Federal/Provincial/Territorial Advisory Committee on AIDS

2006 - 2009 Strategic Plan

EXECUTIVE SUMMARY

HIV/AIDS continues to be a global and national health threat. There are now more people living with HIV in Canada than ever before. Increasing numbers of new infections pose ongoing and new challenges to governments to provide care, treatment, and support and HIV prevention programming. In particular, a striking rise in the number of undiagnosed individuals (27% of the 58,000 individuals) should send chills through policy makers and front line program deliverers in Canada. This "hidden epidemic" poses a potentially greater risk and challenge to our health resources than do those who are aware of and have taken responsibility for their status.

Recognizing that HIV cannot be successfully dealt with by any one jurisdiction, the Council of Deputy Ministers of Health (CDMH) has designated the Federal Provincial Territorial Advisory Committee on AIDS (F/P/T AIDS) as an "ongoing liaison committee". This designation recognizes that ongoing collaboration between governments is fundamental to addressing HIV/AIDS issues in Canada. The United Nations Joint Program on AIDS (UNAIDS) strongly recommends coordinated and collaborative multi-level HIV/AIDS planning to produce better outcomes.

F/P/T AIDS is not a new committee. For the last eighteen years it has been both proactive and responsive in addressing HIV/AIDS issues. The committee has been able to produce in-depth policy and program analysis on emerging HIV/AIDS issues through sharing information and accessing the necessary expertise (see Appendix A). The products of this analysis have informed provincial, territorial, and federal jurisdictions in policy and program development. Since 2006, recommendations for actions on specific HIV/AIDS issues have also been forwarded to the Public Health Network. Through these activities, F/P/T AIDS significantly influences the evolutionary development of a pan-Canadian approach to HIV/AIDS.

In view of its ever-evolving role, in the spring of 2006 F/P/T AIDS engaged in an evidence-based strategic planning process to guide its work for the next three years. F/P/T AIDS has developed a Strategic Plan that will guide the committee's activities and support its leadership role in addressing HIV issues for the next three years.

F/P/T AIDS subscribes to the following mission: F/P/T AIDS contributes to a decrease in the incidence, prevalence, and burden of HIV infections in Canada. To this mission, F/P/T AIDS would add that it contributes to how we understand and address all blood-borne diseases. In focusing on the determinants of health, and by working effectively across organizational and geographic boundaries with decision-makers and those who determine policy, F/P/T AIDS has demonstrated how scientific evidence and the input of individuals can be merged to create tailored yet consistent actions that people are ready to undertake.

Three strategic goals will guide the work of the committee over the next three years:

1. To collaboratively promote further development of public policy on issues related to HIV/AIDS at the federal, provincial, and territorial levels.

2. To promote increased intergovernmental, inter-jurisdictional, and multilevel collaboration on issues related to HIV/AIDS in Canada.

3. To promote the use of epidemiological data and community information in the development of policy, programs, and services in Canada.

Specific objectives and deliverables have been developed under each of the stated goals. Some of the associated activities are broad or ongoing, reflecting process outcomes. Others, arising out of data and epidemiological analysis, are specific, time-limited projects focused on furthering the knowledge required for jurisdictions to develop HIV/AIDS policy, programming, or services.
A section on guiding principles describes the values and activities that characterize how the committee functions. The F/P/T AIDS terms of reference, which include how the committee develops priorities, can be found in Appendix B.

F/P/T AIDS developed this strategic plan based on a history of synergy and successes, which has lead to concrete accomplishments. This document includes a short summary of the positive outcomes experienced by governments by engaging in a collaborative approach to HIV/AIDS issues in Canada.

Compared to the 2003-2006 F/P/T AIDS Strategic Plan, this plan includes a value proposition for the Committee, an updated understanding of the environment in which we must combat the HIV/AIDS epidemic, and an adjusted set of objectives and deliverables, with new activities, and new priorities. This plan was adopted as a working document in September 2006.

TABLE OF CONTENTS

EXECUTIVE SUMMARY 1

INTRODUCTION 5

F/P/T AIDS' STRATEGIC PLAN 2006-2009 6

Vision 6

Mission 6

Values 6

Value Proposition 7

Commitment 9

ENVIRONMENTAL SCAN: CONTEXT 9

Estimates of People Living with HIV at the end of 2005 9

Estimates of New Infections in 2005 11

Aboriginal Canadians 12

Undiagnosed 12

Comment 13

International : A Global Health Issue 13

ENVIRONMENTAL SCAN: CHALLENGES 15

The Narrowing Horizon for Possibility 15

The Deepening Gap 16

Inter-jurisdictional Collaboration 16

Emerging Science and the Cost of New Technologies 16

Stigma and Discrimination 16

STRATEGIC DIRECTIONS 16

Goal #1: To collaboratively promote further development of public policy on issues related to HIV/AIDS at the federal and provincial and territorial levels over the next three years. 17

Goal #2: To promote increased intergovernmental, inter-jurisdictional, and multilevel collaboration on issues related to HIV/AIDS in Canada over the next three years. 19

Goal #3: To promote the use of epidemiological data and community information in the development of policy, programs and services in Canada over the next three years. 21

IMPLEMENTATION & MONITORING **22**

APPENDIX A: F/P/T AIDS KEY REPORTS AND ACCOMPLISHMENTS **23**

APPENDIX B: F/P/T AIDS 2003-2006 TERMS OF REFERENCE **26**

APPENDIX B.1: CRITERIA FOR SETTING PRIORITIES AND DEVELOPING LINKAGES **30**

APPENDIX C: STRATEGIC PLANNING PROCESS LIST OF KEY INFORMANTS **30**

APPENDIX D: RESOURCES **36**

INTRODUCTION

F/P/T AIDS facilitates strong federal/provincial/territorial intergovernmental collaboration in addressing a pan-Canadian approach to HIV/AIDS in Canada, while respecting jurisdictional responsibilities/ activities.

The Federal /Provincial/Territorial Advisory Committee on AIDS (F/P/T AIDS) was established in 1988 by the Conference of Deputy Ministers of Health (CDMH) in order to provide HIV/AIDS policy advice on issues of national relevance to Deputy Ministers. Since that time, the F/P/T AIDS has received on-going funding through the Treasury Board process. The CDMH recognized that HIV does not respect jurisdictional boundaries and that there was a crucial need for concerted intergovernmental action if the epidemic was to be addressed adequately in Canada. No one jurisdiction, on its own, had the capacity to develop and implement the necessary solutions. At the outset, F/P/T AIDS reported directly to CDMH.

In 1994, at the request of the Ministers of Health, F/P/T AIDS prepared a review of Canada's response to HIV/AIDS

In 1998, F/P/T AIDS was redirected from being an advisory committee reporting directly to CDMH to being a subcommittee of the newly formed Advisory Committee on Population Health (ACPH). Providing policy advice on HIV/AIDS to CDMH was affirmed as the mandate of F/P/T AIDS; however, it would now be vetted through ACPH first.

The CDMH approved, in principle, a revised organizational structure for F/P/T committees in 2002. Under the new structure, ACPH was transformed into the Advisory Committee on Population Health and Health Security (ACPHHS). In 2006, with the formation of the Pan-Canadian Public Health Network, F/P/T AIDS was designated as a "liaison committee". Liaison committees are viewed as having ongoing F/P/T collaboration mandates. The mandates include providing advice to and receiving direction and input from the CDMH via the Public Health Network Council. In this context, the F/P/T AIDS will function as a liaison committee reporting to the PHN.

F/P/T AIDS, as one of its planned activities for the year, engaged in a strategic planning process in June 2006. This has proven to be opportune, in light of the new PHN organizational structure. A list of those who participated is provided in Appendix C.

The Federal/Provincial/Territorial Committee on AIDS Strategic Plan describes the processes and strategic directions that will guide the activities of F/P/T AIDS and support its leadership role in addressing HIV/AIDS issues for the next three years. As in the 2003-2006 F/P/T AIDS Strategic Plan, given the nature of the HIV/AIDS epidemic and the intergovernmental context of the Committee, this plan is also a living document that will be reviewed and updated.

F/P/T AIDS' STRATEGIC PLAN 2006-2009

This three-year Strategic Plan builds on past successes by articulating ongoing activities, short- term projects, and concrete deliverables. In light of the ever-evolving nature of the HIV/AIDS epidemic, this Plan will be reviewed on a regular basis as new scientific, medical, and community information becomes available.

Further, the work plan of the committee will be based on the Strategic Plan. A detailed work plan will assist F/P/T AIDS in ensuring that specific activities have measurable outcomes that are linked to and will further the stated goals and objectives of the Strategic Plan.

The foundational elements of the 2003-2006 Strategic Plan — the Mission, Mandate and Values statements — remain constant. For the first time, a Value Proposition has been included. It is derived from past accomplishments combating HIV/AIDS and other blood-borne diseases and from future contributions to which members of the Advisory Committee are committed.

For almost 20 years, members of F/P/T AIDS have described the impact of social determinants on health and health outcomes, focusing attention on the factors that create vulnerability. F/P/T AIDS has deftly presented empirical evidence to policy makers, enabling integrated policies that are locally relevant. The result has had impacts beyond HIV/AIDS. F/P/T AIDS's long experience in influencing and supporting governments and NGOs has made it an effective organization, able to bring insights that have changed both our understanding of blood-borne diseases and our approach to combating them.

Mission

F/P/T AIDS contributes to a decrease in the incidence, prevalence, and burden of HIV infections in Canada.

Mandate

F/P/T AIDS provides public health policy and programmatic advice on issues and priority initiatives related to HIV/AIDS in Canada.

F/P/T AIDS promotes timely, effective, and efficient intergovernmental and inter-jurisdictional collaboration on the prevention and control of HIV/AIDS in Canada.

F/P/T AIDS promotes the generation of knowledge and its application in developing evidence-based responses to HIV/AIDS in Canada.

Values

F/P/T AIDS is a committee based on mutual accountability and shared responsibility. To guide its collaborative processes and work, the committee bases its actions on the following principles:

Evidence Based

F/P/T AIDS bases it work on the analysis of the best data, research, and practice information that is available. Where this information is not available, F/P/T AIDS endeavours to encourage or facilitate the research or data gathering that is necessary to provide an informed analysis of the issue under

consideration. The committee recognizes the importance of the contribution of community-based experience in understanding the impact of HIV/AIDS.

Collaborative

The work of the F/P/T AIDS Committee is collaborative, both in principle and in practice. Although its membership is limited to government representatives, F/P/T AIDS endeavours to meet with and support the involvement of key stakeholders and HIV/AIDS experts. The committee recognizes that HIV is broadly impacted by the determinants of health and therefore supports the importance of intersectoral as well as intergovernmental collaboration. The practice of information sharing and networking between jurisdictions has supported representatives in strengthening their HIV/AIDS expertise. Respective jurisdictions have been provided with cost-effective policy advice supported through the development of shared language and documents on emerging issues.

Flexible

F/P/T AIDS recognizes the need to respond to emerging HIV/AIDS issues in an environment that is influenced by an evolving and changing epidemic, stakeholder responses and advocacy, health system renewal, and jurisdictional changes.

Accountable

The F/P/T AIDS committee representatives are formally accountable to their respective federal, provincial, and territorial departments of health. In addition, F/P/T AIDS, as a liaison committee, is accountable to CDMH through the PHN. F/P/T AIDS is committed to identifying measurable outcomes for the strategic objectives, activities, and initiatives in which it engages.

Consensus Based Decision-Making

F/P/T AIDS and its working groups make decisions by consensus. Consensus means that agreement is reached among all members. Consensus does not necessarily require that each member is fully satisfied with the decision that has been reached; rather, it means that no one is fundamentally opposed and that each member can live with the decision, despite clearly identified differences of opinion. F/P/T AIDS terms of reference, which are found in Appendix B, outline its decision-making process.

Respectful

F/P/T AIDS respects the jurisdictional mandates and responsibilities of its members and partners, while building on common values, principles, interests, and purposes.

Value Proposition

F/P/T AIDS demonstrates that public health and advocacy organizations, working together and with community groups, can combat disease by deliberately coordinating social, behavioral, and medical interventions that discreetly and precisely attack root causes among diverse populations.

Its insight and influence extends beyond the domain of HIV/AIDS. Through nearly 20 years of examining data, creating knowledge, and powerfully presenting recommendations to policy- and decision-makers, F/P/T AIDS has had an impact on the way all related infectious diseases (such as STIs, Tuberculosis and

viral Hepatitis) are addressed. In concert with existing approaches to related diseases, F/P/T AIDS encourages us to consider factors that create vulnerability among specific populations.

F/P/T AIDS's contribution to the entire domain of related diseases rests principally upon two factors: its reliance upon empirical evidence to create new knowledge, and its status as a discrete and effective organization.

F/P/T AIDS values empirical evidence. It creates knowledge from data that informs policy and programmatic action. It is able to integrate science and policy to create appropriate program responses to health concerns. It bridges the divide between scientists and policy-makers. The availability of evidence creates readiness among stakeholders to act.

Effectively addressing the determinants of health means working across organizational and geographic boundaries in a complex environment of competing interests and considerable ambiguity. In this context, F/P/T AIDS creates a platform for discussion and consensus whereby both beliefs and scientific facts can open many ways forward. Its effectiveness as a facilitator of knowledge and action depend upon its status as a discrete, constant and recognizable entity whose priorities are not be balanced against those of competing health concerns. Thus, the benefits that accrue from the F/P/T AIDS to all related diseases depend upon its unique standing within the PHN and the rest of the stakeholder community.

F/P/T AIDS has remained a durable and relevant organization. By studying, listening, and discussing, it has remained with, and sometimes ahead of, the many changing courses of HIV/AIDS.

Discussion

Since its inception in 1988, F/P/T AIDS has contributed a unique focal point for understanding, cooperation, and collaboration among all actors working to fight the epidemic. Its contributions, though often unheralded, have had a major impact on how the disease has been managed in each province and territory and across the nation as a whole. Moreover, as the disease evolves and changes, F/P/T AIDS is uniquely positioned to understand the changes, adapt to them, and encourage others to adjust so that stakeholders are ahead of the disease.

HIV/AIDS is but one of many diseases that concern Canadians. Historically, HIV/AIDS has remained prominent in the public eye, even as other diseases have emerged and then waned. The policy and funding priority given to HIV/AIDS over the past quarter-century has largely been a result of its widespread virulence, its appearance in virtually every demographic group, its over-representation among Aboriginal peoples, its presence in other vulnerable populations or populations most likely to be exposed to HIV, its poor health outcomes and the absence of a cure or a vaccine to prevent new infections.
Some have argued that HIV/AIDS has received undue attention. Consequently, competition for scarce public and private resources has marked the context within which HIV/AIDS and other diseases have been combated.

More recently, strong arguments among policy leaders suggest that HIV/AIDS should be treated as any other chronic disease and on a level policy and funding playing field. Powerful drug cocktails have decreased both the morbidity and mortality of those infected with HIV. Given the improved health outcomes for those living with HIV/AIDS, there is a view that other diseases deserve as much, if not more, attention.

From a local perspective, this is certainly true. In the territories, for instance, the incidence and potential incidence of HIV/AIDS is much lower relative to other health concerns. Interestingly, what gives

enduring value to F/P/T AIDS is its attention to local realities. When realities change, F/P/T AIDS can harness its knowledge and relationships to build pragmatic approaches to addressing blood-borne diseases.
The Committee's support for harm reduction among injecting drug users is an example of attention to local realities. While providing safe injection sites and clean needles is controversial, since doing so can seem to promote illegal drug use, harm reduction has proved to be an effective response to the spread of the disease among injecting drug users and their partners. The greater good to all Canadians rests in stemming the spread of the disease by providing injecting drug users with both safe sites and services to help them stop using.

Commitment

F/P/T AIDS has made the following commitments to support its strategy:

- We will offer sound and honest advice, based on evidence.
- We will avoid reducing complex problems to simple quick-fix solutions. Instead, we will make complex and ambiguous realities clear and offer the possibility for innovative responses to challenges.
- Our initiatives address complex systems. Resistance to change is normal, but it at least demonstrates that the way forward has been carefully considered. Therefore, we will know our audience, help them to "get ready" for change, and offer compelling testimony to justify new tactics.

ENVIRONMENTAL SCAN: CONTEXT

As a means of monitoring the HIV epidemic and assessing the effectiveness of prevention efforts, estimates of the number of people living with HIV are made around the world. The Public Health Agency of Canada's (PHAC) Centre for Infectious Disease Prevention and Control (CIDPC) produces two types of estimates as part of its mandate to monitor HIV/AIDS trends in Canada: prevalence, or the number of people living with HIV (including AIDS), and incidence, the number of new infections in a one-year period. These estimates guide the work done by PHAC and other federal departments under the Federal Initiative to Address HIV/AIDS in Canada.

HIV and AIDS surveillance data do not include individuals who are untested and undiagnosed. Since surveillance data can therefore only describe the diagnosed portion of the epidemic, modeling and additional sources of information are required to describe the epidemic among both diagnosed and undiagnosed Canadians. The methods used to estimate HIV prevalence and incidence at the national level bring together all available data and are described in more detail in the reference given at the end of the document.

This document summarizes the 2005 HIV estimates for Canada.

Estimates of People Living with HIV at the end of 2005

At the end of 2005, an estimated 58,000 people in Canada were living with HIV infection (including AIDS). This represents an increase of about 16% from the 2002 estimate of 50,000 (Table 1). The individuals most affected by the epidemic have been grouped by their HIV exposure category. These include: men who have sex with men (MSM); injecting drug users (IDU); individuals having heterosexual contact with a person who is either HIV-infected or at risk for HIV, or having heterosexual activity as the only identified risk for HIV (Heterosexual/non-endemic); individuals with an origin in a country where HIV is endemic (mainly sub-Saharan Africa and the Caribbean) and no identified MSM or IDU exposure (Heterosexual/endemic); and recipients of blood transfusion or clotting factor, perinatal and occupational transmission (Other).

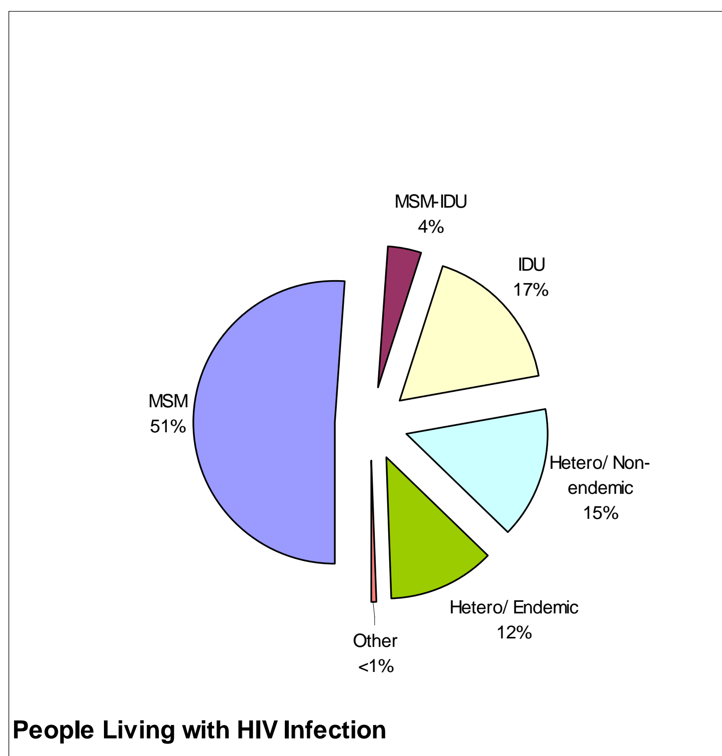
Table 1: Estimated number of individuals living with HIV infection in Canada and associated ranges of uncertainty at the end of 2005 and 2002 (point estimates and ranges are rounded).

	MSM	MSM-IDU	IDU	Heterosexual/ Non-endemic	Heterosexual/ Endemic	Other	Total*
2005	29,600 (24,000-35,000)	2,250 (1,500-3,000)	9,860 (7,800-12,000)	8,620 (6,600-10,600)	7,050 (5,200-8,800)	400 (300-500)	58,000 (48,000-68,000)
2002	26,200 (21,000-31,000)	1,900 (1,200-2,600)	8,900 (7,200-10,600)	6,950 (5,200-8,800)	5,680 (4,000-7,300)	350 (250-450)	50,000 (41,000-59,000)

*Totals were rounded to the nearest 1,000. Unrounded totals were 57,780 for 2005 and 49,980 for 2002 which were used to compute percentages.

At 51%, the men who have sex with men exposure category continues to account for the majority of individuals living with HIV infection in Canada. In comparison, the injecting drug user category accounted for 17%, the heterosexual/non-endemic category accounted for 15%, and the heterosexual/ endemic exposure category accounted for 12% (Figure 1).

Figure 1: Distribution of the estimated number of people living with HIV infection (including AIDS) in Canada at the end of 2005 by exposure category.



<u>Estimates of New Infections in 2005</u>

The number of new HIV infections in Canada in 2005 has not decreased and may have increased slightly compared to 2002. An estimated 2,300 to 4,500 new HIV infections occurred in 2005 compared with 2,100 to 4,000 in 2002 (Table 2).

Table 2: Estimated ranges of uncertainty for the number of new HIV infections in Canada in 2005 and 2002 (ranges are rounded).

	MSM	MSM-IDU	IDU	Heterosexual Non-endemic	Heterosexual: Endemic	Other	Total
2005	1,100-2,000	70-150	350-650	550-950	400-700	< 20	2,300-4,500
2002	900-1,700	60-120	400-700	450-850	300-600	< 20	2,100-4,000

At 45%, the men who have sex with men exposure category continues to account for the greatest portion of new infections (Figure 2). Injecting drug users accounted for 14% of these new infections, while the heterosexual/ non-endemic category accounted for 21% and the heterosexual/ endemic category accounted for 16%.

Persons from HIV-endemic countries continue to be over-represented in Canada's HIV epidemic. While they comprise only 1.5% of the Canadian population, their estimated infection rate is almost 13 times higher than among other Canadians.

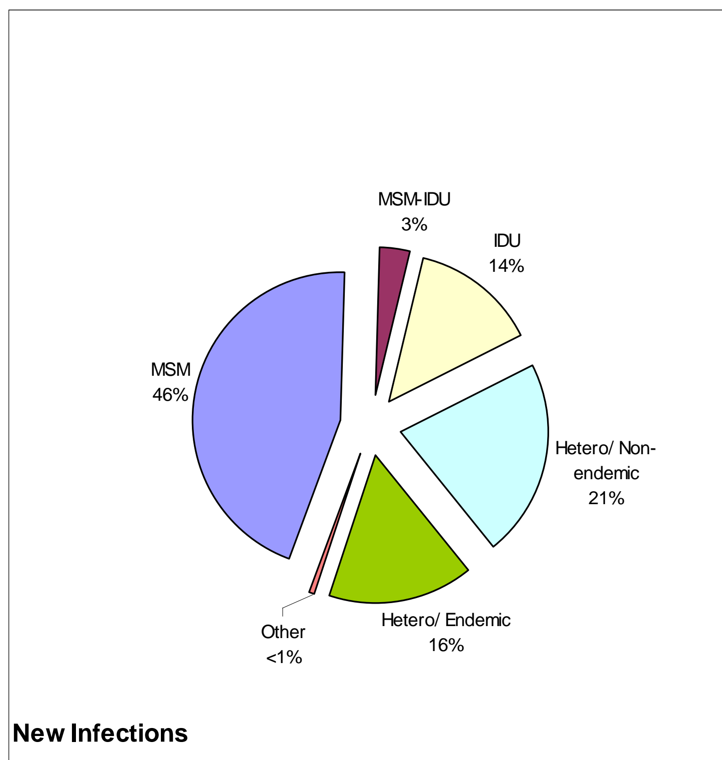


Figure 2: Distribution of the estimated number of new HIV infections in Canada in 2005 by exposure category.

Women

It was estimated that women account for 20% of people living with HIV infection in Canada at the end of 2005. Women were also estimated to account for 27% of all new infections in 2005. Approximately three quarters of the new infections among women were attributed to the heterosexual exposure category (endemic and non-endemic together) and the remainder was attributed to the injecting drug user exposure category.

Aboriginal Canadians

Aboriginal persons continue to be over-represented in the HIV epidemic in Canada. They were estimated to account for 7.5% of persons living with HIV in Canada at the end of 2005 and 9% of all new HIV infections in 2005. This shows an estimated overall infection rate in Aboriginal persons that is nearly 3 times higher than among non-Aboriginals.

At 53%, injecting drug users accounted for a majority of new infections among Aboriginal persons. The heterosexual exposure category accounted for 33% and the men who have sex with men category for 10%. This distribution is quite different from that seen in the wider group of all newly HIV infected Canadians in 2005 (see Figure 2).

Undiagnosed

At the end of 2005, an estimated 27% of the 58,000 individuals living with HIV were unaware of their infection. That makes this group "hidden" to the health care and disease monitoring systems, and so they cannot take advantage of available treatment strategies or appropriate counselling to prevent the further spread of HIV. Indeed, this group poses a potentially greater risk and challenge to our health resources than do those who are aware of and have taken responsibility for their status since they are more likely to spread the disease to others.

Comment

The number of Canadians living with HIV infection will likely continue to increase in the years to come as new infections continue and survival rates improve. This will mean increased future care requirements.

Aboriginal people and persons from HIV-endemic countries continue to be over-represented in Canada's HIV epidemic, highlighting the need for specific measures to address the unique aspects of certain groups. Injecting drug users is the main HIV exposure category among Aboriginal persons while heterosexual activity is the main risk for women and persons from HIV-endemic countries.

There continues to be a sizeable number of people unaware of their HIV infection. Until these individuals are tested and diagnosed, they cannot take advantage of appropriate care and treatment services, nor can they receive counselling to prevent further spread of HIV.

To successfully control the HIV epidemic in Canada, more effective strategies are needed to prevent new infections and provide services for all of the vulnerable populations identified in the Federal Initiative to Address HIV/AIDS in Canada.

International: A Global Health Issue

In May 2006, the Joint United Nations Program on HIV/AIDS (UNAIDS) estimated that there are now 38.6 million people living with HIV/AIDS. The number of people newly infected with HIV in 2005 was estimated at 4.1 million. With nearly 3 million deaths in 2005, the global economic, social and human impact of the HIV/AIDS epidemic has devastating implications.

AIDS is ravaging families, communities, economies and entire countries in the most affected regions of the world. The impact of HIV/AIDS has been particularly devastating in sub-Saharan Africa and the Caribbean, and is increasing in Asia, Eastern Europe, the Middle East, Latin America and the Soviet Union.

Reference

Boulos D, Yan P, Schanzer D, Remis RS and Archibald CP. Estimates of HIV prevalence and incidence in Canada, 2005. Canada Communicable Disease Report 2006; 32(15) (in press). This document is available at: http://www.phac-aspc.gc.ca/publicat/ccdrrmtc/06vol32/dr3215e.html

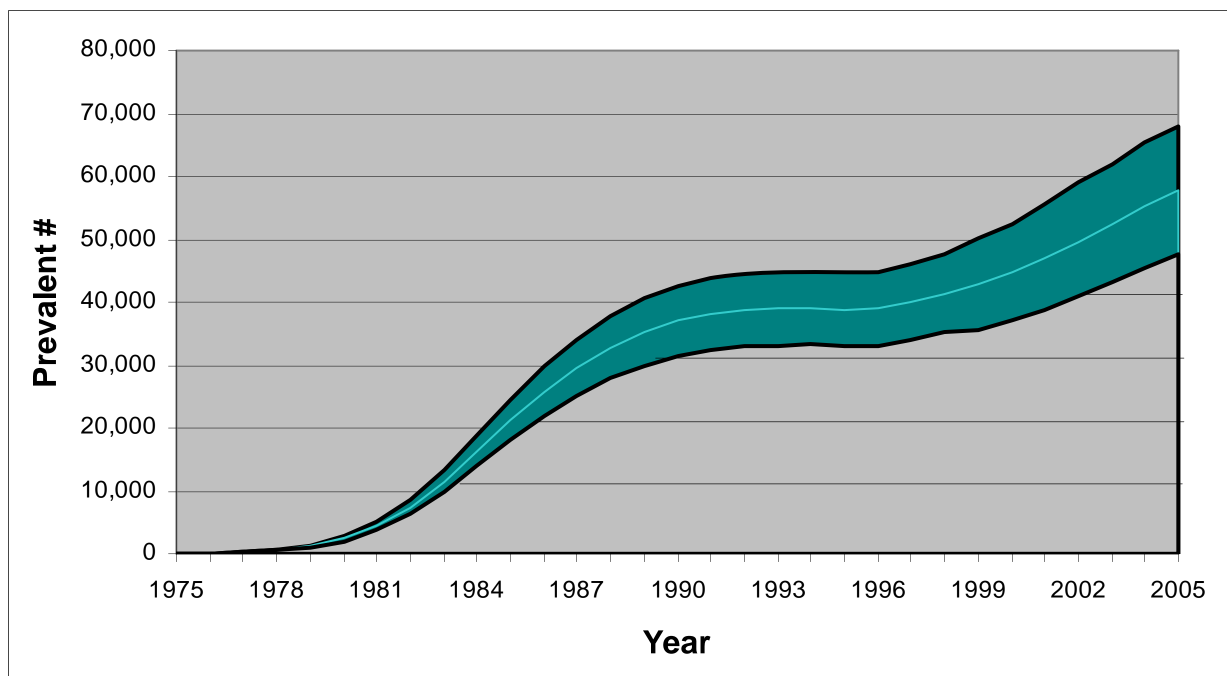


Figure A: Estimated number of individuals living with HIV infection in Canada, including range of uncertainty, by year.

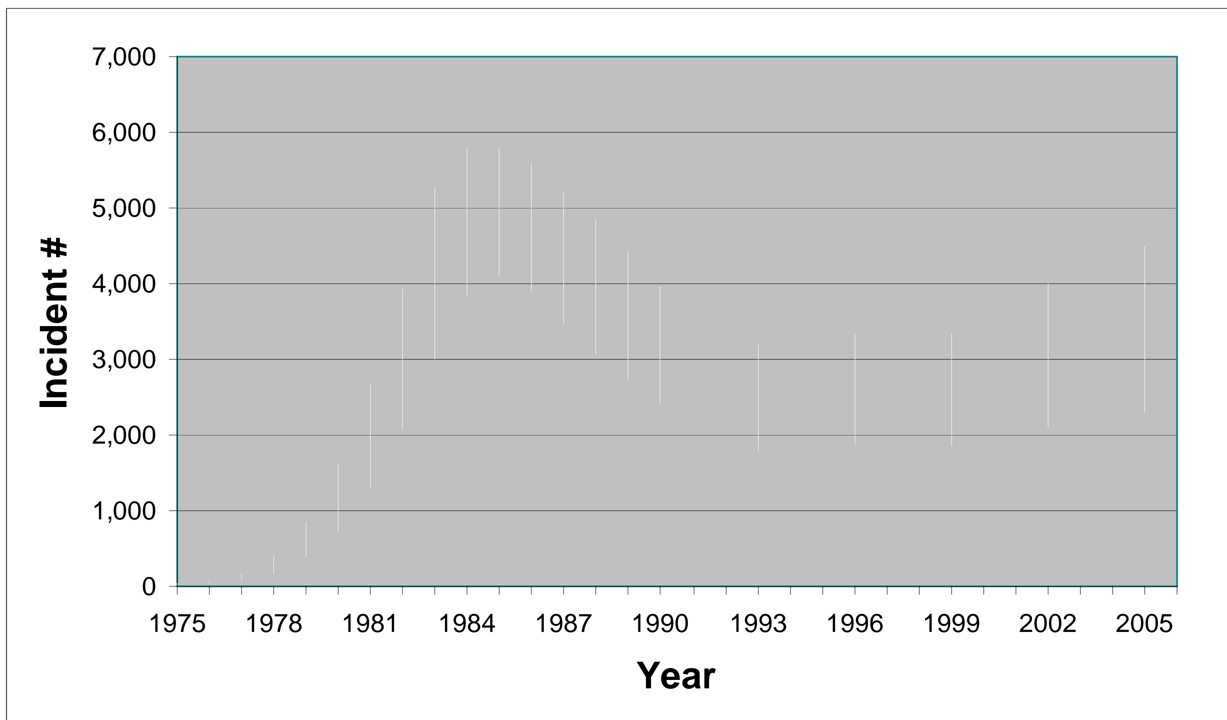


Figure B: Estimated range of uncertainty (represented by vertical bars) in the number of new HIV infections in Canada, for selected years of infection.

ENVIRONMENTAL SCAN: CHALLENGES

Crafting strategic policy is an ongoing and dynamic enterprise. (For this reason, F/P/T AIDS meets three times per year at face-to-face meetings and monthly by teleconference, to both execute and reflect upon its strategy). The capacity to be strategic rests in the ongoing ability of F/P/T AIDS to recognize emerging trends and the opportunities and challenges they present.

The challenges identified by FPT AIDS in June 2006 to successfully combat HIV/AIDS include:

- How to make clear and paramount the complex facts about HIV/AIDS and HIV/AIDS research among Canadians, the media, and policy-makers.
- How to sustain high interest in HIV/AIDS issues among community-based political champions and politicians.
- How to understand and act upon the direct correlation between growing poverty and an increased vulnerability to disease among poorer Canadians and in the populations of low- and middle-income countries.
- How to address the persistent stigma attached to and discrimination against vulnerable populations or populations most likely to be exposed to HIV/AIDS.
- How to ensure that as we learn more about the disease and how it spreads, we continue to challenge our indicators of success and failure and seek new, appropriate measures.
- How to increase the efficiency of our responses to the disease, given the increasing cost of the solution set.
- How to foster evidence-based decision making in political environments that are often driven by ideology.

<u>The Narrowing Horizon for Possibility</u>

The world has become a more fragmented, complex and dangerous place. At the same time, society's expectations for access to wealth and government services are high – particularly among higher income individuals. So while we expect to live with less risk, we are living in a world with more of it. Society must ask: Where do the risks really lie? What are all the possibilities for mitigating them? What can we afford to do? Without the input of many perspectives, the range of possible solutions narrows.

Below are some examples of how the narrowing range of possibilities is affecting the world of HIV/AIDS and other related diseases:

Governments are preoccupied with the security of person and place. As domestic and international demands vie for attention, care will need to be taken to ensure that populations that are vulnerable to health threats do not become more vulnerable and disposable.

Evidence suggests that prohibiting drug use and pouring resources into expensive enforcement does not reduce the social and physical harm associated with drug-taking practices.

Fear of a flu pandemic risks a disproportionate shift of energy and resources away from more immediate health challenges.

Excluding instances of rape and other forms of sexual coercion, we agree that consenting sexual partners are equally responsible for their own sexual health. When it comes to preventing the spread of STIs, sex is a negotiation and a matter of risk mitigation for all partners. Yet some partners who have not disclosed their HIV serostatus have been prosecuted for non-disclosure. This is not true for those who have other

STIs. Consequently, people with HIV/AIDS who engage in high-risk sexual activity have been "criminalized".

The Deepening Gap

The gap between rich and poor is growing wider, the middle class is declining, and we are entering a global era of haves and have-nots that threatens stability within and between nations. How is this phenomenon reflected in the world of HIV/AIDS?

Vulnerable populations or populations most likely to be exposed to HIV are becoming even more at risk. While most Canadians are earning more, First Nations, Inuit and Métis people remain impoverished. These groups have the same economic, social and health profile as the populations of many Third World nations.

Gentrification of the downtown cores of many large Canadian cities has displaced and dispersed the poor. Finding affordable shelter is more difficult, and it has become more difficult to reach and help these groups. Their situation has worsened.

Populations in areas of economic boom are generally at increased health risk because the social infrastructure needed to manage the negative impacts of sudden growth lag behind economic growth. These impacts include increased problematic drug and alcohol use, family abuse and breakdown, unemployment among lesser skilled citizens, gambling, and an increase in high-risk sexual activity. At a global level, the disparity in access to care, treatment and support between richer countries and middle- and low-income countries is growing deeper.

Inter-jurisdictional Collaboration

The F/P/T AIDS document, A National Portrait: A Report on Governments' Responses to the HIV/AIDS Epidemic in Canada, paints an encouraging picture. Most jurisdictions have strategies, action plans, or initiatives that recognize that HIV is an important issue. Across this array of activity, values are common, while approaches are appropriate to local contexts. As well, the HIV surveillance systems present in each jurisdiction are better than the surveillance systems used for other diseases.

Emerging Science and the Cost of New Technologies

Scientific research and the development of new technologies are cornerstones of the HIV/AIDS strategy in Canada. As our knowledge of how to address HIV/AIDS improves, expectations among those living with HIV/AIDS are raised. But we are not always able to afford to do what we know how to do. Unfulfilled expectations among populations can lead governments to make unwise decisions about how to spend dollars allocated to care, treatment and support.

Stigma and Discrimination

Unfortunately, stigma attached to and discrimination directed against vulnerable populations and populations most likely to be exposed to HIV persists. These groups include gay men, First Nations Inuit and Métis people, injection drug users, inmates of correctional facilities and people from countries where HIV/AIDS is endemic.

STRATEGIC DIRECTIONS

The strategic plan summary chart below outlines three strategic primary goals and further breaks them down into key objectives. Key activities and specific deliverables define anticipated actions and outcomes, respectively. This chart forms the basis for a work plan.

F/P/T AIDS generated the following criteria to guide their decisions for their 2006-2009 strategic plan. Each activity must:

- Be coherent with the F/P/T AIDS mission, mandate, and values
- Be concrete and organizationally and materially possible
- Be within the sphere of influence and relationships of members of F/P/T AIDS
- Have identifiable partners
- Have readiness among partners to participate with us

Goal #1: To collaboratively promote further development of public policy on issues related to HIV/AIDS at the federal and provincial and territorial levels over the next three years.

Mandate Linkage: Policy advice on issues related to HIV/AIDS
Challenges Linkage: Steering role of governments
Anticipated Outcomes:

- Increased prevention programs among provinces and territories
- Increased accessibility to prevention programs

Decrease in number of HIV infections

Key Objectives		Key Activities	Notes	Outputs/Deliverables
Provide timely, evidence-based policy advice on issues related to HIV/AIDS.	1	Solicit regular updates on research activities and findings related to HIV/AIDS in Canada	Ongoing activity	Attend Canadian Association of HIV Research
	2	Solicit regular care, treatment, support, and prevention programming updates from member governments	Ongoing activity	Jurisdictional updates and presentations at face to face meetings.
	3	Receive updates from working groups undertaking activities related to HIV/AIDS (e.g. Canadian Working Group on HIV Rehabilitation).	Ongoing activity	Policy Plan Catalogue of updates from working groups
	4	Work with provincial and territorial Ministers of Education to improve HIV / AIDS content in school sexual health curricula	This is a new activity. It is a logical follow-up to the Canada, Youth and Aids conference. Additions to existing curricula could include: Discussing HIV/AIDS in a global context Discussing risk behaviours Understanding the factors that create vulnerability among youth.	F/P/T AIDS members will make representations to provincial and territorial Ministers of Education Meetings with provincial and territorial officials responsible for curricula development Improvements to HIV /AIDS content in curricula Link with other groups who are doing work in this area, e.g. Sexual Health Working

				Group-(Joint Consortium)
	5	Explore opportunities for cooperation and collaboration		More consultations and partnerships with other government departments and community groups
	6	Monitor and analyse responses to multi-drug resistance in selected jurisdictions and develop recommendations for an appropriate and consistent pan-Canadian approach.		
	7	Review P/T considerations regarding HIV Testing and Partner Notification approach being taken by Citizenship and Immigration Canada	Ongoing activity	Annual update from Citizenship and Immigration
	8	Provide leadership in the implementation of "Reducing the Harm Associated with IDU in Canada" framework as it pertains to national HIV/AIDS issues.	This activity was listed in the 2003-2006 Strategic Plan. The F/P/T AIDS has successfully published the "Reducing …" report, as indicated in that plan. Now, the F/P/T AIDS will seek to implement the results of this report by working jointly with other federal, provincial and territorial governmental organizations (e.g., health, security and justice portfolios) to develop ways to deliver an integrated approach to harm reduction and prevention.	Conversations with officials across governments and policy domains towards the development of nationally consistent and locally relevant approaches to harm reduction and prevention.
	9	Review and revise testing and counselling guidelines in all jurisdictions	F/P/T AIDS seeks more uniformity across jurisdictions regarding HIV screening (including pre-natal screening). It seeks standard concomitant responses to screening outcomes. See new Quebec guidelines as possible model.	A national statement on HIV testing A national statement on HIV counselling guidelines A process for reviewing testing and counselling protocols in each jurisdiction Commencement of reviews

Goal #2: To promote increased intergovernmental, inter-jurisdictional, and multilevel collaboration on issues related to HIV/AIDS in Canada over the next three years.
Mandate Linkage: Collaborative actions.
Challenges Linkage: Inter-sectoral and inter-jurisdictional collaboration

Anticipated Outcomes:

- Demonstrable impact on policy and program initiatives that are likely to result in reduced incidence of HIV.
- Reduced vulnerability among populations most affected by HIV/AIDS, evidenced by reduced rates of infection
- Improved SES for First Nations, Inuit and Métis people, resulting in decreased rates of infection among

these groups				
Key Objectives		Key Activities	Notes	Outputs/Deliverables
Lead collaborative efforts among relevant federal, provincial and territorial organizations and community groups to proactively respond HIV/AIDS related issues over the next three years. Lead collaborative practices that will address health determinants to reduce the vulnerabilities of the Canadian population to HIV/AIDS	1	Explore opportunities to enhance collaborative working relationships with national committees and other F/P/T mechanisms	Ongoing activity	
	2	Create new mechanisms for encouraging co-ordination and co-operation among stakeholders.	Create an "others" table at F/P/T AIDS meeting that includes, for instance, members of the FPT Corrections Working Group on Health	Engaged input from representatives of other policy domains.
	3	Create mechanisms to enhance inter-jurisdictional capacity to respond to health determinants that influence vulnerability to HIV.	Ongoing activity	
	4	Develop post release planning guidelines for federal and provincial correctional institutions		Consultations with federal and provincial correctional officials have begun. Guidelines in place
	5	Review UNGASS commitments and summarize implications for F/P/T governments directly, as well as in the annual report to CDMH.	Ongoing activity (recurs every two years)	Summary report of UNGASS commitments and implications for F/P/T governments. (Link to annual report to CDMH)
	6	Collaborate (as appropriate) with the Public Health Agency of Canada in the development of programs, e.g. National HIV/AIDS Awareness Campaign		
	7	Collaborate with National Aboriginal Council on HIV/AIDS (NACHA) to identify opportunities for inter-jurisdictional collaboration to reduce the impact of HIV/AIDS in First Nations, Inuit and Métis communities.	F/P/T AIDS will invite representatives from this group to their table. As a first step, F/P/T AIDS will seek their views on how we can work together. As well, seek to understand their issues.	On-going consultations with NACHA

Goal #3: To promote the use of epidemiological data and community information in the development of policy, programs and services in Canada over the next three years.

Mandate Linkage: Evidence Based Analysis
Challenge Linkage: Leadership: promoting action on HIV/AIDS.
Anticipated Outcome:
Best practices re HIV programming are identified and shared among federal, provincial and territorial agencies.

Key Objectives		Key Activities	Notes	Outputs/Deliverables
To collaborate with the Surveillance and Risk Assessment Division of the PHAC to enhance the quality of the current HIV/AIDS surveillance system in Canada To improve understanding of the HIV/AIDS epidemic in Canada through identification of strategic, targeted epidemiological studies To improve linkage between users and producers of HIV/AIDS epidemiological and surveillance information	1	Encourage implementation of enhanced aspects of existing routine surveillance systems		An improved national HIV/AIDS surveillance system. Enhanced evidence base of information from targeted studies. HIV related policies and programs reflect the latest HIV evidence
	2	Identify gaps in targeted epidemiologic studies for HIV		
	3	Develop a plan to advocate for the resources to address these gaps.		
	4	Build a supportable environment for KE (knowledge exchange) between users and producers of HIV/AIDS epi/surveillance information. Examples include: - Revise funding streams to integrate KE - Examine potential for KE integration into existing activities - Create opportunities for enhanced user competency in using data - Consider establishing a web site to address identified needs of users		
	5	Build best practice in KE of HIV/AIDS epi/surveillance information - Evaluate current system to identify key players, needs, current practice, existing strengths, challenges - Scan existing KE activities in other fields to identify best practices - Ongoing monitoring and reporting on progress		
	6	FPT AIDS stays informed of work plans arising from regular HIV/AIDS Surveillance Meetings, Ottawa		

	7	Revise standard definitions for Exposure Categories, HIV-Endemic Countries and Ethnic categories; address revisions to HIV/AIDS reporting form		
	8	Update/revise 1991 surveillance guidelines including standard data-gathering practices		
	9	Consider rationale and proposal for system evaluation		

IMPLEMENTATION & MONITORING

To maintain flexibility some of the objectives and deliverables in the Strategic Plan are general in their wording. F/P/T AIDS anticipates its work plan, based on and linked to the Strategic Plan will translate these general statements into concrete projects and activities with measurable outcomes and deliverables.

Representatives on F/P/T AIDS report to their respective jurisdictions. By sharing its Strategic Plan and work plan with the PHN and the CDMH, F/P/T AIDS has built in an additional accountability mechanism.

Given the evolution of the epidemic and the governmental context, F/P/T AIDS will update its strategic plan every three years, and prepare an annual report to indicate progress on its work plan.

APPENDIX A: F/P/T AIDS KEY REPORTS AND ACCOMPLISHMENTS

F/P/T AIDS KEY REPORTS & ACCOMPLISHMENTS

Note: This is not an exhaustive list of all the work of F/P/T AIDS, but serves rather as an example of the range of HIV/AIDS issues that have been addressed of significance to Canadians.

1988

- Produced and distributed report Federal / Provincial / Territorial Working Group on Confidentiality in Relation to HIV Seropositivity.

1992

- Produced and distributed a report on "Funding Drug Therapy for HIV Infection AIDS"

1994-1995

- Prepared "Report on Canada's Response to HIV/AIDS" as requested by the Ministers of Health,

1995

- F/P/T AIDS Advisory Committee Statement on Aboriginal People and AIDS
- Report on the Feasibility of a National HIV/AIDS Targeted Public Education Program

1996

- Developed national guidelines/protocols for practice for Partner Notification for HIV.

1998-1999

- Contracted a feasibility study on HIV/AIDS related expenditures in provinces and territories.
- Contracted an environmental scan "Making the Difference" on Aboriginal HIV/AIDS issues.
- Published and distributed "Intergovernmental collaboration on HIV/AIDS…. A Discussion Paper".
- Published a series of monographs on post exposure prophylaxis (PEP) for non-occupational exposure to HIV, which explored the legal ethical and economic dimensions. The monographs were originally presented at a multi-stakeholder conference attended by representatives from across the country. The proceedings from the conference were also published and distributed.

1999-2000

- Reviewed the issues related to the expected release of rapid test kits and impacted manufacturer's.
- Reviewed and distributed national counselling guidelines for rapid test / point of care kits originally developed by BCCDC.
- Alerted all jurisdictions and provided a common briefing note on the use of Nonoxynol – 9.

2000-2002

- Reducing the Harm Associated with Injection Drug Use in Canada, prepared by the five F/P/T Committees (AIDS, Justice, Heads of Corrections, Infectious Disease Working Group) was extensively used in Correctional Service Canada (CSC) Harm Reduction & Methadone Programs, by the RCMP and by the National Parole Board. The Council of Minister of Health approved the release of the paper.
- Background Discussion Paper "Possible Elements of a Pan-Canadian Strategy on HIV/AIDS: A Background Discussion Paper" prepared for F/P/T AIDS by Jan Skirow.

2002

- Produced "Guiding Principles for the HIV Testing of Women During Pregnancy". Provinces and territories committed to distributing them within their respective jurisdictions.
- Alerted stakeholders across the country of difficulties identified in the reliability of rapid test kits

2004- 2005

- Published "A National Portrait: A Report on Governments' Responses to the HIV/AIDS Epidemic in Canada". The report examines the situation of the epidemic in different Canadian jurisdictions from the perspective of provincial and territorial governments and key stakeholders; summarizes the different policy and programming responses to the epidemic; analyses issues of common concern; and identifies means for strengthening the Canadian response to the epidemic.

2005

- Developed an "HIV/AIDS Surveillance and Targeted Epidemiological Studies Plan". This plan was developed to enhance the role of surveillance and targeted epidemiological studies in improving both the understanding of and the response to HIV/AIDS in Canada.

2005

- Published "Persons who fail disclose their HIV/AIDS status: Conclusions reached by an Expert Working Group" in the Canadian Communicable Disease Report, Volume 31-05, March 1, 2005. The article focused on issues around disclosure of HIV status and public health and endorsed a framework developed by the Calgary Health Region for persons who are unwilling or unable to disclose their status, subject to certain recommendations.

Influence on Prevention / Information Distribution / Sharing Initiatives

- Annually information on the themes for National HIV/AIDS Awareness week, World AIDS Day and Aboriginal AIDS Day campaigns are provided to F/P/T AIDS representatives, enabling them to make the information available to their respective communications staff, prepare briefing notes etc.
- Supported the distribution of Schools, Public Health, sexuality and HIV: A Status Report" which was written for the Council of Ministers of Education, Canada.
- F/P/T AIDS supported the distribution of Hepatitis C information resources.

APPENDIX B: F/P/T AIDS 2006-2009 TERMS OF REFERENCE

F/P/T AIDS is a liaison committee within the Public Health Network. F/P/T AIDS facilitates strong federal/provincial/territorial intergovernmental collaboration in addressing a pan-Canadian approach to HIV/AIDS in Canada, while respecting jurisdictional responsibilities/ activities.

Mandate

- F/P/T AIDS provides public health policy and programmatic advice on issues and priority initiatives related to HIV/AIDS in Canada.

- F/P/T AIDS promotes timely, effective and efficient inter-governmental and inter-jurisdictional collaboration on the prevention and control of HIV/AIDS in Canada.

- F/P/T AIDS promotes the generation of knowledge and its application in developing evidence-based responses to HIV/AIDS in Canada.

Strategic Plan and Operational Plan

Given the evolution of the epidemic and the governmental context, F/P/T will review its Strategic Plan every three years to re-affirm the mission and mandate and adapt the strategic directions to the current context.

F/P/T AIDS will implement the Strategic Plan by developing an 18-month work plan, which will implement the strategic directions and identify clear outputs and deliverables. The activities in the work plan will be prioritized based on the criteria identified in Appendix B.1

Membership

One voting member, a senior policy or program official from the provincial/territorial department of health as selected by the Deputy Minister of Health of that jurisdiction will represent each provincial/territorial government.

The federal government-voting member will be a senior federal government representative selected by the Deputy Chief Public Health Officer (DCPHO) of the Infectious Diseases and Emergency Preparedness Branch (IDEP) of the Public Health Agency of Canada, the DCPHO lead of the Federal Initiative to Address HIV/AIDS in Canada. The DCPHO of IDEP will be available to provide guidance to F/P/T AIDS on major policy issues and will be invited to attend one meeting annually.

Four non-voting representatives who will bring expertise in policy, programming, epidemiology, surveillance, aboriginal issues, and correctional issues will also represent the federal government:

- Director of the HIV/AIDS Policy, Coordination and Programs Division (Public Health Agency of Canada);
- Director, Surveillance and Risk Assessment Division (Public Health Agency of Canada.
- An official of the First Nations and Inuit Health Branch (Health Canada); and,
- An official of Correctional Service Canada.

- An official of Citizenship and Immigration Canada.

Chairpersons

The federal voting member will act as the federal co-chairperson.
Provincial/territorial members will nominate a P/T co-chairperson by a closed vote:

- The term of the P/T co-chairperson will be reviewed every two years.
- In the event that the current P/T co-chairperson intends to be considered for continuation, a motion is put forward and seconded, followed by a closed vote. If the incumbent has the support of the majority of P/T members, he/she will continue as P/T co-chairperson. If the incumbent does not receive the support of the majority of P/T members, the floor will be opened for nominations.

Each co-chairperson will have a back-up co-chairperson, who will serve as an alternate in the event that the lead co-chairperson is not available for a meeting, teleconference or other event. Provincial/territorial members will nominate an alternate P/T co-chairperson. The P/T co-chairperson alternate will be reviewed every two years.

Governance

Meetings and Teleconferences

F/P/T AIDS will conduct its work through monthly teleconferences, three face-to-face meetings per year, and ongoing communication among members in between regularly scheduled teleconferences and meetings (e.g. e-mail, teleconferences).

A quorum of 50% of the members will be required for all decisions made during teleconferences and meetings of the full committee.

Working Groups

Working groups will be established as necessary to undertake work required of F/P/T AIDS. Working Groups report to the full Committee. Terms of reference and a schedule of teleconferences and meetings will be established by each working group. Working groups should be time limited, chaired by a member of F/P/T AIDS, include representation from relevant affected communities, non-governmental partners and governmental partners, from departments other than health where possible, and report to F/P/T AIDS.

A quorum of 50% of the members will be required for all decisions made during teleconferences and meetings of the working groups.

Linkages

F/P/T AIDS will, on an as-needed basis, liaise with other bodies that provide information relevant to the development of policy advice and with other mechanisms/forums addressing health issues that have similar risk factors and health determinants to those associated with
HIV/AIDS. Linkages will be defined in the operational plan and prioritized based on the criteria identified in Appendix B.1.

F/P/T AIDS will participate in major policy development, direction setting, work planning, and other multi-sectoral and inter-governmental initiatives of the Federal Initiative to Address HIV/AIDS in Canada (FI). Non-governmental stakeholders will routinely be invited to present at F/P/T AIDS meetings and to participate as full members of working groups to build increased understanding, feedback, and linkages between sectors. This is particularly relevant with respect to stakeholders with expertise in areas such as aboriginal issues, ethno cultural issues, alcohol and other drugs, poverty, and housing.

Decision Making Process

Decisions are supported by committee members within their level of authority, then, if required, taken back to their jurisdiction for consideration.

F/P/T AIDS and its working groups will make decisions by consensus. Consensus means that all members reach agreement. Consensus does not necessarily require that each member is fully satisfied with the decision that has been reached: rather, it means that no one is fundamentally opposed and that each member can live with the decision, despite clearly identified differences of opinion.

If consensus cannot be reached after a reasonable period of discussion, the differing views pertaining to an issue/recommendation will be clearly and fairly recorded in the teleconference or meeting minutes.

- In the absence of consensus, members may make the decision to carry discussion over to the next teleconference or meeting. If consensus still cannot be reached following the second discussion, a decision shall be reached through a vote. Each province, territory, and the federal government shall have one vote. The majority opinion will prevail. The differing views will be clearly and fairly recorded in the teleconference or meeting minutes.

- In the event that a motion is brought to a vote and results in a tie, the default will be to not proceed with the motion, but to refer the issue back to the appropriate working group to gather more information, or solicit additional perspectives to bring back to the full committee. This process will continue until such time as a vote does not result in a tie or the majority of members agree to put the issue to rest.
- In the case of major or contentious issues (e.g., elections of P/T co-chairperson), where neither an F/P/T AIDS member, nor his/her designate is present, the vote will be deferred until such time as the position of each jurisdiction can be canvassed and factored into the vote. In the event that a decision that has been deferred cannot wait for the next teleconference or meeting due to urgent circumstances that arise, the co-chairpersons shall make the decision. The co-chairpersons at the next meeting or teleconference must then explain the urgent circumstances, the decision, and the rationale.

Resources

Budget

As a liaison committee of the Public Health Network, F/P/T AIDS is funded by the Public Health Agency of Canada. For full F/P/T AIDS teleconferences and meetings, the expenses will be covered by the Public Health Agency of Canada as follows:

- Meeting room, translation, interpretation, hospitality, and teleconference costs.
- Transportation for all members of the Committee.
- Hotel and meals for provincial/ territorial representatives.
- Hotel and meals for federal government representatives.

Secretariat

The HIV/AIDS Policy, Coordination and Programs Division, Public Health Agency of Canada will provide secretariat and strategic policy support to the F/P/T AIDS. This support includes the following activities:

- Providing strategic support to the co-chairs and the Committee by preparing, as requested, briefing notes, speaking notes, and presentations;
- Facilitating communication among and between members and sub-committees;
- Providing regular financial and administrative reports;
- Developing work plans;
- Undertaking and disseminating information/research as directed;
- Managing correspondence processes as directed;
- Managing publications and communications processes as directed;
- Administering contracts as directed;
- Preparing the annual reports as directed;
- Preparing and coordinating meetings and teleconferences which includes: working with co-chairs to develop the agenda; assembling meeting binders; inviting guests; managing the logistics; arranging travel and accommodation for participants; preparing and distributing minutes for meetings and teleconferences; following-up on decisions taken during meetings and teleconferences; and processing travel expenditure payments for the members and, if eligible, the honoraria; and,
- Liaising with the Public Health Network Council (PHN) Secretariat and identified stakeholders.

APPENDIX B.1: CRITERIA FOR SETTING PRIORITIES AND DEVELOPING LINKAGES

To ensure the most efficient use of its time and resources, F/P/T AIDS has developed the following criteria to identify which HIV/AIDS issues it will focus on, both in its long - term strategic planning and its short-term consideration of emerging issues. The criteria reflect the values and principles that will continue to guide the work of F/P/T AIDS.

It is recognized that for different projects, each of the criteria may be rated differently.

- Urgency / Importance
    - Is this an issue requiring immediate attention?
- Burden of Illness
    - Will this issue contribute to a major or significant impact on new or emerging HIV infections or the care of those infected?
- Determinants of Health Lens
    - Will this activity inform or facilitate the development of policy that addresses one or more of the determinants of health.
    - What are the external linkages / partnerships needed to address this issue comprehensively?
- Public / Stakeholder Perception
    - Is this issue perceived to be important by the public or key stakeholders?
- Evidence
    - Is there research or data available pertaining to the issue or is there a need to investigate further?
- Historical Effectiveness
    - Have previous interventions been effective?
- Risk
    - What are the risks if this issue is not addressed?
- Mandate
    - Is this within the mission and mandate of F/P/T AIDS?
- Pan-Canadian Implications
    - Is this an issue that all (or a significant portion) of jurisdictions need to address?
- External Factors
    - Is anyone else dealing with this issue?
- Resources
    - Are the financial and human resources available or obtainable?
- Outcomes
    - Will the outcomes be concrete and measurable?

APPENDIX C: STRATEGIC PLANNING PROCESS LIST OF KEY INFORMANTS

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APPENDIX D: RESOURCES

In order to achieve the directions set forth in this strategic plan, adequate financial resources will need to be supported by each jurisdiction. In addition, resources will be determined within the 5 Year Review of the Federal Role in the CSHA as well as the 5 Year Strategic Planning of the CSHA.

As an on-going liaison committee of the ACPHHS, F/P/T AIDS will also have an opportunity to leverage financial resources from the CDMH for requested policy advice. Deliverables to the CDMH will need to be proposed to ACPHHS for inclusion in its annual work plan and budget.

The HIV/AIDS Policy, Co-ordination and Programs Division, Health Canada will provide secretariat and strategic policy support to the F/P/T AIDS. Additional details on the support provided are found in the Terms of Reference enclosed in Appendix B.