House of Commons
CANADA

Standing Committee on Health

HESA • NUMBER 050 • 1st SESSION • 38th PARLIAMENT

EVIDENCE

Tuesday, October 25, 2005

Chair

Ms. Bonnie Brown

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● (0910)

[*English*]

The Chair (Ms. Bonnie Brown (Oakville, Lib.)): Good morning, ladies and gentlemen. It's my pleasure to welcome you to the 50th meeting of the Standing Committee on Health.

This meeting is pursuant to Standing Order 108(2), our study on the Canadian strategy on HIV/AIDS. This morning we welcome Dr. Frank Plummer, director general of the Centre for Infectious Disease Prevention and Control, and Steven Sternthal, acting director on HIV/AIDS policy, both from the Public Health Agency of Canada.

I understand that Dr. Plummer has to leave at 10 o'clock because he has to brief the U.S. Secretary of State on pandemic preparedness and the flu vaccine. Is that correct?

Dr. Frank Plummer (Director General, Centre for Infectious Disease Prevention and Control, Public Health Agency of Canada): It's more like 10:30. I need to be at Foreign Affairs by about 10:45.

The Chair: You are able to stay until 10:30. Thank you very much for clarifying that.

We'll begin with presentations from our witnesses. Then we'll move to questions and answers.

Dr. Frank Plummer: Thank you, Madam Chair.

It's my pleasure to be here to review with the committee the allocation of funding under the federal initiative to address HIV/AIDS in Canada. With me is Steven Sternthal, from the Centre for Infectious Disease Prevention and Control, who is responsible for the HIV/AIDS policy, coordination, and programs division. We will do our best to answer the committee's questions and to assist in its deliberations in any way possible.

As the committee is aware, the decision to double the federal investment in HIV/AIDS over five years was announced by the previous Minister of Health in May 2004. The total amount allocated for this purpose will increase from $42.2 million per year under the former Canadian strategy on HIV/AIDS to $84.4 million annually by 2008-09. This was a direct response to continued calls for increased funding from national non-governmental partners and the scientific community in Canada. It was supported, as you know, by a recommendation from this committee.

The federal initiative to address HIV/AIDS in Canada, unveiled by the current Minister of Health this past January, provides a framework for how these funds will be invested. It has four primary goals.

The first is to prevent the acquisition and transmission of new HIV infections; the second is to slow the progression of disease and improve the quality of life for people living with HIV/AIDS; the third is to reduce the social and economic impact of HIV/AIDS; the final objective is to contribute to the global effort to reduce the spread of HIV and mitigate the impact of this terrible pandemic.

The federal initiative is a partnership of the Public Health Agency of Canada, Health Canada, the Canadian Institutes of Health Research, and Correctional Service Canada. Through funding contributions and partnerships, it also engages non-governmental and voluntary organizations, people living with HIV/AIDS, communities, the private sector, and all levels of government in working toward a society that is free from HIV and AIDS and in alleviating the underlying conditions that make Canadians vulnerable to the epidemic.

The federal initiative provides for a renewed and strengthened federal role in the Canadian response to HIV/AIDS. It builds on lessons learned from past approaches, including the Canadian strategy on HIV/AIDS, which this new initiative replaces. It encompasses recommendations from this committee, as well as from non-governmental stakeholders and the provinces and territories.

The federal initiative also responds to the most up-to-date evidence of the characteristics of the HIV/AIDS epidemic in Canada. Men who have sex with men continue to be the group most affected by this problem, accounting for an estimated 58% of all HIV infections, followed by injection drug users at 20%. For the purposes of our surveillance, we use such terms as MSM for men who have sex with men; injection drug users and heterosexual contact are used to characterize exposure categories, or the most likely ways people became infected with HIV.

Aboriginal persons account for a disproportionately high number of HIV infections. As well, the epidemic is growing among women of all age groups. Disproportionate rates of infection have also been noted among persons in Canada who were born in a country where HIV is highly prevalent. Those are mainly the countries of sub-Saharan Africa and the Caribbean.

All this pointed to the need for a significant shift in the federal response. The shift is evident in this new policy framework.

Specifically, the federal initiative provides for a greater focus on priority populations: people living with HIV/AIDS, gay men, injection drug users, aboriginal people, prison inmates, youth and women at risk for HIV infection, and people from countries where HIV is highly prevalent.

Government collaboration is being increased at all levels through the federal initiative. Federal, provincial, territorial, and municipal governments are cooperating in this effort, and this will leverage funding from other sources and ensure coherence and collaboration across the spectrum of HIV/AIDS policy and programming.

The federal initiative is also supporting social marketing campaigns to increase public awareness of HIV/AIDS in Canada, reduce stigma and discrimination related to people with HIV/AIDS, and encourage those who may be at risk to come forward for HIV testing and treatment.

In areas where it makes sense to do so, the federal initiative is encouraging greater integration of HIV/AIDS prevention, care, and treatment with the prevention, care, and treatment of other diseases, such as hepatitis C and sexually transmitted infections.

The federal initiative also aims to more broadly engage other federal departments and agencies that have mandates related to immigration, housing, disability, social justice, employment, and other determinants of health. To this end, an HIV/AIDS committee at the assistant deputy minister level was announced last year by the Minister of Health, is currently in place, and is working toward a Government of Canada position statement on HIV/AIDS.

Finally, the federal initiative will increase Canada's engagement in the global response to HIV/AIDS, improving the reporting of outcomes achieved by the federal investments in HIV/AIDS.

I would now like to turn to the issue of funding, and specifically to the motion currently before the committee.

The first $5 million of increased federal funding for HIV/AIDS was provided in 2004-05, and was targeted to strengthen front-line responses for populations most at risk of infection and those already living with the disease. This early investment was intended to save lives, avoid further devastation, and reduce the long-term impact of HIV/AIDS on Canadians.

Many worthy and successful projects were supported by this infusion of additional federal dollars. For example, the Community AIDS Treatment Information Exchange, or CATIE, produced treatment information publications for South Asian populations using culturally appropriate language and illustrations.

The Canadian HIV/AIDS Information Centre of the Canadian Public Health Association developed a number of new prevention resources aimed at prisoners, youth at risk, women, and people from countries where HIV is endemic.

Asian Community AIDS Services, a not-for-profit community-based organization in Toronto, held weekend retreats and workshops for people living with HIV/AIDS, youth, and gay men in order to identify their needs and increase their participation in program planning and implementation.

The commitment to strengthen front-line responses will continue over the next four years under the federal initiative. In addition to the $5 million for front-line responses, federal spending on HIV/AIDS grew by an additional $8 million this year. It will continue to grow in increments of $8 million in each of the next three fiscal years, and by $13.2 million in 2008-09, to reach the $84.4 million maximum.

Overall, these ramped-up federal dollars will support increased investment in a wide range of HIV programming and interventions, including more and better front-line programs for the priority populations I mentioned a moment ago. This year, they will begin to strengthen surveillance of risk behaviours for gay men and injection drug users, and do other research to help us understand the epidemic and respond more effectively to it by focusing resources.

This year and into the future, the additional federal funding for HIV/AIDS will be used to improve prevention, education, and support programs and services for aboriginal people and federal inmates. Dr. Daniel Tardif, my colleague from Health Canada, is here today and will be pleased to answer any questions about plans to address HIV/AIDS in on-reserve first nations and Inuit communities in northern Labrador.

In future years, the federal initiative funding will be used to fund the development of vaccines and prevention technologies, and to build on Canada's reputation as a committed, responsible, and effective partner in the global response to this pandemic. Of particular note, the increased funding will allow the government, this year and next year, to ensure a strong federal presence at the International AIDS Conference in Toronto in August 2006. In addition to supporting the core activities of the conference, the Public Health Agency of Canada will provide scholarships for hundreds of Canadians who otherwise would not be able to attend this prestigious event.

A portion of the additional moneys will also be invested in awareness campaigns and other communications and social marketing programs beginning next year, such as those currently being managed by AIDS Vancouver and the Canadian Public Health Association, and this year the Public Health Agency of Canada will begin to work with our partners in the federal initiative to improve the evaluation and reporting of programs and activities supported by federal dollars.

I would like to now address the second point of the motion currently before the committee by drawing attention to the charts that have been prepared for the committee.

Specifically, chart A addresses the issue of salary resources, which are highlighted in red. Chart B identifies the number of full-time equivalents, or federal employees, who will be hired by the four federal partners in implementing the initiative.

First, I would like to inform the committee that no new staff were hired under the federal initiative in 2004-05. In keeping with the commitment of the Minister of Health and the Minister of State for Public Health, the first-year funds were directed entirely to front-line work and were managed by existing staff.

Second, I can confirm that new staff are being hired this year to work on the federal initiative. For example, 44 new staff across the four departments are being hired in 2005-06 to work on implementing the federal initiative. The hiring of this new staff is commensurate with the increased funding and is required in order to meet the obligations under the federal initiative. Specifically, these are scientific capacity in HIV/AIDS research, surveillance, and laboratory work. This will allow the Public Health Agency to implement enhanced surveillance activities for injection drug users and other populations at risk, as well as provide enhanced laboratory reference services for provincial laboratories.

● (0915)

Another obligation is engagement of the voluntary sector in policy and program development, including the development of population-specific approaches to prevention and care.

Another is the public health professional capacity to increase support to on-reserve first nations' and northern Labrador communities' prevention, care, and support efforts, and to strengthen regional partnerships with provincial health care systems.

Another obligation is public health professional capacity, meaning primarily nurses, to deliver surveillance, education, and prevention programs in correctional facilities. This includes such initiatives as safer tattooing, and peer education and counselling programs.

Another is policy development and interdepartmental and intergovernmental coordination and global engagement, such as the assistant deputy minister committee mentioned earlier, as well as international dialogues on key policy issues.

A further obligation is effective management of the grants and contributions programs for community-based organizations and researchers, in line with Treasury Board regulations.

Finally, these new staff will allow us to enhance evaluation and reporting of our efforts.

Finally, let me turn to chart C and comment on overall planned spending. As you can see, grants and contributions for both research and community programs will continue to be a major focus of our federal HIV/AIDS response. The grants and contributions play a central role in mobilizing communities and researchers to take action in preventing new infections, improving the quality of life of people living with HIV/AIDS, and finding a cure for this devastating disease.

Madam Chair, that concludes my opening remarks. I would welcome any questions the committee might have.

● (0920)

The Chair: Thank you, Dr. Plummer.

We'll begin the questions and answers with 10 minutes for the Conservatives. We'll begin with Mr. Merrifield.

Are you going to split your time, Mr. Merrifield?

Mr. Rob Merrifield (Yellowhead, CPC): No, I'll take the first ten.

Thank you very much for your comprehensive review of what you're actually doing. There was a lot of information in a little while, and I'm trying to follow it all. My questions are going to lean more towards filling out some of what I missed, perhaps, than may have actually been in there.

Can you tell us exactly how many people are living with HIV/AIDS in Canada today?

Dr. Frank Plummer: It's approximately 56,000 individuals. That is an estimate; we don't have an exact count.

Mr. Rob Merrifield: Our party certainly recommended the increase in funding when we dealt with this a couple of years ago. It wasn't the increase of funding that concerned us. It was actually the accountability for the funding—actually setting goals and trying to discern some outcomes and point to some tangible outcomes that we could at least put our focus on.

At the time, I think there were only 4,000 new infections per year in Canada. What was last year's infection rate, or do we have any idea?

Dr. Frank Plummer: The median of the estimates of new infections is about 4,000. That's new infections. We have a range from about 2,800 infections to about 5,400, and the midpoint there is about 4,000.

Mr. Rob Merrifield: So it was about 4,000 last year?

Dr. Frank Plummer: Yes.

Mr. Rob Merrifield: So it actually really hasn't changed.

Dr. Frank Plummer: Not in a way we've been able to measure, no.

Mr. Rob Merrifield: It may take some time to see some actual changes.

Dr. Frank Plummer: I think the time lag between these kinds of investments and change is considerable.

Mr. Rob Merrifield: Yes. I understand that. That's why we were really quite focused on the prevention side of it, and I see a good portion is on the prevention side of it.

To get a handle on the prevention side, this is federal money going in; it doesn't account for the provinces and what they're doing respectively. Or is it provincial money as well?

Dr. Frank Plummer: No, this is the federal investment. There are additional investments by provinces.

Mr. Rob Merrifield: Do you know which provinces are investing, and how much? What province is number one in actually working with these funds? I would assume we're dovetailing and not working in silos. Can you explain that?

Dr. Frank Plummer: We do our utmost to coordinate what we're doing with provincial efforts. That's a particular emphasis of the federal initiative—to move away from silo programming to programming coordinated with the provinces. That's done through our regional offices.

I'll ask Steven to comment on the provincial investments.

● (0925)

Mr. Steven Sternthal (Acting Director, HIV/AIDS Policy, Coordination and Programs Division, Public Health Agency of Canada): Some provinces have dedicated HIV funding for things like research, prevention activities, or community funding. Some provinces currently do not; they integrate it as part of the regular public health work they do in the given province.

Actually, our federal-provincial-territorial committee is meeting today. That's the mechanism we've been using now, as part of this federal initiative, to try to coordinate our efforts with the provinces to try to look at opportunities for leveraging other community funding or looking at research to see how we can coordinate our efforts. There definitely is time being spent to work with the provinces on that level.

If you want the specific provinces and the estimates of how much they're spending, I can get you that information. I don't have that off the top of my head.

Mr. Rob Merrifield: I would be interested, if you have that information, in what's actually going in province-wide. If you could give it to the committee, we can pass it around. I don't know—I may be the only one interested, but I think it's good information for us to have.

I had the opportunity to be in Africa at an HIV/AIDS conference in September. I think Réal Ménard, from the committee, was there as well. After discerning what is actually happening in Africa—26 million with HIV/AIDS, the poverty level, the kind of governance they're working under—I came back from that conference a little bit cynical about how we can actually help in the western world. The idea of just antiviral drugs going in there to solve the problem seems a shallow way to approach it. I'm more convinced than ever that we have to concentrate our efforts in a vaccine if we're going to actually get there, and I noticed what you're talking about in this report is something in the future; I also noticed that the government has just recently pulled money away from the vaccine.

I don't know if it's dollars out of this; I don't think so, but can you tell me where we're at on the vaccine—how far along we are?

Dr. Frank Plummer: First of all, I would completely agree with you that antiviral drugs are not going to solve this problem. We need to implement prevention programs that are highly effective now, and also, ultimately, we need to work on an HIV vaccine.

The funding you refer to was funding awarded to CANVAC, the Canadian Network for Vaccines and Immunotherapeutics. It was a competitive funding—it was funded as a network of centres of excellence through the network of centres of excellence program. It's a competitive, peer-reviewed process that's managed independently. CANVAC was funded for an initial seven-year period. Their renewal application came in the spring of this year, and a decision was made not to continue to support it by the peer review committee.

We think that CANVAC and HIV research in general are important. It's important to have an organized HIV vaccine effort in the country, and we're looking at other ways we may support that, but this was a decision made by an independent peer review committee.

Mr. Rob Merrifield: Okay. That independent review committee makes those decisions, but can you tell us how far along we are with vaccine research? I'm getting different numbers; that's why I'm asking where we're at from your perspective.

Dr. Frank Plummer: Do you remember the amounts being invested?

Mr. Steven Sternthal: Just to clarify your question, did you want to know if a vaccine is coming shortly? Is that your question?

Mr. Rob Merrifield: Yes, that's right. I've heard timelines of two years, perhaps, for an HIV/AIDS vaccine for the Asia strain of the HIV/AIDS—not the African one—or perhaps six to seven years. Can you give me something a little more definitive than that?

Dr. Frank Plummer: Sure. My own research work focuses on understanding immunity to HIV and what might be models that can be used for development of vaccines. I'm confident that ultimately we will have an HIV vaccine, but that is some distance in the future. It's not within the next two or three years, and probably not within the next decade.

There is considerable vaccine work going on globally, and Canada has supported that work through things like CANVAC and the International AIDS Vaccine Initiative, which is actually doing vaccine trials in Africa and India. I think we are interested in a larger Canadian vaccine effort. We're meeting tomorrow with representatives of the Gates Foundation and officials of the Canadian government to talk about what kinds of investments Canada might make in vaccine research.

There are many things going on and there is hope. I believe we'll ultimately get there, but it's still a long path ahead.

● (0930)

Mr. Rob Merrifield: So you're a little more pessimistic; you're saying a decade or more.

Dr. Frank Plummer: Considering what it takes to get a vaccine from initial discovery to being widely available, I think that if we found the magic answer today, it would be five years before we got through all the regulatory processes and manufacturing and everything else.

Mr. Rob Merrifield: Is there something we can do to speed the regulatory process up?

Dr. Frank Plummer: There potentially could be. It's possible. I'm not sure—but I certainly agree with you that we need a vaccine urgently.

Mr. Rob Merrifield: I'll get back to what's happening nationally, then, because maybe you don't have all the information on the vaccine thing, and for further questions on that I'll do my own research.

Among those different groups you identified—the aboriginals, the prisoners, the general population, men having sex with men—you say that men having sex with men has the fastest-growing rate, or is the highest proportion, of those who are infected?

Dr. Frank Plummer: They're the highest proportion of those who are infected. Aboriginal populations are disproportionately affected. They make up about 8% of all HIV infections.

Mr. Rob Merrifield: Which of those groups is growing fastest?

Dr. Frank Plummer: Chris, could you help me out here?

My colleague Chris Archibald tells me that infection rates among gay men are gradually increasing, as are infection rates among heterosexual women. Injection drug user rates are dropping.

Mr. Rob Merrifield: Some of the testimony when we were last here dealing with this said that now we have the antiviral drugs, the antiretroviral drugs, and the message out there on the street was that we have the drugs, we have the cure; we don't need to do the prevention. That's the same message we're actually getting, and some of the concerns, in Africa. How do you combat that? There's still no cure for HIV/AIDS; it's usually a death sentence. It's just a matter of time.

Dr. Frank Plummer: That's right. It is a concern, and there is some evidence that perception of these new drugs as a cure has resulted in increased risk behaviour in certain populations.

You have to combat that with accurate information, and it's part of what we will be doing here.

Mr. Rob Merrifield: That's my concern about the money that is put in—that we really focus in on the prevention and lay that message out as aggressively as we can.

From my perspective, I think we get a better opportunity for actually getting to the root of this problem, which we know we can fix with education. It's preventable. As a disease, it's different from cancer or heart disease or some of the other diseases we have; this is one we know how to protect ourselves against. It's a matter of getting that information out as aggressively as we can to a population who can understand.

Dr. Frank Plummer: I absolutely agree with you, and that's a major focus of doing investments.

The Chair: Mr. Ménard.

[*Translation*]

Mr. Réal Ménard (Hochelaga, BQ): Good morning and welcome, gentlemen.

I'd like to broach two subjects. First, I'd like you to turn over to the committee an organization chart identifying the directors of the Public Health Agency and of Health Canada, as well as their positions. I'd also appreciate a document outlining the duties that will be assigned to new staff members. I don't wish to discuss this matter at this very moment, but I would like you to prepare a document for our benefit.

I've been told that for several months now, community groups have been subjected to a form of harassment by Health Canada or the agency. I admit that I was disturbed to hear that and I'd like us to look into this carefully this morning. I'm told that Quebec's share of federal strategy funding represents $1.5 million and that support for community groups totals $1,250,000. I'd like to know how many officials are responsible for managing the ACAP and what kind of resources are allocated to community groups. I was told that the number of managers has gone from three to five. I also heard that excessive controls had been put in place. On average, community groups in Quebec receive $30,000. I'd like to hear about the ACAP program in detail and about social marketing. I've heard talk of $329,000 and of two newly hired public officials.

I assume you have better things to do than harass community groups, in particular groups that mobilize efforts within the community. If I see this trend continuing, I won't hesitate to table additional motions to bring those involved in the harassment before the committee. It's important not to misinterpret the accountability question. We expect the Canadian strategy to be well managed, but we don't expect community groups to be targets of harassment.

● (0935)

[*English*]

Dr. Frank Plummer: In terms of harassment of community groups, we're unaware of any harassing behaviour by our officials. It's something we can look into, and we will get you the information you've asked for concerning the allocation of resources in Quebec.

When you say the staff has grown from three to five, do you refer to staff in the regional office in Quebec?

[*Translation*]

Mr. Réal Ménard: How many people are in charge at this time of managing the strategy in Quebec? Surely you must have some idea.

Mr. Steven Sternthal: I believe that three or four individuals are currently employed at the regional office of the Public Health Agency of Canada.

Mr. Réal Ménard: So then, we're talking about four individuals.

Mr. Steven Sternthal: Right now, yes. That's what I understand.

[*English*]

I think the challenge, and you said it very well, is that we want to maintain the accountabilities—not only those identified by this committee, but also those required by Treasury Board for us in administering grants and contributions—but not, of course, to put such stringent controls that the organizations receiving the funding are unable to actually do the prevention and the support work they have applied to do with the money coming through the competitive processes. Certainly I believe it wouldn't be the intention of the folks in the Quebec regional office, or other regional offices, to do that intentionally.

However, I do know they're currently in a planning phase for the new funding that will be arriving in future years as part of the ramping of the money, so they're probably looking at how best to organize the delivery of the program over the next number of years. Certainly we can go back and ask the regional office for that clarification.

[*Translation*]

Mr. Réal Ménard: First of all, I'd like a breakdown of staff and budgets. I want to know how many people oversee the strategy and what funding is available. I'm also curious about social marketing considerations.

Tell me more about this campaign. Who is running it? Is it run out of the Privy Council Office? We're told that responsibility for all advertising campaigns has now been transferred to the Privy Council. Does that apply to the AIDS awareness campaign as well?

[*English*]

Mr. Steven Sternthal: In the federal initiative, a component called communications and social marketing has been created. My day job, actually, is as the manager of knowledge and awareness leading the PHAC social marketing campaigns. We'll be using two approaches over the next number of years, and Frank alluded to them in his opening remarks.

First, there will be grants and contributions funding for population-specific social marketing campaigns led by community organizations. Currently two projects are in place. One is at the Canadian Public Health Association, focusing on stigma and discrimination, and one is a campaign at AIDS Vancouver, focusing on gay men. In the future, we hope there will be—and we're planning to have—an additional seven or eight population-specific campaigns focusing on the populations Frank identified in his talk—aboriginals, gay men, women at risk, and youth.

[*Translation*]

Mr. Réal Ménard: What is the national budget earmarked for social marketing? What is Quebec's share of the budget and how many people manage these funds?

[*English*]

Mr. Steven Sternthal: The community social marketing activities, by 2008-09, will be approximately $1 million, and they will be managed nationally. They will likely have partnerships within provinces across the country, so they'll need to work with local organizations, but there will have to be a host or sponsor agency that takes on the role of coordinating across the different provinces.

The other role PHAC will be taking on is to actually do some social marketing itself, focusing on stigma and discrimination, because the advice we've received through our work with communities and our government partners is that PHAC is in a good position to actually make some statements around stigma and discrimination that others are not well placed to do—so there's going to be actual government-led—

● (0940)

[*Translation*]

Mr. Réal Ménard: How many officials are overseeing the program? For instance, with respect to the social marketing campaign, you have put an a call for individual tenders. Therefore, the Privy Council was not involved. Specifically, how many officials have been assigned to this program?

Mr. Steven Sternthal: At present, half of one person-year has been s assigned to social marketing.

Mr. Réal Ménard: So then, there's no one in Quebec.

Mr. Steven Sternthal: One person works part time in Ottawa on planning. Resources will be allocated over the next three years.

[*English*]

So we are just really in the early stages of planning those large social marketing campaigns that will not arrive before 2007-08.

The Chair: We'll move now to Mr. Savage, followed by Mrs. Crowder.

Mr. Michael Savage (Dartmouth—Cole Harbour, Lib.): Thank you very much, Madam Chair.

I'd like to first of all talk national and then international, if I could.

You've talked about how a lot of the work you're doing is with community organizations; in fact, they're the pillar of the federal initiative. There are a lot of organizations and other community-based organizations working with people who are directly affected by HIV and AIDS.

In Nova Scotia, we have the AIDS Coalition, which is very active on a lot of different fronts—in education, particularly. Can you tell me how you work with organizations like the AIDS Coalition of Nova Scotia in terms of getting the message out?

Dr. Frank Plummer: Much of the work that we do, and centrally within the agency, is with national organizations. Our regional offices, which we have across the country, are the primary points of contact with local organizations like AIDS Nova Scotia.

Maybe Steven could speak to this.

Mr. Steven Sternthal: Yes. Each regional office holds regular discussions and dialogues with community organizations like the AIDS Coalition of Nova Scotia to try to identify priorities for funding based on the characteristics of the epidemics and the current issues in the environment. They have a competitive process, where groups like the AIDS Coalition of Nova Scotia apply for funding to do specific pieces of educational work with particular communities, whether it be injection and drug use, or it be gay men, and to actually go ahead and deliver programs developed in their communities.

This happens right across the country. The federal initiative supports well over 100 organizations like the AIDS Coalition of Nova Scotia with some of their prevention, outreach, and community development work.

Mr. Michael Savage: Okay. I guess my question would drive to the issue that across Canada there are people in the community who are working with people with AIDS and/or people who have concerns about AIDS. One of my overriding concerns is to make sure that when the federal government invests in new programs it doesn't try to duplicate or replace existing organizations that are doing good work in the community.

We see this in some other areas. I see it in my own area, for people with disabilities, for example, through some other departments. We can often make sure, by demanding accountability, that we have better use of our tax dollars. I want to make sure that community groups that are in touch with local people and have direct impact aren't replaced or pushed aside, but are in fact supported by these initiatives, and that there's cooperation.

Can I reasonably assume that's the case?

Dr. Frank Plummer: Yes, you can. We implement the money from the federal initiative through these kinds of community groups that you speak of. We don't directly deal with populations at risk, except to consult with them. We're not out there working in communities, educating people about safer sex or injection drug use. That's all done through community groups.

Mr. Michael Savage: Okay. Again, I think it's useful. Where accountability is such a watchword and is so important to people, we have to make sure we're also providing services to the people who need the services. So I'm reassured by that.

I'd like to talk a little bit, if I could, about the international scene. Mr. Merrifield mentioned his trip to sub-Saharan Africa as well as the Caribbean, but specifically Africa, where we see an atrocious toll to HIV and AIDS. It's not just to the people who were affected by it, but obviously their families and generations of families who are growing up without parents in countries where the AIDS rate for adults, I think, is in excess of 30%, or in some cases 40%, in countries like Lesotho and Malawi.

My father had an opportunity to spend some time in Africa toward the end of his life, educating some of the poor communities about reproductive health, sexual health, and HIV/AIDS. It's hard to believe that we somehow don't value the lives of people in Africa as much as we value our own, when we look at the international allowance, if you will, of this to happen.

So I'm interested in knowing specifically if one of the goals of your committee is to be involved internationally in reducing the incidence of AIDS. I think education is a big piece of it. I'm wondering if you could talk a little bit about what steps you have taken as well as on the vaccine issue, but about education and other initiatives. What are we doing to work with other nations in the world, particularly those that are most in need?

● (0945)

Dr. Frank Plummer: Within the Public Health Agency of Canada we have a small amount of money for global engagement, and that is really work with multilateral organizations like UNAIDS and the World Health Organization at the multilateral level. The Canadian International Development Agency is the main source of funding for work with countries directly.

Steven, do you have an idea of CIDA'S spending?

Mr. Steven Sternthal: Essentially we have worked very closely with Foreign Affairs and CIDA. Foreign Affairs now has a draft strategy as well on foreign policy around HIV and AIDS, so again it's very much a consolidated effort that we try to put forward.

I have the specific CIDA announcements, and if we can take a moment, I can relay the numbers as well. There have been specific announcements on vaccines and international AIDS vaccines initiatives, and there have been a number of contributions over the past several years to the global fund to fight HIV, TB, and malaria. There have also been contributions to UNAIDS itself so it can function and do its job to coordinate the global response.

Mr. Michael Savage: I am aware that Canada has taken some leadership positions on the international toll that AIDS has taken. But I think specifically in your presentation today you did identify that you want to contribute to the global effort to reduce the spread of HIV and mitigate the impact of the disease.

I certainly think that Canada should take a leading and more active role in making sure this terrible inequity that exists in the world, which allows this to spread through whole populations, affecting families and economies in such an enormous way.... I encourage us to be very involved in that and to work with the Department Foreign Affairs and CIDA to make sure we do everything we can to be of some assistance in this, as well as on the vaccine and education issues.

Dr. Frank Plummer: We certainly agree with that completely, and we are anxious to work with the other departments to try to make sure Canada has the most robust and effective response possible.

Mr. Michael Savage: Thank you very much. I appreciate it.

The Chair: Thank you, Mr. Savage.

We'll move to Mrs. Crowder now.

Ms. Jean Crowder (Nanaimo—Cowichan, NDP): Thank you for your presentation today.

I pulled some statistics off the Government of Canada website on the state of HIV/AIDS and was really disturbed to see that in 2002, 17,000 people, or 30%, were unaware of their HIV infection. I don't know if those numbers have been updated, but if 30% of people were even unaware of their HIV infection, the effectiveness of some of the campaigns that are going on is questionable.

In the stats I looked at, women now account for 25% of all new infections. This trend is particularly strong among women aged 15 to 39. Women also account for 42% of AIDS cases among those aged 15 to 29. At the end of 2002, an estimated 7,700 women were living with HIV in Canada.

Was a gender-based analysis conducted on this particular policy?

Dr. Frank Plummer: We recognize the vulnerability of women to HIV and AIDS, and globally the majority of HIV infections are in women. In Canada, the Public Health Agency takes the issue of vulnerability of women very seriously.

● (0950)

Ms. Jean Crowder: Dr. Plummer, how are women specifically included in developing the strategies and campaigns? I also noted in the backgrounder that one of the goals is partnership engagement, so how specifically are women's communities engaged in this?

Dr. Frank Plummer: Women's communities that are active in HIV and AIDS prevention and care are engaged in the development of the federal initiative, they're engaged at the provincial level, and could be the recipients of funding from the initiative.

Ms. Jean Crowder: Can you tell me if women's groups are in receipt of funding?

Dr. Frank Plummer: Steven.

Mr. Steven Sternthal: As I mentioned, over 100 groups located across the country that are women's organizations are receiving funding.

Ms. Jean Crowder: Could you provide me with a list of those?

Mr. Steven Sternthal: We could get you a list of those groups.

Ms. Jean Crowder: Could you also tell me a bit more about the consultation process? With all respect, often when we consult we go out and ask people a bunch of questions and then go away behind closed doors and make decisions, but we don't include women in the actual decision-making process.

Dr. Frank Plummer: There was an extensive consultative process that went into the development of the federal initiative and also into other things. Perhaps Steven can speak to the process and the extent of the consultation.

Mr. Steven Sternthal: As we know, governments usually do some sort of consultations prior to developing their policy frameworks, and the policy frameworks are developed in secret as part of the cabinet process.

One of the things that were identified early on, both at this committee and in the review of our strategy we conducted in 2003, was that a number of populations were at risk. "Women" was identified and has been identified for a number of years. It was decided that in this new initiative something called population-specific approaches would be developed, where we would actually go ahead and look at the needs of women over the next couple of years to design, as new funding comes online, those specific needs in surveillance, in community programs, in research, and the whole range of activities we need to have in place. There are processes that have already begun this year with the Public Health Agency to begin dialogue with women's organizations.

I was just handed a note. There is a meeting coming up to discuss what's become known as a blueprint for action, focusing on women. We've been connecting with that group as well as with the other women's representatives who have been on, for example, our ministerial advisory council for a number of years to try to make sure we are incorporating the work that's already under way into the development of these approaches.

Clearly, we also understood with this new initiative that we couldn't continue to choose to focus on only women, only gay men, or only aboriginal communities. We have to really begin to have coverage across those who are vulnerable and are living with HIV. That's really the main emphasis in the next four years, identifying those needs, identifying what is already in place—and I'll provide you that information—and then beginning to work with communities to identify what's missing and how we can address those gaps. Some can be addressed by the federal initiative, some are in provincial jurisdictions or other jurisdictions, and we need to work through the appropriate mechanisms and processes.

The Chair: Thank you, Mrs. Crowder.

Ms. Dhalla.

Ms. Ruby Dhalla (Brampton—Springdale, Lib.): Thank you very much for coming.

I wanted to expand a little bit on what Ms. Crowder spoke about in terms of consultation and your working with the different community groups that exist across the country. We all know the paramount importance of trying to address this strategy and, as my colleague Mr. Savage said, ensuring that we do our best in Canada to show leadership so the numbers dramatically come down as we try to eradicate it as much as possible.

What is the nature of involvement of some of the grassroots community organizations that would perhaps exist in a Toronto area that wanted to access funding?

Dr. Frank Plummer: Much of the federal initiative is grants and contributions, and a large amount of that money flows to community organizations through competitive processes that are administered either at the national level or through regional offices.

Do you want to add to that, Steven?

Mr. Steven Sternthal: Yes. The regional office of the Public Health Agency has established a working relationship with the Ontario Ministry of Health as well as the Toronto Public Health department, where all three governments collaborate on community funding initiatives. There's been a really good history in Toronto of maximizing the use of available resources from those three levels of government. Given the nature of the epidemic in Toronto, certainly, a significant portion of resources in Ontario is invested in Toronto...as well as from the Ontario Ministry of Health and the City of Toronto.

● (0955)

Ms. Ruby Dhalla: In addition to that, within the funding that's given you, are there moneys given specifically for educational purposes, especially in dealing with young people who are at either the junior high or high school stage?

Mr. Steven Sternthal: I know that the AIDS Committee of Toronto does do work with youth. I can get you specific information on what they are currently doing. I'm not familiar with any other groups in Toronto that are working on that as well.

Ms. Ruby Dhalla: But there isn't a specific strategy at your end in terms of dealing with youth in an educational respect?

Mr. Steven Sternthal: We have certainly done surveys in the past. There was a survey we funded in partnership with the Council of Ministers of Education about two or three years ago that actually surveyed several thousand grade 7, 9, and 11 students across the country, I think in nine or ten provinces, to look at the awareness and understanding.

We're certainly looking, as part of our social marketing and communications work, at youth as a potential audience, given the perceptions that have been mentioned here around there already being a cure for HIV. Young people therefore think they don't need to protect themselves because there's already a cure with the antiretrovirals. There are certainly those myths among our young people, and we have seen that.

The rise of sexually transmitted infections among youth certainly is worrisome as well. We are looking at youth as one of our populations I mentioned and Dr. Plummer presented earlier.

Ms. Ruby Dhalla: I think it's of paramount importance. As we all know, all of us as parliamentarians send out ten percenters and householders, and if you perhaps worked with Minister Dosanjh's office preparing either a one-pager or a couple of paragraphs about some of your initiatives under way in an educational way for young people, that is something I think all of us would be more than happy to include in the literature that goes out to our constituents. It could educate them and, hopefully, in some way impact on what's going on in the front lines.

The Chair: Thank you, Ms. Dhalla.

I come back now to Mr. Lunney.

Mr. James Lunney (Nanaimo—Alberni, CPC): Thank you, Madam Chair.

I welcome our witnesses today, and I'm glad you're here for this discussion.

We've heard some our colleagues' concerns, and they're not only for our own country. As I understand it, we have about 56,000 people infected—that's a lot—and approximately 4,000 new cases a year. We hear concerns from some of our colleagues about what's going on in Africa and around the world in this regard, about some of the countries that don't have the advantages we have here.

I'm particularly interested in the science aspect of this and what research is going on with the money that's being put into the AIDS strategy. I'm looking at the chart that you provided, chart A, and I'm trying to determine how much money is actually going into primary research. We heard Mr. Merrifield express concerns about funding for vaccine research; that program was not reapproved.

I'm wondering, Dr. Plummer, if you could explain to us from the chart how much of this money is actually going into research, and could you describe for us what type of research is going on and where?

Dr. Frank Plummer: Currently, through the federal initiative, we're allocated through CIHR about $12 million a year for all HIV research. That will grow to $22 million by the 2008-09 fiscal year. In addition to that, there is money invested in HIV research from CIHR's budget. I can't tell you off the top of my head how much of that is directed towards a particular area like vaccines or fundamental science or behavioural research, but we could get those numbers for you.

Mr. James Lunney: Would you have any idea how many projects are under way in the country? Give us some examples of some promising research, since you're involved in viral research yourself.

Dr. Frank Plummer: Well, I'll tell you about my research projects. We're working on trying to understand natural immunity to HIV, and we have a group of women who are exposed to HIV through prostitution. They appear to not become infected because they have immune responses that are protecting them, like with Jenner's milkmaids, which led to the development of smallpox vaccines. We are, with support from the Canadian Institutes of Health Research, the Gates Foundation, and the National Institutes of Health, trying to understand what the basis of this immunity is. We believe that will help us to develop vaccines that imitate this natural immunity.

We can obtain information from CIHR about the number of projects funded across the country. They would number in the hundreds, I think.

● (1000)

Mr. James Lunney: If you or somebody had an overview of that available, I think the committee would be interested. I know I would personally, and I'm sure other members might be.

I wanted to draw to your attention some information that came across my desk recently and ask your opinion, Dr. Plummer in particular. This is from the *Proceedings of the National Academy of Sciences*, September 2005, and it has to do with intravenous vitamin C selectively killing cancer cells. There's a very interesting description here, with the scientists talking about the formation of H_2O_2, which specifically kills the cancer cells. I'm wondering whether that's something you're aware of or whether you might think this is something worth pursuing in Canada—a low-cost, low-tech intervention that might show very great promise. Many of our cancers, as you know, seem to have viral associations.

Dr. Frank Plummer: I'm not familiar with that specific article. Obviously, everyone would support a low-cost, low-tech solution for problems like cancer and HIV. I think that is something we could certainly look at. I'm not aware of any research of that nature going on in Canada.

There have been many claims about vitamin C in the past, and some have not been substantiated, so I think one has to look at these things with a bit of caution. The way the body handles vitamin C is that when you give a lot of it, it's basically excreted in the urine, so it doesn't hang around. The body gets rid of it quite efficiently, so getting levels high is problematic just because of the physiology.

Mr. James Lunney: We're certainly aware of that, but of course it's true of every drug you take. They're all excreted and have excretion times. That's why you keep retaking them.

Interestingly enough, this says the data showed that pharmacologic concentrations of ascorbate killed cancer but not normal cells. Cell death was dependent only on extracellular but not intracellular ascorbate, and that killing was dependent on extracellular hydrogen peroxide formation with ascorbate radical as an intermediate. Ascorbate generated detectable levels of H_2O_2.

Anyway, I want to put that on your radar and suggest that if Canada wants to be a leader and help the people in Africa and other parts of the world, this would certainly merit some investigation.

Dr. Frank Plummer: Sure. We'll look into it a little bit further.

Mr. James Lunney: I'll make sure you have a copy of this.

Dr. Frank Plummer: Thank you.

The Chair: Thank you, Mr. Lunney.

Mr. Savage.

Mr. Michael Savage: Thank you, Madam Chair.

I was going to ask some questions on the research side too, as Mr. Lunney did. I don't want to specifically ask what we're doing now, but do you have a sense of where Canada is internationally in AIDS research?

Dr. Frank Plummer: I think Canada has contributed to HIV research and sort of punched above its weight compared to other countries. It is important in a number of areas. For instance, the drug 3TC is a Canadian development. The understanding of heterosexual transmission of HIV is a Canadian contribution. The understanding of transmission between mother and child through breastfeeding is a Canadian contribution. The understanding of how you can work through peer education models to promote safer sexual behaviours among groups at risk is a Canadian contribution. The HIV clinical trials network based in British Columbia has contributed enormously to improved treatments for HIV, and their work is recognized around the world.

So I think Canada can be very proud of what its scientists have contributed. It has contributed greater than would be expected from a country of its size.

● (1005)

Mr. Michael Savage: I'm pleased to hear that. I very seldom mention my home province, but there is an organization called the Nova Scotia-Gambia Association that does tremendous work in that part of Africa on peer health education. I think that's a tremendous organization.

I assume that as we look at ramping up research spending, that would significantly increase our standing in AIDS research. Are other countries doing a similar type of ramp-up on that?

Dr. Frank Plummer: Some other countries are making major increases in HIV and AIDS spending. Globally, the Bill & Melinda Gates Foundation has made HIV and AIDS a priority. They've invested large sums of money in a number of different HIV research initiatives. For instance, recently they held a competition for HIV and AIDS research projects around the world.

So HIV/AIDS funding is ramping up globally. I can't say for sure where Canada ranks compared to other countries.

Mr. Michael Savage: I want to note that we're going to host the International AIDS conference in Toronto next year, which I think is a very positive thing and an indication of some leadership in this movement. I understand that 20,000 people will be involved in that conference. Can you tell us a little bit about that and how the federal government will be involved in that?

Dr. Frank Plummer: The federal government is a major supporter of this conference and a major participant in it. As you noted, in excess of 20,000 people from all over the world will be coming to the conference. It's the major AIDS conference that is held every two years and alternates between developed countries and developing countries.

It's a major forum for policy-makers, community groups, at-risk people, people with HIV and AIDS, and scientists to come together to talk about the epidemic, progress, and problems. So it is really a very important thing that Canada is hosting this for the third time.

Mr. Michael Savage: Thank you for that.

The Chair: Thank you.

Mr. Ménard.

[*Translation*]

Mr. Réal Ménard: I have two questions for you, if you don't mind. You informed us that an additional $5 million has been budgeted for 2004-2005. That is thanks in part to the work of this committee. As you know, we requested that funding be increased from $42 million to $100 million. Minister Pettigrew has approved a budget of $88 million, but we haven't lost hope and we will continue to put pressure on the government.

Of these additional $5 million - perhaps you don't have that information with you, but I'd like you to send it to me —, how much will go to community groups, more specifically to the ACAP program, the community action program? When your budget does increase by $8 million, how much to you plan to set aside for community groups?

I'm the youngest MP, but also the committee member with the most experience when it comes to strategy matters. I know that the lives of AID/HIV sufferers would never have improved without the help of community groups. I get very upset when I hear about the federal government imposing unnecessary restrictions.

For example, I heard that filling out an application for ACAP program funding could well require 150 hours of community agencies' time and that increasingly, they were visited monthly by your officials. This is truly tantamount to bureaucratic harassment. I'm thinking about one official in particular whose name I won't mention. I sincerely hope that you will enquire into this matter so that community groups are treated with the respect they deserve. I'm not saying that there shouldn't be any accountability, but the strategy should provide for a better approach. Therefore, I'd appreciate your getting this information to me.

My second question may not be your area of responsibility, but I would nonetheless like your opinion on the subject. My colleague Mr. Merrifield and I travelled to Senegal, along with Ms. Jean Augustine, on behalf of the government. I was very disappointed to learn that no company had availed itself of the provisions of Jean Chrétien's legislation that was passed unanimously regarding the export of generic drugs.

That got me to thinking. Shouldn't Health Canada, working with Industry Canada and CIDA, be investing in a pilot project? Once someone has tested the waters, the path will be cleared for generic drug manufacturers to proceed.

Given your budgets, is it feasible to allocate some funds — I can't give you an exact figure — to a pilot project? Are you concerned that generic drug manufacturers are not doing their job, with the tools given to them under Jean-Chrétien's legislation?

● (1010)

[*English*]

Dr. Frank Plummer: Maybe I can answer the last question first, and then I'll ask Steven to talk about the allocation of the dollars.

First let me say that within the Public Health Agency of Canada we have great respect for community groups and work with them all the time. We certainly would not do anything that would be construed as harassing behaviour. It's certainly not condoned, and we will look into this issue.

We are doing a review of grants and contributions—the whole program. Part of the reason is we recognize that some of the requirements we impose on small community groups are onerous, and we're seeing if we can do some things that might make it simplier for them.

In terms of the use of the legislation by generic companies for antiretroviral drugs, we don't have any information on direct responsibility for that. We can look into the issue and try to understand if it is truly the case that companies are just not interested in doing this. We will undertake to do that and will come back to you and the committee with that information.

[*Translation*]

Mr. Réal Ménard: Health Canada has certain responsibilities. It shares responsibility with Industry Canada. In fact, that department is mainly responsible for enforcing the act, but Minister Dosanjh is responsible, among other things, for the storage of drugs that must be labelled differently, that is drugs destined for the export market, and those that are not. However, it's very disconcerting to see generic drug manufacturers not use this legislation because there is no benefit to be derived.

[*English*]

Dr. Frank Plummer: We're not Health Canada, we're the Public Health Agency and we don't have a regulatory role. But we will certainly consult Health Canada and talk to the pharmaceutical industry to the extent we can to try to understand this issue further.

Steven, could you comment?

[*Translation*]

Mr. Réal Ménard: You need to stand up to the industry.

[*English*]

Mr. Steven Sternthal: I don't have much to add, other than that type of a pilot project isn't planned as part of our rollout of federal initiative, but we could look at that in the options.

Again, the opportunity exists with the committee at the assistant deputy minister level to get some of these bigger issues across departments on the table; it's certainly one of the mechanisms where this could be brought forward as well.

[*Translation*]

Mr. Réal Ménard: You will provide written answers to our questions. Correct?

Thank you, Madam Chair. You've been very generous with me.

[*English*]

The Chair: Ms. Dhalla.

Ms. Ruby Dhalla: Thank you very much.

I want to take a second. Ironically, last week I received a letter from a constituent, and I think it really highlights the importance of Canada playing a leadership role in an international arena. She writes:

> Dear Dr. Dhalla:
>
> I'm writing to share my experiences as a volunteer in Kenya with you in hopes that it will help you gain a deeper understanding of how Canada's international development aid is having a real and significant impact on people's lives overseas.
>
> I have just returned from a government-funded youth internship in Nakuru, Kenya, and I have seen firsthand how Kenyans were banding together to bear the burden of this disease. Everyone, from school kids to grandmothers, is involved in the fight against HIV and AIDS. Youth are forming anti-AIDS clubs in schools and spreading awareness about the disease through skits and moving poetry. And grandmothers are caring for kids left behind by their own children who have become incapacitated, or even died, all because of AIDS. And people of all ages are volunteering to take their time in caring for the sick. And they are calling on fellow community members to question their behaviours. And they are supporting orphans, and they're supporting abandoned adults. Communities are fighting every minute of every day with the resources that they have and they are responding in the best way that they possibly can. They are not sitting idly.

The letter goes on, and she talks about more of her experiences in an in-depth manner. She speaks about how, when she was volunteering, her volunteer organization had accessed the Global Fund, to which Canada has contributed quite significantly, whereby funding was raised to $140 million.

Could you talk from a public health perspective on how you are working in conjunction with other departments to ensure that initiatives like the Global Fund, which Canada has contributed to quite significantly, gets funding—but also on how you are working on a multilateral strategy across different jurisdictions of government departments?

● (1015)

Dr. Frank Plummer: The primary way we are working with other government departments is through the ADM committee that was mentioned and also through bilateral relationships between departments. We are working on building a better relationship with CIDA. We feel that CIDA and the Public Health Agency of Canada can and should work closely together on projects like the one you described.

In terms of our direct global contribution, we primarily work at the multilateral level currently, within the Public Health Agency. We do, through our technical experts, provide advice to the World Health Organization or the Pan American Health Organization and, through them, directly to affected countries. That's kind of on an ad hoc basis, on the basis of a request coming from the country or coming through one of these multilateral organizations.

We certainly would support a larger role for our agency working internationally in HIV and AIDS, and we certainly support the contributions to the Global Fund for HIV/AIDS, tuberculosis, and malaria. But this is something that comes through CIDA. We are very supportive of these kinds of initiatives. We'll contribute to the Canadian response to these various initiatives and are anxious to contribute to the global response to HIV and AIDS.

Ms. Ruby Dhalla: One last thing—do you think government departments are operating in silos? Has there been a very comprehensive and focused and targeted strategy towards this so that when our Prime Minister has gone out to the G-8 meeting and has made these commitments, when all of those commitments are filtered down to the bureaucratic level for implementation perhaps, there is a focused, targeted approach? Where are you guys at right now, and where do we need to be five years from now and ten years from now to ensure that we have a comprehensive and integrated strategy, not only for domestic consumption but also at an international level?

Dr. Frank Plummer: I'll let Steven answer that.

Mr. Steven Sternthal: In terms of a working relationship on the international file, in terms of ensuring coherence, for a number of years now there has been a quarterly dialogue between us, CIDA, Foreign Affairs, the Public Health Agency, Health Canada, and CIHR to look at opportunities to collaborate on the international file as well as to discuss with key NGOs that are working internationally the opportunities for collaboration.

With respect to a fully integrated Government of Canada strategy, the federal initiative is really the first step in moving toward a fully integrated Government of Canada strategy that deals with the domestic and international arenas. The ADM committee, when it was established last year, decided that it would begin with a policy statement on HIV and AIDS as a starting point to having a common policy framework for the Government of Canada around HIV. And then out of that could trickle the specific commitments each department would commit to deliver on. Really, that's where it is so far. The federal initiative is clear about what the four departments working on the initiative have to deliver. We partner with the other agencies like CIDA and Foreign Affairs. Then the policy statement will give all of us the common framework within which to work, shortly.

The Chair: Thank you, Ms. Dhalla.

Ms. Jean Crowder: I actually have a question about first nations.

I noticed in your overview that you talked about the capacity to increase support to on-reserve first nations, and I noticed that there was a study that was part of an on-reserve first nations, Inuit, and Métis community project. And when the federal initiative was announced in 2005, a review of the fund was initiated, in March 2005. I wonder if that review has been completed on off-reserve.

Mr. Steven Sternthal: One of our commitments, when we went to Treasury Board with the new initiative, was to review our existing funding programs to ensure that they were aligned with the new policy framework. One of the reviews we did was a review of the non-reserve funding program. That's administrative—

● (1020)

Ms. Jean Crowder: I'm sorry, is that on-reserve or off-reserve?

Mr. Steven Sternthal: That was the off-reserve first nations, Inuit, and Métis funding program. That's administered by PHAC actually, not Health Canada, and that review is just in its final stages. The final report of the independent consultant has just been received by the agency and we're going to be using that report to inform the next request for proposal applications for the fund, which operates on a two-year funding cycle. That funding should be made available to the community and released, probably in the next two months, so that funding can be in place for the beginning of the next fiscal year.

Certainly, it's going to be available shortly, and we can pass along a copy of the report to you.

Ms. Jean Crowder: That would be great, and just as Mr. Savage takes an opportunity to mention his province, I would be remiss in not mentioning British Columbia.

You may not be aware of the CEDAR Project, which was a study that looked at aboriginal youth from Prince George. This study was funded by CIHR and the Institute of Aboriginal Peoples' Health and Status of Women Canada. It speaks to the very pressing need to make sure we have an integrated strategy that looks at on- and off-reserve, because what is happening in Prince George is that many youths go to Vancouver. Then, as one of the elders, Mary Teegee from Takla Lake First Nation, said, their people are dying. Her mother teaches her grandchildren that they are like salmon; it does not matter where they are living, they always come home to die or to be buried.

What's happening, particularly in British Columbia, and I'm sure in many other major cities, is that the youth go to the large centres. As they become ill, they come home, and that's bringing AIDS on reserve. So it's critical that there is an integrated strategy for on and off-reserve, which I'm sure you're well aware of.

I have one other quick question. I don't actually know if I got an answer to this. I asked if a gender-based analysis had been done on the strategy. I just need a yes or no on that.

Mr. Steven Sternthal: A note was handed to me after I gave my answer. One is currently being done right now. We're working with the Bureau of Women's Health and Gender Analysis at Health Canada in doing that. Again, it's in the context of our population approaches and women are one population we need to work effectively on in the future.

Ms. Jean Crowder: One of the things I know is that a group of stakeholders is working on the Canadian perinatal exposure to antiretrovirals registry. I wondered what the status of that particular program is.

Dr. Frank Plummer: As I understand from Dr. Archibald, that program has approached Health Canada and the Public Health Agency in the past for support, but we've not been able to support their programs. We could look into a bit more.

Ms. Jean Crowder: I asked because I understand from some statistics that 96% of the pregnant women known to be living with HIV have received some antiretroviral treatment, but there is no data regarding the potential long-term effects on these women and their children. I know there was some research being discussed.

It seems as if it's an important mechanism, given that we know that so many women in their child-bearing years are infected. It would seem an important piece of information that could make a significant difference because, of course, it impacts on the justice system, on the health system, on the education system, and on all other systems. So it does seem like an important piece of information.

Dr. Frank Plummer: We'll look into that further. Although there may not be data from Canada, I think there are data from other countries in terms of the outcomes among children exposed to these antiretrovirals.

Ms. Jean Crowder: Thank you.

Do I have any time left, Madam Chair?

The Chair: Absolutely not. Thanks, Mrs. Crowder.

I'd like to ask a few questions.

I'm looking at page 1 of your presentation, Dr. Plummer, and I notice the four goals of what is now an initiative, as opposed to the old strategy. In my view, something's missing. Where is finding a cure, which used to be part of the strategy?

Dr. Frank Plummer: I think that would... Where would that come under, Steve?

I guess that would come under all of them, actually, including reducing the social and economic impact of HIV/AIDS and preventing its acquisition and transmission, which are parts of the cure.

● (1025)

The Chair: But still, finding a cure was one of the goals of the HIV/AIDS strategy, and it's obvious by its absence in the list of goals of the initiative.

Mr. Steven Sternthal: Yes, I think one of the criticisms of the previous Canadian strategy was that its goals were extremely lofty, and not measurable and not helpful.

There is a statement in the federal initiative document alluding to society being free of HIV and to infected people having the highest possible quality of life. I think in this context we've equated that with a cure, whereby all of the issues that have been associated with HIV/AIDS have been addressed. We've tried to identify our objectives and goals more concretely, so that we can actually begin to measure against them, which we're required to by Treasury Board. So I don't think—

The Chair: I know that other disease groups are running for a cure, and doing all of those things for a cure, so it seems to me that we've set the bar a little lower than average by not putting those words in. It could end up having an effect on the initiative if in fact less money goes towards the search for a vaccine, which, as everyone agrees, would launch us forward in this field better than almost anything else we could do—if we could get a vaccine.

On page 3, you mentioned prison inmates. This committee suggested that whatever the Correctional Service was getting for prison inmates, they should get an additional $5 million to do their work, because of all the people who came before us, we felt they were the most underfunded. Yet I see that at the end of this rolling out of money, when it gets to approximately $84 million, they would still only be getting $4.2 million.

So my question is, what were they getting before, and how much additional money will they be getting with this new initiative?

Mr. Steven Sternthal: Under the previous Canadian strategy, they received $600,000 of funding through that strategy. In addition, the Correctional Service does use its own budget to provide care and treatment to offenders, including providing methadone and other programs as well.

Under the new initiative they'll run up to $4.2 million, so they will receive an additional $3.6 million out of the federal initiative.

The Chair: Okay. That's good; I like that.

On page 6, you talked about Dr. Tardif being in charge of the first nations initiative. You also talked about addressing HIV/AIDS in on-reserve first nations and Inuit communities in northern Labrador. Are they the only Inuit communities we're going to go after?

Dr. Frank Plummer: Maybe Dr. Tardif could speak to that.

Madam Chair, I'm going to have to—

The Chair: You have to go now, don't you?

Dr. Frank Plummer: Yes, I'm sorry.

The Chair: Thank you so much for being here. I have a feeling you might be back when we talk about the pandemic, or the possible pandemic. Thanks very much.

Dr. Frank Plummer: My pleasure.

The Chair: Dr. Tardif, how come we're just talking about Inuit communities in northern Labrador?

Mr. Daniel Tardif (Director, Communicable Disease Control Division, Primary Health Care and Public Health Directorate, First Nations and Inuit Health Branch, Department of Health): What I understand about the way first nations and Inuit health branch is funded is to care for on-reserve populations and Inuit communities that are not on-reserve but located in Labrador. When we get north of 60 in the territories, it's part of the territorial governments to take care of that, so we don't go there, the way it's set up.

The Chair: Well, we're going after other populations that are part of the provincial governments' responsibility. Why wouldn't we go after Inuit communities that are part of the territorial governments' responsibility?

Mr. Daniel Tardif: It's not part of our mandate to go there.

The Chair: I find that quite a strange answer.

Mr. Steven Sternthal: Madam Chair, I'll clarify that. The role the Public Health Agency has does address this by working with provinces and territories, and it does actually have funding for aboriginal communities not covered by the mandate of first nations and Inuit health branch. So it isn't that we are excluding. That's the mandate on which Dr. Tardif sits and has responsibility for.

The Public Health Agency works with Health Canada, and then works on the rest of where aboriginal people are located in Canada. So they are covered. It's just that we presented his mandate as restricted, which is what he's required—

● (1030)

The Chair: It's a separate thing. Okay, that explains it. Thanks very much.

Now, one of the things I'm worried about is this big conference we're having next year. It seems to me that big conferences can swallow up huge amounts of money. I see you're going to use a fair amount of money next year to ensure a strong federal presence at the conference.

I'm concerned about what kind of bang for our buck we're going to get by shipping a whole bunch of people to Toronto to attend this conference, as opposed to shipping the money out to the community groups who interface with AIDS patients. In other words, I don't want this new money just to make Canada look good in some kind of public relations exercise.

Mr. Steven Sternthal: Sure. For the committee's information, Health Canada and the Public Health Agency are providing $1.5 million to the International AIDS Society for the operations of the conference. It's similar to the commitment made in 1996 when the committee was last held in Vancouver.

Besides putting HIV on the map and raising the profile and awareness of HIV in Canada, the conference offers an opportunity for people in Canada working on HIV to actually go, learn, and meet people working on HIV across countries. So it's a real capacity-building opportunity.

One of the recommendations we've received from communities is that they'd like us to provide funding for scholarships to enable them to participate if they cannot afford it. So some of the funding that is being worked on right now by the Public Health Agency would go to develop a scholarship program for those individuals who could not attend. That's really money that would be given outside of government through grants and contributions for that purpose. It's a one-time affair.

It's unlikely this conference will come back again to a developed country like Canada. I think it's not necessarily only from a PR standpoint, but from a capacity-building and an opportunity for networking standpoint, that our response here in Canada would benefit if many Canadians were there and had the opportunity to share experiences.

The Chair: Thank you.

I have one last question. One of the things raised by Mrs. Crowder was that 30% of the people who are HIV positive don't know.

Mr. Steven Sternthal: Yes.

The Chair: I don't know whether you know this, but often when people go for their annual or biannual physical, the doctor orders a blood series. My feeling is they're not including HIV on that list of things they're checking their patients blood for, whether they think they'll insult the people or what.

So my question is, is it expensive to test for HIV in a blood series? Or is it sort of an attitude among doctors that they don't want to call for it because their patient might feel insulted? If it's not too expensive, could the Public Health Agency start an education campaign for doctors to include it while they're looking for cholesterol levels and all these other things they look for in these blood series?

Mr. Steven Sternthal: I think there has been a lot of debate over mandatory versus voluntary testing for HIV in this country over the years. Currently we recommend that it be voluntary and really be focused on those people who are more likely to be at risk of contracting HIV. So we're not supporting a general population-wide approach to testing.

The actual tests themselves are not that expensive. We can get the committee the actual dollar costs through the provincial laboratories, but really it's not a very efficient way to identify those people who are at risk. If a physician is talking to patients and asking if they are engaging in behaviours that would likely put them in a situation where they may come in contact with HIV, then certainly we would be encouraging family physicians. We have worked with the College of Family Physicians of Canada in the past to develop resources for them to give to family physicians—to actually give them the tools to have that conversation with patients.

But in terms of looking for the 17,000 out of the 30 million we have currently, it probably would not be a very efficient use of resources and time.

The Chair: Unless you're one of the people who is carrying HIV and doesn't know it. I think the days of voluntary.... It isn't a matter of it being compulsory versus voluntary. The stigma has lessened over the years. Most people I know would want to know if they were carrying it. I don't know how to explain this better, but I think the attitude you just showed while you were speaking is an attitude of about ten years or five years ago. It would seem to me that to prevent those 30% of people who have it from not knowing, in other words, to make sure they do know and begin to deal with the issues....

The other thing I would say is that doctors are not having these conversations they're supposed to be having with their patients. It's embarrassing for doctors, particularly with one of the fastest growing groups, which is heterosexual women, who come in and actually may have been infected by their husbands. The husband may not know he has it, and the wife may not know she has it. There's no way a middle-class woman who comes in for a physical is going to have this conversation you talk about with her family doctor. It wouldn't even cross his mind that she might be infected.

If it could become a matter of course that family doctors just include it on the list as they check off boxes as to what they want the blood tested for, why couldn't they check that one off too? We might unveil this 30% who don't know they're carrying it, and those people could be placed right away on the list of people being watched by their doctors to prevent the deterioration of their physical health.

Anyway, enough from me. Thank you very much.

Mr. Carrie.

● (1035)

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, Madam Chair.

I have a couple of questions along the line of my colleague's, the first one being on accountability. You said in the presentation that the goals would be, first, to prevent the acquisition and transmission of AIDS; second, to slow progression; third, to reduce the social and economic impact; and finally, to contribute to the global effort to reduce the spread of AIDS.

I was just wondering, I see this huge ramp-up of money occurring over the next few years. Do you already have the programs in place to collect the statistics so we know, as Madam Chair said, that we are getting a good bang for our buck?

Mr. Steven Sternthal: You are right that accountability will be really important in an environment of ramping up resources so that we use them as effectively and as wisely as possible. There are some in place currently from the previous strategy.

One of the requirements in going back to cabinet and Treasury Board nowadays is to develop what's called a results-based management and accountability framework, where we actually have to articulate the outcomes—these are not in the presentation, but we can certainly make that available to the committee—that the specific money is being invested towards and the impacts we would like to see from those dollars. The other thing we are doing is spending some of the $84 million on actually setting up and expanding those mechanisms so that we have better surveillance of HIV in the country in terms of risky behaviours, and that we have performance data that's showing how the projects we are funding with grants and contributions are reducing new infections.

Part of the accountability requirements placed on the community agencies as well is the need for them to give us information in order for us to tell the story that they are making a difference.

Mr. Colin Carrie: So what you're saying, when you said some are in place, is that you don't have all of the programs in place right now. It's just going to be progressing over the next four years?

Mr. Steven Sternthal: That's right. Part of the rationale for the ramping-up of resources is that there be some upfront planning and development. The current year we're in now is that planning and development time, so that we prepare for the new resources that will arrive in the next three years.

Mr. Colin Carrie: One of my big concerns is that AIDS knows no borders. We're looking at how Canada compares internationally. If I can pull some statistics here, in the States it appears they spend about $12 per capita on HIV and AIDS; in Canada we're spending about $1.40 per capita. In the U.S. the HIV prevalence rate is 94% higher than in Canada. Australia, where they spend only $1.25 per capita, has a 60% lower rate than Canada does.

I was wondering, before we start ramping up our spending, have we looked internationally to see which programs are working and which aren't, so we're not just throwing money at the problem instead of, as we're saying, getting a better bang for the buck?

● (1040)

Mr. Steven Sternthal: Certainly when we were at the committee previously, a couple of years ago, there were quite a lot of presentations made around what evidence we had at the time and what opportunities and gaps we had in place. As we plan our new programs and our new resources, we are actually looking to some best practices and some demonstration projects that will heavily evaluate interventions that we are implementing here in Canada, as well as looking to some of the practices in other countries that we can learn from.

It's an ongoing program development cycle where we put in place certain things, evaluate, and then look as well at what is going on elsewhere. That's part of our approach to implementing the new programs as we go forward.

Mr. Colin Carrie: Are you aware now of the countries that have the best programs for decreasing the prevalence of AIDS?

Mr. Steven Sternthal: As we've indicated earlier, we're looking at population-specific surveillance, research, and interventions. So for each of those, we are identifying the best practices here in Canada and internationally that can be used for those populations.

Mr. Colin Carrie: I have one more quick question on Correctional Service Canada. There was a committee recommendation, 4(d), that called on Correctional Service Canada to "provide harm reduction strategies for prevention of HIV/AIDS among intravenous drug users in correctional facilities"—in other words, things like needle exchanges.

Is this something that is going to be moving forward? Do you agree with that type of strategy?

Mr. Steven Sternthal: The Public Health Agency has been asked by Correctional Service Canada to provide public health advice on the issue of needle exchange in prisons. The Public Health Agency began a process about six months ago to look at that question. We just finished some site visits of prisons in Germany and Spain that currently employ needle exchange programs.

Our intention is to have public health advice back to Corrections through our chief public health officer before the end of the year or in early 2006 as to whether or not it should consider needle exchange in prisons. So it's certainly under study right now. There have been a number of studies in Europe, in particular, and pilot projects that have looked at whether or not that's an appropriate measure to reduce the incidence of hepatitis C or HIV in prison environments.

Mr. Colin Carrie: Thank you.

The Chair: Dr. Lunney.

Mr. James Lunney: It'll be a short one.

We're talking about virus control today. I had hoped to direct this to Dr. Plummer, but we have Dr. Tardif here, and I see that Dr. Tardif is from communicable diseases control division.

You're also an MD and a scientist, so I want to just ask you this.

We're talking about virus control. Last night on the national news there was discussion about COLD-fX, a ginseng product that promotes immune function. Just talk about the avian flu, which Dr. Plummer will be addressing in a briefing right now with the minister and officials. I'm sure it's a matter of concern to Canadians.

I just wonder if you're talking about something like the ginseng product, COLD-fX, produced in Canada. The CMA journal is currently reporting on a study showing that it improves immune function, decreases the frequency of colds and flu, decreases the severity of symptoms if they do contract a cold, and results in a shorter period of convalescence.

So I'm just wondering, in talking about avian flu and a strategy going into this—and in virus control—is anybody doing research, is Health Canada promoting research, on things that promote immune function, like vitamin C; like intravenous vitamin C, which I just mentioned to Dr. Plummer; and products like COLD-fX as a possible way to improve Canadians' immune function and make them resistant to new problems like avian flu?

Is anything being done, and if not, why not?

Mr. Daniel Tardif: I have to admit that I really don't know what is being done on this, because I'm part of first nations and Inuit health branch, not part of the research part of Health Canada, or food and products, these places. I'm not aware of any study being done, but I'm sure we can look at this and send you the information.

Mr. James Lunney: We're talking about a low-tech intervention here, a low-cost intervention. You're from Inuit and aboriginal first nations, and much of this population in particular seems to me to appreciate the natural approach. It seems to me it would be very low cost and perhaps be a good investment for the AHAC to consider a population study—get people on some products that actually show promise in improving immune function and see if we can't reduce the risk of some of these serious infections.

● (1045)

Mr. Daniel Tardif: As Dr. Plummer mentioned, any approach that is low cost and easily accessible is certainly something that we ought to do something about. Obviously, in first nations and Inuit lands they are aware of ways, they have their own ways to approach health. We can always argue that exercise and good sleep is good for the immunity too, and it is very low cost and quite effective. There are probably a lot of things that could be said about different ways of getting there.

Mr. James Lunney: There's recent evidence published in the CMA journal that talks about a specific intervention, a natural product, ginseng. We're not talking about sleep here; we're talking about something with some concrete evidence. Maybe it's something we should take some action on.

Mr. Daniel Tardif: It's noted.

The Chair: Thank you, Dr. Lunney.

On behalf of everyone here, thank you very much, Mr. Sternthal and Dr. Tardif. We've already thanked Dr. Plummer.

Thank you very much for coming and updating us on this. Good luck with your work in implementing the initiative.

This meeting is adjourned.

Published under the authority of the Speaker of the House of Commons

Publié en conformité de l'autorité du Président de la Chambre des communes

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