APPENDIX D – FOR INFORMATION

17 July 2017

Final Report

Global AIDS Monitoring: Reporting on National Commitments and Policy Instrument, Part B (Civil Society Perspectives)

Presented to:
Public Health Agency of Canada

Submitted by:
Marc-André LeBlanc

Email: maleblanc27@gmail.com

Table of Contents

EXECUTIVE SUMMARY

The Public Health Agency of Canada (PHAC) conducted an on-line survey to solicit feedback from Canadian civil society organizations about the status of, and response to, HIV in Canada between 2015 and 2017. The survey was based on the National Commitments and Policy Instrument (NCPI) – Part B. This is the survey instrument developed by the Joint United Nations Programme on HIV/AIDS (UNAIDS) in order to gather civil society input. The survey results have informed the development of this report—the civil society portion of Canada's 2017 Global AIDS Monitoring Report to UNAIDS. Canada has committed to reporting annually on HIV/AIDS in Canada as part of its commitments under the UN General Assembly's various Political Declarations on HIV and AIDS.

A total of 50 respondents completed some or all of the survey, with representation from most provinces and territories, and significant representation from people living with HIV and a range of key populations (gay, bisexual and other men who have sex with men; transgender people; people who use drugs; Indigenous communities; newcomer, refugee and immigrant communities; African, Black and Caribbean communities; sex workers; prisoners). A significant number of respondents indicated that they were from community-based organizations, with a number of respondents involved in education, front-line delivery, peer-based engagement, policy/advocacy, or academic/research.

The categories under which the survey questions are organized are based on the commitments from the 2016 Political Declaration. Many commitments are quite broad, and touch on a number of components. Not all of these components were addressed in the survey. For example, the data on 90-90-90 targets are reported to UNAIDS elsewhere. The NCPI does not include areas for which other evidence is available or for which data would be better captured or more clearly interpreted through other tools.

The results presented in this report represent the views of individuals and civil society organizations that chose to respond to the online survey. They may or may not be representative of civil society stakeholders involved in HIV work in Canada. While it is important to understand these perspectives to address HIV in Canada effectively, they do not necessarily reflect the actual state of laws, policies, and programs in Canada. For an overview of the laws and policies in place in Canada, please refer to Part A of the NCPI report.

KEY FINDINGS

Legal protections for key populations. Most respondents identified several laws or other provisions that provide protection from discrimination based on grounds of sexual orientation and for transgender people in Canada. Conversely, the vast majority of respondents stated that none of the legal protections listed in the survey exist for sex workers in Canada, and that Canada has no specific anti-discrimination laws or other provisions that apply to people who use drugs.

HIV prevention services for people who inject drugs and in prisons. The vast majority of respondents stated that needle and syringe programmes are operational in Canada—except in prisons, where most respondents said they are not operational. Likewise, the vast majority of respondents stated that opioid substitution therapy (OST) programmes are also operational in Canada, while only a slim majority stated that they were available in prisons. A slightly larger majority of respondents stated that condoms and lubricants, and antiretroviral therapy (ART) for all prisoners living with HIV were available in Canadian prisons.

Participation of key populations. When asked about the participation of key populations in the development of policies, guidelines or strategies relating to their health, a clear majority of respondents stated that gay, bisexual and other men who have sex with men and transgender people participate. However, a smaller proportion of respondents believe that sex workers, people who inject drugs, and current or former prisoners participate in such processes.

Violence and discrimination against women, people living with HIV, and key populations. Most respondents identified a number of provisions and programmes in Canada that protect key populations and people living with HIV from violence. Nearly all respondents stated that appropriate medical and psychological care and support for victims of sexual assault are in place in Canada, including: psychological first aid; emergency contraception; safe abortion if a woman becomes pregnant as a result of rape; and, post-exposure prophylaxis (PEP) for sexually transmitted infections and HIV. All respondents stated that Canada has policies in place requiring healthcare settings to provide timely and quality health care regardless of gender, nationality, age, disability, ethnic origin, sexual orientation, religion, language, socio-economic status, HIV or other health status, or because of selling sex, using drugs, living in prison or any other grounds. However, two-third of respondents stated that while policies exist, they are not consistently implemented.

Community-led HIV service delivery. Respondents identified several restrictions and regulatory barriers in Canada to community-led HIV service delivery, including: cumbersome reporting; restrictions requiring that HIV services only be provided in healthcare facilities; and, overly restrictive criteria for eligibility for community-based service delivery. They highlighted recent changes in funding structures and insufficient funding levels as additional barriers that lead to loss of existing services, more restrictive access to such services, and gaps in services, notably in the area of harm reduction. Lack of engagement with people living with HIV and key populations in funding-related decision-making processes was also mentioned.

Rights literacy. Few respondents stated that 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 Canada in the past two years were at scale at the national level. They identified the following barriers: lack of funding; barriers that hinder the target audience in accessing such trainings or capacity-building; lack of political will; and, lack of capacity for delivery of trainings.

Accountability mechanisms to address rights violations and discrimination. A slight majority of respondents stated that mechanisms are in place in Canada to record and address cases of HIV-related discrimination (based on perceived HIV status and/or belonging to any key population). They cited human rights tribunals and commissions, as well as community-based legal services as examples. A large majority of respondents stated that accountability mechanisms are in place in relation to discrimination and violations of human rights in healthcare settings; however, they identified barriers to accessing these mechanisms, such as limited awareness or knowledge of how to use such mechanisms, affordability constraints for people from marginalized and affected groups, and mechanisms not being sensitive to HIV. A majority of respondents stated that legal aid systems are applicable to HIV casework, and identified mechanisms such as community paralegals and special organizations that address legal rights of people living with HIV. However, they also pointed out gaps in the system due to lack of coverage outside of larger centers and the lack of services adapted to HIV. The majority of respondents stated that Canada has documented barriers to access to justice for people living with HIV and key

populations such as prisoners, people who use drugs, sex workers, Indigenous communities, and immigrants and refugees. A large number of respondents specifically made reference to the criminalization of HIV non-disclosure, including its impact on women. Funding and the cost of legal services were mentioned as barriers, as well as stigma, poverty, and the criminalization of sex work.

CONSULTATION PROCESS

The Public Health Agency of Canada (PHAC) conducted an on-line survey to solicit feedback from Canadian civil society organizations about the status of, and response to, HIV in Canada between 2015 and 2017. The survey results have informed the development of this report—the civil society portion of Canada's 2017 Global AIDS Monitoring Report to the Joint United Nations Programme on HIV/AIDS (UNAIDS). Canada has committed to reporting annually on HIV/AIDS in Canada as part of its commitments under the UN General Assembly's various Political Declarations on HIV and AIDS.

PHAC hired Marc-André LeBlanc as an independent consultant to coordinate the consultation process, with Robin Montgomery from the Interagency Coalition on AIDS and Development (ICAD) acting as the Community Representative advising on this project.

Prior to the launch of the survey, PHAC hosted a French and English webinar on May 18th, 2017 to provide a high level overview of the survey and to highlight the significance of the Global AIDS Monitoring Report, linking it to Canada's commitments most recently under the *2016 United Nations Political Declaration on Ending AIDS*. The webinar provided participants with an opportunity to understand the reporting process, to ask questions, and to obtain clarification. A total of 19 people participated in the webinars, in addition to the presenters.

The survey was based on the National Commitments and Policy Instrument (NCPI) – Part B. This is the survey instrument UNAIDS has developed in order to gather civil society input. It included 48 mostly closed-ended questions and potential respondents were advised that the survey would take approximately 30 minutes to complete.

PHAC circulated a survey announcement to an extensive e-mail distribution list comprised of close to 900 civil society stakeholders involved in HIV work and other sexually transmitted and blood-borne infections (STBBIs). It was sent on May 18th, with reminders on May 26th and May 30th. The survey remained open from May 18th to 31st.

A total of 224 respondents clicked on the survey link, of which 86 answered at least one question. Among those, 50 respondents answered questions beyond the demographic section, thus providing input into the UNAIDS survey instrument itself. The survey results are based on those 50 respondents. It is unknown whether these respondents are representative of the 900 stakeholders who were part of the e-mail distribution list, nor is it known if the distribution list is representative of civil society stakeholders involved in HIV work.

Survey results were compiled in early June and summarized in a draft report, which was sent to all survey respondents who indicated an interest in providing comments on the draft report. In addition, members of the Ministerial Advisory Council on the Federal Initiative to Address HIV/AIDS in Canada (MAC-FI) and the National Aboriginal Council on HIV/AIDS (NACHA), which advise the federal Minister of Health, as well as the National Partners group (consisting of eight long-standing national NGOs with a primary or substantial focus on HIV-related issues) received the draft report. Comments and suggested edits were incorporated into this final version of the report.

RESPONDENTS

Of the 50 respondents who completed some or all of the survey, 56% (n=28) identified as representing an organization while 44% (n=22) indicated they were responding to the survey as an individual.

Organizations (n=28). Among respondents representing an organization, most identified as being from regional/provincial organizations (46.4%) or local organizations (39.3%), with the remainder representing a national organization (14.3%). As a group, they serve most of the provinces and territories, with British Columbia, Quebec and Ontario having the most respondent organizations. One or two respondent organizations serve each of Alberta, Manitoba, Saskatchewan, New Brunswick, Prince Edward Island, Newfoundland and Labrador, and the Northwest Territories. No organization indicated that it served Nova Scotia, Nunavut or the Yukon individually, although three (3) respondents were from organizations serving all provinces and territories (national-level work).

Nearly all organizational respondents indicated serving or representing people living with HIV (92.5%). The vast majority also indicated serving or representing gay, bisexual, and other men who have sex with men (71.4%) and people who inject drugs (75%). Approximately half the organizations serve or represent sex workers (53.6%), Indigenous communities* (46.4%), African, Caribbean and Black communities* (42.9%) newcomer, refugee and immigrant communities* (42.9%), or transgender communities* (42.9%). One third of organizations serve or represent prisoners (35.7%) and one out of four organizations (25%) indicated serving or representing other communities.* Totals add up to more than 100% because respondents could select all that apply.

Respondents' organizations work in a wide range of sectors. The vast majority of respondents indicated that they were from a community-based organization (89.3%) and that their focus included education (75%) and front-line delivery (67.9%). Almost half the respondents were from organizations that offer peer-based mentoring/peer advising/peer engagement (46.4%). Approximately one third of organizations were engaged in policy/advocacy (39.3%) or academic/research (32.1%). Only 7.1% were from the private sector or another sector.*

Individuals (n=22). The largest proportion of individual respondents (40.9%) indicated that they live in Ontario, with one to three respondents living in each of the following provinces and territories: British Columbia, Alberta, Saskatchewan, Manitoba, Quebec, Nova Scotia, and the Northwest Territories. No one indicated that they live in New Brunswick, Prince Edward Island, Newfoundland and Labrador, Nunavut or the Yukon.

Half the individual respondents self-identified as being gay, bisexual or other men who have sex with men (50%), and nearly as many identified as being people living with HIV (44.4%). Relatively fewer respondents self-identified as being from Indigenous communities* (11.1%), African, Caribbean and Black communities* (11.1%), newcomer, refugee and immigrant communities* (17.6%) or self-identified as sex workers (5.6%) or people who inject drugs (5.6%). Totals add up to more than 100% because they could select all that apply. No one self-identified as being a prisoner or as transgender. Four

* Please consult Appendix A for a more detailed description of the specific communities served or represented by organizational and individual respondents.

respondents selected none of the options. A few people self-identified as being from other communities* (16.7%).

For more detailed information on respondent demographics, please consult Appendix A.

RESULTS

The narrative summary below presents some of the highlights from the survey findings. The full results in Appendix B are presented in a format that is consistent with UNAIDS reporting requirements, as indicated in the Global AIDS Monitoring Online Reporting Tool. The eight categories under which the survey questions are organized are based on the commitments from the 2016 Political Declaration. At the beginning of each section, the commitment is listed, followed by questions related to that commitment.

Many commitments are quite broad, and touch on a number of components. Not all of these components were addressed in the survey. For example, the data on 90-90-90 targets are reported to UNAIDS elsewhere. The NCPI does not include areas for which other evidence is available or for which data would be better captured or more clearly interpreted through other tools.

The results presented in this report represent the views of individuals and civil society organizations that chose to respond to the online survey. While it is important to understand these perspectives to address HIV in Canada effectively, they do not necessarily reflect the actual state of laws, policies, and programs in Canada.

For example, nearly 13% of respondents stated that people in Canada have not been arrested or prosecuted for using drugs in the past three years, while there have in fact been such arrests and prosecutions. Likewise, nearly 14% of respondents stated that needle and syringe programs were operational in Canadian prisons, whereas no such programs are operational anywhere, in any Canadian prison.

Similarly, over half of respondents (55.1%) stated that transgender people in Canada have been arrested or prosecuted for manifestations of their gender identity in the past three years, whereas there is in fact no crime in being transgender in Canada. This was true even at the time of the survey, before the passage of new legislation that expressly includes gender identity in the hate crimes provisions of the Criminal Code and as a prohibited ground of discrimination in the Canadian Human Rights Act.

For an overview of the laws and policies in place in Canada, please refer to Part A of the NCPI report.

Canadian context

UNAIDS has requested that the same survey be used in all countries. As a result, in some cases the questions do not fit very well within our context. Respondents were asked to answer as best they could.

Many questions asked for information about the situation "in your country". While recognizing that in many cases, the situation may vary in different jurisdictions across the country, respondents were asked to answer as best they could, based on the situation within the context of their organization's work—whether that is at a local, provincial/territorial or national level.

SUMMARY OF THE RESPONSES FROM THE SURVEY TO GATHER PERSPECTIVES FROM CANADIAN CIVIL SOCIETY ORGANIZATIONS – GLOBAL AIDS MONITORING REPORT

Ensure that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020

This section of the survey included questions related to potential access barriers and facilitators, including mandatory HIV testing and the availability of viral load testing, and retention and adherence support services.

Respondents (n=38) were almost evenly split in their belief that mandatory HIV testing is carried out in Canada. Those who stated that it does exist (52.6%) mostly made reference to testing of immigrants and refugees, pregnant women, prisoners, and sexual assault cases.

With regard to viral load testing, respondents (n=43) were almost evenly split between saying that it is only available in specialized centres, available at antiretroviral therapy facilities (either on-site or by referral), or through other means (e.g., laboratories, doctors, community clinics, infectious disease specialists, hospitals, and community organizations).

The vast majority of respondents (out of n=38) stated that community-based interventions (97.4%) and adherence clubs and peer support (84.2%) are available as retention support services in Canada. Other services mentioned include community groups and workshops, as well as multi-disciplinary teams.

Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018

Very few respondents were able to answer survey questions related to the prevention of mother-to-child transmission (PMTCT). Only one person was able to indicate how many facilities in Canada provide PMTCT services (they indicated 25) or how many facilities providing PMTCT services have community accountability mechanisms in place (2376).

The following problems were identified by the few respondents (n=12) who answered the question, *"In the context of PMTCT programmes in your country, are there reports or is there documentation of any of the following?"*: lack of confidentiality and privacy (58.3%); lack of informed, voluntary and prior obtained consent (50%); mandatory or coerced testing and/or treatment for HIV (41.7%); and, forced and coerced abortion, contraception and/or sterilization (16.7%).

A third of respondents (out of n=12) added other grave or systematic human rights abuses, including: the criminalization of HIV non-disclosure; poor detention conditions in some provincial prisons; sex work laws that do not respect rights to safety and health; and, stigma leading some clients to feel unsafe to disclose their HIV status to family members. Given these responses, it is likely that respondents did not limit their comments to the context of PMTCT.

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

This section of the survey included questions related to law enforcement, legal protections for key populations, HIV prevention services for people who inject drugs, HIV prevention services in prisons, participation of key populations, and pre-exposure prophylaxis (PrEP). It should be noted that a relatively large proportion of respondents chose the "I don't know" option when answering questions

related to law enforcement and legal protections for key populations, and HIV prevention services in prison (including testing).

Law enforcement. Two thirds of respondents (68.8% of n=32) stated that possession of a needle/syringe without a prescription could be used as evidence of drug use or cause for arrest in Canada. Three-quarters of respondents (75.5% of n=49) stated that sex workers in Canada have been arrested or prosecuted in relation to selling sex in the past three years and 85.1% (out of n=47) stated that people in Canada have been arrested or prosecuted for using drugs in the past three years. About half the respondents (55.1% of n=49) stated that transgender people in Canada been arrested or prosecuted for manifestations of their gender identity in the past three years, while 77.1% of respondents (out of n=48) stated that people in Canada had not been arrested or prosecuted for consensual same sex sexual acts in the past three years.

Legal protections for key populations. Most respondents (out of n=37) selected a number of legal protections as existing for transgender people in Canada, including: prohibitions of discrimination in employment based on gender diversity (78.4%); constitutional prohibition of discrimination based on gender diversity (73%); other non-discrimination provisions specifying gender diversity (48.6%); and, a third gender is legally recognized (16.2%).

Likewise, most respondents (out of n=40) identified several laws or other provisions specifying protections based on grounds of sexual orientation that were listed in the survey (i.e., constitutional prohibition of discrimination based on sexual orientation (87.5%); hate crimes based on sexual orientation considered an aggravating circumstance (77.5%); incitement to hatred based on sexual orientation prohibited (62.5%); prohibition of discrimination in employment based on sexual orientation (80%); and, other non-discrimination provisions specifying sexual orientation (45%).

Conversely, the vast majority of respondents (78.1% of n=32) stated that none of the legal protections listed in the survey exist for sex workers in Canada (i.e., constitutional prohibition of discrimination based on occupation; sex work recognized as work; other non-discrimination provisions specifying sex work). The majority (72% out of n=25) also stated that Canada has no specific anti-discrimination laws or other provisions that apply to people who use drugs.

HIV prevention services for people who inject drugs. The vast majority of respondents stated that needle and syringe programmes (95.8% of n=48) and opioid substitution therapy (OST) programmes (90% of n=40) are operational in Canada and that naloxone (used to reverse opioid overdoses) is available through community distribution (91.5% of n=47).

HIV prevention services in prison. The majority of respondents stated that needle and syringe programmes were not operational in Canadian prisons (86.2% of n=29), while a slim to large majority of respondents stated that the following prevention services were available: opioid substitution therapy (OST) (55% of n=20), condoms and lubricants (67.7% of n=31), and antiretroviral therapy (ART) for all prisoners living with HIV (80.6% of n=36).

Regarding HIV tests in prisons, all or most respondents stated that they were free of charge (100% of n=31), carried out with the informed consent of prisoners (88% of n=25), equally available to all prisoners (72.7% of n=11), and confidential (70.8% of n=24). A slim majority of respondents stated that they were available at any time during detention (53.3% of n=15) and accompanied by relevant and accessible information (52.6% of n=19) or by confidential pre- and post-test counselling (55.6% of n=18).

Participation of key populations. When asked about the participation of key populations in the development of policies, guidelines or strategies relating to their health, a clear majority of respondents stated that men who have sex with men (90.7% of n=43) participate, as well as transgender people (78.8% of n=33). However, a smaller proportion of respondents believe that sex workers (55.2% of n=29), people who inject drugs (54.8% of n=31), and current or former prisoners (50% of n=20) participate in such processes. However, it should be noted that a relatively large proportion of respondents chose the "I don't know" option when answering these questions.

Pre-exposure prophylaxis (PrEP). The vast majority of respondents (90.9% of n=44) stated that PrEP is available in Canada. When asked about access mechanisms, most respondents (out of n=36) stated PrEP is available through private providers (77.8%), with only a minority stating that it is provided through research (33.3%), as part of a pilot project (27.8%), as national policy (19.4%) or available through the Internet (19.4%).

Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020

Most respondents (out of n=33) identified a number of provisions and programmes that were listed in the survey as existing in Canada to protect key populations and people living with HIV from violence, including: general criminal laws prohibiting violence (100%); programmes to address workplace violence (84.8%); and, programmes to address intimate partner violence (75.6%). Respondents were less unanimous about stating that the following provisions and programmes were in place: interventions to address police abuse (57.6%); interventions to address torture and ill-treatment in prisons (57.6%); and, specific legal provisions prohibiting violence against people based on their HIV status or belonging to a key population (42.4%).

Nearly all respondents stated that the following appropriate medical and psychological care and support for women and men who have been raped and experienced incest are in place in Canada, in accordance with the recommendations of the 2013 WHO guidelines, *Responding to intimate partner violence and sexual violence against women*: first-line support or what is known as psychological first aid (100% of n=33); emergency contraception for women who seek services within five days (100% of n=35); safe abortion if a woman becomes pregnant as a result of rape in accordance with national law (94.1% of n=34); and, post-exposure prophylaxis (PEP) for sexually transmitted infections and HIV (within 72 hours of sexual assault) as needed (96.9% of n=32).

All respondents (n=39) stated that Canada has policies in place requiring healthcare settings to provide timely and quality health care regardless of gender, nationality, age, disability, ethnic origin, sexual orientation, religion, language, socio-economic status, HIV or other health status, or because of selling sex, using drugs, living in prison or any other grounds. However, two-third of them (69.2%) stated that while policies exist, they are not consistently implemented.

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

A slim majority of respondents (57.7% of n=26) stated that young people (15-24 years old) participate in developing policies, guidelines and strategies relating to their health in Canada, but very few respondents (n=8) were able to identify specific decision-making spaces in the national HIV response where such participation might have occurred. The most commonly identified spaces were "technical teams for the development or review of programmes that relate to young people's access to HIV testing, treatment, care and support services", and "civil society coordination spaces of populations most affected by HIV".

Ensure that 75% of people living with, at risk of and affected by HIV benefit from HIV-sensitive social protection by 2020

Respondents (n=34) identified several barriers that limit access to social protection programmes in Canada, as listed in the survey, some of the more commonly selected ones being: fear of stigma and discrimination (100%); lack of information available on the programmes (64.7%); complicated procedures (64.7%); laws or policies that present obstacles to access (52.9%); high out-of-pocket expenses (44.1%); and, lack of documentation that confers eligibility, such as national identity cards (35.3%).

Ensure that at least 30% of all service delivery is community-led by 2020

It should be noted that a large proportion of respondents chose the "I don't know" or "Doesn't apply" options when answering questions related to this section.

Those who did respond (n=18) identified several restrictions in Canada to the registration and operation of civil society and community-based organizations that affect HIV service delivery, as listed in the answer options in the survey. These include: cumbersome reporting and other restrictions on operations (88.9%); territorial restrictions to operations, such as zoning (50%); restrictions on providing services to key populations (38.9%); and, restrictions on registration (22.2%).

In addition, some respondents (n=9) identified regulatory barriers to community-led service delivery, including: restrictions requiring that HIV services only be provided in healthcare facilities (66.7%) and overly restrictive criteria for eligibility for community-based service delivery (66.7%). In the comment fields related to this question, several respondents further expanded on their answers, providing examples of jurisdictional and regulatory restrictions that impede access to services (e.g., restrictions on who may provide HIV care, jurisdictional restrictions for service delivery for Indigenous people (specifically people recognized as "status Indians") living on or off a reserve; testing being reserved for health professionals; and, rapid testing not being available in community-based organization (CBO) settings without the costly addition of a nurse).

The majority of respondents (73.3% of n=15) also identified the "lack of social contracting or other mechanisms allowing for community-led service delivery to be funded from domestic funding" as a factor that hinders access to funding for work by civil society organizations (CSOs) and CBOs in Canada.

All respondents who provided written comments related to this question (n=5) made reference to funding constraints. They highlighted recent changes in funding structures and insufficient funding levels as additional barriers that lead to loss of existing services, more restrictive access to such services, and gaps in services, notably in the area of harm reduction. Lack of engagement with people living with HIV and key populations in funding-related decision-making processes was also mentioned.

In particular, they expressed frustration with the recent federal funding cycle for non-profit organizations working in HIV, citing the slow process for communicating funding decisions, gaps in funding flow, gaps in services as a result of funding decisions, the insufficient levels of funding, the narrow eligibility focus which leads to the exclusion of key activities, and the lack of alternative funding sources for most CBOs engaged in HIV-related work.

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. While a large majority of respondents (95.1% of n=41) stated that there had been some form of 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 Canada in the past two years, there were relatively mixed views about the scale of such activities. Approximately one third of respondents believed that these activities were at scale at the national level (22%) or sub-national level (14.6%). Respondents were more likely to state that they were happening at small scale (41.5%). Most respondents (out of n=42) identified the following barriers: lack of funding (95.2%); barriers that hinder the target audience in accessing such training or capacity-building (69%); lack of political will (64.3%); and, lack of capacity for delivery of training (57.1%).

Accountability mechanisms to address rights violations and discrimination. A slight majority of respondents (60% of n=20) stated that mechanisms are in place in Canada to record and address cases of HIV-related discrimination (based on perceived HIV status and/or belonging to any key population). They cited human rights tribunals and commissions, as well as community-based legal services as examples.

A large majority of respondents (out of n=38) stated that the following accountability mechanisms are in place in relation to discrimination and violations of human rights in healthcare settings, as listed in the survey answer options: complaints procedure (100%); procedures or systems to protect and respect patient privacy or confidentiality (89.5%); and, mechanisms of redress and accountability (65.8%).

The most commonly selected barriers to accessing accountability mechanisms (out of n=32) were: awareness or knowledge of how to use such mechanisms is limited (93.8%); affordability constraints for people from marginalized and affected groups (65.6%); and, mechanisms are not sensitive to HIV (56.3%). Relatively few respondents (21.9%) stated that mechanisms do not function.

Very few respondents (5.1% of n=39) stated that no mechanisms were in place to promote access to justice in Canada. Instead, about two thirds of respondents (69.2%) stated that legal aid systems are applicable to HIV casework, almost half identified community paralegals as a mechanism, and one third identified pro bono legal services provided by law firms (33.3%) and legal services provided by (university-based) legal clinics (30.8%). In the comment field, respondents cited special organizations that address legal rights of people living with HIV, while also pointing out gaps in the system due to lack of coverage outside of larger centers, lack of services adapted to HIV, and the cost of legal services.

The majority of respondents (70.9% of n=17) stated that Canada has documented barriers to access to justice for key populations, people living with or affected by HIV. In the comment section, they stated that a number of organizations and studies had documented such barriers for prisoners, people who use drugs, sex workers, Indigenous communities, immigrants and refugees, and people living with HIV. A

number of respondents specifically made reference to the criminalization of HIV non-disclosure, including its impact on women. Funding and the cost of legal services were mentioned as barriers, as well as stigma, poverty, and the criminalization of sex work.

APPENDIX A: RESPONDENTS

Of the 50 respondents who completed some or all of the survey, 56% (n=28) identified as representing an organization while 44% (n=22) indicated they were responding to the survey as an individual.

Organizations. Among respondents representing an organization (n=28), most identified as being from regional/provincial organizations (46.4%) or local organizations (39.3%), with the remainder representing a national organization (14.3%). They indicated that they serve the following provinces and territories: British Columbia (7), Quebec (7), Ontario (5), Manitoba (2), Prince Edward Island (2), Newfoundland and Labrador (2), Northwest Territories (2), Alberta (1), Saskatchewan (1), and New Brunswick (1). Three (3) respondents were from organizations serving all provinces and territories (national-level work), while none served Nova Scotia, Nunavut or Yukon individually.

Respondents indicated serving or representing the following populations or communities. Totals add up to more than 100% because they could select all that apply.

- People living with HIV (92.9%)
- Indigenous communities (46.4%)
    - Please specify: Lac La Ronge Indian Band; notre territoire regroupe 5 communautés autochtones et 2 Centre d'amitié autochtones (organisme de services pour les autochtones en milieux urbains); All 33 First Nation Communities in Atlantic Canada and the off-reserve population; all Indigenous people with HIV are served; we work with Indigenous communities in BC; 32 reserves in our catchment area; Northern BC. Smithers and surrounding Areas; Ahousaht First Nation, Stz'uminus, Ehattesaht First Nation, Hul'qumi'num Treaty Group, Lake Cowichan First Nation, Snaw-naw-as First Nation, Nuu-chah-nulth Tribal Council, Penelakut Indian Band, Snuneymuxw First Nation, Stz'uminus First Nation; First Nations Community in Ontario; First Nations, Inuit and Metis; urban and rural areas when requested.
- African, Caribbean and Black communities (42.9%)
    - Please specify: All ACB communities; Nous comptons plusieurs usagers d'origine africaine; All African, Caribbean and Black people living with HIV are served; All of the above, including women from these communities; we work with youth living with HIV and youth in families with one or more parent living with HIV; People coming from HIV endemic countries; African and black community; Africaine et haïtienne; Individus provenant de pays ou le VIH est endémique.
- Newcomer, refugee and immigrant communities (42.9%)
    - Please specify: ACB newcomers; Newcomers – Syrian; We are often the initial point of contact in Saskatoon for HIV positive new comers; Nous comptons plusieurs immigrants parmi nos usagers; All newcomers, refugees and immigrant people living with HIV are served; no particular newcomer type; Syrian Refugees; HIV/AIDS Workshops are open to all refugee and newcomers to the community; Newcomers coming from HIV and hepatitis C endemic countries; all applies; Plusieurs PVVIH sans carte d'assurance maladie dans notre clinique communautaire.
- Gay, bisexual and other men who have sex with men (71.4%)
- Transgender communities (42.9%)

    - Please specify: Trans health; Transgender youth; Nous comptons plusieurs transgenres parmi nos usagers; all Transgendered people living with HIV are served; Transgender support group meets at our location; Female to Male Men's Wellness Services; Transgender communities at risk of acquiring HIV and hepatitis C; occasionally; Communautés transgenres PVVIH.
- People who inject drugs (75%)
- Sex workers (53.6%)
- Prisoners (35.7%)
- Others (25%)
    - Please specify: At risk youth; Complex mental health needs; People living with Hepatitis C, Indigenous Youth and Indigenous Women; HIV negative people who may be more at risk of contracting HIV are served; serve all community members; toutes personnes à risque ou sexuellement actives.

Respondents indicated that their organization (n=28) work in the following sectors or areas. Totals add up to more than 100% because they could select all that apply.

- Education (75%)
- Academic/Research (32.1%)
- Policy/Advocacy (39.3%)
- Front line service delivery (67.9%)
- Peer-based mentoring/peer advising/peer engagement (46.4%)
- Community-based organization (89.3%)
- Private sector (7.1%)
- Private foundation (0%)
- Other (7.1%)
    - Please specify: Capacity building and knowledge translation; medical.

Individuals. Individual respondents (n=22) indicated that they live in the following provinces and territories: ON (9), QC (3), NT (3), BC (2), MB (2), AB (1), SK (1), and NS (1). No one indicated that they live in NB, NL, PE, NV or YN.

They self-identified as being part of the following populations or communities. Totals add up to more than 100% because they could select all that apply. The responses below are based on n=18, since four respondents selected none of the options.

- People living with HIV (44.4%)
- Indigenous communities (11.1%)
    - Please specify: Inuvialuit; Urban Anishnabe/Dakota.
- African, Caribbean and Black communities (11.1%)
    - Please specify: East Africa; African woman.
- Newcomer, refugee and immigrant communities (16.7%)
    - Please specify: Immigrant; Immigrated to work in Canada; Came from East Asian country, now a Canadian citizen.
- Gay, bisexual and other men who have sex with men (50%)
- Transgender communities (0%)

- People who inject drugs (5.6%)
- Sex workers (5.6%)
- Prisoners (0%)
- Others (16.7%)
    - Please specify: Francophones; Contaminated blood transfusion; inner city worker.

APPENDIX B: COMPLETE RESULTS FROM THE NCPI (PART B) SURVEY

QUESTIONS RELATED TO THE FOLLOWING COMMITMENTS FROM THE 2016 POLITICAL DECLARATION

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? (n=38)

- No (47.4%)
- Yes (52.6%)
    - Please briefly explain when mandatory testing is carried out and the groups that are affected: Ceux qui appliquent pour le statut d'immigrant ou de réfugié doivent obligatoirement être dépistés au VIH; Immigration - Mandatory HIV testing; mandatory testing for Newcomers; For immigrants/refugee claimants; immigrants and refugees populations; For refugees there is mandatory testing for HIV; Pendant la grossesse, pour l'immigration; immigration screening, and although not mandatory—pregnant women are often tested without their knowledge as part of their regular prenatal check-ups; There is mandatory testing for pregnant women; Pregnant women; pregnant women; only for pregnant women; pour les femme enceinte seulement; pregnancy; Prenatal; HIV Prenatal testing for all women of childbearing age in Ontario; Some correctional institutions test new inmates (i.e. Springhill, Nova Scotia facility); I believe prisoners must undergo HIV testing at their arrival in jail…; Rape cases, Unconsented sex; Sexual Assault cases.

2. Where is viral load testing available in your country? (n=43)

- Available a specialized centres only (37.2%)
- Available at antiretroviral therapy facilities, either on-site or by referral (34.9%)
- Other (27.9%)
    - Please specify: Labs; Provincial and Private laboratories; Family health clinics, community clinics - blood gets sent to provincial lab. Fee for service doctor's practices; Infectious Disease clinic at the QE2 hospital in Halifax, NS; Available only through ID clinic doctor research fiefdom funding; available to any HIV+ person if requested by their doctor. it is the standard to get viral load test with the regular blood work; doctor orders to laboratory; any clinic technically should be able to do those tests; hospitals; numerous sites-community health centres, private physicians' offices, HIV specific organizations; Most areas can provide this testing, however majority do not in Saskatchewan, or have a reputation for discrimination so people do not access services there. Dry blood spot testing would be ideal for remote areas, where testing can be provided but people worry about confidentiality; Organismes communautaires.

3. Are any of the following retention support services available in your country (please select all that apply): (n=38)

- Community-based interventions (97.4%)
- Adherence clubs and peer support (84.2%)
- Other (10.5%)
    - Please specify: Interdisciplinary / Multi-disciplinary teams to address some of the variables that influence retention. Aids service organization offer support services for HIV positive persons. Women's only groups; HIV/AIDS Awareness workshops and Wellness Workshops; None; Come 2018-2019 fiscal year this will change as PHAC has cut 30% of AIDS Services Organizations.

4. Are any of the following adherence support services available in your country (please select all that apply): (n=38)

- Peer counsellors (94.7%)
- Text messages (50%)
- Use of reminder devices (42.1%)
- Cognitive-behavioural therapy (57.9%)
- Behavioural skills training / medication adherence training (63.2%)
- Fixed-dose combinations and once-daily regimens (55.3%)
- Case management (84.2%)
- Peer navigation (81.6%)
- Other (5.3%)
    - Please specify: None; This breakdown should be regional. What is available in Vancouver is not available in all areas of the country.

Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018

5. How many health facilities in the country are providing services for preventing mother-to-child transmission (PMTCT) of HIV? (n=1)

- 25

6. How many of the health facilities providing PMTCT services have community accountability mechanisms in place? (n=1)

- 2367

7. Has a meeting been held at the national level to review PMTCT progress in the past 12 months? (n=4)

- Yes (75%)
- No (25%)

7.1 If yes: (n=3)

a) Were community and civil society represented at the national review meeting? (n=1)
    - Yes (100%)
    - No (0%)

b) Was the opportunity provided for community and civil society to provide comments? (n=2)

- Yes (50%)
- No (50%)

c) Was analysis by community and civil society provided in a systematic manner? (n=2)
   - Yes (50%)
   - No (50%)

d) Was analysis provided by community and civil society documented and disseminated following the meeting? (n=1)
   - Yes (100%)
   - No (0%)

8. Do women living with HIV in your country participate in developing policies, guidelines and strategies relating to PMTCT? (n=15)

- Yes (73.3%)
- No (36.4%)

9. 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): (n=12)

- Mandatory or coerced testing and/or treatment for HIV (41.7%)
- Lack of informed, voluntary and prior obtained consent (50%)
- Forced and coerced abortion, contraception and/or sterilization (16.7%)
- Lack of confidentiality and privacy (58.3%)
- Other grave or systematic human rights abuses (33.3%)
  - Please describe: HIV non-disclosure is criminalized and treated as an aggravated sexual assault cases; criminalization of non-disclosure of HIV status; criminalization of non-disclosure of HIV, extremely poor detention conditions in some provincial prisons (Leclerc in Laval, QC notably), sex work laws that do not respect rights to safety and health; Because of stigma, some clients feel unsafe to disclose their HIV status to family members.

[Unfortunately, the following question was accidentally omitted from the survey. Therefore, results are unavailable.]

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

- *Yes*
- *No*
- *Don't know*

- *Doesn't apply*

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

- *Ensure that 90% of people at risk of HIV infection have access to comprehensive HIV prevention services, including sex workers and their clients, men who have sex with men, transgender people, people who inject drugs and prisoners.*
- *Reach 3 million people with pre-exposure prophylaxis by 2020*
- *Reach 25 million men with voluntary medical male circumcision in high-incidence countries by 2020*
- *Make 20 billion condoms available annually by 2020 in low- and middle-income countries*

Law enforcement

10. Can possession of a needle/syringe without a prescription be used as evidence of drug use or cause for arrest in your country? (n=32)

- Yes (31.3%)
- No (68.8%)

11. Have transgender people in your country been arrested or prosecuted for manifestations of their gender identity in the past three years? (n=49)

- Yes (14.3%)
- No (55.1%)
- Don't know (30.6%)

12. Have sex workers in your country been arrested or prosecuted in relation to selling sex in the past three years? (n=49)

- Yes (75.5%)
- No (8.2%)
- Don't know (16.3%)

13. Have people in your country been arrested or prosecuted for consensual same sex sexual acts in the past three years? (n=48)

- Yes (8.3%)
- No (77.1%)
- Don't know (14.6%)

14. Have people in your country been arrested or prosecuted for using drugs in the past three years? (n=47)

- Yes (85.1%)
- No (12.7%)
- Don't know (2.1%)

Legal protections for key populations

15. Does your country have any of the following legal protection for transgender people (please select all that apply)? (n=37)

- Constitutional prohibition of discrimination based on gender diversity (73%)
- Prohibitions of discrimination in employment based on gender diversity (78.4%)
- A third gender is legally recognized (16.2%)
- Other non-discrimination provisions specifying gender diversity (48.6%)
- No (8.1%)

16. Does your country have any of the following legal protections for sex workers (please select all that apply)? (n=32)

- Constitutional prohibition of discrimination based on occupation (15.6%)
- Sex work is recognized as work (0%)
- Other non-discrimination provisions specifying sex work (6.3%)
- No (78.1%)

17. Does your country have any laws or other provisions specifying protections based on grounds of sexual orientation (please select all that apply)? (n=40)

- Constitutional prohibition of discrimination based on sexual orientation (87.5%)
- Hate crimes based on sexual orientation considered an aggravating circumstance (77.5%)
- Incitement to hatred based on sexual orientation prohibited (62.5%)
- Prohibition of discrimination in employment based on sexual orientation (80%)
- Other non-discrimination provisions specifying sexual orientation (45%)

18. Does your country have any specific antidiscrimination laws or other provisions that apply to people who use drugs? (n=25)

- Yes (28%)
- No (72%)

HIV prevention services for people who inject drugs

19. Are needle and syringe programmes operational in your country? (n=48)

- Yes (95.8%)
- No, not at all (0%)
- No, but needles and syringes can be legally purchased in pharmacies without a prescription (4.2%)

20. Is naloxone (used to reverse opioid overdoses) available through community distribution in your country? (n=47)
    - Yes (91.5%)
    - No (8.5%)

21. Are opioid substitution therapy (OST) programmes operational in your country? (n=40)
    - Yes (90%)
    - No (10%)

HIV prevention services in prisons

22. Are needle and syringe programmes operational in prisons in your country? (n=29)
    - Yes (13.8%)
    - No (86.2%)

23. Are opioid substitution therapy (OST) programmes operational in prisons in your country? (n=20)
    - Yes (55%)
    - No (45%)

24. Are condoms and lubricants available to prisoners in your country? (n=31)
    - Yes (67.7%)
    - No (32.3%)

25. Is antiretroviral therapy (ART) available to all prisoners living with HIV in your country? (n=36)
    - Yes (80.6%)
    - No (19.4%)

26. Are HIV tests in prisons in your country:
    a) Carried out with the informed consent of prisoners? (n=25)
        - Yes (88%)
        - No (12%)
    b) Free of charge? (n=31)
        - Yes (100%)
        - No (0%)
    c) Confidential? (n=24)
        - Yes (70.8%)
        - No (29.2%)
    d) Available at any time during detention? (n=15)
        - Yes (53.3%)
        - No (46.7%)
    e) Accompanied by relevant and accessible information? (n=19)
        - Yes (52.6%)
        - No (47.4%)
    f) Accompanied by confidential pre- and post-test counselling? (n=18)
        - Yes (55.6%)

- No (44.4%)

g) Equally accessible to all prisoners? (n=11)

- Yes (72.7%)
- No (27.3%)

If no, which prisoners do not have equal access? Please specify:

- Good access to testing and treatment in federal prison. Provincial prisons often have very little health services and there can be long interruptions in treatment upon incarceration while the person waits for the prison's health team to see them and re-prescribe medication. Currently, the Leclerc women's prison in Laval, QC is under scrutiny for extremely poor detention conditions.
- Medical units are under staffed, have reported problems with getting to everyone who requires daily doses.

Participation

27. Do men who have sex with men participate in developing policies, guidelines and/or strategies relating to their health in your country? (n=43)

- Yes (90.7%)
- No (9.3%)

28. Do sex workers participate in developing policies, guidelines and strategies relating to their health in your country? (n=29)

- Yes (55.2%)
- No (44.8%)

29. Do people who inject drugs participate in developing policies, guidelines and strategies relating to their health in your country? (n=31)

- Yes (54.8%)
- No (45.2%)

30. Do transgender people participate in developing the policies, guidelines and strategies relating to their health in your country? (n=33)

- Yes (78.8%)
- No (21.2%)

31. Do former and/or current prisoners participate in developing policies, guidelines and strategies relating to their health in your country? (n=20)

- Yes (50%)
- No (50%)

Pre-exposure prophylaxis (PrEP)

32. Is pre-exposure prophylaxis (PrEP) available in the country? (n=44)

- Yes (90.9%)

- No (9.1%)

32.1. If PrEP is available, is it (please select all that apply): (n=36)

- Provided as national policy (19.4%)
- Provided as part of a pilot project (27.8%)
- Provided through research (33.3%)
- Available through private providers (77.8%)
- Available through the Internet (19.4%)

Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020

- *Ensure universal access to quality and affordable sexual and reproductive health-care services, including HIV services, for women.*
- *Eliminate HIV-related stigma and discrimination in health-care settings by 2020.*
- *Review and reform laws that reinforce stigma and discrimination, including on age of consent, HIV non-disclosure, exposure and transmission, travel restrictions and mandatory testing.*

33. Have any of the following provisions related to domestic violence been implemented in your country (please select all that apply)? (n=33)

- Court injunctions to ensure the safety and security of survivors (87.9%)
- Protection services for survivors of domestic violence, such as legal services or shelters (97%)
- Services for the person perpetrating violence (84.8%)

34. Does your country have any of the following to protect key populations and people living with HIV from violence (please select all that apply)? (n=33)

- General criminal laws prohibiting violence (100%)
- Specific legal provisions prohibiting violence against people based on their HIV status or belonging to a key population (42.4%)
- Programmes to address intimate partner violence (75.6%)
- Programmes to address workplace violence (84.8%)
- Interventions to address police abuse (57.6%)
- Interventions to address torture and ill-treatment in prisons (57.6%)

35. 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*:

a) First-line support or what is known as psychological first aid (n=33)

- Yes (100%)
- No (0%)

b) Emergency contraception for women who seek services within five days (n=35)

- Yes (100%)
- No (0%)

c) Safe abortion if a woman becomes pregnant as a result of rape in accordance with national law (n=34)

- Yes (94.1%)
- No (5.9%)

d) Post-exposure prophylaxis for sexually transmitted infections and HIV (within 72 hours of sexual assault) as needed (n=32)

- Yes (96.9%)
- No (3.1%)

36. Does your country have policies in place requiring healthcare settings to provide timely and quality health care regardless of gender, nationality, age, disability, ethnic origin, sexual orientation, religion, language, socio-economic status, HIV or other health status, or because of selling sex, using drugs, living in prison or any other grounds? (n=39)

- Yes, policies exist but are not consistently implemented (69.2%)
- Yes, policies exist and are consistently implemented (30.8%)
- No, policies do not exist (0%)

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

37. Do young people (15-24 years old) participate in developing policies, guidelines and strategies relating to their health in your country? (n=26)

- Yes (57.7%)
- No (42.3%)

37.1 If yes, do young people participate in any of the following decision-making spaces in the national HIV response? (n=8)

- Technical teams for the development, review and update of the national AIDS strategies and plans (12.5%)
- Technical teams for the development or review of programmes that relate to young people's access to HIV testing, treatment, care and support services (50%)
- Expanded UN Joint Teams on AIDS (0%)
- UN thematic teams on legal and policy reform and review (0%)
- National AIDS Coordinating Authority or equivalent, with a broad based multi-sector mandate (0%)
- Global Fund Country Coordinating Mechanism (25%)
- Civil society coordination spaces of populations most affected by HIV (50%)
- Other (12.5%)

- Please specify: National Aboriginal Youth HIV/AIDS Strategy Native Youth Sexual Health Network
- No (25%)

Ensure that 75% of people living with, at risk of and affected by HIV benefit from HIV-sensitive social protection by 2020

38. Do any of the following barriers limit access to social protection programmes in your country (please select all that apply)? (n=34)

- Social protection programmes do not include people living with HIV, key populations and/or people affected by HIV (8.8%)
- Lack of information available on the programmes (64.7%)
- Complicated procedures (64.7%)
- Fear of stigma and discrimination (100%)
- Lack of documentation that confers eligibility, such as national identity cards (35.3%)
- Laws or policies that present obstacles to access (52.9%)
- High out-of-pocket expenses (44.1%)
- People living with HIV, key populations and/or people affected by HIV are covered by another programme (20.6%)
- Other (2.9%)
    - Please specify: funding.

Ensure that at least 30% of all service delivery is community-led by 2020

39. 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)? (n=18)

- Restrictions on registration (22.2%)
- Territorial restrictions to operations, such as zoning (50%)
- Restrictions on providing services to key populations (38.9%)
- Cumbersome reporting and other restrictions on operations (88.9%)
- Other (16.7%)
    - Please specify: Restrictions on access to education for HIV service delivery, therefore limiting the number of available providers who may care for HIV positive persons; PHAC gutting AIDS Service Organizations; Lack of Funding.

40. Does your country have other regulatory barriers to community-led service delivery? (n=9)

- Restrictions requiring that HIV services only be provided in healthcare facilities (66.7%)
- Overly restrictive criteria for eligibility for community-based service delivery (66.7%)
    - Please describe: Restrictions on who may provide HIV care; On/off reserve jurisdictional restrictions for service delivery; Dépistage réservé aux professionnels de santé; Rapid testing is not available in CBO settings with out the costly addition of a nurse; red tape galore ensures that the political money allocated is not utilized; The Federal Liberal

Government is merging HIV funding with HEP C funding, they are cutting services and budgets for HIV organizations. The Public Health Agency of Canada is out of touch with the reality of people who are HIV positive, and we are not present or respected in their decision making.

- Other (33.3%)
    - Please describe: Access to all needed services are available, however some people living with HIV/AIDS choose not to take advantage of these services; The Public Health Agency of Canada has chosen to change its direction on HIV service delivery and is not funding "support" or "harm reduction" at this time. Over 30 long standing ASO's have been defunded across Canada leaving HUGE gaps in service delivery to people living with HIV. It does not in any way align with the 90-90-90 plan. All agencies will lose their funding as of March 31st 2018; Lack of funding. There are many isolated Northern Communities in need of HIV/AIDS, and other harm reduction educational services.

41. Does your country have laws, policies or regulations that hinder access to funding for work by civil society organizations and community-based organizations (please select all that apply)? (n=15)

- Lack of social contracting or other mechanisms allowing for funding of community-led service delivery to be funded from domestic funding (73.3%)
- ”Foreign agents” or other restrictions to accessing funding from international donors (13.3%)
- Other (33.3%)
    - Please describe: Recent budgets are limiting funding to numerous social services organizations; red tape galore ensures that the political money allocated is not utilized; The Federal Government of Canada (Liberal) is slow to respond and to communicate funding decisions. As of the end of May 2017, no federal funding for community-based organizations was flowing to service providers, all funding expired end of March 2017; There are no Community Based Organization streams of exclusive funding. CBO's have to apply with universities, Tribal Councils, and research bodies, ALL of which lobby Ottawa, and ALL of which have access to other forms of funding. CBO's are hand cuffed in how they can lobby, and rely on government funding to do crucial work. PHAC needs to go back to having funding available to AIDS Service Organization and actually listen when we give feed back; The roll out of the Public Health Agency of Canada’s Community Action Fund (CAF) has occurred within the context of an out of date Canadian HIV strategy and without a scale up of funding commensurate with the expansion that now includes the integration of prevention for HCV and other sexually transmitted and blood borne infections (STBBIs). The CAF’s narrow focus and exclusion of key activities to support the coordination of civil society and community has limited the possibilities for civil society to address HIV through this main source of HIV funding in Canada. Several community and civil society organizations are facing severe cutbacks or shutting down and there is no clear mapping of the current landscape to identify where gaps have been left. Regions throughout Canada have been left without federal HIV funding. Although Global Engagement is one of the pillars of Canada’s existing HIV strategy (the Federal Initiative on HIV), civil society-led global engagement activities are no longer a priority of the CAF. There is no parallel funding opportunity elsewhere in the

Canadian government to support, advance and ensure strong Canadian civil society leadership and contribution to evidence-informed global policy development or participation in transparent, inclusive policy review. As a result, this pillar has been left unfunded and Canadian civil society challenged to participate fully in global processes related to Canada's commitments under the SDGs including policy and priority setting and accountability. This shift in funding priorities will also greatly restrict opportunities for Canada to share promising and wise practices in tackling HIV/HCV/STBBIs. A key purpose for identifying promising and wise practice is to promote and facilitate the transfer and application of lessons learned and effective program models to local contexts elsewhere.

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

42. 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: (n=41)

- Yes, at scale at the national level (22%)
- Yes, at scale, at the sub-national level (14.6%)
- Yes, one-off activities (17.1%)
- Yes, at a small scale (41.5%)
- No (4.9%)

43. 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)? (n=42)

- Lack of political will (64.3%)
- Lack of funding (95.2%)
- Lack of capacity for delivery of trainings (57.1%)
- Barriers that hinder the target audience in accessing such trainings or capacity-building (69%)

Accountability mechanisms

44. Does your country have mechanisms in place to record and address cases of HIV-related discrimination (based on perceived HIV status and/or belonging to any key population)? (n=20)

- Yes (60%)
    - Please describe: Il existe des tribunaux et des commissions de droits de la personne qui peuvent examiner ces cas; Human Rights Commission; against the law; human rights; The Ombudsman is in place; it is done by grassroots organizations, not by the government and varies by region; Oui mais par des groupe communautaire et non le gouvernement; Service de plaidoyer fort du Réseau Juridique et VIH Info-Droit à la COCQ-SIDA; Canadian HIV/AIDS Legal Network, primarily focused in Ontario, and BC; It depends on the province that one resides in; Legal services are available for HIV-

related discrimination in Ontario; Specific to sexual abuse of minors and girl prior to age of consent.

- No (40%)

45. Does your country have any of the following accountability mechanisms in relation to discrimination and violations of human rights in healthcare settings (please select all that apply)? (n=38)

- Complaints procedure (100%)
- Mechanisms of redress and accountability (65.8%)
- Procedures or systems to protect and respect patient privacy or confidentiality (89.5%)

46. Does your country have any of the following barriers to accessing accountability mechanisms present (please select all that apply)? (n=32)

- Mechanisms do not function (21.9%)
- Mechanisms are not sensitive to HIV (56.3%)
- Affordability constraints for people from marginalized and affected groups (65.6%)
- Awareness or knowledge of how to use such mechanisms is limited (93.8%)

47. Does your country have mechanisms in place to promote access to justice (please select all that apply)? (n=39)

- Yes, legal aid systems applicable to HIV casework (69.2%)
- Yes, pro bono legal services provided by private law firms (33.3%)
- Yes, legal services provided by (university-based) legal clinics (30.8%)
- Yes, community paralegals (46.2%)
- Yes, other (15.4%)
    - Please describe: Special organizations addressing legal rights of HIV positive persons i.e., cases of disclosure and criminalization; Canadian HIV AIDS Legal Network; legal aid services with limited scope, various public tribunals (human rights, labour rights, housing rights) that provide lawyers, but many gaps in free legal coverage; Aide Juridique publique, mais peut adaptée au VIH; Very few HIV related lawyers who handle cases in Northern BC; There are systems and clinics. But the funding isn't always there. And it's only in bigger communities.
- No (5.1%)

48. Does your country have any documented barriers to access to justice for key populations, people living with or affected by HIV? (n=17)

- No (29.4%)
- Yes (70.6%)
    - Please describe and provide details on the scale: De nombreux groupes (p. ex. Réseau juridique) et études ont démontré et documenté des obstacles sur l'accès à la justice pour les prisonniers, les personnes utilisant des drogues, les travailleuses du sexe, les communautés autochtones, les immigrants et réfugiés et les personnes vivant avec le VIH; There are multiple barriers in some of the key populations e.g. Aboriginal population Prisoners Injecting Drug Users Sex workers; Canada and Ontario to their

great shame, continue to unjustly persecute and prosecute people who are HIV positive for non disclosure of their status. We are the only Canadians who have a criminalized health status; my country has determined that if an HIV+ has unprotected sex they can be charged with sexual assault which is a criminal offence; HIV non-disclosure charges, stigma/discrimination. More than 170 people who allegedly failed to disclose their HIV status have been charged with criminal offences in Canada. There is no evidence that criminalization of HIV non-disclosure acts as a deterrent against participation in behaviours that can transmit HIV. [http://www.catie.ca/en/hiv-canada/4/4-1/4-1-2]. A woman who might be living in an abusive relationship who is positive might decide to go to the police to charge their partner with violence and that partner might threaten to say they didn't disclose their HIV status to them. [http://www.cbc.ca/news/canada/hiv-aids-stigma-treatment-truvada-canada-1.3706333]; Women experience increased violence by those who use the current non-disclosure laws against them as threats, bribery, exploitation, etc; Criminalisation of non-disclosure of HIV Criminal laws against sex work tougher than before despite Supreme Court win; Stigma, poverty, lack of accessible information on where to go; awareness, funding, human resources, stigma preventing people from accessing services; PHAC cutting 30% of AIDS Service Organization funding across Canada. In Saskatchewan that is the population with the highest infection rate. Legal aid is over loaded, and we rely on community groups, but even then it is AIDS Service Organizations that advise them on these matters, and provide access to the population; financial barriers are a major problem; Funding. Low welfare rates. High homelessness. Not enough doctors. Stigma.