Nova Scotia's Strategy on HIV/AIDS

Nova Scotia's Strategy on HIV/AIDS, 2003

Prepared by: Provincial HIV/AIDS Strategy Steering Committee

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The findings and 92 recommendations resulting from the 1999–2000 consultations were contained in *Nova Scotia's Framework for Action on HIV/AIDS (2000)*.

The process and results of the collaborative strategic planning process conducted in early 2002 to initiate development of work plans for future HIV/AIDS action in Nova Scotia were summarized in the report *Planning Steps in Response to Nova Scotia's Framework for Action on HIV/AIDS: Consultant's Report of Regional Workshops for the Strategic Planning Process (2002)*.

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Executive Summary

Introduction

For more than 20 years, the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) have been public health crises for Nova Scotia, Canada, and the entire world. HIV/AIDS has grown into a global pandemic infecting and affecting millions of individuals. Every day approximately 11 Canadians become infected with HIV [1,2].
In Nova Scotia, a total of 596 HIV positive tests were reported by the end of 2002, including 273 diagnosed cases of AIDS and 203 deaths due to HIV or AIDS-related complications [3,4].
The number of actual people with HIV in Nova Scotia is much larger than the reported cases, given that HIV can only be reported when someone is tested positively for the virus. The reported numbers also do not reflect people who have been tested in other provinces.

Much has been accomplished in addressing HIV/AIDS in Nova Scotia, but despite advances in knowledge about how to prevent HIV infection and care for those infected, the virus continues to spread. HIV is more prevalent in populations who experience economic and social marginalization, including men who have sex with men, Aboriginal people, prison inmates, and injection drug users. More needs to be done to address significant gaps and systemic barriers in order to reduce vulnerability to HIV/AIDS in Nova Scotia.

A New HIV/AIDS Strategy for Nova Scotia

Nova Scotia's Strategy on HIV/AIDS (the Strategy) presents a renewed provincial plan to address HIV/AIDS using a population health approach. Because of compelling evidence of the relationship between HIV/AIDS and the broad determinants of health [5], successful implementation of this Strategy will require the development of intersectoral partnerships among government, community, and other stakeholders.

Based on the results of a comprehensive consultation process, the Provincial HIV/AIDS Strategy Steering Committee has developed this Strategy to enhance and strengthen Nova Scotia's ongoing response to HIV/AIDS. The vision for the Strategy is as follows:

> *Nova Scotia is a province that decreases vulnerability to HIV infection through a collaborative strategy. The results of this collaborative strategy are reduced HIV infections and an increased capacity for persons with HIV/AIDS (PHAs) to determine their own treatment path and achieve optimal health and quality of life.*

The Strategy has the following four goals:

1. Integrate HIV/AIDS policy development and service delivery.
2. Improve knowledge and understanding of HIV/AIDS and related issues that affect the risk of infection.
3. Reduce the spread of HIV.
4. Provide Nova Scotians living with and vulnerable to HIV and AIDS with the best possible care, treatment, and support services.

To provide a focus for achieving the goals of the Strategy, the 19 recommended actions have been organized under four strategic directions. These four strategic directions were adapted from the ten strategic directions developed for the *Canadian Strategy on HIV/AIDS (1998)*[1] to ensure that the Strategy was consistent with the national approach. The detailed recommended actions of the Strategy outline specific actions in each of these four areas:

1. Mobilize integrated action on HIV/AIDS.
2. Build a broad research and information sharing strategy.
3. Build a coordinated approach to prevention and harm reduction.
4. Build a coordinated approach to care, treatment, and support services.

From Strategy to Action

The Nova Scotia Advisory Commission on AIDS is best positioned to coordinate the strategy. It will facilitate the development of four intersectoral working groups related to each of the above strategic directions. The working groups will facilitate the development of action plans to address each of the recommended actions for each strategic direction. Action plans will include objectives, required resources, expected outcomes, success indicators, timelines, and an evaluation plan. Because it is not possible to address all recommended actions at the same time, six have been identified as priorities for the first stage of implementation. The Nova Scotia Advisory Commission on AIDS will monitor and report on the progress of the development and implementation of Strategy action plans.

Many dedicated and experienced people have worked hard over the past two decades to respond to HIV/AIDS in Nova Scotia. Implementation of the recommended actions contained in this Strategy will enhance the work that has been accomplished to date, and lead to the reduction and effective management of HIV/AIDS in this province.

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1. Introduction

1.1. Evolution of the Response to HIV/AIDS in Nova Scotia

For more than 20 years the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) have been public health crises for Nova Scotia, Canada, and the entire world. HIV/AIDS has grown into a global pandemic infecting and affecting millions of individuals from all walks of life, ages, and socioeconomic status. Every day approximately 11 Canadians become infected with HIV [1,2]. More often than not these individuals are the most socially and economically vulnerable in our society [1,2].

This document – *Nova Scotia's Strategy on HIV/AIDS* (the Strategy) – is the result of many years of discussion, consultation, and commitment by both government and community to work together in partnership to renew the Strategy. It was produced by the Provincial HIV/AIDS Strategy Steering Committee (the Steering Committee), which is comprised of community and government stakeholders.

The Strategy presents a renewed plan to address HIV/AIDS within a *population health approach*. The inability to control the spread of HIV/AIDS has made it clear that a different approach is necessary to prevent and manage the epidemic.

The population health approach builds on an holistic view of health that recognizes that there are many interrelated factors – known as *determinants of health* – that influence the health and quality of life of populations. The determinants of health profoundly affect vulnerability to HIV infection, the speed at which HIV progresses to AIDS, and a person's ability to manage and live with HIV/AIDS [5]. As most of the determinants of health fall outside the purview of the formal health care system, addressing vulnerability to HIV/AIDS requires the implementation of multiple initiatives within a variety of settings, in partnership and collaboration with diverse sectors and stakeholders [5,6].

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1.2. Rationale for the Renewed Strategy

In 1997, the Nova Scotia Advisory Commission on AIDS presented a brief [7] to the Minister of Health calling for renewal of *Nova Scotia AIDS Strategy* [8], which was launched in 1993. The brief outlined significant changes in the HIV/AIDS epidemic and in the profile of those becoming infected both provincially and nationally necessitating a review of priorities and needs. Many of the recommendations contained in the 1993 Strategy had also been implemented either in whole or in part. However, many of the root causes or systemic issues have not yet been fully addressed [9]. In addition, the federal government was in the process of renewing its HIV/AIDS strategy (the *Canadian Strategy on HIV/AIDS*) and it was important that Nova Scotia's Strategy be congruent with the national approach.

The 1993 Strategy was also viewed by community-based organizations, persons living with HIV/AIDS (PHAs), and other stakeholders as a government-owned initiative that did not provide adequate direction to addressing HIV/AIDS in Nova Scotia as indicated in an initial consultation report (see page 7) [10]. Thus, by 1997 there was a collective call for renewal of the Strategy that reflected the current reality of the epidemic, and a provincial and multisectoral approach to addressing HIV/AIDS in Nova Scotia. As we are now in the third decade of HIV/AIDS, it was essential that needs and priorities be reviewed and revised to ensure the Strategy remains relevant and effective.

1.3 Purpose of the Renewed Strategy

This Strategy is a provincial plan that reflects current priorities, recommended actions, and next steps as identified through consultation with those most impacted by HIV/AIDS, community-based and provincial organizations, and the provincial and federal governments. It is also a *living* strategy that will evolve and be continuously updated as recommended actions are addressed and new priorities emerge. A plan and mechanisms to monitor and evaluate the implementation process and outcomes achieved, and to assess emerging needs has been built into the document.

2. Current Status of HIV/AIDS in Nova Scotia

2.1. Prevalence and Incidence of HIV/AIDS

Prevalence of HIV/AIDS. Health Canada estimates that approximately 49,800 Canadians were living with HIV and/or AIDS at the end of 1999 [11, 12]. Of these, an estimated 15,000 were unaware they are infected [11, 12]. The estimated prevalence rate conflicts with official surveillance reports. (Estimates of HIV/AIDS incidence and prevalence in Nova Scotia are not available; the provincial Department of Health does not calculate estimated rates.)

According to Health Canada, 51,470 positive HIV tests have been reported in Canada between 1985 and the end of 2001, including 18,336 cases of AIDS (since 1983) and 13,357 deaths [12]. In Nova Scotia, a total of 596 HIV positive tests have been reported by the end of 2002, including 273 cases of AIDS and 203 deaths due to HIV or AIDS-related complications [3, 4].

These reported numbers do not reflect the true prevalence of HIV/AIDS in Canada, as well as Nova Scotia. This is because surveillance data include only those persons who sought HIV testing and/or medical care, and/or were given a diagnosis of AIDS [12]. In addition, newly diagnosed HIV/AIDS cases are documented within the province or territory where a person is tested, which is not necessarily where the person currently lives. Community-based AIDS organizations in Nova Scotia suggest that 40% of PHAs living in Nova Scotia have returned to the province after being diagnosed in another province and, thus, do not show up in surveillance reports [13]. This further impedes the ability of public health officials, service providers, and program planners to discern the actual number of PHAs in a particular province.

Incidence of HIV/AIDS and Related Mortality. The national incidence of HIV is estimated to have increased 24% between the end of 1996 and 1999, with approximately 4,200 new infections per year [11, 12]. This is in contrast with official surveillance reports that show an almost 30% decrease between 1995 and 2000, with a slight increase in 2001 [12]. Official surveillance reports do not represent the true incidence of HIV infection.

The reported annual incidence of AIDS cases and HIV/AIDS-related mortality have decreased significantly since the advent of antiretroviral medications in the mid-1990s, which delay or prevent the onset of AIDS and death due to HIV or AIDS-related complications [12]. The decline in the annual number of new AIDS cases, however, has levelled off since 1997. Deaths decreased from a high of 1,477 (AIDS-related) and 1,764 (HIV-related) to a total of 136 (AIDS-related only) in 2001. Due to several limitations in the reporting process, these numbers underestimate the actual number of deaths [12].

The overall decline in AIDS cases and deaths, combined with the increased incidence of HIV infection, means that the number of Nova Scotians (and other Canadians) living with HIV will increase, thereby increasing the risk for further transmission of the virus. This further reinforces the need for a coordinated continuum of care, treatment, support, and prevention services for PHAs [7].

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2.2. Vulnerable Populations

Vulnerable populations. From the early 1980s to early 1990s, HIV/AIDS primarily affected men who have sex with men (MSM) and, to a lesser extent, injection drug users (IDUs) and recipients of infected blood and blood products. Since November 1985, all donations of blood or blood products in Canada have been screened for HIV, making exposure via contaminated blood/blood products extremely unlikely. HIV infection among new population groups has rapidly increased since approximately 1993. For instance, national trends indicate an increase in HIV infection through heterosexual transmission and an increased incidence among adult females (particularly those 15-29 years old) and Aboriginal people [12]. In Nova Scotia, surveillance reports indicate a similar trend [3].

Although national and provincial trends vary slightly to moderately from year to year, social and economic vulnerabilities are driving HIV infection rates among the following:

- **Men who have sex with men (MSM):** Prior to 1996, approximately 70% of adult HIV test reports were attributed to MSM. This decreased steadily to approximately 37% during 1997–99; increased to 42% in 2000; then decreased to 36% in 2001. In terms of AIDS, the proportion of AIDS cases among MSM decreased from 75% prior to 1997 to 45% in 1999; increased to 50% in 2000; and decreased to 46% in 2001 [12,14]. Despite an overall decrease in new HIV/AIDS cases among MSM, this group continues to account for the largest number of reported HIV/AIDS cases in Nova Scotia [3] and Canada as a whole [15].

- **Women:** The proportion of adult cases of HIV occurring in women increased from 11% between 1985 and 1996, to nearly 25% in 2001. The proportion of AIDS cases among women increased from 5.6% before 1992 to 8.3% in 1995, to 16.4% in 1999, and levelled off at 16% in 2001 [12].

  In 2001, women accounted for 44.5% of new HIV diagnoses in the 15–29 age group, an increase from 41% in 2000. Heterosexual contact is the primary risk factor for women [12,14]. Because females are more socially and biologically susceptible to HIV, prevention initiatives must also target heterosexual males who are at-risk of HIV infection and are transmitting it to their female sexual partners.

- **Aboriginal persons:** Although Aboriginals comprise only 2.8% of the Canadian population, they are disproportionately affected by the myriad of social, economic, and behavioural factors that increase vulnerability to HIV/AIDS. They are increasingly over-represented among new HIV diagnoses: 19% in 1998, 24.3% in 1999, 22.3% in 2000, and 25.9% in 2001. The annual proportion of AIDS cases among Aboriginal persons also increased from 1% before 1990 to 10% in 1999, with a decrease to 6.22% in 2001. Rates are highest among Aboriginals who are female and/or under 30 years of age, and/or who inject drugs [12,14].

- **Injection drug users:** Prior to 1996 the proportion of HIV diagnoses attributed to injection drug use (IDU) was 10.7%; this increased significantly to 29.5% in 1995, peaked at over 33% in 1997, and decreased to 24.6% in 2001. The proportion of reported adult AIDS cases attributed to IDU decreased from a high of approximately 20% in 1998–2000 to 14.4% in 2001 [12].

  Although there has been a decrease in reported and estimated infections among those who inject drugs, the number of infections remains very high [11,14]. Given the geographic mobility of injection drug users (IDUs) and their social and sexual interaction with non-users, HIV/AIDS and IDU is a problem that ultimately affects all Canadians [14].

- **Youth (15-29 years of age):** While the limited available HIV/AIDS-related data suggest that HIV/AIDS prevalence among youth is low, data on sexual risk behaviour show the potential for spread is great. The median age for HIV infection has also been dropping steadily (from age 32 before 1983, to age 23 between 1985 and 1990) [14]. Street involved youth, those who inject drugs, females, and young men who have sex with men (MSM) are particularly vulnerable. In 2001, heterosexual contact (41%), MSM (32%), and IDU (21%) accounted for greatest proportion of new HIV cases among youth 20-29 years. Among those 15-19, IDU (40%) and heterosexual contact (35%) accounted for the majority of new cases [14]. Aboriginals who are under 30, particularly females, experience higher rates of infection [12,14].

- **Prison inmates.** According to the Canadian HIV/AIDS Legal Network, since 1996 the prevalence of known cases of HIV (and more so Hepatitis C) in prisons has continued to increase [16]. In federal prisons, known cases of HIV/AIDS increased by over 35% in four years. Various studies conducted in both federal and provincial prisons suggest that inmates living with HIV vary from one in 100 to one in nine. Therefore, the proportion of prisoners with HIV is six to 70 times higher than the proportion of all Canadians with HIV [16].

  Further, according to recently released findings by the Correctional Service of Canada, 1.8% of inmates in all federal penitentiaries were reported to be HIV positive (not including those who are infected and have not come forward for testing) at the end of 2001 (compared to 1.7% at end of 2000). The rate was higher among female (4.7%) offenders, than male (1.7%) [17].

It is important to note that the spread of HIV infection among the above noted populations comprises multiple, overlapping epidemics. The challenges in curbing these epidemics relate to poverty and lack of access to appropriate health and social services among marginalized groups in society [18]. Barriers to accessing services – be they social, economic, political, organizational – increase vulnerability to HIV/AIDS [1].

More research is needed to understand trends and the roots causes (determinants) associated with HIV infection among these and other emerging populations, such as older Canadians (≥50 yrs of age) [12], to inform development of effective prevention and care programs. Increased investment in comprehensive prevention initiatives and care and support services is also urgently needed to respond to the complex needs of vulnerable groups and to address the root causes of vulnerability.

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2.3 Response to HIV/AIDS in Nova Scotia

Based on Nova Scotia Department of Health surveillance reports [3], the first official AIDS diagnosis in the province was in 1983. Since then provincial and federal governments and a network of community-based organizations have informed Nova Scotians about HIV/AIDS-related issues; provided care, treatment and support services; and developed policies that help Nova Scotians stay healthy and/or assist those impacted by HIV/AIDS. Because of various organizations and initiatives, a large number of communities in Nova Scotia have had access to some form of HIV/AIDS support and education, although these have not been equitably available and/or accessible particularly for rural and vulnerable populations.

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It is not possible within this document to summarize and do justice to the significant contribution of various stakeholder groups, but a general overview of the community, provincial, and federal government response is provided below.

Community response. Much of what has been accomplished to reduce the spread of HIV and provide care and support to those infected and affected has been achieved by non-profit and/or voluntary community-based groups. The emergence of HIV/AIDS in the early 1980s galvanized the gay community in Nova Scotia to take the lead in addressing the stigma and discrimination related to HIV/AIDS, and provide care and support to those who were infected. These early efforts spearheaded the community-based AIDS movement in this province and the formation of several community-based AIDS organizations largely made up of and/or run by volunteers.

Provincial government response. The Government of Nova Scotia, with the Department of Health as lead department, has responded with activities such as HIV/AIDS surveillance; funding for key community-based initiatives; and provision of funding and expertise in development of this Strategy, and as well as for the Nova Scotia Task Force on AIDS (1987–88) [19] and the first provincial AIDS Strategy (1993) [18].

Federal government response. The federal government, with Health Canada as lead department, has been a significant partner since the beginning of the epidemic in the areas of HIV/AIDS surveillance, research, and funding of various community-based and national organizations and initiatives. Particularly for Nova Scotia, the AIDS Community Action Program—a component of the *Canadian Strategy on HIV/AIDS*—has provided operational funding to a number of community-based AIDS organizations, as well as project funding to community organizations for various HIV/AIDS related initiatives (see Health Canada's website <www.hc-sc.gc.ca> for links to a list of funded organizations and projects, as well as further information on federal government initiatives related to HIV/AIDS).

3. Overview of the Strategy

3.1. Process of Strategy Renewal

On December 1, 1997, the Minister of Health announced the province's intent to renew the HIV/AIDS Strategy. The Steering Committee was formed in early 1998 representing community and government stakeholders with a mandate to produce a renewed Strategy. It was agreed that a broad consultative process was necessary to inform its development.

A series of public consultations on how to respond to HIV/AIDS in this province was conducted by an outside consultant with representatives of all stakeholder groups in two phases [1]. The first round of consultations occurred over five weeks in the spring of 1999. More than 200 people participated directly in this process and feedback was summarized and presented in a report [10]. In the spring of 2000, a second round of consultations to verify and/or clarify the information was held. This included small group meetings and/or the opportunity to reply by mail or telephone.

Through the consultation process, participants clearly identified the need for a coordinated response to HIV/AIDS. It was recognized that good work is being done in Nova Scotia. However, to increase the impact of this work it must be coordinated and focused.

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A Framework for Action. In September 2000, the Steering Committee produced *Nova Scotia's Framework for Action on HIV/AIDS* [20] —a blueprint for developing a comprehensive approach to HIV/AIDS prevention and treatment in Nova Scotia. The Framework was released by the Minister of Health on December 1, 2000. This document further synthesized findings of the consultation process and presented 92 recommended actions in six areas: prevention and education, harm reduction and testing, population-specific action, community development and service coordination, research and funding, and media.

The Framework encouraged community and government stakeholders to take collaborative action to develop and implement strategies based on the recommended actions. The Framework also called for the establishment of a reconstituted Steering Committee—the Framework for Action on HIV/AIDS Steering Committee—to develop a process to address the recommended actions. The name of the Steering Committee was changed back to the Provincial HIV/AIDS Strategy Steering Committee in early 2003 to more accurately reflect its mandate. The Steering Committee fulfilled its mandate with release of this document.

From Framework to Strategy. A collaborative strategic planning process was conducted by an outside consulting firm in early 2002 to initiate development of work plans for future HIV/AIDS action in Nova Scotia, encompassing the 92 recommended actions. A series of seven workshops were held – six with key partners and stakeholders in the central, eastern, northern, and western parts of the province, and one with relevant federal and provincial government policy makers to

[1] Although designed to be as inclusive as possible, not all communities were reached in the first and/or second round of consultations. Time constraints, lack of awareness of the consultation process, and scheduling difficulties appeared to be contributing factors. Lack of comfort with public forums (e.g., concerns about safety and/or anonymity) and lack of transportation and/or location of the focus groups may also have contributed. Input from representatives of ethnocultural communities cited cultural boundaries (e.g., format of consultations not compatible with community traditions and/or preferences; some women not comfortable in attending forums open to both sexes). It is intended that these barriers will be addressed as the Strategy evolves over time.

address resource provision and policy issues. More than 100 stakeholders from the community and various levels of government attended the workshops. The results of the regional workshops were presented in a report [21] along with a reorganization and reduction of the original 92 recommended actions into more manageable components to enable development of action plans. The report presented potential strategies and/or activities to implement the recommended actions, as well as possible opportunities and challenges to effectively address HIV/AIDS issues in Nova Scotia.

The Steering Committee further revised the recommended actions and reduced their number to ensure they were clear, action-oriented, directed to a particular organization, realistic, and manageable. It should be noted that in all these iterations, great care was taken to ensure the recommended actions reflected the needs and concerns identified through consultation with stakeholders and the current reality of HIV/AIDS in this province.

In addition, it is recognized that some of the recommended actions, either in whole or part, are currently being addressed. In those instances, the intent of the recommended action is to reinforce its importance and/or encourage its continued implementation.

3.2. Context for a Renewed Strategy

3.2.1. Population Health Approach

There are many factors that determine the health of the population, including income, education, employment, early childhood experiences, social and physical environments, and access to health services. The prevalence of HIV/AIDS, like many other diseases, is connected to these factors, or *determinants of health* [6]. For example, people with less income are more likely to have a lower health status than people with higher income.

Successful strategies for responding to HIV/AIDS are those that address the determinants of health, using what is called a *population health approach.* A population health approach recognizes that:

- The determinants of health cross the mandates of many organizations and all levels and departments of government and, therefore, successful strategies need to involve stakeholders from different sectors.
- Many different strategic actions are needed to improve the health of the population – no single action will address all of the determinants of health.
- Citizens must be provided with meaningful opportunities to participate in developing and implementing priorities for action to improve health [6].

A population health approach is the foundation for this Strategy. Successfully implementing the recommended actions in this document will require many organizations to collaborate to make changes that improve Nova Scotia's response to HIV/AIDS. The participation of PHAs and other people affected by HIV/AIDS will be an essential part of implementation.

3.2.2. Addressing HIV/AIDS as a Component of Broader Health System Change

The Strategy cannot be implemented in isolation from the many ongoing changes taking place in Nova Scotia's health system. The Steering Committee ensured throughout the Strategy development process that the recommended actions were in line with the priorities outlined in the Nova Scotia Department of Health's business plan, such as diversity and social inclusion awareness in primary health care; chronic disease prevention infrastructure; blood-borne pathogens; and palliative care.

The Strategy is also consistent with other ongoing health system change processes, such as primary health care renewal and the provincial chronic disease prevention strategy (currently under development). As stated by the provincial Advisory Committee on Primary Health Care Renewal (ACPHCR), a well-coordinated, integrated, and sustainable primary health care system will improve the health status of Nova Scotians [22]. This statement is true for people with and affected by HIV/AIDS, and many of the changes recommended by the ACPHCR will directly support the achievement of recommended actions in this Strategy. The HIV/AIDS Strategy will enhance the changes brought about through primary health care renewal by providing, where necessary, a unique and specific focus to HIV/AIDS issues that might not be addressed by broader health system change.

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3.3. Strategy Vision and Guiding Principles

3.3.1. Strategy Vision

The development and implementation of the Strategy is guided by the following vision:

Nova Scotia is a province that decreases vulnerability to HIV infection through a collaborative strategy. The results of this collaborative strategy are reduced HIV infections and an increased capacity for PHAs to determine their own treatment path and achieve optimal health and quality of life.

3.3.2. Guiding Principles[2]

Nova Scotia's Strategy for HIV/AIDS is based on the following six guiding principles:

1. PHAs, their caregivers and advocates, and people most vulnerable to infection have a central role in policy direction and planning for services that affect them. Policy direction and service planning is gender and culturally inclusive.
2. Nova Scotia's success in reducing the number of new HIV infections and improving the health and well-being of those already infected with HIV depends on:
   - developing a comprehensive and well-coordinated continuum of prevention and restorative health services, including services based on a harm-reduction approach
   - respecting social diversity
   - addressing a variety of factors that reflect the determinants of health including the availability of safe and secure housing; employment; adequate income support; access to health, social, and addiction services; and conditions that affect gay/lesbian/bisexual persons' choices in *coming out* about their sexual orientation. The impact of these determinants on the overall health and quality of life of individuals and communities must be considered and form the basis of programs and services
3. Nova Scotia's approach to HIV/AIDS prevention, care, treatment, and support services should encourage and promote the strengthening of community-based organizations, as well as partnerships across disciplines, government departments, and community organizations.
4. PHAs should have timely access to health care services wherever they live in the province. Services should be provided as close to home as possible. This will be achieved through universal health care services, as well as volunteer and community-based programs.
5. Care, treatment, and support services should be responsive to the needs of PHAs, and enhance self-determination and self-sufficiency to support people in making choices about their care.
6. Cooperation, collaboration, and leadership are required by all stakeholders to achieve the vision of this document. Every stakeholder's participation in implementation of the recommended actions is important and essential.

Every stakeholder's participation in implementation of the recommended actions is important and essential.

[2] Principles are adapted from British Columbia's Framework for Action on HIV/AIDS, Ministry of Health and Ministry Responsible for Seniors (1998), p. 9.

3.4. Strategy Goals and Strategic Directions

3.4.1. Strategy Goals

The overall goals of the Strategy are to:

1. Integrate HIV/AIDS policy development and service delivery.
2. Improve knowledge and understanding of HIV/AIDS and related issues that affect the risk of infection.
3. Reduce the spread of HIV.
4. Provide Nova Scotians living with and vulnerable to HIV and AIDS with the best possible care, treatment, and support services.

3.4.2. Strategic Directions

To provide a focus for achieving the goals of the Strategy, the recommended actions of the Strategy have been organized under four strategic directions. These four strategic directions were adapted from the ten strategic directions developed for the Canadian Strategy on HIV/AIDS [23] to help ensure that the Strategy was consistent with the national approach. Although presented as separate directions, there are issues that are common and cross more than one direction.

The strategic directions for the Strategy are:

1. Mobilize integrated action on HIV/AIDS.
2. Build a broad research and information sharing strategy.
3. Build a coordinated approach to prevention and harm reduction.
4. Build a coordinated approach to care, treatment, and support services.

3.5. Strategic Direction #1: Mobilize integrated action on HIV/AIDS

While Nova Scotia is fortunate to have many experienced and dedicated individuals working in the HIV/AIDS field, there is currently a lack of effective coordinating and integrating mechanisms at the local, regional, and provincial levels. Nova Scotia must mobilize government departments at all levels; district health authorities (DHAs); political leaders; community-based organizations; health care professionals and other service providers; Aboriginal people, African Nova Scotians, and immigrant communities; faith communities; PHAs and other vulnerable populations; and ordinary citizens to take coordinated, collaborative, and integrated action on HIV/AIDS.

This action must be based on the determinants of health within a population health framework, address barriers such as inequities in timely access to health care and other services, and be focused on and driven by people living with and those most vulnerable to HIV/AIDS.

This action must also be linked to and informed by the Canadian Strategy on HIV/AIDS; the Aboriginal Strategy on HIV/AIDS in Canada (under development); other relevant strategies and/or initiatives based on a population health approach (e.g., Nova Scotia's blood-borne pathogens project, findings of the Roundtable on Youth Sexual Health, provincial primary health care renewal); and the global response to the epidemic.

According to the Canadian AIDS Society, if sufficiently funded, community organizations that complement or supplement health services can be "a real alternative to high-cost primary care where the needs of PHAs are addressed with compassion and a wealth of experience" [24]. Mechanisms must be established that enable community stakeholders to participate meaningfully in implementation of the Strategy.

While Nova Scotia is fortunate to have many experienced and dedicated individuals working in the HIV/AIDS field, there is currently a lack of effective coordinating and integrating mechanisms at the local, regional, and provincial levels.

Recommended Action #1.1

Foster a broad community-based health system using a population health approach for Nova Scotians who are vulnerable to HIV infection.

The Nova Scotia Department of Health should take the lead in fostering a broad community-based health system using a population health approach for Nova Scotians who are vulnerable to HIV infection (at-risk of infection and/or infected or affected by HIV). Such a health system would address the determinants of health and have attributes such as

- an holistic approach to health care, including an emphasis on wellness
- inclusion of cultural beliefs and ways of living (e.g., for Aboriginal people, African Nova Scotians and other ethno-cultural populations)
- seamless delivery of services among the various parts of the health and social service systems
- addressing issues such as systemic barriers and inequities in access to care (e.g., geographical location, eligibility criteria, application processes, etc.); health services for gay, lesbian, and bisexual persons; and reaching vulnerable populations
- having relevance for persons with other chronic diseases (i.e., lifelong episodic conditions)
- design, delivery and monitoring processes that feature:
  - inclusion of representatives of the various population groups
  - community level input and involvement
  - horizontal and vertical co-ordination of policies and services
  - intersectoral collaboration with other chronic disease groups
  - inter and intra government departmental policy initiatives and co-ordination
  - leadership and support of the management of the District Health Authorities, Regional Community Services, etc.

Recommended Action #1.2

Allocate sufficient and stable funding sources for community-based HIV/AIDS programming. *(Note: This was identified as a priority action for first stage of implementation.)*

The Nova Scotia Department of Health should take the lead in ensuring sufficient and stable funding sources for community-based HIV/AIDS programming by

- exploring new funding approaches that enable sufficient and stable funding for community-based AIDS organizations and other community-based organizations to maximize sustainability of their programs and services, and to ensure that consumer needs and priorities are met
- fostering discussions between Aboriginal leaders and the federal and provincial health care funding structures specifically relating to HIV/AIDS funding, jurisdictional issues, and programming for Aboriginal people
- supporting and maintaining an effective province-wide network of youth wellness and/or teen health centres/clinics

3.6. Strategic Direction #2: Build a broad research and information sharing strategy

A research and information sharing strategy must be built to identify, obtain, analyse, validate, communicate, and facilitate the use of a broad base of information required to effectively address the Strategy's recommended actions. Such a research and information sharing strategy must support developing processes, capacity building, and leveraging of resources in a way that is consistent with the vision and principles for HIV/AIDS work in Nova Scotia. Mechanisms must be developed to enable partners to learn from the experience, information, and research of local communities, from other provinces/territories, and from other countries [23].

Adequately funded and coordinated research is an essential component of the research and information sharing strategy. Because the public health benefits from adopting a population health approach to HIV/AIDS will only be realized in the long term, research is needed that associates the determinants of health with these long-term outcomes [5].

A research and information sharing strategy includes basic science; clinical research; social science research including community-based initiatives; epidemiological research including national, provincial, and local (including ethnocultural) surveillance; evaluation results and reports from community projects; anecdotal and experiential information; and other relevant information. Partnerships between communities and "professional" researchers within universities/colleges and hospitals should be enhanced. Community-based AIDS organizations and individuals must be supported in developing the necessary capacity to define research priorities and carry-out research, as full and equal partners in research initiatives.

Recommended Action #2.1

a) **Develop an HIV/AIDS research agenda for Nova Scotia as part of a broader national (and/or global) HIV/AIDS research agenda.**

The AIDS Coalition of Nova Scotia should take the lead in facilitating the development of an HIV/AIDS research agenda for Nova Scotia. Provincial research should be developed as part of a broader national (and/or global) HIV/AIDS research agenda. Some of the needs identified to date include:

- gender-specific clinical trials
- the relationship and impact of key socio-economic influences/conditions (such as single parenting, poverty, intimate-partner abuse, and low self-esteem) on risk-taking behaviours among both females and males
- vulnerable youth
- identification of options to establish an infrastructure to address gay and lesbian health issues from a broad health perspective that includes HIV/AIDS and drug use

research

Because the public health benefits from adopting a population health approach to HIV/AIDS will only be realized in the long term, research is needed that associates the determinants of health with these long-term outcomes [5].

b) Strengthen the HIV/AIDS research process.

With the AIDS Coalition of Nova Scotia as the lead, the HIV/AIDS research process should be strengthened by:

- consulting regularly with the HIV/AIDS community to identify current issues needing further research
- actively recruiting skilled researchers including university professors, graduate students, and community research specialists to participate in HIV/AIDS related research
- supporting rural communities in developing expertise in identifying and conducting the types of research they most need (e.g., social, quantitative, or qualitative) and learning to critique research requests
- using qualitative research methods with vulnerable populations to complement or supplement existing quantitative data
- identifying best practices and evaluating innovative local services and partnerships that effectively reach high-risk populations

c) Enhance HIV/AIDS research programs by adopting a population health approach.

With the AIDS Coalition of Nova Scotia as the lead, the Canadian and Nova Scotia research communities (including funding bodies and academic and community researchers) should enhance their HIV/AIDS research programs by adopting a population health approach. This would enable identification of concrete and meaningful findings to assist government and community groups to design and deliver more effective HIV/AIDS prevention, support, and treatment programs for specific vulnerable populations.

Recommended Action #2.2

Determine the validity and feasibility of collecting and identifying HIV/AIDS surveillance data for African Nova Scotians, Aboriginal people, and new immigrant communities. *(Note: This was identified as a priority action for first stage of implementation.)*

The Office of the Provincial Medical Officer of Health, in collaboration with District Medical Officers of Health and the Division of HIV/AIDS Epidemiology and Surveillance, Health Canada, should determine the validity and feasibility of collecting and identifying HIV/AIDS surveillance data for African Nova Scotians, Aboriginal people, and new immigrant communities. Specific actions should include:

- consulting with specific ethno-cultural communities, physicians, and other health professionals who conduct HIV-antibody testing to determine desired data to be collected
- arranging for appropriate exemptions under provincial and federal Human Rights legislation and/or regulations
- providing specific and relevant ethno-cultural data (e.g., age, region, gender) that will help in the design and delivery of effective programming for specific population groups

3.7. Strategic Direction #3: Build a coordinated approach to prevention and harm reduction

A province-wide continuum of services, including services based on harm reduction, will build a coordinated and collaborative approach to HIV/AIDS prevention. This approach must address specific goals, be based on the principles of the Strategy, and include culturally specific programs and outreach initiatives [23].

In the absence of a cure or vaccine, stemming the HIV/AIDS epidemic is almost totally dependent on prevention initiatives—and, theoretically, HIV is 100% preventable [25]. In 1999, the total economic burden of HIV/AIDS in Canada was more than $2 billion in direct and indirect costs (including treatment and losses due to premature death) [26]. In 1997, it was estimated that each HIV infection costs Canada $753,000, i.e., $153,000 in direct treatment costs (such as drug therapy, doctors' fees, hospital care, home care, etc.) and $600,000 in indirect costs (such as loss of income and productivity) [25]. However, adequate and sustainable investments in prevention and education initiatives (especially those targeting vulnerable populations) will result in significant economic (direct and indirect costs) and population health benefits.

Recommended actions for this strategic direction focus on increased investment in three overall areas of HIV prevention:

- education about healthy sexuality and relationships for youth
- adoption of a province-wide continuum of services incorporating a harm-reduction approach, and including expansion of anonymous HIV testing
- public education and awareness about HIV and AIDS

First, it is widely believed that education about healthy relationships and healthy sexuality helps prevent the spread of sexually transmitted infections, including HIV, and reduces unintended pregnancies. A safe and supportive educational environment, with trained teachers and a comprehensive curriculum enables individuals to make healthy choices for themselves by increasing awareness of options, raising self-esteem, and promoting healthy, respectful intimate relationships. It also promotes respect for the inherent dignity and worth of others, tolerance, and acceptance of persons who are different from ourselves [21].

Second, services that have adopted a harm-reduction approach seek to reduce the likelihood that service recipients/clients will contract or transmit HIV, Hepatitis B and/or C, or otherwise harm themselves or other members of the general public. They also enable vulnerable populations to connect with health, social, and community-based services. Evaluation of the Mainline Needle Exchange Program in Halifax concluded that between 1993–97, it saved the health care system approximately $11 million, which otherwise would have been spent treating new cases of HIV/AIDS [27]. After performing sensitivity analysis on the results, researchers calculate a range of total savings between $4 million and $86 million. Consultations with stakeholders indicate that there is a clear need to foster a common understanding of a harm reduction approach among all partners in Nova Scotia.

Currently there is only one anonymous testing site located at Planned Parenthood Metro Clinic in Halifax. Anonymous testing has been shown to encourage people to come forward for testing (especially those who are at increased risk), yielding significant individual and societal benefits [28]. It is crucial that more Nova Scotians, particularly members of vulnerable populations, be tested so that infected persons have early access to care and treatment and are aware of how to prevent transmission of HIV to others; so that those who test negative are aware how to remain HIV-negative; and to enable a more complete picture of the epidemic to guide policy, service, and program-related decisions.

Finally, Nova Scotians need to know that HIV/AIDS continues to be a public health crisis and understand its personal and economic impacts on their lives. Public awareness of the personal and economic impacts of HIV/AIDS must be raised to secure political leadership and support to increase investment in HIV/AIDS and provide sufficient and sustainable funding for innovative prevention initiatives; for coordinated and comprehensive care, treatment, and support services; and for a broad research agenda [23].

Anonymous testing has been shown to encourage people to come forward for testing (especially those who are at increased risk), yielding significant individual and societal benefits [28].

Recommended Action #3.1

a) **Facilitate the creation of safe, supportive educational environments for both students and staff in public schools.**

The Nova Scotia Department of Education, in partnership with the Regional School Boards, should take the lead in facilitating the creation of safe, supportive educational environments for both students and staff, especially for PHAs and for gay, lesbian, bisexual, and trans-gendered individuals.

Such a supportive school environment will require multi-faceted action around the following:

- policies and codes of conduct that promote safety and respect; and zero tolerance for harassment, violence, and homosexual/homophobic bullying
- supportive values of respect for others within the school, the community, and the home
- curriculum and resources on the acceptance of others, sexual health education, and the reduction of homophobia, racism, and sexism
- positive role models
- peer education and support

b) **Facilitate the creation of safe, supportive educational environments for both students and staff in Community Colleges.**

The Nova Scotia Community College should examine their policies related to creating a supportive environment concerning HIV/AIDS, and gay, lesbian, bisexual and trans-gendered persons.

c) **Facilitate the creation of safe, supportive educational environments for both students and staff in universities.**

Student services and/or student councils of Nova Scotia's universities should examine their policies related to creating a supportive environment concerning HIV/AIDS, and gay, lesbian, bisexual and trans-gendered persons.

Recommended Action #3.2

Develop a training strategy for on-going support and professional development of teachers responsible for delivering the sexual health component of the public school curriculum.

The Nova Scotia Department of Education should take the lead in working with Nova Scotia teacher preparation faculties and with the Regional School Boards to ensure that student and classroom teachers have the necessary knowledge and skills to effectively communicate with and instruct students on healthy sexuality, and in particular on HIV/AIDS. This professional strategy would include providing on-going training and support for teachers responsible for delivering the sexual health component of the public school curriculum.

Recommended Action #3.3

a) **Update and provide a healthy sexuality curriculum (including HIV/AIDS, sexism, racism, and homophobia within the context of healthy living) for delivery in every school in Nova Scotia.**

The Nova Scotia Department of Education, in collaboration with Regional School Boards and other relevant stakeholders (e.g., Public Health Services, District Health Authorities), should update and provide a comprehensive and consistent healthy sexuality curriculum (including HIV/AIDS, sexism, racism, and homophobia within the context of healthy living) for delivery in every school in Nova Scotia.

This curriculum should particularly

- provide accurate and up-to-date information on HIV/AIDS, including its relationship with sex and sexuality
- provide French language resource materials on HIV/AIDS for francophone and French immersion schools
- provide culturally relevant approaches and resources for African Nova Scotian, Aboriginal, and new immigrant students
- support successful peer education models
- provide complementary opportunities and resources for parents and community educators to discuss HIV/AIDS and sexuality with children and youth

b) **Make teaching the updated sexual health curriculum a priority within the school system.**

The Nova Scotia Department of Education and the Regional School Boards should make the teaching of this sexual health curriculum a priority within the school system.

Consultations with stakeholders indicate that there is a clear need to foster a common understanding of a harm reduction approach among all partners in Nova Scotia.

Recommended Action #3.4

Develop and implement a comprehensive prevention strategy that includes initiatives based on a harm reduction approach for different populations within a variety of service settings. [This includes a network of anonymous testing services, access to barrier prevention methods, needle exchange programs, and methadone maintenance treatment services in both community and correctional facilities.] *(Note: This was identified as a priority action for first stage of implementation.)*

The Nova Scotia Department of Health, in partnership with the District Health Authorities and other relevant stakeholders, should take the lead in developing and implementing a comprehensive prevention strategy that includes initiatives based on a harm-reduction approach. This strategy would establish a continuum of services throughout Nova Scotia to prevent the spread of HIV and other blood-borne pathogens, as well as reduce other harms associated with high-risk behaviours.

The prevention strategy should be adopted in various service settings throughout the province including, but not be limited to

- adult and youth correctional facilities, and release transition programs
- community-based services and/or outreach services to vulnerable populations
- services for Aboriginal people, African Nova Scotians, new immigrants, and out-of-school youth
- women's facilities (e.g., shelters, prenatal clinics)
- social service agencies
- youth/teen health wellness centres and clinics
- community health facilities

The range of province-wide prevention and harm-reduction services should include, but not be limited to

- discrete access to various types of barrier prevention methods (e.g., male and female condoms, dental dams) at various service sites (provided free if possible)
- an integrated network of anonymous testing sites that meet criteria established by the Provincial Anonymous Testing Steering Committee (see Appendix C)
- needle exchange programs with peer-based delivery and support
- an accessible continuum of methadone services for opioid users that provide or facilitate access to supportive counselling, educational programming, community-based services, and primary health care

The services based on prevention and a harm reduction approach should address

- seamless and coordinated delivery of supports and services (e.g., inmates in transition from the community to correctional facilities, and back into the community upon release)
- peer-based prevention and education programming
- outreach services for the most vulnerable populations
- ongoing program evaluation, dissemination, and uptake of results
- ongoing staff and client (e.g., inmate) training on the harm-reduction philosophy, sensitivity to affected populations, universal precautions for blood-borne pathogens, etc.
- collaboration among service-providers and with the community.

Recommended Action #3.5

Develop and deliver a collaborative awareness campaign to provide the public with information on HIV/AIDS. *(Note: This was identified as a priority action for first stage of implementation.)*

The Nova Scotia Department of Health should take the lead in developing and delivering a collaborative awareness campaign to provide the public with information on HIV/AIDS.

Desired outcomes of the public awareness campaign are

- increased awareness that the HIV epidemic remains a significant public health issue
- increased healthy sexual behaviour
- positive attitudes and beliefs towards those infected and affected with HIV, so that stigmatization and discriminatory action against PHAs, their advocates, and caregivers are reduced
- tolerance and respect for self and others
- public involvement in HIV/AIDS education and community activities (e.g., AIDS Walk)
- recognition of the various "communities" and individuals who have contributed to the AIDS movement.

Special initiatives should continue (e.g., AIDS Awareness Week/World AIDS Day, media events) while a more comprehensive campaign is being developed.

Recommended Action #3.6

Hold a forum with provincial and local media outlets about informing the public about HIV/AIDS in a positive manner.

The Nova Scotia Advisory Commission on AIDS should invite the School of Journalism at the University of King's College to co-host a forum with provincial and local media outlets to look at ways for being a greater resource in informing the public about HIV/AIDS in a positive manner.

Particular areas for the media to address are

- using media opportunities to positively address HIV/AIDS issues (e.g., medical breakthroughs, personal stories)
- increasing the sensitivity of media staff with respect to racism, sexism, homophobia, and HIV/AIDS
- addressing the sensational coverage of HIV/AIDS issues in general and in particular of persons living with HIV/AIDS

3.8. Strategic Direction #4: Build a coordinated approach to care, treatment, and support services

A co-ordinated approach to care, treatment, and support will ensure that people with HIV/AIDS have equitable and seamless access to services; that models and tools are available for individualized treatment and case management; that treatment strategies are centred on quality of life as well as survival; and that all PHAs have access to treatment trials available in Canada.

In the 1999 consultations, concern was expressed about the many barriers to adequate access to treatment, such as third party insurance funding; lengthy waiting lists; misinformed or judgmental health care and/or social service providers; fear of disclosure of HIV status; and lack of availability of some medical and health care services in all areas of Nova Scotia. We must remove systemic barriers to access to care, treatment, and support especially for vulnerable populations.

We must also address illegal drug use as a health and social issue. PHAs need increased access to care, treatment, and support services for problems associated with substance use and mental health issues.

In addition, the recruitment and retention of individuals across all sectors who have expertise in HIV/AIDS, intersectoral collaboration, and an understanding of the determinants of health is required.

Recommended Action #4.1

Establish a seamless continuum of care, treatment, and support services (including improving accessibility to existing and new programs) for PHAs using a case management approach.

The District Health Authorities, in collaboration with the Nova Scotia Departments of Health and Community Services and other appropriate partners, should lead the establishment of a seamless continuum of care, treatment, and support services (including improving accessibility to existing and new programs) for PHAs using a case management approach.

This continuum of services for PHAs should include, but not be limited to:

- Provision of timely and equitable access to services that would
  - remove barriers in accessing care, treatment, and support for PHAs who live outside Halifax Regional Municipality (e.g., travelling clinic, telemedicine, transportation services, etc.)
  - remove barriers to Aboriginal PHAs for accessing services (e.g., funded home care, transportation, and medications)
  - remove barriers for women accessing services by recognizing their unique risk factors, diagnosis, and side effects (e.g., disease manifestation and treatment effects)
  - ensure that all PHAs feel comfortable accessing services, regardless of sexual orientation
  - ensure easier access to primary care physicians who are knowledgeable and comfortable with HIV/AIDS

support

- Support for medication needs that would
  - provide PHAs, who either are presently employed or returning to work, access to provincial pharmacare drug cards when workplace and/or private drug plans are inadequate or not available
  - make HIV/AIDS medications more accessible province-wide (e.g., through depots or specific physicians)
  - ensure provincial coverage of all federally approved HIV/AIDS medications
  - ensure no provincial caps are placed on HIV/AIDS medications as drug therapy and associated costs change
  - recognize the need to financially support PHAs in accessing medications and alternatives to control side effects of HIV medications (e.g., nausea, diabetes, risk for heart disease)
  - enable all PHAs access to treatment trials available in Canada
- Support for programs and services that encompass an holistic approach to health, such as
  - broadly accessible programs that focus on fitness, nutrition, and other needs of PHAs (e.g., to prevent muscle atrophy)
  - recognition of medication side effects and other emerging medical complications, plus the need to coordinate treatment
  - support for traditional, alternative, and cultural-specific healing methods and making them more accessible to Aboriginal PHAs and others wishing the services.
- Income security programs, such as social assistance coverage, with increased flexibility to accommodate inflation and the individual needs of PHAs
- A continuum of affordable housing, home care support, hospice, and palliative care options

We must remove systemic barriers to access to care, treatment, and support especially for vulnerable populations.

Recommended Action #4.2

Examine and, where necessary, develop, enhance, and promote supportive workplace programs to cover PHAs continuing and/or returning to employment.

The Nova Scotia Department of Environment and Labour, in partnership with the Nova Scotia Public Service Commission, should take the lead in working with the government and private sectors to examine their supportive workplace programs and, where necessary, address factors that facilitate PHAs continuing and/or returning to employment.

The supportive workplace programs would be supported by, but not limited to
- policies supporting and enabling PHAs to continue to work (including reasonable accommodation and flexible work arrangements)
- policies addressing occupational health and safety issues around HIV
- employee education, regulatory safeguards and training for managers and supervisors that would counter discrimination and address underlying factors contributing to workplace discrimination around issues of HIV, sexual orientation, and other factors linked to AIDS
- enforceable regulations and laws against discrimination

Recommended Action #4.3

a) **Approve and implement the existing draft policy on blood-borne pathogens for children in care.**

The Nova Scotia Department of Community Services should approve and implement the existing draft blood-borne pathogens policy for children in care.

b) **Provide HIV/AIDS education to child welfare staff and foster parents throughout the province to support the policy.**

The Nova Scotia Department of Community Services and Mi'kmaq Child and Family Services should provide HIV/AIDS education to child welfare staff and foster parents throughout the province to support the policy.

Recommended Action #4.4

Provide coordinated care for PHAs with mental health, substance use, and/or gambling issues by increasing access to care, treatment, and support programs and coordinating these services with ongoing HIV care, treatment, and support services. *(Note: This was identified as a priority action for first stage of implementation.)*

Mental Health Services (Nova Scotia Department of Health), in partnership with Addiction Services (Office of Health Promotion) and the District Health Authorities, should take the lead to provide coordinated care for PHAs by:

- increasing access to care, treatment, and support programs and services for PHAs with mental health issues
- increasing access to care, treatment and support programs and services for PHAs with problems associated with substance use and/or gambling
- coordinating mental health and addiction services with the ongoing HIV care, treatment, and support services for PHAs

These services should apply to personal support networks (e.g., families, partners, friends) of PHAs.

Recommended Action #4.5

Develop/enhance, promote, and support a multi-disciplinary HIV/AIDS curriculum for all care providers while they are in training and/or in professional development programs.

The Nova Scotia Department of Health should convene a meeting with a broad representative group of health and other professionals and educational institutions to develop/enhance, promote, and support a multi-disciplinary HIV/AIDS curriculum for all care providers while they are in training and/or in professional development programs.

The goal of this curriculum will be to build and/or augment the competencies of student and/or current care providers relative to

- the changing nature of the epidemic and progression of HIV infection
- the needs of affected populations and/or the most vulnerable to HIV/AIDS
- the root causes of vulnerability to HIV/AIDS

The training and professional development will cover areas around HIV/AIDS such as

- harm reduction, sexuality, homophobia, and populations at risk
- sensitivity on issues of sexual orientation, socio-ethnic background, gender, vulnerability, etc.
- ethical and legal obligations around confidentiality and disclosure (while addressing systemic barriers to information sharing that impede the delivery of service and good practice)
- the importance of community-based care and support network(s) in treatment planning for PHAs
- mental health needs of PHAs
- case management guidelines.

The scope of care providers should range from PHA's friends and family, community-based volunteers, social services, health services, institutional support services, first responders, etc. The curriculum should be designed so that it is multi-disciplinary and prepared for the various knowledge and skill levels required by the scope of the various care providers.

In the 1999 consultations, concern was expressed about the many barriers to adequate access to treatment.

A co-ordinated approach to care, treatment, and support will ensure that people with HIV/AIDS have equitable and seamless access to services.

Recommended Action #4.6

Develop/enhance a protocol for the support and advocacy for PHAs based on the Cancer Care Nova Scotia patient navigation model. *(Note: This was identified as a priority action for first stage of implementation.)*

The AIDS Coalition of Nova Scotia, in partnership with the Nova Scotia Advisory Commission on AIDS, District Health Authorities, and health and other professional associations, should take the lead to develop/enhance a protocol for the support and advocacy for PHAs, based on the Cancer Care Nova Scotia patient navigation model.

The patient support and advocacy protocol would

- encourage physicians, social workers and all others in the broad case management system to recognize patient support and advocacy needs
- foster, accept, and encourage significant others, supportive individuals, care givers, and advocates to participate in the treatment and care plans of PHAs as desired by the PHAs
- establish support networks for families and caregivers of PHAs so they may access ongoing support and assistance
- support advocacy towards facilitating access for PHAs to ensure that they receive the necessary services and support (e.g., patient navigator within the system, an ombudsman outside the system)

Recommended Action #4.7

Examine the guidelines for insurance coverage of HIV/AIDS cases including illness/disability benefit policies and programs, third party insurance coverage, and the appeal process.

The Nova Scotia Advisory Commission on AIDS should work with the Canadian AIDS Society, the Canadian Life and Health Insurance Association, Inc., and the Provincial/Federal Superintendents of Insurance to examine the guidelines for coverage of HIV/AIDS cases in light of the changing nature of the disease.

In particular, the review should examine, but not be limited to, the following:

- illness/disability benefit policies and programs to ensure they incorporate the characteristics and implications of HIV/AIDS in policies, guidelines, and regulations addressing disabilities (PHAs should be able to avail themselves of rights and benefits similar to those available to persons with disabilities and/or other chronic diseases.)
- third party insurance coverage, to explore with third party insurers the development of provincial standards and policies that would facilitate coordinated and seamless funding coverage between government and non-government-funded services; and examine educational opportunities for both providers and recipients about standards and policies concerning third party funders
- appeal processes, to ensure there is consistency, simplicity, and information so that PHAs and their advocates can easily access the system

Recommended Action #4.8

Convene representatives of various faith communities to discuss increasing the involvement of spiritual care organizations and faith communities in providing a caring and supportive environment for PHAs, their families, and their support networks.

The Nova Scotia Advisory Commission on AIDS should take the lead in convening representatives of various faith communities to discuss and explore ways to increase the involvement of spiritual care organizations and faith communities in providing a caring and supportive environment for PHAs, their families, and their support networks. This outreach should include initiatives for those population groups vulnerable to HIV and stigmatized by HIV/AIDS.

Recommended Action #4.9

Develop policies and/or programming to protect children diagnosed with HIV/AIDS.

Recognizing that the needs of HIV+ children and youth are different from adults, that the Nova Scotia Department of Community Services in collaboration with the Nova Scotia Human Rights Commission should develop policies and/or programming to protect children diagnosed with HIV/AIDS.

The scope of this initiative should assist parents, children and youth, educators, and other care givers regarding consent, disclosure, care, treatment, support, etc., for HIV+ children and youth.

3.9. Critical Success Factors for the Strategy

Throughout the consultation processes used to develop the Strategy, representatives of community-based organizations identified the following factors as critical to the success of the Strategy:

1. HIV/AIDS must be placed in the broader context of the determinants of health.
2. HIV/AIDS prevention must be emphasized for all Nova Scotians, particularly those most vulnerable.
3. A continuum of sustainable, culturally appropriate HIV/AIDS services (prevention, care, treatment, and support) must be provided in each area of Nova Scotia.
4. The provincial government must recognize the role and importance of community-based partners in responding to HIV/AIDS. The work of community-based organizations and affected populations needs to be supported and adequately funded.
5. All sectors of government must demonstrate a solid commitment to the recommended actions outlined in the Strategy.
6. The provincial government must ensure coordination and collaboration across all levels and departments of government.
7. Adequate funding must be provided to implement the recommended actions in the Strategy.

4. Overview of the Recommended Actions

This section presents a high level summary view of all of the recommended actions in a table. The table identifies the proposed lead agency[3] as well as other potential partners for each recommended action. Because it is not possible to work on all the recommended actions at the same time, six have been proposed as priorities for the first stage of implementation. These six priorities are identified with an asterisk (*).

Strategic Direction # 1: Mobilize Integrated Action on HIV/AIDS

Recommended action #	Recommended action	Proposed Lead	Proposed Partners
1.1	Foster a broad community-based health system using a population health approach for Nova Scotians who are vulnerable to HIV infection.	Nova Scotia Department of Health	District Health Authorities, Regional Community Services, various population groups, other chronic disease groups
*1.2	Allocate sufficient and stable funding sources for community-based HIV/AIDS programming.	Nova Scotia Department of Health	Community-based AIDS organizations, other Community-based organizations, Aboriginal leaders, federal and provincial healthcare funding structures, youth wellness and/or teen health centres/clinics

[3] A "lead" organization has been identified for each of the recommended actions. Depending on the nature and comprehensiveness of a particular recommended action, responsibilities of the lead organization could range from facilitating the development of work plans (e.g., organizing a stakeholders' meeting to initiate planning process) to having primary responsibility for addressing the recommended action. The identified leads will also be invited to participate on an appropriate intersectoral working group.

Strategic Direction # 2: Build a Broad Research and Information Sharing Strategy

Recommended action #	Recommended action	Proposed Lead	Proposed Partners
2.1a	Develop an HIV/AIDS research agenda for Nova Scotia as part of a broader national (and/or global) HIV/AIDS research agenda.	AIDS Coalition of Nova Scotia	Funding bodies, academic and community researchers, community groups, government
2.1b	Strengthen the HIV/AIDS research process.	AIDS Coalition of Nova Scotia	Funding bodies, academic and community researchers, community groups, government, rural communities, local services and partnerships
2.1c	Enhance HIV/AIDS research programs by adopting a population health approach.	AIDS Coalition of Nova Scotia	Funding bodies, academic and community researchers, community groups, government
*2.2	Determine the validity and feasibility of collecting and identifying HIV/AIDS surveillance data for African Nova Scotians, Aboriginal people, and new immigrant communities.	Office of the Provincial Medical Officer of Health	District Medical Officers of Health, specific ethno cultural communities, physicians, other health professionals

Strategic Direction #3: Build a Coordinated Approach to Prevention and Harm Reduction

Recommended action #	Recommended action	Proposed Lead	Proposed Partners
3.1a	Facilitate the creation of safe, supportive educational environments for both students and staff in public schools.	Nova Scotia Department of Education	Regional School Boards
3.1b	Facilitate the creation of safe, supportive educational environments for both students and staff in Community Colleges.	Nova Scotia Community Colleges	
3.1c	Facilitate the creation of safe, supportive educational environments for both students and staff in universities.	University Student Services and/or Student Councils	
3.2	Develop a training strategy for on-going support and professional development of teachers responsible for delivering the sexual health component of the public school curriculum.	Nova Scotia Department of Education	Nova Scotia Teacher preparation faculties, Regional School Boards
3.3a	Update and provide a healthy sexuality curriculum (including HIV/AIDS, sexism, racism, and homophobia within the context of healthy living) for delivery in every school in Nova Scotia.	Nova Scotia Department of Education	Regional School Boards, Public Health Services, District Health Authorities
3.3b	Make teaching the updated sexual health curriculum a priority within the school system.	Nova Scotia Department of Education	Regional School Boards

Strategic Direction #3: Build a Coordinated Approach to Prevention and Harm Reduction

Recommended action #	Recommended action	Proposed Lead	Proposed Partners
*3.4	Develop and implement a comprehensive prevention strategy that includes initiatives based on a harm-reduction approach for different populations within a variety of service settings. (This includes a network of anonymous testing services, access to barrier prevention methods, needle exchange programs, and methadone maintenance treatment services in both community and correctional facilities.)	Nova Scotia Department of Health	District Health Authorities, service setting stakeholders, Provincial Anonymous Testing Steering Committee
*3.5	Develop and deliver a collaborative awareness campaign to provide the public with information on HIV/AIDS.	Nova Scotia Department of Health	
3.6	Hold a forum with provincial and local media outlets about informing the public about HIV/AIDS in a positive manner.	Nova Scotia Advisory Commission on AIDS	School of Journalism at the University of Kings College, local and provincial media outlets

Strategic Direction # 4: Build a Coordinated Approach to Care, Treatment, and Support Services

Recommended action #	Recommended action	Proposed Lead	Proposed Partners
4.1	Establish a seamless continuum of care, treatment, and support services (including improving accessibility to existing and new programs) for PHAs using a case management approach.	District Health Authorities	Nova Scotia Department of Health, Nova Scotia Department of Community Services, various appropriate partners
4.2	Examine and, where necessary, develop, enhance and promote supportive workplace programs to cover PHAs continuing and/or returning to employment.	Nova Scotia Department of Environment and Labour	Nova Scotia Public Service Commission
4.3a	Approve and implement the existing draft policy on blood-borne pathogens for children in care.	Nova Scotia Department of Community Services	
4.3b	Provide HIV/AIDS education to child welfare staff and foster parents throughout the province to support the policy.	Nova Scotia Department of Community Services	Addiction Services (Office of Health Promotion), District Health Authorities
*4.4	Provide coordinated care for PHAs with mental health, substance use and/or gambling issues by increasing access to care, treatment, and support programs and coordinating these services with ongoing HIV care, treatment, and support services.	Mental Health Services (Nova Scotia Department of Health)	

Strategic Direction # 4: Build a Coordinated Approach to Care, Treatment, and Support Services

Recommended action #	Recommended action	Proposed Lead	Proposed Partners
4.5	Develop/enhance, promote, and support a multi-disciplinary HIV/AIDS curriculum for all care providers while they are in training and/or in professional development programs.	Nova Scotia Department of Health	Health professional associations, health professional education institutions
*4.6	Develop/enhance a protocol for the support and advocacy for PHAs based on the Cancer Care Nova Scotia patient navigation model.	AIDS Coalition of Nova Scotia	Nova Scotia Advisory Commission on AIDS, District Health Authorities
4.7	Examine the guidelines for insurance coverage of HIV/AIDS including illness/disability benefit policies and programs, third party insurance coverage, and the appeal process.	Nova Scotia Advisory Commission on AIDS	Canadian AIDS Society, Canadian Life and Health Insurance Association, Inc., Provincial/Federal Superintendents of Insurance
4.8	Convene representatives of various faith communities to discuss increasing the involvement of spiritual care organizations and faith communities in providing a caring and supportive environment for PHAs, their families, and their support networks.	Nova Scotia Advisory Commission on AIDS	Various faith communities
4.9	Develop policies and/or programming to protect children diagnosed with HIV/AIDS.	Nova Scotia Department of Community Services	Nova Scotia Human Rights Commission

5. Implementation Plan

5.1. Overview of Implementation Plan

In order for the Strategy to be effective, it must be implemented in a timely and effective manner. To ensure the successful implementation of the recommended actions, three additional recommended actions in this section address the need for overall leadership and accountability for implementation, evaluation, and updating the Strategy.

Processes and mechanisms are outlined for developing overall action plans for each of the four strategic directions; monitoring and reporting on progress and milestones achieved; adjusting action plans as needs change; and ensuring action plans will be implemented. Decision-making structures and authority necessary to support resolution of issues are included. It is also important that work plans to address each recommended action are put in place and include objectives, resources (current and needed), expected outcomes, success indicators, timelines, and an evaluation plan.

Enabling key stakeholders to participate effectively requires the following:

- a lead agency for overall responsibility and accountability for implementation of each recommended action
- implementation, monitoring and evaluation, and updating of the strategy
- intersectoral working groups to support development of implementation plans
- support and capacity building for the provincial, district, and community partners to work together to implement the Strategy

This Strategy is an iterative "living" document and will be continuously reviewed and updated. Needs and priorities may change and new, more pressing, needs may emerge, or alternative strategies may be chosen to meet the objectives.

5.2. Recommended Actions for Implementation of the Strategy

5.2.1. Monitoring and Updating the Strategy

a) **The Nova Scotia Advisory Commission on AIDS should provide the leadership for Nova Scotia's Strategy on HIV/AIDS by**
   - monitoring the implementation of recommended actions
   - reporting annually to stakeholder groups and the public on the progress of the Strategy's implementation
   - compiling the results of needs assessments and evaluations conducted by stakeholders into an overall evaluation report
   - maintaining contact with PHAs, community-based AIDS organizations, government departments, and other stakeholders on issues related to HIV/AIDS
   - updating the Strategy as needs change and/or as evaluations indicate, and producing a status report and updated Strategy by 2007

b) Individuals who represent the diverse nature of HIV and the province should be encouraged to apply for appointment to the Commission.

5.2.2. Coordination of the Implementation Process

a) **The Nova Scotia Advisory Commission on AIDS will form four intersectoral working groups, one for each of the strategic directions identified in the Strategy.** These working groups will provide support to stakeholders to address the recommended actions within each strategic direction. The working groups will include the following members:
   - representatives of community-based AIDS organizations, community/population groups, and other stakeholders identified as the lead for the recommended actions within each strategic direction who will be invited to participate on relevant working groups
   - all relevant provincial government departments and commissions who will be invited to appoint a senior policy staff member and/or program manager(s) as representatives to the appropriate working group(s). These government representatives will report regularly to their respective Deputy Ministers on activities related to their jurisdiction

b) Under the auspices of the Nova Scotia Advisory Commission on AIDS, the Chairs of the four working groups should meet on a regular basis to facilitate development of and oversee the implementation of action plans for the four strategic directions.

c) The Office of the Nova Scotia Advisory Commission on AIDS will
   - provide secretariat support for the working groups
   - provide information and support to assist the working groups with the intersectoral collaboration process
   - use its research capacity and resource library to support Strategy-related initiatives

d) The working groups should work closely with existing committees and groups working on issues that are relevant and/or similar to addressing aspects of the Strategy. This would involve identifying and building on the work of existing groups and organizations and/or, where warranted, encouraging the creation of supporting structures (e.g., a regional interagency committee on health and social issues).

e) The working groups and other relevant committees and/or groups should work closely with any specific population group(s) (e.g., Health Association of African Canadians) who may be developing and implementing HIV/AIDS action plans to address the needs of that population or community.

5.2.3. Capacity Building and Resources for Implementing the Strategy

a) **Capacity building of community-based organizations and government partners, including both staff and volunteers, should be recognized as a key component in the implementation of the Strategy.**

Capacity building includes among other things:

- having sufficient financial resources and stability
- having ongoing staff and volunteer training, supports, and recognition
- understanding population health and intersectoral collaboration philosophy and processes
- developing culturally, socially or population-specific HIV/AIDS resources, training, education, and treatment programs
- including vulnerable populations in program design and implementation
- understanding equity and the removal of program and systemic barriers
- understanding and using community involvement/development philosophies
- informing and involving the public in the implementation process
- participating in public policy

b) The working groups should identify priorities, activities, and resources required for implementing each recommended action of the Strategy. The resources will be identified as being either from existing programs or budgets or as new/additional resources for the relevant organizations, institutions, and government departments.

c) All relevant organizations, institutions and government departments should consider the new or additional resources required for implementing the recommended actions in their budget preparations for fiscal 2004–05 and beyond.

d) The Nova Scotia Department of Health should provide funds in their 2004–05 budget for the coordination of the Strategy implementation process to ensure appropriate inter-governmental and community participation.

5.3. Roles and Responsibilities

Roles and responsibilities of key organizations or sectors necessary for effective implementation of the Strategy are outlined in Appendix D. The roles and responsibilities for each organization/sector are as the Steering Committee has envisioned them to be, not necessarily as they currently exist. Discussing and confirming these roles and responsibilities, and securing support and commitment of key stakeholders within these organizations, is a critical step for implementation of the Strategy. It is expected that all partners will cooperate and collaborate on HIV/AIDS related activities, share resources where appropriate, and identify key issues and priorities from their perspective.

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6. Next Steps

Embracing a framework of population health and social justice, the following next steps are required to develop mechanisms and strategies to address the recommended actions:

1. Communicate the Strategy

The Provincial HIV/AIDS Strategy Steering Committee will implement a communication plan to disseminate the Strategy to stakeholders and the general public. The plan includes key messages and activities (e.g., press release, presentations) to communicate and secure support for the Strategy from multiple sectors including policy makers and politicians, media, other stakeholder groups, and the general public.

2. Establish Intersectoral Working Groups

The Nova Scotia Advisory Commission on AIDS will establish four intersectoral working groups for each strategic direction to facilitate the development of actions plans to address the recommended actions.

The Nova Scotia Advisory Commission on AIDS will be responsible for contacting representatives of organizations identified as a lead for each of the recommended actions to facilitate the formation of the working groups. These lead stakeholders may identify and invite potential representatives from other stakeholder groups to participate on the appropriate working group, if required.

The four working groups will identify and seek participation of groups and individuals working on similar initiatives and issues related to each strategic direction.

3. Identify and Seek Participation of Related Committees and Population/Community Groups

It is critical that partnerships are developed with existing committees and population/community groups working on similar or relevant issues to build on and share expertise and resources, and avoid duplication of work. The four working groups will identify and seek participation of groups and individuals working on similar initiatives and issues related to each strategic direction.

The Strategy also supports Aboriginal organizations, and other groups in Nova Scotia, in developing population-specific strategies or approaches for addressing HIV/AIDS-related issues in a way that is responsive to and respectful of the needs and culture of their respective communities. Aboriginal stakeholders have already initiated discussions on roles and responsibilities for providing HIV/AIDS prevention and support programs to enhance existing services and close the gaps on services not yet in place. The overall goal is to develop an Atlantic Aboriginal HIV/AIDS Strategy. Steps for initiating a process to develop this Strategy have been outlined (see Appendix E).

4. Develop an Action Plan for Each Strategic Direction Including Assessing Existing and Leveraging Additional Resources

Once working groups are established, their first responsibility will be to develop an overall action plan for each strategic direction in consultation with relevant partners. Action plans will prioritize the recommended actions; articulate objectives, expected outcomes, and success indicators; identify required resources (existing and/or additional) and timelines; and state how the plan will be evaluated.

As previously indicated, because it is not possible to address all 19 recommended actions at the same time, the Steering Committee have proposed six as priorities for the first stage of implementation. However, the working groups may also select different or additional priority recommendations for the first stage of implementation. The six recommended actions are as follows:

- Allocate sufficient and stable funding sources for community-based HIV/AIDS programming (#1.2).
- Determine the validity and feasibility of collecting and identifying HIV/AIDS surveillance data for African Nova Scotians, Aboriginal people, and new immigrant communities. (#2.2).
- Develop and implement a comprehensive prevention strategy that includes initiatives based on a harm-reduction approach for different populations within a variety of service settings (#3.4). (This includes a network of anonymous testing services, access to barrier prevention methods, needle exchange programs, and methadone maintenance treatment services in both community and correctional facilities.)
- Develop and deliver a collaborative awareness campaign to provide the public with information on HIV/AIDS (#3.5).
- Provide coordinated care for PHAs with mental health, substance use, and/or gambling issues by increasing access to care, treatment, and support programs and coordinating these services with ongoing HIV care, treatment, and support services (#4.4).
- Develop/enhance a protocol for the support and advocacy for PHAs based on the Cancer Care Nova Scotia patient navigation model (#4.6).

5. Refine Mechanisms for Monitoring, Reporting, and Evaluation

The Nova Scotia Advisory Commission on AIDS has overall responsibility for monitoring implementation of the Strategy, annual reporting on progress to partners, stakeholders, and the public as well as conducting an on-going evaluation of overall implementation and outcomes.

In addition to annual reporting and updating, the first major evaluation and revision of the Strategy will occur in approximately four years after its release, in 2007.

Stakeholders working on individual recommended actions will be encouraged to evaluate their work; results of these individual evaluations will be provided to the Nova Scotia Advisory Commission on AIDS to be included in the overall evaluation report. A process to collect evaluation results of individual initiatives will need to be put in place.

7. Concluding Remarks

Much has been accomplished in addressing HIV/AIDS in Nova Scotia. However, despite advances in knowledge about how to prevent the spread of HIV and care for those infected, the virus continues to flourish, particularly in an environment of social and economic marginalization and vulnerability. More needs to be done to reduce this vulnerability to HIV/AIDS in Nova Scotia.

This document presents a renewed provincial plan to address HIV/AIDS using a population health approach. There is compelling evidence of the relationship between HIV/AIDS and the broad determinants of health [5]. Intersectoral partnerships must be developed and/or enhanced with government, community, and other stakeholders to reduce inequities that lead to or exacerbate the impact of HIV/AIDS on individuals and communities. Commitment at the most senior levels of government to both the Strategy and to partnership with community stakeholders is essential.

Although the current fiscal environment and systemic issues will continue to present challenges, involving all Nova Scotians and remaining responsive and flexible to changing needs and priorities will lead to the reduction and effective management of HIV/AIDS in this province. It should be recognized that many of the recommended actions within the Strategy are not new to Nova Scotia, or specific only to HIV/AIDS. Addressing the need to make systemic changes in the way Nova Scotians participate in and receive *health care* will not only reduce the spread of HIV and provide effective care management to those already infected, but will address issues affecting many other disease areas and their root causes.

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Appendices

Appendix A: Glossary

Aboriginal Nova Scotians
Refers to persons living in Nova Scotia who self-identify as Métis, First Nation, or Inuit, and are of historic First Nation, Inuit, or Métis Nation Ancestry. An Aboriginal person may be status or non-status, and live on or off reserve.

Accessibility
Refers to timely access, without financial or other barriers, to medical or other necessary services. This does not mean immediate access or access that is limited to life-threatening situations; rather it means that service is provided consistent with practice guidelines that ensure that patient/client health is not negatively affected while waiting for care or service [29].

Acquired Immune Deficiency Syndrome (AIDS)
The weakening of the body's immune system by *Human Immunodeficiency Virus (HIV)* (see definition), which permits opportunistic, life-threatening infections to develop. Typical infections include pneumonia, neurological disease, wasting, and cancer, particularly Kaposis sarcoma.

Antiretroviral Therapy (ART)
Drugs that inhibit HIV replication within the immune system in order to slow or reverse disease progression and/or restore immune function. HIV belongs to a group of viruses called retroviruses; therefore, these drugs are called antiretrovirals (ART). A combination of at least three ART drugs or Highly Active Antiretroviral Therapy (HAART) is considered the best way to treat HIV effectively, which is commonly referred to as a drug cocktail or combination therapy. In 2002, there were at least 16 antiretroviral drugs available in Canada.

Blood-borne Pathogens
Pathogenic micro-organisms that are present in human blood and blood products and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus (HCV), and HIV.

Canadian Strategy on HIV/AIDS (CSHA)
Released in 1998, it is the federal government's on-going plan for meeting the challenges of the HIV/AIDS epidemic across Canada and is grounded within a *population health approach* (see definition). The CSHA replaced the National AIDS Strategy I (1990–93) and National AIDS Strategy II (1993–98).

Capacity Building
Strengthening the ability of people, communities, groups, and systems to plan, develop, implement and maintain effective health and social approaches. It can include learning new skills; collaborating with other groups or sectors to share knowledge and resources; institutional and legal reforms; and direct provision of resources (e.g., money, staff, office, space, expertise) [30].

Community HIV/AIDS Stakeholders
For the purposes of this document, refers to not-for-profit and/or voluntary community and/or provincial organizations with a mandate primarily focussed on and/or related to HIV/AIDS (e.g., service provision to PHAs, public education, policy advice). It also includes PHAs, their caregivers and advocates, community leaders (non-government), volunteers, and other interested individuals from the public.

Community-based AIDS Organization
Non-profit organizations that provide information and education to PHAs and the general public, and who assist PHAs with life skills development, financial planning, housing, and care and support.

Community-based Health System
Assures input of communities in identifying and planning strategies and services to improve the health status of the population. It also ensures that teams of providers participate in carrying out these strategies and services at the community level.

Determinants of Health
The entire range of individual and collective factors and conditions – and their interactions – that have been shown to be correlated with health status of both individuals and populations. These factors include income and social status, social support networks, education, employment and working conditions, physical environment, biology and genetic endowment, personal health practices and coping skills, healthy child development, health services, gender, and culture [6].

Discrimination (AIDS related)
Any measure entailing arbitrary distinction among persons depending on their confirmed or suspected HIV serostatus or state of health, as well as those who care and/or advocate for PHAs. It can have an adverse impact on any area of a person's life including housing, employment, access to health care, and access to public services. Discrimination can take place in many shapes and forms; it can be an overt act or subtle. This includes irrational or negative attitudes such as *homophobia* (see definition) and fear of PHAs [31].

Ethnocultural populations
Ethnic origin refers to the country and/or background where a person and/or their ancestors were born. It includes new immigrants to Canada, as well as ethnic background. Ethnic background also refers to cultures such as Acadians in Nova Scotia, *Aboriginal Nova Scotians*, and African Nova Scotians [32].

Equity (in health)
Refers to a state where all people have an equal opportunity to develop and maintain their health through fair and equal access to resources for health. Inequities in health status occur as a consequence of differences in opportunity that result from, e.g., unequal access to health services, inadequate housing, and other social and economic factors [33].

Harm Reduction
Harm reduction is part of a public health approach addressing harmful behaviours that result in various "harms" or risks to individual and communities, including the spread of *blood-borne pathogens*. It places first priority on reducing the negative health, social, and economic consequences of the behaviour affecting the individual, community, and/or society, rather than on eliminating the behaviour. A key feature of services based on a harm reduction approach is the individual's right to choose the place on a "continuum" that reflects degree of readiness or ability to reduce or eliminate the behaviour of concern. Any reduction in harm, no matter how small, is considered positive.

Holistic Health Approach
An approach that looks at health as a balanced state of physical, emotional, mental, spiritual, social, and sexual well-being. It treats individuals as a whole person and uses various methods (including traditional medical and complementary therapies) to treat diseases and/or maintain optimal health [34].

Homophobia
Fear of, aversion to, or discrimination against homosexuals/bisexuals or homosexuality/bisexuality. "External" homophobia (coming from society) can be manifested in a number of ways based on actual or perceived sexual orientation such as denial of services, telling anti-gay jokes, and gay-bashing (violence). It may also be "internal" (within the individual), manifested by low self-esteem or feelings of shame because of one's sexual orientation/identity, and/or denial of one's sexual orientation/identity out of fear of and/or to avoid external manifestations of homophobia.

Human Immunodeficiency Virus (HIV)
HIV is the virus that causes AIDS. HIV infection occurs through exposure to infected blood or to bodily fluids in sufficient quantities. It may be transmitted through unprotected vaginal or anal sex (and to a lesser degree, oral sex) with an infected partner, sharing unsterile needles, receiving contaminated blood and blood products, getting injured by a unsterile needle, or being born to and/or breast fed by a woman infected with HIV.

Incidence of HIV/AIDS
The number of new cases of HIV/AIDS that have occurred within a specified population during a specified period of time (e.g., calendar year).

Injection Drug Users (IDUs)
People who take illicit drugs intravenously with a syringe or needle. Many IDUs share used, unsterilized needles placing them at high risk of transmitting or contracting HIV and other blood-borne pathogens.

Injection Drug Use(ing) (IDU)
Intravenous use of drugs via syringe or needle.

Integrated Health System
A health system that ensures coordination of services and allows providers to work together to improve the health status of the population.

Intersectoral Action
Joint action among health and other groups to improve health outcomes. As a key element of a *population health approach* (see definition), it calls for shared responsibility and accountability for health outcomes with groups and/or sectors (including government and community) not normally associated with health, but whose activities may have an impact on health or the determinants known to influence it [6].

Marginalization
A form of excluding persons and/or communities from the opportunity to participate in the economic and social benefits of society because of, for instance, poverty, illness, substance use, race, gender, sexual orientation, or lack of education. Those who are marginalized have no room for choice, are silent, have little or no resources/capacity to support involvement in decision-making (at individual and/or societal level) or contribute to community, have little or no access to programs and services, and are often institutionally dependent [35].

Men Who Have Sex With Men (MSM)
Men who report either homosexual or bisexual contact. The term "MSM" is used to refer to men who identify as homosexual or bisexual, and men who have sex with men but do not identify as homosexual or bisexual.

Methadone
A synthetic drug used as a substitute narcotic in the treatment of opiate addiction. Methadone maintenance treatment falls under a harm reduction approach, although the tolerance level or threshold (to gain access to or remain in treatment) for using other non-prescription drugs varies depending on the goal of a particular program or service.

Needle Exchange
Refers to a range of programs that provide needle distribution and discard services, as well as other support services (e.g., food, counselling, prevention, and risk reduction) and referral to other relevant programs and services in the community. Needle Exchange services fall under a harm reduction approach.

Nova Scotia Advisory Commission on AIDS
Formed in 1988 and reporting to the Minister of Health, the Nova Scotia Advisory Commission on AIDS advises the provincial government on current and emerging HIV/AIDS issues; works with communities, agencies, and government representatives to support initiatives; helps to develop and revise policies; and provides a resource centre for the Commission, provincial government, AIDS organizations, and students doing research.

Persons Living with HIV/AIDS (PHAs)
Individuals who are living with HIV at any stage of infection, i.e., from initial infection, to development of symptoms and/or dealing with complications, to progression to AIDS.

Population Health Approach
An approach that aims to improve the health status of the entire population and reduce health inequities among population groups. In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions (i.e., the determinants of health) that have a strong influence on health, and places primacy on social justice values such as equity, accessibility, affordability, and respect for human rights in the provision of health care and social services. An underlying assumption of this approach is that reduction in health inequities requires reduction in material and social inequities. The outcomes or benefits of a population health approach, therefore, extend beyond improved population health outcomes to include a sustainable and *integrated health system*, increased national growth and productivity, and strengthened social cohesion and citizen engagement [6].

Prevalence of HIV/AIDS
The total number of cases of HIV/AIDS within a specified population at a particular time.

Sexually Transmitted Infection
Viral or bacterial infections (such as HIV, herpes, chlamydia, or syphilis) transmitted through intimate sexual contact [36].

Stigma (AIDS-related)
A powerful and discrediting social label that radically changes the way individuals view themselves and are viewed as persons. People who are stigmatized are usually considered deviant or shameful and, as a result, are shunned, discredited, rejected, or penalized [30].

Sustainability
The ability of a program, project, or system to continue and be effective over the medium to long term. It considers factors such as whether alliances have been built with relevant power structures or authorities, community support, whether local skills were developed, and if the activity has been integrated into existing activities that have proven longevity. In particular, it asks whether an activity will continue to be effective if it loses all or some external funding. In the long term, the fact that capacity has been built locally is an indicator of sustainability [37].

Vulnerable
To have little or no control over one's risk of acquiring HIV infection or, for those already infected with or affected by HIV/AIDS, to have little or no access to appropriate care or support. It takes into consideration the broad social, cultural, and economic factors that influence vulnerability to HIV/AIDS. Populations considered the most vulnerable to HIV/AIDS include IDUs, women in poverty, men who have sex with men particularly young gay men, Aboriginals, homeless/street-involved, prisoners, and sex trade workers [2]. (It is important to note that this does not imply that *all members* of a particular sub-population are more vulnerable to HIV/AIDS.)

Appendix B: Members of the Provincial HIV/AIDS Strategy Steering Committee

Members of the Provincial HIV/AIDS Strategy Steering Committee include representatives from the following organizations:
AIDS Coalition of Nova Scotia
Healing Our Nations (formerly the Atlantic First Nations AIDS Task Force)
Health Canada, Population and Public Health Branch, Atlantic Region
Nova Scotia Department of Health
Nova Scotia Advisory Commission on AIDS
Planned Parenthood Metro Clinic
Public Health Services (for South Shore Health, South West Health, Annapolis Valley Health Districts)

At various points in time, representatives of the following organizations also participated on the Steering Committee:
AIDS Coalition of Cape Breton
AIDS-LINK Spiritual Care
Canadian Aboriginal AIDS Network, Atlantic Region
Drug Dependency Services, Central Region (now Addiction Prevention and Treatment Services, Capital Health)
Infectious Disease Clinic, QEII Health Sciences Centre
Health Association of African Canadians
Mainline Needle Exchange
Truro and Area AIDS Outreach (now Northern AIDS Connection Society)

Appendix C: Criteria for Establishing Anonymous Testing Sites

Criteria for Site Selection

The Anonymous Testing Steering Committee developed the following criteria for site selection.

1. **Anonymity**
- anonymous (as perceived by the individuals who would be using the location)
- mechanisms in place to ensure ongoing anonymity even after last client contact (e.g., policies regarding staff confidentiality requirements)
- offers a multi-service environment

2. **Philosophy**
- recognition of integral nature of counselling
- willingness to follow provincial protocols including collection of necessary epidemiological information and to be involved in evaluation

3. **Responsiveness to Client Needs**
- involvement of local community in implementation
- able to offer flexibility in hours of operation (such as evenings)
- able to offer flexibility in meeting special needs of clients

4. **Accessibility**
- accessible to the region
- accessible to targeted groups

5. **Capacity**
- skilled individuals willing to deliver service
- able to handle the anticipated volume of tests
- ability to obtain and maintain expertise
- ability to provide efficient and cost-effective service delivery
- quality of service

Criteria for Counsellors

The anonymous testing site counsellor(s) should possess the following attributes:
- client-centred approach to health care
- unbiased positive approach to all clients regardless of gender, race, culture, sexual orientation, and other lifestyle factors
- considerable experience in counselling around sensitive issues
- excellent understanding of and positive approach to HIV/AIDS issues, including those issues facing injection drug users

If at all possible, it is recommended that the person who does the pre- and post-test counselling also be the person who draws the blood for the HIV test. This does not mean that the counsellor needs to be a nurse or a physician.

Criteria to Evaluate Proposals

Based on the information provided above, proposals for potential anonymous testing sites must satisfactorily address the following questions:

- Does the site have the capacity to ensure client anonymity at all times?
- Does the site meet all of the site selection criteria outlined previously?
- Does the site currently have staff that meet the criteria for counsellors?
- What mechanisms are in place to provide emotional support to the counsellors?
- What are the current target populations of the site, and how will the site encourage target populations for anonymous testing to access the site?
- Is the site knowledgeable about the needs of target populations for anonymous testing?
- What arrangements will be made for transporting blood specimens to the laboratory for testing?
- Does the site regularly solicit client feedback about site services?
- Is the proposed budget cost efficient and reasonable? Reflect actual cost of service delivery? Specify the amount of money being requested and/or how much will be covered by other resources (e.g., in kind)?
- Does staff have the capacity to participate in a coordinated evaluation of all regional sites? Is evaluation of the site incorporated into the work plan and budget?

Appendix D: Key Roles and Responsibilities for Nova Scotia Strategy on HIV/AIDS

Note: All partners will cooperate and collaborate in HIV/AIDS related activities, and determine issues and priorities from their perspective.

Community/Non-profit Organizations

Organization	Roles and Responsibilities
Persons Living with HIV/AIDS (PHAs)	• Provide personal input into the design, implementation, and evaluation of HIV/AIDS related policies services • Participate in HIV/AIDS-related activities relative to their own needs
Community-based HIV/AIDS organizations and related community-based organizations and services	• Provides education, training, and HIV testing • Participates in local, provincial, and federal policy development • Advises on HIV/AIDS and related issues • Provide support and advocacy for PHAs • Conduct community-based research
Faith Communities	• Provide a caring and supportive environment for PHAs, their families, and caregivers, especially for those most vulnerable to and/or stigmatized by HIV/AIDS

Government and Related Public Sector Organizations

Organization	Roles and Responsibilities

Nova Scotia Advisory Commission on AIDS	• Advises government on HIV/AIDS issues
	• Identifies emerging issues around HIV/AIDS and their implications for Nova Scotia
	• Provides leadership on implementation of the Strategy by:
	  • Monitoring/tracking implementation of the Strategy and producing annual report
	  • Producing overall evaluation report from needs assessments and evaluations conducted by stakeholders on annual basis or as required.
	  • Producing status report and updating strategy by 2007.

Office of Nova Scotia Advisory Commission on AIDS	• Provides secretariat support for the Nova Scotia Advisory Commission on AIDS and Strategy related working groups • Provides intersectoral coordination and liaison for implementation of the Strategy • Conducts research to support Strategy related initiatives • Maintains a resource library and acts as a clearinghouse on HIV/AIDS research and information
Nova Scotia Department of Health	• Provides government policy direction and priorities for HIV/AIDS • Funds District Health Authorities (DHAs) for delivery of programs and services recommended by the Strategy • Funds the Nova Scotia Strategy on HIV/AIDS • Monitors progress of implementation of the Strategy at DHA level • Provides HIV/AIDS education, prevention, training and conducts research • Facilitates capacity of DHAs to plan for and report on HIV/AIDS services as part of the accountability process • Collaborates with the federal government on HIV/AIDS initiatives • Maintains and reports on HIV/AIDS epidemiological surveillance data
Other Provincial Government Departments	• Incorporate appropriate Strategy recommended actions into their work plans • Monitor and reports progress on implementation to respective departments and/or Strategy related committees
Federal Government (Health Canada)	• Funds the Canadian Strategy on HIV/AIDS • Coordinates federal/provincial/territorial HIV/AIDS work • Develops and maintains standards for epidemiological surveillance and reporting • Maintains Aboriginal HIV/AIDS services and implements relevant recommended actions in the Strategy
Municipal/local Governments	• Enact by-laws and/or adjusts programming and policy related to housing, policing and other services that impact on the HIV/AIDS epidemic
University and other educational Institutions	• Provides HIV/AIDS education, prevention, training and conducts research

Health Service Delivery Organizations

Organization	Roles and Responsibilities
District Health Authorities (DHAs)	• Develop and implement district/business plans to reflect implementation of the Strategy at local level, and report to Dept of Health on progress • Fund continuum of HIV/AIDS services from prevention through to continuing care • Work toward addressing social determinants of health • Deliver treatment, care and support for PHAs • Provide education and prevention (including those based on harm reduction approach) services • Build capacity within the communities to address health issues
Community Health Boards	• Consult with local PHAs, HIV/AIDS community and service providers to determine local HIV/AIDS needs
Health Care Providers	• Collaborate to provide treatment program for PHAs • Conduct research and provides training to health care providers • Provide policy advice to Dept. of Health and others.

Private Sector Organizations

Organization	Roles and Responsibilities
Business Community	• Implement supportive work place policies • Support and/or participate in HIV/AIDS research • Sponsor HIV/AIDS events and initiatives • Provide input into the design, implementation and evaluation of HIV/AIDS-related policies
Media	• Address HIV/AIDS issues in a positive manner • Increase sensitivity of staff to issues related to racism, sexism, homophobia, and HIV/AIDS • Address the issue of sensationalized coverage of HIV/AIDS and of PHAs

Appendix E: Responding to the Aboriginal HIV Challenge In Nova Scotia

Background

Aboriginal people, regardless of where they reside (on/off reserve, urban, rural, and remote) are striving to regain the strength and richness of their cultures among many health and social challenges. Honouring traditional values of honesty, sharing, respect, and faith, is part of rebuilding Aboriginal Nations.

HIV is one virus that has confronted Aboriginal people and communities and challenged these values and strengths. Aboriginal community leaders and other members are beginning to discuss roles and responsibilities in providing prevention and support programs. This has been supported by Healing Our Nations, the only Aboriginal specific HIV/AIDS organization in Atlantic Canada.

To better meet the needs of Aboriginal persons in Nova Scotia, it is time to develop and implement goals that will enhance existing services and close the gap on services not yet in place. These goals are detailed below.

Goals

- Compile a list of existing resources potentially accessed by Aboriginal People in Nova Scotia.
- Determine the shortfalls within existing resources/agencies through consultation with Aboriginal PHAs, Aboriginal persons, and communities.
- Work towards the improvement of services within existing resources, with the support of the Nova Scotia Strategy on HIV/AIDS.
- Enhance capacity of existing resources as an interim measure to better meet the needs of Aboriginal people.
- Develop an Aboriginal-specific Strategy to address all the unique and diverse needs of Atlantic Aboriginal populations, with support of the Nova Scotia Strategy on HIV/AIDS,

Throughout the course of this continuum a foundation of data (Aboriginal Strategy Framework) will be compiled to support the development of a full Aboriginal Strategy to address all the unique and diverse needs of Atlantic Aboriginal populations. The data collected will aid in the implementation of the strategic directions and recommended actions contained within the Nova Scotia Strategy on HIV/AIDS.

Appendix F: References

1. Health Canada. The Canadian Strategy on HIV/AIDS: Moving forward together. Ottawa (ON): Minister of Public Works and Government Services Canada, 1998.
2. Canadian AIDS Society. Health is a human right: Lessons from the community-based AIDS movement, a brief prepared for the Commission of the Future of Health Care in Canada. Ottawa (ON): Canadian AIDS Society, 2002. Available from: URL: <http://www.cdnaids.ca/web/backgrnd.nsf/cl/cas-bg-0034—Fre—Eng>.
3. Nova Scotia Department of Health. HIV/AIDS surveillance report 2000. Halifax (NS): Office of the Provincial Medical Officer of Health, 2001.
4. Personal communication with Tracey MacDonald, Field Surveillance Officer, NS/PE, Health Canada, July 4, 2003.
5. Martin Spigelman Research Associates. HIV/AIDS and health determinants: Lessons learned for coordinating policy and action. A discussion paper for the Ministerial Council on HIV/AIDS.
6. Health Canada. What is the population health approach. Available from URL: <http://www.hc-sc.gc.ca/hppb/phdd/approach/approach.html> 2002.
7. Nova Scotia Advisory Commission on AIDS. Towards a renewed provincial HIV/AIDS strategy. Halifax (NS): Nova Scotia Advisory Commission on AIDS, 1997.
8. Government of Nova Scotia. Nova Scotia AIDS Strategy. Halifax (NS): Government of Nova Scotia, 1993.
9. Interdepartmental AIDS Liaison Committee. Report on the implementation of the Nova Scotia AIDS Strategy. Halifax (NS): Interdepartmental AIDS Liaison Committee, 1995 Mar.
10. Yorke J. Partnership in action: Toward the development of a provincial HIV/AIDS strategy for Nova Scotia. Consultation summary prepared for Nova Scotia Provincial AIDS Strategy Steering Committee. Halifax (NS), 2000.
11. Health Canada. State of the HIV/AIDS epidemic. Ottawa (ON): Health Canada, 2001 Dec. Available from: URL: <http://www.hc-sc.gc.ca/english/media/releases/2001/2001_130ebk4.htm>.
12. Health Canada. HIV and AIDS in Canada: Surveillance report to June 30, 2002. Ottawa (ON): Division of HIV/AIDS Epidemiology and Surveillance, Centre for Infectious Diseases Prevention and Control, Health Canada, 2002.
13. Atlantic Canada HIV/AIDS Migration Pilot Study, 1998, cited in AIDS Coalition of Nova Scotia Support Program Proposal submitted to the Nova Scotia Department of Health, 2002 Feb.
14. Health Canada. HIV/AIDS Epi Updates. Ottawa (ON): Division of HIV/AIDS Epidemiology and Surveillance, Centre for Infectious Diseases Prevention and Control, Health Canada, 2002 Apr.
15. Health Canada. Vulnerable Canadians. Ottawa (ON): Health Canada 2001. Available from: URL: <http://www.hc-sc.gc.ca/english/media/releases/2001/2001_130ebk.htm>.
16. Lines R. Action on HIV/AIDS in prisons: Too little, too late. A report card. Montreal (QC): Canadian HIV/AIDS Legal Network, 2002.
17. Correctional Services Canada. Infectious disease prevention and control in Canadian penitentiaries 2000–01: A report of the Correctional Service of Canada's Infectious Disease Surveillance System. Ottawa (ON): Correctional Services Canada, 2003.
18. Health Canada. Canadian Strategy on AIDS – Backgrounder. Ottawa (ON): Health Canada, 2002. Available from: URL: <http://www.hc-sc.gc.ca/hppb/hiv_aids/can_strat/strat_admin/backgrounder.html>.

19. Nova Scotia Task Force on AIDS. The challenge of AIDS: A Nova Scotian response. Report of the Nova Scotia Task Force on AIDS. Halifax (NS): Nova Scotia Task Force on AIDS, 1988.

20. Provincial HIV/AIDS Strategy Steering Committee. Nova Scotia's Framework for Action on HIV/AIDS. Halifax (NS): Provincial HIV/AIDS Strategy Steering Committee, 2001 Sept.

21. Marshall Consulting and Associates. Planning steps in response to Nova Scotia's Framework for Action on HIV/AIDS: Consultant's report of regional workshops for the strategic planning process. Halifax (NS): Marshall Consulting and Associates, 2002.

22. Report of the Nova Scotia Advisory Committee on Primary Health Care Renewal. Primary health care renewal: Action for healthier Nova Scotians. Halifax (NS): Province of Nova Scotia, 2003 May.

23. Health Canada. Meeting report: Canadian Strategy on HIV/AIDS annual direction-setting meeting. Ottawa (ON): Minister of Public Works and Government Services Canada, 2001.

24. Canadian AIDS Society. Health is a human right: Lessons from the community-based AIDS movement, a brief prepared for the Commission of the Future of Health Care in Canada, p. 4. Ottawa (ON): Canadian AIDS Society, 2002. Available from: URL: <http://www.cdnaids.ca/web/backgrnd.nsf/cl/cas-bg-0034—Fre—Eng>.

25. Albert T, Williams G. The economic burden of HIV/AIDS in Canada (CPRN Study No. H|02). Ottawa, ON: Canadian Policy Research Networks, 1998.

26. Dodds C, Colman R, Amaratunga C, Wilson J. The Cost of HIV/AIDS in Canada. Halifax (NS): GPI Atlantic, 2001.

27. Drow JR, MacLaren CM, Skinner EL. An economic evaluation of the Mainline Needle Exchange. Halifax (NS): Dalhousie University, 1998.

28. Provincial Anonymous Testing Steering Committee. Background document in support of expanded access to anonymous HIV testing services in Nova Scotia. Halifax (NS): Provincial Anonymous Testing Steering Committee, 2001 Dec.

29. Kirby M. The health of Canadians – The federal role: Final report on the state of the health care system in Canada. Volume six: Recommendations for reform. Ottawa (ON): Standing Senate Committee on Social Affairs, Science & Technology, 2002 Oct.

30. Devon Dodd J, Hebert Boyd M. Capacity building: Linking community experience to public policy. Halifax (NS): Population and Public Health Branch Atlantic, Health Canada, 2002.

31. Canadian HIV/AIDS Legal Network. Stigma and discrimination: Definitions and concepts (Info Sheet 2). Available from URL: <http://www.aidslaw.ca/Maincontent/issues/discrimination/e-info-da2.htm> 1999.

32. Nova Scotia Human Rights Commission. Fact sheets, rights on ethnic and national origin. Available from: URL: <http://www.gov.ns.ca/humanrights/rights/ethnicnational.htm> 2003.

33. World Health Organization. Health promotion glossary section II: Extended list of terms. Geneva: World Health Organization

34. Hosein S, editor. Managing your health: a guide for people living with HIV or AIDS, edition. Toronto (ON): CATIE, 1999.

35. Shookner M, Social Inclusion Reference Group. An inclusion lens: Workbook for looking at social and economic exclusion and inclusion. Halifax (NS): Population and Public Health Branch Atlantic, Health Canada, 2002.

36. BC Ministry of Health and Ministry Responsible for Seniors. British Columbia's Framework for Action on HIV/AIDS. Victoria (BC): BC Ministry of Health and Ministry Responsible for Seniors, 1998.

37. UNAIDS. Responses that work and lessons learned: How to identify and propose them for the UNAIDS best practice collection, UNAIDS. Available from: URL: <http://www.gov.ns.ca/humanrights/rights/ethnicnational.htm>.