



TABLE OF CONTENTS

1.0	INTRODUCTION	2
2.0	APPLICATION	2
3.0	PRINCIPLES AND VALUES	4
4.0	OVERVIEW OF PROCESS	6
5.0	DETERMINATION OF RISK TO OTHERS.....	6
	Step 1: Receipt of Notification.....	6
	Step 2: Verification of HIV Status	7
	Step 3: Assessment of Risk.....	8
	Step 4: Consideration of mitigating and other relevant factors.....	10
6.0	INTERVENTIONS.....	11
	Option 1: Voluntary Measures.....	11
	Option 2: Involuntary Disclosure	13
	Option 3: Issuing and Enforcing an Order	14
7.0	OTHER CONSIDERATIONS.....	17
8.0	REFERENCES	18
	APPENDIX I – SUMMARY OF GUIDELINES	19
	APPENDIX II – ESTIMATED TRANSMISSION PROBABILITIES OF ACQUIRING HIV FROM AN INFECTED SOURCE BY ROUTE OF EXPOSURE	22
	APPENDIX III – SAMPLE ORDER (Adapted from Vancouver Coastal Health).....	23
	APPENDIX IV – SAMPLE LETTER (Involuntary Disclosure)	27



1.0 INTRODUCTION

In 1993, the BC Provincial Health Officer released guidelines to assist medical health officers (MHO) when considering how to approach people with Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS) who posed a risk of transmission of HIV to others. These *Public Health Guidelines for Managing Difficult HIV Cases* provided useful information for MHO, and were referenced and adapted by other jurisdictions. In 2010, these guidelines were updated to include advances in HIV/AIDS care, changes in the public health regulatory framework that provides for the collection, use and disclosure of information and legal interventions in relation to communicable diseases. Since 2010, there have been a number of important published studies which have specifically addressed the effect of HIV treatment on reducing the risk of HIV transmission. Furthermore, the US Centers for Disease Control and Prevention have recently published revised estimates of HIV transmission risk^[1] and the effectiveness of condoms in terms of preventing HIV transmission in MSM^[2]. The current revision includes this new information.

While acknowledging the need for guidelines outlining a public health approach to people with HIV/AIDS who may pose a risk of harm to others, it should be recognized at the outset that such cases occur rarely, and such an approach is only a minor (but necessary) component of the strategies for HIV prevention.

The foundation of a successful HIV prevention strategy is built upon a strong proactive educational, promotional, and supportive community approach. When a community approach is in place, people will be aware of HIV, will understand how to protect themselves and others and will have relevant educational materials and programs available to them. In addition, preventive outreach services will be working with populations with a higher incidence of HIV, supportive resources will be available to assist HIV positive individuals to cope with their infection, and the efforts of health services and community agencies involved will be effectively coordinated, with the needs of the clients paramount.

2.0 APPLICATION

The goal of this document is to guide MHO in the exercise of their powers and duties to protect the public from the spread of communicable diseases, in this case to prevent further transmission of HIV. These guidelines are designed to assist MHO in situations where a person poses a risk to others in consequence of his or her inability or refusal to act to prevent transmission of HIV.

The scope of these guidelines is restricted to advice about measures that are available to MHO¹ under the BC *Public Health Act* (PHA)^[3] and regulations when a person with HIV/AIDS is unable and/or refuses to act to prevent further transmission of HIV.² They cover the involuntary disclosure of information, the making of Orders, enforcement of Orders, and other actions.

¹ Note: These guidelines also provide guidance to individuals to whom the MHO has delegated authority in writing; for example, to a public health nurse (under PHA s74).

² Note: This guideline is to provide general orientation to the application of the PHA and related legislation for public health officials who are responsible for implementing the PHA and others affected by the PHA. This guideline is not legal advice and individuals should consult with their legal counsel in determining whether or to what extent the PHA may apply to a particular circumstance. In the event of a conflict between the guideline and the PHA, its regulations or related legislation, the latter prevail.



These guidelines do not address the public health practice of partner notification, which involves assisting an HIV-infected person to voluntarily inform sex and/or drug using partners that they may have been exposed to HIV. Such guidelines are found in the Guidelines for Testing, Follow up, and Prevention of HIV in Chapter 5, Section 2 of the BC Communicable Disease Control Manual[4]. Partner notification differs from involuntary disclosure, in that the infected person determines both the information that is communicated, and how it is communicated, to other persons

Nor do these guidelines address the legal responsibility of people with HIV/AIDS to communicate with their partners. There have been a number of high-profile criminal cases that have highlighted the issue of disclosure of HIV/AIDS-related information[5]. These cases have resulted in the imposition of criminal sanctions against individuals who were aware of their HIV status, but failed to inform risk partners, or take measures to protect partners from infection. The standard of disclosure, as it relates to the criminal law, is determined by the *Criminal Code of Canada* and relevant case law. Although the *Criminal Code* provides one source of law regarding HIV/AIDS and disclosure to others, it is the BC *Public Health Act* and its regulations which provide the legal framework for MHO to deal with difficult HIV/AIDS situations, and is the basis for these guidelines.

The purpose of these guidelines is to assist MHO in dealing with situations in which a person who has been diagnosed with HIV proves unwilling or unable to disclose his or her status to, and/or to cease engaging in high-risk behaviour with, a partner or partners. Non-disclosure of HIV status that results in a significant risk of infection for others occurs primarily in the following situations:

- An individual diagnosed with HIV engages in high risk sexual behaviour with partners without informing them about his or her infection and related risk.
- An individual diagnosed with HIV shares needles and/or other drug paraphernalia with other persons without informing them about his or her infection and related risk.

Any steps a person with HIV/AIDS takes to protect others from infection by HIV may be considered by an MHO in deciding whether or not to disclose that person's HIV status to third parties. For example, an infected person's use of latex condoms during sexual intercourse, engagement in effective HIV treatment resulting in a suppressed HIV viral load or refusal to share needles when using injection drugs, may satisfy a MHO that the person does not pose a significant risk of infection to others – in such instances, public health action may not be required.

A person's ability to control actions that may result in harm to others will determine whether he or she is "unwilling" or "unable" to comply with risk reduction strategies. "Unwilling or unable" people have been described as follows:

"Unwilling" people with HIV/AIDS:

- Possess the mental capacity and opportunity to comply with disclosure of their HIV status and have the capacity to pursue measures to protect others from HIV transmission, but choose to do neither, or
- Have been counseled regarding their responsibility to protect others and/or disclose to others concerning their HIV status, and remain unwilling to demonstrate appropriate corresponding behaviour, or
- Have knowingly made false statements regarding their HIV status to partners, or



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- Have in the past willfully or knowingly misrepresented their HIV positive status to partners and/or behaved in ways that expose others to a significant or unreasonable risk of HIV infection.

“Unable” people with HIV/AIDS:

- Have a diagnosed psychiatric or cognitive impairment such as organic mental illness, developmental disabilities or head injuries, or
- Have external or environmental reasons such as dependency, coercion by, or fear of other persons, which leads them to continue to engage in high risk behaviours, or
- Have no knowledge that they are infected with HIV.

In general, “unable” people with HIV/AIDS can be characterized as:

- Lacking the capacity to form the intention to prevent the spread of HIV; and/or;
- Lacking the capacity to form and implement a reasonable plan of conduct to prevent the spread of HIV.

To summarize, these guidelines set out a framework to assist MHO in working with people with HIV/AIDS who pose a risk of harm to other people because they are “unable or unwilling” to act to avoid transmitting HIV to others. They are not meant to be prescriptive, directive or exhaustive, but to offer guidance in the exercise of discretion.

3.0 PRINCIPLES AND VALUES

The basic principles and values underlying these public health guidelines are:

- The mandate of public health is to protect people, not to punish them.
- Public health interventions must balance the rights of the individual against the duty to protect the public, and sometimes the risk to public safety may outweigh the rights of the individual.
- The most effective measures for preventing HIV transmission within the population are ongoing participation in voluntary testing and treatment, counseling, education, and health promotion programs, which are intended to reach individuals or groups who may be more likely to acquire HIV.
- Reliance upon punitive measures to prevent the spread of HIV may have the opposite effect if fear of stigmatization, discrimination or punishment discourages participation in voluntary programs for HIV prevention and treatment, such as testing or partner notification.
- HIV prevention strategies adopted in partnership with physicians, other health care providers, and community groups, are considered most likely to succeed.
- All members of the public need to understand how HIV is spread, and how to protect themselves and others.

Basic values and principles that should inform decision-making when working with people with HIV/AIDS who pose a risk of harm to others have been articulated by a number of national and international groups. A national expert panel convened by the Federal / Provincial / Territorial



Advisory Committee on HIV/AIDS¹ has suggested that the following principles should inform the choice of management options, including the involuntary disclosure of information:

- Prevention should be the primary objective. The framework should be based fundamentally on a public health rather than a criminal law approach.
- The “least intrusive, most effective” approach to intervention should be followed.
- The focus should be on the risk of transmission posed by particular behaviours.
- Behaviours should be placed in risk categories.
- The response to the failure to disclose should be proportional to the risk of the particular behaviour.
- Specific measures should not be prescribed; rather, a list or menu ought to be provided to health care providers and public health officials to consider in particular circumstances.
- If a person engages in behaviour considered to pose a high risk for HIV transmission to others and the person discloses his or her HIV status to a sexual or drug injection partner, the health care provider should nonetheless counsel the HIV-infected person to modify the behaviour.
- Due process and Charter rights must be respected in interventions that are imposed by the state on the individual. This includes advance notice of the intervention, the right to counsel, timely reviews of decisions rendered, the right to a fair hearing, and the right to appeal decisions.

Finally, the starting point when dealing with public health related information is the obligation to maintain patient confidentiality. This is fundamental to the patient-health care provider relationship, and means that, except in rare situations, the health care provider must not disclose information without the patient’s permission. However, the right to confidentiality is not absolute. In some circumstances, disclosure of information without the permission of the patient may be justified, or even required.



4.0 OVERVIEW OF PROCESS

These guidelines set out a process for use in assessing whether or not a person with HIV might present a significant risk of transmission of HIV to others. As well, they offer options for response to such situations, and include relevant questions and standards to be considered with respect to each option. The application of these guidelines must always be subject to the judgment and discretion of the MHO; accordingly, the interventions are not presented as a strict, step-by-step continuum, but, rather, as options that may or may not be appropriate in particular situations. Further, each option is comprised of a number of elements which may or may not be applicable in any given setting or situation. For convenient reference, a two-page summary of these guidelines is included (see 8.0 – Appendix).

If the MHO is satisfied that the person is not putting, or is no longer likely to put, others unknowingly at risk with his or her behaviour, further intervention may not be warranted. However, other circumstances may indicate that follow up is warranted in order to ascertain whether or not the person's behavior continues to pose a low risk.

5.0 DETERMINATION OF RISK TO OTHERS

Step 1: Receipt of Notification

A MHO may receive reports from physicians, other health professionals, other professionals, or members of the public regarding the risk behaviours of individuals known, or suspected, to be living with HIV/AIDS. Reports may also arise from surveillance or partner notification activities indicating that an HIV positive individual has been named as a recent contact of someone newly diagnosed with HIV or are part of a phylogenetic cluster which is expanding. If such a report suggests that an individual may be placing a third party or parties at ongoing risk of infection with HIV, the MHO has a responsibility to investigate as set out below, and to take action, as appropriate. It should be made clear to an individual reporting a concern that the goal of intervention by an MHO is to prevent the spread of HIV.

The Communicable Disease Regulation (CDR) s6.2[6] describes the notification process for physicians who “reasonably believes that another person may be at risk of harm from an index patient”.³ If a physician comes to believe that a patient poses a risk of transmitting an infection of public health importance to one or more third parties, the physician may provide information about that person to the MHO, in accordance with *Communicable Disease Regulation* (CDR) s6.2.

Relevant matters for the physician to consider in this context include:

- i) What is the standard?

³ In sections of this guideline wording specific to physicians is used (reflecting the wording of the *Communicable Disease Regulation*). In future revisions of the CDR, this wording will change to include all health professionals (as reflected in the *Public Health Act*) and these guidelines will be updated accordingly.



The standard is that the physician “reasonably believes” the actions/behaviours of the person present a risk of infection to others. This is a relatively low standard, requiring that there be a rational basis for the belief that the person poses a risk.

ii) To whom does it apply?

The standard applies to patients that a physician knows or suspects to be infected with HIV. The patient need not have been tested for HIV.

iii) What actions are in question?

The regulation provides a fair degree of scope for the exercise of judgment on the part of the physician who must reasonably believe that “another person” may be “at risk of harm” (the harm being the transmission of the HIV virus). “Another person” may be anyone deemed at risk. For example, there is no requirement that the other person be a cohabitant. Neither is there a need to believe that the other person is definitely, or even likely, at risk of harm. Instead, the standard is only that they “may” be at risk of harm. Factors to consider when assessing the “risk” of behaviour are set out in step 3.

iv) What information may be provided?

The physician may provide the MHO with “relevant information.” This is defined broadly as: “any information that may, directly or indirectly, identify the patient.” This may include, but is not limited to, the person’s name, address, age, and sex. The key is to provide sufficient information to enable the MHO to locate the person and act to prevent harm to others.

It should be noted that the first step for a physician or other health professional, should be to provide risk reduction education and counseling to a person with HIV. Thereafter, if satisfied that the person does not pose a risk to others, further action need not be taken, although ongoing follow up may be warranted.

Step 2: Verification of HIV Status

The CDR s. 6.2 provides for confirmation of the HIV status of a patient by authorizing the physician to disclose information to the MHO, and the MHO to require the person to undergo examination.⁴

Confirmation of HIV status by the MHO is necessary, because a physician may provide information about patients who are infected with HIV, but also about patients whom the physician suspects to be infected with HIV. If the MHO is satisfied that a person is infected with HIV, the MHO should proceed to assess risk, as described below.

⁴ Note that MHOs may also receive reports from non-physicians about possible HIV infected individuals. MHOs are obligated to act on this information based on section 73 (2) of the *Public Health Act*, which requires them to monitor the health of the population in the area for which they have been designated. It is implicit in this section that MHOs are authorized to collect, use and disclose information for this purpose. Also relevant in this regard are sections 26, 27 (1) (a.1) and (b), 32 (c) and s.33.1 (1) (e) of the FOIPP Act, which, read together, authorize MHO to indirectly collect and use personal information necessary for the performance of their duties.



If the MHO only suspects that an individual is infected with HIV, the MHO may seek confirmation by:

- i) Asking the physician for more information about the person, under CDR s.6.2(2)(b)(i); or
- ii) Obtaining information from the regional and provincial communicable disease surveillance databases; or
- iii) Obtaining further information from the person: CDR s.6.2(2)(b)(ii). The MHO may request that the person undergo a test for HIV. If the person is not cooperative, the MHO may issue an Order for testing and examination of the person, under PHA s27, 28, 29, or 49 (see Appendix II for sample Order).
- iv) (If it is confirmed that a person is infected with HIV, the next step is the assessment of risk. If the MHO is satisfied that the person is not infected with HIV, further action may not be necessary, although counseling about the reduction of behaviours that may increase the transmission of HIV may be warranted.

Step 3: Assessment of Risk

Although the CDR provides that an MHO may disclose a person's HIV status to others if there is risk of harm to those others, it should be noted that there are different levels of risk. The MHO must consider the degree to which a person's actions constitute a risk to the health of others before determining how to proceed.

Working in partnership with other health care professionals (including the reporting physician or health professional, and public health nurses) and the person infected with HIV, the following should be considered by the MHO when assessing the overall degree of risk of harm to others the infected person poses, and the potential for interventions to successfully reduce harm:

i) The risk associated with specific behaviours

Not all actions create the same degree of risk. The United States Centers for Disease Control and Prevention has recently calculated revised estimates for the risk of HIV transmission associated with different types of exposures[1]. These provide a good model which can be used as a guide for assessing the degree of risk associated with certain behaviours (see – Appendix II).

ii) The person's HIV status and management of HIV infection

In addition to assessing the risk of transmission associated with a person's actions, it is also important to take into account the status and management of the person's HIV infection. Research has demonstrated that a person's infectiousness will vary over the course of an HIV infection based on disease stage, HIV viral load counts and antiretroviral treatment. For example, an HIV infected individual who is receiving treatment and has a viral load <200 copies/ mL person has a negligible risk of transmitting HIV to their sexual partners[7]. Likewise, individuals in the acute or early stage of HIV infection and those who have advanced HIV disease or AIDS are more likely to transmit HIV to others because their viral



loads are naturally high at these times[8]. If information about a person's clinical stage of infection, viral load and treatment status is available to the MHO, it is useful to consider these factors in the overall context of assessing the risk of harm posed to third parties.

iii) The physical setting or context in which risk occurs

The setting or context for the behaviour(s) that constitute a risk may also have some bearing on the type of intervention that is considered. For example, it may be reasonable to conclude that individuals within an environment such as a bath house who engage in anonymous sexual intercourse with a number of partners, or individuals exchanging goods or money for sex, are aware of the likely higher prevalence of HIV in these situations, and that the risk of HIV infection is significant. Likewise, participants in group sharing of equipment for drug injection may be assumed to understand that they are putting themselves at risk of HIV infection. In circumstances such as these it may be reasonable to assume that all participants have some understanding that their activities may lead to infection with HIV. Accordingly, it is important that MHO consider whether the individual(s) who are at risk of infection from the infected person may be aware of their risk, even in the absence of explicit disclosure of HIV status on the part of the infected person. Consequently, it may be that in some situations it would be unreasonable to expect the infected person to disclose his or her HIV status to each risk partner, and that any intervention should be focused on the infected person's use of risk reduction techniques.

iv) Epidemiologic context

Information from surveillance or partner notification activities may also suggest an ongoing transmission risk, for example if an HIV positive individual has been named as a contact by one or more individuals who have been newly diagnosed with HIV, or is part of a phylogenetically-defined cluster of HIV-infected individuals which is expanding.

v) The estimated duration of exposure and whether this exposure is ongoing

If the infected individual likely has had longstanding HIV infection potential exposures are limited to a single low-risk partner, then the urgency in applying interventions may be less than for someone with acute infection and multiple partners.

vi) The person's willingness and ability to comply with voluntary measures

The purpose of the risk assessment is to determine the likelihood that the infected person will continue to engage in behaviours that pose a risk for HIV transmission, and also to identify the supports or interventions which should be put in place or used to guide the person to avoid putting others at risk of infection. The person should be consulted in order to assess matters such as:

- Knowledge of HIV/AIDS.
- Awareness of behaviours that increase the risk of HIV transmission.



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- Awareness of the measures which can reduce the risk of HIV transmission such as using condoms or seeking HIV treatment.
 - Availability of support systems, including access to appropriate medical care.
 - Need for education or counseling.
 - Presence of medical or psychological conditions that might affect their ability to make informed decisions and take appropriate actions

The MHO should also assess the willingness and ability of the person to comply with voluntary measures to reduce the risk of HIV transmission. The following may indicate that a person is unwilling or unable to act to reduce the risk of infecting others:

- Express or implied refusal to receive counseling.
- Express or implied refusal to take appropriate precautions in behaviour (e.g. refusal to use condoms).
- Express or implied refusal to initiate and maintain effective HIV treatment
- Express or implied refusal to disclose HIV status to sex and/or drug injecting partners.
- Clinical evidence that the person continues to engage in activities that pose a high risk of HIV transmission (e.g. presentation with a sexually transmitted disease after HIV diagnosis and counseling).
- A serious substance use problem that may impair judgment.
- A physician's report containing a clinical opinion that the person is not reducing behaviours that pose a risk of HIV transmission to others.
- A credible report from a third party that the person is not reducing behaviours that pose a risk of HIV transmission to others
- Mental health problems that may influence judgment.

Step 4: Consideration of mitigating and other relevant factors

When assessing activities that may constitute a risk of transmitting HIV, the MHO should be aware of the possibility that other factors may be contributing to the person's ability to take appropriate precautions. In some situations these may militate against a decision to take action related to a person's behavior, or to disclose his or her HIV status.

In particular, the MHO should screen for the possibility that the person is at risk of domestic violence. If the MHO learns that an HIV-infected person is at risk of violence from a partner, disclosure to that partner could pose a threat to the safety of the infected person, his or her children, or others who are close to the person. In such cases, the MHO may consider deferring third party notification.

A person at risk of violence should be referred to relevant counseling and support services, including counseling about practices and behaviours that decrease the risk of HIV transmission. Follow-up should take place to ascertain HIV status and reassess the threat of domestic or other violence. It is always the responsibility of the MHO to balance the competing interests of the third party and the infected person. MHO are encouraged to make such decisions in consultation with the person and the person's physician in order to maximize the safety of the person while assessing when, or if,



concerns about the safety of the person are sufficiently allayed to permit third party disclosure to proceed.

Other situations that may require the MHO to balance competing interests may include, but are not limited to, instances where the infected person is part of a small community and there is a risk that disclosure of HIV status to a partner will result in the community learning about the infection, with the result that the infected person may be put at risk of harm from members of the community. Examples of such situations may include individuals resident within a correctional facility, and individuals living on some First Nations reserves.

6.0 INTERVENTIONS

While it is recognized that it may be very difficult to assess degree of risk because of the difficulty of obtaining reliable information about an infected person's behaviour, the MHO's decision on how to proceed should be based upon a consideration of the results of the assessment of risk and the possible consequences of potential interventions. Proceeding on this basis, the MHO should determine the most appropriate course of action (e.g., education and voluntary measures, involuntary disclosure of the person's HIV status, or issuance or enforcement of a public health Order). The following guidelines may serve to inform this decision-making process:

- i) Regardless of risk level, if satisfied that the person has disclosed and will continue to disclose their HIV status to their partners prior to actions that risk transmission of HIV, more intrusive measures are generally not indicated. Counseling and education should continue as appropriate.
- ii) If there is negligible risk and no voluntary disclosure, in most circumstances only voluntary risk management measures such as education and counseling should be implemented.
- iii) If there is any non-negligible risk and no voluntary disclosure of HIV status, intervention should be considered, with the least intrusive measures utilized first. The urgency in applying the interventions and the nature of the interventions should be proportionate to the assessed risk of transmission.

If at any point the MHO is satisfied that the person has altered his or her behaviour so that others are no longer at risk, further intervention may not be warranted. However, other circumstances may indicate that ongoing support and follow up is warranted to ensure that the person's behavior continues to be low risk.

Option 1: Voluntary Measures

If the MHO believes that the person poses a risk of HIV transmission to others, voluntary measures to address that risk should first be pursued.

Voluntary measures may include, but are not limited to:

- i) Education and counseling



It is widely recognized that interventions which are the least intrusive, least restrictive and most readily available are often the most effective in reducing the risk of transmission of HIV. Consequently, MHO should ensure that the infected person is aware of and has been referred to appropriate supports, such as education and counseling. This may take the form of ongoing sessions over an agreed-upon period of time, and should include other health care providers who are aware of the person's HIV status, such as the physician, public health nurse, and, in some instances, mental health care providers.

Education and counseling sessions should address issues such as:

- Provision of information relevant to education about HIV transmission and the factors that increase and decrease the risk of transmission, including the use of HIV treatment.
- Teaching skills to help avoid the transmission of HIV.
- Modeling open and effective communication with third parties who may be at risk of HIV infection.
- Anticipation and preparation for situations that will arise over the course of the person's HIV infection.

During education and counseling, assessment of the need to reinforce safer sex and drug-using practices may take place, and may lead to the implementation of further measures and precautions.

ii) Establishment of an oral or written agreement

Establishing voluntary objectives with the infected person in the form of an oral or written agreement may be another measure used to reduce risk. The objectives should ensure that the person obtains and acts on appropriate education, counseling and other support. These may include an agreement to use condoms and other preventive measures whenever having sexual intercourse and/or to use clean needles and syringes and not sharing injection equipment when using injection drugs. An oral agreement may, if the MHO considers it effective and appropriate, be confirmed and documented through a letter to the person, which would outline the agreed-upon course of action, establish a timeframe for this action, and set out a schedule for follow-up consultations. The MHO may also establish a written agreement with the infected person (pursuant to PHA s38), which would be signed by the person.

iii) Assistance with notification and counseling of partners

If the identity of the infected person's partners or contacts is known to the MHO, the MHO may offer to inform these partners or contacts on behalf of the person (without identification of the person). This is a routine public health practice which is typically followed when a person is first diagnosed with HIV, but which may also be employed in this context.

iv) Assistance with initiation and continuation of appropriate HIV treatment

HIV treatment has been shown to dramatically reduce the risk of HIV transmission. Early initiation of HIV treatment was shown to be 96% effective in reducing genetically-linked HIV infections within HIV serodiscordant couples in a large multicenter randomized trial[9].



Furthermore, in a study of 586 heterosexual and 308 MSM HIV serodiscordant couples where the viral load of the HIV-infected member of the couple was <200 copies/ mL and the couples reported having sex without condoms, no seroconversions have been observed in over 890 person-years of observation[7]. As such, initiating HIV treatment and ensuring that a viral load of <200 copies/ mL has been achieved can be viewed as an effective means of reducing onward transmission of HIV. The MHO should ensure that the infected person is aware of the preventive benefits of HIV treatment and has been referred clinical care where the physician is experienced in the medical management of HIV infection.

v) Engaging in treatment for drug or alcohol use disorder(s), if appropriate.

If a substance-use disorder is an important component of the risk posed to sexual or drug using partners of the infected person, then engaging in appropriate treatment may be considered an effective risk reduction mechanism.

In the event that follow-up consultations with the person reveal that he or she has reverted to high-risk behaviour and/or continues to fail to disclose his or her status to partners, and has not initiated HIV treatment with evidence of a suppressed viral load, the MHO should consider the possibility of more intrusive measures such as involuntary disclosure of the person's HIV status to contacts, and MHO orders.

Option 2: Involuntary Disclosure

If the MHO's assessment reveals that the person is engaging in high risk activities and shows no willingness or ability to mitigate the risk by altering these behaviours or informing the person's partners or contacts, and the person does not accept the offer by an MHO to inform these partners on behalf of the person, the MHO should consider more direct intervention to protect third parties who may be at risk. If the MHO knows the identity of the person's partners or contacts, and there is evidence of on-going or recent high risk behaviors involving these individuals, the MHO may consider involuntary disclosure of that person's HIV status to third parties.

There are two possible routes for involuntary disclosure:

- i) Without identification of the infected person: Notification of third parties of their possible exposure to HIV without identification of the infected person is desirable in most circumstances.
- ii) With identification of the infected person: If disclosure without identifying the person's identity is not practical or possible, the MHO should consider disclosing information about the person's HIV status and identity to those who may be at risk of harm.

Section 6.2(2)(b)(iii) of the CDR authorizes the MHO to disclose private information about a person. This authority is a reflection of the MHO's duty to protect the health of the public, and an exception to the general rule that personal health information is confidential.

The following factors should be considered before involuntary disclosure of a person's HIV status to a third party is considered by a MHO:



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- The person's HIV status is established as positive.
 - There are reasonable grounds to conclude that the person is engaging in high-risk behaviour.
 - The person has been offered support, education and counseling and is unwilling or unable to alter his or her high-risk behaviour.
 - The person has been offered ongoing medical care including HIV treatment to ensure that they have effectively reduced their risk of transmitting HIV but is unwilling or unable to do so.
 - The person is unwilling or unable to inform a third party who is at risk of HIV transmission about their HIV positive status.
 - The person has refused a physician's and/or MHO's offer to inform the third party on behalf of the person.
 - There is no mitigating reason to postpone or reconsider informing the third party of the person's HIV-positive status.
 - There are reasonable grounds to believe an identifiable third party or third parties is/are at continued risk of HIV transmission because of the infected person's high-risk behavior.
 - The third party has no other reasonable way of knowing their risk, or is unable to assess their risk of HIV infection.

Before disclosing to a third party, the MHO should inform, or make reasonable attempts to inform, the infected person of his or her intention to disclose information to a third party without the person's consent[10]. If feasible, and if time permits, this should take the form of a letter to the person, stating that the person has continued to engage in high-risk behaviour despite efforts to educate and counsel the person; stating that the person has not taken voluntary measures to reduce the risk of transmission; reiterating the requirement to alter high-risk behaviour; and referencing CDR section 6.2(2)(b)(iii) (see sample letter in Appendix IV). If a letter is not possible, the person should be orally informed of the MHO's intention to disclose and the reasons for this, and the conversation should be documented.

In some cases, where a person has been assessed as unable to take steps to prevent the transmission of HIV due to cognitive impairment, s.33.1(1)(m) of the *Freedom of Information and Protection of Privacy Act* (FOIPPA) provides an MHO with the authority to consult with and communicate personal information to the infected person's appointed committee, guardian or representative, if the person has one, or with social workers or other professionals involved in their care.

In the case of a person who poses a risk more generally to the community, or to a wider group of people (e.g., a sex worker), the MHO should seek the advice of the Provincial Health Officer and legal counsel with respect to balancing the privacy rights of the person against the public health duty to respond to public health threats and warn about health risks. Other measures, such as providing general education about HIV prevention to the public or community may be appropriate in this scenario.

Option 3: Issuing and Enforcing an Order



Following involuntary disclosure to a third party, or based on other circumstances, if the MHO reasonably believes that the person continues to pose a risk of harm to others, and voluntary and other measures have been exhausted, it may be appropriate to employ other measures available under public health law. The use of these measures should be discussed with the Provincial Health Officer and legal counsel, and advice sought on the content of any Orders being considered, and the legal process to be followed. See Appendix III for a template of an Order.

For example, the MHO may decide that a formal Order under the *Public Health Act* is warranted. The purpose of issuing an Order is to require behaviour change in order to protect others, and to establish the basis for enforcement actions or court ordered detention, should this prove necessary. Such an Order is issued pursuant to PHA sections 27-29, and a wide range of terms may be included, such as requiring the person to:

- Be under the care of a physician.
- Provide the MHO with information about contacts.
- Be examined (including mental health exams) and tested.
- Take preventive measures (e.g. informing contacts of HIV status, using condoms, initiating and continue HIV treatment).
- Provide evidence of compliance with the Order. (e.g.: monitor HIV viral load)
- Take other action the MHO reasonably believes to be necessary to prevent transmission of infection.
- Stay in a place.
- Stay away from a place.

The choice of measure(s) to include in an Order will depend upon the MHO's determination of risk, and the unique circumstances of the individual whose behaviour may pose a risk of harm to others. Legal advice should be obtained on the drafting of the Order, since the ability to take subsequent legal action may depend on the wording of the Order (see Appendix IV for a sample Order). If a recipient of an Order may have difficulty understanding the Order in consequence of low literacy or cognitive impairment, it would be advisable for the person serving the Order to be accompanied by someone who could explain the Order to the recipient in terms the person will understand.

The requirements related to an Order (contents, instructions to other people such as examiners, service of Orders, expiry of Orders) are found in PHA s. 39-46, and the Public Health Inspections and Orders Regulation (PHIOR) sections 3 and 4. An Order should state, with as much specificity as possible, the authority under which it is made. This may be done by listing all the references to legislation at the beginning of the Order, and/or beside each term of the Order. When an Order contains many provisions, it may be easier for the person to whom it is directed if each provision refers to the authorizing legislation.

The PHA permits a person to have an Order reconsidered, reviewed, and reassessed. An Order must contain information about how the person may have the Order reconsidered under PHA s.43, and should contain information about the person's entitlement to seek a review and/or reassessment, if relevant, under PHA s. 44 and 45 and PHIOR s.4. A copy of all relevant



legislative provisions should be provided to a person to whom an Order is directed, including PHA s.42 (duty to comply with Orders).

If the MHO who issues an Order becomes aware that the person has moved residence to another region of BC, he or she should notify the MHO of the new area of residence. It is not necessary to re-issue the Order (see PHA s.42). If the MHO of the new area of residence has information that leads the him or her to believe that a person in their designated area is in violation of an Order made elsewhere in British Columbia, that MHO is the appropriate MHO to take enforcement action. If an MHO becomes aware that the person under an Order has moved residence outside of BC, he or she should inform the Division of STI/HIV Prevention and Control, who will inform the appropriate public health authority of that region, if feasible.

If a person is not complying with an Order, the MHO has discretion about whether to enforce the Order. There are three enforcement options:

i) Laying of charges

Contravention of an Order is an offence and proceedings may be initiated by laying an information under the *Offence Act*, section 25. It should be pointed out that the failure to comply with Orders made under PHA s. 29 (2) (e) to (g), respecting examinations or preventive measure, is excluded from the offence provisions of PHA s. 99 (1) (k), and cannot be the basis for prosecution. Such a failure may, however, provide the basis for seeking an injunction (see below). If a person is found guilty of contravening an Order, the Court may impose alternative penalties (see PHA s.107), a fine, incarceration, or any combination of these. Since it may be difficult to enforce alternative penalties, it may be advisable to seek a combination of penalties and to request the Court to suspend the fine and/or incarceration so long as the person is complying with the alternative penalty.

ii) Applying to the court for an injunction

An application for a mandatory injunction may be made under s.48 of the *Public Health Act*, if a MHO has evidence that a person is failing to comply with an Order. An injunction is sought by way of an application to the Court, supported by affidavits providing evidence of the contravention of an Order, and requesting the Court to require the person to comply with the Order. An application for an injunction gives the MHO more control over the proceedings than does a prosecution, since the MHO retains and instructs his or her own counsel, rather than relying on Crown counsel. Another distinction is that an injunction is a civil remedy which requires proof on a balance of probabilities (more likely than not), as compared to a conviction which requires proof beyond a reasonable doubt. In the event that a mandatory injunction is issued, and the MHO learns that the person is failing to comply with it, the MHO may bring the matter back before the Court on the basis that the person is in contempt. If found guilty of contempt, the person may be fined or incarcerated, or both.

iii) Applying to the Court for a detention Order



In the unlikely event that a MHO decides that a court ordered detention may be warranted to prevent transmission of HIV and to facilitate treatment, education and counseling, an application may be made, with approval of the Provincial Health Officer, to the Provincial Court in accordance with PHA s. 49 and PHIOR s. 5 (which references the appropriate form 3). Evidence will need to be provided to the Court that the person is infected, and either has contravened an Order to stay in a place or not enter a place, or an Order to remain in a place or not enter a place is not practical, and the person is a danger to public health. The application must also provide information about where the person is to be detained, the length of the detention, and any terms which should be included in the Order, such as provisions for examination, treatment and counselling.

7.0 OTHER CONSIDERATIONS

Except in the most extraordinary of circumstances, public health legislation should be sufficient to deal with people with HIV/AIDS who pose a risk of harm to others. Many commentators have reiterated the preference for relying upon public health measures in all but the most intractable situations[11].

It should not be necessary for an MHO to refer a matter to the police for criminal investigation in order to protect the public health from the transmission of HIV, given the broad range of measures in British Columbia's public health laws which are available to MHO. In the unlikely event that an MHO does consider that a referral to the police may be necessary in order to protect the public health, it is strongly recommended that the MHO discuss the matter with the Provincial Health Officer and legal counsel before proceeding to do so.



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APPENDIX I – SUMMARY OF GUIDELINES

KEY CONCEPTS: These guidelines:

- Apply when persons with HIV infection are unable or refuse to act to prevent transmission of HIV and pose a risk to others (“unwilling or unable”).
- Are based on a public health approach, and provide a framework for Medical Health Officers (MHO) or delegates based on their powers under the *Public Health Act*[3] and *Communicable Disease Regulation*[6]. Prevention of transmission of HIV infection is the primary objective.
- Are not prescriptive, since MHO must act based on their judgment and discretion, adopting a least intrusive and most effective approach. The guidelines do not set out a step-by-step approach but suggest a series of options for intervention, which may or may not be appropriate in any given case.
- Have two main components: i) determination of risk to others; and ii) suggested interventions once risk is verified.

DETERMINATION OF RISK TO OTHERS (p 6)

Step 1	<p><u>Receipt of notification</u> (p 6)</p> <ul style="list-style-type: none"> • A physician, with a reasonable belief that a third party may be at risk of infection from someone who has or may have HIV, may forward relevant information to the MHO • A MHO may receive reports from other service providers or members of the general public regarding the risk behaviours of individuals known or suspected to be living with HIV/AIDS • A MHO may receive information that the a person living with HIV has been identified as a sexual or drug-use partner of individuals newly diagnosed with HIV or that they are part of a phylogenetic cluster which is expanding.
Step 2	<p><u>Verification of HIV status</u> (p 7)</p> <ul style="list-style-type: none"> • HIV status may be confirmed by asking the physician for more information, obtaining information from HIV surveillance databases, asking the person for information, or requesting the person to be tested for HIV
Step 3	<p><u>Assessment of risk</u> (p 8)</p> <ul style="list-style-type: none"> • In order to gain a reasonable understanding of the degree of harm to others which the person poses, the MHO should assess the following: <ul style="list-style-type: none"> i) The risks associated with specific behaviours. ii) The person’s status and management of HIV infection, especially the use of effective HIV treatment. iii) The setting or context in which risk occurs. iv) Whether the individual has been named as a sexual or drug-use partner of individual(s) newly diagnosed with HIV or other STIs. v) Whether the individual is part of a phylogenetically-defined HIV transmission cluster which is expanding. vi) The estimated duration of exposure and whether this exposure is ongoing. vii) The person’s willingness and ability to comply with voluntary measures.
Step 4	<p><u>Consideration of mitigating and other relevant factors</u> (p 10)</p>



	<ul style="list-style-type: none"> • MHO should consider whether there are any factors that may be contributing to a person’s behaviour; such as domestic violence or fear of harm resulting from disclosure. • MHO may consider referral for counseling and support.
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INTERVENTIONS (p 10)

- If satisfied HIV status has been disclosed and will be disclosed, intrusive measures are generally not indicated.
- .
- If risk is negligible and no voluntary disclosure of HIV status, in most cases voluntary measures should be implemented.
- If there non- negligible risk and no voluntary disclosure of HIV status, intervention should be informed by the options below, with the least intrusive measures used before more coercive measures are considered. The urgency in applying the interventions and the nature of the interventions should be proportionate to the assessed risk of transmission.
- **If at any point the MHO is satisfied that others are no longer at risk, further public health action may not be warranted**

Option 1	<p><u>Voluntary measures</u> (p 11)</p> <ul style="list-style-type: none"> • Education and counseling. • Establishment of an oral or written agreement, which may include an agreement to use condoms and other preventive measures whenever having sexual intercourse and/or to use clean needles and syringes and not sharing injection equipment when using injection drugs . • Assistance with notification and counseling of partners. • Initiation and continuation of HIV treatment, along with regular medical monitoring. • . • <u>Engaging in treatment for drug or alcohol use disorder(s), if appropriate.</u>
Option 2	<p><u>Involuntary disclosure</u> (p 13)</p> <ul style="list-style-type: none"> • Refers to involuntary disclosure of a person’s HIV status to an identifiable third party, with or without identification of the person. • The following factors should be considered prior to involuntary disclosure: <ul style="list-style-type: none"> a) Person’s HIV status is established as positive. b) Reasonable grounds to conclude continued engagement in high risk behaviour. c) Support, education and counseling have been offered and person is unwilling or unable to alter high risk behaviour. d) The person has been offered to offered HIV treatment and ongoing medical care but is unwilling or unable to do so e) Person is unwilling or unable to inform a third party at risk about their HIV status. f) Person refuses physician or MHO offer to inform third party on behalf of the person. g) No mitigating or other relevant factor identified. h) Reasonable grounds to believe identifiable third party (parties) at continued risk because of ongoing high-risk behaviour.



	<ul style="list-style-type: none"> i) Third party has no reasonable way of knowing the risk, or is unable to assess the risk. • Prior to disclosure, MHO should inform, or make reasonable attempts to inform, the person of intention to disclose information to third party, without the person’s consent
Option 3	<p><u>Issuing and enforcing an Order</u> (p 14)</p> <ul style="list-style-type: none"> • Other measures have been exhausted and MHO has reasonable belief that person continues to be unable and/or unwilling to prevent further transmission of HIV. • Enforcement powers are provided to MHO by <i>Public Health Act</i> for protection of public health. • Use of Orders should be discussed with Provincial Health Officer and legal counsel. • Orders must meet certain requirements (sample Order in Appendix II), including information about how person can have Order reviewed and/or reassessed. • If person is not complying with an Order, enforcement options include: laying of charges; applying to the Court for an injunction; and applying to the Court for a detention Order.

OTHER CONSIDERATIONS (p 17)

- Except in the most extraordinary situations, public health legislation should be sufficient to protect public health.
- In the event that an MHO considers referral to police necessary to protect the public health, prior discussion with the Provincial Health Officer and legal counsel is strongly recommended.

**APPENDIX II – ESTIMATED TRANSMISSION PROBABILITIES OF ACQUIRING HIV FROM AN
INFECTED SOURCE BY ROUTE OF EXPOSURE**

HIV viral load of potential source	Type of act	Use of condoms or other barriers	Estimated risk per 10,000 acts[1]	Level of risk
Unsuppressed (>200 copies/mL)	Sharing needles or syringes when using injection drugs	N.A.	63 (41–92)	High
	Receptive penile-anal intercourse	No barrier	138 (102–186)	High
		With barrier	41 (31 – 56)*	Moderate
	Insertive penile-anal intercourse	No barrier	11 (4–28)	Moderate
		With barrier	3 (1-8)*	Moderate
	Receptive penile-vaginal intercourse	No barrier	8 (6–11)	Moderate
		With barrier	2 (2 – 3)*	Moderate
Insertive penile-vaginal intercourse	No barrier	4 (1–14)	Moderate	
	With barrier	1 (0 – 4)*	Low	
Oral sex (insertive or receptive)	No barrier	N.A. (0–4)	Low	
Suppressed (<200 copies/mL)	Any sexual act	With or without a barrier	<1 (0 - 30)[7]	Very Low/ Negligible
	Sharing needles or syringes when using injection drugs	N.A.	No data, but likely very low	Very Low/ Negligible

* 70% reduction in HIV transmission associated with consistent condom use for male-to-male sex (reference [2]) and for heterosexual sex (reference [12]).



APPENDIX III – SAMPLE ORDER (Adapted from Vancouver Coastal Health)

**NOTICE TO A PERSON SUSPECTED OR KNOWN TO BE INFECTED WITH A
REPORTABLE
COMMUNICABLE DISEASE
ORDER OF THE MEDICAL HEALTH OFFICER
(Pursuant to Sections 27, 28 and 29, *Public Health Act*, S.B.C. 2008)**

TO: **[name]**

DOB:

ADDRESS:

After reviewing reports and other information provided to or obtained by me in my capacity
as

Medical Health Officer, I have concluded that there are reasonable grounds to believe that:

1. You are infected with Human Immunodeficiency Virus (HIV), a reportable communicable disease (the “Communicable Disease”) under the Public Health Act, S.B.C. 2008, c28.
2. You have been aware of your HIV status since **[date]**.
3. You have received counseling regarding disclosure of your HIV status and regarding precautions needed to prevent transmission of HIV to others, and
4. You have knowingly exposed others to HIV, and
5. You are a person likely to expose others to HIV.

In order to protect the public from contracting the above named reportable Communicable Disease, I hereby exercise my authority under section 29 of the Public Health Act (“PHA”) to order that:

1. You must place yourself under the care of Dr. **[name]** at:

[clinic name, address & phone number]

You must attend appointments weekly (once a week) with Dr. **[name]** (or another physician if Dr. **[name]** is not available) at the Clinic until 30 days after your HIV viral load is first demonstrated to be undetectable by a viral load test.



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2. You must have an HIV viral load test performed at the Clinic once every 30 days. Once your viral load has been demonstrated to be undetectable for one full calendar year, the frequency of viral load tests can be reduced to no less than one viral load test every 90 days. [PHA s. 29 (2) (d) (f) and (h)]
 3. You must pick up all antiretroviral medications prescribed for you, and you must at all times have sufficient antiretroviral medications in your possession to avoid any interruption in your prescribed antiretroviral treatment. [PHA s. 29 (2) (g)]
 3. At any time, if your HIV viral load is elevated to above 200 copies/mL, or a viral load test has not been performed within the time intervals prescribed by this Order, you must attend daily appointments at a location directed by a Medical Health Officer or Public Health Nurse where daily witnessed ingestion of medication can be done. You must continue to attend these daily appointments until the results of a viral load test show that your viral load is below 200, and a care plan has been put in place with the approval of a Medical Health Officer or a Public Health Nurse. [PHA s 29 (2) (c) (g) and (i).]
 4. Your attending physician, Dr. **[name]**, will be given a copy of this Order, and must provide Dr. **[name of MHO]** with copies of your consultation letters and laboratory tests, including information about your viral load, CD4 count and any newly diagnosed sexually transmitted infections. [PHA s. 40 (1)]
 5. You must inform all present and future sexual partners that you are infected with HIV **before** you have sexual contact with them. If a viral load test indicates that your viral load is detectable (is above 200 copies/mL), or a viral load test has not been completed at the intervals prescribed by this Order, you must notify sexual partners **before** you have any sexual contact with them that you are HIV positive **and virally unsuppressed**. [PHA s. 28 (1) (b), and s.29 (2)(b)]
 6. You must avoid sexual contact with other people in circumstances where the discharge or exchange of bodily fluids is possible, except where you are wearing a condom or otherwise in the following circumstance:
 - a. you are having HIV viral load tests at the intervals prescribed by this Order;
 - b. you have been advised by Dr. **[name]** (or another physician at the Clinic) that your last viral load test indicates that your viral load is undetectable; **and**
 - c. you have been taking antiretroviral medications as prescribed to you, without interruption, since your last examination at the Clinic.

[PHA s. 28 (1) (b) and s. 29(2)(g)]



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7. You must refrain from sharing needles with any person for any purpose, including injection, drug use or tattooing. [PHA s. 28 (1) (b)]
 8. You must meet with a Medical Health Officer or Public Health Nurse as directed by a Medical Health Officer. You must respond to telephone or text communications from a Medical Health Officer or Public Health Nurse within one hour of receiving the communication, and you must make yourself available to meet with a Medical Health Officer or Public Health Nurse within one hour of a request from the Medical Health Officer or Public Health Nurse, or as close to one hour as is reasonably possible in the circumstances. [PHA s. 28 (1) (b)]
 9. You must provide advance written notice to Dr. **[name of MHO]** at the address listed below if you intend to change your place of residence, and must provide her with your new address and contact information, including phone numbers. [PHA s. 28 (1) (b)]
 10. You must obtain permission from Dr. **[name of MHO]** in writing before leaving the province of British Columbia for any length of time.
 11. In addition to any other set out in this Order, you must take all reasonable steps to ensure that your HIV does not cause danger to other individuals. If you are not taking tests and treatment as directed by Dr **[name]**, or medication, you must immediately notify Dr. **[name]** (or another physician at the **[clinic name]**) who will report this information to Dr. **[name of MHO]**. If you do not consent to treatment and you are determined to be (or later become) a risk to the public health, additional enforcement actions may be taken against you under the authority of the *Public Health Act* to mitigate that risk.

You may contact the author at:

[name of MHO]
[address of MHO]
[telephone & fax of MHO]

This Order does not expire. I will review the terms of the Order on dd/mm/yyyy .



In accordance with section 43 of the PHA, you may request me to reconsider this Order if you:

1. Have additional relevant information that was not reasonably available to me when this Order was issued,
2. Have a proposal that was not presented to me when this Order was issued but, if implemented, would
 - a. meet the objective of the Order, and
 - b. be suitable as the basis of a written agreement under section 38 of the PHA.
3. Require more time to comply with the Order.

A review of this Order may be requested under section 44 of the Public Health Act, but only after reconsideration has been made.

You are required by section 42 of the PHA to comply with this Order.

If you fail to comply with this Order, I have the authority to take enforcement action against you under Part 4, Division 6 of the PHA.

DATED THIS: Month DD, YYYY

SIGNED: _____
Dr. **[name of MHO]**
Medical Health Officer, **[Name of health authority]**



APPENDIX IV – SAMPLE LETTER (Involuntary Disclosure)

<Include copy of relevant sections of legislation>

TO: *< Insert name of person >*
DOB: *< Insert date of birth >*
ADDRESS: *< Insert address >*

After reviewing reports and other information provided or obtained by me in my capacity as Medical Health Officer, I have concluded that there are reasonable grounds to believe that:

1. You are infected with Human Immunodeficiency Virus (HIV), a reportable communicable disease under the *Public Health Act*, S.B.C. 2008, c28.
2. You have been aware of your HIV status since *< Insert date >*.
3. You have received counseling regarding disclosure of your HIV status and regarding precautions needed to prevent transmission of HIV to others, and
4. You have continued to engage in high-risk behaviour and have not taken voluntary measures to reduce the risk of transmission to others.

Under the *Health Act Communicable Disease Regulation* s.6.2, I am authorized to disclose information to a person who may be at risk of harm from you. This is to advise you that *< Insert name of contact >* will be notified by my office that *< he/she >* is in contact with a person who is HIV positive. The purpose of providing this notice is to alert *< him/her >* that *< he/she >* should be tested for HIV.

I am requesting that you co-operate with my office in notifying your partner. You may or may not choose to be present when *< Insert name of contact >* is informed. Should you decide not to co-operate with or respond to this request, a public health nurse from my office will contact *< Insert name of contact >* independently and advise *< he/she >* of *< his/her >* possible exposure. The public health nurse *< will / will not >* provide *< insert name of contact >* with your name. I can assure you that public health nurses are skilled in providing support, counseling and guidance to contacts of persons with HIV.

I request that, prior to our notifying *< Insert name of contact >*, you make an appointment to see *< Insert name of MHO or delegate >*, at *< Insert address, telephone number >*. One of our public health nurses will be in attendance at your appointment to provide you with information and answer any questions. I ask that you make this appointment by the following date: *< Insert date >*. If you fail to do so, we will proceed to contact *< Insert name of contact >*.



Please do not hesitate to contact me at the address below if you have any questions about this letter.

DATED THIS: < *Insert day* > day of <Insert month, year>.

SIGNED:

< Insert name of Medical Health Officer, credentials >
Medical Health Officer, < Insert Health Authority Name >
< Insert Address, Telephone and Fax number >
