COCQ-SIDA

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Study on LGBTQ2 Health in Canada
House of Commons Standing Committee on Health
BRIEF BY COCQ-SIDA

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The Coalition des organismes communautaires québécois de lutte contre le VIH/sida (COCQ-SIDA), the provincial alliance of community organizations involved in combatting HIV/AIDS, is pleased to have the opportunity to submit this brief to the House of Commons Standing Committee on Health for its study on LGBTQ2 health.

Since 2006, COCQ-SIDA has taken a rights-based approach to its work, paying particular attention to combatting discrimination and meeting the needs of the most vulnerable. Central to that approach are the right to health, the right to human dignity and the right to life.

In Canada, an estimated 51.9% of people living with HIV are gay, bisexual and other men who have sex with men (gbMSM).[1] In Quebec, the figure is just over 54%.[2] In addition, more than half of all new HIV infections in Canada and Quebec occur in gbMSM.[3] Because of the large number of LGBTQ2 people with HIV, COCQ-SIDA would like to draw the Committee's attention to some of the obstacles that people with HIV face in exercising their right to health.

1. Criminalization of HIV discourages access to health services, including screening services, which undermines public health efforts[4]

In Canada, a person living with HIV who fails to disclose his or her HIV-positive status to a partner before sexual relations involving "a realistic possibility of HIV transmission" could face criminal prosecution, regardless of intent to transmit or actual transmission.[5] Canada is one of the countries with the highest number of criminal prosecutions based on non-disclosure of HIV-positive status, along with the United States, Russia, Belarus and Ukraine.[6] People with HIV are generally charged with serious offences, including aggravated sexual assault.

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[1] Public Health Agency of Canada. *Summary: Estimates of HIV incidence, prevalence and Canada's progress on meeting the 90-90-90 HIV targets, 2016. Public Health Agency of Canada, 2018.* Online: https://www.canada.ca/en/public-health/services/publications/diseases-conditions/summary-estimates-hiv-incidence-prevalence-canadas-progress-90-90-90.html#t1
[2] Ibid.
[3] Ibid.
[4] For more information about COCQ-SIDA's position on criminalization and its impacts on the right to health, see COCQ-SIDA, "Position de la COCQ-SIDA sur la criminalisation du VIH". https://www.cocqsida.com/assets/files/mediatheque/Position%20politique%20de%20la%20COCQ%20SIDA%20sur%20la%20criminalisation%20de%20l'exposition%20au%20VIH.pdf [in French only].
[5] R. v. Mabior, 2012 SCC 47, [2012] 2 S.C.R. 584; R. v. D.C., 2012 SCC 48, [2012] 2 S.C.R. 626.
[6] E. J. Bernard. "Global trends in HIV criminalisation: Overview, analysis and country ranking", HIV Justice Network, 2018.

In COCQ-SIDA's view, using criminal law heightens the stigma and discrimination experienced by people with HIV and may discourage people from getting tested or seeking treatment, for fear of being prosecuted. This reluctance is detrimental to prevention "because people who receive a positive diagnosis usually change their behaviour to avoid transmitting HIV and because taking antiretroviral therapy reduces infectiousness and the likelihood of onward HIV transmission."[7]

When fear, stigma and discrimination prevail, "people may choose to ignore the possibility that they may already be, or could become, HIV-positive – even if they know they have taken risks."[8] This wilful ignorance gives the infection free rein and increases the risk of HIV transmission to others.

Criminalization also keeps people with HIV away from the health and social services system, which prevents them from getting treatment. A Canadian study published in 2015 showed that criminalization may actually create barriers to engagement and retention within the cascade of HIV care.[9]

> The expansion of HIV testing to identify the undiagnosed population living with HIV and reach ambitious 90-90-90 UNAIDS treatment targets is a national public health priority. The literature reviewed here offers some evidence that HIV criminalization may introduce an additional structural level barrier to HIV "testing for some individuals, possibly those who anticipate a positive result."[10]

Moreover, the fact that medical records can be entered as evidence in criminal prosecutions may deter people with HIV from openly discussing their risky behaviour and disclosure practices with health professionals and other workers who can provide risk mitigation advice and assistance.[11] Many people with HIV have said they are afraid that this information will be used against them in a criminal case. In other words, criminalization drives people "underground" and diminishes their interest in using health services.[12]

Lastly, criminalization has an adverse effect on access to emergency preventive care. It may deter people from disclosing their HIV-positive status in the event of condom failure or some other accidental exposure to HIV, for fear of criminal prosecution. This limits access to post-exposure prophylactic treatment for the person exposed to HIV.

RECOMMENDATION(S): Like UNAIDS, COCQ-SIDA believes that criminal prosecution should be resorted to only in the very rare cases where there is intentional, actual HIV transmission and that criminal law should not be applied in all other circumstances.

[7] UNAIDS, *Policy Brief – Criminalization of HIV transmission*, 2008, pp. 4, 5.
[8] UNAIDS, *Stigma and Discrimination Fact Sheet*, 2003.
[9] Patterson SE et al. *Journal of the International AIDS Society* 2015, 18:20572 Online: https://doi.org/10.7448/IAS.18.1.20572 [*Patterson*]
[10] Ibid.
[11] Ibid.
[12] E. Mykhalovskiy, "The problem of 'significant risk': Exploring the public health impact of criminalizing HIV non-disclosure," Soc Sci & Med 2011; HIV Non-Disclosure and the Criminal Law (Aug 2010); O'Byrne et al., "Nondisclosure prosecutions and HIV prevention: results from an Ottawa-based gay men's sex survey", 2012.

As long as Canadian law remains unchanged, it will have a detrimental impact on the right to health. Limiting the application of criminal law will

(a) enhance people's accountability for their own sexual health;

(b) encourage people to get tested and make use of HIV treatment, care and support services;

(c) encourage people to disclose their HIV-positive status to their partner in the event of condom failure, so that the partner can seek post-exposure prophylactic treatment;

(d) combat the stigma and discrimination experienced by people with HIV and create an atmosphere that is more conducive to disclosure and access to care.

2. HIV infection-based discrimination impedes access to basic health care for people with HIV

Discrimination in health care can manifest itself in various ways. It lies on a continuum from refusal of care to unwarranted differential treatment to a simple lack of know-how on the health professional's part.

Various Canadian studies have looked specifically at access to dental care for people with HIV since the epidemic started. The studies reported cases of discrimination and attempted to explain them. COCQ-SIDA itself carried out a study of access to dental care for people with HIV in 2012.[13] The data were collected in two ways: a survey of people with HIV and a telephone survey of dental clinics across the province.

The results of COCQ-SIDA's study revealed cases of discrimination in access to dental care, misunderstanding of the disease and negative attitudes toward people with HIV in some dental clinics. In 14% of the cases, the clinics' response suggested that people were treated differently because of their HIV-positive status, in most cases being offered an appointment at the end of the day or simply being refused treatment.[14]

The data also indicated that a significant proportion of people with HIV were afraid of being discriminated against in access to dental care and were uncomfortable about disclosing their HIV-positive status to dental health professionals. About 20% of respondents reported having had trouble finding a dentist, in part because the dentist refused to see them on account of their HIV-positive status.

Although the majority of respondents reported that their visits to the dentist generally went smoothly, some indicated that they were afraid of being treated differently by the dentist (21%), that they were uncomfortable completing a form requiring them to state their HIV-positive status (21%) and that they were uncomfortable with that information being kept on file (19%).[15] More than 19% reported

[13] COCQ-SIDA. "Rapport d'enquête sur les soins dentaires", May 2012. http://www.cocqsida.com/assets/files/2.dossiers/Vers%20un%20acces%20aux%20soins%20dentaires%20sans%20discrimination%20pour%20les%20PVVIH_mai%202012.pdf [in French only].
[14] Ibid., p. 10.
[15] Ibid., p. 8.

that they did not disclose their HIV-positive status to the dentist for fear of having to deal with a breach of confidentiality, being judged or being discriminated against.[16]

RECOMMENDATION(S): Education programs for health professionals should include specific training on HIV/AIDS to improve their attitudes regarding HIV and reduce the barriers to access to basic health care for people with HIV. HIV science updates should be provided in professional development courses for those who are working in the field so that they can adjust their practices. A better understanding of the disease would help dispel prejudices and fears regarding people with HIV so that they can obtain health care free of all forms of discrimination.

3. Distance from urban centres impinges on the right to health of people with HIV

For people living with HIV who do not live in an urban centre, getting access to specialized care can be a complicated process. That complexity is not just a matter of distance; it may also have to do with stigma.

First, the lack of specialists in outlying regions (or outside urban centres) makes health care access difficult for people with HIV. Few health professionals specializing in HIV treatment or related fields practise outside urban centres. There are some programs that enable specialists to mentor general practitioners, but that long-distance support is not a panacea. Patients often have to travel for proper medical follow-up (specialist examinations, specific tests, etc.). In many cases, the travel costs are not covered by insurance. As a result, distance jeopardizes the engagement of people with HIV in the health care cascade.

Second, a fear of confidentiality breaches drives some people with HIV to see doctors in another city. The persistent stigmatization of people with HIV fuels their fear of confidentiality breaches. That is particularly true for people with HIV who reside in sparsely populated areas where services are limited. The small number of clinics increases the chance that a person will run into someone close to them. Terrified that information about their HIV-positive status will fall into the hands of someone they know, some opt for medical follow-up in another city or region, which adds to the distance they have to travel for health care.

RECOMMENDATIONS: To mitigate the effects of distance, mentoring programs between specialists and general practitioners need to be maintained or even improved. In the same vein, it would be helpful to make the system of medical examinations provided by certain specialists in remote areas more universal and structured.

The government should also contemplate services that deal more effectively with the challenges and issues of confidentiality outside urban centres. It would also be useful to have health care-related travel covered by public health care plans to reduce the financial impact and keep people living with HIV engaged in the health care system, no matter their financial capacity or ability to travel.

[16] Ibid., p. 9.

Respectfully,

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