

The Essentials of HIV

Third edition



MOUVEMENT D'INFORMATION
ET D'ENTRAIDE DANS LA LUTTE
CONTRE LE VIH-SIDA À QUÉBEC

PORTAIL
VIH/sida du Québec

Publication compiled and written by:

Emmanuelle Blouin (she)
Outreach worker for professionals
MIELS-Québec
Tel.: (418) 649-1720
recherche@miels.org

Patrice St-Amour (he)
Information and training manager
Portail VIH/sida du Québec
Tel.: (514) 523-4636 Toll-free: 1-877-Portail (767-8245)
education@pvsq.org

With the collaboration of:

- **Marc-Anciel Gaudette**, GBT2Q health and well-being peer helper (MIELS-Québec), for the text “Chemsex.”
- **Louis-Philippe Laviolette**, harm reduction worker (MIELS-Québec), for the text “Harm reduction approach.”
- **Justine Massicotte**, content coordinator (Portail VIH/sida du Québec), for the text “Stigmatization and HIV.”

French editing: Roxane Nadeau

English translation: Andrea Zanin

Review:

- **Salem Rose-Antoine Billard**, youth and community outreach (MIELS-Québec)
- Matie Bombardier, executive director (Portail VIH/sida du Québec)
- Patrick Labbé, preventive intervention development coordinator (MIELS-Québec)
- Camille Thibault, FIC outreach worker with gbMSM (MIELS-Québec)
- Audrey-Ann Thibodeau, youth outreach worker (MIELS-Québec)
- Laurent Trépanier Capistran, lawyer (Service VIH Info-Droits, COCQ-SIDA)
- Marie-Louise Vachon, M.D., M.Sc., FRCP(C), university clinical researcher (infectious and immune diseases, CHUL)
- Camille de Vasconcelos, coordinator, Programme Droits de la personne et VIH/sida (COCQ-SIDA)

The STBBI unit of the Institut national de santé publique du Québec was asked to comment on the pre-final version of this production and, as a result, did not review or endorse the final content, which remains the responsibility of the authors.

Thanks to all those who contributed, directly or indirectly, to the development of this work. We would also like to thank the HIV and Hepatitis C Community Action Fund of the Public Health Agency of Canada for their financial support. The financial sponsors of *The Essentials of HIV* had no input into the content of this guide. Dr. Marie-Louise Vachon has declared that she was a consultant for AbbVie, Gilead and ViiV Healthcare as well as a lecturer for AbbVie and Gilead. Matie Bombardier has declared that she once took part in a working group for ViiV Healthcare. All other individuals who took part in the writing and revision declare no potential conflicts of interest and no financial affiliations or interests of any kind that could have influenced the content of this publication.

Disclaimer

The information contained in this guide is purely general. They aim to convey a variety of information that may help people living with HIV to better understand their situation and to take charge of their health in collaboration with their various support workers and healthcare providers. This guide does not constitute medical advice and should not substitute for a visit, call or consultation with, or advice from, a doctor or other healthcare provider. MIELS-Québec and Portail VIH/sida du Québec do not advise or recommend any particular treatment.

Despite the rigour that was employed in the writing of this publication, MIELS-Québec and Portail VIH/sida du Québec cannot guarantee the reliability, accuracy, currency, usefulness or exhaustiveness of the information contained in this guide. This guide also contains legal information that should not be taken as legal advice or a legal opinion. This document aims to be informative and is not a clinical guide. Healthcare professionals should refer to the guidelines and protocols currently in effect in order to practice their professional activities.

Reproduction of this document

This document is protected by copyright. The reproduction or printing of this document for non-commercial purposes is permitted. Any change to its content must be authorized by MIELS-Québec and Portail VIH/sida du Québec.

The Essentials of HIV, third edition.

©2021 MIELS-Québec and Portail VIH/sida du Québec. All rights reserved.
978-2-9812430-8-9 for the PDF version • 978-2-9812430-9-6 for the print version
Legal deposit — Bibliothèque et Archives nationales du Québec, 2022
Legal deposit — Library and Archives Canada, 2022

MIELS-Québec
625, avenue Chouinard
Québec QC G1S 3E3
Tel.: (418) 649-1720
miels.org

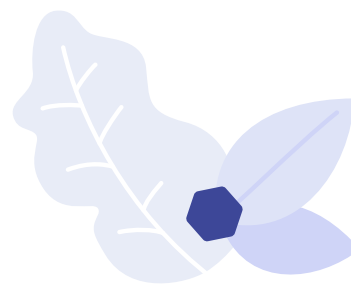
Portail VIH/sida du Québec
2000, rue Notre-Dame Est, Suite 501
Montréal QC H2K 2N3
Tel.: (514) 523-4636
pvsq.org

Introduction

Two Québec-based HIV community organizations, MIELS-Québec and Portail VIH/sida du Québec, joined forces to bring you this document, which provides essential information about HIV. *The Essentials of HIV* is a translation of the revised version of the publication entitled *HIV: What You Need to Know*, published by Portail in 2012. This new version takes into account the many developments that have occurred in the field since the initial publication, in terms of both biological and psychosocial issues.

The removal of the word “AIDS” from the title is an editorial choice that was made by the writing team. We made this choice in order to prevent the confusion that still exists between these two terms (HIV and AIDS) and to reflect the fact that current treatments are able to eliminate AIDS and prevent the transmission of HIV. We must, of course, continue to work to make these treatments available to everyone. Nevertheless, AIDS is still a reality, here and elsewhere.

Emmanuelle Blouin and Patrice St-Amour, in charge of training at MIELS-Québec and Portail VIH/sida du Québec respectively, with the help of their colleagues, are giving you an inclusive and accessible version of the key information from the field of HIV. We hope this document will become a reference guide both for people living with HIV and for their loved ones and the people who support and work with them.



We have taken care to provide tools for professionals in various fields who want to enhance their service provision approaches, more specifically with the aim of making these approaches safer and better tailored to different clientele. Considering the rapid evolution of scientific research in the field of HIV, it's to everyone's advantage to keep their knowledge up to date. As such, we thank you for taking the time to read this publication, which aims to provide information to anyone interested in the subject of HIV, whether for personal or professional reasons or both. Lack of knowledge remains an issue within the population and this inevitably reinforces the stigmatization, even unintentional, of people living with HIV.

Please note that the two organizations can also provide trainings that go deeper on the various topics introduced in this guide. For more information about free trainings, contact [MIELS-Québec](#) or [Portail VIH/sida du Québec](#).

Hyperlinks are included in the digital version of this document only. To download it, visit the [MIELS-Québec](#) or [Portail VIH/sida du Québec](#) websites. ▼

Emmanuelle Blouin and Patrice St-Amour



Note: In this guide, we use anatomical terms to describe genital organs, such as “vagina” and “penis.” We recognize and respect the fact that some people use different terms to describe these parts, such as “girl dick” or other terms (penis) or “front hole” (vagina). We mention some of these terms, but please note that people can use the words they are most comfortable with to describe their own bodies.

Table of contents

STATISTICAL OVERVIEW OF HIV

| | |
|--------------------|---|
| In the world | 4 |
| In Canada | |
| In Québec | |
| Key populations | |

BIOLOGICAL ISSUES

| | |
|---|-----------|
| The difference between HIV and AIDS..... | 7 |
| HIV replication cycle within a CD4 T lymphocyte cell | |
| Phases of HIV infection without antiretroviral treatment | 8 |
| 1 Primary infection | |
| 2 Asymptomatic phase | |
| 3 Symptomatic phase | |
| 4 AIDS | |
| Antiretroviral treatment to halt the progress of HIV infection | 9 |
| Guidelines | |
| The main families of antiretrovirals that block HIV replication | |
| HIV transmission..... | 12 |
| U = U (undetectable = untransmittable) | |
| Transmission and viral load | |
| Sexual transmission | |
| Blood transmission | |
| Perinatal transmission | |
| Transmission and STBBIs | |
| HIV, pregnancy and childbirth..... | 16 |
| Treatment as prevention..... | 17 |
| Pre-exposure prophylaxis (PrEP) | |
| Post-exposure prophylaxis (PEP) | |
| Antiretroviral treatment (ART or ARV) | |

| | |
|---|-----------|
| HIV testing..... | 22 |
| The standard test | |
| The rapid test | |
| The self-test | |
| The importance of knowing your HIV status | |
| Nutrition and HIV..... | 24 |

PSYCHOSOCIAL ISSUES

| | |
|---|-----------|
| Sexuality and HIV | 26 |
| Rethinking sexuality after a diagnosis | |
| HIV and the use of psychoactive substances | 27 |
| <i>Chemsex</i> | |
| The harm reduction approach | |
| Stigmatization and HIV | 29 |
| Consequences of stigmatization | |
| Intersectionality | |
| Tools for reducing stigmatization | |
| Legal aspects and criminalization..... | 31 |
| When is a person required to disclose their HIV status? | |
| Psychosocial support work..... | 33 |
| Welcoming disclosure | |
| Accompanying someone in disclosing to others | |
| General recommendations | |
| Recommended vocabulary..... | 35 |
| List of resources | 37 |
| References..... | 39 |

STATISTICAL OVERVIEW OF HIV



In the world

According to statistics from UNAIDS (2021), around 77.5 million people have contracted HIV since the beginning of the epidemic, meaning since the early 1980s, and 36.3 million people have died of AIDS-related illnesses or complications.

- According to these same 2021 statistics, some 37.7 million people are currently living with HIV in the world.
- Among these people, it's estimated that 73% (27.5 million) have access to antiretroviral treatment.
- Six million, or 16%, are not aware of their HIV-positive status.
- In 2020, about 1.5 million people were newly infected with HIV, compared to three million in 1997.

To learn about the latest statistics and exact figures for the world, consult the UNAIDS [*Fact sheet—Global HIV & AIDS statistics*](#).

To learn about the timeline of events since the beginning of the epidemic, consult [*A History of HIV/AIDS*](#) on the CATIE website.

In Canada

According to statistics from the Public Health Agency of Canada (2018), around 62,000 people are currently living with HIV in Canada. Of this number, 13% (or about 8,300 people) are not aware of their HIV-positive status.

Among the new infections in 2019:

- A bit more than half (56%) are gay or bisexual men or men who have sex with men (gbMSM).
- About one third (30%) are women.

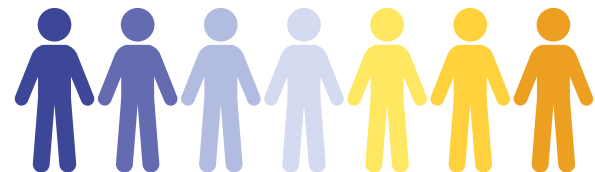
To learn the latest statistics and exact numbers for Canada, see the Public Health Agency of Canada's [*HIV Surveillance Report*](#).

In Québec

According to statistics from the Institut national de la santé publique du Québec (INSPQ) (2021), around 17,500 people are currently living with HIV in Québec. In total, 515 cases of HIV infection were reported in the year 2020. This number included 212 new diagnoses. The HIV epidemic remains concentrated in the following key population groups:

- 54% are gay or bisexual men or men who have sex with men (gbMSM).
- 21% are people from countries where HIV is endemic (present in a permanent way).
- 16% are heterosexual people who do not come from countries where HIV is endemic.
- 6% are injection drug users (IDU).

To learn about the latest statistics and the exact numbers for Québec, see the report from the INSPQ's [*Programme de surveillance de l'infection par le virus de l'immunodéficience humaine \(VIH\) au Québec*](#).





Key populations

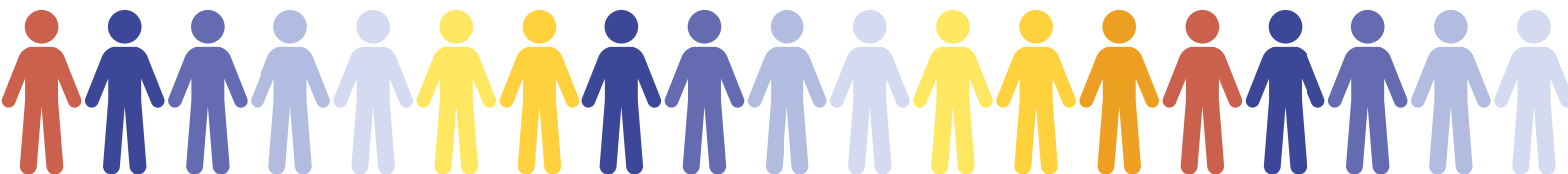
Key (or priority) populations are those that are disproportionately affected by HIV. Because of stigmatization, discrimination and the social determinants of health, these populations are often marginalized and underserved by health services. This leads to a greater likelihood of acquiring and transmitting HIV as well as more limited access to testing, care and treatment.

The “key” dimension of these populations also underscores their resilience in facing the epidemic and its burden and reminds us that these communities hold the key to fighting HIV. Policies should be chosen with the full and direct participation of members of the groups that are affected by those policies.

It’s preferable to avoid expressions such as “target,” “vulnerable” or “at-risk” when describing populations or groups as these terms can increase the stigmatization of certain populations. Everyone is concerned with the possibility of HIV infection, even if the rates vary between populations.

Key groups include, among others:

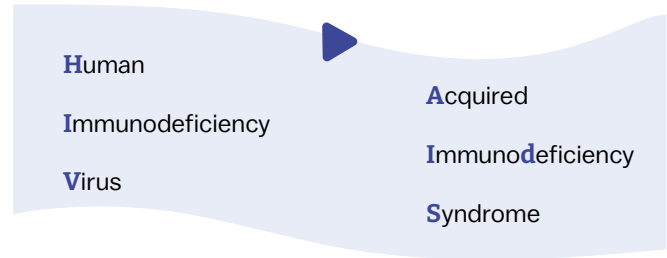
- Men who are gay, bisexual and queer (cis and trans), and other gbMSM (men who have sex with men).
- People who use psychoactive substances by inhalation or injection.
- People who are engaged in the sale, trade or purchase of services related to sex work.
- People who are incarcerated or recently released from detention centres.
- People from countries where HIV is endemic, including people who are newcomers, immigrants or refugees.
- Trans people.
- Indigenous people.
- Young people and women who are in highly vulnerable situations. ▼



BIOLOGICAL ISSUES



The difference between HIV and AIDS



Viruses don't breathe or eat. They're not even alive; they only replicate. HIV is a retrovirus which, in order to replicate, attacks the immune system's cells, particularly CD4 T lymphocytes. Their job is to orchestrate the immune response and defend the body against infections and illnesses that can be caused by viruses, bacteria, fungi, parasites and unhealthy cells, such as cancer cells. Immunodeficiency means that the immune system is weakened, which fosters the likelihood of contracting other infections.

There are two main strains of the virus, HIV-1 and HIV-2. HIV-1 is the most common and the one we mostly see in Canada. If no treatment is undertaken to prevent HIV from replicating, the immune system gets weaker and can no longer defend the body against microorganisms, bacteria and other viruses. The body is then vulnerable to developing opportunistic infections, including some that can be fatal. This step characterizes the HIV infection stage that is called Acquired Immunodeficiency Syndrome, or AIDS. ▼

Step 1: HIV attaches to the host cell's CD4 receptor, and then to a coreceptor (including CCR5 and/or CXCR4) on the surface of the CD4 T lymphocyte cell.

Step 2: HIV penetrates the host cell.

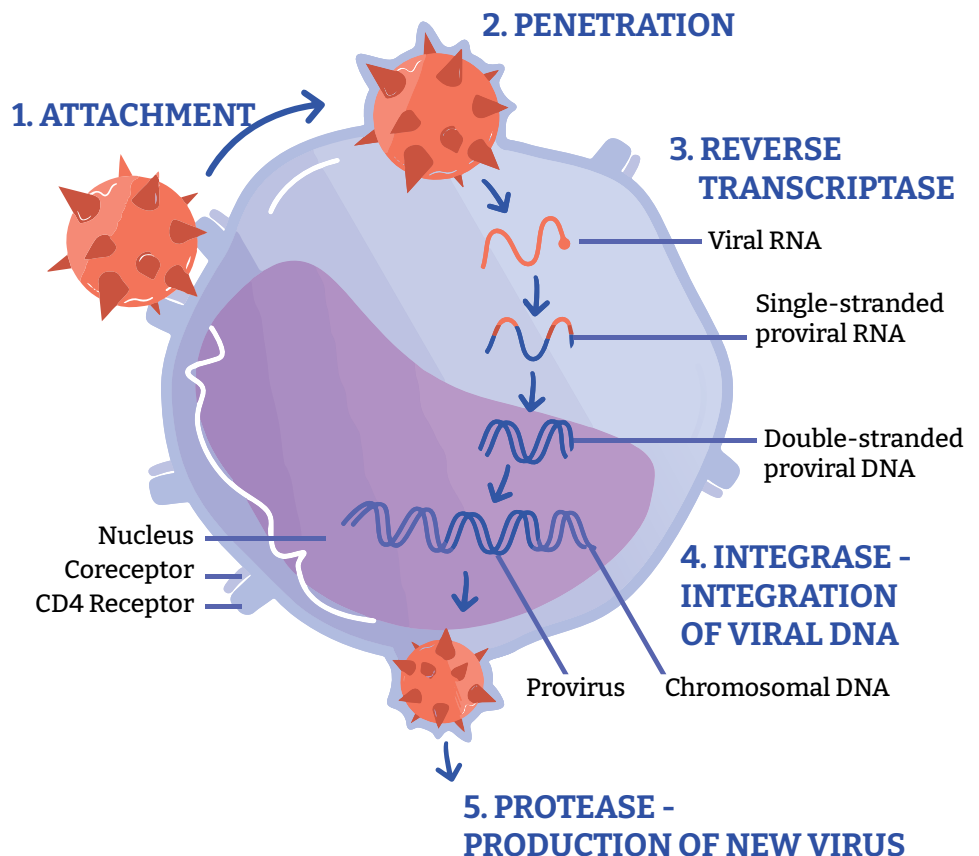
Step 3: HIV uses the reverse transcriptase enzyme to change its genetic material (viral RNA) into genetic material that's compatible with that of the host cell (DNA).

Step 4: HIV inserts the changed viral DNA into the host cell's DNA using the integrase enzyme.

Step 5: The cell produces new copies of the virus. Long chains of viral proteins are produced, and then cut by the protease enzyme. The pieces then assemble and leave the cell to go infect other cells.

As such, in replicating, HIV destroys CD4 T lymphocyte cells, or immunity cells, and weakens the immune system.

HIV REPLICATION CYCLE WITHIN A CD4 T LYMPHOCYTE CELL



Phases of HIV infection without antiretroviral treatment

The length of each phase can vary considerably from one person to another.

1 | Primary infection

This is the period following the virus's entry into the human body. At this stage, the virus multiplies quickly and the likelihood of transmission is high. This first phase occurs in the first weeks following infection and can be accompanied by flu-like symptoms, such as fever, sore throat, muscle pain, fatigue, swollen lymph nodes and skin rashes. These symptoms generally disappear after a few days and can easily go unnoticed.

Seroconversion usually occurs in the two to four weeks following infection, when the immune system starts to produce antibodies to defend itself against HIV. It takes up to three months for the body to produce these new proteins (antibodies), which will try to attack the virus in turn. As soon as a person has anti-HIV antibodies in their blood, that person is HIV-positive. Primary infection can be a critical time for transmission because viral load is potentially very high and the person does not know they have contracted HIV.

2 | Asymptomatic phase

The length of this phase can vary greatly from one person to the next and can last up to 10 years in some cases. In this phase, the person living with HIV generally feels few or no symptoms related to the virus's presence in their body. However, HIV nonetheless remains active and continues to infect other immune system cells, gradually lowering the number of CD4 T lymphocyte cells it uses to replicate. In the absence of treatment, it is not controlled and the infection continues to develop.

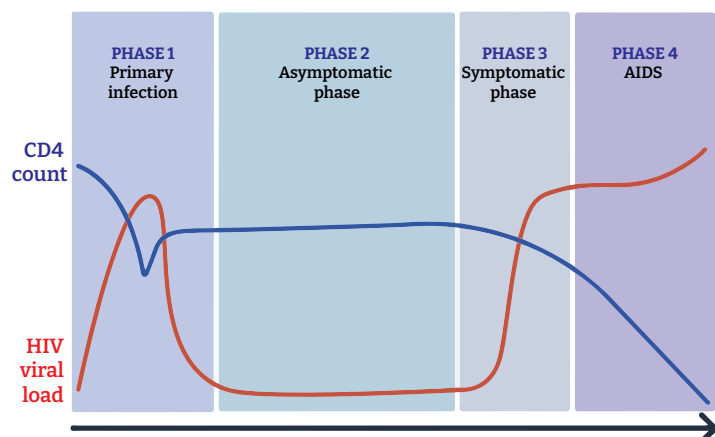
3 | Symptomatic phase

This phase is characterized by the appearance of persistent symptoms due to the weakening of the immune system. The HIV-positive person may start to present symptoms such as chronic fatigue, night sweats, fever, diarrhea or major weight loss. In the absence of treatment, the immune system continues to weaken and the body has more and more difficulty defending itself against other infections. Diagnosis is often made at this phase. At any time, starting antiretroviral treatment can reduce symptoms, as it effectively acts against the infection when medication is taken appropriately.

4 | AIDS

The appearance of opportunistic infections caused by bacteria, viruses, fungi or certain types of cancer (such as pneumonia, or *Pneumocystis jirovecii*, toxoplasmosis, cytomegalovirus, Kaposi's sarcoma and others) designates the AIDS phase. These infections, called opportunistic, rarely appear in people whose immune systems are intact. These infections, particular to HIV, take advantage of the weakened immune system to develop, and some of them can be fatal if no treatment is undertaken at this stage. ▼

Phases of an infection's development WITHOUT treatment



Graphics excerpted from the page [Le VIH et le sida](#)

Antiretroviral treatment to halt the progress of HIV infection

Today, thanks to the effectiveness of antiretroviral treatments, most people living with HIV who have access to this treatment will never develop AIDS. **By receiving appropriate care and treatment, they can live a long time and in good health without transmitting HIV.** For this reason, it's recommended that a person living with HIV should begin this treatment and get care as quickly as possible after being diagnosed in order to preserve their health in the long term. HIV treatment means consulting a team of health professionals on a regular basis and maintaining good adherence to effective antiretroviral therapy.

Guidelines

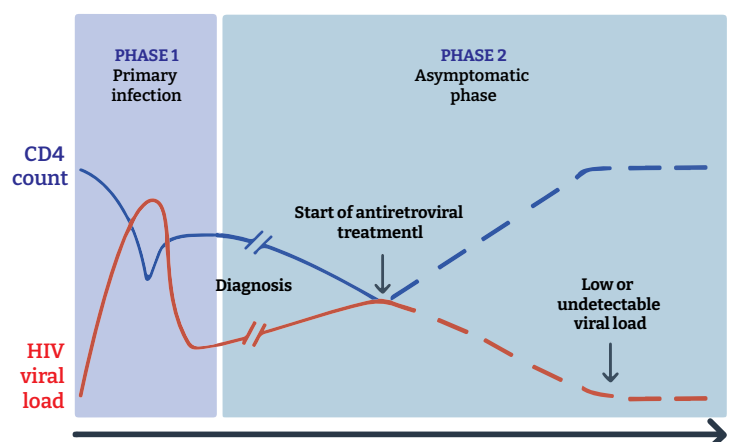
Healthcare providers who offer services to people living with HIV follow guidelines set out by groups of experts. These people base their advice on rigorous scientific studies to determine the best treatment approaches. They also base their work on international orientations and their clinical practices. This work is reviewed regularly in order to make sure the treatment provided takes into account the most recent data.

In using these guidelines, health professionals can advise patients on, among other things, the best time to begin antiretroviral therapy and the appropriate choice of treatment. The Québec guidelines, *Les lignes directrices québécoises*, are available on the Ministère de la Santé et des Services sociaux (MSSS) website.

To succeed in greatly reducing the presence of the virus in the blood, an initial course of antiretroviral therapy should ideally combine medications that work against HIV using at least two different modes of action. This approach is called highly active antiretroviral therapy (HAART).

However, the antiretroviral therapies currently available do not make it possible to completely wipe out HIV infection. This means the virus still remains present in reservoirs, even if its presence in the blood is successfully reduced for an extended period of time and the viral load is rendered undetectable. This means that the number of copies of the virus in the blood is lower than tests are currently able to measure (see the U = U Undetectable = Untransmittable box on page 13).

Phases of an infection's development WITH treatment



As a result, if the antiretroviral therapy undertaken turns out to be very effective, usually it's best to not interrupt it, even for short periods. Stopping the therapy usually leads to an increase in viral load (number of copies of the virus) and a reduction in CD4 T lymphocyte count. These counts could then come back to where they were before the therapy began.

As well, stopping the antiretroviral medication could allow the HIV to mutate and become resistant to certain families of antiretrovirals. These resistances can require you to change treatments, and while other combinations are possible, the therapeutic options remain limited.

Extended treatment holidays increase the likelihood of developing an HIV-related illness and can lead to an AIDS diagnosis. For more information on this subject, see the article [*Quelles conséquences pour l'arrêt temporaire du traitement ARV*](#) (in French only) on the Portail VIH/sida du Québec website.

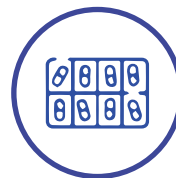
Some antiretroviral treatments may at times cause undesirable side effects. These don't affect everyone; some people never feel any side effects, while others feel more unpleasant effects and will have a harder time adjusting to treatment.

The short-term side effects usually disappear a few weeks after the treatment begins, once the body gets used to it. They can include headaches, digestive problems, fatigue and lack of energy, skin reactions (such as small pimples or red patches), dizziness and sleep problems (such as insomnia or strange dreams). Long-term side effects (such as lipodystrophy) are less common than in the past, but some people may still experience them. Among other things, these include cognitive problems, cardiovascular issues, weight gain and depression. If you feel these undesirable effects, it's recommended to speak with a health professional rather than stopping treatment right away when they appear.

The reported rate of undesirable effects seems to be dropping with the arrival of the most recent molecules. When choosing antiretroviral treatment, the main objective is to select a combination that's not only effective but tailored to the person. This means taking into account the person's underlying health conditions, concurrent medications, previous intolerances and preferences, as appropriate.

To learn more about treatments, see the [summary table](#) about antiretroviral dosages along with photos of the pills. ▼

ADHERENCE STRATEGIES



USE A PILL BOX OR DOSETTE FOR YOUR MEDICATIONS.



PLAN YOUR TRIPS AHEAD OF TIME AND MAKE SURE TO BRING EXTRA MEDICATION.

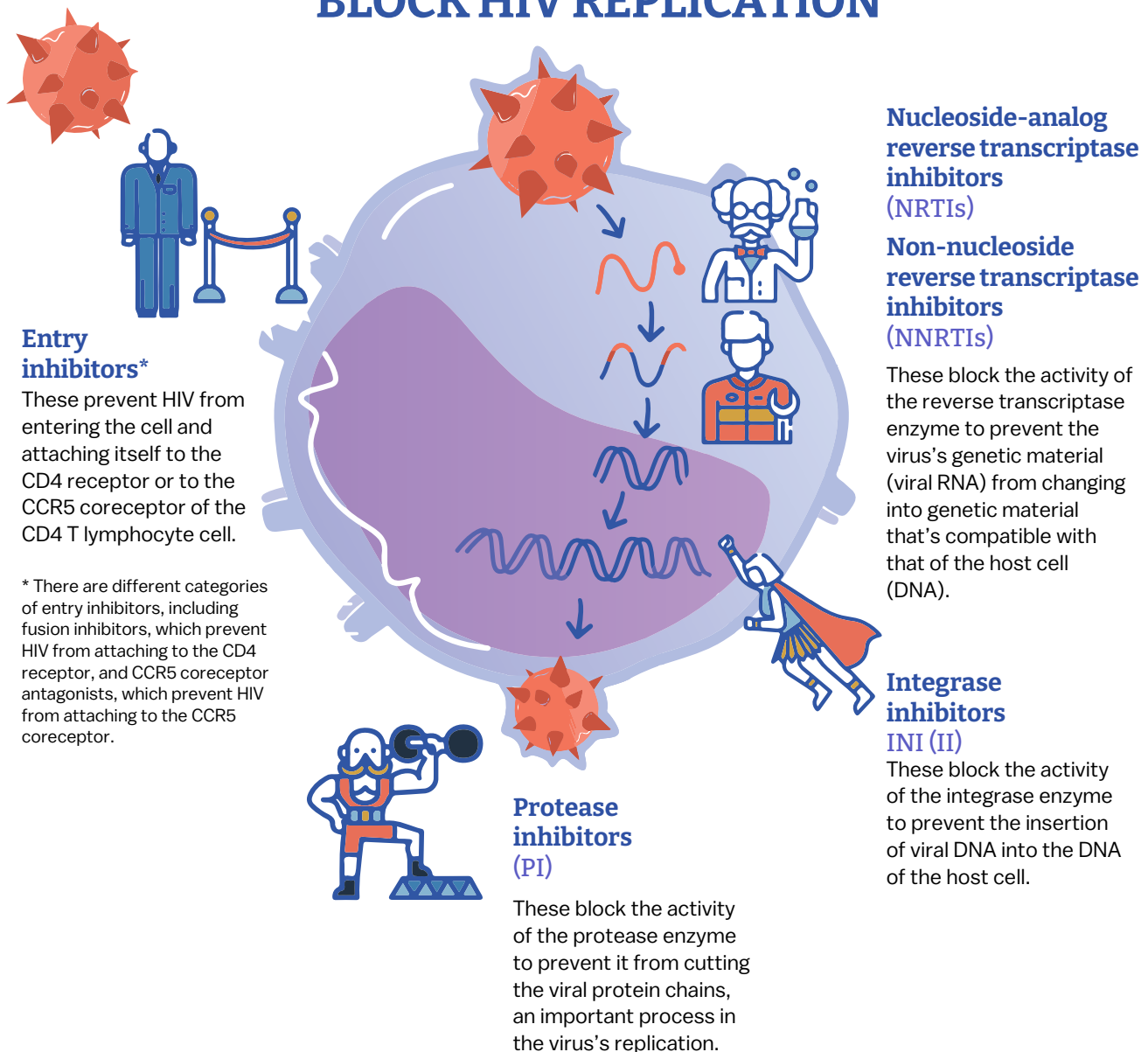


USE AN ALARM OR ELECTRONIC REMINDER.



TALK WITH OTHER PEOPLE LIVING WITH HIV TO FIND STRATEGIES.

THE MAIN FAMILIES OF ANTIRETROVIRALS THAT BLOCK HIV REPLICATION



HIV transmission

Here are the main ways that HIV is transmitted.

| | |
|---|---|
| Sexual transmission | This can happen during sexual activity without a condom, including oral, vagina or anal penetration, when the viral load is above 200 copies per millilitre of blood. |
| Blood transmission | This can happen with blood-to-blood contact, when blood enters the body through an open wound, a cut or an injection. |
| Perinatal (or vertical) transmission | During pregnancy, childbirth or breastfeeding, from an HIV-positive person to their infant. |

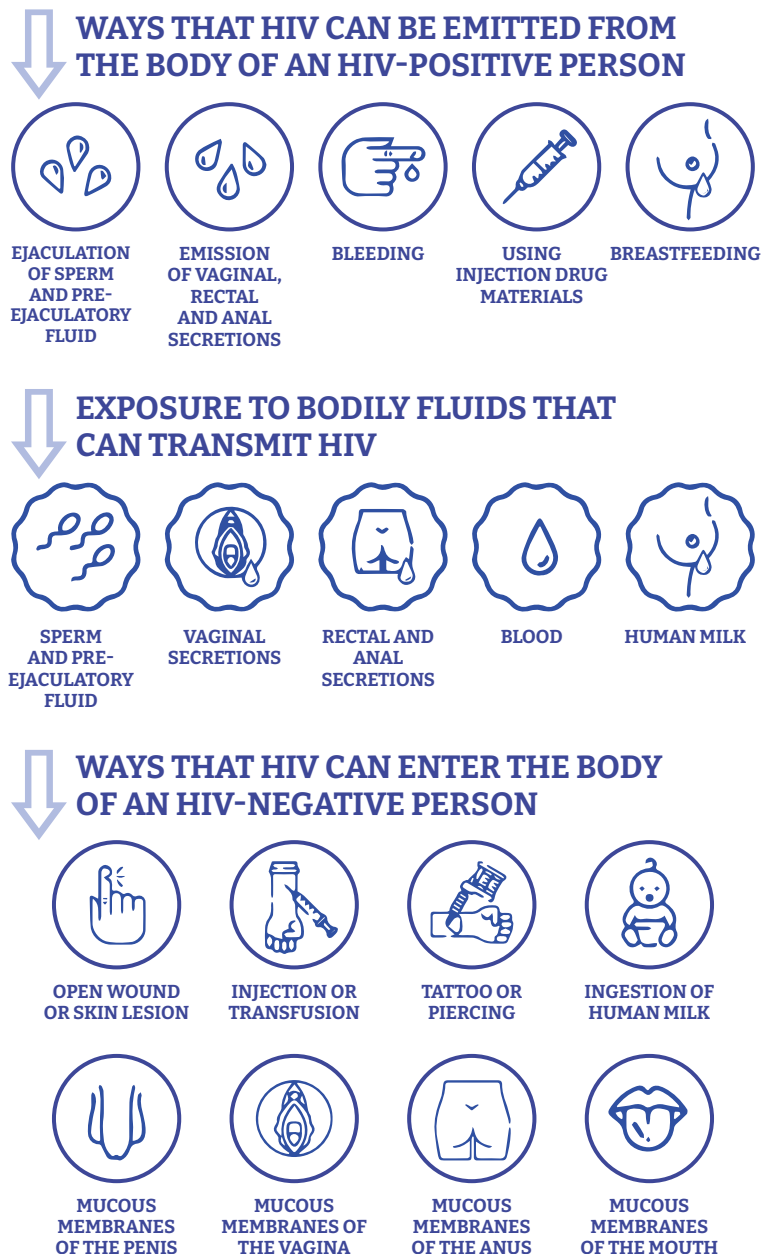
HIV can only be transmitted through the following bodily fluids:

- ▶ Blood
- ▶ Sperm (including pre-ejaculatory fluid)
- ▶ Rectal secretions
- ▶ Vaginal secretions
- ▶ Human milk

Other bodily fluids (such as saliva, tears, sweat, urine and excrement) cannot transmit HIV unless they also contain infected blood. In short, most everyday activities carry no probability of transmission. As well, HIV does not remain active for long outside the human body. Outside a specialized environment, it lasts only between a few minutes and a few hours. Note that viral load, meaning the number of copies of the virus within the bodily fluid, is a major factor in HIV transmission.

Contact between a mucous membrane with a lesion (such as an open wound, inflammation, irritation and so on) with one of these infected bodily fluids can lead to HIV transmission. The mucous membranes most often involved in the sexual transmission of HIV include¹:

- ▶ The anus and rectum
- ▶ The cervix and vagina
- ▶ The foreskin, glans and urethra of the penis
- ▶ The mouth



¹See note on page 1.

In summary, the six following conditions must be present in order for it to be possible for HIV transmission to take place to an HIV-negative person:

1. Presence of HIV.
2. Viral load sufficiently high to cause infection.
3. Exposure to one of the bodily fluids that can transmit HIV.
4. A way for HIV to be emitted from the body of the HIV-positive person.
5. A way for HIV to enter the body of the HIV-negative person.
6. The person's receptivity to HIV.

THE FOLLOWING PRESENT NO RISK OF HIV TRANSMISSION:



SNEEZING



SHAKING HANDS



SHARING DISHES



SHARING A TOILET



KISSING

► U=U (Undetectable = Untransmittable) Transmission and viral load

U = U (Undetectable = Untransmittable) is a social marketing campaign recognized by many community organizations, associations and public health authorities, including the Public Health Agency of Canada (PHAC). In **Québec, the health ministry's position, stated in October 2018, is that a viral load below 200 copies of the virus per millilitre of blood means a negligible likelihood of sexual transmission. In other words, when the viral load is undetectable, HIV cannot be transmitted sexually, hence the expression "undetectable = untransmittable."**

Taking antiretroviral treatment reduces the possibility of transmitting HIV because the quantity of virus in bodily fluids is reduced as a result. The higher the concentration of the virus in bodily fluids, the more the possibility of transmission increases. Studies have proven the concept of "undetectable = untransmittable" using a threshold of 200 copies/ml of blood, a threshold below which the viral load was no longer detectable by the devices used at the time.

Today, with the evolution of technology, the minimum threshold that lab devices can measure is now 20 copies/ml of blood. The vast majority of people who take their antiretroviral treatment as prescribed in the context of regular medical monitoring reach an undetectable viral load within about three to six months after starting treatment. As such, when the viral load is maintained below the threshold of 200 copies/ml of blood for a minimum of six months and with two tests, the concept of U = U applies, and it's considered that the person is no longer able to sexually transmit HIV to another person.

Sexual transmission

HIV can be transmitted during sex by means of a bodily fluid that can contain HIV, such as sperm, pre-ejaculatory fluid, vaginal or rectal secretions and blood, including menstrual blood. Transmission can take place if one of these fluids contains a sufficient quantity of the virus (with a detectable viral load) and comes into contact with an HIV-negative person's mucous membranes (a moist membrane encasing the human body's cavities, such as the orifice of the penis, the foreskin, the vagina, the cervix, the rectum and the mouth) or blood. The likelihood of transmission increases when these tissues bear lesions or inflammation. Even if this does happen, the virus then needs to get past the body's natural defenses before it can cause a permanent infection.

During sex, some practices present higher probabilities of HIV transmission than others. Without the protection of a condom, **anal and vaginal intercourse** are considered high-probability.

For an HIV-negative person, the likelihood of contracting HIV can be 10 to 20 times higher in **receptive anal sex** (receiving anal penetration with an HIV-positive person's penis) as compared to vaginal sex. **Insertive anal sex** (penetration of a penis into the anus of an HIV-positive person) presents a lower likelihood of transmission than receptive anal sex, but it's still a higher probability than vaginal sex.

As for vaginal sex, studies show that **receptive vaginal sex** (receiving vaginal penetration by an HIV-positive person's penis) presents about twice the likelihood of transmission as compared to **insertive vaginal sex** (penetration of a penis into an HIV-positive person's vagina).



This can be explained in part because the thickness of the mucous membrane within the rectum is made up of a thin layer of epithelial cells, which makes it more vulnerable to tears and inflammation, and thus more prone to HIV transmission. In contrast, the mucous membranes of the vagina and the penis are thicker, because they're made up of several layers of epithelial cells. The likelihood of contracting HIV when a person is practicing **oral-genital sex** is very low. The presence of lesions or cuts in the mouth (such as bleeding gums or an irritated throat) could give rise to transmission if a bodily fluid is emitted (sperm, pre-ejaculatory fluid, rectal or vaginal secretions) with a high viral load during oral sex, but this risk remains low.

Sharing sex toys that are not covered with a fresh condom before being used can also be a source of sharing bodily fluids, and thus the sexual transmission of HIV. ▼

PRACTICES THAT CARRY A LIKELIHOOD OF HIV TRANSMISSION



VAGINAL OR ANAL PENETRATION WITHOUT A CONDOM WITH A PERSON WHOSE VIRAL LOAD IS ABOVE 200 COPIES/ML OF BLOOD



SHARING SEX TOYS THAT HAVE NOT BEEN CLEANED



ORAL SEX WITH THE EMISSION OF A BODILY FLUID IN THE PRESENCE OF LESIONS IN THE MOUTH

Blood transmission

HIV can also be transmitted through blood when an HIV-positive person's blood comes into direct contact with an HIV-negative person's blood. This "blood-to-blood" contact can happen:

- When people share injection materials for using drugs or taking medications or steroids
- When people share drug inhalation materials
- When people share non-sterile tattoo or piercing materials
- During a blood transfusion.

With regard to blood transfusions, it's important to note that for many years now, Héma-Québec has analyzed all blood donations in order to detect blood-borne illnesses. In the case of a positive result, the blood donation is destroyed. ▼

Perinatal transmission

Perinatal transmission (also known as vertical or mother-child transmission) is extremely rare in Canada. This can be explained by the implementation of recommendations such as systemic HIV testing offered during pregnancy. This way, it's possible to determine whether a pregnant person is living with HIV without knowing it. The start of anti-retroviral treatment as soon as possible after diagnosis of infection for everyone living with HIV (including pregnant people) can also prevent perinatal transmission.

In Canada, it's recommended that people living with HIV should not breastfeed their newborns, even if their viral load is undetectable. They should instead use infant formula in order to eliminate the possibility of postnatal HIV transmission. See the "HIV, pregnancy and childbirth" section (p. 16) for more detail. ▼

Transmission and STBBIs

Sexually transmitted and blood-borne infections (STBBIs), such as gonorrhea, chlamydia or syphilis, can increase the local concentration of HIV in the sexual secretions of an HIV-positive person, making them more likely to transmit the virus. As well, when an HIV-negative person has an STBBI, the lesions or irritation it causes make the mucous membranes of the genitals more permeable, even in the absence of symptoms. The person is therefore more likely to contract HIV.

Some STBBIs, such as herpes and gonorrhea, can make it easier for HIV to replicate. The proteins they produce support the virus's replication by increasing the viral load in sexual bodily fluids without necessarily increasing the viral load in the blood. An untreated STBBI can quickly become more complicated and can be harder to treat for a person living with HIV.

In the case of a co-infection with HIV and hepatitis C, the HCV viral load is higher, which increases the progression of hepatic lesions as well as the possibility of transmitting viral hepatitis. ▼



HIV, pregnancy and childbirth

Partners who want to have a child are encouraged to get an HIV test in order to know their status. If one of the people is HIV-positive and maintains an undetectable viral load (number of copies of the virus) thanks to taking antiretroviral treatment and getting regular medical monitoring, there is no risk of transmission during sexual intercourse without a condom.

It's recommended that all pregnant people get tested. This is part of the prenatal process unless the person explicitly refuses it. It's to a pregnant person's advantage to get tested for HIV as part of their prenatal medical appointments, and to receive appropriate counseling.

For people who have a high likelihood of contracting HIV during their pregnancy, testing is recommended each trimester. This makes it possible for the pregnant person to get treatment quickly as needed, to stay in good health and to maintain a good quality of life, as well as preventing transmission to the child.

People living with HIV who are pregnant or want to get pregnant can talk to specialists to get advice about the various avenues for treatment and accompaniment. This way, they can be directed toward specialized obstetrical care and HIV management programs.

In Canada, the recommendations for preventing perinatal transmission are as follows:

- ▼ **Take antiretroviral medication during pregnancy, labour and childbirth.**
- ▼ **Give pediatric antiretroviral medication to the baby during its first six weeks of life.**
- ▼ **Use baby formula instead of breastfeeding and avoid pre-chewing the baby's food.**

If these recommendations are respected, there should be no transmission to the baby during pregnancy or childbirth or after they are born.

It is not recommended for an HIV-positive person to breastfeed, even with an undetectable viral load. While few studies on transmission via breastfeeding have been done in the West, we know that the virus can remain present in human mammary glands and milk and this can lead to transmission. Many other factors can facilitate transmission via breastfeeding, such as the breast health of the person breastfeeding (such as inflammation, fissures and mastitis) and the health of the child's mouth (such as cutting teeth and mouth ulcers), which is why breastfeeding is not recommended.

Healthcare providers must be able to provide all the necessary information and support to the people concerned to help them take appropriate measures in relation to breastfeeding. Among other things, this includes considering the associated costs as well as the issues related to disclosing HIV-positive status and cultural pressure to breastfeed, which can require additional counseling. ▼



Treatment as prevention

Pre-exposure prophylaxis (PrEP)

PrEP is an effective treatment intended for HIV-negative people who want to prevent HIV infection. It is available by prescription in Québec and is covered by the Régime d'assurance maladie du Québec (RAMQ) and by private and group insurance. PrEP is the acronym for "pre-exposure prophylaxis", which means taking treatment before exposure in order to reduce the likelihood of contracting an infection. This is a prevention method to use before sexual activity.

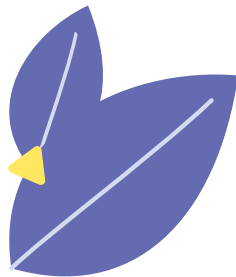
How does it work?

The medications used for PrEP are tenofovir and emtricitabine, which can also be used as part of antiretroviral therapy in combination with other medications for people living with HIV.

Medical monitoring

Medical monitoring is necessary throughout the time a person takes PrEP. At the initial appointment, the person will be tested for HIV and other STBBIs and will get a health check including kidney function and the updating of all vaccinations.

After receiving results that confirm the person is HIV-negative, the doctor will write a prescription for the person to get PrEP at the pharmacy. Then, the prescribing doctor will see the person a month after they start taking the medication, and then every three months afterward. These follow-up appointments will be to renew the prescription up to the next appointment and to do a check-up and STBBI testing.



Who is PrEP for?

According to the current recommendations of the MSSS, PrEP is recommended for HIV-negative people who are highly exposed to HIV, such as gbMSM, sex workers and trans women. This treatment has been proven to be effective at preventing vaginal and anal sexual transmission but is less effective against transmission for injection drug users and is not indicated for the prevention of oral transmission.

It's recommended to assess the situation with people who regularly have sex without a condom (such as for a person who has had anal or vaginal sex without a condom in the last six months). It's beneficial to discuss the options with them and to go over the benefits and drawbacks so they can make an informed decision. For some people, taking PrEP can reduce their anxiety related to HIV and help them experience their sexuality more fully.

The reasons to take PrEP can vary from one person to the next. PrEP can be a good option for a person who:

- has had unprotected sex (anal or vaginal), meaning without a condom, in the last six months with partners whose HIV status they don't know.
- has sex with a partner who is living with HIV and who presents a viral load above 200 copies/ml or who is not taking treatment.
- has already used post-exposure prophylaxis (PEP), meaning emergency treatment administered after an exposure (see the "PEP" section on p. 20).
- has contracted STBBIs several times or who has syphilis or an anal bacterial STI.
- uses injection drugs and sometimes has trouble getting fresh injection materials.
- uses psychoactive substances during sex ("chemsex").

How is PrEP taken?

A person who wants to have access to PrEP can first speak with a healthcare provider or to certain sexual health organizations to get an evaluation and a prescription. Some organizations, such as MIELS-Québec, offer fast-track access to PrEP in order to facilitate access. There are two ways to take PrEP:

- **Continuous dosing**

This consists of taking a pill every day at the same time. From the time the person starts, it takes a few days for the concentration of the medication to be high enough to protect them effectively during sex. The delay is different depending on the type of tissues for which they need protection. It's important for them to talk about this with the person who is monitoring their PrEP:

- **For cervical and vaginal tissue** (vaginal sex without a condom), they must start taking the pills seven to 21 days before first intercourse.
- **For rectal tissue** (anal sex without a condom), they must start taking the pills **four to seven days** before first intercourse.

- **Intermittent (on-demand) dosing**

Canadian guidelines stipulate that this mode of administration can be undertaken only for anal sex for gbMSM (cis gay and bisexual men and men who have sex with men), as well as for trans women. People who have vaginal sex should take PrEP in a continuous way.

This consists of taking **two** pills between **two and 24 hours** before having sex, **one** pill **24 hours** after the first dose, and **a final** pill **24 hours** after the second dose.

If the person has other sexual encounters, they must continue to take a pill every day at the same time, up to 48 hours after the last sexual encounter.

Both methods are effective; it's up to the person to choose which one works best for them after having received accurate information based on their profile and their partners' profile.

Characteristics of the two methods

| Continuous dosing | Intermittent dosing (on-demand) |
|---|---|
| Effective for unplanned sexual encounters | Effective for sexual encounters planned at least two hours ahead of time |
| A bit more expensive than the intermittent approach | A little less expensive than the continuous approach |
| Several clinical trials in diverse population groups have confirmed its effectiveness | Only one clinical trial has confirmed the effectiveness of this method for gbMSM (cis gay and bisexual men and men who have sex with men) and for trans women |
| Possibility of undesirable side effects at the start of treatment that fade over time | |
| Does not prevent other STBBIs and is not a contraceptive | |
| Highly effective if the dosing is respected | |

Some people may experience undesirable side effects, such as diarrhea, nausea, headaches or fatigue. Some of these side effects can be prevented by eating a light meal or snack at the time the pill is taken. Among most people taking this treatment, these side effects disappear on their own within a few days or weeks. There are other, rarer side effects, particularly in relation to bone and kidney health. Initial examinations and medical follow-up can help detect these quickly and prevent health consequences. These side effects are reversible after the person stops taking the medication.

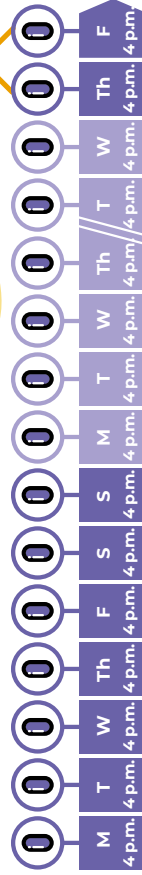
Plans for taking PrEP

Continuous dosing

One pill per day at the same time*, (such as 4 p.m.) for the entire time of the desired protection

* plus or minus two hours

If you choose to stop taking PrEP in a continuous way, you need to keep taking it for several days after your last sexual encounter. Talk with your doctor about stopping PrEP.



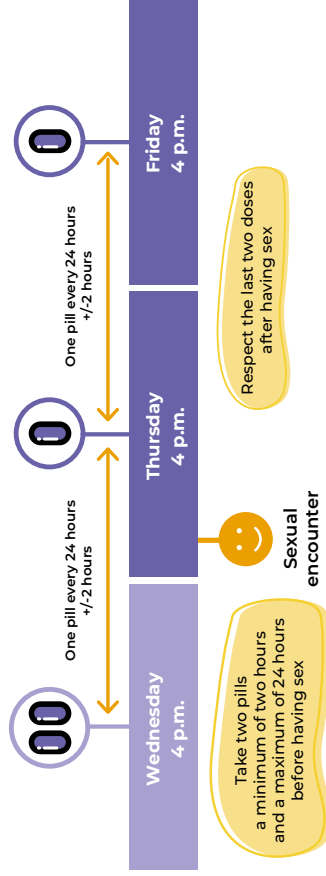
When you start taking PrEP on a daily basis, make sure to take it for seven days before having vaginal sex or a minimum of four days before having anal sex.

Sexual encounter
Sexual encounter
Last sexual encounter

Intermittent dosing

For a single sexual encounter

One pill per day at the same time plus or minus two hours (such as 4 p.m.) starting with two pills between two and 24 hours BEFORE having sex followed by one pill per day for at least 48 hours AFTER having sex



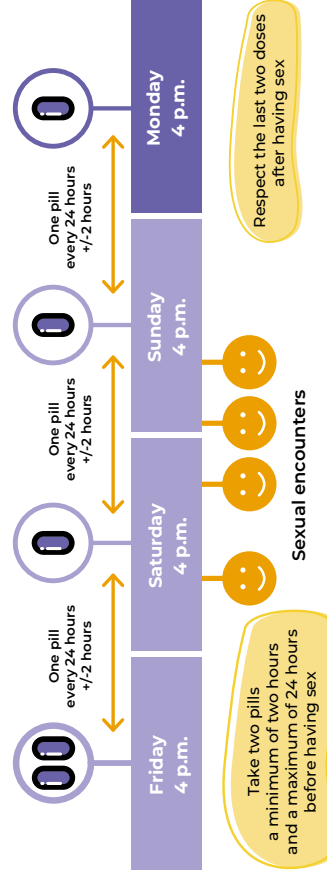
Take two pills a minimum of two hours and a maximum of 24 hours before having sex

Sexual encounter

Respect the last two doses after having sex

Intermittent dosing

For a single sexual encounter



Take two pills a minimum of two hours and a maximum of 24 hours before having sex

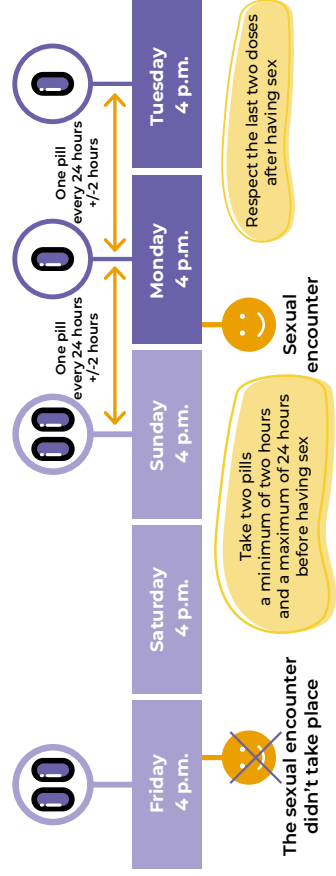
Sexual encounters

Respect the last two doses after having sex

Intermittent dosing

If you didn't end up having sex

If you didn't have sex in the 24 hours after the initial dose, take two pills again before you next have sex



The sexual encounter didn't take place

Sexual encounter

Take two pills a minimum of two hours and a maximum of 24 hours before having sex

Respect the last two doses after having sex

How can a person access PrEP in Québec?

In Québec, all doctors and specialized nurse practitioners can prescribe PrEP. It's also possible to come to a sexual health clinic or to an STBBI testing and prevention service (Service intégré de dépistage et de prévention des ITSS, or SIDEPE) if the person doesn't have a family doctor or for any other reason.

Healthcare providers that offer HIV and other STBBI testing can also orient the person to help them get PrEP. Once they have a prescription in hand, they can obtain the medication

at the prescription counter at a pharmacy. Medical monitoring every four months following that provides the opportunity to conduct regular STBBI testing and deal with side effects. For more information, consult the website maprep.org (in French only), which supports people who are interested in learning more about PrEP by providing a quiz game called *La PrEP est pour moi?* (in French only) as well as a printable PrEP passport. ▼



Post-exposure prophylaxis (PEP)

Taking antiretroviral medication immediately after exposure can prevent HIV infection in an HIV-negative person who was exposed to one of the bodily fluids that can potentially carry the virus. To be effective, this emergency preventative treatment, called post-exposure prophylaxis (PEP), must be undertaken as quickly as possible, ideally within 24 hours or a maximum of 72 hours after exposure to the virus, and maintained every day at a set time for a period of 28 days.

A PEP prescription can be indicated after exposure if the person was exposed to a bodily fluid from a person living with HIV whose viral load is above 200 copies/ml (see the “HIV transmission” section on p. 12) or from a person whose HIV status is unknown. To get access, it's important to consult a healthcare provider as quickly as possible so that the potential HIV transmission can be assessed and PEP can be prescribed as needed. When the source person's HIV status is unknown, the decision of whether or not to undertake preventative treatment is based on likelihood of transmission according to the type of exposure and the partners' profiles. Remember that anti-HIV PEP does not prevent the transmission of other STBBIs.

The Info-Santé telephone service (available all over Québec by dialing 811, option 1) can help a person find a healthcare provider that takes walk-ins. PEP is available in all hospital emergency rooms in Québec. As well, pharmacists are able to initiate a PEP prescription. It's recommended to call ahead of time to make sure the pharmacy has the treatment in stock and that someone who can prescribe is on site. If that's not the case, the person can contact another pharmacy. The person should then see a doctor in the 72 hours following the administration of PEP by a pharmacist.

As well, it's important to inform and encourage people to consult a doctor as quickly as possible after an exposure that carries a likelihood of HIV transmission. Remember that the maximum window for starting PEP is 72 hours after potential exposure. The treatment must be accompanied by medical monitoring for a minimum of three months, including several HIV tests.

Antiretroviral treatment is covered by the Régime d'assurance maladie du Québec (RAMQ) if the person holds a valid health insurance card and is registered for the public medication insurance program. Most personal and group insurance plans offer the same coverage. Note that a fee may be required in most cases. ▼

Antiretroviral treatment (ART or ARV)

In addition to PrEP and PEP, antiretroviral treatment is considered highly effective in preventing HIV transmission. To learn more about this subject, see the U = U (Undetectable = Untransmittable) box on p. 13.

| | Pre-exposure prophylaxis (PrEP) | Post-exposure prophylaxis (PEP) | Antiretroviral treatment (ART or ARV) |
|--------------------|---|---|---|
| For whom? | HIV-negative person | HIV-negative person <u>after</u> a potential exposure to HIV | Person living with HIV |
| When? | Before potential exposure to HIV | After potential exposure to HIV (maximum 72 hours) | After being diagnosed as HIV-positive |
| How? | Before and after HIV exposure | Continuously for a set period of 28 days (later, plan to use PrEP if necessary) | Continuously, maintaining good adherence for maximum effectiveness |
| Medical monitoring | Continuously or on demand; it is possible to stop and restart | Follow-up at weeks 2 and 4, then at three months | Follow-up every three to six months |
| Condition | Adherence to the treatment as prescribed is essential for ensuring its effectiveness in preventing HIV transmission. | | Adherence to the treatment as prescribed is essential in order to keep the viral load under the threshold of 200 copies/ml of blood (or undetectable) to ensure its effectiveness in treating HIV and preventing transmission. |
| Payment | Covered by the Régime d'assurance maladie du Québec (RAMQ) and by private and group insurance plans | | |



HIV testing

According to Canadian national estimates about HIV, about 8,300 people were living with HIV without knowing it (undiagnosed cases) at the end of 2018. This represented 13% of the estimated total number of people living with HIV in the country. Current Québec guidelines recommend annual HIV testing for key populations (see p. 5) and based on the assessment of risk factors, such as, for example, having had an anonymous sexual partner or more than three sexual partners in the past year.

The only way to know for certain if a person has contracted HIV is to get tested. A test generally seeks out traces in the blood of an immune response to HIV infection or the presence of the virus itself, which results in an HIV-positive diagnosis. HIV cannot be detected by a test immediately after an exposure with the potential for transmission. The window period, which is the period between potential transmission and the moment when a test can provide a reliable result, must be taken into account; it varies depending on the type of test used. A person can nonetheless get tested if they deem that they have had a probable HIV exposure. PEP can then be offered, and the person conducting the HIV test can take care of calculating the window period and making an appointment for another test in a few months. The two main types of HIV tests used in Canada are the standard test and the rapid test, whether self-administered or given by a healthcare professional.

The standard test (fourth generation)

The fourth-generation test is the one used in most cases. This test detects both the presence of the p24 antigen (a structural protein in the HIV capsid) and that of HIV antibodies (anti-HIV-1 and 2). The p24 antigen is generally detected between the 14th and 22nd day after infection, while the antibodies are detected between three and 12 weeks after infection. Some laboratories still use third-generation tests which only detect antibodies.

As such, it is possible to obtain a positive HIV test result just a few weeks after infection. However, if the test is negative, it is recommended to repeat it 12 weeks after exposure.

When a standard test gives a positive result, the sample is sent to Québec's public health laboratory, the Laboratoire de santé publique du Québec (LSPQ), for a second analysis. This confirms or negates the first positive result. Only a positive result for the LSPQ confirmation test can confirm an HIV infection diagnosis.

Note that because this test is done using a blood sample, which is sent to a laboratory for analysis, it can take one to two weeks to receive a result. Normally, the healthcare provider who did the test will also give the person their result.

The standard test is available on demand at many places, including family medicine practices, walk-in clinics, sexual health and specialized STBBI clinics, local community services centres (CLSCs) and hospitals. The costs related to this type of test are covered by the Régime d'assurance maladie du Québec (RAMQ) and by private insurance, but some fees (particularly for sample transportation) may be required.

The rapid test (third generation)

This option makes it possible to get a result on site in a few minutes. Rapid tests react only to the presence of HIV antibodies in the blood. It takes up to three months for the body to produce HIV antibodies. This is why this type of test can confirm the absence of infection 12 weeks (three months) after a potential HIV exposure. If the rapid test result is positive, a standard test needs to be done in order to confirm the diagnosis.

The rapid test can be given by healthcare providers in specialized clinics, such as sexual health clinics. Some HIV community organizations also offer the option of being accompanied by a community worker during this process.

The self-test

Since November 2020, it has been possible to get a rapid test that a person can perform on themselves (or accompanied, if the person so desires). This process, also called self-testing, allows people who are concerned about their HIV status to test themselves quickly and easily in the place of their choice.

Just like the rapid test, this test provides an immediate result, but it does not detect HIV right away after a recent exposure. If the result is negative, it's recommended to repeat the test 12 weeks (three months) after the exposure.

A positive result from a self-test is not a diagnosis, however. This is why it's still necessary to make an appointment at a testing clinic afterward in order to get a standard test done. This is done by a healthcare provider and allows the person to get follow-up and start treatment if necessary. For more information, visit the [L'autotest du VIH](#) page on the Portail website (in French only). ▼

The importance of knowing your HIV status

Regardless of the test result, **it's important for a person to know their HIV status** in order to take charge of their health and protect the health of others. As well, it provides information and ways to help people choose appropriate prevention strategies depending on their HIV status.

If the HIV test result is negative, it may trigger a person to start thinking about choosing tailored prevention strategies, such as using condoms and taking PrEP or PEP as needed.

If the HIV test result is positive and the HIV-positive diagnosis is confirmed, it's currently recommended to start treatment as quickly as possible in order to preserve the immune system and thus preserve the person's health. Taking antiretroviral treatment is a tailored strategy to prevent the sexual transmission of HIV, and the data are clear on the subject: when a person living with HIV takes antiretroviral treatment as prescribed and maintains a low or undetectable viral load (below the threshold of 200 copies/ml of blood), they cannot transmit HIV during sexual relations, even if they don't use a condom. In short, when HIV is undetectable, it is untransmittable (U = U). ▼

Link to testing resources

[Map of Québec HIV and STBBI testing sites](#)

[Health centres, community organizations and medical clinics](#)



Nutrition and HIV

To live well with HIV, it's important for a person to be able to take care of themselves every day by adopting healthy life habits. Choosing energizing, nutrient-rich foods can help optimize the immune system.

For people with a detectable viral load (above 200 copies/ml) or a CD4 T lymphocyte count below 200, precautionary measures may need to be taken with regard to food safety. To minimize the likelihood of contamination, some foods should be avoided, including sausages and uncooked meat-based products, raw seafood, raw eggs and products based on raw eggs, and so on. For these people, it's also suggested to separate foods in their grocery baskets to prevent the possibility of cross-contamination, and to choose fresh or frozen foods just before going to the checkout line in order to prevent the appearance of bacteria. Some foods and supplements can influence the treatment's effectiveness (such as St. John's wort, tangelo, grapefruit, calcium tablets and more). Information on this subject can be obtained from a doctor or pharmacist.

Varying food choices can help provide a sufficient amount of essential nutrients. While some foods are richer in nutrients than others, no food is complete when taken alone. The weaknesses of some foods can be complemented by the strengths of others. For instance, legumes are rich in protein but contain little vitamin C, while the opposite is true of oranges.

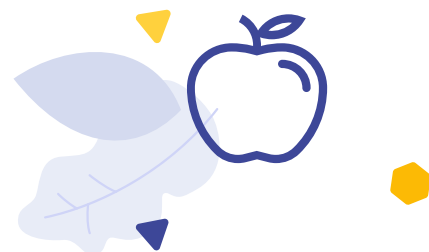
Taking inspiration from the advice provided in the [Canada Food Guide](#), people can meet their needs for vitamins, minerals and other nutrients by eating the recommended quantities and types of foods. Maintaining a balanced caloric intake can be beneficial for the health of people living with HIV since insufficient caloric intake can contribute to weakening the immune system and excess caloric intake is also harmful. Healthy eating, along with regular physical activity, helps reduce the likelihood of developing chronic illnesses such as cancer, diabetes, heart disease and osteoporosis.

People who are active note improved energy levels and better psychological well-being. Regular physical activity and staying in good shape help people handle everyday tasks more easily. It's also very important to stay hydrated by drinking a litre to a litre and a half of water per day in order to regulate body temperature, maintain healthy skin and joints, digest food, help the brain function well, and produce the necessary bodily fluids.

Being active and healthy takes energy! Spreading meals out appropriately throughout the day gives the body opportunities to recharge and prevents fatigue without overloading the digestive system. It's recommended to eat **three meals** a day and **snacks** as needed. People can also get an energy boost by eating bread, cereals and other whole-grain products as well as fruits and vegetables. The carbohydrates (starches and sugars) present in vegetables are the main source of the energy the body needs.

Maintaining strong muscles and bones is necessary in order to retain or increase strength and resilience. For this, the body needs regular intake of protein, calcium and vitamin D.

Regular physical activity helps maintain strength, flexibility, balance and coordination. Careful weight-bearing exercise (such as weightlifting, running, high-impact exercise or carrying heavy loads) are essential to bone health and reduce the risks associated with osteoporosis. However, physical activity should still be tailored to a person's physical condition. Before starting a new physical exercise, a person should check with their healthcare team. ▼



PSYCHOSOCIAL ISSUES



Sexuality and HIV

The news of an HIV-positive diagnosis can cause people, in some cases, to rethink their sexuality and redefine the concept of intimacy within their relationships. At minimum, a period of reflection on the subject can help the person improve their well-being and their sex life.

Rethinking sexuality after a diagnosis

It's totally normal for a person to question the nature of their relationships and the evolution of their sex life. Some people opt for a relationship with a single partner, while others prefer to have relationships with multiple partners, romantic or otherwise. All options are legitimate as long as the person respects their own values and their sexual and relational well-being.

After being diagnosed as HIV-positive, people living with HIV may have different emotional reactions. Some people will feel the need to increase their sexual activity, while others will feel a drop in libido or bring a partial or total halt to their sex life. The length of this period can vary, and during this time, many people have difficulty disclosing their HIV-positive status in sexual contexts, fear that they will no longer be desired, or feel an aversion to sex. Among other things, this may be because they fear transmitting HIV to their partner or partners and fear being stigmatized because of HIV.

This period of questioning can be an opportunity for the person to rethink the expression of their sexuality. It can allow them to become aware of sexual behaviours in which the likelihood of contracting an STBBI is higher. This period can also be a good time to make connections between sexual compulsions and the use of psychoactive substances (alcohol and drugs).

For a person living with HIV, changing their sexual habits can be a source of anxiety and can harm their self-esteem. Working on body image and self-confidence are key elements of improving their ability to be comfortable in their body and have a more satisfying sex life.

Recall that when a person is taking antiretroviral treatment without interruption and is being medically monitored, their viral load (the quantity of virus present in their bodily fluids) can become undetectable within three to six months, on average. Having an undetectable or low viral load (under the detection threshold of 200 copies/ml of blood) eliminates the likelihood of sexually transmitting HIV to other people.

A FEW SEXUAL PRACTICES THAT CARRY NO RISK FOR CONTRACTING HIV



KISSING



MUTUAL
MASTURBATION



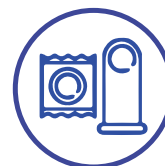
RECEIVING
ORAL SEX*

*However, giving oral sex can include some chance of transmission. See the section on sexual transmission (p. 12) for more details.

A FEW BARRIER METHODS FOR PREVENTING THE SEXUAL TRANSMISSION OF HIV



EXTERNAL
CONDOM



INTERNAL
CONDOM



DENTAL DAM

Condoms can also be a way for a person to reduce their anxiety about the likelihood of transmitting HIV to their partner or partners and prevent the transmission of STBBIs. When people are new to using condoms, some may feel like they're losing the sense of spontaneity in their sex lives. But it is possible to use a condom with a sense of spontaneity and sensuality thanks to self-affirmation, good communication, and the participation of their sexual partner or partners. Some sexual practices, such as kissing, massage and mutual masturbation, also make it possible to explore intimacy with people with no likelihood of transmission since they don't involve any contact between a bodily fluid and an entryway into the body.

Many other strategies can be put into place to increase the sexual satisfaction of people living with HIV. These include, among other things, consulting with mental healthcare providers (sexologists, psychologists and so on), discussion groups on sexual health offered by some HIV prevention community organizations, and discussion and dialogue with their sexual partner or partners. Knowing the conditions for HIV transmission is also an important factor that can help reduce anxiety between partners. See the section on sexual transmission (p. 12) for more details.

All these approaches are likely to help people living with HIV to take pleasure in their sex lives. They can contribute to giving a new meaning to the various dimensions of their sexuality and to experience it in a fulfilling way. As well, remember that each partner must consent for a sexual activity to happen, and this is true for all types of sexual acts (such as intercourse, kissing and so on). The consent of all partners must be clear, freely given, informed and ongoing, and it can be withdrawn at any time. If these conditions are not present, the sexual relations could be considered non-consensual. ▼



HIV and the use of psychoactive substances

The use of psychoactive substances is an important factor to consider when it comes to the transmission of HIV and other STBBIs. For healthcare and social services providers, it can be important to broach the topic with a person who is coming for services related to their psychoactive substance use habits (both drugs and alcohol) in order to counsel and support them appropriately.

Sharing drug use materials can transmit HIV. As well, the lowered inhibitions that come with the use of these substances can have major effects on a person's sexual practices and can lead them to reduce their use of prevention strategies such as condoms.

A range of strategies can be suggested following a harm reduction approach, which aims to encourage safe consumption, in order to help a person reduce the likelihood of contracting or transmitting HIV. Abstinence can also be advised in some contexts if this is what the person wants. The principle of combined prevention can include regular testing, reduced use of psychoactive substances in the context of sex, reduced number of sexual partners, and taking treatment as a prevention method (pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for HIV-negative people and antiretroviral treatment for HIV-positive people). However, these strategies don't all have the same level of effectiveness. For more information on combined prevention, visit the [Projet Mobilise!](#) website. ▼

Chemsex

Chemsex, also known as “party and play” (PnP), is a term that refers to the use of psychoactive substances during sex in order to reduce inhibitions, increase pleasure and sensation, and boost sexual performance and endurance, among other things. PnP sessions most often include the use of “party drugs” such as methamphetamine (crystal meth), GHB/GBL, ketamine, synthetics and other substances such as cocaine, alcohol or erectile dysfunction pills. PnP is especially associated with gay, bisexual and queer men and with men who have sex with men, and it often takes place in groups. Men living with HIV may sometimes be more likely to use psychoactive substances in the context of sex, among other things in response to the consequences of HIV stigmatization on their sexuality.

For more information, you can watch the series by the Institut universitaire sur les dépendances entitled “[Le chemsex en intervention](#)” (in French only).

To learn more about the subject of peer support, visit the website “[Ça prend un village](#)” (in French only). ▼

The harm reduction approach

While an older intervention philosophy on the question of drug use prescribed abstinence at all costs, a harm reduction approach, also known as risk reduction, is an intervention approach that takes a more humanist view. With this in mind, it supports people who use psychoactive substances by meeting them where they are in their journey. There is no longer a question of criminalizing these people—quite the contrary. The harm reduction approach considers that people who feel the need can and should have access to help that comes from a respectful and welcoming place.

Concretely, harm reduction aims to reduce the negative effects of drug use. By having free access to sterile materials (such as pipes, syringes, stericups and so on), people will be less likely to transmit or contract HIV and other blood-borne infections, such as hepatitis C. As well, supervised consumption sites can give people the chance to use in a clean and appropriate place where specially trained staff are there to intervene before and after the use of psychoactive substances, which greatly reduces the likelihood of overdose. As well, at this kind of site, people who use drugs are not criminalized and so don't have to be afraid of being arrested by the police for possession. ▼



Stigmatization and HIV

Scientific progress on antiretroviral treatment has greatly improved the health conditions of people living with HIV. The emergence of tritherapy, starting in 1996, transformed this infection from its previous status as one with fatal complications into one that's a chronic infection with no impact on life expectancy. However, the social consequences related to the stigmatization of people during the early years of the HIV/AIDS epidemic are often considered as the "second phase of the epidemic," which still persists today.

Stigmatization means devaluing an aspect of oneself or others. Stigma acts as a mark on people who have features that transgress social norms. Stigmatization is not innate; it's a view of others and of the self that is constructed based on social interactions starting in childhood. Stigmatization is central to the constitution of the social order because it helps reinforce the structures of power by maintaining inequalities between stigmatized and non-stigmatized people.

Stigmatization is a dynamic process that can be broken down into several behaviours or actions that are interrelated and interdependent:

▼ **Stereotype (cognition)**

Idea or belief about a group of people that obscures the specificities of each individual.

▼ **Prejudice (emotion)**

Pre-formed value judgement about a person or group. A prejudice crystallized by education and the social environment can be more difficult to break down because it requires that a person call into question values with which they have been inculcated since childhood.

▼ **Discrimination (behaviour)**

Concrete action on the basis of a prejudice or a stereotype that leads a person to place an additional burden on the shoulders of a targeted person to prevent the targeted person from having access to the same rights and privileges as others.

Consequences of stigmatization

When a person receives an HIV-positive diagnosis, the people surrounding them may perceive it as a mark that justifies the mechanisms of stigmatization, which can have a considerable impact on the diagnosed person's life. We must also remember that stigmatization affects everyone, and that each person can play a major role in deconstructing prejudices, stereotypes and discriminatory acts toward marginalized groups.

Because they have absorbed perceptions about HIV that are conveyed by society, people who don't live with HIV may have a first cognitive reflex to feel threatened with regard to their health when they're spending time with an HIV-positive person. This can also manifest in the form of a value judgement about the behaviours that can transmit the infection (drug use, sexual orientation, sex work and so on). Nobody is exempt from the possibility of having a stigmatizing attitude or taking discriminatory actions. This is even more problematic when the person holds a position as a health-care provider (doctor, nurse, pharmacist). Stigmatization that's perpetuated within institutions, the community and interpersonal relationships can lead to significant psychological repercussions. ▼

The effects of stigmatization can be seen at many levels, and simultaneously:

▼ **Institutional stigmatization**

The application of policies, laws and procedures that are unfavourable or discriminatory, including at the legislative, policy and systemic levels (such as within religious institutions, health systems, legal systems, police services and so on).

▼ **Concrete stigmatization**

People can experience clear discriminatory acts at the interpersonal level or within their community (such as exclusion, physical or psychological violence, bullying and more).

▼ **Anticipated stigmatization**

The fear of falling victim to discriminatory treatment because of one's HIV status can foster isolation and a sense of shame among people who experience it.

▼ **Internalized stigmatization**

HIV-positive people may take on negative and stigmatizing feelings and opinions about HIV with regard to themselves and other people living with HIV.

▼ **Intersectional stigmatization**

This refers to the relationship between stigma associated with HIV and other forms of oppression. Moralizing against HIV-positive people can be intensified by other forms of marginalization, such as ethnocultural origin, socioeconomic status, gender identity, sexual orientation, age and more.

Stigmatization has pernicious effects on the well-being of people living with HIV. The Stigma Index for People Living with HIV in Quebec research project, led by COCQ-sida, has shown that in Québec, stigmatization can engender lower self-esteem, difficulty integrating into society, a greater likelihood of using psychoactive substances, difficulty finding housing, increased isolation and a lower rate of adherence to antiretroviral treatment. ▼

Intersectionality

The majority of people who are the most affected by HIV/AIDS are members of marginalized groups (and as such, are seen as key populations), whether on the basis of their sexual orientation, their ethnocultural origin, their socioeconomic status, their gender identity or any other aspect of their identity. An HIV diagnosis among people who belong to a marginalized group can place them at the intersection of multiple axes of oppression, creating a major impact on their living conditions and their mental and physical health. As such, it's essential to consider the obstacles created by stigmatization on the basis of different axes of oppression in order to provide effective intervention that's tailored to each person's reality.



Tools for reducing stigmatization

We often forget that prejudice is a fear-based judgement (emotional dimension) that relies on lack of knowledge (cognitive dimension). Take the example of a helping professional who takes a stigmatizing approach toward a client because of the irrational fear of contracting an HIV infection. To prevent prejudices from manifesting in the form of discriminatory treatment, HIV education must also take into account the emotional dimensions of HIV-related stigma.

Studies show that experiences of stigmatization can be transformed into opportunities for empowerment, resistance and social change for the targeted person, especially when the person attacks the problem directly with the support of their loved ones and the community of people living with HIV. The existence of community organizations that provide accompaniment and psychosocial support services is also an important element in working toward destigmatization. People who have a high level of emotional support more easily develop resilience with regard to their HIV-positive status. Resilience is a dynamic process that involves positive adjustment after going through an ordeal, such as having received an HIV diagnosis.

The creation of support programs run by peer helpers is a useful strategy for breaking the isolation of people living with HIV. Peer helping is defined as mutual support among people who are dealing with or have dealt with similar life experiences. The peer helper relationship can provide positive benefits for both the helper (who is giving back to the community) and the person receiving help (who receives understanding and personalized support).

Lastly, a harm reduction approach is key within health institutions and community organizations in order to reduce stigmatization. This approach involves non-judgement and the process of questioning one's own prejudices and stigmatizing practices, whether as a care provider or as an outreach worker. For more details on this approach, see the Harm Reduction Approach section on p. 28. ▼

Legal aspects and criminalization

In 2012, the Supreme Court of Canada declared that a person living with HIV has the legal obligation to disclose their HIV status to their partners before engaging in sexual behaviour that includes a “realistic possibility” of HIV transmission.

At that time, even though this “realistic possibility” was not clearly defined, the Court confirmed that there is no realistic possibility of HIV transmission when a condom is properly worn and the person living with HIV has a low viral load, meaning the quantity of virus in the blood is below 1500 copies/ml.

Since 2019, in Québec, the Directeur des poursuites criminelles et pénales (DPCP), Québec's Director of Criminal and Penal Prosecution, has recognized that there is no realistic possibility of transmission when the person living with HIV meets the three following criteria:

1. Taking antiretroviral treatment as prescribed.
2. Viral load maintained below 200 copies/ml of blood.
3. Medical monitoring every four to six months in order to measure viral load.

This means that if these three criteria are met, no criminal case should be brought for non-disclosure of HIV status, even if a condom was not worn. However, if one of these criteria is not met, the DPCP could consider that there was a “realistic possibility” of transmission, which could lead to criminal charges if the person's HIV status was not disclosed before sexual relations took place. ▼

Even though we can point to reduced levels of criminalization, HIV non-disclosure can still, in some contexts, lead to criminal condemnation. The most commonly used charge is that of aggravated sexual assault, which also comes with a lifetime placement on the sex offenders registry. This unfortunately contributes to reinforcing the prejudices and stigmatization that associate people living with HIV with deviance and criminality. Recall that in 2021, Canada was the country with the fifth-highest number of legal cases related to HIV non-disclosure.

When is a person required to disclose their HIV status?

| Required | Not required | Case by case |
|---|--|---|
| <ul style="list-style-type: none"> • Immigration Application for permanent resident status requires a medical exam. An HIV-positive result can influence the applicant's eligibility. • Before having sexual relations that do not respect one of the three criteria: taking treatment, viral load maintained below the threshold of 200 copies/ml of blood, medical monitoring every four to six months. This can come with the risk of criminal charges (see p. 31). • Private insurance Non-disclosure can void the insurance contract and increase the possibility that this information will be shared with other insurance companies, except when the diagnosis was received after the contract was signed. | <ul style="list-style-type: none"> • Sexual relations with a condom and a low viral load (below 1500 copies/ml of blood) (see p. 31). • Sexual relations with a condom if the three criteria are met (taking treatment, viral load maintained below the threshold of 200 copies/ml of blood, medical monitoring every four to six months) (see p. 31). • Health and social services providers and medical questionnaires The application of universal precautions makes it possible to prevent HIV transmission in healthcare settings. However, disclosing an HIV-positive status can help you receive care that's tailored and of better quality. • Employer Only questions about health conditions that could have a direct effect on a person's ability to perform the job may be asked at the time of hiring. | <ul style="list-style-type: none"> • Sexual relations with a condom and a high viral load (more than 1500 copies/ml of blood) (see p. 31). • Oral sex without a condom (see p. 31). • Other exceptions (such as condom breakage). |

For all legal questions regarding HIV status, contact [VIH Info-Droits](#), a legal information and accompaniment service.

Telephone: Montréal: (514) 844-2477, ext. 34. Outside Montréal (toll-free): 1 (866) 535-0481, ext. 34.

Email: vih-infodroits@cocqsida.com.

Psychosocial support work

Welcoming disclosure

For people living with HIV, disclosing their status, whether to a loved one or to a health care professional, can be complex. It can involve negative reactions, discrimination, and legal aspects to consider in regard to the criminalization of HIV non-disclosure. Because many people believe that having contracted HIV means a person took risks or was careless, HIV-positive people are often wrongly considered as responsible for their health condition. This can reinforce stigmatization and inappropriate reactions from the people around them once they have disclosed. As such, disclosing their status can have major repercussions in the lives of people living with HIV—personal, social and professional.

Disclosure can lead to discomfort, inappropriate questions and judgements because of various misunderstandings. It is totally appropriate for a person to say they lack knowledge on the subject and to go get accurate information from reliable sources. However, this education work should not be entirely the responsibility of people living with HIV themselves once they have disclosed.

An HIV-positive person should always be the one who gets to choose to disclose their status. This is information that should be treated with the greatest possible discretion and should in no case be shared with colleagues or anyone else without justification and without prior agreement. If a person discloses, this is generally a sign of trust, and the service provider can reassure the person who disclosed by thanking them and clarifying that the information will remain confidential.

In this context, the professional's role could be to accompany the person living with HIV by keeping in mind that if they chose to disclose their status, they have decided that it would be better for them than keeping it secret. As such, it is every person's duty to be aware of their own prejudices and to break down any inaccurate beliefs. It is possible to live well with HIV, to have a fulfilling love life and sex life, to work, and even to have children. In short, a disclosure should be greeted with respect, empathy and discretion, while offering judgement-free support and listening.

Accompanying someone in disclosing to others

With the exception of the three criteria presented in the section on legal aspects, the person living with HIV should always be at choice about whether to disclose their HIV status. It is crucial to respect their pace and their decisions about whether or not to share this information with others. In short, it's preferable to accompany them rather than to direct them in this process.

When a service provider accompanies an HIV-positive person who wants to disclose their HIV status, the service provider can help them prepare for the announcement by considering the following elements. First, the motivations for wanting to disclose, meaning their expectations and what they hope to get out of sharing the information. Next, the message and its limits: what they will say, how they will make the announcement, and the boundaries of the person receiving the information. Lastly, it's also important to assess what contexts are favourable for disclosure and what contexts are not; for example, choosing the right time and place to disclose and considering the other person's state of mind.

All this preparation can involve planning conditions that are favourable for disclosure, as well as the form the announcement will take. As well, they may want to think about the various reactions the person hearing the news might have, whether positive or negative.

Whether it's with a sexual partner, in a workplace, with family or in another context, it can be useful for a person to take the time to carefully identify the advantages and disadvantages of disclosing their HIV status before doing so. Using a good decision-making scale can help the person consider the pros and cons before making their decision. Thinking about the obstacles to overcome and about winning conditions—personal, social, cultural and economic—can also help the person make an informed decision.

After a person is diagnosed with HIV or another STBBI, it's recommended that they inform sexual partners who may have been exposed. These people can then get tested in turn, even before symptoms appear, and receive the necessary treatment as needed, which can prevent complications. These people will also thus avoid transmitting the STBBI to others, and in so doing, will help prevent STBBI transmission more broadly.

The process of telling partners should be discussed with the health care provider who gave the person their test results, who is trained to help people find the most appropriate strategies. Portail VIH/sida du Québec also offers a free partner notification service. A person who wishes to can send an anonymous text message to advise all the partners who may have been recently exposed to an STBBI. ▼



General recommendations

For working with people living with HIV and key populations

- Explain the rules of confidentiality and foster an atmosphere of trust.
- Develop skills for working with HIV-positive people. Get educated and stay up to date on the scientific advances in relation to HIV. Share factual information in your setting (such as U = U, PrEP, PEP, safer practices and so on).
- Break down prejudices and fears related to HIV.
- Explore the effects of stigmatization and overcome fears and negative feelings (such as shame).
- Take a non-judgemental attitude and avoid inappropriate curiosity.
- Show openness toward the individual's reality and target their actual needs.
- Provide access to information, sterile drug use materials, condoms and so on.
- Facilitate access to tailored health care by referring them to professionals, community organizations or other specialized services based on their needs. Promote appropriate resources.
- Listen to how the person self-identifies and use neutral or inclusive language to match them, particularly with regard to gender, sexual orientation and relationship models.
- Create a welcoming and safe environment that provides services tailored to priority populations.
- Recognize the specificity of each person's individual needs.
- Use an intersectional approach. Recognize the diversity of the obstacles that people may encounter.
- Take a trauma-informed approach that considers the various forms of violence people may encounter.
- Do not treat people living with HIV differently. Offer them the same service that you would any other person.
- Involve people living with HIV in decision-making processes. Talk with them about prevention strategies, testing and treatment.
- Promote positive sexuality based on resilience and skill-building.
- Opt for "by and for" work in order to break isolation and provide positive, empowering models, particularly by offering peer helper programs.
- Take into account the undesirable side effects of antiretroviral treatment for some people living with HIV, and the consequences of these side effects, and provide tools to help these people manage the anxiety that treatment can bring up.
- Recognize the major mental load on the person who has been diagnosed as HIV-positive and put mechanisms into place to help them manage it.
- Work with people in order to help them counter the effects of the emotional void and isolation that they may feel when living with HIV. ▼

Recommended vocabulary

The words you use are hugely important in building and maintaining a trusting relationship. The vocabulary you adopt can contribute to stigmatizing certain groups and reflecting forms of social hierarchies. Language can, among other things, convey prejudices, values and assumptions that can reinforce negative representations of a diverse range of populations that are already marginalized in society.

To describe a person, it's also preferable to avoid using unnecessary labels and to consider the person first, ahead of their health conditions, in order to place the focus on their inherent worth. It is also preferable to use accurate words based on the context, to pay attention to your non-verbal language and to always prioritize the person's self-identification. The table below suggests language to avoid and language to use.

| Terms to avoid or use with care depending on the context | Terms to use | Explanation |
|---|---|--|
| <ul style="list-style-type: none"> HIV/AIDS | Use the term corresponding to the context: HIV or AIDS. <ul style="list-style-type: none"> HIV testing HIV or AIDS diagnosis | When possible, it's preferable to use only one of the two terms, whichever one is accurate to the context. This helps avoid the undifferentiated use of the words HIV (the name of the virus) and AIDS (the complications related to the virus). |
| <ul style="list-style-type: none"> AIDS virus HIV virus | <ul style="list-style-type: none"> Human immunodeficiency virus (HIV) HIV is the virus that can cause AIDS. | AIDS is not a virus, but rather a set of symptoms. The acronym HIV stands for "human immunodeficiency virus," so it's not necessary to add the word "virus" after it. |
| <ul style="list-style-type: none"> Infected with AIDS AIDS patient AIDS victim or sufferer | <ul style="list-style-type: none"> Person in the AIDS phase (if applicable) | These terms have negative connotations and are often used in error to talk about people living with HIV who are not in the AIDS phase. As well, a person cannot be infected with AIDS, because AIDS is not an infectious agent. |
| <ul style="list-style-type: none"> Infected with HIV | <ul style="list-style-type: none"> Person living with HIV Person exposed to HIV | This term can be perceived as dehumanizing because it labels a person based on their health condition. It's important to use language that prioritizes the individual. |
| <ul style="list-style-type: none"> Clean Dirty | <ul style="list-style-type: none"> Having or not having an STBBI Positive or negative test; used or unused material Sterile material | These terms convey stereotypes and negative judgements about sexuality (HIV or STBBI diagnosis) and the use of psychoactive substances. It's preferable to use accurate terms, without judgement, that reflect the person's exact situation. |
| <ul style="list-style-type: none"> AIDS test | <ul style="list-style-type: none"> HIV testing HIV screening test HIV self-test | We don't test for AIDS, but rather for HIV. |
| <ul style="list-style-type: none"> Risky sexual behaviours Risk of transmission | <ul style="list-style-type: none"> Sex without a condom or other prevention method Likelihood of transmission, probability of transmission | It's preferable to centre prevention on a positive and non-moralizing approach to sexuality, rather than on risks. |
| <ul style="list-style-type: none"> Mother-child transmission | <ul style="list-style-type: none"> Perinatal transmission Vertical transmission | This expression excludes the reality of certain people, such as trans and non-binary people. |
| <ul style="list-style-type: none"> At-risk populations Vulnerable groups | <ul style="list-style-type: none"> Key populations Priority populations | To foster the autonomy, resilience and individuality of the people most exposed to HIV, avoid using expressions with passive or pejorative connotations, as well as ones that imply that all members of a group are vulnerable to HIV. |
| <ul style="list-style-type: none"> Fight against AIDS Putting an end to HIV Protecting against HIV | <ul style="list-style-type: none"> Response to AIDS Ending HIV stigma Preventing HIV transmission | Stigmatized health conditions such as HIV sometimes lead to confusion between the person and the illness. As such, terms with a war-like connotation can imply a fight that targets the people rather than the health condition itself. |

For more information on the terminology to use regarding HIV and AIDS, see the [UNAIDS terminology guidelines](#). For information on respectful language in the context of sexual health, substance use, STBBIs and sources of intersectional stigmatization, see [Language Matters](#). ▼

List of resources

For resources that are directly aimed at key populations, see the [list](#).

HIV and AIDS resources

Portail VIH/sida du Québec

Provincial organization that works to educate the public, and more specifically people living with HIV, on the subject of HIV and other STBBIs using multimedia materials and training workshops. Portail also provides remote support to people concerned about HIV and other STBBIs.

Tel.: (514) 523-4636 · Toll-free: 1877 Portail (767-8245)

Email: info@pvvsq.org

Website: pvvsq.org (in French only)

MIELS-Québec

Community organization centred on aid and peer helper services, as well as on education and prevention services in the Québec region. The Ligne Info-VIH (HIV information line) is for anyone who wants references or information on sexual health.

Tel.: (418) 649-1720/Ligne Info-VIH: (418) 649-0788

Email: dgmieles@miels.org

Website: miels.org (in French only)

VIH Info-Droits (COCQ-SIDA)

Legal information and assistance service dedicated exclusively to questions regarding a person's HIV status. Created to defend the rights of people living with HIV/AIDS. VIH Info-Droits does not offer legal opinions or advice.

Tel.: (514) 844-2477, ext. 34

Toll-free: 1 (866) 535-0481, ext. 34

Email: vih-infodroits@cocqsida.com

Website: cocqsida.com/vih-info-droits.html

(in French only)

Criminalization of HIV non-disclosure (COCQ-SIDA)

Website: cocqsida.com/vih-info-droits/criminalization-of-hiv-non-disclosure.html

List of COCQ-SIDA member organizations

Organizations whose main objective is to reduce the spread of HIV, provide aid and support, or promote health for people living with HIV.

Website: cocqsida.com/qui-sommes-nous/nos-membres (in French only)

Table des organismes communautaires montréalais de lutte contre le SIDA (TOMS)

Coalition of Montréal's HIV community organizations.

Tel.: (438) 521-8609

Email: coordo@toms-mtl.org

Website: toms-mtl.org (in French only)

CATIE

Canadian organization providing information on HIV and hepatitis C. Newsletters, webinars, articles and much more, in both French and English!

Website: catie.ca

World database on travel restrictions related to HIV

Website: hivtravel.org

Cercle Orange

Free reference and support service for people living with HIV in Montréal who do not have access to health care.

Website: cercleorange.ca (in French only)

VIH & Immigration, suis-je admissible?

Information on HIV and immigration into Canada.

Website: immigrationvih.ca (in French only)

Sexual orientation and gender identity

Interligne

Front-line centre for aid and information for people concerned with sexual and gender diversity.

Toll-free: 1 (888) 505-1010

Aid service by email: aide@interligne.com

Live chat at all times, day and night.

Website: interligne.co/en/

RÉZO

Health and well-being for gay and bisexual men and men who have sex with men (gbMSM), both cis and trans.

Email: info@rezosante.org

Tel.: (514) 521-7778

Website: rezosante.org (in French only)

Health

Gouvernement du Québec health and well-being portal

Health and social services resource directory.

Website: sante.gouv.qc.ca/en/repertoire-ressources/

Lists of rapid-access clinics in Montréal

To quickly consult with a professional in Montréal's health and social services network.

Website: sante.gouv.qc.ca/en/repertoire-ressources/consultations-medicales-sans-rendez-vous/

COMMUNITY AND SOCIAL SERVICES ORGANIZATIONS

Directory of community, public and parapublic organizations

(and map) for each of the regions served by 211.

Website: 211qc.ca/en/directory

VIH411.ca

Website for people seeking HIV-related services in Canada. You can search to find services based on your location or on the type of service you're seeking.

Website: hiv411.ca

STBBI TESTING

Map of HIV and STBBI testing sites

for all regions of Québec.

Website: pvsq.org/sitesDépistages (in French only)

Community organizations

Website: pvsq.org/soutien-communautaire/
(in French only)

Info-Santé 811

Free and confidential telephone consultation service that lets you speak with a nurse quickly in the case of a non-urgent health problem. However, in case of a serious problem or urgent need, dial 9-1-1 or go to your local emergency room.

Tel.: 811

Website: quebec.ca/en/health/finding-a-resource/info-sante-811

References

STATISTICAL OVERVIEW OF HIV 3

- Government of Canada (2021). HIV Surveillance Report 2019.
- Gouvernement du Québec. (2021). Répertoire des indicateurs de gestion en santé et services sociaux.
- INSPQ (2021). Communication des données par l'INSPQ avant publication du rapport, 2021.
- UNAIDS (2021). Fact sheet—Global HIV & AIDS statistics.
- UNAIDS (2021). Key populations.

BIOLOGICAL ISSUES

The difference between HIV and AIDS 7

- CATIE (2021). The viral lifecycle and antiretroviral drugs.
- PVSQ (2021). Les traitements du VIH.

Phases of HIV infection without antiretroviral treatment..... 8

- CATIE (2021). HIV testing: Everything you need to know.
- PVSQ (2012). Bruno Lemay, L'Essentiel du VIH/sida.

Antiretroviral treatment to halt the progress of HIV infection..... 9

- CATIE (2021). HIV testing: Everything you need to know.
- CATIE (2021). The viral lifecycle and antiretroviral drugs.
- PVSQ (2012). Benoît Lemire, Rachel Therrien and Bruno Lemay, L'Essentiel du VIH/sida.
- PVSQ (2021). Les traitements du VIH.

HIV transmission..... 12

- CATIE (2020). HIV transmission.
- Passeport santé. Durée de vie des virus sexuels.
- PVSQ (2012). Nicolas Hamel, L'Essentiel du VIH/sida.
- PVSQ (2021). Le VIH et le sida.
- Québec (2018). Position ministérielle – L'effet du traitement des personnes vivant avec le VIH sur le risque de transmission sexuelle de l'infection.

HIV, pregnancy and childbirth 16

- CATIE (2018). Camille Arkell. Pregnancy and infant feeding: Can we say U=U about the risk of passing HIV to an infant?
- PVSQ (2012). Guyline Morin and Nicolas Hamel, L'Essentiel du VIH/sida.
- SOGC (2016). Deborah Money, Karen Tulloch, Isabelle Boucoiran and Sheila Caddy. Lignes directrices pour ce qui est des soins à offrir aux femmes enceintes qui vivent avec le VIH et des interventions visant à atténuer la transmission périnatale: résumé directif. DOI 10.1016/j.jogc.2016.09.055
- WHO (2004). HIV transmission through breastfeeding.

Treatment as prevention 17

- MSSS (2019). Guide pour la prophylaxie et le suivi après une exposition au VIH, au VHB et au VHC.
- MSSS (2019). La prophylaxie préexposition au virus de l'immunodéficience humaine: Guide pour les professionnels de la santé du Québec.
- PVSQ (2012). Jean-Marc Trépanier, L'Essentiel du VIH/sida.
- PVSQ (2021). maprep.org.

HIV testing 22

- PHAC (2020). Approach to HIV screening.
- CATIE (2021). HIV testing: Everything you need to know.
- CATIE (2021). HIV testing technologies.
- INSPQ (2015). Analyses de laboratoire recommandées pour le dépistage de l'infection par le virus de l'immunodéficience humaine (VIH).
- PVSQ (2012). Jean-Claude Chiasson, L'Essentiel du VIH/sida.
- PVSQ (2021). L'autotest du VIH.
- PVSQ (2021). Le VIH et le sida.

Nutrition and HIV 24

- PVSQ (2012). Michèle Cossette, L'Essentiel du VIH/sida.

PSYCHOSOCIAL ISSUES

Sexuality and HIV 26

- Éducaloi (2021). Sexual consent.
- PVSQ (2012). Nathalie Pelletier, L'Essentiel du VIH/sida.

HIV and the use of psychoactive substances 27

- CATIE (2017). Camille Arkell, HIV prevention for people who inject drugs: New biomedical approaches and time-honored strategies.
- INSPQ (2016). Olivier Godin. Crystal meth et réalités à surveiller.
- Projet Mobilise! (2018). Ken Monteith and Joanne Otis, Les stratégies de prévention : différents moyens pour favoriser la santé sexuelle et la prévention du VIH.

Stigmatization and HIV 29

- Valerie A. Earnshaw and Stephenie R. Chaudoir. (2009). From conceptualizing to measuring HIV stigma: A review of HIV stigma mechanism measures. AIDS Behavior 13(6): 1160–1177. DOI 10.1007/s10461-009-9593-3
- Lori A. Chambers, Sergio Rueda et al. (2015). Stigma, HIV and health: a qualitative synthesis. BMC Public Health 15, article number 848. DOI 10.1186/s12889-015-2197-0
- COCQ-SIDA (2020). The Stigma Index for People Living with HIV in Quebec.

Legal aspects and criminalization..... 31

- COCQ-SIDA (2020). Criminalization of HIV non-disclosure.
- COCQ-SIDA (2021). Ligne VIH Info Droits.

Psychosocial support work..... 33

- COCQ-SIDA (2021). Le dire ou pas.
- MSSS (2014). Les partenaires sexuels, il faut s'en occuper!
- PVSQ (2021). Vivre avec le VIH.

Recommended vocabulary 35

- PHAC (2019). Language Matters: Using respectful language in relation to sexual health, substance use, STBBIs and intersecting sources of stigma.
- UNAIDS (2019). UNAIDS terminology guidelines.



MIELS-Québec

625 avenue Chouinard
Québec, QC G1S 3E3

(418) 649-1720
Info-HIV Hotline: (418) 649-0788

miels.org

Follow us!



Portail VIH/sida du Québec

2000 rue Notre-Dame Est, Suite 501
Montréal, QC H2K 2N3

Montréal: (514) 523-4636
Toll-free number: 1-877-Portail (767-8245)

pvsq.org

Follow us!



PORTAIL
VIH/sida du Québec

