CANADIAN AIDS SOCIETY
SOCIÉTÉ CANADIENNE DU SIDA

Nationally Focussed, Community Based
Un vision nationale, une base communautaire

190 O'Connor, Suite 100, Ottawa, ON K2P 2R3
Office/Bureau : 613.230.3580 Fax/Téléc : 613.563.4998

www.cdnaids.ca

The Honourable Jane Philpott, P.C., M.P.
Minister of Health
Confederation Building, Suite 162
House of Commons
Ottawa, ON K1A 0A6

October 13, 2016

Dear Minister Philpott,

We are writing to you in regards to the results of the HIV and Hepatitis C Community Action Fund (CAF) Letter of Intent Process. Among the community-based organizations that we represent, there has been much devastation for both member and non-member organizations. We are one of several organizations across Canada to have received a shocking response from the current round of funding applications, and the results of this process are not simply unacceptable, but will be catastrophic for Canada's ability to respond to the needs of people living with HIV and Hepatitis C. As a national voice for community-based organizations in this sector we are greatly concerned by the potential gaps created by the outcomes of the Letter of Intent Process as well as the fact that the feedback given on applications was, at times, inconsistent with the applications submitted.

The results of this process have annihilated many key actors in the fight against HIV, Hepatitis C and other sexually transmitted and blood-borne infections (STBBI) in Canada. Most importantly, however, this decision will leave the some of the most vulnerable people in Canada in even further jeopardy, and will jeopardize most of the positive social impacts that the Canadian response to HIV, Hep C and other STBBI's have delivered.

The consequence of defunding community HIV and Hepatitis C organizations will be felt from coast to coast to coast, affecting those living with HIV the most. The pattern that has been perceived by both funded and defunded organizations is that there seems to be a shift from funding for prevention and support to funding for prevention in key populations only, leaving tremendous gaps for an already vulnerable population. These gaps will lead to HIV positive people lacking support and becoming disengaged, thus adding to the number of people who remain untreated, and with 21% of the HIV positive population undiagnosed[i], this will do little to address an already out of control epidemic in some parts of Canada. Without services to help people living with HIV, Canada will have no hope of reaching the UNAIDS 90-90-90 goal[ii], despite publicly endorsing it[iii].

Previous funding cycles for both AIDS and Hepatitis C service organizations provided information publicly on what the expectations for the process were and how the funding model

was to be applied to all applications. The HIV and Hepatitis C Community Action Fund did not make this information available. The new funding model and application process was developed privately by the Public Health Agency of Canada (PHAC), and though there were some consultations with the community, the continually changing criteria left many confused as to how it would be applied to the applications when they were received, or, what objective evidence was to be used in the evaluations process. It was also not made clear whether or not the development process and consultations conformed with the GIPA principles, which are specifically designed to ensure greater and more meaningful input from people living with HIV.

Additionally, previous funding cycles have not combined the service networks for HIV, Hepatitis C and other STBBIs into a single pool of funding. By combining them into a single fund, PHAC effectively reduced the funding for all three.

Most concerning is the lack of growth in the funding availability, as the previous Liberal Government promised in 2004 to increase the funding for the Federal Initiative to Address HIV/AIDS in Canada (FI) to $84.4 million by the 2008-2009 fiscal year. This funding allocation, from which the HIV and Hepatitis C Community Action Fund draws its funding, is currently set at $72.6 million. Since the FI has not increased in several years, and more than $13 million has remained unspent between 2008 and 2013[iv], it is misleading to imply that the sector is not underfunded. Furthermore, given the stagnant status of the FI funding, it is unrealistic for the Community Action Fund to use the Federal Initiative to cover the activities of three different community support networks without increasing its allocation.

We are aware that your department stated clearly from the beginning that this process was not meant for status quo funding, and that we were to expect a shift in the funding landscape. However, we could never have predicted the devastating cuts to so many long-standing and important community-based programs. We are not saying that the funded projects, whether with new or existing organizations, do not deserve funding, nor are we against new community based organizations receiving funding. We gladly welcome an increase in service to the community. However, we must be careful not to dismantle existing support networks in order to appear like we are serving new populations, or people will be left without the services they rely upon. We cannot risk a relapse in health and social outcomes for people living with HIV and Hep C by leaving them with a severely limited support network or without one entirely.

Additionally, because of multiple changes in the time-frame of the results delivery process, organizations that were promised 12 months to find alternative funding should their applications not be brought forward now have less than six months to find new funding sources or they will be forced to close. This is unacceptable.

We are also concerned that the projects that have been approved to move on to the next stage of the application process do not reflect the PHAC priorities identified in earlier consultations.

There has been a lack of transparency in reporting which projects will be funded, what populations those projects will serve, and how much money has been dedicated to each of the regions of Canada. The gaps in funding for certain populations, especially Indigenous people and intravenous drug users, are so clearly evident at this stage in planning that larger gaps cannot help but form as organizations try and fill a severely eroded HIV and Hep C service landscape. Unfortunately, the PHAC's expectation that the contingency funds held in reserve will be sufficient to address those gaps is unrealistic given the results we have seen so far.

The response to how people living with and affected by HIV and Hep C should access the services they require, given that many of the organizations that provide them have been defunded, has generally taken one of two unsettling directions: organizations should combine their efforts and share the funding they have been given; or, it is up to the provinces and territories to collaboratively fund these projects in tandem with the federal projects.

Generally, the response that unsuccessful organizations should collaborate with successful ones on their programs means that in order for the important work that was done by organizations that were not given new funding to continue, the funds that were allocated must be divided. Community-based organizations have been existing in a hostile funding landscape for many years under the Conservative Government, a landscape also fueled by this highly competitive process. Organizations have been pitted against each other for funding opportunities and target populations, and have been directed by PHAC and other government organizations to carve out a niche in order to be considered relevant and fundable. All the while, there has been no support for harm reduction in over a decade. To expect organizations to now immediately change to a collaborative approach for serving the population as a whole rather than a niche-based approach, without direction on what those collaborations are expected to look like, and do to do within only six months, only pays lip-service to collaboration.

PHAC is asking organizations that have had their funding reduced, but have still been allowed to go forward, to share their reduced funding with other organizations in order to ensure that services are not cut. To expect that services to the community would not falter as a result of two organizations sharing a single source of funding is misguided.

Additionally, several organizations that had their applications moved forward submitted those applications with the understanding that complementary projects would also move along the process in tandem. If an approved project relies on a now defunded organization in order to cover the entire population, how can we expect to serve the entire community? The only options are to have the two organizations split the money that has been given to cover the complementary populations and deliver a sub-par program that fully addresses the needs of neither group, or, abandon the complementary projects.

By dismantling large portions of a network which relies on the connections between members to serve the community, PHAC has set the entire community up to fail, and placed the groundwork for the erosion of all of the gains made in the HIV and Hep C sectors in the last 30 years. This network has been 30 years in development and has been designed to meet the needs of both current and future clients. To erase the experience and interconnectedness of our network, puts in people who rely on that expertise in a vulnerable position. In only four years, the percentage of HIV positive people who were unaware of their status has dropped from 26% in 2010[v] to 21% at the end of 2014[vi], thanks in no small part to the testing services and support offered by community-based organizations. Early HIV diagnosis leads to earlier treatment and prevents new HIV infections.

Given that each new diagnosis costs $1.3 million[vii] over that person's lifetime, the prevention efforts of Canadian HIV and Hepatitis C community-based organizations that rely on each other to better serve the community should be a priority. By achieving such a large reduction in the percentage of people who are unaware of their infection, Canadian organizations have set Canada on the right track to achieving the first of the UNAIDS 90-90-90 goals, and saved the Canadian people millions of dollars in the costs associated with new transmissions from individuals unaware of their status. However, without support for people living with HIV, we cannot hope to achieve the increases in the number of people on effective antiretroviral medication (ART) required to achieve the other two parts of the 90-90-90 goal.

On the other hand, the response that the provinces and territories will cover the gaps in funding allocations shows a fatal flaw in the understanding of the HIV and Hep C situation in much of Canada. There are many places in Canada where the populations most at risk for HIV and Hep C are invisible populations in the provincial medical landscape. If a physician has the right to refuse to treat these populations, then how is that population going to receive service if the federal government then also refuses to provide for them? To expect the provincial and territorial governments to take on the responsibilities your government has traditionally funded, when it is known that they will not do so, is simply shifting the blame.

The expectation that the provinces and territories will fill in the gaps in funding in only six months without providing a model of how that collaborative approach to funding would work shows a superficial approach to said collaboration. PHAC has not publicly stated that such work is being downloaded onto the provinces, so the provinces cannot be expected to fill a gap PHAC has created.

We are asking that you sit down with us as soon as possible, and discuss what the complete picture of funding looks like, and how gaps in the allocations will be identified and addressed. We are also asking that you provide a detailed accounting of the current funding, broken down by both region and target population, so that gaps in either categorization can be addressed.

Our full request would be to halt the current funding process, and continue status quo funding for one year from the end of the current cycle while the process is revisited in collaboration with community stakeholders and people living with HIV and Hep C. The renewal process should also include consideration for the funds originally promised to the Federal Initiative to Address HIV/AIDS in Canada, so that CAF can be increased to better address the expanded mandate given to applicants. Once the review is complete, the funding process should have its goals and evaluation criteria posted publicly so that organizations can better understand what to expect during the entire process.

At a minimum, we request that PHAC work with the community to determine gaps in funding allocations, and focus on filling those gaps by increasing the value of CAF using some of the funds promised to the Federal Initiative to Address HIV/AIDS in Canada, and giving organizations a full year to wind down or find alternative funding, partnerships, or collaborators, as was one of PHAC's original promises.

In closing, we are hopeful that you have received our meeting request from October 5, as we are eager to discuss these issues. We are sure you can see that a positive and urgent meeting is necessary.

Yours sincerely,

Gary Lacasse
Executive Director

Greg Riehl
Chair, Board of Directors

This letter has also been carbon copied to The Right Honourable Justin Trudeau, Prime Minster of Canada; The Honourable Rona Ambrose, PC, MP, Interim Leader of the Conservative Party; The Honourable Thomas Mulcair, PC, MP, Leader of the New Democratic Party; Rhéal Fortin, MP, Interim Leader of the Bloc Québécois; The Honourable K. Kellie Leitch, PC, MP, Conservative Health Critic; Dr. Siddika Mithani, President of the Public Health Agency of Canada; and, all AIDS Service Organizations in Canada.

---

[i] Public Health Agency of Canada. (2015) Summary: Estimates of HIV incidence, prevalence and proportion undiagnosed in Canada, 2014. Retrieved from http://healthycanadians.gc.ca/publications/diseases-conditions-maladies-affections/hiv-aids-estimates-2014-vih-sida-estimations/index-eng.php#a2

[ii] Joint United Nations Programme on HIV/AIDS, & Joint United Nations Programme on HIV/Aids. (2014). 90-90-90: an ambitious treatment target to help end the AIDS epidemic. *Geneva: UNAIDS*.

[iii] Public Health Agency of Canada, Philpott, J. (2015). *World AIDS Day – December 1, 2015* [Public Statement]. Retrieved from http://news.gc.ca/web/article-en.do?nid=1022689

[iv] Public Health Agency of Canada. Evaluation Directorate (2014). Evaluation of the Canadian Public Health Service Program at the Public Health Agency of Canada: Appendix 2 - Federal Initiative Allocation and Expenditures, 2008-09 to 2012-13. Retrieved from http://www.phac-aspc.gc.ca/about_apropos/evaluation/reports-rapports/2013-2014/diaha-idlvs/app-ann-b-eng.php

[v] Public Health Agency of Canada. (2010). HIV/AIDS Epi Updates - July 2010: Chapter 2: Undiagnosed HIV Infections in Canada. Retrieved from http://www.phac-aspc.gc.ca/aids-sida/publication/epi/2010/2-eng.php

[vi] Public Health Agency of Canada. (2015) Summary: Estimates of HIV incidence, prevalence and proportion undiagnosed in Canada, 2014. Retrieved from http://healthycanadians.gc.ca/publications/diseases-conditions-maladies-affections/hiv-aids-estimates-2014-vih-sida-estimations/index-eng.php#a2

[vii] Kingston-Riechers, J. (2011). *The economic cost of HIV/AIDS in Canada*. Canadian AIDS Society. Available at http://www.cdnaids.ca/the-economic-cost-of-hivaids-in-canada/