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CHALLENGES,
OPPORTUNITIES, AND PRIORITIES:

Findings from a National Policy Consultation on HIV and STBBI Prevention

Among Gay, Bisexual, Trans, Two-Spirit, and Queer Men (GBT2Q) in Canada

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Introduction

Gay, bisexual, trans, Two-Spirit, and queer men (GBT2Q) in Canada continue to be disproportionately impacted by HIV and sexually transmitted and blood borne infections (STBBIs). While only making up an estimated 2-7% of the total male population, GBT2Q still account for approximately 50% of new HIV infections and are similarly overrepresented among new cases of other STBBIs – including syphilis, gonorrhea, and HPV-related cancer. Rates of infectious syphilis cases among GBT2Q have been increasing nationally since 2011. In BC, syphilis cases have almost doubled in the past 5 years (558 in 2013 to 925 in 2018), with approximately 87% of them attributed to GBT2Q. Despite increased community-based responses, and increased availability of PrEP, HIV treatment as prevention, and new testing technologies, STBBIs persist in GBT2Q communities.

In addition to STBBIs, research shows that many GBT2Q face significant health and social challenges which may pose barriers to learning about, accessing, and effectively using STBBI prevention options. Many GBT2Q also experience high rates of depression, anxiety, suicidal thoughts, and problematic substance use (e.g. crystal meth use). They also share common experiences of social marginalization: sexual orientation and gender identity change efforts, discriminatory policies such as the blood donor deferral policy, and family rejection. Rather than being disconnected social problems, these are linked, co-occurring epidemics that impact each other. Often referred to as syndemics, they produce overlapping and mutually reinforcing effects on risk and vulnerability.

Efforts to engage GBT2Q in STBBI prevention and care must consider the context of co-occurring inequities, from substance use to housing insecurity. Combination prevention approaches offer many such tools to meet these needs.

Combination prevention refers to the use of "rights-based, evidence-informed, and community-owned programmes that use a mix of biomedical, behavioural, and structural interventions to have the greatest sustained impact on reducing new infections."[1] Combination prevention is a foundational concept within current UNAIDS policies and programs and can be extended to include other STBBIs.

Although this approach has been successfully implemented in several other countries, progress in Canada remains mixed and uneven, particularly among GBT2Q, and more so among GBT2Q who face additional barriers such as structural racism or discrimination (e.g. those who are Indigenous or racialized, disabled, HIV-positive, and/or drug users, for example).

As noted in the Pan-Canadian STBBI Framework for Action, "It is critical to deliver the most effective interventions, tailored to the needs of people at greatest risk for infection in communities where STBBI are most concentrated."[2] New biomedical interventions such as PrEP, PEP, HIV treatment as prevention, and Gardasil (HPV vaccine) may be game-changing tools, but only if made more widely accessible.

In this report, we outline key themes from a national stakeholder consultation on challenges, opportunities, and priorities for strengthening combination prevention among GBT2Q. Given that the project was conducted before the COVID-19 pandemic, which has disrupted services and supports and exacerbated HIV and STBBI prevention needs, the challenges described in this report may be even

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1 Joint United Nations Programme on HIV/AIDS (UNAIDS), 2010. Combination HIV Prevention: Tailoring and Coordinating Biomedical, Behavioural, and Structural Strategies to Reduce New HIV Infections.

2 Public Health Agency of Canada (PHAC), 2018. Reducing the Health Impact of Sexually Transmitted and Blood-Borne Infections in Canada by 2030: A Pan-Canadian STBBI Framework for Action.

greater and the need to act more urgent. However, new opportunities have also emerged following our consultations, including the introduction of HIV self-testing in Canada and an increase in the number of provinces and territories covering PrEP.

Project Objectives and Activities

In order to increase knowledge, awareness, and responses to combination HIV and STBBI prevention priorities – as well as the range of contextual and structural determinants that influence combination prevention – Community-Based Research Centre (CBRC) organized a series of six regional consultations from November 2018 to October 2019, focused on policy and practice issues affecting access to and uptake of services. Consultations were framed around policy and practice, and access and uptake, in order to provide a simple and practical lens for examining a broad range of potential challenges, opportunities, and priorities for strengthening combination prevention.

Each consultation engaged stakeholders with relevant and diverse expertise to ensure a variety of local, provincial, and/or regional policy and practice perspectives were represented in group discussions. In addition to providing a space for broad and formative discussion of issues for improving GBT2Q policy and practice, our consultations aimed to provide an informal opportunity to connect stakeholders working across related GBT2Q health and social professions in order to facilitate new connections and relationships for future policy-based initiatives.

This consultation project was funded by Gilead Sciences and organized in conjunction with the Advance Community Alliance, a 5-year Public Health Agency of Canada (PHAC)-funded initiative to increase combination prevention access and uptake among GBT2Q in Canada. As the national coordinator of Advance, CBRC partnered with Advance members and partners (Health Initiative for Men, Edmonton Men's Health Collective, OUTSaskatoon, ACT, Gay Men's Sexual Health Alliance, and RÉZO) to co-host these six regional consultations from November 2018 to October 2019. CBRC also organized a nationally oriented consultation in Ottawa in

collaboration with MAX Ottawa in February 2020, where preliminary themes from the regional consultations were shared.

Description of Consultation Events

Consultations were organized as relatively small, informal gatherings (approximately 15-25 participants per event) held over lunch or dinner, and set up in collaboration with local and/or regional partners who assisted with event coordination, including logistics (venue, scheduling, invitations) and small group discussions (e.g. using a note-taking guide). A sample agenda and note-taking guide is included in Appendix B and C, respectively. Invitation lists were developed with the assistance of local partners who identified or helped connect with potential participants from community, public health, research, or other relevant sectors (e.g. government, policy).

Each consultation followed a relatively consistent format with an agenda structured around three small group discussions focused on policy and practice challenges, opportunities, and priorities. Small group discussions were informally facilitated by a CBRC or local partner staff member with the aid of a note-taking guide that included possible discussion prompts and follow-up questions exploring issues around access and uptake of local and/or regional services. Following the consultation, small group discussion notes were collected and organized into preliminary themes representing emerging groups of ideas and considerations with regard to policy and practice challenges, opportunities, and priorities. The preliminary themes are described in the subsequent sections of this report.

Preliminary Consultation Themes and Summary Notes

Our regional consultations suggest many challenges continue to negatively impact GBT2Q access and uptake to HIV and STBBI prevention, testing, and treatment interventions, with significant disparities between provinces, and specific communities of GBT2Q. Factors in the health care system, the GBT2Q community responses, and social policies and programs continue to pose barriers to realizing the benefits of a combination prevention approach.

A variety of structural problems limit the uptake of STBBI interventions, such as:

- institutional stigma and discrimination towards GBT2Q, based on sexual and gender identity, as well as Indigeneity, race, HIV and Hepatitis C status, substance use, relationship status, ability, and class, among others
- high out-of-pocket costs for some health (e.g. ARVs for HIV) and social services (e.g. drug treatment programs), which vary based on provincial or federal plans
- co-occurring health and social issues that exacerbate HIV/STBBI risk (e.g. syndemics)
- silos within the health system
- public policies which create barriers to care (e.g. criminalization of HIV and some substance use)
- poor access to STBBI services, as well as services that address syndemic factors

Our consultations also identified many opportunities to increase access to combination prevention among GBT2Q. These opportunities include emerging technologies – such as self-testing, at-home testing, and injectable ARVs – scaling up community-based responses and research, and addressing longstanding inequities in our society. In addition, our consultations highlight structural policy and practice interventions, including increasing the role of allied health professionals (e.g. pharmacists, outreach workers), co-delivering mental health, substance-related services, and STBBI testing and care), and more meaningful involvement of community-based leaders in combination prevention services.

Based on these preliminary findings, we have also outlined a tentative list of potential combination prevention priorities. Due to the formative nature of our consultations, our preliminary findings should be further explored and developed within specific contexts based on geography, identities, and shared experiences. Participants did not have an opportunity to provide input into the preliminary themes and tentative priorities – this should become the focus for future consultations and policy development. However, despite being preliminary, our themes and priorities still reflect rich examination of a broad and intersecting range of issues which significantly impact combination prevention efforts, and will be useful for both informing current practice and conceptualizing new policy initiatives to strengthen health services and linkage among GBT2Q in Canada.

Challenges Facing GBT2Q Health: Preliminary Themes

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Systemic Oppression in the Health Care System

Siloed Health Care Focused on STBBIs

Public Policies that Undermine STBBI Services

Sexual Health Knowledge among GBT2Q and Providers

Insufficient and Inaccessible STBBI, Mental Health, and Substance Use Services

Challenges for GBT2Q Sexual Health: Preliminary Themes

Consultation participants identified many challenges for strengthening GBT2Q sexual health in Canada. GBT2Q communities are highly diverse, with significant differences in health practices, needs, outcomes, and rates of health care utilization. We have grouped the persistent challenges into the following themes:

- systemic oppression, including cissexism and heterosexism
- dominant focus on STBBIs to the exclusion of other topics
- public policies that undermine combination prevention
- service gaps in STBBI testing and care, mental health and substance use
- research and evidence gaps

Systemic Oppression in the Health Care System

GBT2Q fear being judged, stigmatized, or inadequately supported when accessing health care, often based on the multiple aspects of their identities. While many GBT2Q share experiences of heterosexism (homophobia, biphobia) and cissexism (including transphobia), experiences of judgement and stigma also arise based on Indigeneity, race, HIV and Hepatitis C status, substance use, relationship status, ability, and class. Examples of this systemic oppression include: incorrect pronoun use; assumptions about body parts, partners, identities and STBBI testing needs; dismissal of pain; and judgement directed towards people based on number of sexual partners, drug use, or absence of condom use.

GBT2Q may not access care at all to avoid these situations, or may choose not to disclose sexuality and/or gender identity, sexual activity, drug use, HIV status, use of ARVs, or other health issues and needs to health care providers. When GBT2Q are unsafe or uncomfortable to disclose, they do not receive appropriate care and support, including linkage to commsupportsOur consultations highlighted several examples of the lack of cultural competency among health care providers for GBT2Q:

- Gaps in knowledge of HIV, STBBIs, including fear of exposurance or ignorance of using rectal and throat swabs
- Sexual histories that leave out some GBT2Q experiences (e.g. frontal hole sex, multiple partners) and needs (e.g. reproductive health, HIV care)
- Gendered sexual health guidelines and clinical screening practices do not account for Two-Spirit people or transgender or non-binary GBT2Q
- Limited knowledge of trans bodies needs and experiences, as well as stigmatizing reactions to trans bodies, including unnecessarily asking trans people to show parts of their bodies when it is irrelevant to care
- Limited knowledge of relationship structures and diversity, which can be a barrier to taking relevant sexual histories
- Lack of familiarity with the range of sexual activities and relationships among GBT2Q, as well as broader queer and trans communities
- May not be aware of relevant biomedical tools and strategies to offer GBT2Q clients, including PrEP, PEP, testing at all relevant anatomical sites (i.e. throat, rectum, urethra), treatment, HPV & Hepatitis A & B vaccines
- Lack of familiarity with community-based supports, clinical options for gender-affirming care and support, mental health and substance use, relationship supports, fertility and/or reproductive health needs

As a result of the above, GBT2Q who have developed their own health knowledge through independent study or previous access to competent providers or community health programs have the choice between educating their providers to get the care they need, or go without the care they want, whereas GBT2Q without this knowledge may go without the care they are seeking. Examples include

HIV/STBBI testing, PrEP or PEP, and gender-affirming care.

Consultation participants also raised the issue of health care systems and environments themselves as sometimes unresponsive to the needs of GBT2Q communities. For example, the continued use of gender-specific washrooms, medical forms, and testing protocols overlook needs of Two-Spirit people, and trans and non-binary people. Participants described instances where privacy and/or confidentiality was compromised when accessing services (i.e. clerical staff asking inappropriate questions upon intake), and the relative lack of GBT2Q-affirming primary and integrated care options in most parts of Canada.

Negative experiences with health care providers experienced by an individual or their peers are factors that can push GBT2Q away from health services, meaning people may delay or avoid health services that have individual and community benefit. As well, these experiences can foster distrust of public health activities, such as partner notification for new HIV/STBBI diagnoses.

Systemic oppression is also reflected within policy and practice decisions (i.e. funding decisions) that fail to effectively engage with GBT2Q community leaders. First, GBT2Q are underrepresented in these types of decision-making positions as a result of systemic oppression. Where decision makers are aware of, and concerned about this absence, they may turn to GBT2Q community organizations and stakeholders. However, when these GBT2Q spaces lack sufficient funding and time to engage diverse GBT2Q, the voices that decision makers hear from represent only a portion of GBT2Q communities. As a result, public health decision-making may proceed without the appropriate insights and buy-in from GBT2Q clients and community.

Limited Diversity of GBT2Q in Community and Health Care Initiatives

As community and health care initiatives engage more GBT2Q as patients,

participants, volunteers, and staff, existing systems of oppression, especially colonization, mean some GBT2Q are being left behind. Participants described many groups of GBT2Q who are underserved in existing community and health care initiatives, often as a result of social marginalization. Underserved communities among GBT2Q people include Two-Spirit people, Indigenous people, Black people and People of Colour, suburban, rural, and remote communities; those who are not 'out' about their sexual and/or gender identity; trans and non-binary people; people who use drugs; people who experience mental health problems; youth, seniors, and people living with disabilities. While GBT2Q in these communities are present, they are often made invisible due to systemic oppression.

One of the contributing factors to these gaps are the limited decision-making and leadership roles for GBT2Q who are part of one or more of these communities. One example of how these concerns affect GBT2Q is PrEP access among Indigenous communities. Although PrEP has been fully covered for First Nations and Inuit people through NIHB since 2017, this information was not known, or broadly shared, by many GBT2Q-serving health care providers and organizations until much later. For another example, most queer friendly services and prevention campaigns are tailored to cisgender gay men. As a result, these campaigns may not engage GBT2Q who identify as bisexual, trans or non-binary, or who do not want to be associated with services for gay men.

There is a strong need for leadership from GBT2Q who have previously been made invisible in community health promotion. Yet, these spaces often reflect dominant forms of oppression, and can be unsafe for the very GBT2Q they seek to engage. Currently, community organizations and health care systems alike struggle to meaningfully engage the full diversity of GBT2Q people. Community groups need more funding to expand programming and offer more paid work opportunities.

Siloed Health Care Focused on STBBIs

GBT2Q are experiencing syndemics (multiple, overlapping epidemics), yet much of the support available to GBT2Q people and organizations focuses on HIV and in some cases, STBBIs more broadly. STBBI care is often highly promoted to GBT2Q people, while other types of services are less accessible, whether due to culturally competency, cost barriers, or health system factors.

GBT2Q people access services through a variety of health settings, from community organizations and public clinics, to specialists' offices and emergency rooms (overdose response, mental health crises, suicide attempts). Much of the care that GBT2Q receive in these settings address immediate concerns (e.g. suicidality, overdoses, ARV refills), but are unable to address the broader needs of the GBT2Q experience, including sexual health, mental health, addictions, and relationship supports. Within public health, STBBI services focus on biomedical tools and are under-resourced to address other aspects of health, as well as social, community, and relationship factors. Meanwhile, mental health and substance use issues, and social marginalization among GBT2Q – which together, produce complex health and social needs – are inadequately addressed. These ongoing, overlooked, and unmet health needs can exacerbate STBBI vulnerability

For many GBT2Q, STBBI clinics are the most frequently accessed point of care, and in other cases, the only point of care. When STBBI services are unable to provide combination prevention services, gender-affirming care, reproductive care, mental health care, substance use support, GBT2Q may go without the very services that may reduce their reliance on STBBI services. Access to relevant primary care was noted as a particular challenge for some Two-Spirit people, as well as trans and non-binary people. Given the very limited number of trans-inclusive and competent physicians, trans and non-binary GBT2Q face significant challenges in accessing not only STBBI interventions but primary care in general (including gender-affirming care).

Public Policies that Undermine STBBI Services

A number of public policies and structural factors limit the success of STBBI prevention, testing, and linkage to care.

Rates of illicit substance use among GBT2Q are relatively high, including substances like ecstasy/MDMA, GHB, crystal meth, poppers/amyl nitrates, prescription drugs (e.g. opioids, benzodiazepines), and steroids. Criminalization of these drugs is a barrier to health promotion and prevention of STBBIs and contributes to potential negative outcomes from drug use including overdoses by pushing everything "underground." Criminalization limits access to a safe drug supply, as well as drug checking services, harm reduction services (e.g. naloxone, safer consumption sites), and supplies (e.g. new needles, cookers, pipes). Participants also described the harm that may arise when transitioning from inhalation to injection use of crystal meth.

The criminalization of HIV non-disclosure in Canada is a significant source of stigma towards HIV-positive people. It ignores the science regarding the effectiveness of HIV treatment, and transmission risks. Further, this policy creates powerful disincentives for HIV testing, including among those at greater risk for infection.

Sexual Health Knowledge among GBT2Q and Providers

Knowledge of sexual health and STBBIs varies greatly, among both GBT2Q people and health care providers. In many cases, GBT2Q and providers with expertise around sexual health play an unofficial educator role for their peers, colleagues, and in some cases, providers. Access to sexual health knowledge is often connected to other aspects of a person's identity and experience. For example, GBT2Q living with

HIV often have more knowledge of viral load than their HIV-negative peers. People who speak and read one or both of Canada's official languages often have better access to this information. Heterosexism, cissexism, and sex-negativity contribute to environments where GBT2Q and providers alike may struggle to develop sexual health knowledge.

Participants identified specific knowledge gaps related to HCV transmission and treatment in GBT2Q communities. Some GBT2Q are at greater risk for HCV, such as GBT2Q who inject drugs such as crystal meth, as well as GBT2Q who are living with HIV. Yet, this information is rarely discussed, potentially due to few educational resources available and high prevalence of stigma around HCV among GBT2Q communities.

Some GBT2Q have developed expertise about STBBIs and are able to mobilize this information to identify and access the care that is relevant to them. Yet, many GBT2Q remain unaware of the STBBI tools and strategies available today. In both cases, GBT2Q may experience significant barriers to care, discussed below, that prevent them from acting on the information they have.

Health care providers often base their practice on STBBI clinical guidelines created by provincial or federal public health agencies. Yet, these guidelines do not sufficiently address the needs and experiences of GBT2Q people. For one, these guidelines are often highly gendered. The existing guidelines contribute to providers having less knowledge and sensitivity regarding sexual or gender diversity than GBT2Q people need.

In addition, they contribute to poor clinical outcomes, such as undiagnosed STBBIs due to failure to screen for relevant STBBIs at all pertinent anatomical sites. In the context of knowledge gaps among providers and GBT2Q, individual patients who do not volunteer information about their specific sex and drug use, may not receive information or referrals about appropriate STBBI testing, PrEP, HIV treatment options, and vaccinations. Where GBT2Q are knowledgeable themselves, are in affirming

environments, and have the tools for self-advocacy, GBT2Q may be able to educate providers and avoid these clinical gaps. Yet, it is not the role of patients to be educating providers, and in many cases, GBT2Q are not able to do so. Providers are also not able to adjust their practice immediately. Structural support is needed to ensure all health care providers serving GBT2Q have sufficient knowledge to do so.

In addition, both GBT2Q and their health care providers have varying knowledge about partner care and notification processes in the case of a diagnosis with a reportable STBBI. These differences in knowledge can result in missed opportunities for partners of people who receive a positive STBBI diagnosis.

Insufficient and Inaccessible STBBI, Mental Health, and Substance Use Services

Where GBT2Q and their health care providers have sufficient knowledge of sexual health, there may still be barriers to accessing the very services that are needed. Participants described many challenges related to accessing STBBI prevention, testing and care, as well as mental health, and substance use services.

One persistent barrier we heard from participants across our consultations was the divide between GBT2Q services in urban centres compared to those in rural, remote, reserve and suburban spaces. While there are more GBT2Q-specific services in urban spaces, many GBT2Q outside urban communities cannot access them. Whether GBT2Q choose to live outside urban spaces due to cost, cultural or family ties to non-urban communities, or any variety of other reasons, they require access to STBBI, mental health, and substance use services. Participants noted that gentrification in urban centres as a whole contributes to the decline of queer and trans community spaces, and affordable housing, across Canada.

Barriers to Antiretrovirals (ARVs) for Treatment and Prevention

For some GBT2Q, ARVs are financially out of reach, whether there is a high co-pay or deductible from a private or public insurer. Depending on the province, a lack of access to health insurance may mean the client must pay the full cost. GBT2Q may use ARVs to treat HIV, or to prevent HIV – such as with PrEP or PEP. Cost of ARVs varies between federal, provincial, and territorial plans, meaning access to ARVs may depend on where in the country GBT2Q people live, whether or not they are a Status First Nation, and their refugee, residency, or citizenship status.

Compassionate access programs offered by pharmaceutical companies are also an option that some GBT2Q rely on to get the medications they need. However, our consultations suggest that accessing private and public funding often requires knowing how to "navigate the system", as well as self-advocacy or advocacy by another health care provider. Further, GBT2Q who have private insurance coverage through a parent or partner may have to choose between protecting their privacy and not accessing ARVs, or disclosing their sexual activity to gain access.

Another barrier to getting antiretrovirals is the limited number of health care providers who are willing to prescribe ARVs and provide the required ongoing care. GBT2Q may struggle to find a health care provider who is willing and able to provide primary care that includes HIV needs, whether as treatment or prevention. There are many reasons health care providers may not prescribe PrEP, including gaps in knowledge, sex-negativity, and systemic oppressions including homophobia or transphobia. In addition, GBT2Q who are not comfortable disclosing their need for PrEP to their primary care provider may turn to other options to access PrEP, or go without. PrEP-specific services often have long waitlists, and these services are limited in the types of care they are able to provide. As such, GBT2Q who are on PrEP and seeing a provider regularly may still have unmet health needs because of the silos in our system.

Barriers to STBBI Testing Services

GBT2Q may access STBBI testing services from primary care providers, emergency rooms, GBT2Q-specific clinics or practices, general population STBBI testing settings, and in limited locations, via online lab requisitions, or at-home options. While there are many choices available to provide STBBI services, many GBT2Q continue to face barriers to access.

First, not all STBBI testing services are responsive to GBT2Q people's specific needs, and many GBT2Q do not live nearby a service that is GBT2Q-affirming. Explicitly GBT2Q-affirming STBBI testing services may be available in urban centres, although in many cases, these services have significant waitlists and/or limited hours. As a result, GBT2Q may need to wait weeks between when they try to get tested and when an appointment is available. In addition, drop-in services are also often at capacity, meaning GBT2Q may be turned away from services or face lengthy waits. These wait times are not possible for all GBT2Q, who may have additional work, family, or personal responsibilities that make uncertain wait times difficult or impossible to accommodate.

Reserve, remote, and rural communities often do not have dedicated STBBI testing services. Instead, STBBI services are provided as part of primary care, through emergency rooms, or in community health centres that respond to a host of health concerns. Participants emphasized the ways these settings can make it harder for GBT2Q people to disclose sexual or gender identity, as well as their sex and drug use practices, often due to concerns about privacy and confidentiality. While some GBT2Q have the opportunity to travel to centres with more choices for STBBI testing, whether through work or personal travel, travelling for health care is not always possible whether due to care responsibilities at home, cost, or restrictive time off schedules from work.

Many GBT2Q experience concerns about privacy and confidentiality when accessing STBBI care. When testing, GBT2Q may run into people they know,

whether other GBT2Q people, or non-GBT2Q family members, friends, or neighbours who work in, or are accessing, the same local health centres. Individuals who encounter GBT2Q in these health care spaces may stigmatize GBT2Q, whether based on perceived number of partners, perceived STBBI status, or perceived relationship status.

Some GBT2Q are concerned about the privacy of their STBBI test results, whether based on distrust of public health services, concern about sharing of personal health data with insurance companies, or their colleagues seeing their test results as they make their way through the health system. While some jurisdictions provide anonymous testing options, primarily for HIV, these are not widely advertised or discussed. Confidentiality and privacy concerns also arise when a person is diagnosed with a reportable STBBI.

While there are many emerging options to access STBBI testing, there are persistent barriers to implementation. Many jurisdictions do not have access to recent developments to improve STBBI testing, such as rectal and throat swabs, as well as HIV point of care tests despite their widespread use in several provinces for about a decade. Most recently, HIV self-tests have been approved by Health Canada, but are not widely available or covered by any provincial or territorial government. In addition, there is a continued reliance on brick and mortar STBBI and primary care services, when much STBBI testing can be ordered through online/digital options, from telehealth to GetCheckedOnline.

Barriers to Vaccinations and Emerging Biomedical Prevention Options

While vaccinations are not available for all STBBIs, vaccines are available for HPV and Hepatitis A and B (HAV and HBV). Yet, cost remains a barrier that GBT2Q must navigate when accessing vaccinations.

Publicly-funded HPV vaccine programs fall short of the recommendations from Canada's National Advisory Committee on Immunization (NACI). In most

jurisdictions, universal HPV vaccines have age and gender criteria that exclude many GBT2Q who will benefit from the HPV vaccine. In these cases, GBT2Q can only access the HPV vaccine if they can afford it.

In addition, access to HAV and HBV vaccines varies between jurisdictions, with some GBT2Q eligible for these vaccines, and others left out. In addition to potential financial barriers that GBT2Q may face accessing vaccines for STBBI prevention, knowledge of health care providers is also a limitation. Health care providers may or may not know to offer these vaccines to GBT2Q, or how to support them in accessing the vaccine through publicly-funded programs.

Participants also discussed the need to support research, approval, and implementation of emerging biomedical prevention options, including daily doxycycline as PrEP for syphilis, same-day HCV treatment starts, and injectable HIV medications for treatment and prevention.

Barriers to Mental Health and Substance Use Interventions

Rates of mental health and substance use problems among GBT2Q remain high, while access to affordable and effective interventions continues to be very limited. Unmet mental health and substance use needs can negatively influence sexual health determinants, including access or uptake of STBBI interventions, or increased drug use and sexual risk taking.

GBT2Q have limited access to mental health and substance use supports, from individual and relationship counselling to treatment services. Public and private services, including psychologist and psychiatrist appointments, often have long wait lists, and are often not available at the time when GBT2Q need them most. In addition, many health care providers within the mental health and substance use sector lack the experience and cultural competency necessary to support the many experiences of GBT2Q. In cases where their course of treatment includes

medication, GBT2Q may not be able to afford or access this medication.
To help address the lack of services, many community-based organizations offer group programs to support mental health and substance use. Beyond GBT2Q organizations, Alcoholics and Narcotics Anonymous provide free programs, yet these faith-based and abstinence-focused elements are significant barriers for some GBT2Q. The group structure and "zero tolerance" approach can be a barrier for GBT2Q. GBT2Q may also avoid these groups due to concerns about privacy and confidentiality, such as fear of being outed as queer or trans, or having a mental health issue or substance use concern. In addition, GBT2Q may also want to avoid association with community organizations that are specific to HIV, GBT2Q people, or addictions as a result of ongoing stigma towards substance use.

GBT2Q who cannot access publicly-funded services may have to look for private options, which can be very costly. Counselling or psychotherapy services, including relationship counselling and counselling for survivors of sexual orientation and gender identity and expression change efforts (SOGIECE), may be out of reach financially for individuals without private coverage. Yet, even private health insurance is often insufficient to cover the cost of ongoing services. While some community organizations offer individual counselling, these programs often have long wait times, and encourage or only support short term use.

Many substance use treatment programs have weak evidence of effectiveness, but frequently they are the only source of available support. Further, pharmaceutical interventions are not available to address crystal meth addiction. In addition, many of these programs require a large commitment of time over several weeks and requires time off work.

Research and Evidence Gaps on GBT2Q Health

Access to population-specific data on GBT2Q health in Canada outside of "MTV" (Montreal, Toronto, and Vancouver) remains very limited. These evidence gaps pose

challenges to planning, implementing, and evaluating GBT2Q health in many communities across Canada. Few large-scale studies of Canadian GBT2Q exist, and government data sets and surveys often have incomplete or inconsistent data related to a person's sexual and gender identity, or may not include questions that are more relevant to GBT2Q people. In addition, there are lengthy delays between when data is collected, and when it is made available to community organizations, governments, and researchers outside these study teams. These delays can also prolong inequities that may be identified through the data, unknown to those responsible for making important funding, programming, or policy decisions.

Datasets that do exist specific to GBT2Q are often too small to be able to understand the diversity within GBT2Q communities. Recruiting sufficiently large samples of GBT2Q participants with varied experiences is challenging, often as a result of limited resources and the ways systemic oppression is reproduced even within GBT2Q spaces (i.e. exclusion or marginalization of some GBT2Q). These factors mean there is even less data available to identify and address inequities within GBT2Q communities.

Important community-based and implementation science research is underway to expand the availability of population-specific data, although this often takes place in the metropolises of Montreal, Vancouver, and Toronto. In some ways, generating research in these locations provides the evidence needed to further develop services. In contrast, communities without this type of research may not be able to gather evidence needed to fund programs.

Sex Now is one of the only national datasets for GBT2Q, but the sample size (recent online samples are 6,000-8,000) is still generally insufficient for localized and population-specific analyses. Delays in reporting research findings and knowledge translation from various research projects contributes to frustration among community members who are frequently asked to participate in research, but frequently do not hear about the results or next steps.

Opportunities for Strengthening GBT2Q Health: Preliminary Themes

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Centering of Indigenous and Two-Spirit People in Health Care as Well as GBT2Q Community Initiatives and Organizations

New and/or Emerging Technologies and Approaches to STBBI Care

Increased Community-Based Research and Implementation Science

Increased Political and Policy Leadership for Strengthening GBT2Q Health in Canada

Expanded Capacity, Resources, and Buy-in to Strengthen Cultural Competency in Health and Social Service Settings

Increased Community Capacity to Collaborate with Service Providers and Decision-Makers

1. Centering Indigenous and Two-Spirit People in Health Care as Well as GBT2Q Community Initiatives and Organizations

There is growing awareness among communities, service providers, and policymakers on the need to centre the voices and experiences of Indigenous and Two-Spirit people. Yet, there is limited understanding of past and present colonization, and the unique needs of Indigenous and Two-Spirit people.

Public awareness of the marginalization faced by Indigenous and Two-Spirit people is being made more visible by the work of the Truth and Reconciliation Commission of Canada and the Missing and Murdered Indigenous Women and Girls Inquiry, which included several 2SLGBTQIA+ Calls for Justice. Community organizations are also starting to prioritize Indigenous and Two-Spirit communities in more meaningful ways, such as ensuring participation of community leaders in GBT2Q health promotion and prevention planning, developing campaigns and resources to address specific needs and priorities for Two-Spirit and Indigenous queer and trans people.

Initiatives to increase Indigenous and Two-Spirit engagement within GBT2Q within GBT2Q programs and services are slowly starting to gain momentum, such as the Two-Spirit Dry Lab program at the BC Centre for Disease Control (led by Harlan Pruden), as well as work led by the 2 Spirits in Motion Society. CBRC has also created an Indigenous and Two-Spirit Program Manager position to strengthen knowledge exchange and intervention development initiatives for Two-Spirit

communities across Canada.

While these initiatives are drawing attention to Indigenous and Two-Spirit people, there are many unmet needs within STBBI care and GBT2Q health, especially given the nation-specific context of Indigenous peoples' needs. Many initiatives are pan-Indigenous in scope, despite the distinct cultures, languages, and knowledges of Indigenous communities across Canada. While many organizations want to do this work, not every organization is able to, whether due to time or funding constraints, absence of relationships with Indigenous peoples, or past and ongoing harms towards Indigenous people.

Opportunities to centre Indigenous and Two-Spirit people within GBT2Q health include:

- Establish paid positions for Indigenous and Two-Spirit people within health systems and GBT2Q organizations
- Ensure all service providers receive cultural responsiveness training and ongoing professional development
- Fund Indigenous-led organizations, research, clinics, and cultural programming that serves GBT2Q people
- Implement the Calls to Action for Truth and Reconciliation Commission and Calls for Justice from Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls

2. New and/or Emerging Technologies and Approaches to STBBI Care

Participants identified a number of opportunities to implement new approaches to meet the challenges of accessing STBBI prevention, testing, and treatment:

- Increase involvement and leadership of nurses and nurse practitioners, pharmacists, peers, outreach workers, and community-based organizations in delivering PrEP, HIV treatment, point of care, and at-home tests in non-clinical settings

- Streamline the process for referrals, prescriptions, and follow-up for PrEP and HIV treatment
- Expand on-demand PEP ("PEP-in-Pocket") and event-based PrEP to provide HIV-negative GBT2Q with immediate access to antiretrovirals on an as-needed basis
- Scale up access to integrated health centres that offer STBBI care alongside mental health, substance use, and HIV care
- Expand digital technologies for STBBI testing (e.g. GetCheckedOnline)
- Embed accurate information about HIV transmission and undetectable viral load in health, education, legal, and social systems

Participants noted many emerging innovations, such as injectable ARVs and self-testing technologies, that will address current barriers to care among GBT2Q. Federal and provincial regulators and public payers must expedite access to these innovations as they evolve. Injectable and long-acting ARVs may be especially relevant for GBT2Q who experience challenges taking pills on a daily basis. New STBBI testing technologies including dried blood spot (DBS) testing, HIV self-testing technologies, and multiplex testing (HIV and syphilis) eliminate many of the barriers GBT2Q experience in current services. In addition, participants noted the possibility of doxycycline as pre-exposure prophylaxis for syphilis.

3. Increased Community-Based Research and Implementation Science

Based on several successful studies in Canada to date, participants identified the importance of increasing community-based research and implementation science to strengthen GBT2Q health. In particular, participants highlighted the role that this type of work can play in developing interventions, and evaluating current needs. Participants offered several ideas to increase community-based research and implementation science studies to guide intervention development and evaluation:

- Scale-up national community-based research studies (e.g. Sex Now, Trans PULSE Canada) to strengthen localized and population-specific analyses on combination

prevention priorities
- Increase in GBT2Q-focused research on mental health needs and intersec- tion with sexual health determinants

4. Increased Political and Policy Leadership for Strengthening GBT2Q Health in Canada

Provincial, territorial, and federal governments have many opportunities scale up leadership in the area of GBT2Q health. For example, in recent years, the federal Standing Committee on Health released a report with recommendations to advance LGBTQ2IA+ health in Canada, while the Standing Committee on Justice released a report recommending legislative changes to address the overcriminalization of HIV non-disclosure.

Recommendations from the federal Standing Committee on Health's 2019 study specifically address STBBI prevention priorities, such as:
- working with provinces and territories to increase cultural competency training and education of health care providers (e.g. through professional and regulatory bodies)
- address gaps in coverage for PrEP, HIV treatment, HPV vaccination, hormone therapy and gender affirming surgeries
- restore funding for the federal HIV/AIDS initiative
- update sexual health guidelines
- address syndemics of mental health and substance use
- support comprehensive sexual health education in schools
- increase visibility of queer and trans communities in data collection through federal surveys and research

The Standing Committee on Justice Report identifies a significant political and policy opportunity to address the overcriminalization of HIV non-disclosure, which

continues to punish HIV-positive individuals (including those who are undetectable and cannot transmit HIV through sex), and reinforce stigma which contributes to fear around HIV testing. While this legal framework remains unjust, the linkage of HIV viral load to criminal acts among HIV-positive people means the government has a duty to eliminate barriers, especially financial, to treatment.

It is encouraging to see the needs of GBT2Q communities reflected in these reports, as well as leadership from the federal government in other areas. For example, Canada's Gender Results Framework explicitly includes LGBT2Q+ communities within gender-based analysis policy, funding through the Department of Women and Gender Equality, and increased support to address health priorities, including HIV and STBBIs. Further, the Chief Public Health Officer's Report on Stigma offers opportunities to mobilize new interventions to address stigma through both upstream (e.g. schools, health, social environments) and downstream interventions (e.g. mental health, other social support services) that will benefit GBT2Q.

Federal leadership is needed to implement the recommendations and findings of these reports and continue to invest in LGBT2Q+ community leadership. In addition, opportunities for federal-level policy leadership include:

- implement the Calls to Action for Truth and Reconciliation Commission and Calls for Justice from Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls
- decriminalize all drug use
- foster safe working environments for adult sex workers
- implement national pharmacare, including universal access to gender-affirming care
- expedite review processes for biomedical advances in STBBIs
- update Canada's blood, organ, and tissue donation deferral policies to reflect current evidence
- reverse the ban on poppers

5. Expanded Capacity, Resources, and Buy-in to Strengthen Cultural Competency in Health and Social Service Settings

Despite ongoing challenges, the level of knowledge and expertise on GBT2Q cultural safety and clinical competency is increasing. Participants noted opportunities to scale up and further integrate GBT2Q health within health care and social service programs, continuing medical education courses, and ongoing professional development to address knowledge and skills gap within current workforce. These opportunities include funding for community organizations to develop cultural competency resources for health and social service providers, as well as resources for GBT2Q to use with their providers.

Another opportunity is creating public health and community resources (e.g. directories and resource guides listing local health care providers who are knowledgeable about queer and trans health; positive space campaigns and signage for clinics and doctor's offices) to increase visibility of culturally competent providers.

6. Increased Community Capacity to Collaborate with Service Providers and Decision-Makers

The significant increase in local, provincial, and national GBT2Q-focused community initiatives over the past few years has strengthened the voice and capacity of the community sector to respond to challenges, but also opportunities and priorities. At a national level, the Advance Community Alliance (5-year PHAC-funded initiative to increase access and uptake of combination prevention; partnership between CBRC, HIM, ACT, MAX, and REZO) and CBRC's transition from

BC to operating nationwide has increased capacity for knowledge creation and mobilization (e.g. data analysis and KTE), community collaboration (e.g. interventions) and stakeholder engagement (e.g. advocacy). In the Prairie and Atlantic regions, the Community Alliance project is also facilitating new collaborations with local leaders and organizations, including EMHC, OUTSaskatoon, Halifax Sexual Health Centre. These opportunities help to provide a stronger voice for local communities in those regions, which historically have had very limited funding and resources for GBT2Q-specific programming.

Community leadership and programming continues to expand in many provinces across Canada. The Gay Men's Sexual Health Alliance of Ontario was the first provincial initiative focused on gay and bisexual men in Canada, and continues to lead innovative sexual health programming (e.g. innovative and effective campaigns on sexual health, sexualized substance use). The Network in BC (coordinated by CBRC) developed in response to one of the recommendations from the 2014 Provincial Health Officer's report (HIV, Stigma, and Society), and continues to grow as a platform for knowledge exchange and intervention development among provincial stakeholders. Emerging provincial networks in Alberta, Manitoba, and Nova Scotia are also increasing community capacity and resources to collaborate on new interventions.

Local community organizations and initiatives specific to GBT2Q have also increased in the past 5 years and has significantly increased local programming capacity for sexual health and STBBI interventions. Community awareness, engagement, and mobilization initiatives are helping to reduce the gap in knowledge and programs for combination prevention (e.g. ACT community consultation and "ACTivator" initiatives to identify and respond to intervention gaps).

Federal funding for LGBT2Q programming is increasing through the Department of Women and Gender Equality, as well as inclusion of LGBT2Q communities as priority populations in other federal government funding calls (e.g. PHAC's Community Action Fund, Mental Health Promotion Innovation Fund). CBRC

recognizes the importance of building capacity of a broad spectrum of queer and trans organizations and individuals beyond solely GBT2Q communities.

Priorities for Strengthening GBT2Q Health: Preliminary Themes

Increase Cultural Competency and Skills among Health Care Providers Through Enhanced Training and Education

Strengthen the Role of Communities in the Design, Delivery, and Evaluation of Relevant Health Services

Expand Federal Leadership and Investments in GBT2Q Health

Expedite the Introduction of New STBBI Technologies

Increase Focus on Knowledge Translation and Exchange

Expand Upstream Interventions

1. Increase Cultural Competency and Skills among Health Care Providers Through Enhanced Training and Education

- Increase funding to develop new and/or expanded cultural competency interventions, such as training programs and community or service provider resources developed or offered by post-secondary institutions, health authorities, and community-based organizations
- Work with post-secondary institutions and health professional regulatory bodies to incentivize participation in cultural competency training and education programs

2. Strengthen the Role of Communities in the Design, Delivery, and Evaluation of Relevant Health Services

- Increase funding and opportunities for community stakeholders and organizations to become more engaged in designing, implementing, and evaluation of initiatives to link GBT2Q to care. For example:
  - increase funding of community-led interventions to increase awareness of effective biomedical interventions and availability of tools and resources to access relevant services
  - mandate (and provide financial support for) community involvement in the planning, implementation, and evaluation of services
- Increase funding to community-based organizations and stakeholders to:
  - expand program and research capacity to engage in collaborative delivery and evaluation of services
  - increase capacity to engage and support underserved and/or underrepresented communities (e.g. Indigenous and racialized communities, people living with HIV, newcomers and refugees, people who use drugs, people with mental health issues)

3. Expand Federal Leadership and Investments in GBT2Q Health

- Implement a national pharmacare program that will ensure GBT2Q and other vulnerable communities have access to: PrEP; PEP; HIV treatment; HPV, Hepatitis A and B vaccinations; gender-affirming care (i.e. hormone replacement therapy)
- Empower agencies like the Public Health Agency of Canada to expand STBBI policy leadership across Canada, such as working with the provinces and territories to implement new clinical guidelines for STBBIs, and to support increased access to HPV vaccination (i.e. in line with NACI recommendations)
- Increase access to mental health and substance use interventions by reducing financial barriers for GBT2Q, by increasing the availability of free or sliding scale services within provincial and federal medical plans and at community-based organizations
- Increase investment in biomedical interventions for syphilis and HPV

4. Expedite the Introduction of New STBBI Technologies

- Reduce barriers to the implementation of biomedical tools that have been rigorously evaluated for safety and efficacy in other countries, including self-testing technologies for STBBIs
  - While HIV self-testing is already being evaluated for implementation in Canada, the regulatory process for other technologies (including rapid point of care tests for syphilis and multiplex testing) should be much more streamlined
- Federal regulations that impact the availability of STBBI interventions, such as Canada Post regulations that prohibit the shipment of biological specimens (e.g. preventing mailing of dried blood spots for testing) or Health Canada laws that do not permit importation of drugs (e.g. preventing importation of generic Truvada) should be reviewed to assess whether exemptions can be made

5. Increase Focus on Knowledge Translation and Exchange

- Increase funding for KTE activities within research and health promotion projects to ensure timely reporting of data and research findings
- Increase funding and opportunities for community-led KTE to strengthen the knowledge and evidence base available to community-based organizations and service providers
- Increase coordination and collaboration between key stakeholders to address shared needs for research and evidence
- Provide guidance, capacity building, and resources to academic and community based researchers to enhance KTE
- Increase funding for interventions to strengthen health literacy in combination prevention, including initiatives to increase awareness and self-efficacy among GBT2Q (e.g. knowledge of effective interventions, resources to increase uptake of relevant services), interventions to increase cultural competency among health care providers

6. Expand Upstream Interventions

- Increase the availability of positive, affirming information and resources on sexual orientation and gender identity and expression within schools and other communi ty settings to strengthen visibility and understanding of queer and trans identities
- Increase funding for school and community interventions on comprehensive sex education that is inclusive of all queer and trans people in order to increase health literacy
- Ensure GBT2Q are engaged in development and implementation of strategies focused on poverty, housing, substance use, sex work, and mental health
- Support Indigenous leadership within and beyond GBT2Q health initiatives

Conclusion

GBT2Q communities have a wealth of practical knowledge on how public policies impact individual and structural level health determinants. Yet, there are relatively few opportunities to participate in policy-centered discussions on advancing combination prevention and STBBI health. Consultation participants highlighted the value of these dialogues.

The formative findings from this consultation project are meant to be illustrative of the broad range of policy and practice issues shaping combination prevention of STBBI among GBT2Q in Canada. Given the informal and preliminary nature of our consultations, these findings should be examined in consideration of the local or provincial context, including the availability of relevant services, programs, and supports, such as public health insurance policy which may or may not provide coverage for STBBI-related medications or vaccinations.

A renewed focus on combination prevention approaches provides many opportunities to strengthen GBT2Q health. Our consultations underscore ongoing challenges that negatively impact STBBI prevention and care, including systemic oppression, silos within the health system, and public policies that discourage GBT2Q from accessing STBBI care. Further, the consultations identify many opportunities for policy and practice initiatives to address these needs. Central to this work is leadership, engagement and opportunities for Indigenous and Two-Spirit people. Community-led strategies are an essential component of combination prevention approaches.

Our consultation findings will inform GBT2Q advocacy across the country, whether with federal, provincial or local actors: clinicians, funders, policy makers, law makers, and health decision makers. These preliminary results point to immediate opportunities to strengthen GBT2Q health, including increasing cultural responsiveness among service providers, strengthening engagement of GBT2Q in health care planning and delivery, expediting the introduction of new STBBI technologies, and expanding upstream interventions.

Appendix A: Sample Agenda for Regional Consultations

Advance »
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Regional Policy Consultation on GBT2Q Health & Linkage to Care

Batch Restaurant & Gastropub | 75 Victoria Street - October 16, 2019 - 6:00pm – 8:30pm

Agenda for Policy Consultation:

6:00pm – 6:30pm	Arrivals & Networking: Open Bar
6:30pm – 6:45pm	Introductions, Review of Agenda
6:45pm – 7:15pm	Challenges in Improving GBT2Q Linkage to Care Small Groups: What are some policy and/or practice challenges which impact gay, bi, trans, Two-Spirit, and queer (GBT2Q) men's linkage to services across the continuum of care for HIV and other STBBIs in Toronto and/or Ontario?
7:15pm – 7:50pm	Opportunities for Improving GBT2Q Linkage to Care Small Groups: What are some policy and/or practice opportunities to positively impact GBT2Q men's linkage to services across the continuum of care for HIV and other STBBIs in Toronto and/or Ontario?
7:50pm – 8:20pm	Priorities and Strategies for Improving GBT2Q Linkage to Care Small/Full Group: What are some policy priorities for improving GBT2Q men's linkage to services in Toronto and/or Ontario? What are some strategies that we can undertake to achieve those priorities? What is needed to mobilize these strategies?
8:20pm – 8:30pm	Review of Next Steps, Closing and Thank You

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Appendix B: Sample Note-Taking Guide

Toronto GBT2Q Health Policy Consultation

CHALLENGES IN IMPROVING GBT2Q LINKAGE TO CARE

- What are some policy and/or practice challenges which impact gay, bi, trans, Two-Spirit, and queer (GBT2Q) men's linkage to services across the continuum of care for HIV and other STBBIs in Toronto and/or Ontario?

POSSIBLE DISCUSSION PRIMERS AND QUESTIONS:

- Financial barriers to HIV treatment or prevention (PrEP, PEP)
- Lack of funding/services for broader STBBI testing, treatment, and prevention initiatives (e.g. peer-, community-, home-based testing, HPV vaccinations, doxy PrEP)
- Stigma and lack of cultural competency and/or safety in healthcare settings; lack of training, education, and standards with regard to LGBTQ2 cultural competency/safety
- Lack of capacity among healthcare and/or service providers
- Lack of coordination among HIV/STBBI stakeholders and service providers
- Syndemic health issues among GBT2Q, such as mental health issues and problematic substance use, history of trauma, violence, and/or victimization
- Lack of comprehensive sex education in schools and/or community-based settings
- Lack of awareness, understanding, and/or commitment from governments and institutions on GBT2Q health needs
- Lack of effective engagement with marginalized communities of GBT2Q that may face intersectional barriers to services and community support

NOTES:

POINTS OF CONSENSUS

OPPORTUNITIES FOR IMPROVING GBT2Q LINKAGE TO CARE

- What are some policy and/or practice opportunities to positively impact GBT2Q men's linkage to services across the continuum of care for HIV and other STBBIs in Toronto and/or Ontario?

POSSIBLE DISCUSSION PRIMERS AND QUESTIONS:

- Emerging local initiatives and research (e.g. Toronto to Zero, Gay Men's Health Hub, ACT anonymous POC testing pilot, community-based and public health research – ask the researchers in the group to talk a bit about their research!)
- Possible funding and leadership through the Department for Women and Gender Equality (WAGE), formerly the Status of Women which now has an expanded mandate to address GBA+ (gender-based analysis) and address equity and equality issues for sexual and gender minorities
- Promising developments regarding HIV criminalization (e.g. Justice Committee report and recommendations to move HIV non-disclosure from sexual assault law and create a new provision inclusive of all communicable diseases and requiring actual transmis sion and proven intent)
- Greater understanding and awareness of syndemic health issues impacting GBT2Q men, including increased funding and leadership around PnP/chemsex/sexualized substance use, mental health services and research
- HIV self-testing about to enter the Canadian market! To what extent do we feel this new testing option will impact GBT2Q testing uptake and linkage to care?
- STBBI testing innovations are emerging in Ontario (e.g. GetCheckedOnline)
- Increased GBT2Q community capacity and resources (e.g. Advance Community Alliance, Toronto to Zero, Gay Men's Health Hub)

NOTES:

POINTS OF CONSENSUS

PRIORITIES AND STRATEGIES FOR IMPROVING GBT2Q LINKAGE TO CARE

- What are some policy priorities for improving GBT2Q men's linkage to services in Toronto and/or Ontario?
- What are some strategies that we can undertake to achieve those priorities?
- What is needed to mobilize these

POSSIBLE DISCUSSION PRIMERS AND QUESTIONS:

- How can we address financial barriers to HIV treatment or prevention (PrEP, PEP)?
- What policies or investments are needed to increase STBBI testing, treatment, and prevention initiatives? (e.g. peer-, community-, home-based testing, HPV vaccinations, doxy PrEP)
- How can we concretely address stigma and improve cultural competency and/or safety in healthcare settings?
- What can be done locally or provincially to improve the training, education, and stadards with regard to LGBTQ2 cultural competency/safety
- What is needed to address the lack of capacity among healthcare and/or service providers? More funding? At which levels?
- How can we improve coordination among HIV/STBBI stakeholders and service providers?
- What are some policy strategies or goals for addressing syndemics among GBT2Q?
- How can we increase awareness, understanding, and/or commitment from governments and institutions on GBT2Q health needs?
- What can be done to improve and increase engagement with marginalized communities of GBT2Q (who may face intersectional barriers to services)?

NOTES:

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