Interagency Coalition on AIDS and Development

Coalition interagence sida et développement

Global AIDS Monitoring Report (GAM): Perspectives from Canadian Civil Society

MARCH 2021

Introduction

Every year, Canada, along with other signatories of the *2016 United Nations Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030*, reports on its progress towards meeting the commitments.

The Interagency Coalition on AIDS and Development (ICAD) was contracted by the Public Health Agency of Canada (PHAC) to solicit feedback from Canadian civil society organizations about the status of, and response to, Canada's HIV epidemic in the past two years to inform Canada's submission of the 2020 Global AIDS Monitoring Report (GAM) to the United Nations Joint Programme on HIV and AIDS (UNAIDS).

The GAM is the framework and mechanism though which countries submit reports on progress towards the commitments in the *2016 United Nations Political Declaration on Ending AIDS*, adopted at the United Nations General Assembly High-Level Meeting on AIDS in June 2016.

The community sector holds much of the critical data and information to a country's response to HIV. The civil society and community sectors understand the complexity of context, the needs and challenges that are faced by marginalized, most at-risk and key populations, and are most directly affected by rapidly evolving issues such as the COVID-19 pandemic. With support and buy-in from community and civil society, through the GAM reporting process, nations can continue to fight and strive for the needs of the 10-10-10 that are left behind in meeting the target goals of the UNAIDS 90-90-90 global strategy. Community groups can bring to the table relevant and updated information that will present a more realistic, nuanced, real-time picture of the epidemic in all its diversity and complexity.

Methodology and Engagement of Canadian Civil Society

ICAD reached out to a broad cross-section of civil society leaders to invite them to participate on a Steering Committee. A Steering Committee of four members, representing organizations in Montreal, Winnipeg and Edmonton was formed. The Steering Committee provided valuable oversight and guidance to the survey development, circulation, analysis and reporting.

In preparation for the launch of the survey, ICAD hosted a webinar, which highlighted the significance of the Global AIDS Monitoring Report, linking it to Canada's commitments under the *2016 United Nations Political Declaration on Ending AIDS*. The webinar provided participants with an opportunity to ask questions of clarification, gain awareness and begin to engage with the reporting process. It also provided an opportunity to review the standard GAM survey questions, while giving a rationale as to why these types of questions have been included. The webinar was posted to YouTube so that other members of civil society could access the information. A second webinar will be held to present the final report. Webinar participants and Steering Committee members identified nine questions – beyond the standard GAM survey questions – that would be useful to collect in order to better reflect the HIV-related realities and priorities of Canadian civil society.

An online survey was set up that included the UNAIDS NCPI Part B question set as well as the nine supplemental questions that had been identified through consultation with civil society. A parallel survey was set up in French and the two survey links were circulated widely through ICAD and Steering Committee member networks. In addition, ICAD conducted targeted outreach to help ensure responses

from a wide range of organizations representing diverse key populations. There was a one-and-a-half-week window for the completion of the survey.

The nine supplemental questions are included as a separate section in this report; however, they were interspersed throughout the survey in the most appropriate sections. In addition to the nine supplemental questions, ICAD collected organization information at the beginning of the survey, included a space for comments at the end of each section, and invited respondents to share contact information at the end of the survey if they would like. At the beginning of each section, the UNAIDS fast-track target was listed and UNAIDS definitions were provided as necessary (see Appendix A) and respondents were reminded that they could skip as many questions as they would like.

We received a total of 26 surveys responses (22 English, 4 French) where respondents answered at least one question. Although this was a lower than anticipated response rate, the responses received were of high quality. Notably, the supplemental questions received the most extensive responses indicating that there is significant value added in including context-specific questions, particularly as they relate to key populations.

Limitations

There are several limitations to the survey that should be considered in interpreting the results.

1) The timeframe for survey responses was short (less that two weeks) and came at the end of the Canadian fiscal year (March 31), when organizations find their capacity stretched. This timing was compounded by the survey coinciding with the end of a year of COVID-19 during which organizations faced additional capacity challenges, competing priorities, and staff burnout.

2) The survey is very long and even though there were reminders that respondents did not need to respond to questions that did not fit within their scope of work or expertise, the length of the survey may have been a deterrent.

3) Responses have been left as they were written, and may differ from what is recognized as factual from a policy perspective. There are several possible reasons for these discrepancies:
   a) There is often a discrepancy between what is written in policy and what is experienced at an organizational and/or community level. The universal implementation and consistent application of policy does not necessarily follow from official policies.
   b) There are gaps in knowledge around certain policy issues and these gaps point to areas for education and awareness raising.
   c) There are jurisdictional challenges in responding to the questions. Realities vary across provinces and territories, particularly due to the jurisdictional arrangement of Canada's health care system. Canada's federalism is characterized by a division of powers between the orders of government as defined in the Constitution. Provincial governments are responsible for health provision and therefore while policy may be legislated federally, implementation may differ provincially. While questions frequently referred to "in your country", ICAD instructed respondents to respond based on their own jurisdiction.

d) Some respondents may have responded to questions outside their areas of expertise; however, we did seek to minimize this limitation by making all questions optional and providing frequent reminders to only respond to questions within respondents' scope of knowledge.

Acknowledgements

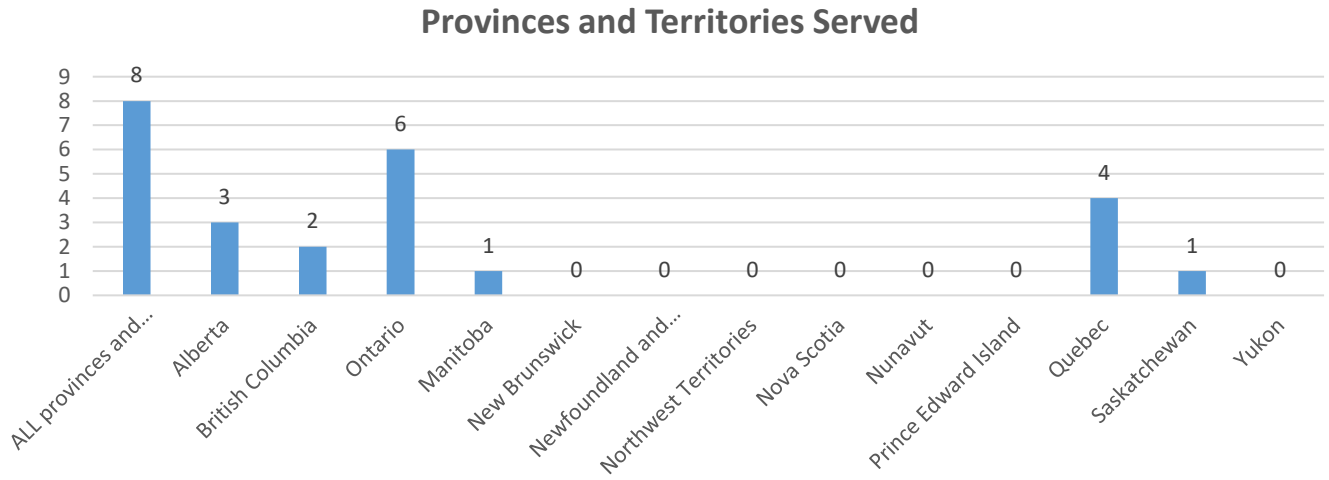
ICAD is grateful to all of those who contributed to the process. We extend a special thanks to:

- Members of the Steering Committee:
  - Ken Monteith, Executive Director, COCQ-SIDA;
  - MaryStella Anidi, Canadian Center for Global Studies
  - Dr. Sunday Olukoju, President, Canadian Center for Global Studies
  - Catherine Broomfield, Executive Director, HIV Edmonton;
- Participants in the introductory webinar;
- San Patten, San Patten and Associates, Inc.;
- And all of those who shared their time, knowledge and experience to complete the survey.

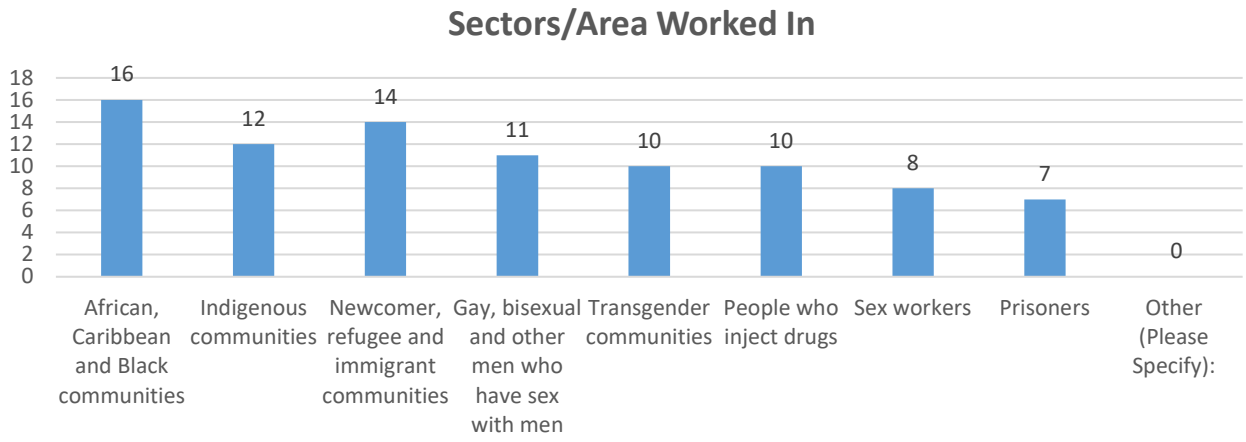
Organizational Information

Participating organizations included a balanced number of national, regional and local organizations, with regional and local respondents from across six provinces. Participating organizations cover a wide range of sectors and communities represented and served, helping to capture an accurate snapshot of the HIV response across Canada.

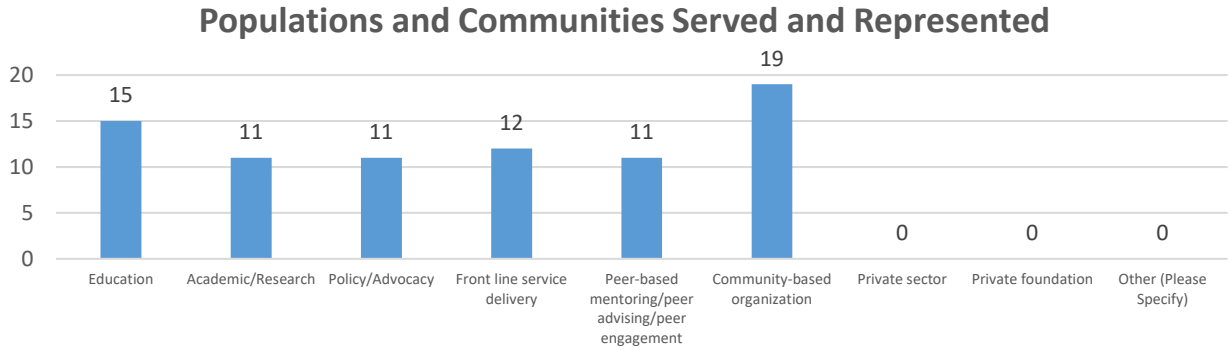
Note that not all respondents answered each question, so the total numbers vary.



While there were not respondents working specifically in every province and territory, eight respondents work across all provinces and territories.



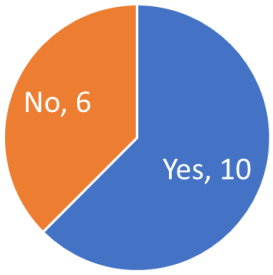
Respondents represented organizations working with a wide variety of key populations. Many respondents work with multiple communities.



All organizations represented were public sector or non-profit and community-based organizations. There were no respondents representing the private sector or foundations.

UNAIDS Fast-Track Commitment #1: Ensure that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020.

1. Does your country have any forms of mandatory (or compulsory) HIV testing that are provided for or carried out? If Yes, please explain.



Two respondents indicated that some provinces have opt-out HIV testing for pregnant women.

Eight of the ten respondents that answered yes explained that the Immigration Medical Examination (IME) includes an HIV test. There were different understandings of the scope of the IME within these responses. One respondent specified that the IME applies to migrants 15 years and older, and two respondents specifically indicated that the process applies to refugees, and then refugees have no power to refuse the test.

Two respondents elaborated further on the requirement for HIV testing:

> *"Unfortunately, drawing from research (i.e., dela Cruz et al.), experiences of Black African Caribbean communities indicate that no efforts are in place to facilitate access and/or continuation of HIV care pre-migration and for some of those who are already living in Canada. Actions (i.e., IME, non referral for care, or supporting access to HIV/health care) deviate from human rights in a developed nation like Canada which is renowned for its human rights foot print."*

> *"As a result of policy changes a couple of years ago, resulting from years of advocacy by community organizations, it is no longer the case that an HIV+ result will likely exclude you from immigrating, because the threshold for what is considered to constitute "excessive demand" on publicly-funded health or social services has been increased; in most circumstances, a person who otherwise qualifies for immigration would now not be declared "medically inadmissible". But the test is still mandatory as a condition of the immigration process."*

2. Where is viral load testing available in your country?

Available at specialized centres only	Available at antiretroviral therapy facilities, either on-site or by referral
7	5

Two respondents also indicated that viral load testing is available at:

- Walk in testing clinics like Life Labs
- HIV clinics located within specific hospitals and Public Health Units

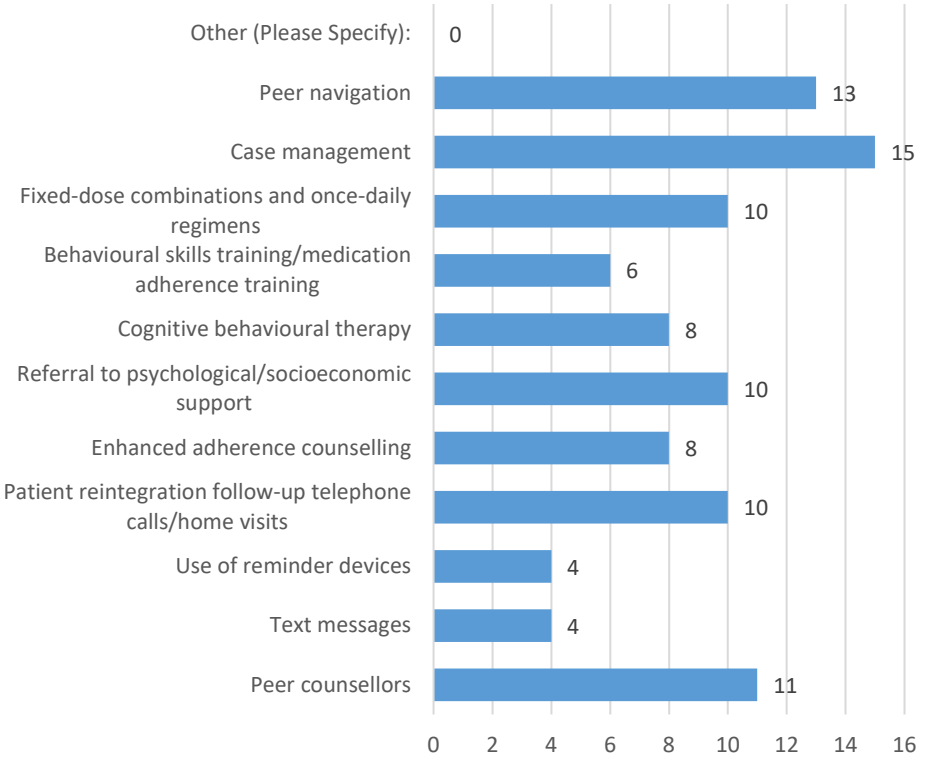
3. Are any of the following retention support services available in your country (please select all that apply)?

Community-based interventions (e.g., patient advocates, treatment, and peer support interventions providing adherence and psychosocial	Adherence clubs and peer support (e.g., peer support, distribution of antiretroviral medicines and assessment by nonclinical or lay providers)
15	3

One respondent added primary healthcare settings such as community health centres to this list.

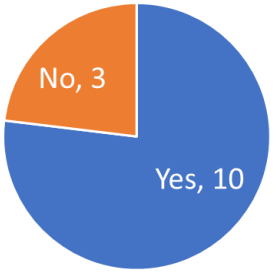
Other responses (n=3) indicated that peer support in Canada is low relative to other countries, and that Federal funding is primarily invested in HIV prevention, which leads to limitation in support services.

4. Are any of the following adherence support services available in your country (please select all that apply)?



This question elicited a wide range of responses, which is likely based on differences across jurisdictions as well as between organizations. One respondent highlighted that there are fewer of these supports than needed, especially in rural areas.

5. Are migrants able to access HIV services (testing, antiretroviral medicines and care)?*



Please provide any additional explanation or comments related to this section:

Two respondents referred to the impact of COVID-19.

"Covid19 has made bare the inequalities faced by people living with HIV, on disability, and of low socioeconomic status."

One respondent indicated that the approval and implementation of self-tests could assist in supporting more access to HIV-related services.

UNAIDS Fast-Track Commitment #2: Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018.

6. How many health facilities in the country are providing services for preventing mother-to-child transmission (PMTCT) of HIV?

Three respondents indicated that these services are widely available (most hospitals/all that provide care to pregnant women). One outlier responded "two".

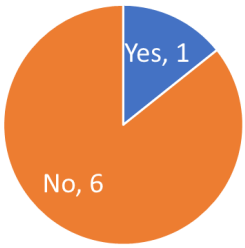
Three others responded "don't know". The low number of responses to this question indicates that this is an area where there is limited knowledge, and it would be difficult for most people to know beyond their own local health authority (given that health is a provincial jurisdiction and health services are often organized by regions within provinces).

7. How many of the health facilities providing PMTCT services have community accountability mechanisms in place?*

This question similarly had few responses. Five responded "don't know", one responded "ten" and one responded "Not aware of a community accountability mechanism in place."

If community accountability mechanisms do exist in these facilities, they are not widely known.

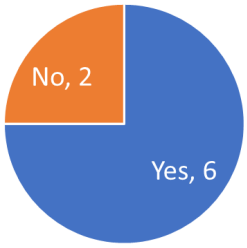
8. Has a meeting been held at the national level to review PMTCT progress in the past 12 months?



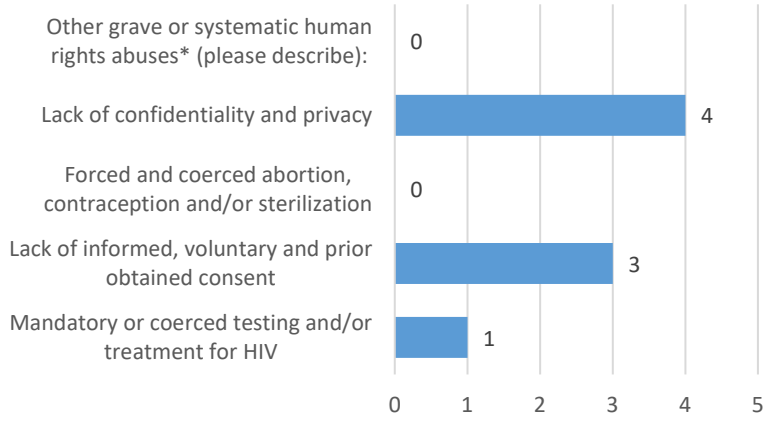
If yes,

	Yes	No
a) Were community and civil society represented at the national review meeting?	0	3
b) Were women living with HIV represented at the national review meeting?	1	3
c) Was the opportunity provided for community and civil society to provide comments?	0	3
d) Was analysis by community and civil society provided in a systematic manner?	0	3
e) Was analysis provided by community and civil society documented and disseminated following the meeting?	0	3

9. Do women living with HIV in your country participate in developing national policies, guidelines and strategies relating to PMTCT?*

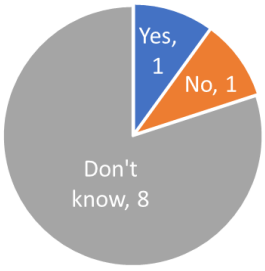


10. In the context of PMTCT programmes in your country, are there reports or is there documentation of any of the following (please select all that apply)?



One respondent indicated that Black women are more likely to be tested without consent. While the number of responses is low, there is an indication that there is need for improvement in the areas of confidentiality, privacy and informed consent.

10.1 If there are reports of any of these situations in your country, is the government carrying out due diligence in responding to them?



Please provide any additional explanation or comments related to this section:

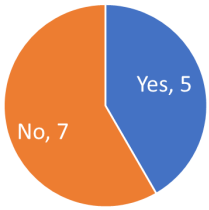
One respondent highlighted that there is work being done to disseminate the Updated Canadian HIV Pregnancy and Parenting Guidelines

A second respondent indicated that COCQ/SIDA's legal services are closely following and challenging human rights violations of people living with HIV.

UNAIDS Fast Track Commitment #3: Ensure access to combination prevention options, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people, especially young women and adolescent girls in high-prevalence countries and key populations—gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners.

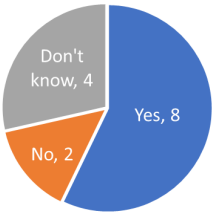
LAW ENFORCEMENT

11. Can possession of a needle/syringe without a prescription be used as evidence of drug use or cause for arrest in your country?

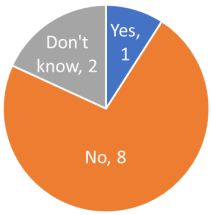


12. Have transgender people in your country been arrested or prosecuted for manifestations of their gender identity in the past three years?

13. Have sex workers in your country been arrested or prosecuted in relation to selling sex in the past three years?



14. Have people in your country been arrested or prosecuted for consensual same-sex sexual acts in the past three years?



15. Have people in your country been arrested or prosecuted for using drugs in the past three years?

Notably, this question has one of the highest response rates and a unanimous response among those that answered, indicating this as an area of concern for Canadian civil society.

Please provide any additional explanation or comments related to this section:

- There needs to be more of a national discussion

LEGAL PROTECTIONS FOR KEY POPULATIONS

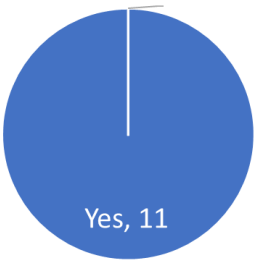
16. Have any constitutional prohibitions of discrimination been interpreted to include gender identity by any of the following?

	Yes	No
Court	**8**	**1**
Government policy	**7**	**2**

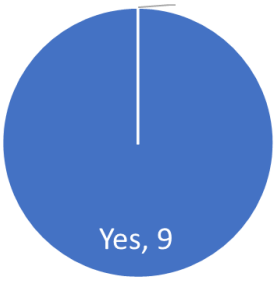
16.1 If yes to any of the above, have these constitutional prohibitions of discrimination been successfully used to protect or advocate for transgender people's rights in the last two years in any of the following (select all that apply)?

Courts	Advocacy with government for law or policy reform	Other (Please Specify):
3	5	0

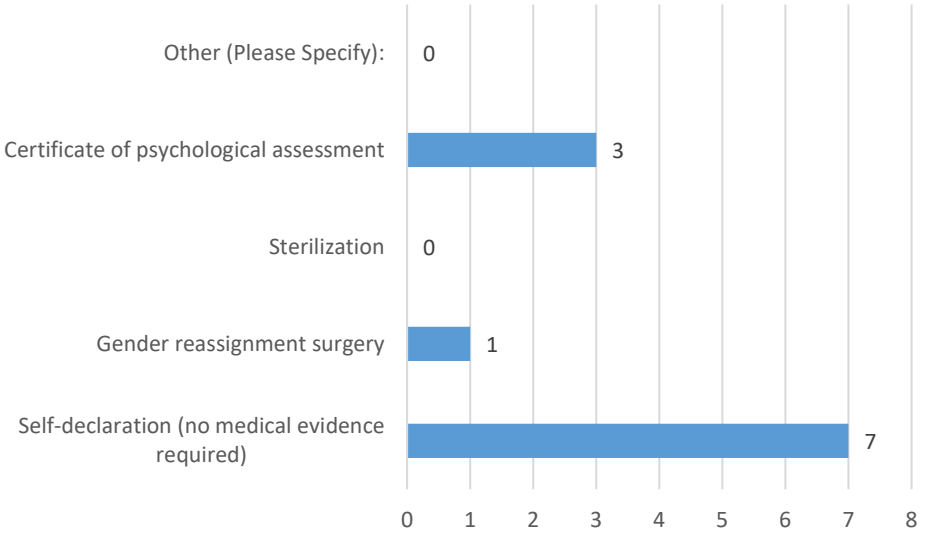
17. Does your country have legal gender recognition laws or policies that enable the legal change of gender?



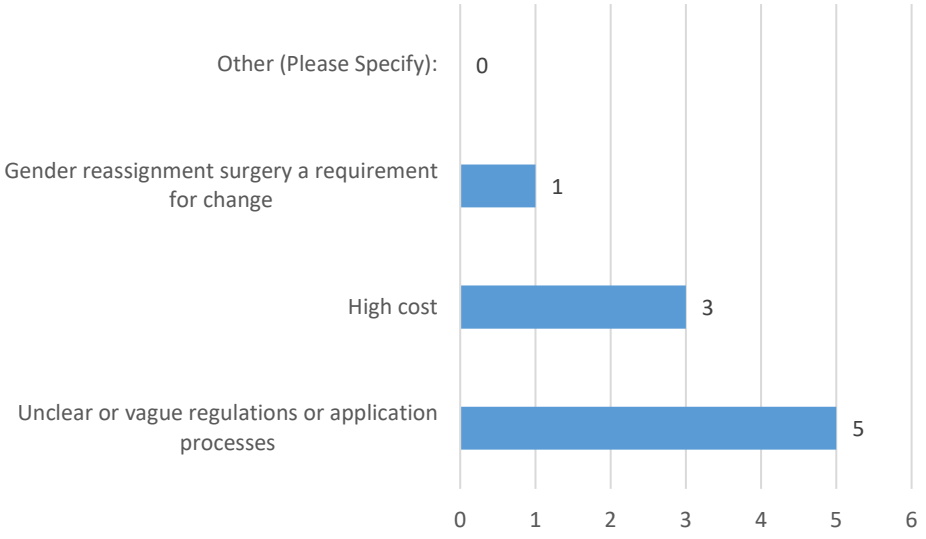
17.1 If yes, are genders other than male and female legally recognized?



17.2 If yes to question 17, are any of the following required in order to change gender (check all that apply)?

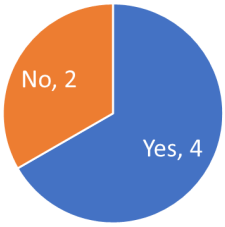


17.3 If a change of gender marker is legally recognized, do any of the following barriers limit its application (check all that apply)?



18. Is it legally possible to change one's name to that of another gender on any of the following (please select all that apply)?

18.1 If yes to any above, is a Gender Recognition Certificate or some other state-mandated certificate required for these changes?



19. Have any constitutional prohibitions of discrimination been interpreted to include sex work by any of the following?

	Yes	No
Courts	7	2
Government policy	7	2

19.1 If yes to any, have these constitutional prohibitions of discrimination been successfully used to protect or advocate for sex workers' rights in the last two years in any of the following (select all that apply)?

Courts	Advocacy with government for law or policy reform	Other (Please Specify):
1	2	0

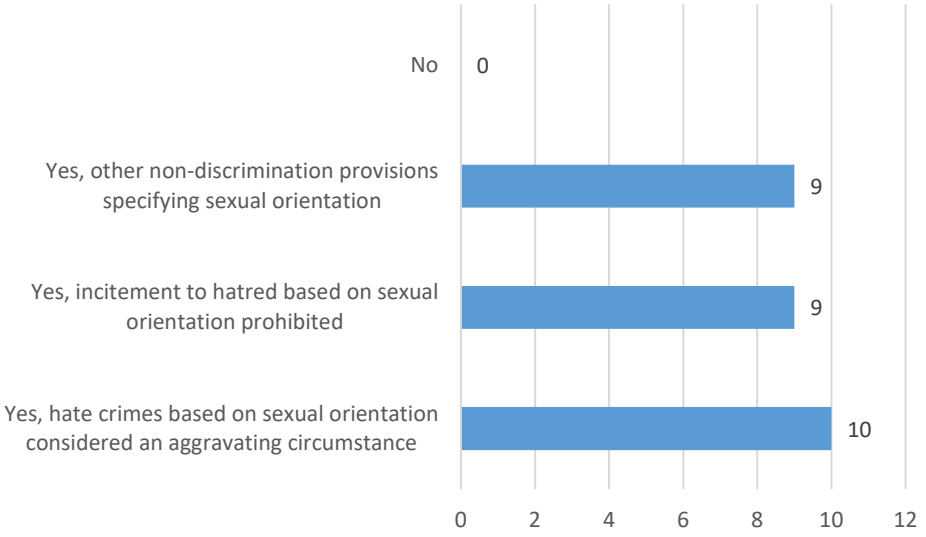
One respondent indicated that:

> *"Current laws on sex work, introduced by the Conservative government in 2014, make it illegal to purchase or advertise sexual services and illegal to live on the material benefits from sex work. Although it is legal to sell sexual services, in some cases it is illegal to solicit in public areas."*

20. Have any constitutional prohibitions of discrimination been interpreted to include sexual orientation by any of the following?

	Yes	No
Courts	7	2
Government policy	7	2

Does your country have any other laws or other provisions specifying protections based on grounds of sexual orientation (please select all that apply)?

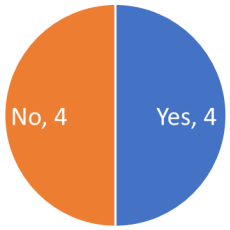


20.1 If yes to any of the above, have these constitutional prohibitions of discrimination been successfully used to protect or advocate for the rights of people on the basis of their sexual orientation in the last two years in any of the following?

Courts	Advocacy with government for law or policy reform	Other (Please Specify):
6	7	1

Other: Human Rights Commission

21. Does your country have any specific antidiscrimination laws or other protective provisions that apply to people who use drugs?

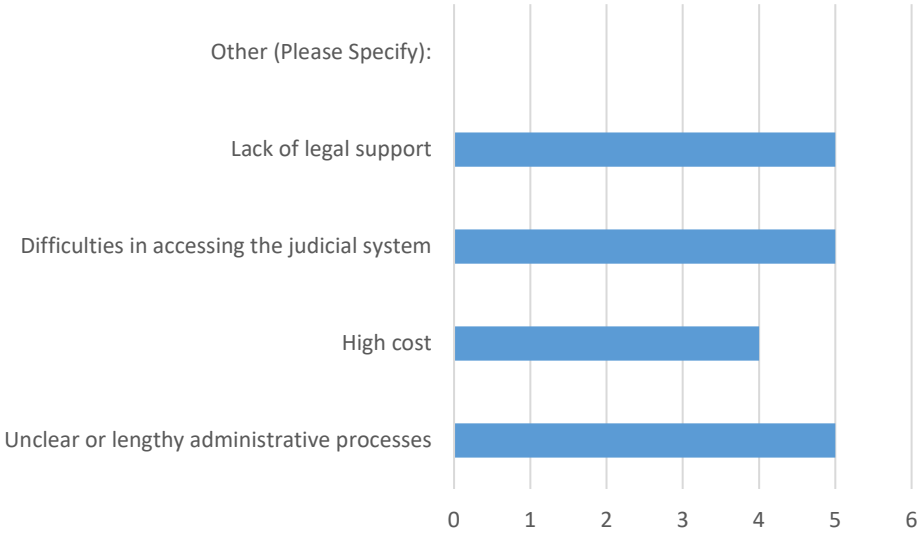


21.1 If yes, have these protective provisions been successfully used to protect or advocate for the rights of people who use drugs in the last two years in any of the following?

Courts	Advocacy with government for law or policy reform	Other (Please Specify):
1	4	0

Other: Good Samaritan/No harm if calling for medical assistance, however, anecdotal information that this is not always protective.

22. Are there any of the following barriers in your country to making use of constitutional or other legislative protections:



Please provide any additional explanation or comments related to this section:

- Funding for legal aid and for non-profit organizations that can support people bringing cases forward has been cut back

HIV PREVENTION SERVICES FOR PEOPLE WHO INJECT DRUGS

23. Are needle and syringe programmes operational in your country?

Yes	No, not at all	No, but needles and syringes can be legally purchased in pharmacies without a prescription
12	1	0

24. Is naloxone (used to reverse opioid overdoses) available through community distribution in your country?

25. Are opioid substitution therapy (OST) programmes operational in your country?

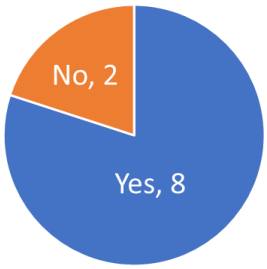
Please provide any additional explanation or comments related to this section:

- Methadone programs are available
- There are also supervised consumption sites

HIV PREVENTION SERVICES IN PRISONS

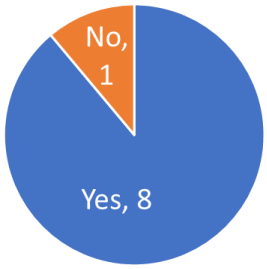
26. Are needle and syringe programmes operational in prisons in your country?

Two organizations responded no (one national and one Ontario-based), indicating that these programs are inconsistently implemented.



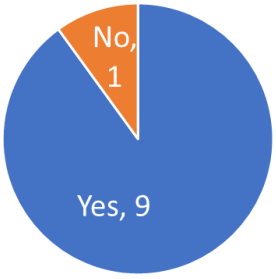
27. Are opioid substitution therapy (OST) programmes operational in prisons in your country?

Again, one national organization responded no, indicating inconsistent implementation.

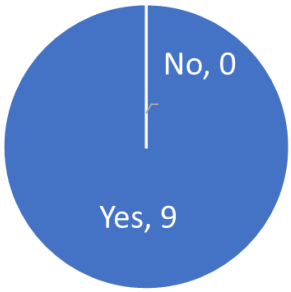


28. Are condoms and lubricants available to prisoners in your country?

One Ontario-based organization responded no, indicating inconsistent implementation.



29. Is antiretroviral therapy available to all prisoners living with HIV in your country?



30. Are HIV tests in prisons in your country:

	YES	NO
a) Carried out with the informed consent of prisoners?	6	1
b) Systematically offered at entry and/or exit?	3	1
c) Free of charge?	7	0
d) Confidential?	2	3
e) Available at any time during detention?	5	0
f) Accompanied by relevant and accessible information?	5	0
g) Accompanied by confidential pre- and post-test counselling?	4	2
h) Equally accessible to all prisoners?	4	2

i) If no to h), which prisoners do not have equal access (please specify):

"HIV services can be denied as a form of punishment."

"Although the above are said to be available, this is inconsistently applied and there are many barriers to their access by prisoners."

31. Is hepatitis C treatment (using direct-acting antivirals) available in prisons in your country?

Please provide any additional explanation or comments related to this section:

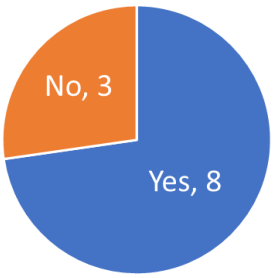
Comments in this section help to explain the range in responses to the above questions:

> *"Stated yes for Q 26-28 however these are not consistently available and there are barriers and discrimination/stigma around"*
>
> *"Not offered through provincial facilities"*
>
> *"Prison settings vary across jurisdictions and services offered to prisoners also vary. Federal prisons are better resourced to meet the HIV prevention, treatment and support care needs of prisoners. While in provincial and territorial prisons, sentences vary from 4 weeks to 6 months. If one is sentenced for 4 weeks, it would be difficult to complete treatment for HEP C which takes 8 weeks."*

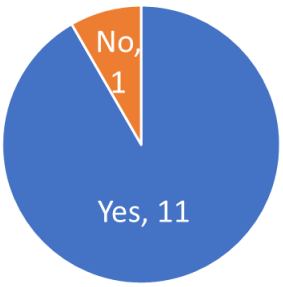
PARTICIPATION

32. Do men who have sex with men participate in developing national policies, guidelines and/or strategies relating to their health in your country?*

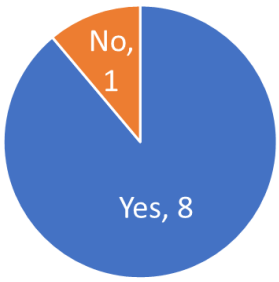
33. Do sex workers participate in developing national policies, guidelines and strategies relating to their health in your country?*



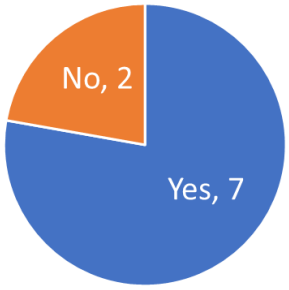
34. Do people who inject drugs participate in developing national policies, guidelines and strategies relating to their health in your country?*



35. Do transgender people participate in developing national policies, guidelines and strategies relating to their health in your country?*



36. Do former and/or current prisoners participate in developing national policies, guidelines and strategies relating to their health in your country?*

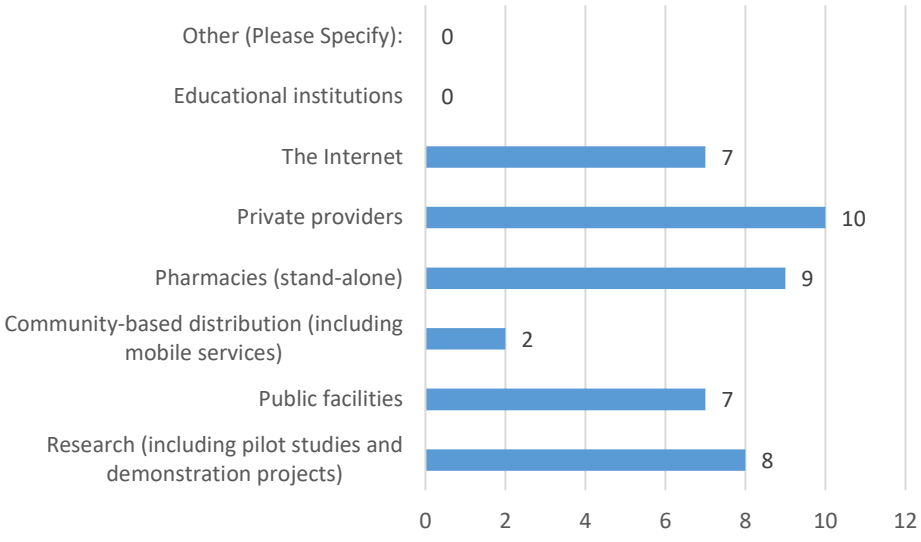


Please provide any additional explanation or comments related to this section:

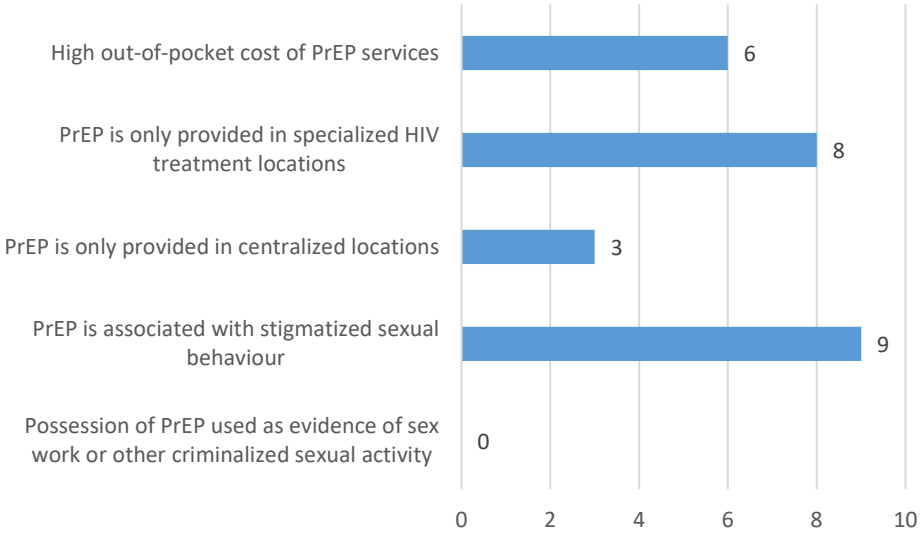
No additional comments provided.

PRE-EXPOSURE PROPHYLAXIS (PrEP)

37. Is pre-exposure prophylaxis (PrEP) medicine available through any of the following in your country (please select all that apply)?



38. Do any of the following barriers limit access to PrEP in your country (please select all that apply):



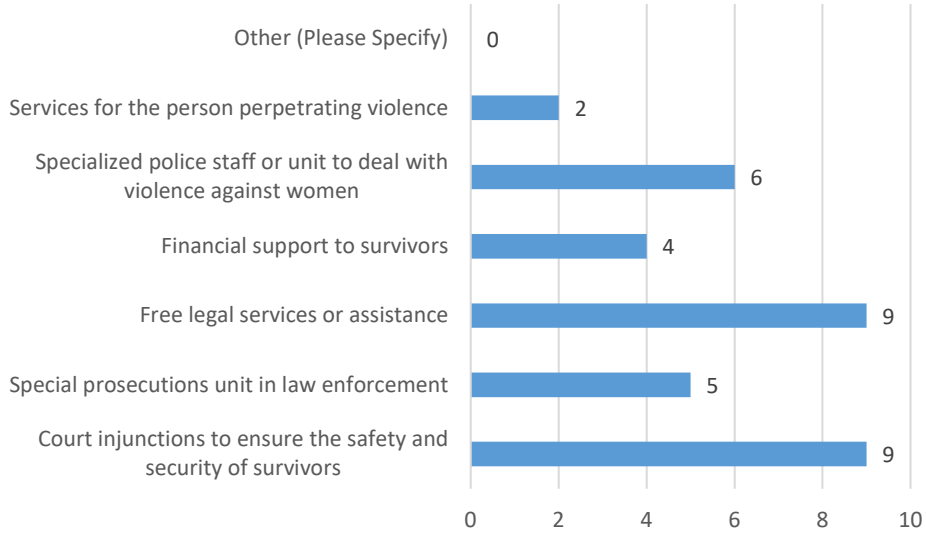
Please provide any additional explanation or comments related to this section:

Respondents highlighted that there is inconsistent access to and uptake of PrEP, and indicated that men who have sex with men, particularly gay white men, have benefitted more than other populations.

Repondents indicated that if people are ineligible for PrEP coverage, they must find other sources/options and then cost may be a factor. Some jurisdictional drug plans provide coverage, though deductibles are often required. Most private drug plans include PrEP drugs as treatment, but not as PrEP.

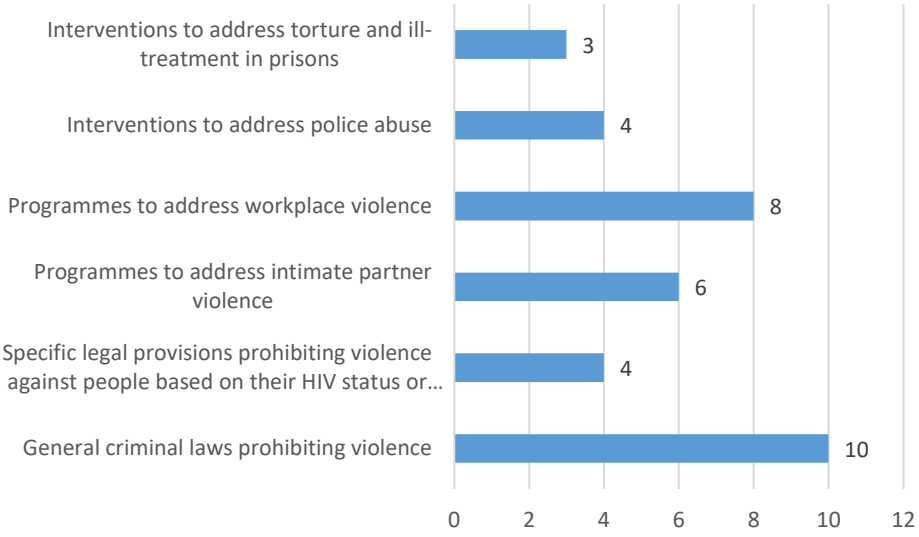
UNAIDS Fast-Track Commitment #4: Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020.

39. Does legislation include any of the following provisions related to violence against women in your country (please select all that apply)?



Comments: MMIWG (Missing and Murdered Indigenous Women and Girls) Inquiry

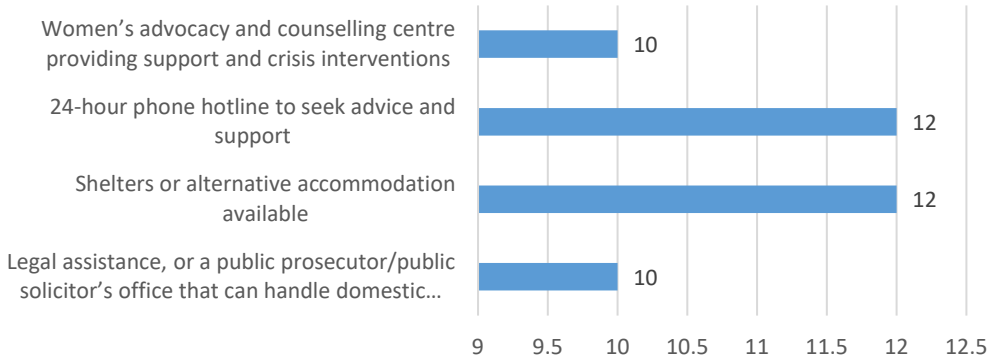
40. Does your country have any of the following to protect key populations and people living with HIV from violence (please select all that apply)?



41. Does your country have service delivery points that provide the following appropriate medical and psychological care and support for women and men who have been raped and experienced incest in accordance with the recommendations of the 2013 WHO guidelines Responding to intimate partner violence and sexual violence against women:

	Yes	No
a) First-line support, or what is known as psychological first aid	12	0
b) Emergency contraception for women who seek services	10	0
c) Safe abortion if a woman becomes pregnant as a result of rape in accordance with national law	12	0
d) Post-exposure prophylaxis for sexually transmitted infections and HIV (within 72 hours of sexual assault) as needed	12	0

42. Does your country have the following services in place for women who have experienced violence (please select all that apply)?



43. Does your country have laws and/or policies in place requiring health-care settings (specifically or as part of broader laws/policies for service providers) to provide timely and quality health care regardless of gender, nationality, age, disability, ethnic origin, sexual orientation, religion, language, socioeconomic status, HIV or other health status, or because of selling sex, using drugs, living in prison or any other grounds?

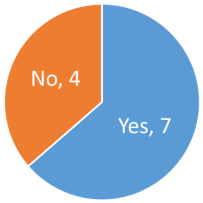
Yes, policies exist but are not consistently implemented	Yes, policies exist and are consistently implemented	No, policies do not exist
11	0	0

Please provide any additional explanation or comments related to this section:

- PrEP and PEP are provided in a spotty way across various jurisdictions. For Q43, there are lots of incidents of people who use drugs, people with mental illness, and Indigenous people receiving discriminatory treatment or denied care in health care settings.
- Each province and territory have their own guidelines, some are better and some are worse
- Option A description ("Yes, policies exist but are not consistently implemented") would apply to many of the previous questions.

UNAIDS Fast-Track Commitment #5: Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020, in order to reduce the number of new HIV infections among adolescent girls and young women to below 100 000 per year.

44. Do young people (15–24 years old) participate in developing national policies, guidelines and strategies relating to their health in your country?*



44.1 If yes, do young people participate in any of the following decision-making spaces in the national HIV response, where they exist?*

	Yes	No	Doesn't Exist
a) Technical teams for the development, review and update of national AIDS strategies and plans	3	2	2
b) Technical teams for the development or review of programmes that relate to young people's access to HIV testing, treatment, care and support services	4	1	1
c) National AIDS Coordinating Authority or equivalent, with a broad-based multi-sector mandate	4	0	4
d) Global Fund Country Coordinating Mechanism	1	1	2
e) Civil society coordination spaces of populations most affected by HIV	6	1	0
f) Community advisory body for hospitals, clinics and/or research projects	6	1	0

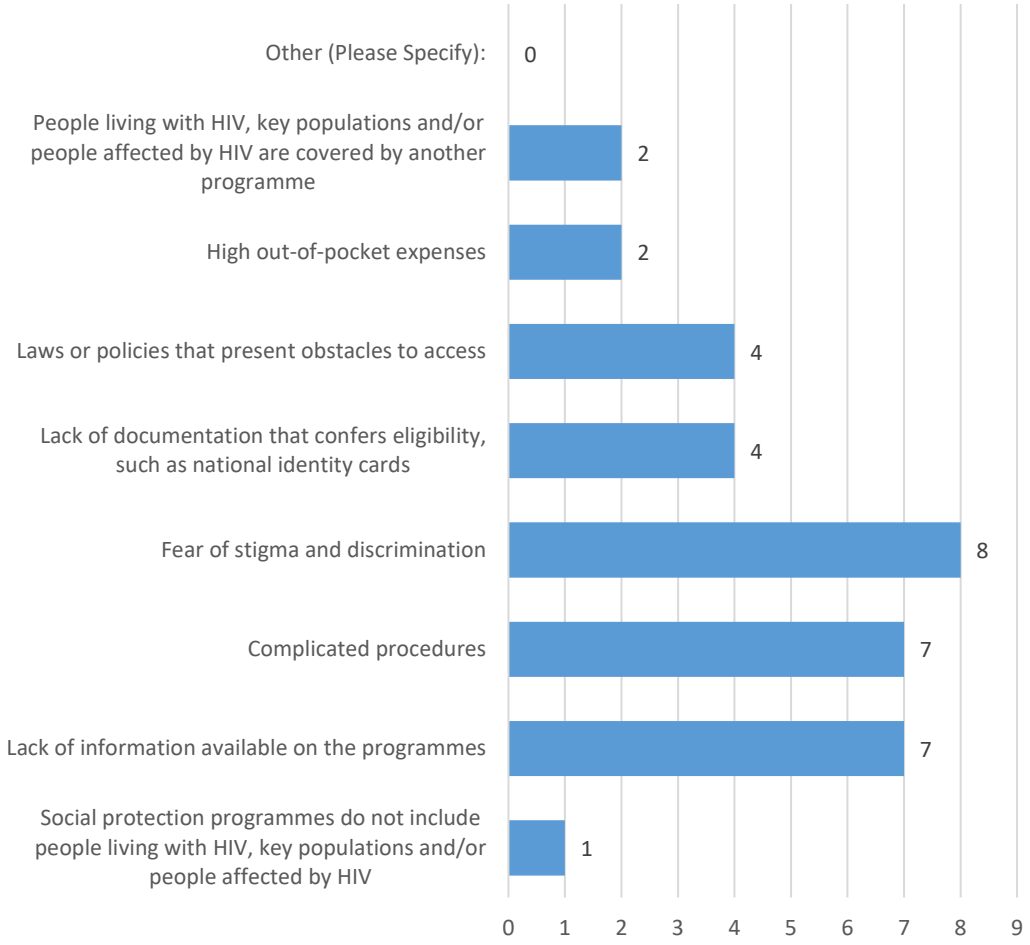
Any "yes" answers above are not universal...youth are engaged inconsistently

Please provide any additional explanation or comments related to this section:

No comments provided

UNAIDS Fast-Track Commitment #6: Ensure that 75% of people living with, at risk of and affected by HIV benefit from HIV-sensitive social protection by 2020.

45. Do any of the following barriers limit access to social protection programmes in your country (please select all that apply)?*



Other:

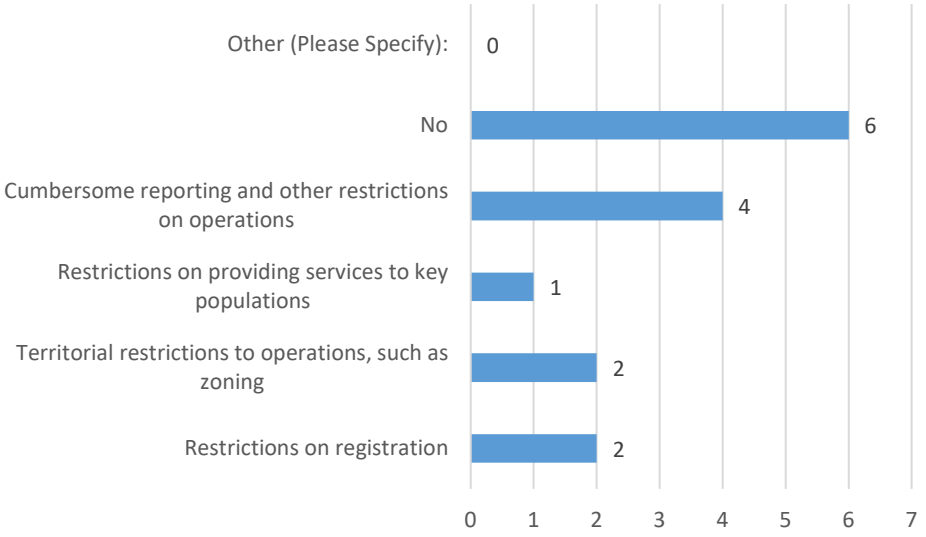
- Bureaucratic and administrative barriers for people to access the supports that they are entitled to
- Each province and territory is different

Please provide any additional explanation or comments related to this section:

No comments provided

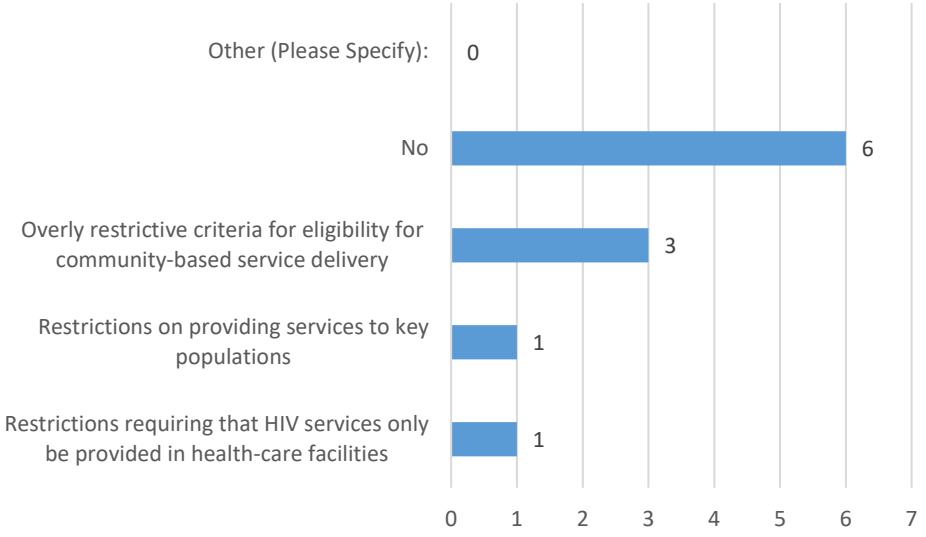
UNAIDS Fast-Track Commitment #7: Ensure that at least 30% of all service delivery is community-led by 2020.

46. Does your country have restrictions to the registration and operation of civil society and community-based organizations that affect HIV service delivery (please select all that apply)?



The Public Health Agency of Canada is the main funder of community-based organizations, but is extremely cumbersome and burdensome in terms of application and reporting processes.

47. Does your country have other regulatory barriers to community-led service delivery (please select all that apply)?



If "Overly restrictive criteria for eligibility for community-based service delivery," please describe:

- Lots of paperwork, inadequate funding available given the need, onerous reporting requirements
- We tend to see the trends on the street before it impacts the epi data and the Government responds years later

48. Does your country have laws, policies or regulations that hinder access to funding for work by civil society organizations and community-based organizations for HIV-related work (please select all that apply)?

Lack of social contracting or other mechanisms allowing for funding of community-led service delivery to be funded from domestic funding	"Foreign agents" or other restrictions to accessing funding from international donors	No	Other (Please describe):
5	0	6	1

Other: Inadequate funds available

Please provide any additional explanation or comments related to this section:

No comments provided

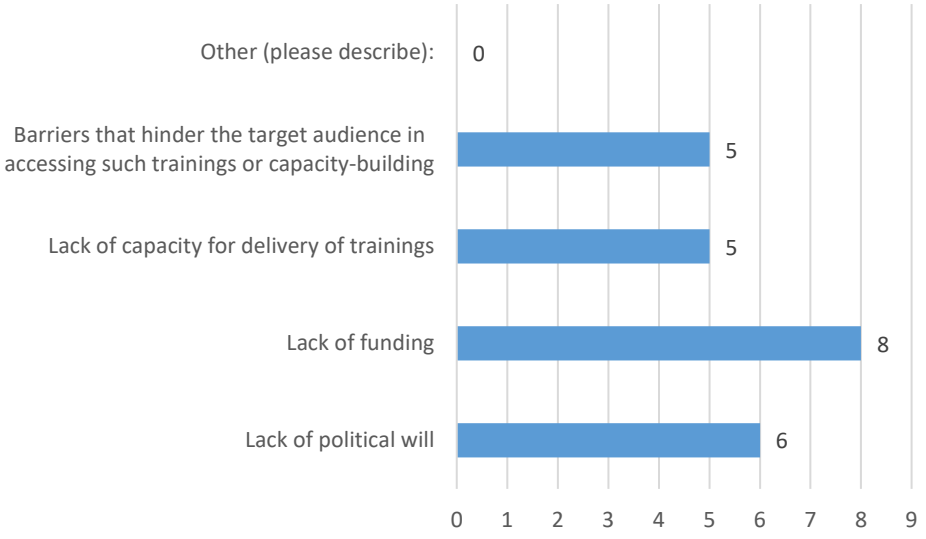
UNAIDS Fast-Track Commitment #9: Empower people living with, at risk of and affected by HIV to know their rights and to access justice and legal services to prevent and challenge violations of human rights.

RIGHTS LITERACY

49. In the past two years have there been training and/or capacity-building programmes for people living with HIV and key populations to educate them and raise awareness about their rights (in the context of HIV) in your country?

Yes, at scale at the national level	Yes, at scale at the sub-national level (in at least one province/region/district)	Yes, one-off activities	Yes, at a small scale	No
3	3	2	0	0

50. Are there any of the following barriers to providing training and/or capacity-building for people living with HIV and key populations to educate them and raise their awareness about their rights (please select all that apply)?



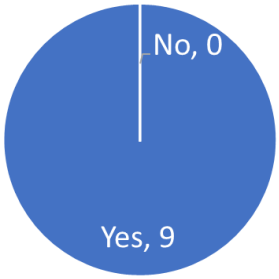
Other:

- More funding for national and local groups to train people living with HIV and build their capacity to know their rights
- Lacking for Indigenous and immigrant populations
- Good programs exist but the need for these outstrips the capacity to deliver widely

Please provide any additional explanation or comments related to this section:
No comments provided

ACCOUNTABILITY MECHANISMS

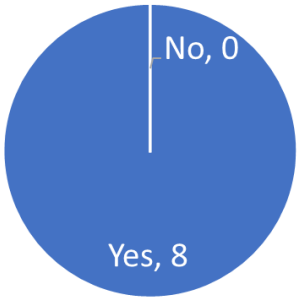
51. Are mechanisms established by the government in place to address cases individual complaints of HIV-related discrimination (based on perceived HIV status and/or belonging to any key population), such as (but not limited to) a national human rights institution, ombudsperson, tribunal or commission?



If yes, please describe:

- However, there is only one HIV legal aid clinic in the country specifically for HIV issues (in Ontario).
- Human Rights Commission
- May be funded by government but not established by government -eg. Legal AIDS Network, REALIZE
- Ce n'est pas un service spécifique au VIH mais la discrétion être simplement illégale.
- Commission des droits de la personne et des enfants

52. Are there mechanisms established by the community and/or nongovernmental organizations to record and address individual complaints of HIV-related discrimination (based on perceived HIV status and/or belonging to any key population)? Examples of such mechanisms include traditional cultural structures or nongovernmental organizations trained to address claims through mediation.



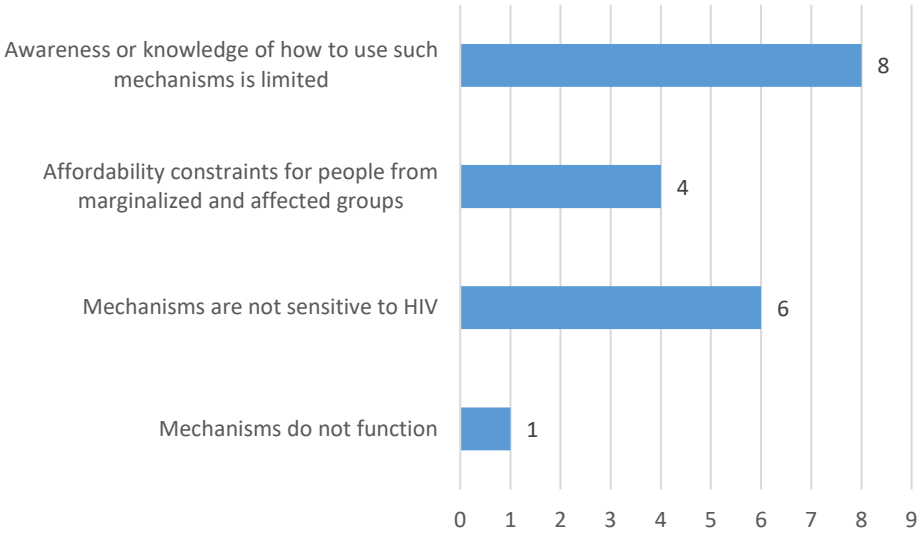
If yes, please describe:

- Inadequate and not in all jurisdictions
- Within ASOs, yes
- La Coalition des Organismes Communautaires Québecois de Lutte Contre le Sida/ service juridique

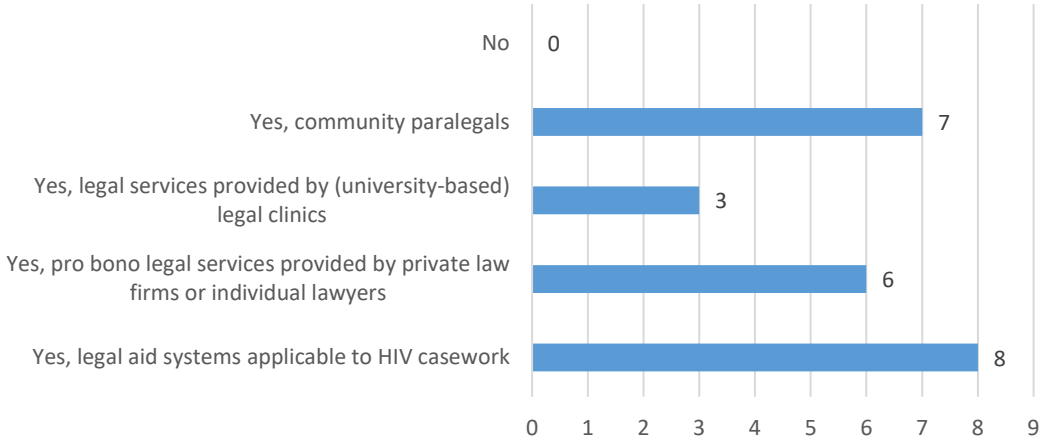
53. Does your country have any of the following accountability mechanisms in relation to discrimination and violations of human rights in health-care settings?

Other: inadequate, not all jurisdictions

54. Does your country have any of the following barriers to accessing accountability mechanisms present (please select all that apply)?



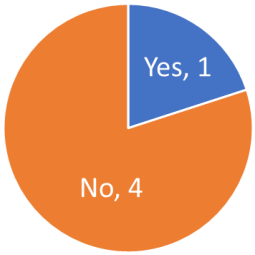
55. Does your country have mechanisms in place for accessing affordable legal services (please select all that apply)?



Yes, other:

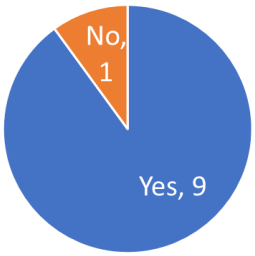
- This varies drastically by jurisdiction, and if there is provincial legal aid funding
- Available, but not in all jurisdictions and the capacity is inadequate to meet the need
- Pro bono over utilized, may not be easy to access

56. Does your country monitor access to justice among key populations or people living with or affected by HIV?



If yes, please describe: (no responses)

57. Do key populations or people living with or affected by HIV face particular barriers in accessing justice in your country?



If yes, please describe:

- Only one national organization and 2-3 local organizations which provide access to justice for PHAs
- Stigma, interpretation of scientific information as it relates to HIV non-disclosure during criminal investigation and discrimination in part due to (legal/systemic) literacy
- Lack of awareness of rights, especially for Indigenous and immigrant populations
- Over criminalized - Canada has more charges and convictions of criminal non-disclosure than anywhere else worldwide
- Stigma and discrimination, varying levels of prosecution, systemic racism
- Stigma and discrimination hinders people from accessing justice
- Manque d'information sur les services disponibles

Supplemental Canada-Specific Questions

The following nine questions were added as supplemental to the standard UNAIDS survey questions, in order to collect data that is more targeted to Canada's context, key populations and prevailing issues. While this data may not be relevant to the Global AIDS Monitoring report submitted by Canada to UNAIDS, civil society representatives identified these questions as being salient for Canada, and hope that the Government of Canada will take note of the priorities identified herein.

Additional Question 1: Canada has endorsed the message that Undetectable equals Untransmittable (U=U). What government policies and/or initiatives have addressed this message? Please describe.

Three respondents indicated that the government initiatives have addressed U=U through the promotion of messages related to the Cascade of Care, public education campaigns (e.g., World AIDS Day) and an anti-stigma campaign (which one respondent described as "limited").

Three other responses indicated that the government response is limited to the provision of funding to promote this messaging and to reinforce the U=U message among organizations' clients, such as through online courses and pamphlets.

Two responses indicated that the work of promoting U=U has been left to HIV organizations, rather than through direct government activity. One respondent wrote:

> *"We expected the Ministry of Health to support this achievement and air it on TVs and radios to encourage people to stay on their meds and even those in hiding to realize that there is hope."*

Two responses referred to the policy impact of U=U, stating that the impact has been limited in relation to criminalization of HIV non-disclosure:

> *"A person living with HIV in Canada still has a legal duty to disclose their HIV status to a sex partner before sex. People living with HIV who incurred criminal sentences are yet to have their sentences commuted."*

> *"Federal Attorney General's directive to Public Prosecution Service (in Dec 2018) instructs that there will no longer be prosecution for alleged HIV non-disclosure to a sexual partner when a person has a suppressed viral load, because the legal test of a "realistic possibility of HIV transmission" is not met. (This directive applies only in the territories, where federal government is responsible for criminal prosecutions; it does not apply in any of the provinces.) The provinces of Ontario and BC both have written prosecutorial policy that there will be no prosecution in such circumstances."*

Additional Question 2: In Commitment 3, UNAIDS refers to "young women and adolescent girls in high prevalence countries and key populations-- gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs, and prisoners".

We have identified the following additional populations that were not named by UNAIDS but are relevant to the Canadian context. Please provide responses where relevant to your expertise. Where these populations overlap/intersect, please respond where you think most appropriate.

Are there any social, legal and/or policy barriers that limit equitable access to the HIV engagement cascade? Please describe.

It is noteworthy that this section elicited the most extensive set of responses overall. The Black Lives Matter and Indigenous Lives Matter movements have likely contributed to a growing awareness and acknowledgement of the impact and experience of racism in HIV-related care among service providers and organizational representatives.

a. For Indigenous people:

Respondents noted that racism, colonialism, distrust of the health care system, HIV-related stigma, and the social determinants of health are barriers to equitable access to the HIV Cascade of Care for Indigenous people. There is inadequate healthcare infrastructure and support for Indigenous peoples, and overrepresentation of Indigenous members in HIV criminalization cases.

Respondents also listed services that lack cultural safety, have inappropriate messaging and lack of information/services in Indigenous languages as barriers. The high cost of services and medications, inequitable health insurance coverage, and lack of available spaces in community-based organizations were also cited.

Multiple respondents noted the challenge of jurisdictional barriers (on reserve vs. off reserve, provincial vs. federal health plans). Respondents indicated that there are scant services in remote communities and that there is a lack of primary care physicians outside of major cities:

> *"For Indigenous people off-reserve, the continuum seems the hardest to attain."*

One respondent cited discriminatory policies that disempower women as a barrier:

> *"Saskatchewan provinces only recently stopped the birth alerts policy that stripped women of their children at birth instead of addressing social gaps that were faced by women of low socioeconomic status."*

One respondent indicated that the Canadian Government has not fully implemented the UN Declaration on the Rights of Indigenous Peoples (UNDRIP).

b. For African, Caribbean and Black (ACB) people:

Respondents overwhelmingly indicated that racism (in healthcare settings and more generally) and HIV-related stigma are barriers to equitable access to health for ACB people, particularly the *"multiple*

dimensions of stigma and discrimination based on race (anti-Black racism), gender, sexual orientation, etc."

Colonization, services with lack of cultural safety, language barriers, and distrust of the health care system were also cited.

Respondents highlighted the significant impacts of the social determinants of health including poverty, unemployment, food and housing insecurity, unemployment/underemployment, and lack of legal status.

Respondents indicated that racialization impacts access to health care:

> *"Many black people and people of colour do not have access to healthcare based on location of the doctors' offices, lack of insurance and lack of technology. Many services are offered online and families can't afford the technology."*

> *"Some end up having fatal outcomes to HIV due to stigma and delaying access to care because of the discrimination they experience in health care settings and/or access to social services is often understated by non-Black people."*

Inaccessible programs and the uneven distribution of funding across the country were also identified as barriers. Two respondents mentioned the overrepresentation of ACB members in HIV-non-disclosure criminalization cases, as well as more general over-criminalization of ACB people.

c. For other racialized communities:

Responses here echoed those provided in regard to ACB communities: racism, HIV-related stigma, services with lack of cultural safety, language barriers, social determinants of health, distrust of health care system, colonization, distrust of health system, inaccessible programs, and delays in receiving healthcare resulting in preventable hospitalizations. Again, the uneven distribution of funding across the country was cited.

One respondent cited the uneven uptake of PrEP which is *"benefitting mostly only gay white men and not members of racialized communities."*

d. For migrants (documented and undocumented):

As with racialized populations, racism, discrimination, language and cultural barriers, and intersections with other forms of stigma, all impact access to equitable health for migrants.

Migrant workers face a lack of access to health services and refugee claimants are not eligible for many social service supports:

> *"We have so many associate family members of migrant workers who have asked our organization why the government doesn't extend insurance for migrant workers."*

For undocumented migrants, information about HIV is hard to find, there is a fear of seeking treatment and it is difficult to access diagnostics and medications without health insurance.

Access across the country is uneven and each province or territory has its own set of rules. The types of medications that are covered also differ across types of insurance plans.

e. For people living with HIV with disabilities:

People living with HIV with disabilities face a lack of targeted prevention messages and services for people with specific types of disabilities. They face stigma, discrimination and are impacted by inequities in the social determinants of health, including challenges with regard to food, transportation and housing. Racism intersects with the barriers faced by this population.

There are multiple systems across the country to access medication and access is unequal across the country, as well as within provinces (e.g., uneven implementation of the Accessibility for Ontarians with Disabilities Act).

f. For people living with HIV who are aging:

People living with HIV who are aging face HIV-related stigma, including in seniors' residences, and experience intersections with racism, isolation, co-morbidities, challenges associated with COVID-19, ageism, high medication costs, and poverty.

There is a lack of targeted prevention messages/services for people who are aging and a need for specific programming to target aging long-term survivors. Again, experiences and access to services differs across jurisdictions.

g. For people living with HIV and co-morbidities (e.g. hepatitis B and C, tuberculosis):

People living with HIV and co-morbidities experience inequities in the social determinants of health, including poverty, and stigma and discrimination. Isolation and COVID-19 have also impacted this population.

Respondents highlighted the differences across jurisdictions for this population, including the lack of primary care physicians outside of urban centres. In Ontario, hepatitis C services are often provisioned through health centres or hospitals, leaving people who are co-infected with few options to access support services from community-based organizations. Respondents also identified high medication costs as a barrier for people living with HIV and co-morbidities.

h. Other:

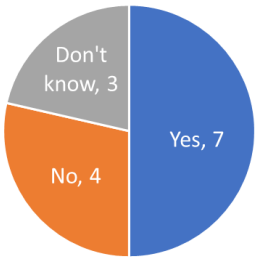
One respondent listed prisoners as a key population, and two respondents highlighted people who use drugs as being heavily impacted by the opioid crisis and by stigmatization. However, both prisoners and people who use drugs are included as a key population in UNAIDS fast track commitment #3 and addressed in the UNAIDS survey.

Youth were also identified as a key population, with poor transition from pediatric to adult care and many young people being lost to care each year.

More broadly, respondents highlighted that stigma and discrimination present barriers to all of the above populations, and that COVID-19 has compounded access, testing and integration into the Cascade of Care.

Additional Question 3: Is race-based data on the HIV Engagement Cascade collected in your jurisdiction?*

If yes, how is it collected? How is it shared? What are its limitations?



Respondents indicated that race-based data is collected in some jurisdictions, but not all, so a national picture is missing. In particular, not all provinces collect or publicize race-based data for Indigenous people.

In some instances, self-reported race-based data is collected on positive test results only, often not on the total number of tests administered. Responses differed as to whether or not it is collected for treatment recipients.

One respondent indicated that in Ontario, race-based data is collected by the Ontario AIDS Network (OAN), and can be accessed by authorized users who require the information. Another respondent indicated that it is collected at testing sites (which is a recent change), and through AIDS service organizations doing intake and data collection, and is shared through the Ontario HIV Trials Network (OHTN). However, it was also noted that access to such data is not readily available. Future Ontario HIV Epidemiology and Surveillance Initiative (OHESI) reports are expected to include Cascade estimates by sex, age, region and priority population (i.e., gay, bisexual, and other men who have sex with men; African, Caribbean, and Black communities; Indigenous peoples; people who use injection drugs; and at-risk women) in order to better inform the prioritization of interventions to improve Cascade engagement.

The following limitations to the collection of race-based data were listed:

- People who access HIV services outside the key centers are usually missing;
- People with undocumented immigration status as well as those with competing family challenges (domestic violence, mental health challenges and precarious housing conditions) resulting in instability are not reflected in the data;
- People in transition--inter provincial and inter-regional migrants--who are wary about the systemic barriers associated with access to treatment are not reflected in the data.

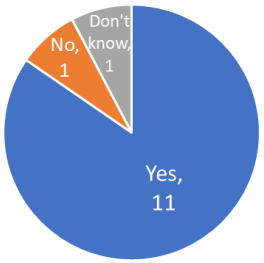
Additional Question 4: Have there been any disruptions to HIV-related services due to COVID-19? Please describe.

The responses to this question indicated that HIV-related services have been impacted by COVID-19 across the cascade. Lockdown led to reduction in those accessing HIV testing, treatment, support and care for a period of time. Testing was heavily impacted as it was not deemed an essential service and was limited during the first lockdown in 2020. One respondent indicated that HIV testing is down by 75 percent. Testing for other STIs has also been impacted.

Community-based organizations providing in-person services have largely been interrupted and outreach to communities has stopped. Many services are closed or operating with dramatically reduced capacity. Frontline prevention and wraparound support, direct outreach into community for engagement and education, psychological services and harm reduction services, have all stopped or slowed down. Medical follow-up appointments have been delayed or moved to teleconference. Surgeries and treatments for comorbidities have been cancelled.

Many services have transitioned to being offered virtually, which comes with many barriers and limitations. Not everyone is open to the virtual transition due to cost limitation, technological literacy and the mental exertion/mental health challenges linked to COVID. It took time for organizations to develop platforms for virtual interactions and there was a lack of equipment and airtime for clients to access services that were available virtually. Fatigue of staff and community during COVID-19 has also been a challenge.

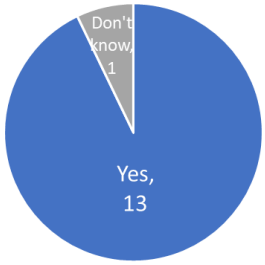
Additional Question 5: Have people in your jurisdiction been arrested or prosecuted in relation to HIV non-disclosure/exposure to risk in the past 3 years?



Comments (please specify jurisdiction):

- Criminalization drives HIV incidence because individuals with unknown HIV status are unwilling to test for HIV for fear of being prosecuted and would rather move from place to place to conceal their identity.
- Every province in Canada
- Québec

Additional Question 6: Have there been discussions in your jurisdiction about policy change in relation to HIV criminalization in the past 3 years?



Please explain and specify your jurisdiction

Several respondents indicated that these discussions are ongoing. Discussions have taken place at a national level (e.g., prosecutorial guidelines) and by some provinces but not by each province/territory.

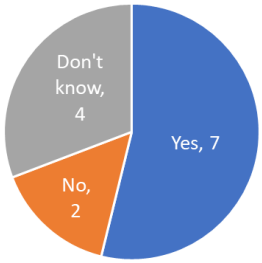
One respondent indicated that a presentation was done by advocates to the Canadian Parliament on the issue. Ontario was listed as one of the provinces that has had discussions. Ontario has had meetings with the Attorney General and changes were promised.

One respondent wrote:

> *"Governmental and civil societal efforts are making some headway, but criminalization for nondisclosure remains a legitimate charge across the country. However, there are emerging prosecutorial guidelines to improve this."*

If yes, has there been adequate opportunity for participation of civil society in these discussions? Please explain and specify your jurisdiction.

Please explain and specify your jurisdiction:



One respondent indicated that the Canadian Coalition to Reform HIV Criminalization has been actively involved in these discussions.

One of the two respondents who said "no", was referring specifically to the context in Alberta where they feel there has been inadequate engagement with civil society about this issue. The second respondent noted that civil society opinions are not sought out; rather, civil society must insist on being part of these discussions.

Additional Question 7: To what extent do you think the government response to HIV in Canada adheres to the principles of Greater Involvement of People Living with HIV and AIDS (GIPA)/Meaningful Engagement

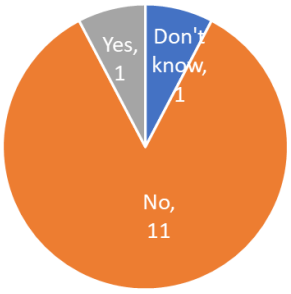
Not at all	Somewhat	Very much
0	10	3

Additional Question 8: Are there any perceived or actual restrictions that limit community-based organizations or individuals from participating in advocacy and/or activism? Please describe.

Respondents indicated that limitations on advocacy are both perceived and actual. Advocacy audits have occurred in the past and respondents indicated that there is a limit of 10 percent of activities for advocacy for NGOs. One person indicated that most Canadian funders will not fund advocacy, and another indicated that advocacy and activism is not allowed if you receive government funds. In other cases, the hesitation to engage in activism stems from the fact that the activism is targeted at the primary source of funding (Ministry of Health).

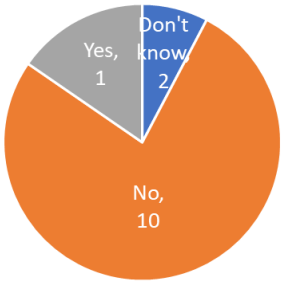
Additional Question 9: Is the government's total HIV budget adequate?

Comments:



Three respondents indicated that government funding has not increased for approximately 10 to 15 years, though the scope of service delivery has. The same amount that was in place for HIV work is now also covering hepatitis C, and other STBBIs.

Additional Question 9.1: Does Canada's community HIV response receive an adequate percentage of the government's total HIV budget?



Additional Question 9.2: How would you want to see any additional funds used?

Respondents overwhelmingly indicated that Canada's community HIV response does not receive an adequate percentage of the overall HIV budget, and identified various areas where additional funds could be used:

- Broader eligibility for addressing the social determinants of health, such as housing, food security, income insecurity
- Broaden funding horizon and opportunities to be inclusive of other grass-root organizations
- Adding funds and capacity bridging in partnering with communities that are impacted by HIV, Hep C, TB and Covid19
- Increasing service delivery and addressing gaps, particularly around testing resource as well as treatment and attainment of detectability.
- Funding programs to build leadership skills and self-esteem in the face of stigma

One respondent indicated the need for multi-year funding, and another indicated that community funding should be increased to reach the percentage stipulated in the Global HIV/AIDS Strategy to 2026.

Respondents wrote:

> *"Let us pay our staff a competitive living wage, paid peer positions, unfettered funding for Safe Consumption Sites"*

> *« Pour des mesures où projet concret sur plus d'une année qui pourrait avoir une atteinte des cibles de l'ONU d'ici 2025. Notamment pour les organisations communautaire pour mettre en place des ripostes communautaire avec une autonomie d'action. »*

Appendix A: Definitions

In some cases (marked with *), UNAIDS provided definitions, which every country was asked to include within the survey. This is to ensure consistency across countries. These were included at the start of each survey section where relevant.

***Community accountability mechanisms** in the context of programmes for preventing the mother-to-child transmission of HIV: These may include any of the following mechanisms.

-Citizen report cards. Large-scale surveys of user feedback used for advocacy to increase public accountability.

-Community scorecards. Facilitated meetings for communities and health workers to score service quality and then to develop remedial action plans in consensus.

-Community client-oriented provider efficient (COPE). A complement to a facility based quality improvement programme that involves the health workers gathering information from surrounding communities.

-Partnership-defined quality. With outside facilitation, health workers and community define and examine quality, set priorities among issues and develop and implement an action plan.

-Patient-focused quality assurance. A process that involves conducting 50–100 client exit interviews every 3–6 months, collating data, setting priorities among issues, drawing up action plans and displaying results.

-Peer and participatory rapid health appraisal for action. Rapidly diagnosing quality using checklists, setting priorities among issues identified, disseminating results and developing a remedial action plan. Community input comes through client interviews and female and male focus group discussions in which quality is ranked on specific indicators.

-Integrated supportive supervision. Quarterly facility visits by a team that includes community representatives. Methods include client interviews and checklists.

-Health committees. Local committees that include community members and monitor service quality. Some make ad hoc visits; others have a more formal monitoring schedule.

***Grave or systematic human rights abuses:** The qualification of grave indicates a serious, flagrant, egregious human rights violation. A violation of the right to life or physical integrity would constitute a grave violation of human rights. Systematic refers to the number of people affected and the frequency. It implies a pattern of violations and not an isolated case

***Migrants** are defined as non-citizens who are in a country other than their country of origin for a stay of longer than six months.

***Participation:** Active and informed participation in formulating, implementing, monitoring and evaluating all decisions, policies and interventions that affect one's health to ensure respect for human rights. It also means ensuring that health systems and interventions are responsive, effective, appropriate and sustainable. Participation is informed when people can access the information required

to participate in a meaningful and effective way. If necessary, capacity-building activities should be carried out to ensure this.

***Social protection:** Defined as "all public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks, and enhance the social status and rights of the marginalised; with the overall objective of reducing the economic and social vulnerability of poor, vulnerable and marginalized groups." Social protection is HIV-sensitive when it is inclusive of people who are either at risk of HIV infection or susceptible to the consequences of HIV.

The following definition was included with the addition questions:

***The HIV Engagement Cascade**—also referred to as the HIV Treatment Cascade, or the HIV care continuum—is a system to monitor the number of individuals living with HIV who are actually receiving medical care and the treatment they need. It was developed to recognize the various steps necessary to engage an individual who needs HIV care, all the way from getting tested for HIV to being able to suppress the virus through treatment, and remain in care. Steps in the cascade include: HIV testing and diagnosis, linkage to appropriate medical care (and other health services), support while in care, access to antiretroviral treatment if and when they are ready, and support while on treatment.