2016 Global AIDS Response Progress Report

– CANADA –

Government of Canada
Report to the Executive Director, UNAIDS

January 2014-December 2015

Canada

Table of Contents

I. Status at a glance

(a) Involvement of stakeholders

The Public Health Agency of Canada led the preparation of the 2016 country report, in consultation with other federal government departments participating in the federal response to HIV/AIDS, as well as civil society stakeholders.

A survey was used to solicit feedback from Canadian civil society organizations about the status of, and response to, the HIV epidemic in the past two years (between 2013 and 2015). Responses have been integrated into this narrative report as applicable. A separate document summarizing the responses is included as Annex 1.

(b) The status of the epidemic

Canada is categorized as having a low general HIV prevalence, with a concentrated epidemic among key populations. The estimated number of Canadians living with HIV (including AIDS) at the end of 2014 was 75,500, a 9.7% increase from 2011.[1] Of this number, an estimated 16,020 people (21% of all those infected) are believed to be unaware that they are HIV-infected. The increase in the number of people living with HIV is due to two factors: new treatments have improved the survival of persons infected with HIV, and new infections continue to occur, largely in key populations. The number of new HIV infections in Canada was estimated at 2,570 (range between 1,940 and 3,200) in 2014. The Public Health Agency of Canada identified a decreasing trend in new HIV infections attributed to injection drug use and heterosexual sex. Some groups continue to be disproportionately affected by HIV/AIDS. Gay men and other men who have sex with men continue to make up the largest group among those newly infected – approximately 54% of all new HIV infections in 2014. People from countries where HIV is endemic continue to be over-represented in Canada's HIV epidemic, with an incidence rate 6.3 times higher than the rate for other Canadians in 2014. Indigenous people[2] continue to be disproportionately affected by HIV, with an incidence rate about 2.7 times higher than the rate for other Canadians in 2014.

(c) The policy and programmatic response

The Government of Canada is committed to a long-term comprehensive approach to addressing HIV/AIDS domestically and internationally. Canada's response to HIV/AIDS involves various levels of government, civil society, the research community, health and public health professionals and those living with or at risk of HIV/AIDS. Through the *Federal Initiative Address HIV/AIDS in Canada (Federal Initiative)* and the *Canadian HIV Vaccine Initiative (CHVI)*, Canada supports research and prevention activities, and facilitates access to diagnosis, treatment, and care particularly for vulnerable populations.

---

[1] Public Health Agency of Canada. 2015. HIV and AIDS in Canada: Surveillance Report to December 31, 2014. Surveillance and Epidemiology Division, Centre for Communicable Diseases and Infection Control, Public Health Agency of Canada.

[2] "Indigenous people" is a term that refers to First Nations, Métis, and Inuit populations.

(d) Data for core indicators that Canada is reporting on:[3]

1.3 Multiple sexual partnerships *Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months*	In 2014, 92.1% of Canadians (11.7 million people) between the ages of 15 and 49 who have ever had sex were sexually active in the previous 12 months. Around 1.7 million of those sexually active (14.8%) reported that they had two or more sexual partners.[4]
1.4 Condom use at last sex among people with multiple sexual partnerships *Percentage of women and men aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse*	In 2014, of Canadians aged 15 to 49 who had two or more sexual partners in the past 12 months, 58.0% used a condom the last time they had sex.[5]
1.5 People living with HIV who know their status *Percentage of people living with HIV who know their status (including data from case-based reporting)*	It was estimated that 79% of people living with HIV in Canada knew their status at the end of 2014.[6]
1.20 HIV incidence rate *Number of new HIV infections in the reporting period per 1,000 uninfected population*	The estimated incidence rate in Canada in 2014 was 0.072 per 1,000 uninfected population (range between 0.055 and 0.090 per 1,000 uninfected population).[7]
2.1 Size estimations for key populations *Number of people engaging in the specific behaviours that put the given population at risk for HIV.*	Population size estimates were developed for MSM and IDU populations for 2014 based on available survey data and a literature review. Population size for inmates reflects inmates in federal prisons only. Canada does not track sex workers and transgender people at the national level. Refer to indicators 2.7, 2.12, and 2.14.
2.7 HIV prevalence in men who have sex with men *Percentage of men who have sex with men risk who are living with HIV*	It was estimated that 6.7% (6.7%-7.9%) of men who have sex with men were living with HIV at the end of 2014.
2.12 HIV prevalence in people who inject drugs *Percentage of people who inject drugs who are living with HIV*	It was estimated that 4.1% (3.3%-4.8%) of people who inject drugs were living with HIV at the end of 2014.

[3] Indicators that Canada is not reporting on, with related rationales, are attached in Annex 2.Note that the Public Health Agency of Canada cannot report on city-level data.
[4] Statistics Canada. 2014. Canadian Community Health Survey 2014.
[5] Ibid.
[6] Public Health Agency of Canada. 2016. Unpublished data based on estimates of HIV incidence, prevalence and proportion undiagnosed in Canada, 2014.
[7] Ibid.

2.14 HIV prevalence in inmates/detainees *Percentage of inmates/detainees who are living with HIV*	The prevalence rate for 2013 was 1.22% (for inmates in federal prisons only).[8]
3.3a Programme level mother-to-child transmission of HIV *Registered percentage of child HIV infections from HIV-positive women delivering in the past 12 months*	The percentage of confirmed perinatal HIV infections, based on reports of HIV-positive women delivering in the past 12 months was 0.86% in 2014.[9]
3.7 Coverage of infant ARV prophylaxis *Percentage of HIV-exposed infants who initiated ARV prophylaxis*	The percentage of reported HIV-exposed infants who received ARV to reduce mother-to-child transmission was 97.4% in 2014.[10] * Available data do not allow for confirmation of time period of ARV provision.
4.7 AIDS-related deaths *Total number who have died of AIDS-related illness in 2015*	The most recent data available is form 2011. In 2011 there were 303 reported deaths from AIDS related illnesses.[11]
7.1 Prevalence of recent intimate partner violence *Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months*	In 2014, 1.1% of women reported experiencing spousal violence from a male or female partner in a current or previous relationship within the past 12 months.[12]
11.11 Congenital syphilis rate (live births and stillbirth) *Percentage of reported congenital syphilis cases (live births and stillbirth)*	0.8 per 100,000 live births in 2011.[13]

II. Overview of the AIDS epidemic

Canada is categorized as having a low general HIV prevalence, with a concentrated epidemic among gay men and other men who have sex with men, people from countries where HIV is endemic, Indigenous people, and other key populations. The latest epidemiological evidence on HIV/AIDS in Canada can be found in *HIV and AIDS in Canada: Surveillance Report to December 31, 2014*.[14] The following is a summary of key information from this report, for the purposes of reporting on Canada's AIDS response.

---

[8] Correctional Service Canada. 2016. Prevalence for 2013, unpublished data.
[9] Public Health Agency of Canada. 2016. Unpublished data based on estimates of HIV incidence, prevalence and proportion undiagnosed in Canada, 2014.
[10] Public Health Agency of Canada. 2015. HIV and AIDS in Canada: Surveillance Report to December 31, 2014. Surveillance and Epidemiology Division, Centre for Communicable Diseases and Infection Control, Public Health Agency of Canada.
[11] Ibid.
[12] Statistics Canada. Family violence in Canada: A statistical profile, 2014. Retrieved February 25, 2016 from http://www.statcan.gc.ca/pub/85-002-x/2016001/article/14303-eng.pdf
[13] Public Health Agency of Canada. Report on Sexually Transmitted Infections in Canada: 2012. Centre for Communicable Diseases and Infection Control, Infectious Disease Prevention and Control Branch, Public Health Agency of Canada. 2015. Retrieved March 8, 2016 from http://www.phac-aspc.gc.ca/sti-its-surv-epi/rep-rap-2012/tb-eng.php#toc
[14] Available at http://healthycanadians.gc.ca/publications/diseases-conditions-maladies-affections/hiv-aids-surveillance-2014-vih-sida/index-eng.php?page=text

The estimated number of Canadians living with HIV (including AIDS) at the end of 2014 was 75,500, a 9.7% increase from 2011.[15] Of this number, an estimated 16,020 people (21% of all those infected) are believed to be unaware that they are HIV-infected. The increase in the number of people living with HIV is due to two factors: new treatments have improved the survival of persons infected with HIV, and new infections continue to occur, largely in key populations.

Since HIV reporting began in Canada in 1985, a cumulative total of 80,469 positive HIV test reports have been reported to the Public Health Agency of Canada. In 2014, 2,044 HIV cases were reported, which represents a 1.5% decrease from the 2,076 cases reported in 2013 and is the lowest number of annual HIV cases since reporting began in 1985.[16] The number of new HIV infections in Canada in 2014 was estimated at 2,570 (range between 1,940 and 3,200). The Public Health Agency of Canada identified a decreasing trend in new HIV infections attributed to injection drug use and heterosexual sex.

Some populations continue to be disproportionately affected by HIV/AIDS. Gay men and other men who have sex with men continue to make up the largest group among those newly infected – approximately 54% of all new HIV infections in 2014. People from countries where HIV is endemic continue to be over-represented in Canada's HIV epidemic. An estimated 358 new infections were attributed to the heterosexual-endemic exposure category in 2014. This category accounted for 13.9% of new infections in Canada in 2014, whereas people born in HIV-endemic countries represented approximately 2.5% of the overall Canadian population according to the 2011 Census. The HIV incidence rate for this population was 40.3 per 100,000 population in 2014, which is 6.3 times higher than the rate for other Canadians (6.4 per 100,000 population). Indigenous people also continue to be disproportionately affected by HIV. Despite representing only 4.3% of the Canadian population, an estimated 9.1% of all those living with HIV in Canada in 2014 were Indigenous, and an estimated 10.8% of all new infections in the same year were among Indigenous people. The estimated new HIV infection rate among Indigenous people was about 2.7 times higher than among non-Indigenous Canadians in 2014.

In 2014, 24.6% of all people diagnosed with HIV were female. Over the past decade, the annual proportion of female cases has remained stable. Overall, the age distribution of positive HIV case reports for females differs from that for males, with females generally diagnosed at a younger age than males.[17]

In 2014, the largest proportion of HIV cases were diagnosed among people aged 30-39 years (31.6%), followed by the 40–49 year age group (22.8%). The proportion of HIV cases among those aged 50 or older increased from 15.0% in 2009 to 21.9% in 2014, surpassing the 20–29 year age group (21.4%) as the third-highest proportion of cases in 2014.

In 2014, among cases where exposure category was known (65.7%), 48.8% of all reported HIV cases in individuals aged 15 or older were attributed to the MSM exposure category.[18]

---

[15] Public Health Agency of Canada. 2015. HIV and AIDS in Canada: Surveillance Report to December 31, 2014. Surveillance and Epidemiology Division, Centre for Communicable Diseases and Infection Control, Public Health Agency of Canada.
[16] Ibid.
[17] Ibid.
[18] Ibid.

The second-most reported exposure category among adults was heterosexual contact, at 29.2% of case reports. There was a near-even distribution of HIV cases attributed to heterosexual contact among people born in a country where HIV is endemic (10.0%), heterosexual contact with a person at risk (9.2%) and heterosexual contact with no identified risk (10.0%).[19]

In 2014, as in previous years, the province of Ontario accounted for the highest number and proportion of reported HIV cases in Canada (837), followed by Quebec (435), Alberta (276), British Columbia (262), and Saskatchewan (121).

III. National response to the AIDS epidemic

Canada is a federation, with responsibilities for health shared across federal and provincial or territorial governments. Provinces and territories deliver health care and hospital services for the majority of the population, while the Government of Canada is responsible for ensuring the availability of health services for specific populations including First Nations people living on reserve, Inuit communities south of the 60th degree parallel, and persons incarcerated in federal prisons. Care, treatment, and support programs are therefore specific to regional epidemiological trends and provincial and territorial communicable disease prevention and control strategies.

In partnership with provincial and territorial governments, the Government of Canada develops health policy; funds the health system and health research; develops and enforces health regulations; and promotes and protects the health of Canadians through leadership, partnership innovation and action in public health. These shared jurisdictional responsibilities require coordination across different levels of government to ensure that the response to HIV/AIDS is sustained, consistent, evidence-based, and effective.

Federal Commitments and Program Implementation

The Government of Canada is committed to action on HIV and AIDS through the Federal Initiative to Address HIV/AIDS in Canada (Federal Initiative) and the Canadian HIV Vaccine Initiative (CHVI).

The Federal Initiative is a partnership of four federal departments and agencies: the Public Health Agency of Canada, Health Canada, the Canadian Institutes of Health Research (CIHR), and Correctional Service of Canada (CSC). Under the Federal Initiative, the Government of Canada monitors HIV and AIDS through its laboratory and national surveillance system; funds research; develops policies, guidance and programs; and supports a community-based response to HIV and AIDS across the country.

The CHVI is a collaboration between the Government of Canada and the Bill & Melinda Gates Foundation, established in 2007 as a contribution to global efforts to accelerate the development of a safe, effective, affordable and globally accessible HIV vaccine. Participating federal departments and agencies are the Public Health Agency of Canada, Health Canada,

---

[19] Public Health Agency of Canada. 2015. HIV and AIDS in Canada: Surveillance Report to December 31, 2014. Surveillance and Epidemiology Division, Centre for Communicable Diseases and Infection Control, Public Health Agency of Canada.

Innovation, Science and Economic Development Canada (formerly Industry Canada), Global Affairs Canada (formerly the Department of Foreign Affairs, Trade and Development), and the Canadian Institutes of Health Research.

Canada provides ongoing financial support to UNAIDS ($4.86 million in 2015) and is currently a member of the UNAIDS Programme Coordinating Board. Canada engages in policy dialogues in international fora such as through the UN system to advance action to reach HIV/AIDS targets with respect to the Sustainable Development Goals.

Canada continues to contribute to the Global Fund to Fight AIDS, Tuberculosis and Malaria. A $650 million commitment (2014-2016) was announced in December 2013, bringing Canada's total commitment to the Global Fund to over $2.1 billion since its inception in 2002.

Internationally, Canada's global HIV/AIDS efforts, through Global Affairs Canada, are focused on prevention, treatment, and strengthening countries' health systems' response to HIV/AIDS. Canada is supporting the delivery of integrated and comprehensive health services for women and children at the local level, which includes HIV testing and counselling, and the prevention of mother to child transmission of HIV services. Global Affairs Canada is working closely with its bilateral, multilateral and civil society partners to deliver on these commitments. This includes support to governments, in addition to Canadian and international civil society organizations, for implementation of national HIV/AIDS strategies and to meet the prevention and treatment needs of vulnerable populations.

Canada supports technical assistance and advice through international working groups and global knowledge translation and exchange forums such as the Inter-Agency Task Team on the Prevention of Mother-to-Child Transmission of HIV (PMTCT) hosted by UNICEF.

Canada has also contributed to global HIV/AIDS efforts through the Public Health Agency of Canada's National Microbiology Laboratory (NML). Through the Canadian Association of HIV Clinical Laboratory Specialists, NML is able to work in collaboration with other HIV clinical laboratories. Together, they develop improved diagnostic and prognostic testing methodologies as well as ways to limit HIV disease transmission and progression of AIDS. Notably, NML's contribution to scientific knowledge on mother-to-child transmission has been incorporated into the WHO's guidance on breast feeding. The new guidelines will impact millions of mothers and infants globally.

Supporting Research

In 2014-2015, CIHR developed and launched seven HIV/AIDS-related funding opportunities to support HIV/AIDS researchers and communities, including four large scale strategic funding opportunities that build additional capacity for HIV/AIDS research. These include CIHR Clinical Trials Network in HIV/AIDS (CTN), CIHR Centres for HIV/AIDS Population Health and Health Services Research. HIV/AIDS Operating Grant Priority Announcements, HIV/AIDS Community-based Research (CBR) Operating Grants and Catalyst Grants, CIHR Travel Awards - three travel award competitions.

CIHR funded the Canadian HIV Observational Cohort (CANOC), which is Canada's largest longitudinal HIV treatment cohort of HIV-positive individuals accessing modern antiretroviral therapy. This project links provincial population health databases with survey studies and conducts multidisciplinary health services research for people living with HIV in Canada, with a

strong consideration of the impact of aging on health outcomes and health service needs. This funding allowed for the CANOC to expand its activities to ten sites across four provinces.

- The Public Health Agency of Canada worked with CIHR to study and test how to alter the expression of host genes to reduce and limit the development of anti-retroviral drug resistance in patients.

- To better understand the HIV epidemic at the provincial and national level, the Public Health Agency of Canada analysed HIV specimens to assess whether or not new HIV cases were in individuals who were recently infected or individuals who have been living unaware of their HIV status. These analyses will allow for more accurate interpretations of HIV transmission surveillance data.

- The Public Health Agency of Canada, in partnership with the WHO, applied molecular epidemiology and modelling transmission patterns of the virus to those who have recently acquired the infection to obtain accurate estimates of the dynamics of HIV transmission. This work is expected to improve the design of preventive interventions and should provide a more accurate picture of traditional public health surveillance.

- Testing methods using dried blood spots (DBS) were improved to reduce the amount of samples required. This improvement in efficiency will increase the scope of infectious agents that can potentially be detected within a single sample including HIV, Hepatitis C and syphilis.

Treatment and Prevention

Persons in Federal Prisons

In 2014-2015, CSC assessed inmates on admission and throughout incarceration by health care professionals using an integrated STBBI screening method. In total, 9,449 HIV/AIDS tests were administered to federal inmates, representing an increase of about 2,362 tests over 2013-2014. Out of 9,449 HIV tests, 4,955, (4,067 in 2013-14) were administered to new inmates. CSC offered educational, prevention and control programs to federal inmates. The Reception Awareness Program (RAP), offered to all newly-admitted inmates, was completed by 37% of the new federal inmates in 2014-2015, compared to 44% in 2013-2014. The decline in RAP participation is due in part to logistical changes in busy reception units. Approximately 79% of institutions had an active Peer Educating Counselling Program and Indigenous Peer Education Counselling support group. In 2014-2015, 93% of inmates known to be living with HIV were on antiretroviral treatment.

First Nations on reserve communities

Among 324 on-reserve communities that reported delivering Community Disease Control & Management, 69% reported delivering education or awareness activities addressing HIV/AIDS and other STBBIs. Of the communities who responded to this question, 82.1% reported that HIV testing was accessible on or near their reserve[20] and 60% responded that HIV treatment was

[20] Near the reserve was defined as close enough to the reserve that travel is not a significant barrier for community members to get tested.

accessible on or near their reserve[20]. During the same reporting period, only 3.7% of communities reported having HIV/AIDS support groups in their communities. Among those communities that did not have an HIV/AIDS support group (n=258), the most common reason provided was that there was not an identified need for one (60.1%), followed by a preference for accessing this service off-reserve (41.1%).

Health Canada works with First Nations to strengthen and expand efforts to reduce HIV through culturally responsive approaches, training of health care professionals and creating and supporting multi-disciplinary approaches. Regional programming focuses not only on preventing the further spread of HIV but also on reducing stigma and discrimination that prevent people from seeking care, and facilitating access to skilled health professionals. Other community based and health promotion programs also provide additional program and funding support to high HIV incidence communities for various community based interventions and programming. Health Canada has also supported the implementation of Point of Care testing in several First Nations communities identified as high risk by our regional staff and First Nations leadership.

IV. Best practices

Political leadership

On World AIDS Day 2015, the Minister of Health released a statement[21] in which she indicated Canada's endorsement of the global UNAIDS 90-90-90 targets. The Minister's statement acknowledged the significant barrier that stigma poses citing it "as a barrier that inhibits people from seeking testing and treatment" and highlighting the need to work collectively so all those living with HIV in Canada are aware of their status, comfortable accessing available treatment, and can take steps to prevent the spread of infection. Civil society organizations mentioned the Government of Canada's increased efforts to improve awareness around HIV non-disclosure laws through community programming since 2013, as well as successful health promotion/prevention initiatives.

Monitoring and evaluation

In 2014-2015, the Public Health Agency of Canada (CCDIC) developed the 2014 Canadian estimates of HIV incidence, prevalence, and the proportion of undiagnosed cases. These estimates are unique globally. Canada is one of the very few countries to produce such estimates on a regular basis, and to show the historical trends along with the estimates for the current year. The result of this technical work is used extensively not only by the Public Health Agency of Canada, but also by provincial and territorial governments, academia, and affected communities in Canada. The Public Health Agency of Canada's computerized algorithm, which estimates trends of incidence of new HIV infections using case-report data of newly diagnosed cases, called EstHIV, has been shared with the British Columbia Centre for Disease Control, the Kirby Institute in Australia and researchers in the United States and Portugal.

The Public Health Agency of Canada's National Microbiology Laboratory (NML), using modern immunologic techniques, implemented what is considered the current gold standard in laboratory diagnostics for tuberculosis (TB) in HIV co-infected subjects. This new tool should assist with limiting HIV disease progression and TB reactivation. In the long run, this will result in improvements in the health of infected subjects.

---

[21] Available at http://news.gc.ca/web/article-en.do?nid=1022689

The Public Health Agency of Canada (NML) evaluated a new rapid test for HIV and syphilis as well as HIV viral load testing technologies that can be used to improve diagnosis and clinical monitoring in point-of-care (POC) settings through the use of a device. The potential implementation of these devices would also improve the efficiency of testing in epidemiological surveillance activities domestically and internationally.

The POC diagnostic tool – PIMA CD4 cartridge – was developed, tested, and evaluated in collaboration with the Clinton Health Access Initiative, the African Society of Laboratory Medicine and private-public partnerships. In addition to being applicable to POC systems in rural and resource-limited settings such as Northern communities in Canada, the new tool will result in efficiencies, improved surveillance, and strengthened diagnosis and treatment.

Treatment and/or support programmes

The Public Health Agency of Canada released a mobile application with the Sexually Transmitted Infections Guidelines on January 15, 2015 geared towards physicians. Based on a survey of physicians, the majority of respondents (84% in 2014, and 83% in 2015) were aware of the guidelines and the majority (83% in 2014, and 76% in 2015) reported using the guidelines. This mobile application ranks highest in downloads among the Health Portfolio's[22] mobile applications targeted to health professionals.[23]

V. Major challenges and remedial actions

a) Progress made on key challenges reported in the 2014 report

In Canada's 2014 report, the process of moving towards a more integrated approach to preventing infections with common transmission routes, common risk behaviours and common social and risk factors (such as poverty, stigma and discrimination, violence, untreated mental illness, and addictions) was identified as a challenge. Canada has made progress on this front. Notably, an integrated community-based funding program (Community Action Fund) was developed to support integrated, community-based interventions to address STBBIs, along with related aspects of health (e.g., mental health, aging) and social determinants of health. Funding to projects is anticipated to start April 1, 2017. Funded projects will be guided by evidence for effective interventions and will be required to evaluate the effectiveness, efficiency and acceptability of the projects for their target audience. In developing the Community Action Fund, the Public Health Agency of Canada engaged civil society through a an iterative series of webinars, face-to-face meetings, and teleconference calls to seek input into the direction of the Community Action Fund. The Fund's objectives, priorities and approach reflect stakeholder input and civil society has identified the process as a positive example of engagement of civil society due to the diverse mechanisms used to engage stakeholders and the responsiveness of the program to address their concerns. As well, Health Canada is working with the Public Health Agency of Canada, Indigenous partner organizations, academia, and community leaders to develop integrated STBBI prevention programs for First Nations people living on-reserve.

---

[22] The Health Portfolio comprises Health Canada, the Public Health Agency of Canada, the Canadian Institutes of Health Research, the Patented Medicine Prices Review Board and the Canadian Food Inspection Agency.

[23] Health Canada – Corporate Services Branch; Web Mobile & Standards: Web analytics (internal document).

Some civil society organizations are concerned that the move towards an integrated approach may divert attention and resources away from HIV-specific programming and that while the scope of work would be expanded from HIV only to other STBBIs, funding would not increase. An integrated approach to prevention supports a more effective and efficient response to all STBBIs, including HIV, through a focus on common transmission routes, risk behaviours, and social and structural risk factors. The Public Health Agency of Canada will continue to support infection-specific approaches, where it makes sense. As such, it is anticipated an integrated response will continue to contribute to progress on Canada's response to HIV.

b) Challenges faced throughout the reporting period that hindered the national response

Civil society indicated that stigma and discrimination faced by key populations, insufficient funding, a lack of acknowledgment/inclusion of Indigenous perspectives in the response, lack of inclusion of marginalized groups (e.g. sex workers and people who use drugs), and difficulties in advancing harm reduction programming were key challenges in the response to HIV/AIDS. As well, the ability to respond to emerging issues, including innovative programs and addressing the needs of the aging HIV-positive population, was raised as a challenge. Civil society also indicated that coordination and collaboration between local/regional, provincial, and national levels of government can sometimes be challenging, noting that there were sometimes inconsistencies and disjuncture between various strategies and key messages. Some civil society organizations called for a renewed federally led national strategy with targets as well as more funding under the Federal Initiative. The Public Health Agency of Canada is engaging stakeholders to identify concrete actions to contribute to meeting the global UNAIDS 90-90-90 targets. This includes reinvigorating action on HIV/AIDS and other STBBIs, with consideration for the concerns outlined above.

c) Remedial action plans to achieve agreed targets

Provinces and territories are primarily responsible for testing and treatment. As such, Canada's ability to meet the global UNAIDS 90-90-90 targets depends primarily on provincial and territorial action within their respective jurisdictions. The Public Health Agency of Canada is engaging with provincial and territorial officials to enhance the national HIV surveillance system by developing national indicators and measures to enable monitoring of progress towards achieving the 90-90-90 targets in Canada. The Public Health Agency of Canada also works closely with national HIV/AIDS stakeholders both informally and through established governance structures to advance Canada's response to HIV/AIDS. The Government of Canada has expressed consistent support for the 90-90-90 targets, most recently in the Minister of Health's statement on World AIDS Day.

VI. Support from the country's development partners – not applicable

VII. Monitoring and evaluation environment

Provinces and territories monitor their jurisdictions independently. Federal Initiative partners conduct monitoring and evaluation in specific activity areas, including national surveillance, research, and community-based programming, in close collaboration public health units, laboratories, health care and other professionals, researchers, and civil society organizations. Specific monitoring and evaluation priorities vary by jurisdiction and by region. Federal monitoring and evaluation comprises periodic planning and reporting against publicly identified results and outcomes.

Annual plans and performance are detailed in Departmental Reports on Plans and Priorities, and Departmental Performance Reports which are tabled before Parliament.[24] An evaluation of the Federal Initiative released in 2014 indicated that the initiative remains relevant and has supported successful local or community-based activities to reduce stigma and discrimination, and contributed to improved access to more effective prevention, diagnosis, care, treatment and support.[25] An evaluation of the CHVI released in 2014 demonstrated that it was successful in supporting collaborations among HIV vaccine researchers, both in Canada and in low- and middle-income countries and in establishing collaborations between academics and the industry sector.[26]

ANNEXES

ANNEX 1: Civil Society Engagement Summary
ANNEX 2: Indicators on which Canada is not reporting

[24] Public Health Agency of Canada Supplementary Information Tables: 2014–15 Departmental Performance Report. Federal Initiative to Address HIV/AIDS in Canada and CHVI. Retrieved February 8, 2016 from: http://www.healthycanadians.gc.ca/publications/department-ministere/phac-performance-supplementary-information-2014-2015-rendement-renseignements-supplementaires-aspc/index-eng.php#a2.6

[25] Public Health Agency of Canada. Evaluation of the Federal Initiative to Address HIV/AIDS in Canada 2008-09 to 2012-13. 2014. Retrieved February 8, 2016 from: http://www.phac-aspc.gc.ca/about_apropos/evaluation/reports-rapports/2013-2014/diaha-idlvs/section-5-eng.php#e5

[26] Public Health Agency of Canada. Evaluation of the Canadian HIV Vaccine Initiative 2009-2010 to 2014-2015. 2015. Retrieved March 16, 2016 from http://www.phac-aspc.gc.ca/about_apropos/evaluation/reports-rapports/2014-2015/chivvi-icvcvih/index-eng.php

Annex 1: Summary of Canada's Civil Society Response Survey

Process for Engagement

An independent consulting firm, Be the Change Group Inc., was contracted by the Public Health Agency of Canada to develop a survey designed to solicit feedback from Canadian civil society organizations regarding the status of, and responses to, the HIV epidemic between 2013 and 2015. The consulting firm led a webinar on January 20, 2016 to provide civil society with an overview of the process for engagement. The survey, based on the 2014 UNAIDS National Commitments and Policy Instrument survey, was developed in consultation with the Public Health Agency of Canada and national HIV/AIDS partners, and was delivered to civil society in January/February 2016. Feedback from national HIV civil society organizations was taken into consideration when developing the final report.

Regional Representation - Distribution of Respondents

Of the 248 respondents that completed some or all of the survey, 12% identified as representing a national organization, 38% represented a regional/provincial organization, and 51% represented a community organization. The represented organizations served/represented a variety of rural, remote, and urban communities with 32% of the represented organizations serving all three types of communities (rural, remote, and urban). 87% of respondents indicated serving only one province or territory, 11% serving all provinces and territories, and 2% serving a combination of some provinces and territories.

Role of Civil Society

Civil society respondents outlined the key role they play in providing HIV programs/services designed to reduce stigma and discrimination and provide legal services and programs/services aimed at prevention among people living with HIV (PHA), gay men and other men who have sex with men (MSM), people who inject drugs, and sex workers. However, a number of respondents believed that efforts to increase civil society involvement in the planning for Canada's response to HIV have been poor over the course of this reporting period (since 2013).

The majority of respondents believed that the civil society sector represented in the HIV response is highly inclusive of diverse organizations (e.g. organizations and networks of PHA, of sex workers, drug users, and faith-based organizations).

Some respondents identified key achievements of civil society relating to messaging, education, and training, including changes to secondary school sexual education curriculum, medical student training, and awareness training for community workers. Others pointed to expanded efforts to improve awareness around HIV non-disclosure laws, and examples of successful health promotion/prevention programming or resources.

Government and National Strategy

Various respondents made positive comments about the ability for civil society to engage with the federal government and some expressed hope that engagement at the federal government level would improve in the future, particularly with the recent endorsement of the global UNAIDS 90-90-90 targets by the Minister of Health.

However, some respondents perceived a lack of commitment due to their view that there is either no national HIV strategy or an outdated strategy[27], insufficient government funding or lost funding due to advocacy, and indifference to the contributions of civil society.

Best Practices

Political Leadership

A number of respondents made positive comments describing provincial governments as supportive, particularly in Ontario and British Columbia. Respondents provided several examples of effective civil society contribution to political commitment and policy, including the Ministerial Advisory Council on the Federal Initiative to Address HIV/AIDS (MAC-FI) and advocacy for improved testing, treatment, harm reduction programming, and other efforts. Respondents identified national and provincial organizations, strategies, and programs that they felt were successful, including the Canadian Positive People Network, Canadian Aboriginal AIDS Network, and the Saskatchewan Indigenous Strategy on HIV/AIDS.

Supportive Policy Environment

There were generally positive comments made about the inclusion of people with HIV, key populations, and/or other vulnerable sub-populations in HIV policy design and program implementation. Respondents provided positive examples of involvement, noting important advisory committees, inclusion in planning and evaluation of strategies and approaches, and government support of the International Indigenous Working Group on HIV/AIDS.

Many respondents noted that Canada has laws, regulations, and/or policies that have improved HIV prevention, treatment, care, and support for key populations and other vulnerable subpopulations. Examples provided include universal healthcare and various medication access programs to provide affordable HIV medication at no cost in Alberta, British Columbia, Ontario, and Quebec as improving access to treatment. Some noted Canada's human rights legislation as beneficial for HIV prevention, treatment, care, and support.

Scale-up of Effective Prevention Programmes

Respondents noted the success of community awareness and service programming, such as public awareness and HIV testing fairs, and improved access to anonymous rapid testing in the community. Some respondents indicated their support for supervised injection facilities (in particular, Insite in Vancouver) and other harm reduction work, treatment as prevention (TasP), outreach services, peer support services, peer leadership training, improvements to medication access for Indian Treaty status peoples, and education and prevention work by at-risk populations. Respondents also highlighted that British Columbia and Ontario's work to improve continuity of care along the treatment cascade should be replicated elsewhere.

Scale Up of Care, Treatment, and/or Support Programmes

Achievements related to improved engagement of PHA and peer communities were noted, including new peer support networks in urban centres and peer navigators (PHA who assist

[27] Some civil society organizations do not consider the Federal Initiative on HIV/AIDS in Canada to be a strategy while others do.

other HIV-positive individuals in developing HIV self-management strategies).

Some respondents described effective cooperation between groups, such as AIDS services organizations and working with care organizations to provide a non-clinical avenue for their clients to access care. The collaborations between these groups, HIV-related organizations, and other health or social service organizations were also noted.

Areas for Further Development

Political Leadership

Several respondents called for a new national HIV strategy with accompanying comprehensive targets and supportive infrastructure, as well as a national pharmacare system to ensure important medications are provided consistently and universally.

Respondents also mentioned that there is room for improvement in government programming and budgeting at the federal, provincial, and local levels to reflect new approaches (e.g. pre-exposure prophylaxis, TasP, and harm reduction) and respond to emerging issues, including changing HIV/AIDS epidemiology.

Supportive Policy Environment

The majority of respondents highlighted law, regulations, or policies that present obstacles to effective HIV prevention, treatment, care, and support for key populations and other vulnerable subpopulations. These included the criminalization of HIV non-disclosure and policies specific to sex workers. Respondents noted that these policies serve as major barriers to people seeking testing, treatment, and care, and have exacerbated HIV transmission. Respondents also described inequities in strategy and programming related to stigma and discrimination for particular populations, including Indigenous people, rural and remote areas (resulting in inequitable access to services), youth, prevention programming for heterosexual males, women, and aging PHA.

A few respondents noted that there is insufficient inter-jurisdictional response to Indigenous populations to address issues stemming from years of policies based on colonization. It was suggested that Indigenous voices could be better represented in programming by improving leadership from on-reserve programs, supporting Indigenous treatment options, and including Indigenous people in strategic discussions to improve medication adherence.

Scale-up of Effective Prevention Programmes and Care

Many respondents had concerns with policies related to health education, harm reduction, and those that may negatively affect testing efforts. They indicated that testing efforts should be expanded to reduce the proportion of people who unaware of their positive HIV status. Others noted that specific populations required more engagement in prevention efforts, including MSM and Indigenous groups.

Scale Up of Care, Treatment, and/or Support Programmes

One respondent noted that a national treatment cascade that builds on ongoing work in British Columbia and Ontario would allow for analysis within Canada's geographies and target populations. The respondent also suggested that a national treatment cascade would improve

Canada's ability to report against global targets.

With PHA living longer and healthier than ever, it was suggested that treatment and care programming should adapt to their unique health needs. Some respondents described the need for mental health and addictions services at the centre of HIV treatment programming, and expanded partnerships at all levels between different service providers to improve the social determinants of health, including housing and food security.

Annex 2: Indicators on which Canada is not reporting

Indicator	Rationale for Indicators deemed not relevant or not available
1.1 Young people: Knowledge about HIV prevention *Percentage of young women and men aged 15–24 who correctly identify both ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	This indicator is sourced from EKOS Public Opinion Research Knowledge, Attitudes, and Behaviours related to HIV (2012). The most recent data was reported in Canada's 2014 Progress Report. No new data is available.
1.2 Young people: Sex before the age of 15 *Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15*	This indicator is sourced from EKOS Public Opinion Research Knowledge, Attitudes, and Behaviours related to HIV (2012). The most recent data was reported in Canada's 2014 Progress Report. No new data is available.
1.6 HIV prevalence from antenatal clinics, by age group *HIV prevalence among women attending antenatal clinics in the general population*	In Canada, provinces and territories are responsible for providing health services to the general population, including antenatal care which falls within family practice. This data is therefore not available at the national level.
1.22 Male circumcision, prevalence *Percentage of men 15-49 that are circumcised*	As Canada's epidemic is a concentrated one with approximately over half of prevalent cases among gay and other men who have sex with men (MSM), circumcision is not currently amongst the recommendations for HIV prevention in Canada. As such, this data is not collected.
1.23 Annual number of men voluntarily circumcised *Number of male circumcisions performed according to national standards during the last 12 months*	As Canada's epidemic is a concentrated one with approximately over half of prevalent cases among gay and other men who have sex with men (MSM), circumcision is not currently amongst the recommendations for HIV prevention in Canada. As such, this data is not collected.
2.1 Size estimations for key populations *Number of people engaging in the specific behaviours that put the given population at risk for HIV.*	Population size estimates were developed for MSM and IDU populations for 2014 based on available survey data and a literature review. Canada does not track sex workers and transgender people at the national level.
2.2 Sex workers condom use *Percentage of sex workers reporting the use of a condom with their most recent client*	Canada does not collect this information at the national level.
2.3 HIV testing in sex workers *Percentage of sex workers who received an HIV test in the past 12 months and know their results*	Canada does not collect this information at the national level.
2.4 HIV prevalence in sex workers *Percentage of sex workers who are living with HIV*	Canada does not collect this information at the national level.

Indicator	**Rationale for Indicators deemed not relevant or not available**
2.5 Men who have sex with men: condom use *Percentage of men reporting the use of a condom the last time they had anal sex with a male partner*	This indicator is sourced from the M-Track surveillance system, managed by PHAC. The most recent data, from the last survey conducted in 2008, was reported in Canada's 2014 Progress Report. No new data is available.
2.6 HIV testing in men who have sex with men *Percentage of men who have sex with men who received an HIV test in the past 12 months and know their results*	This indicator is sourced from the M-Track surveillance system, managed by the Public Health Agency of Canada. The most recent data, from the last survey conducted in 2008, was reported in Canada's 2014 Progress Report. No new data is available.
2.8 People who inject drugs: prevention programmes *Number of needles and syringes distributed per person who injects drugs per year by needle and syringe programmes*	In Canada, provinces and territories are responsible for providing public health prevention services, including needle and syringe exchange/distribution programs. Canada does not track this information at the national level.
2.9 People who inject drugs: condom use *Percentage of people who inject drugs reporting the use of a condom the last time they had sexual intercourse*	This indicator is sourced from the I-Track surveillance system, managed by PHAC. The most recent data, from the last survey conducted in 2012, was reported in Canada's 2014 Progress Report. No new data is available.
2.10 People who inject drugs: safe injecting practices *Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected*	This indicator is sourced from the I-Track surveillance system, managed by PHAC. The most recent data, from the last survey conducted in 2012, was reported in Canada's 2014 Progress Report. No new data is available.
2.11 HIV testing in people who inject drugs *Percentage of people who inject drugs who received an HIV test in the past 12 months and know their results*	This indicator is sourced from the I-Track surveillance system, managed by PHAC. The most recent data, from the last survey conducted in 2012, was reported in Canada's 2014 Progress Report. No new data is available.
2.13 People on opioid substitution therapy *Number of people on opioid substitution therapy (OST)*	In Canada, provinces and territories are responsible for providing public health prevention services, including provision of opioid substitution services. Canada does not track this information at the national level.
2.15 HIV prevalence in transgender people* *Percentage of transgender people who are living with HIV*	Canada does not collect this information at the national level.
3.1 Prevention of mother-to-child transmission *Percentage of HIV-positive pregnant women who received ARV to reduce the risk of mother-to-child*	Canada does not collect this information at the national level.

Indicator	**Rationale for Indicators deemed not relevant or not available**
transmission	
3.2 Early infant diagnosis *Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth*	Data are available on how many infants test positive for virological tests after age 24 months, but does not provide the time frame for when testing was done.
3.3 Mother-to-child transmission of HIV *Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months*	Canada does not currently have national level estimates of mother-to-child HIV transmission. Efforts are currently under way (led by the Public Health Agency of Canada) to develop such statistical models.
3.4 PMTCT testing coverage *Percentage of pregnant women with known HIV status*	In Canada, provinces and territories are responsible for providing public health prevention services, including antenatal care. Canada does not track this information at the national level.
3.5 Testing coverage of pregnant women's partners *Percentage of pregnant women attending ANC whose male partners were tested for HIV during pregnancy*	Given Canada's concentrated epidemic, with an estimated HIV prevalence of 0.01%, routine testing of partners of pregnant women is not part of Canada's HIV testing recommendations.
3.9 Cotrimoxazole (CTX) prophylaxis coverage *Percentage of HIV-exposed infants started on CTX prophylaxis within 2 months of birth*	Not available
4.1 HIV treatment: antiretroviral therapy *Percentage of adults and children currently receiving antiretroviral therapy (ART) among all adults and children living with HIV*	Canada does not currently have national level data on the treatment cascade. Discussions with provinces and territories on how to monitor the treatment cascade are underway.
4.2 Twelve-month retention on antiretroviral therapy *Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy*	Canada does not currently have national level data on the treatment cascade. Discussions with provinces and territories on how to monitor the treatment cascade are underway.
4.2a Twenty-four-month retention on antiretroviral therapy *Percentage of adults and children with HIV known to be on treatment 24 months after initiating treatment among patients initiating antiretroviral therapy during 2013*	Canada does not currently have national level data on the treatment cascade. Discussions with provinces and territories on how to monitor the treatment cascade are underway.
4.2b Sixty-month retention on antiretroviral therapy *Percentage of adults and children*	Canada does not currently have national level data on the treatment cascade. Discussions with provinces and territories on how to monitor the treatment cascade are

Indicator	Rationale for Indicators deemed not relevant or not available
with HIV known to be on treatment 60 months after initiating treatment among patients initiating antiretroviral therapy during 2010	underway.
4.3 HIV care coverage *Percentage of people currently receiving HIV care*	Canada does not currently have national level data on the treatment cascade. Discussions with provinces and territories on how to monitor the treatment cascade are underway.
4.4 Antiretroviral medicines (ARV) stock-outs *Percentage of facilities with stock-outs of antiretroviral drugs*	Given Canada's health system, ART inventory is not centralized at the national level. ART stock-outs are not typically an issue in Canada.
4.5 Late HIV diagnoses *Percentage of HIV positive persons with first CD4 cell count < 200 cells/μL in 2015*	Canada does not currently have national level data on the treatment cascade. Discussions with provinces and territories on how to monitor the treatment cascade are underway.
4.6 Viral Load suppression *Percentage of adults and children receiving ART who were virally suppressed in the reporting period (2015)*	Canada does not currently have national level data on the treatment cascade. Discussions with provinces and territories on how to monitor the treatment cascade are underway.
6.1 AIDS Spending *Domestic and international AIDS spending by categories and financing sources*	Given Canada's government financial tracking system, Canada cannot report spending with this level of detail.
8.1 Discriminatory attitudes towards people living with HIV *Percentage of women and men aged 15–49 who report discriminatory attitudes towards people living with HIV*	This indicator is sourced from EKOS Public Opinion Research Knowledge, Attitudes, and Behaviours related to HIV (2012). The most recent data was reported in Canada's 2014 Progress Report. No new data is available.
Travel restriction data are collected directly by the Human Rights and Law Division at UNAIDS headquarters and therefore, no reporting is needed.	No need to report as per UNAIDS.
10.2 External economic support to the poorest households *Proportion of the poorest households who received external economic support in the last 3 months*	Canada does not collect this information at the national level.
11.1 Co-management of tuberculosis and HIV treatment *Percentage of estimated HIV-positive incident tuberculosis (TB) cases that received treatment for both TB and HIV*	Canada does not collect this information at the national level.

Indicator	**Rationale for Indicators deemed not relevant or not available**
11.2 Proportion of people living with HIV newly enrolled in HIV care with active tuberculosis (TB) – disease *Total number of people living with HIV having active TB expressed as a percentage of those who are newly enrolled in HIV care (pre-antiretroviral therapy or antiretroviral therapy) during the reporting period*	Canada does not collect this information at the national level.
11.3 Proportion of people living with HIV newly enrolled in HIV care started on tuberculosis (TB) - preventative therapy *Number of patients started on treatment for latent TB infection, expressed as a percentage of the total number of newly enrolled in HIV care during the reporting period*	Canada does not collect this information at the national level.
11.4 Hepatitis B testing *Proportion of persons in HIV care who were tested for hepatitis B*	Canada does not collect this information at the national level.
11.5 Proportion of HIV-HBV co-infected persons currently on combined treatment	Canada does not collect this information at the national level.
11.6 Hepatitis C testing *Proportion of people in HIV care who were tested for hepatitis C*	Canada does not collect this information at the national level.
11.7 Proportion of persons diagnosed with HIV-HCV infection started on HCV treatment during a specified time frame (e.g. 12 months)	Canada does not collect this information at the national level.
11.8 Syphilis testing in pregnant women *Percentage of pregnant women accessing antenatal care (ANC) services who were tested for syphilis*	Canada does not track this information at the national level. In Canada, provinces and territories are responsible for providing health services, including antenatal care and syphilis testing. Syphilis testing during pregnancy is recommended for all and is considered standard practice in Canada.
11.9 Syphilis rates among antenatal care attendees *Percentage of antenatal care attendees who were positive for syphilis*	While the topic and indicator are relevant, Canada does not collect this information at the national level.
11.10 Syphilis treatment coverage among syphilis positive antenatal care attendees *Percentage of antenatal care*	While the topic and indicator are relevant, Canada does not collect this information at the national level.

Indicator	**Rationale for Indicators deemed not relevant or not available**
attendees positive for syphilis who received treatment	
11.12 Men with urethral discharge *Number of men reporting urethral discharge in the past 12 months*	While the topic and indicator are relevant, Canada does not collect this information at the national level.
11.13 Genital ulcer disease in adults *Number of adults reported with genital ulcer disease in the past 12 months*	While the topic and indicator are relevant, Canada does not collect this information at the national level.