HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

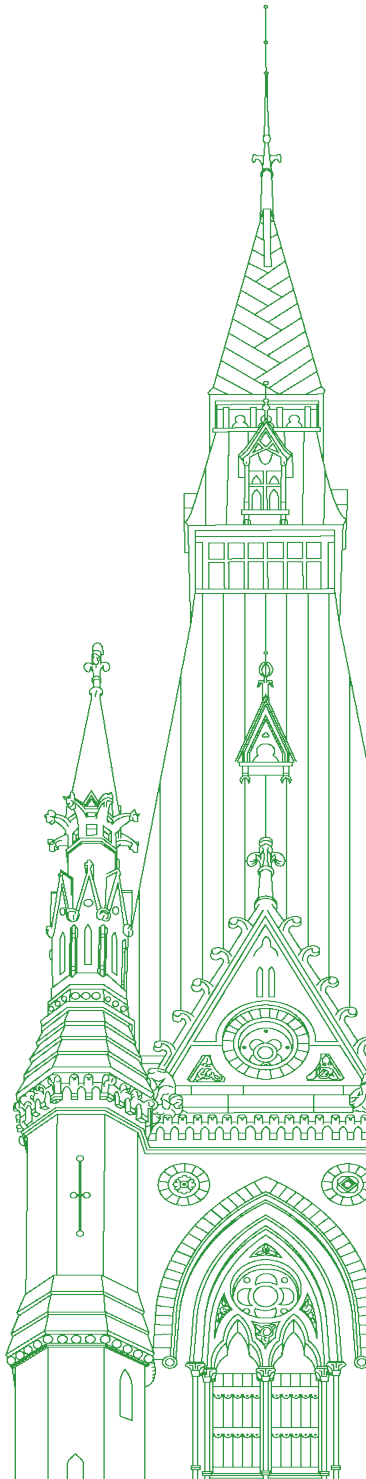
45th PARLIAMENT, 1st SESSION

Standing Committee on Health

EVIDENCE

NUMBER 042

Wednesday, November 4, 2026



Chair: Sukh Dhaliwal

Standing Committee on Health

Wednesday, November 4, 2026

● (1630)

[*English*]

The Chair (Sukh Dhaliwal (Surrey Newton, Lib.)): I call this meeting to order.

Welcome to meeting number 42 of the House of Commons Standing Committee on Health. Today's meeting is taking place in a hybrid format, pursuant to the Standing Orders.

I would like to remind participants of the following points. Please wait until I recognize you by name before speaking. For those participating by video conference, click on the microphone icon to activate your microphone, and please mute yourself when you are not speaking. At the bottom of your screen, you can select the appropriate channel for interpretation: floor, English or French. For members in the room, if you wish to speak, please raise your hand. For members on Zoom, please use the raise hand function. I remind you that all comments should be addressed through the chair.

Pursuant to Standing Order 108 and the motion adopted by the committee on Wednesday, September 23, 2026, the committee shall commence its study of HIV infections in Canada.

Before I welcome the witnesses, I would like to welcome the honourable members who are here today, who are not a regular part of the committee.

I see my dear friend MP Redekopp. You are becoming the regular. We welcome you. We would love to have you here. From my own province of British Columbia, MP Tamara Kronis is here. Welcome. From Saskatchewan, we have Madam Kelly Block. Welcome. You're welcome here, and you can participate as you wish.

On behalf of the committee members, I would like to welcome our witnesses for the first hour.

As an individual, we have Dr. Mia Biondi, an associate professor and a nurse practitioner. Welcome, Dr. Biondi.

From the Public Health Agency of Canada, we have Dr. Crowcroft, vice-president, infectious diseases and vaccination programs branch. We also have Mr. Sternthal, director general, centre for communicable diseases and infection control, infectious diseases and vaccination programs branch.

From the University of Manitoba, we have Dr. Keynan, a professor and an infectious diseases and HIV clinician. We also have Dr. Rueda, a professor and a Canada research chair in infectious diseases, multimorbidity and syndemics.

Welcome to all of the witnesses. We thank you for being here, and we look forward to your valuable input.

I would like to remind witnesses that committee members may ask questions in either French or English. If you require interpretation, please take a moment now to prepare your earpiece and select the listening channel you need in advance.

Each organization has five minutes. I will raise my hand when the five minutes are over, and I will request that you stop.

Let's start with Dr. Biondi for five minutes. Please go ahead.

● (1635)

Dr. Mia Biondi (Associate Professor, Nurse Practitioner, As an Individual): Good afternoon. Thank you for convening here today and for inviting me to speak.

My name is Mia Biondi. I'm Ph.D.-prepared in microbiology, with a program of research studying HIV, viral hepatitis and other STBBIs. I'm a primary care nurse practitioner with clinical experience in street outreach, mental health and addiction, sexual health, and four models of primary care, including refugee health. I'm an associate professor at York University, and I run low-barrier HIV-prevention programs for the province.

I'm going to cover a few different things today, but I would like to start by discussing an attack on harm reduction that's occurring across our country. With closures of supervised consumption sites, a focus towards abstinence-based programming and, more recently, new barriers put on prescribers to prevent safer supply, we cannot forget that harm reduction has been and will continue to be the best way to prevent HIV and STBBIs. Harm reduction offers people safe spaces to receive care and supplies, which definitely prevents onward transmission and supports trust. Harm reduction is consistently impacted by new and changing governments and political pressures. It is the most important tool in our tool box, and yet Canada consistently deprioritizes these solutions. I urge this committee to strengthen intergovernmental coordination of harm reduction across Canada.

A significant aspect of my clinical leadership is focused on the rollout of point-of-care testing. Point-of-care tests can be used in outreach, in clinic, in rural and remote settings and in many other places. They play a role in linking and re-linking individuals back to care and can be used by both health care providers and non-health care providers. Many programs across the country employ peer outreach workers, and they do a far better job than health care providers at reaching people. Appropriately resourcing point-of-care testing across the country, paired with peer-led community-based outreach, will prevent new infections and link individuals to care. Point-of-care testing is well situated under the Public Health Agency of Canada, especially if there is implementation funding to support community.

In addition to harm reduction and testing, prevention through biomedical modalities, such as HIV PrEP, PEP and PiP, are all funded differently across the country. While some individuals have access to private or public coverage, it is not universal, and that leads to inequities. HIV prevention medication has been available in Canada for over a decade. It is safe and effective, and yet many communities do not have access.

African, Caribbean, Black, as well as indigenous women, are overrepresented among those living with HIV, as well as those who should be accessing HIV prevention. This is clearly illustrated by the PrEP-to-need ratio, which is the number of HIV-negative people using PrEP each year. For example, for every man infected with HIV, there are 23 men using PrEP. For every one woman infected, there is one woman using PrEP.

In some of our research in southern Ontario, we recruited 302 women from shelters, addiction treatment centres and women drop-in programs, who were sexually active, using substances, or both. Here, 93% did not have self-perceived risk, but 50% actually had objective risk, and 90% had never ever been offered PrEP or PEP. Even when people did self-identify as having high risks, they either thought they did not qualify for PrEP or they did not believe they had access. We've also shown this in a study with health care providers who do not offer women HIV prevention medications, and this has largely remained unchanged over the last decade.

As you are aware, both the interim federal health and the NIHB are federally funded programs. While some HIV prevention medications are available under IFH, when the federal coverage follows the provincial coverage, often PEP is not covered. In fact, for most communities, PEP is given out only in emergency rooms or in sexual assault environments, under specific protocols and criteria. Furthermore, PEP is often given out in a starter pack, which means that people often leave the emergency room without the full prescription, cannot access the rest and are at risk for HIV, and it's a waste of emergency room resources.

In addition to oral therapy, long-acting injectable PrEP will change the face of HIV globally and in Canada, but we're already behind in rolling it out. With that in mind, and with the understanding that we're going to be able to eventually have yearly injections for long-acting HIV prevention, Canada really needs to move forward if we're able to change this trajectory of new HIV outbreaks.

I would be remiss if I didn't highlight that nurses are the backbone of this work, and that there is a requirement for additional funding to hire nurses to support prevention, testing, treatment and care. At present, these roles are often situated in public health units and sexual health units, and there is no capacity to take on additional roles like HIV prevention care, although nurses would very much like to do this.

● (1640)

Even if an RN cannot prescribe autonomously, my research and the research of others have shown that nurses can provide HIV prevention treatment and viral hepatitis care with just mentorship and training. We should not rely on fly-in physicians when nurses in community are capable and just need to be funded and empowered.

Thank you so much for your time and the opportunity to speak today.

The Chair: Thank you, Dr. Biondi.

We will now go to Dr. Crowcroft and Mr. Sternthal for five minutes between two of you. Please go ahead.

Dr. Natasha Crowcroft (Vice-President, Infectious Diseases and Vaccination Programs Branch, Public Health Agency of Canada): Good afternoon, Mr. Chair, vice-chairs and members of the committee.

My name is Dr. Natasha Crowcroft. I'm the vice-president of infectious diseases and vaccination programs at the Public Health Agency of Canada.

Thank you for the opportunity to discuss HIV and syphilis in Canada and PHAC's contribution to the national response. Joining me today is my colleague Steven Sternthal, director general of the centre for communicable diseases and infection control.

HIV and syphilis disproportionately affect certain populations in Canada, including gay, bisexual and other men who have sex with men; people who inject drugs; indigenous peoples; Black communities, which represent nearly a third of newly reported HIV diagnoses; transgender people; sex workers; and people who are or have been incarcerated. These populations may overlap and the patterns of disproportionate impact vary by infection and region.

Advances in prevention, testing and treatment, as you were just hearing, have transformed our ability to respond to HIV, yet preventable infections continue. PHAC estimates that there were approximately 2,500 new HIV infections in 2024, a nearly 23% increase compared with its updated estimates for 2022—or about seven new infections every day.

Of the estimated 70,900 people living with HIV in Canada, nearly one in 10 was unaware of their status in 2024. This epidemic is not uniform across Canada. In 2024, Manitoba and Saskatchewan had the highest HIV diagnosis rates at 19.5 and 18.6 per 100,000 people respectively, each more than three times the national rate of 5.5 per 100,000. Manitoba's rate nearly tripled between 2019 and 2024, and the province declared an HIV public health emergency in May 2026. Saskatchewan has experienced persistently elevated rates for over a decade. Heterosexual transmission and injection drug use are important factors in both provinces, underscoring the need for approaches that are tailored to local epidemiological trends and community needs.

Canada has made progress toward global HIV targets, but gaps remain. In 2024, an estimated 91% of people living with HIV knew their status, 86% of those diagnosed were receiving treatment and 96% of those on treatment had achieved viral suppression. People who maintain an undetectable viral load do not transmit HIV sexually, otherwise known as U=U, or undetectable means untransmittable.

The Government of Canada's sexually transmitted and bloodborne infections action plan for 2024 to 2030 aims to accelerate prevention, diagnosis and treatment to reduce the health impacts of STBBIs in Canada by 2030. It takes an integrated approach, recognizing that HIV and other STBBIs can cluster and interact within shared social and structural conditions, worsening health outcomes. This is a pattern sometimes known as a syndemic. The plan highlights the need for collaboration across multiple departments, levels of government, indigenous partners and community organizations. Provinces and territories primarily deliver the health services, while PHAC contributes national surveillance, scientific expertise, guidance, coordination and targeted prevention investments.

Trends in other STBBIs are also relevant because they increase the risk of HIV transmission. For example, national infectious syphilis rates more than tripled between 2017 and 2022. Although rates declined in 2023 and preliminary analyses suggest further declines through 2025, they remain elevated. Congenital syphilis has also re-emerged as a public health concern.

Through the community action fund and harm reduction fund, PHAC invests $33.4 million annually in community-based STBBI initiatives. With PHAC's support, community organizations distributed nearly 240,000 HIV self-test kits to more than 60,000 people between 2022 and 2024. In September 2026, the Government of Canada announced a further $5 million for HIV self-testing and peer-based services.

Through its national microbiology laboratory, PHAC has worked with partners to expand access to testing in remote and underserved communities, where access to conventional laboratory services can be challenging. This includes supporting the implementation of point-of-care testing, dry blood spot collection and laboratory training to help bring testing closer to the people who need it. By 2023 to 2024, 235 communities had developed molecular testing capacity for sexually transmitted and blood-borne infections. This represents an important expansion of local testing capacity, with the potential to improve timely access to testing and facilitate earlier connections to care.

● (1645)

Do you want me to stop now?

The Chair: You can take 20 seconds if you want to wrap up.

Dr. Natasha Crowcroft: As Canada's HIV epidemic continues to evolve, PHAC remains committed to working with partners, strengthening evidence-based approaches to prevention and responding to emerging public health needs.

We welcome this committee's study and look forward to its recommendations.

Thank you.

The Chair: Thank you, Dr. Crowcroft.

Now we will go to the University of Manitoba.

Between Dr. Keynan and Dr. Rueda, there are five minutes.

Please go ahead.

Dr. Zulma Rueda (Professor and Canada Research Chair in Infectious Diseases, Multimorbidity and Syndemics, University of Manitoba): Thank you, Chair and members of the committee, for the opportunity to appear.

Canada has made commitments to end HIV as a public health threat by 2030, including a 95% reduction in infections. Canada has not only not decreased but has also reported an increase in new HIV infections of 22% in 2024. The evidence from Manitoba and Saskatchewan shows that Canada's response is failing to meet that commitment. In 2024, Manitoba had Canada's highest rate of new HIV diagnosis, at 19 cases per 100,000 people, followed by Saskatchewan, at 18 cases per 100,000. The national rate was 5.5.

Alberta, Saskatchewan and Manitoba represent 16% of the Canadian population. However, in 2021, they contributed to 38% of new HIV diagnosis. For international reporting and surveillance, the World Health Organization divides the world into six WHO regions. In 2023, Saskatchewan and Manitoba HIV rates were above those in several WHO regions—all of them except Africa—and were above the region of the Americas' average HIV rate.

People newly diagnosed in Manitoba between 2018 and 2021 are experiencing intersecting conditions: unstable housing, injection drug use and mental health conditions. Females represent 50% of new HIV diagnoses and were disproportionately affected by these conditions. The largest total number of new HIV diagnoses occurs in Winnipeg, but the highest rates are in the prairie mountain and northern health regions.

The Manitoba HIV program's December 2025 report found that as of July 1, 2025, only 68% of people had a suppressed viral load. Among those living outside Winnipeg, the proportion was only 58%. Although time to treatment initiation has decreased overall, there are continuing delays in treatment initiation and viral suppression among females, people who inject drugs and people with low incomes.

Dr. Yoav Keynan (Professor and Infectious Diseases and HIV Clinician, University of Manitoba): In 2011, the UNAIDS set the goal of getting to zero, including the elimination of HIV transmission to children by 2015. In Manitoba, two cases of mother-to-child transmission in the last two years highlight the failure in prevention and care, underscoring the consequences and gaps affecting women of reproductive age.

Research from our group in Manitoba has documented a substantial burden for sexually transmitted and blood-borne infections before, at and after HIV diagnosis, and those encounters represent missed opportunities for HIV testing, prevention and linkage to care.

HIV PrEP, as mentioned earlier, can prevent the acquisition of HIV. An analysis of the provinces shows that Manitoba has the lowest prescription of HIV pre-exposure prophylaxis, or PrEP, followed by Saskatchewan, and it shows that only 2% of those prescribed HIV PrEP in Canada are females.

Canada's 95-95-95 commitments are not going to be met, as the Manitoba HIV program figures show serious gaps in treatment coverage and viral suppression. In 2018, CANFAR declared that it was time to act and called for reducing HIV new infections to 500 per year by 2023. Canada had over 2,500 new infections in 2024, and Manitoba is projected to have close to 500 new infections in 2026. We still talk about data from 2024 in 2026.

The STBBI action plan that was mentioned earlier doesn't measure population trends and effectiveness of the programs. We recommend five public health-focused actions on prevention and treatment, and on treatment as prevention.

Increase access to HIV testing to provide timely, appropriately protected community-level data on diagnosis and viral suppression. Communities need this data to identify gaps, advocate for services, and guide local prevention and treatment responses. Testing must lead to services, and the services include the people who are negative being offered prevention with PrEP. People who are newly diagnosed must be linked properly with ongoing supports.

Funding must be sustained and predictable in order to cover the full pathway from diagnosis to treatment. We need to scale up prevention that combines biomedical, behavioural and structural intervention, including the expansion of PrEP, including the long-acting options for women, for people who inject drugs, for people who experience homelessness, and for those who reside in northern and remote parts of the provinces.

Finally, we need to provide clear guidance and dedicated resources for rapid response to HIV transmission occurring in clusters in sexual and social networks. These need to be driven by real-time data and rapid response that is properly resourced. The evidence warrants an urgent response judged by fewer infections as the outcome.

Thank you for giving us the opportunity to speak here today.

● (1650)

The Chair: Thank you, Dr. Keynan and Dr. Rueda.

We will go to the honourable members and start our first round, which is six minutes.

We will start with Dr. Strauss.

Please, go ahead.

Matt Strauss (Kitchener South—Hespeler, CPC): Thank you, witnesses, for being here today.

This is a tremendously endlessly fascinating subject. All of you gave an overview of interventions that are known to work. You gave an overview of risk factors that are known to be problematic. I'm struggling with the why.

The Library of Parliament sent over a very helpful Public Health Agency of Canada report called “HIV in Canada, Surveillance Report to December 31, 2024”. It shows that rates were high in 2015. They came down to a nadir of 4.9 for first-time diagnoses—I think that's per 100,000 people—in 2020. Then it shot up; it doubled over three years.

It looked like we were on track to lick this. Dr. Rueda, I think, mentioned that we had goals to totally abolish transmission of this virus in Canada by 2030, but rates doubled from 2020 to 2023.

I'm putting it out to all of the experts who are here. What is the why? If you have a rationale based on your research or your clinical experience, why has this exploded the way that it has? We've known the risk factors all along. We've had the programs all along. We've had the interventions all along. What has changed?

The Chair: Do you have a certain order for the witnesses to respond?

Matt Strauss: Are there any volunteers?

I might have to ask Dr. Crowcroft, since she's on the public dime, but I'm honestly very interested to hear from anyone who has a convincing suggestion or rationale.

The Chair: We'll head to Dr. Crowcroft first, and then we'll figure it out.

Dr. Natasha Crowcroft: Thank you for your question.

The transmission of HIV is complex, and it occurs in a complex set of social circumstances. The answer to your question isn't the same everywhere, but there are some fundamentals you've heard spoken about just now: access to diagnosis, treatment and follow-up to that treatment, as well as all the preventive activities that stop these outbreaks from happening.

In remote communities, there's a very clear problem with access to care. There is also a suite of social determinants that exist when people are living in overcrowded housing, have a lack of housing or have mental health issues that are unaddressed. There is a whole set of circumstances that make them particularly vulnerable to being exposed to HIV. Then, they have lack of access to preventive, diagnostic and treatment services. All those things combine to make particular communities extremely vulnerable.

In other settings.... We've heard about the risk to women, for example. Black women, in particular, are at very high risk. They are being exposed in Canada but not getting access to treatment. That is partly a health system issue. Health care providers are not thinking about this group as being at risk. They may have a preconception that is now out of date, in terms of who is most at risk of HIV in Canada, and—

● (1655)

Matt Strauss: Can I interrupt you for a second, Dr. Crowcroft?

The Chair: Dr. Keynan had his hand up too.

Matt Strauss: Sure. Let's hear from him.

The Chair: Dr. Keynan, please go ahead.

Dr. Yoav Keynan: Thanks for the question.

As mentioned, there's a combination of multiple factors, at least in Manitoba. The syndemics of substance use, methamphetamine use, over-representation of first nation and indigenous people, as well as houselessness and the crystal methamphetamine epidemic have all contributed to increased rates.

We have a lack of sustainable funding. The epidemiology has changed, but we have insufficient disaggregated data. The fact that we are talking about data from 2024 in the fourth quarter of 2026 showcases this. Without timely data, you can't deploy services to clusters when outbreaks happen, or—

Matt Strauss: May I interrupt you, Dr. Keynan?

Dr. Yoav Keynan: That is one of the points.

Matt Strauss: Thank you, Dr. Keynan.

I'm looking at this 2024 data. I'm in Parliament; I'm far away from it. Are you, as a practising infectious disease doctor in Manitoba, saying that while there's an epidemic of HIV in Manitoba, you don't have access to more up-to-date data than that?

Dr. Yoav Keynan: We have better access to data, but the data is not contained in any public health system. Manitoba Public Health has more up-to-date data than what the Public Health Agency reports on, but it's still not timely or collected in a system anyone can look at. As well, it's not—

Matt Strauss: May I interrupt you there? I want to put that question to Dr. Crowcroft.

It's galling and amazing to me. We went through the pandemic. There was a lack of timely data about COVID, but news organizations and the public health establishment got up to speed after a year. To be hit now with another epidemic, and of a much older disease, in the province of Manitoba and not have up-to-date data is shocking.

Dr. Crowcroft, would you say that your agency has more up-to-date data?

If we can't answer the question of why, I don't know how far this study can go. If the problem with answering why is lack of up-to-date data, please enlighten me. What is the status of that?

The Chair: You have 25 seconds.

Dr. Natasha Crowcroft: We have a need for more timely data. I agree with you. That requires very close collaboration among provinces, territories and the federal level.

Matt Strauss: Is there a gap in Manitoba?

Dr. Natasha Crowcroft: There's a gap nationally in all provinces and territories.

The Chair: Thank you, Dr. Strauss. You're right on time.

We'll go to Dr. Eyolfson for six minutes, please.

Doug Eyolfson (Winnipeg West, Lib.): Thank you, Chair.

I'm very happy that we're doing this study. I'm from Manitoba. I've been a licensed physician there since 1994. My training and the vast majority of my practice was there in emergency departments.

I was motivated to start this study by the recent declaration of a public health emergency in Manitoba. The spread of HIV and syphilis was showing how we need to take a closer look at why this is happening. It's happening in the Prairies, but it's happening all over Canada.

As you've said, there are a lot of different disadvantaged communities. We have good prevention techniques, good treatments and the methods so that people can live long, healthy lives, but right now, they're not working. As my colleague Dr. Strauss said, we're losing ground on a disease that's been around for quite a while now. We first heard about this disease well over 40 years ago. Because we're losing ground and things are getting worse, I think this is an apt time to be looking at this, and I thank you all for your assistance and I thank the committee for helping to bring this about.

My first question is for Dr. Keynan.

You were talking about how Manitoba is so far above the rates of new infections. One of the facts you put out that I found rather shocking was that we have the lowest prescription rate of HIV PrEP, or pre-exposure prophylaxis.

Do you know why that would be the case in Manitoba? What is driving it? What's making Manitoba, where our cases are so high, not have this readily available modality available?

● (1700)

Dr. Yoav Keynan: Thank you for the question, Dr. Eyolfson, and thanks for bringing this important topic to this committee.

There are multiple explanations. It has to do with the awareness of the risk and the fact that the epidemic in Manitoba and Saskatchewan is more balanced between females and males, compared to in other provinces, so the benefits of learning about the epidemic through the 40 years of HIV have not been completely realized.

Prescribers are afraid of prescribing. Because of the supports that are needed for testing, the good news is that we have modalities that will be easier to administer and will require less monitoring, such as long-acting...so we have an opportunity to intervene.

Why is Manitoba losing ground, in theory? The reason there's a public health emergency is that Saskatchewan has been reporting these trends for the past 20 years now, with rates that have been two or three times above the national average. Without a more concerted federal response, it is still in the same place, with 18.6 per 100,000 new infections.

The point is that we need to pool the resources now. We have more tools in our tool box, with more effective options and more options for long-acting injectables that should target the people who are not receiving PrEP. That includes women, people who inject drugs and people who are experiencing houselessness. Those carry the brunt of new infections in Manitoba and should be prioritized for prevention.

Doug Eyolfson: Thank you.

Dr. Keynan or Dr. Rueda, one of the things we've noticed from working in emergency is that in Manitoba, there are a lot of people without access to primary care. They don't know where to go. For far too many people, the emergency department is really the only medical care they get.

In my own experience in emergency, our practice was to give post-exposure prophylaxis. We really only did this when someone came in after an acute event, like a needle-stick. That was usually health care workers from the wards who had just stuck themselves with fresh needles.

My emergency colleagues are going to gnash their teeth at my bringing up one more idea of more work for them to do, but is there a role in unrolling some solutions whereby those who are at risk and present to the emergency department can be offered a prescription for a post-exposure prophylaxis and some rapid referral from the emergency department to the appropriate public health and infectious disease specialists?

The Chair: You have 40 seconds.

Dr. Yoav Keynan: I'll take the first stab at it and then let Dr. Rueda speak.

I think emergency may not be the best place, because of multiple competing priorities and the stretch on and demand for services, but there are multiple amazing community-based organizations that are willing and able. They need supports, but they can do it, both in northern and remote communities and in the cities. There are, for example, some promising projects in shelters that I will let Dr. Rueda tell you about in the limited time.

Thanks.

The Chair: Thank you very much.

The time is up. We will go to the next honourable member.

To all of the witnesses, the honourable member will be speaking in French, so hopefully you are all set with your earpieces.

With that, we will now go to Madam Gaudreau for six minutes.

● (1705)

[*Translation*]

Marie-Hélène Gaudreau (Laurentides—Labelle, BQ): Thank you very much, Mr. Chair.

I would like to thank the witnesses for helping us shed light on how this issue has evolved over the past few decades. I was a teenager in the 1990s—which doesn't make me feel any younger—and, honestly, when we were told about HIV and AIDS, we were all aware of it. We were even afraid of it. In fact, the public health information that was provided was very real.

Today, we're talking about PrEP.

In my mind, it was something that was well known within the gay community. Today, when I talk about it with my 18- and 20-year-old children, they tell me that, even though the treatments aren't curative, people no longer die from HIV and AIDS. That said, as far as PrEP is concerned, I'm really looking forward to asking them this evening whether they're aware that it's not solely associated with the gay community and that there's no reason to stigmatize it.

How do you feel about the fact that, in some places, a single click is all it takes to receive a pill for free? We're currently discussing accessibility. I'd like you to shed some light on this for me, Ms. Biondi.

[*English*]

Dr. Mia Biondi: I want to start by talking about a phenomenon that's been happening in Canada since the beginning of PrEP, which is PrEP gatekeeping.

As you mentioned, there was a tremendous amount of awareness for gay and bisexual men who have sex with men. This largely changed new infections in Canada—I think it's phenomenal—and those folks are on PrEP. Those folks are often also the folks who have privately funded insurance. However, for both providers and, actually, public health, there's an aspect of gatekeeping, like someone is not eligible or we need to do some kind of risk score to decide if someone should or should not seek PrEP.

Where should we be? Where should we be with your kids? We should be in a position where we do universal offering. I should not expect, as a clinician, that someone I don't know well is going to tell me everything about their life, their story and every single risk factor they have, and I think my study actually showed it. People don't self-identify as having those risks, but they actually do have the risks.

If we can move past that gatekeeping, that's great, but the funding is problematic because many provinces do not have universal coverage for PrEP. Manitoba is actually in a leadership role in that. B.C. is in a leadership role, except that sometimes additional paperwork needs to show that people are negative and their kidney function is good, and that's going to prevent folks who are vulnerable and have difficulty accessing services from actually getting the medication.

It's extremely safe. It's extremely effective. We can literally hand it out. In the U.S., by the way, people do hand it out over the counter, in many studies.

I'll stop there.

[*Translation*]

Marie-Hélène Gaudreau: That's really interesting. I agree with Dr. Strauss. How did we end up in this situation? What sort of crisis is needed to get things moving? We're talking about 2,500 cases of infection a year, and the aim is to reduce that to 500 cases a year. What does it take to obtain data that would actually enable us to sound a genuine alarm and take direct public health action, particularly in terms of prevention?

How can we explain the fact that, even today, we are still unable to access this data in order to take action?

I imagine Ms. Crowcroft might be able to answer that question.

[*English*]

Dr. Natasha Crowcroft: Can I ask my...?

[*Translation*]

Steven Sternthal (Director General, Centre for Communicable Disease and Infection Control, Infectious Diseases and Vaccination Programs Branch, Public Health Agency of Canada): Thank you.

As Ms. Crowcroft mentioned earlier, we are working with the provinces and territories to collect data as soon as we are able to do so. In the meantime, we are trying to carry out special studies, such as those identified by Ms. Biondi. We are conducting these in indigenous communities, Black and African communities, and also in 2SLGBTQI+ communities. We have published research in recent years to try to fill the gaps in our knowledge.

Ultimately, it is dialogue and collaboration with the provinces that are crucial to receiving the data and passing it on to those working on the front line in Canada.

● (1710)

Marie-Hélène Gaudreau: I have just one minute left to talk about an issue I've noticed, given that people no longer die from HIV or AIDS. It's a bit like what we saw with COVID-19: We assumed that everyone would be vaccinated. In this case, is it a solution to say that we offer PrEP to everyone? It's as if we're downplaying the long-term risks of having HIV or AIDS.

So, we're sort of caught in the middle: We say there's prevention and awareness raising to be done, but we also say there's treatment to stabilize the condition.

So, what more should we be doing here in Ottawa to meet the target? My target would be, like Rwanda's, to have zero cases per year. What do we need to do?

[*English*]

The Chair: You have 10 seconds.

Dr. Mia Biondi: Perhaps I could just mention the long-acting injectable that is newly Health Canada approved and everyone is aware about, yet it is on no formularies in this country and it has been out for many months. This may be the closest we get to vaccines. We don't know.

No, maybe not everyone should have it, but should everyone be offered it and should we be reaching out to those most vulnerable? I think so.

The Chair: Thank you very much. You're 16 seconds over.

We'll now go to MP Kronis for five minutes.

Tamara Kronis (Nanaimo—Ladysmith, CPC): Thank you so much, Mr. Chair.

Thanks to the witnesses for being here to address this really important issue.

There's a statistic in the data that we received that I found to be quite terrifying, which is the estimate that just under 70% of new HIV infections in Manitoba are people who inject drugs. The reason that is terrifying to me is that I come from Nanaimo, a community on Vancouver Island, where we have a high number of people who are injecting drugs on a daily basis.

Dr. Keynan and Dr. Rueda, my colleague highlighted the fact that the data is behind on this. There is a lack of data. The government just isn't providing up-to-date data. I was wondering if you, being in Manitoba, could talk a bit anecdotally about what this epidemic looks like on the ground. Who is it impacting? In particular, what does the intersection between the opioid epidemic and this emerging HIV epidemic look like in Manitoba?

Dr. Zulma Rueda: The epidemic here is quite different compared with Canada. In Canada, half of the cases of new infections are among gay and bisexual men who have sex with men. In Manitoba, it's mostly driven by heterosexual sex and injection drug use.

There is an intersection of syndemics where 50% of the new HIV infections are in females and 50% are in males. Unfortunately, females are more vulnerable. Among the new infections, half of the females are experiencing homelessness, mental health conditions and substance use.

There is an important thing to consider. HIV PrEP is based on national data. Zero per cent of the people who inject drugs and had indications to receive PrEP were receiving PrEP. First, maybe people are not being offered it or are not accessing it. Second, in many people, we identified significant childhood trauma, like sexual abuse, emotional abuse and physical abuse. Currently, in adulthood, we identify differences by gender. Women experience a lot of intimate partner violence that forces them to use substances. Men experience a lot of street violence. Those conditions are important to consider.

To your question of specific actions that could be taken, one would be to increase awareness among heterosexual people, women, people experiencing homelessness and people who use substances.

We also found differences related to substance use. There was a significant increase in the use of injected crystal methamphetamines since 2014, and, since around 2019, an increase in the use of opiates.

● (1715)

Tamara Kronis: Doctor, I have a limited amount of time left. I'm so happy to hear the level of expertise that you have and the on-the-ground anecdotes.

I worry about other communities like mine, where there is a high incidence of drug injection use. How important is it that the federal government come to the table with real treatment and recovery options for people who are addicted to drugs, particularly injectable drugs?

The Chair: You have 40 seconds.

Dr. Yoav Keynan: I'll try to complement that.

People don't access care. They don't have access to health care and support services. They need wraparound services that meet them where they are. There are examples. Dr. Rueda talked about the syndemics, which are homelessness and injection drug use. Deliver services that include harm reduction, PrEP and testing to where the person is instead of expecting them to make it to a health care setting, which doesn't happen as frequently as it ought to, for all the reasons that Dr. Rueda mentioned.

The Chair: Thank you.

We will go to Mr. Sawatzky for five minutes.

Jake Sawatzky (New Westminster—Burnaby—Maillardville, Lib.): Thank you very much, Chair.

Thank you to all the witnesses for being here today.

Dr. Crowcroft, you mentioned drug use-related transmission. When it comes to prevention, what are some of the measures that can be taken to prevent transmission between people who inject drugs?

Dr. Natasha Crowcroft: The Public Health Agency of Canada supports local communities in working with injection drug users in particular, but also inhalation drug users, to enable a safer use of drugs. The main federal lead responsible for substance use disorders is Health Canada, but some of the community organizations at the Public Health Agency of Canada provide some wraparound care and connection to services.

The actual delivery of what we've been talking about, the pre-exposure prophylaxis, would be a local public health role. The connection to services that are provided is also the responsibility of provinces and territories.

To be clear, there isn't a federal role in the delivery of the health system, including mental health services. We try to provide support where we can and try to address equity in that regard. Many of the pieces that will help protect substance users are not within our jurisdiction but are incredibly important for the prevention of HIV transmission.

Jake Sawatzky: I'd also like to point to the federal funding stream of the emergency treatment fund, which can sometimes be delivered to municipalities and, I believe, in some of these harm prevention spaces.

Would you say that the method of transmission is somebody using a needle to inject drugs and then giving that needle to somebody else? Is that typically how it happens?

Dr. Natasha Crowcroft: As we were saying earlier, it's quite a complex situation, because there are other things that go on in those communities. Sometimes it's through injection. Sometimes it could be through equipment used for inhalation. Sometimes it's related to sexual exposure in association with drug use or that occurs because someone engages in sex work in order to fund the habit.

It's a complex environment but very much interlinked around the social determinants of health that put people in a situation where they have multiple issues—we heard about mental health issues—that make them more vulnerable to addiction. Once they are addicted, that creates a whole host of other issues.

Jake Sawatzky: Could you also speak about whether there is a fear of discrimination or judgment or a certain stigma that might prevent people from coming forward and seeking support for this?

Dr. Natasha Crowcroft: There is certainly stigma associated with this. It's not just because of the injection drug use. There's also the stigma associated with other things around the individual. The communities they come from can themselves be stigmatized. It's a confluence of many sources of stigma.

● (1720)

Jake Sawatzky: Some people have limited access to health care services and perhaps face additional barriers to HIV testing and treatment.

What role can nurse practitioners and community-based health care initiatives play in expanding access to HIV testing and treatment in these communities?

Dr. Natasha Crowcroft: The community organizations we work with are using, for example, the self-testing kits and near-patient testing in order to identify people who need either pre-exposure prophylaxis or access to treatment services. This is very important. Nurses are very often critical for connecting people to care.

Jake Sawatzky: Thank you.

Dr. Biondi might have something to add in the last 30 seconds here.

Dr. Mia Biondi: Yes. I will highlight what I mentioned earlier about registered nurses who are already in publicly funded roles and would like to take on this work. Instead of just doing sexual health care, they may want to take on HIV prevention and treatment, but there are some legislative and community-based barriers that stop them from doing that. That's an easy shift. They're already employed. They can do the work and they have the competency.

Jake Sawatzky: Could you speak to what those legislative barriers are?

Dr. Mia Biondi: Sure.

Again, going back to my thoughts around gatekeeping and specialists, sometimes there isn't the ability to prescribe. If you're a registered nurse in some provinces, you can't prescribe, but we can use things like medical directives. We can also shift prescribing. In British Columbia, many nurses are called certified practice registered nurses, and they prescribe a lot of medications. Legislation can change to empower people to be able to do these things.

The Chair: Thank you very much.

We will now go to Madam Gaudreau for two and a half minutes sharp.

[*Translation*]

Marie-Hélène Gaudreau: I'll speak slowly anyway. The interpreters do good work, but if I speak too quickly, they won't be able to keep up.

This study has helped me understand something about accessibility. We've had universal health care in Quebec, and since the 1990s, we've had pharmacare. In my case, I have naloxone and I'm very familiar with what's known as the morning-after pill. As for PrEP, I thought it was aimed more at stigmatized communities, but I've just learnt more about it. In my view, it's accessible. That's my understanding.

I'd really like you to tell us what applies to us here in Ottawa as well.

Obviously, it's different for each provincial and territorial legislature. We have our own issues in Quebec, and I'll leave it to my colleagues in Quebec to decide whether specialist nurse practitioners, amongst others, can issue prescriptions.

So I'm talking about the legislative barriers in terms of public health here, as far as Health Canada is concerned. What should we do?

Ms. Biondi, could you answer that?

[*English*]

Dr. Mia Biondi: Right now, I don't know if it's legislative, but it's some kind of negotiation that's happening. This long-acting injectable is approved by Health Canada every six months, and as I mentioned, there will be a one-year injectable very soon. It's not legislative. With Health Canada, there needs to be a discussion around negotiation. We never in this country bulk-buy medications, and I don't always understand why. Obviously, that would be an approach to think about.

Would anyone else like to comment on this?

Dr. Natasha Crowcroft: The issue for Lenacapavir is that while it has gone through Health Canada approval—it went through very quickly, so that's credit to Health Canada—it hasn't gotten through the pricing mechanism. We have a health technology assessment process, and it has not been put into that system yet.

That's the issue we're facing. Although it's available in the sense of having been approved, it's not really available on the market.

The Chair: You have 10 seconds.

[*Translation*]

Marie-Hélène Gaudreau: Thank you very much, Mr. Chair.

[*English*]

The Chair: Thank you, Madam Gaudreau.

We're under time, so we'll go to Dr. Strauss for three minutes.

Matt Strauss: Dr. Crowcroft, I'm still so concerned about this issue of a lack of data and not having up-to-date data.

You mentioned that your organization would have some more up-to-date data, but it's incomplete. I'm wondering if you could table what it is that you have that is incomplete and whether you could outline for us in writing what would be necessary to make it complete. Could you table that in writing? I know that's too big a question for three minutes.

I want to hear from everyone on this next point. It's not a gotcha moment. I was hoping to go around the table and see if we have consensus on this.

I think you all identified homelessness as a major risk factor. Dr. Rueda, I think you said that half of the new cases occur in currently unhoused people. I was interested in why the rates have doubled.

I was looking at some data from the cities of Regina and Saskatoon and the province of Manitoba. It seems like homelessness also doubled in each of these municipalities in the 2015 to 2024 period. I'm wondering if each of the experts at the table could tell me, in one or two sentences, if this HIV crisis is at least in part a housing crisis.

I'll start with Dr. Biondi.

● (1725)

Dr. Mia Biondi: I'm going to give my opinion. While homelessness can certainly contribute, the problem is the national systematic attack on harm reduction.

I did hear a mention of treatment and getting people into treatment like OAT. There's a role for that. It's very important. That's not going to be what everybody chooses.

Matt Strauss: I'll go to Dr. Rueda next.

Dr. Zulma Rueda: I want to clarify that 50% of the new infections are among females—

Matt Strauss: Thank you.

Dr. Zulma Rueda: —and 30% are among newly diagnosed males.

Regarding your question, people experiencing homelessness face multiple barriers to accessing preventive services. What would be a potential solution? Why don't we implement testing, treatment and care in shelters, for example?

It's not only about HIV prevention and it's not only about HIV treatment. It's also about offering sexually transmitted testing, treatment and linkage to PrEP in shelters—

Matt Strauss: I'm sorry. I'm going interrupt you there.

I'm still trying to understand why this has happened. The rates have doubled. There's an epidemic going on. The risk factors have always been the risk factors. There are new interventions, but the interventions have always been the interventions.

I'm trying to understand what has changed. I see that homelessness has doubled while new HIV case counts have doubled.

Dr. Keynan, am I crazy to be linking these things?

Dr. Yoav Keynan: No, I don't think you're crazy.

It hasn't doubled. It's houselessness, substance use and the types of substances that are being used. Methamphetamine is driving different behaviour, including different sexual behaviour, and it is increasing the risk of multiple other sexually transmitted infections. It's a combination of poverty, homelessness and the coalescence and convergence of several epidemics, including harmful substances, at least in Manitoba and Saskatchewan.

Matt Strauss: Dr. Crowcroft, I'll turn to you.

The Chair: Thank you, but the time is up.

Matt Strauss: You could table that as well.

The Chair: We'll go to Dr. Jaczek for three minutes, please.

Hon. Helena Jaczek (Markham—Stouffville, Lib.): Thank you, Chair.

Thanks to all the witnesses.

In a previous life, I was a practising public health physician. I want to go back to how primary prevention, testing, PEP and PrEP all cost a lot of money.

Dr. Biondi, you referenced peer-led community outreach. Could you describe what that looks like and what the efficacy might be in primary prevention?

Dr. Mia Biondi: Many community health centres do have peers attached to their programs, but that's not enough. Peer-led work means people with lived and living experience are doing the outreach. They're often also doing the clinical care. Sometimes folks are seeing people in community who I will never see. They will still treat them for hepatitis C, and I will have never even met them. I know that sounds wild, but it's really important. Only those people are going to find people out in the community.

Most peer-led programs are funded through industry and philanthropy. There isn't sustainable peer-led work anywhere in this country. It can be attached to public health units and to community health centres. There's certainly a role to drive that up in a major way. It will also help with harm reduction, overdose prevention and making sure people are not always accessing the toxic drug supply.

Hon. Helena Jaczek: Dr. Crowcroft, to what extent does the federal government feel that primary prevention might be a role where PHAC could play a part, and to what extent is there any funding available for things like Dr. Biondi has described?

Dr. Natasha Crowcroft: Indeed, we do support these models. That's why we support community-based organizations, including ones that provide peer-led services. An example in terms of funding is we have Nine Circles in Manitoba, which has received $1.25 million from the Public Health Agency of Canada to support their activities in Manitoba. Réseau sida et maladies infectieuses in Quebec is another community-based organization. It's part of our model of support.

I would emphasize that we're talking about linkages to care, and that's a major issue. Even if you have those people, getting into care is really difficult. I mentioned the 95-95-95 targets earlier. Canada is at 91% of people living with HIV, which doesn't meet the target. We do much worse on those who are actually diagnosed—so they have been picked up—getting into treatment. This is where the peer-led services really help people navigate into treatment, but the treatment has to be available.

We do hear about access to treatment being a real challenge in some settings and in some provinces and territories. That's not within the federal government's mandate. That is provincial and territorial.

● (1730)

The Chair: Thank you.

Dr. Keynan, even though the time is up, I can give you 20 seconds if you wish to say something.

Dr. Yoav Keynan: Canada and B.C. were pioneers in treatment and prevention, and treatment making people undetectable means untransmissible. I think that looking beyond the role of this is not my role, but seeing that treatment is part of our public health approach to decrease the rate of new infection is a key component that we should not be remiss in mentioning here.

The Chair: Thank you very much.

On behalf of the committee members, I would like to thank all the witnesses for their valuable input.

Thank you to all of you again.

With that, I will suspend the meeting and the second panel will take their seats.

● (1730)

_____(Pause)_____

● (1745)

The Chair: I call this meeting back to order.

We still do not have one person ready, but we have someone from the same organization, so we might as well start.

On behalf of the committee members, I would like to welcome the witnesses joining us for the second hour.

With us from COCQ-SIDA, we have Ken Monteith, executive director. We also had Benoit Racette, but the microphone is not working, so we'll see if it works later on. From Gay Men's Sexual Health Alliance, we have Gilles Charette, director. From Kimamow Atoskanow Foundation, we have Madam Denise Lambert.

I would like to make a few comments for the benefit of the new witnesses.

Please wait until I recognize you by name before speaking. For those participating by video conference, click on the microphone icon to activate your microphone, and please mute yourself when you are not speaking. At the bottom of the screen, you can select the appropriate channel for interpretation: floor, English or French. For those in the room, you can use the earpiece to select the desired channel. Committee members may ask questions in either French or English. If you require interpretation, please take a moment now to prepare your earpiece and select the listening channel you need in advance.

I remind you that all comments should be addressed through the chair.

Each organization has five minutes for opening remarks. Then we will proceed with the rounds of questions.

We're going to go backwards to how I introduced the witnesses. We'll start with Madam Denise Lambert, indigenous health consultant, for five minutes.

Denise Lambert (Indigenous Health Consultant, Kimamow Atoskanow Foundation): Thank you for having me.

I start all my presentations with an acknowledgement that I carry my medicine with me, which is something that was not always privileged to my ancestors.

I'm an indigenous woman from Treaty No. 6 territory in Alberta. I come from the Summer Village of Sandy Beach. I'm a mother of five and a grandmother of eight. I am here bringing together both personal and professional standpoints regarding my understanding of HIV in Canada. I am representing an organization called the Kimamow Atoskanow Foundation, which means, in Cree, “We all work together”.

We had done work in the field of HIV prior to the formal incorporation of our organization in 1992. We have a long-term investment in our ways of conducting ourselves when addressing HIV and other issues. We are considered one of the very few rural, mobile, indigenous organizations in Canada. We have multiple sites in Alberta with the Northern Indigenous Health Alliance, and I acknowledge our partners in High Level, Peace River and Grande Prairie.

We've recently received resources to extend some indigenous community health worker training for self-testing and confirmatory testing into Saskatchewan and Manitoba. We are very proud of our indigenous principled and protocoled approach to health and wellness, meaning that we understand the significance of connection to land, language, ceremony and our relatives, seen and unseen.

We recognize our indigenous HIV researchers and those who are allied with us in programs and approaches.

We also recognize the enduring colonial policies and processes that impact indigenous people's health, including, what we often don't want to state, the racism and discrimination within the health care system.

I also note the existence of multiple sources of evidence that provide a foundation for the work that needs to happen within this study, including the Truth and Reconciliation Commission's calls to action, the United Nations Declaration on the Rights of Indigenous Peoples and the 231 calls for justice for missing and murdered indigenous women and girls.

I also acknowledge the prior work of the federal government with previous national AIDS strategies and involvement with advisory bodies such as the ministerial advisory council on HIV/AIDS and the national aboriginal council on HIV/AIDS. These no longer exist, but they provided mechanisms for, and input into, the current situation going on in this country.

We also recognize that many of the barriers, particularly when I speak about my relations in indigenous communities, are systemic issues. There are also—call them what they are—sexual abuse and sexual violence issues that need to be addressed historically and today. At the core of these are power and control.

We require a deeper acknowledgement and understanding of indigenous science contributions to support western science advances. Some of my colleagues in later groups may speak about ancestral science.

We also believe it's important to have affected indigenous people and communities participating in the profiling of the Canadian HIV and STBBI response, and evaluation that is specific to indigenous peoples and other key populations.

We would also like to see more recommendations on advancing HIV self-testing, confirmatory testing linkages and, most importantly, continuation of care from a community perspective. We need to ensure that the ways we're measuring our successes are accurate and are not just positioning particular organizations.

Finally, on investment in community-based programs—I use that term with specific intention for groups working on the front lines—we need resources in rural and remote communities for the networks of people who have previously been, or currently are, incarcerated, and for our relatives who are without a home. You talked about the unhoused or difficult-to-house. Yes, we have relations living on the street or in places where they can't really survive well. There's the addictions issue.

● (1750)

We need, for the people we love.... We don't speak just of people with lived or living experience. We are people with loved experience. We want to have stronger advocacy to address this multitude of needs.

Nanâskomow. Thank you.

The Chair: Thank you.

Now we will go to Gilles Charette for five minutes.

Gilles Charette (Director, Gay Men's Sexual Health Alliance): Thank you, Chair and members of the committee, for the invitation to appear today. My name is Gilles Charette. I'm the director of the Gay Men's Sexual Health Alliance, or GMSH. We are an alliance of more than 25 community-based organizations with workers around the province of Ontario dedicated to improving the sexual health and well-being of gay, bisexual, queer and other men who have sex with men.

This past July, I attended the International AIDS Conference in Rio de Janeiro. I came away struck by how far HIV science has advanced and how much work remains to ensure that those advances reach the people who need them. We have highly effective treatment, as we heard earlier. We know that people living with HIV who maintain an undetectable viral load cannot transmit the virus to their sexual partners and we have PrEP, a tool that is extraordinarily effective at preventing HIV, yet HIV continues to affect thousands of people in Canada.

In important respects, our public policies and investments have not kept pace with the science, and the public health emergency that we're seeing in Manitoba underscores this urgency. Gay, bisexual and other men who have sex with men, as well as Black and indigenous communities, continue to be disproportionately impacted and affected by HIV. Homophobia, transphobia and racism shape people's experiences of HIV, including whether they feel safe seeking information, testing and care. Addressing these barriers requires sustained public education, including federally supported awareness campaigns.

Canada's approach to the criminalization of HIV non-disclosure is another example of a policy that has not kept pace with scientific evidence. Criminalization can reinforce stigma and discourage testing and openness about HIV status.

At GMSH, our current sexual health campaign is called “If no one ever told you, we will (with love)”. It's grounded in the simple recognition that we can't assume everyone has received the sexual health information they need in a relevant, affirming and judgment-free way.

Recently in Thunder Bay, when local data identified a cluster of new HIV infections disproportionately impacting younger gay, bisexual and other men who have sex with men, the public health unit reached out to GMSH. Together, we strengthened targeted messaging around HIV testing and PrEP, combining local knowledge, public health expertise and community engagement.

Harm reduction is another important part of the work. For example, through “Partying and Psychosis, Responding with Heart”, a training resource that we've developed for service providers, we're helping workers respond to the intersections of substance use, mental health and sexual health with compassion, practical tools and without judgment.

These examples demonstrate what community-based prevention requires: skilled people, trusted relationships and the capacity to respond when needs emerge. However, that capacity needs to exist before a public health emergency arises.

The federal community action fund and the harm reduction fund are essential investments. Renewing and strengthening them is critical but project funding alone can't sustain the community infrastructure prevention requires.

In 2016, a federally funded HIV education position at the organization I led in Kingston lost its funding, and that work did not continue. Currently, GMSH alliance members have received a one-year funding extension for some of their roles, but uncertainty remains beyond those agreements.

When funding disappears, we risk losing experienced workers and the trust that they've earned in community. Community prevention is not simply a series of projects. It's an essential ongoing public health function.

We also need universal access to prevention and treatment. Someone considering PrEP may already be uncertain about whether PrEP is right for them. If they're faced with navigating drug coverage, deductibles and co-payments, that may be enough to discourage them. Prevention needs to be simple and affordable.

In closing, I have three recommendations.

The first is to renew and strengthen federal investments in community-based prevention, including sustained support for public awareness campaigns addressing HIV stigma, homophobia, transphobia and racism.

Second is to establish stable, accountable core funding alongside project funding so organizations can retain experienced staff and trusted community relationships.

● (1755)

The final one is to establish federal-provincial-territorial partnerships to achieve universal barrier-free access to HIV prevention and treatment, including PrEP, without financial barriers.

The Chair: Thank you very much.

I'm going to suspend for a couple of minutes to get the next witness ready.

● (1800)

_____(Pause)_____

● (1800)

The Chair: I call this meeting back to order.

Besides the witnesses we introduced, we have with us Mr. Benoit Racette.

Now we'll go to COCQ-SIDA.

You have five minutes between the two of you.

[*Translation*]

Ken Monteith (Executive Director, Coalition des organismes communautaires québécois de lutte contre le sida): Thank you very much, Mr. Chair. I will be doing most of the speaking.

New cases of HIV and other sexually transmitted and bloodborne infections, or STBBIs, are on the rise across Canada. Although the situation in Manitoba and Saskatchewan is alarmingly severe, with rates per 100,000 inhabitants three times higher than the Canadian average, things are not entirely under control elsewhere either.

We will focus instead on the situation in Quebec.

In 2024, there were 462 new cases of HIV in Quebec, more than 50% higher than in 2019, the year before the COVID-19 pandemic. Furthermore, we know that 44% of new cases for which information is available presented late and had CD4 counts indicating that the infection had been present for a long time before being detected.

We are not meeting the target for HIV testing.

The availability of HIV self-tests can help us better reach populations furthest removed from the health care system, but these tools are expensive. They are beyond the means of marginalized people, and even of community organizations that manage to reach them.

Programs for the free distribution of self-tests, such as the one in 2022 and the one announced recently, could be very useful, but they are time-limited. A one or two-year project will not ensure a sustained response within society.

It should be emphasized that these two self-test distribution projects have been well received by those involved in the fight against HIV, as federal investment in the response to HIV and STBBIs is eroding over time and due to inflation. The same amount of money does not have the same purchasing power today as it did some fifteen years ago.

To support the community's capacity to respond to HIV and STBBIs and to carry out awareness-raising and prevention activities, targeted, stable and ongoing funding must be ensured.

We have witnessed significant medical advances in the treatment and prevention of HIV, but these are of little use if they are not accessible to everyone. In several countries, it is recognized that providing antiretroviral drugs free of charge—whether for pre-exposure prophylaxis or HIV treatment—helps to increase uptake and ensure continuity of care, particularly in the context of a crisis caused by rising rents and food prices faced by the most disadvantaged people.

One solution to this accessibility issue could be the national pharmacare scheme, but the federal government has failed to negotiate its implementation across the country, and antiretroviral medicines are not included in the scheme.

It should also be noted that the recent decision to introduce charges for medication renewals under the interim federal health program has created a further barrier for people living with HIV covered by this program.

Although there have been significant advances in treatment, there has been little progress in terms of the stigma surrounding HIV and the most vulnerable members of our society. The Public Health Agency of Canada recognizes that stigma against certain populations and HIV can hinder access to the benefits we are seeing from treatments.

Sometimes, it is the policies of other government departments that create barriers to care or stigmatize certain populations. We recognize that it would be beyond the remit of this committee to take proactive action on issues such as the criminalization of non-disclosure of HIV status, sex work or the use of psychoactive substances, or to assess the consequences of immigration policies that stigmatize people and leave them without access to adequate health coverage. These issues require that the Minister of Health work in concert with colleagues in other departments to achieve better health outcomes for everyone within our territory.

Protecting the most vulnerable people protects the rest of the population.

Thank you.

● (1805)

[*English*]

The Chair: Thank you very much. That was perfect timing at four minutes and 54 seconds.

Now we'll go to Madam Kronis for six minutes.

Tamara Kronis: Thank you very much, Mr. Chair.

The study that we're doing here is prompted by an increase in HIV diagnoses in Manitoba that is triple the rate of the national average. What that means in concrete terms is that there were 328 new HIV diagnoses in 2025 in Manitoba compared to 90 diagnoses in 2019.

While I heard the witnesses talk about communities across the country, I'm wondering if I could turn to each of you briefly to talk about what you know about the crisis in Manitoba specifically and the incredible statistic that 69% of the new cases are linked to injectable drugs.

Mr. Charette, could you speak specifically to Manitoba?

Gilles Charette: I'm in Ontario and can't speak specifically to the realities of what's taking place in Manitoba, but I can speak to a similar experience.

Tamara Kronis: I'm just going to stop you there because I'd really like to hear about Manitoba. This is a study that is prompted by Manitoba.

Perhaps, Ms. Lambert, you could speak to the crisis in Manitoba specifically.

Denise Lambert: I can say that I have been invited to Manitoba on a couple of occasions to present information, to deliberate the situation in Manitoba and to be of assistance, which is part of our way of working together.

I can say that my comment that it is unacceptable receives some attention.

When you speak to me about the increase from 2019 to 2025, I would want to know what the other factors are in the systems that have affected this, whether it is the housing issue or the funding. Is it a human resource issue? Is it something that's gone on within the communities?

I can't speak to the 69% of the new infections caused by injection drug use. I think that's a common factor across all areas. Injection drug use is a big concern.

● (1810)

Tamara Kronis: I totally understand why it's a big concern, but we're talking about rates that are three times the population.

Mr. Monteith, can you speak to the crisis in Manitoba that is underlying this study?

Ken Monteith: What I can say is based on what the response of the Government of Manitoba has been. It's recognizing it by putting into place what was missing. What was missing was cost-free access to antiretrovirals, promotion and availability of PrEP and testing that is adapted to populations.

Those are the—

Tamara Kronis: I think that's important, but is there anyone here who can speak to data coming out of Manitoba?

Mr. Chair, if that's not the case, given the theme that we're seeing.... We had witnesses in the first hour who talked about not having access to the data that they need. Now we have witnesses in the second hour who aren't able to provide the committee with data around the nucleus of the reason we're doing this study.

I'm wondering when, on the agenda for this study, you're going to bring in those witnesses. Perhaps you might consider accelerating bringing in witnesses who can speak to the core nucleus, on-the-ground data that we need from Manitoba to be able to really ground this work.

The Chair: Madam Kronis, you must be aware that I as chair leave it to the parties—the Conservatives, the Bloc and the Liberals—to make their own decisions on who they're going to invite. That's where it is. Let's work with the witnesses we have.

If you have any more suggestions, you should go to your whip or your lead, Madam Dancho, to figure out who you want on the witness list.

Tamara Kronis: I think it's really important. I'm hoping that we can secure the co-operation of the members across the way. I know that MP Eyolfson is from Manitoba.

I think it's really important here. There's a lot of expertise across the country. My dear friend Chris Bunting, who passed away a couple of years ago, was the long-standing CEO of CANFAR.

We have an anomaly in Manitoba. We have a situation where the incidence of new HIV infections is significantly higher. That's what prompted this. I think it's really important that we get some grounding in the facts on the ground in Manitoba, so we can get the benefit of people's assessment of that causal analysis and really think about what data we need to do this study well.

The Chair: Thank you, Madam Kronis. Your time is up.

We'll go to Madam Chi for six minutes.

Maggie Chi (Don Valley North, Lib.): Thank you to all our witnesses who have come forward to the committee today with incredible information.

You guys are doing incredible work on the ground. We really appreciate it, and we thank you for it.

Ms. Lambert, your perspective is incredibly important because, as we've heard today, making a service available doesn't necessarily mean people feel comfortable using it.

From what you've observed, seen and heard working with indigenous communities, what approaches are working well to build trust and to connect people with information, testing and getting care, particularly in rural and remote communities? What could be adapted by other communities?

Denise Lambert: I got as far as "what is working well", with your question.

Maggie Chi: What is working well to build trust and connect people with care?

Denise Lambert: Very simple questions we ask people when we first meet, no matter the context or situation, are these: Where are you from? Who are you connected to?

The relationships are important, as is knowing which community they come from. That could be a geographic community, an urban setting, certain familial connections or circumstances. I think the initial questions are about determining where the person is coming from, which I know is a principle in many approaches to developing trust.

● (1815)

Maggie Chi: Particularly in rural and remote communities, would you say it's the same approach? Is there anything you're seeing that will work well?

Denise Lambert: What we find works well is when people are connected to that same place or background and can share similarities in terms of locale. We have people who are located seven or eight hours away from a major HIV clinic, yet we can have connections to people who are living with HIV in those communities through the relationships and knowing somebody and trusting them enough to take the long ride to go and see the specialist, which we're hoping we can change a little bit, too.

Maggie Chi: It sounds like there's a lot of groundwork. Thank you so much for doing that and building the trust on the ground.

I want to turn to the prevention side. My next question is for Mr. Charette.

We know that information needs to be accurate and reach people in a way that speaks to their lives and circumstances.

I'm from Ontario. I thank you for all the work you do in Ontario.

You said you have about 25 organizations under the network. You mentioned that there are a lot of barriers and gaps. What are the biggest gaps in understanding HIV prevention today?

Gilles Charette: I would begin with the education, or lack of education, that people are receiving today. While there is some basic sexual health education, it doesn't always speak to the realities of the lives of the communities that are being impacted by HIV.

When we use the example of the recent infections we've seen in Thunder Bay, what we're hearing from the community and workers is that there is a presumption that HIV is no longer a thing, that it's a condition that people contract, but there's a pill for it and you're fine. The degree of import to prevention isn't necessarily there.

I heard a comment earlier about coming from a generation where HIV hovered over your experience like a dark cloud. We're at a time when science has progressed and, thankfully, there's a generation who may not share that concern. That being said, they don't share that concern, so getting the information to younger people.... The campaign we are currently rolling out is focusing on spaces near colleges and universities, because the epi data is suggesting there's a gap in knowledge and a gap in people's perception of their own susceptibility to HIV infection.

Maggie Chi: Okay. Thank you for that.

On getting to young people, what does it mean? Is it getting to university campuses or to social media? What are you finding is the most effective way of reaching them?

Gilles Charette: I would echo what my colleague was saying about people with lived expertise: people in community having conversations and creating a sense of trust because you see your own experience reflected. In designing our campaigns, there's a thoughtfulness around people being able to see their own experience there. We're preparing our messages in ways where younger people can see themselves and their lives identified.

Our campaign—and the next phase of it rolls out in January—will have a presence in college and university residences and campus pubs. That's part of the focus in order to try to get in front of younger folks.

Maggie Chi: Thank you so much.

The Chair: You have 30 seconds.

Maggie Chi: Very quickly, Mr. Charette, can you give us an example of what it looks like when somebody needing help is coming to one of your organizations? What would that look like when they're walking through the door?

Gilles Charette: It would really vary, but I think a lot of it would have to do with asking people about testing and whether that's something they have accessed recently or need to access. Helping to facilitate that would probably be the first thing that comes to mind or, also, whatever questions they have. A lot of times, people are coming in because they have a question about whether PrEP is right for them. They've heard something about it, but they may not have all the information they need.

The Chair: Thank you very much.

Now we will go to Madam Gaudreau for six minutes.

[*Translation*]

Marie-Hélène Gaudreau: Thank you very much, Mr. Chair.

I find this discussion very interesting. The main challenges have been laid out on the table. Indeed, on the one hand, we do need more data. On the other hand, if we want to take action, we still need to carry out proper screening. However, let's be honest: I'm convinced that not everyone around this table feels comfortable talking about sexual health and sexual behaviour. Some people are more comfortable with this than others. That said, what happens when someone feels uncomfortable, thinks they might be infected, realizes they might need a self-test, but is unable to take the necessary steps or doesn't even know such tests exist? In your view, is there anything that could make the process easier while ensuring anonymity?

I'm putting the question to Mr. Charette.

● (1820)

Gilles Charette: I'll try to answer the question in French. I don't often get the chance to use this language.

Marie-Hélène Gaudreau: You're doing very well.

Gilles Charette: Thank you very much.

There are several options.

One program that is widely available in community-based HIV support centres is online services. These are mainly found in apps that people use to arrange sexual encounters or have relationships. Often, people working in the sector are active on these apps to answer questions of this kind and refer people to resources, whether that's in-person testing, anonymous testing or self-testing.

In Ontario, there's a program that started here in Ottawa called GetaKit. People can go online, indicate whether or not they have symptoms, or state how long it has been since their last test. They can have a self-test kit delivered to their home or to an organization, or receive the forms they'll need to take to a LifeLabs centre, for example, to have a blood test. This way, it isn't necessarily anonymous, but it takes away the anxiety people might feel if they have to discuss their sex life with someone in person.

Marie-Hélène Gaudreau: Here, we have an extremely interesting solution. I'm heterosexual and I'm not familiar with Grindr or Scruff. However, when I looked into it, I realized that there is access to prevention, but perhaps only for a short period of time. I didn't even know, until today, that certain things existed. Earlier, I was talking about the morning-after pill, which is not a contraceptive but a preventative measure used after the event, but there's also PrEP. That exists too.

Indeed, when it comes to education, every province that provides services needs to take action. I'm aware of the situation in Quebec. In the 1990s, I received sex education through the education system, just like my daughters, who are young adults. However, in Quebec, the millennial generation did not receive it, because there was a reform.

I think this is an enormous amount of pressure being placed on you. How is it that at the Montreal Pride Festival, there are more prevention stands than places for festivities? Something is going on.

I'm coming back to the issue of screening. Could we do the same thing so that, in every province and territory, when someone receives a diagnosis, they can receive something free of charge by post, amongst other things, to ensure they receive treatment? There must be other schemes like that in place. Is this something that could be relevant?

Gilles Charette: I would think so. The program started in Ottawa as a test, and it's now offered across Ontario. It's a fairly simple system that's accessible online. It's run mainly be a team of nurses or clinicians in Ottawa. Follow-ups take place in Ottawa. There are also partnerships with public health units from other communities that do follow-ups. I imagine that it can be expanded nationwide.

Marie-Hélène Gaudreau: Basically, we have to fix the problem that's occurring in Manitoba. Honestly, if it can be useful to everyone, let's go for it. Let's look at the good practices elsewhere and provide this access.

Ms. Lambert, do you think that access to testing and free prescriptions in the various indigenous communities can genuinely help?

● (1825)

[*English*]

Denise Lambert: I will say that, yes, it does, of course.

We have had an initiative over the last two and a half years called “Take It Personally”, where we encourage indigenous people at a number of different types of events to take their health into their own hands. We have had the self-test kits available. We now, through some of our project funding that we just received, are purchasing the OraQuick tests and making them available. We're looking at the confirmatory testing technology that is available in almost every first nation community, or trying to find out where that exists. We are trying to move beyond their having to go to a regulated health care practitioner in order to access the treatment that should be accessible to all.

The Chair: Thank you very much, Madam Gaudreau.

We'll now go to Dr. Strauss for four minutes.

Matt Strauss: Thank you, Mr. Chair.

Mr. Charette, I am so happy to see you here. I am a huge fan of your organization.

When I worked in public health in the province of Ontario, we were at the end of a three-year pandemic, the COVID-19 pandemic. I sort of became political because I felt that we were not applying the hard lessons learned from the HIV crisis in the 1990s to COVID-19. I was calling for a calm, courageous, compassionate approach. Too often I found that public messaging was fear-based, shame-based and sometimes coercive.

When monkeypox broke out, the Council of Medical Officers of Health in Ontario invited the Gay Men's Sexual Health Alliance to speak to our group. They promoted a calm, compassionate, consent-based approach. Your organization, frankly, put the public health establishment to shame. It led the monkeypox approach in really important ways in the province of Ontario and, I imagine, nationally, and we—you—stopped that epidemic in under six months. I think it was such a credit to your organization, such a credit to the approaches that your organization takes to these sorts of matters.

You said in your opening statement that your funding has been cut, and I'm upset about that. Can you tell me who has cut your funding and what the stated reasons were for that?

Gilles Charette: Let me clarify. In my statement, I was speaking about funding that was cut in an HIV service organization where I was the executive director in Kingston. That was in 2018 and as a result of changes to the community action fund at that time. This meant that some education services that were being offered in southeastern Ontario were cut. The GMSH has workers situated across the province. Some of them have base funding through provincial dollars, and some of them are funded through the community action fund.

There are communities that are saying they've received a one-year extension to this funding for the work but that they don't know what happens on March 31 next year. In communities like Peterborough and Hamilton, what happens to the Gay Men's Sexual Health Alliance's work in our communities in the absence of that funding should it change, be reduced, and—

Matt Strauss: Where does that funding come from right now?

Gilles Charette: It would come through the Public Health Agency of Canada's community action fund.

Matt Strauss: They were just here. I wish we had the opportunity to ask them about that.

Can you let me know when I have 30 seconds left, Mr. Chair?

The Chair: Yes.

Matt Strauss: Ms. Lambert, you talked about sexual violence as being something that is a risk. Every expert has told us about how sexual violence is a risk factor for the propagation of HIV in communities. You talked about the importance of stopping it. What needs to be done? What are the gaps? I know that you don't have the be-all and end-all, magic wand final answer, but in your work, what have you observed? What needs to be done to stop sexual violence?

Denise Lambert: As for a connection between the actual experience of sexual violence by individuals, those of us who work in the health care field have had to create situations and places to be able to discuss the effects of sexual violence and our perception of how we do sex education and how we engage people in the whole STBBI prevention, care and treatment continuum.

The Chair: You have 45 seconds.

Matt Strauss: Thank you.

Chair, my colleague Ms. Kronis made some really important points that the nucleus of the study is about the epidemic in Manitoba. It's shocking to me that it's 2026 and we have a new epidemic in Canada and it's of an old disease. The infectious disease director from PHAC told us that they don't have the proper data to combat this.

I'm wondering if you would seek unanimous consent from the committee to invite the chief medical officer of health for Manitoba as well as the chief medical officer of health for Canada to come speak to us about what these gaps in the data are.

The Chair: Okay.

● (1830)

Maggie Chi: Could I seek some clarification?

The Chair: Sure, Madam Chi.

Matt Strauss: I move that we invite the chief medical officer of health for Manitoba and the chief medical officer of health for Canada to come speak to us about this epidemic and the data gaps that exist.

I thought we'd get it done quickly and that we would have unanimous consent.

Thank you, Chair.

The Chair: Thank you.

Dr. Strauss, as I mentioned earlier, when Madam Dancho is here, she can talk to the Liberals, the Bloc and the clerk, and these things can be done—

Matt Strauss: It seems like we have UC, so—

The Chair: Your time is up. We are, in fact, 35 seconds over.

I'm going to—

Brad Redekopp (Saskatoon West, CPC): I have a point of order.

I heard the member make a motion. Does that not need to be dealt with?

The Chair: He didn't say it was a motion.

Matt Strauss: I said, “I move”.

Maggie Chi: We gave UC.

Matt Strauss: She gave UC. I don't think you saw that. The Liberals nodded.

Maggie Chi: We gave UC. We're all good.

Marie-Hélène Gaudreau: It's good.

(Motion agreed to [*See Minutes of Proceedings*])

The Chair: Mr. Redekopp, you've been the vice-chair. You know that these things can be done prior to coming to these meetings, because when the witnesses are here, I don't want to take their time and the members' time to discuss these things.

I would encourage you, Madam Kronis and Dr. Strauss, that for other things—we have the week off next week, and then we'll come back in two weeks—to please talk to Madam Dancho.

Tamara Kronis: As a point of order, Mr. Chair, we sought unanimous consent, and we got it. I would expect that the motion—

The Chair: Yes, that's done, but I'm telling you this right now for other things you might have in mind that you haven't spoken to.

With that, Dr. Strauss, if you could send the motion to the clerk by email, that would be great. Thank you.

We'll go to the second-last speaker, MP Sidhu, for four minutes.

Sonia Sidhu (Brampton South, Lib.): Thank you to all the witnesses for the very informative testimony.

My question is for Ms. Lambert.

For the people diagnosed with HIV, what are the biggest challenges in getting them started on the treatment? How quickly do they go on the treatment? Anybody can answer.

Denise Lambert: I would say it depends on where they're located and how well they're connected to the health care system.

Sonia Sidhu: Thank you.

Go ahead, Mr. Charette.

Gilles Charette: There are disparities depending on the region that people are in, whether there are infectious disease clinicians in the region or whether this is done primarily through primary care. There would be real gaps that way.

Also, there are people's situations in terms of social determinants. If the person is unstably housed, for example, it gets more difficult to reach individuals and connect them to appointments for their care. That being said, when you can connect somebody to primary care, that opens the door to all sorts of other care, including substance use treatment, housing, etc.

Sonia Sidhu: Thank you.

Manitoba has seen a particularly sharp increase in infection among women. How can we improve early HIV testing for women when they are not considering themselves at risk?

Denise Lambert: Again, I put some attention on the health care system and how it is actually able to get people through the door. Many women may have children or other obligations. When you have to be in a waiting room for in excess of 10 hours, as only one simple example, all of those other needs that are in the home are often more important than the woman's engagement in taking care of their own health. That's what I have observed.

Sonia Sidhu: Mr. Charette, did you want to say something?

Gilles Charette: I think that community is holding onto historical narratives about who HIV impacts. There are communities that are being really impacted by HIV. The instance in Manitoba really speaks to this, but communities, particularly generations, still see this as an issue that's impacting primarily the community the GMSH serves, when in fact it's much larger than that.

There's a campaign in Ontario called KnowHIV. It's really meant to speak to communities who have an outdated experience or knowledge of HIV and get people really questioning whether, for example, tools like PrEP are in fact for them as well.

● (1835)

Sonia Sidhu: Mr. Charette, you talked about how there's a lack of education. Your organizations are doing great work to fill that gap. What is the number one barrier you see for that?

Gilles Charette: I would say we've made progress in some ways in terms of homophobia and transphobia. We're beginning to see a pullback of that. I think the two exist in tandem. If people aren't inclined to be open about their experiences because the social climate around them doesn't create conditions for that to happen, that's a barrier as well.

For example, if we're depending on school teachers to deliver this education, we also have to trust that they have the comfort to be speaking to the experiences of young 2SLGBTQ people, for example. That's not always the case. We certainly see narratives of great resistance around speaking about certain topics in schools.

The Chair: You have 30 seconds.

Sonia Sidhu: Does anyone want to say what should be done? What is the number one piece of advice you want to give to this committee?

Denise Lambert: When you initially asked the question, my first thought was that many of the communities that we work in and serve do not have the technology or access to things as simple as the Internet to access some of the information.

The Chair: Thank you very much.

We'll go to Madam Gaudreau for two minutes.

[*Translation*]

Marie-Hélène Gaudreau: Thank you, Mr. Chair.

I'll be quick. My questions are for Mr. Monteith and Mr. Racette.

Here's some context. Seven years ago, when I was a member of the Standing Committee on Access to Information, Privacy and Ethics we did a study on Pornhub, so I spent many hours examining the issue of pornography. I learned some things, and that is why I'm stunned now. Tell me if I'm wrong, but porn is often the way people learn about sex. Nowadays, it's not just on Pornhub. There's OnlyFans, X and Bluesky, for example. The people aren't necessarily actors, and there isn't necessarily a prior arrangement. These are people putting their own private lives on display.

I noticed the absence of condoms a while ago, in both heterosexual and homosexual relations. Now, I'm learning that these people might have been receiving treatment.

People have to protect themselves. In the 1990s, people were told that wearing a condom was the first step in protecting themselves.

I'd like to hear your thoughts on where things stand with sexual education, considering that most of the content people see makes them think that that is how sex works and that it's normal.

I'd like to hear your opinions, gentlemen. You have 30 seconds.

Ken Monteith: I'll let Mr. Racette answer the question first.

Benoit Racette (Rights and Advocacy Coordinator, Coalition des organismes communautaires québécois de lutte contre le sida): I grew up at the same time as you, Ms. Gaudreau. I heard the same messages you heard that no longer exist.

It's hard to say which organizations are involved in sexual education. By the way, organizations across Quebec provide that education every day, to teach people about contraceptives and PrEP, for example, which isn't well known outside the more predictable groups, if you will. However, these groups need enough resources to do the work.

It has to be integrated, too, of course. Earlier, you were very interested in self-testing. I'd like to remind you that, in Quebec, there wouldn't be free self-testing if it weren't for the federal program. It would be a good idea, then, to support it to foster easy access.

With regard to preventive treatments such as PrEP, there's a deductible, so they should be free, as is the case for other STBBIs. For those, free self-testing is available.

[*English*]

The Chair: Thank you very much. We're almost at the three-minute mark.

With that, on behalf of the committee members, I would like to thank the witnesses for the valuable information they brought.

Our next meeting will be on Monday, November 16. It's on diagnostic imaging capacity.

Is it the will of the committee to adjourn the meeting?

Some hon. members: Agreed.

The Chair: The meeting is adjourned.

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