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Chair

Mr. Bill Casey

Standing Committee on Health

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● (1530)

[*English*]

The Vice-Chair (Ms. Marilyn Gladu (Sarnia—Lambton, CPC)): Good afternoon. Welcome to the 139th meeting of the health committee, where we're continuing our study of LGBTQ2 health in Canada.

Today we have some excellent witnesses. From the British Columbia Centre for Disease Control, we have Dr. Mark Gilbert. From the British Columbia Centre for Excellence in HIV/AIDS, we have Dr. David Moore by video conference. From the Canadian AIDS Society, we have Gary Lacasse, the Executive Director; and from the Gilbert Centre for Social and Support Services, we have Gerry Croteau.

Each of you will have 10 minutes for your opening statement, and we'll begin with Dr. Mark Gilbert.

Dr. Mark Gilbert (Medical Director, Clinical Prevention Services, BC Centre for Disease Control): Great. First off, I'd like to thank the Standing Committee on Health for the invitation to speak here today, and also for dedicating the resources of the committee to this study, which I think is pretty unprecedented in Canada. It's a real sign of progress in society, as well as in the federal government. It's a real honour to be here today.

I'd also like to acknowledge that I'm here today on the traditional, unceded and ancestral territories of the Algonquin peoples.

The focus of my remarks today will be on improving the sexual health of gender and sexual minority Canadians. I'm a gay man, a public health physician who's responsible for some sexual health services in B.C., and a public health researcher who has a focus on gay men's health, testing and digital initiatives around sexual health care. Those are the perspectives that I'll be bringing today. However, on the flip side, I just want to acknowledge that there are other perspectives related to issues of sexual health that I hope you'll get the chance to hear from during this study, including those of two spirit people and gender minorities.

I'll start by outlining some of the challenges that I see related to sexual health. As I'm sure it's no surprise to people in the room, there is a higher burden of sexually transmitted and blood-borne infections among gender and sexual minorities, and I'll call those STBBIs for short. This includes ongoing high or increasing rates of HIV and STIs, particularly syphilis, among gay, bisexual and other men who have sex with men.

Recent experience from Ontario tells us that there continues to be a lot of resistance in society to health education in schools that's relevant to today's youth. Even when that's available, it often is not as relevant for gender and sexual minority youth.

On the other side, we know that health care providers are often not trained or comfortable with providing appropriate sexual health care to gender and sexual minorities, so this lack of education and training really contributes to the many barriers that gender and sexual minority people face in accessing appropriate sexual health care. These include barriers that are common to many Canadians, such as factors like distance to a clinic, opening hours, or wait times for appointments. Also, everyone is affected by the stigma that still surrounds sex and infections in society, and that leads to people's being embarrassed to talk to people about their sexual health, or to providers' feeling uncomfortable asking questions.

Gender and sexual minority people face additional barriers, which are related to the need to talk about their identity or their orientation with their care provider. As you can imagine, many people fear negative reactions. They fear being judged or discriminated against when they do so. Unfortunately, all too often that's based on past negative experiences in health care.

While in some major urban centres—like Vancouver, where I'm from—people may be able to access quite friendly and culturally appropriate LGBT services around sexual health, all these barriers become more pronounced once you go into rural and remote communities.

Finally, there's a strong connection between sexual health and mental health for gender and sexual minority people. I know you've heard from a lot of witnesses already about mental health. As they've discussed, we know that stigma in society against gender and sexual minority people leads to negative experiences, which have an impact on mental health and could lead to a higher prevalence of mental illness.

These same negative experiences and mental health issues, such as substance use, can also lead to sexual risk-taking and a greater chance of infection. This is a concept that's known as syndemics, or synergistic epidemics of these types of factors, and it's been demonstrated from research for gay, bisexual and other men who have sex with men in Canada.

However, we still typically approach sexual health and mental health in silos. This leads to our not providing comprehensive care or tackling the factors that contribute to poor sexual health. For example, in B.C., research by Dr. Travis Salway, who spoke to this committee on Tuesday, has shown that it commonly is reported by members of sexual and gender minorities that they have unmet mental health needs when they're presenting for care in sexual health clinics. That suggests that these are services that are actually probably ideal forums for also thinking about mental health and are a way for engaging people in mental health.

I'll now move to focus on what I think are five opportunities for the federal government to address these challenges.

First, I think that current national sexual health guidelines and resources need to be re-examined to make sure that they're appropriate for all gender identities, such as the Canadian Guidelines on Sexually Transmitted Infections. As we've started to do in B.C., these need to use clinical approaches that are relevant after gender-affirming surgery; need to shift away from gender-binary approaches, talking about men and women or males and females; and need to adopt trauma-informed care as fundamental principles.

Second, there needs to be greater integration across sexual health and mental health. The Public Health Agency of Canada last year released the pan-Canadian STBBI framework for action. It's actually a good step in this direction because it integrates across different infections and also recognizes the impact of syndemics. Certainly, as federal actions follow from this framework, the needs of sexual and gender minorities should be a major focus.

However, I think we need to go further and pay attention to mental health within these sexual health services. Another way to support this nationally could be to incorporate mental health and substance use assessments, as well as brief mental health interventions, within federal guidelines related to STIs or sexual health where this is often not talked about in great detail, as well as within related resources for providers.

We also know that community-based agencies that are working with gender and sexual minority populations are already using integrated or holistic approaches across sexual health, mental health and other domains of health. These agencies are the front line of our society's response to these issues.

Federal community action funds are an important funding source for this work. In the past few years, the community action funds have been expanded from HIV to include hepatitis C. This is good, but it wasn't accompanied by an increase in funding. I think the scope of these funds should be expanded to more fully and embrace sexual health and mental health broadly, but this should be accompanied by an increase in funding.

Third, I would like to build on recommendations of the pan-Canadian framework for action related to testing. I believe we do need a greater range of testing approaches in Canada that make the best use of new and effective test technologies and that empower gender and sexual minority people to get tested. The federal government is already supporting this through the National Microbiology Laboratory's dried blood spot testing service for HIV and hepatitis C, as well as hepatitis B and syphilis. This is being used outside our traditional health care settings—sometimes by non-health care providers—and it has been very well received.

This program should be further expanded in Canada. It would also be important for the National Microbiology Laboratory to think about how similar approaches for other STIs like chlamydia and gonorrhea could also be implemented in this way. For example, this could include a greater focus on self-collected specimens for STBBIs, such as swabs and blood specimens, which a person collects themselves and sends to a lab for testing, and updating Canada Post regulations to allow for sending such specimens by regular mail. Similar programs do exist in many other countries.

One additional area to focus on federally is the licensing of new types of tests for STBBI, as Canada does lag behind other countries. For example, there are rapid tests performed by providers right at the point of care and that give results within minutes. We have one licensed rapid HIV test in Canada compared with seven in the States, and we have Canadian rapid tests for STBBIs that are being used internationally, but not here in Canada. Similarly, there are no home-testing or self-testing kits for HIV that are licensed in Canada. This is an approach that has been shown in other countries to be quite successful, very acceptable and to increase testing.

I imagine that the market size of Canada compared with other countries is one of the factors affecting why industries may not be pushing forward and getting test products licensed here, but I do recommend that Health Canada's therapeutic products directorate, which licenses these tests, consider how more of these products can be brought to the Canadian market. This could be done, for example, by somehow expediting the approval of tests that have already been approved in the U.S., by funding Canadian studies that are needed to validate existing test technologies or by providing special access to permits.

Fourth, there are opportunities related to federal initiatives on e-health or digital health, which is a rapidly growing area in Canada. Studies, including work we've done in B.C., have consistently shown that gender and sexual minority people are highly accepting of online or technology-based approaches that help to overcome the specific barriers I mentioned earlier in terms of accessing sexual health care. This has been shown for HIV prevention interventions.

We've seen this in B.C., where many gay, bisexual and other men who have sex with men have used our program GetCheckedOnline, which is a successful Internet-based testing program for STBBIs. In our research around this intervention, men have reported that they really value this service because it gives them control over testing and is a way to get testing without needing to talk to a provider about their sex lives.

Digital health initiatives also cross provincial borders, and with the ever-increasing access to the Internet does provide opportunities for the federal government to improve health directly. For example, the federal government could directly fund national digital health initiatives for campaigns for gender and sexual minorities, such as sexual health educational resources that can reach youth across Canada. However, there are few national digital health initiatives or research opportunities that are focused on digital health care for gender and sexual minority people, or even more broadly, for sexual health.

One way to improve this gap would be within Canada Health Infoway, which focuses on investments in e-health and digital health in Canada and is funded by the federal government. To date, the work of Infoway has largely focused on electronic medical records, chronic disease prevention and mental health. I recommend that digital health initiatives for sexual health and for gender and sexual minority people be made strategic priorities within Infoway's work.

Finally, the role of the federal government in funding new research related to sexual health for gender and sexual minority people is critical. I recognize there are many research efforts currently funded in this area, but there are other opportunities that should be considered. For example, moving forward with e-health or digital health as one of CIHR's strategic priorities could include funding dedicated to sexual and gender minority populations.

● (1535)

In closing, I am grateful to the committee for seeking to understand the health issues facing LGBTQ2 people in Canada, of which sexual health is just one component. I would encourage the federal government to continue with the excellent precedent that's being established with your study by making sure that sexual and gender minority peoples are meaningfully engaged at all stages in any federal initiatives arising from this study.

Thank you.

● (1540)

The Vice-Chair (Ms. Marilyn Gladu): Excellent. You're right on time.

Dr. David Moore, you have 10 minutes.

Dr. David Moore (Research Scientist, Epidemiology and Population Health Program, British Columbia Centre for Excellence in HIV/AIDS): Thank you, Madam Chair.

On behalf of the BC Centre for Excellence in HIV/AIDS and our Executive Director, Dr. Julio Montaner, I would like to thank the committee for the opportunity to speak today. My name is David Moore. I'm a Research Scientist at the BC-CfE in Vancouver and a professor in the Faculty of Medicine at UBC.

I'd like to start by acknowledging that I am presenting from the unceded traditional territory of the Musqueam, Squamish and Tsleil-Waututh first nations.

The BC-CfE is a provincial agency dedicated to improving the health of British Columbians living with HIV and AIDS. The BC-CfE works in partnership with the B.C. Ministry of Health, health authorities, municipalities and community groups in B.C. to promote evidence-based programs and policies to improve the quality of life for those living with HIV and to protect people from acquiring the virus.

As you've already heard, gay, bisexual and other men who have sex with men—hereafter referred to as "gbMSM"—are disproportionately affected by HIV and other sexually transmitted and blood-borne infections in Canada. Despite great advances in our scientific knowledge, gbMSM continue to experience the largest number of new HIV diagnoses each year amongst all populations at risk. In 2016 they accounted for 48% of new HIV diagnoses in Canada, despite comprising only 3% to 5% of the adult male population. Nationally, the number of new diagnoses amongst gbMSM has remained largely unchanged over the last 10 years. HIV remains a fundamental threat to the health of gbMSM and results in significant costs to the Canadian health care system.

However, recent advances in HIV treatment and prevention have generated great optimism for the potential elimination of HIV as a public health threat among gbMSM. The BC-CfE was at the forefront of developing modern HIV treatment as a highly effective means of preventing the development of AIDS and premature death amongst people living with HIV. More recently, research has shown that effective HIV treatment is 100% effective in preventing HIV transmission. As such, the close to 90% of gbMSM in metropolitan Vancouver who are receiving HIV treatment and have achieved virologic suppression can now be assured that they will have near-normal life expectancy; equally important, they will not transmit HIV to their sexual partners.

The B.C. experience has shown that facilitated access to HIV testing and immediate access to free treatment amongst people living with HIV, or treatment as prevention, known as "TasP", is the key to controlling the epidemic. TasP has now been adopted globally as part of the BC-CfE's proposed 90-90-90 targets for the global rollout of antiretroviral therapy. These targets propose that by 2020, at least 90% of people living with HIV will have been diagnosed, at least 90% of these will be receiving HIV treatment, and 90% of these will have achieved virologic suppression. It's estimated that meeting the 90-90-90 targets will lead to a 90% decrease in AIDS mortality by 2020 and a decrease in HIV infections of 90% by 2030. The 90-90-90 targets have now been formally adopted by the United Nations and by the Government of Canada, yet the implementation of TasP in Canada has been uneven. There is a growing concern that we will fail to meet the 90-90-90 targets on time.

More recently, it has been shown that taking a combination of two antiretroviral medications, or HIV pre-exposure prophylaxis, which is known as “PrEP”, is at nearly 90% effective in preventing HIV acquisition amongst gbMSM at high risk of infection. However, PrEP access across Canada remains suboptimal. Since January 2018 in B.C., PrEP has been available free of charge through BC-CfE for B.C. residents at high risk of acquiring HIV. Since full public funding for PrEP began in B.C., uptake has been very high, with more than 4,000 individuals, of whom 98% are gbMSM, initiating PrEP through the program as of the end of March 2019. As a result, B.C. is currently experiencing the lowest rates of new HIV diagnoses since the mid-1990s. We therefore call on the federal government to secure equitable and effective access to HIV testing and prevention programs, with support for and access to TasP and PrEP at no charge for people living with HIV or those at risk of HIV infection.

● (1545)

While the issues above highlight the great optimism felt about the control of the HIV epidemic, this is not the case for other sexually transmitted infections, blood-borne infections, or STBBIs. As we've heard from Dr. Gilbert, diagnosis rates of hepatitis C, syphilis, gonorrhea, and chlamydia continue to grow each year across the country, and again, gbMSM are heavily overrepresented in these epidemics. Therefore, we support the development and implementation of the government's STBBI action plan, coupled with significant new funding for programming, monitoring, evaluation and research. Without additional funding, our efforts will be diluted and will result in very limited impact for affected communities.

As mentioned by Dr. Gilbert, it's now understood that the syndemics of mental health and substance use disorders play a large role in increasing the vulnerability to STBBIs amongst gbMSM. Public policies developed over the last decades have likely reduced some of the stigma and discrimination faced by gbMSM in Canada. However, frequent and pervasive exposure to stigma and discrimination within the school, home, community and online environments due to one's sexual and/or gender minority status are still common and result in what has been termed “minority stress”. This minority stress is then reflected in much higher rates of substance use and mental health disorders. Compared with heterosexual men, sexual minority men are four times more likely to attempt suicide, two to three times more likely to develop depression and anxiety, and are twice as likely to develop drug dependencies. In order to have a sustainable impact on minority stress experienced by gbMSM, additional attention must be paid towards implementing evidence-based mental health and substance-use disorder services at the community level. We therefore recommend that the federal government work with provincial, territorial and indigenous partners to bridge the gaps in mental health and substance use services for gbMSM.

Another factor that has likely contributed to the continuing stigmatization of HIV, and by extension gbMSM, has been the over-criminalization of HIV exposure in Canada. While steps were taken federally to address this issue in late 2018, these had limited impact across the country. Therefore, we recommend that legislation be put forward to eliminate the over-criminalization of HIV exposure in Canada. We also recommend that the federal government unequivocally endorse the notion that undetectable equals untransmittable as it relates to the transmission of HIV.

As we've also heard, many gbMSM also use substances to cope with mental health challenges related to persistent societal stigma and discrimination. While cigarette smoking and hazardous alcohol use have not received as much attention in the press as illicit substances, they are highly prevalent amongst gbMSM, thus gbMSM are at greater risk of developing a host of illnesses related to tobacco and alcohol use, including cardiovascular disease, cancers, respiratory, kidney and liver diseases. Access to evidence-based smoking and alcohol cessation programming by gbMSM is quite low across the country and needs to be improved. The burden of smoking and hazardous alcohol use and the risks for developing diseases associated with these conditions are multiplied for HIV-positive gbMSM. Therefore, we support the inclusion of LGBTQ+ people as a key population in the federal tobacco control strategy, but recommend that additional funding for that strategy be secured to support community-based approaches to smoking prevention and cessation among LGBTQ+ people.

As well, the use of methamphetamine and other stimulants is highly prevalent among gbMSM. Among participants in our cohort study in Vancouver, 44% of HIV-positive and 10% of HIV-negative gbMSM report methamphetamine use in the previous six months. Participants who reported recent methamphetamine use were more likely to have been diagnosed with an anxiety disorder or depression and scored higher for symptoms for both anxiety and depression in comparison with individuals who did not report recent use. Therefore, we also recommend that additional funding be secured to support research and evidence-based programming to provide treatment and support for gbMSM who are affected by substance use disorders, particularly methamphetamine use and hazardous alcohol use.

● (1550)

In summary, in order to improve the health of gay, bisexual and other men who have sex with men in Canada, we recommend that the federal government take steps to realize the potential for HIV elimination among gbMSM in Canada and better control of other STBBIs. However, we must also work with provincial, territorial and indigenous partners to ensure that we are also addressing the syndemic problems of mental health and substance use disorders, which are important drivers of these epidemics.

Thank you.

The Vice-Chair (Ms. Marilyn Gladu): Thank you very much.

Now we're going to go to Gary Lacasse from the Canadian AIDS Society.

Mr. Gary Lacasse (Executive Director, Canadian AIDS Society): Thank you for inviting CAS to appear before your committee to discuss LGBTQ2 health in Canada.

The Canadian AIDS Society is a national coalition of community-based organizations dedicated to strengthening Canada's response to HIV and AIDS, which includes ongoing collaboration with community partners and Canadian stakeholders that ensure positive health outcomes for our LBGTQ2 populations, among others.

I would like to thank the committee for touring the different organizations across Canada. I see that you have thoroughly discussed chemsex, which includes crystal meth and other drugs that are devastating our communities of gay, bisexual and other men who have sex with men across the country, among other priorities and issues.

I would like to take my time today to focus on LBGTQ2 people living with HIV.

In the early years of the AIDS epidemic in Canada, 84% of the cases were gbMSM, most of whom died in the early years. Then, as drugs became available, they had to quit their jobs and go on social assistance to have access to these life-saving drugs. This created huge barriers for these individuals, their families and their communities, which created social and financial injustices through complacency from all levels of government.

Many of those who survived the epidemic are now facing their senior years with much trepidation. Imagine the double stigma of being gay and having HIV. We still have so much to do, but without an alignment from the federal government all the way down to local government, we will not be able to provide a place of peace and tranquillity for people living with HIV in their senior years.

Nationally today, depending on who does the statistics, 55.4% of new infections are gbMSM. Our work is having some impact, but we still have much to do, as gbMSM are overrepresented in HIV. We do have some good news, as rates in gay neighbourhoods seem to be on a downward trend, and targeted investments there seem to be working. Now we must also coordinate our efforts to reach them outside these neighbourhoods, as many of us who live outside these urban or rural areas are not exposed to prevention methods.

Complacency is truly at the root of the matter. As the Public Health Agency of Canada continues to centralize its efforts to reach gbMSM in gay neighbourhoods across Canada, and thus not effectively reaching all communities, better-aligned awareness campaigns must be developed and adapted accordingly.

Stigma remains one of the biggest issues for people living with HIV today. It is the one central issue that affects most of the social and health outcomes of people living with HIV. On top of all this, overall about 40% of people living with HIV have mental health issues.

Decriminalization of HIV remains one of the priorities for people living with HIV today. We had expected better from this government in addressing the criminalization of HIV. Although the justice minister announced a new directive to help limit unjust prosecutions on December 1 of last year, more should be done. The cases of HIV criminalization in Canada represent one of the highest rates in the world, and have significantly added to the stigma that people living with HIV already face on a day-to-day basis.

I would be remiss if I did not address the HIV funding landscape in Canada. We question the steps that Canada has taken to address HIV, hepatitis C and other sexually transmitted and blood-borne infections—or STBBIs—in recent years through the community action fund and the pan-Canadian STBBI framework for action.

Since the implementation of the CAF, both people living with or affected by HIV and other STBBIs and community-based organizations that serve them have felt its negative effects, as HIV and STBBI rates continue to rise in Canada. Those living with these infections are left behind, with decreased access to support and care. To progress toward the UNAIDS 90-90-90 targets that Canada aims to reach, we suggest the following three steps: reassess the priorities of federal funding; review the population-centred approach; and increase the funding for both testing and secondary prevention through care and support of those affected by, and most of all, at risk or vulnerable to HIV.

● (1555)

There must be a consistent and collaborative dialogue between community-based HIV movements and the federal government, which does not necessarily exist. It is only through long-term and committed engagement that we will reach these targets and reduce the overrepresentation of gbMSM in new infections.

I must also underline the fact that our own surveillance data is significantly flawed in Canada. To be a G7 country without a unified surveillance data reporting system in 2019 is shameful—and imagine, we have data on only 60% of the reported cases of HIV in Canada.

Unfortunately, concerns were raised in our letter to the minister of health in 2016 regarding the likely outcomes of the funding cycle of that year. The implementation of the CAF has left many community-based organizations without the necessary funds to address the priority populations, which represent the highest levels of vulnerability in their own areas. After seeing HIV rates increase by 17% in 2017, a second consecutive annual increase and the highest rate since 2009, it is clear that the new funding model under the CAF has not effectively achieved its goals set out by PHAC, and this is shameful.

Ironically, while the STBBI framework for action highlights the importance of positive prevention, it does not holistically address it. While positive prevention is identified as one of the seven funding priorities of CAF, there is a recognizable lack of emphasis on treatment and care in the descriptions of both CAF priorities and the programs or initiatives funded. We do recognize that treatment is a provincial jurisdiction, but the provinces take their lead from the federal government. If and when there is no leadership at the federal level, the provinces are more likely to let this slide.

With that specifically in mind, CAS launched a national HIV testing day last year, built on the success of the Saskatchewan HIV testing day. It is inconceivable that PHAC would not want, at the very least, to sponsor this effort that we're doing at CAS and coordinate this work at the federal level minimally. This project brings much-needed awareness of HIV and new HIV testing technologies to thousands of Canadians. The government's refusal to support this initiative is indicative of the value it places on community-based organizations, many of whom provide vital services that people living with HIV could not receive anywhere else.

Community-based organizations do most of the same work as the health care sector at 20% of the cost and save more than $1.3 million over the lifespan of somebody infected with HIV. With more mission funding as opposed to only project-specific funding, organizations would be more able to ensure quality, long-term programming rather than constantly scrambling for new sources of funding. This would ensure a full spectrum of prevention, care and support for people living with HIV, specifically LGBTQ2 populations across Canada.

Mission funding would also alleviate the divides in community, as PHAC and Health Canada could ensure collaboration and support amongst community organizations instead of continually pitting them against each other.

We do have the tools to prevent infections: U equals U, that is, the undetectable equals the untransmittable, and PrEP, among others.

We are resolute in our mission of eradicating HIV and supporting those affected. At this precise moment in time, someone out there who is living with HIV or another STBBI and who is not aware of their status is transmitting it to someone else. Why is this? It is because our own health care system outside of our urban settings does not have the tools to prevent HIV and other STBBIs. The system is underfunded and is struggling to survive instead of thriving. How is it that a gay man in Gatineau, across the river, cannot walk into a clinic and be tested for HIV and other STBBIs without feeling stigmatized? Why is it that a gay man in New Brunswick cannot feel comfortable getting tested in New Brunswick? It is because the sexual health clinics are called "women's sexual health clinics". That's why.

● (1600)

Our biggest roadblock to positive health outcomes for anyone in Canada is our own health care system. It is nearly impossible for the most vulnerable and marginalized to access it, and these are the people who are most at risk of HIV. The health care system is broken, and until we recognize that, we will not be able to move forward in a meaningful way that will positively influence the health outcomes of all Canadians, let alone those of the LGBTQ community.

I thank you for the opportunity. I would accept more dialogue around this, as we move forward.

Thank you.

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): Thank you very much.

Now we'll go to Mr. Croteau.

Mr. Gerry Croteau (Executive Director, Gilbert Centre for Social and Support Services): Thank you for inviting me.

The Gilbert Centre is the largest 2SLGBT centre north of Toronto and south of Ungava Bay.

"The homophobia we experience as children spreads throughout our lives like ripples on a pond. I remember everything, and so will your children," and my children.

The impact of being a teenager in the 1960s, at a time when support services for LGBTQ youth were unavailable was that to be gay was to be at risk of criminal prosecution. Disclosure was never an option. Support for many of us within the family structure centred on being normal, for a boy. For many of us, that was hockey, cars and woodworking, and never showing an interest in the arts, theatre or fashion. For girls, it meant home economics, being cheerleaders and never showing interest in activities perceived as male.

Health issues, if any, centred on cuts, concussions and broken bones. By the time the hormones kicked in, there was no sex education. Safer sex practices were not taught, and girls got pregnant if you held their hand—that's a Quebec thing.

Now fast-forward to 2019. The landscape has changed dramatically, in some instances for the better, but in others, it seems to have reverted to the 1990s, as it pertains to the 2SLGBTQ community.

Here I will cite the following. One, Ontario had a lesbian premier, Kathleen Wynne, from 2013 to 2018. Two, on November 2016, Randy Boissonnault was appointed special adviser on LGBTQ issues to Prime Minister Trudeau. Three, in May 2017, Ottawa apologized for past wrongs to the LGBTQ community. Four, in November 2018, Ottawa announced a $450,000 fund to improve the safety of LGBTQ Canadians. Moreover, in 2019 Ontario dropped references in all sex-ed curriculum, to sexual orientation, gender identity and same-sex relationships.

The first bullet point in my brief discusses health issues within urban and rural communities that centre on the 2SLGBTQ community. When it comes to health concerns, many seek out a "gay" doctor, in the hope of being able to be transparent and in a safe place. Discussing health issues such as condom use, STI and HIV testing, mental health and concerns such as the use of PrEP are not easily communicated by health care professionals who are unwilling and unaware or uncomfortable discussing these concerns with their 2SLGBTQ patients.

Stigma remains problematic for gay men, men who have sex with men and HIV-positive folks. In 2016, Health Canada approved Canadian Blood Services and Héma-Québec's application to reduce the men who have sex with men ineligibility period from five years to one year. It remains stigmatizing to cite gay men as somehow being carriers of the HIV virus, or any number of other STIs.

Note that HIV is not only found among gay men, who represent 47% of HIV-positive folks. There remain 53% of others—injection-drug users, women and children. This stigma feeds into the inability of gay men to access health care in a timely manner. Many gay men do not visit their health care professionals, due to stigma, and therefore are not always receiving the proper health care they require.

U=U—undetectable equals untransmittable—the prevention access campaign, is a worldwide message that HIV folks who are undetectable cannot transmit HIV. The medical discovery has been endorsed by over 850 organizations from nearly 100 countries. Some health care professionals remain doubtful of the U=U message, thereby preventing their HIV-positive patients from fully embracing the tremendous freedom that U=U brings.

U=U brings with it the need to adhere to meds, proper diet and exercise. Health care for HIV-positive folks is critical in this country. It's not just good physical health, but also mental health and emotional well-being.

The cost of HIV meds can well exceed $1,000 per month, which is affordable for those who have private insurance, or in Ontario's case, the Trillium drug program. What if you can't afford the meds? We need to make HIV meds available at no cost, as they are in B.C., as mentioned earlier, freeing up the stress of securing meds, and allowing HIV-positive folks to live a healthy life.

HIV specialists are often located in major urban centres, which makes accessibility difficult for rural populations that may have transportation challenges. For some from rural communities, access to a 20-minute appointment could involve a day's commitment, due to buses that run only twice a day, and often require a bus transfer. Bus and train schedules are not always convenient or available in rural Ontario.

● (1605)

With regard to transgender health, within the trans community, many encounter issues, for example, with the use of their preferred name. Government-issued IDs use the name assigned at birth. Using the name assigned at birth and not the preferred name can be triggering.

In many instances, hospital, medical and government forms fail to address transgender folks correctly. The incorrect use of pronouns, sex and health issues that are unique to transgender folks can be very problematic when accessing health care. For example, for a trans woman who hasn't had confirming surgery but is on hormone replacement therapy, it may be awkward, or a trans man may need to have a mammogram if they haven't had top surgery, or a pap smear for cervical cancer. These are areas of concern when accessing health care.

Regarding indigenous communities, in Simcoe County and Muskoka, we have Beausoleil First Nation, Wahta Mohawk First Nation and the Chippewas of Rama First Nation. The problems are many for Canada's indigenous people, including aboriginal, first nation, Métis and Inuit people. They range from higher incidence of mental health problems and lower access to appropriate care—despite greater willingness in the general population to seek mental health care—to systemic public health care issues. Health care is viewed as white man medicine by many in the indigenous communities.

Social media sites that connect men who have sex with men, such as Grindr, Squirt and Facebook have enabled men to access quick and often anonymous sex without much concern about transmission of STIs, such as HIV or HCV. I bring this to your attention, because in rural communities, isolation is a factor and social media tends to bring the 2SLGBTQ community closer together. Accessing sexual encounters is therefore easier—it's GPS-based—and therefore the possibility of transmission of STIs is higher. This increases not only health risks but also health care treatments in a timely manner.

I recommend—and it's a dream, right?—providing training to health care professionals to be more inclusive and diverse in their respective medical practices, from receptionists to the doctors; ensuring that health care professionals are current in their use of terminologies and pronouns; encouraging awareness on the part of health care teams of the need to be willing to assist the 2SLGBTQ clients with their health care concerns, even when it is not within their scope of practice; and ensuring that their medical forms are inclusive of the 2SLGBTQ community.

Government should be mindful when allocating program dollars for short-term funding agreements that this limits the ability to provide ongoing clinical and practical support. In addition, the ability to hire individuals with the needed skill sets is hindered when employers are only able to provide short-term contracts of six months to a year. Short-term contracts are not viable to social workers, as an example.

HIV and ARV medications, including PrEP and PEP, should be free to all Canadians, and trans health care should allow for affordable confirming surgeries to be possible in all provinces—and that includes feminization surgery and language therapy.

To wrap up with some historical context, remember that in Canada, even though our health system is not always up to par for the 2SLGBT community, our LGBT rights are some of the most advanced in the world. Same-sex sexual activity has been lawful in Canada since June 27, 1969. Historically, Canada has frequently been referred to as one of the most gay-friendly countries, with its larger cities featuring their own gay communities, such as Toronto's Church and Wellesley, Montreal's gay village, Vancouver's Davie village and Ottawa's Bank Street gay village.

Global surveys from March 2013 show that 80% of Canada's general population—87% of folks aged 18 to 29—favour social acceptance of the LGBT community. A large majority of Canadians support same-sex marriage, which has been legal since 2005. Polls show that 70% of Canadians agree that same-sex couples have the same rights as heterosexual couples to adopt children. Finally, polls show that 76% of Canadians agree that same-sex couples are just as likely as other parents to raise their children successfully.

In closing, Canada is very gay friendly. Our health care system ought to be as well.

● (1610)

The Chair: Thanks very much.

As you know, many of the committee members just went across the country, and in every community that we went to, we heard about the health care system and the stigmatization and the difficulties faced by the gay community.

Hopefully, we will make some progress at the end of this committee.

Right now, we're going to start our seven-minute round of questions with Mr. Ouellette.

Mr. Robert-Falcon Ouellette (Winnipeg Centre, Lib.): Thank you very much, Mr. Chair and Mr. Casey. Thank you very much to the witnesses for your testimony and getting it on the record.

I just have a few questions. I am wondering if you could talk about PrEP and the health impacts on the gay community, both positive and negative aspects.

Dr. David Moore: Is that directed at any of us?

Mr. Robert-Falcon Ouellette: Anybody can jump in.

Dr. David Moore: Maybe I'll start. In Canada, the short answer is that we don't yet know. Until quite recently, even among gbMSM, where globally there's a lot of community interest in PrEP, PrEP uptake in Canada has been very low. In most provinces, that was thought to be due to an absence of public funding for PrEP, but PrEP has actually been part of the provincial medicare program in Quebec since 2016. Even in Quebec, it seems like uptake there was not as great as might have been expected.

However, it does seem like that's changed recently. Researchers from Quebec have been presenting a lot of data on PrEP uptake and the acceptability of PrEP in Quebec. As I mentioned, in our studies of gay men in B.C. prior to public funding of PrEP, only about 2% of our participants reported using PrEP. Now we're seeing maybe 20% or 30% of participants using PrEP.

Public funding and increasing awareness over time are certainly fostering interest in PrEP, primarily among gbMSM. There's always a concern or perhaps an over-concern that this is going to adversely affect sexual behaviour and that we're going to see an increase in epidemics of other STIs. It's important to remember that PrEP is really targeted to individuals who are already at high risk of acquiring not just HIV but other STIs.

When we see very high rates of syphillis, gonorrhea and chlamydia diagnoses among PrEP users, that's really what we expect. That says we're actually targeting the people who really need this. It remains to be seen whether those rates will continue over time or whether we might in fact get better control of these other STIs, now that we're engaging these people at high risk of acquiring other STIs in regular medical care.

I think it's probably important to mention what we've heard, at least anecdotally, are the mental health benefits of being on PrEP. A lot of people report that their sex lives have improved now that they don't have to worry about catching HIV.

That's my take on it. We're interested in measuring many of these things over time but right now we don't have a lot of information about the real-world use of PrEP in Canada.

Mr. Robert-Falcon Ouellette: The next question I have is related to the needs of gay men and even lesbians. Obviously, it's mostly men who are answering, though, so probably we have a better experience related to that population.

As older gay men become older, what are the health concerns of that population in relation to whether or not they have HIV or AIDS? What are they encountering, not only within the health care system but also within home care and other institutions of the state?

● (1615)

Mr. Gary Lacasse: I can address that because I'm aging at the moment myself.

The issue is our doctors. When we go to see our doctors—I live here in Ottawa, I live in Aylmer in Quebec—they do not understand holistically what a gay man is or what an LGBTQ2 person is. When we say that we would like to have testing for different things, they say, "You're married and shouldn't be having risky sex", or whatever—but that's part of the holistic approach to health care for anybody. We don't know what the risk factors are or if we have a dormant case or whatever.

For me as an aging gay man, one of the biggest priorities is really to be able to have an honest discussion with health care providers, one that is free of stigma and judgment. I am also wondering if, later on, there are going to be some facilities that will take me, a gay man, open-armed.

Mr. Robert-Falcon Ouellette: Do they exist in Canada?

Mr. Gary Lacasse: Some do exist in different pockets in cities across Canada.

Mr. Robert-Falcon Ouellette: Do you know where they exist? Where they might be gay-friendly...?

Mr. Gary Lacasse: There are some in Montreal. I guess there are some in Toronto and in B.C., I think, in Vancouver.

Dr. Mark Gilbert: I think there's one in Vancouver.

Mr. Gary Lacasse: Yes, but rurally, no.

Mr. Robert-Falcon Ouellette: As gay, lesbian and LGBTQ2 communities age, do they then become asexual?

Voices: Oh, oh!

Mr. Robert-Falcon Ouellette Obviously not. That's a no.

Mr. Gerry Croteau: I'd like to add to that.

Mr. Robert-Falcon Ouellette: Yes.

Mr. Gerry Croteau: Remember, I mentioned that those who were in their teens, as I was, when homosexuality was decriminalized in 1969 have a different life experience with regard to sexual orientation and gender identity. We grew up in a time when homosexuality was criminalized. That life experience at that age impacts a lifetime. It just doesn't go away.

There's a history of discrimination, exclusion and fear of stigmatization. Not all seniors wish to be open or to be included in the LGBTQ community. The effects of past discrimination can contribute to the invisibility of seniors. Many seniors have grown older convinced that it's better to keep their sexual orientation a secret. Even heterosexual men and women moving into long-term care facilities are often separated. Husbands and wives are kept in different rooms. Gay men, couples going in, are not given the same room and are not given the same courtesies of conjugal relationships that maybe heterosexual couples have. That's an issue—

Mr. Robert-Falcon Ouellette: Isn't that discrimination?

Mr. Gerry Croteau: Yes.

Mr. Robert-Falcon Ouellette: Would that be against someone's human rights?

Mr. Gerry Croteau: Well, seniors don't tend to go that route. They've just been so accustomed.... In a lot of cases, too, that senior care within long-term care is difficult to come by, at least in our area. When you can get a long-term care home, you try to keep your mouth shut if it means keeping your mouth shut about your sexual orientation.

Mr. Robert-Falcon Ouellette: Even if you are in a relationship—

The Chair: Your time is up.

Mr. Robert-Falcon Ouellette: I have five seconds left, Mr. Chair.

The Chair: No, you don't.

You are over by 25 seconds.

Mr. Robert-Falcon Ouellette: I was just getting going.

The Chair: I will have to penalize you.

Ms. Gladu.

Ms. Marilyn Gladu (Sarnia—Lambton, CPC): I'm going to start with you, Mr. Gilbert. I'm very interested in your comments about testing.

Can you tell me what kinds of testing protocols we should have in place? Give me an idea of how much the equipment costs and how you would see that implemented if you could wave your wand across the country.

Dr. Mark Gilbert: That's a great question.

Generally when I think about advances in testing and how we can harness new approaches, they fall into two camps for me.

One is around ways of streamlining access to existing testing, such as, for example, the program we have with Internet-based testing. Or now, increasingly, we see people who have fast routes to testing. You come in and you can be triaged, if you don't have any problems, to get a simple screening. Those are the things that don't make use of new test technologies per se. They're just different ways of making testing easier.

When it comes to test products, each of those has an associated cost. They vary between products. They can be anywhere in the order of $10 to $20 or higher. Those tests are usually screening tests. They are usually the first test in a testing process, which means that you need to do a confirmatory test as well.

I think the issue around point-of-care tests is that it's not just the cost of the test. You obviously need to have a whole wrap of things that go along with that point-of-care test. For example, you need quality assurance programs, training programs and resources around their delivery. It requires investing much more than just the cost of the test.

Really, I think, this is increasingly where we're going in the future. I'd say that probably over the next 10 years or so we're going to start seeing rapid genetic or molecular tests for HIV, other viruses and sexually transmitted infections, which can be done at the bedside or in a clinic or in non-traditional settings. Increasingly, I think, we're getting more tools, so we want to make sure that for Canada we're able to really take advantage of those news tools as they emerge.

● (1620)

Ms. Marilyn Gladu: Okay. Very good.

Dr. Moore, you were talking about how in B.C. they provide PrEP without charge. Do you have a sense of what the overall cost of that program is? There are about 4,000 people in it, I think you said.

Dr. David Moore: Yes. I'm afraid that I don't actually know the overall cost of that, but one thing that's important to note is that one of the issues that makes this affordable now is in terms of the patent on the two drugs that are actually used for PrEP. One of them was already available as a generic formulation, but the patent on tenofovir actually ran out a year and a half ago.

Now, we're actually able to use generic antiretroviral medications not just for PrEP but also for HIV treatment. The costs of these medications have dropped dramatically. It really makes PrEP a much more financially feasible program now.

Ms. Marilyn Gladu: Do people get it at the pharmacy or at a clinic, or where can they access it?

Dr. David Moore: Like antiretrovirals for HIV treatment in British Columbia, all of the medications are purchased centrally through the Centre for Excellence in HIV/AIDS. Then they are distributed to different regions around the province. Typically they can be delivered to specific pharmacies, and certainly that's the case for HIV treatment. We're still sort of working on that for PrEP. The default thing is that if somebody is in a location where the pharmacy isn't willing or able to receive PrEP medication from the centre for excellence, it can actually be couriered to their doctor's office so that they can receive it directly there.

Ms. Marilyn Gladu: Okay, excellent. Thank you.

Now I'll turn to Gary from the Canadian AIDS Society.

In your comments, it sounded to me that funding to your agency was cut under this government. Was it?

Mr. Gary Lacasse: For the federal community-based organizations or the NGOs, the funding shifted, so instead of nine organizations being funded, there were 17. There were three of us that were cut out, and a lot of other organizations. The contribution went down. We were not successful in gaining any funding. We just find that the funding envelope has not increased since 2008. The Liberal government had guaranteed that this funding envelope would go up, and it didn't. So that's what we're ticked off about, let's say. It would allow for a broader offer of services to people living with HIV across the country, because we have to remember that HIV is the only STBBI that does not have a cure. The rest of STBBIs do have a cure, and the exceptionalism should stay there.

Ms. Marilyn Gladu: What is the actual tangible result of not receiving the funding for your organization?

Mr. Gary Lacasse: For us, we survive. That's great. We have other programs that compensate for the loss of funding from the federal government.

Tangibly, there are resources that were more centred on a community approach that aren't produced anymore. Our national HIV/AIDS walk was cancelled because of funding cuts there and other opportunities that were cut. There's a lot of awareness that came from community, and that's cut out of the landscape completely, and this government does not believe in awareness. So that's something that is there. But overall, I would think that we also have to understand that the landscape for philanthropy is that philanthropists don't want to spend money on things that the government should be paying for.

● (1625)

Ms. Marilyn Gladu: For sure.

Mr. Gary Lacasse: That's a huge roadblock for our organizations.

Ms. Marilyn Gladu: All right.

Now I'll turn to Gerry.

When you're talking about people trying to access a gay doctor, I know there is a doctor shortage across the country that's gone unaddressed, so I can only imagine that it must be even more difficult. Do you have a sense of the availability of gay doctors or clinics across the country where people could be received?

Mr. Gerry Croteau: Across the country, no. In Simcoe County, the largest county in Ontario, in Barry, which is one of the larger cities in the county, we have one gay doctor. And I say "gay doctor" because there are men who are married to women and have sex with men, so they do not go to a gay doctor necessarily. They usually share the same doctor with their wife, so they're very hesitant to talk about sex outside of that relationship. So any concerns they may have about HIV or STBBIs tend not to be discussed with their doctor. They don't get into things like PrEP, or they don't get into things like HIV testing. Mind you, a lot of health care practitioners in our area are now testing in their clinics for HIV, no matter if you are straight or gay. It doesn't matter. Everybody gets tested, young and old.

Ms. Marilyn Gladu: Thank you.

The Chair: Mr. Davies, you have seven minutes.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you to all of you for being here and sharing your experience and wisdom with us.

Mr. Lacasse, I want to start with you. You've already mentioned some statistics about increases in HIV infections. I think you have written in a letter that there was a 14.4% increase in HIV incidence between 2015 and 2017, the largest increase since 2009. I'm just wondering if you know, Mr. Lacasse, that the Government of Canada has endorsed the global targets established by the joint United Nations program on HIV/AIDS and the WHO, and that includes the 90-90-90 target by 2020. Do you know if Canada is on target to meet 90-90-90 by 2020?

Mr. Gary Lacasse: I've been told that we're not going to meet them, but there's no official source.

We have some statistics, but our surveillance data is wrong. We can't even have assured surveillance data in Canada when we only know 60% of where our HIV cases are coming from on our surveillance data. It doesn't make sense. Two years ago, 10,000 people living with HIV disappeared. The estimates went from 75,000 people living with HIV to 63,000 in one year because we rejigged the estimates. I see people shaking their heads, but that's the truth.

When we look at our surveillance data and then we have estimate data, which one is true?

Mr. Don Davies: Is it that we're not meeting our targets or that we have no way of knowing if we're meeting our targets?

Mr. Gary Lacasse: In reality, I think it's both.

Mr. Don Davies: Mr. Lacasse, we know that access to antiretroviral meds is critical to achieving undetectable viral loads, and that's part of the goal. Do you know, roughly, what percentage of gay men in Canada who have HIV have access to antiretroviral meds?

Mr. Gary Lacasse: Everybody has access to get them. It's just that you have to be aware of your status. You have to also have access to those meds and able to afford the copay and so on and so forth.

I can't give you a statistic. I could tell you the broader statistic of how many people living with HIV are on medication by an estimate, but that's not—

Mr. Don Davies: What would that number be?

Mr. Gary Lacasse: Because 90-90-90 is a cascade, so 90—

Dr. Mark Gilbert: I can't remember.

Mr. Gary Lacasse: I can't either. I think about 70% are on their meds.

Mr. Don Davies: If you get that number, can you send it to the committee?

Mr. Gary Lacasse: Yes, I will.

Mr. Don Davies: Dr. Gilbert, when we talk about GLBTQ2S health, all we keep hearing over and over again is about stigmatization and discrimination. I want to ask a question about the blood donor ban on men who have sex with men. We know that there was a promise by this government to eliminate the five-year period of abstinence. That's been reduced to one year I understand. I've heard anecdotal testimony from gay men about the impact that has on their self-worth.

I'm going to ask you directly. Is there any valid scientific evidence that justifies enforcing a one-year period of abstinence on men who have sex with men from donating blood?

Dr. Mark Gilbert: No, there isn't, to my knowledge. My understanding of the decision to go to one year was not so much that it was.... It was based on science in general, in the sense that the five years was too long, but there was a parameter set that it shouldn't be less than a year. I do think there is evidence showing that it could be less than a year. Certainly for some people it could be much less. I know that trying to uncover some of that is an active area of research right now. I have colleagues in B.C. doing research on that.

● (1630)

Mr. Don Davies: The other thing we touched on was the criminalization of HIV. With regard to the provisions in the Criminal Code—if I have it right—requiring people who have HIV to disclose that to their sexual partner, one of the concerns I've heard people express is that it may actually work to actively discourage sexually active adults from getting tested.

Do you have any comment on that? Does it discourage testing? Do you have any concerns about that provision being in the Criminal Code of Canada?

Dr. Mark Gilbert: I don't have any evidence to back that up. I've heard anecdotal evidence or people saying that's a concern, but in terms of actual data, I don't know that.

I think what's important when it comes to testing is to make sure that we have options where people can get anonymous testing—which is something we only recently introduced in B.C. a few years ago—and options where people can actually get tested, so that they can find out their status without being worried about legal repercussions.

Mr. Don Davies: Is that the standard across Canada? Is anonymous testing available?

Dr. Mark Gilbert: Anonymous testing is available in most places in Canada, as far as I know. I can't say for certain it's in every province, but historically it's been one of the first forms of testing that was introduced with HIV testing.

Mr. Don Davies: What about the fact that this is in the Criminal Code at all? It seems to single out a particular virus and impose a particular obligation on a particular group of people. Is that good public policy in your opinion?

Dr. Mark Gilbert: I certainly don't support the criminalization of the non-disclosure of HIV. I think that largely has to do with stigma and is really unwarranted.

Personally, I think there are mechanisms under public health law to deal with cases when someone is potentially transmitting HIV, either unknowingly or knowingly. That's the route we've taken in B. C. We really try to steer away from criminalization. Recent prosecutorial guidelines have been issued on trying to discourage people from being charged. I do really think that public health law is the much better route to go than criminal law.

Mr. Don Davies: Thank you, Mr. Croteau.

I was quite stunned to think of the fact that a gay man would not want to disclose to his own physician something as important to his identity and health as the fact that he's gay.

I know it's anecdotal, but how common is it that gay men feel that it's not safe enough for them to disclose their sexual identity to their own physician?

Mr. Gerry Croteau: I can send you a survey that we did in Simcoe County, which was funded for five years by the Public Health Agency of Canada, of men who had sex with men and who had female partners. For example, you mentioned the blood supply of gay men in 2016, but what about the men who are bi who are married to women who don't identify as gay and who are having sex with men? They are not queried on this at all. Gay men feel even more isolated, because a lot of gay men have sex with married men who are married to women.

When I came out gay, my wife and I had the same doctor. I would not tell my doctor that I was having sex with men, and I would not get tested with him for any kind of sexually transmitted infection that I may or may not have had. I would go into Toronto only because the confidentiality between my doctor, my wife and me seemed to be transparent. Whatever I disclosed to him, he would disclose to my wife and vice versa. I mean, I found out my wife had yeast infections before she told me in some cases.

Mr. Don Davies: Mr. Lacasse, with regard to the federal initiative on AIDS, can you tell us basically what the funding status of that is? Has it changed? What is the government currently putting into it, and what should they be putting into it in your view?

Mr. Gary Lacasse: We estimated that $100 million is lacking in the funding from unspent monies and the increase promised to the initiative in 2004 under the Liberal government. About $113 million is missing overall in the end.

At the moment the fund has been increased, but it's a temporary increase to include prevention and harm reduction for people who use injection drugs. The fund was increased, but specifically for the population of people who used drugs, so the fund stayed stable. In reality, it hasn't gone up. It's only gone up for five years, and that's it; then it was repealed back.

● (1635)

The Chair: Okay.

We have to move on to Mr. McKinnon now.

Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.): I'd like to preface my questions by noting that budget 2019 does provide a $20-million fund over two years for community-level work for LGBTQ2 organizations across the country. It also increased funding for events such as pride festivals and so forth to increase awareness, to increase acceptance and, hopefully, to reduce the stigma.

Having said that, I'd like to continue with Mr. Davies' questioning about HIV criminalization or at least criminalization of non-disclosure. I'd like to note as part of this that the justice committee, which I am a member of, is currently engaged in a study instigated by Mr. Boissonnault on HIV non-disclosure, so I've heard some of this kind of testimony as well. I don't have the witness list in front of me right now, but I think the Centre for Excellence is on it. I would urge anyone who would like to submit a brief to that committee to do so if they're not already on the list.

I'd like to carry on from there and mention, as Mr. Davies pointed out, that one of the problems we're hearing is that the fear of criminalization is an impediment to people getting tested. If they don't know they're infected, they really can't be charged with non-disclosure. I think the identification rate is very low, and much lower than it should be, because of that.

I'm going to ask each of you who would like to comment on this what other impacts on the health of LBGTQ2 people might this criminalization contribute to.

Dr. Moore, would you like to comment?

Dr. David Moore: Sure. Thanks very much.

We do have some data from studies in Vancouver about HIV testing among gbMSM and their reasons for not going for testing. The most recent data we have was collected between 2012 and 2014. In there I think something like 90% of gbMSM living in Greater Vancouver had ever been tested, and 70% of those men had been tested in the last two years. When you ask guys who had not been tested recently why they didn't get tested, the main reason was that they intended to but hadn't got around to it, so it maybe relates to the question of convenience or access or having a gay-friendly doctor to do the testing. The other main reason was that they felt they were at low risk for acquiring HIV. In fact, in looking at that, we did actually find some validity to that, that the guys who didn't get tested who said they were at low risk, were in fact appropriately assessing their risk of acquiring HIV.

We didn't ask specifically about criminalization, but we asked about reportability or having your name reported to public health. That was discussed by some men as a reason for not getting tested, but it was quite a small proportion and quite a way down on the list of reasons for not getting tested.

Mr. Ron McKinnon: Thank you.

Dr. Gilbert.

Dr. Mark Gilbert: To your question, I think I would add that while criminalization of HIV non-disclosure obviously has profound implications for the individuals who are concerned, I think it has a much greater negative impact on society around perpetuation of HIV stigma. Every case gets reported in the news. It just contributes to people's perceptions that people with HIV are irresponsible and are morally bad and wrong. I think that's one of the biggest challenges with HIV non-disclosure and really, I think, something that is really critical to try to change. The federal government does do periodic surveys of anti-HIV stigma attitudes and there remains a substantial proportion of people who have very stigmatizing attitudes towards people with HIV, including attitudes around criminalization. While that's by no means now the largest part of society, it's still significant. I think this is why these kinds of structural policy changes can really help make a difference on societal factors like stigma.

● (1640)

Mr. Ron McKinnon: Thank you.

Mr. Lacasse, would you care to comment?

Mr. Gary Lacasse: I think everything has been said pretty much from a community perspective, but it's really the stigma that comes with it. We really have to ensure that we have language that does not stigmatize people when it comes to health care. If you talk about somebody who is autistic and you add to that HIV criminalization, right there the red flag is going to go up like crazy. I think we have to have a more holistic approach to health care in Canada. We're not doing our job. I'm sorry.

Mr. Ron McKinnon: Thank you.

Mr. Croteau.

Mr. Gerry Croteau: One of the things that is helping to lessen the stigma about getting tested is U=U. Undetectability, with the use of either an internal or external condom, where you don't have to disclose...to a possible partner, has helped to eliminate some of that stigma, although stigma is still there. But definitely in our area—and I speak for Simcoe and Muskoka—many men still do not consider HIV testing to be part of their health regime in the same way they see eyes, dental, prostate, heart, cholesterol, etc....

In many cases as well, confidentiality still plays a big part in rural communities, because in many health care centres in rural communities, you recognize the car, or your wife may work there or a relative may work there in a smaller community, so you hesitate to get tested for HIV because of the fear of having that information divulged to either your employer or someone within the community.

Mr. Ron McKinnon: One of the problems we've heard about already is that there is a lack of instant testing or kits on the market that you can go into a drugstore and get. Would you agree with that position?

Mr. Gary Lacasse: We do the national HIV testing day on June 27 each year now. We get free kits from bioLytical, the company that makes the instant testing kits. We are trying to bring them out to communities that don't use instant testing, but only use blood draw. Point-of-care testing is extremely important with other technologies, like dry blood spots. The more diverse offerings you have for testing, the more people will get tested. It's the Hygrade method; the more you produce, the more people will eat them, whatever.

I think that's the best route to go about it, but our market value is not there for these companies in Canada. We have to have a more express route with the other countries for approving these new methods that are based on science, rather than just our own, because the cost is supposedly prohibitive.

We did point-of-care testing in the Maritimes. We were told by PHAC that we were bringing point-of-care testing kits to the Maritimes, almost as a guerrilla thing. I told them that was not the case. We were doing it with private clinics in New Brunswick that would be testing point of care. We did 37 point-of-care testings in Cape Breton, which had never done it, but since then, Nova Scotia has adopted point-of-care testing, so we're doing something right. Let's continue down that path.

The Chair: Thanks very much.

Now we have to go to our five-minute round, starting with Ms. Gladu.

Ms. Marilyn Gladu: My first question is for Dr. Moore.

I know that the Canadian AIDS Society talked about the HIV rate going up by 17% in 2017, but I got the impression that in B.C. it was going down.

Could you quantify that, and could you say what's happening with hepatitis C rates and syphilis rates in B.C.?

Dr. David Moore: With respect to HIV, we had the lowest number of new HIV diagnoses in B.C. since the mid 1990s in 2017 and 2018. The rate in 2017 seemed anomalously low. In 2018, it is still a decrease, but not as great as it was in 2017. We think we're generally on the right track, although the deceases are not as dramatic as we would like to see. Now that we've been running an HIV PrEP program for a year, in 2019 we hope to see really dramatic drops in new diagnoses amongst gbMSM, because we've seen this really dramatic scale-up of PrEP.

As far as hepatitis C goes, I happened to look at the HCV surveillance report for the country a couple days ago. It generally shows that overall, diagnoses have been on a slow, steady decline since 2012.

Mark Gilbert might know better about HCV rates specific to B.C.

Certainly, men who have sex with men are overrepresented in the HCV epidemic as well, but certainly not to as great an extent as people who use injection drugs. There is still a risk there. Of course, there is a lot of optimism around HCV now with effective and more affordable HCV treatment that is now getting publicly funded. I think that's another place where we're optimistic.

● (1645)

Ms. Marilyn Gladu: When people take PrEP, do they stay on it after they come to the level where they're not transmitting HIV anymore?

Dr. David Moore: It's a different process. You're giving it to people who don't have HIV, so there is nothing to actually measure to see if they're taking it. It was originally licensed and studied as a daily pill that you take every day, to prevent you from getting HIV before you potentially get exposed to it.

Since licencing, and since some of the original studies, there have been other studies that have shown that you can actually use it in a so-called on-demand way. If you're planning on being sexually active, you can take two tablets that day, and then take a tablet a day for up to two days after you last had sex. That actually seems to work just as well as taking it every day.

One of the things we're struggling with as a program is how to measure continued use of PrEP when we know that people are using it in different ways. For the people who are saying they're using it regularly every day, that's fairly easy to monitor. For people who are using it intermittently, it's a bit more challenging.

Ms. Marilyn Gladu: Thank you.

This question can be for anyone.

We heard a lot of testimony about the need for LGBTQ-specific mental health aids. I am honestly not aware of any that existing in the country.

Does anybody know if any exists anywhere that we should be duplicating?

Mr. Gerry Croteau: Could you repeat that question, please?

Ms. Marilyn Gladu: I've heard again and again that there is a need for LGBTQ-specific mental health aids, meaning people who understand what LGBTQ people have experienced and can help them with that. But I am not aware of any of those services and I wonder if anyone here is.

Dr. Mark Gilbert: I certainly know of some community organizations or groups that are offering mental health services for sexual and gender minority people, so in that respect there are sort of tailored programs that are really acknowledging that cultural safety context or trauma people might have, and really informing it in that way.

I am not aware of any other of this type of intervention or tool that's specific to LGBTQ people.

I do think the challenge is really more about taking existing tools and helping them to be adapted or tailored for the population.

Mr. Gerry Croteau: At the Gilbert Centre....

First of all, I want to say one thing about the Gilbert Centre. We do get PHAC funding over five years for an HCV positive self-management program, which is being funded by the Canadian government. We are working in partnership with the University of San Diego and Stanford University and the University of Victoria to bring about a self-management program for people who have HCV, but can't overcome the virus.

I'd welcome sending it to the committee. It's still in draft form. Just don't tell PHAC I'm sending it out ahead of time. But I would like to send it to you if you want, if it would help the committee. It's going to be published and distributed across Canada.

The Gilbert Centre does have a trans and gender diverse program funded through the County of Simcoe. We do have a social worker and we work in partnership with the Canadian Mental Health Association. We have two social workers on staff who deal predominantly with trans folks, but we also deal with gay men through the Gay Men's Sexual Health Alliance, funded by the AIDS bureau of the Ministry of Health and Long-term Care.

The Chair: Thanks very much.

Now we're going to Ms. Sidhu. I understand that you're going to split your time with Ms. Lambropoulos.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you all for being here.

My question is for Mr. Croteau.

You said that health care professionals should be more inclusive. You also mentioned “needed skill sets”. What kinds of skills are you looking for?

Mr. Gerry Croteau: For example, if a trans person goes to a hospital in our area and their health card, from birth, indicates “Michael Smith”, but their preferred name, which is not a nickname, is “Michelle”, many health care providers will not use the preferred name of “Michelle”, even though the person presents as female, and they will say “Michael”.

The patient could be in a waiting room and they're called “Michael Smith” and they're presenting as female and their preferred name is “Michelle”. That's triggering many in the trans community to walk out of that environment, whether it's in a private office of a doctor or a clinic or a hospital waiting room or an emergency room.

● (1650)

Ms. Sonia Sidhu: You mentioned the transportation challenge of accessing health care. The health committee went to Quebec and met with Quebeckers. They have mobile vans. Do you think it's a good idea?

Mr. Gary Lacasse: For mobility, of course. Look at Saskatchewan. There is no public transport in Saskatchewan anymore, and it's the same in all rural areas across the country. They're not all at the same level as Quebec. B.C. has very good transport for inter-rural areas for health, if I'm not mistaken. Even northern Ontario has some really good transport for going down south, but it's not equal across the country.

That's where, in my testimony, I spoke about the fact that every province has its own jurisdiction, which is perfectly okay, but if the federal government is not going to nudge, nudge, tap, tap down, saying that these are the best practices, we're not going to get anywhere.

Ms. Sonia Sidhu: Thank you.

Ms. Emmanuella Lambropoulos (Saint-Laurent, Lib.): Thank you, guys, for being with us today.

I am not a regular member of on this committee, but I am happy to be here for this particular study today.

I am a former high school teacher. I taught quite a bit on gender education and would try my best to be as inclusive as possible in my teaching. Right now I'm working on my master's degree to hopefully get gender education implemented across Quebec from K to grade 11—because I'm from Quebec—and hopefully give that idea to other provinces as well.

Can you please speak to the importance of including this type of education in the classroom. I know this is the health committee, but obviously education is an extremely important preventative measure. Not only does it influence the kids who are experiencing certain issues, such as kids in the LGBTQ2 community who are learning about things that are important for them, but it also educates cisgender, heterosexual children on diversity and learning about differences.

Can you please comment on that?

Dr. Mark Gilbert: Sure. I'll start the comments.

I fully agree. The research has been quite clear that comprehensive sexual education that talks about all the nuances of gender identity and other aspects of sex and mental health is a benefit both to youth who are sexual, and gender minorities and heterosexual youth. It's extremely valuable.

The Adolescent Health Survey in B.C. done by the McCreary Centre is a really powerful source of statistics on youth in schools. Certainly in the work they've done on sexual health, all youth they survey have been very outspoken about the fact they want to get this information into schools, which clearly speaks to the demand for it. But it's often not there, so they're getting information from their peers or from the Internet and feeling that they don't know where to go for that piece of work.

I think the other example that's important within the school environment is thinking about other structural interventions, like gay school alliances and policies around homophobia and bullying, which research has again shown to have positive impacts on mental and physical health among LGBT youth. I think it's critically important for us to intervene in the school environment.

Ms. Emmanuella Lambropoulos: As you know, education is not part of federal jurisdiction. However, we sometimes do fund programs and organizations that work with schools. Through that we can introduce certain programs or some parts of curriculums, even though it's not official. Where do you think the focus should be if the federal government were to intervene in this, such as with CanCode, which works with organizations to introduce coding to the classroom? How do you think the federal government can play a role here?

Dr. Mark Gilbert: I'm not aware of all the options around that. For example, I know there's been funding for SIECCAN to develop the comprehensive sexual health education guidelines that are being reviewed. I think there are ways the federal government is seeking that. I think it's important that kids have access to sexual health education in and out of schools, because we know that while we want to get that comprehensive sex education in every school for every child across Canada, it's going to take a while until we get there. That's why I think that thinking about funding agencies to do online resources or campaigns for youth is also.... Again, it can be within the federal jurisdiction to do that work, which can have that broad national reach.

● (1655)

Ms. Emmanuella Lambropoulos: Thank you.

The Chair: The time's up.

Now we go to Mr. Webber.

Mr. Len Webber (Calgary Confederation, CPC): Thank you all for your testimony.

Mr. Chair, I'm just trying to remember the name of the eHealth palliative care place we toured in Manitoba. What was it called?

Ms. Nadia Faucher (Committee Researcher): The Canadian Virtual Hospice.

Mr. Len Webber: The Canadian Virtual Hospice was strictly a hospice for palliative care.

Dr. Gilbert, you talked a bit about eHealth and the health initiative that is going on in B.C. right now. I didn't quite get the name of that particular eHealth initiative. What was it called again?

Dr. Mark Gilbert: The service that we have is called GetCheckedOnline, which is an online testing service.

Mr. Len Webber: Okay. And it's strictly for B.C. residents?

Dr. Mark Gilbert: As you can imagine, the testing service has to be integrated within labs. People have to submit specimens, so it is geographically bound, but it is a model that potentially could be used elsewhere. We have a CIHR research grant right now that's looking at the feasibility of the model in Toronto as one option around that.

Mr. Len Webber: I think that's incredibly important. It would help a lot of individuals, especially in rural and remote communities where they can easily go online rather than having to see a doctor, who would perhaps be their neighbour too. I think we should be looking into national initiatives for that.

Dr. Moore, you talked a lot about PrEP. You got a lot of questions about it. One in particular was the cost, and you didn't have an answer on that. Is anybody here able to provide information on costs for outpatients on PrEP?

Mr. Gary Lacasse: In the generic formulary in Quebec, it is about $237 for PrEP or ARVs.

Mr. Len Webber: Two hundred and thirty-seven dollars?

Mr. Gary Lacasse: Per month.

But we have to also include the copay that people have to pay on that, which could be prohibitive depending on your revenue. The name brand is about $879 a month.

Mr. Len Webber: So it's dropped significantly since the generic....

Mr. Gary Lacasse: In Quebec, to use my example, when you get your prescription for the brand name, you go to the pharmacy. The pharmacist offers you the generic or the brand name. You choose.

Mr. Len Webber: Okay, I see.

Mr. Gerry Croteau: Excuse me. I might add that there are PrEP clinics. For example, in Simcoe County now you don't have to have a referral from your GP. You can go directly to, in our case, Dr. Colin Lee, who is an associate medical officer of health for Simcoe County, and he will prescribe PrEP without any type of referral. That makes PrEP a lot more accessible, as opposed to going through your general practitioner for a referral.

Mr. Len Webber: There's still a cost involved, depending on—

Mr. Gerry Croteau: There's still a cost involved, of course.

Mr. Len Webber: However, it is free in B.C. You don't pay.

Is that a fact?

Mr. Gerry Croteau: Yes.

Mr. Len Webber: Well, we should all move to B.C. for access to free meds.

Mr. Don Davies: That's what I keep saying.

Mr. Len Webber: Mr. Croteau, I want to talk more about government ID and the fact that there should be more inclusive forms and that the ID should reflect someone's preferred name rather than their name at birth. Why is it so difficult to do that? Are they just strictly refusing to give you a name that you want to be called by? I don't understand.

Mr. Gerry Croteau: There's a cost associated with the change. Sometimes it's prohibitive for some who are, for example, on ODSP, the Ontario disability support program. At this time in Barrie, it's $1,200 a month. A one-bedroom apartment is $1,000 a month, so it's a question of where you want to put your money in terms of that.

Our agency does help with the change, but remembering that it's all part of the mental health process of someone. They just don't decide at age 30 or 50 that they're a trans man or trans woman. It has been a lifelong process.

Preferred name is not a nickname. Some practitioners still refer to it as a nickname. It's not a nickname, it's a preferred name.

● (1700)

Mr. Len Webber: They can go out and legally change their name, but obviously there is a cost there that makes it prohibitive to do that.

Mr. Gerry Croteau: Another thing is that forms are very important. When it's just male or female, it's stigmatized.

Mr. Len Webber: Yes. We've heard that a lot.

Mr. Gerry Croteau: Exactly.

The Chair: The time is up.

Now we'll go to Dr. Eyolfson for five minutes.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Thank you, Mr. Chair; and thank you all for coming.

I've said this at another meeting, but it bears repeating with the medical profession. I graduated from medical school in 1993, and the sum total of our education about LGBT health was that you should be nice to gay people, which is a correct but hardly sufficient.

Because there's a stigma with HIV, one of the challenges we had was that when we wanted to do an HIV test in the hospital environment, there were administrative procedures unique to HIV testing that you didn't see with any other test. I was an emergency physician before doing this, so all of my practice was in the hospital environment.

If a patient came in with jaundice, I would order liver function tests. I would order hepatitis B serology. I would do all of those things. I would just write it on an order sheet, somebody would come and draw the blood, and you would do it.

If it were an HIV test, you needed to fill out a number of forms. You had to document that you had consent to do it, and again, no other laboratory test had that requirement. When a 14-year-old girl came in with abdominal pain and I ordered a pregnancy test, I did not need consent to order that. However, for HIV, you needed consent, and the blood had to be put in special coded tubes that you would put a sticker on so that no one could see it. I understand that it was to preserve confidentiality and that there was stigma that was involved that wasn't involved with any other diagnosis.

At the same time, have there been any other reports that this tends to gum up the works and make practitioners less likely to order this test when it's so much more troublesome to do this? Has that changed in the intervening years?

Dr. Mark Gilbert: David, either you or I can address this.

Dr. David Moore: Yes.

Dr. Mark Gilbert: Go ahead.

Dr. David Moore: Maybe I'll start. What you're describing is a barrier to people getting tested—yes, absolutely. If you create administrative hurdles for people to get tested, not just for the patient but also for the provider, they're not going to do it.

In B.C. we developed provincial guidelines for HIV testing, which included a lot of specific recommendations, but one overall recommendation was that the consent you need for HIV testing should be the same as it is for any other diagnostic test. The Ministry of Health has been funding regional health authorities to promote HIV testing, quite successfully, in B.C. One thing we discovered in doing that was that, yes, a lot of these older procedures where you needed a specific form to do an HIV test in a hospital were still around as recently as 2014-15—we think in B.C. at least. Most people are onboard with a routine offer of HIV testing. Ideally, people should know that they're being tested for HIV and should agree to it, but you don't need to have a long drawn-out conversation about what's going to happen if they test positive.

I'm not sure how widespread that is across the country. Certainly the Public Health Agency of Canada, a few years ago, came out with HIV testing guidelines that again recommended routine offers of HIV testing not necessarily based on reported risk behaviour. I'm not sure specifically what it recommended around consent. You still hear the term “HIV counselling and testing”, which suggests that this is a more involved procedure than doing any other test, and it really shouldn't be.

Mr. Doug Eyolfson: All right.

Dr. Mark Gilbert: I would just add that we can't lose sight of the fact that an HIV-positive result is different from a liver function test result, in terms of its implications. I think what you need to do is to try to find out how you strike that balance between really trying to make it as simple as possible for the testing to occur, while still recognizing that there are some reasons to treat HIV differently. For example, within some of the testing guidelines, part of that was also making sure that people had.... We were saying that you could give people, in paper form at least, key information on HIV that they might need to know—for example, that their positive result is reported to public health.

It's not completely about removing everything that was done before. It's about seeing how that could be made more efficient within a testing process.

● (1705)

Mr. Gerry Croteau: I would add that the accessibility and making HIV testing normalized is the goal. In our centre we have a clinic called “George”, which is a clinic for guys who are into guys. HIV testing is much easier to access because it's in a safer space. The men who come in already know they're in a clinic that is very gay-friendly, and so they're much more comfortable talking not only about getting HIV testing but HCV testing and other STI testing as well.

Mr. Doug Eyolfson: Thank you very much.

The Chair: Okay.

Now we'll go to our last questioner, Mr. Davies.

Mr. Don Davies: Mr. Lacasse, you commented several times on the unacceptable state of data collection in Canada. In your view, why is the Public Health Agency of Canada's surveillance data so inadequate? Do you have any recommendations how we might address that?

Mr. Gary Lacasse: Well, take a look at northern Canada. We were at a conference looking at the framework and the medical officer from Nunavut said, “We take down how many HIV cases we have on the end of a paper at the end of our desk.” If you look at the Quebec model, you will see that they don't transmit all of the information. In the B.C. model, they have asked for all of the information on provenance to be stricken, I believe, though I'm not sure about it.

There's a different model in each province, and so there's no uniform access to collate the data. That's the problem. If it would come, with more jurisdiction around it.... Look, when we had a mental health initiative by this government in 2015, it was tied to transfer payments. Why can't we do that with everything else, to a certain extent, to get things moving and out the door? Sexual health is an important barrier to overall health and mental health, and everything else that comes with that. We have to have a way or mechanism to do it better.

Mr. Don Davies: Dr. Gilbert, I only have about a minute or two left, but I want to ask you and then Dr. Moore what steps the federal government should take to achieve zero new HIV infections in Canada? What advice would you give us on that?

Dr. Mark Gilbert: That's the million-dollar question, right? It's hard to say one thing that would really address it, but I do think it needs to deal with factors at the individual level, such as around access to testing and access to treatment. We know that there are treatment gaps across the province—that's a clear one—in getting us to the third part of 90-90-90. We're focused so much on the "treatment as prevention" biomedical model, but I think we really do have to think about the underlying determinants as well, and about how we deal with those. It continues to create the problem if we're not actually dealing with such underlying determinants as stigma and health care access as well.

Mr. Don Davies: With regard to determinants, are you seeing a connection between, say, socio-economic status, intersectionality, race, indigenous, character—everything? Are those playing a role?

Dr. Mark Gilbert: Definitely, when it comes to looking at this—I know the B.C. epidemic quite well, but I think it probably applies across Canada—we do see that the folks who are at those intersections or margins and who are falling through the cracks are also the people who have probably the greatest difficulty accessing appropriate health care or having it made available to them. I do think those intersections are quite important. Even for one of the key populations—gay, bisexual and other men who have sex with men—we know that intersections within that population are also associated with disparities in access to care and treatment.

Mr. Don Davies: Dr. Moore, I'll give the last word to you. Do you have any advice for the committee on achieving zero new infection rates?

Dr. David Moore: Really, the federal government does have a role to play in trying to engage the provincial governments that have not been as active or engaged in the process. We're quite fortunate in B.C., where the provincial government understood the net benefit to the province of appropriately engaging on HIV early on.

One thing would be to look at policies about things like copayments for publicly funded medications. Those are really deterrents to people getting effective treatment. The other thing would be provincial policies on testing and access to testing. Again, we have this kind of promotion that everybody should know their HIV status in British Columbia. It's not that testing a whole bunch of low-risk heterosexual people is necessarily a direct way to end the epidemic, but we're hopeful that it will remove the stigma around offering an HIV test. It's part of why some people may not get tested or engage in care and that kind of thing.

● (1710)

Mr. Don Davies: Thank you.

The Chair: That winds it up. Thank you.

We think maybe the bells are ringing, so we'll have to end the meeting.

On behalf of the committee, I want to thank you all. This is a most interesting subject. We appreciate your frankness and realistic answers. They will be of great help to us. I think we will have a very interesting report when we're finished because of the quality of the testimony we've gotten everywhere. I think everybody realizes how important and unique this is.

Mr. Gerry Croteau: Thank you.

The Chair: The meeting is adjourned.