PARN—Your Community AIDS Resource Network
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PARN25
COMMUNITY-BASED HIV/STBBI PROGRAMS
SUPPORT. PREVENTION. EDUCTION

United Way Peterborough & District
Change starts here.

May 2015

In This Issue

Board of Directors

Chair: Mark Smith
Vice Chair: Mark Phillips

Members at Large:
Alexa Ferguson
Megan Mattos
Alison Rodgers
Bunny Smith

Hours of Operation

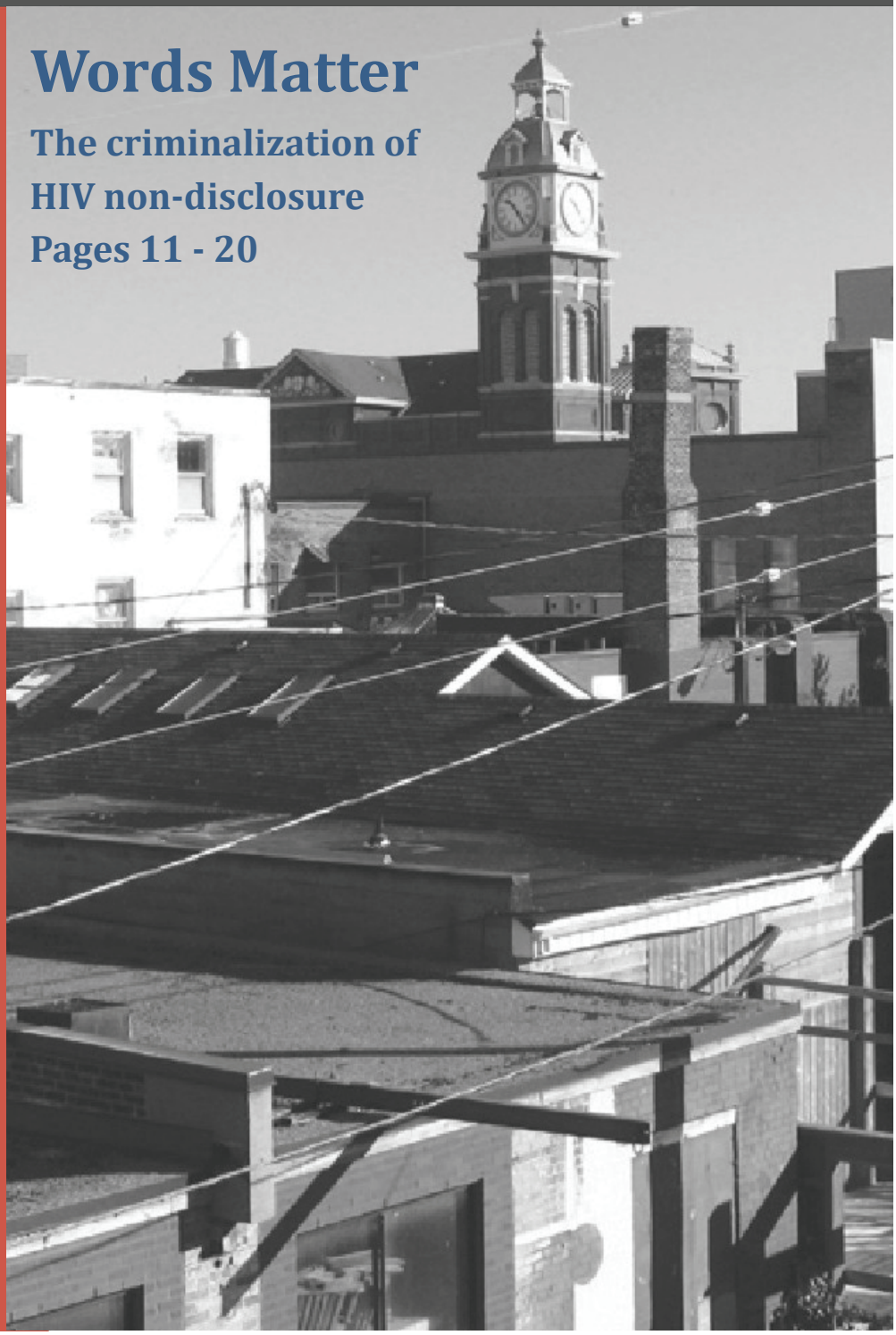
Monday to Friday 9 am—5 pm
Closed Wednesdays from 1.00—3pm

The PARN Office will be closed on Monday, May 18 for Victoria Day.

Words Matter

The criminalization of HIV non-disclosure

Pages 11 - 20



Thank You Peterborough and the Four Counties!

The commitment of our Taste For Life sponsors is changing lives in our community. Please support our sponsors when you can!

We are so thankful to all of the restaurants who partnered with PARN for A Taste For Life, and we hope that you will support them all year round.

Black Honey—(705) 750-0014
Brio Gusto—(705) 745-6100
Capers Restaurant—(705) 653-5262 *Campbellford*
Carlyle Inn & Bistro—(905) 885-5500 *Port Hope*
Electric City Gardens—(705) 749-1909
Elements—(705) 876-1116
Hobart's—(705) 775-4000
Hot Belly Mama's—(705) 745-3544
Rare Grill House—(705) 742-3737
Sam's Place—(705) 876-1900
Shish Kabob Hut—(705) 745-3260
St. Veronus Café, Tap & Grill—(705) 743-5714
The Thirsty Loon Pub—(705) 652-1812 *Lakefield*
Whistle Stop Café—(705) 740-2036

HIV Support Services Update

You are invited to spend a day with Yvette Perreault!

AIDS Bereavement and Resiliency Program of Ontario

Presence. Compassion. Change.

Help us direct ***YOUR*** Community HIV Support Services and Programs

Where have we come from
and where are we going?

Let's find out together!

Lunch, snacks, drinks provided.

Travel and childcare subsidy are available.

Is there anything else we can do to help you to get here?

Yvette will engage us in a meaningful conversation on the complex issues that HIV raises in our communities.

Please RSVP by emailing Lance Brown at lance@parn.ca or by calling 705-749-9110 x 205 or 1-800-361-2895 Please let us know if you need any more information and if you are coming!

Are you a long term survivor?

Are you in need of friendship and support? We may have a group for you—please contact Brittany or Lance for more information.

The Positive Living Room

The program is open to anyone attending The Positive Care Clinic on Thursday mornings. We open at 10am and run until 11:30 – join us Thursday's for a light breakfast, coffee and conversation while you wait!

HIS: Health Information Spaghetti Social

HIS HIV Health Information Support is a group designed to provide opportunities for men who are HIV positive to share information and resources with the goal of building community support systems, promoting self-advocacy and networking. The next HIS group will be held on Wednesday May 27th. The group will run from 5 to 7pm. Dinner will be provided. Please RSVP to Lance at lance@parn.ca

If you are in need of support related services, please contact Brittany , PHA Engagement Worker (brittany@parn.ca) or Lance, HIV Support Services & Programs Coordinator (lance@parn.ca)
Please note that Lance will be out of the office on May 28th.

Overdose Prevention
What You Need To Know To Protect Yourself

Accidental overdose is one of the leading causes of death in Ontario

- Opiates are pain killing drugs like fentanyl, oxycodone, methadone and heroin
- Naloxone is a life saving medication that reverses an opiate overdose for about 30 to 45 minutes.

If you USE or HAVE USED opiates, whether prescribed or illegally, you may be at risk of an overdose and may be eligible for a LIFE SAVING Naloxone kit!

Protect Yourself!

FREE Overdose Prevention Training & Naloxone Kits are Now Available in Peterborough

Next Training Session: **May 11th** at the Lighthouse from **1pm-4pm**

For more information and to register:
Please contact Wayne by phone or e-mail:
705-749-9110 or wayne@harmreductionworks.ca

A Naloxone Kit

Peterborough County City Health Unit

PARN
YOUR COMMUNITY AIDS RESOURCE NETWORK

Peterborough Drug Strategy

May 2015 Update

Ariel O'Neill, Women & HIV Initiative Community Animator
email: **ariel@parn.ca** twitter: @WHAIatPARN

May is sexual assault awareness month

Kawartha Sexual Assault Centre (KSAC) is a leader in our region around sexual assault and promoting local participation in Canada-wide **no one asks for it** initiative. Check their facebook page for details.

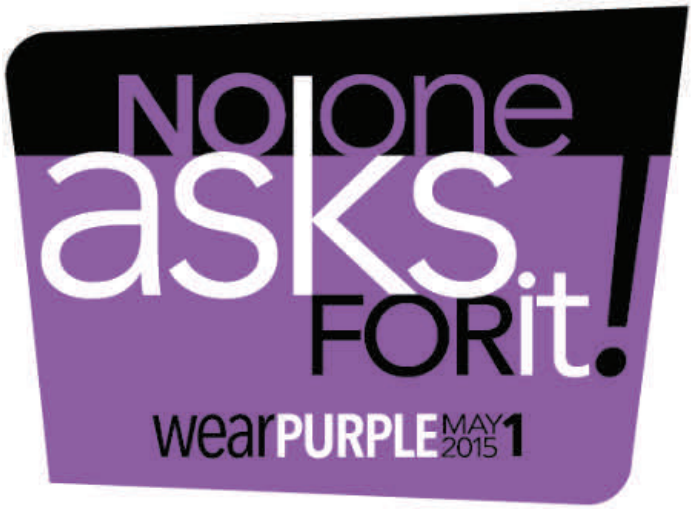
There are three coalitions in the area I belong to that bring service providers together around issues of violence against women on a monthly basis, and at the Northumberland Domestic Abuse Committee, we talked about a **provincial task force that is examining patient experiences of sexual assault**. Until May 30th, Metrac is collecting stories as part of this important initiative.

Go to www.metrac.org/ontariopatients for more information.

Save the Date: June 24th

KAIROS Blanket Exercise organized by E Fry, YWCA Start, Niijkiwendidaa, OAHAS and WHAI @PARN. Learn Canadian and local history from an Indigenous-centred point of view.

Thank you to Community Counselling and Resource Centre Peterborough (CCRC) for their gracious hospitality on April 1st. PARN was contacted by the agency for clarification around HIV disclosure. I screened the film *Positive Women: Exposing Injustice* and facilitated a dialogue that unpacked some of our assumptions, covered the legal framework for HIV disclosure in Canada and highlighted the special vulnerabilities that women living with HIV face.



Kawartha Sexual Assault Centre Launches 4 County Survey For Survivors of Sexual Violence

May is Sexual Assault Awareness Month. On Friday, May 1, 2015, the Kawartha Sexual Assault Centre is launching a survey for survivors of sexual violence across the four county region of Peterborough, Northumberland, City of Kawartha Lakes and Haliburton. This survey, as part of a Status of Women Canada needs assessment, asks all survivors of sexual violence to share their experiences of accessing community services in response to the violence they experienced or in the prevention of further sexual violence. Sexual violence includes experiences such as, childhood sexual abuse, sexual assault, rape, intimate partner sexual violence, sexual harassment, workplace sexual harassment, online sexual cyberbullying, and sex trafficking.

The Kawartha Sexual Assault Centre asks media to launch this survey with us at: **http://fluidsurveys.com/s/4CountySexualViolenceSurvivors/** For more information, please contact Lisa Clarke at lclarke.ksac@nexicom.net or 705-748-5901 ext. 204.

WHAI Radio is off for the summer season. Thanks for listening and joining in. Send me feedback: what (feminist, social justice, health) topics, agencies or change makers would you like to hear about in fall 2015?

1 in 3 women will experience sexual assault in their lifetimes.

PARN25
SUPPORT. PREVENTION. EDUCATION.

Thursday, June 25, 2015, please join us for the 25th Annual General Meeting of the membership of PARN - Your Community AIDS Resource Network. Details will be announced in the June newsletter. Become a PARN member by 5:00pm, Tuesday, May 26th to be eligible to vote and to nominate or be nominated to, and/or to stand for election to the Board of Directors at the AGM. For membership information, contact Peg Town. For information about the board application process, contact Kim Dolan.

AGM25 SAVE THE DATE JUNE25

ATTENTION:

The PARN offices will be closed on Monday, May 18 for the Victoria Day holiday. The offices will reopen on Tuesday, May 19 at 9:00 am.

Drag Bingo
Wednesday, May 13
8pm at The Sapphire Room
137 Hunter Street West

Rainbow Youth Program
Every Thursday, 3.30 - 5.30 pm
Suite 302-2, 159 King Street

HEP-C Community Programs:

Peterborough Hep C Testing & Treatment
Every Tuesday & Thursday , 9am - 4 pm
@ Positive Care Clinic, 159 King Street

Peterborough Hep C Drop In
Tuesday, May 19, 9.30 am - 12.30pm
@ PARN, Suite 302-2—159 King Street

Port Hope Hep C Support Group
Wednesday, May 27, 1pm - 3pm
@ PHCHC, 99 Toronto Street

Haliburton Hep C Support Group
Friday, May 15 , 10am - 2pm
@ HFHT, 7217 Gelert Street

Lindsay Hep C Support Group
Friday, May 8 , 10 am - 1 pm
@ KLCHC, 108 Angeline Street

Rainbow Youth Program Update

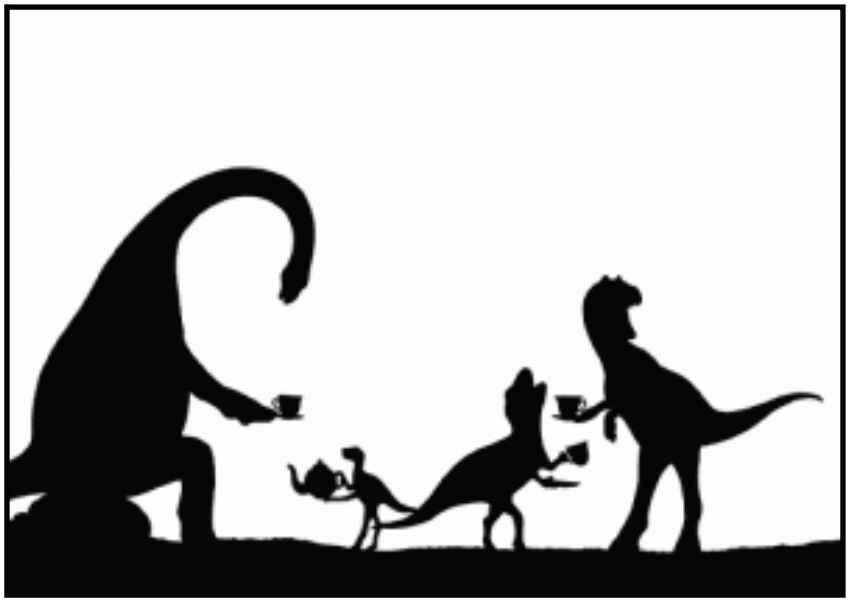
anya gwynne—Rainbow Youth Program Animator
anya@parn.ca—705-749-9110 ext 209

Consent: Not actually that complicated

Instead of our regular update, we have decided to reprint an incredible blog post that was recently brought to our attention. This post originally appeared on rockstar dinosaur pirate princess. We are thankful for the permission to republish this piece, and encourage you to read more great content like this at www.rockstardinosaurpirateprincess.com—anya

A short one today as my life is currently very complicated and conspiring against my preference to spend all of my days working out what to blog. But do you know what isn't complicated?

Consent.



It's been much discussed recently; what with college campuses bringing in Affirmative Consent rules, and with the film of the book that managed to makelack of consent look sexy raking it in at the box office. You may not know this, but in the UK we more or less have something similar to 'affirmative consent' already. It's how Ched Evans was convicted while his co-defendant was not – and is along the lines of whether the defendant had a reasonable belief that the alleged victim consented. From the court documents it appears that while the jury felt that it was reasonable to believe that the victim had consented to intercourse with the co-defendant, it was not reasonable to believe that she'd consented to intercourse with some random dude that turned up halfway through (Evans). The issue in the UK isn't traditionally in the way it's dealt with in court, but in the way it has been investigated –new guidance was recently issued to try to improve this.

It seems like every time an article is written about consent, or a move made towards increasing the onus on the initiator of the sex to ensure that the person they are trying to have sex with, you know, actually WANTS to have sex with them, there are a wave of comments and criticisms.

It seems a lot of people really, REALLY don't get what 'consent' means. From the famous "not everybody needs to be asked prior to each insertion" to the student that (allegedly) thought he'd surprise his partner with some non consensual BDSM to that fucking song to almost every damn comment on any article by anyone that suggests that yes means*yes;* it seems people really have a problem understanding that before you have sex with someone, and that's *every* time you have sex with them, *make sure they want to have sex with you*. **(Continues on next page)**

(Continued from previous page)
This goes for men, women, everyone. Whoever you are initiating sexytimes with, just make sure they are actually genuinely up for it. That's it. It's not hard. Really.

If you're still struggling, just imagine instead of initiating sex, you're making them a cup of tea.

You say "hey, would you like a cup of tea?" and they go "omg fuck yes, I would fucking LOVE a cup of tea! Thank you!*" then you know they want a cup of tea.

If you say "hey, would you like a cup of tea?" and they um and ahh and say, "I'm not really sure…" then you can make them a cup of tea or not, but be aware that they might not drink it, and if they don't drink it then – this is the important bit – *don't make them drink it*. You can't blame them for you going to the effort of making the tea on the off-chance they wanted it; you just have to deal with them not drinking it. Just because you made it doesn't mean you are entitled to watch them drink it.

If they say "No thank you" then don't make them tea. At all. Don't make them tea, don't make them drink tea, don't get annoyed at them for not wanting tea. They just don't want tea, ok?

They might say "Yes please, that's kind of you" and then when the tea arrives they actually don't want the tea at all. Sure, that's kind of annoying as you've gone to the effort of making the tea, but they remain under no obligation to drink the tea. They did want tea, now they don't. Sometimes people change their mind in the time it takes to boil that kettle, brew the tea and add the milk. And it's ok for people to change their mind, and you are still not entitled to watch them drink it even though you went to the trouble of making it.

If they are unconscious, don't make them tea. Unconscious people don't want tea and can't answer t he question "do you want tea" because they are *unconscious*.

Ok, maybe they were conscious when you asked them if they wanted tea, and they said yes, but in the time it took you to boil that kettle, brew the tea and add the milk they are now unconscious. You should just put the tea down, make sure the unconscious person is safe, and – this is the important bit – don't make them drink the tea. They said yes then, sure, but unconscious people don't want tea.

If someone said yes to tea, started drinking it, and then passed out before they'd finished it, don't keep on pouring it down their throat. Take the tea away and make sure they are safe. Because *unconscious people don't want tea*. Trust me on this.

If someone said "yes" to tea around your house last saturday, that doesn't mean that they want you to make them tea all the time. They don't want you to come around unexpectedly to their place and make them tea and force them to drink it going "BUT YOU WANTED TEA LAST WEEK", or to wake up to find you pouring tea down their throat going "BUT YOU WANTED TEA LAST NIGHT".

Do you think this is a stupid analogy? Yes, you all know this already – of course you wouldn't force feed someone tea because they said yes to a cup last week. Of COURSE you wouldn't pour tea down the throat of an unconcious person because they said yes to tea 5 minutes ago when they were conscious. But if you can understand how completely ludicrous it is to force people to have tea when they don't want tea, and you are able to understand when people don't want tea, then how hard is it to understand when it comes to sex?

Whether it's tea or sex, Consent Is Everything.

And on that note, I am going to make myself a cup of tea.

**I actually said this word for word to a friend in the early hours of Sunday morning after a warehouse party. Tea. It's fucking brilliant.*

Different strokes for different folks

This article was written by Bob Leahy and was originally posted at Positive Lite on Monday, April 27. To read more of Bob's work, and to find our more about Positive Lite, please visit: www.positivelite.com

Last week I partnered with Lance Brown from PARN to give a two-and-a half hour presentation to a class of trainee personal support workers. I've been doing this kind of thing, on and off, for twenty years. It seemed timely, though, for an overhaul.

We had the luxury of two and a half hours to go beyond AIDS 101 plus "my poz story", to try and tailor a talk that fully reflects 2015 rather than the preceding years. So, ahead of the talk, I and my ASO peeps spent some time thinking about what the 2015 version of public AIDS education and awareness might look like.

Speakers living with HIV take all kinds of tacks. My own aim has always been to present HIV as a very human condition rather than just a clinical one. Sure, AIDS 101 is necessary but I generally leave it to others. Instead I talk about the impact of the disease - on myself, on others, on the world - rather than the symptoms, treatment or prognosis. It's always gone well, but this time we needed to reflect the fact that HIV has changed – and so our message should change too.

Multiple avenues

But which direction to go? Now I admire anyone who gets in front of an audience and shares their HIV-positive perspective - there is always good in that - but I sometimes worry whether we strike the right note. There is the danger, for instance, of portraying HIV as something horrible, to be avoided at all costs (the "scared straight" approach) with the poz speaker as Exhibit A.

So I don't go there.

Neither am I all that keen on talks which adopt a "just the facts" approach – the ins and outs of HIV prevention, too heavy on the "bodily fluids" and warnings about "condomless sex" that can all too easily turn an audience off sex for good.

So I don't go there.

I have always talked about stigma and how the more marginalized you are the more acutely you are likely to experience it. But now I think we can inject a degree of optimism born of effective treatments, reduced (eliminated?) infectivity and a new place in society for people living with HIV. To do this we have to convey how HIV has changed, how treatment has changed and how prevention has changed – and why people with HIV are, and some will disagree, often pretty damn normal. Good neighbours, good friends, good lovers.

Different Strokes for Different Folks Continued from previous page

We have to convey that people living with HIV are increasingly living strong and healthy lives, and are no danger to anyone. That in itself is a powerful antidote to stigma. Whether a message that depicts us as happy and healthy is a good prevention message no longer concerns me. If we are to battle stigma truly effectively, we cannot portray HIV in the developed world, or by extension the experience of living with HIV, as something to be scared of.

So I don't go there.

Sure, fighting stigma involves pointing out who suffers most from it and why – and hopefully how we deal with that. We also need to make it clear that fighting stigma isn't just about making life easier for us. It's a necessary component of ending the epidemic. Testing, for example, is much more inviting when it relates to a condition that's free of stigma, and so is disclosure of your status.

Into the future

Seems to me our talks today have to be franker than ever, more informed, more rooted in science while still maintaining the personal touch.

I'm sensing that the public knows very little about how HIV is lived today, or what strategies are out there for those who wish to avoid it. Last week's talk with personal support workers was revealing. No one knew about the power of ART to reduce/eliminate transmission risk. No one had heard of PrEP. Clearly they had a vision of HIV rooted in past decades. It is, to be clear, a sympathetic vision, a caring vision – but a vision which no longer reflects the truth

So we got into it. We talked new prevention technologies, we talked successful treatment regimes, and we talked about PrEP, about 90-90-90, about disclosure and the law, about the treatment cascade, even what PARTNER tells us. And we had thoughtful, concerned questions from the audience like "does a person living with HIV still have to reveal their status if they have sex and are undetectable?"

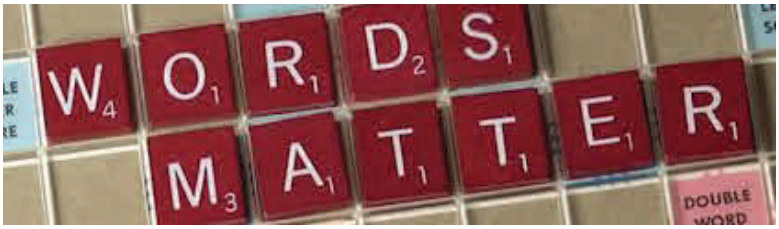
Then I told my story. My take home message has always been unconventional. It is based on the theory that adversity often brings out the best in people. Thus HIV, or any chronic condition for that matter, sometimes has the power not to ruin lives but to elevate them. It's a message about empowerment that I've always hoped counteracts the stigmatized image of HIV. Add in the news about new advances in treatment, prevention and viral load impacts and, I hoped, we would have a winner.

I think we did.

Strikes me though we as a community haven't done a good enough job in bringing the public up to date. No campaign I know of has tackled that. Hell, there are precious few resources to bring people living with HIV up to date. Stigma will go away not by shouting simplistic slogans but by truthfully portraying the experience of living with HIV in 2015. Let's be fearless in going there,

It's vital, after all, that we present in all our messaging, live in front of an audience or online, not just "the face of HIV" but "the NEW face of HIV".

The PARN Perspective: HIV is not a Crime



It has been a challenging month for many people living in the communities we serve.

We have seen people jump to conclusions and make assumptions based on a photo and seven sentences that appeared in a newspaper article on April 8..

We have seen a disturbing amount of oppressive language used casually regarding some of the most marginalized people in our community.

We have seen people threaten violence on social media.

We have seen people – people who know how and why the "war on drugs" failed – advocating for the very same tactics to be wielded against people living with HIV.

We have seen the faces of our service users and friends who feel the impact of these words directly. We have heard them talk about the fear they feel when people in their own community make assumptions, stigmatize, use hateful language and threaten violence against people living with HIV.

These words have meaning. These words matter.

But, we have also seen overwhelming evidence that Peterborough's social justice heart beats as strong as ever. We have seen incredible support for people living with HIV in our community.

We have seen people wade into hostile and combative social media conversations to share evidence-based information and messages of compassion.

We have seen people who have taken the time and effort to understand the complexities around the criminalization of HIV non-disclosure and are working to educate others.

We have seen people speak out against the stigma and fear and hostility that has helped fuel the HIV epidemic for more than 30 years.

We have seen people say that enough is enough: that in 2015 it is time to ensure that all legal and policy responses to HIV/AIDS are based on the best available evidence, the objectives of HIV prevention, care, treatment and support, and respect for human rights.

These words matter, and we are thankful to everyone who has expressed them over the past few weeks on social media, on newspaper comment threads, and through in-person conversations.

At PARN, our goal is to end the spread of HIV in Peterborough, the Four Counties and beyond. We know how words matter.

We know how oppressive and threatening language drives people living with HIV into isolation and further increases the transmission of HIV. We have been seeing it happen since the day we first opened our doors in Peterborough 25 years ago.

But we also know that words of compassion and understanding help build safer and stronger communities for people living with HIV. We know that facts and evidence are what will change attitudes and policies that impact the lives of people living with HIV in our community.

We are grateful to everyone who has used their voice this week to help end the HIV epidemic.

We are hopeful that others will consider the language that they have used over the past few days, the impact that it has on people, and the way that it can have the unintended consequence of fueling HIV transmission.

Words matter.

The PARN Perspective: HIV is not a Crime

To promote an evidence-informed application of the law in Canada, a team of six Canadian medical experts on HIV and transmission led the development of a consensus statement on HIV sexual transmission, HIV transmission associated with biting and spitting, and the natural history of HIV infection. The statement is based on a literature review of the most recent and relevant scientific evidence (current as of December 2013) regarding HIV and its transmission. On these 8 pages, PARN is reprinting this Consensus Statement in full, including the full list of signees of the statement.

Canadian consensus statement on HIV and its transmission in the context of criminal law

Mona Loutfy, MD FRCPC MPH,[1] Mark Tyndall, MD FRCPC ScD,[2] Jean-Guy Baril, MD,[3] Julio SG Montaner, MD FRCPC,[4] Rupert Kaul, MD FRCPC PhD,[5] and Catherine Hankins, CM MD PhD CCFP FRCPC[6]

CONTEXT AND PURPOSE

As leading Canadian HIV physicians and medical researchers, we have a professional and ethical responsibility to inform policy formulation and the criminal justice system in matters related to the health and well-being of our patients and Canadian society[1]. We developed the present statement out of a concern that the criminal law is being used in an overly broad fashion against people living with HIV in Canada because of, in part, a poor appreciation of the scientific understanding of HIV and its transmission. We are concerned that actors in the criminal justice system have not always correctly interpreted the medical and scientific evidence regarding the possibility of HIV transmission, and may not have understood that HIV infection is a chronic manageable condition. This may lead to miscarriages of justice.
HIV transmission is an area of scientific inquiry in which findings and opinions often require interpretation by properly qualified medical experts. Over the past three decades, there have been considerable advances in our scientific and medical knowledge of HIV, how to prevent it and how to optimize treatment for people living with HIV.

The present statement represents our consensus expert opinion regarding the possibility of HIV transmission and the nature of HIV infection. While particular sexual acts are inherently difficult to study and the interpretation of the research related to sexual transmission of HIV is complex, there is broad consensus within the scientific and medical communities based on more than three decades of research. We have reviewed the most relevant and reliable medical and scientific evidence related to HIV and HIV transmission to arrive at our consensus statement. The present statement sets out, in clear, concise and understandable terms, our expert opinion regarding HIV sexual transmission, HIV transmission associated with biting and spitting, and HIV infection as a chronic manageable condition.

We have developed this statement specifically to inform the criminal justice system. We aimed to communicate the medical and scientific evidence in a manner understandable to an educated layperson, and have avoided excessive reliance on technical medical or scientific terminology or statistics. We also focused on the possibility of HIV transmission between individuals engaging in a specific act at a specific time because this is what is at stake in individual criminal cases. The present statement does not extend to HIV transmission at a population level in relation to HIV prevention efforts. The present statement is not intended to be used in the public health setting or to be relied on in the development or delivery of HIV policy and programs including prevention, information, education or counselling..

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The PARN Perspective: HIV is not a Crime

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POSSIBILITY OF HIV TRANSMISSION

Assessing the possibility of HIV transmission

We assess the possibility of HIV transmission according to three categories: low possibility; negligible possibility; and no possibility. We define and rely on these categories for the purposes of informing the criminal justice system about the possibility of HIV transmission between individuals in specific circumstances at a specific time – in other words, the per-act possibility of HIV transmission. Our three categories should not be confused with relative HIV transmission risk categories traditionally used in public health, which describe activities from high risk to no risk.

It is our expert opinion that scientific and medical evidence clearly indicate that HIV is difficult to transmit during sex. Even activities generally considered risky, such as unprotected (ie, without a condom) anal and vaginal sex, carry a per-act possibility of transmission that is much lower than is often commonly believed. It is our expert opinion that the actual per-act possibility of HIV transmission through sex, biting or spitting lies along a continuum from low possibility, to negligible possibility, to no possibility of transmission.

Low possibility: The basic conditions of viral transmission are present. The majority of HIV transmission worldwide is linked to these activities. Although these activities are considered to be the main modes of HIV transmission, the per-act possibility of transmission remains low.

Negligible possibility: The basic conditions of viral transmission are potentially present. Isolated reports of transmission have been linked to some of these activities, although they have been difficult to confirm. The efficiency of transmission appears to be negligible and transmission is highly unlikely, if not impossible in most circumstances.

No possibility: The basic conditions of viral transmission are not present. No occurrence of transmission has been reported. The virus is not transmitted by these activities.

Biology and physiology of HIV transmission: The transmission of HIV during sex is much less likely to occur than commonly presumed. In fact, HIV is difficult to transmit sexually when compared with some other sexually transmitted infections (STIs). Sexual exposure to HIV presents the possibility of HIV transmission only if specific bodily fluids from an HIV-positive individual come into contact with specific cells within the body of an HIV-negative individual. The three bodily fluids that play a principal role in the sexual transmission of HIV are semen (including pre-ejaculate), vaginal fluid and rectal fluid[2].

HIV-containing fluids can cause infection if they enter the sex partner's body through a mucous membrane. The mucous membranes involved in the sexual transmission of HIV are located in the foreskin and urethra of the penis; cervix and vagina; anus and rectum; and mouth and throat. For transmission to take place, HIV must first overcome the cellular defences of the mucous membrane and the body's immune response to pathogens, and then establish an infection in target immune cells. Transmission can only occur if there is a sufficiently high level of the virus in the HIV-infected individual's bodily fluid(s).

Significant factors associated with the sexual transmission of HIV

The significant factors associated with the sexual transmission of HIV relevant to the formulation of our expert opinion are:

- type of sexual act;
- condom use; and
- antiretroviral therapy use and viral load in the HIV-positive individual.

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The PARN Perspective: HIV is not a Crime

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Type of sexual act: For principally biological reasons, some sexual acts involve a lower HIV transmission possibility than others. All other factors being equal, oral sex has a significantly lower possibility of transmission than vaginal or anal intercourse, and anal intercourse has a higher possibility of transmission than vaginal intercourse.

Condom use: Condoms are a cornerstone of HIV prevention. Latex and polyurethane condoms act as an impermeable physical barrier through which HIV cannot pass. When used correctly and no breakage occurs, condoms are 100% effective at stopping the transmission of HIV because they prevent the contact between HIV-containing bodily fluid and the target cells of an HIV-negative individual. Studies at a population level have also shown that even when factoring in possible instances of incorrect use or breakage, the consistent use of condoms dramatically reduces the possibility of HIV transmission. Where the present consensus statement discusses the possibility of HIV transmission in the context of condom use, it is assumed that the condom was applied to the penis and worn throughout sex, and that no condom breakage occurred.

Antiretroviral therapy and viral load: The medications used to treat HIV infection are referred to as antiretroviral therapy. Since the mid-1990s, HIV physicians have been using a combination of antiretroviral drugs to effectively manage HIV infection. Antiretroviral therapy stops HIV from making copies of itself, thereby significantly reducing the overall amount of HIV in an individual's body, which is referred to as 'viral load'.

In Canada, the commonly used laboratory tests can detect viral loads above 40 copies of virus per millilitre of blood. When the concentration of HIV falls below the level that is detectable by laboratory tests, the HIV-positive individual is said to have an 'undetectable' viral load. The goal of antiretroviral therapy is to render the HIV viral load undetectable. Most people living with HIV who take antiretroviral therapy are able to achieve an undetectable viral load. Being on effective antiretroviral therapy, with a controlled viral load, results in improved immune function and a dramatic decrease in illness and mortality

Moreover, because the lower the viral load, the lower the possibility of HIV transmission, being on effective antiretroviral therapy also dramatically reduces the possibility that the individual will transmit HIV. It is worth noting that some people have a low HIV viral load without taking antiretroviral therapy because their immune systems are able to control HIV. These people also have a reduced possibility of transmitting HIV during sex. While small short-lived increases in viral load, known as 'blips', can occur among individuals on effective antiretroviral therapy, they are not an indication that HIV therapy is 'failing' and are not considered to be clinically significant. They have not been shown to increase the possibility of HIV transmission during sex.

Possibility of HIV transmission associated with sexual acts

Vaginal-penile intercourse: Where **neither** a condom **nor** effective antiretroviral therapy is present, vaginal-penile intercourse poses a **low** possibility of transmitting HIV.

Where a condom is used **or** where the HIV-positive individual is on effective antiretroviral therapy, vaginal-penile intercourse poses a **negligible** possibility of transmitting HIV.

The estimate of the per-act probability of HIV transmission associated with unprotected penile-vaginal intercourse without antiretroviral therapy is often cited as one instance per 1000 sexual acts. Estimates based on the most recent scientific studies range between four and eight instances of transmission per 10,000 sexual acts.

Some studies suggest that the possibility of HIV passing from a man to a woman is twice as high as the possibility of HIV passing from a woman to a man. The possibility of HIV passing from a man to a woman decreases when ejaculation occurs outside of the body.

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The PARN Perspective: HIV is not a Crime

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The use of effective antiretroviral therapy by individuals living with HIV has been shown in clinical trials to result in a very significant reduction in HIV transmission to HIV-negative individuals. Overall, the evidence suggests that the possibility of sexual transmission of HIV from an HIV-positive individual to an HIV-negative individual via unprotected vaginal intercourse approaches zero when the HIV-positive individual is taking antiretroviral therapy and has an undetectable viral load. Given that the possibility of HIV transmission is already approaching zero, using a condom in such circumstances would not alter the possibility of HIV transmission in any meaningful way. It would protect both partners from other STIs and unwanted pregnancy.

Anal-penile intercourse: Where **neither** a condom **nor** effective anti-retroviral therapy is present, anal-penile intercourse poses a **low** possibility of transmitting HIV.

Where a condom is used, anal-penile intercourse poses a **negligible** possibility of transmitting HIV regardless of the HIV-positive individual being on effective antiretroviral therapy.

Where the HIV-positive individual is on effective antiretroviral therapy, anal-penile intercourse **likely** poses a **negligible** possibility of transmitting HIV even in the absence of condom use.

The estimate of the per-act probability of HIV transmission associated with unprotected anal-penile intercourse without antiretroviral therapy is often cited as one instance per 100 sexual acts where the HIV-positive individual is the insertive partner, and one instance per 1000 sexual acts where the HIV-positive individual is the receptive partner. The possibility of HIV transmission during anal intercourse also decreases when ejaculation occurs outside of the body.

The published data on the impact of effective antiretroviral therapy on HIV transmission, including the groundbreaking clinical trial referred to as HPTN 052 (Cohen MS et al, 2011), are principally from studies of heterosexual couples in which the predominant sexual activity was vaginal-penile intercourse. At this time, there are insufficient data to conclude that effective antiretroviral therapy provides similar levels of protection in relation to anal-penile intercourse. However, it is our expert opinion that the magnitude of the reduction in the possibility of transmission via vaginal-penile sex observed with effective antiretroviral therapy in HTPN 052 can be extrapolated to anal-penile intercourse when the HIV-positive individual is the receptive partner. Given the significant protective effects of effective anti-retroviral therapy, this magnitude of the reduction in the possibility of transmission can also likely be extrapolated when the HIV-positive individual is the insertive partner in anal-penile intercourse. However, because of the higher biological possibility of transmission associated with anal-penile intercourse when the HIV-positive individual is the insertive partner, more data are needed before we can give a more definitive opinion about the anticipated negligible possibility of transmission in this case. Using a condom in such circumstances would protect both partners from other STIs. Clinical studies are underway to assess the possibility of HIV transmission associated with insertive and receptive anal-penile intercourse when the HIV-positive individual is on effective antiretroviral therapy.

Oral sex: Oral sex performed by an HIV-positive individual on an HIV-negative individual poses **no** possibility of transmitting HIV. Where **neither** a condom **nor** effective antiretroviral therapy is present, oral sex performed on a HIV-positive individual poses a **negligible** possibility of transmitting HIV. Where a condom is used **or** the HIV-positive individual is on effective antiretroviral therapy, oral sex performed on a HIV-positive individual poses a **negligible** possibility of transmitting HIV.

Practising oral sex instead of vaginal or anal intercourse is one of the precautions an individual can take to reduce the possibility of HIV transmission. Oral sex includes oral-penile sex (fellatio) and oral-vaginal sex (cunnilingus). While limited evidence suggests that HIV transmission from oral sex is plausible in cases of fellatio performed on an HIV-positive individual, transmission in such circumstances would be extremely rare. Fellatio without ejaculation in the mouth of the performing HIV-negative individual would pose a lower possibility of transmission than fellatio with ejaculation. Cunnilingus performed on an HIV-positive woman has never been definitely associated with transmission of HIV.

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The PARN Perspective: HIV is not a Crime

(Continued from previous page)

There are no studies investigating the impact of antiretroviral therapy on the possibility of transmission during oral sex. However, given the negligible possibility associated with this sexual activity and the ability of antiretroviral therapy to dramatically reduce the possibility of transmission, it is our expert opinion that the possibility associated with oral sex when the HIV-positive individual is on effective antiretroviral therapy approaches zero.

Other factors associated with the sexual transmission of HIV

Other factors have been associated with HIV transmission, including STIs and male circumcision. However, the influence of these other factors is eclipsed by either condom use or effective antiretroviral therapy in the HIV-positive individual. Each of these two significant factors has an overwhelmingly larger impact on the possibility of HIV transmission than either STIs or male circumcision.

The presence of an untreated STI, especially an ulcerative STI, in either partner has been associated with an increase in the possibility of HIV transmission. However, when used correctly and no breakage occurs, condoms are 100% effective at blocking the transmission of HIV; therefore, the presence of an STI would not increase the possibility of transmission. Clinical studies have not shown a conclusive correlation between an increase in the possibility of HIV transmission and the presence of an STI in individuals who are on effective antiretroviral therapy.

Large-scale trials in Africa have reported that male circumcision reduces by almost two-thirds the possibility of an HIV-negative man acquiring HIV as a result of intercourse with an HIV-positive woman.

Possibility of HIV transmission associated with biting or spitting

Being spat on by an HIV-positive individual poses **no** possibility of transmitting HIV. Being bitten by an HIV-positive individual poses a **negligible** possibility of transmitting HIV when the biting breaks the other person's skin **and** the HIV-positive individual's saliva contains blood. Otherwise, being bitten by an HIV-positive individual poses **no** possibility of transmitting HIV. Biting as a cause of HIV transmission is extremely rare and difficult to confirm. Saliva does not contain enough HIV to transmit the virus and unbroken skin is an effective barrier to the virus. In the small handful of cases in which HIV transmission was reported and attributed to a bite as the likely source, severe trau-

HIV AS A CHRONIC MANAGEABLE DISEASE

ma with extensive tissue (ie, skin) damage and blood were present. Dramatic advances in HIV therapy have transformed HIV infection into a chronic manageable condition. This shift is supported by scientific research demonstrating changes in the rate of death, the cause of death and the life expectancy of individuals living with HIV. The life expectancy for someone infected with HIV at 20 years of age is now estimated to be an additional 50 to 60 years after diagnosis due to the advent of antiretroviral therapy.

Recent modelling studies suggest that the death rate among some groups of people living with HIV is approaching that of the general population. Simply put, in Canada and other developed countries with advanced health care, HIV is no longer fatal. With early and proper care, individuals living with HIV can live long, healthy lives.

In addition to fewer deaths among people living with HIV, the causes of death are shifting away from AIDS-defining illnesses – infections such as *Pneumocystis* pneumonia (PCP) or cancers such as Kaposi's sarcoma – toward non-HIV-related causes. Broadly speaking, individuals living with HIV who receive care no longer die of AIDS, but of the same conditions as HIV-negative people. The main causes of death are now due to heart, liver and lung disease, and non-AIDS-related cancers.

Also, although HIV-related stigma and discrimination persists in our societies, the quality of life of individuals living with HIV has dramatically improved due to the availability of successful treatments.

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The PARN Perspective: HIV is not a Crime

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CONCLUSION

The expert opinion set out in the present statement is based on a review of the most relevant and reliable medical and scientific evidence. The present statement represents our consensus expert opinion, as leading Canadian HIV physicians and medical researchers, regarding the possibility of HIV transmission in various circumstances and the health consequences of HIV infection. We developed this statement because we have a professional and ethical responsibility to assist those in the criminal justice system to understand and interpret current medical and scientific evidence regarding HIV. We are concerned that miscarriages of justice may result when such evidence is not correctly understood or interpreted.

Acknowledgments

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Footnotes

[1]Canadian Medical Association, CMA Code of Ethics (updated 2004). Section 42 states: "Recognize the profession's responsibility to society in matters relating to public health, health education, environmental protection, legislation affecting the health or well-being of the community and the need for testimony at judicial proceedings"

[2]Blood may be involved in sexual transmission only in specific circumstances, such as sex during menstruation or rough sex leading to tissue damage and significant bleeding.

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(Continues on next page)

The PARN Perspective: HIV is not a Crime

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(Continues on next page)

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The PARN Perspective: HIV is not a Crime

Get Informed

The Criminalization of HIV Non-Disclosure

The criminalization of HIV non-disclosure is a complex issue that has stirred debate in our community in recent weeks.

We encourage anyone who is interested in learning more to visit some of the following resources dealing with the criminalization of HIV non-disclosure in order to help further your understanding of why the HIV movement largely rejects legal measures as a response to HIV.

The Ontario Working Group on Criminal Law and HIV Exposure (CLHE) has been working to convince Ontario's Attorney General to create prosecutorial guidelines to stop unjust prosecutions for HIV non-disclosure in Ontario. You can read more about their important work here:http://clhe.ca/

The Canadian HIV/AIDS Legal Network is working to change laws, policies and attitudes surrounding the criminalization of HIV non-disclosure. This page provides a wealth of information on this subject:http://www.aidslaw.ca/site/our-work/criminalization/

The HIV & AIDS Legal Clinic Ontario provides legal services to people living with HIV/AIDS in Ontario that are relevant to their well-being and that enable them to participate fully in the communities in which they live. Check out their resource page for a thorough overview of the criminalization of HIV non-disclosure in Ontario and Canada:http://www.halco.org/areas-of-law/hiv-criminal-law

Positive Women: Exposing Injustice is a 45-minute documentary film produced and directed by Alison Duke in 2012, that tells the personal stories of four women living with HIV in Canada — a Quebecker who was charged for not telling her partner that she had HIV at the beginning of an ultimately abusive relationship, a young woman who chose not to pursue charges against the man who infected her, an Aboriginal woman who has personally faced extreme stigma and threats, and a Latina woman who describes the challenges of disclosure and intimate relationships for women living with HIV. Their stories are real, raw and from the heart, and tell the truth about what it's like to live in a society that all-too-often criminalizes intimate behaviour between consenting adults and discriminates against those living with HIV. Legal experts, doctors, counsellors and support workers also lend their voices to challenge current Canadian laws that are letting down the very women they are meant to protect. You can watch this incredible film here: http://www.positivewomenthemovie.org/

For more information, contact PARN at 705-749-9110 or getinformed@parn.ca

gender journeys

Gender Journeys HKPR
http://tinyurl.com/genderjourneysHKPR
@GenderJourneys

TWICE MONTHLY DROP-INS

Our drop-in groups offer peer and one-on-one support for all trans and gender diverse individuals. Drop-ins offer a loosely structured forum for discussing current issues, connecting with local community, and getting practical and helpful information outside of our structured Gender Journeys programs. This is a peer facilitated drop-in group run by CMHA HKPR staff.

PETERBOROUGH DROP-IN

1st & 3rd Tuesday of the month
6:30pm - 8:30pm

Multi-purpose room, CMHA HKPR
466 George Street North, Peterborough
Use door at back of building (ring bell)

COBOURG DROP-IN

1st & 3rd Tuesday of the month
6:30pm - 8:30pm

Northumberland Hills Hospital
Community Mental Health Services
1011 Elgin Street West, Cobourg

LINDSAY DROP-IN

2nd & 4th Tuesday of the month
6:30pm - 8:30pm

Kawartha Lakes Reach for Recovery
64 Lindsay Street South, Lindsay

For more info please contact:

Jan Tkachuk, Program Coordinator
Tel: 705-748-6711 ext. 2102 | **Email:** jan@cmhahkpr.ca

Canadian Mental Health Association
Haliburton, Kawartha, Pine Ridge
Mental health for all

Ontario Trillium Foundation / Fondation Trillium de l'Ontario
An agency of the Government of Ontario / Relève du gouvernement de l'Ontario

United Way
Member Agency

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Where to go and what you need to know to get tested for HIV.

Questions?

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PARN - Your Community
AIDS Resource Network
159 King Street
Peterborough ON
Phone: 705-749-9110
OR 1-800-361-2895

For a testing site near you call the AIDS and Sexual Health Info Line: 1-800-668-2437

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