Towards a Broader View of Health:

Strengthening Inter-Ministerial Collaboration on HIV/AIDS in Canada

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for the
Ministerial Council on HIV/AIDS

February 2001

Acknowledgements

The authors wish to express their appreciation to the many key informants in Canada and in other countries who shared their knowledge of inter-ministerial collaboration and who gave generously of their time. Their names are listed in Appendix I.

The authors also wish to thank the members of the Championing Committee of the Ministerial Council on HIV/AIDS – Louise Binder, Don Kilby, Ralf Jürgens, Rick Marchand – and Peter MacDougall, Policy Advisor, Ministerial Council, HIV/AIDS Policy, Coordination and Programs Division, Health Canada, for their guidance and input.

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Executive Summary

HIV continues to spread at an alarming rate, both in Canada and in other countries. The Ministerial Council on HIV/AIDS commissioned this paper to identify ways in which collaboration among federal government departments and agencies can contribute to the response to the HIV/AIDS epidemic. This paper is based on information gathered from a review of the literature and interviews with key informants in Canada and in eight other countries.

For the purposes of this paper, collaboration is being defined in a general sense – i.e., as encompassing a broad spectrum of ways of working together. It includes:

- ministers working together to achieve the goals of the Canadian Strategy on HIV/AIDS;
- departments and agencies working together to achieve the goals of the Strategy; and
- departments and agencies integrating HIV/AIDS into their work.

Background

Inter-ministerial collaboration on HIV/AIDS in Canada is not new. There is a history of inter-ministerial collaboration at the federal level and at the provincial-territorial level.

At the federal level, three departments and agencies have had significant involvement: Correctional Service Canada, the Canadian International Development Agency, and the Department of Justice. Other departments and agencies have been involved more peripherally. There has also been an Interdepartmental Coordinating Committee on HIV/AIDS, though it has not been very active.

Among the provinces and territories, perhaps the most interesting example of inter-ministerial collaboration is happening now in British Columbia, where an inter-ministry committee has been established, and where a number of departments and agencies have publicly identified future commitments with respect to HIV/AIDS work.

There has been inter-ministerial collaboration at the federal level in Canada in fields other than HIV/AIDS. There has also been inter-ministerial collaboration on HIV/AIDS in other countries. Lessons can be drawn from these examples and then applied to the task of strengthening collaboration on HIV/AIDS in Canada.

Making the Case for Collaboration

Other departments and agencies should be involved in the response to HIV/AIDS because they can have a fundamental impact on the epidemic.

Increasingly, health is being defined in the context of a population health approach. This approach says that health is based on much more than health care services, and that other factors impact on health. These factors are called determinants of health and include income and social status, social support networks, education, employment and working conditions, social

environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, and gender and culture.

Viewing health from the perspective of the determinants of health makes perfect sense in the context of HIV/AIDS. HIV/AIDS thrives in areas where society breaks down and where the determinants of health are weakest. For example, people with HIV who are poor die sooner then people with HIV with higher incomes. Another example is the challenge to provide HIV prevention and care for people who are homeless. A homeless person does not have a safe space to store condoms and clean needles, or to have safer sex or safer drug use, or (if HIV+) to keep and take medications. Therefore, reducing poverty and improving housing have a positive impact on the HIV epidemic (as well as on a whole range of health issues).

These determinants of health are mostly influenced by departments and agencies other than Health Canada.

There are several other reasons why departments and agencies should collaborate in the response to HIV/AIDS:

- ❑ Some of the other departments and agencies are directly involved in the delivery of health care.
- ❑ It is often useful to bring people with different expertise together to work on an issue.
- ❑ Collaboration helps to stretch resources.
- ❑ Departments and agencies should not be working in isolation.
- ❑ HIV/AIDS work often has broader applications that can benefit other diseases and conditions.
- ❑ Collaboration is required among the departments and agencies that have international responsibilities because Canada plays an important role in the global response to HIV/AIDS.

Case Studies

Six examples of inter-ministerial collaboration were analyzed in depth for this paper:

- ❑ three cases involving collaboration on HIV/AIDS with departments and agencies at the federal level (Canadian International Development Agency, Correctional Service Canada, and the Department of Justice);
- ❑ the Interdepartmental Coordinating Committee on HIV/AIDS;
- ❑ inter-ministerial collaboration on HIV/AIDS in British Columbia; and
- ❑ inter-ministerial collaboration at the federal level in a field other than HIV/AIDS (Family Violence Initiative).

The following lessons emerged from the analysis:

- ❑ Leadership at senior levels is important to successful collaboration.
- ❑ The involvement of the Minister of Health and senior officials at Health Canada are a critical tool in bringing a department or agency on-side.

- ❑ The involvement of community-based HIV/AIDS organizations is a useful strategy for getting other departments and agencies involved.
- ❑ Continued involvement of community-based organizations will help to ensure that collaboration is successful over the long haul.
- ❑ Time and effort is required to convince a department or agency to participate and to build good working relationships.
- ❑ Once a department or agency recognizes that HIV/AIDS is integrally related to its own work, it is more likely to provide funding for HIV/AIDS programming from its own budgets.
- ❑ Sufficient resources (human and financial) need to be built into any inter-ministerial collaboration.
- ❑ Collaboration works best when it creates a win-win situation.
- ❑ Small, focussed working groups are more effective than large committees for getting work done.
- ❑ Good collaboration is proactive as well as reactive.
- ❑ Having the staff resources at Health Canada to work on inter-ministerial policy issues is a critical ingredient to collaboration.
- ❑ It is important for any inter-ministerial collaboration to have a strategic plan that incorporates the activities of the departments and agencies involved.
- ❑ Support from central agencies is important to making inter-ministerial collaboration work.
- ❑ In any inter-ministerial collaboration, resources should be available to train people from the participating departments and agencies on the issues.
- ❑ In any inter-ministerial collaboration, the role of the lead department needs to be clearly spelled out.

Potential Barriers to Collaboration

There are numerous barriers that prevent or weaken inter-ministerial collaboration on HIV/AIDS. At times, they can deter people from taking on the issue in a meaningful way. Some of these barriers are:

- ❑ People have become complacent about HIV/AIDS.
- ❑ Stigma and discrimination based on HIV/AIDS get in the way.
- ❑ Other departments and agencies see HIV/AIDS as just a health issue.
- ❑ Other departments and agencies have many other priorities.
- ❑ The structures and culture of government make collaboration difficult.
- ❑ HIV/AIDS is not seen as a government-wide priority.
- ❑ There is insufficient funding available to do collaboration.
- ❑ For the most part, the HIV/AIDS community is not engaging other departments and agencies.
- ❑ Collaboration within Health Canada itself is not always effective.

Strategies for Successful Collaboration

Lessons learned from existing collaborations and input from key informants were used to identify strategies for successful collaboration.

The following strategies can help get other departments and agencies involved in collaboration:

- ❑ Obtain leadership and commitment at senior levels of government.
- ❑ Make inter-ministerial collaboration a priority within the Canadian Strategy on HIV/AIDS.
- ❑ Obtain buy-in from other departments and agencies.
- ❑ Work the system at different levels.
- ❑ Be prepared to invest time and resources.
- ❑ Provide assistance to community-based organizations to enable them to engage other departments and agencies.
- ❑ Start small and build from there.
- ❑ Consider the establishment of a non-partisan parliamentary group on HIV/AIDS.

The following strategies can help make collaboration work once it has been established:

- ❑ Appoint liaison persons and work one-on-one or in small groups.
- ❑ Be prepared to involve other stakeholders (where warranted).
- ❑ Be realistic about what can be accomplished.
- ❑ Involve other departments and agencies in the planning process.
- ❑ Make collaboration proactive (not just reactive).
- ❑ Build in accountability mechanisms.
- ❑ Design systems to ensure good communications.

The Way Ahead

How should Health Canada and the Minister of Health proceed to strengthen inter-ministerial collaboration on HIV/AIDS at the federal level in Canada? The authors of this paper recommend the following approaches and specific activities. (Please consult *Section 7.0 The Way Ahead: Recommendations* for a discussion of these recommendations.)

Approaches

Health Canada should consolidate its relationships with departments and agencies already involved in inter-ministerial collaboration. Health Canada should also expand inter-ministerial collaboration among new departments and agencies. It should and adopt an incremental approach and select only the most likely candidates for an initial round of inter-ministerial collaboration expansion.

As this incremental approach builds success, more and more departments and agencies will become involved in HIV/AIDS work. Ultimately, this will permit the federal government to adopt a government-wide, coordinated approach to HIV/AIDS, one that takes into account all of the determinants of health.

Health Canada should ensure that any plan it develops to expand inter-ministerial collaboration at the federal level in Canada includes three strategies that are critical to successful collaboration:

- ❑ obtaining leadership and commitment at senior levels;
- ❑ obtaining buy-in from other departments and agencies; and
- ❑ facilitating the participation of community-based HIV/AIDS organizations.

Recommendations with Respect to Recruiting New Departments and Agencies

The following specific activities are recommended:

1. Make inter-ministerial collaboration a priority in the Canadian Strategy on HIV/AIDS.
2. Make inter-ministerial collaboration a greater priority among the responsibilities of staff in the HIV/AIDS Division at Health Canada.
3. Select the departments and agencies to be targeted initially.
4. Build the case for the involvement of the targeted departments and agencies.
5. Identify funding for these inter-ministerial collaborations.
6. Use an individualized, strategic approach to the targeted departments and agencies.
7. Obtain the assistance of community-based HIV/AIDS organizations.
8. Secure buy-in at the highest levels.
9. Ensure that liaison persons are appointed in the participating departments and agencies.
10. Set objectives for each collaboration and develop workplans with the participating departments and agencies.
11. Build in accountability and evaluation mechanisms.
12. Establish working groups (where appropriate).
13. Include the participating departments and agencies in future planning for the Canadian Strategy on HIV/AIDS.

Recommendations with Respect to Enhancing Existing Collaborations

Some of the specific activities recommended above for recruiting new departments and agencies (or variations of these activities) should be applied to the existing collaborations. These include the following:

- ❑ Ensure that the staff of the HIV/AIDS Policy, Coordination and Programs Division are given appropriate support to maintain and enhance current working relationships.
- ❑ Identify any funding needed to enhance current inter-ministerial collaborations.
- ❑ Help to strengthen the relationship between these departments and community-based organizations.
- ❑ Ensure that mutual goals and plans with these departments are reviewed and accountability mechanisms are clear.
- ❑ Maintain communication at senior levels to support ongoing collaboration at programme levels.

The following additional specific activities are recommended:

1. Conduct an evaluation of the existing collaborations.
2. Analyze the results of the evaluations and make changes where appropriate.

Other Recommendations

The authors advance the following additional recommendations:

- ❑ Health Canada should integrate HIV/AIDS into other programmes within its own department (e.g., programmes that deal with family violence, mental health and children) in order to facilitate collaboration with other departments and agencies.
- ❑ Health Canada should provide training on HIV/AIDS issues (as required) to people in other participating departments and agencies.
- ❑ Health Canada should consider developing an educational campaign on population health and the determinants of health, in order to familiarize other departments and agencies with these concepts.

Section 1.0
INTRODUCTION

This section of the paper:

- ❑ *presents a brief overview of HIV/AIDS in Canada and in the world;*
- ❑ *explains why the paper was commissioned;*
- ❑ *reviews the objectives of the paper;*
- ❑ *describes the methodologies used to conduct the research;*
- ❑ *defines "collaboration" in the context of this paper; and*
- ❑ *explains how this paper is organized.*

1.1 HIV/AIDS in Canada and the World

HIV continues to spread at an alarming rate, both in Canada and in other countries.

Canada

Health Canada estimates[1] that at the end of 1999, there were 50,000 people living with HIV/AIDS in Canada. This compares to an estimated prevalence[†] of 40,000 in 1996, an increase of 24 percent over a four-year period. The number of new infections in 1999 was estimated 4,190, about the same number as in 1996. Although the number of new infections remained fairly steady from 1996 to 1999, there were significant changes in the distribution among exposure categories over this period:

- ❑ There was a 30 percent increase in the annual number of new infections among men who have sex with men (from 1,240 to 1,610).
- ❑ The annual number of new infections among heterosexuals increased 26 percent (from 700 to 880).
- ❑ There was a 27 percent decline in the annual number of new infections among injection drug users (from 1,970 to 1,430).

Despite this decline in the numbers of new infections among injections drug users, epidemiologists caution against complacency. The alarming increases in HIV infection among injection drug users in the Vancouver Downtown Eastside in the mid 1990s amply demonstrate the volatility of the epidemic. This volatility can be expected to continue, particularly because the larger problems of poverty, homelessness and addiction remain largely unchanged.

Health Canada estimates that there were 6,800 women living with HIV infection at the end of 1999, an increase of 48 percent over an estimated prevalence of 4,600 in this population in 1996. The number of new infections in 1999 was estimated at 920, about the same number as in 1996.

Health Canada estimates that there were 2,740 Aboriginal people living with HIV/AIDS at the end of 1999, an increase of 91 percent over the estimated prevalence of 1,430 in this population

[†] Prevalence refers to the number of cases in the population at a given moment in time.

in 1996. There were 370 new infections among Aboriginal populations in 1999 (nine percent of all new HIV infections).

The total number of AIDS cases (late stage HIV infection) has been declining, largely due to the advent of new antiretroviral therapies. However, since 1997 the rate of decline has levelled off.

The numbers tell only part of the story. Behind the numbers are individuals, families, neighbourhoods and communities. Many of the people affected by HIV/AIDS are also dealing with other serious issues such as poverty, addictions, discrimination and incarceration. Some also live with other illnesses such as hemophilia, and forms of hepatitis. Since HIV/AIDS frequently strikes younger populations (the median age of infection dropped from 32 years in 1982-1983 to 23 years in 1986-1990[2]), the epidemic has a significant economic impact on the affected individual and, collectively, on society.

> "AIDS is one of the key issues shaping the world today and should rank as high on the list of human concerns as globalization, peace and the environment... AIDS is no longer simply a public health issue: it cuts across agencies, disciplines, and national boundaries... There is no part of society in the hardest hit areas that is not in some way touched by the epidemic. We are talking not only about health, but about education, agriculture, the economy. AIDS threatens to roll back decades of hard-won development. Indeed, it has become a full-fledged development crisis.... The need for a collaborative approach to cross-sectoral issues is evidenced by the continuing spread of AIDS."
>
> – Dr. Peter Piot, Executive Director, Joint United Nations Programme on HIV/AIDS (from a speech given in London, England in September 2000)

There has been progress. New treatments have enabled some people with HIV/AIDS to regain an active lifestyle including, in some cases, returning to work. Prevention and outreach programmes have slowed the spread of HIV. Our understanding of the dynamics of the epidemic has increased significantly since the first reported case in Canada in 1982. However, the pressure remains to do more and to do it more effectively. No cure or vaccine exists; the numbers of people affected continues to increase; it is too soon to measure the full effect of the new treatments; for some people, the side effects of the treatments are debilitating; not everyone can manage the drug regimens; and, over time, people continue to die. Underlying the epidemic are social factors, such as poverty and stigma, that continue unabated.

The World

UNAIDS and the World Health Organization estimate[3] that at the end of 2000, there were 36.1 million people living with HIV/AIDS in the world. In 2000, there were 5.3 million new infections. Each day, another 15,000 people are infected. Since the start of the epidemic, 21.8 million people have died from AIDS, 4.3 million of them children. Over 95 percent of all cases of HIV and all deaths from AIDS occur in the developing world.

The impact of the epidemic on many developing countries is so severe that HIV/AIDS is now being recognized as a threat to world security. The issue has been on the agenda of the United Nations Security Council. In 2001, the United Nations General Assembly will hold a special session to discuss the epidemic.

1.2 Why This Paper Was Commissioned

HIV/AIDS is one of those issues that challenges our traditional structures and the ways in which we respond to health issues. In fact, HIV/AIDS has frustrated all attempts to isolate it and to deal with it strictly as "just a health issue." After over 15 years of confronting HIV/AIDS in Canada, it is timely to reflect on how the federal government structures its response to HIV/AIDS. The Ministerial Council on HIV/AIDS commissioned this paper because it believes that inter-ministerial collaboration is an important tool to help attain the goals of the Canadian Strategy on HIV/AIDS. The council also believes that the positive impact of inter-ministerial collaboration can extend beyond HIV/AIDS and beyond health services.

Collaboration is an important component of Canadian Strategy on HIV/AIDS. The Strategy states that its vision is

> to move towards a nationally shared Strategy with improved collaboration among all levels of governments, among communities, non-governmental organizations, professional groups, institutions and with the private sector.[4]

Inter-ministerial collaboration is not new. There are many examples of collaboration, on both HIV/AIDS and other issues. The council commissioned this paper to gather the lessons to be learned from existing collaborations, and to answer the following questions:

- What are the benefits of inter-ministerial collaboration at the federal level?
- How should we apply the lessons learned from existing collaborations?
- Why should departments and agencies that do not focus on health issues become involved?
- How can we expand collaboration on HIV/AIDS to departments and agencies that have not been involved to date?

1.3 Objectives of the Paper

The objectives of this paper are:

- to briefly describe the history of inter-ministerial collaboration at the federal level in Canada under the Canadian Strategy on HIV/AIDS;
- to describe how other governments have handled inter-ministerial collaboration on HIV/AIDS;
- to discuss the factors that enhance inter-ministerial collaboration; and
- to present recommendations on how Health Canada should proceed to strengthen inter-ministerial collaboration at the federal level.

1.4 Methodology

The work was done in three phases:

- ❑ developing the framework;
- ❑ reviewing relevant documents; and
- ❑ interviewing key informants.

Developing the Framework

The authors consulted the members of the Championing Committee of the Ministerial Council on HIV/AIDS to obtain guidance and to capture their vision for the project. Preliminary interviews were held with staff from the HIV/AIDS Policy, Coordination and Programs Division of Health Canada. The input from the Championing Committee and from Health Canada staff helped to refine research and consultation strategies and to identify issues and problems, the types of information needed, and an initial list of key informants (particularly for Canada).

Reviewing Relevant Documents

A number of relevant documents from Canada and other countries were reviewed, including provincial and federal government reports, and literature on collaboration and on determinants of health. See *Appendix V* for a list of the documents.

Interviewing Key Informants

Key informants in Canada and in other countries were identified and interviewed. Interview questionnaires were developed.

<u>Canada</u>

In Canada, key informants were identified from three different groups:

- ❑ the federal government;
- ❑ provincial and territorial governments; and
- ❑ community-based organizations.

Key informants from the federal government included:

- ❑ staff in the HIV/AIDS Policy, Coordination and Programs Division, Health Canada;
- ❑ staff in other divisions of Health Canada involved in non-HIV/AIDS-specific inter-ministerial collaboration;
- ❑ members of the Interdepartmental Coordinating Committee on HIV/AIDS; and
- ❑ staff in departments that have a history of HIV/AIDS-specific programming.

Key informants from provincial and territorial governments included health department staff in British Columbia, Ontario and Quebec. Some of these key informants were members of the Federal, Provincial and Territorial Advisory Committee on AIDS.

In the community sector, interviews were conducted with representatives of organizations involved in the Canadian Strategy on HIV/AIDS and individual community members active on provincial or federal HIV/AIDS advisory committees.

A complete list of key informants can be found in *Appendix I*.

Other Countries

Contacts previously developed through earlier international HIV/AIDS initiatives were used as a starting point to identify key informants in other countries. The Joint United Nations Programme on HIV/AIDS (UNAIDS) and the International Council of AIDS Service Organizations (ICASO) were also sources of information and contacts. Notices were placed on selected Internet listservs to obtain relevant international input. These notices generated several contacts, particularly from developing countries.

As a result of these efforts, key informants were identified in the following countries:

- ❑ Australia
- ❑ India
- ❑ Sweden
- ❑ Switzerland
- ❑ Thailand
- ❑ Uganda
- ❑ United Kingdom
- ❑ United States of America

Wherever possible, interviews were conducted with key informants from both the government and community sectors in each country.

See *Appendix I* for a complete list of the key informants.

Questionnaires

For the key informant interviews, separate questionnaires were developed for government respondents and for community representatives. The questions were not applied rigidly; rather, they were used as a guide to engage people in conversation, and to help them share examples of inter-ministerial collaboration and reflect on lessons learned from these collaborations. Most of the informants were interviewed by phone, but a few were interviewed in person. Some of the international contacts chose to respond to the questions by e-mail.

Both questionnaires are included in *Appendix II.*

1.5 What is Collaboration?

Collaboration is a way of working together. One source in the literature describes different stages of working together as follows:

- ❑ Cooperation is characterized by informal relationships that exist without any commonly defined purpose, structure or planning process.
- ❑ Coordination is characterized by more formal relationships and understanding of compatible missions. Some planning and division of roles and communication channels are established.
- ❑ Collaboration brings groups together into a new structure with a commitment to a common purpose. This level requires greater clarity of roles and sharing of resources.[5]

Collaboration has also been described as:

> A mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals. The relationship includes: a commitment to: mutual relationships and goals; a jointly developed structure and shared responsibility; mutual authority and accountability for success; and sharing of resources and rewards.[6]

Sometimes, collaboration is defined more generally to encompass a broad spectrum of ways of working together. In this sense, collaboration could include co-operation and coordination, as described in the first definition above.

More and more organizations are trying out various forms of collaboration. Sometimes the funders require this; other times, organizations do it because they see the need to share resources or solve a common problem. At times, collaboration evolves from the simple recognition that success will be more likely when people bring their skills and differing perspectives together to work on a common goal.

Therefore, collaboration is often discussed in the context of independent agencies working together on a common issue or of multi-sectoral projects involving government, private sector and the community. This paper focuses upon collaboration *within* the federal government. Although part of the same "organization," each government department and agency is itself a large organization with its own culture, perspectives and priorities. Bringing these organizations together to work on issues has its challenges. However, the compartmentalized (or "silo") approach to government is being seen as less effective and at times counter-productive in an environment that is increasingly complex and where issues cross jurisdictions.

In this paper, collaboration is being defined broadly, in a way that encompasses a mix of informal and formal working relationships. In the context of the federal government and the Canadian Strategy on HIV/AIDS, therefore, collaboration includes:

- ❑ ministers working together to achieve the goals of the Strategy;
- ❑ departments and agencies working together to achieve the goals of the Strategy; and
- ❑ departments and agencies integrating HIV/AIDS into their work.

By integrating HIV/AIDS into their work, departments and agencies can be said to be collaborating on the Canadian Strategy on HIV/AIDS even when they are not working directly with other departments and agencies.

1.6 How this Paper is Organized

Section 2.0 Background provides a brief history of inter-ministerial collaboration on HIV/AIDS in Canada, at both the federal level and the provincial-territorial level, and in other countries. It also describes inter-ministerial collaboration in other fields at the federal level in Canada.

Section 3.0 Making the Case for Collaboration provides arguments in favour of inter-ministerial collaboration at the federal level in Canada. It also examines the role or potential role of individual departments and agencies in HIV/AIDS.

In Section 4.0 Case Studies, six examples of inter-ministerial collaboration are analyzed in depth. Insights are presented on what worked, what did not work and what lessons were learned.

Section 5.0 Potential Barriers to Collaboration reviews the obstacles to inter-ministerial collaboration that were identified by the key informants interviewed for this paper.

In *Section 6.0 Strategies for Successful Collaboration*, strategies that can contribute to successful inter-ministerial collaboration are identified and described. These strategies emerged from the lessons learned from existing collaborations and from the input of the key informants.

Section 7.0 The Way Ahead: Recommendations provides recommendations for how to strengthen inter-ministerial collaboration on HIV/AIDS at the federal level. It includes a recommended overall approach; recommendations for recruiting new departments and agencies to HIV/AIDS work; and recommendations for enhancing collaboration with existing departments and agencies.

There are five appendices. *Appendix I* provides the names of the people who were interviewed during the research for this paper. *Appendix II* contains the text of the questionnaires used to interview the key informants. *Appendix III* presents a description of inter-ministerial collaboration in eight countries outside Canada. *Appendix IV* lists the goals and objectives of British Columbia's Interministry Committee on HIV/AIDS. Finally, *Appendix V* provides a list of the references consulted during the preparation of this paper.

Note on terminology

The term “other departments and agencies” is used throughout the paper to denote departments and agencies other than Health Canada.

Section 2.0
BACKGROUND

This section of the paper provides a brief history of inter-ministerial collaboration. It is divided into the following sub-sections:

- *inter-ministerial collaboration on HIV/AIDS in Canada;*
- *inter-ministerial collaboration in other fields at the federal level in Canada; and*
- *inter-ministerial collaboration on HIV/AIDS in other countries.*

2.1 Inter-Ministerial Collaboration on HIV/AIDS in Canada

There is a history of inter-ministerial HIV/AIDS collaboration in Canada at the federal level and at the provincial-territorial level. There has also been collaboration between the two levels of government.

Federal Level

The overall responsibility for the implementation of the Canadian Strategy on HIV/AIDS rests with one department: Health Canada. However, other departments and agencies have been involved in the Strategy from time to time. In most cases, the collaboration has been issue-specific and reactive. In a few instances, departments and agencies have taken a more proactive role.

In terms of funding, only one department other than Health Canada (Correctional Service Canada) receives funding directly under the Strategy.

An Interdepartmental Coordinating Committee on HIV/AIDS was established to facilitate linkages among the departments and agencies who have been (or who might become) involved in the Strategy.

The text that follows describes the collaboration of each department and agency that has been involved in the Strategy, and the contribution of the interdepartmental committee. Please note: Some of these collaborative efforts are analyzed in more detail in *Section 4.0 Case Studies*.

<u>Correctional Service Canada (CSC)</u>

CSC started to get involved in HIV/AIDS in the mid-1990s. At that time, a staff person from Health Canada was seconded to CSC to work on HIV/AIDS issues. Since 1998, CSC has received funding directly under the Strategy to implement HIV/AIDS programmes within federal penitentiaries. The funds flow through Health Canada. Currently, CSC receives $600,000 annually through the Strategy and supplements this with about $1,000,000 in funding from its own budgets.

CSC's National HIV/AIDS Program includes the implementation of a national surveillance system and efforts to prevent the spread of HIV (e.g., distribution of condoms, making bleach available, methadone maintenance treatment, peer education and counseling). The HIV/AIDS programmes in CSC are administered by the Health Services Division.

CSC accounts to Health Canada for the funding it receives under the Strategy. There is a fairly good working relationship between Health Canada and CSC on this file.

See *Section 4.0 Case Studies* for a more in-depth analysis of the collaboration with CSC.

Canadian International Development Agency (CIDA)

CIDA has been providing funding for HIV/AIDS projects in developing countries since the early days of the epidemic. Recently, there has been a significant increase in funding and CIDA has become more proactive. In June 2000, CIDA adopted an HIV/AIDS Action Plan. The plan assesses CIDA's past efforts in addressing HIV/AIDS; establishes goals for CIDA's work in this area; provides a list of projects "in the pipeline;" and discusses the challenges for future CIDA programming.

The funding provided by CIDA is not part of the funding envelope for the Canadian Strategy on HIV/AIDS.

See *Section 4.0 Case Studies* for a more in-depth analysis of the collaboration with CIDA.

Department of Justice

The Department of Justice has been involved in several HIV/AIDS-related legal and ethical issues. In the mid-1990s, the Department of Justice consulted with Health Canada and community-based organizations on the issue of whether transmission of HIV/AIDS should be a criminal offence.

In 1993, the department established an inter-departmental working group to help it develop a policy on mandatory HIV testing of persons accused or convicted of sexual assault. In addition to the Department of Justice, the following departments and agencies were represented on the working group: Correctional Service Canada, Status of Women Canada, Secretary of State and Health Canada (including both the HIV/AIDS Division and the Family Violence Initiative).

The Department of Justice also collaborated with Health Canada on the development of a policy on mandatory HIV testing of people who are involved in an accident (and who receive assistance from fire-fighters or "good Samaritans").

See *Section 4.0 Case Studies* for a more in-depth analysis of the collaboration with the Department of Justice.

Citizenship and Immigration Canada (CIC)

Several times since the start of the epidemic, CIC has consulted Health Canada on the issue of whether visitors and prospective immigrants should be tested for HIV infection and, if the test results are positive, banned from entering Canada.

In response to pressure from community-based organizations, and some negative media publicity on the case of a United States citizen living with HIV/AIDS who was refused admission to Canada as a visitor, Citizenship and Immigration Canada and Health Canada worked together to develop an HIV/AIDS training programme for customs and immigration officers.

Human Resources Development Canada (HRDC)

HRDC has had some involvement in HIV/AIDS work, particularly on two issues: income benefits and return-to-work.

HRDC participates on the Canadian Working Group on HIV and Rehabilitation (CWGHR). This is an independent multi-sectoral project funded by Health Canada and by private sector sponsors from the pharmaceutical and insurance industries. Members represent five major stakeholder groups:

- ❑ people living with HIV/AIDS;
- ❑ community based organizations working on HIV and other disability issues;
- ❑ national associations of professionals working in the field of HIV and rehabilitation, including practitioners and academics;
- ❑ private sector organizations and businesses; and
- ❑ federal government departments (Health Canada and HRDC [CPP Division]).

CWGHR identifies new and emerging trends in HIV rehabilitation (including return-to-work issues) and funds research projects in this area.

HRDC also worked with Health Canada on a separate labour force project (involving return-to-work issues). Health Canada provided the funding.

With respect to income benefits, HRDC's role has so far been largely confined to educating representatives of community-based organizations and groups advocating on behalf of clients about benefit levels and entitlement regulations.

Interdepartmental Coordinating Committee on HIV/AIDS

In 1998, the Interdepartmental Coordinating Committee on HIV/AIDS was created. Its mandate is to facilitate linkages among federal departments and agencies and to promote greater collaboration. A total of 17 “participating departments” and “resource agencies” are members of the committee. The committee has met infrequently (about once a year) and its meetings have been devoted primarily to information sharing. In the short time since the committee has been established, there has been considerable turnover among the departmental representatives.

See *Section 4.0 Case Studies* for a more in-depth analysis of the contribution of the Interdepartmental Coordinating Committee on HIV/AIDS.

Provincial and Territorial Level

There is a history of collaboration on HIV/AIDS at the provincial and territorial level among departments and agencies of the same government. There may be lessons that we can learn from this experience that can be applied to inter-ministerial collaboration at the federal level. The following is a brief description of inter-ministerial collaboration on HIV/AIDS in three provinces: Ontario, Québec and British Columbia. In *Section 4.0 Case Studies*, the collaboration in British Columbia is analyzed in more detail.

Ontario

The Ministry of Health is the lead department for HIV/AIDS programming in Ontario. In 1991, HIV/AIDS liaison persons were identified in a number of other departments.

There have been no regular meetings of the liaison persons. However, when an important issue arose, a working group was sometimes established to deal with that issue. These working groups had representation from different departments (and sometimes from other stakeholders). One example was the working group that was created to study issues arising from viatical settlements.[†] The working group included representation from the Ministry of Health, the Ministry of Finance and the insurance industry. As a result of this effort, guidelines were developed for the insurance industry; the guidelines were then adopted nationally.

There were attempts to establish standing committees (e.g., the Inter-Ministerial Committee on Corrections) but these committees did not survive for very long.

Another example of collaboration in Ontario was the participation of the Ministry of Education in a working group composed of various stakeholders that developed an HIV/AIDS curriculum for the schools (see box).

> "After the media frenzy surrounding the news that Rock Hudson had AIDS, the Minister of Health wanted to do something. A team of 13 people was put together. It included representation from the Red Cross, the AIDS Committee of Toronto, Public Health, and the Ministry of Health. One outcome of this was that an educational brochure went into every household in Ontario. In addition, we educated the Minister of Health about HIV/AIDS and he persuaded the Minister of Education that school kids needed prevention information to avoid the kind of crisis in the United States where kids were being kept out of school and their houses were being burnt. As a result, the Ministry of Education became involved in a working group of constituent representatives, volunteers and bureaucrats to develop an AIDS school curriculum."
>
> – Key informant

In the last few years, there have been no significant examples of collaboration on HIV/AIDS among departments and agencies in Ontario.

[†] A viatical settlement involves an insurance company paying out a portion of a life insurance benefit to a policy holder when that person is in the terminal phases of a life-threatening illness.

Quebec

Within the Ministry of Health and Social Services, responsibility for HIV/AIDS programmming lies with the Centre québécois de coordination du sida (CQCS). The CQCS is also recognized as having a mandate to coordinate HIV/AIDS across the government.

In terms of collaboration with other ministries, the CQCS developed joint action plans with two other departments:

- the Department of Public Security (covering HIV/AIDS programming in detention centres); and
- the Department of Education (covering HIV/AIDS education within sexual health courses in the schools).

Each action plan spelled out the roles of each department, the objectives, the activities and a budget. Expenses for the joint action plans are shared between CQCS and the departments involved. CQCS retains some control over how its funds are spent, because of its government-wide mandate for HIV/AIDS programming.

British Columbia

Over the years, there has been some inter-ministerial collaboration on HIV/AIDS in British Columbia, often as a result of pressure on an issue from the community. For example, community concern led to the formation of a working group focusing on poverty and HIV/AIDS. The working group originated in the Ministry of Health and included the social service ministry and community partners. The efforts of this working group led to the commitment to include infant formula in social assistance benefits in the province.

British Columbia has recently taken a very active approach to inter-ministerial planning and collaboration on HIV/AIDS. Inter-ministerial collaboration was identified as a priority in *British Columbia's Framework for Action on HIV/AIDS* in 1998.[7] The B.C. Interministry Committee on HIV/AIDS was established that same year and became quite active in 2000. A total of 12 departments and agencies participate on the committee.

Each department and agency on the committee has defined its current contribution and its future commitments with respect to HIV/AIDS. This information is contained in *British Columbia's Action on HIV/AIDS, Report from the Interministry Committee on HIV/AIDS*, released on December 1, 2000.[8] Its initial work done, the Interministry Committee on HIV/AIDS will move on to address issues that require a collaborative approach.

Another, higher level committee was formed in the Fall of 2000. It involves representation at the assistant deputy minister (ADM) level from the same departments and agencies. The intent is that the ADM committee will eventually look at other health issues that require inter-ministry co-ordination, using HIV/AIDS as the starting point.

See *Section 4.0 Case Studies* for a more in-depth analysis of this recent collaboration in British Columbia.

Inter-Governmental

Because HIV/AIDS crosses jurisdictional boundaries in Canada, there have been instances of collaboration involving departments and agencies from different levels of government.

Although this paper focuses on collaboration between departments and agencies within the federal government, there may be some lessons to be learned from the experience of the Federal, Provincial and Territorial Advisory Committee on AIDS (FPT AIDS). This committee, which is made up of representatives of health departments from the federal government and each province and territory, has a mandate to provide policy advice to the Conference of Deputy Ministers of Health. FPT AIDS has existed in one form or another since 1987, but it experienced periods of inactivity. It was reinvigorated a few years ago after it was given dedicated funding. The committee has developed a workplan and has tackled issues such as drug use and point-of-care HIV testing. It has also established working groups on specific topics (e.g., prisons).

In 1999, FPT AIDS produced a discussion paper entitled *Intergovernmental Collaboration on HIV/AIDS* to focus attention on and help strengthen intergovernmental collaboration as a way of improving the effectiveness of Canada's overall response to HIV/AIDS.[9] The Committee on Population Health through which it reports also released a discussion paper entitled *Intersectoral Action...Towards Population Health* which provides a broad framework and a resource for those working to stimulate and enhance intersectoral action to improve population health and well being.[10]

2.2 Inter-Ministerial Collaboration in Other Fields at the Federal Level in Canada

Inter-ministerial collaboration is a strategy that the federal government employs fairly frequently when programmes and issues cross departmental lines. These collaborations range from short-term ad-hoc working groups to structures that are more durable and extensive. Three collaborations are briefly described below. In *Section 4.0 Case Studies*, the collaboration on the Family Violence Initiative is analyzed in more detail.

Interdepartmental Network on Sustainable Development Strategies

This is a network of 25 departments and agencies involved in formulating and monitoring sustainable development strategies in their respective organizations. Each department and agency in the network is required to prepare sustainable development strategies, including an action plan for integrating sustainable development into its policies and programmes. In 1999, the Network produced a framework document that contained vision statements, principles, and shared goals and objectives.

The Office of the Auditor General reports annually on progress towards sustainable development.

Family Violence Initiative

The Family Violence Initiative started in 1988 and is now into its third phase. It was created because several departments and agencies recognized that family violence was a serious problem and that it crossed departmental lines. Since the start of the initiative, the number of departments and agencies involved has grown from four to 13. Initially, the emphasis was on exchange of information, but the latest phase also involves the development of a strategic plan. Health Canada is the lead department.

See *Section 4.0 Case Studies* for a more in-depth analysis of the Family Violence Initiative.

Canada's Drug Strategy

A national drug strategy was launched in the mid-1980s to provide a vehicle through which the federal government undertakes national coordination on issues related to alcohol and other drugs. This strategy came to an end in 1997 because of a sunsetting clause, but was reinitiated as Canada's Drug Strategy in 1998. In the latest phase, the number of participating departments and agencies grew from 10 to 14. Canada Mortgage and Housing was one of the agencies that was added in recognition of the role that homelessness plays in drug use.

The lead department is Health Canada. Like the Canadian Strategy on HIV/AIDS, the Drug Strategy involves partners from other sectors (provinces, addiction agencies, private sector), uses a targeted approach to prevention, and recognizes the need to address the determinants of the condition. There are two inter-departmental committees: the Assistant Deputy Ministers' Steering Committee on Substance Abuse, which provides direction and approves major decisions, and the Interdepartmental Working Group on Substance Abuse, which coordinates the work.

2.3 Inter-Ministerial Collaboration on HIV/AIDS in Other Countries

Other countries have adopted various approaches to inter-ministerial collaboration. During the research undertaken for this paper, the authors interviewed key informants in eight countries (Australia, India, Sweden, Switzerland, Thailand, Uganda, United Kingdom and United States of America). These interviews helped to identify barriers to collaboration as well as factors that contribute to successful collaboration. These barriers and factors have been incorporated into later sections of this paper. However, the authors did not come across any particular models of collaboration that they believe Canada could usefully emulate. Part of the problem is that most countries have different systems of government, different cultures and different ways of doing things, when compared to Canada. As a result, it is not always possible to take what worked in other countries and apply the same models here.

Please consult *Appendix III* for a brief synopsis of inter-ministerial collaboration in each of the eight countries researched.

Section 3.0
MAKING THE CASE FOR COLLABORATION

This section presents arguments in favour of inter-ministerial collaboration at the federal level in Canada. It is divided into two sub-sections:

- *The first sub-section explains why other departments and agencies should be involved in HIV/AIDS work.*
- *The second sub-section discusses the role or potential role of individual departments and agencies in HIV/AIDS.*

3.1 The Rationale for Involving Other Departments and Agencies

The main reason why other departments and agencies should be involved in the response to HIV/AIDS is that they can have a fundamental impact on the epidemic. They can make a difference. To understand why, we first have to examine the role of population health and the determinants of health on the way in which we approach health services in general, and HIV/AIDS in particular.

Population Health

Our health is based upon much more than health care services, as important as these services are. Population health is a strategy that identifies and responds to multiple factors that impact upon our health. Many of these factors are outside the health system. Population health has been defined as:

> an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions that have a strong influence on our health.[11]

> "Investing in a population health approach offers benefits in three main areas: increased prosperity, because a healthy population is a major contributor to a vibrant economy; reduced expenditures on health and social problems; and overall social stability and well-being for Canadians."
>
> – Strategies for Population Health[12]

For example, when the very basics of food, shelter and income are either missing or in good supply, there is a corresponding negative or positive impact upon the health of affected individuals and communities.

There is a growing trend in Canada to view health within the framework of population health. Health Canada and provincial and territorial health ministries adopted this framework for HIV/AIDS and other diseases and conditions several years ago.

Determinants of Health

Under the population health strategy, the factors that influence health are often referred to as "determinants of health." The determinants include such factors as:

- ❑ income and social status
- ❑ social support networks
- ❑ education
- ❑ employment and working conditions
- ❑ social environments
- ❑ physical environments
- ❑ personal health practices and coping skills
- ❑ healthy child development
- ❑ biology and genetic endowment
- ❑ health services
- ❑ gender and culture[13]

A positive social environment could include such things as social stability, cohesive communities, recognition of diversity, reduction of stigma and discrimination, and respect for human rights. A positive social environment would have a positive impact on the health of individuals in that environment.

> "If you really want to prevent infections and minimize the impact of infections you need to understand why epidemics happen. The 'why' is outside of health care."
>
> – Key informant

Here are a other few examples to illustrate how determinants of health relate to health status:

- ❑ Health status improves at each step up the income and social hierarchy.
- ❑ Income can determine whether a person is able to afford safe housing and to buy sufficient good food.
- ❑ Employment has a significant effect on a person's physical, mental and social health.
- ❑ Paid work provides not only money, but also a sense of identity and purpose, social contacts and opportunities for personal growth.
- ❑ Unemployed people have a reduced life expectancy and suffer significantly more health problems than people who have a job.[14,15]

The Determinants of Health and HIV/AIDS

Viewing health from the perspective of the determinants of health makes perfect sense in the context of HIV/AIDS. HIV/AIDS thrives in areas where society breaks down and where the determinants of health are weakest. For example, people with HIV who are poor die sooner then people with HIV with higher incomes. Another example is the challenge to provide HIV prevention and care for people who are homeless. A homeless person does not have a safe space to store condoms and clean needles, or to have safer sex or safer drug use, or (if HIV+) to keep and take medications. Therefore, reducing poverty and improving housing have a positive impact on the HIV epidemic (as well as on a whole range of health issues).

Work needs to be done on the determinants of health to make any substantive and enduring impact on HIV/AIDS. It is not just a fight against HIV/AIDS, it is a fight against the conditions that cause HIV/AIDS.

The Role of Other Departments and Agencies in the Determinants of Health

In *Towards a Common Understanding: Clarifying the Core Concepts of Population Health*, Health Canada recognized the role of other departments and agencies in improving health:

> Improving health is a shared responsibility that requires the development of healthy public policies in areas outside the traditional health system. Adopting the population health approach will require the analysis and comparison of health consequences of policies and programs across all government departments. It will require a greater understanding of the linkages between the determinants of health and, in the federal context, greater linkages among departments to achieve healthy public policy.[16]

In the research done for this paper, key informants were asked why they thought inter-ministerial collaboration was useful. The most frequent reasons provided were:

- ❑ that the determinants of health have an impact on the HIV/AIDS epidemic; and
- ❑ that these determinants are mostly influenced by departments and agencies other than Health Canada.

Key informants from other departments and agencies did not always use the language of "determinants of health," but they made the same points in other ways.

HIV/AIDS involves a range of issues that other departments and agencies are already dealing with – issues such as women's vulnerability, poverty, drug use, criminal law, and homelessness.

Other Reasons for Collaboration

In addition to the role that other departments and agencies play in the determinants of health, there are other reasons why they should collaborate in the response to HIV/AIDS. Some of these reasons are outlined below:

Some of the other departments and agencies are directly involved in the delivery of health care. (See subsection 3.1 below for examples of this.)

It is often useful to bring people with different expertise together to work on an issue. It is rare that a problem is uni-dimensional. Collaboration brings people with different expertise together. For example, euthanasia is a legal issue but it is also a human issue, and a medical and palliative care issue. No one department or part of a department can cover all perspectives. Policy is usually better when it is developed in a multi-disciplinary fashion.

Collaboration helps to stretch resources. Collaboration can provide an opportunity for departments and agencies to pool resources in order to move smaller projects forward.

Departments and agencies should not be working in isolation. To address an issue as large as HIV/AIDS, departments and agencies need to be working together, under the umbrella of the Canadian Strategy on HIV/AIDS. Collaboration will help to ensure that participating departments and agencies know what is happening in other departments and agencies, and know how their activities fit into the overall strategy.

HIV/AIDS work can have spin-off benefits. Work done on HIV/AIDS often has broader applications that can benefit other diseases and conditions.

Canada plays an important role in the global response to HIV/AIDS. This means that Health Canada needs to work with departments and agencies that have international responsibilities.

3.2 Rationales for Specific Departments and Agencies

Which other departments and agencies should be involved in the response to HIV/AIDS? This is a decision that will have to be made by Health Canada and the departments and agencies themselves. This sub-section presents an analysis of a number of departments and agencies. It provides information on their involvement in the delivery of health care or the determinants of health, and it presents arguments for their involvement in HIV/AIDS. Please note: Some of these departments and agencies are currently involved in HIV/AIDS work (or have been in the past).

The following departments and agencies are directly involved in the delivery of health care:

- ❑ Correctional Service Canada
- ❑ Department of National Defence
- ❑ Veterans Affairs Canada

The following departments and agencies play an important role in other determinants of health:

- ❑ Canada Customs and Revenue Agency
- ❑ Canadian International Development Agency
- ❑ Citizenship and Immigration Canada
- ❑ Correctional Service Canada
- ❑ Department of Finance
- ❑ Department of Foreign Affairs and International Trade
- ❑ Department of Justice
- ❑ Department of National Defence
- ❑ Human Resources Development Canada
- ❑ Indian and Northern Affairs Canada
- ❑ Industry Canada
- ❑ International Development Research Centre
- ❑ Status of Women Canada

There are two central agencies that are not in either of the two lists above but that nevertheless have an overarching impact on federal government programmes and can make an important contribution to the response to HIV/AIDS:

- Privy Council Office and Prime Ministers Office
- Treasury Board Secretariat

Because of their central role in government, these two agencies can be said to have an impact on all of the determinants of health.

Below, the role or potential role in HIV/AIDS of each of the departments and agencies listed above is examined in more detail. The departments and agencies are listed in alphabetical order except that the central or quasi-central departments and agencies are shown at the end.

Canada Customs and Revenue Agency (CCRA)

The mission of the CCRA is to promote compliance with Canada's tax, trade, and border legislation, and regulations through education, quality service, and responsible enforcement, thereby contributing to the economic and social well-being of Canadians.[17] CCRA consists of two components: (a) Canada Customs and (b) Revenue.

The work of Canada Customs relates to the following determinants of health:

- social environments
- education

Customs officers greet visitors to Canada and thus play a role in the immigration process. As such, they share with Citizenship and Immigration Canada (CIC) the link with social environments (see CIC below). Customs officers were included in the HIV/AIDS training programme developed by Health Canada and CIC in the early 1990s.

The link with education is as follows: Customs officers are called upon to rule on the admissibility of foreign publications that might be considered obscene under federal law and regulations. In the past, some HIV/AIDS safer sex materials, particularly those depicting lesbians and gay men, have not been permitted to enter Canada.

The work of the Revenue component of CCRA relates not so much to the determinants of health directly as it does to an issue of capacity building which is of concern to community-based HIV/AIDS organizations and the voluntary sector as a whole. The issue has to do with the impact of the income tax system (and its rules and regulations) on the voluntary sector and the ability of the voluntary sector to attract donations. (This issue is being studied now, as part of the Government of Canada - Voluntary Sector Initiative.)

Canadian International Development Agency (CIDA)

The mission of CIDA is to support sustainable development activities in order to reduce poverty and to contribute to a more secure, equitable and prosperous world.[18]

The work of CIDA relates to all of the determinants of health identified in this paper:

- ❏ income and social status
- ❏ social support networks
- ❏ education
- ❏ employment and working conditions
- ❏ social environments
- ❏ physical environments
- ❏ personal health practices and coping skills
- ❏ healthy child development
- ❏ biology and genetic endowment
- ❏ health services
- ❏ gender and culture

HIV/AIDS is very much a global phenomenon. In fact, infection rates in most developing countries are significantly higher than infection rates in Canada. As a wealthier nation, Canada has a responsibility to share its resources. As well, Canada should recognize that it is in its own self-interest to do so, because crises and impoverishment in other parts of the world have an impact on Canada. As the principal agency of the federal government that channels funding to countries in need, CIDA has an important role to play in the response to HIV/AIDS.

CIDA follows the population health philosophy in its work.

Citizenship and Immigration Canada (CIC)

The mission of CIC is to build a stronger Canada by:

- ❏ deriving maximum benefit from the global movement of people;
- ❏ protecting refugees at home and abroad;
- ❏ defining membership in Canadian society; and
- ❏ managing access to Canada.[19]

CIC is responsible for policy with respect to the entry into Canada of visitors, immigrants and refugees.

The issue that falls within the purview of CIC that is most relevant to HIV/AIDS is the position that Canada adopts with respect to whether prospective visitors, immigrants and refugees should be tested for HIV and, if found to be HIV+, whether they should be excluded from Canada. This

is a human rights issue on a global scale; as such, it relates to one particular determinant of health: social environments. The issue also impacts on social environments in two other ways:

- ❑ Labelling visitors with HIV/AIDS as a threat to public health or safety would send a message to Canadians that they should fear people living with HIV/AIDS in their midst.
- ❑ Barring people living with HIV/AIDS from entering Canada would engender a false sense of security among Canadians (i.e., they would be led to believe that the problem has been stopped at the border).

Correctional Service Canada (CSC)

In its mission statement, CSC states that it "contributes to the protection of society by actively encouraging and assisting offenders to become law-abiding citizens, while exercising reasonable, safe, secure and humane control."[20]

The federal prison system holds concentrated populations of people at risk for HIV and living with HIV. CSC is responsible for providing health services to the inmate population. Because CSC is dealing with an incarcerated population living in restrictive conditions, the department also plays a role in the following determinants of health:

- ❑ education
- ❑ employment and working conditions
- ❑ physical environments

The policy issues that fall within the purview of CSC and that are relevant to HIV/AIDS include:

- ❑ transmission of HIV (condoms, needle exchange, bleach, education, counselling);
- ❑ harm reduction (associated with drug use);
- ❑ quality of care and treatment provided to prisoners living with HIV/AIDS; and
- ❑ parole and early release provisions for prisoners living with HIV/AIDS.

Because the primary mandate of CSC makes it difficult for it to deal with some of these policy issues, CSC can benefit from the advice and support of Health Canada (and other departments and agencies) as it integrates HIV/AIDS into its work.

Department of Justice

The mission statement of the Department of Justice includes the following:

- ❑ helping to ensure that Canada is a just and law-abiding society with an accessible, efficient and fair system of justice; and
- ❑ promoting respect for rights and freedoms, the law and the Constitution.[21]

The work of the Department of Justice relates to the following determinants of health:

- ❑ social environments
- ❑ social support networks

Stigma and discrimination have fuelled the HIV/AIDS epidemic. One of the goals of the Canadian Strategy on HIV/AIDS is "to minimize the impact of social and economic factors that increase individual and collective risk for HIV."[22] The Department of Justice has an important role to play in reducing stigma and discrimination and in creating a supportive social environment for people living with HIV/AIDS and people at risk of HIV infection.

> "Support from families, friends and communities is associated with better health."
>
> – Strategies for Population Health[23]

Human rights legislation that addresses discrimination helps to erode stigma. Examples of such legislation include bills that were adopted in the last few years on hate crimes and on the recognition of gay and lesbian rights and relationships.

Other policy issues that fall within the purview of the Department of Justice and that are relevant to HIV/AIDS include:

- ❑ the criminalization of HIV transmission;
- ❑ drug laws and policy;
- ❑ mandatory HIV testing for persons accused or convicted of sexual assault;
- ❑ mandatory HIV testing for persons involved in an accident;
- ❑ HIV disclosure and the confidentiality of patient/client records;
- ❑ medical use of marijuana; and
- ❑ assisted suicide and euthanasia.

Department of National Defence (DND)

DND provides health care services directly to members of Canada's Armed Forces (both in Canada and when they are working abroad). Therefore, DND has a role to play in the treatment of Armed Forces personnel living with HIV/AIDS. DND is also involved in providing HIV prevention education to members of the Armed Forces, particularly when they are stationed abroad.

In the past, DND Has also been involved in HIV/AIDS human rights issues (as an employer who sought to dismiss a member of the Armed Forces because he was HIV+).

Foreign Affairs and International Trade (DFAIT)

The mandate of DFAIT includes the following:

- ❑ to conduct all diplomatic and consular relations on behalf of Canada;
- ❑ to conduct all official communication between the Government of Canada and the government of any other country and between the Government of Canada and any international organization;
- ❑ to conduct and manage international negotiations as they relate to Canada; and
- ❑ to foster the development of international law and its application in Canada's external relations.[24]

The work of DFAIT is related to the following determinants of health:

- ❑ social environments
- ❑ income and social status

Through its network of embassies and consulates, DFAIT plays a role in the immigration and refugee process. As such, it shares with Citizenship and Immigration Canada (CIC) the link with social environments (see CIC above).

Through its international trade activities, DFAIT is involved in the issue of patent protection for pharmaceutical products as set out in the rules of the World Trade Organization. There is a direct relationship between this issue and the problems being experienced by people living with HIV/AIDS in the developing world in trying to access affordable medicines.

There are two other reasons why DFAIT should be involved in HIV/AIDS:

1. DFAIT has embassies in most countries around the world and also participates in international forums. Canada has a role to play in encouraging the governments of other countries, particularly developing countries, to take a stronger leadership role in the fight against HIV/AIDS. DFAIT could be looking for opportunities to lobby government leaders on this issue (and promote the adoption of a population health approach in these countries).

2. DFAIT coordinates Canada's participation in the United Nations (UN). The UN Security Council and General Assembly has become increasingly active in the response to the epidemic. HIV/AIDS was recently identified as an international security issue. The General Assembly is planning a special session on HIV/AIDS in June 2001. Officials from DFAIT will lead the Canadian delegation to this session. There will be a need for these officials to coordinate their messages with Health Canada.

Human Resources Development Canada (HRDC)

The mission of HRDC is to enable Canadians to participate fully in the workplace and the community. HRDC fulfils its mission through programmes and activities in the following areas: employment insurance benefits, income security, investment in human resources, and labour.[25] HRDC is also responsible for the federal government's homelessness initiative.

The activities of HRDC relate to the following determinants of health:

- ❑ income and social status
- ❑ employment and working conditions
- ❑ social environments
- ❑ physical environments

"Physical environments" includes housing. For the homeless, obtaining employment, income, housing and access to health services is extremely difficult. Efforts to reduce homelessness and to provide adequate housing can have a positive impact on the health of people living with HIV/AIDS and on the spread of HIV and other communicable diseases.

Other policy issues that fall within the purview of HRDC and that are relevant to HIV/AIDS include:

- ❑ the level of benefits and the rules governing eligibility for income programmes (e.g., employment insurance and the Canada Pension Plan);
- ❑ disability;
- ❑ return-to-work; and
- ❑ HIV/AIDS education in the workplace.

There is an opportunity to develop more flexible income programmes that will impact the lives not only of people living with HIV/AIDS, but also of people with other disabilities.

Indian and Northern Affairs Canada (INAC)

The mission of INAC is to work together to make Canada a better place for First Nations, Inuit and other northern peoples.[26] The work of this department in relation to First Nations peoples applies mainly to people living on reserve. Although health services on reserve are provided by Health Canada, INAC nevertheless plays a role in a large number of determinants of health:

- ❑ income and social status
- ❑ social support networks
- ❑ education
- ❑ employment and working conditions
- ❑ social environments
- ❑ physical environments (including housing)
- ❑ healthy child development
- ❑ gender and culture

On its own website, INAC describes the extent to which First Nations people live below the health and social standards of Canadians as a whole. They frequently live in conditions of poverty, unemployment and inadequate housing. They often have little control over the direction of the their own lives and communities. Efforts to improve the determinants of health and the self-determination of First Nations people will significantly improve their lives overall and, specifically, in terms of communicable diseases, drug use and HIV/AIDS.

Industry Canada

Industry Canada's mission is to foster a growing, competitive, knowledge-based Canadian economy. This involves, among other things, implementing programmes to increase Canada's share of global trade and setting rules and services that support the effective operation of the marketplace.[27]

The work of Industry Canada relates primarily to one determinant of health: income and social status. Industry Canada is responsible for laws and regulations that govern intellectual property, which includes patent protection for pharmaceutical products. These laws and regulations affect the price of treatments for most prescription drugs, including HIV/AIDS drugs. The price of HIV/AIDS drugs influences the ability of people living with HIV/AIDS to access these drugs at an affordable price.

International Development Research Centre (IDRC)

IDRC is an agency of the federal government that helps communities in the developing world find solutions to social, economic, and environmental problems through research.28

IDRC's links to the determinants of health – and the rationale for the involvement of IDRC in HIV/AIDS – are similar to the links and rationale presented above for the Canadian International Development Agency (CIDA).

Status of Women Canada (SWC)

The mission of SWC is to promote gender equality, and the full participation of women in the economic, social, cultural and political life of the country. SWC focuses its work in three areas: improving women's economic autonomy and well-being, eliminating systemic violence against women and children, and advancing women's human rights.[29]

The work of SWC links with the following determinants of health:

- ❑ income and social status
- ❑ social support networks
- ❑ employment and working conditions
- ❑ social environments
- ❑ gender and culture

Gender issues play an important role in the HIV/AIDS epidemic. Inequalities in relationships make women more vulnerable to contracting HIV. Abuse of and violence against women also contribute to their vulnerability. Women have less access to health care services than men. SWC can provide a useful analysis of these issues and can contribute to building effective responses to HIV/AIDS in Canada.

Veterans Affairs Canada

The mission of Veterans Affairs Canada is to provide veterans, qualified civilians and their families with the benefits and services to which they are entitled; to promote their well-being and self-sufficiency as participating members of their communities; and to keep the memory of their achievements and sacrifices alive for all Canadians.[30]

Veterans Affairs Canada provides health care services directly to veterans and their families. Therefore, the department plays a role in providing care and treatment to veterans and their families who are living with HIV/AIDS.

Veterans Affairs Canada also provides income support services to veterans and their families. In this context, the work of the department relates to one of the determinants of health: income and social status.

Central and Quasi-Central Departments and Agencies

Department of Finance

The Department of Finance Canada is responsible for providing the Government of Canada with analysis and advice on the broad economic and financial affairs of Canada.[31]

Through the budget process, the department has a significant impact on the spending plans of other departments and agencies. As a result, the work of the Department of Finance relates to most or all of the determinants of health identified in this paper.

The Department of Finance holds the purse strings, so it is important for officials in that department to have a complete understanding of the impact of HIV/AIDS both in Canada and globally. The department would likely have a say in any attempt to increase funding for the Canadian Strategy on HIV/AIDS and for international development.

Privy Council Office and Prime Minister's Office
Treasury Board Secretariat (TBS)

The role of the Privy Council Office and the Prime Minister's Office is to provide advice and support to the Prime Minister and to the Cabinet, and to promote the effective functioning of government.[32]

The mission of TBS is to help the Government of Canada manage its human, financial, information and technology resources prudently and in a manner that best supports the government's objectives and priorities. The responsibilities of TBS for the general management

of the government affect initiatives, issues and activities that cut across all policy sectors managed by departments and agencies.[33]

Support from central agencies could greatly enhance inter-ministerial collaboration. Each department of government tends to operate as a separate fiefdom. There are two things that will convince other departments to get involved in HIV/AIDS: (a) they recognize a self-interest in participating; or (b) they are persuaded that HIV/AIDS is a government-wide priority. The central agencies can play a critical role in advancing both arguments.

Section 4.0
CASE STUDIES

Analysis of existing collaborative efforts can provide useful insights in terms of what worked, what did not work, and what other lessons can be learned from the experience. Six case studies are presented in this section. They involve different types of collaboration:

- *Three cases involve collaboration on HIV/AIDS with departments and agencies at the federal level (Canadian International Development Agency, Correctional Service Canada, and the Department of Justice).*
- *One case involves the work of a federal body (the Interdepartmental Coordinating Committee on HIV/AIDS).*
- *One case involves inter-ministerial collaboration on HIV/AIDS in a province (British Columbia).*
- *One case involves inter-ministerial collaboration at the federal level in a field other than HIV/AIDS (Family Violence Initiative).*

Please note: The descriptive information on these collaborations that is contained in Section 2.0 Background *is repeated here (and enhanced).*

4.1 Canadian International Development Agency (CIDA)

Description

CIDA has been providing funding for HIV/AIDS projects in developing countries since the early days of the epidemic. Some examples of projects currently being funded by CIDA are:

- a project in Malawi that focuses on encouraging the behavioural change needed to prevent the further spread of HIV;
- a project to improve the delivery of primary health care in Bangladesh by increasing women's access to a wide range of reproductive health services, including information about HIV/AIDS; and
- a project in Romania (in partnership with the United Nations Children's Fund) that supports grassroots innovative projects providing socio-medical services and preventive education activities for children infected and affected by HIV/AIDS.

Funding for HIV/AIDS is provided from CIDA's regular programming budgets. In recent years, CIDA has designated funds specifically for HIV/AIDS. Prior to that, individual HIV/AIDS projects competed with other projects for funding.

Recently, there has been a significant increase in funding and CIDA has become more proactive. In June 2000, CIDA adopted an HIV/AIDS Action Plan. The plan assesses CIDA's past efforts in addressing HIV/AIDS; establishes goals for CIDA's work in this area; provides a list of projects "in the pipeline;" and discusses the challenges for future CIDA programming. CIDA consulted with community-based HIV/AIDS organizations and development NGOs on the preparation of the HIV/AIDS Action Plan.

CIDA has also identified HIV/AIDS as one of four social development priorities, alongside health and nutrition, basic education and child protection

The funding provided by CIDA is not part of the funding envelope for the Canadian Strategy on HIV/AIDS. Until the last few years, there has been little interaction between CIDA and Health Canada. However, since the onset of the most recent phase of the Strategy in 1998, and the establishment of an international HIV/AIDS programme within Health Canada, there is greater liaison on this file between the two organizations. This is evident not only at the bureaucratic level, but also at the ministerial level. Officials from the international HIV/AIDS programme in Health Canada regularly brief their Minister, the Hon. Allan Rock on international HIV/AIDS issues. Mr. Rock then discusses these issues with his colleague, the Hon. Maria Minna, Minister of International Development. Ms. Minna has raised some of these issues with her officials in CIDA.

Analysis

How CIDA Got Involved

CIDA recognized early in the epidemic that HIV/AIDS was a significant threat to health and development in resource-poor countries. It responded by funding HIV/AIDS projects in these countries. So, CIDA is an example of an agency that has integrated HIV/AIDS into its activities on an ongoing basis. It has done so for some time. In terms of working with Health Canada on the issue, however, it has taken time to develop a relationship. This may be due to one or more of the following factors:

- ❑ the fact that the culture of the two organizations is quite different;
- ❑ the fact that CIDA gets its HIV/AIDS funding outside the Strategy; or
- ❑ the fact that there was no international component to the HIV/AIDS programming within Health Canada until 1998.

It has taken time and the commitment of individuals in both CIDA and Health Canada to build the working relationship that exists now.

What Has Worked Well

- ❑ CIDA recognized from the outset that it had a role to play in the response to HIV/AIDS.
- ❑ CIDA has integrated HIV/AIDS into its work, though more work needs to be done to mainstream HIV/AIDS into its non-HIV/AIDS programming and into the programming carried out by its partners (e.g., NGOs, businesses).
- ❑ From the outset, CIDA has provided funding from its own budgets.
- ❑ The Minister of International Development, the Hon, Maria Minna, has been very visible on HIV/AIDS issues.

- ❑ The involvement of the two Ministers (the Hon. Allan Rock and the Hon. Maria Minna) has been very helpful. When Mr. Rock discusses issues with Ms. Minna, and Ms. Minna then raises these issues with her officials, this sends a signal to the people in CIDA that these issues are important.
- ❑ CIDA now acknowledges the link between its HIV/AIDS programming and the Canadian Strategy on HIV/AIDS.
- ❑ Health Canada took the time to learn about CIDA and did not simply try to impose its own goals and approaches.
- ❑ The fact that Health Canada and CIDA both use a population health strategy gives the two organizations some common ground on which to build.

What Has Not Worked as Well

- ❑ In terms of the Canadian Strategy on HIV/AIDS, CIDA was really outside the loop for many years. It was acting on its own and had few dealings with Health Canada. This situation has been corrected only recently.
- ❑ CIDA has not had a close working relationship with community-based HIV/AIDS and other NGOs working on development and HIV/AIDS issues. The consultation around the development of CIDA's HIV/AIDS Action Plan is a positive development, but it is not yet clear whether CIDA will undertake meaningful consultation on an ongoing basis.

Lessons to Be Retained

- ❑ Leadership at senior levels is important to successful collaboration.
- ❑ Continued involvement of community-based organizations will help to ensure that collaboration is successful over the long haul.
- ❑ Time and effort is required to build good working relationships.
- ❑ Once a department or agency recognizes that HIV/AIDS is integrally related to its own work, it is more likely to provide funding for HIV/AIDS programming from its own budgets.

4.2. Correctional Service Canada (CSC)

Description

CSC's involvement in HIV/AIDS issues started slowly. In the mid-1990s, CSC invested some of its own funds and a staff person was seconded from Health Canada to work on HIV/AIDS at CSC.

Since 1998, CSC has received funding directly under the Canadian Strategy on HIV/AIDS to implement HIV/AIDS programmes within federal penitentiaries. The funds flow through Health Canada, but they are designated for CSC. The expenditure of these funds is approved by the Treasury Board Secretariat. Currently, CSC receives $600,000 annually through the Strategy. CSC accounts to Health Canada for how it spends these funds.

CSC also supplements the Strategy funds with about $1,000,000 in funding from its own budgets.

CSC's National HIV/AIDS Program includes the implementation of a national surveillance system and efforts to prevent the spread of HIV (e.g., distribution of condoms, making bleach available, methadone maintenance treatment, peer education and counseling). The HIV/AIDS programmes in CSC are administered by the Health Services Division. Initially, the staff assigned to administer these programmes were seconded from Health Canada, but now CSC staff are doing this work.

CSC participates in Health Canada's annual HIV/AIDS workplans development process.

Analysis

How CSC Got Involved

CSC got involved in HIV/AIDS work primarily as a result of pressure applied by community-based organizations over many years on the issue of HIV/AIDS and prisons. Media attention and subsequent public criticism of Health Canada and CSC – over their failure to the address the epidemic in prisons – became a political problem in the early 1990s. Several other factors helped to persuade CSC to take on the issue and to increase its response over time:

- ❑ mounting epidemiological evidence of the prevalence of HIV/AIDS in prisons;
- ❑ the 1994 report of the Expert Committee on AIDS and Prisons;
- ❑ further research and additional reports on HIV/AIDS in prisons;
- ❑ the promise of funding from the Strategy; and
- ❑ pressure from Health Canada and successive Ministers of Health.

The involvement of the Ministers of Health and of senior officials in Health Canada (up to the deputy minister level) was a critical factor.

What Has Worked Well

- ❑ Although it took some time, CSC has bought in. It recognizes that it has a role to play within the Canadian Strategy on HIV/AIDS.
- ❑ CSC has integrated HIV/AIDS into its own departmental workplans.
- ❑ CSC has provided some funding from its own budgets.
- ❑ There is a fairly good working relationship between Health Canada and CSC on this file.
- ❑ This collaboration is a win-win situation. Health Canada benefits in that work is done on HIV/AIDS in prisons, a critical component of the Strategy. CSC benefits from the expertise in Health Canada on health and HIV/AIDS issues.
- ❑ The decision to replace seconded staff from Health Canada with CSC staff – to administer the HIV/AIDS programmes at CSC – has helped to improve the credibility and acceptance of these programmes within CSC.

What Has Not Worked as Well

- ❑ CSC does not have as good a relationship with community-based organizations as Health Canada does. It does not involve the community consistently in planning or evaluating its HIV/AIDS programming.

Other Comments

- ❑ CSC is the only department other than Health Canada that receives designated HIV/AIDS funds under the Canadian Strategy on HIV/AIDS.

Lessons to Be Retained

- ❑ It can take time to convince a department or agency to participate.
- ❑ The involvement of community-based HIV/AIDS organizations is a useful strategy for getting other departments and agencies involved.
- ❑ Continued involvement of community-based organizations will help to ensure that collaboration is successful over the long haul.
- ❑ Dedicated funding is an incentive for collaboration.
- ❑ Once a department or agency recognizes that HIV/AIDS is integrally related to its own work, it is more likely to provide funding for HIV/AIDS programming from its own budgets.
- ❑ The involvement of the Minister of Health and senior officials at Health Canada are a critical tool in bringing a department or agency on-side.
- ❑ Collaboration works best when it creates a win-win situation.

4.3 Department of Justice

Description

The Department of Justice has been involved in several HIV/AIDS-related legal and ethical issues.

In the mid-1990s, the Department of Justice consulted with Health Canada and community-based organizations on the issue of whether transmission of HIV/AIDS should be a criminal offence. This was a major issue at the time, particularly as a result of high profile cases, most notably that of Charles Ssenyonga, who was accused of infecting women with HIV through sexual intercourse and whose trial began in Ontario in 1992. There was pressure from various sources (including private members bills) to create an HIV-specific offence in the Criminal Code. In January 1995, the federal Minister of Justice, the Hon. Allan Rock, declared that he was considering an amendment to the Criminal Code to make it a crime to knowingly communicate HIV infection, but also made it clear that he intended to seek advice on the issue. The Department of Justice sought the advice of Health Canada on the public health implications. There were also community groups actively working in this issue that established contact with Department of Justice officials and assisted them in their policy analysis. Ultimately, the decision was made not to create a specific offence.

In 1993, the Department of Justice was faced with demands for mandatory HIV testing of persons accused or convicted of sexual assault. This was in response to a campaign initiated by a woman in Québec who was the survivor of a sexual assault. The department called upon Health Canada for information on testing. Then, an inter-departmental working group was pulled together to help develop a policy on the issue.[34,35] In addition to the Department of Justice, the following departments and agencies were represented on the working group: Correctional Service Canada, Status of Women Canada, Secretary of State, and Health Canada (including both the HIV/AIDS division and the Family Violence Initiative).

Recently, the Department of Justice again sought information from Health Canada on HIV testing. This was in response to several private members bills introduced in the House of Commons that would allow mandatory HIV testing of people who are involved in an accident (and who receive assistance from fire-fighters or "good Samaritans"). The Department of Justice and Health Canada have worked together to oppose mandatory testing in these circumstances.

The department has used its own funds to pay for its work on HIV/AIDS. In addition, Justice provided co-funding with Health Canada for consultations and policy papers carried out by the Canadian HIV/AIDS Legal Network on the issue of criminalization of HIV/AIDS (starting in November 1995).[36]

Analysis

How the Department of Justice Got Involved

The Department of Justice got involved in reaction to events (e.g., pressure to create a criminal offence due to high profile HIV sexual transmission cases, and lobbying by a sexual assault survivor to have all persons accused or convicted of sexual assault tested for HIV) and because it had ministers (first the Hon. Allan Rock, and then the Hon. Anne McClellan) who were sensitive to HIV/AIDS issues and who believed it was important to seek advice on the appropriate response.

The Department of Justice got involved in the criminalization and sexual assault issues without receiving any extra funding from the Canadian Strategy on HIV/AIDS because (a) the issues were directly relevant to its mandate; (b) the work it did on HIV/AIDS was similar to the type of work it does on other issues; and (c) it was able to obtain resources from other departments and agencies (expertise as well as people participating on the working group) and community-based HIV/AIDS organizations (advice and information, including policy papers).

What Has Worked Well

- ❏ The departments and agencies on the working group worked well together to come up with policies.
- ❏ The fact that the Department of Justice had lawyers in many departments and agencies meant (a) that it had a good sense of the needs of these other departments and agencies (and what they could contribute); and (b) that it already had a policy process that involved inter-ministerial collaboration.

- ❑ Staff at Health Canada have been accessible and helpful in providing scientific information (e.g., testing issues).
- ❑ There were staff in Health Canada (in the HIV/AIDS division) tasked with inter-ministerial policy development.
- ❑ When the working group was established, buy-in was obtained from assistant deputy ministers in each department and agency.

What Has Not Worked as Well

- ❑ While the Department of Justice is seen as having reacted well to events, it has not been particularly proactive (in terms of identifying issues and working to defuse them before they become crises).

Lessons to Be Retained

- ❑ Leadership at senior levels is important to successful collaboration.
- ❑ Once a department or agency recognizes that HIV/AIDS is integrally related to its own work, it is more likely to provide funding for HIV/AIDS programming from its own budgets.
- ❑ The use of a working group to deal with a specific issue can be an effective strategy.
- ❑ Good collaboration is proactive as well as reactive.
- ❑ Having the staff resources at Health Canada to work on inter-ministerial policy issues is a critical ingredient to collaboration.
- ❑ The involvement of community-based organizations can help to ensure that collaboration is successful over the long haul.

4.4 Interdepartmental Coordinating Committee on HIV/AIDS

Description

Created in 1998, the Interdepartmental Coordinating Committee on HIV/AIDS brings together 17 departments and agencies that have an interest in HIV/AIDS. The mandate of the committee is to facilitate linkages among federal departments and agencies with a view to:

- ❑ ensuring joint collaboration on and management of activities; and
- ❑ enhancing multisectoral approaches.

Membership on the committee includes the following "participating departments:"

- ❑ Canada Customs and Revenue Agency
- ❑ Canadian International Development Agency
- ❑ Citizenship and Immigration
- ❑ Correctional Service Canada
- ❑ Department of Foreign Affairs and International Trade
- ❑ Department of Justice
- ❑ Department of Indian Affairs and Northern Development
- ❑ Department of National Defence
- ❑ Human Resources Development Canada

- ❑ Industry Canada
- ❑ Medical Research Council of Canada
- ❑ Status of Women Canada
- ❑ Veterans Affairs Canada

and the following "resource agencies:"

- ❑ Department of Finance
- ❑ International Development Research Centre
- ❑ Privy Council Office
- ❑ Treasury Board Secretariat

When it was established, the committee was expected to undertake some or all of the following activities:

- ❑ exchange information on relevant activities and on developments and trends affecting HIV/AIDS;
- ❑ report on lessons learned;
- ❑ identify opportunities for joint policy development;
- ❑ contribute to the development of workplans for the Canadian Strategy on HIV/AIDS;
- ❑ help to coordinate and integrate federal efforts on HIV/AIDS;
- ❑ undertake special inter-ministerial projects to address gaps, establishing working groups as required; and
- ❑ participate in the evaluation of the Strategy.

The representatives on the committee were appointed by the deputy ministers in each department and agency. The representatives were usually at the senior policy advisor or senior programme officer level.

The committee was expected to meet three times a year. In practice, the committee has met infrequently (about once a year) and its meetings have been devoted primarily to information sharing. As well, in the short time since the committee has been established, there has been considerable turnover among the departmental representatives.

Analysis

<u>General Observations</u>

- ❑ There is an imbalance on the committee. Some departments and agencies have significant involvement on the HIV/AIDS file, while others have little or no involvement.
- ❑ The committee has a rather large mandate, but its activities have been limited primarily to information sharing.
- ❑ There was a noticeable lack of enthusiasm for the committee, from both Health Canada officials and departmental representatives interviewed for this paper. Part of the problem was that many representatives felt they did not have time for long meetings. Also, there seemed to be a sense among the representatives that they were there to move *another* department's agenda forward (i.e., Health Canada's) as opposed to their own.

- Departments and agencies were asked to appoint representatives to the committee without any real effort having been made to obtain buy-in from these organizations with respect to their involvement in HIV/AIDS. It is possible, therefore, that the representatives of some departments and agencies were not strongly committed to the work of the committee. The fact that there has been considerable turnover on the committee lends credence to this view.
- The committee is rather large and therefore somewhat unwieldy. There has been a tendency to create smaller ad-hoc working groups to deal with specific issues rather than engage the entire committee on these issues.

Lessons to Be Retained

- Small, focussed working groups are more effective than large committees for getting work done.
- For committees of this kind to be successful, participating departments and agencies need to buy in to the process; and the mandate and activities of the committee need to be focussed.
- Good information sharing is important.
- Having identified individuals in each participating department and agency (as a starting point when an issue arises) is helpful.

4.5 British Columbia

Description

British Columbia has taken an active approach to inter-ministerial planning and collaboration over the last year.

Inter-ministerial collaboration was one of the priorities included in *British Columbia's Framework for Action on HIV/AIDS* in 1998.[37] Under the Framework, the B.C. Interministry Committee on HIV/AIDS was established. The committee reports to the Minister of Health through an assistant deputy minister. The committee was expected to make periodic reports. Until recently, however, the committee was not very active and there was considerable turnover amongst its members. In 2000, the committee was revived and is now quite engaged.

The purpose of the B.C. Interministry Committee on HIV/AIDS is:

- to create a governmental forum to address the personal, social and economic impacts of HIV/AIDS in British Columbia; and
- to work together to develop and coordinate government services and policies that will reduce the spread of HIV/AIDS and improve the quality of life for people living with HIV/AIDS and their caregivers.[38]

The B.C. Interministry Committee on HIV/AIDS includes representation from:

- ❑ Office of the Provincial Health Officer
- ❑ Ministry of Aboriginal Affairs
- ❑ Ministry of Advanced Education
- ❑ Ministry of Attorney General
- ❑ Ministry for Children and Families
- ❑ Ministry of Education
- ❑ Ministry of Health (including Aboriginal Health, the HIV/AIDS Division and the Women's Health Bureau)
- ❑ Ministry of Women's Equality
- ❑ Ministry of Social Development and Economic Security (including B.C. Housing)

Health Canada is an ex-officio member.

Secretariat services are provided by the HIV/AIDS Division of the Ministry of Health, which is the lead department for HIV/AIDS in the province.

For most of 2000, the B.C. Interministry committee on HIV/AIDS met once every six weeks. Ministries were asked to define their current activities related to HIV/AIDS and, more importantly, their future commitments. They were informed that the information would be included in a public report. HIV/AIDS Division staff followed up with ministry representatives to finalize their commitments and *British Columbia's Action on HIV/AIDS, Report from the Interministry Committee on HIV/AIDS* was released on December 1, 2000.[39] It contained a list of current activities and future commitments for each participating department and agency.

The *Report* states that the Interministry Committee on HIV/AIDS and the plans of the departments and agencies are based on two guiding principles:

- ❑ a population health approach that considers all the determinants of health; and
- ❑ a harm reduction approach that accepts that drug use will not be eliminated and, therefore, focuses on reducing the harm to the individual, the community and society.

In its *Report*, the responsibilities and next steps of the committee are outlined. The committee will continue to address issues that require a collaborative approach (with input from the Minister of Health's HIV/AIDS Advisory Committee and other stakeholders). The *Report* says that the committee is responsible for:

- ❑ analyzing emerging trends, issues and problems in HIV/AIDS;
- ❑ encouraging healthy public policy;
- ❑ responding to gaps and challenges in HIV/AIDS services; and
- ❑ coordinating HIV/AIDS policies and services across government.

The *Report* sets out the goals and objectives of the committee (see *Appendix IV*).

To help carry out these activities, four working groups will be established. The responsibility of the working groups will be to actively seek out potential areas for collaboration. The working groups will review issues and develop recommendations on:

- corrections;
- women's health;
- benefits and services; and
- addictions.

In recognition of the particular challenges Aboriginal communities face, the Aboriginal Health Division of the Ministry of Health will establish a working group on Aboriginal issues. The division will work with community organizations, the Ministry of Aboriginal Affairs and other government branches to coordinate Aboriginal HIV/AIDS policies and programmes.

The B.C. Interministry Committee on HIV/AIDS will produce an annual workplan containing the activities of all participating departments and agencies. This workplan will be based on the future commitments identified by the departments and agencies. The committee will also report on its achievements in coordinating HIV/AIDS-related policies, programmes and services when each workplan is issued. The HIV/AIDS Advisory Committee will contribute to the development of the Interministry Committee's workplan by identifying issues and priorities for provincial action.

The Director, HIV/AIDS Division, Ministry of Health is the official liaison between the committee and the Ministry of Health. The HIV/AIDS Division has been expanded to enable it to provide secretariat support for the reactivated committee and its working groups.

The Ministry of Health does not normally provide money to the other ministries, but it does influence programming through its leadership on the HIV/AIDS file. The interaction created by the B.C. Interministry Committee on HIV/AIDS has helped to generate bilateral activities between individual departments and agencies. For example, the Ministry of Health and the Ministry of Women's Equality both came up with money to fund small education projects. The Ministry of Health also provided materials to be distributed to women in 150 transition houses.

In addition to the B.C. Interministry Committee on HIV/AIDS, another committee was formed in the Fall of 2000, this time at the assistant deputy minister (ADM) level. The same ministries are involved. The ADM committee will be co-chaired by an ADM in the Ministry of Health and by the Provincial Health Officer. The Minister of Health wrote each ministry asking that they appoint an ADM who would both attend the ADM HIV/AIDS committee and also oversee the implementation of that ministry's portion of the workplan of the Interministry Committee on HIV/AIDS. The intent is that the ADM committee will eventually look at other health issues that require inter-ministry co-ordination. HIV/AIDS is seen as the starting point.

Analysis

Because these developments are relatively recent, it is not possible at this stage to do an in-depth analysis or draw any definitive lessons from the experience. However, there are some aspects of the B.C. approach that appear to be quite positive:

- ❑ There is commitment at very senior levels, in the Ministry of Health and in other departments and agencies.
- ❑ There is a built-in accountability mechanism (a public report that outlines ministry commitments, and follow-up reports expected).
- ❑ The approach is based two important frameworks: (a) population health and the determinants of health; and (b) harm reduction.
- ❑ There is a link between the Interministry Committee on HIV/AIDS and the Minister of Health's HIV/AIDS Advisory Committee.
- ❑ The HIV/AIDS Division was expanded specifically to provide secretariat support to the Interministry Committee on HIV/AIDS.
- ❑ The committee is using working groups to focus upon specific priority issues.
- ❑ Community-based HIV/AIDS organizations participate in the process of identifying priorities (primarily through the Advisory Committee).

4.6 Family Violence Initiative

Description

The objectives of the Family Violence Initiative are:

- ❑ to promote public awareness of the risk factors of family violence and the need for public involvement in responding to it;
- ❑ to strengthen the criminal justice system and housing systems to respond to family violence; and
- ❑ to support data collection, and research and evaluation efforts, in order to identify effective interventions.[40]

The push for an initiative on family violence came from departments and agencies other than Health Canada that recognized family violence as a serious problem. It has only recently been structured as a health issue. Health Canada, as lead department, provides some coordination. It is responsible for convening meetings of an inter-departmental working group, and for running the Family Violence Clearinghouse.

The Family Violence Initiative started in 1988 and is into its third phase. Phase I (1988-1992) was funded for $40 million and involved four departments and agencies:

- ❑ Health and Welfare Canada (as it was then known)
- ❑ Canada Mortgage Housing Corporation
- ❑ Department of Justice
- ❑ Solicitor-General

Although Health and Welfare Canada was the lead department, each department and agency went to Treasury Board with its own submission, and received funds directly.

During Phase I, an Inter-Departmental Working Group (at the director level or below) and a Steering Committee (at the assistant deputy minister level) were established.

Phase II (1991-1995) was funded for $136 million. In this phase, two departments were added:

- ❏ Department of the Secretary of State
- ❏ Indian and Northern Affairs Canada

During this phase, the Steering Committee reduced its activities and was eventually disbanded. Also, the frequency of the meetings of Inter-Departmental Working Group was reduced. Instead, small, ad-hoc working groups were set up to deal with specific issues.

Phase III started in 1995 and is ongoing. Due to government austerity measures, the funding for the Family Violence Initiative in this phase was cut to $7 million annually. Despite the cutbacks, the initiative has been able to maintain some of its activities. The fact that there were earlier phases, and the fact that the issue itself has a high profile, helped to keep the initiative alive. Individual departments and agencies have had to find innovative ways to fund their programmes. For example, Indian and Northern Affairs Canada went back to Treasury Board for more funding (in order to carry on the programmes it had started under Phase II) and received $13 million.

The Inter-Departmental Working Group continued to function and, even with the reduced funding, grew to 13 departments and agencies. To the earlier list were added:

- ❏ Royal Canadian Mounted Police
- ❏ Status of Women Canada
- ❏ Statistics Canada
- ❏ Canadian Heritage
- ❏ Human Resources Development Canada
- ❏ Employment Insurance Canada
- ❏ Canadian International Development Agency

It should be noted that family violence is a very small file in some of these departments.

In Phase III, smaller, ad-hoc working groups continued to operate. Also, a common symbol for the Family Violence Initiative was adopted.

In Phase III, seven of the 13 departments and agencies received funding through the Family Violence Initiative. Some of them use their portion of the funding to co-fund activities with other departments and agencies involved in the initiative. The six departments and agencies that do not receive funding from the initiative address family violence issues through existing departmental programmes and activities.

In Phase III, for the first time, there has been an attempt to develop a coordinated approach to addressing family violence. In previous phases, it was very much each department and agency doing its own thing. A strategic plan for the Family Violence Initiative is now being developed.

Analysis

How this Initiative Got Started

It is interesting to note that it was the departments and agencies outside Health Canada that identified family violence as an issue needing to be addressed and that recognized that the issue crossed departmental boundaries.

What Has Worked Well

- ❑ The departments and agencies have worked as a team to exchange information and to coordinate submissions to Treasury Board Secretariat and Cabinet.
- ❑ The use of a common symbol has helped to identify this as an issue that goes beyond a particular department.
- ❑ Establishing small, ad-hoc working groups to deal with specific issues was useful.

What Has Not Worked as Well

- ❑ There has been high turnover on the Inter-Departmental Working Group. As a result, keeping people up to speed has been a challenge.
- ❑ Although the initiative has been around since 1988, it is only in the last little while that there has been attempt to develop a strategic plan.
- ❑ Demonstrating results for the initiative as a whole has been difficult given the disparate departments and agencies that are involved. For example, one organization might be building houses, while another is trying to change people's behaviour.
- ❑ Senior management, in Health Canada and in the other departments and agencies, have not demonstrated significant leadership on this issue or commitment to this initiative. As a result, the initiative is very dependent on the personal level commitment of the representatives on the Inter-Departmental Working Group.
- ❑ There has been little support from any of the central agencies.
- ❑ No resources have been identified to train people involved in the initiative on family violence issues.
- ❑ The role of the lead department (Health Canada) has not been clearly delineated.
- ❑ Although they have not crippled the initiative, the cuts in funding have resulted in some activities being curtailed.
- ❑ Because Health Canada runs the clearinghouse, the other departments and agencies do not always see the clearinghouse as “theirs.” As a result, they do not always send their materials to the clearinghouse.

Other Comments

- ❑ It has taken time for the departments and agencies to work well together.
- ❑ People involved with this initiative feel that stopping family violence does not have a high level of public support.

Lessons to Be Retained

- ❑ When a department or agency recognizes that it has a role to play, it is more likely to buy in to an inter-ministerial initiative, and more likely to find funds from its own organization to support the initiative.
- ❑ The use of a common symbol can help to strengthen the identity of an inter-ministerial collaboration.
- ❑ It is important for any inter-ministerial collaboration to have a strategic plan that incorporates the activities of the departments and agencies involved.
- ❑ Leadership at senior levels is important to successful collaboration.
- ❑ Support from central agencies is important to making inter-ministerial collaboration work.
- ❑ In any inter-ministerial collaboration, resources should be available to train people from the participating departments and agencies on the issues.
- ❑ In any inter-ministerial collaboration, the role of the lead department needs to be clearly spelled out.
- ❑ Time and effort is required to build good working relationships.
- ❑ Sufficient resources (human and financial) need to be built into any inter-ministerial collaboration.
- ❑ The use of small working groups to handle specific issues is an effective strategy.

Section 5.0
POTENTIAL BARRIERS TO COLLABORATION

This section discusses some of the barriers to inter-ministerial collaboration at the federal level in Canada that were identified by the key informants. Some strategies for overcoming these barriers are included in Section 6.0 Strategies for Successful Collaboration.

There are numerous barriers that prevent or weaken inter-ministerial collaboration on HIV/AIDS. At times, they can deter people from taking on the issue in a meaningful way. Understanding the barriers can help people avoid some of the problems and find ways to overcome the barriers. Below, the barriers are listed and explained.

People have become complacent about HIV/AIDS.

HIV/AIDS is less visible now than it once was. With the epidemic nearing its third decade, and with people living longer, many people no longer see HIV/AIDS as an urgent issue. This makes it more difficult to engage other departments and agencies.

Stigma and discrimination based on HIV/AIDS get in the way.

The stigma around HIV/AIDS continues to affect the environment for collaborative work. As it has since the beginning of the epidemic, HIV/AIDS continues to hit people in our society who are most vulnerable and who are already marginalized – for example, drug users; gays, lesbians and transgendered people; Aboriginal people; the homeless; and people with backgrounds of abuse. The impact of this is two-fold: (a) some people in government are uncomfortable with the issue and do not want to be involved; and (b) the people who are marginalized are not able to command a government response.

Other departments and agencies see HIV/AIDS as just a health issue.

Although Health Canada understands that HIV/AIDS is more than just a health issue, other departments and agencies have different paradigms. When they think AIDS, they think condoms. They do not understand the role of the determinants of health in HIV/AIDS, how the activities of their departments and agencies impact on the determinants of health, and how HIV/AIDS impacts on their activities. Until now, there has not been much work done to develop an analysis and a rationale for the involvement of other departments in HIV/AIDS.

Other departments and agencies have many priorities.

The federal government deals with issues that are large in scope and enormously complex. Departments and agencies have a lot of programmes to deliver. There are many competing demands on their time. They would have to find room for activities related to HIV/AIDS and they may not be anxious to do so, particularly if they see HIV/AIDS as secondary to their mandate. People can be resistant to taking on another issue.

The structures and culture of government make collaboration difficult.

Government is compartmentalized. For the most part, departments and agencies work in isolation. They are like independent corporations. It is hard for them to think outside of their jurisdiction. As well, departments and agencies have to compete with one another for funding and so they are understandably protective of their resources. The resulting turfism and territorialism can frustrate attempts at collaboration.

The complex decision-making processes of government departments and agencies also make collaboration difficult. It can take a long time to get a decision in one organization, but when several organizations are involved timelines tend to get stretched.

HIV/AIDS is not seen as a government-wide priority.

HIV/AIDS has not been identified by the Prime Minister, the Privy Council Office or other central agencies as a government-wide priority (unlike, for example, the deficit). This makes it more difficult to engage other departments and agencies in the fight against HIV/AIDS.

There is insufficient funding available to do collaboration.

Although dedicated funding may not be required for every HIV/AIDS project in another department or agency – the Department of Justice, for example, has done HIV/AIDS work in the past without any extra funding – funding would certainly facilitate collaboration. Some departments and agencies may not be prepared to spend money on HIV/AIDS if it has to come from their own budgets. Currently, the Canadian Strategy on HIV/AIDS includes funding for only one department outside Health Canada (Correctional Service Canada). It would be difficult to find more money in the current Strategy budget for collaboration because any such funding would have to be diverted from other critical programmes. In fact, many HIV/AIDS stakeholders are arguing that the current allocation of $42.2 million a year is insufficient to meet today's needs and should be significantly increased.

For the most part, the community is not engaging other departments and agencies.

The community-based HIV/AIDS movement has historically been a catalyst for change. However, its resources are stretched. Community leaders often have multiple commitments; many are volunteers, and many also live with HIV/AIDS. As a result, with the exception of Correctional Service Canada (CSC), community organizations have not interacted significantly with departments and agencies outside Health Canada. (Some national and local community-based organizations have dealt with CSC on prison issues.) Where government departments and agencies are not being pressured by the community, they are less likely to become engaged.

Collaboration within Health Canada is not always effective.

There are difficulties in communication, coordination and collaboration within Health Canada that get in the way of effective collaboration with other departments and agencies.

Based on some of the interviews with key informants, it is evident that a lack of effective coordination within Health Canada can hinder comprehensive policy development. One example of this is the recent revelation that Health Canada advised Citizenship and Immigration Canada (CIC) that potential immigrants should be tested for HIV infection (and denied entry to Canada if found to be HIV+) for reasons of public health. This reversed a long-standing policy. Key informants indicated that the new position was not well-coordinated or fully resolved among the different divisions of Health Canada that are involved in HIV/AIDS before advice was provided to CIC. Nor were any other departments and agencies consulted (other than CIC). If a collaborative culture existed, it would have been assumed that HIV/AIDS players, both within HC and other departments, would have been interested in contributing their perpective on the issue and that their persepective would be valuable. The Canadian International Development Agency (CIDA) is a good example of this. Although CIDA has no direct responsibility for immigration, its role in human rights internationally and its signficant HIV/AIDS profile in other countries would have made it a good candidate for consultation.

Within Health Canada, much of the HIV/AIDS programming has remained separate from other programming. To be able to credibly approach other departments to undertake HIV/AIDS-related work, Health Canada will need to ensure that HIV/AIDS is integrated into its other health-determinant-related programmes. Furthermore, staff in some of these other programme areas in Health Canada have contacts with other departments and agencies that would be useful in any attempt to expand inter-ministerial collaboration. For example, three programmes – mental health, family violence and children – deal with the issue of housing. If these programmes were more involved in HIV/AIDS, this would make it easier for Health Canada to approach other departments and agencies that deal with housing (such as the Department of Labour) and to work with them on HIV/AIDS-related housing issues.

Section 6.0
STRATEGIES FOR SUCCESSFUL COLLABORATION

This section discusses a number of strategies that can contribute to successful inter-ministerial collaboration at the federal level in Canada. These strategies emerged from (a) the lessons learned from existing collaborations and (b) the input of the key informants. The strategies have been divided into two categories:

- *strategies to make collaboration happen; and*
- *strategies to make collaboration work.*

Please note, however, that there is some overlap between the categories.

6.1 Strategies to Make Collaboration Happen

This sub-section looks at strategies that can help to get other departments and agencies involved in collaboration.

Obtain leadership and commitment at senior levels of government.

In the context of the fight against HIV/AIDS, the importance of political will should not be underestimated. A clear signal from the highest levels of the government and the bureaucracy – that HIV/AIDS is a priority, that it cuts across departmental barriers, that many departments and agencies are expected to be involved in the response to HIV/AIDS, and that they will be supported to do this work – would go a long way to making inter-ministerial collaboration happen.

In the context of the federal government as a whole, this leadership could come from the Prime Minister and from central agencies such as the Privy Council Office and Treasury Board.

Thailand

In Thailand, in the early 1990s, the Prime Minister's office assumed responsibility for managing the HIV/AIDS programme and the Prime Minister himself chaired an inter-ministerial committee. As soon as he became involved, the level of participation on the committee rose and funding for HIV/AIDS was significantly increased. Responsibility for overall coordination of the response to HIV/AIDS shifted back to the Department of Health after two years, but the Prime Minister remains involved with the committee.

In the context of individual departments and agencies, the leadership could come from ministers and deputy ministers. Public statements about HIV from ministers are very helpful. For example, when the Hon. Maria Minna, the Minister of International Development, added her voice to that of the Hon. Allan Rock, Minister of Health by speaking publicly on World AIDS Day in 1999, that sent an important signal that the response to HIV/AIDS extends beyond Health Canada.

Make inter-ministerial collaboration a priority within the Canadian Strategy on HIV/AIDS.

The Canadian Strategy on HIV/AIDS stresses the importance of collaboration and partnerships, but does not specifically mention collaboration between federal government departments. If the Strategy were to identify inter-ministerial collaboration as a priority, this would help to facilitate such collaboration.

> "When Health Canada identified the need for an HIV/AIDS training programme for customs and immigration officers several years ago, discussions with Citizenship & Immigration did not advance very far until the Deputy Minister of Citizenship & Immigration lent his personal support to the idea. After that, things went more smoothly."
>
> – Key informant

Obtain buy-in from other departments and agencies.

For inter-ministerial collaboration to be successful, other departments and agencies have to buy in to the process. They have to own the issue. Inter-ministerial collaboration will be much more effective: (a) if departments and agencies understand why they should be involved and how they can help; and (b) if they decide they want to be involved (as opposed, for example, to simply following orders from a central agency).

Before buy-in can happen, the case for the involvement of individual departments and agencies needs to be clearly articulated. For most departments and agencies, this means explaining how the determinants of health affect HIV/AIDS and how the work of their departments and agencies relates to the determinants of health. It means showing how HIV/AIDS is relevant to the work of their organizations.

Buy-in will be much more likely to occur if Health Canada can identify a win-win scenario when it approaches other departments and agencies. Here are two examples of win-win scenarios:

- the involvement of these departments and agencies will benefit not only the Canadian Strategy on HIV/AIDS but also the organizations themselves; and
- a political problem has been identified that (a) can be solved by different departments and agencies working together or (b) will become a worse headache if not addressed now.

Work the system at different levels.

To get departments and agencies on side, it may help to engage them at different levels of the bureaucracy. Simultaneous approaches could be made, for example, at the ministerial level, at the level of senior officials and at the branch level. If, during the course of making these approaches, it is possible to identify a champion – i.e., someone who will sell the concept within the department or agency – this will increase the chances of success.

Since people have different ways of learning about issues and becoming engaged, approaching them on a personal level can be very effective. It can help people understand the reality of HIV/AIDS beyond the statistics. Perrin Beatty, who was Minister of Health when the first National AIDS Strategy was developed, knew someone who was living with HIV/AIDS; this

personal knowledge helped him cut through the issues. Collaboration is more likely to succeed if ministers and other officials are provided with the opportunity to meet and hear the perspectives of people living with HIV/AIDS.

Be prepared to invest time and resources.

Making collaboration happen will require an investment of time, people and money.

Collaboration does not happen overnight. It takes time to convince a department or agency to get involved, and then to work with that organization to develop a plan of action.

Within Health Canada, resources will need to be devoted to making collaboration a reality. It may make sense to designate a staff person to be responsible for negotiating and establishing collaborative initiatives with other departments and agencies. As these initiatives become established, and more and more working groups are formed, it may be necessary to provide secretariat support for these working groups from within Health Canada.

Finally, it is unlikely that many departments and agencies will be interested in doing collaborative work on HIV/AIDS without some dedicated funding.

Provide assistance to community-based organization to enable them to engage other departments and agencies.

Health Canada has benefited throughout the epidemic from the expertise that community activists have brought to the table. As was pointed out in *Section 5.0 Potential Barriers to Inter-Ministerial Collaboration*, community-based organizations have not interacted significantly with other departments and agencies, with the exception of Correctional Service Canada. These departments and agencies are more likely to become involved in collaborative efforts if community-based organizations are prodding them to do so, and if the community-based organizations are prepared to work with the departments and agencies to educate them on the issues and to assist them with the development of appropriate responses. It is unlikely that the community-based organizations will be able to take on this work within existing resources.

Also, some work may be required to help other departments and agencies connect with community-based HIV/AIDS organizations and to help these organizations identify the right people in the departments and agencies.

Start small and build from there.

In Canada, meaningful inter-ministerial collaboration on HIV/AIDS at the federal level has so far involved only a handful of departments and agencies. Employing an incremental approach to getting other departments and agencies involved might be an effective strategy. This approach would be advantageous for several reasons:

- Health Canada could select only the most likely candidates for an initial round of inter-ministerial collaboration expansion. This would increase the chances that these initial collaborations will be successful. Success would build Health Canada's credibility and could

then be used to entice other departments and agencies to become involved.

- If there are limited resources that can be applied to inter-ministerial collaboration expansion, either in terms of people's time or in terms of dedicated budgets, it makes sense to start with a limited number of departments and agencies.
- By doing a few new collaborations first, Health Canada would learn from experience what works and what does not work, and could then apply these lessons to later collaborations.

Test

A key informant shared the test he uses to help determine whether particular departments and agencies should be involved in inter-ministerial collaboration on a given issue:

- Is it going to improve health outcomes? Will lives be saved?
- Will it be worth the money? (Will it be worth the trees cuts down for the paper it will take?)
- Will it be worth the time invested?

Encourage the establishment of a non-partisan parliamentary group on HIV/AIDS.

The presence of a non-partisan parliamentary group on HIV/AIDS could promote greater collaboration among departments and agencies. There are two reasons for this:

- The work of the committee could help to raise the profile of HIV/AIDS.
- The non-partisan nature of the committee would reinforce the notion that HIV/AIDS is a shared priority and concern.

This approach has been tried in Australia and the United Kingdom with some success. In Canada, there was an ad-hoc parliamentary group in the early 1990s. It was followed in 1995 by a more formalized group that was disbanded in 1997. These groups provided a parliamentary forum for the discussion of HIV/AIDS issues. Whether or not this would work in the current Canadian context, or whether this would be considered a priority at this time, are questions that may require further reflection.

6.2 Strategies to Make Collaboration Work

This sub-section looks at strategies that can help make collaboration work once it has been established.

Appoint liaison persons and work one-on-one or in small groups.

Large inter-departmental committees have not been very successful (see *Section 4.0 Case Studies*). Experience in Canada and in other countries reveals that collaboration is more effective when the lead department is working with individual departments and agencies one-on-one, or where small working groups are formed to deal with specific issues. The one-on-one approach is useful when dealing with an issue that really only affects one department or agency. Working groups can be set up when there is an issue that affects two or three departments and agencies. Working groups are most effective when the participants have sufficient authority to make decisions or have ready access to people who can make decisions.

Departments and agencies that have agreed to become involved could appoint liaison persons to work with Health Canada and to participate in the working groups. It may make sense to hold periodic meetings of the liaison persons for the purpose of exchanging information.

Be prepared to involve other stakeholders (where warranted).

Where working groups are established to deal with specific issues, it may sometimes make sense to include representation from the provinces and territories, or from community-based organizations.

Be realistic about what can be accomplished.

Over time, collaboration is more likely to be successful if expectations are kept in check. If a department or agency is getting involved in HIV/AIDS for the first time, it is a good idea to be pragmatic about what can be accomplished. In dealing with other departments and agencies, Health Canada will need to remember that it does not control the agenda and that it may need to be prepared to compromise.

Involve other departments and agencies in the planning process - strategically.

It is important to ensure that departments and agencies that are doing HIV/AIDS work are involved in the planning process for the Canadian Strategy on HIV/AIDS. For collaboration to be successful, these departments and agencies must be seen as partners in the process.

However, it is also important to be strategic about how the departments and agencies participate. If a particular department is involved in only one or two specific initiatives, it may have no interest in sending someone to a four-day Strategy planning session. It may, however, be happy to participate in a short meeting that focuses more on (a) how the department's initiatives can contribute to the Strategy and (b) what changes to the Strategy the department might like to suggest.

Make collaboration proactive (not just reactive).

Much of the collaboration on HIV/AIDS that has occurred in the federal government has been reactive – i.e., departments and agencies reacting to events. An example of this is the work that was done by the Department of Justice around HIV testing in cases of sexual assault (see *Section 4.0 Case Studies*). Good collaboration is also proactive. Departments and agencies could identify potential problems (and emerging issues) and act to resolve them before they turn into crises. An example of proactive collaboration would be the Department of Justice producing recommendations on ways to ensure the confidentiality of records of HIV/AIDS clients kept by social workers and psychologists.

Proactive collaboration requires that good planning systems be in place. Health Canada (and other stakeholders) will need to work with departments and agencies to identify which issues need to be addressed.

Build in accountability mechanisms.

It is important to ensure that the departments and agencies that participate in inter-ministerial collaboration on HIV/AIDS are held accountable for their actions.

One way to do this is for Health Canada to develop a memorandum of understanding with each department and agency. The memorandum would spell out exactly what work the department or agency has agreed to undertake, when the work will be performed, and what the funding mechanisms and reporting requirements are. The memorandum could be used to ensure that the department or agency involved remains accountable for its actions. This approach proved successful in Québec (see *Section 2.0 Background*). The potential advantages of this approach need to be weighed against the time and effort required to implement it.

Another option is for Health Canada to obtain commitments from participating departments and agencies and then make these commitments public. This approach has been adopted in British Columbia for inter-ministerial collaboration on HIV/AIDS in that province. Participating ministries were asked to make commitments and were told that their commitments would be made public in a report. British Columbia has also promised to produce follow-up reports.

Design systems to ensure good communications.

Sharing information on HIV/AIDS programming can help build collaboration. There are two broad categories of information that are relevant to this discussion:

- ❑ information on HIV/AIDS programmes in Health Canada that would be of interest to other departments and agencies; and
- ❑ information on HIV/AIDS programmes in other departments and agencies that would useful to share.

The challenge will be to ensure that the information is presented in a useful format and that the volume of information is not overwhelming.

As frequently happens with HIV/AIDS, there are programmes that are developed with HIV/AIDS funding that have an impact on other diseases and programmes. For example, Correctional Service Canada recently prepared a computer learning module on infectious diseases (how they are spread, how to take precautions); this module could be shared with other departments and agencies.

Section 7.0
THE WAY AHEAD: RECOMMENDATIONS

This section presents recommendations for how to strengthen inter-ministerial collaboration on HIV/AIDS at the federal level in Canada. It is divided into four sub-sections:

- ❑ *the recommended overall approach;*
- ❑ *recommendations for recruiting new departments and agencies;*
- ❑ *recommendations for enhancing collaboration with existing departments and agencies; and*
- ❑ *other recommendations.*

In the last section, a number of strategies for successful collaboration were presented. These were based on lessons learned from existing collaborations in Canada and in other countries. All of them are important and should be considered in any plan to expand collaboration in Canada. But what needs to happen now in Canada to strengthen inter-ministerial collaboration on HIV/AIDS at the federal level? How should Health Canada and the Minister of Health proceed? Below, the authors present a possible road map.

7.1 Overall Approach

Health Canada should consolidate its relationship with departments and agencies already involved in inter-ministerial collaboration.

Health Canada should expand inter-ministerial collaboration among new departments and agencies. It should adopt an incremental approach and select only the most likely candidates for an initial round of inter-ministerial collaboration expansion. Given the competing priorities, given the demands on people's time (both in Health Canada and in other departments and agencies), and given that inter-ministerial collaboration on HIV/AIDS is not an easy sell in some departments and agencies, this is the approach that is most likely to succeed in the long run. Please see *Section 6.0 Strategies for Successful Collaboration* for a discussion of the advantages of the "start small" approach.

As this incremental approach builds success, more and more departments and agencies will become involved in HIV/AIDS work. Ultimately, this will permit the federal government to adopt a government-wide, coordinated approach to HIV/AIDS, one that takes into account all of the determinants of health.

Health Canada should ensure that any plan it develops to expand inter-ministerial collaboration at the federal level in Canada includes three strategies that are critical to successful collaboration:

- ❑ **Obtaining leadership and commitment at senior levels.** Ministers and senior officials in all of the participating departments and agencies need to lead the way and need to send out the right signals. Attempts should be made to get the Prime Minister to speak publicly about the importance of HIV/AIDS issues and the need for a response that cuts across departmental lines. Consideration needs to be given to how best to involve the central agencies in

HIV/AIDS. For some others issues, they are at the table (e.g., Canada's Drug Strategy Working Group, Sustainable Development Network) and play an ongoing advisory role. This helps to ensure that they are kept current with the issues. It also provides the collaborating departments and agencies access to the expertise and the broader government experience of the central agencies.

- **Obtaining buy-in from other departments and agencies.** Inter-ministerial collaboration will have a much greater chance of success if other departments and agencies share ownership of the issue.

- **Facilitating the participation of community-based HIV/AIDS organizations.** Community-based organizations are uniquely positioned to promote the involvement of other departments and agencies and to assist these organizations in planning and implementing their HIV/AIDS programmes.

All three strategies are discussed in more detail in *Section 6.0 Strategies for Successful Collaboration.*

7.2 Recruiting New Departments and Agencies

The following specific activities are recommended:

1. Make inter-ministerial collaboration a priority in the Canadian Strategy on HIV/AIDS.

The Strategy guides the response to HIV/AIDS at the federal level in Canada. It should clearly identify inter-ministerial collaboration as a policy direction.

2. Make inter-ministerial collaboration a greater priority among the responsibilities of staff in the HIV/AIDS Division at Health Canada.

Inter-ministerial collaboration is more likely to happen if staff and management recognize that they have a responsibility to make it happen. One possibility is to assign the responsibility for negotiating and coordinating inter-ministerial collaboration to one staff person in the division. It may make more sense to assign the responsibility to several different staff persons based on their areas of responsibility. Or, it may be possible to combine these two approaches (one person with overall responsibility and other persons reaching out to specific departments and agencies). Health Canada should consider providing additional funding to allow this expansion of responsibilities to occur without disrupting existing programmes.

3. Select the departments and agencies to be targeted initially.

Health Canada should consult with the Ministerial Council on HIV/AIDS and community-based organizations concerning the selection of departments and agencies to be targeted. The choice should be based on the following criteria:

- ❑ Which departments and agencies have the greatest impact on HIV/AIDS and related determinants of health?
- ❑ Which departments and agencies are most likely to be receptive, given their own priorities and needs?

4. Build the case for the involvement of the targeted departments and agencies.

It is important to do the groundwork and research, and to have a solid case before approaching the departments and agencies that have been selected. The case for each department and agency will be different.

5. Identify funding for these inter-ministerial collaborations.

The funding should be in addition to what is already in the Canadian Strategy on HIV/AIDS funding envelope.

6. Use an individualized, strategic approach to the targeted departments and agencies.

The approaches should be made at different levels in each organization – for example, from Minister of Health to the minister of the target organization; from assistant deputy minister in Health Canada to his or her counterpart in the target organization; and from senior policy advisors and programme officers in Health Canada to people at their level in the target organization. Health Canada should build on existing relationships wherever possible. Personal contacts in the target organizations will be very helpful.

7. Obtain the assistance of community-based HIV/AIDS organizations.

The community-based organizations can help to persuade the targeted departments and agencies to buy in. Health Canada should provide support and guidance to the community-based organizations to enable them to fulfil this role. This activity should be coordinated with activity #6.

8. Secure buy-in at the highest levels.

If a targeted department or agency does agree to participate, Health Canada should make sure that buy-in is obtained at the highest level of the targeted organization.

9. ***Ensure that liaison persons are appointed in the participating departments and agencies.***

These are the people who will liaise with Health Canada on the file, so they will be critical to the success of any collaborative efforts.

10. ***Set objectives for each collaboration and develop workplans with the participating departments and agencies.***

Health Canada and the departments and agencies concerned should jointly establish objectives for each collaboration. Once the objectives are established, workplans can be developed.

11. ***Build in accountability and evaluation mechanisms.***

Two ways of building in accountability are to make the workplans public or to negotiate memoranda of understanding with the participating departments and agencies. Evaluation mechanisms will help ensure accountability and will also be useful in monitoring both outcomes of the collaboration and the actual process of collaboration.

12. ***Establish working groups (where appropriate).***

Working groups may make sense when there are several players involved in a specific issue – for example:

- ❑ more than one other department or agency;
- ❑ different branches in the same department or agency;
- ❑ one other department or agency and a community-based organization;

or some combination of the above.

13. ***Include the participating departments and agencies in future planning for the Canadian Strategy on HIV/AIDS.***

The participating departments and agencies should be involved in the direction-setting process and the workplan process.

7.3 Enhancing Existing Collaborations

The existing collaborations are assumed to be those involving the Canadian International Development Agency (CIDA), Correctional Service Canada (CSC), and the Department of Justice.

Some of the specific activities recommended above for recruiting new departments and agencies (or variations of these activities) should be applied to the existing collaborations. These include the following:

- ❑ Ensure staff of the HIV/AIDS Policy, Coordination and Programs Division are given appropriate support to maintain and enhance current working relationships.
- ❑ Identify any funding needed to enhance current inter-ministerial collaborations.
- ❑ Help to strengthen the relationship between these departments and community-based organizations.
- ❑ Ensure that mutual goals and plans with these departments are reviewed and accountability mechanisms are clear.
- ❑ Maintain communication at senior levels to support ongoing collaboration at programme levels.

The following additional specific activities are recommended:

1. Conduct an evaluation of the existing collaborations.

The existing collaborations should be evaluated in terms of both outcomes and process. The evaluation of each collaboration should also include a process to identify new and emerging issues for that department or agency (with assistance from the Ministerial Advisory Council on HIV/AIDS and community-based groups) and to determine which of these issues would be best addressed through collaborative activities.

Health Canada should arrange for the consultation to be done externally – i.e., by people from outside Health Canada and the departments and agencies concerned.

2. Analyze the results of the evaluations and make changes where appropriate.

Each of the three existing collaborations is quite different and will likely require different approaches.

The collaboration with CSC is well established. CSC is the only other department or agency receiving funding directly under the Canadian Strategy on HIV/AIDS. Nevertheless, the evaluations may reveal that changes are required to the way Health Canada and CSC work together or to the substance of the HIV/AIDS work done at CSC.

CIDA is somewhat of a special case. Although it has been doing HIV/AIDS work for many years, its funding does not come from the Strategy, and it is only in the last few years that CIDA has begun liaising with Health Canada on the HIV/AIDS file. It is very important that the two organizations strengthen their collaboration on international HIV/AIDS issues. The evaluation and the subsequent analysis of the results should help to determine how they can best work together.

In the past, collaboration with the Department of Justice has been fairly successful. As has been pointed out in this report, however, the department could and should become more proactive.

7.4 Other Recommendations

- ❑ Health Canada should integrate HIV/AIDS into other programmes within its own department (e.g., programmes that deal with family violence, mental health and children). This would facilitate collaboration with other departments. (For a more detailed discussion of this point, see *Section 5.0 Potential Barriers to Collaboration*.)

- ❑ Health Canada should provide training on HIV/AIDS issues (as required) to people in other participating departments and agencies.

- ❑ Health Canada should consider developing an educational campaign on population health and the determinants of health, in order to familiarize other departments and agencies with these concepts. It would be useful if such a campaign could be implemented prior to approaching other departments and agencies with respect to collaboration. Another option is to integrate education on population health and the determinants of health into the actual approaches.

Appendix I
KEY INFORMANTS

This appendix provides a list of the key informants interviewed for this paper.

Canada

Danielle Auger, Head, Centre québécois de coordination du sida (CQCS), Ministry of Health and Social Services (MHSS)
Russell Armstrong, Consultant; and former Executive Director of the Canadian AIDS Society
Dr. Yves Bergevin, Senior Health Specialist, Health, Population and Nutrition, Canadian International Development Agency
Sandra Black, Coordinator, National Infectious Disease Program, Correctional Service Canada
Jay Browne, former Coordinator, AIDS Bureau Ministry of Health, Ontario and Chair of first advisory committee on HIV/AIDS in Ontario: Ontario Prevention & Education Panel on AIDS (OPEPA)
Theodore de Bruyn, Consultant; and former policy advisor in the HIV/AIDS Policy, Coordination and Programs Division, Health Canada
Richard Burzynski, Executive Director, ICASO; and former Executive Director of the Canadian AIDS Society
Tracey Donaldson, Policy Advisor, Government Affairs, HIV/AIDS Policy, Coordination and Programs Division, Health Canada
Patricia Dunberry, Legal Council, Department of Justice
David Hoe, A/Manager, Policy Development Unit, HIV/AIDS Policy, Coordination and Programs Division, Health Canada
Ralf Jürgens, Executive Director, Canadian HIV/AIDS Legal Network; and member of the Ministerial Council on HIV/AIDS
Catherine Kane, Status of Women Canada
Elena Kanigan, Director, HIV/AIDS Division, Ministry of Health, British Columbia
Roger Le Clerc, Executive Director, Coalition des organismes québécois de lutte contre le sida; and Co-Chair of the Ministerial Council on HIV/AIDS
Ellissa Lief, former Senior Council, Criminal Law Policy Section, Department of Justice
Lisa Mattar, Manager, Policy and Coordination Unit, Canada's Drug Strategy Division, Health Canada
Frank McGee, Coordinator, AIDS Bureau, Ministry of Health and Long-Term Care, Ontario
Carol MacLeod, Policy and Program Analyst: Family Violence Prevention, Health Promotions and Programs Branch, Health Canada
Martin Méthot, [at the time] Senior HIV/AIDS Advisor, International Affairs Directorate, Health Canada
Carole Morency, Senior Counsel, Department of Justice
Dr. Michael V. O'Shaughnessy, Director, B.C. Centre for Excellence; and former Director of the Federal Centre for AIDS, Health Canada
Don Seaton, HIV/AIDS community volunteer and Co-Chair of the B.C. Minister of Health's HIV/AIDS Advisory Committee
Steven Sternhal, A/Manager, Monitoring, Evaluations and Operations Unit, HIV/AIDS Policy, Coordination and Programs Division, Health Canada
John Stinson, A/Manager, Strategy Management Unit, HIV/AIDS Policy, Coordination and Programs Division, Health Canada
Darryl Sturtevant, Director, Mental Health and Rehabilitation Reform Branch, Ministry of Health and Long-Term Care, Ontario; and former Senior Policy Advisor at the AIDS Secretariat, Health Canada
Elisse Zack, Program Coordinator, Canadian Working Group on HIV and Rehabilitation (CWGHR)
Art Zoccole, Executive Director, Canadian Aboriginal AIDS Network

Other Countries

Judy Auerbach, Prevention Science Coordinator, and Behavioral and Social Science Coordinator, Office of AIDS Research, National Institutes of Health, Bethesda, United States of America
Robert Griew, Executive Director, AIDS Council of New South Wales, Sydney, Australia; and community representative on the InterGovernmental Council on AIDS, Hepatitis C and Related Diseases; and former senior official in Aboriginal Health, Commonwealth Department of Health and Aged Care
Dr. Richard A Keenlyside, Global AIDS Activity, National Center for HIV, STD & TB Prevention Centers for Disease Control and Prevention, Atlanta, United States of America
Cathy Mead, Executive Office, National Public Health Partnership, Melbourne, Australia; former Head, National Centres for Disease Control, Commonwealth Department of Health and Aged Care, Sydney, Australia
Sophia Mukasa Monico, Executive Director, The AIDS Support Organisation (TASO), Kampala, Uganda
Eamonn Murphy, Australian Agency for International Aid, Sydney, Australia; and former Director, HIV/AIDS and Hepatitis C Division, National Centres for Disease Control, Commonwealth Department of Health and Aged Care
Kay Orton, HIV Health Promotion/Prevention Programme, Department of Health, United Kingdom
Nick Partridge, Chief Executive, Terrence Higgins Trust Lighthouse, London, United Kingdom
Dr. Dinesh Paul, Joint Director, National Institute of Public Cooperation and Child Development, New Delhi, India
Gunilla Rådö, Principal Administrative Officer, HIV/STD Programme, Ministry of Health and Social Affairs, Sweden
Wiwat Rojanapithayakorn, UNAIDS Asia-Pacific Inter-Country Team Leader for Thailand, Bangkok, Thailand
Mary Scott, former Head, National Centres for Disease Control, Commonwealth Department of Health and Aged Care, Sydney, Australia
Jean-Jacques Thorens, Office de santé publique, Berne, Switzerland
Helen Watchirs, Law Faculty, Australian National University, Canberra, Australia

Appendix II
QUESTIONNAIRES FOR KEY INFORMANT INTERVIEWS

Two questionnaires were used for the key informant interviews, one for government respondents and one for community respondents. Both questionnaires are reproduced below.

Questionnaire for Government Respondents

1. Do you have any questions about this project or the process before we begin?

2. Do you see inter-ministerial collaboration as a useful approach to confronting the HIV/AIDS epidemic? Why? Or why not?

3. What do you see as the main barriers to initiating or maintaining inter-ministerial collaboration?

4. Please provide example(s) of inter-ministerial collaboration in your country.

    a. How did it work?
    b. Was it a one shot project or ongoing?
    c. How did it begin?
    d. Was (is) it effective?
    e. Did you have to convince other departments to become involved? How did you do this?

If Effective:

    f. Why do you think it was effective? What were the contributing factors?
    g. What were the problems along the way? How were these overcome?
    h. What were the results? What were the key lessons learned?

If NOT Effective:

    ❑ Why do you think it was not effective? What were the contributing factors?
    j. What were the key lessons learned from this experience?

5. What do you think is necessary for inter-ministerial collaboration to be successful?

    a. Any cautions, pitfalls to avoid?
    b. How do you think people from other ministries can best be drawn into working collaboratively or integrating HIV/AIDS into their ministry?
    c. Is there any particular structure or form that you would recommend for inter-ministerial collaboration?

6. What government departments would you like to see be more involved in responding to HIV/AIDS and why?

7. Is there anyone else you suggest we should talk to on this issue? If yes, do you have their contact information?

8. Do you have any other ideas or comments about inter-ministerial collaboration that you'd like to pass on?

Questionnaire for Community Respondents

1. Do you have any questions about this project or the process before we begin?

2. Do you see inter-ministerial collaboration as a useful approach to confronting the HIV/AIDS epidemic? Why? Or why not?

3. How well do you think your federal government has done in terms of inter-ministerial collaboration?

    a. Has it been successful?
    b. What has worked? What has not worked?
    c. What lessons have been learned?

4. What government departments (federal or provincial/state) would you like to see be more involved in responding to HIV/AIDS and why?

5. What do you think is necessary for inter-ministerial collaboration to be successful/to work?

6. Other contacts:

    a. Are there other examples of inter-ministerial collaboration in HIV/AIDS that you recommend we explore? If yes, can you recommend a contact person and do you have their contact information?
    b. Is there a non-HIV model you recommend we explore? If yes, can you recommend a contact person and do you have their contact information?

7. Do you have any other ideas or comments about inter-ministerial collaboration that you'd like to pass on?

Appendix III
INTER-MINISTERIAL COLLABORATION ON HIV/AIDS IN OTHER COUNTRIES

This section provides brief descriptions of inter-ministerial collaboration on HIV/AIDS in eight countries: Australia, India, Sweden, Switzerland, Thailand, Uganda, United Kingdom and United States of America.

Australia

Australia has used inter-ministerial collaboration at the federal level from the early days of the epidemic. For the most part, collaboration has been between individual departments and agencies on an as-needed basis. There is no overarching inter-departmental committee on HIV/AIDS. Instead, inter-departmental committees and working groups are formed when required for specific purposes. For example, there is an inter-departmental committee established each year to plan World AIDS Day activities. Recently, an inter-departmental committee was formed to oversee the implementation of a programme on AIDS vaccine research (funded by a grant from the National Institutes of Health in the United States). The committee includes representation from the health department, the agency that regulates drugs, the National Health Medical Research Council, the taxation department and the Australian Agency for International Development.

In many cases, collaboration in Australia has involved other players besides federal government departments and agencies. A good example of this was the inter-departmental working group that was formed in the early 1990s around legal reform issues. It involved the federal department of health, the federal Attorney General department, the state Attorney General departments, and community-based HIV/AIDS organizations. The report from this working group led to important changes in the law.

Some of the departments and agencies outside of the health department participate on the Australian National Council on AIDS, Hepatitis C and Related Diseases, the equivalent of Canada's Ministerial Council on HIV/AIDS.

India

There is good coordination and convergence of HIV/AIDS activities with other programmes in India. The lead agency in government on HIV/AIDS is the National AIDS Control Organisation (NACO) in the Ministry of Health. NACO has started involving various ministries, departments and institutions in its HIV/AIDS programme. The following is a partial list:

- National Institute of Public Cooperation and Child Development (NIPCCD)
- Social Sciences
- Ministry of Health
- National Labour Institute, Ministry of Labour
- Confederation of Indian Industries
- National Law Institute
- National Institute of Mass Communication

NIPCCD is an autonomous body working under the aegis of the Department of Women and Child Development. NIPCCD has been given responsibility for planning and guiding NACO on issues related to women, children and HIV/AIDS. Similarly, several other institutions located under different ministries have been given responsibility for guiding NACO in their respective specialties.

Sweden

In Sweden, the Ministry of Health and Social Affairs is responsible for the HIV/AIDS strategy. In terms of implementation of the strategy, three authorities have responsibilities in different areas:

- the National Institute of Public Health is responsible for coordinating the preventive measures for HIV/STD at the national level;
- the Swedish Institute for Infectious Disease Control coordinates research activity; and
- the National Board of Health and Welfare is the authority responsible for supervision of health care and efforts to prevent the spread of disease (under the Communicable Diseases Act).

At times, coordination between these three authorities is not as effective as it needs to be. Sweden is attempting to address this problem in a new National Action Plan on prevention of STD/HIV which is being developed. The plan will cover the period 2001-2005.

To coordinate its work at the national level, the National Institute of Public Health has set up two expert groups:

- the National AIDS Council, with representatives from central authorities, the county councils, municipalities, NGOs and other interest groups; and
- an authority group with representatives from a number of central authorities, such as the National Agency for Education, the National Prisons and Probation Administration, the Board for Occupational Safety and Health, and the Immigration Board.

Most of the programmes regarding HIV/AIDS are carried out on the national level.

Support to United Nations organizations and development cooperation are handled by the Ministry of Foreign Affairs. There is collaboration between the Ministry of Health and the Ministry of Foreign Affairs regarding Swedish international policy for HIV/AIDS.

Switzerland

Currently, there is no formal mechanism for inter-ministerial collaboration in Switzerland. An inter-department working group was formed in 1990, but it only lasted a few years and is expected to formally disband this year. Its role was mainly limited to the exchange of information.

There have been a few instances of one-on-one collaboration between the health department and individual departments. One example involved the department that handles internal personnel matters in the federal public service, which conducted an information campaign on HIV/AIDS within the public service.

Thailand

Unlike Canada, Thailand is a unitary state. Inter-ministerial collaboration has played a very important role in the response to HIV/AIDS in that country.

An inter-departmental committee was formed in the late 1980s. However, it did not start functioning effectively until 1991 when the Prime Minister agreed to chair the meetings of the committee. The level of representation from the various departments went up significantly once the Prime Minister became the chair. So did the allocated budgets. For the next two years, it was the Prime Minister's Office that

coordinated the response to HIV/AIDS in Thailand. In 1993, responsibility for coordination shifted back to the health department, but the inter-departmental committee remains active and is still chaired by the Prime Minister. The committee meets four times a year. Strategic Planning for the HIV/AIDS strategy is coordinated by the National Economic and Social Development Bureau, which is in the Prime Minister's Office. Each year, the bureau collects the plans from each department and rolls them into one.

Most of the inter-ministerial collaboration in Thailand occurs on a bilateral basis between the health department and individual departments. The following are examples of this collaboration:

- Education department (inclusion of HIV/AIDS in the school curricula, training of teachers, etc.)
- Interior department (programmes in rural areas)
- Labour and social welfare department (workplace education; support for persons living with HIV/AIDS)
- Agriculture department (prevention education, dealing with mobile populations)
- University affairs department (research, technical development)
- Communications department (working with mobile populations)

Uganda

Uganda's structural approach to control HIV/AIDS started in 1986 with the establishment of the AIDS Control Programme in the Ministry of Health. In 1992, the government realized that HIV/AIDS was more than a health issue and that it needed a more high profile response. As a result, a statutory body, the Uganda AIDS Commission, was created to coordinate HIV/AIDS activities. The commission is attached to the President's office. It coordinates and harmonizes AIDS control activities in Uganda and is in charge of formulating policy guidelines. In 1993, the Commission began to oversee a multi-sectoral approach to control AIDS.

In Uganda, HIV/AIDS is everybody's disease; there is no one group which is more vulnerable than the other. Rather, vulnerability is more influenced by the context. Because ministries deal with contexts (e.g., environment), this underscores the need for collaboration. In Uganda's multi-sectoral approach, AIDS control programmes have been established in all the line ministries, each of which has a budget and specific activities.

However, many of the ministries have struggled. The government grants were not designated specifically for HIV/AIDS activities. Integration of HIV/AIDS into the normal activities of the ministries did not go smoothly. Another problem arose when no one was put specifically in charge of the AIDS Control Programme; instead, it was left in the hands of the Permanent Secretary, whose many other duties made it difficult for him to pay attention to HIV/AIDS issues. However, the Ministry of Health managed to organize itself well and carries out many prevention and care activities. Some of the other ministries have done work in prevention, sensitization and education (e.g., Ministry of Education and Sports).

In Uganda, the following ministries are considered key in confronting the HIV/AIDS epidemic: Health, Local Government, Agriculture, Education and Sport, Internal Affairs, Defence, Transport and Communications, Gender, Culture and Community Development, Labour, and Information and Broadcasting.

United Kingdom

The United Kingdom (U.K.) does not have a lot of inter-ministerial activity. Collaboration happens on an ad hoc, as-needed basis. Here are some examples of the work being done in departments and agencies other than the health department:

- **International Aid.** The Department for International Development supports some programmes outside of U.K., specifically vaccine development. The department has established links with NGOs and colleagues in the health department.
- **Drug use.** There is a team within the health department that makes contact with the Home Office regarding legal issues.
- **Prisons.** Until recently, the Prison Health Care System was the responsibility of the Home Office. However, this responsibility has now shifted to the health department.

The U.K. has drafted a new HIV/AIDS strategy and a sexual health strategy, and these have been integrated. Another positive component of the U.K. approach is the existence of an all-parliamentary group on HIV/AIDS. This group crosses party lines, so this helps to keep HIV politically non-partisan.

Community-based organizations have identified collaboration as an area of weakness in the U.K. response. Although people living with HIV/AIDS have needs that cannot be addressed by the health department (in areas such as social security and employment), government departments in the U.K have a history of being competitive. This makes collaboration difficult. So does the fact that the health department is also one of the least powerful departments. There is talk in government circles about "joined-up government," a concept that refers to developing seamlessness between departments, but this has not yet led to a lot of collaboration.

An interesting development outside HIV/AIDS is the establishment of a new governmental structure called the Social Exclusion Unit. This unit, which is removed from individual departments, is designed to deal with issues that are significant, that are identified as priorities and that impact disproportionately upon marginalized groups. The issues are dealt with by seconding people from different departments into the unit. Teenage pregnancy is one of the issues being dealt with in the unit. It is an issue that shares some of the same messages as HIV/AIDS education.

United States of America

Most of the inter-ministerial collaboration that occurs at the federal level in the United States of America (U.S.) involves international HIV/AIDS issues. The identification of AIDS as a security issue in the U.S. (in 2000) has led to the establishment of an initiative that involves a number of agencies and departments and that is designed to address international HIV/AIDS issues. The organizations involved in this initiative are:

- Department of State
- Centers for Disease Control and Prevention
- United States Agency for International Development (USAID)
- National Institutes for Health
- Department of Defence
- Human Resources and Services Administration, in the Department of Health and Human Services
- Central Intelligence Agency
- Department of Treasury
- International Trade, Department of Commerce
- Office of International and Refugee Health

The Department of State is the lead agency. Three or four working groups have been formed to address specific issues, such as legislation and funding. This project is just getting underway. The working groups are currently trying to define roles, objectives and initiatives.

This initiative was set up very quickly, without a lot of time for planning. However, it is too soon to evaluate its effectiveness.

Appendix IV
BRITISH COLUMBIA'S INTERMINISTRY COMMITTEE ON HIV/AIDS: GOALS AND OBJECTIVES

The Interministry Committee on HIV/AIDS has established the following goals and objectives for action on HIV/AIDS.

GOALS	OBJECTIVES
Improved information sharing between ministries and coordinated program and service delivery on HIV/AIDS-related issues	• Develop a description of all HIV/AIDS-related policies, programs and services across government. • Increase understanding of the HIV/AIDS-related policies, programs and services of all social policy ministries and how these are interrelated. • Base changes to policies, programs and services on current and relevant research and "best evidence" and best practices literature.
Improve the knowledge base of all members of the Interministry Committee to allow each member to become an expert or champion on HIV/AIDS issues within their respective ministry	• Increase the knowledge of all members through regular discussions and presentations. • Invite guest speakers to Interministry Committee meetings to present on emerging issues related to HIV/AIDS, particularly high priority issues identified in the committee's work plan. • Ensure committee members are apprised of ongoing, current HIV/AIDS research.
Collaborate to solve problems and gaps with cross-ministry impacts or implications	• Facilitate informed, healthy public policy decision making by discussing proposed changes to HIV/AIDS-related policies, programs and services among participants of the Interministry Committee before decisions are made. • Using the inventory of policies, programs and services, identify and prioritize problem areas and gaps requiring interministry action. • Address, from an interministry perspective, problem areas or gaps (up to three per year) to change or recommend changes to government policies and actions.
Be accountable	• Report regularly to the Minister of Health and each respective Minister on the Interministry Committee's accomplishments. • Meet regularly with the Minister's HIV/AIDS Advisory Committee co-chairs to discuss priorities that will inform the Interministry Committee's work plan. • Release regular reports on the work of the Interministry Committee.

Appendix V
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This appendix provides information on the references cited in this paper, as well as other documents and websites that were consulted during the research conducted for this paper.

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