Public Health Management of HIV Exposure and Non-Disclosure

Manitoba
Public Health Branch

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This guideline is informed by and replaces the Winnipeg Regional Health Authority's *Managing HIV Non-Disclosure Guideline*

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Abbreviations

ARV	Antiretroviral
CD	Communicable disease
HIV	Human immunodeficiency virus
MOH	Medical Officer of Health
PHN	Public Health Nurse
STBBI	Sexually transmitted and bloodborne infection
STI	Sexually transmitted infection

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1. Purpose

These guidelines are to assist regional public health teams to apply an appropriate and consistent approach to the public health management of situations where people diagnosed with human immunodeficiency virus (HIV) infection do not disclose their HIV status before engaging in activities that put others at risk of contracting HIV.

2. Scope and Goal

This guideline applies to regional Public Health Nurses (PHNs), Communicable Disease Coordinators (CD Coordinators), Medical Officers of Health (MOHs), and other public health staff working in collaboration with health care practitioners supporting the care of people living with HIV. These guidelines do not address public health partner notification practices.

3. Definitions

Non-disclosure of HIV status that results in a significant risk of infection for others occurs primarily when an individual diagnosed with HIV engages in moderate to higher-risk activity with contacts without informing them about their infection and related risk, and public health has reason to believe the activity and non-disclosure will continue.

The following definitions(1, 2) are to assist in determining if a client is unwilling or unable to disclose their HIV status, and/or to take measures to prevent HIV transmission. Factors that shape willingness and ability may be dynamic and difficult to assess.

Unwilling Client: A client (excluding an unable client) who meets any of the following criteria:

- Possesses the mental and environmental capacity and opportunity to adhere to disclosure of their HIV status and has the capacity to pursue measures to protect others from HIV transmission, but does neither
- Has been informed regarding their responsibility to protect others and/or disclose their HIV status to others with whom they engage in transmission risks (their contacts), but remain unwilling to or fails to do so
- Has knowingly made false statements regarding their HIV status to contacts, or has knowingly or willfully misrepresented their HIV status to contacts

Unable Client: A client who lacks the capacity to form the intention and/or implement a plan to prevent the transmission of HIV due to any of the following criteria:

- Has a psychiatric diagnosis or cognitive impairment such as organic mental illness, developmental disabilities or head injuries, or intermittently disabled (e.g., temporary or undiagnosed psychosis), or
- Experiences an external or environmental reason such as dependency, coercion by, or fear of other persons, which leads them to continue to engage in activities of risk for HIV transmission, or

- Has no knowledge that they are HIV-positive

Counselling: In the context of this document, counselling refers to a basic skill set in the scope of nursing practice for engaging in an open-ended, client-centered conversation about the concern; assessing client understanding and knowledge; assessing individual, social, and environmental barriers; developing trust and rapport, and supporting collaboration and choice.

HIV Transmission Risk: HIV in general is not considered highly transmissible as the estimated risk of infection per act are generally less than 3%, with sexual exposures lower risk than injection with used equipment.(3-6) The categories below provide guidance for assessing HIV transmission risk associated with activities. However, there are additional factors to consider in assessing transmission risk, including (but not limited to) concurrent sexually transmitted infections (STIs), genital ulcers or mucosal injury, repeated exposure, viral load related to infection stage (seroconversion), medication adherence, drug resistant virus, and condom failure.(5) The setting or context in which activities occur must also be considered in assessing risk, feasibility of disclosure, and appropriate public health response.

No Risk Activity: Transmission of HIV is theoretically not possible, and no observations of transmission have been published, e.g., kissing, body rubbing, and injecting substances that have not been shared or exposed to another person's blood using a new needle and syringe.(4)

Negligible Risk Activity: Transmission of HIV is theoretically possible but unlikely, and no observations of transmission have been published. Examples include spitting or biting,(7) fellatio, cunnilingus, or anilingus with barrier (i.e., sex dam), digital stimulation of genitals.(4) There is a negligible risk of sexually transmitting HIV through penile-anal or penile-vaginal intercourse when an HIV-positive individual adheres to ARV therapy and maintains a suppressed viral load of less than 200 copies/mL on consecutive measurements every 4 to 6 months, with or without condom use.(3)

Lower-Risk Activity: Transmission of HIV is theoretically possible. Published reports confirm the transmission of HIV through these activities, though reports are mostly case reports and anecdotal reports, and often may occur only under certain conditions, e.g., fellatio, cunnilingus, or anilingus without barrier; injection of substances that have not been shared or exposed to another person's blood using a used needle and syringe that has been cleaned with bleach;(4) penile-anal or penile-vaginal intercourse with an internal or external condom; penile-anal or penile-vaginal intercourse while taking ARV treatment without confirmation of suppressed viral load (less than 200 copies/mL on consecutive measurements every 4 to 6 months).(3, 8)

Moderate to Higher–Risk Activity: Transmission of HIV is theoretically possible. Published scientific studies repeatedly confirmed an association of these activities with HIV transmission, e.g., penile-anal or penile-vaginal intercourse without condom in the absence of anti-retroviral treatment (anal receptive is higher risk than vaginal receptive intercourse). Sharing sex toys also poses transmission risk.(4) Transmission risk is higher with any other concomitant STIs. Sharing needles or syringes is among the highest risk for transmission.

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4. Background

While acknowledging the need for guidelines outlining a public health approach to people living with HIV who may pose a transmission risk in the context of non-disclosure, it should be recognized that such cases occur rarely, and such an approach is only a minor (but necessary) component of the strategies for HIV prevention.(2)

All interventions are aimed at providing improved quality of life for the person living with HIV, as well as protecting the health of the public. The determinants of health of the person(s) are addressed through the use of a comprehensive assessment and various interventions such as community support, harm reduction counseling, and efforts toward engagement and retention in HIV care.

In Canada, a number of criminal offences can be related to a person's non-disclosure of their HIV status where transmission of HIV occurs, or where the activity puts another person at significant risk of transmission[6-8,16].(9-12) However, this document does not address the legal responsibility to disclose HIV status or the *Criminal Code*. This direction focuses on the public health sector response to non-disclosure, and the legal framework available in *The Manitoba Public Health Act* and its regulations.

The goals of public health in HIV non-disclosure situations are to reduce the potential for HIV transmission by:

- encouraging/supporting people living with HIV to reduce their risk of transmitting HIV, including engagement and retention in HIV care and treatment; and
- addressing barriers to risk reduction, engagement in care, and/or disclosure, including social or environmental barriers such as housing/shelter, income, social support, mental health and wellness; and
- facilitating/supporting individuals to disclose their HIV-positive status prior to engaging in activity whereby HIV can be transmitted to another individual (disclosing to contacts); and
- in some cases, notifying contacts of their potential exposure to HIV (contact notification)

Public health should attempt to maintain therapeutic relationships with clients in order to successfully counsel prevention strategies, and support engagement and retention in care.

Where repeated attempts to support prevention practices and HIV disclosure fail, an important distinction must be made between clients who are unable or unwilling to disclose their HIV status to contacts. Although issuing and enforcing public health orders is possible, engagement through supportive and voluntary measures is the preferred public health approach.

The measures available through use of The Public Health Act by MOHs are as follows:

- Issuing a Section 43(1) Communicable Disease Order under *The Public Health Act* (C.C.S.M. c. P210), and the subsequent enforcement of the Order, if violated, by the MOH who may proceed to the next step;
- Application to a justice under Section 47(1) for an Order to Apprehend under *The Public Health Act* (C.C.S.M. c. P210), and the subsequent enforcement of the Order, if deemed appropriate, by the justice who may proceed with an Order to Examine, Treat and Detain under Section 49(1);

- Application of penalties under *The Public Health Act* (C.C.S.M. c. P210), should any of the above Orders be ignored or contravened, consisting of a fine of not more than $50,000 or imprisonment for a term of not more than six months, or both; and;
- Referral to a crown prosecutor for criminal charges and prosecution under the federal *Criminal Code*.

4.1 Underlying Principles

The Underlying Principles that frame this set of guidelines are drawn largely from the consensus statements and advisory documents (see Validation and References), and the Pan Canadian Sexually Transmitted and Blood Borne Infection (STBBI) Strategic goals:(13)

- Reduce incidence of STBBI;
- Improve access to testing, treatment, and ongoing care and support;
- Reduce stigma and discrimination that create vulnerabilities to STBBI

For HIV specifically, public health supports the current 90-90-90- targets:(14)

- 90% of all people living with HIV know their status,
- 90% of those diagnosed receive ARV treatment, and
- 90% of those on treatment achieve viral suppression.

The basic principles and values around managing persons who are “unwilling” or “unable” to take appropriate precautions to prevent the transmission of HIV are:

1. The primary concern of public health officials should be to reduce the risk of HIV transmission;

2. Failure to disclose one’s HIV-positive status may be influenced by more than an inherent unwilling disposition of the client. Environmental factors that contribute to non-disclosure may similarly prevent a client from engaging in HIV care and treatment. Public health’s goal should be to reduce these barriers to disclosing HIV status wherever possible, and reduce their risk for transmission through treatment and/or changes in risk activities.

3. Public health recognizes and values working in partnership and cooperation with physicians, other health care providers and community groups to support people living with HIV, and in the management of complex situations as they occur.

4. Every effort is taken to identify and arrange for provision of necessary support or interventions for persons who may be unwilling or unable to protect themselves and others. Public health must strive to recognize and protect the needs of all groups in society, including those who experience disadvantage and discrimination for whatever reason.

5. Action taken by public health officials should be proportional to the risk of HIV transmission posed by the client. No risk and negligible risk activities should lead to nothing more than counseling/education of clients. Engagement in moderate to higher-risk activities should result in greater and quicker escalation to intrusive measures than low-risk activities.

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6. Actions taken by public health to address a non-disclosure situation should follow a graduated approach of beginning with less intrusive measures and progressing to more intrusive measures as necessary.

7. Public health interventions must balance the rights of the individual with the duty to protect the public, where risk to public safety can sometimes override the rights of the individual.

8. Public health officials should acknowledge progress towards adhering to disclosure responsibilities. Persistent refusal or failure to disclose should be met with reminders of the risks, as well as the potential of more intrusive action by public health officials.

9. Clients should not be subjected to a rigid algorithm of escalating measures. Rather, public health officials should exercise judgment in employing the set of available options taking into consideration the context of the client, the specifics of the case, and the likelihood of success.

10. The burden of evidence against a client must be stronger for more intrusive measures to be justified. Counseling, which carries little restriction of freedom, may be justified by circumstantial evidence of non-disclosure. Apprehension under *The Public Health Act*, which temporarily denies most freedom, can be justified only if there is very strong evidence of non-disclosure combined with moderate or higher-risk activity that will likely continue without apprehension and detention. Apprehension and detention can only occur through an order of the court. Further, incarceration is the only available means for detention, which introduces new harms to the client.

11. Even when consistent disclosure of HIV-positive status is achieved by the client, counseling on reduction of transmission risks should continue to be offered, preferably by the client's ongoing health care providers.

12. Unwarranted punitive measures taken against a relative "few" difficult cases could impair the effectiveness of voluntary programs for the "many" other cases, through increased stigmatization or fear of discrimination, and lead to increased spread of HIV.

13. A real or perceived failure to deal effectively with non-disclosure situations could impair the credibility of the public health service, and perhaps lead to public pressure for unnecessarily coercive measures to be taken against people living with HIV.

14. As no public health service can guarantee protection against HIV infection, it is necessary for everyone to understand how HIV is spread, and to act to protect themselves and others.

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5. Procedure

5.1 Initiation

Public Health awareness of HIV non-disclosure situations may come from a variety of sources such as phone call/letter from an individual in the community, health care provider or social service agency; or a laboratory result may be received by Public Health for another sexually transmitted or blood borne infection on an individual with previous HIV diagnosis.

On receipt of a public health complaint or concern regarding HIV non-disclosure, the situation or complaint should be reviewed with the CD Coordinator (who may consult with the MOH) to determine if further investigation is warranted.

5.2 Determination of Risk:

The PHN will first confirm that the client is diagnosed with HIV and not disclosing their HIV status to their contact(s). This should include the following:

- Confirm that an HIV test was conducted and that the client tested positive.
  - If the client is suspected to be HIV-positive (e.g., named multiple times as a contact to HIV) but there is no record of HIV testing or previous positive result, consult CD Coordinator or MOH. Efforts may be made to encourage testing of the individual.
- Confirm from the client record that the client was informed of HIV status and counseled to disclose status to contacts.
- Confirm there is evidence that the client did not disclose their HIV-positive status to a contact. At this stage, evidence need not be strong and may be only suggestive (e.g., documented client statements, documented statements of contacts, positive STBBI tests).
- Assess the status of the client's HIV care engagement, including ARV treatment and viral load.
- Consider the context or setting in which the potential HIV transmission may occur and the likelihood that those at risk of acquiring HIV may have some understanding that their activities may lead to HIV infection (e.g., anonymous sex venues, sex work encounters).
- All public health follow-up related to a non-disclosure situation is documented in the client's PHIMS HIV Case Investigation. If case investigation close, re-open investigation, update disposition (e.g., follow up in progress), author note.

If the client does not satisfy the criteria above, the rest of this procedure will not apply yet. The PHN should focus on confirming HIV status (if not already done). If confirmed, complete the HIV case investigation per protocol, and document in PHIMS.

5.3 Counseling of Client in Non-Disclosure Situations

Counseling for the client should begin by exploring their past contact with public health or primary health/HIV care and their understanding of the information received. In particular, the PHN should explore the client's:

- belief in the accuracy of the HIV-positive diagnosis,

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- understanding that lack of explicit disclosure of HIV-positive status to contacts may open up the possibility of more intrusive coercive action under *The Public Health Act* or criminal prosecution, and
- their understanding of ways that HIV is transmitted and how to reduce their HIV transmission risk and contraction of other STBBI.

Upon assessment of client's current knowledge of their HIV status, including obligation to disclose HIV-positive status to contacts, and risk reduction strategies, the PHN should support to fill any gaps in client knowledge or resources.

- Provide general information about the legal duty to disclose HIV status to contacts if engaging in sex or other activity that poses a realistic possibility of HIV transmission.(15)
- Refrain from interpreting the law, attempting to offer legal advice, or analyzing the client's specific situation from a legal standpoint.(15) Offer the client materials from reliable sources of up-to-date information.(16)
- Advise the client of the confidentiality of their public health record and advise of the limited circumstances their file can be accessed by a third party (i.e., subpoena from justice system). Explain that individuals can independently access the criminal justice system if they believe that they were placed at risk for a CD.

The PHN should also identify barriers to the client's ability to disclose HIV status to contacts. A plan should be negotiated with the client to reduce and eventually eliminate these barriers. The PHN may need to engage other services (e.g., housing, food security, substance use services, primary care services, mental health services) to support the client-identified needs.

The PHN and health care partners should facilitate treatment of co-morbid conditions as well as investigate access and barriers to ARV therapy and ongoing viral load monitoring.

Clients should be offered regular testing for other STBBI such as syphilis, gonorrhea, and chlamydia.

Where the PHN or care partners have questions about the mental status of a client who may be deemed "unable", a mental status assessment should be undertaken. Consultation with client's care provider(s) will assist to determine where to refer client for assessment. Referral resources to consider:

- Client's current care provider, e.g., community mental health worker, psychiatrist or counselor.
- Informal consultation with local community mental health resources, or cultural supports, or other counselor (may include mobile or crisis services).
- In the event where a client is not willing to receive the involvement of mental health services, the care team can identify next steps and whether steps should be taken to facilitate an involuntary psychiatric assessment through the justice system under *The Mental Health Act.*

The PHN should try to identify if there is any well-identified individual(s) or group of people at particular proximate risk of contracting HIV from the client (e.g., contact(s) with ongoing exposure who are unaware of the client's HIV status). If the client is engaging in moderate to higher-risk activity with a well-identified contact group or individual, the CD Coordinator and MOH should be consulted for contact notification considerations.

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If initiating an HIV Non-Disclosure public health response, the PHN should inform the CD Coordinator and MOH of the identification of the non-disclosing client and the interventions initiated. Document in PHIMS Investigation as follows (see **Table 1**):

- Create an Intervention (Type) Public Health Act Follow-up, (Sub-type) Non-disclosure assessment
- Author a Note OR create and upload a summary document for the HIV Investigation that summarizes the information below (Note type: CDC MOH Consult may be used). Upload any relevant context documents such as referrals to public health.
- Inform the CD Coordinator and MOH about the non-disclosure referral in the way that would normally be done outside of PHIMS (e.g., email or case conference).

Table 1 – PHIMS Investigation Note or Summary Document for Non-Disclosure Referral to MOH
History of positive HIV test and diagnosis awareness (dates/approximate dates/by whom)
History of education and counselling about HIV transmission risks and duty to disclose status to contacts (dates/approximate dates/by whom)
Current status of HIV care engagement (may use Definitions of MBHIVP(17))
Current or recent client engagement in other health or social services (voluntary or involuntary, e.g., corrections)
Evidence of activities or practices that are moderate or higher-risk for HIV transmission (e.g., named as a contact to STBBI, subsequent STI infections, contacts who subsequently tested positive for HIV)
Evidence of non-disclosure to contacts
Plan or suggested next steps
Additional Comments or concerns (e.g., client's social environment, supports, barriers to disclosure, considerations of unable/unwilling)

In the intervening period, the CD Coordinator and MOH should be updated regularly (every 1 to 6 months depending on the circumstances) on the status of the client. Document progress in PHIMS investigation Notes.

Once the client has resolved non-disclosure issues, or is no longer engaging in moderate or higher-risk activities (e.g., is engaged in care/taking ARV medications), the PHN should inform the CD Coordinator and MOH of this development. In the the PHIMS Intervention, (Type) Public Health Act Follow-up, (Sub-type) Non-disclosure assessment, update disposition to "discontinued" or other resolving disposition and author a Note describing how the situation has resolved.

5.4 Continued Counseling & Reassessment

The PHN will meet regularly with the client to assess progress, to identify new issues to address, and to reinforce counseling around risk reduction and disclosure. This includes an assessment of social and environmental supports and facilitators, enablers and incentives, referral to available social supports such as social work, counselling, peer navigators, cultural supports.

Where the client continues to participate in counseling and in the other elements of the management plan, this phase of counseling and barrier-reduction may continue indefinitely.

- The PHN should document any evidence of risk reduction or improved disclosure practices or intent/willingness to disclose, which could include reduced incidence of STIs and/or statements by contacts that disclosure is occurring.
- If the client becomes uncooperative in participating with counseling and the management plan, or there continues to be evidence that the client is participating in moderate or higher-risk activities without disclosing to contacts, the PHN should remind the client that non-disclosure opens up the possibility of more intrusive coercive action including CD Orders under *The Public Health Act* or potential criminal prosecution if their nondisclosure is reported to the police by any of their partners.
- For clients who are uncooperative, the PHN, in consultation with CD Coordinator and regional MOH, should consider forming an **oral (documented) or written (signed) contractual agreement** with the client, explaining specific expectations of risk reduction (e.g., ARV treatment or changes in sexual and/or drug use practices and/or disclosure). Such an agreement should outline the agreed-upon course of action, establish a timeframe for this action, and clarify a follow-up schedule including regular PHN and/or clinic visits for counseling and/or testing (e.g., routine periodic STI testing), or other supports the client would find helpful. Such an agreement should also contain space for the client to provide any comments or perspectives they wish to include. Upload any contractual agreement or other shared documents to the PHIMS HIV Case Investigation.

5.5 Consideration for Additional Involuntary Measures

Once the PHN feels that all supportive non-coercive voluntary avenues to facilitate client disclosure have failed, the PHN should discuss the issue with the CD Coordinator and MOH, and if requested by the MOH refer the client to an advisory committee. The PHN should document in the PHIMS HIV Case investigation as follows:

- Update the PHIMS Intervention: (Type) Public Health Act Follow-up, (Sub-type) Non-disclosure assessment, as necessary
- Upload any relevant context documents
- Author a note or a summary document for upload to the investigation detailing pertinent information (see **Table 2**):

Table 2 – PHIMS Investigation Note or Summary Document for Non-Disclosure Advisory Committee Consideration
History of positive HIV test and diagnosis awareness (dates or approximate dates)
History (dates or approximate dates available and by whom) of education and counselling about HIV transmission risks and duty to disclose status to contacts
Current status of HIV care engagement (may use Definitions of MBHIVP(17))
Current or recent client engagement in other health or social services (voluntary or involuntary, e.g., corrections)
Evidence of activities or practices that are moderate or higher-risk for HIV transmission (e.g., named as a

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contact to STBBI, subsequent STI infections, contacts who subsequently tested positive for HIV)
Evidence of non-disclosure to contacts
Additional Comments or concerns (e.g., client's social environment, barriers to disclosure)
Psychiatric or Mental Health Assessment (as applicable)
Assessment of Whether Client is "Unwilling" or "Unable"
Management to date and Outcomes
Suggested next steps including suggested members for advisory committee (health and social service providers, supports)

The MOH may convene an advisory committee that may include any of the following:

- PHN case manager for the non-disclosing client
- Other MOHs
- Legal representative
- Ethics representative
- Representative(s) from the client's primary care team and/or HIV care team
- Mental health expert (e.g., psychiatrist, mental health counsellor)
- First Nations, Inuit or Metis counsellor, support, or elder representative

The advisory committee will consider the client's case and determine, with the advice and recommendation of the PHN and Primary Care representative, whether the client should be considered unwilling or unable. This assessment may require a formal mental status evaluation.

Upload any mental status evaluation to the PHIMS Investigation.

If the client is deemed unable, the PHN and the care team will discuss how best to support the client and continue to counsel the client to reduce risk of HIV transmission. *The Public Health Act* will only be used in rare extreme circumstances when imminent danger to a vulnerable person(s) is deemed to exist. Contact notification of suspected exposure would follow according to provincial protocol.

If the client is deemed unwilling, the advisory committee will formulate the plan of action taking into consideration the following in forming a proportional response:

- The client's anticipated ability to follow the plan of action
- Intention to commit harm
- Availability of other non-coercive options
- Anticipated success of coercive measures to changing behaviour
- Willingness to participate in continued counseling
- Specificity, immediacy, and "vulnerability" of potential contacts
- Risk of activities in which the client is engaging

The advisory committee will consider the following options and make recommendations:

- Continued counseling
- Contractual agreement if not already initiated (see 4.5),

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- Issuing a Section 43(1) CD Order under *The Public Health Act* (C.C.S.M. c. P210), and reminding the client of possible consequences of failure to comply with the Order, for example:
  - prosecution for an offence under the *Public Health Act* (s. 90(1)(b) – failure to comply with an order made under the PHA.
  - application for temporary detention to a justice under Section 47(1) for an Order to Apprehend under *The Public Health Act* (C.C.S.M.c. P210)
- Warning of contacts under The Public Health Act and the Personal Health Information Act, or
- Referral to a crown prosecutor for consideration of criminal charges under the federal Criminal Code (as a rare absolute last resort option where it is necessary to reduce the risks of significant harm to the health or safety of another individual or to address a threat to public health).

If a Section 43(1) CD Order is issued by the MOH, delivery of the Order to the client should not be undertaken by a public health nurse, but should preferably be referred to a "process server" in accordance with the regional procedure for issuing Public Health Medical Orders.

- Document the CD Order in PHIMS HIV Case Investigation.
  - Author a note,
  - Document advisory committee summary and recommendations for upload context document,
  - Add Intervention: (Type) Public Health Act Follow-up, (Sub-Type) CD Order Issued.

5.6 Resolution of Refusal or Failure to Disclose

Where a client begins to consistently disclose their HIV-positive status to contacts, or reduces their risk for transmission significantly, the non-disclosure situational follow up may be concluded. However, counseling should continue on reducing transmission risk, and the PHN should work with the HIV or primary care provider to ensure that adequate support remains to reduce the likelihood that the client revert to non-disclosure and moderate or higher-risk activity.

Document all follow up in PHIMS in the HIV Case Investigation. Update the Intervention dispositions. Upload relevant context documents. Author notes.

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6. Validation and References

1. HIV Positive Individuals Who are Unwilling or Unable to Prevent the Spread of HIV in Alberta. Alberta Health Services; 2015; Available from: https://open.alberta.ca/dataset/376a4ee2-b93d-44b3-8065-478a365e1ebd/resource/5d2df284-5a61-4974-b91e-48dfccd0fcaa/download/hiv-positive-spread-hiv-report-2015.pdf.

2. Guidelines for Medical Health Officers: Approach to people with HIV/AIDS who may pose a risk of harm to others. BC Centre for Disease Control; 2017; Available from: http://www.bccdc.ca/resource-gallery/Documents/Communicable-Disease-Manual/Chapter%205%20-%20STI/MHO-guidelines-PLWH-risk-of-transmission.pdf.

3. LeMessurier J, Traversy G, Varsaneux O, Weekes M, Avey MT, Niragira O, et al. Risk of sexual transmission of human immunodeficiency virus with antiretroviral therapy, suppressed viral load and condom use: a systematic review. CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne. 2018;190(46):E1350-E60.

4. HIV Transmission: Guidelines for Assessing Risk, 5 ed. Canadian AIDS Society; 2004; Available from: http://www.cdnaids.ca/wp-content/uploads/Guidelines-2005-English-Final.pdf.

5. HIV Transmission Risk: A Summary of the Evidence. Ottawa: Public Health Agency of Canada; 2012; Available from: https://www.catie.ca/sites/default/files/HIV-TRANSMISSION-RISK-EN.pdf.

6. Loutfy M, Tyndall M, Baril J-G, Montaner JS, Kaul R, Hankins C. Canadian consensus statement on HIV and its transmission in the context of criminal law. Canadian Journal of Infectious Diseases and Medical Microbiology. 2014;25(3):135-40.

7. Cresswell F, Ellis J, Hartley J, Sabin C, Orkin C, Churchill D. A systematic review of risk of HIV transmission through biting or spitting: implications for policy. HIV medicine. 2018;19(8):532-40.

8. Criminal Justice System's Response to Non-Disclosure of HIV. Part B: HIV Transmission Risks and Sexual Activity. Justice Canada; 2017; Available from: https://www.justice.gc.ca/eng/rp-pr/other-autre/hivnd-vihnd/p3.html.

9. Fact Sheet – Justice Canada's Report on the Canadian Justice System's Response to HIV Non-Disclosure. Justice Canada; 2017; Available from: https://www.canada.ca/en/department-justice/news/2017/12/fact_sheet_hiv_non-disclosureandthecriminallaw.html.

10. Community Consensus Statement. Canadian Coalition to Reform HIV Criminalization; 2017; Available from: http://www.hivcriminalization.ca/community-consensus-statement/.

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11. 2nd Community Consensus Statement. Canadian Coalition to Reform HIV Criminalization; 2022; Available from: http://www.hivcriminalization.ca/2022-consensus-statement/.

12. Position Statement on Harm Reduction. Winnipeg Regional Health Authority; 2016; Available from: https://wrha.mb.ca/files/public-health-position-statement-harm-reduction.pdf.

13. Pan Canadian STBBI Strategy. Public Health Agency of Canada; 2018; Available from: https://www.canada.ca/en/public-health/services/infectious-diseases/sexual-health-sexually-transmitted-infections/reports-publications/sexually-transmitted-blood-borne-infections-action-framework.html.

14. Estimate of HIV incidence, prevalence, and Canada's progress on meeting the 90-90-90 HIV targets, 2020. Public Health Agency of Canada; 2022 [updated July 2022]; Available from: https://www.canada.ca/en/public-health/services/publications/diseases-conditions/estimates-hiv-incidence-prevalence-canada-meeting-90-90-90-targets-2020.html.

15. Legal and Clinical Implications of HIV Non-Disclosure. Canadian Association of Nurses in AIDS Care; 2013; Available from: https://canac.org/wp-content/uploads/2016/02/26450.pdf.

16. Criminal Law & HIV Non-Disclosure in Canada. Canadian HIV/AIDS Legal Network; 2014; Available from: http://www.hivlegalnetwork.ca/site/wp-content/uploads/2014/09/CriminalInfo2014_ENG.pdf.

17. HIV Client Engagement Status Definitions. Winnipeg: Manitoba HIV Program; 2022 [updated 2022 June; cited 2022 October 18]; Available from: https://mbhiv.ca/wp-content/uploads/2022/06/HIV-Client-Status-Definitions-FINAL.pdf.

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Appendix: HIV Non-Disclosure Algorithm

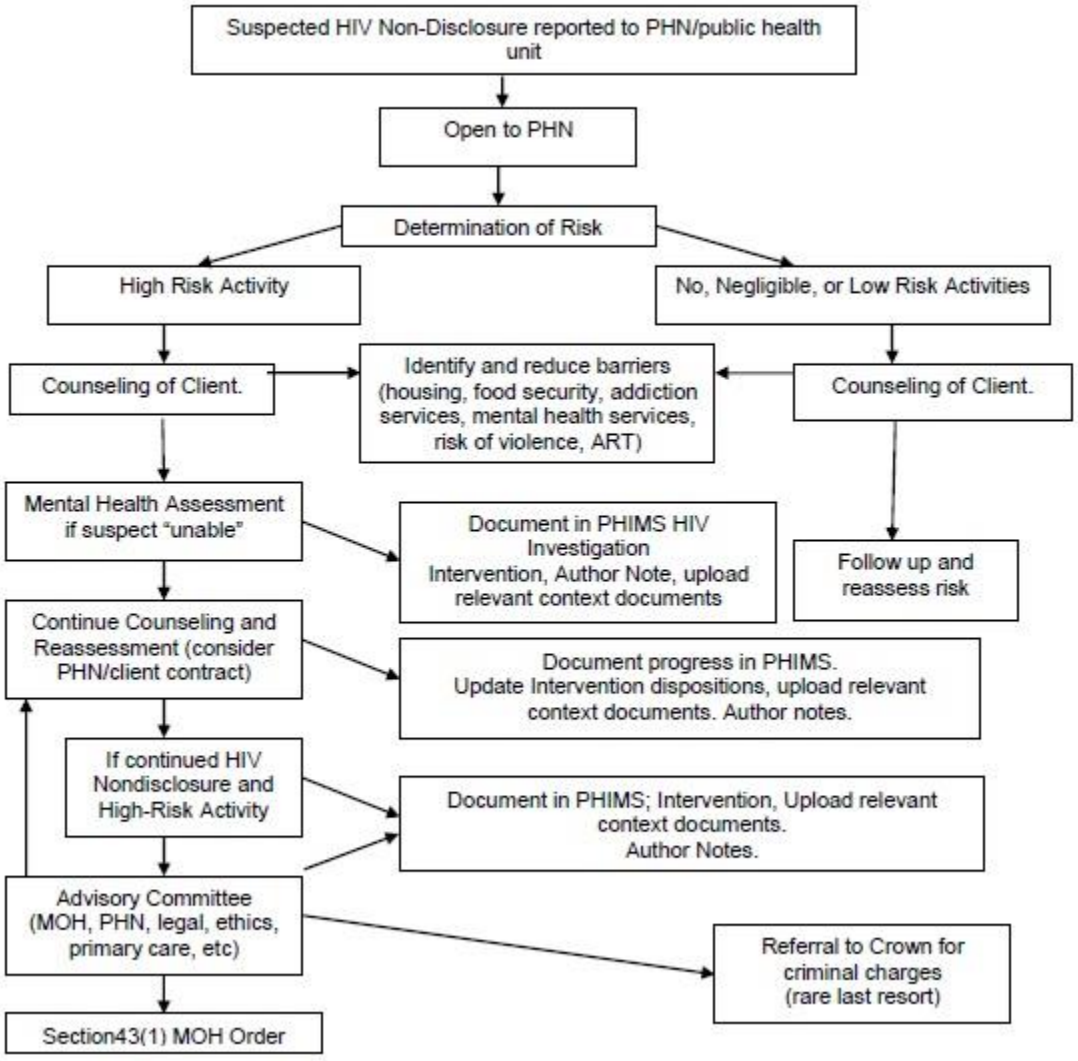

Figure 1 – HIV non-disclosure algorithm