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# AIDS Community Action Program (ACAP) Grants and Contribution Allocation Project 2005

# Public Health Agency of Canada Regional Offices

## Final Report

**Prepared for**

Public Health Agency of Canada Regional Offices

San Patten and Associates
Health Research and Evaluation Consulting

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# 1 List of Acronyms

| | |
|---|---|
| ACAP | AIDS Community Action Program |
| ASO | AIDS Service Organization |
| CBO | Community-Based Organization |
| CSHA | Canadian Strategy on HIV/AIDS |
| G&C | Grants and Contributions |
| PHAC | Public Health Agency of Canada |
| P/T | Provincial/Territorial |
| RD | Regional Directors |
| RO | Regional Offices |

# 2 Introduction to the Report

San Patten and Associates were contracted by the Public Health Agency of Canada, Regional Offices (PHAC RO) to prepare a discussion paper that provides options and recommendations for an allocation formula. Principal researchers were San Patten, MSc. and Roxanne Felix, MSc.

This allocation formula will guide regional distribution of Grants and Contribution (G&C) resources under the regional AIDS Community Action Program (ACAP), beginning April 1, 2006.

# 3 Background to the Report

## The AIDS Community Action Program

The AIDS Community Action Program (ACAP) is one component of the *Federal Initiative to Address HIV/AIDS in Canada.* ACAP is a federal funding program that supports local, regional, and provincial/territorial community-based organizations addressing HIV/AIDS issues across Canada.

The Regional Offices (ROs) of the Public Health Agency of Canada (PHAC) required a discussion paper to provide options and make recommendations on G&C resource allocations for ACAP beginning April 1, 2006. This paper will be used by the Regional Directors of PHAC ROs to determine the distribution of ACAP grants and contributions resources across the seven regions: Atlantic provinces, Quebec, Ontario, Manitoba/Saskatchewan, Alberta, British Columbia, and the Northern Territories (Northwest Territories, Nunavut and Yukon), beginning in April, 2006.

In August 2004, the Minister of Health announced that the Canadian Strategy on HIV/AIDS (CSHA) would double from $42.2M to $84.4M over the next 5 years. In January 2005, the *Federal Initiative to Address HIV/AIDS in Canada* was launched, replacing the Canadian Strategy for HIV/AIDS (CSHA), with a ramping up of ACAP grants and contributions across the country. The ACAP G&C allocation was assigned to PHAC Regions to manage as one of the eight Responsibility Centres for the Initiative.

ACAP is a federal funding program that supports local, regional and provincial/territorial community-based organizations in addressing HIV/AIDS issues across Canada. ACAP programming reflects the principles of community development; health promotion; partnerships and collaboration; population health; and planning and evaluation. These principles are in alignment with the policy direction of *The Federal Initiative:* partnership and engagement; integration and accountability.

ACAP funding supports programming in the following areas:

- **Prevention Initiatives** to prevent HIV in populations known to be vulnerable to HIV
- **Health Promotion for People Living with HIV/AIDS** to increase the capacity of people living with HIV to manage their condition (services, treatment, support, work, learning), and support for people affected by HIV
- **Creating Supportive Environments** to reduce social barriers that prevent people living with HIV, those at risk, and those affected from accessing health care and social services. Targeted environments include (but are not limited to): prisons, addiction treatment, professional groups (nurses, educators, pharmacists, physicians, etc.), workplaces, other non-profits, general public

- **Strengthening Community Based Organizations** to increase the skills and abilities of the people who work at all levels of the community-based HIV movement: board, staff and volunteers.

ACAP G&C resources are available for operational funding (available to AIDS Service Organizations) and for time-limited project funding (available to community organizations that deal with HIV/AIDS as part of their wider programming).

ACAP plays a key role in influencing the development and implementation of provincial and territorial programs designed to support community-based HIV/AIDS work. Previous evaluation reports of the National AIDS Strategy clearly indicate that continued federal support for ACAP is integral to any success the federal government hopes to have in preventing the spread of HIV and in creating supportive social environments for people living with HIV/AIDS[1]. ACAP is also an invaluable funding program in facilitating multi-sectoral participation in the population health framework.[2]

## Previous ACAP G&C Allocation Formula

For this fiscal year (2005-2006), additional ACAP grants and contributions that initially became available in November 2004 were allocated based on a resource allocation formula created for the program in the mid 1990's. A review of this resource allocation formula was carried out in 1998-1999, in the second year of the CSHA. The results of that review were captured in the report, "ACAP: Allocations for Regional HIV/AIDS Programming (October 2000)."

The formula, with weighted criteria for ACAP grants and contributions, consisted of:

- An allocation based on population (40% weighting)
- A base amount for each province and territory (25%)
- An allocation based on provincial/territorial rates of AIDS cases per million (25%)
- An allocation based on the extent to which funding is available from provincial/territorial governments for ACAP-type activities (10%)

More information about the previous ACAP G&C allocation formula is provided in the literature review.

## Need for a New ACAP G&C Allocation Formula

During the 1998-1999 review, several limitations were raised about the ACAP G&C allocation formula, leading the Working Group (October 2000) of that process to conclude that "monitoring and development work should continue toward an improved ACAP Allocation Formula, based on relevant data and new formulas for combining multiple data sources to arrive at accurate and appropriate prevention and care/support indicators." The Working Group also made recommendations for the development of an improved ACAP resource allocation formula in the future, including the need for:

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[1] Health Canada. *ACAP Allocations for Regional HIV/AIDS Programming – A discussion paper*. September 1999.
[2] Susan Dann & Associates. *The PPHB Regional Office Role in HIV/AIDS*. May 2003.

- A solid evidence base and the existence of proven formulas for using multiple data sources when determining resource allocations;
- Clarification of the degree to which provincial/territorial funding of community-based AIDS work should influence ACAP allocations; and
- Readiness of those affected by changes in the allocation, to manage that shift in the allocation.

Since this review and subsequent recommendations were made, the epidemic has changed significantly, and much work has been done to address the HIV/AIDS epidemic in Canada by governments and other stakeholders.

## Project Goal and Objectives

The goal of this consultancy was to prepare a discussion paper with evidence-informed options for allocating regional grants and contributions resources for ACAP, based on various sources of data and input from ACAP consultants, managers, Regional Directors (RDs) and other key stakeholders as determined through the HIV/AIDS Allocation Working Group (hereafter the "Working Group").

The objectives for this consultancy were to:

- Conduct a literature review of critical past documents that will inform the allocation of ACAP G&C resources
- Develop two to three G&C allocation models
- Consult with stakeholders to assess appropriateness of G&C allocation models
- Present the Working Group with a discussion paper providing options and recommendations on ACAP G&C allocation models

The ACAP G&C resource allocation models should meet the following principles, set by the Working Group:

- Current level of ACAP funding to each region will not be reduced. Only new resources, beginning April 1, 2006, will be considered in the formulation of future ACAP resource allocation models.
- New resources must allow for adequate and equitable capacity for each region.
- Options for allocating ACAP resources are evidence-informed.
- Respect for the directions of *Leading Together: Canada Takes Action on HIV/AIDS* and *The Federal Initiative to Address HIV/AIDS in Canada*

## Advisory Groups

The ACAP G&C Resource Allocation project was advised by three separate federal stakeholder groups, comprised of overlapping memberships:

1) HIV/AIDS Allocation Working Group – comprised of ACAP staff (program and evaluation consultants), and program managers from the PHAC Regional Offices and the HIV/AIDS Division.

2) Regional HIV/AIDS Network Working Group – comprised of ACAP program consultants

3) Epidemiology Working Group – comprised of staff from the Surveillance and Risk Assessment Division, Communicable and Acquired Infections Division (STI and HCV program consultants), HIV/AIDS Policy, Coordination and Programs Division, and ACAP staff.

In addition, the ACAP G&C Allocation Framework underwent review by key community and provincial/territorial government stakeholders across Canada through a consultation process.

# 4 Literature Review

## Introduction

The first step in the preparation of this discussion paper was to synthesize currently available information relevant to the provision of community-based HIV/AIDS prevention, care, and support programming. As such, this paper was prepared to provide an overview of the following:

- Policy direction determined by the national HIV/AIDS strategies: *Leading Together: Canada Takes Action on HIV/AIDS* and *The Federal Initiative to Address HIV/AIDS in Canada*; as well as ACAP goals within the context of these strategies
- Factors affecting the development of the HIV/AIDS epidemic in Canada
- Availability of standardized epidemiological data and its relevance to ACAP allocation models
- Considerations in the development of a future ACAP allocation model, informed by key findings from previous departmental work in this area

## Policy Direction - National Strategies and ACAP Objectives

The model for ACAP allocation across regions should reflect ACAP goals and the national policy directions which they support. This section of the literature review provides a brief overview of the directions provided by *Leading Together: Canada Takes Action on HIV/AIDS*, *The Federal Initiative to Address HIV/AIDS in Canada* and ACAP goals within the context of these strategies.

*Leading Together: Canada takes Action on HIV/AIDS* was developed by a broad cross-section of Canadian organizations and individuals involved in HIV/AIDS policy, programming and research. The plan provides a blueprint for a strategic and coordinated Canadian response to the HIV/AIDS epidemic so that "by 2010, the end of the epidemic is in sight". Its goals are to:

- Reduce social inequities, stigma and discrimination that threaten people's health and well-being
- Prevent the spread of HIV
- Provide timely, safe and effective diagnosis, care, treatment and support for all people living in Canada with HIV/AIDS, and
- Contribute to global efforts to fight the epidemic and find a cure

No single organization or sector can claim ownership of this program; it is a call to action for all Canadians and all sectors of society to become aligned in a national HIV/AIDS response. This response reflects the broader values of Canadian society, more specifically: a commitment to social justice and human rights; recognition of

diversity; support of participation and empowerment; global responsibility; and mutual accountability.

*The Federal Initiative to Address HIV/AIDS in Canada* outlines the Government of Canada's renewed approach to dealing with HIV/AIDS in light of the direction provided by *Leading Together.* For the purposes of this review, it is important to highlight the three policy directions that should guide all federal decision making and relationships in HIV/AIDS activities.

- **Partnership and Engagement** – *The Federal Initiative* recognizes that coherent action by people, organizations and systems involved in the HIV/AIDS response is critical to reaching the goals of the Federal Initiative. These partnerships should cross government levels (federal, provincial, territorial and municipal), different government departments, sectors (voluntary, professional, non-governmental and private) and national boundaries. Partnerships should focus on addressing the determinants of health and outlining defined roles and responsibilities.
- **Integration** – Many people living with and vulnerable to HIV/AIDS have complex health needs and may be vulnerable to other infectious diseases, such as those transmitted sexually or by injection drug use. Programs should address barriers to services for people living with or vulnerable to multiple infections and conditions that have an impact on their health.
- **Accountability** - The federal government will foster mutual accountability among its delivery partners and will make public their achievements and challenges on an annual basis through the World AIDS Day report.

ACAP is a federal funding program that contributes to the fulfillment of actions and priorities outlined in *Leading Together* and *The Federal Initiative.* It supports local, regional and provincial/territorial community-based organizations addressing HIV/AIDS issues across Canada. It contributes to three of the four goals of the *Leading Together* strategy that focus on domestic efforts, and subsequently, to the fourth goal focused on international efforts by strengthening the capacity of Canadian AIDS service organizations to provide global contributions.

ACAP programming reflects the principles of community development; health promotion; partnerships and collaboration; population health; and planning and evaluation. These principles are in alignment with the policy direction of *The Federal Initiative:* partnership and engagement; integration and accountability. ACAP funding supports programming in the following areas:

- **Prevention Initiatives** to prevent HIV in populations known to be vulnerable to HIV
- **Health Promotion for People Living with HIV/AIDS** to increase the capacity of people living with HIV to manage their condition (services, treatment, support, work, learning), and support for people affected by HIV
- **Creating Supportive Environments** to reduce social barriers that prevent people living with HIV, those at risk, and those affected from accessing health care and social services. Targeted environments include (but are not limited to): prisons,

addiction treatment, professional groups (nurses, educators, pharmacists, physicians, etc.), workplaces, other non-profits, general public

- **Strengthening Community Based Organizations** to increase the skills and abilities of the people who work at all levels of the community-based HIV movement: board, staff and volunteers.

ACAP resources are available for operational funding (available to AIDS Service Organizations) and for time limited project funding (available to community organizations that deal with HIV/AIDS as part of their wider programming).

ACAP plays a key role in influencing the development and implementation of provincial and territorial programs designed to support community-based HIV/AIDS work. Previous evaluation reports of the National AIDS Strategy clearly indicate that continued federal support for ACAP is integral to any success the federal government hopes to have in preventing the spread of HIV and in creating supportive social environments for people living with HIV/AIDS[3]. ACAP is also an invaluable funding program in furthering multi-sectoral participation in the population health framework[4].

## Developments in the HIV/AIDS Epidemic

This section of the report provides a brief overview of some epidemiological developments that should be considered in the development of an ACAP resource allocation model.

- Data shows that the HIV/AIDS epidemic in Canada is not one generalized epidemic, but rather a series of established and emerging epidemics within certain vulnerable populations.
- The number of people living with HIV/AIDS may increase significantly through the coming years given the limitations of new treatment options and the number of new infections.[5]
- The emergence of highly active antiretroviral treatments in the late 1990s has prolonged and improved the quality of life of many HIV-infected Canadians; difficulties in accessing treatment, treatment failures, toxic side effects and drug resistance have become more and more common, presenting barriers to getting ahead of the epidemic.[6]
- Men who have sex with men (MSM) remain the group most affected by HIV/AIDS in Canada, but the epidemic has gained a foothold in other vulnerable populations – Aboriginal people, inmates, intravenous drug users (IDUs), at-risk youth and women, and people from countries where HIV is endemic.[7]

[3] Health Canada. *ACAP Allocations for Regional HIV/AIDS Programming – A discussion paper*. September 1999.
[4] Susan Dann & Associates. *The PPHB Regional Office Role in HIV/AIDS*. May 2003.
[5] Martin Spigelman Research Associates. *A National Portrait: Report on the Current State of the HIV/AIDS Epidemic Across Canada.* 2004.
[6] Government of Canada. The Federal Initiative to Address HIV/AIDS in Canada: Strengthening Federal Action in the Canadian Response to HIV/AIDS. 2004.
[7] Government of Canada. *The Federal Initiative to Address HIV/AIDS in Canada: Strengthening Federal Action in the Canadian Response to HIV/AIDS*. 2004.

- At the end of 2002, an estimated 56,000 people in Canada were living with an HIV infection.[8] Approximately 30% (almost 17,000) of these individuals were unaware of their infection and, thus, were not accessing treatment and might have unknowingly transmitted the virus to others. Early analysis suggests that these individuals were more likely to belong to an ethnic group other than White and had been infected by routes other than MSM or IDU.[9]
- A significant proportion of people living with HIV have other illnesses that complicate their care. For example, 1999 data shows that just over 11,000 people living with HIV in Canada (or more than 20%) were co-infected with Hepatitis C. That number has since increased to close to 14,000 people.[10]
- The HIV/AIDS epidemic varies across regions. In most provinces, MSM remains the largest exposure category while in others, IDU has become the most significant exposure category. Infections among people from HIV-endemic countries are more common in some provinces than in others. Similarly the proportion of men to women who were diagnosed as HIV positive in 2003 differs from region to region.[11]
- Four of Canada's most populated provinces account for a very significant number of people living with HIV/AIDS. British Columbia, Alberta, Ontario and Quebec have accounted for 95% of all HIV positive cases reports since 1985, while the remaining nine provinces and territories have accounted for only 5%. This distribution is reflected in the variance between regions in efforts to address this epidemic.[12]

## Available Epidemiological Data

This section will provide an overview of epidemiological data which is currently available and of relevance to potential ACAP G&C allocation funding models. Of considerable interest was a survey on the value of epidemiological indicators for resource allocation in HIV prevention programs targeted to epidemiologists and public health professionals with extensive experience in HIV epidemiology.[13]

The next set of national HIV estimates will pertain to the year 2005 and will be produced in 2006. Please refer to *HIV/AIDS Epi Updates* for the methods used to estimate HIV prevalence and incidence and the limitations of this data.

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[8] Public Health Agency of Canada. *HIV/AIDS Epi Updates*, *May 2005,* Surveillance and Risk Assessment Division, Centre for Infectious Disease Prevention and Control, Public Health Agency of Canada, 2005.

[9] Martin Spigelman Research Associates. *A National Portrait: Report on the Current State of the HIV/AIDS Epidemic Across Canada*. 2004.

[10] *Leading Together: Canada Take Action on HIV/AIDS (2005-2010)*. Canadian HIV/AIDS Information Centre. 2004.

[11] Martin Spigelman Research Associates. *A National Portrait: Report on the Current State of the HIV/AIDS Epidemic Across Canada*. 2004.

[12] Martin Spigelman Research Associates. *A National Portrait: Report on the Current State of the HIV/AIDS Epidemic Across Canada*. 2004.

[13] WilliamsResearch.com Inc., *A survey of Canadian epidemiologists and public health professionals on the evaluation of indicators for the allocation of resources for HIV Prevention programs*. March 1999.

**Population**: Total number of individuals living in each province and territory (P/T); can be sub-divided into age groups.

- Population estimates can be considered as criteria for prevention programming. However, when total population estimates (and not sub-groups according to age and gender) are used as a criterion, this means that all age groups and both genders are being counted as equal targets for prevention programming.
- Statistics show that most people become infected between the ages of 15 and 45. Prevention efforts should focus on populations most likely to engage in unsafe sexual practices and unsafe needle use, the key modes of HIV transmission. Although age statistics for IDUs are not reliable, age statistics regarding sexual behaviour clearly show that most sexually active Canadians with more than one sexual partner are between the ages of 15 and 44. Reports from front-line community workers and those working in addiction services suggest that most Canadian IDUs would also be captured within this age range.[14] Therefore, the population size of 15-45 years would serve as good criteria for prevention programming.

**HIV - Prevalence:** Total number of individuals in each P/T who are currently living with HIV infection

- HIV prevalence statistics would be a preferred allocation criterion to determine the distribution of resources for projecting the health promotion, care and support needs of people living with HIV/AIDS.[15]

**HIV-Incidence:** Total number of individuals in each P/T who were estimated to be living with their HIV infection at the end of a specified year.

- HIV incidence should be considered as a key factor when assessing the need for prevention programs. Both consultation with the Laboratory Center for Disease Control in 2000 and the survey of epidemiologists supported this finding.[16] Incidence rates can be considered to indicate the future threat posed by the HIV/AIDS epidemic.

**AIDS Cases:** Total number of Canadians who are diagnosed with AIDS.

- AIDS incidence reflects HIV incidence many years earlier. While useful, it is insensitive to recent changes in HIV incidence within regions, communities, age groups and transmission groups.[17]
- If necessary, AIDS incidence could be a valid and reliable proxy indicator of HIV prevalence. However, AIDS incidence was still considered an inferior measure in 1999 because of reporting delays, the lack of standardized reporting and testing policies across provinces and territories, and region-to-region migration of people.

[14] Health Canada. *ACAP Allocations for Regional HIV/AIDS Programming – A discussion paper.* September 1999.
[15] ibid
[16] Health Canada. ACAP: Allocations for Regional HIV/AIDS Programming. October 2000.
[17] WilliamsResearch.com Inc., *A survey of Canadian epidemiologists and public health professionals on the evaluation of indicators for the allocation of resources for HIV Prevention programs*. March 1999.

AIDS incidence was definitively identified as *not* being useful for prevention or health promotion programming.[18] Using AIDS cases as criteria in prevention programming rewards the reporting of AIDS cases rather than the prevention of new infections.[19] As well, with the advent of highly active antiretroviral therapy, people with HIV are living much longer than they did in the early 1990s before they develop AIDS. Further consultation with epidemiologists should be undertaken to determine whether AIDS cases would still be an appropriate criteria to consider for the health promotion, care and support needs of people living with HIV/AIDS.

- If included in the ACAP allocation formula, this criterion should only be used in conjunction with other surrogate measures of HIV prevalence (including estimates provided from seroprevalence studies and mathematical models).[20]

### Exposure Categories

- HIV prevalence, HIV incidence and AIDS incidence statistics are available for the following exposure categories: men who have had sex with men (MSM); injecting drug users (IDU); MSM-IDU; heterosexual (either contact with a person who is either HIV-infected or at risk of HIV, heterosexual, or origin in a country where HIV is endemic); and other (recipients of blood transfusion or clotting factor).
- HIV prevalence and incidence estimates for exposure categories are available only for Ontario, Quebec, British Columbia and Alberta. However, these four provinces account for over 85% of the population of Canada and over 95% of reported HIV and AIDS diagnoses.[21]

### Sex Categories

- Male/female breakdown is available for general population estimates, HIV prevalence and HIV incidence.
- The female category can be sub-divided to pregnant women and women of child-bearing age.[22]

### Ethnicity Categories

- First Nations population estimates are available for population size.
- Ethnicity categories are available for positive HIV test reports.
    - Between 1998 and 2004, a total of 29.4% of positive HIV test reports have included ethnic information. HIV ethnicity data is provided by British Columbia, Yukon, Alberta, Northwest Territories, Nunavut, Saskatchewan, Manitoba, New

[18] WilliamsResearch.com Inc., *A survey of Canadian epidemiologists and public health professionals on the evaluation of indicators for the allocation of resources for HIV Prevention programs.* March 1999.
[19] National Institute of Medicine. *No Time to Lose - Getting More from HV Prevention.* Washington, DC: National Academy Press. 2000
[20] WilliamsResearch.com Inc., 1999
[21] Public Health Agency of Canada. *HIV/AIDS Epi Updates, May 2005,* Surveillance and Risk Assessment Division, Centre for Infectious Disease Prevention and Control, Public Health Agency of Canada, 2005.
[22] ibid

Brunswick, Nova Scotia, Prince Edward Island and Newfoundland and Labrador.[23]

- Ethnicity categories are available for AIDS case.
  - In 2003, 83.5% of AIDS cases included ethnic information.

**Immigrant Categories** – Born in a country where HIV is endemic

- Population estimates of immigrant populations are available by their place of birth for provinces and territories.
- Immigrant status categories are available for estimates of HIV prevalence and HIV incidence.
  - It is estimated that in 2002, approximately 7-10% of total prevalent infections and 6-12% of incident infections were among persons who were born in a country where HIV is endemic

### Sexually-Transmitted Infection Rates

- Rates of chlamydia, gonorrhea and infectious syphilis are nationally notifiable diseases and are available by province/territory and sex.
- Herpes Simplex Virus (HSV) infection and human papilloma virus (HPV) are thought to be the most prevalent STI's in Canada but are not notifiable diseases. There are estimated rates available by province/territory and sex.
- Estimates of Hepatitis C incidence rates are available by province/territory. These rates are not reliable in identifying outbreaks, in monitoring trends in incidence and patterns in the risk factors for transmission.[24]
- The last estimates of Hepatitis C prevalence rates were produced in 1999.

### Behavioural Data

- According to the Williams Research survey, behavioural research is considered a key factor when assessing the need for prevention programs. Such information takes into account the resources needed for groups with high prevalence of risk behaviour who have so far had low HIV incidence and prevalence but may have the biggest potential impact for the future.[25]
- There are some estimates of population sizes of MSM, MSM-IDU, and IDU for each province. However, the reliability and standardization of this data should be further investigated.
- Currently in development is a HIV and Hep C (HCV) associated risk behaviour enhanced surveillance system (I-track) that tracks risk behaviours among IDUs.

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[23] ibid
[24] http://dsol-smed.phac-aspc.gc.ca - *Notifiable Diseases On-Line*
[25] WilliamsResearch.com Inc., *A survey of canadian epidemiologists and public health professionals on the evaluation of indicators for the allocation of resources for HIV Prevention programs*. March 1999.

- Estimates of other vulnerable populations (i.e. inmates, youth-at-risk) are available for provinces and territories. However, again the reliability and standardization of such data would need to be investigated.

### Determinants of Health

A deep understanding of the pathways or mechanisms that lead to HIV infection is needed in order to target prevention strategies. Evidence points to factors that fall into categories of material, psychosocial, and political/economic areas. The materialist pathway considers lack of resources such as adequate income, toxic environments, affordable housing, and access to education and employment[26]. The psychosocial pathway looks at how these material factors translate into biological factors such as chronic stress, which then can lead to disease. It also looks at how social issues such as social support, discrimination, and lack of connections to social infrastructures such as political decision making and financial institutions lead to disease. The political/economic pathway considers the structural root causes of chronic disease.

- There is data available for indicators of different determinants of health. Some of these indicators are standardized across regions (i.e. income levels), while others are not (i.e. homelessness).
- None of the documents analyzed for this literature review have made a formal assessment on whether such indicators would serve as adequate criteria for HIV prevention initiatives.

### Geographic Spread

- There is data available on population density (population per square foot).
- Data can also be provided on the ratio of urban to rural areas in a province or territory.

## Considerations for ACAP G&C Allocation Formula

### Previous ACAP G&C Allocation Model

ACAP G&C resources were allocated across the regions according to a formula that weighted four different criteria. Weighting refers to the amount of dollars divided between each province and territory. The criteria of "population" weighting of 40% means that 40% of the total regional allocation would be divided among each province and territory based on their total population. For example, 40% of $6.85 M is $2.74 M. If Manitoba contained 10% of Canada's population, Manitoba would receive an allocation under this formula criterion of $274,000.

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[26] The Tides of Change: Addressing Inequity and Chronic Disease in Atlantic Canada, A Discussion Paper. Karen Hayward and Ronald Colman. Prepared for Population and Public Health Branch, Atlantic Regional Office, Health Canada. July 2003.

The formula with weighted criteria for ACAP Grants and Contributions was:

- An allocation based on population (40% weighting)

This criteria met ACAP's objectives of targeted prevention and, to some degree, supportive social environments by allocating dollars to where most of Canada's population lived and, thus, providing the best opportunity for prevention initiatives to reach the most people.[27]

- A base amount for each province and territory (25% weighting)

The inclusion of this criterion ensured a minimal funding base within each jurisdiction and helped ensure that community groups in each province or territory, regardless of other funding available, were supported in providing baseline HIV/AIDS programming.[28] [29] The inclusion of this criteria meant that 25% of ACAP funding would be divided equally among each province and territory, not region. Therefore, even though there are 3 territories in the Northern Territories; each territory received an equitable allocation.

- An allocation based on provincial territorial rates of AIDS cases per million (25% weighting)

This criterion helped address the ACAP objective of health promotion for people living with HIV/AIDS.[30]

- An allocation based on the extent to which funding is available from provincial/ territorial governments for ACAP-type activities (10% weighting)

The inclusion of this criterion helped to ensure that the capacity for the community to deliver HIV/AIDS programming was somewhat equal across Canada. The goal was to ensure that any Canadian affected by HIV/AIDS could be assured of some access to community-based programs and services no matter where she/he lived. This component of the formula provided extra funding to regions to support community mobilization in the *absence* of provincial and/or territorial government support.

This formula guided ACAP regional allocation until the fiscal year (FY) 1999-2000. For FY 2000-2001 and 2001-2002, all regions received their 1999-2000 amounts as an ACAP funding base. An extra $233 K was re-allocated in each respective FY (2000-2001 and 2001-2002) from National ACAP project funding to the regions. Half (50%) of this funding was destined for prevention and 50% for care and support.

This extra funding ($233,000) was allocated across the regions according to two criteria:

- Each province's or territory's populations between the ages of 15-44, so as to direct ACAP funds to regions where prevention initiatives are likely to have the greatest impact (based on 1996 census data)

[27] Health Canada. *ACAP: Strategies for NAS III: A discussion paper*. October 28, 1997.
[28] Health Canada. *ACAP: Strategies for NAS III: A discussion paper*. October 28, 1997.
[29] Health Canada. *ACAP: Allocations for Regional HIV/AIDS Programming*. October 2000.
[30] Health Canada. *ACAP: Strategies for NAS III: A discussion paper*. October 28, 1997.

- Provincial/territorial AIDS rates as of June 1998, so as to support people living with HIV/AIDS

### Considerations for Future ACAP Allocation Models

The ACAP allocation formula should be reflective of the new federal policy directions

- ACAP funding, in general, contributes directly to 3 out of the 4 goals aimed at domestic HIV/AIDS efforts, as outlined in the national strategy, *Leading Together: Canada Take Action on HIV/AIDS (2005-2010)*. It also indirectly contributes to the fourth goal aimed at global engagement by building the capacity of Canadian AIDS service organizations to contribute to global HIV/AIDS efforts.
- Accountability is valued in both national strategic documents. Given such direction, there is a responsibility to use the most current available evidence to inform decisions without compromising the current HIV/AIDS infrastructure that exists in community-based programming. In cases where standardized data is not available for key indicators of the HIV/AIDS epidemic with respect to prevention, care, treatment or support needs, efforts should be made to implement standard data collection across regions.
- Accountability should also be reflected in ACAP's efforts to facilitate community-based programming to pro-actively respond to new and emerging trends of vulnerability to HIV infection. The ACAP allocation formula should not only consider current vulnerable populations, but allocate resources in consideration of emerging prevention needs.
- The national strategies also reflect a commitment to social justice and human rights[31] and partnerships[32]. Such direction indicates that there should be serious consideration of the feasibility of including criteria in the ACAP allocation model that reflect the determinants of health. Furthermore, ACAP's four funding areas are best achieved through a population health approach, such as engaging with multi-sectoral partners to reduce vulnerabilities, create supportive environments or contribute to health promotion for people living with HIV.
- Finally, *The Federal Initiative to Address HIV/AIDS in Canada* values integration. The ACAP allocation model should consider the complexities of those living with and vulnerable to HIV/AIDS, particularly with respect to co-morbidities of other STIs and Hep C with HIV/AIDS.

The ACAP allocation formula should be reflective of ACAP objectives

- When considering resource allocation priorities, the following principles have been highlighted by the CD Howe Institute:[33]
    - limited resources should be used in a manner that produces maximum benefit

[31] *Leading Together: Canada Take Action on HIV/AIDS (2005-2010).* Canadian HIV/AIDS Information Centre. 2004.
[32] *The Federal Initiative to Address HIV/AIDS in Canada: Strengthening Federal Action in the Canadian Response to HIV/AIDS.* 2004.
[33] Mitton C, Donaldson C and Currie G. *Managing Medicare: The Prerequisite to Spending or Reform.* C.D. Howe Institute Commentary. January 2001.

- the process for setting priorities should be open and explicit
- principles of both equity and efficiency should be considered
- process should be evidence-based wherever possible

- Given that there will never be an "adequate" amount of money to do all that should be done in the efforts to stem the HIV/AIDS epidemic, it should be recognized that the allocation model should reflect ACAP priorities. That is, the model should ensure ACAP fulfills its role as a *national* program, reflecting pan-Canadian priorities that have been defined to fit within a national framework.[34]
- The four components of ACAP are as follows: prevention initiatives; health promotion for people living with HIV/AIDS; creating supportive environments and strengthening community-based organizations.
- Prevention funding, when allocated on the basis of reported number of AIDS cases approach, rewards people for counting cases of AIDS instead of preventing HIV infections. As well, prevention should be targeted not only to those who are not currently infected with HIV (i.e. the general population) but also to those who are living with HIV/AIDS and not aware of their status.[35]
- Addressing the health determinants is key to reducing vulnerability and preventing the spread of HIV/AIDS. The HIV virus chiefly finds its targets among people already victimized by poverty, racism and discrimination, homelessness and mental illness.[36] Critical action should be considered in order to control the epidemic among population groups most vulnerable.[37]
- The Institute of Medicine (USA) recommends allocating only a portion of total [prevention] funding on the basis of HIV/AIDS prevalence or incidence. Remaining funds should be discretionary and allocated on the basis of effective practice and the infections avoided.[38]
- The previous discussion is based on the assumption that the objectives of ACAP programming will remain the same. However, any changes in ACAP objectives or other related national strategies focused on blood borne pathogens or STI's will need to be considered.
- Based on the literature reviewed, criteria that need to be considered for current ACAP programming are population sizes, HIV prevalence, criteria that reflect the determinants of health and vulnerable populations at risk.

New resources must allow for adequate and equitable capacity for each region

[34] Martin Spigelman Research Associates. *Getting Ahead of the Epidemic: The Federal Government Role in the Canadian Strategy on HIV/AIDS 1998-2008*. June 2003.
[35] Martin Spigelman Research Associates. *Getting Ahead of the Epidemic: The Federal Government Role in the Canadian Strategy on HIV/AIDS 1998-2008*. June 2003.
[36] ibid
[37] Susan Dann & Associates. *The PPHB Regional Office Role in HIV/AIDS*. May 2003.
[38] Martin Spigelman Research Associates*. Getting Ahead of the Epidemic: The Federal Government Role in the Canadian Strategy on HIV/AIDS* 1998-2008. June 2003.

- The previous criteria of having territorial/provincial contributions worth 10% weighting was an attempt to ensure equitable HIV/AIDS services across Canada. A criticism of this criterion emerged, stating that its continuation could serve as a disincentive for provinces/territories to increase their funding of community-based HIV/AIDS work. However, the elimination of this criterion would make it difficult for the Public Health Agency of Canada to fulfill its responsibility to maintain and improve the health of Canadians in each region and limit its ability to focus on those most at risk. [39]
- Many of the regions, mostly those with smaller populations, have HIV/AIDS strategies and services in place, but not to a great extent. These organizations have to rely on ACAP for large portions of their operational funding. In the past, there were guidelines on how ACAP funding should be split between operational and project funding in each region. However, because community-based HIV/AIDS infrastructure is not uniform across Canada, regions have been calling for flexibility in how this is administered. Currently, 30% of ACAP funding must respectively go to both operational and project funding. The remaining 40% can be spent according to community consultation. If flexibility is enhanced in how ACAP can be divided between operational and project funding, it would be easier to establish equitable HIV/AIDS services across Canada.
- Those groups most vulnerable to HIV infections vary across the regions. For example in Alberta, Manitoba and New Brunswick, the number of newly reported HIV cases are disproportionately represented among Aboriginal people. Yet in Quebec, Ontario, and Manitoba, the incidence of HIV positive cases had increased the most among persons from HIV endemic countries. While vulnerable populations need to be considered in the ACAP allocation model, in order for this criteria to be equitably met, there needs to be agreement among regions on which vulnerable populations are a priority or this criteria needs to be met respectively *within* each region.
- The geographic size and population size of regions vary significantly. Equity can be built into the allocation model by considering indicators of the geographic spread of a province or whether a region is serving more than one province or territory.

Options for allocating ACAP resources are evidence informed

- In order for the ACAP allocation model to be evidence-based, it should use the most recent data and be based on criteria that are most reflective of the goals of ACAP programming.
- Prevention funds should be allocated to reach populations at highest risk and to support programs that are cost-effective.[40] While no data is collected on cost-effectiveness currently, there are opportunities to allocate based on populations

[39] Health Canada. *ACAP: Allocations for Regional HIV/AIDS Programming.* October 2000.
[40] National Institute of Medicine. *No Time to Lose – Getting More from HV Prevention.* Washington, DC: National Academy Press. 2000

who are most vulnerable; however, as pointed out above; these populations vary regionally and vary over the development of the HIV/AIDS epidemic.

- Multiple sources of scientific information should be employed when planning allocation. This direction is consistent with the recommendations of the Centers for Disease Control and Prevention in the United States. They stated that "synthesis of multiple sources of scientific information is useful for the optimal allocation of resources for HIV prevention".[41]
- In Australia, the Australian Government provides funding to its States and Territories in public health for communicable diseases (particularly HIV/AIDS); cancer screening; and health risk factors. The distribution of the funding is based on a formula that takes account of a range of factors including: State and Territory population numbers and proportion of Aboriginal and Torres Strait people, levels of mortality, socio-economic factors, and other factors that affect the cost of delivering services in the individual State or Territory. This formula has been developed to reflect key determinants of health and wellbeing in communities.[42]

<u>Current level of ACAP funding to each region will not be reduced</u>

Only new resources, beginning April 1, 2006, will be considered in the formulation of future ACAP resource allocation models

- While respecting that the current HIV/AIDS community-based infrastructure must be maintained, the allocation model should also accommodate adjustments so that funding allocation is based on the most current and comprehensive data available.
- A number of options should be considered regarding the timing of the implementation of the future ACAP allocation model, in order to allow adjustment to changes in funding for each region.

<u>The ACAP allocation model should consider the readiness of those affected by changes in funding levels to manage that shift in allocation</u>

- The transition between the National AIDS Strategy I and National AIDS Strategy II was difficult for many community-based AIDS organizations. To help alleviate this, Health Canada provided transitional funds to ACAP operationally funded groups while NAS II funding guidelines were being finalized[43]. Therefore, transitional funds for AIDS organizations will only be required if ACAP funding guidelines change or do not remain within a Population Health framework.

## Conclusions

The literature reviewed in this document provides clear direction the issues to be considered in the creation of a new regional ACAP G&C allocation model. Given that

[41] WilliamsResearch.com Inc., *A survey of Canadian epidemiologists and public health professionals on the evaluation of indicators for the allocation of resources for HIV Prevention programs.* March 1999.
[42] http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-pubhlth-about-phofa-phofa.htm
[43] Health Canada. ACAP: Strategies for NAS III: A discussion paper. October 28, 1997.

the key policy directions for federal action and decision-making are partnership and engagement, integration and accountability, criteria for the allocation model should reflect the most current and available data, the values and goals of ACAP programming, and ensure that the evolving nature of the HIV/AIDS epidemic is considered.

# 5 Development of ACAP G&C Allocation Framework

A draft ACAP G&C Allocation Framework was developed, based on the literature review, input from the ACAP Working Group, and input from the Epidemiology Working Group. The draft Framework was then circulated to community and provincial/territorial government stakeholders for consultation (see section 6 for description of consultation process and findings).

## Data Inclusion Criteria

The draft G&C Allocation Framework focused on the regional distribution of ACAP funding according to indicator data that is collected in a standardized and reliable manner across all provinces and territories. While the consultants and the Regional Allocation Working Group recognize that there are many other indicators that would be desirable to include in the Framework, they chose to include only data that is available across all provinces and territories. Thus, the resulting Framework is not an ideal complete picture of the HIV epidemic across Canada as measured through all relevant determinants of health indicators or all relevant vulnerable population measures. The Framework does, however, aim to include the highest level of quality data currently available with a strong acknowledgement of missing indicators and resulting inadequacies in reflecting the full spectrum of vulnerable communities and vulnerability factors.

## Principles

The ACAP G&C Allocation Framework was designed to strike an appropriate balance between the three principles of equity, burden and vulnerability. These are the three principles that together most reflect the purpose of ACAP funding. However, it should be noted that these three principles as stand-alones will not reflect the purpose of ACAP. Rather, the three principles must be balanced against one another. Also, the principles can actually oppose one another on any given issue and thus the need for balance cannot be overemphasized. Burden and equity, for example, can be oppositional in that allocating resources to a region in proportion to its burden of HIV infections may oppose efforts to distribute funding so that all provinces and territories can maintain at least a minimal level of HIV programming. Below are analyses of each of the three principles, their rationale and inadequacies.

**Burden:**

ACAP funding should reflect the realities of how HIV affects certain regions in Canada more than others. The principle of burden reflects the present circumstances in a given province or territory. Those regions with highest levels of prevalent HIV carry the highest burden with respect to HIV care and support, as well as indicate areas that most need ongoing and sustained HIV prevention. As such, HIV prevalence is the only criteria for this principle.

*ACAP G&C resources are allocated to the provinces and territories according to their burden of HIV.*

Providing resources on the basis of proportionality (i.e., allocating ACAP funding to provinces/territories according to their proportional burden of HIV) creates a situation in which those provinces/territories with highest rates of HIV are favoured in the allocation of ACAP resources. According to the US National Institute of Medicine[44], proportionality has limitations in that it rewards the reporting of HIV cases rather than the prevention of new infections, and largely reflects where the epidemic has been, rather than where it is going. It should be noted, however, that the present burden of HIV can indicate where the epidemic is going when considered along with other factors such as exposure categories.

**Vulnerability**

It is stated in *The Federal Initiative* that the government of Canada and its partners "…will work toward a Canada free from HIV and AIDS and the underlying conditions that make Canadians vulnerable to the epidemic." [45] The principle of vulnerability reflects future trends in HIV rates and introduces an element of prediction. According to *The Federal Initiative*, HIV/AIDS must be addressed not only from a biological point of view but also from social, economic and human rights perspectives, taking into account the root causes, determinants of health and other dimensions of the epidemic.

*ACAP G&C resources are allocated to the provinces and territories according to their vulnerability for HIV infection.*

Thus, ACAP funding allocation should reflect the root causes of HIV infection due to individuals' social, economic, ethnocultural, behavioural, age or gender-related vulnerabilities. Furthermore, *The Federal Initiative* aims to develop discrete approaches to addressing the epidemic for people living with HIV/AIDS, gay men, injection drug users, Aboriginal people, prison inmates, youth and women at risk for HIV infection, and people from countries where HIV is endemic. Therefore, the vulnerability principle is reflected in this Framework through three types of criteria: incidence of related diseases, indicators of determinants of health, and estimates of vulnerable populations.

[44] National Institute of Medicine. 2000. No time to Lose - Getting More from HIV Prevention. Washington, DC: National Academy Press.
[45] The Federal Initiative to Address HIV/AIDS in Canada – page 6.

The challenge in integrating the principle of vulnerability is that it is difficult to provide reliable and standardized data for all meaningful indicators of HIV vulnerability. There are key indicators of vulnerability that are inevitably more available than others, and thus weight the Framework more heavily towards certain vulnerable groups. Ideally the vulnerability principle in the ACAP G&C Allocation Framework would be reflected in population size estimates for all of the vulnerable populations identified in *The Federal Initiative*. However, reliable population counts across provinces and territories are available only for Aboriginal peoples, immigrants from HIV-endemic countries and inmates in federal prisons. Estimates of percentage contribution to the 2002 national incidence and prevalence totals by province and territory and exposure category could serve as proxy data for the other vulnerable populations (men who have sex with men and injection drug users). The limitation of the population incidence estimates is that they are available only for some individual provinces or multi-province/territory regions.

## Equity

The Canada Health Act (1984) was created because of a commitment to remove financial barriers to health care for all Canadians. It declared that "the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial penalty."

*The ACAP G&C Allocation Framework must allow for adequate and equitable capacity for each province and territory to address HIV prevention, care and support needs.*

While all of the activities supported by ACAP would not necessarily be classified as "health services" that are subject to the Canada Health Act, the Act provides five principles that reflect the expectations of Canadians and should guide public policy development in order to provide certain guarantees for Canadian residents.

Two of these principles, universality and accessibility, are specifically relevant to the concept of equity. *Universality* demands that all residents in a province have access to public health-care insurance and insured services on uniform terms and conditions. This principle sought to make insured services available to everyone, everywhere. *Accessibility* demands that insured persons must have reasonable and uniform access to insured health services, free of financial or other barriers. No one may be discriminated against on the basis of such factors as income, age, and health status.

Both universality and accessibility form the basis for equity in health, which essentially refers to the "fair and just distribution of health resources"[46]. The concept of equity differs from that of equality; the measure of health care equity is not that everyone receives the same service or the same number of services, but that the service provided is based on need. In Canada, equity is generally described as "equal

[46] Issues in Equity and Responsiveness in Access to Health Care in Canada, Health Canada 2001) http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2001-certain-equit-acces/2001-certain-equit-acces_e.pdf

access (or equal service) for equal need". Therefore, equitable access is defined as "provision of health services in a way that provides an equal opportunity for all citizens to achieve maximum health."[47]

In concordance with the statement above, this ACAP G&C Allocation Framework aims to support *equity across provinces and territories* by accounting for the variation in resource requirements to implement ACAP programming across Canada. Equity is incorporated into this Framework in an attempt to reflect difficulty and cost of applying programs and reaching target populations in certain regions of the country. For community members in Atlantic Canada[48], equity was defined as meaning that greater resources and more services should be made available to the most vulnerable and needy groups in society. Participants agreed that the long-term goal of promoting equity is to improve the health of the most vulnerable groups.

In the prior version of the ACAP G&C Allocation Framework, equity was reflected by factoring in the contribution of provincial/territorial governments to HIV programs, and balancing federal contributions accordingly. However, the unavoidable effect of factoring in provincial funding is that either: 1) regions are penalized (i.e., receive lower amounts of federal funding) for having strong provincial contribution which becomes a disincentive for provincial funding sources; or 2) regions with strong provincial funding receive proportionately more funding than those with less provincial funding, which penalizes the community organizations in some provinces twice over.

Thus, the ACAP G&C Allocation Working Group has decided to eliminate the provincial funding levels as a factor in the funding allocation formula and use the criteria of cost of living and level of remoteness to reflect equity across provinces and territories.

## Description of the Framework

The following table is a summary of the draft ACAP G&C Allocation Framework that was circulated for consultation. It included the major components proposed for the Framework and details about each of the criteria with respect to:

- Principles – Burden, Vulnerability and Equity
- Criteria - Criteria supporting each principle have been selected for inclusion in this G&C Allocation Framework on the basis that the criteria are both relevant and collected in a standardized manner across all provinces and territories. However, it is important that the data included in the allocation model, while being available and accurate, also reflects the values of stakeholders. For this reason, consultation is being used to determine which of these indicators would be useful, and if so, to what degree.
- Rationale – an explanation of why the criteria are included under each principle.
- Description – summary definition of the Framework criteria

[47] ibid

[48] The Tides of Change: Addressing Inequity and Chronic Disease in Atlantic Canada, A Discussion Paper. Karen Hayward and Ronald Colman. Prepared for Population and Public Health Branch, Atlantic Regional Office, Health Canada. July 2003.

- Programming - the type of programming for which the criteria serve as an indicator - Prevention; Health Promotion, Care and Support (HPCS); Creating Supportive Environments (CSE); Strengthening Organizations (Strengthening)
- Source – the individuals and/or government departments that will supply the data
- Units – the measurement units for each of the components
- Year of best available data - the most recent year for which there is complete and nationally standardized data
- Weight – the relative weighting (percentage) which each of the components will be assigned

## Construction of the Formula

There are two options for how the allocation formula will be constructed with respect to the relationship between the three principles.

B = Burden
V = Vulnerability
E = Equity

Option #1

B + V + E = 100%

In this option, although each principle may have a different weighting, each of the principles are weighed on the same level.

Option #2

(B x E) + (V x E) = 100%

In this option, burden and vulnerability are each adjusted according to equity, and then added together. The degree to which equity adjusts burden and vulnerability distributions will depend on both the weight chosen for equity and the distribution of equity criteria among the provinces and territories.

## Frequency of Application of the Formula

Once finalized, the allocation formula will be applied for funding beginning in April 2006 and calculated for fiscal years 2006-07, 2007-08 and 2008-09 based on budgeted ACAP amounts as defined by *The Federal Initiative to Address HIV/AIDS* in Canada. The calculation of ACAP G&C allocations for the next three fiscal years will allow each region to plan for future community-based HIV/AIDS program development and delivery.

## Draft ACAP G&C Allocation Model for Consultation

It should be noted that this is an outline of the draft ACAP G&C Allocation Model that was circulated to community and provincial/territorial government stakeholders for them to consider in the consultation process.

| Principle | Burden | Vulnerability | | | | | | | Equity | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Criteria** | **HIV Prevalence** | **HIV Incidence** | **STI Incidence** | **Hep C Incidence** | **Low Income Cutoffs** | **Literacy** | **Vulnerable Populations** | **Age 12-50** | **Cost of Living** | **Level of Remote-ness** |
| **Descrip-tion** | Total number in each province or territory (P/T) who are currently living with HIV infection. | Total number in each P/T who tested positive for HIV in the most recent year. | Chlamydia, gonorrhea and infectious syphilis are notifiable and standardized across all provinces. | New diagnoses of Hep C infections by P/T. | Percent of population in each P/T that is below the low income cut-off. | Percent of population in each P/T that is below Level 3, considered to be the minimum skill level for successful participation in society. | Population estimates or direct counts of Aboriginal peoples, MSM, IDUs, people from HIV-endemic countries, & prisoners. | Size of the general population in each P/T within the ages of 12-50. | The average cost of living for basic amenities (food, shelter, transport-ation, clothing). | Measure of the proportion of the population in each P/T that is classified as rural-remote. |
| **Rationale** | HIV prevalence reflects the current burden of care & support programs | HIV incidence reflects the need for both prevention, and care and support programs. | According to the Federal Initiative, programs must address barriers for people living with or vulnerable to multiple infections and conditions that have an impact on their health. STI incidence and new diagnoses of Hep C are indicators of unsafe sexual and injecting practices, respectively. Furthermore, those with STIs are physiologically at greater risk of contracting HIV. Because no reliable co-infection data is available, these indicators do not directly reflect HIV burden. | | Proportions of people in each P/T living below low income cutoffs and minimum literacy levels are two data sets for socio-economic determinants of health that directly affect HIV risk and/or access to HIV prevention education (versus determinants that affect health generally), and are collected in a standardized manner across Canada. Other important determinants such as housing/homelessness and social supports are not available in a standardized manner across all P/Ts. | | The FI aims to develop discrete approaches to addressing the epidemic for specific vulnerable populations. | People between the ages of 15-50 represent those most at risk of contracting HIV. Age group 12-14 will include youth before or around the time of initiating sexual activity. | Cost of living can serve as a proxy indicator of difficulty applying programs or reaching target audiences. | Level of remote-ness can serve as a proxy indicator of difficulty applying programs or reaching target audiences. |

| Principle | Burden | Vulnerability | | | | | | | Equity | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Criteria** | **HIV Prevalence** | **HIV Incidence** | **STI Incidence** | **Hep C Incidence** | **Low Income Cutoffs** | **Literacy** | **Vulnerable Populations** | **Age 12-50** | **Cost of Living** | **Level of Remote-ness** |
| **Program-ming** | HPCS and Prevention | HPCS and Prevention | Prevention | Prevention | Prevention and CSE | | Prevention and CSE | Prevention and CSE | CSE and Strength-ening | CSE and Strength-ening |
| **Source** | Surveillance and Risk Assessment Division, Centre for Infectious Disease Prevention and Control, PHAC | Surveillance and Risk Assessment Division, Centre for Infectious Disease Prevention and Control PHAC | Sexual Health & STI Section, PHAC | Hepatitis C Program, PHAC | Statistics Canada (Census data) | | Census Canada, Correctional Service Canada, Citizenship & Immigration Canada, First Nations and Inuit Health Branch, special studies | Census Canada | Census Canada | Rural Secret-ariat |
| **Units** | % distribution by P/T | % distribution by P/T | Per 100,000 | | Low income cut-offs in each P/T | | Proportion of total population | Proportion of general population | Average cost of living for each P/T | Proportion of general population that is remote |
| **Year of Best Available Data** | 2002 – sex and exposure categories available | 2002 – sex and exposure categories available | 2002 – latest complete year; first 2 quarters of 2004 and 2003 levels are available | 2002 - Remis report (2005) and Hep C surveillance data | Most recent data is 2003 income levels | Last census data published in 2003 (2001 data) | Last census data published in 2003 (2001 data) | 2004 project-ions based on 2001 census data | Last census data published in 2003 (2001 data) | |
| **Weight** | *See consultation results* | | | | | | | | | |

# 6 Consultation with Community and Provincial/Territorial Government Stakeholders

## Methods

Once a draft ACAP G&C Allocation Framework was developed by the Consultants and reviewed by the ACAP G&C Allocation Working Group and the Epidemiology Working Group, the consultation was conducted using the following steps:

- Development of consultation guidelines for regional, provincial or national ASO coalitions to gather input from their members.
- Development of a list of stakeholders to be consulted and an interview guide for consultations, which was sent to Working Group members for review. Based on input gathered from the Working Group, a list of stakeholders, their contact information, and an interview guide was finalized.
- Dissemination of consultation questions to regional ASO coalitions for them to distribute and request responses within 3 weeks (see Consultation Guide in Appendix A). Approximately three key contacts representing stakeholders per region were interviewed.
- Epidemiology consultation was conducted both prior and during the consultation in order to clarify the data sources, their reliability and standardization across all provinces and territories.
- Consultation with community and provincial/territorial government stakeholders via telephone interviews and/or written responses to assess appropriateness of resource allocation models.
- Presentation of a discussion paper providing options and recommendations on regional ACAP allocation models to the Working Group.

## Scope of the Consultation on the ACAP G&C Allocation Framework

It was acknowledged by both the Working Group and the Consultants at the inception of the project that there would be limitations in the scope of the consultation component. The consultation process for the development of the ACAP G&C Allocation Framework was limited by both time and resources, and thus did not include a random sampling of all community and provincial/territorial government stakeholders across Canada. The short timelines and restricted budget limited the extent to which the Consultants could consult with the stakeholders across the seven regions. Ideally, consultations in each ACAP region should have included a cross-section of ACAP program consultants, provincial health counterparts, and a range of community-based organizations (ASOs, non-ASOs, ACAP recipients, non-ACAP recipients) representative of all organizations in that region. Consultation, ideally, would also have been engaged at multiple stages in the development of the Allocation

Model, including a formative stage of developing priority criteria to be included in the framework, as well as reviewing a draft framework. It would also have been ideal to conduct such consultations in face-to-face meetings, however the travel expenses would exceed the budget for this contract. All efforts were made to conduct consultations with individuals who were representative of the government and community in each region. It was expected that ASOs, for example, would be represented wherever possible by provincial coalitions and opportunity was given for those coalitions to consult with their members. However, one concern raised was that no standardized process for each province and territory was developed for inclusion of community-based organizations who were not ASOs (i.e., not focused solely on HIV/AIDS, but focused on vulnerable populations) or ACAP recipients.

It should be noted that concurrently, a national review process of ACAP funding program was taking place in light of the new *Federal Initiative to Address HIV/AIDS in Canada.* The focus of the ACAP review is the program structure and recipients for distribution of funds *within* regions, while this ACAP G&C Allocation Framework focuses solely on the distribution of funds *across* regions.

The consultation plans for the two reviews are directly reflective of their different levels of focus – the consultations for the ACAP G&C Allocation Framework predominantly include regional, provincial, territorial or national stakeholders, while the consultations for the ACAP program review will include to a greater degree community-based organizations within provinces and territories who are current and potential recipients of ACAP funding.

## Consultation Respondents

A total of 29 stakeholders reviewed the draft ACAP G&C Allocation Framework and responded to the consultation questions in writing and/or via telephone interview.

A list of respondents is included in Appendix B.

Respondents to the consultation request included:

- 11 community-based organizations (CBO), representative of all provinces/territories except Québec[49]
- 10 provincial/territorial government representatives (3 of which were medical epidemiological specialists)
- 8 RHAN members (representing 7 PHAC Regional Offices)

[49] The Coalition des Organismes Communautaires Québécois de lutte contre le SIDA (COCQ-Sida) advised its members by email (October 18, 2005) to not participate in the consultation on the ACAP allocation review. Thus, the consultation findings do not include input from Québec community stakeholders. However, the Québec provincial government sent their official position in writing which are included in the provincial/territorial representative portion of the analysis.

# Consultation Results

## The Principles of Burden, Vulnerability and Equity

Overall, there was support for the three principles and for valuing all three principles equally in importance. There was recognition amongst stakeholders of the challenge of finding an appropriate balance between burden and vulnerability. It was noted, for example, that to have a long-term impact on burden, there must be adequate focus on primary prevention and vulnerability.

*These 3 principles are interesting and sensitive. They can bring a clear view of the situation within all different regions of Canada.* (RHAN member)

*The 3 principles and the criteria are relevant. They create a good portrait that takes main regional uniqueness into account.* (RHAN member)

### Burden

Although 'burden' was intended as an epidemiological term to denote prevalence of certain disease in a population (i.e., 'burden of disease'), some community members noted that it had a negative connotation, and it was suggested that it be replaced with the label 'HIV Prevalence'.

Respondents noted that it was important to include a measure of HIV prevalence because it provides a cumulative measure, given that people with HIV live longer and have complex needs. Therefore, the cost of providing care and support services increases steadily.

*The needs (costs of prevention, treatment and support services) of an educated HIV positive gay man who lives a stable lifestyle will likely be vastly different from the HIV positive IDU who lives on the street. Burden should not be considered without matching to vulnerability.*(Provincial Government)

At least 3 provinces highlighted that HIV prevalence does not accurately reflect "impact on the care/treatment/support services", in their province because prevalence statistics are gathered from the locations where people are tested, rather than where people are living. The three northern territories all emphasized that burden should not have greater weight than vulnerability, as it is especially common that residents undergo HIV testing in a southern province rather than be tested in their own territory because of the perceived lack of confidentiality and fear of stigma.

*Burden of illness and size of population in the long run has been ignored and not recognized strongly enough, rather based on political concerns such as [our province] having lots of sources of funding and seen as a "rich" province. Even with all our resources, we're not winning the battle.* (Provincial Government)

Some respondents noted that not all people living with HIV represent equal levels of need with respect to care, treatment and support services. Individuals of lower socioeconomic status who are socially isolated are more likely to require extensive support services and outreach, as compared to someone from a more privileged, less marginalized social group.

*Burden tells us where we've been, not where we're going and isn't accurate for northern communities.* (CBO Representative)

Another respondent noted that HIV prevalence should be measured as rates, not absolute values.

**Vulnerability**

All respondents felt that vulnerability is an important principle to include, and that its corresponding criteria included in the Allocation Framework were appropriate. Indicators mentioned by participants were often already considered in the development of the draft framework, but were not included because the data were not available from a standardized and reliable source.

*Taking vulnerability into consideration is not only a more appropriate principle to take into consideration, but a novel concept for our region. In that currently the only cure we have is prevention, and the vulnerability principle is prevention based, logic dictates that funding preventative education programs is tantamount to reducing new incidents of HIV infections.* (CBO Representative)

Generally, vulnerability was the principle which was considered the weakest, in terms of lacking comprehensive and reliable data. Most respondents acknowledged the difficulty of reflecting vulnerability accurately in the allocation formula. Respondents generally felt that the model has sound recommendations in terms of good data sources for the principle of vulnerability. Some noted the complexity of vulnerability and the lack of reliability in measuring the precise size of populations that are vulnerable to HIV. Others noted that the extent of vulnerability within a region can change within a short time span, depending on social and economic factors.

*Any region of the country that has high burden will also have a high proportion of populations who are vulnerable to HIV infection.(CBO Representative)*

Some respondents noted that burden and vulnerability were very interdependent and should be balanced in the allocation formula.

<u>Incidence of Related Diseases</u>

Incidence of related diseases was generally supported by all participants as an appropriate criterion of vulnerability, and reflected trends in the health sector to address blood-borne pathogens and STIs under one strategic plan. Numerous developments are taking place nationally and regionally that are leading to integration of prevention efforts on HIV, HCV, Sexually Transmitted Infections (STI) and tuberculosis (TB), leading to more Integrated Infectious Disease Strategies. This has been prompted by the rate and increased risk for co infection and commonality in risk behaviours.

*Given the move towards integration, it is appropriate that Hep C and STI incidence are also included. (Provincial Government)*

Vulnerable Populations

Many participants expressed concerns that allocating resources based on targeted vulnerable populations, after decades of work towards eliminating stigma of "risk groups" and moving more towards a focus on risk behaviors, is counterproductive. However, other respondents understood that this criterion is in alignment with *The Federal Initiative's* focus on vulnerable populations.

*Inclusion of Aboriginal estimates will reflect the overrepresentation of Aboriginal persons who are HIV-positive, and that Aboriginal persons exhibit higher risk factors for contracting HIV, and the wider range of support required for extended family members vs. non-Aboriginal communities. (CBO Representative)*

One vulnerable population noted as missing from the vulnerability criteria was the prison populations. However, it was recognized that prison population counts account only for people presently in prison, and does not account for former inmates, and also that there would be standardized data only for federal penitentiaries.

One respondent noted the particular difficulties in defining vulnerability of people who are or have been imprisoned.

*Do you count the Corrections stats for the province in which they are incarcerated, or in the province of origin where they have lived and probably will return? Do you treat the provincial and federal numbers differently? Do you count the long term imprisonments as they really are more of a Corrections responsibility and not that of a CBAO? (CBO Representative)*

One weakness in the data that was highlighted by some respondents was information about First Nations, Métis and Inuit peoples.

*First Nations and Inuit Health Branch says they are responsible for those who are on-reserve. But there is a big difference between on-reserve vs. off-reserve access to services. What is happening to First Nations in this country is disturbing and distressing to all of us.* (Provincial Government Representative)

Some respondents expressed particular concern about the lack of population estimates for the vulnerable population of gay men and MSM (men who have sex with men), and noted that some data exists[50] (e.g., number of same sex couples by province and territory, number of children of same sex couples), but there is no count of the number of gay men living within the provinces and territories. Other vulnerable populations that were noted as missing data in the formula were:

- Transient populations
- Refugee populations
- Women at risk

*HIV among gay men doesn't neatly fit into considerations of gender or culture. We talk about a gender inclusion lens, but we need to do the same from a homophobia lens, inclusion perspective. (CBO Representative)*

[50] From Census Canada and from the website: www.gaydemographics.org

Low Income and Literacy

One respondent noted that low income and literacy levels might be used to identify people within vulnerable populations who are most at risk, but low literacy or low incomes on their own would not be a valid way to identify people at risk of HIV.

*Low income and literacy are good proxies for unemployment, low education levels and homelessness which can influence the increase in engagement of high risk activities. (RHAN member)*

On the other hand, another respondent felt that there should be a focus on determinants of health such as income and education – factors that make people vulnerable, rather than focusing on who is vulnerable.

Population Aged 12-50

At least two respondents noted that they would like the age category to be expanded to include seniors because there is a steady increase in the number of people over the age of 50 living with HIV. However, the intent of the population criteria is to reflect those at risk of HIV, not the aging of people living with HIV who were infected before they were seniors.

Respondents noted that in general, people between the ages of 12 and 50 are at risk only when they also have other risk factors, such as being a member of a vulnerable population. The age category is quite broad and thus captures a significant size of the Canadian population, so respondents were not sure how meaningful the data will be. At the same time, it was acknowledged that this category does capture vulnerable populations that may not have available population-specific data, namely youth and women at risk. Also, it was recognized that the age group reflects the estimated 30% of Canadians living with HIV who do not know that they are infected.

**Equity**

The rationale for including an equity principle was to account for differences in the difficulty of running programming, and was meant to replace the provincial funding level criteria. However, some respondents still would have liked a mechanism for leveraging provincial contributions.

*There is a critical minimal level of funds needed to fund this operation, regardless of the size of the province. Therefore, I would recommend that the formula be amended to:*
*ACAP allocation = Base amount per province + Rest of the formula (Community Member)*

Two informants felt that one way of building in an equity measure within the formula would be to provide a base level of funding.

One respondent thought that the equity principle should apply to how funding is distributed *within* a region as opposed to between regions. He felt that resources should be allocated across provinces and territories based on burden and vulnerability, and then ACAP regional offices would take into account factors of equity (such as the varying costs that individual organizations face to provide similar programs and services) by providing a range of funding levels for particular programs and services.

*To qualify for a higher than average amount of funding for a particular program or service, an organization would have to demonstrate that the costs of delivering services were higher than for other organizations in the region: however, the initial decision on whether the organization qualified for funding should be based on burden and vulnerability. (Provincial Government)*

Level of Remoteness

Respondents generally understood the value of a level of remoteness criterion. They explained that in rural-remote areas, smaller communities are less likely to have comprehensive infrastructure to meet all the prevention, diagnosis, care, treatment and support needs of community members. They also noted that smaller communities are more likely to be affected by problems with confidentiality. Both of these reasons requires individuals to travel to either access services, or requires organizations to spend more resources on providing outreach to remote communities.

*Consider that it may take two hours one way to provide services to support an entire community of 300 people with one or two persons who are living with HIV, and that community is no less deserving of services than the family that lives within a few blocks of an ASO in Downtown Victoria. (Provincial Government)*

One respondent interpreted level of remoteness as a diversity issue, in terms of having the capacity in a region to provide services in a variety of ways to overcome barriers of addictions, language, culture, sexual orientation, etc. Larger populated provinces also have a greater variety of specialized organizations; while in smaller provinces, it means one organization must try to find creative part-time ways or partnerships to provide the services to a diverse (albeit smaller) number of individuals.

One respondent cautioned that the level of remoteness criterion might put too much emphasis on the Aboriginal population, which is already accounted for under the vulnerable population criterion. One individual suggested calculating the proportion of Aboriginal people in each province living in rural-remote areas.

*This population lives mainly in remote area and they are already taken into account in "Vulnerable populations". Also, Aboriginal people are already "covered" with FNIHB or other Aboriginal Initiatives. (RHAN member)*

One respondent noted that equity should also measure the geographic coverage relative to the location of organizations. In provinces with large geographic regions and few urban centres providing services, a significant barrier for people to access services is the time/distance, which is a financial challenge to both the clients and the service providers. For example, a province may not have extremely remote populations, but they do only have two centers to provide services to a large province (e.g., Saskatchewan).

*Although our burden is lower relatively speaking and we have a smaller population, the capacity is stretched to a limit over a large geographic area, almost to the point where the situation is the equivalent of no coverage at all. Vulnerable populations are dispersed across the province, a person has to travel far to remote areas, and barriers are complex.* (CBO Representative)

Many respondents (particularly from those provinces with large urban centres) noted that there are difficulties in providing programming that are associated with being located in high-density cities, and thus the Framework should include a measure for population density. The example was given that for a person living in poverty in a big urban center, even with lots of services, the wait times for those services and finding transportation can still present barriers to accessing services. Respondents found it difficult to rationalize how remoteness should be given advantage over population density.

*The flip side of remoteness is the high concentration of IDUs, MSM, at-risk youth and women, etc. in urban centres, as it relates to HIV vulnerability. (CBO Representative)*

*On a day to day basis, if you're a person living in poverty in the downtown core, you have to pay more (higher cost of living) than those who live in rural areas than those who have cars or where things are cheaper. Often in urban centres, individuals can live and function without any social support. (Provincial Government)*

Some respondents pointed out that including level of remoteness is based on the premise that providing services in large urban areas is easier than providing services in rural-remote areas because there are more services available and "it's easier to do prevention work," and they questioned this assumption. Transportation challenges, for example, exist in large urban centres for people who are living in poverty, who live on the outskirts of the core of downtown services, and must rely on public transit. Furthermore, the large population size means that there are long waiting lines and waiting lists for services even if they are accessible over a short walking distance.

## Data Inclusion Preferences for Vulnerable Populations

Stakeholders were asked to reflect on the question of how best to include vulnerable populations in the Allocation Framework, given the inability to provide reliable population size estimates for all vulnerable population. The three options were:

a. ONLY include census data (i.e., direct population size counts) that is available across all provinces and

territories - Aboriginals, people from HIV-endemic countries and prison inmates

b. Include census data in option 'a' AS WELL AS population incidence estimates for IDU and MSM as a proxy for population estimates even though these estimates are not available for all provinces and territories

c. Do not include any data on vulnerable populations, given that there is no complete and standardized data for all vulnerable populations across all provinces and territories

The majority of respondents selected option B.

Most of the respondents supported option 'b' because they felt that the funding allocation formula should be based on the maximum amount of available data:

- some respondents felt that vulnerability needs to be partially assessed by anecdotal data or at least regional data (e.g., British Columbia, on-line survey of MSM Population)
- one respondent felt that experts in the country could "help make our soft estimates as 'hard' as possible"
- some respondents wanted inclusion of "soft data" or anecdotal, local, one-time information from isolated studies to measure the size of vulnerable populations in their province.
- some respondents noted that hard data (e.g., from census or surveillance) isn't always necessarily reflective of the local situation, nor is completely reliable. For example, risk factor reporting is unreliable in HIV surveillance because someone may rather say they acquired HIV through heterosexual contact rather than through MSM or IDU contact.
- some respondents felt that census data is very limiting, and that other information such as data from I-track, M-track, Enhanced Surveillance Study on Street Youth (EHSS), etc. be included
- one group of community respondents noted that they would support option 'b', provided that data for vulnerable populations can be obtained for the four provinces that represent 85% of HIV cases (BC, Alberta, Ontario and Québec)

*If the framework for allocation is too rigid then it may miss out on being able to utilize soft data and anecdotal evidence that would help us identify and addressing growing trends before these trends overwhelm us. (CBO Representative)*

*We should go with what we know, and trust our different scientists with what we can get. If there is huge controversy, it might be good to have some triangulation, separate models down by separate scientists and see if they come up with same figures for the population incidence estimates. (Provincial Government)*

*We need to strike a balance between systematically collected data, and data that is not complete across all jurisdictions. But we must favour systematically collected data.* (CBO Representative)

Individuals who selected option 'a' wanted to include only data that is collected universally across the country. Very few respondents selected option 'c'.

Other options were suggested for including data on vulnerable populations:

- Create a ranking based on HIV levels attributed to vulnerable populations within each province/territory
- Create a provincial advisory committee of community organizations and health care professionals that would be representative of at-risk populations
- Allow a mechanism for including anecdotal information to explain some of the issues related to the principles that statistics do not necessarily address (eg., migration between urban/rural settings, new trends amongst IDUs and MSM).
- Semi-annual and annual ACAP reports and program evaluations are designed to inform trends, emerging issues and populations, but are not acknowledged as data collection tools in the Allocation Framework.

*"Why do we do reporting of our programs, if not to inform on program development and resource requirements?"* (CBO Representative)

## Ranking of Vulnerability Criteria

Stakeholders were asked to rank the criteria from 1 (the highest) to 7 (the lowest) in terms of best measures of the principle of Vulnerability. They were also permitted to choose to rank more than one (or all) equally.

| | Community | Provincial | RHAN Members | Average Ranking Score | Overall Rank |
|---|---|---|---|---|---|
| HIV Incidence | 3 | 4 | 2 | 3 | **2** |
| STI Incidence | 2 | 6 | 3 | 3.67 | **4 (tied)** |
| Hep C – New Diagnoses | 4 | 3 | 4 | 3.67 | **4 (tied)** |
| Low Income Cut-Offs | 5 | 2 | 3 | 3.33 | **3** |
| Literacy | 6 | 5 | 5 | 5.33 | **5** |
| Vulnerable Populations | 1 | 1 | 1 | 1 | **1** |
| Population Aged 12-50 | 7 | 7 | 6 | 6.67 | **6** |

Note: 6 respondents ranked all seven of the vulnerability criteria equally (out of a total of 20 that did indicate a ranking) and 4 respondents did not conduct a ranking at all.

## Ranking of Equity Criteria

Stakeholders were asked how they would weigh the criteria (using percentages) under the principle of equity. Of the 25 respondents to this question, 9 thought they should be equal (3 did not respond).

| | Community | Provincial | RHAN | Overall |
|---|---|---|---|---|
| Cost of Living | 40.71 | 40.71 | 43.57 | **41.66** |
| Level of Remoteness | 59.29 | 59.29 | 56.43 | **58.34** |

Three respondents noted that level of remoteness and cost of living are inter-related, so either should be equal, or that the formula should just include one of the criteria.

## Objectives of the Draft Framework

Generally, the stakeholders felt that the Allocation Framework was a "good attempt" at meeting the stated objectives of the Framework, but highlighted that the need for good data/surveillance (e.g., unreliability of HIV prevalence data, lack of data on transient communities and certain vulnerable populations). Some respondents commented that the Allocation Framework did a good job of incorporating some of the concepts from *The Federal Initiative*.

*This framework is very comprehensive and will allow for equitable, evidence based distribution of ACAP resources across the provinces/territories. (Community)*

The stakeholders were asked if the regional allocation decision resulting from the draft framework, given the data available, would be:

### a. Evidence-based

Overall, there was satisfaction that this objective was being met:

- Of the stakeholders who responded to this question, 10 felt that yes, the framework would produce evidence-based allocation decisions (6 RHAN members, 1 CBO representative, 3 provincial government representatives).
- 3 respondents felt that the framework was a "good attempt" or "maybe"
- And 2 CBO representatives said no, the framework would not produce evidence-based allocation decisions.

### b. Appropriate

There was overall support for the allocation framework meeting this objective, but mostly from provincial government and RHAN representatives:

- 10 stakeholders said yes (5 provincial government representatives and 5 RHAN members)
- 4 felt that this framework was either a "good attempt", "better than before" or "maybe" (1 CBO, 1 provincial government, 1 RHAN member)

- 3 respondents said no, the framework was not appropriate (2 CBO, 1 provincial government)

c. **Address the burden of HIV across Canada**

There was stronger support for the framework meeting this objective:

- 11 respondents did feel that the framework addresses the burden of HIV across Canada (2 CBO, 4 provincial government representatives, 5 RHAN members)
- 2 RHAN members said "maybe"
- and 1 CBO representative said no

d. **Anticipate future trends in HIV**

There was wide variance in responses regarding the meeting of this objective. However, many respondents indicated that there did not seem to be any expectation that the model should anticipate future trends.

- 5 respondents felt that the framework does anticipate future trends in HIV (1 provincial government representative, 4 RHAN members)
- 2 stated "somewhat" (1 CBO representative, 1 provincial government representative)

*We would not expect the allocation process to anticipate future trends in HIV. It can only deal with current data. Future trends should be identified by front line organizations and communicated to ACAP in other ways (e.g., program evaluations and reports, proposals for funding). (Community)*

- and 7 respondents felt that the framework did not anticipate future trends (4 CBO representatives, 1 provincial government representative, 2 RHAN members)

One respondent (provincial government representative) felt that Canada is verging on "a major explosion of HIV in First Nations communities and amongst youth (young MSM or heterosexual)" and that the data currently available does not allow us to anticipate future trends in HIV: "Especially with census data our most marginalized won't even be in the census."

Amongst some respondents, it was identified that the ability of the formula to predict future trends through the vulnerability principle will be limited by the fact that this principle is using data taken at a given time for a given period. Unless the formula is updated and reapplied regularly, the predictive power of the formula is limited. At the same time, it was recognized that the formula could not be applied on a regular basis given the need for stable level of funding in provinces and territories to allow for longer term planning.

**Weighting of the Formula - Option A:**

B + V + E = 100%

Stakeholders were asked to indicate how they thought the three principles should be weighted (using percentages) if the first formula construction option was used.

| | Community | Provincial | RHAN | Average |
|---|---|---|---|---|
| Burden | 32 | 28 | 37 | **32.3** |
| Vulnerability | 41 | 37 | 34 | **37.3** |
| Equity | 27 | 35 | 29 | **30.3** |

There were 22 responses to this question; of these, four responded with qualitative responses. Six respondents did not answer this question (four CBO representatives, one provincial government representative and one RHAN member).

Taking into account some of the qualitative responses in the consultation findings, the Consultants would recommend a weighting of 30% burden, 40% vulnerability, and 30% equity.

Generally, CBO and provincial government representatives placed more of an emphasis on vulnerability (particularly as reflected in the vulnerable population criteria), while RHAN members placed slightly more emphasis on burden.

It is interesting to note that some CBO representatives used their own programming composition between addressing burden (i.e., providing care, treatment and support services) and addressing vulnerability (i.e., providing prevention services) to answer this question rather than thinking about regional allocation between provinces and territories. There was also some confusion created when respondents compared the valuing of burden vs. vulnerability based on how they predicted it would translate to operational vs. project funding availability.

Some of the stakeholders provided their rationale for their weightings:

- *We weighed burden less, even though in our province we tend to have to focus mostly on addressing burden. But when we looked at province to province, we leaned more toward vulnerability and equity being equal and burden being less.* (Provincial Government Representative)
- *The number of people living with HIV in a province/territory is DIRECTLY connected to capacity to achieve both prevention and burden outcomes. Outside of the notion in an abstract way of rewarding for higher burden, one has to consider that there are a larger number of people that need services…but we wanted to be clear on the fact that burden has a real connection directly to prevention issues.* (CBO Representative)
- *Burden will be the hardest to assess appropriately accross all P/T's so it should be given the less weight.* (CBO Representative)

**Weighting of the Formula - Option B:**

(B x E) + (V x E) = 100%

Stakeholders were asked to indicate how they thought the three principles should be weighted (using percentages) if the second formula construction option was used.

| | Community | Provincial | RHAN | Average |
|---|---|---|---|---|
| Burden | 40 | 44 | 51.4 | **45.1** |
| Vulnerability | 60 | 56 | 47.1 | **54.4** |

Taking into account some of the qualitative responses in the consultation findings, the Consultants would recommend a weighting of 40% burden and 60% vulnerability.

There were 23 responses to this question, 2 in a qualitative manner; 5 stakeholders did not respond to this question (1 RHAN member and 4 provincial government representatives).

Some of the stakeholders provided their rationale for their weightings:

- *Burden will be the hardest to assess appropriately accross all provinces and territories, so it should be given the less weight.* (RHAN member)
- *Vulnerability should be given greater weight, recognizing the evidence base, the principals/recommended actions of Leading Together and the Federal Initiative, and the greater need to target resources to communities and populations where they will have the most impact.* (CBO representative)

One respondent (Provincial Government Representative) articulated why Option B would make the most sense in terms of construction of the formula:

- *The biggest cities have the highest HIV prevalence. Equity needs to be factored into vulnerability and burden, so option two is better. What if HIV is low, and cost of living is high? Cost of living by itself would not be important. It would be the same as applying level of remoteness. So, we need to look at the combination of HIV burden with the equity factors – level of remoteness and cost of living should not be considered alone.*

In terms of the weighting of equity in formula Option B, there was no real consensus amongst consultation respondents. The importance of this question was to discern the extent to which equity should adjust the weight of burden vs. vulnerability, and whether that equity adjustment should be to differing or equal degrees. Their answers ranged from 10 – 80% but the Consultants discerned that the respondents did not fully understand the question. Two respondents clearly understood the concept of using equity to adjust burden and vulnerability, but they provided differing answers as to how equity should be weighted.

*There are different arguments for prevention and support. If you have HIV wherever you live, you need services for sure, and if you live in a remote area, there is nowhere to go for treatment and support – need to find a way to balance that out for sure. But from prevention side, if a gay man lived in Thunder Bay and chose to have unprotected sex, it would be much safer than making that choice in downtown Toronto.* (Provincial Health Representatives)

One respondent (CBO Representative) proposed a hybrid formula construction:

ACAP allocation = Base amount per province/territory + Remainder to be allocated.

The remainder would then be allocated by Regions on this basis:
(Vulnerability x Equity) + (Burden x Equity)

Equity could either:

a) Be equally weighted using the same indicator, or

b) Be weighted differently using the same indicator, or
c) Have a unique indicator for  component, or
d) Have a different weighting for the two indicators for each component.

**Overall Impressions**

The participants were asked for their overall comments on the draft Allocation Framework. Some of the stakeholders were appreciative of the new framework:

- *It was a good discussion to have and we like it in a lot of ways but we just need to be aware that it's not perfect.* (CBO Representative)
- *A very good approach that is well thought out.  Different conceptual pieces included are good, definitions are also really thoughtful and it considered a lot of the problems that we wrestle with on a daily basis.  Given the limitations around what we know about the epidemic, it is probably as close as we can get to an equitable way of dispersing funding.* (Provincial Government Representative)
- *I congratulate the committee in their effort to put this framework in place. It is a good start.* (Provincial Government Representative)

One ASO coalition wanted to continue with status quo, given that they felt unready to adopt the new Allocation Framework:

- *While acknowledging that the current process for resource allocation is unclear to all participants and in spite of the lack of evaluative information provided; the majority of participants stated a preference to extending the existing process for resource allocation until a more complete community consultation and more adequately supported tool can be developed.* (CBO Representative)
- *Our biggest question was total focus on Federal Initiative when we are being told to work in partnerships.  What about using provincial, down to RHA information and planning to inform this process? What about the information we provide in our annual semi-annual reports?*  (CBO Representative)

One provincial government representative also wanted to continue with status quo. While they felt that the principles were legitimate, they felt the criteria proposed did not adequately capture these principles and that a "per capita" approach for the allocation of ACAP resources was most objective and appropriate.

- *The stated principles … are in themselves legitimate principles, except that the criteria used can be random or even hypothetical in some cases …The principles place too much focus on criteria that provide more or less reliable indicators, depending on whether it is a matter of available data or estimates (e.g., prevalence of HIV, data on vulnerable populations).  it is our opinion that a "per capita" formula is the only formula that can facilitate a fair allocation of ACAP resources.*(Provincial Government Representative)

One respondent noted that the Allocation Formula needs to more explicitly incorporate federal legislation regarding human rights and equal access to health care services:

- *We need to be careful to incorporate other federal legislation in principles such as "equity" and "vulnerability". If we do not properly address gay men then we are not properly incorporating human rights legislation around "equal access" to services. We have to make a referral to human rights legislation re: equal access to services for IDUs, gay men, etc. With equity and vulnerability, these should be incorporated. Other health legislative pieces around universality should be integrated somehow into the definition. As it currently reads, it does not do this.* (CBO Representative)

Some respondents expressed concerns around the Allocation Framework being responsive to Canada's HIV epidemic:

- *Since the data is often 2-3 years behind, how will trend analysis and forecasting be done? How often will adjustments be made to the allocations? The epidemiology can change quickly and funding decisions must reflect emerging issues, outbreaks, changes in vulnerable populations. At least every 3 years, we should re-assess and respond to population change and population levels in incidence. While 5 years are nice to provide stability but not realistic in provision of services.* (Provincial Government Representative)
- *It's a good starting point, but we should be able to adjust the formula as new data becomes available.* (RHAN member)

Some stakeholders noted that the review of the draft Allocation Framework highlighted the importance of data collection:

- *From a national perspective, more work needs to be done on standardized data collection. Not just routine surveillance. I think that PHAC is a bit limited by cooperation from provinces and territories, but I still think concerted effort in that direction is necessary. PHAC needs to be pushy. If really are interested in collecting information nationally, we need to stop comparing "apples and oranges" because surveillance procedures are so different.* (Provincial Government Representative)

There was also a request to allow more flexibility in the Framework to account for political context:

- *I would like a little bit more flexibility to reflect geography, population and political differences (for example, provincially, politicians in one province may see HIV infection due to injection drug use as personal choice). Marginalized groups may not be part of the political forum and in some provinces there are no public pressures to deal with different things. The formula should be flexible to account for those differences (political will and public pressure). The old situation (penalizing a province for provincial support) also is not the answer.* (Provincial Government Representative)

Some respondents felt the Framework is too reliant on epidemiological data and doesn't provide appropriate focus on the Determinants of Health and/or primary prevention. The Determinants of Health do not address issues faced by gay men, for example, such as homophobia/ heterosexism. However, respondents were not able to provide suggestions about reliable and standardized mechanisms for incorporating those factors. Other respondents appeared to understand the challenges associated with finding reliable and standardized sources of data:

- *The framework seems comprehensive as it includes STIs, Hep C and determinants of health wherever possible.* (RHAN member)

## Process Issues

### Inclusion

During the course of the consultation, some community groups advocated for more explicit inclusion of input from CBOs not currently (or traditionally) funded by ACAP as well as those who aren't AIDS service organizations. These CBOs were assured that their input was welcome, as long as it was rolled up with the community responses from that province or territory (as the Consultants were not able to manage individual responses from all interested CBOs). Also, the Canadian AIDS Society inquired about why it had not been included as a community stakeholder in the consultation and it

was explained that the Working Group was interested in the perspectives of provincial-level and territorial-level organizations.

Timeframe

It was also noted by a few respondents that the consultation process was too rushed to allow for broader involvement of stakeholders (e.g., Aboriginal health services agencies). Timelines were also restrictive for the province of Québec which had to translate consultation materials into French (led by the Québec PHAC Regional office), and then translate French responses back into English. Many participants expressed concern that the timeline to participate was inappropriate in comparison to the significance of the issue, and demonstrated lack of respect to the community. A few participants noted that the ACAP Allocation process should have been initiated over a year before when new funding levels for *The Federal Initiative* were first announced, giving more time for full and meaningful engagement of community stakeholders. Some participants expressed a lack of trust in the process due to the short timelines and lack of advance information from PHAC that the allocation process was going to happen.

Community Engagement

Some stakeholders noted that the consultation was valuable for collecting insights not provided by epidemiological or census data.

> *What is of utmost importance is that the consultation process draws from a diversity of regions and communities and that there is a mechanism for addressing what may not be made obvious by data currently available to us in terms of the reality of HIV work and related issues across the provinces and territories.* (CBO Representative)

> *PHAC should come to the community to identify the existing allocation strengths and weaknesses and identify the content of question 6 [the objectives of the Framework] as the goals of a re-defined allocation formula. Participants feel that a national consultation in this manner would provide a strong tool with community support."* (CBO Representative)

Some respondents felt that there are still opportunities for PHAC to facilitate ASO/CBO participation across Canada to improve definitions of the principles and criteria, and explore more comprehensive and integrated measurement tools in regards to Burden and Vulnerability at a provincial or territorial level, as well as Equity at a national level.

For future community consultations, PHAC should make efforts to include stakeholders from the beginning of the development process. Also, the consultation methods should allow opportunity for community groups (especially Aboriginal groups) to articulate the principles and criteria in their own language.

Capacity to Contribute

Some CBO representatives noted that the consultation process would have been better understood and more participation would have occurred if the consultations had been conducted through a regional workshop. Some participants felt that having a contracted ACAP representative facilitating the consultation in the region would have been more appropriate than local ASO or Regional Coalition staff.

Some participants felt that the questions were inaccessible for CBOs which do not already have a relationship with ACAP, and do not have familiarity with the language and culture of federal health programs. One participant felt that the complexity of the concepts in this consultation process was a serious barrier to collecting relevant information from stakeholders to inform the development of the allocation model.

Background Information

The Consultants noted that the literature review should have been provided along with the consultation guide to provide more rationale for why certain principles and criteria were included or excluded. Even though the literature review may be perceived as an overwhelming amount of information by some stakeholders, there were a few comments that it would have been useful for the respondents to have more background information on how the ACAP allocations have been determined in the past, which criteria were used in the last funding cycle, and more thorough definitions of the criteria in the proposed Framework. Some participants felt that the background information was lacking in regards to why this process in underway at this time and within this timeframe, making it difficult and uncomfortable for some to participate.

Anxiety About Funding Levels

Some stakeholders (particularly representatives of CBOs) noted that the consultation process created some stress regarding the threat of loss of revenue. Some CBOs noted that their constituents expressed hesitation to participate in the consultation process, but "a sense of 'damned if you do – damned if you don't' prevailed."

> *We fought for years to get increase funding, want to get it doubled as expected. We really feel if there is an allocation change, there will be have and have-not provinces.* (CBO Representative)

Lack of Focus on Inter-Regional Allocation

> *A funding formula is only one piece of a good funding model. It is imperative that the regional office have the opportunity to provide input and information that will affect how dollars are allocated.* (Provincial Government Representative)

Some respondents commented on issues not directly related to this consultation and commented on issues that related to distribution of ACAP funding within regions, which contributed, at least in part, to the anxiety about funding levels. CBO representatives, in particular, found it difficult to consider the Allocation Framework through the lens of differences *between* provinces and territories, and were able to focus only on the implications for their own region. Some stakeholders did understand the difference between this allocation process and the funding decisions that

need to happen within regions. The consultation guide should have placed more emphasis on the fact that the ACAP G&C Allocation Framework referred to ACAP funding between provinces/territories, not *within* provinces.

## Data for Future Allocation Processes

Stakeholders suggested several criteria that are not already included in the proposed Allocation Formula. In some cases, the data does not yet exist in a standardized and reliable way across all provinces and territories, and in some cases, the data does exist but had not been considered for inclusion by the HIV/AIDS Allocation Working Group and Epidemiology Working Group. However, they are listed here for consideration in future allocation processes.

### Vulnerability

- Co-infections (STIs or Hep C or mental illness or addiction, AND HIV)
- Lymphogranuloma Venereum (LGV) incidence (Concurrent infection with HIV, other STI, and hepatitis C has been common among the cases reported)
- Tuberculosis prevalence/incidence
- Overdose death reports
- Addiction rates: gambling, alcohol and other substance abuse
- Levels of domestic violence
- Vulnerable Populations:
  - Gender distribution
  - Break down of three Aboriginal groups – Métis, First Nation and Inuit
  - Anticipated growth rates for Aboriginal populations
  - Transient, seasonal workers, or mobile populations
  - General immigration and proportion of refugees, not just those from "HIV-endemic countries"
  - Exposure categories from HIV case reports
  - Behavioural data: M-Track (MSM) and I-Track (IDU) studies
  - Estimates of the size of other vulnerable populations: inmates, youth-at-risk, MSM
- Determinants of Health
  - Unemployment rates
  - Housing indicators
- Capacity of Local/Regional Health and Community Systems
  - Quality and effectiveness of HIV services provided
  - Accessibility of health services (including addiction/treatment/ methadone services)
  - Level of inclusion of PHAs with prevention and support services
  - Indicators for end-of-life care

### Equity

- Population density (to reflect urbanity as a balance to level of remoteness)

# 7 ACAP G&C Allocation Formula Options

The ACAP G&C Allocation Formula options presented in this paper are a combination of results from the consultation (with community stakeholders, provincial health representatives, and RHAN members) outlined above, and expert opinions of the ACAP G&C Allocation Working Group and Epidemiological Advisory Group. The Working Group used the results of the consultation to develop and assess four options for the ACAP G&C Allocation from 2006-2007 and on. These four options are the result of the Working Group efforts plus input from RHAN, regional office managers and Regional Directors.

For each of the four options, principles developed by the Working Group for the allocation process were used to assess their appropriateness:

- Current level of ACAP funding to each region will not be reduced.
- Options for allocating ACAP resources are evidence-informed. Thus, the latest and most relevant data available should be used.
- New resources must allow for adequate and equitable capacity for each region. The challenges in delivering programs and services in remote parts of the country need to be considered. At the same time, interventions also need to address geographic areas where vulnerable populations are overly represented in the epidemic if we are to get ahead of the epidemic.
- Respect for the directions of the new *Federal Initiative* and *Leading Together.* ACAP must align with the directions of the new strategy. Specifically, ACAP should support discrete approaches to address the epidemic of priority populations of the FI and address the three policy directions of partnership, integration and accountability.

The four options proposed by the Working Group were:

Option 1 – Status Quo: Continue using the current four-criteria ACAP allocation formula developed for the National AIDS Strategy.

Option 2 – Three Principle Framework: Apply the framework using the three principles and criteria based on consultation feedback and the average of weightings suggested by stakeholders for each principle of the framework.

Option 3 – Option 2 Enhanced: Enhance Option 2 with revised weightings by the Working Group to ensure the resulting allocations are directed to geographic areas that have highest proportions of populations vulnerable to HIV/AIDS in Canada.

Option 4 – Current Level Plus: Use current allocations in 2005/06 as the base level of funding. Then apply an allocation distribution derived from option 3 to the ramped-up increases from 2006/07 – 2008/09 to arrive at new allocation levels.

## Selection of Preferred Option for Allocating ACAP G&C

After much deliberation and the weighing of several factors, including the lack of available data on determinants of health for vulnerable populations, Option 3 (Option 2 Enhanced) was chosen as the preferred formula to allocate the ACAP G&C under *The Federal Initiative.* Option 3 was selected because this formula:

- Is grounded in evidence, incorporates the consultation results, and reflects expert opinion,
- Directs funding to geographic areas which have the highest proportions of populations vulnerable to HIV/AIDS in Canada,
- Adheres to all of the principles developed by the Allocation Working Group,
- Provides a distribution of funding that is consistent with the regions in which there are most prevalent cases of HIV,
- Addresses the directions of *The Federal Initiative on HIV/AIDS* and the *Leading Together* plan, and
- Overall, best reflects the HIV epidemic in Canada.

See table below for the distribution of ACAP allocation under Option 3. While Manitoba/Saskatchewan and Atlantic regions do not receive additional increases beyond 2005/06 under this option, both regions have received initial ramped-up increases under *The Federal Initiative* (FI) in 2004/05 (allocation levels increased from 2003/04 to 2005/06 by $232k for the Manitoba/Saskatchewan and by $358k for the Atlantic provinces).

| | 2003/04 (pre-FI) | 2004/05 (Year 1 of FI) | 2005/06 (Year 2 of FI) | 2006/07 | 2007/08 | 2008/09 | |
|---|---|---|---|---|---|---|---|
| BC | 1,010,000 | 1,339,461 | 1,339,956 | 1,515,709 | 1,761,891 | 2,329,827 | 17% |
| AB | 682,687 | 905,799 | 906,129 | 906,129 | 906,129 | 984,575 | 7% |
| MB/SK | 710,000 | 941,949 | 941,949 | 941,949 | 941,949 | 941,949 | 7% |
| ON | 2,037,000 | 2,701,474 | 2,702,466 | 3,017,212 | 3,473,671 | 4,556,482 | 33% |
| QU | 1,563,000 | 2,072,665 | 2,072,765 | 2,229,137 | 2,493,496 | 3,189,937 | 23% |
| NB, NL, NS, PEI | 1,098,175 | 1,456,184 | 1,456,184 | 1,456,184 | 1,456,184 | 1,456,184 | 10% |
| YT, NWT, NT | 291,595 | 396,510 | 396,680 | 396,680 | 396,680 | 441,046 | 3% |
| **Total** | **$7,392,457** | **$9,814,042** | **$9,816,129** | **$10,463,000** | **$11,430,000** | **$13,900,000** | 100% |

The other 3 options were not chosen because of the following rationale:

- Option 1 does not address the new directions of *The Federal Initiative* and *Leading Together*, specifically the use of a populations-based approach. Maintaining status quo is not in keeping with the recommendation of the 1998/99 review of the ACAP allocation formula for the development of a new formula that uses currently relevant data. The current formula relies on AIDS cases, which are not reliable indicators of the epidemic in terms of targeting prevention efforts. Also, the existing formula factors in provincial or territorial contributions to community-based HIV/AIDS programming, a factor which manifests as either favouring provinces/territories which do not contribute as much as others, or allocates more ACAP funding to provinces that already have relatively larger amounts of funding.

- While Option 2 most closely reflects stakeholders' feedback and places emphasis on providing equitable access to services in remote communities, the equity principle significantly outweighs vulnerability and burden principles. This option results in increases for the northern territories outweighing the combined increases for the 3 of the 4 provinces that represent 95% of HIV reported cases in Canada. Under this option, the north received a substantial increase of $1.577M from 2005/06 to 2008/09 while the total combined increase for Ontario, Quebec and Alberta is only $1.238M. Under this option, the allocations for these 4 provinces represent 64% of the total ACAP allocations in 2008/09, which is less than the current level of 71% in Option 1.

- In Option 4, with a base amount of $9.18M (the allocation level in 2005/06), a large portion (71%) of the total ACAP allocation under the FI is distributed using the outdated current formula which has been established in the assessment of Option 1 as being faulty with many limitations. One such limitation is the use of AIDS cases in the old formula which are not reliable indicators of the epidemic in terms of targeting prevention efforts. Thus, 71% of the funding amounts of Option 4 does not take into consideration the recommendations from the literature review nor the consultations, which means that it will not significantly address the new directions of *The Federal Initiative* and *Leading Together*, specifically, the use of a vulnerable population based approach. Under Option 4, only 29% ($4.08M) of the ACAP allocation will be distributed using the new formula resulting in the improvement to the evidence-base for the ACAP allocation being minimized. However option 3 was determined to more closely meet the principles developed by the Working Group.

# 8 Final ACAP G&C Allocation Framework

Based on the decision of the PHAC Regional Offices to use Option 3 as outlined in the previous section, the new funding formula being applied to the ramped-up ACAP funding increases is comprised of the following criteria and weightings:

| Stratum | Burden | Vulnerability | | | | | | | | | | | | | Equity | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 Category | 30.0% | 60.0% | | | | | | | | | | | | | 10.0% | |
| | HIV Prevalence | HIV Incidence | STI Incidence | | | Hepatitis C | Vulnerable Populations | | | | | | | General Population at Risk | General Population at Risk | Level of Remote-ness |
| 2 Indicator | 100% | 22.0% | 15.0% | | | 15.0% | 38.0% | | | | | | | 10.0% | 50.0% | 50.0% |
| | Distribution of Estimated HIV Prevalence #'s (2002) | Distribution of Estimated HIV Incidence #'s (2002) | Chlamydia Case Reports (2002) | Syphilis Case Reports (2002) | Gonorrhea Case Reports (2002) | Estimated Hepatitis C Incidence | Immigrant (2004) | Incarcerated #'s P/T Jurisdiction (2002) | Aboriginal (2001 Census) | MSM (2002 incidence estimate) | IDU (2002 incidence estimate) | MSM-IDU (2002 incidence estimate) | High Risk Heterosexual (2002 incidence estimate) | Population (M+F) between the Ages 12-50 (Stat. Can. estimate for 2004) | Population (M+F) between the Ages 12-50 (Stat. Can. estimate for 2004) | % of Total Population that is Rural (2001) |
| 3 Sub-Indicator | 100% | 100% | 33.3% | 33.3% | 33.3% | 100% | 14.3% | 14.3% | 14.3% | 14.3% | 14.3% | 14.3% | 14.3% | 100% | 100% | 100% |

The sources of data for each of the sub-indicators are included in Appendix C.

# 9 Proposed ACAP G&C Allocation for Each Option

The following table compares current ACAP allocation levels for 2003/2004 (pre-FI) and 2005-2006 (second year into the FI) with each option's allocation distribution for 2008-2009 when the increases in ACAP are fully ramped-up.

| PHAC Regions | 2003/2004 Pre-FI[51] Level | 2005/2006 2nd Year into FI | 2008/2009 | | | |
|---|---|---|---|---|---|---|
| | | | Option 1 - Status Quo | Option 2 - 3 Principle Framework | Option 3 - Option 2 Enhanced [52] | Option 4 - Current Level Plus |
| British Columbia Region | 1,010,000 | 1,339,956 | 1,897,427 | 1,981,550 | 2,329,827 | 2,089,755 |
| Alberta Region | 682,687 | 906,129 | 1,283,112 | 865,464 | 984,575 | 1,200,576 |
| Saskatchewan/ Manitoba Region | 710,000 | 941,949 | 1,333,834 | 1,189,485 | 941,949 | 1,210,259 |
| Ontario Region | 2,037,000 | 2,702,466 | 3,826,791 | 3,459,829 | 4,556,482 | 4,162,858 |
| Quebec Region | 1,563,000 | 2,072,765 | 2,935,112 | 2,595,198 | 3,189,937 | 3,083,115 |
| Atlantic Region | 1,098,175 | 1,456,184 | 2,062,011 | 1,834,944 | 1,456,184 | 1,624,440 |
| Northern Territories | 291,595 | 396,680 | 561,713 | 1,973,530 | 441,046 | 528,997 |
| **Total** | **$ 7,392,457** | **$ 9,816,129** | **$ 13,900,000** | **$ 13,900,000** | **$ 13,900,000** | **$ 13,900,000** |

[51] FI, *The Federal Initiative to Address HIV/AIDS in Canada*
[52] Adjustments were made to ensure all regions will minimally continue to receive current level (2005/06) of ACAP funding.

# 10 Conclusions

This discussion paper provides recommendations on the G&C allocations for the AIDS Community Action Program (ACAP), a federal funding program that supports community-based HIV/AIDS programming across Canada.

The resource allocation framework proposed here employs the most reliable and standardized data available in order to respond appropriately to the HIV epidemic. In order to do so, the framework reflects three principles:

**Burden**, in order to respond to the current burden of HIV/AIDS

**Equity**, in order to ensure all Canadians get equitable access to HIV/AIDS services

**Vulnerability**, in order to prevent the further spread of HIV/AIDS to those populations at-risk.

Overall, respondents appreciated the attempt by PHAC to develop an allocation framework that is fairer, evidence-based and aligned with *The Federal Initiative*. While the consultation process had flaws due to constraints of time and resources, the Working Group felt that there was valuable information and perspectives gathered from the consultation that informed the ACAP G&C Allocation process.

The final version of the ACAP G&C Allocation Model is reflective of the new *Federal Initiative's* policy directions, is reflective of ACAP objectives, will allow for adequate and equitable capacity for each region, and as much as possible, ensures that the allocation of ACAP resources is evidence informed. There is still room for improvement with respect to the data available to truly reflect the HIV/AIDS epidemic in Canada from the determinants of health and vulnerable population perspectives. In addition to the decision to adopt Option 3, a commitment was made to work towards the development of a stronger science base to support and incorporate the principles of burden, vulnerability and equity in future decisions. However, the end result of the Allocation Framework is based on the best available evidence available.

# Appendix A

## ACAP Regional Resource Allocation Framework
## CONSULTATION GUIDE FOR HIV/AIDS COMMUNITY AND PROVINCIAL/TERRITORIAL GOVERNMENT STAKEHOLDERS

### Background:

The AIDS Community Action Program (ACAP) is one component of the *Federal Initiative to Address HIV/AIDS in Canada*. ACAP is a federal funding program that supports local, regional, and provincial/territorial community-based organizations addressing HIV/AIDS issues across Canada.

San Patten and Associates were contracted by the Public Health Agency of Canada, Regional Offices (PHAC RO) to prepare a discussion paper that provides options and recommendations for an allocation formula. This paper will be used by the Regional Directors of PHAC RO to determine the distribution of ACAP grants and contributions resources across the seven regions: Atlantic provinces, Quebec, Ontario, Manitoba/ Saskatchewan, Alberta, British Columbia, and the Northern Secretariat (Northwest Territories, Nunavut and Yukon) from April 1, 2006 and on until another review of allocations is deemed to be required.

### Purpose:

The purpose of the consultation is to gather input from key stakeholders in order to develop the most relevant, evidence-based and equitable resource allocation formula possible.

### Participants:

Due to limitations in time and budget, the consultants are limited in the extent to which stakeholders across the seven regions can be consulted. The consultants will make every effort to include a cross-section of representatives from organizations that are recipients of ACAP funding, ACAP program consultants and PHAC regional directors, provincial health counterparts, and national and provincial epidemiological experts.

### Request for Participation by ACAP Funding Recipients:

In order to gather the most representative range of responses to the proposed ACAP Regional Resource Allocation Framework, some ASO Coalitions are gathering responses from their members, while other regions are choosing to consult with their members as well as non-ASOs. The coalitions include:

- Pacific AIDS Network
- Alberta Community Council on HIV
- Ontario AIDS Network

- COCQ-SIDA
- AIDS New Brunswick
- AIDS Coalition of Nova Scotia
- AIDS Committee of Newfoundland and Labrador

In regions where no provincial or regional coalition exists, other ASO representatives will be asked to provide input on behalf of the ACAP recipients in their regions. The coalitions (or other representative ASOs) are asked to distribute the consultation questions to their members and gather responses within 3 weeks (by October 14th). The consultants will compile and analyse all of the responses and use them to inform the final version of the ACAP Regional Resource Allocation Framework.

**Instructions for ASO Coalitions (or ASO Representatives where no Coalition exists):**

Please send this consultation guide to your members asking for their participation.

Next, we kindly request that you compile their responses by **October 14th**. You do not need to analyze their responses; simply group them together in one document so that you can tell the consultants how your members responded to each question.

The consultants (San Patten or Roxanne Felix) will contact you to set up an interview about your coalition's feedback on the Framework. Interviews will be conducted the week of **October 17th**.

**Request for Participation by Provincial Health Representatives:**

Please review the ACAP Regional Resource Allocation Framework and consider the consultation questions below, by **October 7th**. In the meantime, you will be contacted by the consultants (San Patten or Roxanne Felix) to set up an interview for the week of **October 10th**. If you would prefer to respond in writing, please email your responses to san.patten@shaw.ca by **October 14th**.

## Consultation Questions for HIV/AIDS Community and Provincial/ Territorial Government Stakeholders

**Please review the ACAP Regional Resource Allocation Framework and then answer the questions below.**

1. Please describe your position and role with respect to community-based HIV/AIDS programming.
2. Based on your understanding of the HIV/AIDS issues in your own province or territory, how appropriate are the three principles of the framework (burden, vulnerability, and equity)?
   a. Burden: *ACAP resources are allocated to the provinces and territories according to their population's burden of HIV*
   b. Vulnerability: *ACAP resources are allocated to the provinces and territories according to their population's vulnerability for HIV infection*
   c. Equity: *new resources must allow for adequate and equitable capacity for each province and territory*
3. Given the definition of the principles, do we have the appropriate criteria for addressing these principles? If no, what would you change?
4. Given the limitations in data for vulnerable populations, how should they be included in the Framework? Please select one of the following:
   d. ONLY include census data (i.e., direct population size counts) that is available across all provinces and territories - Aboriginals, people from HIV-endemic countries and prison inmates
   e. Include census data in option 'a' AS WELL AS population incidence estimates for IDU and MSM as a proxy for population estimates even though these estimates are not available for all provinces and territories
   f. Don't include any data on vulnerable populations, given that there is no complete and standardized data for all vulnerable populations across all provinces and territories
   g. Other option?
5. a) Please rank the criteria from 1 (the highest) to 7 (the lowest) in terms of best measures of the principle of Vulnerability. You may also choose to rank more than one (or all) equally.

   ____ HIV Incidence

   ____ STI Incidence

   ____ Hep C Incidence

   ____ Low Income Cut-Offs

   ____ Literacy

   ____ Vulnerable Populations

____ Population Aged 12-50

b) How would you weigh the criteria (using percentages) under the principle of Equity?

____ Cost of Living

____ Level of Remoteness

6. Given the data available to us, do you think the overall framework will:
   a. ensure that the regional allocation decision is evidence-based
   b. ensure that the distribution of ACAP resources is appropriate
   c. ensure that it will address the burden of HIV across Canada, and
   d. anticipate future trends in HIV?

7. a) If the first formula option is used, how should the three principles be weighted relative to one another?

   ____ Burden ____ Vulnerability ____ Equity

   What did you consider in their weightings? If there are any additional principles, how would you weight those?

   c) If the second formula option is used, how should burden and vulnerability be weighted relative to one another?

   ____ Burden ____ Vulnerability

   What did you consider in their weightings? If there are any additional principles, how would you weight those?

   d) If the second formula option is used, to what degree should equity adjust both burden and vulnerability (0 to 100%, where 100% means equity overrides the allocation by burden and vulnerability and 0% means equity has no effect on allocation)?

   ____ Equity

8. Do you have any other comments about the allocation framework?

# Appendix B

## ACAP G&C Allocation Framework – Consultation Contacts

| Region | Name | Organization | Role |
|---|---|---|---|
| British Columbia | Marcie Summers | Positive Women's Network | Executive Director, Marcie is also on the Board of Directors of PAN. She has tremendous expertise, experience and familiarity with all of the issues pertaining to the exercise. |
| British Columbia | Brian Mairs | Okanagan Aboriginal AIDS Society | Program Coordinator for an Aboriginal AIDS Service Organisation. |
| British Columbia | Joanne Fahr | McLaren Housing Society of British Columbia | Executive Director |
| British Columbia | Stephen Smith | Ministry of Health Services | Manager, Blood Borne Pathogens<br>Communicable Disease and Addiction Prevention<br>Population Health and Wellness |
| British Columbia | Dr. Robert Hogg | BC Centre for Excellence in HIV/AIDS | Director, HIV/AIDS Drug Treatment Program - Both Stephen Smith and myself suggest speaking to Bob because of his tremendous expertise in observational epidemiologic research and population-based research. |
| Alberta | Nora Johnston & Neil MacDonald | Alberta Health and Wellness | Population and Health Strategies – Project Team Leader and Senior Team Leader |
| Alberta | Dr. Ameeta Singh | Alberta Health and Wellness | Infectious Diseases Medical Consultant |
| Alberta | Jennifer Vanderschaeghe | Alberta Community Council on HIV | Chair of ACCH Board of Directors |
| Saskatch-ewan | Dr. Huiming Yang and Suzannah Fairburn | Saskatchewan Health | Chief Medical Health Officer and Provincial HIV/BBP/IDU Consultant |
| Saskatch-ewan | Christine Smith | AIDS Programs South Saskatchewan | Executive Director |
| Manitoba | Trina Larsen | Public Health Branch Manitoba Health | Program Coordinator HIV and HCV<br>CDC Unit |
| Manitoba | Mike Payne | Nine Circles Community Health Centre (NCCHC) | Executive Director |

| Region | Name | Organization | Role |
| --- | --- | --- | --- |
| Ontario | Frank McGee | Ministry of Health and Long-Term Care | Coordinator - AIDS Bureau Community Health Branch |
| Ontario | Rick Kennedy | Ontario AIDS Network | Executive Director |
| Québec | | Ministère de la santé et des services sociaux du Québec (MSSSQ) | National direction in public health |
| Nova Scotia | Mahnaz Farhang Mehr | Nova Scotia Department of Health | Coordinator, Communicable Disease Prevention |
| Nova Scotia | Larry Baxter | extensive personal and professional experience in community based action on HIV/AIDS | |
| Nova Scotia | Robert Allan | AIDS Coalition of Nova Scotia | Executive Director |
| Yukon | Cheryl Jackson | Blood Ties, Four Directions | Executive Director |
| Nunavut | Dr. Geraldine Osborne | Government of Nunavut | Associate Medical Officer of Health, Department of Health and Social Services |
| Northwest Territories | Wanda White | Government of Northwest Territories | Communicable Disease Specialist |

# Appendix C

## Data Sources for Criteria

| Sub-Indicator | Source | Weblink |
|---|---|---|
| HIV Prevalence | Surveillance and Risk Assessment Division, Centre for Infectious Disease Prevention and Control, PHAC | http://www.phac-aspc.gc.ca/publicat/epiu-aepi/epi-05/index.html |
| HIV Incidence | | |
| Chlamydia Case Reports (2002) | Public Health Agency of Canada, 2002, Canadian Sexually Transmitted Infections Surveillance Report. CCDR2005;31S2:1-39. Table 1.2, p.28 | http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/05vol31/31s2/index.html |
| Syphilis Case Reports (2002) | Public Health Agency of Canada, 2002, Canadian Sexually Transmitted Infections Surveillance Report. CCDR2005;31S2:1-39. Table 3.2, p. 38 | |
| Gonorrhea Case Reports (2002) | Public Health Agency of Canada, 2002, Canadian Sexually Transmitted Infections Surveillance Report. CCDR2005;31S2:1-39. Table 2.2, p.33. | |
| Hepatitis C | Bloodborne Pathogens Section, Blood Safety Surveillance and Health Care Acquired Infections Division, Health Canada | Not applicable |
| Immigrant (2004) | Citizenship and Immigration Canada Website | http://www.cic.gc.ca/english/pub/facts2004/index.html |
| Aboriginal (2001 Census) | Statistics Canada, Census of Population, 2001 | http://www40.statcan.ca/l01/cst01/demo40a.htm?sdi=aboriginal |
| Incarcerated #'s P/T Jurisdiction (2002) | Statistics Canada, Census of Population, 2001 | http://www40.statcan.ca/l01/cst01/legal31a.htm |
| MSM (2002 incidence estimate) | Surveillance and Risk Assessment Division, Centre for Infectious Disease Prevention and Control, PHAC | Not applicable |
| IDU (2002 incidence estimate) | | |
| MSM-IDU (2002 incidence estimate) | | |
| High Risk Heterosexual (2002 incidence estimate) | | |
| Population (M+F) between the Ages 12-50 | Statistics Canada, Census of Population, 2001-estimate for 2004 | Not applicable |
| Level of Remoteness | Rural Research Note, Agriculture and Agri-Food Canada Publication Number 2138/E, June 2002, Government of Canada, Appendix 1, p. 5 | http://www.rural.gc.ca/research/note/note1_e.phtml |