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## 1.0 INTRODUCTION

This document guides and assists Medical Health Officers (MHOs) on how to approach people living with Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS) who may pose a risk of transmission of HIV to others.

These guidelines have been updated to include new evidence regarding the effect of antiretroviral (ARV) treatment on reducing HIV transmission risk [1]. As well, the HIV pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) program have been expanded in British Columbia, increasing access to these medications for individuals classified as ‘high risk’ of acquiring HIV. The availability of a highly effective preventive measure against HIV, along with an increasing scientific understanding of HIV transmission risk has changed the landscape of HIV in the province. The current revision includes this new information. While acknowledging the need for guidelines outlining a public health approach to people living 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.

## 2.0 APPLICATION

The goal of this document is to guide MHOs in the exercise of their powers and duties to protect the public from the spread of communicable diseases, in this case to prevent the transmission of HIV.

The purpose of these guidelines is to assist MHOs in managing situations where:

- A person is living with HIV/AIDS, *AND*
- Is unable or unwilling to disclose their HIV/AIDS status to partners, *AND*
- Whose partners are determined to likely be at high risk of having acquired or acquiring HIV from the individual living with HIV/AIDS, *OR*
- Continues to engage in behaviours or activities deemed to be high risk of HIV transmission

The scope of these guidelines is to advise on measures that are available to MHOs or individuals to whom the MHO has delegated authority under the BC *Public Health Act* (PHA) [2] and regulations when a person living with HIV/AIDS is unable or refuses to act to prevent further transmission of HIV.<sup>1</sup> They are not meant to be prescriptive, directive or exhaustive, but to offer guidance in the exercise of discretion.

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<sup>1</sup> Note: This guideline provides general orientation to the application of the PHA and related legislation for public health officials who are responsible for implementing 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 prevails.



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These guidelines do not address the public health practice of partner notification, which involves assisting a person living with HIV 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 [3]. With partner notification, the person living with HIV determines both the information that is communicated and how it is communicated to other persons.

These guidelines also do not speak to the legal responsibility of people living 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 [4]. These cases have resulted in the imposition of criminal sanctions against individuals who were aware of their HIV status, but failed to inform partners at risk, or take preventative 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. There are ongoing efforts to update the prosecutorial standards for HIV non-disclosure in Canada to better reflect the scientific evidence of HIV transmission risk and to narrow the use of criminal prosecutions only to situations where a realistic risk exists or an actual transmission occurred [5, 6]. 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 MHOs to manage difficult HIV/AIDS transmission situations, and is the basis for these guidelines.

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

"Unwilling" people living 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 or deliberately avoid further testing regarding their HIV status and/or treatment status (viral suppression) to partners, or
- Have in the past willfully or knowingly misrepresented their HIV positive status to partners or behaved in ways that expose others to a significant or unreasonable risk of HIV infection.

"Unable" people living 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 activities, or
- Have no knowledge that they are infected with HIV.



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In general, “unable” people living 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.

### **3.0 PRINCIPLES AND VALUES**

The principles and values underlying these public health guidelines are:

- The mandate of public health is to protect, not punish people.
- The best prevention strategy with HIV transmission is to retain individuals in the healthcare system where they feel safe and supported.
- Public health interventions must balance the rights of the individual against the duty to protect the public. Sometimes the risk to public safety may outweigh the rights of the individual.
- The most effective measures for preventing HIV transmission within the population include 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.
- Members of the public need to understand how HIV is spread, and how to protect themselves and others.
- Acknowledging that Indigenous peoples face systemic racism in the healthcare system,<sup>2</sup> it is critical to ensure that cultural safety and trauma-informed practice inform the approach to managing HIV transmission risk. Individuals involved in this process should be trained to provide culturally safe and trauma-informed care.

Basic values and principles that should inform decision-making when working with people living 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/AIDS<sup>3</sup> suggested the following principles should inform the choice of management options, including the involuntary disclosure of information:

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<sup>2</sup> For more information, see the In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care report, available online at: <https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Full-Report-2020.pdf>

<sup>3</sup> For more information, visit: <https://www.canada.ca/en/public-health/services/reports-publications/canada-communicable-disease-report-ccdr/monthly-issue/2005-31/persons-who-fail-disclose-their-hiv-aids-status-conclusions-reached-expert-working-group.html>



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- 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 activities.
  - Behaviours or activities should be placed in risk categories.
  - The response to the failure to disclose should be proportional to the risk of the particular activity.
  - Specific measures should not be prescribed; rather, a care plan ought to be provided to health care providers and public health officials to consider in particular circumstances. Providing testing and treatment options outside the local community could support retention in care.
  - If a person engages in activities considered to pose a high risk for HIV transmission to others and the person discloses their HIV status to a sexual or drug injection partner, the health care provider should nonetheless counsel the person living with HIV to mitigate the risks of the behavior and provide supportive strategies.
  - Due process and 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.

Patient confidentiality 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. The MHO should be consulted when considering involuntary disclosure of medical information.

#### **4.0 OVERVIEW OF PROCESS**

These guidelines set out a process to assess whether or not a person living with HIV might present a significant risk of transmission of HIV to others. They offer options for responding to such situations, and 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 strict, but, rather, are options for consideration in the particular situation. Further, each option is comprised of a number of elements which may or may not be applicable in any given setting or situation.

If the MHO is satisfied that the person is not putting, or is no longer likely to put, others unknowingly at risk with their activities, further intervention may not be warranted in alignment with the “least intrusive, most effective” principle. 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 significant risk.



## 5.0 DETERMINATION OF RISK TO OTHERS

### SUMMARY OF DETERMINATION OF RISK TO OTHERS

<b>Step 1</b>	<p><b><u>Receipt of notification</u></b></p> <ul style="list-style-type: none"> <li>• A health professional or service provider 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 (or the MHO designate).</li> <li>• A MHO may receive information that 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 of concern (e.g. rapid expansion).<sup>4</sup></li> </ul>
<b>Step 2</b>	<p><b><u>Verification of HIV status</u></b></p> <ul style="list-style-type: none"> <li>• 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.</li> </ul>
<b>Step 3</b>	<p><b><u>Assessment of risk</u></b></p> <ul style="list-style-type: none"> <li>• In order to gain a reasonable understanding of the degree of risk to others which the person poses, the MHO should assess the following: <ul style="list-style-type: none"> <li>i) The risks associated with specific activities.</li> <li>ii) The person's status and management of HIV infection.</li> <li>iii) The setting or context in which risk occurs.</li> <li>iv) Whether the individual has been named as a sexual or drug-use partner of individual(s) newly diagnosed with HIV or other STIs that would occur with unprotected sexual contact.</li> <li>v) Whether the person at risk would otherwise be eligible for preventive interventions (PrEP or PEP) based on existing eligibility guidelines.</li> <li>vi) The person's willingness and ability to comply with voluntary measures.</li> </ul> </li> </ul>
<b>Step 4</b>	<p><b><u>Consideration of mitigating and other relevant factors</u></b></p> <ul style="list-style-type: none"> <li>• MHOs should take into consideration any measures a person living with HIV/AIDS takes to prevent transmission.</li> <li>• MHOs should consider whether there are any factors that may be contributing; such as intimate partner violence or fear of harm resulting from disclosure.</li> <li>• MHOs should consider referral for counseling and wrap-around care (e.g. outreach case management) prior to any additionally interventions.</li> <li>• Whether the individual is part of a phylogenetically-defined HIV transmission cluster of concern (e.g. rapid expansion).</li> </ul>

#### Step 1: Receipt of Notification

A MHO may receive reports regarding the risk activities of individuals known, or suspected, to be living with HIV/AIDS. Reports may also arise from surveillance or partner notification activities

<sup>4</sup> Information about monitoring of HIV phylogenetic clusters can be found at in the study by Poon *et al*, Lancet HIV. 2016 May;3(5):e231-8 which is available at <https://pubmed.ncbi.nlm.nih.gov/27126490/>



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indicating that a person living with HIV has been named as a recent contact of someone newly diagnosed with HIV or are part of a phylogenetic cluster of concern (such as rapid expansion) as determined by a MHO or Provincial Health Officer. 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.

Under the PHA Reporting Information Affecting Public Health Regulation s. 3 (4), health professionals who “[have] reason to believe that another person may be at risk of harm” may disclose information about the tested person or information about a person who may be at risk of harm from a tested person to the MHO.

Relevant matters for the reporting health professional to consider in this context include:

i) What is the standard?

The standard is that the health professional “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. The standard applies to a person that a health professional knows or suspects to be HIV positive. The patient need not have been tested for HIV.

ii) What actions are in question?

The regulation provides a fair degree of scope for the exercise of judgment on the part of the health professional who reasonably believes 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. The standard is only that they “may” be at risk of harm. Factors to consider when assessing the “risk” of activities are set out in step 3.

iii) What information may be provided?

The health professional 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, sex, and contacts believed to be at risk. 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 health professional should be to provide risk mitigation strategies, counseling, and connection with peer-led HIV organizations to a person living with HIV, as described in the Guidelines for Testing, Follow up, and Prevention of HIV of the BC Communicable Disease Control Manual [3]. 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 PHA Reporting Information Affecting Public Health Regulation s. 3 (1) provides for confirmation of the HIV status of a patient by authorizing the health professional to disclose information to the MHO.

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

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

- i) Asking the health professional for more information about the person; or
- ii) Obtaining information from the regional and provincial communicable disease surveillance databases; or
- iii) Obtaining further information from the person. 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 s. 27, 28, and 29 (see Appendix II for sample Order).
- iv) If it is confirmed that a person is living with HIV, the next step is the assessment of risk. If the MHO is satisfied that the person is not living with HIV, further action may not be necessary, although counseling on HIV transmission risk may be warranted.

## **Step 3: Assessment of Transmission Risk**

Although the Reporting Information Affecting Public Health Regulation provides that an MHO may disclose a person's HIV status to others if there is risk of harm to others. 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 with other health care professionals and partners, such as the reporting clinician, public health nurse, Indigenous partners, community supports (where appropriate) and the person living with HIV, the following should be considered in the global risk assessment:

- i) The risk associated with specific activities

Not all actions create the same degree of risk and some situations may have negligible risk. For example, there may be a situation where someone is diagnosed with HIV who is in a long-term, non-sexual relationship with a partner. In this specific scenario, there may not be a need to proceed with involuntary disclosure if the MHO has completed a global risk assessment and concluded there is negligible historical and current risk of transmission.

The United States Centers for Disease Control and Prevention has provided estimates for the risk of HIV transmission associated with different types of exposures [1]. These provide





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a good model which can be used as a guide for assessing the degree of risk associated with certain activities (see Appendix I).

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 consider the status and management of the person's HIV infection. An assessment of a person's period of infectivity and timing of diagnosis can help inform the risk assessment. Research has demonstrated that a person's infectiousness will vary over the course of the infection based on disease stage, HIV viral load and antiretroviral treatment. Situations which result in a significant risk of infection to others occurs primarily in the following situations:

- An individual diagnosed with HIV who is not consistently taking anti-retroviral therapy (ART) and/or does not have an HIV viral load <200 copies/mL and is engaging in condomless vaginal or anal sex without informing their sexual partners about their HIV status and related risk.
- An individual diagnosed with HIV who is not consistently taking ART and/or does not have an HIV viral load <200 copies/mL and is sharing injection equipment with others without informing them about their HIV status and related risk.

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 [3]. 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 posed to third parties.

iii) The physical setting or context in which risk occurs

The setting or context for the activity/activities that constitute a risk may also have some bearing on the type of intervention that is considered. For example, it may be reasonable to infer 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 these activities may lead to infection with HIV. Accordingly, it is important that MHOs consider whether the individual(s) who are at risk of infection may be aware of their risk, even in the absence of an explicit disclosure of HIV status on the part of the person living with HIV. Consequently, it may be unreasonable to expect the person living with HIV to disclose their HIV status to each partner in these circumstances, and that interventions should focus on risk mitigation strategies.



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iv) Epidemiologic context

Information from surveillance or partner notification activities may also suggest an ongoing transmission risk, for example if a person living with HIV 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 that is concerning, such as rapid expansion.

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

The purpose of the risk assessment is to determine the likelihood that the person living with HIV will continue to engage in activities that pose a risk for HIV transmission, to assess the person's reliability when reporting compliance with preventive measures, 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. The person should be consulted in order to assess matters such as:

- Knowledge of HIV/AIDS.
- Awareness of activities that increase the risk of HIV transmission.
- Awareness of the measures which can reduce the risk of HIV transmission such as using condoms or adhering to HIV treatment.
- Availability of support systems, including access to appropriate medical care.
- Need for education, counseling and/or peer support.
- 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 partners who use injection drugs (PWID).
- Clinical evidence that the person continues to engage in activities that pose a high risk of HIV transmission.
- A severe substance use disorder that may impair judgment and decision-making.
- A health care provider's report containing a clinical opinion that the person is not reducing activities that pose a risk of HIV transmission to others.
- A credible report from a third party that the person is not reducing activities that pose a risk of HIV transmission to others.
- Mental health issues that may influence judgment.
- Lack of ARV treatment during pregnancy.



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**Step 4: Consideration of mitigating and other relevant factors**

Any steps a person living with HIV/AIDS takes to prevent transmission may be considered by a MHO in deciding whether or not to disclose that person's HIV status to third parties. For example, an individual living with HIV who uses latex condoms during sexual intercourse, engages in effective HIV treatment resulting in a suppressed HIV viral load or refuses to share needles when injecting 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.

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 or inability to take appropriate precautions. In some situations, the only appropriate response is to optimize mental health, substance use, or outreach supports.

In particular, the MHO should screen for the possibility that the person is at risk of intimate partner violence. If the MHO learns that a person living with HIV is at risk of violence from a partner, disclosure to that partner could pose a threat to the safety of the person living with HIV, their children, or others who are close to the person. In such cases, the MHO may consider alternative strategies to optimize the individual's participation in treatment and support programs.

A person at risk of violence should be referred to relevant counseling and support services, including counseling about practices and activities that decrease the risk of HIV transmission. Follow-up should take place to ascertain HIV status and reassess the threat of intimate partner or other violence. It is always the responsibility of the MHO to balance the competing interests of the third party and the person living with HIV. MHOs are encouraged to make such decisions in consultation with the person and the person's health care provider 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 circumstances that may require the MHO to balance competing interests may include, but are not limited to, instances where the person living with HIV 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 their HIV status. Examples of such situations may include individuals residing in rural, remote, or First Nations communities. When working with Indigenous clients, it is essential to ensure every effort is made to provide a high level of culturally safe care and support. MHOs should consider involving and collaborating with Indigenous partners and organizations to ensure culturally safe care is being provided.

**6.0 INTERVENTIONS**

While it is recognized that it may be challenging to assess the degree of risk because of the difficulty obtaining reliable information about an individual's activities, the MHO's decision on how to proceed should be based upon a consideration of the results of the global risk assessment 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 with a risk of HIV transmission, more intrusive measures are generally not indicated. Counseling and education should continue as appropriate.
- ii) If there is low or 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 moderate or high risk and no voluntary disclosure of HIV status, intervention should be considered, with the least intrusive measures utilized first.

If at any point the MHO is satisfied that the person has altered their activities 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.

**SUMMARY OF INTERVENTIONS**

<b>Option 1</b>	<p><b><u>Voluntary measures</u></b></p> <ul style="list-style-type: none"> <li>• Routine follow-up for new diagnosis of HIV, as described in the Guidelines for Testing, Follow up, and Prevention of HIV of the BC Communicable Disease Control Manual [3].</li> <li>• Education and counseling.</li> <li>• Establishment of an oral or written agreement.</li> <li>• Assistance with notification and counseling of partners.</li> <li>• Initiation and continuation of HIV treatment, along with regular medical monitoring.</li> <li>• Agree to use condoms and other preventive measures whenever having sexual intercourse.</li> <li>• Ensuring the use of clean needles and syringes and not sharing injection equipment when using injection drugs.</li> <li>• Engaging in treatment for substance use or alcohol use disorder(s), if appropriate.</li> </ul>
<b>Option 2</b>	<p><b><u>Involuntary disclosure</u></b></p> <ul style="list-style-type: none"> <li>• Refers to involuntary disclosure of a person’s HIV status to an identifiable third party, with or without identification of the person.</li> <li>• The following factors should be considered prior to involuntary disclosure: <ul style="list-style-type: none"> <li>a) Person’s HIV status is confirmed positive.</li> <li>b) Reasonable grounds to conclude continued engagement in high risk activities.</li> <li>c) Support, education, and counseling have been offered and person is unwilling or unable to alter high risk activities.</li> <li>d) The person has been offered HIV treatment and ongoing medical care but is unwilling or unable to engage in treatment and care.</li> </ul> </li> </ul>



	<ul style="list-style-type: none"> <li>e) Person is unwilling or unable to inform a third party at risk about their HIV status.</li> <li>f) Third party is believed to be at risk of acquiring HIV infection (known or believed to be HIV negative status).</li> <li>g) Person refuses a health professional or MHO offer to inform third party on behalf of the person.</li> <li>h) Reasonable grounds to believe identifiable third party (parties) are at continued risk because of ongoing high-risk activity.</li> <li>i) Third party has no reasonable way of knowing the risk, or is unable to assess the risk and would likely not be eligible for prevention interventions (e.g. PrEP/PEP)</li> <li>j) No mitigating or other relevant factor identified.</li> </ul> <ul style="list-style-type: none"> <li>• Prior to disclosure, MHOs should inform, or make reasonable attempts to inform, the person of intention to disclose information to third party, without the person’s consent</li> </ul>
<b>Option 3</b>	<p><b><u>Issuing and enforcing an Order</u></b></p> <ul style="list-style-type: none"> <li>• Other measures have been exhausted and the MHO has reasonable belief that the person continues to be unable or unwilling to prevent the transmission of HIV.</li> <li>• Enforcement powers are provided to MHO by <i>Public Health Act</i> for protection of public health.</li> <li>• Use of Orders should be discussed with Provincial Health Officer and legal counsel.</li> <li>• Orders must meet certain requirements (sample Order in Appendix II), including information about how person can have Order reviewed and/or reassessed.</li> <li>• If the 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.</li> </ul>

**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

Less intrusive and restrictive interventions are often the most effective in reducing the risk of HIV transmission. Consequently, MHOs should ensure that the person living with HIV is aware of and has been referred to educational and counseling supports that meet the particular needs of the patient. Low-barrier, culturally safe, and trauma-informed supports should be offered as needed. This may take the form of ongoing sessions over an agreed-upon period of time, and may 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 or Indigenous partners/representatives.

Education and counseling sessions should address issues such as:



- Providing information and education about HIV transmission and the factors that increase and decrease transmission risk, including HIV treatment, safer sex and drug use practices.
- 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.

ii) Establishment of an oral or written agreement

Establishing voluntary objectives with the person living with HIV 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. 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 person living with HIV (pursuant to PHA s. 38), which would be signed by the person.

iii) Assistance with notification and counseling of partners

If the identity of the 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 among HIV serodiscordant couples in a large multicentre randomized trial [7]. Four key studies illustrate the effectiveness of antiviral therapy on reducing the risk of HIV transmission among serodiscordant couples. In these studies, no seroconversions were identified among nearly 4000 HIV serodiscordant couples included in these studies who reported having sex without condoms and the viral load of the HIV-positive partner was considered virally suppressed [8]. As such, consistent adherence to HIV treatment and ensuring that a viral load of <200 copies/ mL has been achieved can be viewed as an effective means of eliminating the risk of HIV transmission. The MHO should ensure that the individual living with HIV is aware of the preventive benefits of HIV treatment and has been referred to appropriate clinical care where the physician is experienced in the medical management of HIV and where the patient can receive clinical care that meets their specific needs, including low-barrier, culturally safe, and trauma-informed care.

In the event that follow-up consultations with the person reveal that they have not initiated HIV treatment with evidence of a suppressed viral load, and they continue or have reverted to high risk



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activity in the absence of a disclosure of their status to partners, 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 living with HIV is engaging in high risk activities and shows no willingness or ability to mitigate the risk by altering these activities or informing their partners or contacts, and the person does not accept the offer by a 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 person living with HIV: Notification of third parties of their possible exposure to HIV without identification of the person living with HIV is desirable in most circumstances.
- ii) With identification of the person living with HIV: 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.

The PHA Reporting Information Affecting Public Health Regulation s. 13 authorizes the MHO to disclose personal 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:

- The person's HIV status is established as positive.
- There are reasonable grounds to conclude that the person is engaging in high-risk activity.
- The person has been offered culturally safe, low-barrier, and trauma-informed support, education and counseling and is unwilling or unable to participate in the care.
- The person has been offered appropriate medical care (culturally safe, low-barrier, and trauma-informed), 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 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 status.



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- There are reasonable grounds to believe an identifiable third party or third parties is/are at continued risk of HIV because of the high-risk behavior of the person living with HIV.
  - The third party has no other reasonable way of knowing their risk, or is unable to assess their risk of exposure to HIV.

Before disclosing to a third party, the MHO should inform, or make reasonable attempts to inform, the person living with HIV of their intention to disclose information to a third party without the person's consent [9]. If feasible this should take the form of a letter to the person, stating that the person has continued to engage in high risk activity 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 activity; and referencing the Reporting Information Affecting Public Health Regulation s. 13 (see sample letter in Appendix III). If a letter is not possible, the person should be verbally 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, the *Freedom of Information and Protection of Privacy Act* (FOIPPA) s. 33 provides an MHO with the authority to consult with and communicate personal information to the appointed committee, guardian or representative of the person living with HIV or, if the person has one, 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 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 II 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 s. 27, 28, and 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.





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- 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 activities 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 II for a sample Order). If a recipient of an Order may have difficulty understanding the Order because of language barriers, 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 to s. 46, and the Public Health Inspections and Orders Regulation (PHIOR) s. 3 and s. 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, they 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 them 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, they should inform the Clinical Prevention Services, STI/HIV Services at the BC Centre for Disease 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:



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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 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 their 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 HIV positive, 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.



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## **7.0 OTHER CONSIDERATIONS**

Except in the most extraordinary of circumstances, the PHA should be sufficient in situations with people living 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 [10].

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. Similar guidance in other Canadian jurisdictions are generally in alignment with the overarching approach and general principles informing HIV non-disclosure as described in this document [11, 12]. In the unlikely event that a 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 – 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)[13]	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 [14]) and for heterosexual sex (reference [15]).



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**APPENDIX II – 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 you 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)]
  7. You must refrain from sharing needles with any person for any purpose, including injection, drug use or tattooing. [PHA s. 28 (1) (b)]



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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 **[clini 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.

This Order does not expire. I will review the terms of the Order on dd/mm/yyyy. In accordance with section 43 of the *Public Health Act*, 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.





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You are required by section 42 of the *Public Health Act* 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 *Public Health Act*.

You may contact me at:

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

DATED THIS: Month DD, YYYY

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

DELIVERY BY:

Enclosure: Excerpts of the *Public Health Act*



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### **APPENDIX III – 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 activities and have not taken voluntary measures to reduce the risk of transmission to others.

Under the *Public Health Act Reporting Information Affecting Public Health Regulation s13*, 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 *< they >* are in contact with a person who is HIV positive. The purpose of providing this notice is to alert them that they 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 *them of their* 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 living 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 >*.



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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 >