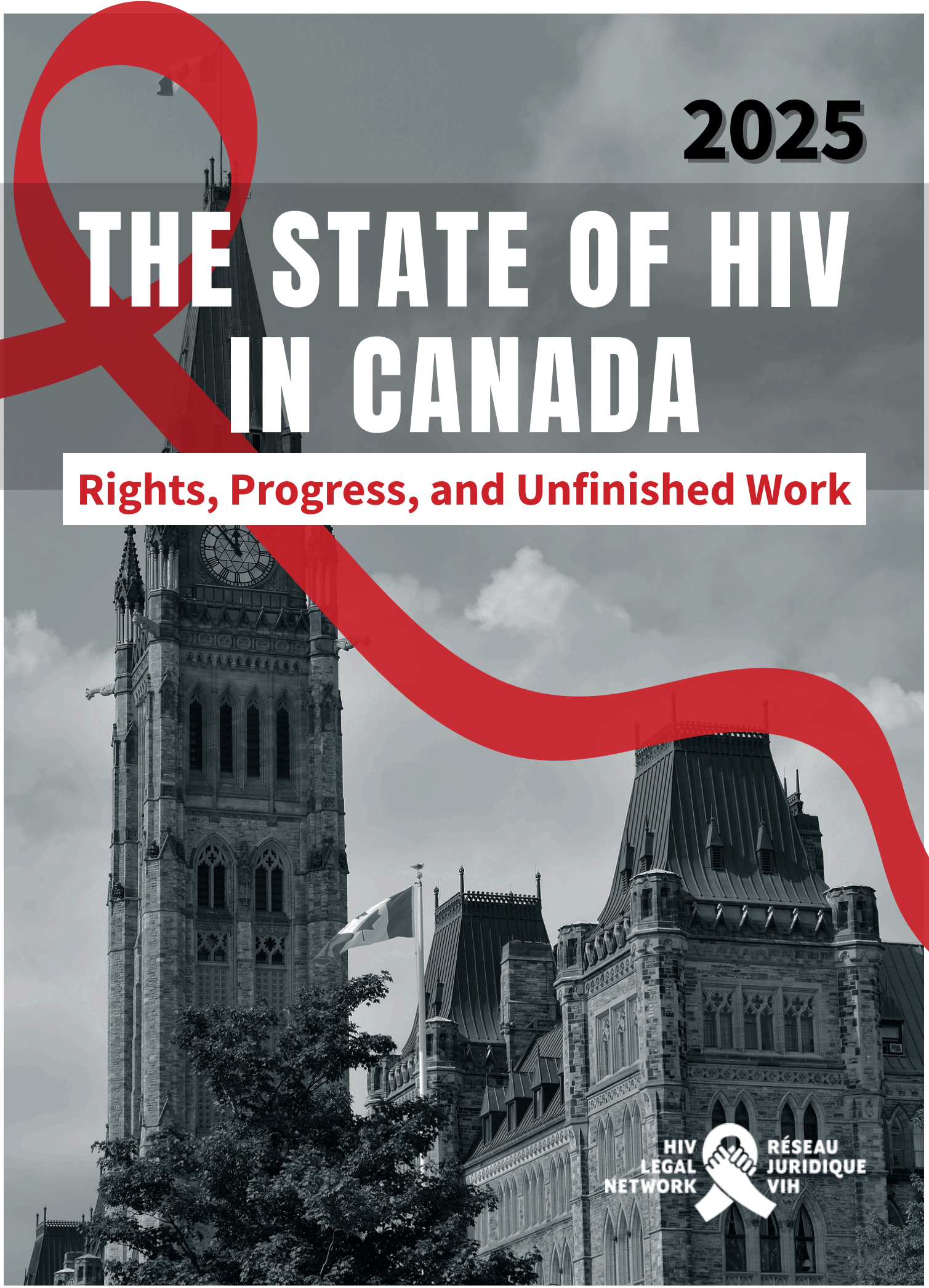
2025

THE STATE OF HIV IN CANADA

Rights, Progress, and Unfinished Work



HIV LEGAL NETWORK

RÉSEAU JURIDIQUE VIH

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ACKNOWLEDGEMENTS

The HIV Legal Network acknowledges that we are situated on Turtle Island, the lands and unceded territories of many different Indigenous groups and communities who have respected and cared for this land since time immemorial. We are accountable to these communities.

As advocates committed to addressing ongoing injustices and health inequities, we recognize that many of these harms are the result of colonization and its ongoing impacts, including practices and institutions that must be dismantled and reshaped to respect Indigenous people and Indigenous ways of knowing and being.

In addition, it is critical that we acknowledge the legacy of anti-Black racism and its relationship to criminalization and punitive laws and practices.

We know that the greater involvement and meaningful engagement of people living with HIV is central to any successes in the fight against HIV. It is to the millions of people with experience of HIV, both those living and those who have gone before us, to whom we are indebted, some forty years into this epidemic.

Our work is always guided by and in collaboration with those with lived and living experience, including people living with HIV, 2SLGBTQ+ people, people who use drugs, sex workers, people with experience of incarceration, newcomers to this land, members of other marginalized and racialized communities, and people living with hepatitis C, to name only a few. The recommendations contained within this document must be implemented in meaningful consultation with those with lived expertise, for whom we hold the highest regard.

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ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
ART/ARV	antiretroviral therapy
BC-CfE	British Columbia Centre for Excellence in HIV/AIDS
CDSA	*Controlled Drugs and Substances Act*
CSC	Correctional Service of Canada
DBS	dried blood spot
gbMSM	gay, bisexual, and other men who have sex with men
HCV	hepatitis C virus
HIV	human immunodeficiency virus
ID	infectious disease specialist
IFHP	Interim Federal Health Plan
MD	medical doctor
NP	nurse practitioner
NSP	needle and syringe program
PEP	post-exposure prophylaxis
Pharm/Ph	pharmacist
PNSP/PNEP	prison needle and syringe program/prison needle exchange program
POC	point-of-care
PrEP	pre-exposure prophylaxis
PWID/PWUD	person who injects drugs/person who uses drugs
PCEPA	*Protection of Communities and Exploited Persons Act*
SCS	supervised consumption services
STBBI	sexually transmitted and blood-borne infection
Tx	treatment
UNAIDS	Joint United Nations Programme on HIV/AIDS
UPHNS	urgent public health need site
U=U	Undetectable equals Untransmittable
VAC	Veterans Affairs Canada
WHO	World Health Organization

CONTEXT: WHY ENDING THE HIV EPIDEMIC MATTERS

Human immunodeficiency virus (HIV) is a virus that attacks the immune system. It is spread through contact with certain body fluids from a person with HIV. Without treatment, it can lead to acquired immunodeficiency syndrome (AIDS), a condition where the body can no longer fight infections effectively. However, with today's antiretroviral therapies (ART), HIV is a manageable chronic condition. Effective treatment reduces the amount of HIV in the body (i.e. viral load) to undetectable levels (achieving U=U), allowing individuals to live long and healthy lives and preventing transmission to others.

HIV at a Glance

- Since the beginning of the HIV epidemic, 91.4 million people have acquired HIV and about 44 million people have died of AIDS.[1]
- **Globally:** 40.8 million people were living with HIV at the end of 2024[1] and 31.4 million of those were accessing treatment.[2] The world has made major progress, but new infections continue, particularly where stigma and inequities persist.
- **In Canada:** About 65,270 people were living with HIV at the end of 2022, and an estimated 1 in 10 did not know their status.[3] After a period of decline, Canada has seen new cases of HIV increase in recent years.[4] In 2023, heterosexual exposure accounted for more new HIV diagnoses than exposure among men who have sex with men, and the number of women and gender-diverse people acquiring HIV continues to rise.[5]

Ending the HIV epidemic in Canada is both a public health imperative and a matter of human rights.

Each missed opportunity for prevention or treatment deepens inequities and delays our shared goal of ending the epidemic. When we remove barriers and build systems that help people prevent HIV or stay healthy and achieve an undetectable viral load that prevents transmission, we strengthen our health system as a whole. Fewer new cases means healthier communities and shared resources that can go further toward care and well-being for all.

Access to HIV prevention, treatment, and care is a human rights obligation and a core part of the right to health. The right to health is universal, and it requires HIV services to be available, accessible, and of good quality. Not only is the protection of human rights essential to safeguard human dignity in the context of HIV, but it ensures an effective, rights-based response to the epidemic.

What's needed now: equitable access, human rights, and sustained leadership and commitment, so that everyone in Canada can benefit from these life-saving advances.

Global Commitment

The Joint United Nations Programme on HIV/AIDS (UNAIDS) established a global health sector strategy on HIV to help end AIDS as a public health threat by 2030.[6] The World Health Organization (WHO) and Canada have endorsed this strategy.[7]

Human Rights

HIV is more than a health issue. It is a matter of human rights. HIV is deeply intertwined with stigma, discrimination, and inequalities reflected in laws and policies, which create barriers to prevention, treatment, and care.

A rights-based approach to ending HIV means ensuring that everyone can access prevention, testing, treatment, and care without stigma, discrimination, or criminalization. It creates the conditions for a successful HIV response and affirms the dignity of people living with, and at greater structural risk of, HIV.[8]

Laws and policies that penalize HIV non-disclosure, sex work, or drug use fuel stigma, create fear, pose barriers to prevention, and drive people away from services. Reforming these barriers is essential to ending HIV.

Health Equity

HIV does not affect everyone equally. Social and structural inequities such as poverty, racism, colonialism, sexism, homophobia, transphobia, housing instability, and unequal access to healthcare shape who is most at risk and who benefits least from progress. When we remove barriers that exclude people from care, we build health systems that better serve us all.

High Stakes

The costs of inaction are high, both human and economic.[9] Every preventable infection represents years of avoidable illness, ongoing treatment costs, and unrealized potential.

Ending the HIV epidemic requires more than medical innovation. It requires environments that make health possible for everyone. That means ensuring people at risk of HIV have the information, tools, and support they need to prevent infection, and that people living with HIV can stay healthy, thrive, and avoid onward transmission. When our systems make it easy for people to protect their health and for communities to care for one another, we move closer to a Canada where HIV transmission is rare, and everyone can live free from stigma, discrimination, and inequity.

"Our international commitments regarding HIV and AIDS are actually commitments we made to Canadians. These are commitments to prevent, test, and treat the people in our own country. We can't let them down."

- Jody Jollimore, Executive Director, CATIE

"The 90-90-90 targets [prior targets to 95-95-95] show that, in Canada by 2020, we had diagnosed nearly 90% of everyone living with HIV, but had only linked about 77% to care, with only about 73% of those in care achieving viral suppression. This means that testing efforts alone, without dedicated and established linkage-to-care pathways, may only exacerbate the inequities experienced by people living with HIV. In fact, testing for HIV without working equally hard to create safe pathways to engage and stay in care is unethical."

- Dr. Patrick O'Byrne, Professor of Nursing at University of Ottawa

WHO IS DISPROPORTIONATELY IMPACTED BY HIV IN CANADA?

HIV can affect anyone, regardless of age, sex, gender, sexual orientation, race, or ancestry. However, in Canada the HIV epidemic is concentrated among certain populations because of structural and social factors that create health inequities.[10]

Populations disproportionately impacted by HIV — often referred to as "key populations" — are frequently marginalized and/or criminalized and face a range of human rights abuses that increase their risk of acquiring HIV and create barriers to prevention, care, and treatment.[11]

These inequities are rooted in contextual factors, including the social determinants of health, as well as legal, political, and historical forces that shape vulnerability. Experiences of stigma, discrimination, and marginalization based on race or ethnicity, colonialism and intergenerational trauma, disability, immigration status, social class, sexual orientation, gender identity, drug use, incarceration, and sex work all contribute to social and structural inequities that influence health outcomes.[7] Disparities in education, employment, income, food security, mental health support, housing, and access to health and social services further compound these risks.[10] People who hold multiple marginalized identities face markedly higher levels of stigma, highlighting how intersecting social positions shape the lived experience of HIV.[12]

HIV disproportionately impacts key populations:

- gay, bisexual, and other men who have sex with men (gbMSM)
- people who use drugs (PWUD)
- sex workers
- people who have experienced incarceration
- transgender and gender-diverse people
- Indigenous people
- Two-Spirit people
- Black people
- newcomers, migrants, and immigrants to Canada from countries with high HIV prevalence

With respect to Indigenous people in particular, the evidence of discrimination and inequities in the provision of healthcare services — including lack of access to services in rural and remote areas as well as the lack of Indigenous-specific programming and culturally informed approaches — continues to pose major barriers to HIV prevention, care, and treatment.

Importantly, being part of a key population does not, in itself, constitute a risk for HIV. Rather, it is the intersection of these inequities over time that creates disproportionate vulnerability and harm.

"Stigma continues to harm people living with HIV in Canada, but its effects are unequal. Our research shows that Black and Asian people living with HIV were 1.6 and 2.5 times more likely to report greater internalized stigma compared to their white counterparts. Additionally, we found that compared to white participants, Indigenous participants were 1.6 times more likely to report greater anticipated stigma. Stigma experiences are not homogenous and it is clear that tailored approaches to eradicating stigma are urgently needed."

- REACH Nexus Stigma Index data

THE VALUE OF PREVENTION AND TREATMENT

The lifetime cost of a new HIV diagnosis in Canada is $1.44M.[9]

$1.44M
average lifetime cost of a new diagnosis in Canada

2,434
new HIV cases in Canada in 2023[5]

$3.5 B
increase in cost for 2023 alone

To end the HIV epidemic, Canada must create the conditions that make prevention and treatment easy to access and sustain.

This means ensuring:

- People at risk of HIV have real and equitable opportunities to safeguard their health through access to HIV education, testing, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), safer sex supplies, and harm reduction supplies and services.
- People living with HIV can remain healthy and prevent transmission through uninterrupted access to culturally responsive care, treatment, and support.

Prevention in Practice:
Increasing PrEP uptake in Ottawa in 2017 to 2021 coincided with a 50-60% decrease in new HIV diagnoses among men who have sex with men.[13]

A Prevention Opportunity Missed

"In December 2024, peers who use drugs in a northern community were educated on PrEP. A handful of those who recently tested negative for HIV expressed a desire to start PrEP. However, by April 2025, when we were set up with Freddie [online prescribing service] to get access to PrEP, all of them had tested positive for HIV. Every single one of them. It was devastating."
- Shohan Illsley, Executive Director, Manitoba Harm Reduction Network

"We know that early and consistent HIV treatment saves lives and stops transmission. Yet for too many people in Canada, access still depends on where they live, what kind of coverage they have, or whether they can afford the copays. If we're serious about ending HIV, we need to make sure the system itself doesn't stand in the way of people starting and staying on treatment."
- Dr. Mona Loutfy, Infectious Disease Specialist and founder of the Women and HIV Research Program

ENDING THE EPIDEMIC: GLOBAL TARGETS

Canada has committed to meeting the global targets for HIV testing and treatment. The 2025 targets are:

- **95% of people living with HIV are diagnosed**
  Ensuring widespread access to HIV testing and encouraging people to get tested to know their status.

- **95% of those diagnosed are on treatment**
  Ensuring people who test positive have access to and begin antiretroviral therapy (ART).

- **95% of those on treatment are virally suppressed**
  This target emphasizes the importance of consistent adherence to ART, which leads to undetectable viral load and prevents transmission of HIV.

In addition to the 95-95-95 targets, the *Global AIDS Strategy* includes these indicators:[4]

INDICATOR	2025 TARGET
Legal and policy environment: % of countries that have punitive legal and policy environments that affect the HIV response (i.e. that deny or limit access to services).	Less than 10%
New HIV infections	No more than 5 per 100,000 of the population
# of children 0-14 years newly infected with HIV per year	20,000 globally; domestic target needed
Number of people dying from HIV related causes per year	250,000 globally; domestic target needed
Prevention: number of needles or syringes distributed per person who injects drugs (PWID)	200
Stigma and discrimination: % of people living with HIV who experience stigma and discrimination	Less than 10%
Late-stage disease: percentage of people starting antiretroviral therapy with a CD4 count of less than 200 cells/mm3 (or stage III or IV)	No more than 20%

Additional data is needed to track Canada's progress on the number of children newly infected each year, the number of needles or syringes distributed per PWID, stigma and discrimination experienced, and late-stage disease diagnosis.[4] This data availability, and the relevance of some of these indicators in Canada, influenced the metrics chosen for this report.

METRICS TO MEASURE OUR PROGRESS

These metrics were developed in consultation with community, research, laboratory, and clinician partners and reflect the leading indicators they identified as most essential to monitoring progress, taking into account global targets and indicators. Together, they measure the policy and system conditions that enable Canada to reduce new HIV cases and achieve the 95-95-95 targets.

Metric 1: New HIV Case Rates

One of the global targets for ending the HIV epidemic is a maximum rate of new infections of 5 per 100,000 by 2025. This metric tracks how close each jurisdiction is to meeting this benchmark.

Metric 2: Prevention

HIV is a preventable infection. This metric evaluates government leadership and investment in evidence-based prevention tools:

a. The provision of **new drug use equipment and safer sex supplies** prevents transmission of HIV and other sexually transmitted and blood-borne infections (STBBI). This metric determines whether safer drug and sex supplies are available at no cost to the client or to the provider of the supplies, including in correctional facilities.

b. **PrEP** (pre-exposure prophylaxis) is a medication strategy that uses antiretroviral drugs to prevent HIV infection. When taken as prescribed, PrEP blocks HIV from replicating in the body if someone is exposed to the virus. It is recommended for individuals who are HIV-negative but have a higher risk of contracting HIV through sexual activity or injection drug use. While daily oral pills work for many, adherence remains an issue, and some populations at higher risk of HIV exposure benefit from a long-acting injectable option.[14,15] This metric determines whether a jurisdiction provides both a daily oral and a long-acting injectable PrEP option at no cost to everyone who is eligible for health insurance, with no wait periods.

Metric 3: Testing

Timely, accessible HIV testing is essential to ending the epidemic. Expanded HIV testing has been found to be cost-saving and/or cost-effective.[13] This metric assesses whether the jurisdiction has implemented three evidence-based testing strategies that reduce barriers and increase early diagnosis:

a. **Free rapid testing:** Is HIV point-of-care testing available at no cost to clients or testing services?

b. **Diverse specimen options:** Do provincial laboratories accept at least one alternative to venous blood (i.e. dried blood spot, finger prick, oral fluid) for HIV screening, confirmatory testing, or viral load monitoring?

c. **Anonymous / non-nominal testing:** Can individuals access HIV testing without providing their name? This is measured by whether all standard lab test requisition forms include a check box for non-nominal or anonymous testing requests.

Metric 4: Treatment Access and Continuity

Antiretroviral therapy is the standard of care for all individuals diagnosed with HIV, as soon as possible after diagnosis. It reduces the amount of HIV in the body (i.e. viral load) to undetectable levels (U=U), allowing individuals to live long and healthy lives and preventing transmission. Treatment is recommended for everyone diagnosed with HIV, regardless of their stage of infection, and treatment adherence (i.e. not missing doses) is essential. This metric assesses whether provincial and federal drug plans, along with related policies, enable timely and equitable access to ART and support continuity of treatment.

Metric 5: Legal Environment

The legal and policy landscape directly shapes access to prevention, care, and support. This metric assesses whether some of the jurisdiction's laws and policies support or undermine effective HIV responses. It considers: criminalization of HIV non-disclosure, sex work, and drug use; access to supervised consumption services (SCS) and needle and syringe programs (NSP) in the community; access to sterile needles and syringes in prison (PNSP).

Metric 6: Data and Evaluation

Evaluating progress toward ending HIV requires data systems that track both clinical outcomes and the social and structural factors influencing HIV risk, prevention, and care. Consistent, transparent reporting allows jurisdictions to identify gaps, allocate resources, and monitor progress toward national and global targets.

This metric assesses whether four key indicators are being monitored, evaluated, and publicly reported:

a. **PrEP Uptake:** Does the jurisdiction monitor and publicly report the number of people accessing PrEP, including by region and/or population?

b. **Care Cascade:** Are regular updates available on the HIV care cascade (diagnosed → on treatment → virally suppressed)?

c. **Key Population Reporting:** Does the jurisdiction include race/ethnicity, gender, and exposure category in annual surveillance reports of new HIV diagnoses to inform key population care cascades and targeted interventions?

d. **Stigma Monitoring:** Does the jurisdiction monitor HIV-related stigma — both in the general public and as experienced by people living with HIV — using consistent, community-informed indicators in public health surveillance or community health assessments?

KEY TAKEAWAYS

While Canada has made considerable progress toward addressing the HIV epidemic and establishing an effective care cascade, **HIV is currently on the rise**.

Progress on achieving our 95-95-95 targets has stalled and HIV remains a pressing issue in this country that has both economic and human rights implications.

Great disparities exist between provinces and territories, with **Manitoba and Saskatchewan leading by far in the number of new diagnoses nationwide.** No province or territory has met all of the 95-95-95 targets — two have met the diagnosis target, two have met the treatment target, and six have met the viral suppression target. Based on the available data, **British Columbia** is closest to achieving the 95-95-95 targets, at 95-94-96.

The 95-95-95 targets do not capture the impact of other essential prevention strategies, such as PrEP, harm reduction, or access to safer drug use and sexual health supplies. Monitoring these measures alongside treatment outcomes would give us a more complete understanding of — and help strengthen — our collective HIV prevention response.

Criminalization and punitive laws and policies continue to undermine HIV prevention, treatment, care, and human rights. Laws and policies that criminalize HIV non-disclosure, sex work, and drug use create barriers to testing, drive stigma, and increase vulnerability to HIV. Evidence-based law and policy reform is essential to building an enabling environment for HIV prevention, treatment, and care. Laws and policies that deny people, including those in prison, access to essential healthcare also increase HIV risk.

Better healthcare provider education and support for prescribing PrEP is critical to reducing new infections. Many people who could benefit from PrEP are not being offered it because healthcare providers remain uncertain about prescribing it or are uncomfortable discussing HIV risks. Improving healthcare provider training and confidence in PrEP is a key step toward preventing new HIV cases in Canada. A forthcoming update to Canada's 2017 *HIV PrEP and PEP Guidelines* will provide evidence-based recommendations to engage a broad range of healthcare providers.[15]

Cost remains a barrier to ART and PreP access in some jurisdictions. Ensuring universal, no-cost access to ART and PreP for those living with and at greater risk of contracting HIV, respectively, are key to preventing HIV transmission.

NATIONAL PROGRESS

Progress toward 95-95-95 HIV targets (2022)[3]

89% of PLHIV diagnosed › **85%** of those diagnosed on treatment › **95%** of those on treatment virally suppressed

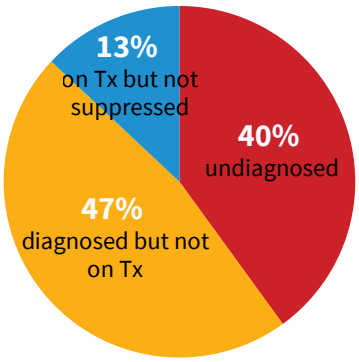
Estimated # of PLHIV (2022)[3]
65,270

New case rates per 100,000 (2023)[13]
6.1

New cases (2023)[13]
2,434

1 in 10 PLHIV
did not know their status (2022)[3]

People not engaged or represented in the HIV care continuum in Canada, 2022[4]



16,413
PLHIV not engaged in the HIV care continuum (in the 9 jurisdictions where data was available)

35%
increase in new cases from 2022 to 2023[12]

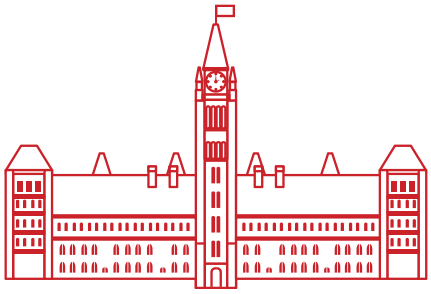
1 person
infected every 4 hours (2023)

309
HIV-related deaths (2022)[4]

"Canada's progress towards achieving the 95-95-95 targets has stalled since 2020."
- Public Health Agency of Canada Report, 2023[4]

FEDERAL HIV RECOMMENDATIONS

The Government of Canada plays a critical role in advancing HIV prevention, testing, treatment access, human rights, data collection, and health equity, particularly for key populations whose health coverage or environments fall under federal responsibility (i.e. Indigenous peoples, people in federal correctional facilities, refugee claimants, and federally funded community programs). Strong federal leadership is essential to achieving national commitments, including 95-95-95 targets and the goal of ending HIV as a public health threat by 2030.



Support Prevention

- [ ] Sustain and expand federal funding for community-based HIV prevention and harm reduction programs, including culturally grounded, Indigenous-led initiatives and tailored, low-barrier programs for other key populations.
- [ ] Improve and expand the Prison Needle Exchange Program (PNEP), addressing barriers to access; increase access to safer sex supplies, sterile tattoo/cutting equipment, and community-equivalent opioid agonist therapies across all federal prisons.

Support Diagnosis, Rapid Linkage to Care, and Viral Suppression

- [ ] Support low-barrier testing models, including community-based and peer-led testing.
- [ ] Fund community-based linkage-to-care programs to support rapid ART initiation and ongoing treatment adherence.
- [ ] Expand the Interim Federal Health Program (IFHP) to provide PrEP and ART coverage for all migrants not yet eligible for provincial/territorial drug plans as a public health measure.
- [ ] Support the development and national dissemination of evidence-based clinical guidance and training resources to help healthcare providers confidently prescribe PrEP and ART, including in rural, remote, and underserved communities.

Support an Enabling Legal Environment

- [ ] Reform the *Criminal Code* to end the criminalization of HIV non-disclosure in line with scientific evidence and human rights standards.
- [ ] Repeal provisions in the *Controlled Drugs and Substances Act* that criminalize people who use drugs and impede their access to health and harm reduction services.
- [ ] Repeal all sex work-specific offences in the *Criminal Code*.
- [ ] Support the scale-up of harm reduction services, including supervised consumption services, across the country through low-barrier federal exemptions and, if necessary, funding.
- [ ] Fund and support efforts to reduce stigma and discrimination affecting people living with HIV and key populations.

Support Data-Driven Decision Making and Accountability

- [ ] Improve national HIV surveillance by supporting standardized reporting on PrEP uptake, the care cascade by key populations, stigma indicators, and late-stage diagnoses across all provinces and territories.

ALBERTA

Estimated # of PLHIV (2022)[4]	New case rates per 100,000 (2023)	New cases (2023)	Progress toward 95-95-95 HIV targets (2022)[4]
5,534	10.8	507	92% ›XX% ›XX%

Prevention

- Some safer drug and sex supplies available at no cost in community with barriers, but not in corrections.
- Only daily oral PrEP regimens are available to everyone eligible for provincial health insurance, at no cost and with no wait period.

Testing

- Rapid HIV POC tests not available at no cost.
- Multiple specimen collection types available for HIV screening, confirmatory testing, and viral load monitoring.
- Non-nominal or anonymous lab testing not available.

Treatment Access & Continuity

- Multiple recommended ART regimens are available at no cost, with no wait times, for everyone eligible for provincial health insurance.
- All experienced, licensed prescribers can prescribe ART.
- Dispensing is available from centralized pharmacy only.
- Treatment adherence support is publicly funded.

Legal Environment

- Minimal guidance to limit prosecution for HIV non-disclosure; no measures to reduce repression of sex workers; increasing repression against PWUD; increasing barriers to SCS and NSPs; no measures taken for PNSPs.

Data & Evaluation

- Number of people accessing PrEP not regularly monitored with data publicly available.
- HIV care cascade regularly monitored with data publicly available.
- Key population metrics reported for new HIV cases included in annual surveillance reports.
- HIV stigma monitoring unknown.

Alberta has the **third-highest rate of new HIV cases** in Canada. **Amid an increasingly repressive legal environment for populations vulnerable to HIV** and **limited low-barrier testing and prevention options**, the province must strengthen **evidence-based, accessible prevention services** to complement its relatively open PrEP and ART prescribing landscape.

BRITISH COLUMBIA

Estimated # of PLHIV (2022)[4]	New case rates per 100,000 (2023)	New cases (2023)	Progress toward 95-95-95 HIV targets (2022)[4]
9,364	2.8	154	95% › 94% › 96%

Prevention

- Safer drug and sex supplies are available at no cost in community; safer sex supplies available in corrections but with barriers.
- Only daily oral PrEP regimens are available at no cost through BC-CfE, but not all applications are approved.

Testing

- Rapid HIV POC tests are available at no cost.
- Multiple specimen collection types are available for HIV screening, confirmatory testing, and viral load monitoring.
- Non-nominal or anonymous testing is available on all standard requisition forms.

Treatment Access & Continuity

- Multiple recommended ART regimens are available at no cost, with no wait times, for everyone eligible for provincial health insurance.
- All MDs and NPs can prescribe ART.
- Dispensing is available through centralized or community-based pharmacies.
- Treatment adherence support is publicly funded.

Legal Environment

- Guidance to limit prosecution for HIV non-disclosure; no measures to reduce repression of sex workers; rollback in measures to reduce repression against PWUD; SCS and NSPs supported; no measures taken for PNSPs.

Data & Evaluation

- Number of people accessing PrEP regularly monitored with data publicly available.
- HIV care cascade regularly monitored with data publicly available.
- Some key population metrics reported for new HIV cases included in annual surveillance reports.
- HIV stigma monitoring unknown.

With the **second-lowest provincial new HIV case rates**, **strong public data dashboards**, and policies that support **low-barrier testing** and **fully covered ART and PrEP regimens**, British Columbia (BC) is close to achieving global targets. Opportunities to further strengthen BC's HIV response include addressing community reports of **inconsistent PrEP approvals**, gaps in the **legal environment** for people vulnerable to HIV, and a next step of **key-population care-cascade reporting**.

MANITOBA

Estimated # of PLHIV (2022)[4]	New case rates per 100,000 (2023)	New cases (2023)	Progress toward 95-95-95 HIV targets (2022)[4]
2,662	20.2	280	81% › 83% › 78%

Prevention

- Safer drug and sex supplies are available at no cost in community; safer sex supplies available in corrections.
- Only daily oral PrEP regimens are available to everyone eligible for provincial health insurance at no cost and with no wait period.

Testing

- Rapid HIV POC tests are available at no cost.
- Multiple specimen collection types are available for HIV screening, confirmatory testing, and viral load monitoring.
- Non-nominal or anonymous lab testing is not available.

Treatment Access & Continuity

- Multiple recommended ART regimens are available at no cost, with no wait times, for everyone eligible for provincial health insurance.
- All experienced MDs, NPs, and HIV Pharms can prescribe ART.
- Dispensing is available through community-based pharmacies.
- Treatment adherence support is not publicly funded.

Legal Environment

- No guidance to limit prosecution for HIV non-disclosure; no measures to reduce repression of sex workers; new coercive measures regarding PWUD; some support for SCS and NSPs; no measures taken for PNSPs.

Data & Evaluation

- Number of people accessing PrEP not regularly monitored with data publicly available.
- HIV care cascade regularly monitored with data publicly available.
- Some key population metrics reported for new HIV cases included in annual surveillance reports.
- HIV stigma monitoring unknown.

Manitoba now has the **highest rate of new HIV cases in Canada**, with transmission occurring primarily among people who inject drugs. Rates have tripled since 2019 and are projected to keep rising. The province must urgently prioritize **evidence-based prevention tools**, including treatment as prevention, and create a **legal environment that supports rather than deters** people from accessing HIV care and prevention services.

NEW BRUNSWICK

Estimated # of PLHIV (2022)	New case rates per 100,000 (2023)	New cases (2023)	Progress toward 95-95-95 HIV targets, combined NB and PE (2022)[4]
unknown	4.9	41	88% › 99% › 97%

Prevention

- Safer drug and sex supplies are available at no cost in community, but not in corrections.
- Only oral PrEP regimens are available to everyone eligible for provincial health insurance. Full or shared coverage based on the rules of the drug plan, but manufacturer support programs cover out-of-pocket costs for branded products.

Testing

- Rapid HIV POC tests are available at no cost.
- Multiple specimen collection types are available for HIV screening, confirmatory testing, and viral load monitoring.
- Non-nominal or anonymous lab testing is available by request, but not on standard lab requisition form.

Treatment Access & Continuity

- Multiple ART regimens are available, but copays or deductibles create cost barriers for people eligible for provincial health insurance, based on the rules of the drug plan.
- Only MDs can prescribe ART.
- Dispensing is available through designated centralized pharmacies.
- Treatment adherence support funding is unknown.

Legal Environment

- No guidance to limit prosecution for HIV non-disclosure; no measures to reduce repression of sex workers or PWUD; SCS and NSPs supported; no measures taken for PNSPs.

Data & Evaluation

- Number of people accessing PrEP not regularly monitored with data publicly available.
- HIV care cascade regularly monitored with data publicly available.
- Some key population metrics reported for new HIV cases included in annual surveillance reports.
- HIV stigma monitoring unknown.

Although New Brunswick's **new HIV case rates remain low**, access to PrEP and ART is **constrained by copays**, the **reluctance** of many primary care providers to prescribe PrEP (leaving most prescribing to specialists), and physician-only ART prescribing. **Testing policies are quite accessible**, but the care cascade indicates a need to increase opportunities for diagnosis.

NEWFOUNDLAND

Estimated # of PLHIV (2022)	New case rates per 100,000 (2023)	New cases (2023)	Progress toward 95-95-95 HIV targets (2022)[4]
unknown	3.5	19	95% › 88% › 98%

Prevention

- Safer drug and sex supplies are available at no cost in community; only safer sex supplies available in corrections, and with barriers.
- Oral and injectable PrEP regimens available to everyone eligible for provincial health insurance. Full or shared coverage based on the rules of the drug plan, but manufacturer support programs cover out-of-pocket costs for branded products.

Testing

- Rapid HIV POC tests not available.
- Multiple specimen collection types are not available for HIV screening, confirmatory testing, and viral load monitoring.
- Non-nominal or anonymous lab testing is available by request at two clinics, but not on standard lab requisition form.

Treatment Access & Continuity

- Multiple ART regimens are available, but copays or deductibles create cost barriers for people eligible for provincial health insurance, as per the drug plan rules.
- All MDs and NPs can prescribe ART.
- Dispensing is available through community-based pharmacies.
- Treatment adherence support is not publicly funded.

Legal Environment

- No guidance to limit prosecution for HIV non-disclosure; no measures to reduce repression of sex workers; SCS not supported; NSPs supported; no measures taken for PNSPs.

Data & Evaluation

- Number of people accessing PrEP not regularly monitored with data publicly available.
- HIV care cascade regularly monitored with data publicly available.
- Key population metrics not reported for new HIV cases included in annual surveillance reports.
- HIV stigma monitoring unknown.

Although Newfoundland and Labrador's new HIV case rates remain relatively low, both reports from community and the care cascade indicate that persistent barriers — including **unaffordable copays**, **long wait times for assessment**, and **limited primary care provider knowledge about PrEP and HIV care** — hinder timely access to both PrEP and ART and require **provincial action to support an equitable, public-health approach to HIV**.

NOVA SCOTIA

Estimated # of PLHIV (2022)	New case rates per 100,000 (2023)	New cases (2023)	Progress toward 95-95-95 HIV targets (2022)[4]
unknown	3.1	33	87% › 88% › 93%

Prevention

- Safer drug and sex supplies available at no cost in community; only safer sex supplies available in corrections, and with barriers.
- Oral and injectable PrEP regimens available to everyone eligible for provincial health insurance. Full or shared coverage based on the rules of the drug plan, but manufacturer support programs cover out-of-pocket costs for branded products.

Testing

- Rapid HIV POC tests are available at no cost.
- Multiple specimen collection types are not available for HIV screening, confirmatory testing, and viral load monitoring.
- Non-nominal or anonymous lab testing is available by request at two clinics, but not on standard lab requisition form.

Treatment Access & Continuity

- Multiple recommended ART regimens are available at no cost, with no wait times, for everyone eligible for provincial health insurance.
- All MDs and NPs can prescribe ART.
- Dispensing is available through centralized pharmacies and can be mailed at no cost if needed.
- Treatment adherence support is not publicly funded.

Legal Environment

- No guidance to limit prosecution for HIV non-disclosure; no measures to reduce repression of sex workers or PWUD; some support for SCS and NSPs; no measures taken for PNSPs.

Data & Evaluation

- Number of people accessing PrEP not regularly monitored with data publicly available.
- HIV care cascade regularly monitored with data publicly available.
- Some key population metrics (i.e. gender) reported for new HIV cases included in annual surveillance reports.
- HIV stigma monitoring unknown.

While Nova Scotia's **new HIV case rates remain low** and **ART is available without copays**, **barriers persist** for some — including **copays** for some who would benefit from PrEP, a lack of publicly funded **adherence supports**, and **uneven access to low-barrier testing** — highlighting opportunities for a more equitable and coordinated provincial approach to HIV prevention and care.

ONTARIO

Estimated # of PLHIV (2022)[4]	New case rates per 100,000 (2023)	New cases (2023)	Progress toward 95-95-95 HIV targets (2022)[4]
23,172	4.6	723	90% › 86% › 98%

Prevention

- Safer drug and sex supplies available at no cost in community with barriers, safer sex supplies available in corrections with barriers.
- Oral and injectable PrEP regimens available to everyone eligible for provincial health insurance. Full or shared coverage based on the rules of the drug plan, but manufacturer support programs cover out-of-pocket costs for branded products.

Testing

- Rapid HIV POC tests are available at no cost.
- Multiple specimen collection types are not available for HIV screening, confirmatory testing, and viral load monitoring.
- Non-nominal or anonymous lab testing is available by request at specific clinics, but not on standard lab requisition form.

Treatment Access & Continuity

- Multiple ART regimens are available, but copays or deductibles create cost barriers for people eligible for provincial health insurance, as per the drug plan rules.
- All MDs and NPs can prescribe ART.
- Dispensing is available in community-based pharmacies.
- Treatment adherence support is not publicly funded.

Legal Environment

- Minimal guidance to limit prosecution for HIV non-disclosure; increasing repression against sex workers and PWUD; increasing barriers to SCS and NSPs; no measures taken for PNSPs.

Data & Evaluation

- Number of people accessing PrEP regularly monitored with data publicly available.
- HIV care cascade regularly monitored with data publicly available.
- Key population metrics reported for new HIV cases included in annual surveillance reports.
- HIV stigma monitored.

Ontario benefits from the **strongest publicly available HIV data dashboards** and **programs that help mitigate copays and deductibles**, yet its care cascade shows a need for **improved linkage to treatment supports following diagnosis**, and the **increasingly repressive legal environment** for populations vulnerable to HIV highlights key areas for improvement.

PRINCE EDWARD ISLAND

Estimated # of PLHIV (2022)	New case rates per 100,000 (2023)	New cases (2023)	Progress toward 95-95-95 HIV targets, combined NB and PE (2022)[4]
unknown	2.4	4	88% › 99% › 97%

Prevention

- Safer drug and sex supplies available at no cost in community, but not in corrections.
- Only daily oral PrEP regimens available to everyone eligible for provincial health insurance, at no cost and with no wait period.

Testing

- Rapid HIV POC tests available at no cost.
- Multiple specimen collection types are available for HIV screening, confirmatory testing, and viral load monitoring.
- Non-nominal or anonymous lab testing is available by request at one location, but not on standard lab requisition form.

Treatment Access & Continuity

- Multiple recommended ART regimens are available at no cost, with no wait times, for everyone eligible for provincial health insurance.
- All MDs and NPs can prescribe ART.
- Dispensing is available through a centralized pharmacy and couriered if needed at the client's cost.
- Treatment adherence support is publicly funded.

Legal Environment

- No guidance to limit prosecution for HIV non-disclosure; no measures to reduce repression of sex workers; no measures taken for PNSPs.

Data & Evaluation

- Number of people accessing PrEP not regularly monitored with data publicly available.
- HIV care cascade regularly monitored with data publicly available.
- Key population metrics not reported for new HIV cases included in annual surveillance reports.
- HIV stigma monitoring unknown.

PEI's **new HIV case rates are very low**, and the province offers **fully covered PrEP and ART** along with **publicly funded navigation and adherence supports.** Reports from community indicate the **centralized dispensing system creates access barriers** for some, particularly rural patients who must travel or pay courier costs, presenting an opportunity to ensure equitable access across the province.

QUEBEC

Estimated # of PLHIV (2022)[4]	New case rates per 100,000 (2023)	New cases (2023)	Progress toward 95-95-95 HIV targets (2022)[4]
19,101	5.4	unknown	89% › 82% › 96%

Prevention

- Safer drug and sex supplies available at no cost in community; safer sex supplies available in corrections.
- Oral and injectable PrEP regimens available to everyone eligible for provincial health insurance. Full or shared coverage based on the rules of the drug plan but manufacturer support programs cover all out-of-pocket costs.

Testing

- Very limited availability of rapid HIV POC tests at no cost.
- Very limited multiple specimen collection type options available for HIV screening, confirmatory testing, and viral load monitoring.
- Non-nominal or anonymous lab testing is available by request at some locations, but not on standard lab requisition form.

Treatment Access & Continuity

- Multiple ART regimens are available, but copays or deductibles create cost barriers for some people eligible for provincial health insurance, based on the rules of the drug plan.
- Experienced MDs, NPs, and Pharms can prescribe ART.
- Dispensing is available from community-based pharmacies
- Treatment adherence support is not publicly funded.

Legal Environment

- Minimal guidance to limit prosecution for HIV non-disclosure; no measures to reduce repression of sex workers; some measures to reduce repression against PWUD; increasing barriers to SCS; no measures taken for PNSPs.

Data & Evaluation

- Number of people accessing PrEP not regularly monitored with data publicly available.
- HIV care cascade regularly monitored with data publicly available.
- Some key population metrics reported for new HIV cases included in annual surveillance reports.
- HIV stigma monitoring unknown.

Quebec's **new HIV case rates are very close to global targets**, but the care cascade indicates a need to **improve diagnosis and linkage to treatment.** Opportunities for a stronger and more equitable HIV response include **expanded low-barrier testing**, **elimination of ART copays and deductibles**, and **publicly funded adherence supports**. Quebec should not move backwards on an enabling legal environment.

SASKATCHEWAN

Estimated # of PLHIV (2022)[4]	New case rates per 100,000 (2023)	New cases (2023)	Progress toward 95-95-95 HIV targets (2022)[4]
3,754	19.4	233	76% › 73% › 84%

Prevention

- Safer drug and sex supplies have very limited availability at no cost in community; availability in corrections unknown.
- Oral and injectable PrEP regimens available to everyone eligible for provincial health insurance, at no cost and with no wait period.

Testing

- Rapid HIV POC tests are available at no cost.
- Multiple specimen collection types are available for HIV screening, confirmatory testing, and viral load monitoring.
- Non-nominal or anonymous lab testing availability unknown.

Treatment Access & Continuity

- Multiple recommended ART regimens are available at no cost, with no wait times, for everyone eligible for provincial health insurance.
- Approved MDs, NPs, and Pharms with collaborative prescribing agreement can prescribe ART.
- Dispensing is available in community-based pharmacies
- Treatment adherence support unknown.

Legal Environment

- No guidance to limit prosecution for HIV non-disclosure; no measures to reduce repression of sex workers; increasing repression of PWUD; increasing barriers to SCS and NSPs; no measures taken for PNSPs.

Data & Evaluation

- Number of people accessing PrEP not regularly monitored with data publicly available.
- HIV care cascade regularly monitored with data publicly available.
- Some key population metrics reported for new HIV cases included in annual surveillance reports.
- HIV stigma monitoring unknown.

With Saskatchewan experiencing the country's **second-highest rate of new HIV cases**, and with community reporting high rates of **stigma** and a **lack of evidence-based policy choices**, the province must provide strong leadership to **coordinate services**, support **effective linkage to care**, and create a **legal environment that enables — rather than hinders — HIV prevention and care**.

YUKON

Estimated # of PLHIV (2022)[4]	New case rates per 100,000 (2023)	New cases (2023)	Progress toward 95-95-95 HIV targets, (2022)[4]
82 YT, NW, NU combined	2.2 YT, NW, NU combined	unknown	92% › XX% › XX% YT, NW, NU combined

Prevention

- Safer drug and sex supplies available at no cost in community, but not in corrections.
- Only oral PrEP regimens available to everyone eligible for territorial health insurance, at no cost and with no wait period.

Testing

- Rapid HIV POC tests not available.
- Multiple specimen collection types not available for HIV screening, confirmatory testing, and viral load monitoring. (Only very limited POC options.)
- Testing under an alias is available by request, but no non-nominal or anonymous testing option on standard lab requisition form.

Treatment Access & Continuity

- Multiple ART regimens are available, but copays or deductibles create cost barriers for people eligible for provincial health insurance, based on the rules of the drug plan.
- Only IDs can prescribe ART.
- Dispensing is available in community-based pharmacies.
- Treatment adherence support is not publicly funded.

Legal Environment

- Federal guidance to limit prosecution for HIV non-disclosure applies; no specific measures to reduce repression of sex workers or PWUD; SCS and NSPs supported; no measures taken for PNSPs.

Data & Evaluation

- Number of people accessing PrEP not regularly monitored with data publicly available.
- HIV care cascade regularly monitored with data publicly available.
- Key population metrics reporting in annual surveillance reports unknown.
- HIV stigma monitoring unknown.

Although **HIV prevalence and new case rates remain very low** across the three territories, including Yukon, opportunities exist to strengthen an equitable HIV response through **lower-barrier testing** and **expanded prescriber** options.

ENABLING LEGAL ENVIRONMENT

A rights-based approach is essential to ending the HIV epidemic. Such approaches affirm the dignity of people living with and at greater structural risk of HIV, and create the legal and social conditions necessary for effective prevention, treatment, and care.[8]

Through the Sustainable Development Goals, Canada and other United Nations Member States have committed to leaving no one behind and to ending the HIV epidemic by 2030. Achieving this requires dismantling stigma, discrimination, and legal, human rights, social, and gender-related barriers that increase vulnerability to HIV and limit access to prevention, treatment, and care services.[8]

The *Global AIDS strategy* that Canada supports includes a commitment to creating an **enabling legal environment** to ensure that:

- less than 10% of countries have punitive legal and policy environments that deny or limit access to services;
- less than 10% of people living with HIV and key populations experience stigma and discrimination; and
- less than 10% of women, girls, people living with HIV, and key populations experience gender inequality and violence.

Laws targeting people living with HIV or key populations reduce service uptake, increase HIV incidence, and deepen inequities. Law and policy reforms, including decriminalization of key populations, are essential to removing barriers to access to prevention, treatment, and care for the most marginalized and improve health outcomes.[8]

This includes:

- decriminalizing HIV non-disclosure;
- decriminalizing sex work; and
- decriminalizing activities related to drug use.

Criminalization and Marginalization of Key Populations

Despite Canada's human rights advances, including around the decriminalization and protection of 2SLGBTIQ+ communities,[17] many key populations, including people living with HIV, sex workers, and people who use drugs, continue to face criminalization and marginalization that undermine their health and safety.

Canada has long been known for its harsh laws punishing **HIV non-disclosure**, which fuel stigma and can discourage testing and treatment. Laws prohibiting sex work marginalize and endanger sex workers, heightening their risk of violence and hampering their access to HIV services. And while Canada has taken some progressive steps in drug policy at the federal level, efforts to decriminalize personal drug use in Canada have stalled and even regressed. In several provinces, people who use drugs — particularly those also experiencing homelessness — face increased repression alongside policies that restrict access to harm reduction services, voluntary treatment, shelter, and housing.

Incarceration further compounds these harms. People in prison continue to be denied equivalent access to healthcare and harm reduction measures available in the community, increasing HIV risks in prison.

The federal government has acknowledged that stigma, discrimination, and criminalization are major barriers to effective STBBI prevention and care. The Government of Canada's *STBBI Action Plan 2024-2030* commits to supporting First Nations, Inuit, and Métis leadership and self-determination, addressing stigma, and advancing work to reduce the over-criminalization of HIV non-disclosure, as well as diverting people who use drugs away from the criminal legal system. However, the plan is silent on other forms of criminalization that continue to undermine Canada's HIV response.

To meet its international commitments, Canada must make bolder commitments to a comprehensive, rights-based approach that replaces punishment with support and removes all legal and policy barriers to HIV prevention, care, and treatment.

The Criminalization of HIV Non-Disclosure

In Canada, people living with HIV can be charged, prosecuted, convicted, and imprisoned for not disclosing they have HIV before sex — often under the charge of aggravated sexual assault, one of the most serious offences in the *Criminal Code*. If convicted, they can face a life sentence and mandatory registration as a sex offender. No other medical condition is treated in this way.[18]

Canada is known internationally for its harsh approach to HIV non-disclosure (often referred to as HIV criminalization). While often justified as a public health measure, HIV criminalization in fact undermines HIV prevention, treatment, care, and support. Fear of prosecution can dissuade people from getting tested, disclosing their status, or seeking care, directly contradicting public health goals.

More than 200 people have been charged to date in relation to HIV non-disclosure.[19] HIV criminalization infringes the human rights of people living with HIV, who are often also members of other marginalized, stigmatized, and/or criminalized communities:

- Black people make up 4.3% of the population in Canada but represent at least 22% of those criminally charged in cases of alleged HIV non-disclosure.[20]
- Many of the women who have been charged are Indigenous.[21] Some are survivors of sexual violence, revealing how HIV criminalization compounds existing inequities and violence against people living with HIV.

There is no specific offence of "HIV non-disclosure" in the *Criminal Code*. Instead, courts have interpreted non-disclosure before sex that poses a "realistic possibility" of transmission as possibly invalidating consent. This test, established by the Supreme Court in 1998, has been applied inconsistently across provinces, and prosecutors have not always kept pace with scientific advancements showing that individuals on effective treatment or using prevention methods pose no realistic risk of transmission.[22]

The federal government has acknowledged the harms of over-criminalization[23] and has taken some measures to limit criminal prosecutions. In 2018, the federal Attorney General issued a directive limiting HIV-related prosecutions. However, the directive only applies in federal jurisdictions (i.e. Yukon, Northwest Territories, and Nunavut). Only some provinces have adopted guidance, including BC, Alberta, Ontario, and Quebec.[24]

While guidelines for prosecutors can help prevent some arbitrary arrests and prosecutions, transformative change can only come with law reform. Advocates have long called for reform, including the removal of HIV non-disclosure from sexual assault law and aligning the law with current science.[25]

Although the federal government announced consultations on law reform in 2022, no action has followed. As a result, people living with HIV continue to face fear, stigma, and criminalization, despite clear evidence that punitive laws do not protect public health.

"People living with HIV have been living under the heavy threat of criminalization for decades. We cannot continue to wait for change, and for the 'justice' system to catch up with science and human rights. We need the Government of Canada to act now, alongside a community that is experiencing harms daily."
- Colin Johnson, activist living with HIV and member of the Canadian Coalition to Reform HIV Criminalization's Steering Committee[26]

The Criminalization of Sex Work

Sex workers in Canada continue to face numerous human rights violations. The criminalization of sex work — and the stigma that accompanies it — forces sex workers to live and work in precarious circumstances that diminish their control over their working conditions and increase the risk of violence, other abuse, and HIV. In contrast, the decriminalization of sex work has been shown globally to improve safety, autonomy, and health outcomes for sex workers.

Efforts to improve the health and safety of sex workers and prevent HIV must begin with **respect for sex workers' autonomy, dignity, and human rights. Decriminalizing sex work is a necessary first step**.

In 2013, the Supreme Court of Canada delivered a landmark decision ruling that the *Criminal Code*'s provisions prohibiting various aspects of sex work violated sex workers' rights protected by the *Canadian Charter*.[27]

In response, the federal government adopted the *Protection of Communities and Exploited Persons Act* (PCEPA) in 2014,[28] a law that continues to prohibit all aspects of sex work. The Act criminalizes public communication for the sale of sexual services, purchasing or communicating to purchase sex (i.e. criminalizing clients), materially benefiting from sex work, procuring, and advertising sex work, while providing sex workers some immunity from prosecution.[29]

More than 10 years later, sex workers in Canada still risk prosecution, arrest, and deportation. They face constraints on communicating the terms and conditions of sex, working with third parties, and operating from a fixed indoor location. Indigenous, Black, trans, and migrant women are particularly targeted and over-policed under PCEPA.[30] Migrant sex workers are also penalized under immigration laws that prohibit people without permanent status from working in sex work settings.[31]

"Sex workers who are Indigenous, Black, migrant, and trans experience the most harmful impacts of the criminalization of sex work, as we are communities that are already overpoliced and underprotected. We need sex work laws removed from the *Criminal Code* so there is at least one less tool law enforcement can use against us."[32]
- Monica Forrester, Ontario-based sex worker and one of the applicants challenging PCEPA in court

As long as sex work remains criminalized, sex workers cannot realize their rights to security of the person, liberty, autonomy, health, equality, and just and favourable conditions of work — rights protected under both the *Canadian Charter* and international human rights law. For more than a decade, sex worker-led organizations, including the member groups of the Canadian Alliance for Sex Work Law Reform, have called for the repeal of all sex work-specific criminal laws and the engagement of provincial legislation related to occupational health and safety, employment standards, and public health to address rights violations faced by sex workers.[33]

In 2022, a federal committee studying PCEPA concluded that "the Act causes serious harm to those engaged in sex work by making the work more dangerous."[34] Despite this finding, the federal government has taken no action to reform the sex work laws, and rather has defended these laws in court.

Instead, significant public funding of anti-human trafficking initiatives has led to harmful surveillance, raids, arrests, and deportations of sex workers. **Anti-human trafficking efforts that focus on eradicating sex work instead of promoting the rights of sex workers increase rather than address abuses against sex workers**, forcing them to work in greater secrecy and isolation, increasing their vulnerability to targeted violence, and creating barriers to the HIV response.

"Local police services, including Saskatoon and Regina, have vice or specialized units that conduct targeted operations. Enforcement tends to focus on purchasers and related offences, but these laws still create barriers and risks for sex workers across the province."

- Miranda Deck, Communications Manager, Prairie Harm Reduction, Saskatchewan

The Criminalization of People Who Use Drugs

In Canada, drug use continues to be largely treated as a criminal law issue with immediate impacts on the health of people who use drugs. Since 2016, more than 53,000 people have died from the toxic, unregulated drug supply, with Indigenous people disproportionately affected.[35] And yet, access to healthcare and social services, including housing and shelter, is limited and people who use drugs continue to face criminalization and human rights violations.

Extensive evidence shows that the reliance on criminal law enforcement (commonly known as "the war on drugs") carries enormous financial costs and takes a terrible human toll on people who use drugs. Furthermore, criminalizing and incarcerating people for drug use or denying access to effective health services only fuels the spread of infections such as HIV and hepatitis C (HCV). Notably, injection drug use is the second most reported HIV exposure category among women in Canada.[36] Protecting and promoting the human rights of people who use drugs is necessary and effective in both upholding their right to health and preventing HIV.

In Canada, the federal *Controlled Drugs and Substances Act* (CDSA) prohibits simple possession, meaning it is a crime to possess "controlled substances" such as opioids, cocaine, methamphetamines, and ecstasy, even for personal use. Increasingly, people who use drugs are also facing drug trafficking charges and more severe punishments for trafficking convictions,[37] with Black and Indigenous people in Canada being disproportionately charged, prosecuted, and incarcerated for drug offences.[38,39]

Health Canada Expert Task Force on Substance Use: Drug Policy and Reconciliation

"Canada's colonial policies and systems cause harm to First Nations, Inuit, and Métis people, families, and communities by disconnecting them from the strengths held within their nationhood, language, land, and culture. (…) Reconciliation for First Nations, Inuit, and Métis people, families, and communities in Canada requires equitable resource capacity to ensure access to distinctions-based services that are culture- and land-based; a trauma informed continuum of care; harm reduction services; and evidence informed by people who use drugs and alcohol (…) Immediate, comprehensive policy change is needed to redress the historical and ongoing harms to First Nations, Inuit, and Métis people, families, and communities.

For First Nations:

- who have a history of trauma, the odds of using opioids in a harmful way are 2.9 times greater than those who do not have a history of trauma.
- who are experiencing grief and loss, the odds of using opioids in a harmful way are 2.8 times greater than those who did not experience grief or loss."[40]

In addition to federal legislation prohibiting simple possession, some provincial and municipal laws and police operations punish activities related to drug use that occur at the intersection of poverty and homelessness.[41] These laws and operations increase repression against the most marginalized people who use drugs. The current context in Canada is also marked by growing attempts by some provinces and municipalities to limit harm reduction services and authorize involuntary treatment and detention of people who use drugs.

While falling short of adopting necessary law reform decriminalizing drug possession for personal use, the federal government has acknowledged the negative health and social impacts of criminalizing people who use drugs and **committed to support policies and approaches that "divert people who use drugs away from the criminal justice system and towards health and social services."**[7,42]

These federal measures include:

- The 2017 *Good Samaritan Drug Overdose Act*, which provides limited immunity from arrest and prosecution for simple possession for individuals who seek emergency help during an overdose.
- 2020 guidance to drug prosecutors from the Public Prosecution Service of Canada to limit simple possession prosecutions.
- 2022 CDSA amendments requiring peace officers and prosecutors to consider alternatives to laying or proceeding with charges for simple drug possession, recognizing that "problematic substance use should be addressed primarily as a health and social issue." (This led to a prosecutorial directive in Quebec limiting prosecutions related to simple drug possession.[43])

In 2023, British Columbia secured a CDSA exemption from Health Canada to decriminalize personal possession of up to a cumulative 2.5 grams total of opioids, crack, or powder cocaine, methamphetamine, or ecstasy by people over the age of 18 in specific locations only.[44] But in 2024, the federal government rejected the City of Toronto's request to decriminalize personal drug possession[45] and BC recriminalized public drug possession.

After a long-term decline, rates of police-reported drug crime increased from 2023-2024.

In 2014, 75% of all drug offences were possession charges, compared to 42% in 2024. This decline was likely driven by cannabis legalization in 2018 and changes in police practices following federal and provincial initiatives to limit simple possession charges. However, police-reported drug crime rose in 2024,[46] fueled by increasingly coercive and punitive approaches to drug use spreading across the country.

Canada must not turn back.[47]

People who use drugs and human rights organizations continue to mobilize to reform Canada's drug laws, urging governments to move away from punishment, fully decriminalize people who use drugs,[48] and adopt a rights-based, pragmatic model of legal regulation for all drugs.[40]

Legal and Policy Barriers Preventing Access to Harm Reduction and Care for People Who Use Drugs

Harm reduction is an evidence-based, public health approach that reduces the health, social, and economic harms associated with substance use, including HIV, HCV, and other STBBI. Grounded in human rights and justice, harm reduction principles include supporting people without judgment, coercion, discrimination, or requiring that they stop using drugs as a precondition of support.[49] It is a vital component of Canada's HIV response and integral to both the *STBBI Action Plan 2024-2030*[7] and the *Canadian Drugs and Substances Strategy*.[42]

Despite overwhelming evidence of its effectiveness, harm reduction remains highly politicized and vulnerable to shifting political priorities. Stigma, criminalization, and discrimination against people who use drugs continue to impede access to care and weaken political and financial support for these services. In addition, legal and policy barriers specific to harm reduction services continue to be erected at all levels of government.

"[Folks that are multiply marginalized] are going to be less inclined to come physically down to access the [supervised consumption] services because (…) they are just putting themselves in an environment downtown where police interaction is more likely to occur, and why take that risk necessarily if you can hopefully find other ways of acquiring harm reduction supplies from friends. And again, that works until it doesn't, and it obviously takes the one time where you share a needle and you contract a blood-borne illness."[37]

- Harm Reduction Worker from Ontario

"Anytime someone fears police, we know that increases isolation. It decreases the likelihood of accessing services, it decreases our ability to find someone in need of help during a toxic drug interaction. Part of the point of decriminalization is to make sure people get the care they need, including access to harm reduction. BC's recriminalization of drug use in public spaces is a dangerous step backwards."

- DJ Larkin, Executive Director, Canadian Drug Policy Coalition

NB: This report focuses on two essential harm reduction interventions for preventing HIV among people who use drugs: supervised consumption services (SCS) and needle and syringe programs (NSP). Other critical programs, such as safe supply or opioid agonist therapy, also play key roles and are subject to important legal and policy developments, but are not covered in depth here.

Supervised Consumption Services

Supervised consumption services (SCS) provide safe, hygienic spaces where people can use drugs under the supervision of trained staff or volunteers. These evidence-based health services prevent overdose (or toxic drug) deaths, reduce HIV and HCV transmission through harm reduction education and supplies, and connect clients to health and social support services. They also lessen public drug use and discarded drug use equipment.[50]

Canada's *STBBI Action Plan 2024–2030* and *Canadian Drugs and Substances Strategy* both include commitments to support the establishment of SCS and temporary overdose prevention sites through streamlined federal approvals, in collaboration with provinces and territories.[7]

HIV continues to disproportionately affect women who use drugs in Canada.
In 2022, 36% of HIV cases among women and girls aged 15 and older were linked to injection drug use, compared to 13% among men and boys. Gender-based violence and other inequities heighten these risks. Gender-sensitive and culturally appropriate SCS can provide not only safer conditions for drug use but also a refuge from violence and an entry point to care.

To operate legally, SCS must receive a federal exemption from Health Canada. While Health Canada's flexible approach in recent years has allowed expansion of SCS, service implementation is scaling back. Plans to develop a stable, long-term regulatory framework have stalled, and Health Canada has reportedly added new requirements for exemption applications, likely in response to provincial pushback, making it more difficult to operate SCS.

In some provinces, access has deteriorated sharply. In Ontario alone, at least 10 sites have closed in 2025. **Some provincial governments have withdrawn funding and/or have passed restrictive legislation, forcing existing sites to close and preventing new sites from opening.** These measures undermine Canada's public health commitments and threaten to reverse hard-won progress in preventing HIV, HCV, and overdose deaths.

"I do think that [the forced closure of the only SCS in Thunder Bay by the Ontario government] is going to continue to drive [drug] use underground (…) There's going to be more and more risk taking, which means there will be more and more fatalities, but there [will] also be more and more infectious diseases spread through this as well."[51]
- Holly Gauvin, Executive Director of Elevate NWO, a harm reduction agency based in Thunder Bay, speaking about the Ontario government's forced closure of SCS in 2025

Needle and Syringe Programs

Needle and syringe programs (NSP) have operated in Canada for nearly four decades, providing new drug use equipment to prevent the spread of HIV, HCV, and other infections. NSPs are among the most effective and well-established harm reduction programs in the world, with extensive evidence showing their benefits for both individual and public health.

While there are no federal legal or policy barriers to NSPs, new restrictions have begun to appear in some provinces, including Saskatchewan and Ontario. These include prohibitions on the types of equipment that can be distributed, how it may be provided, and where the programs can operate. Such measures reflect a troubling reversal of Canada's long-standing commitment to harm reduction and threaten to erode progress toward ending HIV and other STBBI transmission.

"A growing number of harm reduction services in Alberta, which have been central responses to the HIV epidemic, are now being defunded. What will their closure mean for Albertans? Without access to wrap-around services that include best harm reduction practices, blood-borne and sexually transmitted infections will rise. Hospital use and costs will also increase due to more skin, organ and bone infections, more ICU stays, and even amputations. The cost of infections like these is a high price to pay compared to a harm reduction kit that costs around a dollar."

- Bonnie Larson,
Clinical Assistant Professor in the University of Calgary Department of Family Medicine

Healthcare and Harm Reduction in Prisons

HIV and HCV are far more prevalent in Canadian prisons than in the general population. This is partly because communities already disproportionately affected by HIV — including people who use drugs and Indigenous people — also face disproportionate rates of incarceration. But it also reflects health services in prison that are not equivalent to those available outside prison, which is a violation of human rights.[52]

Limited access to **opioid agonist therapy, condoms and safer sex supplies, sterile injection equipment, and other harm reduction measures** drives HIV and HCV transmission in prisons and increases public health costs. Although some correctional systems have policies supporting safer sex supplies, access remains inconsistent and stigmatized. Often, people in prison must request these supplies from staff, deterring use in environments where sex is treated as prohibited behaviour.

Access to other harm reduction services in prison is even more scarce. Despite documented drug use and injection in correctional settings, the Correctional Service of Canada (CSC) is the only jurisdiction to operate a Prison Needle Exchange Program (PNEP), currently in 11 federal institutions. The program was introduced in 2018 following a lawsuit by a former prisoner and community partners.[53] However, the program remains largely inaccessible.[54] This falls short of the commitment in the federal *STBBI Action Plan 2024-2030* to expand needle exchange and overdose prevention programs in all federal correctional facilities.

Mass Incarceration of Indigenous People in Canada

Indigenous people make up 32% of the federal prison population but only 5% of the adult population in Canada. Among women, the disparity is even greater — about half of federally incarcerated women are Indigenous. This overrepresentation stems from the enduring impacts of colonialism and systemic racism and contributes to poorer health outcomes, including increased risk of HIV, HCV, and toxic drug injuries and death.

Both the Truth and Reconciliation Commission and the National Inquiry into Missing and Murdered Indigenous Women and Girls have called on all governments to reduce overincarceration and ensure culturally safe and appropriate health and harm reduction services in prisons.[55]

To uphold the right to health for people in prison, all jurisdictions must ensure meaningful access to healthcare and harm reduction, equivalent to community standards. At minimum, this includes access to:

- safer sex supplies;
- opioid agonist therapy;
- STBBI education, testing, treatment, and counselling;
- PrEP and PEP;
- new drug-use equipment; and
- safer tattooing and skin-piercing services.[55]

"The mass incarceration of Indigenous people is a direct continuation of colonial laws and policies that have displaced, criminalized, and marginalized Indigenous communities for generations. Harm reduction must address these systemic harms by supporting Indigenous-led, culturally grounded approaches that restore power, self-determination, and wellness for First Nations, Inuit, and Métis people, both in prison and in the community."

- Trevor Stratton, Indigenous Leadership Policy Manager, CAAN Communities, Alliances & Networks

MONITORING AND EVALUATION METHODOLOGY

Metric 1: New HIV Case Rates

Rationale:
One of the global targets for ending the HIV epidemic is reducing new cases to a rate of 5 per 100,000 annually.

Monitoring and Evaluation Methodology:
We reviewed the reports of new cases of HIV in 2023 for each province and territory (reported as both number of cases and rates per 100,000).

If rates are at or below the 2025 target, we list them as green. If rates are above but close to the 2025 target, we list them as yellow. If rates are far above the 2025 target, we list them as red.

Table 1. New reported cases of HIV, 2023. (2025 Target = 5 per 100,000 population)

Prov/Terr	HIV Rate	HIV Cases	Source
Alberta	10.8	507	56
British Columbia	2.8	154	57
Manitoba	20.2	280	58
New Brunswick	4.9	41	59
Newfoundland & Labrador	3.5	19	60
Nova Scotia	3.1	33	61
Ontario	4.6	723	62
Prince Edward Island	2.4	4	63
Quebec	5.4	Unknown	5
Saskatchewan	19.4	233	64
Yukon	Unknown	Unknown	N/A

Metric 2: Prevention

i. Safer drug and sex supplies access

Rationale:

The provision of new single-use drug equipment and safer sex supplies prevents transmission of HIV and other STBBI.

Monitoring and Evaluation Methodology:

We reviewed jurisdictional harm reduction policies to determine whether safer drug and sex supplies are available at no cost to clients or to the provider of the supplies, including in correctional facilities.

ii. PrEP access

Rationale:

PrEP is a medication strategy that uses antiretroviral drugs to prevent HIV infection. It is recommended for individuals who are HIV-negative but have a higher risk of contracting HIV through sexual activity or injection drug use. While daily oral pills work for many, adherence remains an issue, and some populations at higher risk of HIV exposure benefit from a long-acting injectable option.[12]

Monitoring and Evaluation Methodology:

We reviewed jurisdictional drug formularies to determine whether both daily oral and long-acting injectable PrEP regimens are available at no cost to everyone who is eligible for health insurance, with no wait periods.

Table 2. Safer drug and sex supplies and PrEP access policies, 2025.

Prov/ Terr	Safer drug and sex supplies available at no cost		Daily oral and long-acting injectable PrEP regimens available[66]	
	In community	In corrections[65]	Daily oral	Long-acting injectable
AB	Y, with barriers	N	Y	N
BC	Y	Sex supplies with barriers	Y	N
MB	Y	Sex supplies	Y	N
NB	Y	N	F/S	N
NL	Y	Sex supplies with barriers	F/S	F/S
NS	Y	Sex supplies with barriers	F/S	F/S
ON	Y, with barriers	Sex supplies with barriers	F/S	F/S
PE	Y	N	Y	N
QC	Y	Sex supplies	F/S	F/S
SK	Y, with many barriers	Unknown	Y	Y
YT	Y	N	Y	N
NIHB/CSC/VAC	Unknown	CSC: sex supplies with barriers	Y	Y

F/S: full or shared coverage based on the rules of the drug insurance plan

Metric 3: Testing

Rationale:
Timely, accessible HIV testing is essential to ending the epidemic. This includes accessible rapid testing options, alternatives to venous blood for HIV screening, confirmatory testing, viral load monitoring, and anonymous or non-nominal testing options. These approaches provide accessible, low-barrier routes to diagnosis and care, ensuring people can test in ways that are safe, convenient, and supportive of their circumstances.

Monitoring and Evaluation Methodology:
We requested information on jurisdictional testing policies and laboratory forms to determine:

- Whether HIV point-of-care (POC) is available at no cost to clients or testing services.
- Whether provincial laboratories accept at least one alternative to venous blood (i.e. dried blood spot, finger prick, or oral fluid) for HIV screening, confirmatory testing, and viral load monitoring.
- Whether all standard lab test requisition forms include a check box for non-nominal or anonymous HIV testing requests. (Jurisdictions that allow non-nominal or anonymous at some locations or by request were also noted.)

Table 3. HIV testing access policies, 2025.

Prov/Terr	HIV POC tests available at no cost	Diverse specimen options	Non-nominal or anonymous testing option on req form
Alberta	N, only a pilot at 1 location	Y, DBS	N
British Columbia	Y	Y, POC & DBS	Y
Manitoba	Y	Y, DBS	N
New Brunswick	Y	Y, DBS	N, but non-nominal available by request
Newfoundland & Labrador	N	N	N, but available by request through two clinics
Nova Scotia	Y	N	N, but available by request through two clinics
Ontario	Y	N	N, but available by request at specific locations
Prince Edward Island	Y	Y, DBS	N, but available by request at one location
Quebec	Y, but very limited	Y, POC but very limited	Available at some locations
Saskatchewan	Y	Y, DBS	Unknown
Yukon	N	N	N, but can use an alias

Metric 4: Treatment Access and Continuity

Rationale:
Antiretroviral therapy (ART) is the standard of care for all individuals diagnosed with HIV, as soon as possible after diagnosis. It reduces the amount of HIV in the body (viral load) to undetectable levels (U=U), allowing individuals to live long and healthy lives and preventing transmission. Treatment is recommended for everyone diagnosed with HIV, regardless of their stage of infection, and treatment adherence (i.e. not missing doses) is essential.

Monitoring and Evaluation Methodology:
We reviewed jurisdictional treatment coverage, prescribing, dispensing, and adherence-support policies to determine:

- Whether multiple recommended ARTs are available at no cost to everyone who is eligible for public health insurance, with no wait periods.
- Who can prescribe ARTs (i.e. is it limited to specialists, or more accessible?).
- Whether ART dispensing is centralized or can be picked up at community-based pharmacies.
- Whether the jurisdiction funds adherence support programs.

Table 4. HIV treatment access and continuity policies, 2025.

Prov/ Terr	Multiple Recommended ARTs available?[67]	Coverage: Deductible or copay?[67,68]	Who can prescribe?[68]	Central dispensing or community-based dispensing?	Publicly-funded adherence support?
AB	Y	N	MD, NP, Ph	Centralized	Y
BC	Y	N	MD, NP	Centralized but can be sent to community pharmacy	Y
MB	Y	N	MD, NP, HIV Ph	Community	N
NB	Y	Y	MD	unknown	unknown
NL	Y	Y, in most cases	MD, NP	Community	N
NS	Y	N	MD, NP	Centralized but mailed at no cost if needed	N
ON	Y	Y, in most cases	MD, NP	Community	N
PE	Y	N	MD, NP	Centralized	Y
QC	Y	Y	MD, NP, Ph	Community	N
SK	Y	N	MD, NP, Ph with Collaborative Prescribing Agreement	Community	Unknown
YT	Y	Y	ID	Community	N

Metric 5: Legal Environment

Rationale:
The legal and policy landscape can directly shape access to prevention, care, and support.

Monitoring and Evaluation Methodology:
We reviewed jurisdictional laws and policies to determine if they support or undermine effective HIV responses. Our review considered:

- Criminalization of HIV non-disclosure, drug use, and sex work;
- Access to supervised consumption services (SCS) and needle and syringe programs (NSPs); and
- Access to needle and syringe programs in prison.

Table 5. HIV legal environment scan, 2025.

Prov/ Terr	Measures taken to limit HIV criminalization	Measures taken to reduce repression against sex workers	Measures taken to reduce repression against PWUD	Measures taken to facilitate access to SCS and NSPs	Measures taken to provide PNSP
Fed	Yes and No. Directive released to prosecutors that limits prosecution against PLHIV, but stopped short of reforming the law criminalizing HIV non-disclosure.	No. Federal laws criminalize all activities related to sex work, while providing sex workers limited immunity from prosecution; the government has defended these laws in court.	Yes and No. Federal laws criminalize activities related to personal drug use; measures were taken to authorize diversion from prosecution for personal drug possession and mandatory minimum sentences for drug offences repealed.	Yes. Federal government adopted measures to allow scale up of SCS but these have stalled in recent years with real risk of moving backwards.	Yes. In 2018, the federal government authorized establishment of a "Prison Needle Exchange Program" in some federal prisons but there remains no meaningful access.
AB	Yes. Limited prosecutorial guidance adopted on HIV non-disclosure.	No	No. Policing of PWUD has increased and a law was adopted in 2025 allowing for involuntary drug treatment.	No. Established SCS licensing requirements in 2021 and cut some funding for harm reduction.	No
BC	Yes. Prosecutorial guidance adopted to limit prosecutions of HIV non-disclosure.	No	Yes and No. Decriminalized personal possession in 2023 but recriminalized drug possession in public space in 2024.	Yes. Adopted a Ministerial Order in 2016 allowing overdose prevention services; some provide inhalation services.	No

Table 5. HIV legal environment scan, 2025, cont'd.

Prov/ Terr	Measures taken to limit HIV criminalization	Measures taken to reduce repression against sex workers	Measures taken to reduce repression against PWUD	Measures taken to facilitate access to SCS and NSPs	Measures taken to provide PNSP
MB	No	No	No. Adopted a law in 2025 allowing for detention of "intoxicated people" who used drugs for up to 72 hrs instead of current 24.	Yes and No. Meant to open a unique SCS rooted in an Indigenous cultural approach, but project has been delayed.	No
NB	No, but a prosecutorial policy is being developed.	No	No	Yes. Using federal class exemption to facilitate operating one UPHNS.	No
NL	No	No	Unknown	Unknown	No
NS	No	No	Unknown	Yes. Some financial support provided to two SCS.	No
ON	Yes. Limited prosecutorial guidance adopted on HIV non-disclosure.	No. Repression increasing as a result of new laws and investments in anti-human trafficking.	No. Repression increasing as a result of new laws, including a 2025 law punishing people who use drugs in public spaces.	No. In 2024, a law passed forcing many SCS to close and banned some services from providing NSP.	No
PE	No	No	Unknown	Unknown	No
QC	Yes. Limited prosecutorial guidance adopted on HIV non-disclosure.	No	Yes. Policy adopted to divert people from the criminal legal system for personal drug possession following CDSA amendments.	No. Legislation passed in 2025 limiting SCS establishment.	No. PNSP endorsed 10 years ago but not implemented.
SK	No	No	No. Repression increasing as a result of new laws and intention announced to pass involuntary drug treatment legislation.	No. Stopped provision of new pipes in 2024 and enforced 1:1 needle exchange; adopted law in 2025 declaring syringes and pipes "street weapons."	No
YT	Yes, federal directive applies.	No	Yes and No. Authorities say they do not pursue standalone charges for simple possession but YT is 2nd in Canada for police-reported drug offences.	Yes. In 2022, declared a substance use health emergency and used the federal class exemption to open its first SCS with inhalation services.	Yes and No. Policy published suggesting PNSP will be introduced, but no evidence to date of implementation.

Metric 6: Data and Evaluation

Rationale:
Evaluating progress toward ending HIV requires collecting data that not only track clinical outcomes but also reflect lived realities, inequities, and systemic barriers. Without strong, transparent, and inclusive data systems, jurisdictions cannot make meaningful progress or hold themselves accountable for meeting national and global HIV targets. Moving forward, updated WHO guidelines require increased monitoring of the care cascade for key populations.[69]

Monitoring and Evaluation Methodology:
We reviewed jurisdictional data collection practices to determine whether these four indicators are being monitored, evaluated, and reported:

- PrEP Uptake: Is the number of people accessing PrEP monitored and reported publicly?
- Care Cascade: Are regular updates available on the HIV care cascade (diagnosed → on treatment → virally suppressed)?
- Key Population Reporting: Does the jurisdiction include race/ethnicity, gender, and exposure category in annual surveillance reports of new HIV diagnoses to support key population care cascades and targeted interventions?
- Stigma Monitoring: Does the jurisdiction monitor stigma experienced by people living with HIV using consistent, community-informed indicators in public health surveillance or community health assessments?

Table 6. HIV data and evaluation policies, 2025.

Prov/ Terr	PrEP Uptake monitored and reported?	Care Cascade updated regularly?	Key population reporting?	Stigma monitoring?
AB	N	Y	Y	Unknown
BC	**Y**	Y	Exposure cat. and gender	Unknown
MB	N	Y	Exposure cat. and gender	Unknown
NB	N	Y	Exposure cat. and gender	Unknown
NL	N	Y	N	Unknown
NS	N	Y	Gender	Unknown
ON	**Y**	Y	Y	Y
PE	N	Y	N	Unknown
QC	N	Y	Exposure cat. and gender	Unknown
SK	N	Y	Exposure cat. and gender	Unknown
YT	N	Y	Unknown	Unknown

DATA GAPS AND LIMITATIONS

- Surveillance systems vary across jurisdictions, making cross-province/territory comparisons challenging.

- In some Public Health Agency of Canada (PHAC) reports, not all provinces and territories had submitted data, resulting in incomplete national datasets.

- In some PHAC publications, provinces and territories are grouped into regions or data are suppressed due to low counts to protect confidentiality, limiting the ability to analyze trends or differences at the jurisdictional level.

- There is very limited available data for Nunavut and the Northwest Territories, so these jurisdictions were not included in the evaluations.

- Availability of disaggregated data for several key populations varies across the provinces and territories, restricting analysis of HIV outcomes and care experiences by key population.

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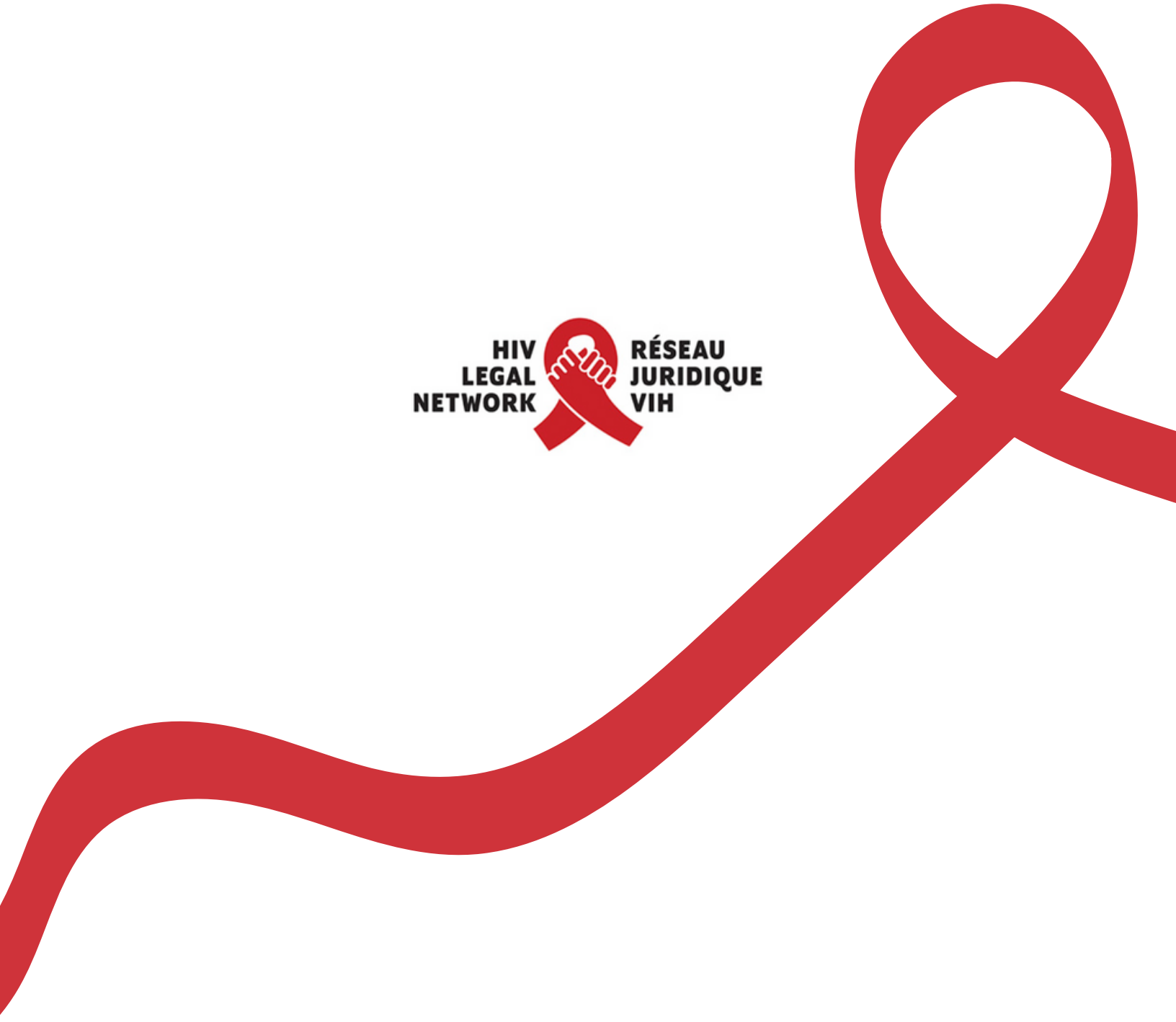

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