



Leading Together:

Canada Takes Action on HIV/AIDS

Foreword

For 30 years, concrete action has been undertaken by Canadian society to combat HIV and AIDS. Progress has been made however emerging issues continue to challenge the way in which we respond as Canadians.

Leading Together is one of the many integral components to manage and curb the impact of HIV/AIDS in Canada. It considers new ways to move forward – renewed commitment, partnership, innovation – to achieve the outcomes we would like to achieve as a nation. It describes a bold vision where we want to be in a Canada-wide, multi-sectoral response to HIV/AIDS. It is intended to help guide Canadian sectors of civil society and governments in this call to action.

When the Leading Together Championing Committee took the responsibility to renew the *Leading Together: 2005-2010* call to action, it recognized the essential participation and input of key stakeholders to ensure the path forward would address the concerns of Canadians who work collaboratively to achieve optimum results. We consulted with key stakeholders, surveyed People Living with HIV/AIDS, AIDS Service Organizations and community leaders to do so. We believe we have been successful in providing a document that represents the comprehensive views of those living with or working in the HIV/AIDS response. We encourage Canadians to continue to share your stories and to put this document to use in the planning and delivery of programs and services which will enable us, as Canadians, to develop a more effective, coordinated response that will stop the virus and save lives.

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Acknowledgments

Leading Together: Canada Takes Action on HIV/AIDS is a renewal of the 2005-2010 call to action, which was developed collaboratively by stakeholders involved in the Canadian response to HIV/AIDS. The renewal of *Leading Together* was overseen by the Leading Together Championing Committee (LTCC), a representative group of stakeholders from across Canada, as well as other experts recruited for the Leading Together Editorial Board (LTEB).

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Table of Contents

A Call to Action.....	1
Who Is the Call to Action for?.....	1
A Coordinated and Collaborative Approach.....	2
How <i>Leading Together</i> Was Developed.....	3
How to Use <i>Leading Together</i>	3
The Commitment.....	3
The Vision	4
The Mission	4
The Values.....	4
Goals	5
HIV/AIDS in Canada: Why Everyone Needs to Lead Together.....	5
Increasing Rates in Canada	5
Increasingly Complex Needs	6
Access to Treatment.....	6
A Changing Prevention Landscape	7
Stigma and Discrimination	7
Determinants of Health and Health Inequities.....	7
Growing Demand for Services.....	8
Reducing Costs	8
Saving Lives	8
Supporting Innovative Research.....	9
Strategic Directions for the Future.....	9
Leading Together - Strategic Framework (Logic Model).....	11
Goal #1: Prevent the Spread of HIV/AIDS in Canada through Health Promotion, Behavioural and Biomedical Prevention and Protection Efforts.....	12
Goal #2: Strengthen Diagnosis, Care, Treatment and Support Services for those living in Canada	29
Goal #3: Enhance Capacity to Address Health and Social Inequities in Canada	34
Goal #4. Active Engagement in Global Efforts.....	42
Conclusion.....	49
Acronyms.....	50
References.....	51

A Call to Action

More than 30 years after the first AIDS case was diagnosed, HIV is still with us. Despite progress in both prevention and treatment, HIV remains a serious cause of morbidity, mortality and economic and social disruption. Millions of people around the world have now been infected, including tens of thousands in Canada. However, tools are available or in development, which allow individual countries and the global community to envision and plan an “End to AIDS” in the long term as reflected in the United Nations Joint Programme on HIV/AIDS vision statement ‘Getting to Zero: *Zero Infections, Zero Discrimination, Zero AIDS Related Deaths*’¹. Currently, there is neither a cure for AIDS nor a vaccine to prevent new infections. A renewed and strengthened approach would contribute to halt and reverse the impacts of this preventable disease.

Leading Together renews the call to action made in *Leading Together 2005-2010* and leverages past progress with a renewed commitment. It reflects common goals and allows all Canadians to speak with one collective voice—to lead together.

Leading Together provides a strategic blueprint and recognizes the strength of a collective, multi-sectoral and coordinated pan-Canadian response to the call to action against HIV/AIDS.

Who is the Call to Action for?

The ‘Call to Action’ is directed to every sector: community-based AIDS organizations, people living with HIV/AIDS, physicians, other health professionals and care providers, public health units, researchers, human rights groups, advocacy groups, prevention services, substance dependence programs, correctional facilities, organizations that support prisoners, organizations that work with street youth, school boards and health teachers, organizations that work with new immigrants, Aboriginal organizations, housing programs, social service organizations, hospice palliative and end-of-life care programs, and governments at every level.

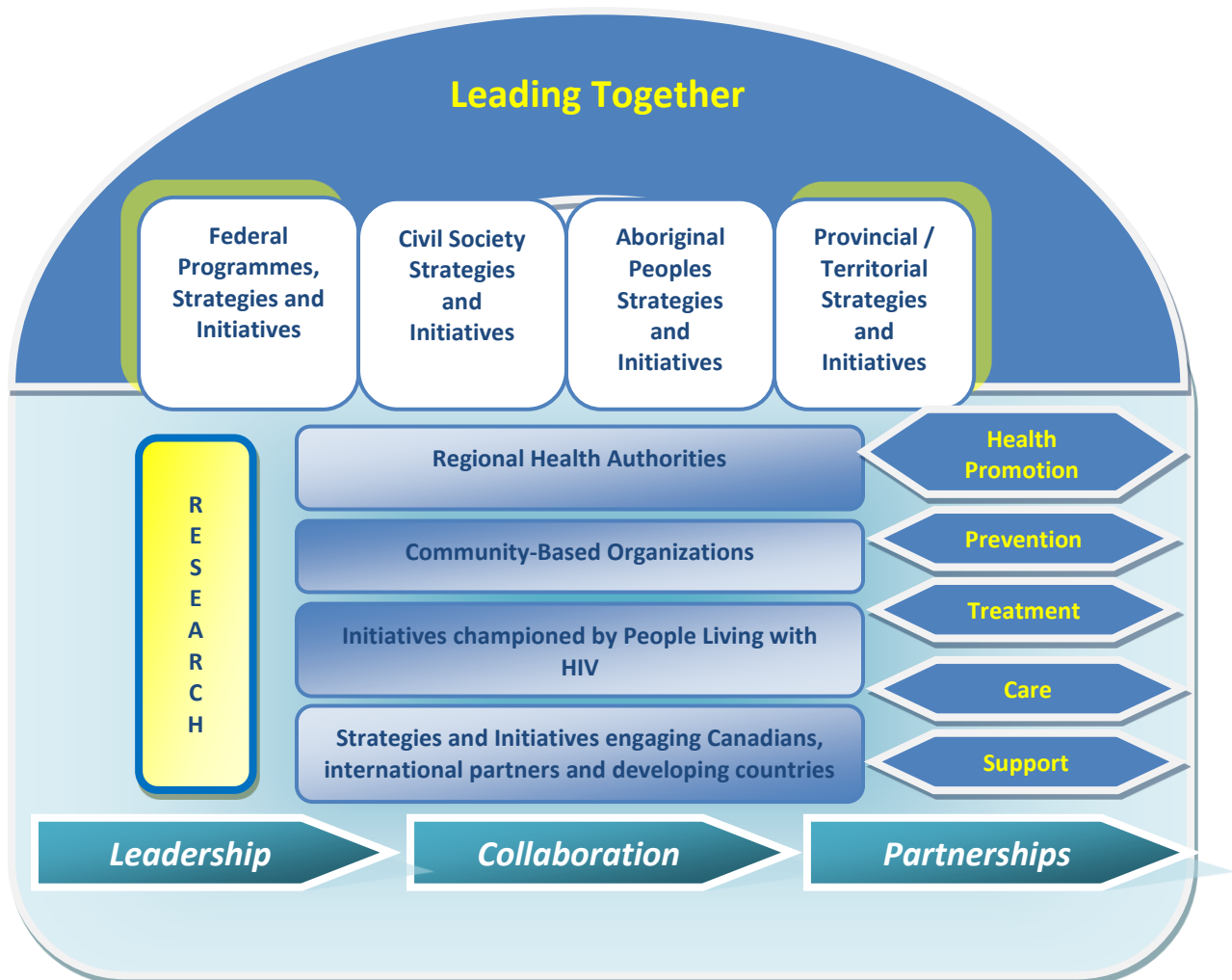
As a blueprint, *Leading Together* promotes a strategic, coordinated approach and shared responsibility to tackle both HIV and the underlying determinants of health and health inequities that influence and fuel new infections with significant effects on people infected, affected and at risk. It encourages effective and productive partnerships among jurisdictions, within the health care system and with other sectors that can help mitigate the impact of HIV and prevent new HIV infections, such as social services, education, housing and justice. It promotes empowerment of people living with and at risk of HIV, recognizing their strengths and encouraging them to participate in meaningful ways in the programs and services that affect their lives.

By working together, new infections will be prevented and life will be improved for people living with HIV/AIDS, as well as their families and communities.

A Coordinated and Collaborative Approach

Leading Together promotes a coordinated and collaborative response. Working and leading together toward common goals strengthens capacity and achieves greater results. *Leading Together* also recognizes that organizations and individuals have different, and often overlapping, roles and priorities. Some may be focused on treatment services, others on prevention programs and services, research, policy development, or program delivery. Some may service one particular population (e.g. Aboriginal peoples), others may service a particular setting (e.g. correctional facilities). Some address local issues while others address provincial/territorial, federal or international issues. Now more than ever, Canada’s response needs to enable the intersection between treatment and prevention programs. While different jurisdictions and services may not all agree on a specific approach, all share the same goals and values – including the respect for human rights and social justice.

Each jurisdiction and organization will have strategic plans and priorities for HIV/AIDS and all their activities collectively contribute to achieving the goals of *Leading Together*.



How *Leading Together* Was Developed

Many people across Canada helped develop the original *Leading Together 2005-2010* call to action, including people living with HIV/AIDS, service organizations, clinicians and other health care professionals, researchers, national HIV/AIDS organizations and governments. The first *Leading Together* edition was published in 2005. The *Leading Together* Championing Committee (LTCC) was established in 2006 to promote its use.

In 2010, the LTCC revisited the call to action and the progress achieved to date. The LTCC conducted a gap analysis, reviewing documents and surveying key informants from across the country. It also conducted an online survey to help identify any changes required in the call to action. Based on the feedback from stakeholders across Canada, the LTCC determined that the underlying principles and values of *Leading Together* had stood the test of time and are on the right path. They must, however, keep pace with new knowledge and emerging needs.

To renew the call to action, the LTCC established a multi-stakeholder *Leading Together* Editorial Board (LTEB) to guide the revisions, and consulted with the key national partners to review drafts and provide advice on content. The LTCC has reviewed and endorsed the final *Leading Together* renewal document.

How to Use *Leading Together*

Leading Together sets out a strategic blueprint for a collective pan-Canadian response to HIV/AIDS. It is owned by all stakeholders and partners across Canada involved in the response to HIV/AIDS.

It provides a clear vision, mission and values and outlines the goals to be pursued. It provides the data, research and information needed to support planning, education, communication, and the identification of priorities, as well as to assist in the development of proposals and initiatives. In addition, it lays out the key strategies and actions to achieve success. This blueprint can help support governments, organizations and programs across Canada in their ongoing commitment to address HIV/AIDS.

Leading Together does not claim to have all the answers. It recognizes that there are differences of opinion on some issues and respects those differences while encouraging open discussion and debate. Hundreds of people and organizations across the country are involved in HIV/AIDS programs and services and share responsibility for activities and initiatives are part of the pan-Canadian response to HIV/AIDS.

Since the use of *Leading Together* is voluntary, the LTCC has not set targets; rather it describes desired outcomes. Groups and individuals are encouraged to reflect on these. It is the partners' responsibility (community, service provider, government) to set their targets and monitor their progress as part of the collective effort.

One of the goals of the LTCC is to find effective ways to monitor the uptake and progress of *Leading Together*, and to actively champion its use across the country. To that end, all partners are encouraged to set concrete targets and report their achievements to the LTCC. The www.leadingtogether.ca website and other mechanisms may be used to share successes with Canadians.

The Commitment

The Vision

Leading Together shares the vision that the end of the HIV/AIDS epidemic in Canada is in sight. Guided by this vision, a future will be created where:

- People living with or at risk of HIV/AIDS are partners in shaping the policies and programs that affect their lives, and their rights and dignity are respected.
- People living with or at risk of HIV/AIDS have access to high-quality, effective services that meet their needs, and enjoy better health and well-being, regardless of where they live in Canada.
- The health and social inequities that fuel the spread of HIV/AIDS, including poverty, homelessness, discrimination, and stigmatization, have been reduced or eliminated.
- Canada is a leader and steward in addressing HIV/AIDS domestically and globally.

The Mission

- Champion the health needs and respect for human rights of all people living with or at risk of HIV/AIDS.
- Work collaboratively to develop an effective response to HIV/AIDS in Canada and abroad.
- Act boldly and strategically to end the HIV/AIDS epidemic.

The Values

The response to HIV/AIDS reflects the broader values of Canadian society:

- **Social Justice** - All members of society will have their basic needs met, equitable access to quality services, opportunities to participate, and be treated fairly. They will have equitable access to the determinants of health, including income, housing and social support.
- **Respect for Human Rights** - The dignity and worth of every person are recognized. All people, regardless of their sexual orientation, race, ethnicity, culture, gender, or risk behaviour are important. Their human rights – including economic, social, cultural, civil and political rights – are recognized, respected, protected and realized. Not one life is expendable.
- **Diversity** - Individual and cultural differences and diversity are recognized, respected and valued.
- **Participation and Empowerment** - The participation of all is supported, especially people living with HIV/AIDS and the most disadvantaged. An environment that empowers people to make healthy choices is sought.
- **Global Responsibility** - As a caring and affluent nation, Canadian resources and knowledge will contribute to international efforts to address HIV/AIDS.
- **Mutual Accountability** - Lives are at stake, and resources are to be used wisely. Everyone is accountable for using resources to make a substantial, positive difference in people's lives and to achieve shared goals.

- **Commitment to Evidence-Informed Approaches and Research to Discover Innovative Prevention and Treatment Tools** – Decision-makers and practitioners have the best available tools to help improve the quality and delivery of prevention, diagnosis, treatment, care and support programs and services to all citizens.

Goals

Four goals will continue to be pursued:

1. Prevent the spread of HIV/AIDS through health promotion, behavioural and biomedical prevention and protection efforts.
2. Strengthen diagnosis, care, treatment and support services.
3. Build capacity to reduce health and social inequities.
4. Be an active player in global efforts to end the epidemic and find a cure.

The work involved in the achievement of these goals will be reflected in the strategies and actions to be undertaken now and in the future.

HIV/AIDS in Canada: Why Everyone Needs to Lead Together

There are a number of drivers behind the renewed commitment to *Leading Together*. The current state of the epidemic in Canada necessitates a strengthened and coordinated response. The number of people living with HIV/AIDS continues to rise in Canada and demand for services is growing. Those living with HIV/AIDS have increasingly complex needs; treatment may not be readily or equally available or accessible to everyone; a range of determinants of health plays a significant role in fuelling the epidemic²; and stigma and discrimination persist.

The following provides an overview of these key drivers.

Increasing Rates in Canada

The number of Canadians living with HIV/AIDS continues to rise as there are still new infections every year and PHA are living longer. An estimated 3,175 Canadians were newly infected with HIV in 2011. At the end of 2011, an estimated 71,000 people in Canada were living with HIV infection—up about 11.4% since 2008. It is further estimated that approximately one quarter of Canadians who are living with HIV do not know they are infected³.

HIV/AIDS continues to have a disproportionate impact on certain segments of society. In 2011, nearly half of all new HIV infections in Canada were among men who have sex with men. About 37% were among people infected via heterosexual transmission, and nearly half were from countries where HIV is endemic. People who inject drugs accounted for approximately one in every seven new infections in Canada. Aboriginal peoples continue to be over-represented in the HIV epidemic in Canada. They

accounted for an estimated 8.0% of persons living with HIV/AIDS in Canada at the end of 2011 and 12.2% of all new HIV infections in 2011. The estimated HIV infection rate among Aboriginal peoples is almost 3.5 times higher than among non-Aboriginals. At the end of 2008, approximately 1.72% of the federal prison population were known to be living with HIV/AIDS, compared to 0.2% of the Canadian population⁴.

Incidence rates differ by sex, race and ethnicity, and are highest among men who have sex with men. These rates are also quite high among people from countries where HIV is endemic and Aboriginal peoples. In Canada, rates are increasing in populations that are highly mobile (e.g. moving to Canada from other countries and moving within Canada) and in heterosexual populations. Rates of some sexually transmitted infections (STI), such as syphilis and gonorrhoea, are also increasing which can increase the risk of HIV/AIDS transmission.

Increasingly Complex Needs

With the advent of highly active antiretroviral therapy (HAART), people living with HIV/AIDS (PHA) are living much longer than they did in the 1980s and 1990s, when the time between diagnosis and death was often measured in months. Living with a life-threatening infectious disease takes an immense toll on people's health, quality of life, finances, independence and self-esteem. Although antiretroviral therapies for HIV/AIDS are effective for many people, they are associated with a range of serious side effects, such as cancer, heart disease, peripheral neuropathy, and neurocognitive impairments.⁵

A significant proportion of PHA have other illnesses or infections, such as hepatitis C, that threaten their health and complicate care. This blueprint focuses on HIV/AIDS, however, there is a widespread consensus on the need to adopt comprehensive public health strategies that recognize and address the interconnectedness between HIV/AIDS and other diseases. Many PHA are also coping with complex issues, such as substance dependence or mental illness. Aging and conditions associated with aging are also complicating care for PHA.

Because of complex health needs, PHA often face high prescription drug costs, as well as costs associated with complementary therapies (e.g. vitamins, acupuncture) that may not be covered by government or private health plans. The financial impact of HIV/AIDS can be exacerbated by reduced or inflexible employment opportunities, or by complicated disability and social assistance plans that offer supports to accommodate the needs of people who may become ill early in their careers and who may experience periods of ill health where they cannot work.⁶

Access to Treatment

While progress has been made in treating HIV/AIDS, many people – in both large urban centres and small, rural and remote communities – continue to have problems accessing care and treatment, including long-term care, hospice palliative care and end-of-life care. This problem is exacerbated by the shortage of physicians and other health care providers and the complex care needs of PHA.

As we seek a cure, it is important to recognize that while death rates due to HIV/AIDS dropped significantly in the mid-1990s, Canadians continue to die from AIDS and from other conditions associated with HIV. Most people dying now from AIDS were either not treated at all, not treated soon

enough, or faced challenges finding the right treatments to meet all their health care needs. Some cannot tolerate the medications or they have strains of the virus that are resistant to treatment.⁷

A Changing Prevention Landscape

For much of the history of HIV/AIDS in Canada, correct and consistent condom use has been recognized as the single most effective way to prevent the sexual transmission of HIV. Condoms have served as the cornerstone of prevention responses, along with other intervention strategies such as needle and syringe programs to address transmission among those who inject drugs. In recent years, studies suggest that new prevention technologies hold considerable promise as potential new additions to the prevention toolbox. These include vaccines, vaginal and anal microbicides, and pre- and post-exposure prophylaxis, ‘treatment as prevention’ and combination prevention efforts. Much more remains to be done to explore innovative new strategies to reduce HIV transmission and improve the management of HIV/AIDS. In a changing prevention landscape, it is critical that a broad collaborative approach is taken to ensure that health practitioners and service providers are aware of existing and new evidence on prevention technologies, and support their utilization and uptake within communities across the country.

Stigma and Discrimination

For people who belong to marginalized groups, the stigma they face as a result of HIV/AIDS may be compounded by homophobia, racism, classism, gender inequality and negative attitudes toward population groups, including people who use drugs and people working in the sex trade.

People living with HIV/AIDS who are part of a specific ethnic or cultural community - such as Aboriginal peoples and people from countries where HIV is endemic - often experience a layering of stigma and discrimination within their respective communities.⁸ This has implications for both PHA and for the community. People may become isolated, less willing to seek forms of prevention, diagnosis and treatment, and may be less willing to disclose their status to others. When this happens, the community is less able to prevent the spread of HIV/AIDS or to provide support for those who are ill, and people in the community who are at risk may be less willing to be tested⁹. Stigma affects access to treatment in prisons. Some prisoners may refuse treatment because they do not want other inmates to know they have HIV.¹⁰

Determinants of Health and Health Inequities

For many HIV-infected individuals there are a number of socio-economic conditions that threaten their health. Determinants of health - including income, housing, gender, social supports and education - play an integral part in the spread of HIV/AIDS. Determinants of ill health - such as poverty, homelessness, abuse, negative childhood experiences, and education and, in the case of Aboriginal peoples, colonization - can lead to powerlessness in relationships, self-esteem issues, a compromised sense of community, and influence decisions to access or seek health services (i.e. fear). Other health issues, such as substance dependence or mental illness, may also interfere with people’s judgment or ability to protect themselves.¹¹

To stop the spread of HIV/AIDS and to improve care, it is necessary to respond strategically and coordinate efforts to address both the individual and socio-economic determinants that put people at risk.

Growing Demand for Services

As of 2011, HIV incidence rates are relatively stable and the number of PHA is increasing as people with the disease are living longer. As a result, the demand for care, treatment and support services is growing. The ability and capacity to meet the growing demand is a challenge with respect to financial and other resources.

Organizations and jurisdictions report increasing problems attracting and retaining skilled workers, including staff for community-based agencies, volunteers, physicians and researchers. This is due in part to the availability and accessibility of resources, the increasing complexity of client needs, the challenge of working with marginalized populations, and non-competitive salaries offered by community-based AIDS service organizations compared to the health and social service sectors. Many organizations also serve clients with co-infections and co-morbidities, such as hepatitis C, which require specific expertise and more coordination with other service providers. Enhancing a strategic and coordinated use of expertise, resources and funds can serve to achieve common goals and meet the emerging demands.

Reducing Costs

The economic costs associated with HIV/AIDS continue to rise. In Canada in 2010, one study estimated a combined health care and labour productivity lifetime cost equivalent to \$ 920,000 per person living with HIV/AIDS, which can be extended to \$ 1.3 million if quality of life is included in the estimate.¹² Another study estimates direct lifetime care and treatment costs to be approximately \$750,000 per person living with HIV/AIDS.¹³ Treatment costs vary depending on where people live and where they are treated. For example, people living in rural or remote areas who must travel to receive care often incur significantly higher costs. While it is possible to calculate the direct treatment costs associated with HIV, the personal and social costs of each case of HIV - for the person infected, his or her friends and family, and society - are immeasurable.

Saving Lives

Recognizing that country contexts, health systems infrastructure and social supports differ, some higher income countries have recently undertaken more aggressive approaches as part of their national strategies which are demonstrating immediate results in reducing HIV infection (e.g. integrated prevention strategies in the United Kingdom and Australia). By monitoring and sharing promising practices used in Canada and in other countries, Canadian partners can use this information and enhance evidence-informed approaches applied in Canada.

By working together to step up health promotion, prevention, diagnosis, care, treatment and support programs, thousands of new infections can be prevented and years added to the lives of Canadians who

are living with HIV/AIDS. In turn, society will reap the enormous economic, social and personal benefits of their productivity and creativity.

Supporting Innovative Research

The number of scientific advances in the field of HIV/AIDS in recent years illustrates the significant impact new discoveries are having in addressing HIV/AIDS. In addition to the new prevention technologies, there have been major advances in new drugs to treat serious co-infections such as hepatitis C. Substantial progress has also been made in the design and testing of an HIV vaccine. For the first time, there is a 'Global Scientific Strategy Towards an HIV Cure'¹⁴ to collaborate and coordinate global research to discover either a sterilizing or functional cure for HIV, based on the critical threshold of new data that show it is biologically feasible. Much of the innovative research is performed by Canadian investigators in collaboration with the private sector and many international partners. For example, treatment as prevention is under study as an approach to reduce HIV transmission. Over the last year clinical trials have unequivocally proven the preventative effects of treatment in addition to well-known individual benefits (HPTN052 study¹⁵). Implementation science and research must now be brought to the forefront to ensure these results are effectively integrated into the HIV response and that ethical and human rights considerations are fully accounted for in the process.

The recognition of multiple ways of knowing and understanding the risks and impacts of HIV/AIDS is critical to research. Research methodology that utilizes the strengths of communities affected, a balance between biomedical, behavioural and operational sciences with lived-experiences and stories, will ensure that Canadian research paradigms are reflective and responsive to the complexity of the epidemic in Canada. Particularly for Aboriginal peoples, respect for traditional knowledge and community strengths are vital to understanding HIV/AIDS through a decolonized lens.

Strategic Directions for the Future

Everyone involved in the Canadian response to HIV/AIDS - governments, community organizations, health care providers, research organizations and individuals - is called upon to focus collective efforts on strategies to support the following four key goals:

1. Prevent the spread of HIV/AIDS through health promotion, behavioural and biomedical prevention and protection efforts.
2. Strengthen diagnosis, care, treatment and support services.
3. Build capacity to reduce health and social inequities.
4. Be an active leader in global efforts to fight the epidemic and find a cure.

In support of these goals, strategies and actions, success factors have been developed to guide future efforts. All the strategies are supported by critical success factors that, when woven together, support the

blueprint for a coordinated and strategic Canadian response to HIV/AIDS. These critical success factors include the development and implementation of strategies that are based on the following:

1. A commitment to social justice, respect for human rights and ‘determinants of health’ approach.
2. Leadership and innovation at all levels of government, by stakeholders and partners.
3. Greater and more meaningful participation of people living with or at risk of HIV.
4. Early interventions for diagnosis and treatment.
5. Research, evidence and surveillance to track and monitor HIV/AIDS and gain further knowledge.
6. A sustained response of long-term, comprehensive programs and services.
7. Population-specific approaches, prevention initiatives and targeted responses that respect culture and diversity, and that are age and gender appropriate.
8. A commitment to continuous quality improvement.
9. Support discovery and innovative research for new medicines and therapies.

Leading Together – Strategic Framework (Logic Model)

VISION: The end of the HIV/AIDS epidemic in Canada is in sight

- People living with or at risk of HIV are partners in shaping the response.
- Canada-wide access to high-quality effective services.
- Reduction / elimination of health inequities.
- Canada is a leader and steward in the fight against HIV/AIDS.

MISSION and VALUES

- Champion health needs and respect for human rights of all people living with or at risk of HIV/AIDS
- Work collaboratively to develop an effective response to HIV/AIDS in Canada and abroad.
- Act boldly and strategically to end the HIV/AIDS epidemic.

Social Justice

Human Rights

Diversity

Participation & Empowerment

Global Responsibility

Mutual Accountability

GOAL #1

Prevent HIV through health promotion, prevention and protection efforts

STRATEGIES:

- 1.1 Determinants of Health
- 1.2 Human Rights
- 1.3 Stigma & Discrimination
- 1.4 Monitoring & Evaluation
- 1.5 Population Based

GOAL #3

Build capacity to reduce health and social inequities.

STRATEGIES:

- 3.1 Involve People at risk or living with HIV/AIDS
- 3.2 Public Awareness
- 3.3 Political Leadership
- 3.4 Strengthen Community Organizations
- 3.5 Skilled Competent Health Care Providers
- 3.6 New Knowledge

GOAL #2

Strengthen diagnosis, care, treatment and support services.

STRATEGIES:

- 2.1 Treatment Effectiveness
- 2.2 Treatment Access
- 2.3 Determinants of Health
- 2.4 Long-Term, Hospice Palliative & End-of-Life Care
- 2.5 Quality of life and well-being

GOAL #4

Be an active player in global efforts to fight the epidemic and find a cure

STRATEGIES:

- 4.1 Increase Canadian Awareness & Action
- 4.2 Deliver on Commitments
- 4.3 Use lessons learned for the domestic response
- 4.4 Technical Assistance & Advice to Global Efforts
- 4.5 Global research efforts to end the epidemic

Goal #1: Prevent the Spread of HIV/AIDS in Canada through Health Promotion, Behavioural and Biomedical Prevention and Protection Efforts

Desired Outcomes

- New HIV infections are reduced.
- Jurisdictions take a harmonized approach to data collection, including standardized questions on the determinants of health, social well-being and quality of life, as well as HIV risks and status. This enables anticipation of emerging trends and guides health promotion and prevention efforts.
- All jurisdictions have access to timely information on people's social well-being and quality of life, their risks and HIV status to anticipate new trends and guide health promotion, prevention and protection efforts.
- Individuals and communities at risk have access to the education, income security, housing, social support and employment opportunities needed to maintain and improve their health and reduce their vulnerability to HIV infection.
- All jurisdictions have supportive policies and laws in place that promote health and reduce or eliminate the social and economic inequities that fuel the spread of HIV/AIDS.
- Members of communities most vulnerable to HIV infection have the knowledge, skills, supportive environments, programs and prevention technologies to help them protect themselves from the acquisition and/or transmission of HIV/AIDS, other sexually transmitted infections (STI) and blood-borne pathogens.
- Former and currently incarcerated individuals have access to effective education and prevention measures that aim to reduce the risk of acquiring HIV/AIDS in prison and through their reintegration into society.
- People living with HIV/AIDS are actively involved in health promotion efforts and lead positive prevention programs.

"HIV and AIDS is a very serious issue for our province. Our government is committed to supporting the strategy [Saskatchewan HIV Strategy 2010-2013] to reduce the number of new cases of HIV and improve the quality of life for those who are now diagnosed and living with HIV, but it's vital that we work collaboratively with First Nations and Métis and health and community based partners. This issue needs to be addressed on many levels."

Don McMorris, Saskatchewan Minister of Health, May 13, 2010 – launch of Saskatchewan HIV Strategy 2010-2013

Strategies and Rationale

HIV/AIDS is a preventable disease and its transmission can be stopped.

1.1 Determinants of Health Approach

In Canada, a social justice and 'determinants of health' approach to HIV/AIDS prevention is being undertaken to address the root causes of ill health and enhance people's overall health and well-being. Through thoughtful, informed, structured and sustained efforts, continued improvements and results in

addressing the determinants of health can be achieved. Poverty, homelessness, substance dependence, violence, mental illness, stigma, racism and discrimination, access to employment opportunities, powerlessness and choice, legal status (i.e. undocumented refugees) and access to social supports can create an environment in which HIV/AIDS and other illnesses may spread.

Public policies in many sectors, including education, housing, taxation, social services, justice, enforcement, immigration and income stabilization can have a direct and immediate impact on PHA and communities at risk. For example, shelter stability can provide a measure of safety and security and may be a factor in an individual's engagement in risk-related behaviours, such as negotiating sex and engaging in unsafe sexual practices to seek and secure a place to stay. Public and private investments in affordable housing can enhance people's ability to access safe, affordable and secure shelter. These investments also provide a means for people to find and keep shelter as well as improve their personal income, health and safety.

There is a growing body of research on the role of violence and trauma - particularly early in life - on HIV risk. For example, the Canadian Institutes of Health Research-funded Cedar Project in British Columbia shows the link between trauma and sexual abuse, problematic substance use and HIV risk in young Aboriginal people.¹⁶ Studies in the United States show that a history of trauma increases HIV risk for African American women.¹⁷

A community that is knowledgeable about the link among the determinants of health, health inequities, human rights and HIV is more likely to support social justice-based programs and services. People are more likely to support programs that distribute safer injection equipment when they understand that these programs help reduce infections and blood-borne pathogen transmission, strengthen social networks and link people who use drugs with primary care and substance use treatment services.

1.2 Respect for Human Rights Approach

Policies and laws that reinforce respect for and protection of human rights for people with or at risk of HIV/AIDS are found to be effective measures that improve health outcomes. Most of the social factors that affect people's health, such as housing, access to health services, safety, income, employment and the right to live free of violence and discrimination, are considered from a human rights perspective.¹⁸

The challenge for the public health sector is balancing the rights of the individual with the protection of public health. A comprehensive public health approach (i.e. testing, counselling, partner notification, encouraging people to disclose, and providing support and referrals to services) takes into account the underlying risk factors and conditions that may affect people's ability to disclose their status while reinforcing individual responsibility to protect the health of others.¹⁹

1.3 Stop Stigma and Discrimination

Stigma and discrimination create barriers to assessment, diagnosis, treatment and care. Research has reinforced the impact of stigma and discrimination on people with or at risk of HIV/AIDS - many of

whom are already marginalized because of their sexual orientation, race, gender, substance use, criminal record, record of imprisonment or involvement in the sex trade. In one study, gay men living with HIV reported experiencing discrimination within the gay community and a sense of being judged by other gay men for having HIV. This stigma was associated with anxiety, loneliness and depression. It also has implications for HIV transmission; gay men living with HIV who felt most stigmatized within their community were more likely to seek partners in settings that facilitate anonymous sex.²⁰

In older adults with or at risk of HIV/AIDS, stigma has a negative effect on their willingness to be tested, to disclose their HIV status, to seek health services and their sense of social support.²¹ This same pattern is seen in PHA in African and Caribbean communities in Toronto. Because of stigma, they fail to seek out services and often delay accessing treatment once they are diagnosed.²² HIV-positive mothers in the United States who perceive greater stigma report higher levels of depression, anxiety, and physical symptoms as well as more alcohol use.²³

In the June 2001 *Declaration of Commitment on HIV/AIDS*²⁴ and the June 2011 *Political Declaration of Commitment on HIV/AIDS*²⁵, all the member states of the United Nations General Assembly, including Canada, made a commitment to develop national plans to confront stigma and to take other measures to eliminate all forms of discrimination and protect human rights. Addressing stigma and discrimination in the general population and in the communities most affected by HIV are essential to reduce the spread and impact of HIV.

1.4 Monitor and Track the Epidemic

Surveillance is essential in order to understand Canada's epidemic, identify new trends and develop effective prevention and care programs. Provinces and territories collect surveillance data on HIV/AIDS in their jurisdiction, including the number of people being tested, test results, risk factors for infections, AIDS reports and AIDS deaths. They share their data with the Public Health Agency of Canada (PHAC), which manages the national surveillance program and issues epidemiological and surveillance reports.

PHAC helps characterize and understand the HIV epidemic in Canada, and, in collaboration with provincial/territorial and local public health practitioners and community-based organizations, develops and implements enhanced biological and behavioural surveillance studies, and provides technical assistance to jurisdictions conducting targeted studies. Federal departments and agencies such as the Correctional Service of Canada also have ongoing surveillance programs and share data with PHAC and federal partners as contributing evidence to inform policy and program interventions.

1.5 Population-Based Approach

Although anyone can become infected with HIV/AIDS, certain populations are more vulnerable. Canada has taken a population-based approach, focusing on populations living with and at risk of HIV/AIDS. A targeted population-based approach considers the specific factors that place people at risk.

It is important that communities and individuals have targeted cultural, gender-sensitive and age-appropriate prevention education, treatment, care and support programs. They also benefit from social and structural interventions, such as accessible, safe and affordable housing, employment, access to programs that address poverty and prevention technologies.

1.5.1 Gay, Bisexual, Two-Spirit and other Men Who Have Sex with Men

Gay, bisexual, two-spirit and other men who have sex with men continue to be the group most affected by HIV/AIDS in Canada. In 2011, they accounted for 48.3% of new HIV infections nationwide and 46.7% of PHA.²⁶

A range of individual and structural factors appear to put gay and other men who have sex with men at greater risk of HIV infection. This population's experience of homophobia, related stigma and discrimination has a significant and overarching impact on its determinants of health and influences the population's vulnerability to HIV. Canadian and international research reveals an interplay between societal homophobia and other mutually reinforcing structural risk factors within this population - described as 'syndemics' - which together drive the HIV/AIDS epidemic among gay and other men who have sex with men.²⁷ Risk factors include childhood experiences of homophobic bullying and sexual abuse; stigma and discrimination; a lack of social support; and anti-gay harassment and violence. These factors influence the likelihood of individuals engaging in problematic substance use, experiencing poor mental health outcomes, and engaging in unprotected sex, thus increasing exposure to and risk of infection.

At the individual level, while many gay and other men who have sex with men practice safer sex consistently, unprotected sex is associated with: the unavailability of or difficulty in using condoms; trust and relationship issues; momentary lapses; stressful events such as job loss or loss of a partner; and assumptions about the HIV status of partners based on situational factors.

The complex factors that affect risk for gay and other men who have sex with men argue for targeted HIV prevention strategies that take into account the overarching impact of homophobia and address the unique needs and realities of sub-populations such as trans men who have sex with men, ethno-cultural minority and Aboriginal men. Interventions should also seek to better understand and build on sources of resiliency for this population, such as safe and supportive social contexts; access to social support networks including friends, romantic partners, family and the broader gay community; and the resiliency demonstrated by the gay community's early and effective response to HIV/AIDS.²⁸

1.5.2 People Who Inject Drugs

Injection drug use was responsible for approximately 17% of new HIV infections in 2011, down from 33% in the mid-1990s. While the number of new HIV infections related to injection drug use has dropped since the 1990s, this population remains highly vulnerable. HIV infections related to injection drug use are occurring in large urban cities, smaller towns and rural communities and are affecting a growing number of Aboriginal people, especially women.²⁹

People who inject drugs are at higher risk of a range of health problems associated with substance use, including overdoses and injection related infections (e.g. skin, bone and heart). If they share needles, they

are also at high risk of acquisition and transmission of communicable diseases, such as HIV, hepatitis C and other blood-borne infections. As a result, a growing number of people who inject drugs are co-infected with HIV and hepatitis C. People who inject drugs or smoke crack cocaine are at higher risk of HIV/AIDS.³⁰

Reducing and preventing the harms associated with problematic substance use requires a comprehensive, evidence-informed public health approach that uses all available tools, such as health promotion, education, illness prevention, surveillance, testing, screening, treatment and - in some circumstances - enforcement. The stigma associated with both drug use and HIV infection can reduce access to health services and social supports among people who use drugs.³¹ In some jurisdictions, interventions have included programs and services designed to reduce the sharing of needles and other drug equipment, to create safer environments, reduce risky behaviours and connect people to health and social services such as treatment programs.

From a public health perspective, harm reduction is part of a comprehensive approach to addressing drug use that includes a range of options. Provinces and territories have developed a range of harm reduction and treatment programs for people who use drugs, including outreach services, needle distribution and recovery programs, methadone maintenance and other substitution therapy, supervised injection sites and treatment services. The province of Saskatchewan includes harm reduction in its provincial HIV/AIDS strategy. The province of British Columbia and the city of Vancouver support a supervised injection site. Many municipalities in Canada have needle distribution, recovery, and/or exchange programs. All provinces and territories have methadone maintenance treatment for people who use opioids. Correctional Service of Canada provides Opiate Substitution Therapy (methadone and suboxone) in federal correctional facilities.

Prevention programs are reportedly more effective when combined with other health and social services, such as outreach programs, non-judgmental primary care, access to stable housing and food, substance dependence and withdrawal management programs in collaboration with law enforcement and the justice system – as well as efforts to help people who use drugs (peers) to organize support groups.³²

There is growing evidence that prevention programs lead to improved access to other health and substance dependence treatment services.³³ Given the strong link between depression and substance dependence, better access to mental health services may help reduce problematic substance use, the risk of HIV, hepatitis C and other associated health and social problems. Improved pain management can reduce the non-medical use of substances for pain. Effective HIV prevention programs for people who inject drugs need to address the risks associated with unprotected sex and needle sharing. The sexual partners of people who inject drugs are at high risk of HIV, even if they do not use the injection drugs themselves.

1.5.3 Aboriginal People

Distinct recognition of, and responses to, the progressive and complex HIV epidemic among Aboriginal Peoples in Canada is of critical importance. *Leading Together 2005-2010* raised concern about the

potential for HIV to spread among Aboriginal people. Over the last few years, cases of HIV in Aboriginal communities have increased. In 2011, 32.7% of new HIV diagnoses in provinces/territories that collect race/ethnicity data were among Aboriginal people (up from 22.2% in 2003) - despite the fact that Aboriginal people make up only 6.9% of the population in these provinces/territories. In 2011, the rate of new infections among Aboriginal peoples was estimated to be 3.5 times higher than among non-Aboriginal people in Canada.³⁴

The HIV epidemic is different in Canada's Aboriginal population - a disproportionate number of Aboriginal women and youth are affected compared to the general population:

- Between 1998 and 2008, 48.8% of Aboriginal people who tested HIV positive were women, compared with 20.6% in the general population.
- Over that same period, 33.5% of reported Aboriginal HIV diagnoses were in young people: 5.6% among young people under the age of 20 and 27.9% among those between 20 and 29. These rates are much higher than the 1.6% and 19.6% for the same age groups in the non-Aboriginal population.
- Aboriginal women who are HIV positive tend to be infected at a younger age and are more likely to be diagnosed with AIDS.
- In 2008, 63.6% of HIV diagnoses in Aboriginal people were attributed to injection drug use, compared to only 11.3% among non-Aboriginal Canadians.³⁵

Access to testing and treatment is key for Aboriginal Peoples. While vertical HIV infections (i.e. mother-to-child transmission) have been dramatically reduced in the general population, Aboriginal infants remain disproportionately affected. From 2004 through 2011, 17 Aboriginal infants were confirmed infected with HIV via mother-to-child transmission.³⁶ This may reflect a lack of appropriate access to health care for some Aboriginal women, such as specialized pre-natal care and access to antiretroviral therapy for prevention of vertical transmission.

Approaches to HIV prevention, care, treatment, support, research and related policy frameworks must consider the legacy of intergenerational trauma and abuse to the concentrated HIV epidemic among Aboriginal peoples. Issues are compounded by poverty, addictions, incarceration, racism, discrimination, loss of culture, mobility (on and off reserve and from rural to urban areas), and related determinants of health. Aboriginal people are highly vulnerable to many health problems, including HIV. Mental health is a key factor in healthy decision making, influencing spiritual, physical, emotional and social connections. These factors have implications for individuals, families and communities. Within Aboriginal communities, HIV prevention initiatives need to address related underlying health and social issues. They also need to be led by Aboriginal Peoples and grounded in Aboriginal culture, healing and the intertwining of body, mind and spirit.

The *Aboriginal Strategy on HIV/AIDS in Canada II* states, “The creation of a common ground for Aboriginal Peoples to develop our own ways to take control of this disease remains fundamental... Seeking out ideas for working together across our differences and our territories continues to be our greatest hope for reaching the end of this epidemic”.³⁷

In 2007, the United Nations adopted the *Declaration on the Rights of Indigenous Peoples*³⁸, which sets out the individual and collective rights of indigenous peoples, including rights to culture, identity, language, employment, health and education. It “emphasizes the rights of indigenous peoples to maintain and strengthen their own institutions, cultures and traditions and to pursue their development in keeping with their own needs and aspirations”. It prohibits discrimination and promotes their full and effective participation in all matters that concern them and their right to remain distinct and to pursue their own visions of economic and social development. Canada endorsed this declaration on November 12, 2010.

The determinants of health affect the resilience and ability of individuals, families and communities to make healthy choices. In the Aboriginal context, it is also essential to include awareness of the Aboriginal reality when designing interventions. The ongoing legacy of colonization, devastation of the residential school system, removal of children to foster care, silencing of the Aboriginal voice, loss of traditional roles and enduring racism all impact the present health and well-being of Aboriginal peoples.

Aboriginal Strategy on HIV/AIDS in Canada II for First Nations, Inuit and Métis Peoples from 2009 to 2014

1.5.4 African, Caribbean and Black Populations living in Canada

In much of Africa and many countries in the Caribbean, the prevalence of HIV is high.³⁹ HIV is not just a crisis for people from these regions living in countries where HIV is endemic - it is also a serious health concern for people from Africa and the Caribbean who settle in other parts of the world. Over the past 40 years a growing number of people have immigrated to Canada from Africa and the Caribbean. In Canada over 90% have settled in Ontario and Quebec, but more are now making their home in Atlantic Canada and in the Prairies.

According to the 2006 Census, only 2.2% of the Canadian population were born in a country where HIV is endemic. However, in 2011, an estimated 16.9% of new HIV infections in Canada were attributed to heterosexual transmission among individuals from these countries. In 2011, the estimated incidence rate among people from countries where HIV is endemic was about 9 times higher than among other Canadians.⁴⁰

The risk is not limited to recent immigrants, nor is it fully captured in the number of cases attributed to heterosexual transmission or endemic risk factors:

- In Ontario, an estimated 30% to 45% of new infections among African, Caribbean and Black Canadians occurred in Canada.
- Between 1980 and 2004, 21% of positive HIV test results in the Black population in Toronto were attributed to the men who have sex with men, 1% to the men who have sex with men/people who inject drugs, almost 2% to people who inject drugs and 20% to high or low risk heterosexual activities.

A range of social factors affect HIV prevention, access to health care and related services among African, Caribbean and Black populations. These include the stigma associated with HIV within their communities; access to social supports; experience of racism and discrimination in the larger society; the challenges associated with immigration (e.g. settlement issues, poverty, financial security or dependence, access to affordable housing); cultural attitudes and practices (e.g. gender norms, views and access to information on sex or sexuality, unsafe male circumcision, female genital mutilation); and barriers accessing health services (e.g. culturally sensitive services) and comprehensive, coordinated and targeted prevention efforts.

1.5.5 People from Other Ethno-cultural Groups

Although some jurisdictions in Canada do not collect data on the race and/or ethnicity of people testing positive for HIV, those that do report a substantial percentage of infections among racial groups other than Aboriginal peoples, Black and Caucasian. In 2011, 13% of new diagnoses were in people from other ethnic groups, including Asian, Latin American, South Asian/West Asian/Arab, and 'other'.⁴¹

Like African, Caribbean and Black communities, other ethno-racial groups in Canada face a range of social issues that can affect their health and risk of acquiring HIV. These include access to social supports; HIV stigma within their communities; experience of racism and discrimination in the larger society; challenges associated with immigration (e.g. settlement issues, poverty, financial dependence, access to affordable housing); language barriers; cultural attitudes (e.g. views and access to information on sex or sexuality); barriers accessing health services (e.g. culturally sensitive services), and comprehensive, coordinated and targeted prevention efforts.

1.5.6 People in Prison

In 2008, 58% of people newly admitted to a federal correctional facility had a voluntary blood test to screen for HIV. At year-end in 2008, about 1.72% of the federal prison population were known to be living with HIV, a rate significantly higher than that in the Canadian population as a whole (0.2%). Studies in provincial prisons have also shown that HIV seroprevalence rates in prisoners are at least 10 times higher than in the general population.⁴²

High rates of HIV infection in the prison population are due to a history of high-risk behaviours, including injection drug use and work in the sex trade. The majority (91%) of new admissions positive for HIV on admission were already aware of their status; however screening inmates on admission is also invaluable as nearly three newly diagnosed infections are detected for every 1,000 HIV screening tests conducted. Overall, the prevalence of HIV infection in federal prisons remained stable between 2000 (1.70%) and 2008 (1.72%). Of the known HIV positive federal inmates, on average, 64.4% were receiving treatment with HAART.

In the 2007 Correctional Service of Canada (CSC) National Inmate Infectious Diseases and Risk-Behaviours Survey, 4.5% of male inmates and 7.9% of female inmates self-reported having ever tested

positive for HIV. However, methodological differences make it difficult to compare the cross-sectional, self-reported data with health services data based on laboratory results.

Individuals in groups disproportionately affected by HIV (e.g., Aboriginal peoples, people who use injection drugs, racial/ethnic minorities) are overrepresented in prisons because the social, structural, economic and behavioural factors that contribute to HIV are also associated with increased likelihood of incarceration. While this sheds partial light on why prison populations have a high prevalence of HIV, research suggests that the prison environment itself may also lead to increased risk of infection while in prison through structural conditions, behaviours and attitudes that may be detrimental to health (e.g., drug use, tattooing, body piercing, violence, unequal power relations, stigma, decreased feeling of autonomy, lack of social support).

"By entering prisons, prisoners are condemned to imprisonment for their crimes; they should not be condemned to HIV and AIDS. There is no doubt that governments have a moral and legal responsibility to prevent the spread of HIV among prisoners and prison staff and to care for those infected. They also have a responsibility to prevent the spread of HIV among communities. Prisoners are the community. They come from the community, they return to it. Protection of prisoners is protection of our communities."

United Nations Commission on Human Rights

Most prison systems in Canada have taken steps to reduce the risk of HIV transmission by providing education, safer sex supplies (condoms, dental dams, and lubricants), bleach for cleaning tattooing, piercing and injecting equipment, Opiate Substitution Therapy and Substance Abuse Programs (i.e. methadone, suboxone), and anti-retroviral treatment for people living with HIV. CSC developed a *Public Health Strategy for Offenders in CSC in 2010*⁴³ which includes: prevention, control, and treatment support; health education and awareness programs; surveillance and epidemiology; and partnerships. The *Strategy* also includes a focus on Aboriginal and women populations. Some prisons have also incorporated programs based on sources of resiliency for this population including: access to social support networks such as family, elders or cultural leaders, and peer support groups; access to higher education; employment training and development of employability skills; creating more supportive environments based on dignity and respect; and access to mental health services. However, previous investigations have reported gaps in preventative services for specific prison populations, and gaps between policy and practice.⁴⁴

1.5.7 Women

Nearly one quarter (23.3%) of positive HIV test reports in 2011 were among women (females aged 15 years and older) - up from less than 10% in 1995. The majority of women diagnosed with HIV in Canada are of African, Caribbean or Aboriginal origins, and most acquired HIV through injecting drugs (29.9% in 2011) or heterosexual contact with a high-risk partner⁴⁵ (24.3% in 2011). Many have a history of trauma or violence.⁴⁶

The increasing rate of HIV infection in women in comparison to men reflects a gender-based differential. The evidence showed that heterosexual women are biologically, economically, socially and culturally more vulnerable to HIV infection than heterosexual men.⁴⁷ Poverty—a key social determinant of health—

often leads to situations where women trade sex for survival. Economic dependence limits women's ability to leave dangerous relationships or negotiate safer sex with their partners. Domestic and sexual violence, abuse and coercion affect women's ability to protect themselves.

Lesbian, bisexual, queer and transgender (LBQT) women have, since the early days of the HIV epidemic, been largely absent from the HIV prevention discourse in Canada. Further, LBQT women who are living with HIV are often marginalized from the development and implementation of HIV services and as such, as less likely to come forward to access HIV services despite their HIV risks and vulnerabilities.^{48,49}

Women who are most at risk and marginalized may not have the knowledge, economic resources or power within their relationships to ensure their partners use condoms or practise safer sex. They need information and social support, as well as access to prevention tools they can control themselves, such as microbicides and preventive vaccines. Because of the stigma associated with HIV, some women do not use traditional HIV services. Instead, they seek services from other organizations, such as their doctor or other health services, shelters, domestic violence programs, settlement services and other organizations that serve women but do not necessarily have expertise in HIV/AIDS-related services.

1.5.8 Youth

Some populations of youth in Canada are at high risk of HIV infection, including street-involved youth, transient youth, youth who inject drugs, gay youth and Aboriginal youth. For example, a 2007 study involving British Columbia youth who used drugs found an HIV prevalence rate of 8%.⁵⁰ In 2008, the majority of positive HIV test reports among youth were attributed to the men who have sex with men category. Also in 2008, 40.9% of all HIV case reports including race/ethnicity information among youth were among those who identified as Aboriginal.⁵¹ Growing evidence shows that young people who experience bullying and violence early in life are more vulnerable to STI and substance dependence later in life due to self-esteem and risk-taking behaviours. Programs for Aboriginal youth are particularly encouraged as the Aboriginal population is much younger than the general population in Canada.⁵²

To prevent the spread of HIV, other STIs, and blood-borne infections, all prevention programs targeting at-risk communities need to include age-appropriate information and peer-led initiatives for youth. These programs are stronger when they involve organizations and agencies that serve marginalized or transient youth. HIV prevention messages and skills are most effective when they are positioned with larger health and social support programs for youth.

1.5.9 Infants born to Women Living with HIV

Canada has made significant progress in reducing the number of infants born with HIV. In 2001, for example, a total of 168 infants were prenatally exposed to HIV; 17 (or 10.1%) of these were confirmed to be infected. In 2008, by contrast, 4 out of a total of 238 exposed infants (1.7) were confirmed infected.⁵³ Canada has effective prevention strategies, including prenatal testing, use of antiretroviral therapy during pregnancy and Caesarean sections. However the greatest risk remains for babies whose mothers do not

receive prenatal care - therefore do not have access to prenatal HIV testing or services to improve their health and protect the health of their unborn children.

HIV infections are rising among Aboriginal women, women from countries where HIV is endemic, and women who inject drugs. Special efforts are required to ensure access to prenatal care and culturally appropriate information on the benefits of HIV testing during pregnancy. As with all HIV testing, providers are ethically and legally required to ensure that pregnant women give informed consent.⁵⁴ Providing attention to the health needs of HIV-infected fathers and others who raise children will support successful parenting, improve the quality of family life, and benefit the overall health and well-being of children.

1.5.10 People Living with HIV/AIDS

An estimated 3,175 Canadians were newly infected with HIV in 2011. An estimated 71,000 people were living with HIV/AIDS (PHA) in Canada at the end of 2011. PHA in Canada are a diverse group: key populations affected are gay men and other men who have sex with men, people who use injection drugs, people from HIV-endemic countries, Aboriginal people, people in prison, youth at-risk and women.⁵⁵

The life paths and experiences of PHA prior to and after HIV infection are unique and varied; however, they are all influenced by determinants of health. Determinants such as gender, social environments and access to health services play a strong role in influencing vulnerability to HIV infection, quality of life, treatment adherence and outcomes, and mortality. The diversity of PHA in Canada means that different populations face different challenges. For some, these may include linguistic and cultural barriers to accessing health care and support services. For others, there may be challenges in addressing addiction or unstable housing.

Although treatment is widely available to PHA who need it, a range of socio-economic factors affect access and adherence to treatment, as well as the health of PHA. Lower socio-economic status is associated with delays in seeking treatment and increased mortality amongst those accessing treatment.

Many PHA live in poverty prior to infection, and the health challenges of living with HIV can also mean that people leave or reduce their paid employment. Although income support and coverage for antiretroviral medications are available for those in need, many PHA struggle to pay for complementary medications and therapies, as well as nutritious foods.

Many PHA experience HIV as an episodic disability where health can be interrupted by unpredictable periods of ill health and disability. The uncertainty and periods of ill health can mean that PHA leave the workforce or reduce their productive hours. Canadian research on PHA and employment emphasizes the positive benefits of work for PHA - independence, empowerment, engagement with others, self-worth and daily structure. Employment status is strongly associated with improved quality of life for PHA.

Stigma and discrimination continue to affect aspects of PHA's lives, from their relationships with intimate partners, family and friends, to their community, their workplace and society at large. For many, this stigma is compounded by other forms of discrimination including racism, sexism and homophobia.

Community engagement and support have been a central part of the response to HIV/AIDS in Canada and continue to be key sources of resilience for PHA. Community organizations and governments across Canada are involved in providing treatment, care, support and services to PHA, and work on prevention, education, and countering stigma and discrimination.

People who know they have HIV play a critical role in HIV prevention. Positive prevention initiatives, based on the principles of health promotion, actively promote the physical, mental, spiritual and sexual health of PHA. They empower PHA by ensuring they receive appropriate treatment, care and support in dealing with complex psychosocial issues (e.g. depression, denial, rejection, isolation, grief and loss), as well as other services that enhance health (e.g. adequate nutrition and housing). They help deal with issues of HIV status disclosure and the practice of safer sex and safer substance use. Positive prevention also serves to promote healthy relationships between sexual partners.

The trend to focus more on positive prevention is driven by the desire of PHA to prevent transmission and protect themselves from re-infection and from other STI that could threaten their health and increase the risk of HIV transmission.

1.5.11 The Need for Increased HIV Testing

HIV is often a slow-acting virus. People can be infected for many years and not know it. It is estimated that as many as 25% of Canadians who had HIV did not know they were infected at the end of 2011.⁵⁶ PHA are most infectious when they are first infected and then later in the course of the disease, when their viral load is high and their immune system weakens.

One of the most effective ways to stop HIV transmission is to ensure that people who are infected know their HIV status. People who are diagnosed early and offered appropriate treatment and support live longer in better health than those diagnosed later in the course of HIV disease. They are also better able to prevent HIV transmission. When voluntary HIV testing is accompanied by pre- and post-test discussion and informed consent, it is both an effective early intervention (i.e., linking people who are infected with care) and an effective prevention strategy (i.e., providing those engaging in risky behaviours with information and support for behaviour change and possible treatment, reducing the risk of HIV to others).

A range of barriers to testing may include the following: access to and knowledge of the benefits of testing, treatment and culturally sensitive services; a misperception of their risk of HIV infection; stigma associated with HIV/AIDS and other STI; perceived implications related to disclosing HIV status⁵⁷ where some may feel it is safer not to know their HIV status. Despite these barriers, promoting regular voluntary testing in communities with high rates of HIV infection (i.e., gay men, people who inject drugs, Aboriginal peoples and people from countries where HIV is endemic) is an effective way to detect infection and link people to treatment and prevention programs. Evidence is emerging as to the cost-effectiveness of including HIV testing as part of an individual's routine medical care. Routine testing could reduce the number of people unaware of their HIV infection status which was estimated to be 25% (14,500 - 21,500) of Canadians living with HIV in 2011.⁵⁸

Goal #1: Prevent the Spread of HIV/AIDS in Canada through Health Promotion, Behavioural and Biomedical Prevention and Protection Efforts

<i>Strategies</i>	<i>Actions to be Taken</i>
1.1 Determinants of Health Approach	<ul style="list-style-type: none">• Continue to raise awareness of the underlying social factors that contribute to the spread of HIV/AIDS, such as income, housing and gender• Develop municipal, provincial/territorial and federal housing policies, programs and services that give more people with or at risk of HIV/AIDS access to stable, appropriate and affordable housing• Develop social assistance policies and programs that give people with or at risk of HIV/AIDS greater income security• Create more employment opportunities for people living with long-term debilitating illnesses• Improve food security for people living with and at risk of HIV/AIDS• Create programs that will reduce violence and other social inequities (e.g., anti-bullying programs, mental health promotion programs, domestic violence initiatives, and programs designed to reduce physical and sexual abuse)• Survey people living with and at risk of HIV/AIDS to assess their access to income, housing, employment, social support, health services and other determinants of health
1.2 Human Rights Approach	<ul style="list-style-type: none">• Continue public dialogue about the legal aspects of HIV/AIDS exposure and transmission• Enforce legislation, policies and other measures designed to protect the rights of PHA, and use other measures, including communication and education, to make the public aware of human rights issues• Provide access to legal assistance for people living with or at risk of HIV/AIDS who are dealing with discrimination or other human rights violations• Identify and address any laws, policies and practices that create barriers to people accessing HIV health promotion, illness prevention, diagnosis, care, treatment and support services• Develop prosecutorial guidelines to help guide the legal system (i.e. enforcement officers, judicial prosecutors) to make informed decisions when considering charges for alleged non-disclosure of HIV, to inform the application of the criminal law and to provide guidelines to assist people living with HIV to make informed decisions on HIV disclosure
1.3 Stop Stigma and Discrimination	<ul style="list-style-type: none">• Implement communication/education initiatives, including age-appropriate education programs for children and youth, designed to fight all types of discrimination (e.g. racism, homophobia, sexism), violence and abuse• Implement education programs designed to reinforce that problematic substance use is a health issue and make the general public more supportive of health programs and services for people who are substance dependent• Enhance capacity at all levels – local, community, provincial/territorial and federal - to respond immediately and effectively to discrimination• Create an environment within gay communities, Aboriginal communities and ethno-cultural and ethno-racial communities that affirms members living with HIV/AIDS and their place in the community

- Enhance the use of data collection tools, such as surveys targeted to people living with and at risk of HIV/AIDS about their experience with stigma and discrimination to guide anti-stigma and discrimination efforts
- Continue to advocate for a public health approach to HIV disclosure
- Redouble efforts to understand the structural factors that lead to stigma and discrimination

1.4 Monitor and Track the Epidemic

- Continue to improve the quality and consistency of HIV data collected in all jurisdictions
- Enhance the capacity within existing HIV surveillance systems to analyze data and provide timely information and reports to guide prevention programs
- Maintain and expand geographic coverage of existing second-generation surveillance systems, and continue to develop and implement second generation surveillance focussed on Aboriginal peoples, and people from HIV-endemic countries
- Conduct research on and evaluate effective prevention strategies for communities vulnerable to HIV/AIDS, and use the findings to inform prevention programs
- Increase surveillance work on HIV/AIDS and multi-drug resistant tuberculosis, and on non-infectious co-morbidities (e.g., cardiovascular health, diabetes)

1.5.1 Population-Based Approach - Men who have sex with men

- Expand geographic coverage of the M-Track surveillance system to obtain pan-Canadian monitoring data on HIV prevalence and associated risk factors
- Implement comprehensive prevention programs that:
 - are peer-planned and led (greater and meaningful involvement) by PHA
 - are evidence-informed
 - increase resilience
 - address the complex factors that increase risk
 - address the barriers/problems men who have sex with men face in using condoms
 - provide the education and support that can help gay men protect themselves
 - build support for PHA within the gay community
 - address and reduce homophobia and create safe, supportive communities
 - are integrated into broader health promotion and health/well-being initiatives for gay men, beginning at a young age

1.5.2 Population-Based Approach - People who Inject Drugs

- Involve people who inject drugs in meaningful ways in planning and implementing HIV prevention, treatment care and support programs
- Provide effective peer-led outreach to the substance dependent community
- Continue to develop and provide comprehensive, person-centred health and social services for people who use substances, including primary care, housing, food, income security, mental health services, and withdrawal management treatment programs (including long-term residential withdrawal management treatment)
- Maintain and expand effective, evidence-informed prevention, substitution therapy and treatment programs
- Address the mental health and trauma issues that can lead to problematic substance use
- Develop effective evidence-informed prevention initiatives for people who use crack cocaine
- Ensure that people receive appropriate pain management services to help reduce the non-medical use of substances
- Develop prevention programs specifically targeted to Aboriginal peoples and women who inject drugs or have partners who inject drugs

- Develop prevention interventions specifically for people whose partner(s) inject drugs
- Continue to expand geographic coverage of the I-Track surveillance system to obtain pan-Canadian monitoring data on HIV prevalence, HCV exposure, and associated risk factors

**1.5.3 Population-Based Approach
- Aboriginal Peoples**

- Implement comprehensive, peer-led, culturally appropriate prevention and treatment/support programs that:
 - support principles of self-determination
 - reflect the diversity in Aboriginal communities
 - recognize the role of family and community networks
 - enlist the active support of Aboriginal leaders
 - integrate HIV prevention into broader Aboriginal-delivered health and wellness programs that address mental health issues, problematic substance use, inter-generational trauma, domestic violence and unemployment
 - reinforce the Aboriginal view of the interrelationships among body, mind, heart and spirit
 - focus on the unique needs of youth, women, families, two-spirit men and women
 - are age and gender specific
 - increase the number of trained Aboriginal health care providers and educators
 - reduce HIV stigma within the Aboriginal community, and build support for people who are infected
 - evaluate and share culturally relevant evidence-informed interventions
- In collaboration with provincial/territorial/local public health authorities and local Aboriginal-led community-based organizations, pilot and implement the A-Track surveillance system at select sentinel sites
- Invest in research on the HIV-related needs of Aboriginal peoples and effective interventions to enhance understanding of the impact of stigma, depression, substance use and sexual violence to inform culturally appropriate programs

**1.5.4 Population-Based Approach
- People from Sub-Saharan Africa and the Caribbean living in Canada**

- Continue to develop comprehensive peer-led programs for people from HIV-endemic countries that:
 - provide culturally appropriate prevention guidelines, information and education programs that address the issues that contribute to the spread of HIV/AIDS, including long-term discordant heterosexual partnerships, reproduction, testing, disclosure and partner notification issues, immigration issues
 - address the impact of racism and other discrimination on this population's response to HIV/AIDS
 - enhance access to HIV information and services and access to employment and housing
 - address the complex issues of women in these communities (e.g. gender inequality, violence, isolation, physiological differences in HIV treatment)
 - address the issues of black men who have sex with men
 - reduce HIV stigma in the community, which isolates people who are infected, and build support for PHA
- Continue to develop and implement second-generation surveillance studies in this key population in Ontario and Quebec.

1.5.5 Population-Based Approach

- Improve the collection and reporting of data on race, ethnicity and country of

- *People from Other Ethno-cultural Groups*
 - origin in testing and other surveillance programs
 - Work with ethno-cultural communities to develop culturally appropriate prevention strategies
 - Address stigma and discrimination within these communities

- 1.5.6 Population-Based Approach**
- *People in Prison*
 - Provide age, gender and culturally appropriate prevention and treatment services for inmates including:
 - Information and ongoing education to help prevent the spread of HIV/AIDS, other STIs and blood-borne infections, and to provide access to tools that would prevent the spread of infections (e.g. condoms, dental dams, etc.) equivalent to those available in the community.
 - Peer education, counseling and support programs
 - HIV, STI and hepatitis C testing.
 - Treatment and support programs for HIV, hepatitis C, other STI and blood-borne infections and support to encourage treatment adherence.
 - Opioid substitution therapy for people on methadone and Suboxone when they enter the facility and those who want to begin treatment while incarcerated
 - Mental health and substance dependence treatment services
 - Targeted programs for women, youth, men who have sex with men, gender variant and transgendered persons and Aboriginal people in prisons and other correctional facilities
 - Support for safer sex in private family visitation programs
 - Effective discharge planning and links to prevention and support programs in the community

- 1.5.7 Population-Based Approach**
- *Women*
 - Implement comprehensive prevention initiatives that meet the diverse needs of Aboriginal women, African and Caribbean women living in Canada, women in other ethno-racial groups affected by HIV/AIDS, women who inject drugs and other at-risk women.
 - Develop targeted prevention initiatives for women working in the sex trade. Support initiatives designed to enhance women’s ability to reduce their risk (e.g., development of microbicides, anti-violence programs, women’s shelters, substance dependence treatment programs for women)
 - Develop prevention and support programs to meet the specific needs of women and children
 - Engage men in the development and implementation of innovative approaches to change harmful social and cultural practices and norms, as part of HIV prevention

- 1.5.8 Population-Based Approach**
- *Youth*
 - Implement peer-led, age-appropriate prevention initiatives for all youth—and ensure youth are full participants in planning, implementing and evaluating prevention initiatives
 - Develop culturally and age-appropriate sexual health interventions and integrate them into health programs for youth
 - Work with ministries of education, school boards and schools to develop age-appropriate sex education programs, as well as programs that help children develop the skills and self-esteem to make informed decisions
 - Design programs targeted to meet the needs of at-risk youth, including gay youth, Aboriginal youth and street-involved youth

- 1.5.9 Population-Based Approach**
 - Develop community-based education and support programs to reach high-risk mothers and ensure they receive pre- and post-natal care

- Infants Born to Women Living with HIV

- Reinforce the importance of prenatal testing programs for both parents
- Develop programs and supports for children and youth living with HIV
- Maintain continued health of parents and caregivers responsible for children's health and well-being

***1.5.10 Population-Based Approach
– People Living with HIV who Do Not Know they are Infected***

- Continue to promote prenatal testing and prenatal care for all pregnant women and their partners
- Develop targeted, culture/gender-sensitive and age-appropriate strategies to encourage more people at high risk to be tested
- Identify and eliminate barriers to HIV testing among people at risk
- Reduce stigma and discrimination
- Make testing more accessible (e.g., anonymous, routine, point-of-care)
- Normalize testing so it becomes part of the yearly physical exam or assessment

***1.5.11 Population-Based Approach
– People Living with HIV who Know they are Infected***

- Continue to implement PHA-led positive prevention programs designed to help PHA manage the challenges of leading healthy sexual lives with an infectious disease
- Develop support programs for children and youth living with HIV/AIDS and their families

Goal #2: Strengthen Diagnosis, Care, Treatment and Support Services for those living in Canada

Desired Outcomes

Treatment for HIV and HIV-related illness or co-infections is more accessible, affordable and effective, with fewer side effects or health complications.

People living with HIV/AIDS:

- Know their status early so they can receive appropriate care and maintain their health.
- Have access to a full continuum of culturally appropriate health services, from diagnosis to ongoing wellness and, if needed, hospice palliative care and end-of-life care.
- Have access to treatments that help them manage co-morbidities or successfully treat co-infections.
- Have access to high-quality rehabilitation programs and services.
- Live longer in better health.

Strategies and Rationale

The quality of HIV care, treatment and support in Canada is among the best in the developed world, but some people - particularly those in rural and remote areas, and in marginalized urban communities⁵⁹ - still struggle to access testing, care and treatment services. As the needs of PHA become more complex, services will undergo changes. The main challenges in HIV diagnosis, care, treatment and support in Canada to consider are:

- The complex treatment needs of population groups, including varying contexts and issues faced by PHA, people who are substance dependent, and people who are not diagnosed until they are in the later stages of HIV infection.
- The co-morbidities associated with HIV/AIDS, such as: cancer; heart, liver, kidney disease; muscular-skeletal problems; issues related to their treatment; and treatment of HIV (HAART).
- The complex treatment needs of people who are co-infected with HIV, tuberculosis (TB), hepatitis C, other STI and/or blood-borne infections.
- The high rate of depression in PHA. The complex treatment and support requirements of people who have mental illness and substance dependence issues.
- The unique treatment needs of women living with HIV/AIDS (e.g., reproductive issues, managing drug treatments during menopause).
- The neurocognitive disorders associated with HIV/AIDS.
- The access of PHA to assistance with basic necessities, such as income, employment opportunities, housing, food and disability benefits.
- The challenges faced by PHA of living many years with an infectious illness that is life-threatening if not appropriately treated.

- The impact of stigma and discrimination.
- The issues associated with relationships, disclosure and effective prevention strategies specific for PHA.
- The physical and mental impact of aging with HIV/AIDS as well as the increased demand for long-term care, hospice palliative care and end-of-life care services.

2.1 Improve Treatment Effectiveness

After almost two decades of experience with HAART, clinicians and PHA are identifying problems, such as treatment failures, drug resistance and side effects. There are also serious challenges when dealing with co-infection with hepatitis C, other co-morbid conditions and/or concurrent disorders, such as mental illness or substance dependence.

As PHA age, they will develop conditions associated with aging, such as arthritis, osteoporosis, heart disease, liver disease, cognitive losses and dementia - but at younger ages than people not living with HIV/AIDS. Some of these conditions are the result of aging; others are due to HIV or HIV treatments. It is critical that care providers be knowledgeable about these other conditions, and focus on treating HIV in the context of other health problems.

The changing and complex care for people over time highlights the requirement to continue to develop new, more effective treatments; strategies to reduce drug resistance; treatments for co-morbidities; vaccines and microbicides; and ultimately, a cure. Effective ways are needed to close the gap in treatment outcomes for women and Aboriginal peoples who tend to be diagnosed later in the course of HIV. A recent study on co-morbidities also highlighted the importance of health promotion for PHA, including addressing general nutrition and habits such as smoking which can compromise health.

2.2 Improve Access to and Engagement in Treatment

Many Canadians living with HIV/AIDS continue to face barriers to accessing treatment such those related to geography and distance, culture and language, bureaucracy and regulation, and stigma and discrimination. Transportation cost is a substantial issue for people in rural and remote areas who have to travel to obtain services. People who inject drugs are sometimes denied access to antiretroviral therapy on the basis that they may not be able to adhere to complex treatment regimens; however, research indicates that with appropriate education and support, people who inject drugs have the same adherence rates as other PHA⁶⁰. Prisoners sometimes discontinue antiretroviral treatment while in prison because of concerns about stigma⁶¹ or experience treatment interruption due to other issues including transfers between institutions or discharge planning and procedures. People who are co-infected with HIV and hepatitis C sometimes have trouble accessing treatment for hepatitis C.

2.3 Social Determinants of Health Approach to Care and Support

People living with HIV/AIDS are a highly diverse group socio-economically and culturally. While some are working and managing their illness, a growing number are struggling to meet basic needs and to live a

full life in the midst of a long-term, life-threatening illness. Some PHA would benefit from a wide range of culturally appropriate support services that can assist with practical, as well as psychosocial elements, such as housing, food, social support and prevention strategies. Many services that PHA require are beyond the traditional mandate of health programs. To respond to these issues, a comprehensive approach to services and the engagement of partners, such as actors in income and housing sectors, calls for collaboration at all levels of government and in communities.

One of the key gaps for PHA is ensuring access to flexible employment opportunities that accommodate their ability to work. Rigid workplace and disability insurance policies can prevent someone living with HIV/AIDS from returning to work or working part-time and gaining the benefits associated with employment (e.g. better health, social support, integration into society, contributing to the economy). The impact of these policies is not limited to PHA; rather they affect people with long-term episodic illnesses. PHA also benefit from access to training programs, help in developing skills and finding employment.

2.4 Improve Access to Long-Term Care and End-of-Life Care

In the 1980s and early 1990s - when people were dying relatively quickly from AIDS - those working in the field were leaders in end-of-life care. A number of hospice programs were developed specifically for people with AIDS because existing programs could not meet their needs. Since the advent of HAART in 1996, many buddy and hospice programs have redirected their resources to provide supportive housing or day programs. As PHA age, they are more likely to develop co-morbid conditions, including serious cognitive impairments that affect their independence and ability to manage daily activities.

Although PHA are living longer, they are aging faster. According to *Maison d'Hérelle* in Montreal, a 50 year-old living with HIV is like a 65-year-old without HIV. As PHA enter into their 50s, more are requiring long-term care and more are dying. Organizations like Casey House in Toronto and *Maison d'Hérelle* report having more clients with complex rehabilitation cases related to complicated musculoskeletal disorders, chronic pain and neurological impairments. They are also seeing more clients with substance dependence - who live alone, are on social assistance and are living in relative poverty.⁶²

As people age with HIV/AIDS, having access to culturally sensitive, long-term care and compassionate end-of-life care become important. This calls for long-term care providers to understand on the complexities of male and female PHA in addition to training in how to provide culturally sensitive care. HIV service providers require more education on the importance of hospice palliative and end-of-life care, including pain management, supportive care and spiritual support.

2.5 Improve quality of longer life in better health

Both during periods of significant health challenges and periods of good health resulting from successful treatment, PHA benefit from attention to measures promoting well-being and quality of life. HIV is often responsive to treatment so that it can be chronically managed.

Goal #2: Strengthen Diagnosis, Care, Treatment and Support Services

Strategies

Actions to be Taken

2.1 Improve Treatment Effectiveness

- Develop comprehensive treatment programs that meet the needs of all PHA and:
 - Ensure people who inject drugs, prisoners and others who are marginalized have access to the best available HIV treatment and pain management
 - Ensure people living with HIV/AIDS who inject drugs have the opportunity to maintain or begin medications (e.g. antiretroviral therapy, methadone) when incarcerated and when they make the transition back into the community
 - Improve services for PHA who live with mental illness
 - Increase understanding of and access to traditional healing methods for Aboriginal peoples
 - Enhance capacity to care for people with co-infections and co-morbidities, including hepatitis C, heart disease, cancer, liver disease, arthritis, osteoporosis, neurocognitive disorders and dementia
- Conduct research into key aspects of HIV diagnosis, care, treatment and support including:
 - Early diagnosis strategies
 - Drug resistance strategies
 - Strategies to minimize the side effects of treatment
 - Wellness promotion and response to HIV-related conditions
 - New antiretroviral and immune-modulatory therapies and regimens
 - Effective treatments for people who are co-infected with HIV/AIDS and hepatitis C
 - Complementary therapies
 - Strategies that address organ damage (i.e. treatment and organ transplants)
 - Prevalence of HIV-related impairments, activity limitations and participation restrictions, and the role of rehabilitation in improved health
 - Population-specific treatment needs (e.g. women, older people)
- Provide opportunities for men and women living with HIV/AIDS to participate in clinical trials, regardless of where they live or are being treated
- Support rehabilitation programs and services for PHA, and educate rehabilitation professionals on HIV and their role in treatment and support

2.2 Improve Access to and Engagement in Treatment

- Develop strategies to overcome barriers to travel for specialized care
- Support research on complementary and alternative therapies and educate PHA and providers about their safety and effectiveness
- Develop and implement programs designed to improve access to appropriate, effective treatments - including rehabilitation services - for people with co-infections and/or co-morbidities
- Expand access to post-exposure prophylaxis
- Develop measures aimed at reducing disparities in treatment across the country.
- Conduct research into key aspects of HIV/AIDS diagnosis, care, treatment and support services

2.3 Social Determinants of Health Approach

- Address the housing, income, employment and other health and social needs of PHA. This requires the involvement of all government levels (municipal (i.e.

to Care and Support

housing), provincial, territorial and federal (i.e. income security and taxation) and key actors in communities (i.e. private sector employment)

- Support PHA in coping with the psychosocial issues associated with a long-term, life-threatening illness
- Support employers in creating workplace opportunities that endorse identified needs of PHA, including income security, access to health benefits, workplace accommodations, and challenges with stigma and discrimination in the workplace

2.4 *Improve Access to Long-Term Care and End-of-Life Care*

- Educate long-term care providers and ensure access to appropriate, culturally sensitive long-term care for PHA
- Provide access to home care, respite care, compassionate leave, pain and symptom management, non-prescribed therapies and hospice palliative care providers - 24 hours a day, 7 days a week
- Rebuild capacity to provide hospice palliative care for PHA, and educate providers about the benefits and importance of high quality hospice palliative and end-of-life care

2.5 *Quality of life and well-being*

- Implement PHA-led positive prevention programs designed to help PHA manage the challenges of leading healthy sexual lives with an infectious disease and promotes quality of life and well-being.

Goal #3: Enhance Capacity to Address Health and Social Inequities in Canada

Desired Outcomes

People living with or at risk of HIV/AIDS will:

- Be leaders in Canada's response to HIV/AIDS.
- Play a meaningful role in the research, programs and services that affect their lives.

The Canadian public will:

- Be knowledgeable about HIV, STI and blood-borne diseases and how to reduce their risk.
- Be aware of the impact of HIV/AIDS in Canada and the rest of the world.
- Understand the factors that contribute to the spread of HIV.
- Support programs and services to prevent HIV infection and to provide care, treatment and support to those infected with and affected by HIV/AIDS.
- Be supportive of people with or at risk of HIV infection.

Political leaders will:

- Support comprehensive, intra- and inter-governmental knowledge, awareness and coherence in the response to HIV/AIDS and broader public health issues.
- Ensure HIV/AIDS remains a health and socio-economic priority.
- Be supportive of people with or at risk of HIV infection.

Local, regional, provincial/territorial and federal health policy makers and planners will:

- Develop, implement and support effective health policies and programs.
- Work across their governments to address the determinants of health that contribute to HIV infection.
- Ensure health professionals are knowledgeable and have the capacity and tools to provide care, services and supports for HIV, AIDS, co-infections and co-morbidities.
- Be supportive of people with or at risk of HIV infection.

Community-based HIV/AIDS service organizations will:

- Develop and maintain the skills, knowledge, resources and capacity to respond to current and emerging needs.
- Be leaders in developing innovative models of service, sharing evidence-informed best or wise practices that address the root causes of HIV infection and other illnesses. Provide services that meet the needs of people living with or at risk of HIV/AIDS at all stages of their lives.
- Strive to establish and maintain partnerships with other community-based agencies and service providers to meet the complex needs of people living with or at risk of HIV/AIDS.

Health care providers will:

- Have the knowledge, skills and resources to provide high-quality, evidence-informed HIV/AIDS care and services.
- Understand the range of cultures, beliefs and attitudes of populations affected by HIV/AIDS and provide stigma-free, linguistically, age, gender and culturally appropriate care and services.
- Understand the inter-relationships amongst HIV, AIDS and other STI, blood borne diseases and co-morbidities, and provide effective prevention and treatment, care and services.

Researchers and research organizations will:

- Engage people living with or at risk of HIV/AIDS, service providers and policy makers in research.
- Make significant contributions to generate knowledge about HIV/AIDS and innovative responses.
- Share their findings effectively with community-based organizations, care providers, the international scientific community, and public health and policy makers to inform efforts to reduce HIV transmission, improve health and quality of life for people living with and at risk of HIV/AIDS to reduce vulnerability, improve quality of life and find a cure.

Strategies and Rationale

Leading Together is an ambitious plan that looks beyond traditional HIV prevention and treatment strategies and takes steps to reduce the social inequities, stigma and discrimination that threaten people's health and well-being. To achieve these goals, it is important that Canada has the people, resources and structures to take a 'determinants of health' and social justice approach to HIV/AIDS. This requires the awareness and support of the Canadian public; maintaining funding at a level that will allow maintenance and improvement of programs and services; research and knowledge to guide work, as well as the capacity to monitor and evaluate programs so they have more impact.

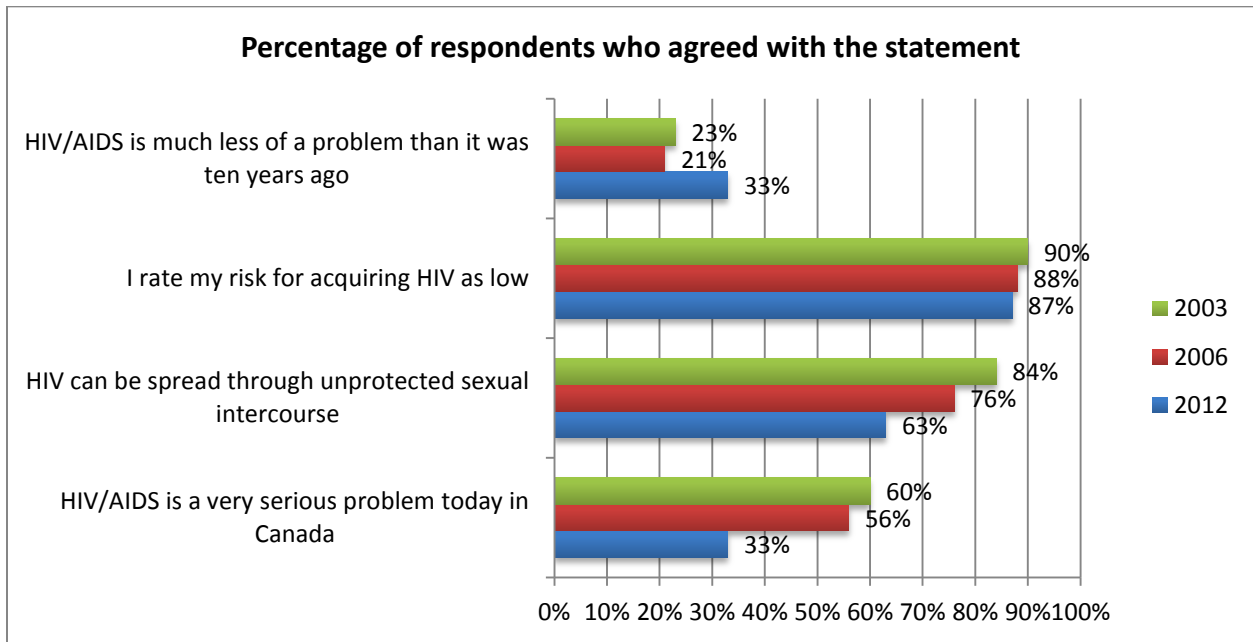
3.1 Meaningful Involvement of People Living with or at Risk of HIV Infection

The meaningful involvement of people living with or at risk of HIV/AIDS is key to ending the epidemic. From the beginning, people living with or at risk of HIV/AIDS have played a vital role in establishing community-based programs and services, shaping provincial, territorial and federal policies, and advocating for research and treatments.

3.2 Public Awareness and Support

In 2003, 2006 and 2012, HIV/AIDS Attitudinal Tracking Surveys reported findings around awareness, attitudes, knowledge and behaviours related to HIV/AIDS among people living in Canada. Results from the 2012 survey show that both knowledge and awareness about HIV/AIDS in Canada are on the decline.⁶³ When asked to identify ways that HIV is transmitted, 63% were able to identify unprotected sexual intercourse, down from a high of 84% in 2003. In 2012, 33% of respondents stated that HIV/AIDS is a very serious problem in Canada today, a decrease from 60% in 2003.⁶⁴ Over each study cycle about the same numbers of people (4 in 10 Canadians) know or have known someone living with HIV/AIDS,

and the attitude toward PHA is generally compassionate and improving. Stigmatising and discriminatory attitudes toward people living with HIV are on the decline. However, stigma toward HIV/AIDS as a health condition remains an issue for the majority of Canadians. 69% of people believe that stigma prevents people from telling others about their infection, 38% believe that stigma is a deterrent to HIV testing, and 55% believe that people with HIV/AIDS face discrimination in housing, health care or employment.



Most Canadians (91%) say they would be supportive of a friend living with HIV/AIDS and 81% would be comfortable working with someone living with HIV/AIDS. However, just over half would be uncomfortable if a close friend or family member was dating someone living with HIV/AIDS. These percentages are largely unchanged or somewhat improved over 2006 findings. Most Canadians (86%) believe that PHA have a responsibility to protect others. In addition to concerns related to the stigma associated with HIV as an infection, large numbers of respondents also indicated that stigma comes about as a result of the association between HIV infection and membership in certain populations and with certain behaviours. When asked what creates fear or discomfort when confronted with the presence of HIV/AIDS, 60% cited the association with casual or promiscuous sex, 56% cited the association with injection drug use, and 55% cited the association with homosexual sex as strong factors.

Ensuring the public’s access to credible and evidence-based education and information is one measure to raise public awareness, knowledge, understanding and support for HIV/AIDS response efforts in Canada.

Over recent years, court cases involving HIV disclosure issues have raised the Canadian public’s awareness of HIV. As of January 2012, more than 130 people living with HIV in Canada have been criminally charged. In Canada, under certain circumstances, individuals who do not disclose their positive

HIV status to a sexual partner can be charged with a criminal offence including assault, sexual assault, aggravated sexual assault or murder.

In October 2012, the Supreme Court of Canada determined that a serious risk of bodily harm occurs when there is a realistic possibility of transmission of HIV. In the view of the Supreme Court, disclosure is unlikely to be necessary in instances where a condom is used and where an alleged perpetrator's viral load is almost non-detectable. The decision provided clear guidance on the option not to disclose under specific conditions. The ruling provided clarity for medical professionals about their legal obligations with regard to counselling patients and medical record-keeping. Following the Supreme Court decision, some experts remain concerned that the application of criminal law in cases of non-disclosure of HIV, including police press releases of names and photos of accused individuals and the often sensationalized media coverage of prosecutions, may affect public attitudes towards people living with HIV, which may in turn have impacts on testing, counselling and treatment.

3.3 Political Leadership and Support within Health Systems

Political leadership at all levels in government and in health services is critical to achieve shared goals and desired outcomes for HIV/AIDS and broader public health issues.

Political champions can help ensure that HIV remains a key public health issue. The level of political support for efforts to end the epidemic can be reflected in terms of speaking out on HIV issues, the amount of funding allocated to HIV/AIDS programs and services, exploring the public health impact and coherence of public policies and the willingness to work closely with other systems (e.g. housing, income support, corrections, employment) to meet the needs of people living with or at risk of HIV/AIDS.

Recently, a number of jurisdictions and the global effort have moved to integrate responses to HIV with responses to tuberculosis, STI, viral hepatitis and other blood-borne pathogens. Over time, it will be important to monitor this evolution to ensure that new programmes contribute to HIV/AIDS commitments.

Support for and continued investments in research and medical tools for HIV and HIV-related illnesses have resulted in and can contribute towards broader benefits for a wide range of other diseases and conditions. Advances are being made in diagnosis and detection of infections using molecular biology technology; rapid diagnostics, treating cancers, osteoporosis and immune dysfunctions; and investigating the cellular processes affecting longevity and many other contributions. Continued support for and investment in research and development are key to ensure Canadian technical expertise contributes to the domestic and global advancements in prevention, diagnosis, treatment, care and support.

The Government of Canada continues to support a long-term approach to addressing HIV and AIDS that targets the root causes that make people vulnerable to infection. ... The better we understand the root causes that put people at risk, the better we can tailor our prevention approaches to meet their specific needs.

- The Honourable Leona Aglukkaq, federal Minister of Health, speaking at the XVIII International AIDS Conference, Vienna, 2010.

3.4 Stronger Community-based Organizations

Canada has an extensive network of community-based HIV/AIDS organizations and public health units involved in advocacy and awareness raising, policy and program development, prevention, support and research. Community-based organizations and others working on the front line are a vital link between those affected by HIV/AIDS and health care delivery systems and governments. In the early days of HIV/AIDS, community-based organizations were able to respond more quickly than governments and created the first AIDS hospices. Many of these original hospices are now an integral part of health care services and receive substantial public funding.

Effective organizations have the capacity to respond to the emerging needs of people with or at risk of HIV/AIDS. Consistent with a ‘determinants of health’ approach, it is important for community-based organizations to focus time and energy to develop effective working relationships with others (e.g. mental health services, treatment for substance dependence, housing programs, income programs, food banks, legal services). This calls for innovation and willingness to reassess the best ways to co-ordinate services for PHA (e.g. HIV-specific programs, more integrated programs that address a range of issues, such as HIV and hepatitis C, or HIV and substance dependence).

Community -based organizations have made important contributions to understanding HIV and related legal and policy issues, in human rights terms, and in articulating what a human rights-based approach to HIV entails, both in domestic and international responses. Without community involvement the advancements made in all aspects of HIV treatment, care and support, prevention and community-based research would not be near the levels they are today. Their continued involvement is essential.

For the future, continued collaboration across and with community-based organizations can serve to optimize resources, maintain and build capacity, promote the exchange of knowledge and information with which to build evidence-informed approaches to current and emerging issues related to HIV/AIDS in Canada.

3.5 Skilled, Competent Health Care Providers

It is important for Canada to have more health professionals willing to work with PHA - particularly in rural and remote areas - and professionals who can provide culturally appropriate and linguistically accessible services for populations at risk, such as Aboriginal peoples, people from countries where HIV is endemic and people with current or previous problematic substance use.

The majority of HIV medical care is provided by a small number of physicians. For example, in Ontario in 2008, about 40 physicians ordered viral load tests for about 10,000 PHA and their caseloads ranged from 100 to more than 800 patients.⁶⁵ Because of the complex needs of PHA, this trend will likely continue. It is difficult for professionals who only see a small number of PHA to remain current. This situation is particularly troublesome for professionals working in smaller communities, where they do not have easy access to specialists who can provide information and advice. The challenge will be attracting

new physicians who want to specialize in HIV care to replace the growing number who are expected to retire over the next 5 to 10 years, and ensure that PHA have access to their services.

3.6 New Knowledge

Canada has developed considerable expertise in HIV research and has made major contributions to domestic and global efforts to understand and stop HIV, including the discovery of 3TC⁶⁶; establishment of the efficacy of protease inhibitors in antiretroviral combinations; new knowledge about HIV immunology among people who have studied the African sex trade; major work on drug resistance; contributions to international vaccine research towards an HIV cure; studies to identify the behavioural factors that contribute to the spread of HIV/AIDS in different populations; and evaluation of prevention initiatives for people who inject drugs.

Canadian researchers have been at the forefront of research into treatment as prevention and are actively involved in basic, clinical, epidemiological and psychosocial/ behavioural research in HIV, and in surveillance, monitoring and evaluation. Social scientists are exploring the structural barriers and social inequities that put people at risk or compromise their care, such access to safe, stable and affordable housing, stigma and discrimination, unemployment and secure income, poverty and immigration status. Canada is also a leader in community-based research, which directly involves PHA and community-based organizations in identifying research questions, conducting research and using research findings to improve services.

Maintaining and enhancing this research capacity requires attracting new researchers, defining research roles and priorities, and continuing to support rigorous research on emerging issues surrounding HIV/AIDS.

Goal #3: Enhance Capacity to Address Health and Social Inequities in Canada

<i>Strategies</i>	<i>Actions to be Taken</i>
3.1 Meaningful Involvement of People Living with HIV	<ul style="list-style-type: none">• Continue to support the active, meaningful involvement of people living with or at risk of HIV/AIDS in all research, programs and services that affect their lives• Continue to provide capacity-building programs to help people with or at risk of HIV/AIDS develop the skills necessary to play a meaningful role in planning, delivering and evaluating HIV-related research, programs and services• Enhance volunteer and employment opportunities for people living with or at risk of HIV infection
3.2 Public Awareness and Support	<ul style="list-style-type: none">• Identify high-profile leaders at all levels - among PHA, communities at risk, local communities and all levels of government - who will speak out and raise public awareness of HIV/AIDS and its impact• Develop ongoing communication strategies and key messages for the public, political leaders and the media about the impact of HIV/AIDS, the continuing epidemic in Canada and globally, and the importance of ongoing support• Enhance the effective and strategic use of the media—nationally, provincially, territorially and locally - to raise awareness and correct misconceptions about HIV/AIDS• Respond immediately to negative or inaccurate information about HIV/AIDS, people with or at risk of HIV/AIDS, and/or factors that affect their health
3.3 Political Leadership and Support	<ul style="list-style-type: none">• Monitor the social and economic costs of the response to HIV/AIDS, and use that information to seek collaborations and allocate funding to where it will be most effective and achieve results• Identify, support and recognize champions• Promote services that address the social determinants of health and the social inequities that contribute to HIV, including adequate incomes, affordable housing, mental illness and problematic substance use services• Encourage dialogue across jurisdictions on common goals and how to achieve them
3.4 Stronger Community-Based Organizations	<ul style="list-style-type: none">• Implement and evaluate innovative, sustainable organizational models that have the potential to meet the complex health and social needs of communities at risk and PHA from diagnosis to end-of-life• Develop effective working relationships among AIDS organizations and other agencies that share responsibility for serving people with or at risk of HIV/AIDS• Develop, evaluate and share effective interventions• Implement strategies to attract, train and retain skilled staff, peers and volunteers
3.5 Skilled, Competent Health Care Providers	<ul style="list-style-type: none">• Incorporate education about HIV/AIDS - including the importance of stigma-free services—into training and continuing education programs for all health and social service professionals• Develop education, support, mentorship and other innovative programs to attract and retain the appropriate number and expertise of health professionals in HIV diagnosis, care, treatment and support

- Explore the potential to use technology to link primary care providers, particularly those in small communities, with infectious disease specialists
- Develop shared-care models that will explore the potential for an inter-professional team approach (e.g., nurse practitioners, primary care physicians, specialists, physiotherapists, occupational therapists, speech language pathologists, vocational counsellors, counsellors, nutritionists, and community-based services) to meet complex client needs and support sole practitioners
- Explore and develop the potential for nurses and nurse practitioners to provide more HIV care

3.6 New Knowledge

- Continue to support HIV research in Canada and internationally
- Encourage collaboration among researchers and research funding agencies nationally and internationally to achieve common goals
- Continue to attract and mentor young researchers
- Invest in junior and senior researchers to keep them in Canada and working in HIV and related fields
- Enhance capacity to evaluate interventions
- Develop innovative knowledge exchange strategies to ensure research findings are shared and new knowledge is incorporated into practice

Goal #4: Active Engagement in Global Efforts

Desired Outcomes

- Canadians are aware of the global HIV/AIDS epidemic and support Canadian efforts to assist.
- Canada works with its partners to deliver on global commitments, including the 2011 *Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS*.⁶⁷
- Canada uses the lessons learned from other countries to strengthen the domestic response to HIV
- Canada provides technical assistance and advice to global efforts to respond to HIV/AIDS.
- Canada contributes to global research efforts to end the epidemic.

Strategies and Rationale

At the end of 2011, an estimated 34 million people worldwide were living with HIV, 2.5 million new infections among adults and children, and 1.7 million AIDS related deaths according to the *UNAIDS 2012 World AIDS Day Report*.⁶⁸ More than 95% of HIV infections occur in low and middle income countries; 69% of people living with HIV are in Sub-Saharan Africa, and in this region 58% are women. In these countries, factors such as poverty, stigma, gender inequality and other forms of discrimination and disempowerment are driving the epidemic. The situation is complicated by the fact that the epidemic exacerbates poverty, costing already poor countries financial and human resources. In many countries, high death rates from AIDS-related causes lead them to continue to seek support for strengthened health systems, accelerated access to affordable, safe and effective antiretroviral therapy and other medicines, improved and equitable access to quality prevention, diagnosis, treatment, and care and support services.

Since 2002, the epidemic has stabilized: the 2.5 million people who were newly infected with HIV in 2011 represent a 20% reduction since 2001; the 1.7 million AIDS-related deaths show a 24% decline since 2005. In 2011, new infections in children were 43% lower than in 2003 and 24% lower than in 2009. From 2009 to 2011, the number of people accessing HIV treatment increased by 63%. Between 2001 and 2011, TB-related AIDS deaths have decreased globally by 25%. Further, between 2009 and 2011, there has been a 45% increase of people with TB/HIV co-infection who are accessing treatment.

Despite this progress, significant gaps in treatment coverage remain with specific populations underserved in access to prevention, treatment, care, and support services including men who have sex with men, people who inject drugs, sex workers, women and children. 14.8 million people living in low and middle income countries are eligible for treatment, yet only 8 million are on treatment: only 47% of adults and 23% of children receive antiretroviral therapy. Vertical transmission of HIV from mother-to-child through pregnancy lags behind global efforts to tackle HIV. Coverage of pregnant women receiving the most efficacious antiretroviral regimens to prevent vertical transmission (excluding single-dose nevirapine) was estimated at 48% in 2010. This falls short of the 90% coverage target set out in the *Global Plan Towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive*.⁶⁹

Despite efforts, significant human rights issues affect the global response to HIV/AIDS. Systemic discrimination, homophobia and societal violence against women, men who have sex with men, transgender and gender variant populations, migrant populations, sex workers, people who use drugs and other marginalized population groups create situations which drive the epidemic to expand and challenge attempts to provide prevention, treatment and care services. For instance, of the estimated 34 million people living with HIV globally, about half do not know their HIV status. In some countries, testing rates are low and many people are diagnosed late in the course of the disease. In other cases, weak health systems challenge the scaling up of treatment programs, however, this is highly variable with some low-resource settings being able to successfully scale up testing.⁷⁰ Efforts to support respect for, promotion and protection of human rights are critical to altering the course of HIV. Continued support to build local community capacity of those most affected by HIV to mitigate the impact of HIV/AIDS and to enable the delivery of necessary prevention, treatment, care and support services is essential to achieve global targets, and see a world free from HIV/AIDS.

Strengthening linkages between global and domestic responses can expand the reach of contributions being made by Canadian researchers, policy makers, non-governmental organizations, technical experts, community actors, members of the media and others; as well, to enhance how contributions of others inform the Canadian response. Enhanced coordination and coherence of responses and increased efforts to build and share knowledge on promising practices and evidence-informed approaches can serve to inform national, regional and global responses. Viruses know no borders. As a nation, Canada benefits when other nations are healthy.

4.1 Increase Canadian Awareness and Action

Canada has been a significant contributor to advance human rights on the global stage and is signatory to numerous international tools and commitments to uphold action to respect, promote and protect human rights, reduce stigma and discrimination, promote gender equality, sexual and reproductive health and rights, and the rights of the child and of marginalized populations.

As a State Party to the *International Covenant on Economic, Social and Cultural Rights*, Canada made a commitment to “*take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources, with a view to achieving ... the rights recognized in the present Covenant by all appropriate means...*”⁷¹ Canada’s contributions to and recognition of international policy instruments can serve to raise awareness and action on human rights and socio-economic determinants of health that can both influence and impact health sector responses to HIV/AIDS.⁷²

For instance, Canada has played a leading role in raising awareness of human rights and homophobia, and supports efforts to decriminalize homosexuality and to end violence directed towards persons on the basis of their sexuality. Canadians work with others to promote and protect the human rights of all citizens including on the basis of sexual orientation and gender identity.

By strengthening Canadian coordination, cooperation and collaboration with other countries, global institutions, non-governmental organizations and institutions, multilateral and international actors, the private sector, and PHA in other countries, Canadian support and expertise contributes to raising awareness of the issues and impacts of HIV/AIDS, and to put into place a range of interventions for all people to lead healthy and productive lives, and to help realize their rights to the highest attainable standard of physical, sexual and mental health.

4.2 Deliver on global commitments

As part of the Millennium Development Goals, the global community committed, by 2015, to halt and begin to reverse the spread of HIV/AIDS to achieve universal access to treatment for HIV/AIDS for all those who need it. The current global environment is recognizing that progress and achievement of targets can be made through a renewed sense of shared responsibility, while ensuring that the principles of national ownership, mutual accountability and sustainability underpin the future global HIV/AIDS response. As one instrument, the 2011 *Political Declaration on HIV/AIDS: Intensifying Our Efforts to Eliminate HIV/AIDS*⁷³ was adopted unanimously by member states - including Canada - at the General Assembly of the 2011 United Nations High-Level Meeting on HIV/AIDS. The *Political Declaration* is a global commitment, includes new targets and builds on the momentum of the HIV/AIDS response; it can serve to guide Canadian efforts in the global response.

Canadians are making significant contributions globally to achieving the targets set out in the *Political Declaration*, with particular attention to eliminating new HIV infections among children, ensuring people have access to treatment, reducing the sexual transmission of HIV, and vaccine research and development. For example, the prevention of vertical transmission of HIV from mothers to children is an important component of Canadian efforts to save the lives of mothers and children through Canada's contribution to the G8 *Muskoka Initiative on Maternal, Newborn and Child Health*.⁷⁴ Furthermore, as the co-chair for the *Commission on Information and Accountability for Women's and Children's Health*, Canada supported the inclusion that one of the 11 indicators be

In 2011, countries assembled to review progress achieved in realizing the 2001 and 2006 United Nations General Assembly Special Session on HIV/AIDS (UNGASS) Declaration of Commitment on HIV/AIDS and *Political Declaration of Commitment on HIV and AIDS* with a view to guide and intensify the global response to HIV/AIDS. In June 2011, Canada joined other member states to adopt the 2011 *Political Declaration: Intensifying our Effort to Eliminate HIV and AIDS*, noting the following key targets to guide the response to 2015 (UN Resolution 65/277):

- Reduce sexual transmission of HIV by 50 per cent by 2015
- Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015
- Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths
- Have 15 million people living with HIV on antiretroviral treatment by 2015
- Reduce tuberculosis deaths in PHA by 50 per cent by 2015
- Reach a significant level of annual global expenditures in low and middle income countries
- Enhance synergies with development sectors (i.e. human rights, gender, education, poverty).
- Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV.
- Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts.

“antiretroviral prophylaxis among HIV-positive pregnant women to prevent vertical transmission of HIV, and antiretroviral therapy for women who are treatment-eligible.”

Sustaining and scaling-up successes in the field of access to treatment will require that all efforts are made to reduce the cost of and increase access to medications. Over the past decade, pricing has decreased significantly⁷⁵, notably a steady decline in African countries; for example, Mozambique has seen a 45% decrease in ARV costs from 2009-2011. Currently Canada is engaged in a number of trade agreement negotiations which has raised concerns for some groups over the potential impact these agreements could have on health and social issues (i.e. patents, cost of medicines). Work remains to ensure that new and innovative funding supports quality medicines and health technologies.

The Government of Canada is engaged in a number of initiatives aimed at increasing access to antiretroviral treatment for HIV in developing countries, including meeting funding commitments to the Global Fund to Fight AIDS, Tuberculosis and Malaria. Canada continues to support efforts to increase community awareness of and support for HIV/AIDS testing, prevention, and treatment; and efforts such as the 2010 *Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV* to eliminate gender inequalities, gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV.

4.3 Canada uses lessons learned from other countries to strengthen the domestic response to HIV

It is important to strengthen linkages between global and domestic responses. Canada's researchers, policy makers, community actors, members of the media and others have much to contribute to - and much to learn from - the global effort which can inform, be adapted and adopted to the domestic context, and achieve results for Canadians.

Canadian non-governmental organizations (NGO), particularly ethno-specific organisations, have strong linkages with organisations in low and middle income countries. Through twinning programs, internships and educational exchanges, valuable lessons are learned about the response to HIV in urban and rural settings in other countries. Although Canada is in general a low prevalence country, in some areas and communities infection rates are comparable to those in Sub-Saharan Africa. Lessons from the response in high prevalence countries as well as in rural and remote areas of other countries can be directly relevant to Canada.

Canada's contribution to and involvement in various multilateral bodies (e.g. World Health Organization, United Nations Joint Programme on HIV/AIDS, United Nations Fund for Children) and global technical teams and networks also result in the exchange of information and expertise on effective programs that can be applied in Canada.

4.4 Technical assistance and advice to global efforts to respond to HIV/AIDS

Globally, there is a recognized need to enhance prevention efforts, improve HIV treatment patient retention rates, affordability of second- and third-line treatments; and explore new ways of expanding and

sustaining access to prevention and treatment. Efforts where Canadians are contributing include enhancing program management capacity and tools, the production of quality and effective medicines, biomedical research, addressing drug resistance and developing new and efficient diagnostic tools.

Through technical assistance Canadians are working with developing countries, national civil society organizations, multilateral organizations and academic institutions around the world to support country led efforts to fight the epidemic. Canadians are actively working with low and middle income countries around the world, helping to increase local capacity to fight the epidemic, provide care, evaluate programs, conduct clinical trials of new prevention technologies, and monitor the spread of disease.

Canadians are significant contributors to technical assistance, exchange and support through a range of areas and disciplines including, but not limited to gender equality; epidemiology, surveillance and mathematical modelling; laboratory science, diagnostics, community strengthening and capacity building; research and development towards a vaccine and new prevention technologies; monitoring and evaluation.

4.5 Global research efforts to end the epidemic

Canadian investigators are at the forefront of discovery. They are working to reduce the number of infections and improve the health of those infected in Canada and around the world. Canadians are actively seeking ways to build knowledge on the root causes of HIV vulnerability and resiliency and invest in innovative research and practices across biomedical, behavioural, societal and operational science to identify promising and effective interventions.

HIV researchers from all disciplines and research fields are seeking ways to expand collective knowledge about HIV, its progression and impact, and efforts that can be made to curtail the spread of the disease. They also continue to pursue long-term strategies such as the discovery of new diagnostic tools, safe and effective vaccines and a cure for HIV. Specifically, Canada is a key contributor to the global effort to find a safe, effective and affordable vaccine under the Canadian HIV Vaccine Initiative and through program support to engage and partner with global institutions and local expertise to build capacity in low and middle income countries.

Canadian investments in science and research can further develop Canadian-based research capacity and technical expertise. These investments can ensure Canada continues to contribute to international efforts to end the epidemic.

Goal #4: Active Engagement in Global Efforts

<i>Strategies</i>	<i>Actions to be Taken</i>
4.1 Increase Canadian Awareness and Action	<ul style="list-style-type: none">• Increase and maintain public awareness on the global HIV epidemic and Canada's contribution to the global response• Make effective use of World AIDS Day (December 1 – annually) to draw attention to the global epidemic and Canada's contributions• Make use of calendar events, including recognition days for human rights, STOP TB campaigns and others, to raise awareness of the intersection of issues as they relate to HIV/AIDS and to promote community action in the response• Use social media to sustain public interest throughout the year• Encourage efforts to raise awareness of and contribute to the realization of international commitments in Canada and abroad (e.g., <i>International Labour Organization Recommendation No. 200: HIV and the World of Work</i>, <i>International Guidelines on HIV/AIDS and Human Rights</i>, <i>Convention on the Rights of Persons with Disabilities</i>)• Support, strengthen and empower organizations and networks working in low and middle income countries to address the HIV epidemic
4.2 Deliver on commitments	<ul style="list-style-type: none">• Deliver on commitments and Canada's share of funding to the Global Fund to Fight AIDS, Tuberculosis and Malaria• Support, strengthen and empower organizations and networks working to address the HIV epidemic in developing countries• Support global efforts aimed at achieving the HIV/AIDS Millennium Development Goal 6 and health related goals• Support global efforts aimed at eliminating vertical (mother-to-child) transmission• Support initiatives aimed at increasing access to antiretroviral treatment for HIV in developing countries• Support developing partner countries in strengthening their health systems to respond to the HIV/AIDS epidemic• Work towards meeting the official development assistance target of 0.7% of Gross National Income• Engage in coordinated approaches and partnerships with all levels of governments, civil society, donors, multilateral organizations and the private sector• Strengthen, respect, protect, promote and enforce human rights agreements• Champion measures to protect and promote HIV/AIDS and global health in Canada's foreign policy (including international trade and investment agreements)• Pursue innovative financing mechanisms for health as are being explored by other high income countries including European Union and the United States• Support the work of the United Nations Special Rapporteur, as well as other international mechanisms that contribute to realizing the right to the highest attainable standard of physical, sexual and mental health• Support global efforts to eliminate HIV/AIDS-related discrimination, homophobia, and to respect, protect and fulfill the human rights of PHA and of individuals and groups vulnerable to discrimination and marginalization• Support global efforts to reduce gender-based discrimination and gender-based violence, promote gender equality, and promote and protect sexual and

reproductive health and rights

- Ensure Canada's efforts to promote access to prevention, treatment, care and support make meaningful contributions to global efforts including improving access to affordable and effective pharmaceutical products including, but not limited to, treatment options for HIV/AIDS, tuberculosis, malaria and other diseases

4.3 Use lessons learned from other countries to strengthen the domestic response

- Support and promote partnerships between Canada and other countries, including global organizations, NGOs and other civil society groups, to enhance knowledge exchange and learning to strengthen the response to HIV in Canada

4.4 Technical assistance and advice to global efforts to respond to HIV/AIDS

- Make strategic use of Canadian expertise in global efforts to respond to the epidemic, guided by the priorities of the countries requiring assistance
- Promote partnerships between Canada and other countries, global organizations and institutions and civil society groups to share best and promising practices
- Support technical exchange, build capacity and fund successful product development partnerships with global organizations and local expertise
- Seek ways to enhance collaborative efforts, to maximize resources, the exchange of knowledge and build capacity across health and social sectors in the response to HIV/AIDS
- Build capacity in program management, health technologies and to respond to biomedical advancements

4.5 Global research efforts to end the epidemic

- Continue to participate in global research efforts to develop HIV/AIDS treatments, technologies, vaccines, microbicides and prevention strategies and cure, particularly the new Canadian HIV Vaccines Initiative Research and Development Alliance.
- Comply with international guidelines for conducting health research
- Continue to strengthen and build capacity for global health research in Canada and in developing countries
- Contribute to global capacity in surveillance, monitoring, tracking and evaluation to build the evidence base of effective and high impact treatment and prevention interventions
- Support basic science and laboratory science efforts in development of new tools (i.e. diagnostics) and to inform treatment and prevention options

Conclusion

“The AIDS response has been remarkably successful in transforming a deafening demand for inclusive policy processes and evidence-informed, rights-based programmes into tangible achievements measured in lives saved and dignity restored. ...We see increasing optimism that progress on these interdependent goals can be achieved – particularly if they are tackled together” - Michel Sidibé, UNAIDS Executive Director, 2009.

In June 2001, the United Nations challenged all countries around the world to work together to address HIV/AIDS. Canada is one of 189 countries that adopted the *2001 UNGASS Declaration of Commitment on HIV/AIDS*. The Commitment was renewed in 2006 with Canada agreeing to strengthen HIV programs at home and to contribute to worldwide efforts to combat HIV/AIDS. In 2011, Canada endorsed the *Political Declaration on HIV/AIDS* and its new targets. This renewed commitment challenges national and global actors to devise innovative approaches to achieve specific targets that respond to the evolving nature of the global HIV epidemic.

Leading Together is a key step in fulfilling that promise by:

- describing a bold vision for Canada as a nation in managing the HIV epidemic
- setting out a hopeful, comprehensive, strengths-based approach to HIV/AIDS that focuses on the underlying health and social issues that put people at risk of HIV/AIDS and other health problems
- challenging all those in Canada involved in HIV/AIDS to work together to develop a more effective, coordinated response that will eradicate the virus and save lives.

Acronyms

AIDS	Auto-immune deficiency syndrome
CSC	Correctional Service of Canada
GTAG	Global Treatment Access Group
HAART	Highly Active Antiretroviral Therapy
HIV	Human immunodeficiency virus
LGTB	Lesbian, bisexual, queer and transgender
LTCC	Leading Together Championing Committee
LTEB	Leading Together Editorial Board
OECD	Organisation for Economic Co-operation and Development
ODA	Overseas Development Assistance
PHA	People Living with HIV/AIDS
PHAC	Public Health Agency of Canada
STI	Sexually Transmitted Infections
TB	Tuberculosis
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNODC	United Nations Office on Drug and Crime
WHO	World Health Organization

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