
PUBLIC HEALTH AGENCY OF CANADA
AND
NATIONAL COLLABORATING CENTRE
FOR INFECTIOUS DISEASES

HIV PREVENTION FORUM

Meeting Summary

April 12-13, 2007
Delta Hotel
Ottawa, Ontario

Public Health Agency of Canada

Our mission is to promote and protect the health of Canadians through leadership, partnership, innovation and action in public health.

National Collaborating Centre for Infectious Diseases

Our mission is to protect the health of Canadians by facilitating the use of evidence and emerging research on infectious diseases to inform public health programs and policy.

This report is available (PDF):

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Background and Introduction

This report summarizes the discussions that took place at the HIV Prevention Forum held April 12-13, 2007, at the Delta Hotel in Ottawa, Ontario. The forum was organized jointly by the Public Health Agency of Canada (PHAC) and the National Collaborating Centre for Infectious Diseases (NCCID). The objectives of the workshop were as follows:

- To present an overview of HIV prevention undertaken or supported by the Government of Canada under the Federal Initiative, the NCCID and other stakeholders;
- To highlight best practices and evidence-informed HIV prevention interventions and to identify opportunities in HIV prevention research, knowledge exchange and promotion of best practices; and
- To encourage HIV prevention partnerships across jurisdictions and among public health providers/practitioners/policy makers, community-based service organizations, laboratories, researchers and their institutions and other key stakeholders.

The forum was divided into two parts. The first part focused on information and knowledge sharing and included four panel discussions. These panels were intended to provide participants with different perspectives from the international, federal, provincial and municipal levels, community groups and researchers. In the second part, participants were provided with an opportunity to discuss HIV prevention issues; to identify strategies to support and/or address testing, surveillance, co-infection and knowledge transfer and dissemination; and to determine which of these strategies garner the most support.

One hundred and twenty-eight participants representing a diverse group of stakeholders, including people living with or affected by HIV/AIDS, researchers, federal, provincial, territorial and municipal governments, community-based and national voluntary organizations, health care professionals, public health professionals and international experts took part in the forum. A list of participants is provided in Appendix A.

Welcome

Dr. Allan Ronald, Scientific Director, National Collaborating Centre for Infectious Diseases and Geneviève Tremblay, Manager, Public Health Agency of Canada

Allan Ronald and Geneviève Tremblay began the workshop by welcoming participants and highlighting the importance of coming together to eliminate the HIV epidemic. Geneviève Tremblay noted that input received during the workshop would be used to inform and support the development of a PHAC policy framework on prevention. She encouraged participants to take advantage of the forum to identify new partnerships and strategies to sustain their prevention efforts.

Opening Remarks

Dr. David Butler-Jones, Chief Public Health Officer of Canada

Dr. David Butler-Jones provided the opening address to participants. He introduced the Public Health Agency of Canada, according to its enabling legislation and touched on his own dual role as deputy head responsible advising the Minister of Health on matters of public health and on the operations of the Public Health Agency and as Chief Public Health Officer of Canada responsible for speaking to Canadians as a credible and trusted voice on public health issues.

Quoting Sir William Osler, a physician, Dr. Butler-Jones said: "*To prevent disease, to relieve suffering and to heal the sick—this is our work.*" When dealing with a pandemic, such as HIV/AIDS, success relies on seizing opportunities to reflect on common challenges and to discuss roles and responsibilities in addressing them. Prevention may take different forms, but it is ultimately about achieving the best outcomes, ensuring the balance between prevention, care and treatment and using the required expertise and evidence to do so.



Examples of prevention include introducing earlier and reinvigorated use of Highly Active Antiretroviral Therapy (HAART); developing health policy that protects the public and reduces stigma and discrimination; supporting research that includes behavioural and community-based research; better understanding the results of male circumcision studies; new technologies (vaccines, vaginal and rectal microbicides); harm reduction, such as the consistent use of condoms and clean needles; broadening HIV testing and counselling; strengthening community capacity considered to be our critical edge; supporting the GIPA principle; and supporting population-specific approaches, a hallmark of our response.

Dr. Butler-Jones reminded participants of the need to be strategic and that public health must focus on individuals, communities and their interaction. Public health is the organized effort of society to improve health and well-being. He said that the forum was about achieving a better understanding of the opportunities that lie ahead and to identify the strategies to assist us in seizing them. He concluded his remarks quoting Henry Van Dyke: "Use what talents you possess, for the woods would be very silent if the only birds that sang were those that sang best."

International Perspective Panel

Four panellists from different countries were invited to provide information on initiatives that were underway in their specific jurisdictions and to share best practices and lessons learned. Copies of the following presentations are available under separate cover.

Sustaining HIV Prevention: HIV Testing in Health Care Settings **Dr. Kevin Fenton, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention** **Centers for Disease Control and Prevention, United States of America**

Dr. Kevin Fenton explained how routine testing was an important part of the Centers for Disease Control's (CDC) HIV Prevention Strategy. He began his presentation by providing an overview of the key populations affected by HIV/AIDS and of current HIV testing practices in the United States. The CDC estimates that the majority of individuals diagnosed with HIV/AIDS were infected through sexual contact and that approximately 1.2 million Americans living with HIV/AIDS are undiagnosed.

Based on this information, the CDC has issued revised recommendations for HIV testing of adults, adolescents and pregnant women in health care settings. HIV testing is seen as an important part of a comprehensive HIV prevention strategy and new evidence has shown that awareness of HIV infection leads to substantial reductions in high-risk sexual behaviour. The revised recommendations suggest routine and voluntary HIV screening in health care settings for all persons between the ages of 13 and 64 and that screening should be repeated annually for people with known risk. Patients who test HIV positive should be linked to clinical care, counselling, support and prevention services.

Dr. Fenton highlighted that the implementation of the revised testing recommendations will require new partnerships and strategies with national organizations in addition to providing training and technical assistance. For example, the CDC is working with the New York City Health and Hospital Corporation and has achieved significant results thus far with the number of diagnoses nearly doubling within the first year of implementation. The CDC is developing implementation guidelines for different settings in collaboration with key stakeholders.

Dr. Fenton believes that the proposed screening strategy is feasible in health care settings under current laws, rules and regulations. He concluded by saying that a number of implementation initiatives were underway and that partnerships would be key to their success.



HIV Prevention – A French Perspective

Dr. Pascal Chevit, Head, HIV/AIDS Division, Ministry of Health, France

Dr. Pascal Chevit provided the French epidemiological context where it is estimated that 130 000 people are infected with HIV and 6 000 new cases are diagnosed every year. The epidemic mostly affects men having sex with men (MSM), people originating from Africa and women. However, increased access to antiviral treatments has significantly reduced the number of deaths caused by HIV/AIDS. Dr. Chevit then explained that the main actors in HIV prevention in France include the Ministries of Health and Education, the National Institute for Prevention and Health Education (INPES – Institut national de prévention et d'éducation pour la santé) and various associations funded through government contributions. Dr. Chevit added that most activities are controlled centrally at the national level and that a smaller number of initiatives are lead by local communities.

Dr. Chevit cited some achievements of France's HIV/AIDS prevention strategy, including increased blood transfusion security, reduced risk among injecting drug users (IDU), decreased mother –to- child transmission and increased use of condom among youth. He also noted areas of concerns, such as the low level of testing, insufficient sexual health education, the situation in prisons, the vulnerability of sex workers and the increased rates of transmission among MSM.

The fight against HIV is increasingly challenging. HIV prevention is no longer a priority in France (although it remains politically sensitive) and the number of groups advocating for the fight against HIV seems to have decreased. Promising innovative technologies, such as the second generation of feminine condoms, pre-exposure treatments, circumcision, and HIV vaccines give some hope, however, many questions need further exploration and debate, such as the admission of MSM in blood donation programs, rapid-testing and systematic testing approaches, and prevention strategies for detainees to name a few.

Dr. Chevit concluded his presentation by sharing his thoughts on the future of HIV prevention which includes more systematic testing, favours population-specific approaches, and mobilizes individuals and collective resources to create a community approach.

Australia's Response to HIV Prevention

Dr. Bronwen Harvey, Medical Advisor, HIV/AIDS and STI Section, Targeted Programs and Prevention Branch, Department of Health and Ageing, Australia

Dr. Bronwen Harvey gave an overview of Australia's response to HIV. She began her presentation by providing a brief description of Australia's demographics and government. Starting in the mid-1980s, Australia developed a coordinated response to HIV and launched its first National HIV Strategy in 1989. This strategy required a "partnership approach" and cooperative involvement of the community, medical and scientific professionals and the government. Australia is now implementing its *Fifth National HIV/AIDS Strategy (2005-2008)* which aims to reduce HIV transmission and minimize the personal and social impacts of HIV/AIDS infections for priority target groups, including homosexually active men, people living with HIV/AIDS, Aboriginals and Torres Strait Islander people, IDUs, sex workers and people in custodial settings.

Australia has comparatively low rates of HIV/AIDS in the IDU, sex worker and general populations. However, similarly to other developed countries, HIV/AIDS continues to affect a larger number of MSM. The annual number of HIV diagnoses has risen over the past five years, while prevalence has increased as a result of the availability of HAART.



Australia has a strong and proven capacity to deliver effective HIV prevention programs that Dr. Harvey attributes to community involvement in service delivery and development of prevention education; a well-established infrastructure and partnerships amongst governments, communities and researchers; and the early introduction and continuation of needle and syringe exchange programs, which has significantly lowered HIV/AIDS rates in the IDU population. Dr. Harvey explained Australia's challenge in understanding the drivers responsible for the increase in HIV infections. She suggested that some important factors to consider include the "safe sex" message fatigue; the availability of HAART; and the increasing rates of sexually transmitted infections (STIs).

Dr. Harvey indicated that Australia's health prevention community needs to revitalize its approach to maximize its impact. The Australian Government has commissioned researchers to examine existing qualitative and quantitative data, including surveillance and social research data and is consulting stakeholders to better understand what is driving the increase in infections. The results will inform the development of revitalized education and prevention efforts.

Challenges for Gay Men's HIV Prevention Work in England **Nick Partridge, Chief Executive, Terrence Higgins Trust, United Kingdom**

Nick Partridge focused his presentation on HIV prevention among gay men since they constitute 75% of new diagnoses in the United Kingdom, particularly among gay men over the age of 30. Behavioural research and epidemiology suggest that:

- positive and negative men are using risk reduction measures;
- men with undiagnosed HIV account for a significant percentage of HIV transmission;
- there is no evidence of increasing HIV incidence in men under 25 years in London;
- risk behaviours change with age;
- there is a lack of awareness amongst some groups of men of their proximity to HIV;
- the gay male population is changing as a result of migration, especially in London; and
- the sexual health of positive gay men is worsening.

The British Department of Health has been funding the Community HIV/AIDS Prevention Strategy (CHAPS) since 1996. This strategy is coordinated by the Terrence Higgins Trust and regional community-based partners. Local health authorities also fund prevention activities outside of CHAPS. According to Mr. Partridge, HIV prevention is no longer a national priority and does not receive sufficient funding. HIV prevention is now part of a broader sexual health strategy. Mr. Partridge noted that HIV cannot be treated as a preventable epidemic and that efforts should focus on reducing the onward transmission of HIV by undiagnosed people.

Mr. Partridge concluded his presentation with some key messages:

- There is a need to re-invest in gay men's HIV prevention and to expand national HIV prevention programmes with gay men.
- National and local programmes must be integrated and community-based HIV testing should be encouraged.
- Additional interventions should be provided at HIV testing sites and additional work is required with people living with HIV and STDs.

Question and Answer Period

After the four presentations, participants were provided with an opportunity to ask questions. The following summarizes some of the key discussion points.

- Members of the panel touched on their countries' low HIV infection rates among IDUs following the introduction of harm reduction and needle exchange programs. For example, in France, while HIV infection rates among IDUs are low, the increase in hepatitis C could be attributed to the disease being more easily transmissible than HIV.



- The importance of community-based prevention in other countries was addressed by all panellists:
 - Australia recognizes the importance of engaging community groups and has developed good working relationships with them.
 - In the UK, most work is done by community organizations and the public health department.
 - The United States acknowledges the significant contribution of community-based organizations and non-governmental organizations in the implementation of its strategy.
 - For historical and cultural reasons, it was noted that France has thus far been sceptical of community-based approaches and its impact on national cohesion.
- The CDC was able to obtain support from key communities that were affected by HIV/AIDS through extensive consultations with various stakeholders. When the recommendations were released, the Association for People Living with AIDS expressed its support, but stressed that prevention strategies should focus on individuals and protect their rights. The recommendations have inspired some debate. While some states have chosen to maintain their existing testing guidelines, many others have begun a review of their legislation to enable these recommendations. The CDC recognizes the importance of evaluating the effectiveness of these recommendations and will rely on communities and partnering agencies to capture and monitor the outcomes of these strategies.
- Wider and more accessible HIV testing is crucial, but must be accompanied by other prevention efforts.
- The UK has observed that epidemic trends can be deduced from recent infection cases and is still considering how to harness advances in testing technologies to identify recently infected individuals and appropriate interventions to reduce further transmission. The CDC is facing a similar challenge and is considering using social networks and redeveloping partner notification strategies among other approaches.

Federal, Provincial/Territorial, Municipal Perspective Panel

The next panel focused on the Canadian public health context at the various levels of government. In particular, they were asked to describe their preferred future for HIV prevention and how this future could be achieved. Copies of the following presentations are available under separate cover.

The Federal Initiative to Address HIV/AIDS in Canada

Nina Arron, Director, HIV/AIDS Policy, Coordination and Programs Division, PHAC

Nina Arron provided an overview of the Federal Initiative to Address HIV/AIDS in Canada (Federal Initiative). The goals of the Federal Initiative are to prevent the acquisition and transmission of new infections; to slow the progression of the disease and improve quality of life; to reduce the social and economic impact of HIV/AIDS; and to contribute to the global efforts to reduce the spread of HIV and mitigate the impact of the disease.

Leading Together – Canada Takes Action on HIV/AIDS (2005-2010), developed by a broad range of stakeholders with the support of PHAC, lays out the optimal, ideal response to HIV/AIDS in Canada and calls for bold action on many fronts, including for federal leadership as a cornerstone of the way forward. The Federal Initiative is distinct from *Leading Together* but contributes to the broader pan-Canadian response envisioned in this visionary document.

Partners involved in the Federal Initiative include PHAC, Health Canada, the Canadian Institutes of Health Research (CIHR) and Correctional Services Canada. Key areas of action include

program and policy interventions; knowledge development; communications and social marketing; coordination, planning, evaluation and reporting; and global engagement.

Looking into the future, Ms. Arron noted that PHAC must remain responsive to the epidemic and support Canada-wide action on HIV and AIDS. Public health and prevention happen at the community level and the actions of the federal government must bring value to this work. For PHAC, this means enhancing relationships with provinces and territories around information sharing; providing accurate and precise public health advice to Canadians; ensuring a strong science capacity and strengthened internal capacity and infrastructure; strengthening relationships between domestic and international policy; and ensuring that resources achieve intended results. The federal government cannot do it all – part of its role is to convene partners from across the country and beyond, to have discussions and debates around themes, such as HIV prevention and to take away the knowledge, expertise and views of those involved to inform and influence PHAC's strategies and actions.

HIV Prevention in Canada: The Future

Dr. Michael Rekart, Director, STD/AIDS Control, BC Centre for Disease Control

Dr. Michael Rekart presented his preferred future and stressed the importance of understanding the current situation in Canada before identifying possible actions to move forward. Dr. Rekart feels a time when there will be a noticeable yearly decline in the number of new HIV cases is within reach and could be achieved using current knowledge, technologies and tools. Here are some of his suggestions:

1. Nucleic acid amplification testing (NAAT) should be used to identify individuals with acute HIV. Genotyping acute traits would ease the identification of social networks that are at increased risk and enable targeted community-based risk reduction programmes.
2. NAAT could also be used to identify individuals with acute HCV. According to his research, HCV-positive individuals are likely to test HIV positive within three years and HIV-positive individuals are likely to test HCV positive within one year. HIV and HCV NAAT technologies share similarities and integrated prevention strategies could address co-infection risks.
3. There should be an increased focus on HSV-2 prevention and prophylaxis. Dr. Rekart expressed the strong belief that herpes is the most important sexually transmitted infection in the HIV epidemic and that there is a need for a dynamic herpes strategy in Canada.
4. The number of HIV patients taking antiretrovirals (ARVs) must increase. Only 30% to 50% of qualified patients currently take ARVs. They reduce the viral load and improve the quality of life. New ARVs are less toxic and easier to take than their predecessors. ARV treatment is a conduit to prevention, harm reduction, drug treatment and control of other communicable diseases.
5. HIV testing programs should be expanded to include more point-of-care settings and rapid testing should be made more widely available, especially in marginalized communities that would normally not seek HIV testing. This includes additional testing for inmates, Aboriginal communities, ethnic communities, rural settings and patients with others STDs.
6. Additional investments are required for community-based programs. Community-based programs could offer positive prevention strategies, such as sero-sorting, prevention at high-risk venues, cyber-outreach programming, and community-based research. Communities are also in a better position to provide targeted messages to reach those affected in their communities.



The future of HIV Prevention in five years: Perspectives of a regional public health division

(Translated from : *Avenir de la prévention du VIH dans cinq ans (2012) : Perspectives d'une direction de santé publique régionale*)

Dr. Alix Adrien, Physician Consultant, Montreal Public Health Department

Dr. Alix Adrien explained the organizational structure behind the delivery of health and social services in Quebec. The Ministry of Health and Social Services delegates the responsibilities of improving the health and well-being of provincial residents, activity planning and resource distribution to 18 regional agencies. Health and Social Services Centres were created by merging local community health centres (CLSCs), residential and long-term care centres (CHSLDs) and general and specialized hospital centres (CHSGSs).

Dr. Adrien highlighted *Leading Together's* continued relevance in the province of Quebec:

1) HIV and other sexually transmitted infections are still an important public health problem in Quebec with HIV prevalence rates of 17% in IDUs (2005-2006) and 12% in MSM (2005) and HIV incidence among IDUs and MSMs of 3.9/100 p-y (1995-2005) and 0.6/100 p-y (1996-2001) respectively. The majority of people infected with syphilis are also infected with HIV. Meanwhile, hepatitis C incidence doubled among IDUs between 2003 and 2006 (SurvUDI, 2006); 2) The needs of HIV -positive individuals are increasingly complex and the distribution of sterile injection equipment to IDUs only responds to 10% of needs; 3) Stigmatization and discrimination threaten HIV- positive people and communities at risk; 4) Poverty and other social factors are fuelling the epidemic; 5) There are still myths about HIV, which lead to increased risks and a reduction in support services, and; 6) There is a need for sustained funding to support HIV research, prevention and care. For instance, funding for surveillance activities should be increased to develop second- generation surveillance among vulnerable populations and to understand the link between crack use and HIV, and hepatitis C epidemics among IDUs.

Dr. Adrien emphasized the importance of moving from services for the general population to targeted services for populations at risk in the fight against STIs. Montreal's Public Health Division provides and funds a continuum of interventions related to sexual health promotion and the prevention and protection against sexually transmitted diseases for vulnerable populations. These interventions include surveillance, health promotion, prevention, health protection, treatment, healing and sustainable health. Coherent public health messages are required for new prevention technologies: circumcision for MSM, serosorting, microbicides, ARVs for prevention, vaccine, rapid testing, etc. This will be helped by implementing a strong knowledge transfer culture amongst health professionals.

Dr. Adrien concluded by highlighting the importance of creating strong coalitions and developing powerful intersectorial actions by improving living conditions of vulnerable populations; reducing stigmatization against these groups; and involving these populations in the planning, implementation and evaluation of the interventions.

HIV Prevention: A View From the Local Level

Dr. Rita Shahin, Associate Medical Officer of Health, Toronto Public Health

Dr. Rita Shahin provided an overview of some of the city of Toronto's accomplishments, including the successful control of prenatal transmission and the reduction of HIV transmission in the IDU populations through syringe exchange and screening programs. Still, Toronto is experiencing an increase in the number of men living with HIV and in the number of newly diagnosed cases, a significant proportion of which are among MSM. Toronto has also experienced an increase in new STI co-infections cases over the past 15 years.



Dr. Shahin's preferred future includes an increased focus on primary prevention (i.e. targeted prevention and harm prevention strategies), early testing and diagnosis, and prevention for positives.

Dr. Shahin believes this is achievable and will require the development of strategic partnerships between public health and people living with AIDS, AIDS service organizations, community organizations, governments, researchers, bathhouses, Internet Service Providers and with other large cities. Collaboration between all these groups is necessary to develop common goals and to evaluate programs to improve them.

Among the tools and support systems required to achieve this preferred future are improved public health surveillance mechanisms, ongoing and timely behavioural surveillance data, evidence-based strategies, pilot programs and models, knowledge exchange and transfer to support effective interventions at the local level, the identification of optimal strategies and messages to reach HIV- positive individuals and the pooling of HIV prevention efforts on a larger scale.

Question and Answer Period

After the four presentations, participants were provided with an opportunity to ask questions. The following summarizes some of the key discussion points.

- The revision of the Canadian testing guidelines was highlighted along with the fact that PHAC is developing a testing policy framework and accompanying guidance document.
- The difficulty of enforcing Section 22 of Ontario's public health legislation, which requires HIV -positive individuals to disclose their status, was highlighted in reference to some of the prosecution of cases in Ontario of HIV -positive individuals who have failed to disclose their HIV status to their sexual partners.
- Constitutional jurisdictions responsibilities would require federal-provincial-territorial agreements to address the issue of sexual health education in schools at a national level.
- The decrease in sexual health education in schools can be attributed in part to reductions in funding from the local and provincial/territorial levels. After the 1998 amalgamation of Ontario school boards, the curriculum shifted its emphasis to more literacy, math and technology resulting in a decrease of hours dedicated to physical education where sexual health education was taught.
- Participants debated whether rapid HIV testing strategies would be appropriate without adapting pre- and post-testing counselling measures. Counselling for rapid testing needs to be adapted and individuals who tested positive should still be further tested using standard testing methods and offered post-testing counselling. Rapid testing would require third-party quality assurance programs and adequate infrastructure, but existing barriers, which prevent individuals from getting tested must be addressed.
- Participants discussed the role of supervised injection sites as part of HIV prevention efforts.
- Some participants felt that the lack of success with respect to HIV prevention could be attributed to insufficient funding.
- Participants engaged in a discussion around the merits and concerns around the "opt-in/opt-out" testing models. Some felt that opt-in testing is a barrier to testing, while others felt that testing without proper consent could be harmful to individuals.



Survey of Public Health Practitioners – HIV Prevention Priorities

This presentation is available under separate cover.

National Collaborating Centre for Infectious Diseases

Dr. Allan Ronald, Scientific Director, National Collaborating Centre for Infectious Diseases

Dr. Allan Ronald provided an overview of the National Collaborating Centres for Public Health and the National Collaborating Centre for Infectious Diseases (NCCID). The mandate of the NCCID is *to bridge the ongoing research and evidence in infectious diseases with the program and policy questions of front-line practitioners and public health policy makers*. One of the NCCID's priorities is to reinvigorate HIV prevention and respond to the recognized need for a more strategic and coordinated approach to HIV prevention by public health jurisdictions in Canada through the effective use of knowledge, best practices and evidence.

Additional investment in HIV prevention is needed because each infection is tragic and care for HIV- infected patients is only sustainable globally if there are successful prevention interventions. Existing interventions to be considered and further evaluate include routine testing with the option to refuse, preventions strategies for people infected with HIV, enhanced support for discordant couples, diagnosis of acute primary infection with behavioural change, increased STI control and partner notification.

Dr. Ronald explained that the NCCID organized a survey to engage front -line practitioners and determine priorities for HIV prevention and perceived obstacles; to create expectations of change; and to encourage the creation of networks with PHAC, public health communities and other health care providers. The top three priorities identified by respondents included contact tracing and partner notification, testing for early diagnosis and STI control to reduce HIV transmission. Respondents were also asked if they felt sufficiently prepared to address sexual health issues and how much time they typically spent in counselling (Additional results from the survey are available in his presentation).

He concluded by identifying next steps and mentioned that it was important to clearly identify roles and responsibilities and to map out how the various groups involved are being funded.

Community Perspective Panel

The next series of presentations focused on the community perspective related to HIV prevention. In particular, panellists were asked to describe their preferred future for HIV prevention and how this future could be achieved. Copies of the following presentations are available under separate cover.

Strong recognition and support for the involvement of “Communities” in the fight to end HIV

Phillip Banks, Director, HIV Prevention and Awareness, AIDS Vancouver

Communities and community organizations have an undeniable role to play in the planning, implementation, and evaluation of HIV prevention strategies and initiatives. They can act as cultural, social or linguistic brokers, interpreters and translators of social norms, researchers, evaluators, program planners, developers, deliverers, agents of change, leaders and links. In order for communities affected by HIV to be meaningfully involved in HIV prevention, greater attention and support must be given to building and maintaining community infrastructure. This involves supporting leadership development and coordination, partnership development and collaboration opportunities, skills building and sustainable funding.



Phillip Banks shared what he considers to be the top three priorities for the empowerment of communities:

1. Improve leadership and coordination of HIV prevention strategies and initiatives;
2. Provide greater support for collaboration and partnerships within communities and between community organizations across the country; and
3. Increase opportunities for HIV prevention practitioners and PHAs to receive skills development training.

He concluded his presentation by sharing elements of his preferred future for HIV prevention, which included:

- A well- conceived, well- funded HIV prevention infrastructure with well- coordinated multi- sectoral partnerships where community groups and individuals play a key role;
- Population- specific approaches are supported by training and technical assistance in best practices intervention planning, implementation and evaluation;
- Community organizations can access funding and engage in knowledge exchange and transfer among themselves in a non-competitive environment;
- HIV prevention practitioners are nurtured and supported to remain in the sector; and
- A national centre for excellence in HIV prevention would be created.

HIV Prevention Forum – Community Perspectives **Monique Doolittle-Romas, Executive Director, Canadian AIDS Society**

Monique Doolittle-Romas' preferred future includes capturing and sharing proven strategies and best practices, using measures that are culturally appropriate, and making prevention a larger priority fully integrated in the mindset of all Canadians.

Canada is a role model for multi-sectoral partnerships as demonstrated by the Canadian HIV Vaccines Plan and the Canadian Microbicides Action Plan. While inter-sectoral partnerships continue to be crucial, non-traditional and community-based partnerships are an encouraging and growing trend. Peer and community buy-in for prevention programs are essential. Communities have ideas and require investment.

Ms. Doolittle-Romas believes the Canadian HIV/AIDS Skills Training Symposium could become a national forum for dialogue and knowledge transfer for many players involved in Canada's response to HIV/AIDS. She also noted the "*Leading Together*" targets as helpful guides, noting that this living document would need to be reviewed in the future. Many examples of good work are carried out in communities in response to HIV/AIDS and they must be recognized and built upon to improve prevention strategies.

To achieve this preferred future, Ms. Doolittle-Romas felt that some priorities, attitudes and support systems would need to shift. For example, governments must recognize the leadership role and effort that local groups and national organizations have assumed and provide them with adequate funding. The general perception that HIV/AIDS is under control since the disease has moved from a life-threatening disease to a long-term disability must be countered. Lastly, renewed focus is required for the most affected populations such as gay men and in communities where the epidemic is just beginning to emerge.

Ms. Doolittle-Romas emphasized the importance of taking action stressing that Canada has the necessary knowledge, practices and a committed HIV/AIDS movement, which includes researchers, community groups, policy analysts and people living with HIV/AIDS. However, additional resources are required to help these groups move forward.



HIV Prevention Forum

René Lavoie, Consultant, Quebec Coalition of Community Organizations against AIDS (COCQ-SIDA)

René Lavoie explained the importance of continuously adapting strategies regarding HIV/AIDS. HIV is a mutating, adapting and changing virus, which requires changing strategies. Gaining a better understanding of the epidemic is key and new knowledge must be integrated into the development of appropriate solutions. Mr. Lavoie shared some examples of previous HIV/AIDS campaigns that became irrelevant with the emergence of new treatment options or when they did not consider their full impact on the target audience. For example, one campaign, intended to encourage safer-sex practices by illustrating the unwanted side-effects of HIV treatment. Unfortunately, the campaign in fact discouraged infected individuals from accessing treatment.

The capacity to adapt and to manage change is important. Mr. Lavoie cautioned against using treatment as the sole prevention strategy recommending instead a balance between ensuring the well-being of infected individuals and strategies to prevent further transmission. While sero-sorting may increase the risk of super-infection, HIV prevention interventions remain imperfect and additional research is necessary to identify more adequate prevention strategies.

Mr. Lavoie concluded his presentation by urging community-based and voluntary sector organizations, research and government to break down the silos and create new strategic partnerships.

Question and Answer Period

After the presentations, participants were provided with an opportunity to ask questions. The following summarizes some of the key discussion points.

- The challenges faced by community-based organizations on matters of addictions treatment, needle exchanges, harm reduction and prevention for positives were highlighted.
- Partnerships must be explored with the business community to make a difference. One participant pointed to his local community's experience where the community-based organization partnered with the downtown business community, the police and other community groups to address HIV issues.
- Partnering with ethno cultural organizations can provide value by sharing knowledge and effective strategies. However, some indicated that partnering with some of these organizations could prove difficult if, for example, they were unwilling to recognize gay men living in their communities.
- Concern was expressed about the perceived lack of action on the part of public health to address HIV issues among the gay population as a human rights issue.
- Small community-based organizations are competing for funds individually, while they should be looking to partner with other community-based and regionally based organizations. There was an acknowledgement that some communities may be reticent to partner as it presents new challenges.
- Some participants expressed their concern that the forum did not provide enough for opportunities to discuss issues affecting vulnerable populations, in particular the Aboriginal community.
- Increased attention should be provided to primary prevention strategies and should focus on access to services and youth education. There was a sense that young gay men would be better informed and would enjoy healthier sexual relationships if they had access to services after their "coming out". Collaboration should be pursued with all ministries of Education..
- Vancouver was highlighted for its efforts to re-engage communities on HIV prevention, shifting from addressing HIV in gay men in favour of a broader gay men's health promotion approach.



Research Perspective Panel

The next group of panellists was asked to share their thoughts on HIV prevention from a research perspective. In particular, they were asked to describe their preferred future for HIV prevention and how this future could be achieved. Copies of the following presentations are available under separate cover.

Innovation and Strategic Direction in HIV/AIDS Research

Dr. Bhagirath Singh, Scientific Director, Institute of Infection and Immunity, Canadian Institutes of Health Research

Dr. Bhagirath Singh explained the mandates of the CIHR and the Institute of Infection and Immunity (III); the area of the CIHR that deals with HIV- related research among other topics. HIV research is one of the institute's strategic areas and III is responsible for ensuring that Federal Initiative funding for research is invested in relevant research programs across Canada. In total, the CIHR invested over \$35 million in HIV/AIDS research in 2006-2007.

The CIHR HIV/AIDS Research Advisory Committee (CHARAC) is a diverse group representing many sectors that provides leadership and advice for HIV/AIDS research. After extensive consultation, the committee has identified 'prevention technologies and interventions' as being one of six strategic research priorities in HIV/AIDS for the CIHR. Dr. Singh highlighted the importance of ensuring alignment to reduce duplication of efforts and maximize strategic use of funds. He explained that behavioural, social and medical interventions are all important aspects of a comprehensive approach to the prevention of HIV. Biomedical and clinical research in prevention technologies, as well as culturally sensitive behavioural and social intervention studies and analyses of legal and policy issues are research areas that need to be addressed.

Looking towards the future of HIV prevention research, Dr. Singh believes that further emphasis on knowledge creation, capacity building and training, partnerships, knowledge translation and international linkages is required. Elements of his preferred future included:

- A comprehensive research program in HIV prevention leading to the development of new prevention technologies and effective social and behavioural approaches to prevention for vulnerable populations;
- Larger, multidisciplinary research teams collaborating to address the challenges of HIV prevention research;
- A coordinated approach to funding HIV prevention research in Canada and strong relationships among researchers, stakeholders and research funders, which foster the uptake and use of current knowledge;
- Greater coordination among research funders and international organizations;
- Stronger mechanisms to support knowledge translation to other researchers, policy makers, community and funders; and
- A robust, diverse and well-trained community of HIV/AIDS researchers in Canada.

Dr. Singh also listed key accomplishments that were achieved under all these areas.

HIV Prevention Forum: The Preferred Future

Dr. Ted Myers, President, Canadian Association for HIV Research (CAHR)

Dr. Ted Myers shared his personal perspectives on HIV prevention research. He assumes that a biomedical HIV prevention solution will not be available or rolled out by 2012 and that there will continue to be increased need and emphasis on evidence-based strategies for prevention, human rights, and better understanding of behaviours and factors that contribute to risk taking.



Regardless of the prevention scenario, education, health promotion, and policy initiatives informed by research will continue to be important.

Dr. Myers asked participants to reflect on which research areas Canada had been a leader or a follower in terms of technology, access, community engagement, understanding social and psychological determinants, policy and legislation and societal forces. He emphasized the importance of strategic partnership across jurisdictions and internationally. Strategic partnerships are reflected in CAHR's objectives and are needed to establish a strengthened role for research in a national HIV strategy, to increase cross-jurisdictional partnerships, and to increase collaboration with international partners.

Dr. Myers concluded his presentation by sharing principles for sustaining, enhancing and supporting prevention research, such as:

- Acknowledging that an evidence base for prevention and intervention research is essential;
- Ensuring balance across disciplines;
- Continuing to support research in Canada;
- Encouraging projects national in scope to permit comparison;
- Continuing to refine existing technologies and techniques and to monitor and assess disease impact;
- Investing in ongoing behavioural social research; and
- Obtaining more evidence on the impact of specific policies, the roles of social determinants and public campaigns to reduce stigma.

The Evaluation of Vancouver's Medically Supervised Safer Injection Facility and The Case for Expanding Access to Highly Active Antiretroviral Therapy to Curb the Growth of the HIV Epidemic

Dr. Julio Montaner, Director, BC Centre for Excellence in HIV/AIDS

Dr. Julio Montaner presented the results from research on the evaluation of Vancouver's medically supervised safer injection facility and the expansion of highly active antiretroviral therapy (HAART) use to curb the spread of HIV.

A great deal of rigorous scientific evidence on the impact of supervised injection sites (SIS) has demonstrated significant positive impacts and rules out potential negative effects of these sites. Given the positive health and community impacts of SIS, it is clear that facilities, such as InSite in Vancouver should remain open. Dr. Montaner believes that closure of the site could result in a deterioration of public order, the potential for elevated HIV incidence, and lives lost due to fatal overdoses. He also believes that new SIS delivery models should continue to be rigorously evaluated.

The use of HAART has shown to be effective in reducing the transmission of the virus in mother-to-child transmissions, in discordant couples, and in ecological studies from BC and abroad. His conclusions thus far are that HAART has evolved dramatically over the last decade and is cost-effective when used in a traditional patient-centered model and even more cost-effective considering its potent effect on secondary HIV prevention. Dr. Montaner hopes to pursue his hypothesis and presented a proposal to evaluate the impact of expanding HAART on HIV Incidence in British Columbia and in a second related project in Malawi.

Question and Answer Period

After the presentations, participants were provided with an opportunity to ask questions. The following summarizes some of the key discussion points.



- Some participants shared their concerns about the expanded use of HAART as a prevention tool:
 - Some participants felt that neither testing nor treatment should ever become mandatory. However, without recommending mandatory treatment, this therapy may have a significant impact on the number of newly diagnosed cases.
 - There were some disagreements on whether research had demonstrated that HAART not only reduced the viral load blood but also in seminal and vaginal fluids.
- Participants agreed on the need to clearly articulate messaging flowing from research.. HIV prevention issues are complex and researchers need to be supported by community organizations to translate research into practice. Community groups must also support researchers during the planning phase and assist with the interpretation of results.
- Views from Aboriginal peoples, people living with AIDS, gays and prisoners, among others, must be solicited when identifying research priorities. It is important to ensure a community advisory voice throughout the process. An example of this being CIHR's advisory committee, composed of 13 people responsible for representing various points of views.
- Given the evidence related to SIS, many participants asked if and when PHAC would take a position on this issue.
- It was suggested that funding for a prevention trial network would be valuable.

GUEST SPEAKER

LESSONS LEARNED IN HIV PREVENTION

Dr. Cate Hankins, Chief Scientific Advisor and Associate Director, Department of Policy, Evidence and Partnerships, UNAIDS

Dr. Cate Hankins was invited as a guest speaker to share her experiences in HIV prevention and lessons learned. She is a chief scientific advisor and associate director at UNAIDS in Geneva, Switzerland. She started by explaining how her work in Canada has prepared her for international work in her new position and shared some of the lessons she learned throughout her career thus far. Dr. Hankins's mantra is "know your epidemic." This can be achieved by reviewing the latest 1,000 cases of infected individuals. She encouraged participants to review UNAIDS's policy position paper entitled Intensifying HIV Prevention, which identifies the principles for effective HIV prevention programs and the essential HIV prevention policy and pragmatic action. In the last part of her speech, Dr. Hankins shared her views on what Canada could do to effectively confront the HIV epidemic.

Address on Public Health and Human Rights

Presentation on Public Health and Human Rights

Louise Binder, Chair, Canadian Treatment Action Council

Louise Binder was invited to present her views on the debate of protecting public health and human rights. Although these may seem irreconcilable, she believes that with imagination, creativity and the involvement of the population impacted by these public measures that it is possible to develop policies that will both protect public health and human rights. She began her presentation by sharing examples that illustrated the potential incompatibility of these two principles. Examples included criminalization of HIV- positive people alleged not to have disclosed; mandatory testing for people including pregnant women; and treating HIV positive-people even when they do not need treatment for their HIV, but solely as a prevention measure.



Ms. Binder continued by defining Public Health and Human Rights and illustrated that neither the *Code of Public Health* nor the *Human Rights Declaration* provided individuals with an unfettered right to do what they want without considering the impact on others.

She believes that the obvious course is for good public health policies, including developing health systems, treatment access, anonymous testing (as well as nominal testing), education and awareness programs, condom distribution, harm reduction, laws against violence against women, and providing education and employment for women. By involving those at whom these policies are aimed, it is possible to create policies that will be effective and accepted. Although it may be more work in the short term, they will prove to be more effective in the long run.

Working Sessions

In the following four working sessions, participants were provided with an opportunity to discuss key challenges and opportunities that needed to be addressed on the following four themes: testing, surveillance, co-infection, and knowledge transfer and dissemination. A presentation was provided on each of the themes to set the context for the discussion. Participants were asked to describe their preferred future and what needed to be achieved, and to recommend three strategies that would help address the issues. At the end of each session, participants were asked to vote for those strategies they most supported, while the results of the vote were not binding on any entity (government or organizations), these recommendations could inform future discussions, policy/program development or action by any of the participants who took part in this forum. The following provides a summary of the key points under each theme. Additional details captured from the table report books are available in the appendices at the end of this report.

Presentation: Testing

Marc-André Gaudreau, Manager, HIV/AIDS Policy, Coordination and Programs Division, PHAC

Marc-André Gaudreau provided context on the issue of testing and counselling services. He started by highlighting that Canada has one of the highest rates of people aware of their HIV status. He indicated that historically, Canada has generally created an environment of easily available voluntary testing supported by counselling services to encourage people to get tested and referral to appropriate health care services. By knowing their status and with proper individualized pre- and post- test counselling, Canadians are in a better position to protect themselves, as well as others from being infected, and to access appropriate care, treatment and support, when necessary.

With the transmission of HIV more likely to occur during the acute stages of infection, there is work to be done in increasing the proportion of Canadians aware of their sero-status. However, any increase in awareness rates would also necessitate health systems that are prepared to provide the additional care, treatment and support required. The World Health Organization is recommending that countries, like Canada, consider making testing and counselling more accessible through STI clinics, services targeted to populations at higher risk and that any decision with respect to the testing and counselling approach used be guided by an assessment of the social and epidemiological context.

Marc-André provided information about two promising testing technologies including rapid testing and Nucleic Acid Amplification Testing (NAT). Some studies demonstrated that there has been an increase in the rates of testing uptake when rapid testing is offered, as well as a higher satisfaction rates among people testing because of a reduction in anxiety around the testing process and its flexibility for use in communities and outreach settings. As the technology



advances and costs decrease, NAT will become another means to enable additional people to become aware of their HIV status earlier in the disease process.

Increasing the willingness of individuals to be tested requires addressing the barriers so that HIV testing becomes desirable rather than risky. In Canada, this means continuing to develop approaches to HIV testing and counselling that are informed by both public health science and human rights. Marc-André concluded his presentation by inviting the group to provide input that would support the development of a policy framework, which will guide decisions related to HIV testing policies in Canada.

Key discussion points related to testing

The following identifies the key points that were shared by participants related to testing.

The key challenges and opportunities related to testing include:

- Barriers for individuals to get tested, such as lack of awareness, lack of appropriate testing methods in different populations/areas, quality control issues related to rapid testing, and fear that positive results will lead to discrimination, stigma, criminalization, or violence (against women)
- Lack of access to testing facilities, especially in remote areas, in Aboriginal communities and for women
- Lack of knowledge among health care providers around treatments
- Concerns related to confidentiality and privacy
- Lack of education and social attitudes
- Inconsistent offering of counselling
- Public health care needs to be less reactive and more focused on primary prevention

Elements of the Preferred Future:

- Testing environments where people feel safe and comfortable across Canada
- Harmonized evidence-based public health practices, legislation and policies across Canada
- Testing is more widely available and accessible
- Improved public health care perception of risk
- Better and more consistent counselling
- Better understanding of targeted population at risk and practices adapted to various populations
- Normalization of HIV testing
- Increased testing to help identify unknown people living with HIV

Top Recommended Strategies:

1. Perform an environmental scan of current provincial and territorial testing policies, programs, evaluations, and legislations. Analyze these through a human rights perspective and work towards harmonized national testing standards and guidelines, which include a routine offer of testing with counselling and creating safe, comfortable and accessible testing facilities. (Lead: Public Health Network Council).
2. Provide comprehensive sexual health education to youth and extend to all groups with adjustments for specific populations. Testing should be discussed as part of a larger dialogue on social determinants of health. The intent is to decrease stigma and discrimination and increase desire to know HIV status (Lead: Youth in target groups; youth organizations, coalition with parents and teachers).
3. Ensure that all testing in Canada is accompanied by counselling in partnership with public health agencies and community ASOs, and enable non-health care workers to do pre-



counselling and post-counselling for individuals with negative results (Lead: Community and public health).

4. Increase readiness and support for the community by ensuring equity and dedicated funding. The continuum of prevention should include services, such as testing, care, treatment and support (Lead: Communities).

More details are available in Appendix B.

Presentation: Surveillance for HIV Prevention

Dr. Robert Remis, Professor, Department of Public Health Sciences, University of Toronto

To inform the discussion on surveillance, Dr. Robert Remis shared his perspectives on the challenges and opportunities related to surveillance. He noted that surveillance should be defined as “information for action” and that it should be done only if there is an intention to act on the indicators being observed. Good indicators must be valid, objective, quantifiable, feasible and stratified by population at risk, gender, age and geographic location. Key indicators for HIV prevention include:

- characterization of populations at risk
- HIV infection incidence and prevalence
- migration of HIV-infected persons
- AIDS incidence and prevalence
- CD4+ count and viral load in newly diagnosed persons
- HIV-related and other cause mortality
- HIV testing uptake in at-risk, pregnant women and the general population
- proportion of HIV-infected persons knowing their sero-status
- uptake of HIV prevention and treatment
- persons assessed and eligible for ARV treatment
- persons receiving ARV treatment
- ARV prophylaxis for mother-infant transmission
- at-risk sexual and other behaviours
- other sexually transmitted infections

Dr. Remis presented several information systems and programs that could be used to obtain key indicator data. These include census data, dedicated population-based surveys, special studies, enhanced HIV surveillance, notifiable diseases, outbreak investigations, and behavioural and serologic surveys. He believes that systematic programming of epidemiologic and behavioural research helps to explain, as well as to monitor infection and testing. Despite their problems, cohort studies in at-risk populations provide rich data on HIV incidence, determinants and risky behaviour.

Although this data will be used to evaluate the impact of HIV prevention policies and programs, it is important to consider that results may reflect the impact of multiple or repeated programs and other factors. Proper evaluation mechanisms should include adequate infrastructure and clearly defined processes and expected outcomes. In conclusion, he noted that an inventory of current HIV prevention related policies and programs would be extremely helpful to orient future efforts.

Key discussion points related to surveillance:

The key challenges and opportunities related to surveillance include:

- Certain populations are in denial and religion can be a barrier
- Lack of evaluation related to usefulness and timeliness of programs
- Lack of clarity in roles and responsibilities and lack of leadership
- Lack of long-term funding



- Meaningful engagement from front-line workers required (at the community level)
- No standardization in collecting data (e.g. for Aboriginal peoples or incarcerated individuals)
- Limitations of the reporting system and reporting infrastructure

Elements of the Preferred Future:

- Better understanding of communities
- Better partnerships, especially among federal, provincial and territorial governments and local communities
- Engaged communities and capacity -building knowledge for communities
- More timely, appropriate, useful data for those who need it and increased data collection of acute/recent cases
- Surveillance data is used in work planning
- Effective and efficient national notifiable disease system for HIV, HCV and STIs
- Accessible inventory of HIV prevention investments and outcomes
- PHAC has taken a leadership role
- Increased awareness and data collection standards for Aboriginal peoples

Top Recommended Strategies:

1. Restructure profiling and interview the last 1,000 HIV positive cases using a holistic process (Lead: Community organizations and people living with HIV/AIDS)
2. Enhance leadership from PHAC for systemic surveillance of HIV services in prisons
3. Organize a separate consultation/forum to identify Aboriginal surveillance issues to increase level of awareness, change attitudes and address concerns. (Lead: PHAC)
4. Evaluate the HIV surveillance system and support evaluation projects at provincial level in tandem with the national identification of core indicators (process, outcomes, impact). Make linkages to *“Leading Together”* (Lead: PHAC)

More details are available in Appendix C.

Presentation: Co-infection with Sexually Transmitted Diseases (STDs) **Dr. Paul MacPherson, Assistant Professor of Medicine, Division of Infectious Diseases, Ottawa Hospital**

Dr. Paul MacPherson explained how STDs affected transmission of HIV and how HIV in turn affects the presentation and treatment of STDs. In HIV-negative individuals, STDs break down natural barriers and thus facilitate entry of HIV. In HIV-positive individuals, STDs not only attract lymphocytes carrying HIV to the genital track, but also stimulate replication and release of new HIV particles. By increasing HIV viral loads in the genital track, STDs significantly increase the risk of HIV transmission. While there are conflicting studies on the issue, it is generally accepted that treatment of STDs may decrease the transmission of HIV.

HIV increases transmission and severity of other STDs. For example, HIV- positive individuals who have herpes tend to have more frequent and severe outbreaks, more frequent shedding of the herpes virus during asymptomatic periods, and greater risk of developing acyclovir-resistant herpes. HIV-1 infected patients treated with HAART also tend to have frequent reactivation of the herpes simplex virus.

Although he was pleased with the fact that women can be vaccinated against the human papilloma virus (HPV), Dr. MacPherson wondered why the vaccine was not being offered to men



considering that there is a higher incidence of HPV-associated malignancies in MSM compared to women and to the general population.

Dr MacPherson concluded his presentation by sharing data on the syphilis epidemic in Ottawa, which demonstrated how 48% of MSM who had syphilis were also HIV positive. One of the greatest challenges for public health care workers is that there are multiple and different concurrent HIV epidemics that each requires different strategies to effectively reduce transmission.

Key discussion results related to co-infection:

The following challenges and opportunities were shared by participants regarding co-infection.

- Inconsistent harm reduction approach
- Lack of knowledge among gay men about increased risk of infections
- Lack of standardized screening for anal cancer
- Myths related to HPV vaccines and their unavailability to men
- Lack of collaboration (except during outbreaks)
- Funding initiatives are set up with boundaries or specific disease targets
- Difficulty in integrating programs and/or integrating without clear objectives
- Lack of accessible pharmaceutical drugs
- Lack of funding for STIs
- Different populations may require different approaches
- Health care workers are not always comfortable with discussing sexual issues
- Need to provide comprehensive school- based education
- Need a consistent safer sex message
- Opportunities to share resources and expertise, but must be careful that disease do not fall off the agenda and that funding goes to HIV
- Assumptions and associated stigma issues related to the model of transmission

Elements included in the Preferred Future:

- Harm reduction approach to prevention
- Open and transparent discourse with all stakeholders about integration
- Integrated approach for HIV and STIs on testing, diagnosis, prevention, treatment and counselling
- Parallel Hepatitis C and HIV message (when appropriate)
- Successful pilot projects would be pursued and implemented as innovative prevention programs

Top Recommended Strategies:

1. Offer routine testing for HIV, HCV, Syphilis, Gonorrhea and Chlamydia (Lead: Public Health Network Council).
2. Provide ongoing sexual health education in schools and other areas to normalize and identify barriers.
3. Provide population -specific responses to prevention, treatment and management of co-infections, because different populations have different priorities. Expand co-infection research to include risk factors and co-morbidity. (Lead: Community and Public Health)
4. Develop a sustainable community- based Hepatitis C and co-infection strategy that provides dedicated care funds across the provinces and territories. Garner support from every provincial and territorial health minister and front-line public health workers (Lead: F/P/T, NCCID, all provincial and territorial public health agencies).



5. Merge program initiatives by key populations and have stipulations that service providers offer integrated HIV, HepC, STI service to reduce duplication of efforts; to increase collaboration by building strong relationships; and to better adapt to emerging trends and needs. This may involve some restructuring of community organizations/service provisions (e.g. Nine Circles Health Centre in Winnipeg merged at request of community).
6. Break down the silos separating community, research and public health efforts, as well as within public health groups. Maximize on the ability to work on approaches for prevention where there are common issues, risk groups, etc. (Lead: All)

More details are available in Appendix D.

Presentation: Knowledge Transfer and Dissemination

Dr. Sean B. Rourke, Scientific and Executive Director, Ontario HIV Treatment Network; Associate Professor of Psychiatry, University of Toronto, Research Scientist, Centre for Research on Inner City Health, St. Michael's Hospital

Dr. Sean B. Rourke shared his perspectives on how to improve knowledge transfer and exchange (KTE). He presented some of the high-level building blocks for effective KTE that included reading up on the Canadian KTE gurus; implementing steps on how to build and use evidence-based results to inform decision-making; and developing mechanisms to evaluate the impact. From his perspective, Jonathan Lomas, CEO for the Canadian Health Services Research Foundation, and Dr. John N. Lavis, Canada Research Chair in Knowledge Transfer (KT) at McMaster University are two great examples of Canadian gurus in the field.

Dr. Rourke discussed Mr. Lomas' five principles to KT: 1) KTE is a contact sport and team game; 2) written materials, in whatever form, are not enough to consistently transfer knowledge; 3) KT is about coordinating three "teams": those who create the knowledge, those who disseminate it and those who can use it; 4) the best form of KT is co-production of the research; and 5) it is as important to equip decision-makers with the tools to find and use research as it helps researchers and others to communicate it. Sean also outlined suggestions on how to build and use evidence-based research to inform decisions; this included a framework from Dr. Lavis and systematic approach to KT which includes: 1) identifying what message needs to be transferred; 2) to whom the message should be delivered; 3) by whom the message should be delivered; 4) how the message should be delivered; and 5) with what effect (evaluation). Researchers should also take advantage of existing systematic reviews and knowledge base and especially use evidence that has already been synthesized (e.g., The Cochrane Collaboration). Any knowledge transfer initiative should also be supported by adequate mechanisms to evaluate the impact of the knowledge used in the decision-making process.

To facilitate knowledge transfer and dissemination, it is important to bring the right people together, to create opportunities to interact and build partnerships and to be creative, flexible and adaptable. Dr. Rourke believes that although funding is essential, more capacity must be built through mentorship and training and more community-academic-policy partnerships are required.

Key discussion results related to knowledge transfer and dissemination

The following identifies the key points that were shared by participants regarding knowledge transfer and dissemination.

The key challenges and opportunities related to knowledge transfer and dissemination include:

- Lack of communication
- No true partnerships



- Not enough engagement of the community, academics and policy makers during the planning phase prior to research
- Prevention needs professional recognition alongside medical research
- Academics could be trained to obtain a better understanding of good KTE practices
- Lack of technical access
- Lack of capacity
- There are structures in place but they have not reached their potential
- No time to read research and reports and a lot of time is spent on choosing funding and administration

Elements included in the Preferred Future:

- Meaningful community engagement and partnerships in the KTE process
- Positive impacts resulting from research, interpretation of research and good engagement of KTE
- Policies and programs are informed by best evidence available in an efficient manner
- Adequate funding is available
- Continuous human capacity building for KTE
- Recognition of the worth/value of difference experience and expertise
- Best practices defined through different sources

Top Recommended Strategies:

1. Develop a mechanism for collecting and synthesizing HIV prevention research and program experience. Information should be housed by an independent body and knowledge should be translated into feasible recommendations for HIV Prevention Action (Lead: NCCID).
2. Ensure inclusion of key stakeholders in research projects from inception (Lead: Researchers).
3. Create more flexible funding applications and RFPs to provide financial resources that will bring people together for training and encourage capacity building (Lead: CIHR and PHAC).
4. Establish and ensure knowledge exchange mechanisms that engage and are relevant to all professionals, including front-line researchers, public health, and school educators (Lead: CBOs, federal, provincial/territorial governments).
5. Identify champions from every sector and bring them together to identify solutions (Lead: champions from every sector).
6. Assess historical research funding priorities to understand how research has informed policy and practice and develop strategically driven research priorities (i.e. no more HIV research in a vacuum).

More details are available in Appendix E.

Other recommendations:

At the end of the working session, participants offered the following recommendation, which was largely supported by the group:

- Develop a national framework for HIV prevention incorporating elements of a national prevention strategy. Cross reference this framework with an inventory of effective HIV prevention initiatives and use the framework as a guide for sustained long-term funding commitment (42 votes).



While supported by a many participants, some wondered why a national HIV strategy was not being recommended instead. However, the majority agree that the development of a national framework would be an important accomplishment, establishing a common playing ground for those wanting to participate in HIV prevention efforts.

Closing Remarks

Nina Arron, Director, HIV/AIDS Policy, Coordination and Programs Division, PHAC
Dr. Allan Ronald, Scientific Director, National Collaborating Centre for Infectious Diseases

Nina Arron and Allan Ronald closed the meeting by thanking all participants for their contribution. It was indicated that a report would be prepared following the meeting and would be distributed to participants. PHAC will develop a policy framework for HIV prevention, which will provide broad direction for engaging in HIV Prevention in Canada. Following the development of this framework, more specific guidelines can be created to address issues related to specific prevention areas.

NCCID will continue to move forward on this issue and will attempt to involve additional groups and communities in the discussion, to explore options in support of more bundled services, to increase understanding of HIV prevention issues, to clarify roles and responsibilities of all parties involved and to address some of the barriers and limitations identified during the forum.



Appendix A – Workshop Participants

Name	Organization
Aggie Adamczyk	Public Health Agency of Canada, Communications
Barry Adam	University of Windsor, Researcher
Harry Adams	National Aboriginal Council on HIV/AIDS, Pedagogical Counselor, CIHAN, Kativik School Board Continuing Education
Dr. Alix Adrien	Montreal Regional Public Health Dept. Consultant physician; Residency Program in Community Medicine-McGill University, Director; McGill University Dept. Epidemiology & Biostatistics, Assistant Professor
Pam Amulaku	Public Health Agency of Canada, Program Consultant, Regional AIDS Network, Alberta Region
Dr. Chris Archibald	Public Health Agency of Canada, Director, Surveillance and Risk Assessment Division
Nina Arron	Public Health Agency of Canada, Director, HIV/AIDS Policy, Coordination and Programs Division
Jackie Arthur	Public Health Agency of Canada, Senior Policy Advisor, HIV/AIDS Policy, Coordination and Programs Division
Chris Armstrong	Canadian International Development Agency, A/Team Leader, HIV/AIDS Policy Branch
Phillip Banks	AIDS Vancouver Director, HIV Prevention Services
Kevin Barlow	Canadian Aboriginal AIDS Network, Executive Director
Bronwyn Barrett	Positive Women's Network, Support Program Coordinator
Larry Baxter	Nova Scotia Advisory Commission on AIDS, Chair
Julie Bernier	First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC), Coordonnatrice technique VIH/sida en milieu urbain,
Louise Binder	Canadian Treatment Action Council, Chair
Eirikka Brandson	BC Centre for Excellence in HIV/AIDS, Program Analyst, HIV/AIDS Drug Treatment Program
Dr. James Brooks	Public Health Agency of Canada, Chief - Genetics, National HIV Laboratories
Barb Bowditch	Prince Albert Sexual Health Clinic, HIV/Hep.C Consultant / Case worker
Dr. Bluma Brenner	McGill University, Researcher
Neil Burke	Public Health Agency of Canada, Manager, HIV/AIDS Policy, Coordination and Programs Division
Dr. David Butler-Jones	Public Health Agency of Canada, Chief Public Health Officer
Dr. Liviana Calzavara	University of Toronto, Researcher
Wayne Campbell	BC Persons With AIDS Society, Secretary
Lisungu Chieza	AIDS Committee of Toronto Board Member, Voices of Positive Women, Women's Community Education Coordinator
Dr. Pascal Chevit	Ministry of Health of France, Head, HIV/AIDS Division
Joanne Csete	Canadian HIV/AIDS Legal Network, Executive Director
Ian Culbert	Canadian Public Health Association, Director, HIV/AIDS Information Centre
Jeanette Doucet	Pauktuutit Inuit Women of Canada, Manager, Sexual Health and HIV/AIDS Policy and Programs
Katherine Dinner	Public Health Agency of Canada, Research Analyst, Community Acquired Infections Division



Tracey Donaldson	Health Canada, Senior Policy Analyst, Office of the Drug Strategy Secretariat and Strategic Policy
Monique Doolittle-Romas	Canadian AIDS Society, Executive Director
Willow Dunlop	YouthCo. AIDS Society, Sexual Health Programs Coordinator
Dr. Andrew Ember	Human Resources and Social Development Canada, Medical Advisor, Canada Pension Plan
Dr. Kevin Fenton	United States Centers for Disease Control and Prevention, Director, National Center for HIV/AIDS, Viral hepatitis, STD and TB Prevention
Linda Findlay	Alberta Health and Wellness, Project Manager, Population Health Strategies
Jacqueline Gahagan	Ministerial Council on HIV/AIDS Dalhousie University, Researcher
Marc-André Gaudreau	Public Health Agency of Canada, Manager, HIV/AIDS Policy, Coordination and Programs Division
Jennifer Geduld	Public Health Agency of Canada, Manager, Surveillance and Risk Assessment Division
Sheila Genaille	National Aboriginal Council on HIV/AIDS Métis National Council of Women
Dr. Mark Gilbert	BC Centre for Disease Control, Physician Epidemiologist, Division of STI/HIV Prevention and Control
Joseph Jean-Gilles	GAP-VIES (groupe d'action pour la prévention de la transmission et l'éradication du Sida), Coordonnateur
Trevor Gray	Prisoners with HIV/AIDS Support Action Network, Youth and Outreach Education Coordinator
Lise Guérard	Ministère de la santé et des services sociaux du Québec, chef de service, Direction de la protection de la santé publique
Jennifer Gunning	Canadian Institutes of Health Research, Team Lead, HIV/AIDS Research Initiative, Institute of Infection and Immunity
Dr. Catherine Hankins	UNAIDS, Chief Scientific Advisor
Miki Hansen	AIDS Vancouver Island, Executive Director
Marie Anésie Harerimana	Centre de ressources et d'interventions en santé et sexualité (CRISS), Coordonnatrice
Christine Harmston	Health Canada, Senior Advisor, International Affairs Directorate
Dr. Bronwen Harvey	Government of Australia, Medical Adviser, STI & HIV/AIDS Section, Targeted Programs and Prevention Branch, Department of Health
Jordana Heaton	Public Health Agency of Canada, Senior Policy Analyst, Strategic Policy Directorate
Catherine Henderson	Human Resources and Social Development Canada, Program Advisor, Program Management Housing and Homelessness Branch
Sue Hicks	National Collaborating Centre for Infectious Diseases, Consultant
Brian Huskins	Ministerial Council on HIV/AIDS
Gayatri Jayaraman	Public Health Agency of Canada, Manager, Community Acquired Infections Division
Lilja Jonsdottir	Public Health Agency of Canada, Policy Analyst, HIV/AIDS Policy, Coordination and Programs Division
Rick Kennedy	Ontario AIDS Network, Executive Director
Dr. Joel Kettner	Manitoba Department of Health, Chief Medical Officer of Health
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Appendix B – Table Report Book Notes on Testing

Table 1 – Testing
<p>Key Challenges and Opportunities:</p> <ul style="list-style-type: none"> • Language of testing – routine offering vs. routine testing; • Routine testing – inconsistent offering of counselling; • Stereotyping – as barrier to offering and asking for testing; • Training provided to health care providers does not include focus on sexual health issues; • Key populations (women under-tested, generic framework, key populations, sub-framework); • Some health care providers – time to do counselling / time demand; • Lack of access – Need testing available at multiple sites; • Point of care funding – who pays? • Lack of knowledge among health care practitioners about treatment options for those who test positive; • Confidentiality; • People don't come back for test results; • Home test kits – 1-800 numbers for test kits in package insert.
<p>Preferred Future:</p> <ul style="list-style-type: none"> • Have an environment where people feel safe and comfortable to come forward for testing; • Harmonized evidence-based public health practice, legislation and policies across Canada for testing that reflect human rights approach. Health care providers move from one jurisdiction to another; • Testing would be more available/accessible. Testing comes to people vs. people going to test sites away from local community); • Quicker access to results.
Recommendations
<p>1. Perform an environmental scan of current provincial and territorial testing policies, programs, evaluations, and legislation AND analyze these through a human rights lens and work towards harmonized national testing standards and guidelines, which include (1) routine offer with counselling, (2) safe and comfortable, (3) accessible. Lead: Public Health Network Council Support from: F/P/T AIDS Community, ASOs Proposed timeframe: 2007-2008 Number of votes received: 28 votes</p> <p>2. Start discussions with professional medical organizations and CMA on physicians' attitudes, concerns, barriers, training, resources around routine HIV testing offering. Lead: PHAC Support from: Council of Medical Officers of Health, ASOs Proposed timeframe: 2007-2008 Number of votes received: 15 votes</p> <p>3. Some type of general public consultation on their attitudes/perceptions of HIV testing (e.g. routine offer, counselling, terminology, safe/comfortable/accessible, role of care provider, sites, stereotyping, point-of-care and home testing costs). This would inform policy making, social marketing, and framing. Lead: PHAC / CAS Support from: FPT AIDS and ASOs Proposed timeframe: 2007-2009 Number of votes received: 4 votes</p>



Table 2 – Testing

Key Challenges and Opportunities:

- Physical access and various populations (e.g. women, rural/urban) Aboriginal;
- Perception of risks by health care professionals;
- Personal relating to benefits/communities.

Preferred Future:

- Increased access to testing through various access points (MDs, street, anonymous, rapid point-of-care);
- Improved health care professionals' perceptions of risk;
- Better and more consistent pre-/post- testing counselling;
- Best practices for various populations;
- Better understanding of at-risk communities and how to translate into efficient, accurate and useful ways to individuals/patients;
- Better training of health professionals and clinicians.

Recommendations

1. Identify and compile best practices regarding testing by population and risks. Identify current gaps.
Lead: Public Health Network Council
Support from: Provinces and Territories
Proposed timeframe: 1 to 2 years
Number of votes received: 7 votes
2. Develop physician and other clinician training and guidelines regarding the risk and pre-/post-counselling with a holistic sexual approach.
Lead: PHAC
Support from: Provinces and Territories, Professional Associations, ASOs
Proposed timeframe: 2 to 3 years
Number of votes received: 3 votes
3. Increase capacity for testing infrastructure.
Lead: Provinces and Territories and Regional Health Authorities
Support from: Federal Government
Proposed timeframe: 3 to 5 years
Number of votes received: 3 votes

Table 3 – Testing

Key Challenges and Opportunities:

- People living with HIV who do not know their serostatus;
- Barriers exist currently for people to be tested;
- Currently health care professionals are more reactive than pro-active (i.e. does not focus on primary prevention).

Preferred Future:

- Increased testing to help identify unknown persons living with HIV;
- Reduced barriers to testing;
- Doubled testing rates and decreased number of undiagnosed people within the next 3 years by 50%;



Table 3 – Testing	
<ul style="list-style-type: none"> Environment where testing is available, accessible, affordable and respectful of an individual's choice; with proper infrastructure and support services (i.e. funding, training, resources, personnel, etc.); 	
Recommendations	
<ol style="list-style-type: none"> Point-of-care testing (would require training of health care providers). Lead: Support from: Proposed timeframe: Number of votes received: 0 votes National consistency (e.g. guidelines that are sensitive to provincial, population groups, human rights issues, etc.). Lead: Support from: Proposed timeframe: Number of votes received: 2 votes Reduce stigma and discrimination and improve societal level, environmental level, which enhances environment for person to choose to be tested. Lead: Support from: Proposed timeframe: Number of votes received: 5 votes Research testing issues (i.e. barriers), validate the targets, cohort studies (individual / population and providers). Clarify perception and misconceptions of economic burden of care versus prevention. Lead: Support from: Proposed timeframe: Number of votes received: 5 votes 	

Table 4 – Testing	
Key Challenges and Opportunities:	
<ul style="list-style-type: none"> ASO/Public health partnerships in supporting testing; Non-medical professional involvement in counselling; Ensuring that testing is available/accessible to all who want it and that all are aware of it; Barriers to testing availability/accessibility/awareness included, but not limited to, inconsistent policies across jurisdictions, determining the most appropriate testing methods in different populations/areas, quality control issues re: rapid testing, assurances that a positive test does not lead to discrimination, normalization vs. special informed consent, incorporating new technologies/ proper mix, barriers to informed consent, enhanced training / sensitivity of health professionals, anonymous vs. non-anonymous testing preferences, costs associated with testing and who pays, concerns of one prevention tool used at expense of others, addressing larger determinants issues, e.g. stigma. 	
Preferred Future:	
<ul style="list-style-type: none"> Testing available to all and accessible in urban and rural areas; People are educated about testing and understand the impacts; 	



Table 4 – Testing

- People who want to get tested can get counselling and support and consent;
- Stigma is no longer a barrier to testing;
- All testing technologies are utilized widely;
- Canadian standards for testing recommendations ;
- Opt-out is not our preferred future;
- Prevention efforts co-exist with testing.

Recommendations

1. All testing in Canada is accompanied by counselling in partnership with public health agencies and community ASOs. There is better value -based training for health professionals. Enable non-health care workers to do pre- and post -negative testing counselling. Cultural and population -specific counselling and testing availability.
Lead: Community and Public Health
Support from: NCCID
Proposed timeframe: Start now
Number of votes received: 16 votes
2. Optimized use of new testing technologies (NAAT, Point-of-care, and Recency) and guidelines for knowing when and how to use them, counselling guidelines and tracking of positives and negatives.
Lead: PHAC and FPT AIDS
Support from: Provinces and Territories Public Health
Proposed timeframe: Now
Number of votes received: 4 votes
3. Reduce negative effects of testing (stigma, loss of jobs, etc.) by doing education in schools and social marketing. Encourage people to get tested and normalize HIV/AIDS without minimizing it.
Lead: Government and Community
Support from: Public Health
Proposed timeframe: by 2010
Number of votes received: 2 votes

Table 5 – Testing

Key Challenges and Opportunities:

- Stigma and discrimination;
- Criminalization for non-disclosure ;
- Violence associated with post-testing;
- Undue prevention message (with negative reinforcement risk activity);
- Culturally appropriate services are generally not accessible;
- Access;
- Privacy of testing site;
- Infrastructure (i.e. testing sites).

Preferred Future:

- Prevention message to include testing which is sensitive/adapted to the population and culture.



Table 5 – Testing	
Recommendations	
1.	<p>Greater involvement of people living with AIDS. PHAs must be involved in all message planning development and delivery.</p> <p>Lead: Support from: Proposed timeframe: Number of votes received: 4 votes</p>
2.	<p>Increased sexual health education for youth.</p> <p>Lead: Support from: Proposed timeframe: Number of votes received: 7 votes</p>

Table 6 – Testing	
Key Challenges and Opportunities:	
<ul style="list-style-type: none"> • People don't pick up results; • People don't know where to get tested; • Need to ensure appropriate referral services; • Need more information on what's happening; • People who test negative repeatedly are getting appropriate counselling; • When testing is targeted, many feel it's not their problem: "I'm not at risk, because I'm not gay!" 	
Preferred Future:	
<ul style="list-style-type: none"> • Education and promotion of where to get tested; • Two approaches: <ul style="list-style-type: none"> ○ Targeted to high -risk population (this means campaigns that are different for different groups); ○ Normalize testing for everyone; • Follow-up referral services in place for increase in testing; • Testing part of annual exam; • Guidelines for contact tracing. 	
Recommendations	
1.	<p>Offer testing as part of annual check-up for everyone and include campaign for normalizing testing and shorten the pre- and post- test counselling.</p> <p>Lead: Canadian College of Family Physicians Support from: PHAC, MOHs, Communities Proposed timeframe: 1 to 2 years Number of votes received: 14 votes</p>
2.	<p>Educate physicians. A large % is unaware of the symptoms of primary infection. Counselling and referral.</p> <p>Lead: Local public health and continuing medical education. Support from: Community and public health Proposed timeframe: 1 year Number of votes received: 7 votes</p>



Table 6 – Testing

3. Rapid testing.
Lead: Health Canada and industry
Support from:
Proposed timeframe:
Number of votes received: 0 votes

Table 7 – Testing

Key Challenges and Opportunities:

- Need support services and guidelines for newly diagnosed when they connect with ASO, public health, etc.;
- Need support for the people who offer the testing;
- Point-of-care testing (rapid) what is the quality assurance?

Preferred Future:

- Testing guidelines clarify the support needed after newly diagnosed;
- New for key values and principles for testing;
- Continuous education (competency/skills development) is built in for practitioners who are offering testing and support;
- Quality control and quality assurance for point-of-care testing;
- Point-of-care – Clear guidelines as to when to use it. (Settings, pragmatic timing for testing, etc.);
- Community readiness needs to be part of an HIV prevention strategy;
- Human resources in rural and remote communities for people on HIV treatment.

Recommendations

1. Testing values: Human rights foundations, inclusiveness, community support systems in place and funding – equity and dedicated funding. This is true across the country. Need readiness and support for the community. Continuum of prevention, testing, care, treatment and support through capacity building of communities.
Lead: Community groups
Support from: FPT government's health and social services, local community leaders and people living with aids.
Proposed timeframe: 2 years
Number of votes received: 16 votes
2. Policies should reflect global access to testing but not prescribed testing (i.e. not 13-64) not just because you are pregnant, etc.) We do not believe in policies for mandatory testing for any reason.
Lead: Provincial/territorial governments
Support from: Local communities, Federal governments, people living with HIV/AIDS
Proposed timeframe: Now
Number of votes received: 4 votes
3. New federal health funding transfer for the above should be designated HIV funds for testing to the provinces and territories.
Lead:
Support from:
Proposed timeframe:
Number of votes received: 2 votes



Table 9 – Testing

Key Challenges and Opportunities:

- Testing for specific population;
- Access and protection of human rights;
- Education about testing (in schools delivered through all the lenses of sensitivity to specific populations). Education on testing is not widespread or delivered in all schools;
- Sensitivity to population specificities and impact of socio-economic factors;
- Stigma and discrimination (power relationships);
- Geography – testing access in rural communities – anonymous and voluntary;
- Socio-economic structures that enable stigma and discrimination;
- Medical community needs better sensitivity training from community-based organizations and seropositive people.

Preferred Future:

- Accessible, anonymous option, routine offer testing, with pre- and post- testing counselling that is well informed by sensitivities to specific population;
- Comprehensive sexual health education for youth that addresses testing in a larger framework. Dialogue should include social determinants of health to set youth up to know their status;
- Identifiable movement towards addressing socio-economic factors in social determinants;
- A comprehensive strategy in place to ensure that testing is in fact voluntary and process is sensitive to individual specifics (language, culture, gender, sexuality, etc.).

Recommendations

1. Widely accessible routine offer (anonymous testing with pre- and post- test counselling that is sensitive to the diversity of specific population (as determined and evaluated by members of these communities and populations).
Lead: Target population and community organizations
Support from: PHAC, researchers and medical professionals)
Proposed timeframe: Short term
Number of votes received: 6 votes
2. Comprehensive sexual health education for youth and extended to all groups with adjustments for specific population that discusses testing as part of a larger dialogue on social determinants of health. The goal is to decrease stigma and discrimination and increase desire to know sero-status).
Lead: Youth in target groups; youth organizations, coalition with parents and teachers
Support from: Parents and teachers, provincial health and education ministries, federal health
Proposed timeframe: Short term
Number of votes received: 29 votes
3. A comprehensive strategy for ensuring that tests are voluntary and sensitive to specific populations.
Lead: Populations affected directly
Support from: Medical practitioners, PHAC, Researchers
Proposed timeframe: Short term
Number of votes received: 3 votes



Table 12 – Testing

Key Challenges and Opportunities:

- Consensus to move forward with federal and provincial guidelines fully informed by experience of AIDS movement and essential role played by pre- and post- testing counselling, informed consent, and confidentiality of process and results;
- Consensus on importance of knowing your status, increased access to testing reductions in number of people who do not know their status;
- Importance of addressing social and systemic barriers (e.g. government and health care systems);
- Homophobia;
- Attitude towards people who use injection drugs;
- Racism;
- Violence against women;
- Strengthening broader health care system response (i.e. family physician);
- Strengthening broad system capacity to acknowledge and address social determinants of health (i.e. education, housing, poverty);
- Strengthen core “exceptional” response (i.e. AT sites, sexual health centres, community outreach, specialized physicians).

Preferred Future:

- Section not filled out.

Recommendations

1. Areas to be addressed include:
 - Physician training and financial incentive to counsel and learn regarding HIV;
 - Better integration of sexual health training for health care workers and physicians; (2 votes)
 - Implementation of rapid point-of-care testing strategy;
 - Use of new technology (e.g. telehealth to increase access in rural, northern, remote communities; (1 vote)
 - Well-funded evaluation integral to implementation and ongoing development; (1 vote)
 - Political climate is important contextual piece;
 - Meaningful inclusion and leadership of/from communities affected;
 - Need description and analysis of what different provincial/territorial systems are providing, including assessment of system indicators and health outcomes;
 - Inter-generational analysis to prevention (i.e. experience of HIV different for young people today than 10 years ago); (1 vote)
 - Theory driven and evidence-based policy and practice.

Table 14 – Testing

Key Challenges and Opportunities:

- Ideological challenges;
- Access to testing;
- Is it always in everyone’s best interest to know status;
- Testing issues/challenges specific to certain groups;
- Changing social attitudes;
- Barriers regarding knowing your status – discrimination;
- Any test always suggested, but always required consent;
- Educating public and physicians (physicians giving testing and counselling);



Table 14 – Testing

- Counselling time and billing of physician;
- Challenge to evaluating strategies for testing is dependent on indicators used for evaluation (e.g. using just % testing for pre-natal testing strategies does not encompass all indicators needed to be evaluated);
- Criminalization and liability associated with knowledge of HIV status. This is a not an incentive to testing;
- Use testing as a means to keep HIV negative – negative (i.e. important post- testing counselling).

Preferred Future:

- When evidence exists, we want PHAC to take a leadership role to advance P.H. initiatives (i.e. supervised injection sites, safe tattooing in corrections);
- Support technology to develop point-of-care NAAT test – resources;
- PHAC takes a leadership role in areas of HIV prevention with proven effectiveness.

Recommendations

1. Clearly articulate a human rights framework for public health action in HIV and set parameters for action.
Lead: PHAC
Support from: Community
Proposed timeframe: Now
Number of votes received: 13 votes
2. Targeted strategies for specific populations and venues within informed consent and counselling.
Lead: PHAC
Support from: Community Stakeholders
Proposed timeframe:
Number of votes received: 4 votes
3. Evaluation framework for testing success be broad and not just be the number of people tested – follow-up with care, etc. Clearly identify what the objective of testing is.
Lead: PHAC
Support from:
Proposed timeframe:
Number of votes received: 4 votes



Appendix C – Table Report Book Notes on Surveillance

Table 8 – Surveillance
<p>Key Challenges and Opportunities:</p> <ul style="list-style-type: none"> • Certain populations in denial (e.g. African, Caribbean, Aboriginal, Southeast Asia, homeless, poor); • Religion as a barrier (education, services lacking).
<p>Preferred Future:</p> <ul style="list-style-type: none"> • Better defined “at-risk” populations (i.e. MSM, people from endemic countries); • Capacity building knowledge with all Canadian communities; • Better partnerships to better inform all Canadians; • To better know our communities (community public health partnership); • Funding and resources (government); • Engage these communities to participate in surveillance data/reporting/programs (comm.); • Government and community organizations need to include addressing issues on the determinants of health (i.e. poverty, homelessness).
Recommendations
<p>1. Restructure profiling and interview the last 1,000 HIV positive cases in a holistic process. Lead: Community organizations and people living with HIV/AIDS Support from: Researchers, PHAC and local and provincial/territorial health Proposed timeframe: Number of votes received: 28 votes</p>

Table 10 – Surveillance
<p>Key Challenges and Opportunities:</p> <ul style="list-style-type: none"> • Lack of evaluation – usefulness and timeliness; • Lack of defined leadership / clarity of roles between F/P/T and local communities; • Emphasis on availability and usefulness of data at community level / NGO.
<p>Preferred Future:</p> <ul style="list-style-type: none"> • Timely, appropriate, useful data to those who need it; • Surveillance data is used for action and has an impact; • Collection of data on (examples) of acute/recent infections and on linkages from diagnosis to treatment.
Recommendations
<p>1. Evaluation of HIV surveillance system. Support evaluation projects at provincial/territorial level in tandem with national identification of core indicators (process, outcomes, impact) with links to Leading Together (includes intervention of current surveillance activities and components). Lead: PHAC Support from: P/T Leads Proposed timeframe: Setup – 6 months to a year, Implementation 2 years Number of votes received: 12 votes</p> <p>2. Pilot projects to enhance use of surveillance data for community organization (interpretation, transfer, involvement in / guiding surveillance activities): rural/urban; community and</p>



Table 10 – Surveillance

<p>population specific – generate best practices. Lead: Provinces and territories and community groups Support from: PHAC Proposed timeframe: Setup – 6 months to a year, Implementation 1 to 2 years Number of votes received: 10 votes</p>
<p>3. Development of standardized, long-term data sharing agreements between P/T and Federal levels of government to enhance quality of data at national levels as appropriate for role in surveillance. Lead: PHAC Support from: Provinces and Territories Proposed timeframe: 6 months to 1 year Number of votes received: 7 votes</p>

Table 11 – Surveillance

<p>Key Challenges and Opportunities:</p> <ul style="list-style-type: none"> • Leadership / Cooperation; • Lack of support for cohort structures; • Reporting system / Infrastructure limitations; • Lack of incentives for P/T and lack of long- term planning funding; • Meaningful engagement of front-line.
<p>Preferred Future:</p> <ul style="list-style-type: none"> • Effective and efficient national notifiable disease system for HIV, HCV and STIs; • Comprehensive and accessible inventory of HIV prevention investments and outcomes; • HIV prevention research network.
<p>Recommendations</p>
<p>1. F/P/T coordination, cooperation and investment. Lead: PHAC led by CPHO Support from: All P/T governments Proposed timeframe: 3 to 5 years Number of votes received: 4 votes</p>
<p>2. Contract an organization to develop the inventory analysis. Lead: NCCID, National NGOs Support from: PHAC, CBOs Proposed timeframe: 2 to 3 years Number of votes received: 10 votes</p>
<p>3. Create an HIV Prevention Research Network. Lead: Industry body co-funded by CIHR and PHAC Support from: CAHR, researchers, CBOs Proposed timeframe: 2 to 3 years Number of votes received: 0 votes</p>



Table 13 – Surveillance

Key Challenges and Opportunities:

- PHAC leadership: definition of leadership and role – time to step up!
- Collection of data regarding Aboriginal peoples – no ethnic identifiers, no standardizations, jurisdictional issue;
- Collection of data regarding HIV services for incarcerated individuals – no standardizations, problems regarding the basic services in prison;
- General problems with roll-out of FI.

Preferred Future:

- PHAC to take leadership role vis-à-vis all departments and jurisdictions – in action, language, communication, standards;
- Increased awareness and standards around surveillance of Aboriginal peoples (ethnic identifiers standards and research set aside and ear marked for surveillance of Aboriginal peoples (i.e. testing, monitoring, evaluation, etc.)).

Recommendations

1. PHAC develops definition and common language frameworks (i.e. leadership → then moves forward into action).
Lead: PHAC
Support from:
Proposed timeframe:
Number of votes received: 0 votes
2. Separate consultation/ forum to identify Aboriginal surveillance issues to deepen level of meaningful surveillance into attitudes, concerns, etc.
Lead: PHAC
Support from: FNIHB / CAAN / NACHA/ CIHR
Proposed timeframe:
Number of votes received: 13 votes
3. Leadership from PHAC for systemic surveillance of HIV services in prisons.
Lead: PHAC
Support from: Federal and provincial corrections services, CBOs
Proposed timeframe: 2 to 3 years
Number of votes received: 14 votes



Appendix D – Table Report Book Notes on Co-infection

Table 1 – Co-Infection
<p>Key Challenges and Opportunities:</p> <ul style="list-style-type: none"> • Harm reduction approach – inconsistent approach across and within; • Lack of knowledge (among gay men) about increased risk of infections; • Lack of standardized screening for anal cancer; • Myths related to HPV vaccines if recommended by doctor, people tend to get it. Unavailability of vaccine for men; • Lack of collaboration (except during outbreak); • Managing with administration of Gardasil – emphasize consistent use of condoms – consistent safer sex messages; • Lack of comprehensive, school- based sexual education.
<p>Preferred Future:</p> <ul style="list-style-type: none"> • One-stop screening – continuum of services; • Harm reduction approach to prevention.
Recommendations
<ol style="list-style-type: none"> 1. Routine offering of testing for HIV, HCV, Syphilis, Gonorrhea and Chlamydia. Lead: Public Health Network Council Support from: F/P/T AIDS / ASOs, Canadian Sexual Health Federation Proposed timeframe: 2007-2009 Number of votes received: 17 votes 2. Strategic research for screening for anal cancer for males and females, as well as research for HPV vaccines for men. Lead: CIHR / Cancer Canada Support from: ASOs / HIV clinicians / Research Community Proposed timeframe: 2007-2012 Number of votes received: 5 votes 3. Offer comprehensive range of harm reduction services across the continuum. Lead: Canada's Anti-Drug Strategy (Justice Canada & Health Canada) Support from: Canadian Harm Reduction Network / ASOs Proposed timeframe: 2007-2009 Number of votes received: 8 votes

Table 2 – Co-Infection
<p>Key Challenges and Opportunities:</p> <ul style="list-style-type: none"> • Section not filled out.
<p>Preferred Future:</p> <ul style="list-style-type: none"> • Section not filled out.
Recommendations
<ol style="list-style-type: none"> 1. Health care provider capacity building and education. Develop tools for physicians and other HC providers, best practices for physicians, explore integrated models, etc. Lead: PHAC and NCCID



Table 2 – Co-Infection

- Support from:** Professional Organizations
Proposed timeframe: 3 years and ongoing
Number of votes received: 3 votes
2. Break down the silos. Community / Research / Public Health. Health groups within public health. Maximize on ability to work on common approaches to prevention because of common issues, risk groups, etc.
Lead: All
Support from: All
Proposed timeframe: Now
Number of votes received: 12 votes
3. Population -specific responses to prevention, treatment and management of co-infections. Different populations have different priorities (e.g. gays: syphilis, LGV, Aboriginal: Hep C). Expand co-infection research to include risk factors and co-morbidity (e.g. addiction and mental health). Increase use of CB knowledge (i.e. Anecdotal).
Lead: Community and Public Health
Support from: Research community
Proposed timeframe: Longer term
Number of votes received: 14 votes

Table 3 – Co-infection

Key Challenges and Opportunities:

- Funding initiatives are set up with boundaries or specific disease targets (i.e. Hep C or HIV);
- Systematic challenges to “system” that hinders integration;
- Pharmaceutical / drug issues (i.e. accessible drugs);
- Different populations may require different approaches;
- Health care workers barriers (sex discussions are difficult, not comfortable with the language, not enough time with each patient);
- There are opportunities to share resources and expertise, but must be careful that certain diseases do not fall off the agenda and that funding goes to HIV.

Preferred Future:

- Integrated approach for HIV and STI testing, diagnostics, prevention effort, treatment, and counselling.

Recommendations

1. Sexual health education (ongoing) in schools and other area to normalize and identify barriers.
Lead:
Support from:
Proposed timeframe:
Number of votes received: 15 votes
2. Train PHC providers on STI and HIV. Re-evaluate how we train/educate physicians, nurses, etc. Define roles and responsibilities and “who is best at delivering what message?”
Lead:
Support from:
Proposed timeframe:
Number of votes received: 5 votes



Table 3 – Co-infection

3. National / Provincial / Territorial STI guidelines on when to provide vaccines (i.e. immunization), prophylaxis, etc.
Lead:
Support from:
Proposed timeframe:
Number of votes received: 0 votes

4. Maintain separate funding, but allow for flexible local response and customization. This can help improve accountability, coordination and communication.
Lead:
Support from:
Proposed timeframe:
Number of votes received: 3 votes

Table 4 – Co-Infection

Key Challenges and Opportunities:

- Assumptions and associated stigma issues (i.e. model of transmission);
- Language challenge, does “sexual health” terminology raise barriers?
- Poorly equipped systems to test/standards (e.g. anal paps), identifying different trends;
- How to integrate while simultaneously acknowledging key differences and without perceived “watering down” of agenda issues;
- No sharing of best practices across Canada and globally;
- Current political climate receptive to integration?
- Integration initiatives already underway in many places whether formal or not;
- An opportunity to raise awareness about other health issues at same time (educational opportunity).

Preferred Future:

- Greater integration of HIV, Hep C, STI, surveillance/database, programming, funding etc.
- PHAC would be independent of government and able to take positions on “sensitive issues” and set standards/guidelines.

Recommendations

1. Environmental Scan of STI Services (treatment and prevention) across country in conjunction with HIV Environmental scan brought under “Testing” session. This would also include collection of data on incidence, services, mapping, and access to clinics/treatment. This may identify relationship between lack of access and incidence (gaps).
Lead: PHAC and community
Support from: Public Health, Regional Health Authorities
Proposed timeframe:
Number of votes received: 11 votes

2. Based on information collection (from previous recommendation), devise national standards for services (prevention, treatment and diagnostic services).
Lead: NCCID and PHAC
Support from: Provincial and Territorial government groups, community
Proposed timeframe:
Number of votes received: 3 votes



Table 4 – Co-Infection

3. Merge program initiatives by key populations and have stipulations that service providers offer integrated HIV, HepC, STI service to reduce duplication of efforts, to increase collaboration by building strong relationships, and better adapt to emerging trends and needs. This may involve some restructuring of community organizations/service provisions (e.g. Nine Circles Health Centre in Winnipeg merged at request of community).
Support from: Community and funders
Proposed timeframe:
Number of votes received: 12 votes

Table 5 – Co-infection

Key Challenges and Opportunities:

- Macro context: Integration of wider (population health) mandates into public health;
- Lack of structural integration;
- Silo funding, review original reasons for separate funding;
- Integrations – restructuring is often a “top-down” approach, which disempowers practitioners and community (will be impacted most by reform);
- Structural integration is in process without clear objectives and strategic implementation since it is happening before dialogue. Challenge how to catch up with what is happening.

Preferred Future:

- Structural integration of hep A, B, C, HIV, STIs, TB on all levels. Federal and provincial/territorial governments and municipalities provide resources (targeted) to enable provision of services at the community level;
- Open and transparent discourse with all stakeholders about PHAC integration with provinces/territories and communities;
- Developed integrated surveillance structures (there are integrated labs), but the challenge is with privacy laws. It's difficult to draw links in surveillance.

Recommendations

1. Structural integration of HIV with STDs and other co-infections. Catch up with public health structural integration and reform initiatives. Assess what is happening, strategically position our restructuring.
Lead: PHAC and provinces
Support from:
Proposed timeframe:
Number of votes received: 8 votes
2. Do a “ground” front-line analysis of what is happening; what are the needs/resources and integration required.
Lead:
Support from:
Proposed timeframe: Now
Number of votes received: 2 votes
3. Achieve open and transparent debate at all levels (PHAC, provinces/territories, municipalities, community) about integration and restructuring.
Lead:
Support from:
Proposed timeframe:
Number of votes received: 0 votes



Table 5 – Co-infection
<p>4. Work on knowledge transfer of the synergies between various pathogens for practitioners and community. Lead: Support from: Proposed timeframe: Number of votes received: 0 votes</p>

Table 6 – Co-infection
<p>Key Challenges and Opportunities:</p> <ul style="list-style-type: none"> Section not filled out.
<p>Preferred Future:</p> <ul style="list-style-type: none"> Section not filled out.
Recommendations
<p>1. Linking HIV with STI and blood borne pathogens (for screening, prevention, counselling and service delivery). Lead: Support from: Communities and government with guidelines Proposed timeframe: Number of votes received: 9 votes</p> <p>2. Address the social determinants of health (mental health and housing). Lead: Support from: Proposed timeframe: Number of votes received: 3 votes</p> <p>3. Changing funding structure and look at how communities engage with governments. Lead: Support from: Proposed timeframe: Number of votes received: 2 votes</p>

Table 7 – Co-infection
<p>Key Challenges and Opportunities:</p> <ul style="list-style-type: none"> No funding available for STIs; At front line, HIV/AIDS funds are used for integrated strategies for Hep C and STIs; How to parcel prevention message together and separately; Concern about Federal Hep C funding.
<p>Preferred Future:</p> <ul style="list-style-type: none"> Parallel Hep C and HIV messages when appropriate (not always the same issues); Community organizations, which have experience with HIV/AIDS are leaders in Hep C response with supportive resources (human and financial); Success of pilot projects would be pursued to implement innovative prevention programs (i.e.



Table 7 – Co-infection

- safer tattooing programs, SIS, etc.);
- Needle exchange programs, including safer injection equipment (i.e. cookers, water, etc.);
- Workplace policies that include Hep C;
- There will be safer inhalation programs (kit distribution, inhalation rooms, etc.);
- Peer-to-peer prevention programs).

Recommendations

1. The federal government develops a sustainable community- based Hep C and co-infection strategy that provides dedicated care funds across the provinces and territories. Garner the support of all provincial and territorial health ministers and front-line public health practitioners. Integrate HIV, STIs and Hep C.
Lead: F/P/T, NCCID, every Public Health (P/T)
Support from: ASOs, local Public Health, Hep C groups and related groups, and people who are co-infected
Proposed timeframe: 2007-2008
Number of votes received: 12 votes
2. Continue the federal Hep C strategy until the above strategy is in place to reduce the harm related to the acquisition and transmission of HIV, Hep C, and STIs among key populations within the determinants of health.
Lead: PHAC
Support from:
Proposed timeframe:
Number of votes received: 0 votes
3. Build sustainable community capacity based on human rights.
Lead: Community
Support from: F/P/T, NCCID
Proposed timeframe: Now
Number of votes received: 2 votes
4. Provide education on prevention and co-infection information in schools, youth programs, practitioners, doctors, nurses and service providers.
Lead:
Support from:
Proposed timeframe: 1 vote



Appendix E – Table Report Book Notes on Knowledge Exchange and Dissemination

Table 8 – Knowledge Exchange and Dissemination
<p>Key Challenges and Opportunities:</p> <ul style="list-style-type: none"> • Communication; • No true partnerships with all players.
<p>Preferred Future:</p> <ul style="list-style-type: none"> • Section not filled out.
Recommendations
<p>1. Identify champions from every sector, bringing them together to identify solutions. Lead: Champions from every sector Support from: Proposed timeframe: 1 year Number of votes received: 8 votes</p> <p>2. Provide training programs for those interested in influencing policies and practices (creating knowledge brokers). Lead: Champions from every sector Support from: All Proposed timeframe: 1 year Number of votes received: 7 votes</p> <p>3. Create an inventory, application and dissemination for tailoring of knowledge base. Lead: Champions from every sector Support from: All Proposed timeframe: 1 year Number of votes received: 1 vote</p>

Table 9 – Knowledge Exchange and Dissemination
<p>Key Challenges and Opportunities:</p> <ul style="list-style-type: none"> • Bringing together community, academics and policy makers during the planning phase before research starts; • Prevention needs professional recognition along side medical research; • Training of academics to understand and adopt good KTE practices.
<p>Preferred Future:</p> <ul style="list-style-type: none"> • Meaningful community engagement and partnership in the KTE process; • Adverse impact of research, interpretation of research and poor engagement of KTE on populations being researched.
Recommendations
<p>1. Demand for SOPs for KTE and assurance and oversight of implementation on research, especially CBR. Lead: CIHR/PHAC Support from: Multi-stakeholder approach Proposed timeframe: 2 years</p>



Table 9 – Knowledge Exchange and Dissemination

<p>Number of votes received: 2 votes</p> <p>2. Leadership from Public Health in using evidence to inform government to convene a working group to advise on the immediate issues and policy. Lead: PHAC, CAS, Provinces/Territories Support from: NGOs, CAHR, etc. Proposed timeframe: Now Number of votes received: 6 votes</p> <p>3. Governance structures for Centres of Excellence should integrate a community component to promote good research and KTE. Lead: Provincial/territorial funding Support from: Proposed timeframe: 2 years Number of votes received: 7 votes</p>

Table 10 – Knowledge Exchange and Dissemination

<p>Key Challenges and Opportunities:</p> <ul style="list-style-type: none"> • Lack of technical access for KTE. Recognize values/worth of different experiences/expertise brought to the discussion; • There are structures in place (e.g. National Collaborating Centres) but their potential has not yet been achieved; • Lack of capacity for KTE; • Canadian and international experience exchange; • IT – blessing/curse (information overload / IT deprived solution); • Maintain partnerships and networks.
<p>Preferred Future:</p> <ul style="list-style-type: none"> • Policies and programs are informed by best evidence available in an efficient manner; • Adequate funding; • Continuous human capacity building for KTE; • Effective networks and partnerships are made and maintained; • KTE provides added value to existing programs; • Recognition of worth/value of different experiences and expertise; • Best practices defined through different sources of information (medical, community experiences, etc.).
<p>Recommendations</p> <p>1. Establish and ensure knowledge exchange (collection and transfer) mechanisms that engage and are relevant to all professionals (Front- line research, public health, school educators, etc.) “Knowledge Broker Mechanisms”. Lead: CBOs, Federal, provincial/territorial governments. Support from: PHAC/NCCID Proposed timeframe: 6 to 8 weeks for GOC approval and announcements/approvals Number of votes received: 9 votes</p>



Table 10 – Knowledge Exchange and Dissemination

<p>2. Building and expanding capacity for knowledge transfer and exchanges at the community level. Lead: CBOs, Federal, provincial/territorial governments. Support from: PHAC Proposed timeframe: Number of votes received: 1 vote</p>
<p>3. Address imbalances in accessing opportunities related to KTE activities (e.g. funding, research, training). Lead: CIHR, Academia Support from: CBOs, PHA Proposed timeframe: Number of votes received: 3 votes</p>

Table 11 – Knowledge Exchange and Dissemination

<p>Key Challenges and Opportunities:</p> <ul style="list-style-type: none"> Section not filled out.
<p>Preferred Future:</p> <ul style="list-style-type: none"> Section not filled out.
<p>Recommendations</p>
<p>1. Develop a mechanism for collecting and synthesizing HIV prevention research and programs experience (This should be housed by an independent body). Translate this knowledge into feasible recommendations for HIV Prevention Action. Lead: NCCID Support from: Federal, provincial /territorial governments Proposed timeframe: 1 year Number of votes received: 13 votes</p>

Table 12 – Knowledge Exchange and Dissemination

<p>Key Challenges and Opportunities:</p> <ul style="list-style-type: none"> Section not filled out.
<p>Preferred Future:</p> <ul style="list-style-type: none"> Section not filled out.
<p>Recommendations</p>
<p>1. Integrate KTE and multi-stakeholder partnerships in research funding requirements. This requires a cultural shift in how we think about research and update of findings. It also requires creative incentives and support to assist people in working in a new way. Lead: Support from: Proposed timeframe: Number of votes received: 4 votes</p>



Table 12 – Knowledge Exchange and Dissemination

2. Assessment of research funding priorities historically to understand how research tracks have informed policy and practice as jump -off points to develop strategically driven research priorities. (No more HIV research in a vacuum) Basic + social + community + policy = whole picture and solution
Lead:
Support from:
Proposed timeframe:
Number of votes received: 8 votes

3. Develop new mechanisms of reward for knowledge development and uptake (e.g. academic needs/drivers versus community needs/drivers)
Lead:
Support from:
Proposed timeframe:
Number of votes received: 3 votes

Table 13 – Knowledge Exchange and Dissemination

Key Challenges and Opportunities:

- No time to read research, reports, etc. Always in the reactive mode, no time for uptake;
- This is frustrating. All the time is spent choosing funding and administration;
- Need to build skills and capacity.

Preferred Future:

- Section not filled out.

Recommendations

1. Need an easily accessible pool of research and best practices that has been reviewed and analyzed to inform as to what has worked well for others and information as to what is the most effective.
Lead: PHAC and CIHR
Support from:
Proposed timeframe:
Number of votes received: 8 votes

2. More flexible funding applications / RFPs that will provide financial resources to bring people together for training, capacity building and that will be flexible and adaptable.
Lead: CIHR and PHAC
Support from:
Proposed timeframe:
Number of votes received: 9 votes

3. PHAC to take on the role of champion of evidence-based knowledge and transferring this to the public (i.e. about supervised injection sites, co-infection issues).
Lead: PHAC
Support from:
Proposed timeframe:
Number of votes received: 2 votes



Table 14 – Knowledge Exchange and Dissemination

Key Challenges and Opportunities:

- Section not filled out.

Preferred Future:

- Section not filled out.

Recommendations

1. Ensure inclusion of key stakeholders in research projects from inception in a meaningful way.
Lead: Researchers
Support from: Funding bodies
Proposed timeframe:
Number of votes received: 12 votes
2. Funding/resources need to be available to support partnerships and foster meaningful participation in research and knowledge transfer and exchange
Lead: CIHR and other funding bodies
Support from: PHAC and other stakeholders
Proposed timeframe:
Number of votes received: 1 vote

