HANSARD

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STANDING COMMITTEE

ON

HEALTH

Tuesday, April 12, 2022

LEGISLATIVE CHAMBER

Access to Birth Control and Sexual Health Services

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HEALTH COMMITTEE

Trevor Boudreau (Chair)
Kent Smith (Vice-Chair)
Chris Palmer
John White
Danielle Barkhouse
Hon. Patricia Arab
Rafah DiCostanzo
Susan Leblanc
Kendra Coombes

[Hon. Patricia Arab was replaced by Lorelei Nicoll.]

In Attendance:

Judy Kavanagh
Legislative Committee Clerk

Gordon Hebb
Chief Legislative Counsel

WITNESSES

Department of Health and Wellness
Jeannine Lagassé, Deputy Minister
Tanya Penney, Senior Executive Director, Clinical

Nova Scotia Health Authority
Karen Oldfield, Interim President and CEO
Dr. Todd Hatchette, Chief - Division of Microbiology, Dept. of Pathology and Laboratory

Wellness Within
Martha Paynter, Board Chair and Coordinator

IWK Health
Dr. Melissa Brooks, Dept. of Obstetrics and Gynecology

Sexual Health Nova Scotia
Leigh Heide, Provincial Coordinator

HALIFAX, TUESDAY, APRIL 12, 2022

STANDING COMMITTEE ON HEALTH

9:00 A.M.

CHAIR
Trevor Boudreau

VICE CHAIR
Kent Smith

THE CHAIR: This is the Standing Committee on Health and I'm Trevor Boudreau, the MLA for Richmond and Chair of the committee today.

Today we will hear from witnesses regarding access to birth control and sexual health services. I think it's probably good timing for this committee topic, given that April is Sexual Assault Awareness Month.

I would ask everybody here to please turn off your phones or put them on silent. In case of an emergency, you would please exit through the back door on Granville Street, walk down the hill towards Hollis Street, and gather in the courtyard of the Art Gallery of Nova Scotia.

I would ask everyone to please keep your masks on during the meeting unless you are speaking. Apparently, as Chair I am the exception to this rule, but I will put my mask on as well. I will ask committee members now to introduce themselves for the record by stating their name and constituency, starting with Ms. Leblanc.

[The committee members introduced themselves.]

THE CHAIR: For the purpose of Hansard, I will also recognize the presence of Legislative Counsel Gordon Hebb and Legislative Committee Clerk Judy Kavanagh.

As I mentioned earlier, the topic today is access to birth control and sexual health services, and we have a number of witnesses. I'm going to ask the witnesses to introduce themselves, starting with Deputy Minister Lagassé.

[The witnesses introduced themselves.]

THE CHAIR: Thank you, everyone. We have a number of witnesses today. We will get into our questioning in just a minute, but first we'll actually have our witnesses give opening statements. I'll begin with Deputy Minister Lagassé.

JEANNINE LAGASSÉ: Good morning, Mr. Chair and members of the committee. Thank you for the opportunity to be with you today.

On behalf of Ms. Penney and myself, we are pleased to be here in attendance with representatives of the Nova Scotia Health Authority, IWK, Wellness Within, and Sexual Health Nova Scotia to answer your questions on access to birth control and sexual health services. We know this is an important subject that touches the lives of individuals, couples, and families.

It is a subject that encompasses a broad range of initiatives, programs, and services. I know that we will touch upon many important topics throughout our discussion this morning. However, before we get to that discussion, I would like to take a few minutes to tell you about some of the existing initiatives, programs and services, and some changes coming as it relates to sexual health for Nova Scotians.

Although the announcement for Nova Scotia's health care plan is pending, I can say that a goal of government, the department, and our service delivery partners is to transform health care in our province, addressing long-standing barriers to good health - be it physical, mental, or sexual health, or just the overall well-being of Nova Scotians.

Work to reduce barriers is something that has been under way for some time, but we know we can always do more. We are currently reviewing our policy on gender-affirming care. We are committed to working with the 2SLGBTQ+ community to identify and remove any barriers we can without compromising best practice care.

The Nova Scotia Family Pharmacare Program and the Department of Community Services Pharmacare Benefits program both help reduce the cost and increase access to prescription contraceptive products. Since 2020, Nova Scotians have had access, at no charge, to pharmacy contraception management services through their local pharmacy. This service helps people make an informed decision on which contraceptive is right for them and allows the pharmacist to prescribe it. This is just one example of the important role pharmacists play in supporting good health and access to care.

During the pandemic, it was necessary for our health system to temporarily reduce some services at various stages. Unfortunately, sexual health care services were not immune to reduced services at various times. However, the pandemic has made us adapt and look at different ways of working. This led to service improvements, like in the case of STI testing, that will continue. I'm sure our partners at the NSHA will have more to say about that.

Lastly, recently we have seen a new initiative in reproductive care. The Province recently announced the Nova Scotia Fertility and Surrogacy Rebate that applies equally for all Nova Scotians. This will help individuals and families cover some of the cost of fertility treatments or surrogacy-related medical expenses. I would add, Nova Scotia is the first province in Canada to provide this kind of support for surrogacy.

We know there is still very much work to do in these and other areas. We will continue to look for opportunities to collaborate with our partners and stakeholders.

In closing, I want to acknowledge and thank the many partners across the province - some of whom are present today - for being a voice for Nova Scotians and for the support they provide on the front lines for the services we will be discussing today. Thank you very much.

THE CHAIR: Thank you, deputy minister. Ms. Oldfield, do you have opening remarks?

KAREN OLDFIELD: Thank you, Mr. Chair, I do. Good morning, all. Hello, witnesses. Thank you for having us here today.

I would like to acknowledge, as you have, Mr. Chair, that April is Sexual Assault Awareness Month. We are now into the third year of the COVID-19 pandemic. We know that stress and isolation increase both the risk and the degree of violence in Canada, with known increases in sexual violence, domestic violence, and femicide. In Nova Scotia, those who experience sexual assault have 24/7 access to the Sexual Assault Nurse Examiner Program. People can learn more about these services on our website at nshealth.ca/sane.

Birth control and sexual health services comprise a wide spectrum of services from various branches within and partners connected to our system. Today, you will have the benefit of hearing from several of those involved in aspects of these services. These subjects very much illustrate how health care is not just a hospital-based system, and Nova Scotia Health is not the be-all and end-all of health services in the province.

Rather, meeting the health needs of Nova Scotians is a partnership among large and small agencies, specialists, family doctors, providers, and communities. For many, issues related to sexual health are managed by their regular primary care provider or their

pharmacist or a clinic in the community that may offer confidential advice. Others may require support navigating the system or care from a hospital-based specialist.

We also recognize that not all Nova Scotians have access to a regular primary care provider, or if they do, are comfortable going to that provider for sexual health needs, so having multiple ways to access services is important.

When the Women's Choice Clinic was established in 2017 and the requirement for primary care referral to access abortion services eliminated, some barriers to care were removed. We now have a self-referral process, a central intake number, and a network of providers around the province willing to prescribe medical abortion. Still, gaps and barriers remain. We need to expand the network of providers to ensure people in all parts of the province have access to this care close to home.

Our organization is proud to have a long-standing prideHealth service that works to improve access to health services which are safe, coordinated, comprehensive, and culturally appropriate for people who are two-spirit, lesbian, gay, bisexual, transgender, queer, intersex, and asexual. That service has not expanded over time, although demand has.

While we work with partners to better meet the needs of people of diverse gender identity and sexuality, I want to be clear that as with our organizational need to address systemic racism and be more welcoming to our patients and staff who are Black, Indigenous, and people of colour, the responsibility falls to all of us - not just those people in positions focused on that work.

Inequities in the system, or experiences that leave people feeling unwelcome, affect health, safety, opportunity, confidence in the system, and sense of self, and that has to change. I look forward to our discussion here this morning. Thank you.

THE CHAIR: Thank you, Ms. Oldfield. Ms. Paynter, do you have any opening remarks?

MARTHA PAYNTER: Thank you for the opportunity to speak with you today. One of the most significant barriers to reproductive health equity in Nova Scotia and Canada is the cost of contraception. Providing free contraception results in significant cost savings and improvements in population health. Governments save between $7 and $10 for every dollar invested in contraception.

As a nurse providing abortion care, I see how patients return again and again. Because while abortion services are rightly publicly funded, contraception is not, and abortion becomes the only recourse. The cost to Nova Scotia taxpayers of an abortion procedure is roughly $2,000. Compare this to $400 for an intrauterine device that provides

effective birth control for five years, or even $30 for a monthly pack of birth control pills. Contraception is a wise investment.

When people can plan their pregnancies, evidence shows that they are better able to care for their families, complete their education, achieve employment, and are less likely to experience intimate partner violence and poverty. Yet, in Canada, half of all pregnancies are unintended, and one in every three people with a uterus will have an abortion in their lifetime.

Unintended pregnancies are disproportionately experienced by people already marginalized by poverty, discrimination, and social exclusion. Access to free contraception can break this cycle. Recognizing the key role of contraception in healthy growth and development, the Canadian Pediatric Society recommends governments provide universal access to no-cost contraception to all youth under 25.

One of the most innovative and important changes to sexual health services in Nova Scotia over the past decade was the introduction of self-referral for abortion services and public funding of a centralized hotline: 1-833-352-0719. This approach reduced wait-times and costs, and improved outcomes. Nova Scotia can continue to demonstrate public sector leadership in sexual health by committing to free contraception for all.

Providing free contraception will result in significant cost savings and improvements in population health for the people of this province. Thank you.

THE CHAIR: Thank you, Ms. Paynter. Dr. Brooks, do you have any opening remarks?

MELISSA BROOKS: Good morning and thank you for the invitation to meet with this committee. I would like to begin my remarks by sharing that access to abortion services within Nova Scotia has significantly improved in recent years, but there's still more work that needs to be done. Eliminating the requirement for referral to the Women's Choice Clinic and universal access to Mifegymiso, the drug used for medical abortion, are great steps forward.

However, despite that abortion is one of the most common gynecological procedures or surgeries, patients seeking surgical abortion are often forced to leave their community to access this service. Also, Nova Scotia is one of the few provinces in Canada that does not provide elective termination of pregnancy past 16 weeks gestational age. People in need of this service often have to travel out of province, which is a huge barrier that often prevents them from accessing the service entirely.

I would be remiss if I didn't agree with Dr. Paynter to say that the one area that I think Nova Scotia could make great advances in reproductive services is in providing universal access to contraception. In Nova Scotia, as in many provinces around the

country, the lack of access to universal pharmacare creates a huge gap in access to contraception, especially long-acting, reversible contraception such as IUDs and subdermal contraceptive implants.

[9:15 a.m.]

We know that one in three workers in Nova Scotia does not have access to private prescription drug coverage, and Family Pharmacare does not fill the gap adequately. I see this almost on a daily basis in my clinical practice.

Research from around the globe has shown that providing barrier-free access to contraception is not only cost-effective but provides cost savings in the long run. Nova Scotia could be a leader in Canada in advancing reproductive care with universal contraceptive access.

As I mentioned, I want to reiterate that there are good things happening in reproductive care in Nova Scotia, but there's still much work to be done and alternative solutions to consider. I thank you for inviting me to participate in this session today. I'm more than happy to answer any questions and to work with members of the committee to improve reproductive care for all Nova Scotians.

THE CHAIR: Thank you, Dr. Brooks. Mx. Heide, do you have any opening remarks?

LEIGH HEIDE: I do, thank you. Good morning. Thanks for having me. I want to tell you a little bit about Sexual Health Nova Scotia, as I frequently get the "Who?" question.

Sexual Health Nova Scotia is a community-based non-profit provincial organization, of which I'm the provincial coordinator. We encompass a network of six sexual health centres across the province. Those are in Cape Breton, Pictou County, Cumberland County, Sheet Harbour, Halifax Sexual Health Centre, and South Shore, which serves Lunenburg and Queens Counties.

Through advocacy, education, navigation, and partnership, we support members of our communities to access the sexual health services they need. Halifax Sexual Health Centre is currently the only centre in our network that houses a full-time clinic. Our five rural centres all provide support and health navigation for folks seeking clinical sexual health services. They also advocate for increased sexual health services such as STI testing, gender-affirming care, and access to birth control in their communities. All of our centres provide free safer-sex supplies to the public, to high demand. They provide all of these services, plus many more on extremely low and precarious funding.

Our hope is that all people in the province can access comprehensive, inclusive, and affirming sexual health services when and where they need them. Unfortunately, this is not a reality we see very often right now in Nova Scotia. The COVID pandemic has exacerbated already challenging situations, specifically for youth, those living rurally and low-income, 2SLGBTQ+ folks, and racialized, disabled, and other folks who have been traditionally underserved in the health care system.

We hope that conversations like the one that we'll have today will impact the system of health care in ways that will make critical, essential sexual health services available in all our communities.

THE CHAIR: Thanks, Mx. Heide. That concludes our opening remarks. We're going to get into the Q&A side of it.

The way it works, for those of you who are new to it, is each caucus gets 20 minutes to ask questions of witnesses. Following those 20 minutes - depending on how much time we have left, we're probably going to go to 10:40 - we'll break it up into three equal parts for "rapid-fire", as we call it here. They'll get some more questions on the other side.

I would remind everybody to wait to be recognized, so that it'll all come through the Chair. That way, Legislative TV can get your microphones on so that it can be heard. After that, we'll have some closing remarks from our witnesses as well.

With that being said, the Liberal caucus will begin. I see Ms. DiCostanzo - you have your hand up.

RAFAH DICOSTANZO: Thank you, Mr. Chair. Welcome to all. I'm sure this is going to be a very interesting conversation. Hopefully we all can learn from this - the value of birth control to women and the access.

One of the things I was really happy about when my colleague, Randy Delorey, brought in the increased scope for pharmacists, and giving them birth control was one of the major ones, besides the renewal of medications. I was really excited.

My daughter is a pharmacist. I know how much they were fighting to do more with their scope. They're very well-educated and know how to do this. Also with pharmacists, the access is the best thing, because it is so much easier to go to your pharmacy than to get an appointment with a doctor. I have a very good relationship with my pharmacist over many years. To me, that was a very good move to allow pharmacists to take over to increase access for women.

My question is: Are you tracking how many pharmacists are prescribing birth control? How many clients are being served, and what birth controls are being prescribed? What are they learning about the access - where are we with that, if you don't mind?

THE CHAIR: MLA DiCostanzo, who would you like to direct that question to?

RAFAH DICOSTANZO: We'll start with the deputy minister, and then she can give it to whomever.

THE CHAIR: Deputy Minister Lagassé.

JEANNINE LAGASSÉ: As I said in my opening remarks, under the expanded scope of practice for pharmacists, the contraception management consultation service began in 2020. I can't tell you how many pharmacists are actually doing this service, but they are all able to within their scope of practice. I can tell you that within the first year of the initiative, about 4,000 people gained access to that service through community pharmacies.

RAFAH DICOSTANZO: Do we have any idea if with certain medications they are doing the same as what doctors are doing? Four thousand - what was it before? Has it increased because of pharmacists compared to doctors?

JEANNINE LAGASSÉ: The 4,000 number is just the pharmacy service itself. When the expanded scope of practice came in 2020, that would be the number for that first year of the service, pharmacists alone. I can tell you also that in that same year, 2021, about 60,000 people filled prescriptions for contraceptive products across the province. That comes from our drug information system.

RAFAH DICOSTANZO: These are good numbers. I hope most young ladies or women are able to access this through the pharmacists.

The other question when it comes to pharmacists is: What training has been provided to them when it comes to stigma and cultural appropriateness? There are many newcomers and different religions that are not accepting of birth control. Are pharmacists being trained? What do we know about that?

JEANNINE LAGASSÉ: I do know that when there's an expanded scope of practice like that, there usually are training programs through the Nova Scotia College of Pharmacists, and also through the Pharmacy Association of Nova Scotia. All pharmacists have a continuing education requirement to maintain their licence, so there are training programs through those organizations.

Some of my other partners may have other information they may want to contribute.

THE CHAIR: Do any other witnesses have anything further? Ms. Paynter.

MARTHA PAYNTER: I wanted to respond to two things. The first is in light of you raising the issue of cultural appropriateness, can we in this session use gender-inclusive language? Practise that. It does take some getting used to, but we can do it.

It's fantastic that that scope was expanded, obviously, no question, but when the most effective contraception is long-acting, reversible means - like the IUD and the Nexplanon implant - the pharmacist can't insert those. We have a device in hand that they can prescribe, but how are you going to use it if you don't have a clinician who can insert the device? Not to mention the cost that Dr. Brooks and I have already raised. Those are my two comments.

RAFAH DICOSTANZO: I appreciate that very much, especially the first one.

Of course, access to birth control is a preventive measure, but for a variety of reasons, access to safe, confidential, stigma-free abortion is important to those who want a termination of pregnancy. We are learning a lot about the impact of COVID-19 on different aspects of health care, and access to abortion would be no different. What impact have we seen in reduced staffing across health authorities, and how is that service being offered at the moment?

THE CHAIR: MLA DiCostanzo, who would you like to direct . . .

RAFAH DICOSTANZO: Jeannine Lagassé, and she can forward it now - COVID-19.

JEANNINE LAGASSÉ: I think that would be more of a service delivery question, so I think I'd have to ask one of our partners to answer that one.

THE CHAIR: Dr. Brooks, I see your hand up.

MELISSA BROOKS: I can probably speak to that a bit. Our clinic, the Women's Choice Clinic, has stayed open the entire time. We never closed. We certainly did have some reduction in staff at times. Some of our staff were moved to different areas of the hospital to provide backup for places that were higher needs, but we continued to function. There certainly were times when our wait-list maybe got a bit longer, because of that, but overall, we've managed to cope.

One thing that has changed during the pandemic, globally really, is that more people are providing medical abortion through telemedicine and that has also been a thing also in Nova Scotia. I think that's been a very good improvement and change that has occurred during the pandemic, and access to things like ultrasound.

I guess one of the big barriers is access to quick bloodwork services. With needing to make appointments for bloodwork, it's often hard to get a bloodwork appointment within a few days, even within a month. That has been a bit of a challenge for us, but overall, we've managed to keep abortion services going. I think there has been some improvement in abortion care in providing it through telemedicine.

RAFAH DICOSTANZO: Thank you, and that's good to hear. There were over 1,600 reported abortions per year at four Nova Scotia Health Authority sites offering surgical and chemical abortions. On average, how many people access this service annually right now?

THE CHAIR: Dr. Brooks, did you want to try?

MELISSA BROOKS: Yes, because of the changes with Mifegymiso - that's the medication that we use to provide medical abortion. It was kind of brought up that our clinic, the Women's Choice Clinic - we also have a network of abortion providers that people who need abortions will call in, and we can refer them to those people in their own community.

We can track those numbers but there certainly may be people outside of our network in various places in the province who prescribe Mifegymiso, so we wouldn't actually know about that through the Women's Choice Clinic. Because of that, we may have less accurate numbers. Before, when we were the only game in town, so to speak, we could say that we basically do all the abortions and there were usually around 1,300 to 1,500 a year.

It seems like that number has gone down. It's not clear if that's because the number of abortions in the province has gone down or if that's because there are people in their own communities who are doing them without our knowledge. It seems like there's a decrease, but it could just be that there are more people providing them outside of our network.

THE CHAIR: I see that Ms. Paynter has her hand up as well.

MARTHA PAYNTER: I'd add a couple of things to what Dr. Brooks was saying. One of the things that happened in 2017, P.E.I. opened their clinical services. P.E.I. used to rely on us, so that was about 150 cases a year that are now repatriated to P.E.I. to look after themselves, so that's one of the things.

As Dr. Brooks said, we have over two dozen prescribers in our network - physicians and nurse practitioners - who do the prescribing in their home communities. From the 1-833 number, the nurses at the clinic make all of the arrangements for ultrasounds, bloodwork, for the referral to the physician, so it expedites things for patients who are using that service - but it does cause this disconnection in the data. However, if we

look to the number of scripts for Mifegymiso, we can get that total number. It's just pulling that data together.

[9:30 a.m.]

The last thing I wanted to respond to was that although we did have slight increases in our wait times, I want everybody to understand that it's extremely fast to get an abortion through the clinic - a week in general. Wait times has a very different meaning in this world than arthroplasty.

RAFAH DICOSTANZO: It is understandable, you really have to move fast and to offer it. In 2018, there was a study of family medicine resident students and they found that 79 per cent of recipients reported never observing or assisting with an abortion during their training. Eighty per cent of residents reported receiving less than one hour of education on abortion. I have the information and I can table that.

Has that changed? What specific training is provided here in Nova Scotia to build more capacity for our doctors?

THE CHAIR: Dr. Brooks, I see you're nodding.

MELISSA BROOKS: I probably will take that. I am also an assistant professor at Dalhousie. One of my colleagues, Dr. Yoshida, who works at the clinic with us, does do a lecture for the family medicine residents here at Dalhousie on medical abortion. In Canada, most early surgical abortions are done by family doctors, you're right, but most family doctors wouldn't come out of family medicine residency competent to do that. Most of them would require additional training.

Certainly, at the clinic, we are open to accommodating residents who are interested in abortion provision. We will have family medicine residents come and rotate at our clinic, but it's not a standard rotation for all residents that's required for family medicine residents. For our gynecology residents, they all do rotate through the clinic. Most gynecologists, because the D&C for an abortion is similar to D&Cs we do for other reasons, would be competent to complete at least an early abortion at the end of their training.

I think it is a different world now with medical abortion because medical abortion would require much less training and most family doctors could be competent to do that. They are all receiving at least a lecture on medical abortion and then they're welcome to come to our clinic. The teaching clinic at Dalhousie and the family medicine teaching clinic, they're also looking at incorporating medical abortion into their clinics as well.

THE CHAIR: Ms. Paynter.

MARTHA PAYNTER: One other thing. Dr. Brooks and I also lead an inter-professional, six-hour course across all the health professional faculties at Dalhousie. Social work, nursing, nurse practitioners, medicine, and pharmacy are all welcome to take this course. It has expanded education over the past two years of its offering. I think we've trained about 250 students. That's novel to Dalhousie. It doesn't exist anywhere else.

THE CHAIR: MLA DiCostanzo.

RAFAH DICOSTANZO: Do I understand that it's optional, not obligatory, to take this course?

MARTHA PAYNTER: That's correct. It's part of the obligatory inter-professional education regimen, but the students choose between different options in that menu of course offerings.

RAFAH DICOSTANZO: There are only four locations where surgical abortions are offered through the NSHA. That includes the Women's Choice Clinic at the QEII, the South Shore Regional, the Valley Regional, and the Colchester East Hants Health Centre. Missing from this are locations in Yarmouth, Amherst, Antigonish, and Sydney.

What is being done for the NSHA to expand the access? Maybe to Karen Oldfield?

THE CHAIR: Ms. Oldfield.

KAREN OLDFIELD: Let me start by saying that I'm listening intently. I'm learning intently. One of the things that I am trying really hard to do today is to figure out where I may need to further advocate and do additional transformation within our health care system.

I don't know the answer to your question. I've made a note and so we will get back to you.

RAFAH DICOSTANZO: That's a very honest reply. I thank you for that.

THE CHAIR: I see Dr. Brooks's hand up as well.

MELISSA BROOKS: I could speak to what I think some of the barriers are in those places to not offering access. I used to be an obstetrician-gynecologist in Truro, in Colchester. I did abortions when I was there too. In places outside of the Nova Scotia Women's Choice Clinic, it's generally gynecologists in the community who are doing them. Generally, there would be two issues. One is that there isn't a gynecologist willing to provide the service.

More often than not, it is institutional barriers in terms of whether it's being able to provide the service. Often, they're done in the OR, so you need extra OR time. You need anesthetists and nurses who are willing to participate, which is often a barrier.

I know that there are gynecologists in Cape Breton Regional Hospital, as well as in Cumberland, who would be more than willing to do abortions. But despite their best efforts, they've never been able to get everyone on board to provide that service, whether it's because there are people within their hospital who are actively anti-choice and blocking the service being available, or if it's more in terms of services that are available and things like that. I think it is either having access to the gynecologist or other barriers in terms of instituting that service.

THE CHAIR: MLA DiCostanzo, you have three minutes. I apologize to witnesses - I cut off at a hard stop at the 20 minutes, so if you're in the middle of an answer, I apologize.

RAFAH DICOSTANZO: I will pass the last three minutes to my colleague, and in the second half she can take over as well.

LORELEI NICOLL: Nova Scotians who have experienced sexualized violence require specialized emergency care, and they need to be able to access that care anywhere in the province. Sexual assault nurse examiners are vital. They provide specialized medical and forensic emergency care, including supportive care, evidence collection, and sharing information.

Under the last government, this service was available at 18 hospitals and health centres 24 hours a day and seven days a week. I think you mentioned that. How many nurses are employed to deliver this service across the province, and how many victims on average are they supporting? It would be Karen Oldfield or deputy minister Lagassé.

JEANNINE LAGASSÉ: I can give you a few of the statistics that I have. There are seven staff currently across the province, and there are now 20 sites where the service can be accessed. It is, as you said, a 24/7 service that people can contact. As of March 2022, there were approximately 240 people who accessed the program in 2021-22.

LORELEI NICOLL: Knowing the staffing challenges, obviously, and to clarify you said 26 locations is what you're referring to?

JEANNINE LAGASSÉ: Twenty - two-zero.

THE CHAIR: MLA Nicoll - and just bring your microphone down a little bit.

LORELEI NICOLL: Knowing the staffing challenges that the COVID-19 wave is having on our health care system, is it still a dedicated service provided in all hospitals? Have these nurses been pulled off their duties to care or deployed and allocated elsewhere?

JEANNINE LAGASSÉ: Not that we are aware of, that the nurses have been taken off the service. We also have VON that help to provide the service in some of the locations throughout the province.

LORELEI NICOLL: That was my next question. The VON is expanding access in the Eastern Shore area, and you're mentioning that, but are there other service gaps that exist? Is it just in the Eastern Shore where the VON is providing that service?

JEANNINE LAGASSÉ: I do not know if there were other locations, but we'll just take a quick look and we'll try to get back to you on that.

THE CHAIR: MLA Nicoll, you have 15 seconds.

LORELEI NICOLL: Should I do a little dance in 15 seconds? I will wait for the 15 seconds to go by.

THE CHAIR: The Liberal time is up. It is now the NDP caucus' turn to ask questions. I see MLA Leblanc with her hand up. You may begin.

SUSAN LEBLANC: Thank you all for being here. I just wanted to follow up on that question before I begin my regular questions. I just want to clarify that the deputy minister said that there are seven staff over 20 sites who provide sexual assault nurse examiner services. The service is 24/7, and I just don't understand how that's at all possible. I can't square that circle.

You mentioned the VON, but I assume that the answer is that someone who has been sexually assaulted and goes for those services has to wait for several hours before they're seen. Can you just confirm how all that works?

TANYA PENNEY: The seven full-time equivalents that Deputy Minister Lagassé referenced are really some coordination positions and some management positions, so it doesn't necessarily mean that there are only seven sexual assault nurse examiner providers across the province. We use VON services, there are nursing staff who are on call 24/7 for a variety of service delivery areas across the province.

SUSAN LEBLANC: Well, that's better, but when people present at the hospital or one of these sites, do you have a sense of how long folks have to wait before they are seen by a SANE nurse?

TANYA PENNEY: I don't have that information off the top of my head. Although I would say that when coming to the emergency department, people can access sexual assault help in three or four different ways. One is that they can actually call and self refer with the numbers that are provided to Ms. Oldfield's www.nshealth.sane website. Oftentimes, the sexual assault nurse examiner will come to the emergency department or the facility where the person presented. Or if it's safe and appropriate, we may actually get the person who has had that unfortunate trauma to where the sexual assault nurse examiner is, because it may be a more appropriate area.

Or we could actually have a conversation and a collaboration across the current emergency department provider and the sexual assault nurse examiner so that they can collaborate together. It really does depend on which stream to take, which is the most appropriate for the person who's experienced the trauma.

SUSAN LEBLANC: Thank you very much. I'm going to go back to my original plan here.

We are really glad that everyone is here today. We're very happy to be hearing from you all. I feel like it's important to set the stage a little bit right now. We have a new government that has just released its first budget, and the budget has no new funding for access to midwifery, sexual health services, collaborative or community health services, prideHealth, or particular commitments to expanding reproductive or sexual health inside our public system.

We've already heard from so many of you who are experts in this field today, in this short amount of time, how attention to these services and this type of health care is better for individuals who are getting that service, and also saves the system a ton of money and a ton of people power, as it were. So when the government promises to fix health care, it has to mean women's health, sexual health, and reproductive health too.

Dr. Hatchette, I just have to say that - you will probably not remember this - you taught me how to do a nasal swab in Dartmouth North at one of the amazing first testing sites. So you are my teacher, and I went on to swab many, many hundreds of people in a rapid testing site area. I feel like I'm meeting my mentor again.

I want to start by asking you - because you are in the system right now - a little bit about the state of our health care system and the impact on people's ability to access everything from diagnostic imaging or routine procedures to elective surgeries. We know that COVID has had a significant impact on the health care system, but the situation is particularly bad right now.

I just read a CBC article that came out today that quotes Dr. Lisa Barrett about how we used to be number one in the country, and it seems like now we're quite far behind other jurisdictions. Whether it be more people than at any point waiting for five years, waiting

for surgery; thousands of people waiting for CT scans, ultrasound, or MRI; thousands of surgery cancellations - people are very scared about their ability to access health care, in particular in this new this sixth wave or whatever it is. Things just seem to be feeling a bit out of control.

[9:45 a.m.]

My question to you, Dr. Hatchette, is: What is the most concerning to you about the state of our health care system at the moment?

DR. TODD HATCHETTE: Thanks, and I'm flattered that you remember me as a mentor.

That's a tough question. I mean, our health care system has been strapped prior to the pandemic. This has only amplified the issues. In addition to the excess that COVID has put on in terms of in-patient care, all of the other ancillary services have been impacted and will continue to be impacted as long as people continue to get infected with COVID.

We are seeing a lot of staff off. These are staff who are necessary to provide the in-patient services. They're the staff who are necessary to provide the outpatient services - family physicians, lab support staff, DI staff. If this is the new normal, then we need to account for that and take it into consideration as we make HR planning, et cetera.

I think that we can look at technologies to try to improve some of the services, but ultimately it comes down to people. If the people are off sick, you're going to have to take that into account. If this is going to go on for weeks, which the modelling suggests it will, we'll need to make sure that we try to staff things appropriately.

SUSAN LEBLANC: I hope it's not the new normal. I hope that the old normal is not the new normal. I hope we can actually address some of the systemic issues, as you say. I'm wondering if you have any thoughts about what the government can do right now to turn the corner on the health care backlogs in general.

TODD HATCHETTE: I think that, again, pre-emptively thinking of where the funding is going to be required, knowing that we're going to have shortages in people and staff is the biggest one. That's not an easy challenge to overcome. It has been highlighted that nursing staff, physicians, allied health care workers are in short supply, and this is only exacerbating that.

Nova Scotians have the tools at hand to try and prevent COVID-19 from happening. Whether that horse is out of the barn is a bigger question. There's tons of COVID-19 out there, based on our positivity rates and what we're seeing in terms of absenteeism. We've got a lot of COVID-19 out there, and I don't think it's going to be an easy thing to turn around.

SUSAN LEBLANC: We've seen STI testing scaled back to make capacity for COVID-19 testing. Can you comment on the impacts on access to sexual and reproductive health during the pandemic and now?

TODD HATCHETTE: Absolutely. There are two aspects to the question. One will be the clinical access to care. Early on in the pandemic, pretty well all outpatient care was shut down, so for those who required access through their family physicians, that was difficult. Access to family physicians is a challenge. Our clinic was shut down as well because all outpatient care was shut down within the health authority.

As things progressed, we were able to keep the clinic open and modify what we do so that we can try to increase the number of patients seen, by making it a same-day, appointment-based clinic, rather than the first-come, first-served that it had been.

In addition, we tried what I call an asymptomatic stream, where individuals will call, discuss their issues with the nurse, and if they don't need to see a physician - meaning they just want to get gonorrhea and chlamydia screening - we actually set up their specimen collection kits to be picked up at the front desk. They go collect their specimens themselves and just drop them off, and they never have to see a physician. That's increased the ability of people to get screening for gonorrhea and chlamydia, in particular, which has been actually quite effective. We do have positive cases that are then followed up within our clinic or called in a prescription by one of the attending physicians.

We have made modifications to our clinic to try to accommodate the challenges for COVID-19, which actually have been well received. I think the patients appreciate the fact that they don't have to wait hours to be seen, like they had to with the first-come, first-served, given the same-day appointments.

I can't really comment on turnaround times because it is a same-day appointment. We're only open Mondays and Thursdays. We do turn people away because the booking slots are filled, so we probably could have a day or two more and still have room to increase the availability to STI screening.

We predominantly are an STI clinic, so we do the screening prevention, but we don't do a lot of the birth control provision or anything along those lines. It's more screening for STBBIs - so also blood-borne infections. We do draw blood in the clinic, which I think is one of the reasons why people like coming to the clinic - it's a one-stop shop. Our nurses will draw the blood on individuals who want screening for things like syphilis and HIV. They don't have to book another appointment with blood collection, which has been a challenge during the pandemic.

Then, if we switch to lab provision services - there's no question that the pandemic has provided unprecedented challenges from a lab system perspective, right from access to the specimen collection - whether that be blood collection or any of the other testing we do.

We do have a pandemic plan which we follow quite closely. We prioritize specimens that need to be suspended in order to redeploy the resources to ensure that we can meet the needs for any emergency, COVID-19 being the one here.

Unfortunately, as TI services are part of that in the gonorrhea and chlamydia tests that we do, prior to COVID-19 was the largest volume of testing that we would do in our lab, and those resources just had to be redeployed. They were suspended during each wave for about a month but then reopened. Since that time, we've acquired some new instruments so that we've been able to maintain services even during this wave.

It has been a significant challenge to ensure that we can do those and, unfortunately, they just had to be paused for a time.

SUSAN LEBLANC: Thank you very much, Mr. Chair, and Dr. Hatchette. I'm going to change my focus for a moment and ask some questions of the department. In the past years, our caucus has raised the issue many times of access to prescription contraceptives. We've heard about it today, pointing out the contradiction in the fact that MSI will cover access to abortion, both medical and pharmaceutical, but not the preventive access to birth control.

As we've heard, an IUD can cost $400, or $30 for a month of oral contraceptives. While they may be covered under Family Pharmacare or private insurance, or sometimes the Department of Community Services, depending on who you are talking to, it is not covered by MSI.

Is the department looking at the full coverage of any other forms of prescription contraceptives? I guess I'll ask that to the deputy.

JEANNINE LAGASSÉ: Thank you for the question. In our minister's mandate letter, there is a requirement to look at the formulary and how we put drugs onto the formulary. So there will be a review-of-everything process, and what is currently on the formulary, through that process.

The other thing about devices is that we do currently have - as you've said, Pharmacare currently covers drugs, not devices. I think that's the other big issue that we're looking at right now - is have the processes be able to determine what devices we may put onto the formulary.

SUSAN LEBLANC: Sure, yes. I remember that this is a conversation we had last year at some point. The former Minister of Health and Wellness had some reason why this didn't work very well - because the device is not covered but the people are covered. As Dr. Paynter has pointed out, you need someone to insert the device, so that part is covered but not the device. It's very complicated but surely in 2022 we can figure out this kind of thing.

I understand that you are looking at the formulary and there are so many pressures on the formulary, I get it. This is why we should have universal pharmacare, but when you're looking at the formulary do you have a metric? We've heard from these experts that this type of provision would save a lot of money. We've heard that an abortion costs $2,000 compared to $400, and times that by however many people are accessing. Is that part of the metric that goes into it? If we're talking about how to fix health care and find the savings, and then redeploying the savings in other places - are you looking at that type of metric?

JEANNINE LAGASSÉ: The work on that mandate item is in its very early stages. As CEO Karen Oldfield has already said, to be here today, for us to hear from the other partners who are here today, is very valuable. There's information from today's session that I will take back to the department to speak with folks in the pharmaceutical section to say: here are some areas we should look at, here are some people we should talk to and different ways. Again, listening and learning, and taking it back to inform that review.

THE CHAIR: I see that Dr. Brooks has her hand up as well.

MELISSA BROOKS: I just wanted to make a comment about the Family Pharmacare because I think there is a bit of a misconception about Family Pharmacare. I mentioned that it doesn't really fill the gap. With Family Pharmacare there is a deductible, and the deductible is based on your income. I've never been able to find any document that really explains how it is calculated.

Most young, healthy people are not on a lot of medication, so often they don't have enough prescriptions to meet the deductible. Then when they want an IUD - an IUD costs $400 - even if they have Family Pharmacare, they haven't had enough prescriptions to get through their deductible, so they still have to pay $400.

It doesn't really help those young, healthy people. I think Family Pharmacare is maybe great for someone who maybe has a lot of drug costs, if they have chronic health problems or things like that. But for the young, healthy people trying to access contraception, it doesn't help. That's why at the Women's Choice Clinic, we'll get donations to buy IUDs that we can give out to people who don't have access to drug coverage.

The Department of Community Services coverage does cover hormonal IUDs, so Mirena and Kyleena - it doesn't cover copper IUDs - but we give them out like candy. Literally, we go through hundreds, and we could go through hundreds more. We give out at least a few a day out. There are so many people at our clinic who need that service and they just fall through the cracks of the system.

THE CHAIR: Dr. Paynter, I apologize for not saying Doctor previously.

MARTHA PAYNTER: You actually have one month until my defense. One more month of Ms. (Interruption) Then it's Dr. Martha forever.

I have two points. One is that there is a missing piece to this that we have to come back to again and again and again. That is that this entire discussion is gendered. To exclude these products, whether it be the copper IUD - which is actually quite infrequently used - or any of the hormonal options, it's a gender equity issue. Not funding it is very simply gender discrimination - very pure and simple. That's our baseline here. We're operating in a context of daily discrimination against the people with uteruses in this province.

The second piece is that we are just so happy when we have these free IUDs that we can give out. This is just the best thing ever, but you cannot model your contraception program on the IUD alone, having only one option - and an option that you have to insert through the cervix is, frankly, a coercive regime.

You have to offer people options. They cannot, to protect themselves from unintended pregnancy, only have one way to go that you, or a charity, or a government have determined that this is the one acceptable way. We are continuing to deal with the legacy of colonial abuse against Indigenous peoples' very bodies. We have to be very conscious of the message it sends when only one approach is acceptable to this province.

THE CHAIR: MLA Leblanc, you have 45 seconds.

SUSAN LEBLANC: Okay, well I'd love to hear from Mx. Heide.

THE CHAIR: Mx. Heide.

LEIGH HEIDE: Thank you. I really want to second, and third, and fourth everything you just said. I also wanted to make the point that one of the things that our sexual health centres do is operate a contingency fund, or a compassionate care fund - they're called different things. Essentially, when clients say that they need Plan B, or need access to birth control because they can't afford it, there are sometimes little pockets of money that our organization has pulled together - from donations and project grants or whatever - to help out folks.

I want to make the point that our five rural centres operate on an annual operational budget of less than $50,000 a year. These little compassionate care funds are something that they have taken on because the health care system hasn't made it accessible for folks.

THE CHAIR: Perfect timing. I was just calling order.

Order, the NDP time for first round is up. We now move onto the PC caucus. Mr. Palmer.

[10:00 a.m.]

CHRIS PALMER: Thank you to all of you for coming here today. It's very clear that we have very knowledgeable panel of witnesses today and a very passionate group. I appreciate that. I know all Nova Scotians appreciate everything you do in your capacity.

I'd like to go back to the topic of sexual violence prevention. That's been referenced a few times. This is Sexual Assault Awareness Month. There are some initiatives out there for communities and groups regarding sexual assault awareness and what can be done - in particular, the Sexual Violence Prevention Innovation Grant that provides up to $5,000 to support communities and groups.

I guess I'll direct my question to Deputy Minister Lagassé. Could you please talk to us - and maybe for those who might be watching at home - a bit about this Sexual Violence Prevention Innovation grant, and tell us what you hope the impact of it will be on communities that are applying for it? Maybe as a second to that, could you tell us about any previous grant winners and some of the things that they have focused those grants on?

JEANNINE LAGASSÉ: Thank you for the question. I'm not an expert on that program because it does fall under the Department of Community Services. It's one of our department partners who operate that program, so I wouldn't want to speak on their behalf. I apologize that I don't have a lot of information about that today because it is a DCS program.

CHRIS PALMER: I appreciate that. We'll reach out to the Department of Community Services to get that.

I'm going to switch gears again and talk a little bit about those seeking to become pregnant and those seeking fertility options in our province. We all have friends, acquaintances, people who have been trying to conceive, or have a child, for many years and the difficulties and struggles that they've had. Reproductive care has been front and centre for many years. There are definitely families seeking treatment or who need surrogates to help them have a child or have often struggled with the high costs that are involved in that.

I guess I'll direct my question to Deputy Minister Lagassé or anybody on the panel who would like to answer it. Could you tell us a little bit about the new fertility rebate program that the government has instituted that is obviously going to help a lot of people? Could you tell us a bit more about that? A secondary question is: Could you tell us how many families you are expecting to benefit from this initiative over the next little bit?

JEANNINE LAGASSÉ: Thank you for the question. The rebate is coverage for all people who require fertility treatments or to cover medical costs of surrogacy. There is no

limit on the number of treatments that an individual can claim, but the maximum claim is $20,000 per year, with a maximum rebate of $8,000.

The program is estimated for this year at about $3 million. That would be the amount that we think will be used in the first year.

CHRIS PALMER: My follow-up question is: Do you have an indication, or could you maybe tell us how many families or individuals will be able to take advantage of that, from any data that you might have?

JEANNINE LAGASSÉ: I think on kind of the straight math it's about 375.

CHRIS PALMER: This program is unique in Canada. I was wondering if you might be able to share with us how this program compares to initiatives to support surrogacy in other provinces. Is that something that the deputy minister could answer?

JEANNINE LAGASSÉ: It's my understanding that this is the first program of its kind in Canada related to surrogacy costs.

CHRIS PALMER: Just one last question I'll have for you on this program. I'm not sure who might be able to answer this question. How do you feel this fills a gap, compared to other tax credits that are out there? What's deductible under the federal taxes? Would you have an idea?

JEANNINE LAGASSÉ: I think the thing about this program is that it's available to all Nova Scotians. Anyone can come forward to access this particular program and it covers costs that are not covered through other programs. That's why the decision was made to structure it in the way that it is.

CHRIS PALMER: I want to just finalize by saying thank you again to all of you for appearing today. I appreciate the answers to the questions. There's no doubt the program will definitely help many people seeking to conceive and have a child. Thank you. I pass it on to my colleague.

THE CHAIR: MLA John White.

JOHN WHITE: Thank you, Mr. Chair. Ms. Tanya Penney, I think I'm going back to you to the Sexual Assault Nurse Examiner program. I wonder if you can tell me a little more about how that works in rural areas.

TANYA PENNEY: The sexual assault nurse examiners are a group of registered nurses with advanced training. They have the ability to testify in court, and really have their competencies built up to make sure that we actually provide trauma-informed care.

If you think about how this rolls out in a rural facility, it could be that the nurse examiner could present to the patient, depending on where the person presented in the health care system. We could actually arrange for the person to get to the nurse if it's a more appropriate area, or there could be some conversations, again virtually, through the people at the facility where the person presented and the sexual assault nurse examiner's program to make sure that person is getting competent and safe trauma-informed care.

JOHN WHITE: Is it normal that in a rural area they'd expect delays because of that system and the way it's working there? Is that typical?

TANYA PENNEY: I wouldn't say that there are delays.

JOHN WHITE: Good to hear that. I think my next question is to deputy minister Lagassé. Can you tell us a little more about the challenges people in rural areas face in general with access and birth control?

JEANNINE LAGASSÉ: I actually don't know if I can answer that one, if I'd be the best person on the panel to answer that. I think may be one of our partners at the end might be best.

THE CHAIR: I see Mx. Heide had their hand up first.

LEIGH HEIDE: A lot of my answers come from hearing back from our sexual health centres in different rural areas and their client experiences that are shared with them. A lot of what we hear of as barriers are lack of money, obviously. We've talked about that today, but then lack of access as well, so not having a family doctor.

The access to birth control through pharmacies is a good option. It does help with rural area access as well, but there are limitations. There are some issues around community pharmacies in small, rural areas and people feeling uncomfortable asking for things from a pharmacist they've known since they were five - which is my case in Mahone Bay - so that's one issue.

I think access to transportation really also affects all of these things because for many health care services, folks have to travel. That can be a huge barrier if they are low-income or they don't have access to transport, they're asking people to do them a favour. Our Halifax Sexual Health Centre sees clients from all over the province - people driving from Cape Breton, people driving from Yarmouth regularly. This is not an anomaly. There are obviously those barriers around funding, transportation, all of that to get to the Halifax Sexual Health Centre.

Telemedicine has helped, I would say, in being able to get prescriptions that way, but there are so many sexual health services that you need to be seen in person. When we

talk about things like IUDs or the Nexplanon insert, people need to see a doctor, at the end of the day.

I will quickly share an anecdotal story of a young person who contacted one of our centres to ask if they could insert the Nexplanon insert themself because they could not get an appointment with a doctor and they were not sure how to go about it. This was a young person who watched a YouTube video and felt that they could probably do it. Of course, we discouraged that strongly. But that's not a bizarre situation in the sense that we get calls frequently about people at their wits' end trying to figure out how to get birth control or STI testing or any of the services they need, in their small, rural communities especially. There are huge barriers. I could go on, but I'll pause.

THE CHAIR: MLA White.

JOHN WHITE: Those are all my questions. I think I'm passing on to MLA Smith.

THE CHAIR: MLA Smith.

KENT SMITH: Thank you again, everyone, for being here today. Madame Lagassé, a question for you to start. I only have a couple, and it's going to be about gender-affirming care. One of the things that I've said in other committees and when folks are asking me about this job is, what do you like about it and what don't you like about it? One of the things I like is I get to learn a lot of things that in other situations I may not know very much about. Gender-affirming care is one of those things. I'm wondering if, in layperson terms, you can explain what that means to everyone here, and if you can explain what the province is doing to support folks who need gender-affirming care.

JEANNINE LAGASSÉ: If the member is okay, I'm going to ask Ms. Penney to take that particular question, because the file for gender-affirming care does fall within her clinical branch in the department.

TANYA PENNEY: What I would say is that all Nova Scotians really deserve options and access to health care that meets their needs. We know the transgender, gender-diverse, and intersex Nova Scotians really experience challenges to accessing appropriate and timely care. The clinical portfolio recognizes this and is very, very committed to redefining gender-affirming care.

When you think about gender-affirming care, you think about it from a health promotion, a health prevention - really a holistic approach. Gender-affirming surgery is but one piece of gender-affirming care. How people access health services in a culturally confident way is hugely important to us.

KENT SMITH: This question I'm going to turn to Mx. Heide. I don't want to get too personal as I sit here, but I have a blended family and I have a stepchild. We're going

through some things at home that I personally may need some resources in the future relating to gender confusion, gender identity. I'm just wondering what resources are out there for parents, stepparents who need a little bit of extra help?

LEIGH HEIDE: That's a great question, and I think there are a lot of different answers. I guess it depends on what kind of resources a person is looking for.

First of all, I will say that gender identity and the full diversity of that needs to be covered in our education system. We obviously know parents are going to play a big role in this, but so that families are supported when kids are going to school and that they are able to be their full selves at school, and then also for all kids to learn what gender identity means and all of that.

We know that's unfortunately not happening the way it needs to be. Part of that is around curriculum, part of it is certainly around the knowledge and comfortability - I don't think that's a word - of teachers. So there's just more training that needs to happen all around that, and more funding resources that need to go into that.

In terms of community resources, we certainly have some within our network - Halifax Sexual Health Centre and SHNS, we call it for short, www.shns.ca. There are some resources there. We will often share from other organizations as well. Planned Parenthood Toronto has done some great resources on their site, www.teenhealthsource.ca. There's a lot out there.

In terms of youth being able to get access to resources that meet their personal experience, it's important to have a connection to an organization or a group that can answer those specific questions for youth and their families because resources won't always be tailored to what a youth is going through.

Shout-out to the Youth Project here that is a wonderful partner organization of ours who could, like all of us, use more funding for their programs and services. They are certainly a great organization for youth and families to reach out to. What we would like to see though is that resource support across the province because the Youth Project is one non-profit with staff who are meant to be responsible for the whole province. That's really hard to do.

That's the same for our Sexual Health Centres. Our staff there will respond to questions, and we have a gender-affirming year program at South Shore Sexual Health Centre, which is amazing. Anyone of any age, any identity can access free or low-cost gender-affirming items, things like binders, gaffs, that kind of thing. It's a wonderful program that will run out of funding very soon. It was funded by a couple of project grants without sustainable funding for that program. We're trying to figure out how to make that a provincial program, but we have no funding for that.

[10:15 a.m.]

With that comes a bit of a counselling support piece. Kids don't just come in and take their thing and leave. There's discussion about how they're doing, what their needs are, and often families will come with. Some of that happens virtually as well. They can reach out and ask questions of our Sexual Health Centre staff. The Youth Project has a program very similar.

That does exist, but these things happen when there are grants. The Sexual Violence Prevention Innovation fund is a good example of that. A few great projects sprung up from that fund. I was responsible for one, the Healthy Relationships program with the youth project, and it ends when the grant ends. There was a lot of good work around gender-affirming support that kind of fell away as grants fall away.

THE CHAIR: MLA Smith.

KENT SMITH: I may connect with you after the meeting just to discuss it in greater detail.

You talked a lot about the partner organizations, which is great. You touched a little bit on the education system. Are you the best person on the panel to talk about the education system and the changes and evolution that have happened in our school systems as it relates to education on gender identity?

LEIGH HEIDE: I'm one person who can speak to that. I think possibly here, I have a lot of second-hand knowledge, in a sense, from our Sexual Health Centre staff who go into schools and deliver education and programming. Then I hear back from them about what the experiences are. Also, having previously worked with the youth project and then being a partner, I have the knowledge of that as well. I can speak to some of that, yes.

I think one of the things that we see a lot in our schools is sort of short-timed projects around gender-affirming programming, healthy relationships, programming for 2SLGBTQ youth. Like I said, there's been quite a bit of it. It happens in pockets when there's a grant of $5,000 and then it disappears. It's not sort of built in in a long-term way.

Gender identity is covered in the curriculum in Nova Scotia. However, like all sexual health and gender topics in the curriculum, there are curriculum outcomes. Then it is up to the individual teachers. They do what they can to meet those outcomes, but how do they meet them, what do they cover, and how comprehensive is it? Does it really speak to the kids who are in the room and their realities?

What we hear is that it's not, by and large, meeting the needs, unfortunately. We try to supplement that, but all of our rural centres have one staff member and, as I said, an

operational budget of less than $50,000 a year and are asked by schools to come in and do these quick 30-minutes on gender diversity. It doesn't work like that. It needs to be built in.

We're not funded through the Department of Education and Early Childhood Development at all, by the way. We are asked constantly to go into schools to supplement. Teachers are doing the right thing when they do this. They're asking us because they know we have the knowledge. They're recognizing a lack of training and knowledge around a topic and they're reaching out and asking for help. That's the right thing to do,

But we can't meet the need with the funding that we have. We just can't. It's quite patchwork and inconsistent. We don't always have a great idea of how it looks across the province in different areas, but we hear a lot from young people that they're not getting their needs met around those topics.

THE CHAIR: MLA Smith, you have 45 seconds.

KENT SMITH: Well, I could echo my colleague, the member for Cole Harbour-Dartmouth, and do a little dance for 45 seconds or I could say thank you very much and happily move on to the next round of questioning. Thank you, Mr. Chair, and thank you for the answers.

THE CHAIR: That will be the time for the PC caucus. We'll have seven minutes per caucus in the rapid-fire. That will get us to 10:40 a.m. - so seven minutes each.

We'll begin with MLA Nicoll.

LORELEI NICOLL: I want to thank the NDP for putting this topic on the agenda because, from what I've been listening to, it really needed to be had. Hopefully, that's not just a discussion that's had because this happens to be Sexual Assault Awareness Month.

In my short time as an MLA, my takeaway from this is that I'm hearing service providers giving me great information on what needs to happen, but then I'm hearing from the government that they're glad we're here because we're hearing it from the service providers. If we didn't have this meeting, would you not be collaborating? It's just a takeaway from what I'm hearing. Like I said, this is my first meeting of this committee, so it's just my intake.

As someone who volunteered for 20 years, being a former school advisory council Chair in high school, and who very much worked together with youth networks and things like that, to hear that - in the particular case that Mx. Heide referenced about the desperation of this one person and the fact that gender equity and identity, especially in the rural areas - it's still where it's at.

I mean, in my time at the high school level, the public health nurses are there. They're tasked with doing the yeoman's work of providing advice and support. They do a great job, but at the end of the day - I was in shock because one high school was saying, well, we have condoms and we can't keep them in stock. Then the other school is saying that nobody is using the condoms because the partner prefers it without.

I don't know when you're going to start having these hard conversations about how you're going to have it built in, to Mx. Heide's question and point. At the end of the day - and I'm looking at the business case that Ms. Paynter pointed out regarding the IUD - the device being covered by MSI needs to happen.

Deputy minister Lagassé, you've said you're in a review process. Can there be hope that this device would actually be available to those who want it? Economically, the business case says it's the best way forward. It's time to start looking at these properly. It shouldn't matter where the person lives across Nova Scotia.

Those are my takeaways. Basically, I'm asking that of the deputy minister.

THE CHAIR: Deputy Minister Lagassé.

JEANNINE LAGASSÉ: It is too early in the review to make any commitment on any changes that would be made at this time. I can tell you that there is a fulsome review of the formulary going on and other aspects of coverage.

LORELEI NICOLL: Well, as someone who didn't feel that I needed to be the person to have the conversation about providing menstrual products in municipal facilities and then have it escalated at the provincial level - it's 2022, and I've heard many times since I've been here that a fulsome review is being had. I'm sorry if I seem impatient at this particular juncture.

There's a Women's Choice Clinic - and I'm just going to stick to my script now - at the QEII. They have a program where women who are unable to afford birth control but receive an abortion can have an IUD inserted free of charge. As someone mentioned - I think it was MLA Leblanc - saying that you have MSI for the person, but the device is not covered. The funds to pay for this are through the QEII Foundation. Last year, the government made an investment in the foundation to cover the costs for up to one year. There's a need for more sustainable funding, as we've heard. What conversations are under way and being had in that regard, as part of your review?

JEANNINE LAGASSÉ: I'm not aware of any recent particular discussions about that topic, but I will ask in the department when I get back. I'm sure that there will be some further discussion about that program.

LORELEI NICOLL: Could you follow up and provide me with that information, please? Thank you.

I'll pass it on to my colleague.

THE CHAIR: MLA DiCostanzo. You have a minute and 45 seconds.

RAFAH DICOSTANZO: I'll try to really take advantage of that time. I was a medical interpreter at the refugee clinic, and I remember there was a program by the resident gynecologist, who did it once or twice a month. That was an amazing program. I wanted to ask if that's still there.

As you're saying, these gifts and all the refugees who I interpreted - I must have witnessed at least 10 insertions of IUDs and five or six abortions. I've learned a lot about what that means to the newcomers. Most of those women had 6 to 10 kids, and they were having these IUDs put in and not telling their husbands because they don't want another kid, and they are not allowed to have birth control, and they're not allowed to have that.

I wanted to know, is that program still going? It was fantastic, and is there a way that we can expand on that program?

MELISSA BROOKS: Yes, that program is still going. That was a resident initiative, so we do work with the newcomer clinic, and they are there once a month. They provide pap screening and IUDs, or contraception I guess, contraceptive prescriptions.

One of the barriers they do come across in that program is that copper IUDs - which tend to be the preference of patients they see there, as opposed to the hormonal IUDs - are considered devices so they are not covered by any of the drug plans. Again, we try to access free IUDs when we can but that's not easy. That was one of the barriers.

THE CHAIR: Order, the Liberal's time for the second round is over. I will pass the time on to the NDP and MLA Leblanc.

SUSAN LEBLANC: Thank you, Mr. Chair. I'm going to talk really fast. The first thing I want to do is make a quick comment on the deputy minister's comment about the access to fertility treatments. I just want to say that I feel that it is a fundamentally flawed comment that fertility treatments will not be available to everyone because everyone needs to be able to pay up front and that is not the case in Nova Scotia. We need to make sure that fertility treatment and surrogacy support is in the universal system.

I want to ask about the term "partners" because I hear this often across government. I hear the Health Authority and the department talk about our partners. Frankly, I don't see how that is an accurate description of the relationship between Sexual Health Nova Scotia and the department, or Wellness Within and the department.

If partnership was happening, then those organizations would be funded properly and Mx. Heide would not have to run an organization on $50,000 a year and spend most of their time writing project grants for very important situations or very important projects that then, as they said, end - and then it's back to the drawing board to figure out how to address the issues.

To address the issues that we are experiencing in Nova Scotia in a systemic way, organizations need to have sustainable, operational funding that is adequate. I just want to get that out there. It is befuddling to me that the Department of Education and Early Childhood Development is not a partner of Sexual Health Nova Scotia. It really should be.

I want to ask Mx. Heide: Sexual Health Nova Scotia is chronically underfunded, what would be the impacts of stable, reliable, increased funding to your organization?

LEIGH HEIDE: There's not really a good, short way to answer that. It would be huge - the impact. For one thing, this is the kind of thing that we're putting some energy towards right now. We're trying to make folks understand that our five rural centres - and I can speak about Halifax and the unique challenges they face as well, being the only clinic in our network - the five rural centres have one staff member each. They have an executive director who goes into schools and delivers programs, who goes into the community and gives out free safer sex supplies.

During the pandemic, our ED in Cape Breton drove their own vehicle all around Cape Breton to bring people condoms and safer sex supplies. More staff would be a huge part of the impact, right? They each should have several staff.

If you think about the women's centre structure it is actually somewhat comparable there. Having worked in a women's centre, I can speak to that. A women's centre in a small community has maybe $300,000 or more of annual funding and our Sexual Health Centre might have around $50,000. You can imagine that the difference would be more staff - staff who can do those individual pieces, and then programs that they know are going to go on all year all the time.

Our South Shore Sexual Health Centre had to close for four months of the year last year because they didn't have funding to pay their one staff member. So they aligned it with the school year so they could be open during the school year and go into schools - again, not funded by the Department of Education and Early Childhood Development. Then we're closed from May to September. That will happen again, without funding. That will be the case this year. It will be the case next year.

So being able to be open full-year, have more staff members, programs that they know can continue, the gender-affirming Gear project that we're getting so much attention they won a national award for, yet it will end any minute.

[10:30 a.m.]

SUSAN LEBLANC: Thank you for that answer. Before I pass on to my colleague here, I will just say that - never mind. I lost my train of thought.

THE CHAIR: MLA Coombes.

KENDRA COOMBES: I understand my colleague's frustration in this, because it's very frustrating to hear the word "partners" and know that the funding is not available.

I want to talk about the rural area, and that is with regards to access to full reproductive sexual health care, and the lack of funding in those areas where they're really needed. They're not getting the access to physicians. They're not getting the access to fertility doctors. They're not getting the access to abortion. They're not getting access to gender-affirming care - and the full-on sexual health. I would like to ask: What needs to be done in the areas outside the HRM to give more robust, full, sexual health and reproductive health care to Nova Scotians?

THE CHAIR: MLA Coombes, who are we directing . . .

KENDRA COOMBES: I believe Dr. Paynter has put her hand up.

MARTHA PAYNTER: I'll speak to this. Thank you for the question. One of the things that's really apparent in this discussion is that sexual and reproductive health in this province is treated as an add-on. I went to the town halls, I think they were called, that Ms. Oldfield hosted in four different sites about health last Fall. Kevin Orrell was there, and the Premier was there. I raised the issue - shocker - of sexual and reproductive health and was informed that at the fourth town hall, that was the first time it had been raised.

Everybody has sexual health all your life. It is absolutely basic, foundational to your well-being. The chronic underfunding is really, it causes so many population health sequelae that result in all kinds of harm to our economy. Sorry, I was trained as an economist before I was a nurse.

What I want to bring up first is how we are not using who we have. Mx. Heide raised the issue of physicians who aren't prescribing, or pharmacists who aren't inserting. We have RNs prescribing in this province now. We have nurse practitioners prescribe, insert. They have prescribed abortion now for four, five years, I think. Midwives can be doing all of this work. Midwives are primary care providers for reproductive health. They can do all this stuff. Why are we not using and empowering the people we already have, and who are so critical to those rural and remote sites in the province?

The other thing I wanted to . . .

THE CHAIR: Order. The time has expired for the NDP questions. It's now the PC caucus questions. MLA Barkhouse.

DANIELLE BARKHOUSE: Thank you all for coming here. I'm rather enjoying just sitting back and listening to what you're all saying and the questions that are being asked. Of course, the questions tend to bleed into each other, but I'm going to ask some of the ones I have anyway. I think this should go to Deputy Minister Lagassé: What steps are being taken to expand health care services in a culturally relevant way to improve the sexual health of Nova Scotians?

JEANNINE LAGASSÉ: We're starting work through the department, the NSHA and the IWK, related to the preparation of the health equity framework. We're doing quite a bit of work in that regard. Ms. Penney and her group, and in the work they're doing in reviewing the gender-affirming care policy, we're looking at how we could get out into community, how we hear from people, and how we develop things with community.

We currently have received a proposal from a group in relation to gender-affirming care. We're looking at how we can engage with that group. The department has been reviewing the proposal that was put forward. Now Ms. Penney and her group are looking at how they can engage with that group to learn further from them as we develop the new parts of the policy. Ms. Penney may have something she'd like to add in that regard.

TANYA PENNEY: I think I would just add to Deputy Minister Lagassé's comments. It's exceptionally important for us to develop a policy that incorporates lived experience from the community that we're trying to write the policy for. I think I would just reaffirm that through that statement.

DANIELLE BARKHOUSE: Okay, great. This has been kind of answered, but not really, and kind of asked, but not really, so I'm going to go back to this. I think Mx. Heide or maybe Deputy Minister Lagassé could answer this or Karen Oldfield, maybe. Can you share what work is being done to make health care services more welcoming and inclusive? What educational opportunities are there for health care staff to support their learning regarding this situation?

THE CHAIR: Mx. Heide.

LEIGH HEIDE: I may not be the best person because I don't have much control over training and education, so we'll pass it on.

I wanted to say that there has been collaboration between prideHealth, which has a part-time staff of one, by the way, for the whole province, and a couple of other non-profits - CBRC and the Halifax Sexual Health Centre - to offer training around 2SLGBTQ health care, specifically gender-affirming health care.

These are physician training courses that are free, Mainpro accredited, have been offered here virtually, and are really easy to take. There have been a few of them developed and run now. There's another one coming up shortly. That's a great initiative that hopefully will continue. That is coming from pockets of funding as well, so I can't speak to whether it will continue. That's just one piece, and it is optional. Physicians have to decide to do it, but they've been well taken. There have been a lot of people at them.

THE CHAIR: Ms. Oldfield.

KAREN OLDFIELD: I wouldn't really have too much to add other than to echo the comments around prideHealth. I've met at least one individual involved in that during our "Speak up for healthcare" tour. As has been noted for most of the morning, one person can only do so much, so it is important to determine the ways that we can help and support, and get the education and the important parts out across the system and across the province.

DANIELLE BARKHOUSE: Dr. Hatchette, what efforts are planned or are under way to increase public awareness and education around STIs?

TODD HATCHETTE: Other than the sort of programs that have been already talked about, I'm not sure that there are any particular public awareness issues.

I think, if I may, one of the biggest challenges is that we don't have an STBBI to oversee what the goals of care are and what the initiatives should be. PHAC does have an STBBI plan, and without having a program to sort of oversee it properly, it is going to be hard to achieve that with piece-meal funding and piece-meal integration.

DANIELLE BARKHOUSE: Thank you. I'm sorry, I was writing some of this stuff down as we go. I'm done. Thank you for all your answers here today. That actually has me thinking of more questions that I might reach out to some of you and find out.

THE CHAIR: The honourable member for Kings West.

CHRIS PALMER: I just want to go back. There's no doubt that the fertility rebate is going to help many hundreds of Nova Scotians, as has been referenced by the deputy minister. We've talked about how it's including surrogacy.

Just to expand on that, could you please talk to us about how that's going to help inclusive families and how that's going to really be a positive in that end of things. I'll address that to anybody on the panel.

THE CHAIR: Ms. Penney.

TANYA PENNEY: I think your question is around the fertility rebate and its inclusiveness. I think that's the most exciting piece of the rebate - that it is inclusive, and it is not necessarily just for heterosexual couples. I agree.

THE CHAIR: MLA Palmer, are you finished? We had 15 seconds left, but at this point we'll end the question and answer. We'll move on to closing remarks. If anyone is open for closing remarks, I'll look to our witnesses.

Ms. Oldfield.

KAREN OLDFIELD: I really appreciate the time today, and I particularly appreciate the questions and the answers. I've appreciated meeting the folks here at the witness table. I've made a lot of notes.

I just want to summarize my takeaways because I think they are important. Ms. Paynter made a point towards the end that everyone has sexual health your whole life. That's something I'm going to take away from this session today and go forward as we move to make decisions and inform ourselves as to parts of the system that need further attention, deeper attention, stronger partnerships.

I've made a note that the Department of Community Services was referenced. They are a partner, but they're not here today. The Department of Education and Early Childhood Development, a very important component, and they're not here today.

We do need to find ways to resource support across the province. That is another really important note. We have a number of rural MLAs present. There are so many more things that can be done, but the good news here is that the issues are being talked about, they're on the table. We have an opportunity to walk forward and to learn and to do the things that are right for the people of our province. Thank you for that opportunity to learn today.

THE CHAIR: Do any other witnesses have closing remarks? Ms. Paynter.

MARTHA PAYNTER: I want to close by really emphasizing how this province has made - I've been doing abortion work for 20 years, and what this province achieved in 2018 was really extraordinary, world-class. We have the best access to abortion in the world. You can get it from any primary care prescriber, it is completely decriminalized. We have a very, very big country, though, and so that's the issue - this transportation issue. Aside from that - we can't do anything about that.

Really, when I look at this - and I'm very interested in efficiencies and achievable gains, and places where we can lead and do really well - I see universal access to contraception as filling so many needs. Mx. Heide raised all of these issues about gender-affirming care, and contraception is gender-affirming care. You get an IUD, you're not

going to have a period for five years. That feels really good if that's the kind of gender-affirming care that you're looking for.

[10:45 a.m.]

Universal access, it helps all the youth who don't have to disclose to their parents and go through private insurance. They just get the care they need. You can't drive to Halifax if you're 13 years old. It addresses this issue about this month dedicated to understanding and highlighting the issues with sexual assault and intimate partner violence. Contraception prevents that. It prevents poverty, it prevents low educational outcomes, it prevents unemployment. It is the best win-win we could possibly imagine, and it's definable and achievable.

I want to leave by really wishing us well on a path forward where we can get that done, and again lead nationally and internationally in the way we care for the people of this province.

THE CHAIR: Thank you, Ms. Paynter. Mx. Heide.

LEIGH HEIDE: I want to speak generally in these closing remarks to sexual health services and access, because Doctor Paynter said everything that I wanted to say about access to birth control, so that's done. Thank you so much for having all of us here today.

In terms of that general access to sexual health services, when I think about that, - and I think about being underfunded in the way that we've talked about today - what comes to mind right away for me is that the federal budget had a few million dollars allocated to sexual gender reproductive health services, which we were jumping up and down with our federal affiliate, Action Canada, to see that in there. To my knowledge - and I could be corrected on this for sure - none of it made it to Atlantic Canada, or at least not Nova Scotia. We applied; we were rejected. We applied with our partners, prideHealth, CBRC, the AIDS Coalition, the Nova Scotia Advisory Commission on AIDS. We put in a joint application. No.

Then came our provincial budget, which we were like, maybe there will be something in here for us, and it didn't feel like there was. There were a few things that we thought that could stretch to include us in this way or that way, but not really. We've been feeling a little bit disappointed, a little bit let down lately by budgets.

I also want to try to clarify our funding structure a little bit. We have an annual grant application with the Department of Health and Wellness. I apply for it every year. The application is pretty much the same, but it is never guaranteed - any year we could not get it. That hasn't happened, thankfully, but we also haven't had an increase of more than $16,000 in 20 years. Some of our staff at the sexual health centres are making less than what they were making when they were hired six years ago, for example, so we really need

an increase to our operational funding. We also need it to be guaranteed that it is not about to disappear.

It is extremely stressful, as you can imagine. I need a vacation about this time every year, after I fill out the 30-page application and do this for the next two weeks, or however long. We feel like we've actually built a pretty good relationship with the folks who work with us on that grant.

The system pieces don't change so it's not really about the human relationship. We should have funding from the Department of Community Services, we should have funding from the Department of Education, from the Status of Women. These are questions that I really don't have answers to, but I would like to explore more with anyone who is willing to look at that.

I also wanted to mention about policies and strategies specific to sexual health, and gender-affirming care, and comprehensive education. It's really important that we have these things in place, that they are written down. The policy that was referenced on gender-affirming care was created by a couple of volunteers who felt passionately about the challenging system of gender-affirming care in the province right now. That policy, oh my gosh, if you haven't read it, go read it right after this meeting. It is amazing and wonderful and comprehensive. I can't believe what these student volunteers did with this work.

There are people with the knowledge just out there in our community, going to school, living their lives, they're trans and gender-diverse people. Obviously, everybody has sexual health, so there are a lot of folks who have a lot of knowledge on this stuff and can help create strategies and policies that will really support us. Those things are what we can look to then when we are looking for funding. We can say, well it's here, we need to do it. I just wanted to restate the importance of that.

Lastly, I'll just say about partnership. I do take everybody's points on what partnership means, in a sense. Just know that at least for Sexual Health Nova Scotia, we want to be partners with as many government, non-profit communities, everybody. We love partnership. I think it's one of the things we do best, so come and partner with us.

THE CHAIR: Thanks, Mx. Heide. Dr. Brooks, or deputy minister.

That concludes our topic for today. I'd really like to thank the witnesses on behalf of the committee for coming here today - a lot of insight, information, and a lot to look at.

At this point, I'll let the witnesses leave. I would like to take a short three-minute break while they're leaving and then we'll come right back to committee business.

[10:49 a.m. The committee recessed.]

[10:54 a.m. The committee reconvened.]

THE CHAIR: Order. We're going to get back into committee business. We have a number of items to discuss with respect to committee business today.

The first two items are correspondence from the Minister of Seniors and Long-Term Care re: staffing calculations. This was a response to a letter sent by the committee after our meeting of February 8th. You were all forwarded that correspondence. If that's okay, we can move on.

The second item is correspondence from the Office of Healthcare Professionals Recruitment re: staffing vacancies. It was a response to request for information made at the meeting of March 8th. We were forwarded this correspondence on March 29th and again yesterday. That's fine.

The next item is date of May meeting on government initiatives of ambulance availability and off-load delays and Department of Health and Wellness response. This is one of the last couple of committee topics left. None of the witnesses for the other topics can appear on May 10th, which is our typical day. There's an opportunity to have that topic on Thursday, May 12th in the morning or Tuesday, May 17th either in the morning or the afternoon.

MLA Smith.

KENT SMITH: If there's an option to provide feedback on this, my two cents would be the 17th, please and thank you.

THE CHAIR: MLA DiCostanzo.

RAFAH DICOSTANZO: That would be suggestion as well, so I'm glad it works.

THE CHAIR: MLA Palmer.

CHRIS PALMER: I agree with the date. I just do note that the Veterans Affairs Committee does meet that day, and we just have to make sure - we're not on the 17th?

THE CHAIR: Ms. Kavanagh.

JUDY KAVANAGH: The Veterans Affairs Committee normally does meet on the third Tuesday of the month, but in May that particular meeting has been rescheduled. I think it's going to be on another date.

KENT SMITH: It was changed. You're correct.

THE CHAIR: I guess for the committee, would we prefer the afternoon, as is normal for Health, or would we prefer the morning? Afternoon? If there's consensus for the 17th in the afternoon, that would be okay. I get consensus, so the meeting will be moved from the May 10th to May 17th at our regularly scheduled time. Perfect.

We do have a meeting confirmed for June 14th. Deputy Minister Lagassé and Dr. Strang will appear for the vaccine booster shots. The other topic - the next one was we had as a committee agreed to have a seventh topic in our six-month period. That was with the cardiac arrest outcomes. I think it was Heart and Stroke Foundation of Nova Scotia had reached out to us. We wanted to do it in the six-month period. The committee instructed the clerk to arrange a special meeting. The witnesses would be available on May 31st or June 21st. The clerk suggested any of the times noted here, whether it's 2:00 p.m. to 4:00 p.m. on the 31st or 9:00 a.m. to 11:00 a.m. or 10:00 a.m. to noon on the 21st.

Just some brief discussion about this. We do know that June 21st is getting close to graduations and that sort of thing. I see that MLA Barkhouse has her hand up as well.

DANIELLE BARKHOUSE: I just wanted to state that May 31st would be the best, I think, for most here.

THE CHAIR: MLA Leblanc.

SUSAN LEBLANC: Yes, May 31st makes sense to me. I guess 2:00 p.m. to 4:00 p.m. is the time that they can come?

THE CHAIR: The time we have is 2:00 p.m. to 4:00 p.m., so if there's consensus from the committee for that, we can take that.

The last item on the committee business is the agenda setting. June 14th will conclude our current list of agenda topics.

MLA Smith.

KENT SMITH: Sorry to interrupt. Can I request a five-minute extension to the meeting time just to make sure we get through this?

THE CHAIR: Is that okay with everybody, a five-minute extension? We have consensus, with 40 seconds left for a five-minute extension.

Do we want the committee to hold the agenda-setting meeting at the end of a meeting, like a 10-minute rush job, or do we want to hold a separate agenda meeting in July to go over the topics for the next six? MLA Smith.

KENT SMITH: There's nothing I'd love more than a full-on meeting in July to sort out the topics for our next round.

[11:00 a.m.]

THE CHAIR: July 12th would be our typical meeting time, in the middle of Summer. It's our second week in July. If everybody is okay with that, we could have our July 12th meeting as our agenda-setting meeting. That gives caucuses time to come up with topics as well.

That covers all the business I have. That was very well done. Is there any further business?

Hearing none, our next meeting will be scheduled for Tuesday, May 17th from 1:00 p.m. until 3:00 p.m. Our witnesses will be - the topic will be, the Department of Health and Wellness, and IUOE Local 727 re government initiatives of ambulance availability and offload delays, and DHW response.

If that's okay, the meeting is adjourned.

[The committee adjourned at 11:01 a.m.]