HOUSE OF COMMONS
CANADA

STRENGTHENING THE CANADIAN STRATEGY ON HIV/AIDS

REPORT OF THE STANDING COMMITTEE ON HEALTH

Bonnie Brown, M.P.
Chair

June 2003

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CHAIR'S FOREWORD

The Standing Committee on Health is very concerned about the HIV/AIDS situation in Canada. While Canadians continue to be infected at an alarming rate, the resources allocated to the current Canadian Strategy on HIV/AIDS have not changed in 10 years.

Having listened carefully to the insightful testimony offered by witnesses, the Committee now calls for appropriate long-term funding to curtail the progression of this disease. The goal is to ensure an effective and viable strategy to counter the devastating effects of this preventable illness.

On behalf of the members of the Committee, I would like to thank the witnesses who gave so generously of their time and expertise. As always, we appreciate the professional guidance provided by the researchers from the Library of Parliament, Nancy Miller Chenier and Sonya Norris, and the clerk of the Committee, José Cadorette. In addition, we are grateful for the continuing support of the editors, interpreters, console operators and others whose hard work and team effort have made this report possible.

I would also like to thank the individual members of the Committee who wholeheartedly participated in this study and shared their wisdom and concern for this important issue.

THE STANDING COMMITTEE ON HEALTH

has the honour to present its

THIRD REPORT

In accordance with its mandate under Standing Order 108(2), your committee has conducted a study on the Canadian Strategy on HIV/AIDS and reports its findings and recommendations.

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LIST OF RECOMMENDATIONS

RECOMMENDATION 1 on increased funding

On overall funding and evaluation for the renewed Canadian Strategy on HIV/AIDS, the Committee recommends that:

(a) The federal government increase the total funding for the renewed federal Canadian Strategy on HIV/AIDS to $100 million annually;

(b) This increased federal funding specifically designate $5 million annually to each of the two at-risk sub-populations (First Nations and Inuit as well as inmates) falling under federal jurisdiction;

(c) This increased federal funding specifically designate $5 million annually to Canadian researchers engaged in vaccine development;

(d) This increased federal funding be reviewed in two years to ensure that it is appropriate to changes in the status of the disease and its economic, physical and social impact on Canadians;

(e) This increased funding be contingent on the establishment of five-year measurable goals and objectives for decreasing the number of new cases each year.

RECOMMENDATION 2 on effectiveness and accountability

To ensure an effective strategy and ongoing evaluation of the renewed Canadian Strategy on HIV/AIDS funding, the Committee recommends that:

(a) Health Canada be mandated to take the lead role in coordinating, implementing and reporting on a comprehensive and collaborative renewed Canadian Strategy on HIV/AIDS;

(b) Health Canada establish a specific Canadian Strategy on HIV/AIDS secretariat with designated budget and personnel to carry out this lead role;

(c) Health Canada work with its federal partners to ensure that the Canadian Strategy on HIV/AIDS include appropriate, clear, measurable five-year goals and objectives as well as a process for evaluation and accountability;

(d) Health Canada coordinate work with its federal partners to review the total Canadian Strategy on HIV/AIDS funding amount and allocation within two years; and,

(e) Health Canada, through the Minister of Health, report annually to Parliament on the Canadian Strategy on HIV/AIDS, including a focus on goals and achievements according to Treasury Board guidelines.

RECOMMENDATION 3 on overall allocation

With respect to the overall distribution of Canadian Strategy on HIV/AIDS funding, the Committee recommends that:

(a) As part of the two-year review of the Canadian Strategy on HIV/AIDS, Health Canada work with its federal partners to examine the division of funds to ensure that it meets changing needs for prevention, treatment, research and community living of those with HIV/AIDS;

(b) Health Canada, in partnership with other federal departments and agencies involved in the renewed Canadian Strategy on HIV/AIDS, expand the prevention strategies and ensure that they are specifically targeted to meet the individual needs of the diverse communities at risk;

(c) Health Canada and its federal partners ensure that awareness and prevention programs are increasingly administered by affected communities including people living with HIV/AIDS, youth, Aboriginal or ethnic communities and are more sensitive to culture, age and gender.

RECOMMENDATION 4 on specific affected groups

With respect to the funding distribution for specific affected groups, the Committee recommends that:

(a) Health Canada increase prevention strategies targeted specifically to youth to be delivered in a sequentially age appropriate manner, to be targeted to areas frequented by youth, and to be inclusive of the specific needs of youth in rural and remote areas;

(b) Health Canada and other federal partners provide stable, long-term funding for regional Aboriginal AIDS service organizations to develop culturally appropriate practices to fight HIV in the community and to help implement specific programs to deal with the HIV/AIDS-related needs of the disproportionately large Aboriginal population in prisons;

(c) Health Canada and other federal partners ensure that stronger provisions and funding arrangements are made to support individuals who are negatively affected by the social stigmas and discrimination associated with HIV/AIDS, and that such individuals are provided greater accessibility to medical services, employment, social support, etc.;

(d) Correctional Service Canada provide harm reduction strategies for prevention of HIV/AIDS amongst intravenous drug users in correctional facilities based on eligibility criteria similar to those used in the outside community (as per the recommendation of the December 2002 report of the Special Committee on the Non-Medical Use of Drugs);

RECOMMENDATION 5 on specific research

With respect to the funding distribution for specific research, the Committee recommends that:

(a) The Canadian Institutes of Health Research consider allocating public research dollars to gender specific and culturally appropriate investigations;

(b) The Canadian Institutes of Health Research consider allocating public research dollars to investigations of effective non-pharmaceutical alternatives for prevention and treatment.

RECOMMENDATION 6 on coordination

For the overall coordination of the Canadian Strategy on HIV/AIDS, the Committee recommends that:

(a) Health Canada take the primary responsibility for ensuring that the renewed Canadian Strategy on HIV/AIDS is implemented and that a report on the expected outcomes and achievements from the Strategy activities is provided annually to the House of Commons and referred to the Standing Committee on Health;

(b) Health Canada coordinate a comprehensive interdepartmental and interagency Canadian Strategy on HIV/AIDS with measurable goals;

(c) In addition to the current partnership with Correctional Service Canada and the Canadian Institutes of Health Research, the Canadian Strategy on HIV/AIDS include coordinated work with the Canadian International Development Agency on international issues, Indian and Northern Affairs Canada on Aboriginal support issues, Human Resources Development Canada on employment concerns, Justice Canada on human rights questions, Citizenship and Immigration Canada on immigrant and refugee health and Industry Canada on vaccine development and drug access issues.

RECOMMENDATION 7 on extended federal partnership

For an expanded and cooperative federal partnership, the Committee recommends that:

(a) The federal government devise a blueprint for a more comprehensive and coordinated interdepartmental/interagency Canadian Strategy on HIV/AIDS that addresses the domestic and international health, justice, economic and other needs of the Canadian population affected by HIV/AIDS;

(b) The federal government ensure that any related funding commitment to international research is made after consultation with the Canadian research community and that any research funding to foreign researchers is directed primarily to research fields where Canadian researchers are not working or are not suited to engage in themselves;

(c) The federal government make bilateral involvement between the HIV/AIDS research community in Canada and developing countries a condition of international research funds, especially with regard to clinical trials, vaccine development and drug resistance, and encourage researcher exchanges.

THE COMMITTEE FOCUS

Five years ago, in May 1998, the federal government announced the current Canadian Strategy on HIV/AIDS (CSHA). This included an annual funding allocation of $42.2 million. Health Canada is currently undertaking a five-year review of the Strategy and is preparing a report for the Minister of Health in June 2003.

Strategy Chronology

1990 — budget of $112 million over three years ($37.3 million annually)

1993 — $203.5 million over five years ($40.7 million annually) with emergency discretionary funding of up to $1.5 million per year

1998 — $42.2 million annual funding with review in five years

The Standing Committee on Health agreed to examine the CSHA in response to concerns about annual funding expressed by the major non-governmental partners. They questioned the fact that annual funding has remained static over the last 10 years of the HIV/AIDS epidemic. Furthermore, although Health Canada asserted that there was now a long-term funding commitment, they were anxious about the potential directions that might be proposed to the Minister through the five-year review.

To gain greater understanding of the federal government's responsibilities and actions, the Committee held meetings with key governmental and non-governmental partners. The federal partners included: Health Canada, Correctional Service Canada (CSC), Canadian Institutes of Health Research (CIHR). The non-governmental organizations included:

- Canadian HIV Trials Network
- Canadian Treatment Action Council
- Canadian Aboriginal AIDS Network
- Canadian Association for HIV Research
- Canadian AIDS Society
- Canadian HIV/AIDS Legal Network
- International AIDS Society
- YouthCO AIDS Society.

THE CANADIAN HIV/AIDS SITUATION

The Committee heard that reports on the Canadian HIV/AIDS situation in the late 1990s suggested that the annual number of positive HIV tests was decreasing and that advances in treatments would prevent many early deaths. In spite of these encouraging signs, witnesses pointed out that, in 2002, Canadians continued to be infected at a rate of about 4,000 per year, adding an estimated $600 million annually to future medical costs.

The increased number of people living with HIV, from about 30,000 in 1993 to more than 54,000 in 2003, has led to continuing and greater demands for care, treatment and support.

A. The Changing Epidemic

The Committee learned that the characteristics of the AIDS epidemic have changed to include many diverse population groups. Although positive HIV test reports among men who have sex with men still accounted for the largest number of positive HIV tests and AIDS cases, by 2001, there was a slight decrease from previous years. In addition, positive HIV test reports and reported AIDS diagnoses among users of injection drugs continued a downward trend.

However, the troubling signs of a shift toward exposure through heterosexual transmission worried the Committee. According to witnesses, in 2001, women constituted 50% of positive HIV tests for individuals aged 15 to 29 years. Younger women in the child-bearing range are a particular concern considering the possibility of mother-to-child transmission. In addition, the proportion of reported AIDS cases among Blacks and Aboriginal persons increased significantly so that Aboriginal peoples accounted for more than one-quarter of all new cases. Also, in the downtown eastside of Vancouver, known as one of Canada's poorest neighbourhoods with a high proportion of injection drug users and Aboriginal peoples, there were infection rates of HIV as high as 40% in some populations.

B. New Challenges

Witnesses emphasized that, at the same time as the HIV/AIDS epidemic became more complex and involved more subgroups, the virus continued to mutate and became resistant to many drugs. They pointed out that vaccines in clinical trials have not yet proven effective and some individuals using antiretroviral therapies over the long-term have developed heart disease, organ damage and other health consequences.

Prevention efforts also face a number of barriers. Some endeavours have stalled as Canadians have lost the sense of urgency about the harmful potential of HIV/AIDS for them personally and for public health generally. For particular groups such as youth, Aboriginal peoples and inmates, social, cultural and technical barriers have limited the types and degree of effective interventions.

C. The Way Forward

Overall, witnesses argued that the changing nature of the HIV/AIDS epidemic and its associated challenges reinforced the need for a well-funded and coordinated national strategy on HIV/AIDS. They agreed with the current goals of the CSHA such as preventing the spread of HIV; finding a cure; providing effective vaccines, drugs and

therapies; ensuring care, treatment and support for persons living with HIV/AIDS, their caregivers, families and friends; minimizing the adverse impact of HIV/AIDS on individuals and communities; and, minimizing the social and economic factors that increase the risk of HIV infections.

However, witnesses expressed doubt that the goals could be achieved within the current resources. Where early actions by Strategy partners had been focused on a particular at-risk population (men who have sex with men), other groups were increasingly exposed through injection drug use and heterosexual contact. With the emergence of other at-risk subgroups found among youth, Aboriginal people, immigrants and women, the existing resources were stretched too thinly and current efforts could not reach all with the same effectiveness.

FUNDING AND EVALUATION FOR THE CANADIAN STRATEGY ON HIV/AIDS

The Committee heard that, because funding for the Canadian Strategy on HIV/AIDS has remained at its current level of $42.2 million since 1993, it has not kept pace with infection rates, research, treatment patterns or inflation. Witnesses noted that, although Canada's initial response to the epidemic was admirable and while the CSHA continues to get good value for its investment, Canada is losing ground quickly and must rejuvenate its approach.

A. Overall Funding

The Committee heard that overall funding for the CSHA needs to be increased significantly. Most witnesses indicated that it should double, to at least $85 million. They emphasized that federal funding is essential to HIV/AIDS work in particular. Where other disease areas can rely on significant charitable, or private, contributions, non-governmental funding sources are extremely limited if not absent from the HIV/AIDS area.

Many witnesses referred to the report, entitled *Taking Stock: Assessing the Adequacy of the Government of Canada Investment in the Canadian Strategy on HIV/AIDS*, prepared for the Ministerial Council on HIV/AIDS in January 2001 (Martin Spigelman Research Associates). It emphasized that funding for the CSHA had not kept pace with the increase of HIV/AIDS; the real value of the investment had eroded because of inflation; and the commitment did not take into account the growing federal surplus.

The Spigelman report (and many witnesses) pointed to the long-term cost-savings that could accrue from a healthier level of investment in the CSHA. Each prevented case of HIV would save approximately $150,000 per year ($15,000 in drugs alone at current levels, but increasing continually). If the current rate of infection at 4,000 cases per year were reduced to 1,700 cases per year, $4 billion would be saved in the next five years. It

was emphasized, however, that the changes in social behaviour required to bring about such declines in infection rates, would come only with substantial investment.

In addition, the Committee heard that Canada's investment at home into HIV/AIDS should not be outpaced by its investment internationally. Witnesses pointed to quadrupled funding for HIV programs from the Canadian International Development Agency (CIDA) between 2000 and 2005. They also noted the recent substantial investments in the International AIDS Vaccine Initiative and the UN Global Fund Against HIV, Tuberculosis and Malaria. In contrast, the total national investment in HIV research as well as per capita dollars for each infected individual placed Canada among the lowest of the developed countries.

B. Federal Responsibilities

The Committee learned that Health Canada, as the lead federal department for issues related to HIV/AIDS, oversees the major funding decisions related to the $42.2 million annual funding, and also is responsible for delivery of health services to registered First Nations and Inuit clients. Correctional Service Canada, which is allocated less than one million dollars, addresses concerns in the federal inmate population. In addition, although the Canadian Institutes of Health Research with an allocation close to 10 million dollars respond to multiple research needs, some witnesses suggested that additional research emphasis on Aboriginal and inmate groups under federal jurisdiction would benefit individuals in similar situations across the country.

The non-governmental organizations pointed to serious inadequacies in the level and nature of the response to populations under federal jurisdiction such as First Nations and Inuit people in the general population and inmates in federal correctional institutions. Over the last decade, while the rates of HIV/AIDS have increased sharply among certain subgroups in these specific populations, the level of funding has remained the same. The Health Committee wants to ensure adequate future support for federal government commitments to these populations falling directly under its responsibility.

C. Vaccine Research

Witnesses specifically identified vaccine research as warranting a separate category of funding with the suggestion that at least $5 million annually was needed for work on vaccines. Where about $1.3 million is currently allocated to HIV vaccine development in Canada, the United States provides $400 million and France about $8 million Euros.

Witnesses explained that the effort to develop a vaccine is a long-term one and cannot effectively be compressed into short-term forecasts. They noted that the 2002 decision by the CIDA to make a one-time contribution of $50 million to the International AIDS Vaccine Initiative was taken without any discussion with Canada's

research community. They stressed that this decision to fund a global non-governmental consortium founded in 1996 without any consultation with Canadian researchers was considered an affront to an already underfunded research community.

D. Evaluation

The call for increased funding was accompanied by an appeal for clear and transparent assessment of the established goals and the subsequent outcomes related to the renewed CSHA. Witnesses emphasized that the greater allocation of resources would yield measurably positive results. Undoubtedly, evaluation is an important component for assessing the extent to which the goals and objectives have been achieved. All participants expressed a strong commitment to seeking effective measures for reducing and, if possible, eliminating HIV/AIDS.

The Committee supports the individuals and groups involved in the various components of the CSHA and their desire to know if all parties accomplished what they said they would do. Working with government partners, the organizations involved in HIV/AIDS understand that measures to achieve the ultimate goal of elimination of HIV/AIDS require careful assessments, regular adjustment of decisions, and occasional reallocation of resources among various components of the CSHA. Established goals and objectives require ongoing monitoring and review to assess their relevance to the changing dimensions of the disease and of affected individuals. The continual review of emerging evidence can assist decision making and, in turn, improve outcomes.

The Committee agrees with those witnesses who suggested that federal funding for the CSHA double to at least $85 million annually. However, some witnesses also emphasized that the federal government with its specific constitutional responsibility for certain Aboriginal and inmate populations should allocate additional funding specifically targeted for these two groups identified as higher risk. Witnesses also called for dedicated funding to support Canadian researchers in the development of vaccines. Moreover, the Committee expects that the renewed Strategy will include improved accountability and better information to Parliament on where the funds are spent, how the programs are delivered, and what outcomes are achieved.

RECOMMENDATION 1 on increased funding

On overall funding and evaluation for the renewed Canadian Strategy on HIV/AIDS, the Committee recommends that:

(a) The federal government increase the total funding for the renewed federal Canadian Strategy on HIV/AIDS to $100 million annually;

(b) This increased federal funding specifically designate $5 million annually to each of the two at-risk sub-populations (First Nations and Inuit as well as inmates) falling under federal jurisdiction;

(c) This increased federal funding specifically designate $5 million annually to Canadian researchers engaged in vaccine development;

(d) This increased federal funding be reviewed in two years to ensure that it is appropriate to changes in the status of the disease and its economic, physical and social impact on Canadians;

(e) This increased funding be contingent on the establishment of five-year measurable goals and objectives for decreasing the number of new cases each year.

RECOMMENDATION 2 on effectiveness and accountability

To ensure an effective strategy and ongoing evaluation of the renewed Canadian Strategy on HIV/AIDS funding, the Committee recommends that:

(a) Health Canada be mandated to take the lead role in coordinating, implementing and reporting on a comprehensive and collaborative renewed Canadian Strategy on HIV/AIDS;

(b) Health Canada establish a specific Canadian Strategy on HIV/AIDS secretariat with designated budget and personnel to carry out this lead role;

(c) Health Canada work with its federal partners to ensure that the Canadian Strategy on HIV/AIDS include appropriate, clear, measurable five-year goals and objectives as well as a process for evaluation and accountability;

(d) Health Canada coordinate work with its federal partners to review the total Canadian Strategy on HIV/AIDS funding amount and allocation within two years; and,

(e) Health Canada, through the Minister of Health, report annually to Parliament on the Canadian Strategy on HIV/AIDS, including a focus on goals and achievements according to Treasury Board guidelines.

FUNDING DISTRIBUTION

The distribution of the Canadian Strategy for HIV/AIDS has also remained static over the years. The funding continues to be allocated among 10 program areas as follows:

Program	Budget (millions)[1]
Prevention	$3.90
Community Development and Support to National NGOs	$10.00
Care, Treatment and Support	$4.75
Research	$13.15
Surveillance	$4.30
International Collaboration	$0.30
Legal, Ethical and Human Rights	$0.70
Aboriginal Communities	$2.60
Consultation, Evaluation, Monitoring and Reporting	$1.90
Correctional Service of Canada	$0.60

A. Overall Allocation

The partners involved in the original funding allocation exercise in the late 1990s felt that the focus across the 10 program areas remains valid. They emphasized that all program areas contributed to the overall goal of reducing HIV/AIDS and that all were equally affected by insufficient funding. While suggesting that new funding should cover similar program areas, witnesses identified some specific areas where money needed to be directed. Health Canada also acknowledged that, the five-year review currently underway includes an examination of funding reallocation and adequacy concerns.

Witnesses saw the funding increase as necessary to ensure:

- Prevention successes similar to the United Kingdom and Australia;
- Expansion of effective harm reduction initiatives;
- Outreach to high-risk communities, especially youth;
- Population health initiatives for those living with HIV;
- Programs specific to Aboriginal communities;
- Enhanced community service by NGOs;

[1] These budget allocations remain identical in the subsequent Monitoring report (1999-2000) as well as in *Canada's Report on HIV/AIDS 2001*.

- Surveillance improvements; and,
- Research work on HIV/AIDS.

B. Allocations for At-Risk Populations

Witnesses were particularly concerned that funding be focused on the newer at-risk populations found among women, youth, Aboriginals, immigrants and inmates. In their view, the "new face of AIDS" required changes to prevention strategies, treatment strategies, community outreach programs, and other efforts to reduce HIV/AIDS among these at-risk populations.

The Committee heard that the original design of programs under the CSHA concentrated on a specific at-risk population, primarily men who have sex with me. Now, with the epidemic affecting additional groups, witnesses called for increased funding within the CSHA to develop new approaches. They suggested that specifically targeted efforts could include peer education and interactive theatre for youth, culturally appropriate programs for Aboriginal people, and methods sensitive to rural needs.

Correctional Service Canada reported that its CSHA allocation of $600,000 (1.4%) was quickly absorbed by initial program development to address the unique needs of the prisons. With the significant increase of infection rates in federal correctional institutions, CSC spends substantially more than the allocated money on HIV/AIDS related care, treatment and support as well as infectious disease surveillance for federal inmates.

C. Allocations for Research

Witnesses also highlighted the underfunding of research on HIV/AIDS. It was suggested that as little as 30% of research proposals receive funding nationally. In addition, although Canada's HIV research at the start of the epidemic was significant, and while the research still produces good value for the money invested, witnesses felt that the country is now falling behind.

The Committee was told that research encompassing social and cultural dimensions as well as biomedical and health services aspects must be supported. Areas of research identified as crucial for the near future included work on culturally appropriate programs for Aboriginal peoples, on effective social interventions for young people and on elements pertinent to women such as specific drug trials and microbicide production.

Under the current CSHA, Health Canada partners with the Canadian Institutes of Health Research to fund multiple areas of related research. Of the $13.15 million allocated to research through the Strategy, the CIHR currently distributes about $10.2 million. In addition, it dedicates another $5 million of its funds for research aimed at increasing the quality and duration of life of HIV-infected individuals, reducing disease transmission and progression and improving treatment. While acknowledging that the

CIHR has multiple demands on its resources, the Committee would like to see an expanded focus on elements of HIV/AIDS research.

The Committee heard from witnesses that specific funding efforts must be directed to marginalized at-risk subgroups of the Canadian population found among youth, Aboriginal peoples, women, rural inhabitants, immigrants, sex trade workers and inmates. Witnesses also noted the need for particular emphasis on community-based approaches, culturally appropriate research, gender-based research including microbicides and drug-trials, as well as research aimed at non-pharmaceutical alternatives to treatment. Furthermore, they pointed to Canada's international obligations under the Declaration of Commitment adopted by the United Nations General Assembly Special Session on HIV/AIDS in 2001 establishing targets for overall prevention and reduced prevalence among youth as well as committing resources to eliminate discrimination and to increase research.

RECOMMENDATION 3 on overall allocation

With respect to the overall distribution of Canadian Strategy on HIV/AIDS funding, the Committee recommends that:

(a) As part of the two-year review of the Canadian Strategy on HIV/AIDS, Health Canada work with its federal partners to examine the division of funds to ensure that it meets changing needs for prevention, treatment, research and community living of those with HIV/AIDS;

(b) Health Canada, in partnership with other federal departments and agencies involved in the renewed Canadian Strategy on HIV/AIDS, expand the prevention strategies and ensure that they are specifically targeted to meet the individual needs of the diverse communities at risk;

(c) Health Canada and its federal partners ensure that awareness and prevention programs are increasingly administered by affected communities including people living with HIV/AIDS, youth, Aboriginal or ethnic communities and are more sensitive to culture, age and gender.

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With respect to the funding distribution for specific affected groups, the Committee recommends that:

(a) Health Canada increase prevention strategies targeted specifically to youth to be delivered in a sequentially age appropriate manner, to be targeted to areas frequented by youth, and to be inclusive of the specific needs of youth in rural and remote areas;

(b) Health Canada and other federal partners provide stable, long-term funding for regional Aboriginal AIDS service organizations to develop culturally appropriate practices to fight HIV in the community and to help implement specific programs to deal with the HIV/AIDS-related needs of the disproportionately large Aboriginal population in prisons;

(c) Health Canada and other federal partners ensure that stronger provisions and funding arrangements are made to support individuals who are negatively affected by the social stigmas and discrimination associated with HIV/AIDS, and that such individuals are provided greater accessibility to medical services, employment, social support, etc.;

(d) Correctional Service Canada provide harm reduction strategies for prevention of HIV/AIDS amongst intravenous drug users in correctional facilities based on eligibility criteria similar to those used in the outside community (as per the recommendation of the December 2002 report of the Special Committee on the Non-Medical Use of Drugs);

RECOMMENDATION 5 on specific research

With respect to the funding distribution for specific research, the Committee recommends that:

(a) The Canadian Institutes of Health Research consider allocating public research dollars to gender specific and culturally appropriate investigations;

(b) The Canadian Institutes of Health Research consider allocating public research dollars to investigations of effective non-pharmaceutical alternatives for prevention and treatment.

FEDERAL INTERDEPARTMENTAL COLLABORATION

Currently, Health Canada, Correctional Service Canada and the Canadian Institutes of Health Research are the federal participants in the CSHA. Health Canada is the lead federal department for issues related to HIV/AIDS and coordinates the resources allocated to CSHA. As noted above, CIHR administers most of the research funds for CSHA while CSC focuses on funding for HIV/AIDS endeavours in the federal correctional environment. The Canadian International Development Agency works outside of Canada on social development priorities including HIV/AIDS.

A. Concerns with Current Federal Partnership

With respect to funding through the current CSHA, the Committee heard several concerns that relate to federal departments and agencies and the nature of collaborative action among them. For example, witnesses raised issues about the adequacy of funding for federal inmates through the limited dollars available to CSC to work in numerous institutions across the country with varied inmate populations. They also suggested that the proportion of overall CIHR funding allocated to HIV/AIDS research outside the CSHA is not enough to distribute through multiple institutes and across diverse areas such as biomedical, clinical, health services, population health.

While supporting Canada's involvement in international efforts to combat HIV/AIDS, witnesses questioned several aspects of CIDA's approach and activities. They disagreed with the lack of consultation with Canadian researchers. They pointed out the inappropriateness of sending vaccine research money to non-Canadian researchers through the International AIDS Vaccine Initiative while domestic research remains underfunded. Recognizing CIDA's five-year investment of $270 million would benefit the domestic as well as the worldwide fight against HIV/AIDS, the Committee wants links between the efforts in Canada and support for Canadian-initiated studies of drug resistance in developing countries. With its similar focus on prevention, community action, care, treatment and support, human rights, the Committee seeks assurances of greater collaboration with Canadian HIV/AIDS partners when CIDA increases its funding for HIV/AIDS to $80M annually by 2005. It would like to see clearer coordination between international funding and the CSHA, with some funding linked to relevant domestic efforts.

B. Need for Extended Federal Partnership

Over the years of the CSHA, Health Canada took a role as the primary department and worked on building a collaborative environment for those affected by the

HIV/AIDS epidemic. However, it is unclear how Health Canada interacts with, provides support for and maintains oversight of the activities of other relevant federal departments and agencies. Witnesses mentioned other policy areas important to HIV/AIDS efforts that fall within the mandate and activities of federal departments not currently involved in the CSHA.

Among its goals, the current Strategy aims to minimize the adverse impact of HIV/AIDS on individuals and communities as well as address the social and economic factors that increase the risk of HIV infections. These goals go beyond the scope of Health Canada, CSC and CIHR. For example, poverty, homelessness, employment assistance and disability fall within the realm of Human Resources and Development Canada. Social support, housing and other issues pertinent to Aboriginal people affected by HIV/AIDS are the responsibility of Indian and Northern Affairs Canada. Human rights concerns around stigma and discrimination experienced by people with HIV/AIDS are important issues for Justice Canada. Citizenship and Immigration Canada has reason to be concerned about the health status of new populations, both immigrant and refugee. Establishing the infrastructure for vaccine testing and working with pharmaceutical companies to provide less costly access to drugs could be a focus for Industry Canada.

The Committee became aware of concerns about the lack of coordination among federal departments and agencies involved with administering HIV/AIDS funding. Witnesses pointed to the need for increased funding for HIV/AIDS awareness, prevention, and treatment strategies in federal prisons, for more communication about research priorities and about international commitments from federal agencies, and for strengthened interdepartmental collaboration.

RECOMMENDATION 6 on coordination

For the overall coordination of the Canadian Strategy on HIV/AIDS, the Committee recommends that:

(a) Health Canada take the primary responsibility for ensuring that the renewed Canadian Strategy on HIV/AIDS is implemented and that a report on the expected outcomes and achievements from the Strategy activities is provided annually to the House of Commons and referred to the Standing Committee on Health;

(b) Health Canada coordinate a comprehensive interdepartmental and interagency Canadian Strategy on HIV/AIDS with measurable goals;

(c) In addition to the current partnership with Correctional Service Canada and the Canadian Institutes of Health Research, the Canadian Strategy on HIV/AIDS include coordinated work with the

Canadian International Development Agency on international issues, Indian and Northern Affairs Canada on Aboriginal support issues, Human Resources Development Canada on employment concerns, Justice Canada on human rights questions, Citizenship and Immigration Canada on immigrant and refugee health and Industry Canada on vaccine development and drug access issues.

RECOMMENDATION 7 on extended federal partnership

For an expanded and cooperative federal partnership, the Committee recommends that:

(a) The federal government devise a blueprint for a more comprehensive and coordinated interdepartmental/interagency Canadian Strategy on HIV/AIDS that addresses the domestic and international health, justice, economic and other needs of the Canadian population affected by HIV/AIDS;

(b) The federal government ensure that any related funding commitment to international research is made after consultation with the Canadian research community and that any research funding to foreign researchers is directed primarily to research fields where Canadian researchers are not working or are not suited to engage in themselves;

(c) The federal government make bilateral involvement between the HIV/AIDS research community in Canada and developing countries a condition of international research funds, especially with regard to clinical trials, vaccine development and drug resistance, and encourage researcher exchanges.

APPENDIX A
LIST OF WITNESSES

Associations and Individuals	Date	Meeting
Canadian HIV Trials Network	17/03/2003	24
Martin Schechter, National Director / Canada Research Chair in HIV/AIDS and Urban Population Health		
Canadian Treatment Action Council / Voices of Positive Women		
Louise Binder, Chair		
YouthCO AIDS Society		
Sheena Sargent, Education Programs Coordinator		
Canadian Institutes of Health Research	19/03/2003	25
Bhagirath Singh, Scientific Director, Institute for Infection and Immunity		
Karl Tibelius, Director, Research Capacity Development		
Correctional Service Canada		
Sandra Black, National Coordinator, Infectious Diseases Program		
Françoise Bouchard, Director General, Health Services		
Department of Health		
Howard Njoo, Director General, Centre for Infectious Disease Prevention and Control		
Steven Sternthal, Acting Director, HIV/AIDS Policy, Coordination and Programs Division		
Canadian Aboriginal AIDS Network	24/03/2003	26
Art Zoccole, Executive Director		
Canadian AIDS Society		
Paul Lapierre, Executive Director		
Canadian Association of HIV Researchers		
Kenneth Rosenthal, President / Professor, McMaster University		
Canadian HIV/AIDS Legal Network		
Ralf Jürgens, Executive Director		
International AIDS Society		
Mark Wainberg, President Elect / Director, McGill AIDS Centre		

REQUEST FOR GOVERNMENT RESPONSE

Pursuant to Standing Order 109, the Committee requests that the government table a comprehensive response to this report.

A copy of the relevant Minutes of Proceedings (*Meeting Nos. 24, 25, 26, 33, 34, 37 and 38, including this report*) is tabled.

Respectfully submitted,

Bonnie Brown, M.P.
Chair

Canadian Alliance Dissenting Opinion

Issued by Rob Merrifield, Senior Health Critic
Carol Skelton, Deputy Health Critic
Betty Hinton, Deputy Health Critic

INTRODUCTION

The HIV/AIDS epidemic continues to take a devastating toll on the health and lives of thousands of Canadians. This is all the more troubling when it is widely recognized that HIV/AIDS is 100 per cent preventable. In our minority report, we highlight the need within the Canadian Strategy on HIV/AIDS (CSHA) for a more aggressive emphasis on HIV prevention. The Canadian Alliance believes a more focused, coordinated and sustained effort needs to be undertaken by governments, health authorities and community organizations to prevent the spread of HIV. We are convinced that this will pay dividends in improved human health, spared lives and reduced health care expenditures.

FUNDING

The Canadian Alliance supports increased funding for the Canadian Strategy on HIV/AIDS. Because of the continuing severity of the epidemic, the reality of more Canadians living with HIV/AIDS and the fact that annual funding for the Strategy has remained unchanged for several years, we support a greater financial commitment for the CSHA.

But while the Committee recommended an increase in funding to $100 million per year, we think an increase to $85 million is reasonable and appropriate. We do so on the following grounds:

First, several of the witnesses from the Canadian HIV/AIDS community who appeared at committee specifically requested an approximate doubling of annual funding for the Strategy from $42.2 million to $85 million. While a greater increase is unlikely to be rejected, the federal government must weigh the spending needs of numerous competing health and non-health priorities.

Second, some of the at-risk populations for which the Committee recommended specific funding allocations (eg. $5 million for First Nations and Inuit, $5 million for inmates) represent not new spending priorities but ones already included in the Strategy. A doubling of the CSHA to $85 million using the existing distribution of spending priorities would result in a doubling of funds for these at-risk, sub-populations, including $5.2 million for First Nations and Inuit.

Finally, it must be recognized that success in the fight against HIV/AIDS is not a mere function of dollars spent. The United States, at $12 per capita, spends far more on HIV/AIDS than does Canada, at $1.40 per capita. And yet, the U.S. has an HIV prevalence rate 94 per cent higher than Canada's. By contrast, Australia, at $1.25 per capita, spends less than Canada and has an HIV prevalence rate 60 per cent lower than in Canada. According to the Ministerial Council on HIV/AIDS, "Clearly, spending alone does not correlate with a country's success in preventing the spread of HIV/AIDS."[1] These findings point to the need to look beyond dollars and cents to early, effective and continually monitored HIV/AIDS prevention strategies.

Recommendation:

That funding for the Canadian Strategy on HIV/AIDS be increased to $85 million per year.

PREVENTION

The Canadian Alliance believes that a strategic and sustained focus on prevention should be the centrepiece of a renewed Canadian Strategy on HIV/AIDS. Many commentators have noted that HIV/AIDS is 100 per cent fatal and 100 per cent preventable.

The Canadian Strategy on HIV/AIDS currently includes no clear, coordinated plan for HIV prevention. We consider this an important deficiency. Accordingly, we are calling for an HIV Prevention Strategic Plan, similar to that adopted by the U.S. Centers for Disease Control and Prevention (CDC) in January 2001.[2] Such a plan should include clear and measurable objectives, and be subject to regular monitoring and updating to ensure program efficacy.

We concur with the Committee's recommendation that the CHSA set five-year measurable goals for decreasing the annual number of HIV infections. We note that the Ministerial Council on HIV/AIDS cited shortcomings with the CSHA in this area: "The Strategy has goals and policy directions, and it encompasses a broad range of activities. But it does not have clear, precise and quantifiable objectives."[3]

The Canadian Alliance believes the Committee's call for five-year measurable goals should be taken one step further. We are calling for a targeted reduction in the annual rate of new HIV infections in Canada from over 4000 to 2000, within five years. (A similar objective is included in the CDC's strategic plan.) Such a reduction would save

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1 See *Taking Stock: Assessing the Adequacy of the Government of Canada Investment in the Canadian Strategy on HIV/AIDS*, Ministerial Council on HIV/AIDS (2001), pp. 19-25.

2 *HIV Prevention Strategic Plan Through 2005*, Centers for Disease Control and Prevention, January 2001.

3 See *Taking Stock,* p. 32.

10,000 lives and prevent additional financial stresses on the health care system of hundreds of millions of dollars.

Programs funded through the HIV Prevention Strategic Plan should include ones which reflect the “ABC” model of preventing HIV infection, an approach which has proven very effective in Africa and is being adopted elsewhere. The ABC approach — Abstinence for unmarried adolescents, Be faithful for married couples or individuals in committed relationships and Condom use for those involved in high-risk behaviours — provides a clear, consistent message while targeting specific groups.

Recommendations:

That the Canadian Strategy on HIV/AIDS include a five-year HIV Strategic Prevention Plan. The plan should include clear and measurable objectives, as well as a process for accountability and regular evaluation.

That the HIV Strategic Prevention Plan include the goal of reducing the annual rate of new HIV infections in Canada from over 4000 to 2000 within five years.

That the HIV Strategic Prevention Plan allocate funds for programs based on the “ABC” model (Abstinence, Be faithful, Condom use where necessary).

Correctional Service Canada and Harm Reduction

The Canadian Alliance opposes committee recommendation 4(*d*) calling for Correctional Service Canada (CSC) to provide “harm reduction” strategies for the prevention of HIV/AIDS among intravenous drugs users in correctional facilities. Such strategies would see the introduction of needle exchanges to our federal prisons. This represents a fundamental shift from CSC’s current official policy of zero tolerance for illegal drugs. It would also amount to an admission of defeat to the disturbing reality of heightened drug use and abuse among inmates.

Needle exchanges will contribute to increased drug use among inmates and consequently, higher levels of HIV/AIDS, hepatitis and other conditions. In addition, by increasing the number of needles in our prisons, guards will be subject to greater risk of injury and intimidation. We believe Correctional Services Canada’s official policy of zero tolerance for illegal drugs should be maintained.

Recommendation:

That Correctional Service Canada maintain an official and enforced policy of zero tolerance for illegal drugs. Federal prisons should not embrace "harm reduction" measures, such as needle exchanges, for the prevention of HIV/AIDS among Canadian inmates.

Supplementary Opinion

Standing Committee on Health
Report on Strengthening the
Canadian Strategy on HIV/AIDS

Svend J. Robinson, MP

The New Democratic Party supports the recommendations of this report, but feels that it does not go far enough. We believe that the report should have also addressed the issues of cost and access to medications required by people living with HIV/AIDS, as well as the urgent need for Canada to contribute further resources to the global fight against the illness.

My New Democrat colleagues and I acknowledge and value the dedication and hard work of my fellow Committee members in holding hearings with a variety of important witnesses on the subject of the Canadian Strategy on HIV/AIDS. Like my colleagues, I want to thank all of the witnesses who appeared before us. Their evidence was of great value for its depth and insight.

In its report, the Committee has taken some important steps towards strengthening Canada's HIV/AIDS Strategy; however, it does not go far enough. The following are the key areas in which we believe that the report must be strengthened:

1. The Canadian Institutes of Health Research should consider funding public sector research on drug regime management studies, especially with regard to optimizing dosages.

2. Health Canada should work closely with consumer groups to facilitate HIV/AIDS drug approvals and to ensure surveillance follow-up.

3. The federal government should work with provinces and territories to implement the recommendations on prescription drugs relevant to HIV/AIDS contained in the Romanow Commission report, particularly by establishing a National Drug Agency, improving consistency in drug access and licensing nation-wide, developing a new medication management program for certain chronic and life-threatening illnesses, and most importantly reviewing Canadian patent policy with a view to reducing costs of prescription drugs.

4. Health Canada should work more closely with provinces and territories to ensure countrywide coverage for anti-Retroviral Treatment (ART) by health care providers.

5. Health Canada should work with provinces and territories to establish suggested standards for HIV treatment and for consistent Canada-wide access to routine pre-natal testing.
6. The federal government should increase its contribution to the global fight against HIV/AIDS and move towards the establishment of a Government of Canada International HIV/AIDS Strategy that reflects the principles and priorities set out by the affected nations through the UNAIDS program.

7. The federal government should provide leadership in ensuring that developing countries not be hindered by the interests of international pharmaceutical monopolies in their attempts to provide cheap and effective pharmaceutical drugs for their citizens living with HIV/AIDS.

8. The federal government should support a permanent solution under Article 30 of the TRIPS agreement, rather than supporting a 'waiver' solution to Paragraph 6 of the Doha Declaration, so as to improve the access of developing countries to generic HIV/AIDS and other drugs imported from other countries.

These are the key areas in which we believe the report should be strengthened.

MINUTES OF PROCEEDINGS

Wednesday, May 28, 2003
(*Meeting No. 38*)

The Standing Committee on Health met at 3:41 p.m. this day, in Room 308, West Block, the Chair, Bonnie Brown, presiding.

Members of the Committee present: Carolyn Bennett, Bonnie Brown, Jeannot Castonguay, Brenda Chamberlain, Raymonde Folco, Betty Hinton, Rob Merrifield, Svend Robinson, Hélène Scherrer, Carol Skelton and Yolande Thibeault.

Acting Member present: Bernard Bigras for Diane Bourgeois.

In attendance: *From the Library of Parliament*: Nancy Miller Chenier and Sonya Norris, research officers.

Witnesses: *From the Canadian Biotechnology Advisory Committee*: Mary Alton Mackey, Member, and Co-chair, GM Foods Steering Committee. *From the Canadian Food Inspection Agency*: Greg Orriss, Director, Bureau of Food Safety and Consumer Protection; Bart Bilmer, Director, Office of Biotechnology. *From the Canadian General Standards Board*: Doryne Peace, Chair, Committee on Voluntary Labelling of Foods Obtained or Not Obtained through Genetic Modification; Marian Gaucher, Secretary, Committee on Voluntary Labelling of Food Obtained or Not Obtained through Genetic Modification. *From the Department of Health*: Karen L. Dodds, Director General, Food Directorate, Health Products and Food Branch; Paul Mayers, Acting Associate Director General, Food Directorate, Health Products and Food Branch.

Pursuant to Standing Order 108(2), the Committee held a session on the labelling of genetically modified foods.

Mary Alton Mackey, Greg Orriss and Doryne Peace made brief statements and, with other witnesses, answered questions.

At 5:02 p.m., the sitting was suspended.

At 5:05 p.m., the Committee proceeded to sit *in camera*.

Pursuant to Standing Order 108(2), the Committee resumed its study on the Canadian Strategy on HIV/AIDS.

The Committee resumed consideration of a draft report.

It was agreed, — That, the Committee adopt the draft report, entitled *Strengthening the Canadian Strategy on HIV/AIDS*, as amended, as the third report of the Committee to the House.

It was agreed, — That, pursuant to Standing Order 109, the Committee request that the government table a comprehensive response to this report.

It was agreed, — That the Chair be authorized to make such typographical and editorial changes as may be necessary without changing the substance of the report.

It was agreed, — That, pursuant to Standing Order 108(1)(*a*), the Committee authorize the printing of brief dissenting and/or supplementary opinions as appendices to this report, immediately after the signature of the Chair, and that the opinions be sent to the Clerk of the Committee in electronic form in both official languages on/or before 3:00 p.m. on Monday, June 2, 2003.

It was agreed, — That the Chair, or her designate, be authorized to present the report to the House.

It was agreed, — That the Clerk of the Committee organize a press conference on tabling day, after the tabling of the report.

It was agreed, — That, having heard the update on the labelling of genetically modified foods, the Committee not pursue the subject further at this time.

At 5:23 p.m., the Committee adjourned to the call of the Chair.

José Cadorette
Clerk of the Committee