	
IDU	2	0	5	1	
Heterosexual contact	0	1	0	6	
HIV/AIDS-endemic countries	1	2	2	2	
NIR/NIR-Hetero/Other	0	2	2	5	
Recipient of clotting factor	0			1	
Perinatal	0	1			

Organization

Nova Scotia first articulated a strategy for addressing HIV/AIDS in 1993. More recently, the Nova Scotia Advisory Commission on AIDS – with representation from a broad range of stakeholders – articulated a new strategy that has been accepted by government. The Strategy emphasizes collaboration across sectors and established four goals, i.e.:

- to integrate HIV/AIDS policy development and service delivery;
- to improve knowledge and understanding of HIV/AIDS and related issues that affect the risk of infection;
- to reduce the spread of HIV/AIDS; and
- to provide Nova Scotians living with and vulnerable to HIV and AIDS with the best possible care, treatment and support services.

The Strategy recommends 19 actions organized within four strategic directions, namely mobilize integrated action, build a broad research and information sharing strategy, coordinate prevention and harm reduction activities, and undertake efforts to provide care, treatment and support. These respect the Strategy's six guiding principles including, for example, a commitment that persons living with HIV/AIDS, their caregivers and advocates, and people most vulnerable to infection "have a central role in policy direction and planning for services that affect them."[103]

The Strategy also promotes a population health philosophy, noting that the "inability to control the spread of HIV/AIDS has made it clear that a different approach is necessary to prevent and manage the epidemic."[104] It also notes the importance of aligning the provincial strategy with the broader Canadian Strategy on HIV/AIDS. Finally, it identifies who must be involved in each of the recommended actions as well as who has lead responsibility. It does not provide a time frame or a detailed implementation and accountability plan.

While the Strategy is considered to be a very useful document for providing direction, it has not elicited great public attention and is hampered by there:

- being only one staff person within government focusing primarily upon HIV/AIDS; and
- not being resources attached for its implementation and operations.

In part this is because HIV/AIDS is not the priority it was some years ago and is not "on the public or political radar." Some have suggested that while the Strategy itself is a good articulation of both the problem and the province's needs, it has not yet resulted in any concrete action although the government has established committees to consider its various priorities. The province is currently working on both developing standards for blood-borne pathogens and an Aboriginal AIDS strategy. Furthermore, the Department of Education has a "healthy relationships" component within its school curriculum that includes issues such as sexually transmitted infections and HIV/AIDS.

The government of Nova Scotia does not provide operational funding to community-based AIDS service organizations although in some cases it may provide project funding, for example for the needle exchange programs and for anonymous testing. It has also committed approximately $0.5 million to address blood-borne pathogens. Operational and project funding are available to local organizations through the PHAC AIDS Community Action Program.

[103] Nova Scotia, 2003:10.

[104] Nova Scotia, 2003:1.

Coordination and Cooperation

The process used to develop the Nova Scotia strategy suggests a commitment to collaboration and cooperation. Initiated by government in 1997, the process came to involve a wide range of stakeholders and an extensive series of consultations and public workshops. Indeed, funding for the public consultations was provided not only by the provincial government but also by five of the country's major pharmaceutical companies. One lesson emerging from the consultation and developmental process is that collaboration is "a slow and sometimes painful process" although certainly a worthwhile approach. There are plans to re-establish an interdepartmental committee as the new provincial strategy comes into effect.

Through the past number of years, the provincial government has been devolving responsibility for health services to nine District Health Authorities. This has raised some concern about access to services across the different districts. The province defines what the Health Districts have to do but leaves the "how" to their discretion. Access is also an issue because services such as anonymous testing for HIV, methadone treatment and some counselling services are largely situated in Halifax and people in other communities have to travel there at their own expense.

The ASOs speak of having a good relationship with those government staff having some responsibility for HIV/AIDS. All stakeholders recognize the importance of working together.

The provincial HIV/AIDS coordinator also maintains a good working relationship with her colleagues in the regional PHAC office. This office solicits provincial input on the funding requests it receives from community agencies. Nova Scotia also contributes to and benefits from the FPT AIDS committee and its efforts to share information, to discuss common issues, to identify priorities and influence policy. Finally, it participates in the FPT-AIDS Atlantic Regional Committee.

Testing, Prevention, Care and Treatment

Physicians throughout Nova Scotia offer both nominal and non-nominal testing upon request as well as anonymous testing. The Planned Parenthood Metro Clinic in Halifax also offers anonymous testing. HIV testing is part of routine screening for pregnant women, employing an opt-in model.

The province's drug plan includes coverage for anti-retroviral drugs in those cases where the individual is not privately covered. There are provincially-funded needle exchange programs in Cape Breton and Halifax, and satellite programs in the western and northern parts of the province.

HIV/AIDS-related information, along with that concerning STIs more generally, is provided to students through the school system with the content being the responsibility of the Department of Education in consultation with public health authorities.

Knowledge

PHAC supports the Nova Scotia effort to collect and analyze epidemiological information by funding a Federal Surveillance Officer position in the province. This person is situated within the provincial Department of Health and endeavours to improve the province's data base and offer better information on incidence and trends relating to both HIV/AIDS and other conditions. PHAC is said to play a vital and invaluable role in helping provinces collect, analyze and share their data. The province has a Memorandum of Understanding which defines the data to be shared with PHAC.

Strengthening the Effort

Key informants suggested the following initiatives to strengthen the provincial response to the epidemic:

- provide financial resources for addressing HIV/AIDS and assign a higher priority to HIV/AIDS within the health care system.
- develop a stronger commitment to HIV/AIDS among the province's District Health Authorities.
- blend efforts to address HIV/AIDS with those focusing on other blood-borne pathogens in order to raise its profile. It may be possible to obtain HIV/AIDS-related funding as part of such a broader initiative.
- provide additional training and support to general physicians in smaller communities so as to ensure they are current on clinical issues and can provide appropriate care to people living with HIV/AIDS.
- direct additional funding to the effort to manage HIV/AIDS in smaller communities and rural areas.
- integrate HIV/AIDS more fully into the population health model and address income and employment issues.

3.10 Prince Edward Island

Surveillance Highlights

Surveillance data from Prince Edward Island are included with those from Nova Scotia in order to protect confidentiality and as a result of an agreement between the two jurisdictions. Highlights from these data include the following.

- in Prince Edward Island and Nova Scotia together, the number of people diagnosed with HIV/AIDS is relatively small and considerably lower than in the mid-1990s. In 1995, for example, there were 32 newly reported cases of HIV infection compared to 16 in 2002 and four in 2003.
- for the entire period to December 31, 2003, MSM accounted for 74% of all AIDS cases. It also accounted for one of the four newly reported cases of HIV infection in 2003 and for nine of the sixteen cases in 2002.
- there were two newly reported cases of HIV infection resulting from IDU in 2003. There had not been any in this exposure category in 2002.

Nova Scotia and Prince Edward Island

Indicator	Year				
	2003	2002	2001	2000	1995
AIDS Cases					
Number of AIDS cases reported by year	2	5	3	7	32
Cumulative number of AIDS cases reported	300	298	293	290	
Newly reported AIDS cases by sex					
male	2	5	3	6	30
female	0	0	0	1	2
Total number of reported AIDS cases by exposure category	**To Dec. 31, 2003**				
MSM	223				
MSM/IDU	8				
IDU	14				
Blood/Blood products	20				
Endemic country	9				
Heterosexual contact/NIR	24				
NIR	2				
HIV Infection					
Total number of reported HIV cases	4	16	15	16	32
Reported HIV cases, by gender	**To Dec. 31, 2003**				
Male	534				
Female	80				
Newly-reported cases of HIV Infection by exposure category					
MSM	1	9	2	4	
MSM/IDU	0	0	0	1	
IDU	2	0	5	1	
Heterosexual contact	0	1	0	6	
HIV/AIDS-endemic countries	1	2	2	2	
NIR/NIR-Hetero/Other	0	2	2	5	
Recipient of clotting factor	0			1	
Perinatal	0	1			

Organization

Prince Edward Island has both a small population (135,300) and a small number of people living with HIV/AIDS, both contributing to the epidemic not being high on the "public radar screen." Its strategy for addressing HIV/AIDS was developed 10 years ago and has not been updated. The Communicable Diseases and Immunization Programs in the Office of the Chief Health Officer, Department of Health and Social Services, is responsible for HIV/AIDS-related policy and coordination in addition to its other responsibilities. Four regional health authorities (West Prince Health, East Prince Health, Queens Health, Kings Health) and the Provincial Health Services Authority are mandated to deliver all health services and supports.

There is only one community agency specifically focused on HIV/AIDS, i.e. AIDS PEI. It is a registered charity that began as a community-based support group for those living with HIV/AIDS. Currently, it operates a Speakers' Bureau and food bank, distributes educational information and condoms, and administers both an Emergency and a Health Maintenance Fund. It has also been involved in three projects addressing hepatitis C. The province does not fund AIDS PEI but the organization does receive approximately $110,000 annually for operational funding and approximately $35,000 for project funding from ACAP.

The AIDS PEI client base remained steady for a decade but then doubled in the past year. The organization estimates that there are many people living with HIV/AIDS in Prince Edward Island who are not accessing their services, perhaps because of confidentiality concerns. Other organizations, such as those focused on addictions, play some role in the provincial effort to address the epidemic.

Coordination and Cooperation

AIDS PEI enjoys a strong working relationship with the regional ACAP office. The Government of Prince Edward Island does not have an interdepartmental committee addressing HIV/AIDS-related issues although representatives of different departments sit on various AIDS PEI committees. The province does participate with the other Atlantic provinces in the FPT-AIDS Atlantic Regional Committee. This committee brings together representatives of both the provincial and federal governments in an effort to collaborate across provinces and to compensate for the small number of staff people in each jurisdiction involved directly with HIV/AIDS-related policy and programming. At this time, the committee does not include representatives of community-based organizations.

The committee works collaboratively on various prevention initiatives and is endeavouring to adopt a common approach to harm reduction. It is currently planning to host a conference on that issue and to involve a variety of non-traditional partners such as pharmacists from the region. It also hopes to explore alternate funding models in which federal and provincial funds are pooled. The committee has recently drafted a Work/Action Plan for 2004-2005 and is now in the process of identifying timelines and resource needs for each activity.

Table 4, FPT-AIDS Atlantic Regional Committee Work/Action Plan 2004-05

Objective	Action/Activities	Indicators/Outputs
Increase awareness of harm reduction initiatives and issues facing people who inject drugs in the Atlantic region.	Disseminate information (new research, best practices, etc) from community-based organizations and the federal and provincial governments through the IDU master stakeholder list.	New research and relevant best practices are shared across sectors in the Atlantic region.
	On FPT teleconferences and at FPT meetings, share information on harm reduction and issues facing people who inject drugs.	FPT members share information on relevant initiatives at meetings and on quarterly teleconferences.
	Develop committee of multi-sectoral stakeholders to organize and plan regional harm reduction conference.	Multi sectoral committee is established. Harm reduction conference is organized.
	Hold regional harm reduction conference.	Regional harm reduction conference is held.
Increase profile of harm reduction and IDU issues on federal/provincial agenda in the Atlantic region	Coordinated and more frequent briefings on harm reduction and current IDU issues across federal and provincial government departments.	Deputy Ministers and Health Canada's Regional Director General are briefed in a coordinated manner on issues relating to harm reduction and IDU.
	Collaborate/increase dialogue with other branches of Health Canada and provincial departments of health to bring important information and evidence to senior government officials.	Important information about harm reduction and IDU is shared with senior level officials in the federal and provincial governments.
Enhance and support information sharing/knowledge development around harm reduction and IDU issues in the Atlantic region	Conduct environmental scan/profile of IDU in the Atlantic region.	Scan completed.
	Develop and pilot standardized data collection tools for needle exchange programs in the Atlantic region.	Standardized data collection tool for NEPs is created by multi-stakeholder group and piloted.
	Compile inventory of harm reduction stakeholders in the Atlantic region.	Inventory of Atlantic harm reduction stakeholders is created.
	Develop linkages with Corrections in the Atlantic region.	Linkages with Corrections are established.

PHAC has also assigned one of its Field Surveillance Officers to Prince Edward Island and Nova Scotia, to assist with the collection and analysis of surveillance data.

Testing, Prevention, Care and Treatment

There is a strong "culture of caring" in Prince Edward Island but at the same time very considerable stigma and discrimination still associated with HIV/AIDS. As a result, confidentiality is always a significant issue and, it has been suggested, that it "is not easy to be HIV positive in PEI" because of these concerns. Much of the assistance provided to individuals occurs in informal ways. The culture of caring, for example, has resulted in the provincial Department of Health using what flexibility exists within provincial policies and programs to provide care and support to people who may not otherwise be able to access the necessary care and treatment for HIV/AIDS.

Both nominal and non-nominal testing are available through physicians in PEI. Anonymous testing is not available and there is no policy concerning prenatal screening for HIV. Such screening depends upon the woman involved and her physician. Concerns about confidentiality would compromise efforts to promote more extensive testing for HIV.

Treatment is available on the island although those living with HIV/AIDS may go to Moncton or Halifax for more specialized services. In some cases, the Department of Health and Social Services may provide some financial assistance to those leaving the province for such treatment. It will also pay for any medications required as long as they are listed on the provincial formulary.

PEI does not have a sexual health clinic and sexual health education is offered only in Grade 9 in the school system, for those youth and families who wish to participate.

Knowledge

The regional ACAP office goes to great lengths to share knowledge with the province and with community-based organizations that are endeavouring to address the epidemic. This may include efforts to inform them of funding opportunities as well as recent studies concerning the epidemic and best practices for addressing the epidemic.

Strengthening the Effort

Key informants suggested the following initiatives to strengthen the provincial response to the epidemic:

- vigorous efforts to promote public awareness of HIV/AIDS, to educate the public on transmission, prevention and harm reduction issues, and to reduce stigma and discrimination.
- enhance the level of cooperation that exists among community-based organizations and the provincial government.
- enhanced funding and resources committed to communicable disease prevention.
- improve accessibility to testing, treatment and care so as to reduce the need for people to leave PEI for these.

3.11 Newfoundland and Labrador

Surveillance Highlights

- Newfoundland and Labrador had 11 newly reported cases of HIV infection in 2003 compared to one in 2002, five in 2001, three in 2000 and seven in 1995. Before 2003, virtually all these cases were in the MSM exposure category. In 2003, however, five of the 11 cases were in this exposure category and another five were ascribed to heterosexual contact.
- nine of the eleven newly reported cases in 2003 occurred among men.
- the number of newly diagnosed cases of AIDS is very small – in 2003 for example, there was only one such case – although there have been 88 cases diagnosed since 1985. Eighty percent of these were among men and 20% among women.

Newfoundland and Labrador[105]

Indicator	Year				
	2003	**2002**	**2001**	**2000**	**1995**
AIDS Cases					
Number of AIDS cases reported by year	1	1	3	2	6
Cumulative number of AIDS cases reported	88	87	86	83	59
Newly reported AIDS cases by sex					
male	1	1	3	2	6
female	0	0	0	0	0
Newly reported AIDS cases by exposure category					
MSM	1	1	3	1	2
IDU	0			1	
MSM/IDU	0				1
Blood products	0				1
Heterosexual contact	0				1
Not Identified	0				1
AIDS-related deaths	N/A	0	0	4	10

[105] Source: Disease Control and Epidemiology Division, Department of Health and Community Services, Government of Newfoundland and Labrador. HIV/AIDS Cumulative Statistics, Newfoundland and Labrador, 1984 – December 31, 2003. See also Canada, Health Canada, 2004.

Newfoundland and Labrador *(continued)*

Indicator	Year				
	2003	2002	2001	2000	1995
HIV Infection					
Total number of reported HIV cases	11	1	5	3	7
Newly reported cases of HIV Infection by exposure category					
MSM	5	1	4	2	4
IDU	1	0	0	1	0
Heterosexual contact	5	0	1	0	1
HIV/AIDS-endemic countries	2	0	0	0	0
Not identified	0	0	0	0	2
Newly reported cases of HIV Infection by sex					
Men	9	1	5	3	5
Women	2	0	0	0	2
Newly reported cases of HIV Infection by age	**Cumulative to 2003**				
0-14	8				
15-19	11				
20-29	89				
30-39	83				
40-49	20				
50-59	6				
60+	1				
ANS	4				
Total	222				

Organization

In 1993, the Government of Newfoundland and Labrador responded to the epidemic with a report entitled "Towards the Development of a Comprehensive HIV/AIDS Strategy for Newfoundland and Labrador." Useful at the time for providing direction and enhancing awareness, the document is now dated and work is underway on a new strategy, with completion expected in the Fall of 2004. The Steering Committee responsible for developing the new strategy consists of a representative group of stakeholders.

The Department of Health and Community Services is responsible for policy and intergovernmental issues, various surveillance and other matters as appropriate while the Regional Health Boards are responsible for delivering HIV/AIDS-related services and programs. Unlike in some other jurisdictions, there is not a specific bureau that is responsible for HIV/AIDS-related matters which is a reflection of the small number of cases in Newfoundland and Labrador.

In general, public concern relative to HIV/AIDS is not high, again because of the small number of people infected with or directly affected by the condition. In essence, the epidemic "has fallen off the public radar," an example of which is the declining number of people participating in the annual AIDS Walk.

The province does not specifically identify funds for HIV/AIDS but rather includes these resources within its larger health services budget. It does provide annual funding of approximately $9,000 to an AIDS service organization in St. John's to maintain a 1-800 information line. The ASO receives the majority of its funds through the PHAC AIDS Community Action Program and fund raising. That ASO, however, has only three staff in spite of assuming some responsibility for hepatitis C education with additional funding from the federal Hepatitis C Program. It also manages a small needle exchange program.

Coordination and Cooperation

The 1993 strategy envisioned an interdepartmental committee responsible for the strategy's administration. This committee was never established although ad hoc committees have been organized for specific purposes as required. Inter-agency cooperation is evident within the Steering Committee overseeing the new strategy's development. It consists of representatives from a variety of departments in the provincial government, community agencies and consumer groups.

Government, community agencies and health authorities are well-connected and communicate openly and frequently in part because of:

- the province's relatively small population and cohesive nature; and
- the commitment of those in government and in the community most directly responsible for HIV/AIDS-related issues.

The current initiative to develop a new HIV/AIDS Strategy was jointly proposed by the Department of Health and Community Services and the AIDS Committee of Newfoundland and Labrador (ACNL). Representatives of the Regional Health Boards, meanwhile, sit on the ACNL Board. A provincial representative from the Department of Health and Community Services sits on the national FPT AIDS Committee as well as on the FPT-AIDS Atlantic Region Committee.

There are also relationships, both formal and informal, between the province's HIV/AIDS-related activities and its other health and social initiatives.

Testing, Prevention, Care and Treatment

There are fourteen Regional Health Boards providing the vast majority of health and community services within the Province of Newfoundland and Labrador. Services vary between boards depending, first, on need and, second, on whether the board directs community or institutional services. Generally, HIV/AIDS services are delivered in the common

basket of health services with some boards devoting considerably more attention to the epidemic than others. The Health Care Corporation of St. John's, for example, offers clinics specifically for people with HIV/AIDS due, in part, to its role as a tertiary care centre. However, Department of Health and Community Services policy ensures some measure of consistency across the regions.

The province generally targets the general population for its educational efforts although some of the health boards target specific groups. The province has a provincial drug program that covers HIV/AIDS-related pharmaceuticals. Additionally, prenatal testing for HIV, employing an opt-out model, is provided to all pregnant women, with participation rates being over 90%. There is some concern that this testing is not always accompanied by the pre and post test counselling that was to be available.

Knowledge

As in other jurisdictions, epidemiological information is gathered regularly and shared with PHAC. There is a specific contribution to other AIDS-related research through Memorial University of Newfoundland.

Strengthening the Effort

Key informants in Newfoundland and Labrador suggested that the following measures would strengthen the provincial response to HIV/AIDS:

- provide additional information through the school system.
- complete and implement the new provincial strategy.
- provide AIDS Service Organizations, including the Native Friendship Centre in Goose Bay, with the resources needed to reach out to isolated communities such as those in Labrador.

3.12 Nunavut, the Northwest Territories (NWT) and Yukon[106]

Surveillance Highlights

- the number of people living with HIV/AIDS is small in these three jurisdictions. In total, there have been only two HIV positive tests reported in Nunavut along with 36 in the Northwest Territories and 37 in Yukon. At the same time, however, these jurisdictions also have very small populations.

Table 5, Nunavut, NWT and Yukon Population, 2001[107]

	Nunavut	Northwest Territories	Yukon
Total Population	26,745	37,360	28,675
Total Population, Age 15+	16,820	27,250	22,640

- the two Nunavut cases were diagnosed in 2002 and 2003. The NWT reported one new HIV positive case in both 2002 and 2003 while Yukon reported three cases in 2002 and four in 2003.
- the male to female ratio for HIV infection, November 1985 – to December 2003, is 2:1 in Yukon, 5:1 in the Northwest Territories and 6:1 in Canada as a whole.[108] Both Nunavut cases have been men.
- Yukon has six reported cases of AIDS while the NWT has 17 and Nunavut none.[109]

[106] These three jurisdictions are being reviewed together because of the small number of key informants available for discussion and the need to respect the confidentiality of their remarks.

[107] See 2001 Census of Canada. **http://www12.statcan.ca/english/census01/home/index.cfm**.

[108] The male/female ratio for Nunavut is not available. See Canada, Health Canada, 2004:22.

[109] Although data from those jurisdictions indicate six (Yukon) and 17 (NWT) AIDS cases, the Health Canada Surveillance Report to December 31, 2003, indicates eight and 19 cases respectively. See Canada, Health Canada, 2004:41.

Nunavut

Indicator	Year[110]			
	2003	2002	2001	2000
AIDS Cases				
Cumulative number of AIDS cases reported	0	0	0	0
HIV Infection				
Newly-reported cases of HIV Infection	1	1	0	0

[110] Nunavut was created in April 1999. Data for the period prior to that date are not available.

Northwest Territories

Indicator	Year				
	2003	2002	2001	2000	1995
AIDS Cases					
Number of AIDS cases reported	0	0	0	0	3
Cumulative number of AIDS cases reported	17	17	17	14	11
Newly reported AIDS cases by sex					
male	0	0	0	0	2
female	0	0	0	0	1
HIV Infection					
Total number of reported HIV cases	1	1	2	0	0
Reported cases of HIV Infection, 1987-2003		**2003**		**1987-2003 (36 cases)**	
Reported cases of HIV Infection by exposure category					
MSM		0		16	
MSM/IDU		0		2	
IDU		0		6	
Heterosexual contact		0		8	
Perinatal		0		2	
Blood Products		0		1	
Hetero or HIV-endemic countries		1		1	
Reported cases of HIV Infection by sex					
Men				30	
Women				6	
Reported cases of HIV Infection by age					
<15				2	
20-29				7	
30-39				16	
40-49				9	
50+				2	

Yukon

Indicator	Year				
	2003	**2002**	**2001**	**2000**	**1995**
AIDS Cases					
Number of AIDS cases reported by year	0	2	0	2	2
Cumulative number of AIDS cases reported	6	6	4	4	—
Newly reported AIDS cases by sex					
male	0	0	0	1	2
female	0	2	0	1	0
HIV Infection					
Total number of reported HIV cases	4	3	4	5	1
Newly reported cases of HIV Infection by exposure category					
MSM	0	0	0	0	—
MSM/IDU	0	0	0	1	—
IDU	2	1	2	4	—
Heterosexual contact	2	1	0	0	—
HIV/AIDS-endemic countries	0	0	0	0	—
NIR/NIR-Hetero/Other	0	1	2	0	—
Newly reported cases of HIV Infection by sex	**1985-2003**				
Male	27				
Female	13				

Organization

The epidemic's defining characteristic in Nunavut, the NWT and Yukon is the small number of people currently living with HIV/AIDS. There were, however, five new HIV+ cases reported in the three jurisdictions in 2003, four of which were in Yukon. There were no new AIDS cases reported in that year. Yukon is unique – in the north and in Canada – in that over 32% of its reported cases of HIV infection since 1985 are among women. In contrast, women in the NWT represent only 12% of all reported cases. The male to female ratio in Yukon for HIV positive test reports, is 2:1 compared to 5:1 in the Northwest Territories and 6:1 for Canada as a whole.

The NWT discussed the potential for an HIV/AIDS strategy in the mid-1990s and is currently finalizing a strategy for addressing Sexually Transmitted Infections more generally. Nunavut and Yukon have not articulated strategies specifically focusing on HIV/AIDS. Instead each incorporates HIV/AIDS as part of broader public health efforts that include other sexually transmitted infections and blood-borne pathogens. In all three jurisdictions, it is suggested that this broader approach may be more effective for addressing the more immediate threat posed by STIs and hepatitis C and for avoiding duplication of effort. This approach could also engage people and enable them to avoid the stigma associated with HIV/AIDS. As such, it may make prevention, care and treatment efforts more palatable to small communities.

Each jurisdiction's health department uses its public health staff to monitor HIV/AIDS and to address HIV/AIDS-related issues as part of their overall responsibilities. Their having the same range of responsibilities as larger public health units in larger jurisdictions – for identifying outbreaks, partner identification, information and prevention – results in considerable pressure. Given the geographic size of each jurisdiction, there is limited capacity at the community level to respond to blood-borne infections.

Coordination and Cooperation

In the NWT, there is some HIV/AIDS-related awareness across departments and officials from a variety of community and government offices are involved in the effort to articulate a new STI strategy. The strategy committee includes staff from the departments of Education, Culture and Employment (ECE) and Justice as well as from the Status of Women organization in Yellowknife, community groups, native youth, community wellness coordinators and people working with street-involved youth. Front line workers in ECE and in the schools are involved in HIV/AIDS-related educational efforts.

Cooperation across departments and agencies in all three northern jurisdictions is enhanced by their small populations and lack of rigid bureaucracy. Public health staff, for example, have ready access to people in other departments. They also have strong working relationships with community agencies addressing HIV/AIDS and hepatitis C although the number of such agencies is very small and their capacity is limited. In Nunavut, for example, only Pauktuutit – the Inuit Women's Association – is engaged in such efforts while in Yukon, only the Blood Ties Four Directions Society is available as a community resource. Since AIDS Yellowknife ceased operations, there is no similar organization in the NWT.

Reporting systems are in place in all three jurisdictions with the results being shared with PHAC as part of the national surveillance system. PHAC provides direction and assistance as required to these three jurisdictions although it has not placed a Field Surveillance Officer in any of the northern public health offices.

Through a partnership with health authorities in northern Alberta, the GNWT provides extra training to local physicians so as to ensure that treatment is available in the communities themselves. Turnover among physicians, however, makes it imperative that this training take place on an on-going basis.

Testing, Prevention, Care and Treatment

Addressing, identifying and treating HIV in the three jurisdictions is compromised by most communities having very small populations. People are concerned about their condition becoming public knowledge.

Nurses in most of the smaller northern communities are responsible for most testing. Anonymous testing is not available in any of these jurisdictions although all include HIV tests in their prenatal screening. Since 2000, the NWT has employed the opt-out model while Yukon and Nunavut use the opt-in model. In 1996, the NWT also began offering HIV, tuberculosis, hepatitis C and STI testing to all people entering the correctional system. These tests have indicated that hepatitis C is currently a more significant problem. New cases identified in this way are referred for care and treatment and the NWT is experimenting with a new team-based, integrated health care system in nine pilot project sites.

In Nunavut, Pauktuutit, has sponsored a series of community education and awareness youth fairs addressing both hepatitis C and HIV/AIDS, with funding from the federal government's Hepatitis C Program.

The geographic size of each northern jurisdiction combined with their very small populations and communities pose a formidable treatment and care barrier. Treatment, for example, can be very costly because of medical travel and the need for some people to travel south for this treatment. Efforts are made to inform local physicians on treatment issues through partnerships with universities and hospitals in the south.

Needle exchange programs are not in place in either the NWT or Nunavut in part because the injection drug problem is not very significant at present. In Whitehorse, the Blood Ties Four Directions Society operates a small needle exchange program with funding from the Yukon Government. This organization has four staff people offering a range of programs, for example the needle exchange, a "living room group" to provide support, and some youth and health promotion activities. It also provides training to service providers in other agencies, hosts workshops and brings an educational message to various schools. Its funding is very limited, however, particularly in light of the high cost of travel in the north.

Although caring is characteristic of people and communities in the north, volunteerism within the HIV/AIDS sector specifically is not well developed. This may be due to the stigma associated with HIV/AIDS and to the AIDS service organizations not having the resources necessary to develop a volunteer network or to train volunteers.

Knowledge

Epidemiological information is gathered and shared with PHAC. Both Pauktuutit and the Blood Ties Four Directions Society have prepared evaluations and reports on their PHAC and Health Canada funded projects although largely for accountability purposes.

Strengthening the Effort

It has been suggested that efforts to address HIV/AIDS in the three northern jurisdictions could be strengthened by:

- committing additional financial resources to build knowledge and awareness before HIV incidence rates increase.
- funding formula and funding levels that recognize the inordinately high costs associated with community-based measures in the north and with medical travel.
- working proactively, particularly in light of high STI rates, to prevent HIV from becoming rooted in the north. This will depend upon developing both public awareness and a political commitment to address HIV/AIDS.
- efforts to develop health promotion and infection-prevention models that are well suited for communities in the northern regions.
- introducing measures to strengthen public health generally, to capture the attention of community leaders, and to overcome both the stigma associated with HIV and the tendency to deny its threat.

A National Portrait 4

The provincial and territorial pictures, taken together, provide a portrait of the national effort to address HIV/AIDS. The following identifies and considers the key characteristics of that national portrait.

This portrait is dominated by one particularly important theme: the need for heightened public awareness of and enhanced political commitment to HIV/AIDS. Key HIV/AIDS advocates in virtually every jurisdiction said that HIV/AIDS appears to have fallen off the policy map as a result of:

- until recently, the declining number of new HIV positive test reports;
- the small number of people living with HIV/AIDS in jurisdictions other than BC, Alberta, Ontario and Quebec;
- the improvements in the treatment and care options available to people living with HIV/AIDS, and the misconception that HIV/AIDS is now curable; and
- the emergence of new priorities, the heightened concern with other pathogens and epidemics, and the focus on acute care rather than prevention and population health.

Key informants suggested these factors were being compounded by the public increasingly associating the epidemic with marginalized populations – injection drug users and Aboriginal people primarily – and with certain inner city neighbourhoods. These are not groups or geographical areas that elicit a great deal of public attention and public concern.

Key informants spoke of the importance of renewed political leadership and of building and restoring public awareness. Public awareness, political commitment and leadership are key to strengthening the policy response to HIV/AIDS, in part by obtaining the financial resources needed to address the threat, to deal with the epidemic's increasing complexity and to meet the needs of those living with HIV/AIDS.

4.1 Different Epidemics in Different Jurisdictions

The provincial and territorial pictures emphasize that there is not one epidemic in Canada but rather several epidemics.

First, at least at present if not in the future, there is one epidemic in four provinces where a very significant number of people are infected and living with HIV/AIDS. British Columbia, Alberta, Ontario and Quebec have accounted for 95% of all HIV positive test reports since 1985 while the remaining nine provincial and territorial jurisdictions have accounted for only 5%.[111]

This distribution helps to explain why some jurisdictions are doing more to address the epidemic while others are doing less. British Columbia, Alberta, Ontario and Quebec each have elaborate strategies focusing specifically on HIV/AIDS. Each commits significant – although, according to some key informants, not necessarily adequate – resources to the epidemic and has a broad range of prevention, harm reduction, care, treatment and support services in place. Each also commits considerable resources to research and to building the knowledge base that is required to effectively address the epidemic. The federal government's own effort generally resembles that of these four jurisdictions. It too has a well-articulated strategy and commits significant resources to the efforts encompassed within that strategy. Recently, for example, it has committed to doubling the annual CSHA budget over the next five years.

Many of the other nine jurisdictions – all with smaller populations – also have strategies and services in place but not to the extent or with the level of funding of those identified above. Several, for example, provide no or only minimal funding to those organizations endeavouring to address the epidemic at the community level. These organizations have to rely on the federal government's AIDS Community Action or Hepatitis C programs for operational or project funding, or upon fundraising. Key informants were concerned that these jurisdictions were not prepared for the outbreak that could well occur some time in the future.

At the same time, however, the absolute number of reported cases can be deceiving. To indicate the threat posed by the HIV/AIDS epidemic in the different jurisdictions, it may be more useful to examine rates, i.e. the number of positive HIV test reports per 100,000 population. **Table 6** presents this rate by jurisdiction, based upon 2001 population data from Census Canada and the number of newly reported HIV positive cases (2003) as presented by Health Canada. **Figure 9** illustrates this pattern.[112] It is important to note, however, that Table 6 and Figure 9 present this rate only for reported cases and do not consider those cases that have not been diagnosed or reported. It is estimated that as many as one-third of all current cases have not been reported.

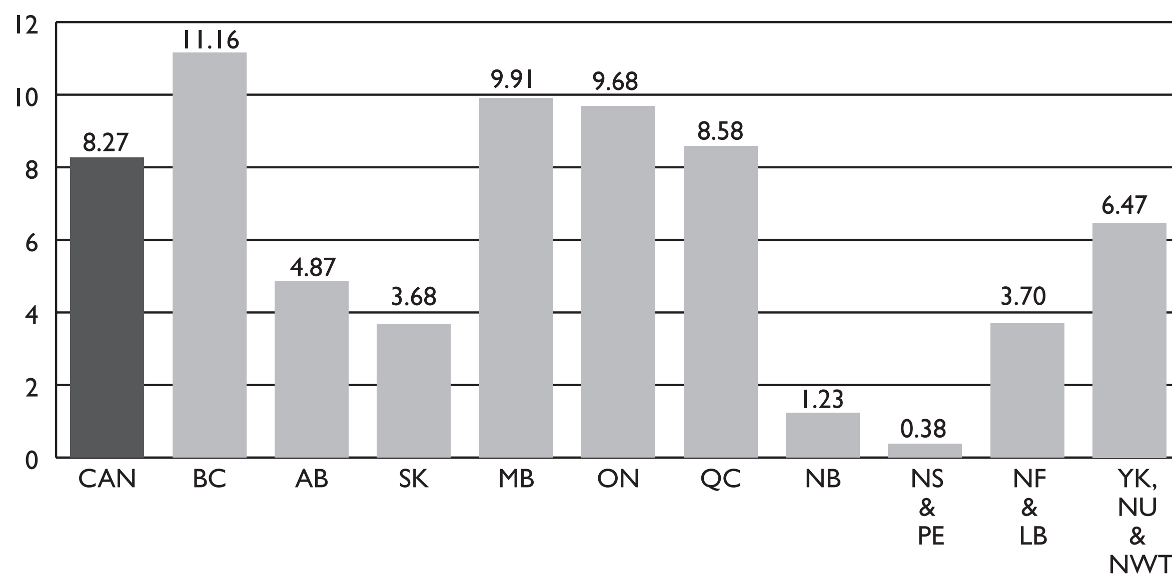
[111] Canada, Health Canada, 2004:23.

[112] Population data are from the 2001 Census of Canada, **http://www12.statcan.ca/english/census01/home/index.cfm**. The number of positive HIV reports are from Canada, Health Canada, 2004:23. The rate/100,000 population is based on the formula: (number of reported cases in 2003/total population) x 100,000.

Table 6, Number of Positive HIV Test Reports/100,000 population, by Jurisdiction

Jurisdiction	Population, 2001	Number of HIV+ Test Reports, 2003	HIV+ Test Reports/ 100,000 Population
Canada	30,007,090	2,482	8.27
British Columbia	3,907,735	436	11.16
Alberta	2,974,810	145	4.87
Saskatchewan	978,935	36	3.68
Manitoba	1,119,585	111	9.91
Ontario	11,410,045	1,104	9.68
Quebec	7,237,480	621	8.58
New Brunswick	729,500	9	1.23
Nova Scotia	908,005	4	0.38
Prince Edward Island	135,290		
Newfoundland & Labrador	512,930	19	3.70
Nunavut	26,745	6	6.47
Northwest Territories	37,360		
Yukon	28,675		

Figure 9, Number of HIV+ Test Reports/100,000 Population, 2003



Second, the epidemic's character is different across jurisdictions. MSM remains the largest exposure category, while the IDU exposure category continues to be significant. Infections among people from HIV-endemic countries are more common in some jurisdictions than in others. Similarly the proportion of men to women who were diagnosed as HIV positive in 2003 differs from jurisdiction to jurisdiction. In Yukon, for example, the male/female ratio was 2:1 while in New Brunswick, Nova Scotia and Prince Edward Island, it was 7:1. Lastly, in three provinces for which appropriate data are available, the proportion of newly reported infections among Aboriginal people also varies considerably.

Importantly, even within a single jurisdiction, there are distinct differences in the epidemic across regions. In Quebec and Manitoba, for example, those living with HIV/AIDS are largely concentrated in Montreal and Winnipeg respectively. In Alberta, the epidemic in Edmonton is largely in the IDU exposure category and involves Aboriginal people while in Calgary it is largely in the MSM category and involves non-Aboriginal people.

This speaks to the importance of the pattern evident in most jurisdictions of regional or local health authorities and municipalities playing a larger role in planning the response to the epidemic and providing services. They may be in the best position to understand and respond to local needs.

At the same time, however, there is a concern about the epidemic being more of a priority to some regional or local health authorities than to others, and about access to services being inconsistent across these authorities. Some key informants suggested that:

- governments have fragmented responsibility for HIV/AIDS through regionalization;
- with regionalization, there is no clear champion promoting HIV/AIDS awareness, planning and action; and
- governments have few meaningful accountability measures in place to ensure consistency, to build cooperation across regions or to ensure that they all recognize the significance of the epidemic's threat.

While the regional authorities' priorities may simply reflect prevalence, they may ignore the reality that no community is immune and every community may have some people living with HIV/AIDS.

4.2 Articulating a Strategy

Most jurisdictions have articulated a strategy for addressing HIV/AIDS. Invariably these are strong and insightful documents that present useful information and incorporate what is currently known about HIV/AIDS, the conditions responsible for its spread and the efforts needed both to address the epidemic and to reduce its impact. In most cases – for example in Ontario and Nova Scotia – the strategies are the result of inclusive processes that helped to build partnerships and promote understanding among the different stakeholders. These strategies are generally welcomed by both government and community agencies for the information, direction, context and encouragement they provide.

Nevertheless some of these strategies have been challenged by some non-government HIV/AIDS advocates because:

- they are not accompanied by dedicated funding adequate to the tasks and actions they promote;
- they do not include measurable objectives and accountability requirements, and do not endeavour to ensure access everywhere in the province or territory;
- their implementation assumes that regional or local health authorities share a commitment to the strategy's goals and objectives; and
- in some cases, they do not appear to influence governmental policy and efforts in any meaningful way.

Strategies are very useful documents and serve a variety of purposes. However to be both credible and effective, quantifiable objectives, effective accountability measures and adequate resources are necessary. Very often, however, the jurisdictions' strategies do not include such elements.

Some jurisdictions have broadened the scope of their strategies so as to include efforts to address the broad range of blood-borne pathogens and STIs. This serves several purposes, for example reducing duplication and integrating efforts designed to achieve a common purpose. Some key informants also suggested that this approach may also serve to strengthen public awareness and political commitment given the more recent concern with hepatitis C, Severe Acute Respiratory Syndrome (SARS), West Nile Virus and other pathogens. This broader focus may enable community based organizations to access a broader range of funding sources and thereby enhance their capacity and stability.

Others suggest, however, that integrating HIV/AIDS with other pathogens could weaken the effort to address this epidemic particularly in light of HIV most commonly being transmitted, in most jurisdictions, through unsafe sexual behaviour.

4.3 Organization

In some jurisdictions – those with more profound epidemics – there are offices in government with staff directly responsible for managing the response to HIV/AIDS. Their responsibilities are extensive, i.e. to develop policy, coordinate and liaise with other government and community agencies, fund certain community or research activities, promote awareness in other departments and across government, advise on new clinical and social developments, and monitor the epidemic's course.

In most other jurisdictions, these HIV/AIDS-related activities are undertaken by a single individual and represent only one aspect of his or her responsibilities. In spite of the epidemic's less pronounced presence in those jurisdictions, these individuals may be hard pressed to remain ahead of the epidemic and give it the level of attention it requires.

At the same time, it appears few jurisdictions have standing interdepartmental committees for addressing issues related to the epidemic. This may limit the governments' ability to bring a population health approach to their efforts and to ensure that the range of supports are in place to reduce HIV vulnerability or to address adequately the needs of people living with HIV/AIDS. It may mean, for example, that social assistance policy may not adequately accommodate the needs of this group of people, or that housing policy is not consistent with the jurisdiction's HIV/AIDS strategy. It may mean that sexual health programs being designed for the schools are not benefiting from the insights of those for whom HIV/AIDS and other blood-borne pathogens are a priority.

Conversely, some jurisdictions have deliberately chosen not to create interdepartmental committees so as to avoid bureaucratizing their response to the epidemic. Instead, they prefer ad hoc committees focusing on specific issues, problems or needs.

Key informants invariably emphasized the importance of community-based organizations as partners in the effort to address the epidemic. At the same time, however, they often raised the issue of how stretched these organizations are at present because of:

- the increasing number of people living with HIV/AIDS;
- the level of unmet need; and
- the challenge inherent in reaching remote geographical communities and marginalized cultural communities.

The agencies' situation is exacerbated by their having to assume more and more responsibilities, for example for managing various harm reduction programs such as needle exchanges or for reaching out to those infected with or at risk of becoming infected with hepatitis C.

Agencies are willing to take on these additional responsibilities but they need adequate resources if they are to fulfill those responsibilities. They require the organizational stability that comes only with operational funding. This funding, key informants suggested, is vital for building the infrastructure and developing the capacity required to respond consistently to problems that are not going to disappear in the near future. Although ACAP meets this need for some organizations, many others are struggling.

Although many of these organizations have very good and long-term relationships with government funders, there is a perception that application, reporting and accountability requirements are growing more cumbersome. Some community organizations suggested that the involvement of regional or local health authorities is compounding their administrative burden. Too much time, effort and energy, they said, is being consumed by these requirements, and some organizations have declined the invitation to apply for project funding.

In terms of organizing the response to HIV/AIDS, some key informants wanted to see a more vigorous federal role, however this opinion was not endorsed by all the administrations. Clearly the federal government contributes to efforts at the provincial, territorial and community level, for example through ACAP, the First Nations and Inuit Health Branch or through funding national non-governmental organizations. Nevertheless some stakeholders feel that the federal government could be doing more to assist the provincial and territorial jurisdictions by:

- undertaking a national effort to enhance public awareness;
- expanding the current effort to assist jurisdictions – and the smaller ones in particular – to gather and analyze epidemiological data and to undertake the social research and cohort studies that will provide insights into the most vulnerable populations;
- strengthening the PHAC and Health Canada regional offices given their strong and supportive relationship with the provincial and territorial jurisdictions; and
- addressing the epidemic among particularly vulnerable populations or in areas where the problem's magnitude may require responses beyond the capacity of local authorities.

These propositions are not, however, endorsed by all governments.

4.4 Cooperation and Coordination

Most often and in most jurisdictions, there appears to be a strong relationship between departments and indeed between governments in addressing the HIV/AIDS epidemic. Interdepartmentally, as in Ontario, the relationship may be forged on an ad hoc basis and may be focused on specific issues. In other jurisdictions, such as in the north, the bureaucracies' relatively small size and informal structures may facilitate building effective relationships. In many jurisdictions, cooperation is enhanced by the relationship between individuals while in others, it may benefit from their experience with interdepartmental committees.

Intergovernmental cooperation is also strong with federal, provincial and even municipal governments – in Winnipeg, Prince Albert and Saint John for example – working together on harm reduction and other HIV/AIDS-related issues. In Atlantic Canada, PHAC and the four provincial governments work together and collaboratively within the FPT AIDS Atlantic Regional Committee. In Alberta, the federal, provincial and municipal

governments work hand in hand not only with each other but also with community agencies to plan, to develop priorities and to allocate a common federal/provincial funding pool. Other jurisdictions are experimenting with or developing similar structures that bring together the broad range of stakeholders in a common effort.

Often there is also a strong relationship and even a partnership between the provincial government and the regional PHAC and Health Canada offices. There are similarly strong relationships between the PHAC and provincial/territorial offices responsible for gathering and analyzing epidemiological data. There appears to be a less strong relationship, however, among those agencies responsible for correctional services and those more directly responsible for health and HIV/AIDS, or among those agencies having responsibility for the health of Aboriginal people on and off reserve.

This commitment to cooperation and coordination has faced a new challenge in recent years as jurisdictions have devolved ever greater responsibility for health services design and delivery to regional, district or local health authorities. The approach likely ensures that these services are sensitive to local needs. At the same time, however, regional or local autonomy – and the absence of meaningful accountability requirements relating to HIV/AIDS specifically – can mean fragmentation and less cooperation and coordination.

Key informants in some jurisdictions also suggested that Aboriginal organizations are not adequately involved in these cooperative and coordinated efforts. In some cases, the organizations themselves may not view HIV/AIDS as a priority. In other cases, the structures may not be culturally appropriate or the funding not adequate for their involvement. In all jurisdictions, the lines between the federal and provincial realms of responsibility and between services on and off reserve complicate the situation.

4.5 Testing, Prevention, Care and Treatment

Every jurisdiction has an array of services available to those living with HIV/AIDS. The issues in this regard relate more to access, to comprehensiveness and to adequacy.

All jurisdictions, for example, understand the population health concept and its importance in reducing vulnerability and addressing the epidemic through the long term. All appreciate that stigma and discrimination increase vulnerability to HIV infection and all, in some way, consider the epidemic within a human rights framework. Most promote principles relating to population health and to respect for human rights, and indeed the federal role in this regard is particularly pronounced. Yet all jurisdictions have to struggle with the challenge of implementing these principles. Improving population health is a long-term undertaking; addressing wait times is a short-term necessity. Funding most often goes to the latter rather than the former.

The jurisdictions are also similar with regard to their care and treatment services, with the differences being in terms of quantity and delivery systems. Most jurisdictions, for example, offer nominal and non-nominal testing for HIV and some offer anonymous testing as well. All test for HIV as part of their prenatal screens although, as indicated in **Table 7**, some employ an opt-in model while others use as opt-out model.

Table 7, Consent Models for Prenatal HIV Testing, by Jurisdiction

Jurisdiction	Opt-in	Opt-out
British Columbia	✓	
Alberta		✓
Saskatchewan	✓	
Manitoba		✓
Ontario	✓	
Quebec		✓
New Brunswick[113]		✓
Nova Scotia	✓	
Prince Edward Island	–	–
Newfoundland and Labrador		✓
Nunavut	✓	
Northwest Territories		✓
Yukon	✓	

Furthermore most jurisdictions provide some prevention and sexual health information – whether relating to HIV/AIDS specifically or to STIs more generally – in their schools. Those most directly responsible for HIV/AIDS, however, are not necessarily involved in these efforts in every jurisdiction.

The different jurisdictions all have programs or community agencies that target their efforts to particularly vulnerable groups, for example Aboriginal people, those from HIV-endemic countries or injection drug users. Most jurisdictions have important harm reduction programs in place, for example needle exchanges although in at least one jurisdiction, there is no government funding for the program. Some have mobile units that take the needles to where they are needed in order to ensure their availability. Some also have or are considering supervised injection sites as the next step in minimizing the potential for harm.

Jurisdictions also have programs to ensure that low income does not prevent people from accessing the pharmaceuticals needed to live with their HIV/AIDS. In one jurisdiction, these can be delivered by mail so as to protect client privacy. The issue with these programs, almost everywhere, is not access to the drugs but rather the timeliness of approving new drugs and the portion of costs that must be borne by some individuals.

Similarly treatment is available everywhere in Canada and in many places, arrangements have been made to bring the specialized knowledge of urban centres to small and remote communities. Nevertheless, treatment in these latter communities may be compromised by the stigma and discrimination still associated with HIV/AIDS and by the concern some people have with their condition becoming common knowledge. Key informants suggested this situation is particularly acute in many First Nations communities where the reality of HIV/AIDS has yet to be openly acknowledged.

Perhaps the sharpest difference among jurisdictions is in terms of the community care provided to people living with HIV/AIDS or vulnerable to HIV infection. Ontario, Quebec and Manitoba, for example, have community clinics that can offer a comprehensive and integrated array of housing, transportation, home care, hospice and other supportive services for those living with HIV/AIDS. Others offer little in this regard. Limited resources, the lack of public awareness and the absence of political commitment prevent some jurisdictions from responding in this comprehensive manner.

[113] Policy is not yet in place in New Brunswick but the province is moving toward an opt-out model with informed consent.

4.6 Knowledge

Every jurisdiction is involved in some efforts to build knowledge concerning HIV/AIDS, at least by gathering and analyzing surveillance data and then sharing these with PHAC. Provincial and territorial officials responsible for surveillance acknowledge both the important role played by PHAC in this regard and the quality of the Canadian system. They are all participating in efforts to explore whether definitions and data collection methods can be further standardized. These data are enriched by the cohort and other targeted studies funded by the federal and some provincial governments.

Some key informants would welcome more leadership and direction from the federal government in this regard, however this position is not endorsed by all administrations. Those who support this position would like to see the federal government working more energetically toward a standardized national system and working to minimize the differences evident across jurisdictions. They recognize, however, that the federal government has little authority in this area and can only encourage the other jurisdictions to track and report cases in certain ways. It has been suggested that such coaxing would be possible if the Field Surveillance Officer program was expanded or if greater funding was available specifically for this purpose.

Some would also like to see the federal government undertake more social research, cohort studies and trace-back studies that would build a better understanding of the epidemic's roots in the different jurisdictions. These studies would certainly contribute to efforts to effect behavioural change everywhere in Canada. They would also complement the work currently underway in those jurisdictions with the more pronounced epidemics. Both the Ontario and Quebec strategies, for example, place some emphasis on and provide some funding for research. Similarly British Columbia provides support for the BC Centre for Excellence in HIV/AIDS, the BC Centre for Disease Control and the Knowledge Transfer Unit at the University of British Columbia. Alberta, meanwhile, also funds a "community developer" position whose mandate is to assist community organizations to undertake research at the local level.

Key informants also suggested there is a need for efforts to develop more timely and dynamic information-gathering and research processes. Currently, new knowledge presented in academic and government-based studies is rarely new at the street level and within community agencies. These sources want more effort committed to the timely dissemination of knowledge, and to knowledge transfer and application. These can best be achieved, they say, through effective partnerships between researchers and community service providers, and between research institutions and community organizations. They further emphasized the importance of evaluation so as to ensure that the Canadian efforts can be continually improved.

It was suggested that researchers need to have a "service culture" if their work is to be of practical value.

5 Conclusions

The HIV/AIDS epidemic remains a serious problem in and to all jurisdictions in Canada, if not at present then most certainly in the future. In some jurisdictions with few new reports of HIV infection, for example, the incidence of sexually transmitted infections speaks to unsafe sexual practices that place people at risk of HIV infection. Injection drug use and hepatitis C prevalence in some communities and in both federal and provincial correctional centres speak also to the risk of HIV infection.

It is by no means assured that the decade of declining incidence will continue into the future.

5.1 A Sound Foundation

All jurisdictions in Canada have responded to the HIV/AIDS epidemic and most have laid a sound foundation both for addressing the current epidemic and for responding to it in the future as need arises. Most have articulated a comprehensive, sound and well-considered strategy that provides direction to stakeholders. Some have formal structures in place for managing HIV/AIDS policy and activities while others manage these in a less structured but no less effective manner.

Invariably, the different jurisdictions are monitoring the epidemic and are attempting to improve their surveillance and reporting systems. Public health delivery systems endeavour to ensure partner notification and are promoting an awareness of HIV/AIDS and of sexual health in their schools and among their vulnerable populations. Jurisdictions include HIV testing as part of their prenatal screening programs and have nominal, non-nominal and sometimes anonymous testing available.

Additionally, all jurisdictions have some projects and organizations – some with federal rather than provincial or territorial funds – in place to reduce vulnerability and harm, and to provide care and support. Many of these are the responsibility of local health authorities and, in many jurisdictions, municipal governments have become actively engaged in the effort to address the epidemic. In some jurisdictions, all the different stakeholders are working together within community-based committees to define priorities and to allocate resources. In some jurisdictions also, stakeholders are endeavouring to find ways to transcend the boundaries that currently compromise efforts to bring a seamless array of services and supports to Aboriginal people.

Treatment and appropriate pharmaceuticals are available virtually everywhere in Canada and mechanisms are in place to ensure that physicians have access to the advice and support they need in order to provide quality care. This means that people – marginalized or mainstream – receive good care regardless of whether they live in urban or rural and remote centres. The outstanding problem – and one that has not been resolved anywhere – is the reluctance of many small communities to acknowledge there is a problem and to introduce education and prevention measures.

Furthermore, after two decades of experience, there is a good understanding of what is needed to effectively address the epidemic, for example particular treatment regimens, community partnerships, culturally appropriate services, targeted prevention efforts sustained through the long term, a variety of harm reduction initiatives, a focus on vulnerable populations and efforts to overcome the stigma associated with HIV infection. Most understand the importance of a population health model and a human rights framework for effectively preventing HIV infection through the long term.

This is not to say, however, that this model or framework is in place everywhere in Canada or that all jurisdictions are acting on the knowledge they have. HIV/AIDS advocates highlighted the need for heightened public awareness, increased resources and re-energized leadership to address the epidemic.

5.2 Strengthening the Canadian Response

The provincial and territorial pictures, the national portrait and the project's key informants all suggest means for building on this foundation in order to strengthen the Canadian effort to address the HIV/AIDS epidemic.

First and foremost, efforts are needed to promote public awareness and concern, and "to put HIV/AIDS back on the public radar." Such efforts might include national awareness and education campaigns and the broader dissemination of surveillance and epidemiological information. They could also involve efforts to integrate HIV/AIDS with campaigns directed at other blood-borne pathogens and sexually transmitted diseases even though this approach has both advantages and disadvantages. This approach, at the very least, would serve to help place HIV/AIDS within a broader public health and perhaps population health context.

Second, there is a necessity to continue to increase political commitment and leadership to effectively address the epidemic in a vigorous and comprehensive manner. Political commitment and leadership are vital:

- for promoting public awareness, providing clear direction, dispelling stigma and preventing discrimination;
- for acquiring the resources needed to build, disseminate and apply new knowledge, to effectively prevent the epidemic's spread, and to provide appropriate care, treatment and support; and
- for ensuring that prevention, treatment, care and support efforts are available to all people everywhere in Canada.

Third, there is a need in Canada to shift public awareness and government spending from the treatment of disease to population health, from medical technology to children's well-being, and from short-term palliatives to long-term solutions. Efforts to promote population health – for example, by better protecting children from violence or through adequate housing – are the key to preventing HIV infection in the future.

There is not yet a cure for HIV/AIDS, a vaccine to prevent infection or a way to ensure safe behaviour among all those currently infected. Controlling the epidemic, therefore, requires efforts to address the roots of HIV vulnerability, including poverty and discrimination. This is no small undertaking. It will entail a shift that has eluded governments for many years already. But it is absolutely essential if Canada is ever to get ahead of this and other epidemics.

Fourth, effectively managing the epidemic will require continued efforts to build on existing cooperative mechanisms and partnerships across governments and across sectors, for the purpose of planning, delivering and funding programs. Inherent in this are efforts to strengthen and stabilize the community organizations that, at present, are struggling to cope with ever increasing needs and numbers, and with an increasingly broad range of issues. Inherent in this also is an effort to address the epidemic more effectively within the Aboriginal population in part by addressing the stigma still evident in small communities, in part by overcoming the conservatism surrounding sexual health education, and in part by addressing the jurisdictional issues that provide service on the basis of where people live.

HIV/AIDS is a complex disease and an ever-changing epidemic. Through the past decades, governments in Canada have built a strong foundation for addressing both the disease and the epidemic. But commitment to doing so has faded over time as other priorities emerged. A renewed commitment to effective action and to cooperative partnerships is needed, everywhere in Canada, if Canadians are to effectively address the HIV/AIDS epidemic.

References

Alberta Blood-borne Pathogens Surveillance Working Group. 2003. Alberta Blood-borne Pathogens Surveillance Report 2003. Edmonton, AB. Alberta Health and Wellness.

Alberta Community Council on HIV. n.d. *What is the Alberta Community HIV Fund?* **http://www.acch.ca/HIVachf.htm**.

Alberta Health and Wellness and Health Canada. 2001. Alberta Aboriginal HIV Strategy, 2001-2004. Spring.

Alberta. 1999. HIV in Alberta, 1998/99 – 2002. Alberta Health Strategy. Alberta Health and Wellness. March.

BC Aboriginal AIDS Task Force. 1999. The Red Road, Pathways to Wholeness: An Aboriginal Strategy for HIV and AIDS in BC.

BC Centre for Disease Control. 2000. Chee Mamuk, "New Work." A Report on the HIV Epidemic Among Aboriginal People in British Columbia for the Year 2000. STD/AIDS Control and Chee Mamuk.

British Columbia Centre for Disease Control Society. 2000. HIV/AIDS Update, Annual 2000. Prepared by Robbie G. MacDougall, Michael L. Rekart, et. al.

British Columbia Centre for Disease Control Society. 2001. HIV/AIDS Update, Annual 2001. Prepared by Robbie G. MacDougall, Michael L. Rekart, et. al.

British Columbia Centre for Disease Control Society. 2002. HIV/AIDS Update, Annual 2002. Prepared by Robbie G. MacDougall, Michael L. Rekart, et. al.

British Columbia. 2003. Priorities in Action in Managing the Epidemics. HIV/AIDS in B.C.: 2003-2007. BC Ministry of Health Planning and BC Ministry of Health Services. September.

Canada, Correctional Service Canada. 2003. Infectious Diseases Prevention and Control in Canadian Federal Penitentiaries, 2000-01.

Canada, Health Canada. 2000. National Trends of HIV and AIDS in Canada. Canada Communicable Disease Report. Vol. 26(23) December.

Canada, Health Canada. 2003(a). Estimates of Prevalence and Incidence in Canada, 2002. Canada Communicable Disease Report. Vol. 29(23), December.

Canada, Health Canada. 2003(b). HIV/AIDS, Epi Updates. Surveillance and Risk Assessment Division, Centre for Infectious Disease Prevention and Control Population and Public Health Branch, Population and Public Health. May.

Canada, Health Canada. 2003(c). HIV and AIDS in Canada. Surveillance Report to June 30, 2003. Population and Public Health Branch. November.

Canada, Health Canada. 2003(d). Government of Canada 2003 Report to the Secretary General of the United Nations on the UNGASS Declaration of Commitment on HIV/AIDS.

Canada, Health Canada. 2004(a). HIV and AIDS in Canada: Surveillance Report to December 31, 2003. Surveillance and Risk Assessment Division, Centre for Infectious Disease Prevention and Control. April.

Canada, Health Canada. 2004(b). I-Track. Enhanced Surveillance of Risk Behaviours Among Injecting Drug Users in Canada. Pilot Survey Report. Surveillance and Risk Assessment Division, Centre for Infectious Disease Prevention and Control. February.

Canada, Ministerial Council on HIV/AIDS. Special Working Group on Aboriginal Issues. 2001. Situational Analysis: A Background Paper on AIDS/HIV and Aboriginal People. Ottawa: Minister of Public Works and Government Services Canada.

Elliott L, Blanchard J. 1999. The Winnipeg Injection Drug Epidemiology Study: A Study of the Epidemiology of Injection Drug Use and HIV Infection in Winnipeg, Manitoba. Final Report.

Jürgens, R. 1996. HIV/AIDS in Prisons: Final Report. Canadian HIV/AIDS Legal Network and the Canadian AIDS Society. (**http://www.aidslaw.ca/Maincontent/issues/prisons/2SUMMARY.html**)

Manitoba Health. 1995. Manitoba's Provincial AIDS Strategy.

Manitoba Health. 2001(a). Provincial Sexually Transmitted Diseases Control Strategy. Communicable Disease Control Unit. August.

Manitoba Health. 2001(b). Communicable Disease Management Protocol. HIV Infection and AIDS. Communicable Disease Control Unit. November.

Manitoba Health. 2002. An Update on the Continuing Implementation of the Manitoba Provincial AIDS Strategy. Communicable Disease Control Unit. Winter.

Manitoba Health. 2003. Manitoba Health Statistical Update on HIV/AIDS, 1985-June 2003. Communicable Disease Control Unit.

Manitoba Sexuality Education Resource Centre. **http://www.serc.mb.ca/**.

Manitoba, Public Health. 2003. Communicable Disease Control Unit. Manitoba Health Statistical Update on HIV/AIDS 1985-June 2003. Manitoba Health, July 15, 2003.

Manitoba, Public Health. Communicable Disease Control Unit. Reportable Diseases Manitoba. CDC Annual Review Calendar Year 2001. Manitoba Health.

Manitoba. 2003(a). Aboriginal AIDS Strategy Round Table Chair Appointed on World AIDS Day. December 1.

Manitoba. 2003(b). Manitoba Statistical Update on HIV/AIDS, 1985-June 2003. July 15, 2003.

Montreal Public Health Department. 2002. Portrait of the HIV/AIDS Epidemic in Quebec December 2002. Adapted from: Direction des communications du ministère d e la Santé et des Services sociaux. Portrait de l'épidémie VIH/Sida au Québec, décembre.

Northwest Territories. 2004. Notifiable Diseases for the NWT, October 2003 – December 2003. Epi North, Vol. 16(1).

Nova Scotia Advisory Commission on AIDS. 2003. Nova Scotia's Strategy on HIV/AIDS.

Ontario Advisory Committee on HIV/AIDS. 2002. A Proposed HIV/AIDS Strategy for Ontario to 2008. June.

Ontario, Ministry of Health and Long-Term Care. 2002. Public Health and Epidemiology Report Ontario. 13(7), September 30.

Ontario. 1997. Mandatory Health Programs and Service Guidelines. Ministry of Health/Public Health Branch. December.

Quebec, Ministère de la santé et des services sociaux. 2003. Portrait of the HIV/AIDS Epidemic in Quebec, December 2002. Adaptation prepared by the Montreal Public Health Department.

Québec, Santé et Services sociaux. 1999. AIDS in the Workplace. Let's do something about it! And How.

Quebec, Santé et Services sociaux. 2000. Preventing AID and other STDs through sexuality education for students with intellectual impairments. Compendium of teaching and learning activities geared to adapted curricula.

Québec, Santé et Services sociaux. 2002. Portrait de l'infection par le VIH et du SIDA au Québec. Décembre 2002. Analyses et surveillance.

Quebec, Santé et Services sociaux. 2003. Surveillance des cas de syndrome d'immunodéficience acquise (SIDA). Cas Cumulatifs 1979-2003.

Québec, Santé et Services sociaux. 2004. Stratégie Québécoise de lutte contre l'infection par le VIH et le SIDA, l'infection par le VHC et les infections transmissibles sexuellement. Orientations 2003-2009.

Québec. 2003. Surveillance de l'infection par le Virus de l'immunodéficience humaine (VIH) au Québec. Rapport préliminaire 2002-2003. Santé et Services sociaux.

Remis, Robert et. al. 1998. Report on HIV/AIDS in Ontario, 1981 to 1996.. Prepared for the AIDS Bureau, Ministry of Health. July.

Remis, Robert et. al. 1999. Report on HIV/AIDS in Ontario, 1997-1998. Prepared for the Ontario Ministry of Health and Long-Term Care. November.

Remis, Robert S. et. al. 2001. Report on HIV/AIDS in Ontario, 2000. Prepared for the AIDS Bureau, Ontario Ministry of Health and Long-Term Care. December.

Remis, Robert S. et. al. 2002. Report on HIV/AIDS in Ontario, 2001. Prepared for the AIDS Bureau, Ontario Ministry of Health and Long-Term Care. November.

Remis, Robert S. et. al. 2003. Report on HIV/AIDS in Ontario, 2002. Prepared for the AIDS Bureau, Ontario Ministry of Health and Long-Term Care. November. (www.phs.utoronto.ca/ohemu)

Saskatchewan Health, the Prince Albert Health District and Health Canada. 1998. Prince Albert Seroprevalence and Risk Behaviour Survey.

Saskatchewan Health, the Regina Health District and Health Canada. 2000. The Regina Seroprevalence Study: A Profile of Injection Drug Use in a Prairie City.

Saskatchewan Health. 2004. Guidelines for the Management of Potential Exposures to Hepatitis B, Hepatitis C, HIV and Recommendations for Post-Exposure Prophylaxis. Saskatchewan Subcommittee on HIV/AIDS. January.

Saskatchewan, Provincial Health Strategy Team. 2002. At Risk: Recommendations for a Strategy on HIV, Blood-borne Pathogens and Injection Drug Use. Regina.

Spigelman, Martin. 2003. Getting Ahead of the Epidemic: The Federal Government Role in the Canadian Strategy on HIV/AIDS, 1998-2008. Prepared for Health Canada and the Five-Year Review Advisory Committee. June.

Yukon. 2004. Yukon Health Status Report, 2003.

Appendix A
FPT AIDS Advisory Committee Representatives

Co-Chairs/Co-présidents

Ontario
Mr. Frank McGee, AIDS Coordinator
AIDS Bureau, Community Health Branch
Ministry of Health and Long-Term Care
Tel: (416) 327-8797
E-mail: **frank.mcgee@moh.gov.on.ca**

Canada
Dr. Frank Plummer, Director General
Centre for Infectious Disease Prevention & Control, Public Health Agency of Canada
Tel: (613)941-4339
E-mail: **frank_plummer@phac-aspc.gc.ca**

Members/Membres

Nova Scotia
Ms. Mahnaz FarhangMehr
Coordinator, Communicable Disease Prevention and Control
Tel: (902) 424 – 1748
E-mail: **Farhanma@gov.ns.ca**

Alberta
Dr. Ameeta Singh
Infectious Diseases Medical Consultant
Office of the Provincial Health Officer
Tel: (780) 415 2825
E-mail: **ameeta.singh@gov.ab.ca**

Saskatchewan
Mr. John Mitchell, HIV/BBP/IDU Consultant
Population Health
Tel: (306) 787-2633
E-mail: **jmitchell@health.gov.sk.ca**

Québec
Ms. Lise Guérard, Chef de service
Service de lutte contre les Infections Transmissibles Sexuellement et par le Sang
Téléphone: (514) 873-9892,
Courriel: **lise.guerard@msss.gouv.qc.ca**

Northwest Territories
Dr. Kami Kandola, Medical Health Officer
Stanton Territorial Health Authority
Tel: (867) 669-9032
E-mail: **kami_kandola@gov.nt.ca**

Yukon
Dr. Bryce Larke
Yukon Medical Health Officer
Tel: (867)667-5716
E-mail: **bryce.larke@gov.yk.ca**

Manitoba
Ms Trina Larsen, Program Coordinator
HIV/AIDS & HCV
Tel: (204) 788-6787
E-mail: **tlarsen@gov.mb.ca**

New Brunswick
Ms. Beth McGinnis, Project Manager
Public Health Management Services
Tel: (506) 444-2158
E-mail: **beth.mcginnis@gnb.ca**

Prince Edward Island
Ms. Anne Neatby, Coordinator
Communicable Diseases and Immunization Programs, Office of the Chief Health Officer
Tel: (902) 368-5272
E-mail: **amneatby@gov.pe.ca**

British Columbia
Mr. Warren O'Briain, Director
HIV and Addictions, Prevention and Wellness Planning
Tel: (250) 952-2481
E-mail: **Warren.OBriain@gems6.gov.bc.ca**

Nunavut
Ms. Carolina Palacios, CDC Consultant
Tel: (867) 975-5787
E-mail: **cpalacios@gov.nu.ca**

Newfoundland & Labrador
Mr. Morgan Pond
Department of Health & Community Services
Tel: (709) 729-3769
E-mail: **mpond@gov.nl.ca**

Canada
Mr. Grafton Spooner, A/Director
HIV/AIDS Policy, Coordination and Programs Division, Public Health Agency of Canada
Tel: (613) 941-2673
E-mail: **Grafton_Spooner@phac-aspc.gc.ca**

Canada
Dr. Chris Archibald, Director
Surveillance and Risk Assessment Division
Public Health Agency of Canada
Tel: (613) 941-3155
E-mail: **chris_archibald@phac-aspc.gc.ca**

Canada
Mr. Daniel Tardif, Director
Communicable Disease Control
First Nations and Inuit Health Branch
Health Canada
Phone (613) 948-6405
E-Mail: **daniel_tardif@hc-sc.gc.ca**

Canada
Mr. Alan Sierolawski, Manager
National Infectious Disease Program
Correctional Service Canada
Tel: (613) 947-4887
E-mail: **SierolawskiAR@CSC-SCC.GC.CA**

Secretariat/Secrétariat

Public Health Agency of Canada
Ms. Meredith Willis, Program Consultant
HIV/AIDS Policy, Coordination & Programs Division
Tel: (613) 946-6675
Email: **meredith_willis@phac-aspc.gc.ca**

Public Health Agency of Canada
Ms. Tanya Lary, A/Manager
HIV/AIDS Policy, Coordination & Programs Division
Tel: (613) 954-0628
Email: **tanya_lary@phac-aspc.gc.ca**

Appendix B
Project Overview

A National Portrait: A Report on the HIV/AIDS Epidemic in Canada OVERVIEW

HIV/AIDS has cut a swath through vulnerable communities in Canada, leaving 13,000 deceased and over 55,000 today living with the virus and its consequences. Governments have each responded to the epidemic in their own way but their efforts have been somewhat hampered by the lack of detailed and readily available information about (i) the epidemic's presence in each jurisdiction and (ii) each jurisdiction's policy and programmatic response.

The Federal/Provincial/Territorial Advisory Committee on AIDS is preparing this National Portrait so as to fill that information gap. Its objectives are:

- to document the epidemic's presence in each Canadian jurisdiction;
- to summarize each jurisdiction's policy and program to the epidemic; and
- to identify issues of current concern.

The National Portrait may serve as a foundation for a more cohesive and more fully collaborative, inter-governmental response to the epidemic.

Dr. Martin Spigelman is preparing this portrait for FPT AIDS, building on his previous work for the Ministerial Council on HIV/AIDS and for Health Canada, for example his review of The Federal Government Role in the CSHA, 1998-2003 (**http://www.hc-sc.gc.ca/hppb/hiv_aids/can_strat/publications/ahead.html**). The project's methodology will include a review of the epidemiological data from each jurisdiction and of other national, provincial and territorial documents on HIV/AIDS, as well as interviews with both governmental and non-governmental key informants in each jurisdiction.

For further information, please contact:

Tanya Lary
HIV/AIDS Policy, Coordination & Programs Division
Public Health Agency of Canada
Tel: (613) 954-0628, Fax: (613) 952-3556
Email: **tanya_lary@phac-aspc.gc.ca**

Appendix C
Surveillance Data Template

Jurisdiction

Indicator	Year			
	2002	**2001**	**2000**	**1995**
Prevalence Estimate				
AIDS Cases				
Number of AIDS cases reported by year				
Cumulative number of AIDS cases reported				
Newly reported AIDS cases by sex:				
male				
female				
Newly reported AIDS cases by Exposure Category				
MSM				
IDU				
Heterosexual contact				
Newly reported AIDS cases by age				
children & youth				
adults				
seniors				
AIDS-related deaths				

Jurisdiction *(continued)*

Indicator	Year			
	2002	2001	2000	1995
HIV Infection				
Total number of reported HIV cases				
Newly-reported cases of HIV Infection by exposure category				
MSM				
IDU				
Heterosexual contact				
HIV/AIDS-endemic countries				
Newly-reported cases of HIV Infection by Sex				
Men				
Women				
Newly-reported cases of HIV Infection by ethnicity				
Aboriginal people				
• men				
• women				
Asian (by sex if available)				
Black (by sex if available)				
Others (by sex if available))				
Newly-reported cases of HIV Infection by age				
Perinatal				
Youth (15-24)				
Adults (ages …)				
Adults (ages …)				
Seniors				

Appendix D
Key Informants and Interview Guide

Key Informants	Organization
British Columbia	
Warren O'Briain	Government
Dr. Perry Kendall	Government
Erik Ages	Community Organization
Mikki Hanson	Community Organization
Dr. Elizabeth Whynot	Provincial Heath Services Authority
Alberta	
Dr. Ameeta Singh	Government
Linda Findlay	Government
Dr. S. Houston	Government
Sherry McKibbon	Community Organization
Denise Lambert	Community Organization
Angela Kaida	Government
Saskatchewan	
John Mitchell	Government
Dr. Ross Findlater	Government
Christine Smith	Community Organization
Margaret Akan	Community Organization

Key Informants	Organization
Manitoba	
Trina Larsen	Government
Dr. Carole Beaudoin	Government
Michelyn Wood	Government
Daryn Bond	Community Organization
John Stinson	Community Organization
Ontario	
Frank McGee	Government
Dr. Robert Remis	University
Dr. Kirsten Rottensten	Government
Nancy Peroff	Government
Rick Kennedy	Community Organization
Quebec	
Lise Guérard	Government
Dr. Bruno Turmel	Government
Luc Gagnon	Community Organization
Mme Lyse Pinault	Community Organization
New Brunswick	
Maureen McIntosh	Government
Haley Flaro	Community Organization
Dr. Maureen Baikie	Government
Julie Dingwall	Community Organization
Nova Scotia	
Mahnaz FarhangMehr	Government
Larry Baxter	NS Advisory Commission
Robert Allen	Community Organization
Prince Edward Island	
Robin MacArthur	Health Canada
Barb Gibson	Community Organization
Newfoundland and Labrador	
Morgan Pond	Government
Cathy O'Keefe	Government
Michelle Boutcher	Community Organization
Nunavut	
Carolina Palacios	Government

Key Informants	Organization
Northwest Territories	
Dr. Kami Kandola	Government
Wanda White	Government
Jill Christensen	Community Organization
Yukon	
Dr. Bryce Larke	Government
Colleen Hemsley	Government
Janet LeCamp	Community Organization
Canada	
Dr. Christopher Archibald	Health Canada, PPHB
Jennifer Geduld	Health Canada, PPHB
Dr. Marcus Lem	Health Canada, FNIHB

KEY INFORMANT INTERVIEW GUIDE

Note: Under "key informants" in the following Table:

- FPT – jurisdiction's representative on the FPT Advisory Committee.
- CMHO – jurisdiction's Chief Medical Health Officer
- OG – other government or Health Authority staff as identified by the FPT representative
- CR – representative(s) of community-based HIV/AIDS service or other organizations

Policy and Program Issues	Key Informants
A. Administration and Delivery	
1. Does your jurisdiction have a particular HIV/AIDS strategy or a series of activities and undertakings? Advantages/disadvantages?	• FPT • CMHO • CR
2. Is there a lead government office directly responsible for HIV/AIDS-related matters? Responsibilities; number of staff? If "no," how are HIV/AIDS-related activities managed?	• FPT
3. Is there an interdepartmental committee addressing HIV/AIDS-related issues? Who is involved; role? Accomplishments?	• FPT • CMHO • OG
4. Are there regional or local health authorities in this jurisdiction and if so, what is their role in planning or administering the jurisdiction's response to HIV/AIDS? Links with the provincial/territorial authority? Are there regional HIV/AIDS service plans? How are access and service made consistent across regions?	• FPT • OG • CR
B. Coordination and Cooperation	
5. Is there a committee or other structure for on-going liaison among government, community agencies and/or Health Authorities? Who is involved; roles, responsibilities and activities? Accomplishments and effectiveness?	• FPT • OG • CR
6. Nature and extent of inter-governmental cooperation, e.g., with Health Canada or Correctional Service Canada? Other? Strengths & shortcomings? Means of improving?	• FPT
7. Relationship, if any, with other health strategies? Funding, data or policy linkages? Strengths and shortcomings?	• FPT • CMHO • OG
8. Advantages/disadvantages, challenges/opportunities associated with working cooperatively across jurisdictions, departments and health concerns?	• FPT • CMHO • CR
C. Funding	
9. Does this jurisdiction specifically identify the funding committed to HIV/AIDS? How much and what is included in this calculation?	• FPT • OG
10. *(Where appropriate)* What system is in place for allocating and spending HIV/AIDS-related funding via health authorities or community agencies?	• FPT • OG

Policy and Program Issues	Key Informants
D. Prevention, Treatment and Care	
11. Are there specific efforts to educate/inform teachers, health care professionals or other groups about HIV/AIDS? Are protocols in place for health care professionals and/or others?	• FPT
12. Are there specific efforts directed toward employers or the workplace?	• FPT
13. Is there a special program for providing anti-retroviral drugs? Is the cost covered by government?	• FPT • CMHO
14. Prenatal testing? Percentage take-up? Percentage of HIV-infected pregnant women receiving antiretrovirals?	• FPT • CMHO
15. Special programs to meet the particular needs of those living with HIV/AIDS (housing, transportation, respite, hospice, etc.)?	• FPT • OG • CR
E. Testing	
16. Jurisdiction's policies/protocols on HIV testing? Nominal, non-nominal, anonymous? Number or percent tested by year among pregnant women, inmates in correctional centres, and/or others?	• FPT
H. Knowledge, Research and Evaluation	
17. Who is responsible for collecting, analyzing and disseminating epidemiological data? To what extent and how is information shared with Health Canada, other jurisdictions, municipalities, health authorities and NGOs/ASOs? Strengths/shortcomings of the national epi reporting system?	• FPT • CR
18. To what extent do the jurisdictions fund research and evaluation, including community-based program evaluations?	• FPT • CR
19. How is new knowledge concerning treatment or best practice disseminated? Efforts to apply new knowledge? Strengths and shortcomings of these efforts?	• FPT • CR
I. Conclusions and Recommendations	
20. Anticipated trends, 2004 – 2010?	• all
21. Issues of current concern? Emerging issues?	• all
22. Means for strengthening the jurisdiction's response to HIV/AIDS?	• all