RATIONALE

Advances in science and medicine have significantly enhanced the life expectancy and quality of life of people living with human immunodeficiency virus (HIV), reduced the risks of virus transmission, and diminished the likelihood of disease progression to acquired immunodeficiency syndrome (AIDS). Nevertheless, the HIV epidemic remains a serious public health challenge affecting Canadian society. Moreover, deeply-entrenched features of the social, economic, and political fabric of society discriminatorily heighten the vulnerability of certain key populations\(^a\) to HIV. As such, the public health response to HIV should be anchored in longer term goals of social and economic development for all.

As we approach the target international deadline to end AIDS by 2030\(^1\), it is important to adhere to best available scientific evidence and protect public health, while affording appropriate protections for human rights as they relate to the prevention, testing and treatment of HIV/AIDS.

SCOPE

The aim of this policy is to provide guidance to physicians, policy-makers, and the general public on issues related to the prevention, testing, and treatment of HIV/AIDS and on the physician’s ethical obligations and society’s moral obligations in the national response to HIV, and towards people and communities living with or affected by HIV.

Physicians should be aware of relevant legislation, regulatory requirements, and policies in the jurisdiction in which they practice.

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\(^a\) The Public Health Agency of Canada (PHAC) identifies key populations affected by the HIV epidemic as gay, bisexual and other men who have sex with men, people who inject drugs, Indigenous people and people from countries where HIV is endemic. See Background Paper for more details.
A. PUBLIC HEALTH

1. PREVENTION

1.1 The CMA endorses international scientific consensus\(^2\) on treatment as a method of HIV prevention. The risk of transmitting HIV from a person living with HIV who is on antiretroviral therapy and has achieved an undetectable viral load (less than 50 copies of viral ribonucleic acid per milliliter) in their blood for at least six months is negligible to non-existent.

1.2 The CMA supports the Government of Canada’s endorsement of the Joint United Nations Programme on HIV/AIDS global treatment targets, which call for 90 percent of people living with HIV to know their serostatus, 90 percent of those diagnosed with HIV to be on treatment and 90 percent of those on treatment to have achieved viral suppression.

1.3 Pre-exposure prophylaxis (PrEP) is recommended for key populations (i.e., populations at high-risk of transmission). The CMA encourages provincial and territorial governments to consider covering the cost of PrEP for such populations, with funding provided by the federal government, where needed and appropriate.

1.4 Biomedical preventative strategies such as PrEP, post-exposure prophylaxis, antiretroviral therapy to achieve viral load suppression, and condom use should be paired with social and structural interventions addressing syndemics (i.e., intertwined epidemics, e.g., trauma and abuse, stigma, poverty, housing instability, addiction) driving HIV infection among key populations. Specifically, the CMA encourages counselling on harm reduction and the further establishment and expansion of supervised consumptions sites and clean-needle programs in high-risk regions.

1.5 The CMA recognizes that HIV-related stigma, discrimination and the criminalization HIV status non-disclosure to sexual partners are barriers to the uptake of HIV testing and treatment by populations at risk of transmission. Consequently, the CMA calls on all levels of government, the health care workforce and community organizations to sustain and scale up programming to combat discrimination and eliminate the criminalization of persons living with HIV.

1.6 The CMA calls on all levels of government to ensure that the application of the criminal law is commensurate with the risks of HIV transmission according to the most up-to-date medical and scientific evidence.

2. TESTING

2.1 To protect the individual’s right to privacy and bodily integrity, informed consent\(^b\) must be obtained from a patient before testing. The CMA endorses informed mandatory testing for HIV infection in cases involving the donation of blood, body fluids or organs.

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\(^b\) According to the PHAC, “informed consent” in the context of HIV testing means that: 1. the client has the capacity to consent to the test offer; 2. the client’s consent to the test offer is voluntary; 3. the client has been properly informed of the benefits and risks of taking the test or refusing the test; 4. the client fully understands the offer. The CMA Code of Ethics and Professionalism guides physicians to communicate accurately and honestly with the patient in a manner that the patient understands and can apply, and confirm the patient’s understanding” (Article 5), to “empower the patient to make informed decisions regarding their health by
2.2 HIV testing should be carried out in accordance with international human rights standards, the rights protected under the Canadian Charter of Rights and Freedoms, and the following three principles deriving from the PHAC Guidelines:

- **Counselling**: Patients should receive pre- and post-test counselling
- **Informed Consent**: Patients should have the opportunity to give informed and voluntary consent prior to HIV testing
- **Confidentiality**: Patients should have their right to privacy respected. The care provider must keep as confidential the fact that the patient has undergone HIV testing and the result(s) of any such test(s) taken.

2.3 When a patient is diagnosed with HIV, the physician should counsel the patient on the importance of disclosing their serostatus to recent and future sexual partners in accordance with Canadian law.

2.4 Pre- and post-test counselling should be delivered with cultural competence and sensitivity. Physicians (especially those serving key populations) are encouraged to engage in continuing professional development to acquire and ameliorate these skills.

2.5 Early diagnosis is associated with better treatment outcomes. The CMA encourages the public to know their HIV status and recommends that voluntary HIV testing be offered as part of routine care, especially for patients with known risk of infection.

2.6 To enhance the accessibility of HIV testing, the CMA encourages the establishment of additional access points across Canada, including anonymous testing sites. While discouraging the use of self-testing kits that have not been reviewed and approved by health authorities, the CMA notes that the World Health Organization (WHO) Guideline Development Group reviewed the evidence on self-testing kits and recommended that the approach be used as an addition to HIV testing services. The CMA urges Health Canada to similarly conduct a review of the evidence and consider a nation-wide introduction of safe, accessible and effective testing through self-administered testing kits.

2.7 Vertical mother-to-child transmission is preventable; the CMA encourages newly expectant mothers to know their HIV status. Moreover, physicians should advocate that HIV testing be offered as a facet of basic prenatal care.

3. **TREATMENT**

3.1 People living with HIV/AIDS should not face prejudice, stigma, or discrimination when seeking clinical care. Physicians have an ethical obligation to accept their patient without discrimination on the basis of medical condition unless there are legitimate reasons for refusal.

3.2 Early intervention significantly reduces morbidity and mortality associated with HIV infection. The CMA recommends that treatment begin at the time of diagnosis, as per WHO guidelines.
Additionally, primary care physicians should screen patients living with HIV for predictors known to increase the risk of mortality associated with the disease (e.g., smoking, hazardous drinking, depression).

3.3 Affordability is a significant barrier to the uptake, proper administration of, and adherence to antiretroviral therapy. Treatment should be made universally accessible and governments should support their implementation.

3.4 Clinical care alone is insufficient in the case-level and public health response to HIV. Additional supports must complement clinical care. These supports should be responsive to the needs of key populations and address the social determinants of health (e.g., abuse, poverty, housing and food instability, addiction).

4. CONFIDENTIALITY

4.1 When providing HIV testing and treatment services to patients, the CMA urges physicians to practice the rigorous standard of confidentiality described in the CMA Code of Ethics and Professionalism (Article 18). Where indicated by law, physicians should report cases of HIV infection and AIDS to designated authorities strictly with the threshold of information required to comply with the law. All reasonable steps should be taken to inform the patient of the information disclosed to public health authorities.

4.2 The disclosure of a patient’s HIV status to a current sexual partner may be appropriate if physicians are confronted with an HIV-infected patient who is unwilling to inform the person at risk. Such disclosure may be justified when all of the following conditions are met: (1) the partner is at risk of infection and has no other reasonable means of knowing the risk; (2) the patient has refused to inform their sexual partner; (3) the patient has refused an offer of assistance by the physician to do so on the patient’s behalf; and (4) the physician has informed the patient of his or her intention to disclose the information to the partner.

4.3 The CMA stresses the need to respect the right to confidentiality of people living with HIV and consequently recommends that legal and regulatory safeguards to protect such confidentiality be established and maintained.

5. FUNDING AND RESOURCES

5.1 All levels of government should provide resources for adequate information and education of health care professionals and the public on HIV-related diseases; research into the prevention and treatment of HIV infection and AIDS; and the availability and accessibility of proper diagnosis and care for all people living with HIV. Governments should ensure that such resources are responsive to the disproportionate impact of HIV on key populations.

5.2 All levels of government should scale up comprehensive responses to the HIV epidemic and support the implementation of quality and evidence-based preventative, testing and treatment

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strategies at national, provincial and local levels. Grounded in social justice, human rights and health equity, these strategies must be designed, implemented, and evaluated by, with, and for the communities affected by the epidemic.

5.3 The Government of Canada should update the 2004 Federal Initiative to Address HIV/AIDS and renew the robust financial commitments made more than a decade ago to scale up the national HIV/AIDS response.5

B. HEALTHCARE SETTINGS

1. POTENTIAL OCCUPATIONAL EXPOSURE

1.1 In the event of possible occupational exposure, physicians should voluntarily undergo testing for HIV infection and take post-exposure prophylaxis as a precautionary measure.

1. Physicians should receive adequate financial compensation in the case of HIV infection acquired as a result of accidental occupational exposure. Physicians and other health care providers with HIV infection have the same rights as others to be protected from wrongful discrimination in the workplace.

2. PHYSICIANS LIVING WITH HIV

2.1 In keeping with the magnitude of the problem and the risks posed, all physicians, including those who are living with HIV, should implement best practices to reduce the risk of transmission of HIV in the health care setting,

2.2 It is recommended that physicians who participate in exposure prone practices (EPPs), or whose scope of practice has the potential to require them to participate in EPPs, know their serologic status and to undergo testing at appropriate intervals.

3. EDUCATION

3.1 Physicians should ensure that their knowledge of HIV infection and AIDS is up to date.

3.2 Physicians should counsel patients and the public in the prevention of HIV by informing them of means available to protect against the risk of HIV infection and to avoid further transmission of the virus.

3.3 Health authorities should maintain an active public education program on HIV, to enhance public knowledge and reduce the stigma and discrimination associated with the disease.
References


