National Collaborating Centre
for Infectious Diseases

Centre de collaboration nationale
des maladies infectieuses

National Collaborating Centre for Infectious Diseases

Review of Provincial and Territorial Partner Notification Guidelines and Legislation for Sexually Transmitted and Blood Borne Infections

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National Collaborating Centre for Infectious Diseases, (NCCID)

A National Review of Partner Notification for Sexually Transmitted Blood Borne Infections, (STBBIs)

(HIV, Hepatitis B, Hepatitis C, Chlamydia, Gonorrhea, Syphilis)

1. Introduction

This document is a national overview of the legislation, regulations and guidelines relevant to partner notification (contact tracing) in the management of STBBIs. It includes only information available on the web sites of the Provinces, Territories and the Public Health Agency of Canada. Constituencies were not contacted to validate the information or to provide additional off line information.

The sections of the document include the following:

1. An overview of the websites for the Provincial/Territorial Public Health Legislation; the regulations relevant to STBBIs and the guidelines and protocols available for the management of STBBI's, specifically partner notification.,
2. The regulations related to the legislation that address partner notification.
3. The case definitions for the specific STBBIs.
4. The recalcitrant sections of the legislation for non-complacency in mandated treatment regimes.
5. The partner notification parameters for each of the STBBIs.

The Appendix provides websites for the reportable disease notification forms

There are noted information gaps in sections of the document where online information was not located.

2. Provincial/Territorial and National Legislation, Regulations and Guidelines

Province/ Territory	Public Health Legislation	Communicable Disease Regulations	Guidelines/Protocols; for STBBIs
Alberta	http://www.qp.alberta.ca/documents/Acts/P37.pdf	http://www.canlii.org/en/ab/laws/regu/alta-reg-238-1985/latest/	http://www.health.alberta.ca/documents/Guidelines-Chlamydia-Trachomatis-2012.pdf http://www.health.alberta.ca/documents/Guidelines-Gonococcal-Infections-2012.pdf http://www.health.alberta.ca/documents/Guidelines-Syphilis-2012.pdf http://www.health.alberta.ca/documents/Guidelines-Hepatitis-B-Acute-Case-2011.pdf http://www.health.alberta.ca/documents/Guidelines-Hepatitis-C-Acute-Case-2013.pdf http://www.health.alberta.ca/documents/Guidelines-Hepatitis-C-Chronic-Case-2013.pdf http://www.albertahealthservices.ca/ps-1001306-gov-ab-ph-notifiable-disease-guidelines.pdf
British Columbia	http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_08028_01	http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/12_4_83	http://www.bccdc.ca/dis-cond/comm-manual/CDManualChap5.htm http://www.phac-aspc.gc.ca/std-mts/sti-its/guide-lignesdir-eng.php http://www.bccdc.ca/NR/rdonlyres/328189F4-2840-44A1-9D13-

			D5AB9775B644/0/HepatitisB_Sept_2009.pdf http://www.bccdc.ca/NR/rdonlyres/CEC67337-3E94-4FD3-B21C-63A71014619D/0/CPS_Hep_Guidelines_HCV_20130709.pdf ***Additional info for Health Professionals:*** http://www.bccdc.ca/NR/rdonlyres/B8BC9263-839A-4FA8-822F-5D9B351223BA/0/STI_DST_Noncertified_Syphilis_20120914.pdf
Manitoba	http://web2.gov.mb.ca/laws/statutes/ccsm/p210e.php	http://web2.gov.mb.ca/laws/regs/pdf/p210-037.09.pdf	http://www.gov.mb.ca/health/publichealth/cdc/protocol/chlamydia.pdf http://www.gov.mb.ca/health/publichealth/cdc/protocol/gonorrhea.pdf http://www.gov.mb.ca/health/publichealth/cdc/protocol/hepb.pdf http://www.gov.mb.ca/health/publichealth/cdc/protocol/hepc.pdf http://www.gov.mb.ca/health/publichealth/cdc/protocol/hiv.pdf http://www.gov.mb.ca/health/publichealth/cdc/protocol/syphilis.pdf http://www.gov.mb.ca/health/publichealth/cdc/protocol/index.html http://www.gov.mb.ca/health/publichealth/cdc/protocol/hiv_postexp.pdf

New Brunswick	http://www.gnb.ca/0062/PDF-acts/p-22-4.pdf	http://www.gnb.ca/0062/PDF-regs/2009-136.pdf	***Unable to locate guidelines online***
Newfoundland	http://www.assembly.nl.ca/legislation/sr/statutes/c26.htm http://www.assembly.nl.ca/legislation/sr/statutes/P37-1.htm	***Unable to locate related regulations***	http://www.health.gov.nl.ca/health/publichealth/cdc/STBBI_Sept2010.pdf http://www.health.gov.nl.ca/health/publications/diseasecontrol/s4_diseases_preventable_by_routine_vaccination.pdf
Northwest Territories	http://www.justice.gov.nt.ca/PDF/ACTS/Public%20Health.pdf	http://www.justice.gov.nt.ca/Legislation/..%5CPDF%5CREGS%5CPUBLIC%20HEALTH/Reportable%20Disease%20Control.pdf	http://www.hss.gov.nt.ca/sites/default/files/cdcmanfulldoc.pdf http://www.hss.gov.nt.ca/sites/default/files/hiv_aids_manual.pdf
Nova Scotia	http://nslegislature.ca/legc/statutes/health%20protection.pdf ***Detailed guide for the Health protection Act:*** http://www.gov.ns.ca/hpp/publications/Guide_HPA_05.pdf	http://www.gov.ns.ca/just/regulations/regs/hpacomds.htm http://www.canlii.org/en/ns/laws/regu/ns-reg-195-2005/latest/ns-reg-195-2005.html	http://www.gov.ns.ca/hpp/publications/cdc_manual.pdf http://novascotia.ca/dhw/populationhealth/surveillanceguidelines/Chapter_10_Sexually_Transmitted_Infections.pdf http://novascotia.ca/dhw/populationhealth/surveillanceguidelines/Chapter_9_Bloodborne_Pathogens.pdf
Nunavut	http://www.canlii.org/en/nu/laws/stat/rsnwt-nu-1988-c-p-12/latest/rsnwt-nu-1988-c-p-12.html	http://www.canlii.org/en/nu/laws/regu/rrnwt-nu-1990-c-p-13/latest/rrnwt-nu-1990-c-p-13.html	***Unable to locate guidelines online***

Ontario	http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90h07_e.htm#BK24	http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_910558_e.htm http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90h07_e.htm#BK29	http://www.health.gov.on.ca/english/providers/program/pubhealth/oph_standards/ophs/progstds/protocols/sexual_health_sti.pdf http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/chlamydia_cd.pdf http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/gonorrhea_cd.pdf http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/syphilis_cd.pdf http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/hep_b_cd.pdf http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/aids_cd.pdf http://www.health.gov.on.ca/english/providers/program/pubhealth/oph_standards/ophs/progstds/protocols/population_health_assessment.pdf http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/sexual_health_sti.pdf
Prince Edward Island	http://www.gov.pe.ca/law/statutes/pdf/p-30.pdf **CHAPTER P-30 PUBLIC HEALTH ACT Repealed by 2012(2nd),c.20,s.76.**	http://www.canlii.org/en/pe/laws/regu/pei-reg-ec560-13/latest/pei-reg-ec560-13.html http://www.gov.pe.ca/law/regulations/pdf/P&30-05.pdf	***Unable to locate guidelines online***

Quebec	http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_2_2/S2_2_A.html	***Unable to locate related regulations***	***Unable to locate guidelines online***
Saskatchewan	http://www.qp.gov.sk.ca/documents/english/Chapters/1994/P37_1.pdf	http://www.qp.gov.sk.ca/documents/English/Regulations/Regulations/P37-1R6.pdf http://www.qp.gov.sk.ca/documents/english/Regulations/Regulations/p37-1r11.pdf	http://www.health.gov.sk.ca/cdc-section5 http://www.health.gov.sk.ca/cdc-section1 http://www.health.gov.sk.ca/cdc-section6 http://www.health.gov.sk.ca/communicable-disease-control-manual
Yukon	http://www.gov.yk.ca/legislation/acts/puhesa.pdf	http://www.gov.yk.ca/legislation/regs/oic2009_185.pdf http://www.canlii.org/en/yk/laws/regu/yco-1961-48/latest/yco-1961-48.html	***Related info for Health Professionals:*** http://www.hss.gov.yk.ca/ifo_professionals.php 2013 http://www.hss.gov.yk.ca/pdf/comm_diseases.pdf
PHAC			http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/09vol35/35s2/Chlamy-eng.php http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/09vol35/35s2/Gonorr-eng.php http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/09vol35/35s2/Syphilis-eng.php

			http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/09vol35/35s2/Hep_B-eng.php http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/09vol35/35s2/Hep_C-eng.php http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/09vol35/35s2/HIV_VIH-eng.php http://www.phac-aspc.gc.ca/std-mts/sti-its/cgsti-ldcits/section-5-8-eng.php

3. Regulations: Partner Notification, STBBIs

Province/ Territory	Regulations: Partner Notification
Alberta	http://www.canlii.org/en/ab/laws/regu/alta-reg-238-1985/latest/ **Sexually Transmitted Diseases** (including Chancroid, Gonococcal Infections, Lymphogranuloma Venereum, Mucopurulent Cervitis, Non-gonococcal Urethritis, Syphilis) Investigation of Contacts and Source of Infection - The medical officer of health shall ensure that an attempt is made to identify, locate and examine the sexual contacts of all cases - Sexual contacts shall be either treated at once or treated on the basis of clinical and laboratory findings, whichever the medical officer of health or attending physician determines. **HIV:** Investigation of Contacts and Source of Infection - The medical officer of health shall ensure that an attempt is made to identify, locate and offer counselling and testing to sexual, needle sharing and perinatal contacts of the patient. *Reporting Requirements:* Individual occurrences are reportable by all sources to the medical officer of health within 48 hours (see sections 22(1)(b) and 23 of the Act). **Hepatitis, Non-A, Non-B :** Investigation of Contacts and Source of Infection - The medical officer of health shall attempt to identify the source of the infection. *Reporting Requirements:* Individual occurrences are reportable by all sources to the medical officer of health within 48 hours (see section 22(1)(b) and 23(a)(ii) of the Act). **Hepatitis B (Cases and carriers) :** Investigation of Contacts and Source of Infection The medical officer of health shall attempt to identify (a) the source of infection, and (b)contacts in need of prophylaxis including, but not limited to, newborn infants and persons with needlestick exposures. *Reporting Requirements Hep B:* Individual occurrences (all cases and, in addition, carrier state in pregnant women) are reportable by all sources to the medical officer of health within 48 hours (see section 22(1)(b) and 23(a)(ii) of the Act).

British Columbia	http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/12_4_83 **Reportable disease** (2) Where a physician knows or suspects that an animal or another person is suffering from or has died from a communicable disease, he shall, without delay and in accordance with section4, make a report to the medical health officer if the disease (a) is listed in Schedule A, or (b) becomes epidemic or shows unusual features. (4) The medical health officer shall forward a report received under this section, within 7days of receiving it, to the Provincial health officer, together with any further information requested by the Provincial health officer. (5) A report required to be made without delay shall be made by telephone or by any similar rapid means of communication. (1) A report made under section 2 (2) shall include (a) the name of the disease,(b) the name, age, sex and address of the infected person, and (c) appropriate details if the disease reported is epidemic or shows unusual features.
Manitoba	http://web2.gov.mb.ca/laws/regs/pdf/p210-037.09.pdf **Duty to Identify Contacts** *Identifying contacts* 20(1) A health professional who diagnoses a person as being infected with a disease requiring contact notification must request the person to provide the health professional with information about the identity of other persons with whom he or she had, or may have had, sufficient contact to transfer the infection. *Type of information to request* 20(2) The phrase "information about the identity of other persons" in subsection (1) includes information under the categories specified in a form approved by the minister under section 22. Person must provide contact information 21 A person requested to provide information under subsection 20(1) must, to the best of his or her ability, provide that information. Manner in which a report must be made and submitted 22 Upon receiving information under section 21, a health professional, not including a medical officer or a public health nurse, must make a report in a form approved by the minister; and (b) submit the report to the person, and within the time, specified or otherwise referenced in the form. *The following diseases are diseases requiring contact notification.* AIDS Acquired Immunodeficiency Syndrome, Chancroid Haemophilus ducreyi , Chlamydia trachomatis, Neisseria gonorrhoeae, HIV Human immunodeficiency virus, LGV Lymphogranuloma venereum (Chlamydia trachomatis),Syphilis Treponema pallidum pallidum, Tuberculosis complex Mycobacterium tuberculosis, Mycobacterium africanum, Mycobacterium canetti ,Mycobacterium bovis

New Brunswick	http://www.gnb.ca/0062/PDF-regs/2009-136.pdf **Reporting contacts** A medical practitioner, nurse practitioner or nurse who provides professional services to a person who has a sexually transmitted disease, tuberculosis, measles, meningococcal (invasive) disease or other communicable disease shall, when requested by the medical officer of health or a person designated by the Minister, inform the medical officer of health or person designated by the Minister of the following: (*a*) the names of all known contacts of the person; (*b*) the addresses of all known contacts; and (*c*) the telephone numbers for all known contacts
Newfoundland	Unable to locate any related regulations
Northwest Territories	http://www.justice.gov.nt.ca/Legislation/..%5CPDF%5CREGS%5CPUBLIC%20HEALTH/Reportable%20Disease%20Control.pdf **Within 24 Hours After Reportable Disease Diagnosis** 4. (1) A health care professional shall, within 24 hours of making a reportable disease diagnosis, (a) begin to carry out the specific control measures for the reportable disease, including treating or monitoring the person in accordance with the specific control measures for the reportable disease; (b) make reasonable efforts to carry out the activities identified in paragraph (a) of the definition "contact tracing" in subsection 1(1) in accordance with the specific control measures; (c) provide the person with information on the reportable disease and the specific control measures that he or she should follow; (d) advise the person to comply with the specific control measures; and (e) provide the Chief Public Health Officer with information respecting the contact tracing and specific control measures that have been initiated or carried out. (2) If circumstances prevent a health care professional from performing his or her duties in accordance with this section, the person in charge of the health facility where the health care professional made the diagnosis, shall ensure that the duties are assigned to and performed by another health care professional at the health facility within 24 hours after the health care professional makes the diagnosis. (3) The health care professional who is assigned duties under subsection (2) shall comply with the requirements of subsection 4(1). (4) The person in charge of the health facility where the health care professional makes the diagnosis shall ensure that the requirements of section 4 are complied with and that a health care professional performs his or her duties in accordance with this section. **5.** (1) A person in charge of a health facility may, at any time and for any period of time, make arrangements with the person in charge of another health facility to have that facility carry out, on behalf of the facility requiring assistance and within the specified time, any or all of the requirements set out in section 4. (2) Notwithstanding any arrangements made under subsection (1), the person in charge of a health facility where a health care professional makes a reportable disease diagnosis shall ensure that the requirements of section 4 are complied with. (3)

	Notwithstanding any arrangements made under subsection (1), the person in charge of a health facility who agrees to provide assistance to another health facility in carrying out any or all of the requirements of section 4 shall ensure that the requirements for which he or she agreed to provide assistance are complied with. (4) Where an arrangement made under subsection (1) must be carried out, the person in charge of the health facility requiring assistance shall immediately notify the Chief Public Health Officer of the arrangement. **More than 24 Hours After Reportable Disease Diagnosis** 6. Sections 7 to 11 apply after 24 hours has passed from the time a health care professional makes a reportable disease diagnosis. 7. (1) A health care professional who is assigned to a reportable disease case shall, during the period or periods of time he or she is assigned to the case that occur within seven days after the making of the reportable disease diagnosis, make reasonable efforts to carry out the activities identified in paragraphs (b) and (c) of the definition "contact tracing" in subsection 1(1) in accordance with the specific control measures for the disease. (2) The person in charge of the health facility where the health care professional makes the reportable disease diagnosis, shall ensure that a health care professional assigned to the reportable disease case performs his or her duties in accordance with this section. 8. (1) A health care professional who is assigned to a reportable disease case shall, during the period or periods of time of that assignment, (a) carry out or continue to carry out the specific control measures for the disease, including treating or monitoring the person; and (b) comply with any directions of the Chief Public Health Officer. (2) The requirements listed under subsection (1) must be complied with until the Chief Public Health Officer determines that the person (a) is no longer infected with a reportable disease; (b) is no longer contagious; or (c) no longer presents a significant risk to the public health. 9. (1) A person in charge of a health facility where a person with a reportable disease or suspected reportable disease is examined, monitored, tested or treated shall, (a) ensure the specific control measures for the disease, including treatment and monitoring, are carried out; and (b) ensure any directions of the Chief Public Health Officer are complied with. (2) A person in charge of a health facility referred to in subsection (1) shall perform the duties listed under that subsection until (a) the person is no longer a patient of the health facility; or (b) the Chief Public Health Officer determines that the person (i) is no longer infected with a reportable disease, (ii) is no longer contagious, or (iii) no longer presents a significant risk to the public health. 10. (1) A health care professional who is assigned to a reportable disease case shall, during the period or periods of time of that assignment, provide the Chief Public Health Officer with information respecting the case, including information about the specific control measures that have been or are being carried out, in accordance with (a) the specific control measures for the disease; (b) any directions of the Chief Public Health Officer; and (c) these regulations. (2) A health care professional shall provide the information referred to in subsection (1) until the Chief Public Health Officer determines there is no longer a need to provide such information. (3) A person in charge of a health facility where a health care professional has been assigned to a reportable disease case shall ensure that the health care professional provides information to the Chief Public Health Officer in accordance with this section, and shall provide the Chief Public

	Health Officer with the required information if circumstances prevent the health care professional from doing so. 11. The Chief Public Health Officer shall ensure that a person infected with a reportable disease receives any necessary treatment and monitoring until the person (a) is no longer infected with a reportable disease; (b) is no longer contagious; or (c) no longer presents a significant risk to the public health. **Investigation by the Chief Public Health Officer** 12. (1) Where the Chief Public Health Officer is notified of the discovery of a case of a reportable disease or has reason to believe or suspect that there is such an occurrence, he or she shall investigate or cause an investigation to be made and if satisfied that action is necessary, shall ensure that the specific control measures for the disease are taken. (2) During an investigation the Chief Public Health Officer shall have access to any registers that are established and maintained under the Act and any immunization records held by a health facility, in order to (a) assess the risk of a reportable disease outbreak within a (i) health facility, (ii) community, (iii) region, (iv) specific class of persons, or (v) specific class of places; (b) respond to any potential risk; and (c) determine the appropriate isolation measures and facilities that are or may be required.
Nova Scotia	http://www.gov.ns.ca/just/regulations/regs/hpacomds.htm **Medical officer may require person to give information** **5 (1)** If a medical officer believes that a person has been or is engaging in an activity that may result in the transmission of a communicable disease, the medical officer may instruct that person in writing to provide the medical officer with any information respecting the activity. **(2)** In order to determine the existence of a communicable disease, a medical officer may require any information concerning the disease, including the sources or suspected sources of the disease and the names and addresses of any persons who may have been exposed to or become infected with the disease, from any person who is reasonably suspected of knowing the information. **Identification and notification of contacts in accordance with Manual and guidelines** **12** The identification and notification of contacts must be done in accordance with the Manual and any contact notification guidelines that are adopted by the Chief Medical Officer.
Nunavut	http://www.canlii.org/en/nu/laws/regu/rrnwt-nu-1990-c-p-13/latest/rrnwt-nu-1990-c-p-13.html **Mandated** Where a medical practitioner or nurse has received a positive test result for one of his or her patients or a medical practitioner, nurse or dentist has reason to believe or suspect that one of his or her patients is infected with a communicable disease, the medical practitioner, nurse or dentist shall (a) in the case of a disease listed in Item I of Schedule A, (i) immediately notify the Chief Medical Health Officer by telephone, and (ii) within 24 hours, send a written report to the Chief Medical Health Officer in a form approved by the Chief Medical Health Officer; (b) in the case of a disease listed in Item II of Schedule A, within seven days send a written report to the Chief Medical Health Officer in a form approved by the Chief Medical Health Officer;

	(c) advise the patient to adopt the specific question; control measures for the communicable disease in question; (d) provide the patient with the necessary information to comply with paragraph (c); and e) within seven days of giving notice under paragraph (a) or (b), (i) in accordance with guidelines provided by the Chief Medical Health Officer, carry out contact tracing or surveillance of those aspects of the occurrence and spread of the communicable surveillance. disease that are pertinent to the effective control of the disease, or (ii) request the Chief Medical Health Officer to carry out the contact tracing or surveillance
Ontario	http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90h07_e.htm#BK29 *Duty to report disease* 25. (1) A physician or a practitioner as defined in subsection (2) who, while providing professional services to a person who is not a patient in or an out-patient of a hospital, forms the opinion that the person has or may have a reportable disease shall, as soon as possible after forming the opinion, report thereon to the medical officer of health of the health unit in which the professional services are provided. R.S.O. 1990, c. H.7, s. 25; 1998, c. 18, Sched. G, s. 55 (2). *Duty of hospital administrator to report re disease* 27. (1) The administrator of a hospital shall report to the medical officer of health of the health unit in which the hospital is located if an entry in the records of the hospital in respect of a patient in or an out-patient of the hospital states that the patient or out-patient has or may have a reportable disease or is or may be infected with an agent of a communicable disease. R.S.O. 1990, c. H.7, s. 27 (1). *Duty of superintendent of institution to report re disease* (2) The superintendent of an institution shall report to the medical officer of health of the health unit in which the institution is located if an entry in the records of the institution in respect of a person lodged in the institution states that the person has or may have a reportable disease or is or may be infected with an agent of a communicable disease. R.S.O. 1990, c. H.7, s. 27 (2). *When report to be given* (3) The administrator or the superintendent shall report to the medical officer of health as soon as possible after the entry is made in the records of the hospital or institution, as the case may be. R.S.O. 1990, c. H.7, s. 27 (3).
Prince Edward Island	http://www.canlii.org/en/pe/laws/regu/pei-reg-ec560-13/latest/pei-reg-ec560-13.html A person directed by the Chief Public Health Officer shall submit reports of notifiable diseases or conditions, with any further information as may be required, as directed to the Chief Public Health Officer and to the appropriate agencies of the Government of Canada for purposes of national disease surveillance. (EC560/13) 4. A person who is, or is suspected of being, infected with a communicable disease, including a suspected carrier or contact, shall (a) if the person suspects an infection or is informed by a medical practitioner or public health official that he or she is or is suspected of being infected, place himself or herself under the care of a medical practitioner or direction of a public health official; (b) submit to diagnostic examination, treatment and control measures as directed by the medical practitioner or Chief Public Health Officer; and (c) identify any contact, and provide any other relevant information that may be required, to the medical practitioner or Chief Public Health Officer. (EC560/13)

Quebec	http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_2_2/S2_2_A.html General Information on reportable diseases but not on contacts
Saskatchewan	http://www.qp.gov.sk.ca/documents/english/Regulations/Regulations/p37-1r11.pdf **Infected person communicating with contacts** **6**(1) Subject to subsection (3) and section 11, a person who communicates with his or her contacts pursuant to subclause 33(4)(c)(i) of the Act shall do so within 72 hours after the diagnosis. (2) A person who communicates with his or her contacts pursuant to subclause 33(4)(c)(i) of the Act shall: (a) inform each contact of his or her exposure to the disease in question; and (b) explain to each contact the contact's duty: (i) to protect himself or herself by going to a physician or clinic nurse for testing and care; and (ii) to take all reasonable measures to reduce significantly the risk of infecting others. (3) If it is not practicable to communicate with the contacts within the periods specified in subsection (1) or subsection 11(3), the person shall ask the physician or clinic nurse to communicate with the contacts. **Physician or clinic nurse communicating with contacts** **7**(1) A physician or clinic nurse who is asked to communicate with the contacts of a person who is infected with, or is a carrier of, a category II communicable disease: (a) shall do so as soon as possible within 14 days after receiving the request; And (b) if it is not possible to complete the communication with the contacts within the 14 days mentioned in clause (a), shall immediately refer the list of contacts to a designated public health officer.(2) In communicating with a contact, a physician or clinic nurse shall:(a) inform each contact of his or her exposure to the disease in question; **Disease Control** (b) explain to each contact the contact's duty:(i) to protect himself or herself by going to a physician or clinic nurse for testing and care; and (ii) to take all reasonable measures to reduce significantly the risk of infecting others; and (c) provide counselling. **Designated public health officer communicating with contacts** **8** Where a designated public health officer receives a list of contacts, the designated public health officer shall:(a) inform each contact of his or her exposure to the disease in question; (b) explain to each contact the contact's duty:(i) to protect himself or herself by going to a physician or clinic nurse for testing and care; and (ii) to take all reasonable measures to reduce significantly the risk of infecting others; and (c) provide counselling. A person who is diagnosed as being infected with human immunodeficiency virus and who communicates with his or her contacts pursuant to subclause 33(4)(c)(i)of the Act shall do so as soon as possible within 30 days after the diagnosis..
Yukon	http://www.gov.yk.ca/legislation/regs/oic2009_185.pdf http://www.canlii.org/en/yk/laws/regu/yco-1961-48/latest/yco-1961-48.html Every medical practitioner who has reason to believe or suspect that one of his patients is infected with a communicable disease shall advise such patient, any persons attending him and

	any known contacts or carriers, to adopt the specific control measures for such disease and shall give them the necessary instructions there for.

4. Case Definitions: Partner Notification, STBBIs

4. (a) Chlamydia

Province/ Territory	Case Definitions: Chlamydia
Alberta	http://www.health.alberta.ca/documents/Guidelines-Chlamydia-Trachomatis-2012.pdf **Chlamydia trachomatis:** Confirmed case **Genital Infections** Laboratory evidence of infection in genitourinary specimens (e.g., endocervical, urethral or vaginal swab; urine)[1]: • Isolation of Chlamydia trachomatis by culture OR • Detection of Chlamydia trachomatis nucleic acid (e.g., PCR) OR • Detection of Chlamydia trachomatis antigen. **Extra-genital Infections** Laboratory evidence of infection in rectum, conjunctiva, pharynx or other extra-genital sites from appropriate specimen (e.g., rectal, conjunctiva, throat or skin swab): • Isolation of Chlamydia trachomatis by culture OR • Detection of Chlamydia trachomatis nucleic acid (e.g., PCR) OR • Detection of Chlamydia trachomatis antigen. **Perinatally Acquired Infections** Laboratory evidence of C. trachomatis infection in nasopharyngeal or other respiratory tract specimens (e.g., nasopharyngeal swab auger suction, throat swab) or in urine from an infant who developed pneumonia in the first six months of life: • Isolation of Chlamydia trachomatis by culture OR • Detection of Chlamydia trachomatis nucleic acid (e.g., PCR) OR • Detection of Chlamydia trachomatis antigen OR Laboratory evidence of Chlamydia trachomatis in conjunctival specimens[1] from an infant who developed conjunctivitis in the first month of life: • Isolation of Chlamydia trachomatis by culture OR • Detection of Chlamydia trachomatis nucleic acid (e.g., PCR) OR • Detection of Chlamydia trachomatis antigen

British Columbia	Unable to locate online
Manitoba	http://www.gov.mb.ca/health/publichealth/cdc/protocol/chlamydia.pdf **Chlamydia trachomatis** Case Definition: Confirmed Case Detection of chlamydia trachomatis in a clinical specimen by appropriate laboratory technique (i.e., nucleic acid amplification, nucleic acid detection, direct fluorescent antigen [DFA]).Clinical specimens may be obtained from genitourinary sites, rectal, conjunctival and other extra-genital sites. For perinatal infection, specimens may be obtained from nasopharyngeal and other respiratory sites.
New Brunswick	Unable to locate online
Newfoundland	http://www.health.gov.nl.ca/health/publichealth/cdc/STBBI_Sept2010.pdf **Chlamydia trachomatis** Confirmed case - **Genital Infections** Laboratory evidence of infection in genitourinary specimens: detection of Chlamydia trachomatis by culture OR detection of Chlamydia trachomatis nucleic acid OR detection of Chlamydia trachomatis antigen) Confirmed Case - **Extra-genital infections** Laboratory evidence of infection in rectum, conjunctiva, pharynx and other extra-genital sites: detection of Chlamydia trachomatis by culture OR detection of Chlamydia trachomatis nucleic acid OR detection of Chlamydia trachomatis antigen Confirmed Case—**Perinatally Acquired Infections** Laboratory evidence of infection: Detection and confirmation of Chlamydia trachomatis in nasopharyngeal on other respiratory tract specimens from an infant who developed pneumonia in the first 6 months of life: isolation of Chlamydia trachomatis by culture OR demonstration of Chlamydia trachomatis nucleic acid OR demonstration of Chlamydia trachomatis antigen OR Detection and confirmation of Chlamydia trachomatis in conjunctival specimens from an infant who developed conjunctivitis in the first month of life: isolation of Chlamydia trachomatis by culture OR

	demonstration of Chlamydia trachomatis nucleic acid OR demonstration of Chlamydia trachomatis antigen Laboratory confirmation of infection: detection of Chlamydia trachomatis by appropriate laboratory techniques in genitourinary specimens
Northwest Territories	Unable to locate online
Nova Scotia	http://novascotia.ca/dhw/populationhealth/surveillanceguidelines/Chapter_10_Sexually_Transmitted_Infections.pdf **Genital** Confirmed Case: Laboratory evidence of infection in genitourinary specimens: - Detection of Chlamydia trachomatis by culture OR - Detection of Chlamydia trachomatis nucleic acid OR - Detection of Chlamydia trachomatis antigen **Extra-Genital** Confirmed Case: Laboratory evidence of infection in rectum, conjunctiva, pharynx and other extra-genital sites: - Detection of Chlamydia trachomatis by culture OR - Detection of Chlamydia trachomatis nucleic acid OR - Detection of Chlamydia trachomatis antigen **Perinatally Acquired** Confirmed Case: Laboratory evidence of infection: - Detection and confirmation of Chlamydia trachomatis in nasopharyngeal or other respiratory tract specimens from an infant in whom pneumonia developed in the first 6 months of life: - Isolation of Chlamydia trachomatis by culture OR - Detection of Chlamydia trachomatis nucleic acid OR - Detection of Chlamydia trachomatis antigen OR - Detection and confirmation of Chlamydia trachomatis in conjunctival specimens from an infant who developed conjunctivitis in the first month of life: - Isolation of Chlamydia trachomatis by culture OR - Detection of Chlamydia trachomatis nucleic acid OR - Detection of Chlamydia trachomatis antigen
Nunavut	Unable to locate online, may use the NWT documents

Ontario	http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/chlamydia_cd.pdf **Chlamydia trachomatis:** Case Classification, Confirmed case Chlamydia trachomatis detected in an appropriate clinical specimen,(e.g. urogenital tract, rectal specimen).
Prince Edward Island	Unable to locate online
Quebec	Unable to locate online
Saskatchewan	http://www.health.gov.sk.ca/cdc-section5 Case Definition (Public Health Agency of Canada, 2008) **Genital Infections:** Confirmed Case: Laboratory evidence of infection in genitourinary specimens: detection of Chlamydia trachomatis by culture; OR detection of Chlamydia trachomatis nucleic acid; OR detection of Chlamydia trachomatis antigen. **Extra-genital Infections:** Confirmed Case: Laboratory evidence of infection in rectum, conjunctiva, pharynx and other extra-genital sites: detection of Chlamydia trachomatis by culture; OR detection of Chlamydia trachomatis nucleic acid; OR detection of Chlamydia trachomatis antigen. **Perinatally Acquired Infections:** Confirmed Case: Laboratory evidence of infection: detection and confirmation of Chlamydia trachomatis in nasopharyngeal or other respiratory tract specimens from an infant who developed pneumonia in the first 6 months of life: isolation of Chlamydia trachomatis by culture; OR demonstration of Chlamydia trachomatis nucleic acid; OR demonstration of Chlamydia trachomatis antigen. OR detection and confirmation of Chlamydia trachomatis in conjunctival specimens from an infant who developed conjunctivitis in the first month of life: isolation of Chlamydia trachomatis by culture; OR demonstration of Chlamydia trachomatis nucleic acid;

	OR demonstration of Chlamydia trachomatis antigen.
Yukon	Unable to locate online
PHAC	http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/09vol35/35s2/Chlamy-eng.php **3.1 Confirmed case- Genital Infection** Laboratory evidence of infection in genitourinary specimens: detection of Chlamydia trachomatis by culture OR detection of Chlamydia trachomatis nucleic acid OR detection of Chlamydia trachomatis antigen **3.2 Confirmed Case—Extra-genital infections** Laboratory evidence of infection in rectum, conjunctiva, pharynx and other extra-genital sites: detection of Chlamydia trachomatis by culture OR detection of Chlamydia trachomatis nucleic acid OR detection of Chlamydia trachomatis antigen **3.3 Confirmed Case—Perinatally Acquired Infections** Laboratory evidence of infection: Detection and confirmation of Chlamydia trachomatis in nasopharyngeal or other respiratory tract specimens from an infant in whom pneumonia developed in the first six months of life: isolation of Chlamydia trachomatis by culture OR demonstration of Chlamydia trachomatis nucleic acid OR demonstration of Chlamydia trachomatis antigen OR Detection and confirmation of Chlamydia trachomatis in conjunctival specimens from an infant who developed conjunctivitis in the first month of life: isolation of Chlamydia trachomatis by culture OR demonstration of Chlamydia trachomatis nucleic acid OR demonstration of Chlamydia trachomatis antigen

4. (b) **Gonorrhea**

Province/ Territory	Case Definitions: Gonorrhea
Alberta	**http://www.health.alberta.ca/documents/Guidelines-Gonococcal-Infections-2012.pdf** **Gonorrhea** Case Definition *Confirmed Case-Genital Infections* Laboratory confirmation of infection: detection of Neisseria gonorrhoeae in genitourinary specimens by appropriate laboratory techniques, (e.g., isolation of Neisseria gonorrhoeae by culture, demonstration of Neisseria gonorrhoeae nucleic acid) *Confirmed Case-Extra-Genital Infections* Laboratory confirmation of infection: detection of Neisseria gonorrhoeae in specimens from pharynx, rectum, joint, conjunctiva, blood, and other extra-genital sites, by appropriate laboratory techniques, (e.g., isolation of Neisseria gonorrhoeae by culture, demonstration of Neisseria gonorrhoeae nucleic acid) *Confirmed Case-Perinatally Acquired Infections* Laboratory confirmation of infection: detection of Neisseria gonorrhoeae from a neonate in the first 4 weeks of life leading to the diagnosis of gonococcal conjunctivitis, scalp abscess, vaginitis, bacteremia, arthritis, meningitis or endocarditis, by appropriate laboratory techniques, (e.g., isolation of Neisseria gonorrhoeae by culture)
British Columbia	Unable to locate online
Manitoba	http://www.gov.mb.ca/health/publichealth/cdc/protocol/gonorrhea.pdf **Gonorrhea:** Case Definition *Confirmed Case:* Isolation of Neisseria gonorrhoeae from any site by culture or detection of Neisseria gonorrhoeae by nucleic acid amplification test (NAAT). Males having intracellular diplococci present on stain of urethral exudates are also considered laboratory confirmed cases. *Clinical Case:* Urethral or cervical/vaginal discharge without laboratory confirmation, in a person with a history of sexual contact with a laboratory-confirmed case in the preceding six to eight weeks. Cases include both genital and extra-genital infections. Perinatally-acquired cases are cases occurring in neonates (up to four weeks of age), leading to the diagnosis of

	gonococcal conjunctivitis, scalp abscess, vaginitis, bacteremia, arthritis, meningitis or endocarditis. *Note:* Surveillance reports include only laboratory confirmed cases.
New Brunswick	Unable to locate online
Newfoundland	http://www.health.gov.nl.ca/health/publichealth/cdc/STBBI_Sept2010.pdf **Confirmed Case of Genital Infection** Laboratory confirmation of infection: detection of Neisseria gonorrhea by appropriate laboratory techniques in genitourinary specimens. **Confirmed Case of Extra-genital Infections** Laboratory confirmation of infection: detection of Neisseria gonorrhea by appropriate laboratory techniques in specimens from pharynx, rectum, joint, conjunctiva, blood, and other extra-genital sites. **Confirmed case of Perinatally Acquired Infection** Laboratory confirmation of infection: detection of Neisseria gonorrhea by appropriate laboratory techniques in a neonate (up to 4 weeks of age) leading to the diagnosis of gonococcal conjunctivitis, scalp abscess, vaginitis, bacteremia, arthritis, meningitis or endocarditis **Clinical Case** urethral or cervical/vaginal discharge without laboratory confirmation, in a person with a history of sexual contact with a laboratory confirmed case in the preceding six to eight weeks **Note:** Reports to the Provincial CDS system includes only laboratory confirmed cases. Contact information may be recorded with the case in the provincial CDS.
Northwest Territories	Gonorrhea is not included in CDC Manual
Nova Scotia	http://novascotia.ca/dhw/populationhealth/surveillanceguidelines/Chapter_10_Sexually_Transmitted_Infections.pdf **Genital Confirmed Case:** Laboratory confirmation of infection in genitourinary specimens: Detection of Neisseria gonorrhoeae by culture OR Detection of Neisseria gonorrhoeae nucleic Acid **Extra Genital Confirmed Case:**

	Laboratory confirmation of infection from pharynx, rectum, joint, conjunctiva, blood and other extra genital sites: Detection of Neisseria gonorrhoeae by culture OR Detection of Neisseria gonorrhoeae nucleic acid **Perinatally Acquired Confirmed Case:** Laboratory confirmation of infection from a neonate in the first 4 weeks of life leading to the diagnosis of gonococcal conjunctivitis, scalp abscess, vaginitis, bacteremia, arthritis, meningitis or endocarditis: Detection of Neisseria gonorrhoeae by Culture OR Detection of Neisseria gonorrhoeae nucleic acid
Nunavut	Unable to locate online
Ontario	http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/gonorrhea_cd.pdf **Gonorrhea:** Case Classification for Confirmed Case Neisseria gonorrhoeae detected in an appropriate clinical specimen (e.g., urogenital,rectal or throat [pharyngeal] swab) **Laboratory Confirmation** Any of the following will constitute a confirmed case of Gonorrhea: - Positive Neisseria gonorrhoeae culture Positive for Neisseria gonorrhoeae nucleic acid amplification test (NAT) - Positive Gm negative intracellular diplococci on urethral smear (male only) **Approved/Validated Tests Standard culture for Neisseria gonorrhoeae** NAT for Neisseria gonorrhoeae Gram negative diplococci on a smear of urethral discharge (male only)
Prince Edward Island	Unable to locate online
Quebec	Unable to locate online
Saskatchewan	http://www.health.gov.sk.ca/cdc-section5 **Genital Infections:** Confirmed Case:

	Laboratory confirmation of infection in genitourinary specimens: detection of Neisseria gonorrhoeae by culture; OR detection of Neisseria gonorrhoeae nucleic acid. **Extra-genital infections:** Confirmed Case: Laboratory confirmation of infection from pharynx, rectum, joint, conjunctiva, blood and other extra-genital sites: detection of Neisseria gonorrhoeae by culture; OR detection of Neisseria gonorrhoeae nucleic acid. **Perinatally Acquired Infections:** Confirmed Case: Laboratory confirmation of infection from a neonate in the first 4 weeks of life leading to the diagnosis of gonococcal conjunctivitis, scalp abscess, vaginitis, bacteremia, arthritis, meningitis or endocardidtis: detection of Neisseria gonorrhoeae by culture; OR detection of Neisseria gonorrhoeae nucleic acid.
Yukon	Unable to locate online.
PHAC	**http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/09vol35/35s2/Gonorr-eng.php** **Gonorrhea** **3.1 Confirmed case—Genital Infections** Laboratory evidence of infection in genitourinary specimens: detection of Neisseria gonorrhoeae by culture OR detection of Neisseria gonorrhoeae nucleic acid **3.2 Confirmed Case—Extra-genital infections**

	Laboratory confirmation of infection from pharynx, rectum, joint, conjunctiva, blood and other extra-genital sites: detection of Neisseria gonorrhoeae by culture OR detection of Neisseria gonorrhoeae nucleic acid **3.3 Confirmed Case—Perinatally Acquired Infections** Laboratory confirmation of infection from a neonate in the first four weeks of life leading to the diagnosis of gonococcal conjunctivitis, scalp abscess, vaginitis, bacteremia, arthritis, meningitis or endocarditis: detection of Neisseria gonorrhoeae by culture OR detection of Neisseria gonorrhoeae nucleic acid **Lab Comments:** A positive test for Gram-negative intracellular diplococci in symptomatic males with urethral discharge provides a presumptive diagnosis for gonorrhea in men.

4 (c) Syphilis

Province/ Territory	**Case Definition: Syphilis**
Alberta	http://www.health.alberta.ca/documents/Guidelines-Syphilis-2012.pdf Confirmed case **Primary Syphilis** Laboratory confirmation of infection: Identification of Treponema pallidum by dark-field microscopy, fluorescent antibody or equivalent examination of material from a typical lesion (chancre) or a regional lymph node OR Detection of Treponema pallidum nucleic acid (e.g., Polymerase Chain Reaction (PCR)) in an appropriate clinical specimen

	OR Presence of one or more chancres, and reactive treponemal serology, regardless of nontreponemal test reactivity, in individuals with no previous history of syphilis OR Presence of one or more chancres and a fourfold or greater increase in the titre over the last known non-treponemal test (e.g., Rapid Plasma Reagin (RPR), Venereal Disease Reporting Laboratory (VDRL)) in individuals with a past history of syphilis treatment. **Secondary Syphilis** Laboratory evidence of infection: Identification of Treponema pallidum by dark-field microscopy, fluorescent antibody or equivalent examination of mucocutaneous lesions, condylomata lata and reactive serology (non- treponemal and treponemal) OR Detection of Treponema pallidum nucleic acid (e.g., PCR) in an appropriate clinical specimen OR Presence of typical signs or symptoms of secondary syphilis (e.g., mucocutaneous lesions, alopecia, loss of eyelashes and lateral third of eyebrows, iritis, generalized lymphadenopathy, fever, malaise or splenomegaly) AND either: A reactive serology (non-treponemal and treponemal) OR A fourfold or greater increase in titre over the last known non-treponemal test. **Early Latent Syphilis (< 1 year after infection)** Laboratory confirmation of infection: An asymptomatic patient with reactive serology (treponemal and/or non-treponemal) who, within the past 12 months, had one or more of the following: non-reactive serology, symptoms suggestive of primary or secondary syphilis exposure to a sexual partner with primary, secondary or early latent syphilis. **Late Latent Syphilis (> 1 year after infection or of unknown duration)** Laboratory confirmation of infection: An asymptomatic patient with persistently reactive treponemal serology (regardless of non-treponemal serology reactivity) who does not meet the criteria for early latent disease and who has not been previously treated for syphilis.

	Neurosyphilis, Early (< 1 year after infection) Laboratory confirmation of infection: Fits the criteria of a confirmed case of primary, secondary or early latent syphilis AND one or more of the following: Reactive CSF-VDRL in non-bloody cerebrospinal fluid (CSF), Detection of Treponema pallidum nucleic acid (e.g., PCR) in CSF or vitreous humor, Clinical evidence of neurosyphilis AND either elevated CSF leukocytes OR elevated CSF protein in the absence of other known causes. **Neurosyphilis, Late (> 1 year after infection)** Laboratory confirmation of infection: Reactive treponemal serology (regardless of non-treponemal serology reactivity) AND one or more of the following: Reactive CSF-VDRL in non-bloody cerebrospinal fluid (CSF), Clinical evidence of neurosyphilis AND either elevated CSF leukocytes OR elevated CSF protein in the absence of other known causes. **Tertiary Syphilis Other than Neurosyphilis** Laboratory confirmation of infection: Reactive treponemal serology (regardless of non-treponemal test reactivity) together with characteristic late abnormalities of the cardiovascular system, bone, skin or other structures, in the absence of other known causes of these abnormalities (Treponema pallidum is rarely seen in these lesions although, when present, it is diagnostic) AND No clinical or laboratory evidence of neurosyphilis. **Congenital Syphilis** See Public Health Notifiable Disease Management guideline for Congenital Syphilis.
British Columbia	Unable to locate online
Manitoba	http://www.gov.mb.ca/health/publichealth/cdc/protocol/syphilis.pdf **Incubating Syphilis** Case Definitions

	An asymptomatic person with a history of sexual exposure within the past 10-90 days to a partner with a confirmed diagnosis of infectious syphilis; plus either a reactive serology (nontreponemal and treponemal); or at least a four-fold (e.g., 1:8 to 1:32) increase in titre over the last known nontreponemal test. Incubating syphilis is a subset of Early Latent **Primary Syphilis:** Identification of *Treponema pallidum* by dark field microscopy, fluorescent antibody, or equivalent examination of material from a chancre or regional lymph node; or presence of one or more typical lesions (chancres), and reactive treponemal serology, regardless of nontreponemal test reactivity, in individuals with no previous history of syphilis; or presence of one or more typical lesions (chancres) and at least a four-fold (e.g., 1:8 to 1:32) increase in titre over the last known nontreponemal test in individuals with a past history of syphilis treatment. **Secondary Syphilis:** Identification of *Treponema pallidum* by darkfield microscopy, fluorescent antibody, or equivalent examination of mucocutaneous lesions and condyloma lata; or presence of one or more typical mucocutaneous lesions, alopecia, loss of eyelashes and lateral third of eyebrows, iritis, generalized lymphadenopathy, fever, malaise, or splenomegaly; plus either a reactive serology (nontreponemal and treponemal); or at least a four-fold (e.g.,1:8 to 1:32) increase in titre over the last known nontreponemal test. **Early Latent Syphilis:** An asymptomatic person with reactive serology (nontreponemal and treponemal) who within the past one year had ONE of the following: 1) non-reactive serology; 2) symptoms suggestive of primary or secondary syphilis; or 3) exposure to a sexual partner with primary, secondary or early latent syphilis. **Late Latent Syphilis:** An asymptomatic person with persistently reactive treponemal serology (regardless of nontreponemal serology reactivity) who does not meet the criteria for early latent disease and who has not been previously treated for syphilis. **Neurosyphilis:** Reactive treponemal serology (regardless of nontreponemal serology reactivity) and one of the following: 1) reactive CSF-VDRL in non-bloody cerebrospinal fluid (CSF);2) clinical evidence of neurosyphilis and CSF pleocytosis (particularly lymphocytes) in the absence of other known causes; or 3) clinical evidence of neurosyphilis and elevated CSF protein in the absence of other known causes. Neurosyphilis may be seen during primary or secondary syphilis stages and can occur at any time after initial infection. **Tertiary Syphilis other than Neurosyphilis:** Presence of reactive treponemal serology (regardless of nontreponemal test reactivity) together with characteristic abnormalities of the cardiovascular system, bone, skin or other structures, in the absence of other known causes of these abnormalities (*Treponema pallidum*

	is rarely seen in these lesions, although when present is diagnostic); and no clinical or laboratory evidence of neurosyphilis. **Congenital Syphilis:** Identification of *Treponema pallidum* by darkfield microscopy, fluorescent antibody, or equivalent examination of material from nasal discharges, skin lesions, placenta or umbilical cord, or autopsy material of a neonate (up to four weeks of age); or reactive serology (treponemal and nontreponemal) from venous blood (not cord blood) in an radiographic evidence of congenital syphilis, whose mother is seropositive for syphilis without documented evidence of adequate treatment.
New Brunswick	Unable to locate online
Newfoundland	http://www.health.gov.nl.ca/health/publichealth/cdc/STBBI_Sept2010.pdf **Syphilis Case Definition** The following case definitions are not complete; for complete details on all case definitions, please refer to: http://www.phac-aspc.gc.ca/hcai-iamss/bbp-pts/index-eng.php **Primary Syphilis:** Confirmed Case Laboratory confirmation of infection: identification of *Treponema pallidum* by dark-field microscopy, fluorescent antibody , or equivalent examination of material from a chancre or a regional lymph node or presence of one or more typical lesions (chancres), and reactive treponemal serology, regardless of non-treponemal test reactivity, in individuals with no previous history of syphilis or presence of one or more typical lesions (chancres) and at least a 4-fold (e.g. 1:8 to 1:32) increase in the titre over the last known non-treponemal test in individuals with a past history of syphilis treatment **Secondary Syphilis:** Confirmed Case Laboratory evidence of infection: identification of *Treponema pallidum* by dark-field microscopy, fluorescent antibody or equivalent examination of mucocutaneous lesions, condylomata lata and reactive serology (non-treponemal and treponemal) or presence of typical mucocutaneous lesions, alopecia, loss of eyelashes and lateral third of eyebrows, iritis, generalized lymphadenopathy, fever, malaise or splenomegaly, and either a reactive serology (non-treponemal and treponemal) or at least a 4-fold (e.g.1:8 to 1:32) increase in titre over the last known non-treponemal test. NOTE: The possibility of a prozone reaction should be considered in individuals who are suspected of having secondary syphilis but whose non-treponemal test is nonreactive. **Early Latent Syphilis:** Confirmed Case Laboratory confirmation of infection: an asymptomatic patient with reactive serology (non-treponemal and treponemal) who within the past 12 months had one of the following: non-

	reactive serology, symptoms suggestive of primary or secondary syphilis, exposure to a sexual partner with primary, secondary or early latent syphilis
Northwest Territories	Unable to locate online
Nova Scotia	http://novascotia.ca/dhw/populationhealth/surveillanceguidelines/Chapter_10_Sexually_Transmitted_Infections.pdf **Early Congenital Confirmed Case:** Laboratory confirmation of infection: Identification of Treponema pallidum by dark-field microscopy, fluorescent antibody or equivalent examination of material from nasal discharges, skin lesions, placenta, umbilical cord or autopsy material of a neonate (up to 4 weeks of age) OR Reactive serology (non-treponemal and treponemal) from venous blood (not cord blood) in an infant/child with clinical, laboratory or radiographic evidence of congenital syphilis (including evidence on physical examination, on radiographs of long bones, a reactive CSF VDRL, an elevated CSF cell count or protein without other cause) , whose mother is without documented evidence of adequate treatment OR Detection of Treponema pallidum DNA in an appropriate clinical specimen **Primary Confirmed Case:** Laboratory confirmation of infection: Identification of Treponema Pallidum by dark-field microscopy, fluorescent antibody, nucleic acid testing, or equivalent examination of material from a chancre or a regional lymph node OR Presence of one or more typical lesions (chancres) and reactive treponemal serology, regardless of non-treponemal test reactivity, in individuals with no previous history of syphilis OR Presence of one or more typical lesions (chancres) and a fourfold or greater increase in the titre over the last known non-treponemal test in individuals with a past history of syphilis treatment **Secondary Confirmed Case:** Laboratory evidence of infection: Identification of Treponema pallidumby dark-field microscopy, fluorescent antibody, nucleic acid testing or equivalent examination of mucocutaneous lesions, condylomatalata and reactive serology (non-treponemal and treponemal) OR

	Presence of typical signs or symptoms (e.g. mucocutaneous lesions, alopecia, loss of eyelashes and lateral third of eyebrows, iritis, generalized lymphadenopathy, fever, malaise or splenomegaly) AND either a reactive serology (non-treponemal and treponemal) OR a fourfold or greater increase in titre over the last known non-treponemal test **Early Latent Confirmed Case:** Laboratory confirmation of infection: An asymptomatic patient with reactive serology (treponemal and/or non-treponemal) who within the previous 12 months had one of the following: Non-reactive serology OR Symptoms suggestive of primary or secondary syphilis OR Exposure to a sexual partner with primary, secondary or early latent syphilis **Late Latent Confirmed Case:** Laboratory confirmation of infection: An asymptomatic patient with persistently reactive treponemal serology (regardless of non-treponemal serology reactivity) who does not meet the criteria for early latent disease and who has not been previously treated for syphilis **Infectious Neurosyphilis Confirmed Case:** Laboratory confirmation of infection: Fits the criteria for Primary, Secondary or Early Latent AND one of the following: Reactive CSF VDRL in non- bloody cerebrospinal fluid (CSF) OR Clinical evidence of neurosyphilis AND either elevated CSF leukocytes OR elevated CSF protein in the absence of other known causes **Non-Infectious Neurosyphilis Confirmed Case:** Laboratory confirmation of infection: Reactive treponemal serology (regardless of non- treponemal serology reactivity) AND one of the following: Reactive CSF VDRL in non-bloody cerebrospinal fluid (CSF) Clinical evidence of neurosyphilis AND either elevated CSF leukocytes OR elevated CSF protein in the absence of other known causes **Tertiary Confirmed Case:**

	Laboratory confirmation of infection: Reactive treponemal serology(regardless of non-treponemal serology test reactivity) together with characteristic late abnormalities of the cardiovascular system, bone, skin or other structures, in the absence of other known causes of these abnormalities (T. pallidum is rarely seen in these lesions, although when present, is diagnostic) AND No clinical or laboratory evidence of neurosyphilis
Nunavut	Unable to find
Ontario	http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/syphilis_cd.pdf **Confirmed Case-Primary Syphilis** Laboratory confirmation of infection: Identification of Treponema pallidum by dark-field microscopy, direct fluorescent antibody microscopy, nucleic acid testing, or equivalent examination of material from a chancre or a regional lymph node OR Presence of one or more typical lesions (chancres), and reactive treponemal serology, regardless of non-treponemal test reactivity, in individuals with no previous history of syphilis OR Presence of one or more typical lesions (chancres) and a significant (i.e., fourfold or greater) rise in the titre over the last known non-treponemal test in individuals with a past history of appropriate syphilis treatment **Confirmed Case-Secondary Syphilis** Laboratory confirmation of infection: Identification of Treponema pallidum by dark-field microscopy, direct or indirect fluorescent antibody microscopy, nucleic acid amplification test(NAT) or equivalent examination of mucocutaneous lesions, condylomata lata and reactive serology (non-treponemal and treponemal), OR Presence of typical signs or symptoms of secondary syphilis (e.g., mucocutaneous lesions, alopecia, loss of eyelashes and lateral third of eyebrows, iritis, generalized lymphadenopathy, fever, malaise or splenomegaly) and either a reactive serology (non-treponemal and treponemal) or a significant (i.e., fourfold or greater) rise in titre of a non-treponemal test **Confirmed Case-Early Latent Syphilis (<1 year after infection)** Laboratory confirmation of infection: An asymptomatic patient with reactive serology (treponemal and/or non-treponemal) who within the past 12 months had one of the following: Non-reactive serology

	Previous signs/symptoms suggestive of primary or secondary syphilis Exposure to a sexual partner with primary, secondary or early latent syphilis **Confirmed Case-Late Latent Syphilis (>1 year after infection or of unknown duration)** Laboratory confirmation of infection: An asymptomatic patient with persistently reactive treponemal serology (regardless of non-treponemal serology reactivity) who does not meet the criteria for early latent disease and who has not been previously treated adequately for syphilis **Confirmed Case-Neurosyphilis** <u>Infectious (<1 year after infection)</u> Laboratory confirmation of infection: Fits the criteria in above, AND one of the following: Reactive cerebrospinal fluid – veneral diseases research laboratory (CSF-VDRL) in non-bloody cerebrospinal fluid (CSF) Clinical evidence of neurosyphilis and either elevated CSF leukocytes or elevated CSF protein in the absence of other known causes <u>Non-infectious (>1 year after infection)</u> Laboratory confirmation of infection: Reactive treponemal serology regardless of non-treponemal serology reactivity AND one of the following: Reactive CSF-VDRL in non-bloody CSF Clinical evidence of neurosyphilis and either elevated CSF leukocytes or elevated CSF protein in the absence of other known causes **Confirmed Case-Early Congenital Syphilis (within 2 years of birth)** Laboratory confirmation of infection: Identification of Treponema pallidum by dark-field microscopy, direct fluorescent antibody microscopy or equivalent examination of material from nasal discharges, skin lesions, placenta, umbilical cord or autopsy material of a newborn (up to 4 weeks of age) OR Reactive serology (non-treponemal and treponemal) from venous blood (not cord blood) in an infant/child with clinical, laboratory or radiographic evidence of congenital syphilis OR Detection of Treponema pallidum deoxyribonucleic acid (DNA) in an appropriate clinical specimen **Confirmed Case-Tertiary Syphilis Other than Neurosyphilis** Laboratory confirmation of infection: Reactive treponemal serology (regardless of non-treponemal test reactivity) together with characteristic late abnormalities of the cardiovascular system, bone, skin or other structures,

	in the absence of other known causes of these abnormalities. (T. pallidum is rarely seen in these lesions, although when present, is considered diagnostic.) AND No clinical or laboratory evidence of neurosyphilis
Prince Edward Island	Unable to locate online
Quebec	Unable to locate online
Saskatchewan	http://www.health.gov.sk.ca/cdc-section5 **Primary Syphilis Confirmed Case** Laboratory confirmation of infection: identification of Treponema pallidum by dark-field microscopy, fluorescent antibody, nucleic acid testing or equivalent examination of material from a chancre or a regional lymph node; OR presence of one or more typical lesions (chancres), and reactive treponemal serology, regardless of non-treponemal test reactivity, in individuals with no previous history of syphilis; OR presence of one or more typical lesions (chancres) and at least a 4-fold (e.g., 1:8 to 1:32) increase in the titre over the last known non-treponemal test inindividuals with a past history of syphilis treatment. **Secondary Syphilis Confirmed Case** Laboratory evidence of infection: identification of Treponema pallidum by dark-field microscopy, fluorescent antibody, nucleic acid testing or equivalent examination of mucocutaneous lesions, condylomata lata and reactive serology (non-treponemal and treponemal); OR presence of typical mucocutaneous lesions, rash (especially on palmar aspects of hands, soles of feet/trunk), alopecia, loss of eyelashes and lateral third of eyebrows, iritis, generalized lymphadenopathy, fever, malaise or splenomegaly, AND either a reactive serology(non-treponemal and treponemal) OR a fourfold (e.g., 1:8 to 1:32) or greater increase in titre over the last known non-treponemal test. NOTE: The possibility of a prozone reaction should be considered in individuals who are suspected of having secondary syphilis but whose non-treponemal test is non-reactive. **Early Latent Syphilis (< 1 year after infection) Confirmed Case** Laboratory confirmation of infection:

	an asymptomatic patient with reactive serology (non-treponemal and/or treponemal) who within the past 12 months had one of the following: non-reactive serology; symptoms suggestive of primary or secondary syphilis; exposure to a sexual partner with primary, secondary or early latent syphilis. **Late Latent Syphilis (> 1 year after infection or of unknown duration) Confirmed Case** Laboratory confirmation of infection: an asymptomatic patient with persistently reactive treponemal serology (regardless of non-treponemal serology reactivity) who does not meet the criteria for early latent disease and who has not been previously treated for syphilis **Neurosyphilis Confirmed Case** Laboratory confirmation of infection: reactive treponemal serology (regardless of non-treponemal serology reactivity) and one of the following: reactive CSF-VDRL (Venereal Disease Research Laboratory) in non-bloody cerebrospinal fluid (CSF); clinical evidence of neurosyphilis AND either elevated CSF leukocytes OR elevated CSF protein in the absence of other known causes. **Tertiary Syphilis Other Than Neurosyphilis Confirmed Case** Laboratory confirmation of infection: reactive treponemal serology (regardless of non-treponemal test reactivity) together with characteristic abnormalities of the cardiovascular system, bone, skin or other structures, in the absence of other known causes of these abnormalities (Treponema pallidum is rarely seen in these lesions although, when present, is diagnostic); AND no clinical or laboratory evidence of neurosyphilis. **Early Congenital Syphilis (within 2 years of birth) Confirmed Case** Laboratory confirmation of infection: identification of Treponema pallidum by dark-field microscopy, fluorescent antibody or equivalent examination of material from nasal discharges, skin lesions, placenta, umbilical cord or autopsy material of a neonate (up to 4 weeks of age); OR reactive serology (non-treponemal and treponemal) from venous blood (not cord blood) in an infant/child with clinical, laboratory or radiographic evidence of congenital syphilis, whose mother is without documented evidence of adequate treatment; OR detection of Treponema pallidum DNA in an appropriate clinical specimen

Yukon	Unable to locate online
PHAC	http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/09vol35/35s2/Syphilis-eng.php **Confirmed case—Early Congenital Syphilis (within 2 years of birth)** Laboratory confirmation of infection: identification of *Treponema pallidum* by dark-field microscopy, fluorescent antibody or equivalent examination of material from nasal discharges, skin lesions, placenta, umbilical cord or autopsy material of a neonate (up to four weeks of age. OR reactive serology (non-treponemal and treponemal) from venous blood (not cord blood) in an infant/child with clinical, laboratory or radiographic evidence of congenital syphilis* whose mother is without documented evidence of adequate treatment OR detection of *Treponema pallidum* DNA in an appropriate clinical specimen **Confirmed Case—Primary Syphilis** Laboratory confirmation of infection: identification of *Treponema pallidum* by dark-field microscopy, fluorescent antibody, nucleic acid testing, or equivalent examination of material from a chancre or a regional lymph node OR presence of one or more typical lesions (chancres) and reactive treponemal serology, regardless of non-treponemal test reactivity, in individuals with no previous history of syphilis OR presence of one or more typical lesions (chancres) and a fourfold or greater increase in the titre over the last known non-treponemal test in individuals with a past history of syphilis treatment **Confirmed Case—Secondary Syphilis** Laboratory evidence of infection: identification of *Treponema pallidum* by dark-field microscopy, fluorescent antibody, nucleic acid testing or equivalent examination of mucocutaneous lesions, condylomata lata and reactive serology (non-treponemal and treponemal) OR presence of typical signs or symptoms of secondary syphilis (e.g. mucocutaneous lesions, alopecia, loss of eyelashes and lateral third of eyebrows, iritis, generalized lymphadenopathy, fever, malaise or splenomegaly) AND either a reactive serology (non-treponemal and treponemal OR a fourfold or greater increase in titre over the previous known non-treponemal test

	Confirmed Case—Early Latent Syphilis (< 1 year after infection) Laboratory confirmation of infection: an asymptomatic patient with reactive serology (treponemal and/or nontreponemal) who, within the previous 12 months, had one of the following: non-reactive serology symptoms suggestive of primary or secondary syphilis exposure to a sexual partner with primary, secondary or early latent syphilis **Confirmed Case—Late Latent Syphilis (> 1 year after infection or of unknown duration)** Laboratory confirmation of infection: an asymptomatic patient with persistently reactive treponemal serology (regardless of non-treponemal serology reactivity) who does not meet the criteria for early latent disease and who has not been previously treated for syphilis **3.6 Confirmed Case—Neurosyphilis** **Infectious (< 1 year after infection)** Laboratory confirmation of infection: Fits the criteria in 3.2, 3.3 OR 3.4 above AND one of the following: reactive CSF-VDRL in non-bloody cerebrospinal fluid (CSF) clinical evidence of neurosyphilis AND either elevated CSF leukocytes OR elevated CSF protein in the absence of other known causes **Non-infectious (> 1 year after infection)** Laboratory confirmation of infection: reactive treponemal serology (regardless of non-treponemal serology reactivity) AND one of the following: reactive CSF-VDRL in non-bloody CSF clinical evidence of neurosyphilis AND either elevated CSF leukocytes OR elevated CSF protein in the absence of other known causes **Confirmed Case—Tertiary Syphilis Other than Neurosyphilis** Laboratory confirmation of infection: reactive treponemal serology (regardless of non-treponemal test reactivity) together with characteristic late abnormalities of the cardiovascular system, bone, skin or other structures, in the absence of other known causes of these abnormalities (*T. pallidum* is rarely seen in

	these lesions although, when present, it is diagnostic) AND no clinical or laboratory evidence of neurosyphilis

4. (d) Hepatitis

Province/ Territory	**Case Definitions: Hepatitis**
Alberta	http://www.health.alberta.ca/documents/Guidelines-Hepatitis-B-Acute-Case-2011.pdf **Hepatitis B Acute Case** *Case Definitions* Confirmed Case Laboratory confirmation of infection: Hepatitis B surface antigen (HBsAg) positive and immunoglobulin M antibody to hepatitis B core antigen (anti-HBc IgM) positive in the context of a compatible clinical history or probable exposure; or Loss of HBsAg over 6 months in the context of a compatible clinical history or probable exposure *Probable Case* Acute clinical illness a person who is epidemiologically linked to a confirmed case (acute or chronic), acute clinical illness is characterized by a discrete onset of symptoms and jaundice or elevated serum aminotransferase levels **Hepatitis B Chronic** *Case Definitions for Confirmed Chronic Carrier* Laboratory confirmation of infection: persistence of Hepatitis B surface antigen (HBsAg) positivity for more than 6 months in the context of a compatible clinical history of probable exposure or HBsAg positive and immunoglobulin M antibody to hepatitis B core antigen (anti-HBc IgM) negative or total antibody to Hepatitis B core antigen (anti-HBc total) positive and HBV DNA positive and HBsAg negative and Antibody to Hepatitis B Surface Antigen (anti-HBs) negative *Probable Chronic Carrier*

	Laboratory confirmation of infection: HBsAg positive in the context of compatible clinical history and/or appropriate epidemiologic exposure, e.g., self reported past history of Hepatitis B, born in Hepatitis B endemic country http://www.health.alberta.ca/documents/Guidelines-Hepatitis-C-Acute-Case-2013.pdf **Hepatitis C Acute** *Confirmed Case: Acute or Recent Infection* Confirmed detection of hepatitis C virus antibodies (anti-HCV) or hepatitis C virus RNA (HCV RNA) in a person with discrete onset of any symptom or sign of acute viral hepatitis within the previous 6 months of current positive test. AND Negative anti-HAV IgM and negative anti-HBc IgM or HBsAg test AND Serum alanine aminotransferase (ALT) greater than 2.5 times the upper normal limit. OR Confirmed detection of hepatitis C virus antibodies (anti-HCV) or HCV RNA in a person with a documented anti-HCV negative test within the preceding 12 months OR Detection of hepatitis C virus RNA (HCV RNA) in a person with a documented HCV RNA negative test within the preceding 12 months, excluding those undergoing HCV treatment or therapy. OR Individuals who have had a sustained virologic response (SVR) for six months post-treatment and become HCV RNA positive within 12 months of SVR should be considered as having an acute or recent infection for surveillance purposes, even though some of these cases may be post-treatment relapses http://www.health.alberta.ca/documents/Guidelines-Hepatitis-C-Chronic-Case-2013.pdf **Hepatitis C Chronic** *Case Definitions* *Confirmed Case* Detection of anti-hepatitis C antibodies (anti-HCV) and should be confirmed by a second manufacturer's EIA, immunoblot or nucleic acid (e.g., PCR) for HCV-RNA. OR Detection of hepatitis C virus RNA (HCV-RNA).

British Columbia	http://www.bccdc.ca/NR/rdonlyres/328189F4-2840-44A1-9D13-D5AB9775B644/0/HepatitisB_Sept_2009.pdf **Acute hepatitis B infection:** *Confirmed case:* Hepatitis B surface antigen (HBsAg) and immunoglobulin M antibody to hepatitis B core antigen (anti- HBc IgM) positive in the context of a compatible clinical history or probable exposure Acute clinical illness is characterized by a discrete onset of symptoms and jaundice or elevated serum aminotransferase levels OR Clearance of HBsAg in a person who was documented to be HbsAg positive within the last six months in the context of a compatible clinical history or probable exposure. *Probable case:* Acute clinical illness in a person who is epidemiologically linked to a confirmed case **Chronic hepatitis B infection:** *Confirmed case:* HBsAg positive for more than 6 months OR Detection of HBsAg and anti-HBc IgG in the documented absence of anti-HBc IgM. **Hepatitis B infection of undetermined status:** HBsAg positive AND does not fit the criteria for either an acute case or a chronic infection. http://www.bccdc.ca/NR/rdonlyres/CEC67337-3E94-4FD3-B21C-63A71014619D/0/CPS_Hep_Guidelines_HCV_20130709.pdf **Hepatitis C** Note: There is no serological marker for acute infection. The terms acute and chronic hepatitis C are defined within the limits of laboratory testing results **Acute Hep C** Documented seroconversion within the past 12 months (i.e. Detection of hepatitis C virus antibodies (anti-HCV) in a person with a documented anti- HCV negative test within the preceding 12 months) *"Acute Hepatitis C" Chronic Case* - Anti-HCV reactivity but cannot ascertain when seroconversion occurred : HCV infection is considered chronic when anti-HCV testing indicates:

	1) seroconversion occurred >12 months prior OR 2) anti-HCV reactivity has existed for >12 months OR 3) duration of anti- HCV reactivity of ≤ 12 months cannot be established, such as in the case of a person with no previous anti-HCV tests on record "Hepatitis C" Case
Manitoba	http://www.gov.mb.ca/health/publichealth/cdc/protocol/hepb.pdf 1.1 **Confirmed Case of Acute Infection** Laboratory confirmation of infection as demonstrated by: hepatitis B surface antigen (HBsAg) positive PLUS immunoglobulin M antibody to hepatitis B core antigen (anti-HBc IgM) positive in the context of a compatible clinical history or probable exposure OR loss of HBsAg within a six month period after testing HBsAg positive in the context of a compatible clinical history or probable exposure 1.2 **Confirmed Case of Chronic Infection** Laboratory confirmation of infection as demonstrated by: HBsAg positive for longer than six months with or without symptoms OR HBsAg positive, anti-HBc IgM negative and anti-HBc total positive OR detection of hepatitis B virus (HBV) DNA over a period greater than six months by a validated nucleic acid amplification test (1, 2). **1.3 Confirmed Unspecified Case** - HBsAg positive OR detection of HBV DNA by a validated nucleic acid amplification test AND does not fit the criteria for either acute orchronic case definitions above. http://www.gov.mb.ca/health/publichealth/cdc/protocol/hepc.pdf **Hepatitis C** Confirmed case that does not distinguish acute from chronic infection (1):

	Detection of anti-hepatitis C antibodies in blood (anti-HCV Ab) by enzyme immunoassay (EIA), confirmed by nucleic acid test (NAT) for hepatitis C virus RNA (HCV RNA), immunoblot or by a second manufacturer's EIAa OR Detection of HCV RNA in blood
New Brunswick	Unable to locate online
Newfoundland	http://www.health.gov.nl.ca/health/publications/diseasecontrol/s4_diseases_preventable_by_routine_vaccination.pdf **Hepatitis B** *Confirmed case* Hepatitis B surface antigen (HBsAg) and immunoglobulin M antibody to hepatitis B core antigen (anti-HBcIgM) positive in the context of a compatible clinical history or probable exposure OR Clearance of HBsAg in a person who was documented to be HBsAg positive within the last six months in the context of a compatible clinical history or probable exposure *Probable case* Acute clinical illness in a person who is epidemiologically linked to a confirmed case *Chronic carrier confirmed case* HBsAg positive for more than 6 months OR Detection of HBsAg in the documented absence of anti-HBc-IgM OR Detection of HBV DNA for more than 6 months *Unspecified confirmed case* Does not fit the criteria for either of the above AND HBsAg positive OR Detection of HBV DN http://www.health.gov.nl.ca/health/publichealth/cdc/STBBI_Sept2010.pdf **Hepatitis C** *Confirmed Case that does not distinguish Acute from Chronic Infection* Detection of anti-Hepatitis C antibodies (anti-HCV) (positive anti-HCV tests should be confirmed by a second manufacturer's EIA, immunoblot or NAT for HCV RNA). OR

	Detection of Hepatitis C virus RNA *Clinical Evidence* Acute clinical illness is characterized by a discrete onset of symptoms and jaundice or elevated serum aminotransferase levels. Chronic infections may present with disease flares with similar symptoms and signs
Northwest Territories	http://www.hss.gov.nt.ca/sites/default/files/cdcmanfulldoc.pdf **Hepatitis B** Clinical Description: Hepatitis B is a viral infection of the liver caused by the Hepatitis B Virus in the blood, semen and vaginal fluids. Hep B can cause a wide spectrum of manifestations. **Hep B Carriers** Clinical Definition: HbsAg-positive for 6 months of IgM anti-HBc-negative and HBsAg-positive **Hepatits C** Clinical Description: An infection of the liver caused by the Hepatitis C (HCV) virus, an RNA virus. Six major genotypes and more than 90 subtypes have been identified. An individual may be infected with more than one genotype.
Nova Scotia	http://novascotia.ca/dhw/populationhealth/surveillanceguidelines/Chapter_9_Bloodborne_Pathogens.pdf *Acute Confirmed Case:* Hepatitis B surface antigen (HBsAg) and immunoglobulin M antibody to hepatitis B core antigen (anti-HBcIgM) positive in the context of a compatible clinical history (including serum aminotransferase levels >2.5 times the upper limit of normal) or probable exposure OR Clearance of HBsAg in a person who was documented to be HBsAg positive within the last 6 months in the context of a compatible clinical history or probable exposure *Chronic Confirmed Case:* HBsAg positive for more than 6 months OR Detection of HBsAg in the documented absence of anti-HBc-IgM OR

	Detection of HBV DNA for more than 6 months *Unspecified Confirmed Case:* Does not meet the criteria for acute or chronic hepatitis B AND HBsAg positive OR Detection of HBV DNA
Nunavut	Unable to locate online
Ontario	http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/hep_b_cd.pdf *3.1 Confirmed Case (Acute Case)* Laboratory confirmation of infection: Detection of Hepatitis B surface antigen (HBsAg) and Immunoglobulin M (IgM) antibody to Hepatitis B core antigen (anti-HBc) in the context of a compatible clinical history or probable exposure OR Loss of HBsAg over 6 months in the context of a compatible clinical history or probable exposure *3.2 Chronic Case (Carrier)* Laboratory confirmation of infection: Detection of HBsAg with a negative IgM anti-HBc OR Presence of HBsAg for over 6 months OR Presence of HBV DNA for over 6 months *3.3 Probable Case (Acute Case)* Acute clinically compatible signs and symptoms in a person with an epidemiologic link to a laboratory-confirmed case OR Acute clinically compatible signs and symptoms and detection of HBsAg (and anti-Hepatitis A virus [HAV] and Hepatitis C virus [HCV] negative) when the test for IgM antibody to anti-HBc is not available
Prince Edward Island	Unable to locate online
Quebec	Unable to locate online

Saskatchewan	http://www.health.gov.sk.ca/cdc-section6 *Hepatitis C Acute* Detection of hepatitis C virus antibodies (anti-HCV) or hepatitis C virus RNA (HCV RNA) in a person with discrete onset of any symptom or sign of acute viral hepatitis (see Section 5) within 6 months preceding the first positive HCV test AND negative anti-HAV IgM, and negative anti-HBc IgM or HBsAg tests AND serum alanine aminotransferase (ALT) greater than 2.5 times the upper normal limit. OR Detection of hepatitis C virus antibodies (anti-HCV) in a person with a documented anti-HCV negative test within the preceding 12 months. OR Detection of hepatitis C virus RNA (HCV RNA) in a person with a documented HCV RNA negative test within the preceding 12 months. *Confirmed Case:* Unspecified (including chronic and resolved infections) Detection of hepatitis C virus antibodies (anti-HCV) OR Detection of hepatitis C virus RNA (HCV RNA). **Hep B unable to locate info**
Yukon	http://www.hss.gov.yk.ca/disease_guildelines.php Under Development
PHAC	http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/09vol35/35s2/Hep_B-eng.php **Hepatitis B (Acute Case)** **Acute case Confirmed case** Hepatitis B surface antigen (HBsAg) and immunoglobulin M antibody to hepatitis B core antigen (anti-HBcIgM) positive in the context of a compatible clinical history or probable exposure OR Clearance of HBsAg in a person who was documented to be HBsAg positive within the last six months in the context of a compatible clinical history or probable exposure **Probable case**

	Acute clinical illness in a person who is epidemiologically linked to a confirmed case **Hepatitis B (Chronic Carrier)** Confirmed case HBsAg positive for more than 6 months OR Detection of HBsAg in the documented absence of anti-HBc-IgM OR Detection of HBV DNA for more than 6 months **Unspecified Confirmed case** Does not fit the criteria for either 3.1 or 3.2 above AND HBsAg positive OR Detection of HBV DNA http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/09vol35/35s2/Hep_C-eng.php **Hepatitis C** **Confirmed Case That Does Not Distinguish Acute from Chronic Infection** Detection of anti-hepatitis C antibodies (anti-HCV) (positive anti-HCV tests should be confirmed by a second manufacturer's EIA, immunoblot or NAT for HCV RNA) OR Detection of hepatitis C virus RNA

4. (e) HIV

Province/ Territory	**Case Definitions: HIV**
Alberta	http://www.albertahealthservices.ca/ps-1001306-gov-ab-ph-notifiable-disease-guidelines.pdf Confirmed Case *Adults, Adolescents and Children ≥18 months:*

	Detection of Human Immunodeficiency Virus (HIV) antibody with confirmation (e.g. EIA screening with confirmation by Western blot or other confirmatory test) OR Detection of HIV nucleic acid (e.g. DNA-PCR or plasma RNA) OR Detection of HIV p24 antigen with confirmation by neutralization assay OR Isolation of HIV in culture. *Children < 18 months (on two separate samples)* Detection of HIV nucleic acid (e.g. DNA-PCR or plasma RNA) OR Detection of HIV p24 antigen with confirmation by neutralization assay OR Isolation of HIV in culture. *Probable Case* Children <18 months (on a single sample)* Detection of HIV nucleic acid by quantitative or qualitative NAT.
British Columbia	Unable to locate online
Manitoba	http://www.gov.mb.ca/health/publichealth/cdc/protocol/hiv.pdf **HIV** Case Definition The case definition of human immunodeficiency virus (HIV) infection relies on the detection of HIV antibody, nucleic acid or antigen by laboratory methods or isolation of HIV in culture. Seroconversion Illness Acute self-limited mononucleosis-like illness lasting for one to two weeks occurring within several weeks to months after infection with HIV. Window Period The period between initial infection and antibody detection is known as the window period and is usually two weeks to three months. Rarely, window periods lasting years may occur in immunocompromised persons. Acquired Immunodeficiency Syndrome (AIDS) Case Definition

	Those who meet the case definition for HIV infection PLUS any one of the following indicator diseases (based on Case Definitions for Communicable Diseases under National Surveillance, *November 2009, Public Health Agency of Canada):* <u>Indicator Diseases for Adult and Pediatric Cases</u> Bacterial pneumonia (recurrent)*• Candidiasis (bronchi, trachea or lungs)• Candidiasis (esophageal)*CD4+ T-lymphocyte count of < 200 cells/µL or CD4+ T-lymphocyte percentage of total lymphocytes of < 14 (CDC 2008 Surveillance Case Definitions) Cervical cancer (invasive) Coccidioidomycosis (disseminated or extrapulmonary) Cryptococcosis (extrapulmonary) Cryptosporidiosis chronic intestinal (> one month duration) • Cytomegalovirus diseases (other than in liver, spleen or nodes) Cytomegalovirus retinitis (with loss of vision)* • Encephalopathy, HIV-related (dementia) Herpes simplex: chronic ulcer(s) (> one month duration) or bronchitis, pneumonitis or esophagitis) • Histoplasmosis (disseminated or extrapulmonary) Isosporiasis, chronic intestinal (> one month duration) Kaposi's sarcoma* Lymphoma, Burkitt's (or equivalent term) Lymphoma, immunoblastic (or equivalent term) • Lymphoma (primary in brain) Mycobacterium avian complex or Mycobacterium kansasii (disseminated or extrapulmonary)* Mycobacterium of other species or unidentified species (disseminated or extrapulmonary)* Mycobacterium tuberculosis (any site, pulmonary* or trapulmonary, disseminated) Pneumocystis jiroveci (formerly Pneumocystis carinii) pneumonia (PCP)*Progressive multifocal leukoencephalopathy. Salmonella septicemia (recurrent)Toxoplasmosis of brain* Wasting syndrome due to HIV <u>Indicator Diseases that Apply Only to Pediatric Cases (< 15 years old)</u> Bacterial infections (multiple or recurrent, excluding recurrent bacterial pneumonia) Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia* These conditions may be diagnosed presumptively; otherwise, definitive diagnosis is required. Criteria for presumptive and definitivediagnoses are provided on the back of the Health Canada HIV/AIDS case report form.
New Brunswick	Unable to locate online
Newfoundland	http://www.health.gov.nl.ca/health/publichealth/cdc/STBBI_Sept2010.pdf **HIV** Confirmed case *Adults, Adolescents and Children >18 months:* detection of HIV antibody with conf irmation (e.g. EIA screening with confirmation by Western blot or other confirmatory test) OR detection of HIV nucleic acid (e.g. DNA PCR or plasma RNA) OR HIV p24 antigen with confirma tion by neutralization assay

	OR isolation of HIV in culture *Children < 18 months (on two separate samples collected at different times*) detection of HIV nucleic acid (e.g. DNA PCR or plasma RNA) OR HIV p24 antigen with confirma tion by neutralization assay OR isolation of HIV in culture *For pediatric cases only (<15 years old)* Bacterial infections (multiple or recurrent, excluding recurrent bacterial pneumonia)* Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia+ * must have laboratory evidence of HIV infection + may be diagnosed presumptively if laboratory evidence of HIV infection is present
Northwest Territories	http://www.hss.gov.nt.ca/sites/default/files/cdcmanfulldoc.pdf **Only Provides Clinical Description: A viral infection caused by the Human Immunodeficiency Virus (HIV) that is characterized by several stages. AIDS (Acquired Immunodeficiency Syndrome) is the late stage of HIV infection.
Nova Scotia	http://novascotia.ca/dhw/populationhealth/surveillanceguidelines/Chapter_9_Bloodborne_Pathogens.pdf *Confirmed Case:* One or more of the specified indicator diseases (see below) AND Meeting the case definition of HIV infection: Indicator diseases for adult & pediatric cases - Bacterial pneumonia (recurrent)*: -Candidiasis (bronchi, trachea or lungs) -Candidiasis (esophageal)* -Cervical cancer (invasive) -Coccidioidomycosis (disseminated or extrapulmonary)

	-Cryptococcosis (extrapulmonary) -Cryptosporidiosis chronic intestinal (>1 month duration) -Cytomegalovirus diseases (other than in liver, spleen or nodes) -Cytomegalovirus retinitis (with loss of vision)* -Encephalopathy, HIV-related (dementia) -Herpes simplex: chronic ulcer(s) (>1 month duration) or bronchitis, pneumonitis or esophagitis -Histoplasmosis (disseminated or extrapulmonary) -Isosporiasis, chronic intestinal (>1 month duration) -Kaposi's sarcoma* -Lymphoma, Burkitt's (or equivalent term) -Lymphoma, immunoblastic (or equivalent term) -Lymphoma (primary in brain) -Mycobacterium avian complex or M.Kansasii (disseminated or extrapulmonary)* -Mycobacterium Of other species or unidentified species -M. tuberculosis (disseminated or extrapulmonary) -M. tuberculosis (pulmonary)* -Pneumocystis jirovecii (formerly Pneumocystis carinii) pneumonia (PCP)* -Progressive multifocal leukoencephalopathy -Salmonella septicemia (recurrent) -Toxoplasmosis of brain* -Wasting syndrome due to HIV Indicator diseases that apply only to pediatric cases (<15 years old) -Bacterial infections (multiple or recurrent, excluding recurrent bacterial pneumonia): -Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia*
Nunavut	Unable to locate online
	http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/aids_cd.pdf

Ontario	**Confirmed Case of Human Immunodeficiency Virus (HIV) Infection** *Children < 18 months:* •Detection of HIV nucleic acid (by deoxyribonucleic acid [DNA] polymerase chain reaction [PCR]) or p24 antigen (p24 Ag) in two separate samples collected one month and four months after delivery Adults, Adolescents and Children >18 months: Detection of HIV antibody with confirmation OR Detection of HIV nucleic acid or p24 antigen **Confirmed Case of Acquired Immunodeficiency Syndrome (AIDS)** A positive test for HIV infection with confirmation AND Definitive diagnosis of one or more AIDS indicative diseases (See Section 5.2)
Prince Edward Island	Unable to find
Quebec	Unable to find
Saskatchewan	not located in current CDC manual/ Unable to find
Yukon	Unable to locate online
PHAC	http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/09vol35/35s2/HIV_VIH-eng.php **Confirmed Case in Adults, Adolescents and Children ≥ 18 months:** detection of HIV antibody with confirmation (e.g. EIA screening with confirmation by Western blot or other confirmatory test) OR detection of HIV nucleic acid (e.g. DNA PCR or plasma RNA) OR HIV p24 antigen with confirmation by neutralization assay OR isolation of HIV in culture **Children < 18 months (on two separate samples collected at different times):** detection of HIV nucleic acid (e.g. DNA PCR or plasma RNA) OR HIV p24 antigen with confirmation by neutralization assay OR

	isolation of HIV in culture

5. Recalcitrant Sections from the Public Health Acts

Province/ Territory	Recalcitrant Sections
Alberta	So **_ ;** www.qp.**alberta**.ca/documents/**Act**s/P37.pdf **Recalcitrant Patients Issue of certificate** **39(1)** Where a physician, community health nurse, midwife or nurse practitioner knows or has reason to believe that a person (a) is infected with a disease prescribed in the regulations for the purposes of this section, and (b) refuses or neglects (i) to submit; (A) to a medical examination for the purpose of ascertaining whether the person is infected with that disease, or (B) to medical, surgical or other remedial treatment that has been prescribed by a physician and that is necessary to render the person non-infectious, or (ii) to comply with any other conditions that have been prescribed by a physician as being necessary to mitigate the disease or limit its spread to others, the physician, community health nurse, midwife or nurse practitioner shall immediately notify the medical officer of health in the prescribe **(2)** Where the medical officer of health is satisfied as to the sufficiency of the evidence that the person may be infected, the medical officer of health shall issue a certificate in the prescribed form. **(3)** A certificate pursuant to subsection (2) must be issued within 72 hours of the date of service of the notification pursuant to subsection (1) **(4)** Where the physician referred to in subsection (1) is a medical officer of health in the health region in which the alleged infected person is located, the physician may issue the certificate referred to in subsection (2). **5)** A person in respect of whom a certificate is issued may apply by originating notice to a judge of the Court of Queen's Bench at any time for cancellation of the certificate. **(6)** The originating notice shall be served on (a) the medical officer of health who issued the certificate, and (b) the chief executive officer of the facility in which the applicant is detained, if the applicant is under detention at the time of the application, not less than 2 days before the motion is returnable. **(7)** Notwithstanding subsection (6), a judge of the Court, on the ex parte application of the person referred to in subsection (5), may dispense with the service of the originating notice under subsection (6) or authorize the giving of a shorter period of notice. **(8)** Where the judge considers it appropriate to do so, the judge may order that the application under subsection (5) be heard in private. **(9)** The judge may grant or refuse the order applied for and may make any other order the judge considers appropriate. **Authority of certificate** **40(1)** A certificate is authority (a) for any peace officer to apprehend the person named in it and convey the person to any facility specified by the medical officer of health within 7 days from the date the certificate is issued, (b) for a physician to perform any test or physical examination required to determine whether that person has a communicable disease and to detain that person at the facility for the period required to obtain the result of the

	examination,(c) for any physician to treat or prescribe treatment for that person in order to render that person non-infectious, with or without the consent of the person, and to detain the person for that purpose, and (d) for a physician to prescribe any other conditions necessary to mitigate the disease or limit its spread to others **(2)** The medical director of, or in the medical director's absence the attending physician at, a facility to which a person is conveyed under subsection (1) shall ensure that the person is examined under that section within 24 hours after the person's arrival at the facility. **(3)** Where a person is detained pursuant to a certificate, the medical director of the facility in which the person is detained shall forthwith (a) inform the person or the person's guardian, if any, of the reason for the issuance of the certificate,(b) advise the person or the person's guardian, if any, that the person has a right to retain and instruct counsel without delay, and (c) give the person or the person's guardian, if any, a copy of section 39. **Release** **41(1)** Subject to subsection (2), a person who is detained in a facility pursuant to a certificate shall be released not later than 7 days after the date the person is admitted to the facility pursuant to the certificate, unless an isolation order is issued under section 44.**(2)** A person who is detained in a facility pursuant to a certificate shall be released forthwith if the physician who examines the person certifies,(a) that there is no evidence of active disease, or (b) that, although there is evidence of active disease, the physician is satisfied that the person will comply with the treatment and any other conditions ordered by the physician in a manner that will ensure the protection of the public health. **Notification of release** **42** Where a person is released pursuant to section 41, the physician who examined the patient or the medical director of the facility shall, on the release of the patient, forthwith notify the medical officer of health who issued the certificate of the circumstances of the release. **Treatment after release** **43(1)** Where a person is released pursuant to section 41(2)(b), the person shall comply with the treatment and any other conditions that are prescribed by any physician assigned by the medical director of the facility.**(2)** Where a person who has been required to submit to treatment or comply with conditions following the person's release fails to undergo treatment or comply with the conditions, a medical officer of health may issue an order in the prescribed form to a peace officer or other person to apprehend that person and return that person to the facility.**(3)** On receipt of an order under subsection (2), a peace officer or other person is empowered to arrest without warrant the person named in it and return that person to the facility.**(4)** Sections 41 and 42 and subsections (1), (2) and (3) apply to a person who is arrested and returned to a facility under subsection (3). **Isolation order** **44(1)** Where one physician supported by a laboratory report demonstrating evidence of an infectious agent certifies or 2 physicians certify that a person is infected with an organism that produces a disease prescribed in the regulations for the purposes of this section and that the person refuses or neglects, (a) to submit to medical, surgical or other remedial treatment, or (b) to comply with any other conditions that have been prescribed by a physician as being necessary to mitigate that disease or to limit its spread to others, the physician or physicians shall each issue an isolation order in the prescribed form. **(2)** Subsection (1) applies whether or not there is a certificate in existence in respect of the person who is the subject of the isolation order or orders. **(3)** A physician issuing an isolation order shall forthwith send a copy of the isolation order to the Chief Medical Officer.

Authority of isolation order

45(1) An isolation order under section 44 is authority for a health practitioner to observe, examine, care for, treat, obtain biological specimens from, control and detain in a facility the person named in it with or without that person's consent until the order is cancelled under section 46. **(2)** A person in respect of whom isolation is ordered under section 44 shall be re-examined by a physician at least once every 7 days to ascertain whether the person may be released under section 46.

Cancellation of isolation order

46(1) Where, after separate examinations by each of them, 2 physicians are of the opinion that a person in respect of whom isolation has been ordered under section 44,(a) is not infectious, or (b) will comply with the conditions of the person's discharge, the 2 physicians shall issue an order in the prescribed form cancelling the isolation order.**(2)**Immediately on issuing an order cancelling an isolation order, the physicians who signed the order shall send a copy of it to the Chief Medical Officer.

Warrant for examination

47(1) Any person who has reasonable and probable grounds to believe that a person,(a) is infected with a disease prescribed in the regulations for the purpose of this section, and (b) refuses or neglects (i)to submit;(A) to a medical examination for the purpose of ascertaining whether the person is infected with the disease, or (B) to medical, surgical or other remedial treatment that has been prescribed by a physician and that is necessary to render the person non-infectious, or (ii) to comply with any other conditions that have been prescribed by a physician as being necessary to mitigate the disease or limit its spread to others, may bring an information under oath before a judge of the Provincial Court.

Where an information is brought before a judge of the Provincial Court under subsection (1) and the judge is satisfied that the person with respect to whom the information is brought should be examined in the interests of the person's own health or the health of others and that the examination cannot reasonably be arranged in any other way, the judge may issue a warrant in the prescribed form to apprehend that person for the purpose of the examination.**(3)**A warrant under this section may be directed to any peace officer and shall name or otherwise describe the person with respect to whom the warrant is issued.**(4)**Where a peace officer apprehends a person pursuant to a warrant under this section, the person is deemed to be a person in respect of whom a certificate has been issued under section 39.

Duty on issue of isolation order

48Where a person is detained pursuant to an isolation order or orders, the medical director of the facility in which the person is detained shall forthwith (a) inform the person or the person's guardian, if any, of the reason for the issuance of the isolation order or orders, (b) advise the person or the person's guardian, if any, that the person has a right to retain and instruct counsel without delay, and (c) give the person or the person's guardian, if any, a copy of section 49.

Application to Court for cancellation

49(1)A person in respect of whom isolation is ordered may apply by originating notice to a judge of the Court of Queen's Bench at any time for cancellation of the isolation order or orders.**(2)**The originating notice shall be served on (a) the physician or physicians who issued the isolation order or orders, and (b) the chief executive officer of the facility in which the applicant is a patient not less than 7 days before the motion is returnable.**(3)**Notwithstanding subsection (2), a judge of the Court, on the ex parte application of the person referred to in subsection (1), may dispense with the service of the originating notice under subsection (2) or authorize the giving of a shorter period of notice.**(4)**Where the judge considers it appropriate

	to do so, the judge may order that the application under subsection (2) be heard in private.**(5)**The judge may grant or refuse the order applied for and may make any other order the judge considers appropriate. **Unauthorized absence** **50(1)**Where a person in respect of whom isolation has been ordered leaves the facility and leave of absence has not been granted by the medical director of the facility, the medical director may issue an order in the prescribed form to a peace officer or other person ordering the return of the person to the facility.**(2)** An order issued pursuant to subsection (1) is sufficient authority for the person to whom it is directed to apprehend the person named in it and return the person to the facility.**(3)** A person who is returned to a facility under this section may be detained until the conditions under section 46 have been met. **Transfer to another facility** **51(1)** The medical director of the facility in which a person is detained may, for reasons of treatment or in compliance with the person's wishes, transfer the person to another facility, on completing a memorandum of transfer in the prescribed form.**(2)** Where a person is transferred under subsection (1), the authority to detain, control and treat the person continues in force in the facility to which the person is transferred. **Leave of absence** **52(1)**The medical director or an attending physician at a facility in which a person is detained may grant the person a leave of absence from the facility subject to any terms and conditions prescribed by the medical director or attending physician to ensure that the public health is protected.**(2)**Where a person is on a leave of absence granted under this section and it appears to the medical director or the attending physician that the person is not complying with the conditions to which the leave of absence is subject, the medical director or attending physician may revoke the leave of absence and recall the person to the facility.**(3)**Section 50 applies in the case of a person who has been recalled under subsection (2) and fails to return to the facility in accordance with the instructions of the medical director or attending physician.
British Columbia	**Public Health Act; one of several sections related to penalties** http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_08028_01 **Extra Info HIV specific:** http://www.bccdc.ca/NR/rdonlyres/F1557A81-792B-4AEA-95D4-344140A705C7/0/GuidelinesforMHO_December2010.pdf **Imposing administrative penalties** (1) If by regulation a person is authorized to impose an administrative penalty, the person may impose an administrative penalty in the amount permitted by the regulations if satisfied on a balance of probabilities that a person has done any of the following: (a) contravened a prescribed provision of this Act or a regulation made under it; (b) failed to comply with an order of a health officer; (c) failed to comply with a requirement of a licence or permit issued under this Act. (2) An administrative penalty may be imposed by serving notice of the administrative penalty in the prescribed manner. (3) If a person is subject to an administrative penalty, the person must do one of the following within the prescribed time: (a) pay the administrative penalty; (b) dispute the administrative penalty in accordance with the regulations, including disputing the amount of the administrative penalty on any ground permitted by the regulations;

	(c) agree, in writing, with the person who imposed the administrative penalty to do one or more things, including paying a reduced administrative penalty, that the person imposing the administrative penalty reasonably believes would (i) be sufficient for the protection of public health, and (ii) if applicable, bring the person into compliance with this Act, the regulations or an order made under it, or a term or condition of the person's licence or permit. (4) If an administrative penalty is disputed or made the subject of an agreement under subsection (3), the person who is subject to the administrative penalty must pay the administrative penalty or any part of it that remains outstanding (a) under the terms of the agreement, (b) on receiving notice following a dispute that the person remains subject to all or part of the administrative penalty, or (c) on receiving notice that the person failed to meet the terms of the agreement to the satisfaction of the person who imposed the administrative penalty. (5) If a corporation contravenes this Act or a regulation made under it, or fails to comply with a requirement of a licence or permit issued under this Act or an order made under this Act, an employee, an officer, a director or an agent of the corporation who authorized, permitted or acquiesced in the contravention is also liable under this section even though the corporation is liable for or pays an administrative penalty.
Manitoba	http://web2.gov.mb.ca/laws/statutes/ccsm/p210e.php **Offences** 90(1)A person is guilty of an offence who (a) contravenes a provision of this Act; (b) fails to comply with an order made under this Act or with a term or condition of a licence, permit, approval or other authorization issued under this Act; (c) knowingly makes a false or misleading statement to the minister, the chief public health officer, a director, a medical officer, an inspector, a health officer, a public health nurse or any other person acting under the authority of this Act; (d) knowingly makes a false or misleading statement in an application, report, record or return given or required under this Act, or knowingly provides false or misleading information under this Act; (e) hinders, obstructs or interferes with, or attempts to hinder, obstruct or interfere with, the minister, the chief public health officer, a director, a medical officer, an inspector, a health officer, a public health nurse or any other person acting under the authority of this Act; or (f) conceals or destroys, or attempts to conceal or destroy, any record, information or thing relevant to an inspection or investigation under this Act. **Continuing offence** 90(2) When an offence under this Act continues for more than one day, the person is guilty of a separate offence for each day the offence continues. **Directors and officers of corporations** 90(3) If a corporation commits an offence under this Act, a director or officer of the corporation who authorized, permitted or acquiesced in the commission of the offence is also guilty of the offence. **Penalties**

	90(4) A person other than a corporation who is guilty of an offence under this Act is liable on summary conviction, (a) for an offence other than an offence described in clause (b), to a fine of not more than $50,000. or imprisonment for a term of not more than six months, or both; and (b) for an offence resulting from the failure to comply with an emergency health hazard order, to a fine of not more than $100,000. or imprisonment for a term of not more than one year, or both. **Penalties for corporations** 90(5)A corporation that is guilty of an offence under this Act is liable on summary conviction, (a) for an offence other than an offence described in clause (b), to a fine of not more than $500,000.; and (b) for an offence resulting from the failure to comply with an emergency health hazard order, to a fine of not more than $1,000,000. **Time limit for prosecution** 90(6)A prosecution for an offence under this Act may be commenced not later than two years after the day the alleged offence was committed. **Court Orders to prohibit or Require Actions** **Court order where order or direction contravened** 91(1)Despite any other remedy or penalty, if a person contravenes an order under this Act or a direction under clause 67(2)(a) (special measures), the court may — on application made without notice by the person who made the order, or by the chief public health officer or the minister — make an order (a) prohibiting the person from doing anything that contravenes the order or direction; or (b) requiring the person to do anything necessary to comply with the order or direction. **Court order where Act contravened** 91(2)Despite any other remedy or penalty, if a person contravenes any provision of this Act, the court may, on application without notice by the chief public health officer or the minister, make an order preventing the person (a) from continuing or repeating the contravention; or (b) from doing anything that will, or is likely to, result in the contravention continuing or being repeated. **Terms and conditions** 91(3)The court may make an order under this section on any terms or conditions that it considers appropriate
New Brunswick	**http://laws.gnb.ca/en/ShowPdf/cs/P-22.4.pdf** **Offences** **52**(1) A person who violates or fails to comply with any provision of the regulations commits an offence. **52**(2) A person who violates or fails to comply with a term or condition of a licence or approval commits an offence

	52(3) A person who violates or fails to comply with an order made by a medical officer of health or a public health inspector commits an offence. **52**(4) A person who violates or fails to comply with a provision of this Act that is listed in Column I of Schedule A commits an offence.. **Penalties** **53**(1) For the purposes of Part II of the *Provincial Offences Procedure Act*, each offence listed in Column I of Schedule A is punishable as an offence of the category listed beside it in Column II of Schedule A. **53**(2) Where an offence under this Act continues for more than one day, *(a)* the minimum fine that may be imposed is the minimum fine set by the *Provincial Offences Procedure* *Act* multiplied by the number of days during which the offence continues, and *(b)* the maximum fine that may be imposed is the maximum fine set by the *Provincial Offences Procedure* *Act* multiplied by the number of days during which the offence continues. **Proceedings to restrain contravention of order** **54** Notwithstanding any other remedy or penalty, the contravention of an order made under this Act may be restrained by order of a judge of The Court of Queen's Bench of New Brunswick upon application without notice by the person who made the order, the chief medical officer of health or the Minister. **Proceedings to prohibit continuation or repetition of** **contravention** **55** Where any provision of the Act or the regulations is contravened, notwithstanding any other remedy or penalty imposed, the Minister may apply to a judge of The Court of Queen's Bench of New Brunswick for an order prohibiting the continuation or repetition of the contravention or the carrying on of any activity in the order that, in the opinion of the judge, will or will likely result in the continuation or repetition of the contravention by the person committing the contravention, and the judge may make the order and it may be enforced in the same manner as any other order or judgment of The Court of Queen's Bench of New Brunswick.
Newfoundland	http://www.assembly.nl.ca/legislation/sr/statutes/c26.htm **General**

	34. In a case not otherwise specifically provided for in this Act, a person willfully committing a breach of this Act shall be subject to a penalty not exceeding $100, or in default of payment, to imprisonment for a period not exceeding 30 days, or to both a fine and imprisonment.
Northwest Territories	http://www.justice.gov.nt.ca/legislation/..%5CPDF%5CACTS%5CPublic%20Health.pdf **Offence and Punishment** *Offence and punishment* **49.** (1) A person who contravenes or fails to comply with this Act, the regulations, or an order made under this Act or the regulations, is guilty of an offence and is liable on summary conviction, (a) in the case of an individual, (i) for a first offence (A) to a fine not exceeding $10,000, or to imprisonment for a term not exceeding six months, or to both, and (B) to a further fine of not more than $1,000 for each day during which the offence continues, and (ii) for a second or subsequent offence (A) to a fine not exceeding $25,000, or to imprisonment for a term not exceeding 12 months, or to both, and (B) to a further fine of not more than $2,500 for each day during which the offence continues; … (b) in the case of a corporation,(i) for a first offence(A) to a fine not exceeding$50,000, and (B) to a further fine of not more than $2,500 for each day during which the offence continues, and (ii) for a second or subsequent offence(A) to a fine not exceeding $100,000, and (B) to a further fine of not more than $5,000 for each day during which the offence continues *Failure to comply with order* (2) Where a person is convicted of an offence in respect of the failure to comply with an order made under this Act or the regulations, the court may, in addition to any other penalty that may be imposed, order the person to comply with the order. … *Vicarious liability* (4) In a prosecution for an offence under this Act, it is sufficient proof of the offence to establish that it was committed by an employee or agent of the accused, in the course of the employment or agency relationship, whether or not the employee or agent is identified or has been prosecuted for the offence, unless the accused establishes that (a) the offence was committed without the knowledge of the accused; and (b) the accused exercised due diligence to prevent the commission of the offence.
Nova Scotia	http://nslegislature.ca/legc/statutes/health%20protection.pdf **Offences and penalties** 71 (1) Every person who fails to comply with this Part or the regulations or with an order made pursuant to this Part or the regulations is guilty of an offence and is liable on summary conviction to (a) in the case of a corporation, a fine not exceeding ten thousand dollars; or (b) in the case of an individual, a fine not exceeding two thousand dollars or to imprisonment for a term of not more than six months, or both.

	(2) Where an offence under this Part or the regulations is committed or continued on more than one day, the person who committed the offence is liable to be convicted for a separate offence for each day on which the offence is committed or continued. (3) Notwithstanding subsection (1), a person who is guilty of a second or subsequent offence, other than by virtue of subsection (2), is liable to (a) in the case of a corporation, a fine of not exceeding fifty thousand dollars; or (b) in the case of an individual, a fine not exceeding ten thousand dollars or to imprisonment for a period of not more than one year, or both. *2004, c. 4, s. 71.* **Offences by employees, agents or corporations** 72 (1) In a prosecution for an offence under this Part or the regulations, it is sufficient proof of the offence to establish that it was committed by an employee or agent of the accused, whether or not the employee or agent is identified or has been prosecuted for the offence, unless the accused establishes that the offence was committed without the knowledge or consent of the accused. (2) Where a corporation commits an offence under this Part or the regulations, any officer, director or agent of the corporation who directed, authorized, assented to, acquiesced in or participated in the violation of this Part or the regulations is guilty of the offence and is liable to the punishment provided for the offence, whether or not the corporation has been prosecuted. (3) Unless otherwise provided in this Part, no person shall be convicted of an offence under this Part or the regulations if the person establishes that the person exercised all due diligence to prevent the commission of the offence. *2004, c. 4, s. 72.*
Nunavut	http://www.canlii.org/en/nu/laws/stat/rsnwt-nu-1988-c-p-12/latest/rsnwt-nu-1988-c-p-12.html (current to 2011 but there is no other updated Public health act) 23. Every person who,(a) contravenes this Act or the regulations,(b) obstructs a Medical Health Officer or a Health Officer in the exercise of his or her powers or in the performance of his or her duties under this Act or the regulations, (c) neglects, fails or refuses to comply with an order or direction given to him or her by a Medical Health Officer or a Health Officer in the exercise of his or her powers or the performance of his or he duties under this Act or the regulations,(d) without the authority of a Medical Health Officer or a Health Officer, removes, alters or interferes in any way with anything seized or detained under this Act, or (e) owns, constructs, operates or maintains any installation, building, place or thing mentioned in this Act or the regulations that does not comply with the requirements of this Act or the regulations, is guilty of an offence and liable on summary conviction to a fine not exceeding $500 or to imprisonment for a term not exceeding six months or to both.
Ontario	http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90h07_e.htm#BK24 **Penalty** **101.**(1)Every person who is guilty of an offence under this Act is liable on conviction to a fine of not more than $5,000 for every day or part of a day on which the offence occurs or continues. R.S.O. 1990, c. **Corporation** (2)Where a board of health, a municipality or any other corporation is convicted of an offence under this Act, the maximum penalty that may be imposed for every day or part of a day on

	which the offence occurs or continues is $25,000 and not as provided in subsection (1). R.S.O. 1990, c. H.7, s.101 (2); 1997, c.30, **Directors, officers, employees and agents** (3)Where a corporation, other than a board of health or a municipality, is convicted of an offence under this Act,(a) each director of the corporation; and (b) each officer, employee or agent of the corporation who was in whole or in part responsible for the conduct of that part of the business of the corporation that gave rise to the offence ,is guilty of an offence unless he or she satisfies the court that he or she took all reasonable care to prevent the commission of the offence. .
Prince Edward Island	**Source; Public Health Act;** http://www.gov.pe.ca/law/statutes/pdf/p-30.pdf CHAPTER P-30 PUBLIC HEALTH ACT Repealed by 2012(2nd),c.20,s.76.
Quebec	http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_2_2/S2_2_A.html **138.**The following persons are guilty of an offence and are liable to a fine of $600 to $1,200: (1)any physician or nurse who fails to make a report required under section 69; (2)any physician or chief executive officer of a public or private laboratory or medical biology department who fails to make a report required under section 82; (3) any physician who fails to give a notice required under section 86; (4) any health professional who fails to give a notice required under section 90.2001, c. 60, s. 138. **139.**Any person who, within the scope of application of Chapter XI, impedes or hinders the Minister, the national public health director, a public health director or a person authorized to act on their behalf, refuses to obey an order they are entitled to give, refuses to give access to or communicate the information or documents they are entitled to require, or conceals or destroys documents or other things relevant to the exercise of their functions is guilty of an offence and is liable to a fine of $1,000 to $6,000.2001, c. 60, s. 139.**140.** person who reports or provides false, incomplete or misleading information or a document that is incomplete or contains false or misleading information in order to deceive the Minister, the national public health director, a public health director or a person authorized to act on their behalf is guilty of an offence and is liable to a fine of $1,000 to $6,000. Penal proceedings for an offence under the first paragraph are prescribed one year after the prosecutor is apprised of the commission of the offence. However, proceedings may not be instituted more than five years after the commission of the offence.2001, c. 60, s. 140. **141.**Any person who assists or who incites, advises, encourages, allows, authorizes or orders another person to commit an offence under this Act is guilty of an offence .A person convicted of an offence under this section is liable to the same penalty as that provided for the offence the person assisted or incited another person to commit.2001, c. 60, s. 141.

	142. In the case of a second or subsequent offence, the minimum and maximum fines prescribed in this Act are doubled.2001, c. 60, s. 142.
Saskatchewan	http://www.qp.gov.sk.ca/documents/english/Chapters/1994/P37_1.pdf **and penalty** person who contravenes any provision of this Act or a regulation, bylaw or order made pursuant to this Act is guilty of an offence and liable on summary conviction: case of an individual: (i) for a first offence:(A) to a fine of not more than $75,000; and urther fine of not more than $100 for each day during which the offence continues; and (ii) for a second or subsequent offence: (A) to a fine of not more than $100,000; and (B) to a further fine of not more than $200 for each day during which the offence continues; and (b) in the case of a corporation: (i) for a first offence:(A) to a fine of not more than $100,000; and (B) to a further fine of not more than $1,000 for each day during which the offence continues; and (ii) for a second or subsequent offence: (A) to a fine of not more than $250,000; and urther fine of not more than $5,000 for each day during which the offence continues. **by corporations, etc.** **62** Where a corporation is guilty of an offence mentioned in section 61, every officer, director, manager or agent of the corporation who directed, authorized or participated in the commission of the offence is also guilty of the offence and is liable on summary conviction to the penalties for the offence that are set out in section 61, whether or not the corporation has been prosecuted. **n** **63** No prosecution with respect to an alleged offence pursuant to this Act or any regulations, bylaws or orders made pursuant to this Act is to be commenced after two years from the day of the commission of the alleged offence.

Yukon	http://www.gov.yk.ca/legislation/acts/puhesa.pdf **22** Every person who(a) violates any of the provisions of this Act or the regulations; (b) obstructs a medical health officer or health officer in the exercise of their powers or in the carrying out of their duties under this Act or the regulations; (c) neglects, fails, or refuses to comply with an order or direction given to them by a medical health officer or health officer in the exercise of powers or the carrying out of duties under this Act or the regulations; (d) without the authority of a medical health officer or health officer removes, alters, or interferes in any way with anything seized or detained under this Act; or (e) owns, constructs, operates, or maintains any installation, building, place, or thing mentioned in this Act or the regulations that does not comply with the requirements thereof, commits an offence and is liable on summary conviction to a fine of up to $5,000 for each day the offence continues or imprisonment for a term not exceeding six months, or both fine and imprisonment. *S.Y. 1997, c.18, s.11; R.S., c.136, s.20.*

6. Partner Notification Parameters

6. (a) Chlamydia

Province/ Territory	Partner Notification Parameters
Alberta	http://www.albertahealthservices.ca/hp/if-hp-the-blue-book.pdf http://www.health.alberta.ca/documents/Guidelines-Chlamydia-Trachomatis-2012.pdf *Management of Contacts* *Partner Notification* •Partner notification will identify those at risk, reduce disease transmission/re-infection and ultimately prevent disease sequelae. •It is mandated under the Public Health Act that every attempt is made to identify, locate, examine and treat partners/contacts of all cases. •Physician/case manager are required to provide partner names and locating information on the Notification of STI Form and forward to STI Services. •If testing and/or treatment of partner(s) are not confirmed on the Notification of STI Form, STI Services will initiate follow up by a Partner Notification Nurse. o Partner Notification Nurse (PNN) is specially trained to conduct notification of partners and contacts in a confidential manner that protects the identity of the index case. o The phone number for your designated PNN is available by calling STI Services at 780-735-1466 or toll free 1-888-535-1466. •All contacts should be screened for HIV and other STI. •All contacts should be instructed about infection transmission. • All contacts should be provided with individualized STI prevention education, targeted at developing knowledge, skills, attitudes and behaviors to reduce the risk and prevent recurrences of STI. • STI Services initiates follow-up on all out of province/country referrals of cases and partner(s). *Preventive Measures* • Ensure appropriate treatment of Chlamydia trachomatis for cases.

	•Interview case, identify and ensure appropriate treatment and follow-up of Chlamydia trachomatis for sexual partner(s). •Include information about risk for STI during pre-travel health counseling. •Ensure STI services are culturally appropriate, and readily accessible and acceptable.
British Columbia	**Mandated in the Public Health Communicable Disease Act Regulations** http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/12_4_83 **Timelines** A report required to be made without delay shall be made by telephone or by any similar rapid means of communication. reports by hospital **3** In addition to the requirements of section 2, the administrator or other person in charge of a hospital shall, within 7days, make a report to the medical health officer respecting a patient admitted to the hospital who is suffering from a reportable communicable disease or from rheumatic fever. **Information Required** A report made under section 2 (2) shall include (a)the name of the disease,(b)the name, age, sex and address of the infected person, and (c) appropriate details if the disease reported is epidemic or shows unusual features. A report made under section 3 shall include (a) the name of the disease,(b) the name, age, sex and address of the patient, and (c) the name and address of the physician or other person who is or has been attending the patient. (4) All reports referred to in this section shall include any further relevant information requested by the medical health officer. 5)A report made under section 2 (2) or (3) or 3 respecting a person who voluntarily submitted to testing for Human Immunodeficiency Virus must omit the name and address of the person if that person so chooses. **BC uses PHAC Guidelines for STI's:** **Mandated** Reportable by laboratories and physicians to local public health authorities in all provinces and territories. **Timelines** All partners who have had sexual contact with the index case within 60 days prior to symptom onset or date of specimen collection (if asymptomatic) should be tested and empirically treated regardless of clinical findings and without waiting for test results. The length of time for the trace-back period should be extended: 1) to include additional time up to the date of treatment 2) if the index case states that there were no partners during the recommended trace-back period, then the last partner should be notified

	3) if all partners traced (according to recommended trace-back period) test negative, then the partner prior to the trace-back period should be notified. Parents of infected neonates (i.e., mother and her sexual partner[s]) should be located, clinically evaluated and treated
Manitoba	http://www.gov.mb.ca/health/publichealth/cdc/protocol/chlamydia.pdf **Chlamydia trachomatis** **Mandated** Patients should be referred to a physician, public health nurse or other health care professional for support with partner notification All confirmed cases of *Chlamydia trachomatis* are reportable by laboratory to the Communicable Disease Control Branch, Manitoba Health and Healthy Living, for Public Health follow-up. All confirmed cases of *Chlamydia trachomatis* are reportable by attending health care professional to the Communicable Disease Control Branch, Manitoba Health and Healthy Living for Public Health review. **Timelines** If the case is a male or female with symptomatic, uncomplicated chlamydial infection, all sexual contacts exposed two months prior to the onset of symptoms in the case, up to and including the interview date, should be examined, tested and provided empiric treatment. If the case is a male or female with asymptomatic chlamydial infection, or with repeated infections (i.e., two or more infections in a 12-month period), the interview period should extend to a minimum of three months prior to the diagnosis of the case. NOTE: When resources are limited, priority for partner notification should be directed toward youth/young adults < 25 years of age (58). **Information Required** Interview case for history of exposure, risk assessment, contacts, adequacy of treatment and promotion of safer sex practices. Interview contacts and provide empiric treatment, with risk assessment and promotion of safer sex practices. **Risk Factors** Sexually active individuals (regardless of age) and individuals under age 25 should be tested more often than annually, in the following circumstances; – all women undergoing intrauterine device, insertion ,all women undergoing termination of pregnancy or D&C, individuals with more than one sex partner in the past year ,individuals with a new sex partner in the past two months, individuals whose sex partner has other sex partners, sex partners of those with chlamydial infection, street-involved individuals, individuals involved in substance use(injection drug use, glue sniffing, etc.),individuals with a

	history of an STI in the past year, individuals engaging in sex trade activities ,history of unprotected sex with a person in one of the above categories
New Brunswick	Only able to locate lay fact sheets
Newfoundland	http://www.health.gov.nl.ca/health/publichealth/cdc/STBBI_Sept2010.pdf **Chlamydia trachomatis** **Mandated** Partner notification may be done by the client, public health or physician as decided by the attending health care professional in consultation with office of the Regional Medical Officer of Health (RMOH). Investigations and reporting are the responsibility of the office of the Regional Medical Officer of Health (RMOH). As the lead in the region the RMOH collaborates with family physicians, Communicable Disease Control (CDC) and public health staff to provide effective and confidential follow-up of laboratory confirmed cases of STIs and BBPs or sexually transmitted infections (STIs) and bloodborne pathogens. Communicable disease control nurse (CDCNs) or community health nurses (CHNs) educated in communicable disease and nurse practitioners (NPs) are permitted to undertake testing for STIs or BBP at selected sites within a regional health authority under direction/designation of their MOH. **Timelines** (BBPs) contact follow up and notification is required and is completed in a confidential and timely manner at the local or regional level Laboratory: Routine reporting to CMOH, RMOH and attending physician within four working days for all list B STIs. RMOH or designate: Assign and initiate investigation within four working days Every attempt must be made to identify, locate, examine and treat partners/contacts; of cases If physicians/HCP of the case other than the MOH or the CDCN,CDN or NP completes the follow up of contacts then they are to notify the RHA that this follow up has been taken place If a physician/HCP may choose to have the assistance of the MOH or the CDCN, CDN or NP to do contact tracing and follow up for the notifiable STI case then the physician /HCP shall advise the RHA of this within two weeks of receiving notification of the case In absence of a response from the physician/HCP within the two week time frame to the RHA then the appropriate STI services will be initiated by the MOH or the CDCN,CDN or NP Partner notification should include partners who have had sexual contact with the index case within 60 days. If there has been no sexual partner(s) in the 60 day period then trace back to last sexual partner. These contacts should be notified of their risk and advised to be tested.

	Treatment of sexual partners is recommended (without waiting for laboratory confirmatory results). **Risk Factors** Exchange of infected secretions during intimate contact is necessary for transmission. The bacteria can affect oral, vaginal, rectal or urethral tracts. Newborns delivered vaginally are at risk and may develop conjunctivitis and pneumonia. As well, prepubertal children who present with genital, urethral, or rectal infections should be considered for possible cultures to rule out sexual abuse. **Reporting Process** Physicians, laboratories, communicable disease control nurses (CDCNs), and infection control practitioners (ICPs) must report suspect or confirmed cases to the Regional Medical Officer of Health (RMOH) RMOH office will notify local physicians, nurse practitioners, community health nurses, and CDCNs in the particular region as required for follow-up and case investigation as applicable, RMOH reports to provincial office as per list B,CDCN enters the case into the electronic reporting system and completes an outbreak form if indicated Provincial Disease Control reports the aggregate case data to Public Health Agency of Canada, provides an analysis of the case/s with reports in the Communicable Disease Report (CDR) **Newfoundland/Labrador Policy** All laboratory confirmed reportable STIs and BBPs are to be reported to the RMOH or designate, appropriately treated and case follow-up completed. Reports from the provincial public health laboratory are sent to the office of the RMOH, CMOH (Chief Medical Officer of Health) as well as the attending physician. Reporting of these infections allows for public health agencies to monitor the prevalence and incidence of these infections in the community and thus help to plan prevention and intervention programs to reduce the risk of infection and disease. Reportable STIs in Newfoundland and Labrador include: Chancroid, Chlamydia, Gonorrhea, Lymphogranuloma venereum (LGV),Syphilis, Reportable BBPs in Newfoundland and Labrador include: Hepatitis C,HIV infection, Hepatitis B (See Section 4 Diseases Preventable by Vaccination)
Northwest Territories	http://www.hss.gov.nt.ca/sites/default/files/cdcmanfulldoc.pdf **Mandated** Partner notification, treatment and counselling are indicated for any infection or syndrome that is predominantly transmitted sexually. **Patient referral:** Patients inform their own partners without the direct involvement of health care providers or public health authorities. **Provider referral:** Health care providers and/or public health authorities notify partners of the patient.

	Reporting and Follow-up Chlamydia trachomatis infection must be reported, on the STI Report Form, to the Office of the Chief medical Health Officer (OCMHO), within 7 days of diagnosis or lab confirmation. All partners who had sexual contact with the index case at least 60 days prior to diagnosis must be located, evaluated and tested. If no sexual partner(s) in the last 60 days, trace back to last sexual partner. Staff of the OCMHO will assist with partner notification, when they reside outside the NWT is required. Repeat diagnostic testing for Chlamydia trachomatis is NOT routinely indicated if a recommended treatment is given and taken, AND signs and symptoms have disappeared, AND there is no re-exposure to an infected partner. Repeat testing is recommended if compliance is questionable, symptoms do not disappear and if the patient is a child or pregnant woman. **Risk Factors** Identify those at high risk for STIs and note that both females and males may be asymptomatic: Sexual contact with person(s) with known STI. Youth <25 years of age with multiple partners. Street involvement (e.g. homelessness). Intercourse with new partner in last 2 months. >2 sexual partners in the last 12 months. No contraception or non-barrier methods used. Injection drug use (also at a higher risk of HIV, Hepatitis B and C). Persons immigrating from or having sex in countries where certain STIs are currently epidemic, and their sexual partners. Men who have sex with men. Commercial sex workers. **Other Public Health Measures** Educate on safer sexual practices.
Nova Scotia	Comprehensive manual, unable to copy http://www.gov.ns.ca/hpp/publications/cdc_manual.pdf
Nunavut	http://www.canlii.org/en/nu/laws/regu/rrnwt-nu-1990-c-p-13/latest/rrnwt-nu-1990-c-p-13.html **Mandated in Regulations for all Reportable Communicable Diseases** Where a medical practitioner or nurse has received a positive test result for one of his or her patients or a medical practitioner, nurse or dentist has reason to believe or suspect that one of his or her patients is infected with a communicable disease, the medical practitioner, nurse or dentist shall (a) in the case of a disease listed in Item I of (i) immediately notify the Chief Medical Health Officer by telephone, and (ii) within 24 hours, send a written report to the Chief Medical Health Officer in a form approved by the Chief Medical Health Officer;(b) in the case of a disease listed in Item II of Schedule A, within seven days send a written report to the Chief Medical Health Officer in a

	form approved by the Chief Medical Health Officer;(c) advise the patient to adopt the specific control measures for the communicable disease in question; d) provide the patient with the necessary information to comply with paragraph (c); and (e) within seven days of giving notice under paragraph (a) or (b),(i) in accordance with guidelines provided by the Chief Medical Health Officer, carry out contact tracing or surveillance of those aspects of the occurrence and spread of the communicable disease that are pertinent to the effective control of the disease, or (ii) request the Chief Medical Health Officer to carry out the contact tracing or surveillance. http://www.gov.nu.ca/health/information/communicable-disease States there is a CDC Manual but no links are available
Ontario	http://www.health.gov.on.ca/english/providers/program/pubhealth/oph_standards/ophs/progstds/protocols/population_health_assessment.pdf http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/sexual_health_sti.pdf **Chlamydia trachomatis** **Mandated** The board of health shall ensure that the medical officer of health or designate receives reports of sexually transmitted infections and blood-borne infections and responds in accordance with the Health Protection and Promotion Act and the Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol, 2008 (or as current). Laboratory confirmed cases shall be reported to the medical officer of health by persons required to do so under the Health Protection and Promotion Act, R.S.O. 1990. **Timelines** Symptomatic*: All sexual contacts of the case within at least 60 days prior to the onset of symptoms through date of treatment. Asymptomatic*: All sexual contacts of the case within at least 60 days prior to the date of specimen collection through date of treatment. Parents of infected neonates Data collection, reporting and information transfer The board of health shall: a) Use the integrated Public Health Information System (iPHIS) or any other method specified by t he Ministry of Health and Long-Term Care (the “ministry”) to notify the ministry of cases and contacts of reportable STIs including BBIs. It is required to include all disease-specific information specified in O. Reg.5695 under the HPPA.

	1b) Include as much relevant information as possible to facilitate locating, counseling, and treatment of cases of reportable STIs/BBIs. A laboratory report alone is insufficient. As described in disease-specific iPHIS user guides 6 or any other documentation or method identified by the ministry or the Ontario Agency for Health Protection and Promotion (herein referred to as Public Health Ontario (PHO)), as specified by the ministry, case information shall include as much of the following as possible: i) Infection/diagnosis; ii) First name, last name (with the exception of anonymous HIV testing); iii) Birth date or birth year if date of birth not available; and iv) Gender. Other data elements to be collected and reported for cases of reportable STIs/BBIs could include but are not limited to: v) Address/telecommunications; vi) Case/encounter date (e.g., onset date, reported date, etc.); vii) Treatment; viii) Site of infection; and ix) Risk factors (e.g., exposure setting, medical risk factors, and behavioural/social factors). c) Include as much relevant information as possible to facilitate the location, counseling and treatment of contacts. As described in disease-specific iPHIS user guides 6or any other documentation or method identified by the ministry or PHO, as specified by the ministry, information shall include as much of the following as possible: i)Infection/diagnosis; ii)First name, last name; iii)Birth date or birth year if date of birth not available; and iv)Gender. Other data elements to be collected and reported on contacts could also include but are not limited to: v) Address/telecommunications; vi) Contact (e.g., sexual, maternal, household, etc.); vii) Case/encounter date (e.g., onset date, reported date, etc.);

	viii) Treatment; and ix) Risk factors (e.g., exposure setting, medical risk factors, behavioural/social factors). d) Refer information on cases and contacts that are outside the health unit directly to the appropriate board of health within Ontario, using iPHIS or any other method specified by the ministry. e)Refer information on cases/contacts outside of Ontario or Canada to the Public Health Division, of the ministry, using iPHIS or any other method specified by the ministry.
Prince Edward Island	Unable to locate online
Quebec	Unable to locate online
Saskatchewan	http://www.health.gov.sk.ca/cdc-section5 http://www.health.gov.sk.ca/cdc-section1 **Chlamydia trachomatis** **Mandated** The client, health care provider, MHO or their designate may notify the partner. When the person with the STI chooses to notify his or her contacts, they must inform the contact of the exposure, explain their duty to get tested and take all reasonable measures to reduce the risk of exposing others.1 If the affected person does not wish to notify their contacts on their own, the physician or clinic nurse can complete the partner notification. If the health care provider is unable to do this within 14 days, it should be referred to Public Health to complete. Notification by the health care provider occurs confidentially with the consent of the infected person. Partners will be notified of the possibility of their exposure to an STI (without naming the index case) and their responsibility to get tested and to take all reasonable measures to reduce the risk of exposing others (e.g., condoms, period of abstinence, safer sex practices, etc.) Role of Saskatchewan Regional Health Authorities Each RHA has public health staff including Communicable Disease Coordinators, Public Health Inspectors, Public Health Nurses, and others working with the MHO to assist in communicable disease control. They are responsible for the public health follow up of individual cases and contacts that reside within the RHA's jurisdiction. First Nations Health Agencies FNIH and NITHA are each responsible for the coordination and public health follow up of individual cases and contacts that reside in First Nations communities in their jurisdiction. The follow up is provided by Community Health Nurses (CHNs) and Environmental Health Officers (EHOs) employed by the First Nation or FNIH.

	Timelines *Control of Contacts* To prevent reinfection, partners need to be assessed, tested, treated, and counselled. All partners who have had sexual contact with the index case within 90 days prior to symptom onset or date of diagnosis should be tested and treated. If there is no partner during this period, the last partner should be tested and treated. Neonates born to infected mothers must be tested for Chlamydia trachomatis. **Who Performs Partner Notification?** The client, health care provider, MHO or their designate may notify the partner. When the person with the STI chooses to notify his or her contacts, they must inform the contact of the exposure, explain their duty to get tested and take all reasonable measures to reduce the risk of exposing others **Risk Factors** Sexual contact with a chlamydia-infected person; a new sexual partner or more than two sexual partners in the past year; previous sexually transmitted infections (STIs); vulnerable populations (for example injection drug users, incarcerated individuals, sex trade workers, street youth, aboriginal etc.). **Reporting Process** Following the investigation of the case, detailed information shall be documented in the electronic public health case management and surveillance system called Integrated Public Health Information System (iPHIS) within 14 days. MHOs are required to submit case reports of notifiable and unusual communicable diseases to the Saskatchewan Ministry of Health. From time to time, additional information is requested from the Coordinator of Communicable Diseases (Deputy Chief Medical Health Officer) at the Ministry of Health for enhanced surveillance purposes. This information may be collected through the use of a specialized form or it may be documented on the electronic public health case management and surveillance system. The Ministry of Health compiles the information into a statistical report that is provided to the communicable disease contacts in Saskatchewan Health Regions and First Nations health agencies. De-identified case information is sent to the Centre for Infectious Disease Prevention and Control, Public Health Agency of Canada for “National Notifiable Diseases”. Role of the Ministry of Health, Population Health Branch Reports nationally notifiable communicable diseases to PHAC for national disease surveillance and statistical summaries (e.g., Canadian Communicable Disease Report, Disease Surveillance On-Line, etc.). Role of Saskatchewan Disease Control Laboratory

	Provides infectious disease surveillance information enabling early detection of outbreaks and monitoring of disease trends. Provides copies of notifiable communicable disease laboratory reports to MHOs, the ordering practitioner and Saskatchewan Ministry of Health.
Yukon	Unable to locate online
PHAC	http://www.phac-aspc.gc.ca/std-mts/sti-its/cgsti-ldcits/section-5-2-eng.php **Reporting and Partner Notification** *Chlamydia trachomatis* infections are reportable by laboratories and physicians to local public health authorities in all provinces and territories. All partners who have had sexual contact with the index case within 60 days prior to symptom onset or date of specimen collection (if asymptomatic) should be tested and empirically treated regardless of clinical findings and without waiting for test results. The length of time for the trace-back period should be extended: to include additional time up to the date of treatment if the index case states that there were no partners during the recommended trace-back period, then the last partner should be notified if all partners traced (according to recommended trace-back period) test negative, then the partner prior to the trace-back period should be notified. Parents of infected neonates (i.e., mother and her sexual partner[s]) should be located, clinically evaluated and treated. Local public health authorities are available to assist with partner notification and help with appropriate referral for clinical evaluation, testing, treatment and health education. If resources for local public health authority support are limited, priority for partner notification should be directed toward youth/young adults <25 years of age

6(b) Gonorrhea

Province/ Territory	**Partner Notification Parameters**
Alberta	http://www.health.alberta.ca/documents/Guidelines-Gonococcal-Infections-2012.pdf *Management of Contacts for Gonorrhea* *Partner Notification* Partner notification will identify those at risk, reduce disease transmission/re-infection and ultimately prevent disease sequelae.

	It is mandated under the Public Health Act that every attempt is made to identify, locate, examine and treat partners/contacts of all cases. (1) Physician/case manager are required to provide partner names and locating information on the Notification of STI Form and forward to STI Services. If testing and/or treatment of partner(s) are not confirmed on the Notification of STI Form, STI Services will initiate follow up by a Partner Notification Nurse. Partner Notification Nurse (PNN) is specially trained to conduct notification of partners and contacts in a confidential manner that protects the identity of the index case. The phone number for your designated PNN is available by calling STI Services at 780-735-1466 or toll free 1-888-535-1466. All contacts should be screened for HIV and other STI. All contacts should be instructed about infection transmission. All contacts should be provided with individualized STI prevention education, targeted at developing knowledge, skills, attitudes and behaviors to reduce the risk and prevent recurrences of STI. STI Services initiates follow-up on all out-of-province/country referrals of cases and partner(s). Preventive Measures Ensure appropriate treatment for Neisseria gonorrhoeae cases. Interview case and identify and ensure appropriate treatment and follow-up of Neisseria gonorrhoeae for sexual partner(s). Include information about risk for STI during pre-travel health counselling. Make STI services culturally appropriate, and readily accessible and acceptable, regardless of economic status. Educate the case, sexual partner(s), and the public about symptoms, transmission and prevention of infection including: personal protective measures including the correct and consistent use of condoms, abstinence, delaying onset of sexual activity developing mutually monogamous relationships, reducing the numbers of sexual partners, discouraging anonymous or casual sexual activity and sound decision making.
British Columbia	**Mandated in the Public Health Communicable Disease Act Regulations** http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/12_4_83 **Timelines** A report required to be made without delay shall be made by telephone or by any similar rapid means of communication. reports by hospital **3** In addition to the requirements of section 2, the administrator or other person in charge of a hospital shall, within 7 days, make a report to the medical health officer respecting a patient admitted to the hospital who is suffering from a reportable communicable disease or from rheumatic fever. **Information Required** A report made under section 2 (2) shall include (a) the name of the disease,(b) the name, age, sex and address of the infected person, and (c) appropriate details if the disease reported is epidemic or shows unusual features.

	A report made under section 3 shall include (a) the name of the disease,(b) the name, age, sex and address of the patient, and (c) the name and address of the physician or other person who is or has been attending the patient. (4) All reports referred to in this section shall include any further relevant information requested by the medical health officer. 5) A report made under section 2 (2) or (3) or 3 respecting a person who voluntarily submitted to testing for Human Immunodeficiency Virus must omit the name and address of the person if that person so chooses. **BC uses PHAC Guidelines for Partner Notification** **http://www.phac-aspc.gc.ca/std-mts/sti-its/guide-lignesdir-eng.php** Reporting and Partner Notification Case finding and partner notification are critical strategies for maintaining control of gonococcal infections in Canada. Local public health authorities may assist with partner notification and with appropriate referral for clinical evaluation, testing, treatment and health education. Gonococcal infections are reportable in all provinces and territories; positive test results should be reported to local public health authorities. All partners who have had sexual contact with the index case within 60 days prior to symptom onset or date of specimen collection (if the index case is asymptomatic) should be notified, tested and empirically treated regardless of clinical findings and without waiting for test results. The length of time for the trace-back period should be extended in the following three circumstances: To include additional time between the date of testing and date of treatment, If the index case states that there were no partners during the recommended trace-back period, the most recent partner should be notified, and If all partners traced (according to recommended trace-back period) test negative, the last partner prior to the trace-back period should be notified. When a neonate is confirmed to have gonorrhea, the mother and her most recent sexual partner plus any other partners within 60 days of delivery should be located, clinically evaluated and empirically treated regardless of clinical findings and without waiting for test results.
Manitoba	http://www.gov.mb.ca/health/publichealth/cdc/protocol/gonorrhea.pdf **Gonorrhea** **Mandated** Patients should be referred to a physician, public health nurse or other health care professional for support with partner notification. Public Health will be notified of all cases in order to coordinate contact management and ensure that it is completed.

	All positive laboratory tests are reportable by laboratory to the Communicable Disease Control Branch, Manitoba Health and Healthy Living for surveillance and Public Health follow up. All clinical and laboratory-confirmed cases are reportable by the attending health care professional to the Communicable Disease Control Branch, Manitoba Health and Healthy Living for surveillance and Public Health follow-up. **Timelines** Operators of Manitoba clinical laboratories are required to submit clinical isolate sub-cultures of Neisseria gonorrhoeae to Cadham Provincial Laboratory (CPL) within seven days of report for surveillance purposes. Where the case is a male or female with symptomatic uncomplicated gonorrhea, all sexual contacts exposed two months prior to the onset of symptoms in the case, up to and including the interview date, should be examined, tested and offered treatment. Where the case is a male or female with asymptomatic gonorrhea, complicated gonorrhea or repeated infections (i.e., two or more infections in a 12-month period), the interview period should extend to three months prior to the diagnosis of the case. **Information Required** Interview case for history of exposure, risk assessment, contacts, adequacy of treatment and promotion of safer sex practices. Interview contacts and provide epidemiological treatment, with risk assessment and promotion of safer sex practices. **Risk Factors** Frequency of testing will depend upon individual risk circumstances: women prior to insertion of an intrauterine device; women prior to therapeutic abortion or D&C; sexually active adolescents and adults < 25 years of age; individuals with more than one sex partner in the past year; individuals with a new sex partner in the past year; individuals whose sex partner has other sex partners; sex partners of those with gonococcal infection; sex workers and their sexual partners; street-involved individuals; individuals involved in substance use (i.e., injection drug use, glue sniffing); individuals with a history of STI in the past year; anyone with a history of unprotected sex with a person in one of the above categories.
New Brunswick	Unable to locate online
Newfoundland	http://www.health.gov.nl.ca/health/publichealth/cdc/STBBI_Sept2010.pdf **Gonorrhea** **Mandated** Partner notification may be done by the client, public health or physician as decided by the attending health care professional in consultation with office of the Regional Medical Officer of Health (RMOH).

	Investigations and reporting are the responsibility of the office of the Regional Medical Officer of Health (RMOH). As the lead in the region the RMOH collaborates with family physicians, Communicable Disease Control (CDC) and public health staff to provide effective and confidential follow-up of laboratory confirmed cases of STIs and BBPs or sexually transmitted infections (STIs) and bloodborne pathogens Communicable disease control nurse (CDCNs) or community health nurses (CHNs) educated in communicable disease and nurse practitioners (NPs) are permitted to undertake testing for STIs or BBP at selected sites within a regional health authority under direction/designation of their MOH. **Management of Contacts:** Partner notification, including partners for two months previous, is critical in maintaining control of this disease. **Timelines** (BBPs) contact follow up and notification is required and is completed in a confidential and timely manner at the local or regional level Laboratory: Routine reporting to CMOH, RMOH and attending physician within four working days for all list B STIs. RMOH or designate: Assign and initiate investigation within four working days Every attempt must be made to identify, locate, examine and treat partners/contacts; of cases If physicians/HCP of the case other than the MOH or the CDCN,CDN or NP completes the follow up of contacts then they are to notify the RHA that this follow up has been taken place If a physician/HCP may choose to have the assistance of the MOH or the CDCN, CDN or NP to do contact tracing and follow up for the notifiable STI case then the physician /HCP shall advise the RHA of this within two weeks of receiving notification of the case In absence of a response from the physician/HCP within the two week time frame to the RHA then the appropriate STI services will be initiated by the MOH or the CDCN,CDN or NP Partner notification, including partners for two months previous, is critical in maintaining control of this disease. **Reporting Process** Physicians, laboratories, communicable disease control nurses (CDCNs), and infection control practitioners (ICPs) must report suspect or confirmed cases to the Regional Medical Officer of Health (RMOH) RMOH office will notify local physicians, nurse practitioners, community health nurses, and CDCNs in the particular region as required for follow-up and case investigation as applicable, RMOH reports to provincial office as per list B,CDCN enters the case into the electronic reporting system and completes an

	outbreak form if indicated Provincial Disease Control reports the aggregate case data to Public Health Agency of Canada, provides an analysis of the case/s with reports in the Communicable Disease Report (CDR) **Newfoundland/Labrador Policy** All laboratory confirmed reportable STIs and BBPs are to be reported to the RMOH or designate, appropriately treated and case follow-up completed. Reports from the provincial public health laboratory are sent to the office of the RMOH, CMOH (Chief Medical Officer of Health) as well as the attending physician. Reporting of these infections allows for public health agencies to monitor the prevalence and incidence of these infections in the community and thus help to plan prevention and intervention programs to reduce the risk of infection and disease. Reportable STIs in Newfoundland and Labrador include: Chancroid, Chlamydia, Gonorrhea, Lymphogranuloma venereum (LGV)Syphilis Reportable BBPs in Newfoundland and Labrador include: Hepatitis C,HIV infection, Hepatitis B (See Section 4 Diseases Preventable by Vaccination)
Northwest Territories	http://www.hss.gov.nt.ca/sites/default/files/cdcmanfulldoc.pdf **Mandated** Partner notification, treatment and counselling are indicated for any infection or syndrome that is predominantly transmitted sexually. **Patient referral:** Patients inform their own partners without the direct involvement of health care providers or public health authorities. **Provider referral:** Health care providers and/or public health authorities notify partners of the patient. *Reporting and Follow-Up:* Neisseria gonorrhoeae must be reported, on the STI Report Form, to the Office of the Chief *Medical Health Officer (OCMHO), within 7 days of diagnosis or lab confirmation.* All partners who had sexual contact with the index case at least 60 days prior to diagnosis must be located, evaluated and tested. Staff at the OCMHO will assist with partner notification, outside the NWT. Repeat diagnostic testing for Neisseria gonorrhoeae is NOT routinely indicated if a recommended treatment is given and taken, AND signs and symptoms have disappeared, AND there is no re-exposure to an infected partner. Test of cure is recommended if compliance is questionable, symptoms do not disappear and if the patient is a child or pregnant woman. **Information Required** Neisseria gonorrhoea must be reported, on the STI Report Form, to the Office of the Chief Medical Health Officer (OCMHO), within 7 days of diagnosis or lab confirmation. **Risk Factors**

	Identify those at high risk for STIs and note that both females and males may be asymptomatic: Sexual contact with person(s) with known STI. Youth <25 years of age with multiple partners. Street involvement (e.g. homelessness). Intercourse with new partner in last 2 months. >2 sexual partners in the last 12 months. No contraception or non-barrier methods used. Injection drug use (also at a higher risk of HIV, Hepatitis B and C). Persons immigrating from or having sex in countries where certain STIs are currently epidemic, and their sexual partners. Men who have sex with men. Commercial sex workers. **Other Public Health Measures** Promote condom use Educate on safer sexual practices
Nova Scotia	Unable to copy from manual http://www.gov.ns.ca/hpp/publications/cdc_manual.pdf
Nunavut	http://www.canlii.org/en/nu/laws/stat/rsnwt-nu-1988-c-p-12/latest/rsnwt-nu-1988-c-p-12.html **Mandated in Regulations for all Reportable Communicable Diseases** Where a medical practitioner or nurse has received a positive test result for one of his or her patients or a medical practitioner, nurse or dentist has reason to believe or suspect that one of his or her patients is infected with a communicable disease, the medical practitioner, nurse or dentist shall (a) in the case of a disease listed in Item I of (i) immediately notify the Chief Medical Health Officer by telephone, and (ii) within 24 hours, send a written report to the Chief Medical Health Officer in a form approved by the Chief Medical Health Officer; (b) in the case of a disease listed in Item II of Schedule A, within seven days send a written report to the Chief Medical Health Officer in a form approved by the Chief Medical Health Officer; (c) advise the patient to adopt the specific control measures for the communicable disease in question; d) provide the patient with the necessary information to comply with paragraph (c); and (e) within seven days of giving notice under paragraph (a) or (b),(i) in accordance with guidelines provided by the Chief Medical Health Officer, carry out contact tracing or surveillance of those aspects of the occurrence and spread of the communicable disease that are pertinent to the effective control of the disease, or (ii) request the Chief Medical Health Officer to carry out the contact tracing or surveillance.
	http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/sexual_health_sti.pdf

Ontario	**Gonorrhea** **Mandated** The board of health shall ensure that the medical officer of health or designate receives reports of sexually transmitted infections and blood-borne infections and responds in accordance with the Health Protection and Promotion Act and the Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol, 2008 (or as current). Laboratory confirmed cases shall be reported to the medical officer of health by persons required to do so under the Health Protection and Promotion Act, R.S.O. 1990. **Timelines for Gonorrhea** Symptomatic*: All sexual contacts of the case within at least 60 days prior to the onset of symptoms through date of treatment. Asymptomatic*: All sexual contacts of the case within at least 60 days prior to the date of specimen collection through date of treatment. Parents of infected neonates. **Information Required** Lab Confirmed Case: b) Include as much relevant information as possible to facilitate location, counselling, and treatment of cases of reportable STIs/BBIs. A laboratory report alone is insufficient. Case information shall include as much of the following, as described in disease-specific iPHIS user guides3 or any other documentation or any other method specified by the ministry: i) Infection/diagnosis; ii) First name, last name (with the exception of anonymous HIV testing); iii) Birth date or birth year if date of birth not available; and iv) Gender. Other data elements to be collected and reported for cases of reportable STIs/BBIs could include: v) Address/telecommunications; vi) Case/encounter date (e.g., onset date, reported date, etc.); vii) Treatment; and viii) Risk factors (e.g., exposure setting, medical risk factors, and behavioural/social factors). Contact information; C) Include as much relevant information as possible to facilitate the location, counselling and treatment of contacts .Information shall include as much of the following information as possible as described in disease-specific iPHIS user guides or any other documentation or any other method specified by the ministry: infection/diagnosis; ii) First name, last name; iii) Birth date or birth year if date of birth not available; and iv) Gender. Other data elements to be collected and reported on contacts could also include :v) Address/telecommunications; iv) Contact (e.g., sexual, maternal, household, etc.); vii) Case/encounter date (e.g., onset date,

	reported date, etc.); viii) Treatment; and, ix) Risk factors (e.g., exposure setting, medical risk factors, behavioural/social factors). The board of health shall also include collection of as much of the following information as described in disease-specific iPHIS user guides or any other documentation or any other method specified by the ministry: First name, last name of contact(s); Birth date or birth year; Gender Address/telecommunication; Contact (e.g., sexual, casual, etc.); Relevant case/encounter date; and risk factors . Ensure that contact tracing is completed when partner notification is done by the health care provider or the case. d) Refer information on cases and contacts that are outside the health unit directly to the appropriate board of health within Ontario, using iPHIS or any other method specified by the ministry. e) Refer information on cases/contacts outside of Ontario or Canada to the Public Health Division, of the ministry, using iPHIS or any other method specified by the ministry **Risk Factors:** i) Having sexual contact with person(s) with a known STI; ii) Being sexually active and under 25 years; iii) Having a new partner or having had multiple partners in the past year; iv) Being street involved and/or homeless; v) Being a sex worker; vi) Having anonymous sexual partners; vii) Being a victim of sexual assault/abuse; viii) Injection drug use; ix) Using other substances such as alcohol or chemicals (e.g., cocaine, ecstasy) **Reporting Process** The board of health shall: use the integrated Public Health Information System (iPHIS) or any other method specified by the Ministry of Health and Long-Term Care (the "ministry") to notify the ministry of cases and contacts of reportable STIs including BBIs. It is required to include all disease-specific information specified in O. Reg. 5692 under the HPPA. The board of health shall conduct surveillance of: Sexually transmitted infections; Blood-borne infections; Reproductive outcomes; Risk behaviours; and Distribution of harm reduction materials/equipment in accordance with the Population Health Assessment and Surveillance Protocol, 2008 (or as current)and the Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol, 2008(or as current).
Prince Edward Island	Unable to locate online

Quebec	Unable to locate online
Saskatchewan	http://www.health.gov.sk.ca/cdc-section5 http://www.health.gov.sk.ca/cdc-section1 **Gonorrhea** **Mandated** The client, health care provider, MHO or their designate may notify the partner. When the person with the STI chooses to notify his or her contacts, they must inform the contact of the exposure, explain their duty to get tested and take all reasonable measures to reduce the risk of exposing others. If the affected person does not wish to notify their contacts on their own, the physician or clinic nurse can complete the partner notification. If the health care provider is unable to do this within 14 days, it should be referred to Public Health to complete. Notification by the health care provider occurs confidentially with the consent of the infected person. Partners will be notified of the possibility of their exposure to an STI (without naming the index case) and their responsibility to get tested and to take all reasonable measures to reduce the risk of exposing others (e.g., condoms, period of abstinence, safer sex practices, etc.) Role of Saskatchewan Regional Health Authorities Each RHA has public health staff including Communicable Disease Coordinators, Public Health Inspectors, Public Health Nurses, and others working with the MHO to assist in communicable disease control. They are responsible for the public health follow up of individual cases and contacts that reside within the RHA's jurisdiction. First Nations Health Agencies FNIH and NITHA are each responsible for the coordination and public health follow up of individual cases and contacts that reside in First Nations communities in their jurisdiction. The follow up is provided by Community Health Nurses (CHNs) and Environmental Health Officers (EHOs) employed by the First Nation or FNIH. **Timelines** Gonorrhea From Lab/Practitioner to Public Health**:** Within 72 hours. From Public Health to Saskatchewan Ministry of Health: Within 2 weeks. Public Health Follow-up Timeline**:** Initiate within 72 hours. Control of Contacts

	Due to the changing epidemiology of this disease, case finding and contact tracing are critical in the control of gonococcal infections. The following contacts must be located, clinically evaluated and treated: - all sexual partners of cases within the past 90 days prior to symptom onset or date of diagnosis if asymptomatic, if no partners within this time frame, last sexual partner; parents of infected neonates; persons implicated in sexual abuse cases. Contacts should receive clinical evaluation, testing, treatment and health education. Contacts should abstain from unprotected intercourse until treatment of both partners is complete (7 days after completion of single dose therapy). **Risk Factors** Risk factors include: -sexual contact with a person with proven infection or a compatible syndrome; - unprotected sex with a partner from a highly endemic area (either international or within Canada); -previous gonorrhea and other STI infection; -vulnerable populations (for example street-involved youth, commercial sex workers and their - sexual partners, - sexually active youth <25 years of age with multiple partners, - men who have unprotected sex with men); - substance use. **Reporting Process** Following the investigation of the case, detailed information shall be documented in the electronic public health case management and surveillance system called Integrated Public Health Information System (iPHIS) within 14 days. MHOs are required to submit case reports of notifiable and unusual communicable diseases to the Saskatchewan Ministry of Health. From time to time, additional information is requested from the Coordinator of Communicable Diseases (Deputy Chief Medical Health Officer) at the Ministry of Health for enhanced surveillance purposes. This information may be collected through the use of a specialized form or it may be documented on the electronic public health case management and surveillance system. The Ministry of Health compiles the information into a statistical report that is provided to the communicable disease contacts in Saskatchewan Health Regions and First Nations health agencies. De-identified case information is sent to the Centre for Infectious Disease Prevention and Control, Public Health Agency of Canada for “National Notifiable Diseases”. Role of the Ministry of Health, Population Health Branch

	Reports nationally notifiable communicable diseases to PHAC for national disease surveillance and statistical summaries (e.g., Canadian Communicable Disease Report, Disease Surveillance On-Line, etc.). Role of Saskatchewan Disease Control Laboratory Provides infectious disease surveillance information enabling early detection of outbreaks and monitoring of disease trends. Provides copies of notifiable communicable disease laboratory reports to MHOs, the ordering practitioner and Saskatchewan Ministry of Health.
Yukon	Unable to locate online
PHAC	http://www.phac-aspc.gc.ca/std-mts/sti-its/cgsti-ldcits/section-5-6-eng.php Reporting and Partner Notification Case finding and partner notification are critical strategies for maintaining control of gonococcal infections in Canada. Local public health authorities may assist with partner notification and with appropriate referral for clinical evaluation, testing, treatment and health education. Gonococcal infections are reportable in all provinces and territories; positive test results should be reported to local public health authorities. All partners who have had sexual contact with the index case within 60 days prior to symptom onset or date of specimen collection (if the index case is asymptomatic) should be notified, tested and empirically treated regardless of clinical findings and without waiting for test results. The length of time for the trace-back period should be extended in the following three circumstances: To include additional time between the date of testing and date of treatment, If the index case states that there were no partners during the recommended trace-back period, the most recent partner should be notified, and If all partners traced (according to recommended trace-back period) test negative, the last partner prior to the trace-back period should be notified. When a neonate is confirmed to have gonorrhea, the mother and her most recent sexual partner plus any other partners within 60 days of delivery should be located, clinically evaluated and empirically treated regardless of clinical findings and without waiting for test results.

6. (c) Syphilis

Province/ Territory	Partner Notification Parameters
Alberta	http://www.health.alberta.ca/documents/Guidelines-Syphilis-2012.pdf *Management of Contacts* *Partner Notification* Partner notification will identify those at risk, reduce disease transmission/re-infection and ultimately prevent disease sequelae. It is mandated under the Public Health Act that every attempt is made to identify, locate, examine and treat partners/contacts of all cases. Physician/case manager are required to provide partner names and locating information on the Notification of STI Form and forward to STI Services. If testing and/or treatment of partner(s) are not confirmed on the Notification of STI Form, STI Services will initiate follow up by a Partner Notification Nurse. Partner Notification Nurse (PNN) is specially trained to conduct notification of partners and contacts in a confidential manner that protects the identity of the index case. The phone number for your designated PNN is available by calling STI Services at 780-735-1466 or toll free 1-888-535-1466. All contacts should be screened for HIV and other STI. All contacts should be instructed about infection transmission. All contacts should be provided with individualized STI prevention education, targeted at developing knowledge, skills, attitudes and behaviors to reduce the risk and prevent recurrences of STI. STI Services initiates follow-up on all out of province/country referrals of cases and partner(s). *Primary Syphilis* All contacts in the last three months, regardless of symptoms or signs, must be located, examined, tested and treated. It may be necessary to extend this time period until a sexual contact is identified. Named contacts should be treated prophylactically. If the contact refuses treatment, repeat serology monthly until three months has elapsed since last sexual contact with infected individual. Sexual partners must be treated at the same time to prevent re-infection. *Secondary and Early Latent Syphilis* All contacts of secondary syphilis in the last six months and early latent syphilis in the last 12 months regardless of symptoms or signs, must be located, examined, tested and treated if applicable. It may be necessary to extend this time period until a sexual contact is identified. All individuals with contact within the preceding three months should be treated prophylactically. If the contact refuses treatment repeat serology monthly until three months has elapsed since last sexual contact with infected individual. *Late Latent Syphilis*

	When appropriate, a serologic test for syphilis should be performed on long-term sexual partners. Children born to females with LLS should be tested, regardless of current age of child, based in estimated duration of infection in mother. *Presumptive* Persons who are treated as contacts to confirmed infectious syphilis should not be interviewed for contacts until it has been confirmed that they also have infectious syphilis.
British Columbia	http://www.bccdc.ca/NR/rdonlyres/B8BC9263-839A-4FA8-822F-5D9B351223BA/0/STI_DST_Noncertified_Syphilis_20120914.pdf Management of Syphilis Contacts For RN(c) see CRNBC Treatment of STI Contacts DST Syphilis contact management is centralized through the BCCDC. Direction for follow-up of contacts to confirmed syphilis cases occurs in collaboration with the BCCDC STI Clinic registered nurse responsible for syphilis. Contact to Primary, Secondary or Early Latent Syphilis perform routine sexual health history, exam, and STI screening and offer HIV serology to sexual contacts treat all sexual contacts of a client diagnosed with primary, secondary, or early latent syphilis for the 3 months preceding the diagnosis of the infection follow-up of women with syphilis acquired during the perinatal period will include testing and/or treatment of infants as per the direction of the managing physician and the BCCDC STI Clinic physician perform syphilis serology on all sexual contacts of a client diagnosed with: *primary syphilis* within the 3 months preceding the start of symptoms in the client (index case) *secondary syphilis* within the 6 months preceding the start of symptoms in the client (index case) *early latent syphilis* within the 12 months preceding the diagnosis of infection note contact to syphilis and include both syphilis screening and syphilis confirmatory tests on the lab requisition *Contact to Late Latent Syphilis* offer routine sexual health history, exam, and STI screening including HIV serology to sexual contacts treat only those contacts who have reactive syphilis serology syphilis serology is required for all current and ongoing sexual contacts note contact to syphilis and include both syphilis screening and syphilis confirmatory tests on lab requisition follow-up of women with late latent syphilis infection will include syphilis serology for children 18 years or younger as per the direction of the BCCDC STI Clinic physician **British Columbia uses PHAC guidelines for STI's:** http://www.phac-aspc.gc.ca/std-mts/sti-its/guide-lignesdir-eng.php

	All sexual contacts of confirmed cases of infectious Syphilis are followed by the Epidemiology nurse at the BCCDC
Manitoba	http://www.gov.mb.ca/health/publichealth/cdc/protocol/syphilis.pdf **Syphilis** **Mandated** All positive syphilis tests (both nontreponemal and treponemal) are reportable by laboratory operators to the Communicable Disease Control Unit, Manitoba Health. All cases and contacts are reportable by attending health care professionals to the Communicable Disease Control Unit, Manitoba Health **Timelines** Close collaboration between Public Health and Primary Care in addition to timely completion and return of NSTD forms; are crucial to ensure there is sufficient information to identify and locate sexual contacts in a timely manner Rapid identification and investigation of sexual partners/contacts is essential to locate persons with early (primary, secondary, early latent) or incubating syphilis. All sexual and perinatal contacts identified within the following time periods should be located, tested, and treated if serologically reactive: Primary Syphilis during the three months prior to the onset of chancre and up to and including the interview date Secondary Syphilis during the six months prior to onset of clinical symptoms And up to and including the interview date Early Latent Syphilis one year prior to diagnosis Late Latent Syphilis Marital and long term sex partners of patients with latent syphilis should be evaluated clinically and serologically for syphilis and treated on the basis of the evaluation findings. Children of persons with late latent syphilis should be assessed as appropriate. Congenital Syphilis Assess mother and her sexual partner(s). **Information Required** Interview case for history of exposure, risk behaviours, sexual contacts, adequacy of treatment, and promotion of safer sex practices. Interview sexual contacts
New Brunswick	Unable to locate info online
	http://www.health.gov.nl.ca/health/publichealth/cdc/STBBI_Sept2010.pdf

Newfoundland	**Syphilis** *Management of Contacts:* Pre-test and post-test counseling should be offered to those who are at risk. This should be done in a confidential manner by an individual who has training or experience in this area. This opportunity should also be used to provide education about prevention strategies. This should include safer sex practices and harm reduction strategies. Contracts may require testing for other STIs and BBIs. If suspected occupational exposure to potential blood or body fluids occurs in a health care facility, baseline testing should be performed. Occupational exposure must be reported to your occupational health department for follow up and recommended action. The baseline testing should include screening for exposure to hepatitis B & C as well as HIV. Consideration must be given to using HIV post exposure prophylaxis as antiretroviral agents can have severe side effects, careful consideration must be given to the benefits and risks of this prophylaxis. **Mandated** Partner notification may be done by the client, public health or physician as decided by the attending health care professional in consultation with office of the Regional Medical Officer of Health (RMOH). Investigations and reporting are the responsibility of the office of the Regional Medical Officer of Health (RMOH). As the lead in the region the RMOH collaborates with family physicians, Communicable Disease Control (CDC) and public health staff to provide effective and confidential follow-up of laboratory confirmed cases of STIs and BBPs or sexually transmitted infections (STIs) and bloodborne pathogens Communicable disease control nurse (CDCNs) or community health nurses (CHNs) educated in communicable disease and nurse practitioners (NPs) are permitted to undertake testing for STIs or BBP at selected sites within a regional health authority under direction/designation of their MOH. **Timelines** (BBPs) contact follow up and notification is required and is completed in a confidential and timely manner at the local or regional level Laboratory: Routine reporting to CMOH, RMOH and attending physician within four working days for all list B STIs. RMOH or designate: Assign and initiate investigation within four working days Every attempt must be made to identify, locate, examine and treat partners/contacts; of cases If physicians/HCP of the case other than the MOH or the CDCN,CDN or NP completes the follow up of contacts then they are to notify the RHA that this follow up has been taken place If a physician/HCP may choose to have the assistance of the MOH or the CDCN, CDN or NP to do contact tracing and follow up for the notifiable STI case then the physician /HCP shall advise the RHA of this within two weeks of receiving notification of the case

	In absence of a response from the physician/HCP within the two week time frame to the RHA then the appropriate STI services will be initiated by the MOH or the CDCN,CDN or NP The time frame for partner notification will depend on the stage of the infection. Primary syphilis contacts include sexual contacts 3 months prior to onset of symptoms. Secondary syphilis includes sexual partners who had exposure during the past 6 months. Early latent includes sexual contacts one year prior to diagnosis. For those who have had sexual contact with an individual who has been diagnosed with late latent syphilis, an assessment of the marital or long term partners and children should be completed. For those identified as having congenital syphilis, the mother and her sexual partners should be tested. For exposure that has occurred in the past 90 days to infectious syphilis then the individual who was exposed should be treated. If the exposure was greater than 90 days treatment should be based on the results of serological assessment. **Reporting Process** Physicians, laboratories, communicable disease control nurses (CDCNs), and infection control practitioners (ICPs) must report suspect or confirmed cases to the Regional Medical Officer of Health (RMOH) RMOH office will notify local physicians, nurse practitioners, community health nurses, and CDCNs in the particular region as required for follow-up and case investigation as applicable, RMOH reports to provincial office as per list B,CDCN enters the case into the electronic reporting system and completes an outbreak form if indicated Provincial Disease Control reports the aggregate case data to Public Health Agency of Canada, provides an analysis of the case/s with reports in the Communicable Disease Report (CDR) **Newfoundland/Labrador Policy** All laboratory confirmed reportable STIs and BBPs are to be reported to the RMOH or designate, appropriately treated and case follow-up completed. Reports from the provincial public health laboratory are sent to the office of the RMOH, CMOH (Chief Medical Officer of Health) as well as the attending physician. Reporting of these infections allows for public health agencies to monitor the prevalence and incidence of these infections in the community and thus help to plan prevention and intervention programs to reduce the risk of infection and disease.
Northwest Territories	http://www.hss.gov.nt.ca/sites/default/files/cdcmanfulldoc.pdf **Mandated** Partner notification, treatment and counselling are indicated for any infection or syndrome that is predominantly transmitted sexually. **Patient referral:** Patients inform their own partners without the direct involvement of health care providers or public health authorities. **Provider referral:** Health care providers and/or public health authorities notify partners of the patient.

	Reporting and Follow-up Syphilis must be reported, on the STI Report Form, to the Office of the Chief Medical Health Officer (OCMHO), within 7 days of diagnosis or lab confirmation. Contact tracing should be done on sexual contacts during, and about 90 days prior to, symptomatic periods of index case. **Information Required** Syphilis must be reported, on the STI Report Form, to the Office of the Chief Medical Health Officer (OCMHO), within 7 days of diagnosis or lab confirmation. **Risk Factors** Identify those at high risk for STIs and note that both females and males may be asymptomatic: Sexual contact with person(s) with known STI. Youth <25 years of age with multiple partners. Street involvement (e.g. homelessness). Intercourse with new partner in last 2 months. >2 sexual partners in the last 12 months. No contraception or non-barrier methods used. Injection drug use (also at a higher risk of HIV, Hepatitis B and C). Persons immigrating from or having sex in countries where certain STIs are currently epidemic, and their sexual partners. Men who have sex with men. Commercial sex workers. **Other Public Health Measures** Educate on safer sexual practices. Needle Exchange Program. Discuss safer sexual practices and good personal hygiene. Screening should be done early in pregnancy.
Nova Scotia	unable to copy from manual http://www.gov.ns.ca/hpp/publications/cdc_manual.pdf
Nunavut	http://www.canlii.org/en/nu/laws/regu/rrnwt-nu-1990-c-p-13/latest/rrnwt-nu-1990-c-p-13.html **Mandated in Regulations for all Reportable Communicable Diseases** Where a medical practitioner or nurse has received a positive test result for one of his or her patients or a medical practitioner, nurse or dentist has reason to believe or suspect that one of his or her patients is infected with a communicable disease, the medical practitioner, nurse or dentist shall (a) in the case of a disease listed in Item I of (i) immediately notify the Chief Medical Health Officer by telephone, and

	(ii) within 24 hours, send a written report to the Chief Medical Health Officer in a form approved by the Chief Medical Health Officer;(b) in the case of a disease listed in Item II of Schedule A, within seven days send a written report to the Chief Medical Health Officer in a form approved by the Chief Medical Health Officer;(c) advise the patient to adopt the specific control measures for the communicable disease in question; d) provide the patient with the necessary information to comply with paragraph (c); and (e) within seven days of giving notice under paragraph (a) or (b),(i) in accordance with guidelines provided by the Chief Medical Health Officer, carry out contact tracing or surveillance of those aspects of the occurrence and spread of the communicable disease that are pertinent to the effective control of the disease, or (ii) request the Chief Medical Health Officer to carry out the contact tracing or surveillance.
Ontario	http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/sexual_health_sti.pdf **Syphilis** **Mandated** The board of health shall ensure that the medical officer of health or designate receives reports of sexually transmitted infections and blood-borne infections and responds in accordance with the Health Protection and Promotion Act and the Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol, 2008 (or as current). Laboratory confirmed cases shall be reported to the medical officer of health by persons required to do so under the Health Protection and Promotion Act, R.S.O. 1990. **Timelines** Contact Notification Primary syphilis case: 3 months prior to onset of symptoms Secondary syphilis case: 6 months prior to onset of symptoms Early latent case: 1 year prior to the diagnosis Early congenital syphilis case: Assess mother and her sexual partner(s) Late Latent Case: As late latent syphilis is not considered infectious, consider the assessment of marital or other long-term partners and children as appropriate. Report only case classifications specified in the case definition to PHD. Cases shall be reported using the integrated Public Health Information System (iPHIS), or any other method specified by the Ministry within five (5) business days of receipt of initial notification **Information Required** Lab Confirmed Case:

	b) Include as much relevant information as possible to facilitate location, counseling, and treatment of cases of reportable STIs/BBIs. A laboratory report alone is insufficient. Case information shall include as much of the following, as described in disease-specific iPHIS user guides or any other documentation or any other method specified by the ministry: i) Infection/diagnosis; ii) First name, last name (with the exception of anonymous HIV testing); iii) Birth date or birth year if date of birth not available; and iv) Gender. Other data elements to be collected and reported for cases of reportable STIs/BBIs could include: v) Address/telecommunications; vi) Case/encounter date (e.g., onset date, reported date, etc.); vii) Treatment; and viii) Risk factors (e.g., exposure setting, medical risk factors, and behavioral/social factors). Contact information; c) Include as much relevant information as possible to facilitate the location, counseling and treatment of contacts .Information shall include as much of the following information as possible as described in disease-specific iPHIS user guides or any other documentation or any other method specified by the ministry: infection/diagnosis; ii) First name, last name; iii) Birth date or birth year if date of birth not available; and iv) Gender. Other data elements to be collected and reported on contacts could also include :v) Address/telecommunications; iv) Contact (e.g., sexual, maternal, household, etc.); vii) Case/encounter date (e.g., onset date, reported date, etc.); viii) Treatment; and, ix) Risk factors (e.g., exposure setting, medical risk factors, behavioural/social factors). The board of health shall also include collection of as much of the following information as described in disease-specific iPHIS user guides or any other documentation or any other method specified by the ministry: First name, last name of contact(s); Birth date or birth year; Gender; address telecommunication; Contact (e.g., sexual, casual, etc.); Relevant case/encounter date; and •risk factors .Ensure that contact tracing is completed when partner notification is done by the health care provider or the case. **Reporting Process** The board of health shall: use the integrated Public Health Information System (iPHIS) or any other method specified by the Ministry of Health and Long-Term Care (the “ministry”) to notify the ministry of cases and contacts of reportable STIs including BBIs. It is required to include all disease-specific information specified in O. Reg. 5692 under the HPPA. The board of health shall conduct surveillance of: Sexually transmitted infections; Blood-borne infections; Reproductive outcomes; Risk behaviours; and Distribution of harm reduction materials/equipment in accordance with the Population Health Assessment and Surveillance Protocol*, 2008* (or as current) and the Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol, 2008(or as current).

Prince Edward Island	Unable to locate online
Quebec	Unable to locate online
Saskatchewan	http://www.health.gov.sk.ca/cdc-section5 *Partner Notification* Partner notification for syphilis is based on the stage of syphilis in the index case. Any sexual or perinatal contacts of the case that occurred within the following time periods must be located, tested and treated if serology is reactive. *Partner Notification Timeline* Primary syphilis: 3 months prior to the onset of symptoms Secondary syphilis: 6 months prior to the onset of symptoms Early latent: 1 year prior to the diagnosis Late latent: Assess marital or other long-term partners and children as appropriate Congenital: Assess mother and her sexual partner(s) Stage undetermined: Assess/consult with a colleague experienced in syphilis management *Prophylaxis/Abstinence/Follow-up* All contacts should be tested for syphilis to determine their baseline status. Follow-up serology should be based on the date of last sexual exposure to syphilis. This date should be included on Contact Referral forms when referring a contact to an outside health authority or jurisdiction. *Education* All contacts should receive counselling regarding: communicability, incubation period, transmission, and signs and symptoms of syphilis; the risk for re-exposure; ways to reduce their future risk of exposure; the importance of abstinence during entire incubation period and until serologic testing at the end of the incubation period has been confirmed to be non-reactive; the need for follow-up serology and the timing of the serology; the follow-up recommended in the event that they develop signs and symptoms including abstaining from sexual contact until they have seen a physician/nurse (or health care provider) for re-assessment
Yukon	Unable to locate online
	http://www.phac-aspc.gc.ca/std-mts/sti-its/cgsti-ldcits/section-5-10-eng.php

PHAC

Reporting and Partner Notification

Infectious syphilis (primary, secondary and early latent syphilis) is reportable in all provinces and territories and notifiable to the Public Health Agency of Canada.
Non-infectious syphilis (late latent, cardiovascular and neurosyphilis) may be reportable at the provincial/territorial level but is not notifiable to the Public Health Agency of Canada.
All sexual or perinatal contacts within the following time periods need to be located, tested and treated if serology is reactive.

Table 5. Partner Notification

Stage of syphilis	Trace-back period
Table 5 - Footnote *	
Trace-back period refers to the time period prior to symptom onset or date of specimen collection (if asymptomatic).	
Primary syphilis	3 months[Table 5 - Footnote *]
Secondary syphilis	6 months[Table 5 - Footnote *]
Early latent	1 year[Table 5 - Footnote *]
Late latent/tertiary	Assess marital or other long-term partners and children as appropriate; the decision to test these contacts depends on estimated duration of infection in source case.
Congenital	Assess mother and her sexual partner(s)
Stage undetermined	Assess/consult with a colleague experienced in syphilis management

The length of time for the trace-back period should be extended:

to include additional time up to the date of treatment
if the index case states that there were no partners during the recommended trace back period, then the last partner should be notified
if all partners traced (according to recommended trace-back period) test negative, then the partner prior to the trace-back period should be notified.

6 (d) Hepatitis

Province/ Territory	Partner Notification Parameters
Alberta	http://www.health.alberta.ca/documents/Guidelines-Hepatitis-B-Chronic-Carrier-2011.pdf **Hepatitis B Acute Case** *Management of Contacts* Assess for a history of prior hepatitis B immunization or disease. Serology (HBsAg and anti-HBs) may be required to determine status and is generally recommended for the following individuals: persons at high risk of past infection, household members who may have been previously immunized through a universal program (e.g., grade 5, 12 or Endemic Programs) individuals with prior to immunization, and individuals from endemic countries. See current Alberta Immunization Manual for list of endemic countries. See also Annex 2 – Geographical distribution of chronic hepatitis B virus infection. **Recommended follow-up is based on results of serology:** if anti-HBs positive, client immune, no further follow-up. if HBsAg positive, follow-up required to determine case status (acute or chronic). Public health follow-up done as appropriate. if HBsAg negative and anti-HBs negative recommend: HBIG, when indicated, and hepatitis B vaccine series. **Vaccinated persons who are non-responders (refer to the current Alberta Immunization Manual):** if after one series, anti-HBs is negative initiate a second series (i.e., doses 4,5 & 6), offer post-vaccination serology after the fourth dose, if negative anti-HBs, complete the second series, offer post-vaccination serology, if anti-HBs negative after completion of the second series and a significant exposure occurs, offer two doses of HBIG one month apart. Community exposures to blood and/or body fluids. Refer to the current Alberta Guidelines for Post-Exposure in Non-Occupational Settings. S**ignificant contacts of an acute case**; Sexual contacts, needle sharing partners, or other blood/body fluid exposure in the past 14 days. Arrange for immediate serology through the personal physician or MOH [or designate]. If the contact is susceptible (HBsAg negative, anti-HBs negative), recommend HBIG and hepatitis B vaccine series. Initiate hepatitis B vaccine series concurrently or as soon as possible after HBIG has been given. **Sexual contacts, needle sharing partners or other blood/body fluid exposures occurring more than 14 days prior to case diagnosis but less than 6 months (for adequate public health contact tracing, go back six months from onset date to identify contacts).** Recommend pre-vaccination serology. This should be done prior to, or at the time of the first dose of hepatitis B vaccine. If the contact is susceptible, initiate a hepatitis B vaccine series, Recommend post-vaccination serology.

	All other household contacts. Recommend pre-vaccination serology. If the contact is susceptible, initiate hepatitis B vaccine series. Post-immunization serology is not required as the sero-conversion rate is usually 90% or more in healthy adults and 98% in children. **Newborns at birth whose mother or primary caregiver is an acute case.** No pre-vaccination serology is required. HBIG should be offered as soon as possible. Initiate hepatitis B vaccine series. Recommend post-vaccination serology. **Infants less than 12 months of age whose mother or primary caregiver is an acute case** No pre-vaccination serology is required. HBIG should be offered as soon as possible and within two weeks of last contact. Initiate hepatitis B vaccine series. If the infant has had only one dose of vaccine, the second dose should be administered if the interval is appropriate or HBIG given if the immunization is not due. The vaccine series should be completed as scheduled If the infant has had two doses of vaccine, the infant should be presumed protected and HBIG is not required. The vaccine series should be completed as scheduled. Recommend post-vaccination serology. http://www.health.alberta.ca/documents/Guidelines-Hepatitis-C-Acute-Case-2013.pdfHepatitis C **Management of Contacts** Persons who are identified as contacts of IDUs should be given priority for follow-up by public health personnel and should be notified of possible exposure to HCV by the case or by public health personnel. Short-term sexual contacts should be assessed for risk behaviors and appropriate testing for STIs, hepatitis C and other BBIs should be recommended. They should be notified by the case or by public health personnel. Most long-term sexual partners of HCV positive persons test anti-HCV negative, however, they may elect to be assessed by their physician. Infants born to HCV positive mothers should be followed up by a pediatric infectious disease physician or an expert in hepatitis C infection **Reporting** Alberta Health Services and First Nations and Inuit Health Branch The MOH (or designate) shall forward the preliminary Notifiable Disease Report (NDR) of all confirmed cases to the CMOH (or designate) within two weeks of notification and the final NDR (amendment) within four weeks of notification. For out-of-zone reports, the MOH (or designate) first notified shall notify the MOH (or designate) where the case resides by mail, fax or electronic transfer and fax a copy of the positive laboratory report within 48 hours (two days).
British Columbia	**Refers to the PHAC website for STI Guidelines* But also provides** **BC Guidelines** PHAC: http://www.phac-aspc.gc.ca/std-mts/sti-its/cgsti-ldcits/section-5-7-eng.php BC: http://www.bccdc.ca/NR/rdonlyres/328189F4-2840-44A1-9D13-D5AB9775B644/0/HepatitisB_Sept_2009.pdf MOH

	Confirm the diagnosis with the attending physician before contacting the client. For clients with a clinical presentation of hepatitis infection in the absence of available laboratory confirmation, discuss follow up with the Medical Health Officer (MHO) or delegate. Initiate a report in the Communicable Disease Surveillance System (CDSS) module of iPHIS. For an acute infection, obtain a history of risk factors/potential exposure for the six month period preceding serological diagnosis. Complete the Hepatitis B Enhanced Surveillance Report and submit to BCCDC Hepatitis Services. If risk factors indicate the possibility of a transfusion transmissible infection, (where client has been donor or recipient) follow the reporting process in the Transfusion Transmissible Infections chapter of the Communicable Disease Control Manual Arrange for a person with acute infection to be retested at six months, to determine if they have become a chronic carrier. Report in iPHIS as chronic hepatitis B if this occurs, while maintaining the previous report of the acute infection. All persons who are HBsAg positive are potentially infectious. The infectivity of chronically infected individuals varies from high (HBeAg positive) to modest (anti-HBe positive.) **Timelines** Note: When the client is a newly identified chronic carrier, and there is no determination of when acute infection occurred, identify contacts in the six months prior to chronic status being known. Identify case contacts in the 6 months prior to onset of symptoms. The incubation period for hepatitis B is 45 to 160 days, with an average of 90 days **Risk Factors** Pre vaccination testing; Testing for HBsAg, anti-HBc and anti-HBs is recommended for the following: Persons at high risk of having been infected (i.e., IDU, STW, sexual partners of HBV infected individuals and persons born in a country of high hepatitis B prevalence). Testing will identify those already infected or immune, for whom vaccine will confer no benefit, and assist in the medical management and contact follow-up of those individuals found to be infected. Individuals with chronic HCV or other chronic liver diseases, Students entering health care professions who have been previously vaccinated, but their response to initial vaccination is unknown. **CONTACT MANAGEMENT** Identify case contacts in the 6 months prior to onset of symptoms. The incubation period for hepatitis B is 45 to 160 days, with an average of 90 days. Initiate appropriate immunoprophylaxis of contacts. Ascertain hepatitis B vaccination status and/or whether anti-HBs level has been previously determined. Co-ordinate provision of hepatitis B vaccine and HBIg as required to all contacts. Counsel case and contacts about minimizing further transmission of hepatitis B virus. Refer to section 9.0 entitled “Health Teaching to Prevent Transmission of HBV.” http://www.bccdc.ca/NR/rdonlyres/CEC67337-3E94-4FD3-B21C-63A71014619D/0/CPS_Hep_Guidelines_HCV_20130709.pdf **Hepatitis C** CONTACT MANAGEMENT Public health personnel or a primary care provider can assist a case with identifying contacts that may be at-risk of infection. When possible, further assistance with notifying contacts may be provided.

Manitoba	http://www.gov.mb.ca/health/publichealth/cdc/protocol/hepb.pdf http://www.gov.mb.ca/health/publichealth/cdc/protocol/hepc.pdf **Hepatitis** **Mandated** All positive laboratory results noted in the case definition are reportable to the Communicable Disease Control Branch, Manitoba Health and Healthy Living. All acute cases, newly identified chronic cases and unspecified cases are reportable to the Communicable Disease Control Branch, Manitoba Health and Healthy Living by the attending health care professional. Cases are referred to the health jurisdiction (i.e., Regional Health Authority [RHA], First Nations Inuit Health Branch [FNIHB]) of residence for follow-up. Operators of Manitoba clinical laboratories are required to submit the residual serum or plasma specimens from individuals who tested positive for hepatitis B virus to Cadham Provincial Laboratory within seven days of report for surveillance purposes. Positive test results identified through the local Canadian Blood Services are reportable to the Communicable Disease Control Branch, Manitoba Health and Healthy Living **Timelines** Contacts of cases are: all sexual, household as well as needle, razor or toothbrush-sharing contacts within the six months prior to the symptom onset date of the case. Chronic cases; All current sexual, needle/razor/toothbrush sharing and/or household contacts as well as those contacts within the previous six months should be identified (21). This timeframe should be extended further back if contact was frequent and after infection developed (when this can be estimated). **Information Required** Determination of risk factors for acquisition of hepatitis B Contact identification to determine source and extent of transmission of infection and to prevent further spread by immunization, Immunization history **Risk Factors** Any patient with hepatitis B infection believed to have been acquired sexually should be considered at high risk for other STIs, including HIV, and should be offered testing for gonorrhea, chlamydia, syphilis and HIV Any patient with hepatitis B infection believed to have been acquired parenterally should be considered to be at risk for HIV and HCV, and should be offered testing for both. Appropriate identification and follow-up of: Contacts of acute and chronic cases, Perinatal contacts Individuals who have sustained an exposure to blood and body fluids (e.g., needlestick injury in a health care worker) and are deemed at risk of acquiring infection. Post-immunization Testing; Post-immunization testing for individuals at high risk of exposure or re-exposure to HBV-infected individuals which may include the following: infants born to HBV-infected mothers; sexual partners and household, contacts of chronic carriers; and those who have been immunized because of occupational exposure. **For contacts of chronic hepatitis B cases:** HBIG should be considered if sexual or needle/razor/toothbrush contact occurred for the first time in the previous two weeks Pre-immunization screening of all contacts for markers of infection may be performed at the same time as the first dose of vaccine or vaccine plus HBIG are given. Post-immunization testing for anti-HBs should be undertaken for individuals likely to have ongoing household, sexual or needle-sharing contact with a case. Babies born to HBsAg-positive mothers should receive HBIG

	and HBV vaccine after birth. Vaccine and HBIG may be given at the same time but at different sites **Reporting Process** http://www.gov.mb.ca/health/publichealth/cdc/protocol/hepbc_caseform.pdf The Manitoba Health and Healthy Living Investigation Form for Hepatitis B and C Positive Cases should be completed by Public Health for all clients testing positive (this applies to all cases new to Manitoba) and forwarded to the Communicable Disease Control Branch, Manitoba Health and Healthy Living. Reporting to Canadian Blood Services; If there is reasonable possibility that the source of infection in a client testing positive for hepatitis B is the receipt of blood or blood products, or there is a history of blood donation, Manitoba Health and Healthy Living will inform Canadian Blood Services. **Hepatitis C** **Mandated** Reporting same as Hepatitis B It is recommended that interviewing for contact information be done by the first health professional (e.g., physician, public health nurse) who interviews the case as there may not be a subsequent opportunity to do so. **Timelines** Individuals who are contacts of injection drug users should be given priority for follow-up by Public Health. Contacts with exposure within one year of the first positive test obtained from the index case should be followed up. However, there may be situations where more distant contact identification and notification are indicated depending on the period of infectivity, the significance of the exposure, the feasibility of notification and prioritization of contacts at risk. Needle-sharing partners who test negative for HCV should be re-tested every six to 12 months if needle-sharing continues *Perinatal Contacts*: It is important to establish whether HCV was transmitted to the child It is recommended that perinatal contacts who are well not be tested for HCV until after one year of age. Additional testing (e.g., at 18 months) may be necessary. **Information Required** Where possible, case follow-up should consist of face to face meeting for the following purposes: education and recommendations, regarding future management; contact identification and follow-up; and completion of the Manitoba Health and Healthy Living Investigation Form for Hepatitis B and C Positive Cases. If the primary care provider elects to manage the case on his/her own, he/she should complete the investigation form and return it to Manitoba Health and Healthy Living. The public health nurse may contact the client for further education and an interview. In many instances, the public health nurse responsible for the case will be expected to complete the investigation form, more distant contact identification and notification are indicated depending on the period of infectivity, the significance of the exposure, the feasibility of notification and prioritization of contacts at risk.
Newfoundland	http://www.health.gov.nl.ca/health/publichealth/cdc/STBBI_Sept2010.pdf http://www.health.gov.nl.ca/health/publications/diseasecontrol/vpd_2010.pdf **Hepatitis C** **Mandated**

	Partner notification may be done by the client, public health or physician as decided by the attending health care professional in consultation with office of the Regional Medical Officer of Health (RMOH). Investigations and reporting are the responsibility of the office of the Regional Medical Officer of Health (RMOH). As the lead in the region the RMOH collaborates with family physicians, Communicable Disease Control (CDC) and public health staff to provide effective and confidential follow-up of laboratory confirmed cases of STIs and BBPs. or sexually transmitted infections (STIs) and bloodborne pathogens Communicable disease control nurse (CDCNs) or community health nurses (CHNs) educated in communicable disease and nurse practitioners (NPs) are permitted to undertake testing for STIs or BBP at selected sites within a regional health authority under direction/designation of their MOH. **Timelines** (BBPs) contact follow up and notification is required and is completed in a confidential and timely manner at the local or regional level Laboratory: Routine reporting to CMOH, RMOH and attending physician within four working days for all list B STIs. RMOH or designate: Assign and initiate investigation within four working days Every attempt must be made to identify, locate, examine and treat partners/contacts; of cases If physicians/HCP of the case other than the MOH or the CDCN,CDN or NP completes the follow up of contacts then they are to notify the RHA that this follow up has been taken place If a physician/HCP may choose to have the assistance of the MOH or the CDCN, CDN or NP to do contact tracing and follow up for the notifiable STI case then the physician /HCP shall advise the RHA of this within two weeks of receiving notification of the case In absence of a response from the physician/HCP within the two week time frame to the RHA then the appropriate STI services will be initiated by the MOH or the CDCN,CDN or NP Contact notification must be undertaken in all cases of HCV infection All HCV -positive persons who have previously received or donated blood should be reported in confidence to the local Canadian Blood Services by the province **Risk Factors** The risk of transmission to long term sexual partners is very low. Contacts who may have shared contaminated injection drug related equipment or who are at risk for HCV infection should be screened. Education on HCV transmission should be provided. Risk reduction strategies should be discussed and screening for HIV is also recommended. **Reporting Process** Physicians, laboratories, communicable disease control nurses (CDCNs) and Infection Control Practitioners (ICPs) must report confirmed cases of HCV infection to the Medical Officer of Health HCV is reportable by physicians to the local public health authorities, Regional offices are responsible for follow-up of identified cases of HCV infection and for the electronic reporting to the provincial office of Disease Control, The RMOH or designate must contact the primary health care provider to determine ,the need for education, pre-test and post-test counseling and partner notification. Provincial Disease Control, reports aggregate case information to Public Health Agency of Canada provides an analysis of the case/s with reports in the Communicable Disease Report (CDR) **Newfoundland/Labrador Policy** All laboratory confirmed reportable STIs and BBPs are to be reported to the RMOH or designate, appropriately treated and case follow-up completed. Reports from the provincial public health

	laboratory are sent to the office of the RMOH, CMOH (Chief Medical Officer of Health) as well as the attending physician. Reporting of these infections allows for public health agencies to monitor the prevalence and incidence of these infections in the community and thus help to plan prevention and intervention programs to reduce the risk of infection and disease. Reportable STIs in Newfoundland and Labrador include: Chancroid, Chlamydia,Gonorrhea,Lymphogranuloma venereum (LGV) Syphilis Reportable BBPs in Newfoundland and Labrador include: Hepatitis C,HIV infection, Hepatitis B (See Section 4 Diseases Preventable by Vaccination) Hepatitis B **Management of Contacts:** Contacts are identified and followed-up to allow for those who are at risk of infection the opportunity to be screened and vaccinated if they are not already infected. Contacts include immediate household contacts as well as others who may be at risk through sexual contact or as a result of sharing items that may result in the transmission of hepatitis B infection. Infants born to hepatitis B carrier mothers should be given hepatitis B vaccine as well as hepatitis B immune globulin (HBIG) immediately after delivery. Susceptible children <1 year in the same household of an acute case or a chronic carrier should also be given HBIG. Infants should also be followed by their physician for any required treatment and care. **Procedure and Reporting Requirements** Physicians, laboratories and communicable disease control nurses (CDCNs), and infection control practitioners (ICPs) must immediately report suspect or confirmed cases to the Regional Medical Officer of Health (RMOH) RMOH office will notify local physicians, nurse practitioners, environmental health officers, community health nurses, CDCNs, and ICPs, in the particular region as required for follow-up and case investigation RMOH reports to provincial office as per list A CDCN enters the case into the electronic reporting system and completes an outbreak report form if indicated Provincial Disease Control reports the aggregate case data to Public Health Agency of Canada provides an analysis of the case/s with reports in the Communicable Disease Report (CDR) **General procedure** Confirm the diagnosis, and confirm whether or not the case has been informed and treated. If confirmation is delayed request immediate notification of test results from the laboratory Obtain required demographic information in relation to the case and the attending physician Contact the case to determine if this individual is in a situation where there is a high risk of transmission of the illness (childcare, health care worker etc.) Investigate the most probable source of infection which should include: recent exposure to someone else who is sick with similar symptoms, travel history , attendance in childcare, school, daycare, healthcare settings Conduct contact tracing to determine if any contacts are from a high risk group Conduct contact tracing to inform contacts of any prophylaxis, vaccine and/or exclusion measures

	If an outbreak is identified an outbreak team is formed to complete the investigation and follow-up required Educate case and contacts regarding the disease Complete case detail investigation forms
Northwest Territories	http://www.hss.gov.nt.ca/sites/default/files/cdcmanfulldoc.pdf **Hepatitis B** **Reporting and Follow-up** All suspect or confirmed cases of HBV must be reported to the Office of the Chief Medical Health Officer (OCMHO) within 24 hours. *Hepatitis Investigation Form* is to be completed. **Other Public Health Measures** Investigation of contacts and source of infection should be done and post-exposure prophylaxis offered (Hepatitis B Immune Globulin and/or Hepatitis B vaccine). See Hepatitis B Post-Exposure Algorithm on page 14. Prenatal HBsAg screening of all pregnant women. Vaccination and HBIG administered to infants born to HBsAg-positive mothers decreases risk of transmission by 95%. Needle exchange programs. Consider doing Hepatitis B vaccinations for high-risk groups: Health care workers especially those exposed to blood. Patients with hemophilia, chronic liver disease and others receiving repeated blood transfusions or on hemodialysis. Injection drug users. Those with multiple sexual partners. Inmates of long-term correctional facilities. Those with history of multiple STDs such as gonorrhea, chlamydia, syphilis, herpes and HIV. Those infected with Hepatitis C. **Public Education** Advise those infected with HBV to reduce transmission of infection to others by: Not donating blood, semen, breastmilk, body organs or tissues; Not sharing toothbrushes, dental floss, razors, earrings or manicure equipment (articles that might have traces of blood); Keeping all open cuts and sores bandaged until healed; Discussing with sexual partner(s) the fact that you are infected with HBV. Inform sexual partners of the availability of hepatitis B vaccine. Protection from infection cannot be ensured until the vaccine series has been completed and a protective anti-HBs level demonstrated through testing. Use of latex condoms will reduce the risk of HBV transmission; Putting articles with blood on them (e.g. tampons, pads, Kleenex, dental floss and bandages) in a separate plastic bag before disposing into household garbage; Disposing of bloody sharp items (razor blades, needles etc) into a hard container, taped shut; Using bleach to clean up blood spills. Wet surfaces with 1 part bleach to 9 parts water and leave sitting for 10 minutes before wiping off; Not sharing drug snorting or smoking equipment such as straws or pipes, or injection equipment such as cookers, cotton, filters, water, syringes and needles;

	Avoiding pregnancy until HBsAg negative or identified as a chronic carrier; Advising your doctor, dentist, and anyone who might come into contact with your blood (such as those who do electrolysis, acupuncture, body piercing, and tattooing) that you are infected with HBV. **Hepatitis B Carriers** **Reporting and Follow-up** All suspect or confirmed cases of HBV must be reported to the Office of the Chief Medical Health Officer (OCMHO) within 24 hours. *Hepatitis Investigation Form* is to be completed. **Other Public Health Measures** Ongoing assessment of household and sexual contacts to assess need for Hepatitis B Vaccine. **Public Education** Safer sexual practices to prevent transmission. Do not donate blood. Avoid alcohol, tobacco, drugs and other substances toxic to the liver. Importance of balanced diet and regular exercise. Do not share razors, toothbrushes, needles, tweezers, nail files/clippers etc. **Hepatitis C** **Reporting and Follow-up** All suspect or confirmed cases of hepatitis must be reported to the Office of the Chief Medical Health Officer (OCMHO) within 24 hours. *Hepatitis Investigation Form* is to be completed. **Other Public Health Measures** Harm reduction efforts: needle-exchange programs, addiction programs and drug substitution. Partner notification is warranted in instances of illicit drug sharing. Because the risk of sexual transmission of HCV appears to be lower than for HBV or HIV, partner notification is not warranted. Hepatitis A and Hepatitis B vaccine. **Public Education** Safer sexual practices to prevent transmission. Do not donate blood. HCV infected persons have a responsibility to inform potential sexual partners that there is a risk of infection. Breastfeeding is safe as long as nipples are not cracked and bleeding. Transmission through breast milk is unlikely. Discussion of healthy lifestyle and information to minimize liver damage e.g., avoid intake of alcohol, tobacco, and hepatotoxic drugs, eating a well balanced diet, and having regular medical checkups. Importance of balanced diet and regular exercise. Do not share razor, toothbrushes, needles, etc.

Nova Scotia	Comprehensive manual, unable to copy http://www.gov.ns.ca/hpp/publications/cdc_manual.pdf
Nunavut	http://www.canlii.org/en/nu/laws/regu/rrnwt-nu-1990-c-p-13/latest/rrnwt-nu-1990-c-p-13.html **Mandated in Regulations for all Reportable Communicable Diseases** Where a medical practitioner or nurse has received a positive test result for one of his or her patients or a medical practitioner, nurse or dentist has reason to believe or suspect that one of his or her patients is infected with a communicable disease, the medical practitioner, nurse or dentist shall (a) in the case of a disease listed in Item I of (i) immediately notify the Chief Medical Health Officer by telephone, and (ii) within 24 hours, send a written report to the Chief Medical Health Officer in a form approved by the Chief Medical Health Officer;(b) in the case of a disease listed in Item II of Schedule A, within seven days send a written report to the Chief Medical Health Officer in a form approved by the Chief Medical Health Officer;(c) advise the patient to adopt the specific control measures for the communicable disease in question; d) provide the patient with the necessary in formation to comply with paragraph (c); and (e) within seven days of giving notice under paragraph (a) or (b),(i) in accordance with guidelines provided by the Chief Medical Health Officer, carry out contact tracing or surveillance of those aspects of the occurrence and spread of the communicable disease that are pertinent to the effective control of the disease, or (ii) request the Chief Medical Health Officer to carry out the contact tracing or surveillance.
Ontario	http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/sexual_health_sti.pdf **Hepatitis** **Mandated** The board of health shall ensure that the medical officer of health or designate receives reports of sexually transmitted infections and blood-borne infections and responds in accordance with the Health Protection and Promotion Act and the Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol, 2008 (or as current). Laboratory confirmed cases shall be reported to the medical officer of health by persons required to do so under the Health Protection and Promotion Act, R.S.O. 1990. **Timelines** Contact notification for Hepatitis B&C is variable Report only case classifications specified in the case definition to PHD. Cases shall be reported using the integrated Public Health Information System (iPHIS), or any other method specified by the Ministry within five (5) business days of receipt of initial notification **Information Required** **Contact information**; c) Include as much relevant information as possible to facilitate the location, counselling and treatment of contacts .Information shall include as much of the following information as possible as described in disease-specific iPHIS user

	guides3 or any other documentation or any other method specified by the ministry: infection/diagnosis; ii) First name, last name; iii) Birth date or birth year if date of birth not available; and iv) Gender. Other data elements to be collected and reported on contacts could also include :v) Address/telecommunications; iv) Contact (e.g., sexual, maternal, household, etc.); vii) Case/encounter date (e.g., onset date, reported date, etc.); viii) Treatment; and, ix) Risk factors (e.g., exposure setting, medical risk factors, behavioural/social factors). The board of health shall also include collection of as much of the following information as described in disease-specific iPHIS user guides or any other documentation or any other method specified by the ministry: First name, last name of contact(s); Birth date or birth year; Gender; Address/telecommunication; Contact (e.g., sexual, casual, etc.); Relevant case/encounter date; and risk factors . Ensure that contact tracing is completed when partner notification is done by the health care provider or the case. **Risk Factors:** i) Having sexual contact with person(s) with a known STI; ii) Being sexually active and under 25 years; iii) Having a new partner or having had multiple partners in the past year; iv) Being street involved and/or homeless; v) Being a sex worker; vi) Having anonymous sexual partners; vii) Being a victim of sexual assault/abuse; viii) Injection drug use; ix) Using other substances such as alcohol or chemicals (e.g., cocaine, ecstasy **Reporting Process** The board of health shall: use the integrated Public Health Information System (iPHIS) or any other method specified by the Ministry of Health and Long-Term Care (the "ministry") to notify the ministry of cases and contacts of reportable STIs including BBIs. It is required to include all disease-specific information specified in O. Reg. 5692 under the HPPA. The board of health shall conduct surveillance of: Sexually transmitted infections; Blood-borne infections; Reproductive outcomes; Risk behaviours; and Distribution of harm reduction materials/equipment in accordance with the Population Health Assessment and Surveillance Protocol, 2008 (or as current) and the Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol, 2008(or as current).
Prince Edward Island	Unable to locate online
Quebec	Unable to locate online
Saskatchewan	http://www.health.gov.sk.ca/cdc-section6 **Hepatitis C (Hep B has no guidelines)** *Contacts/Contact Investigation* *Contact Definition* High risk contacts are defined as: those who have shared injection drug use and non injection drug use

	equipment with the case; children born to an infected mother; individuals who have been exposed to blood or body fluids contaminated with blood (sharing razors, toothbrushes, or via bites or needlestick injuries). Lower risk contacts are defined as: household contacts; sexual contacts. Contacts should be traced back to 6 months prior to onset of symptoms or to onset of risk behaviour for cases who are asymptomatic. Children born to women previously identified to be HCV infected should be tested for HCV infection; the duration of presence of passive maternal antibody in infants can be as long as 18 months. Refer to Exposures to blood and body fluids should be managed as per Saskatchewan Guidelines for the Management of Exposures to Blood and Body Fluids. When personal service or medical/dental facilities are identified as a potential source for exposure, further investigation of other clientele may be warranted.
Yukon	Notes that Hepatitis B guidelines are under development on gov health page, no hep c guidelines exist
PHAC	http://www.phac-aspc.gc.ca/std-mts/sti-its/cgsti-ldcits/section-5-7-eng.php **Reporting, Partner Notification and Follow-up for Hepatitis B (no Hepatitis C STI guidelines)** Acute hepatitis B is a reportable infection in all Canadian jurisdictions. Partner notification/contact tracing is essential to identify those at risk of acquiring hepatitis B, both to clarify their immune status and to provide vaccine protection to the non-immune. Contacts include the following: Sexual and percutaneous exposures during the period of infectivity. Children of hepatitis B–infected mothers who did not receive HBIG and vaccine at birth. Those living in the household of the index case.

6. (e) HIV

Province/ Territory	**Partner Notification Parameters**
Alberta	http://www.health.alberta.ca/documents/Guidelines-Human-Immunodeficiency-Virus-2011.pdf *Key Investigation* Identify household and other intimate contacts for potential blood exposure from the case. Partners should be traced based on estimated duration of infection in index case. Contacts include:

	Needle-sharing partners, persons who share sharps and other items potentially contaminated with blood e.g., razors, toothbrushes, other persons with an identified exposure to blood or other body fluids capable of producing HIV infection, long-term and short-term sexual partners, victims of sexual assault, and children born to HIV-positive mothers. *Management of Contacts* It is a public health responsibility to ensure that partner notification and follow-up takes place. All HIV-positive individuals are assumed to be infectious and capable of transmitting the virus through exchange of blood and body fluids. They must, therefore, be interviewed to identify and disclose names of their sexual and needle-sharing partners. Partner notification and follow-up of drug sharing and sexual partners must be undertaken on all reported cases of HIV infection and AIDS. In order to protect the identity of the source, neither the source identity, the date, nor the nature of the exposure should be revealed to the contact. Tracing of partners should be based on the estimated duration of infection. If the date of seroconversion is known, all partners in the six months prior to the positive testing should be identified. If the seroconversion date is unknown, all partners, as far back as practical, should be identified. All identifiable partners should be notified within one month of the case disclosing contact information. It is recommended to meet with the contact in person. Collaboration between the primary care physician, public health personnel and the infectious disease physician is essential. Public health personnel should be available to assist physicians with partner notification and help with appropriate referral for clinical evaluation, testing, treatment, and health education. Both the physician and public health personnel conducting contact tracing, should always provide partners with information that includes: modes of transmission, disease process, how to modify risk behaviors, telephone numbers and addresses of support agencies and testing clinics. All partners should be encouraged to be tested for HIV and given specific details on where to be tested, and how it will be reported if positive. Pregnant female contacts should be given priority for follow-up. One negative HIV antibody test may be inadequate due to the possibility of being in the “window period”, or having ongoing risk behaviour. Therefore, based on continued risk behaviour, it is recommended that additional testing be performed during pregnancy and/or prior to delivery. If the woman does not return for retesting, public health personnel and/or the primary care physician should make attempts to contact her and provide additional information and/or support. If the contact is a pregnant woman, in addition to standard HIV testing, a HIV specialist should be consulted regarding additional tests (e.g., HIV RNA) and/or further HIV antibody testing. If the contact is found to be HIV positive, immediate referral should be made to a HIV specialist. (See Prenatal HIV: Public Health Guidelines for the Management and Follow-up of HIV Positive Women and their Infants, Alberta Health and Wellness).

	Infants Children born to HIV-positive women should be referred to a specialist in pediatric infectious diseases for assessment as soon as possible after delivery. For infants born to HIV-positive mothers who have not taken antiretroviral prophylaxis, perinatal transmission can still be significantly reduced by starting antiretroviral therapy as soon as possible after birth, preferably within one to four hours following birth. A specialist in pediatric infectious diseases should be consulted in all cases (See Prenatal HIV: Public Health Guidelines). HIV-positive mothers should not breastfeed. Provincially-funded infant formula can be obtained through the Northern or Southern Alberta HIV Programs. *Other Contacts* Individuals exposed to blood and other body fluids capable of producing HIV infection: should be notified of potential HIV exposure, and should be assessed by an infectious diseases physician for chemoprophylaxis
British Columbia	**Mandated in the Public Health Communicable Disease Act Regulations** http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/12_4_83 **Timelines** A report required to be made without delay shall be made by telephone or by any similar rapid means of communication. reports by hospital **3**In addition to the requirements of section 2, the administrator or other person in charge of a hospital shall, within 7 days, make a report to the medical health officer respecting a patient admitted to the hospital who is suffering from a reportable communicable disease or from rheumatic fever. **Information Required** A report made under section 2 (2) shall include (a)the name of the disease,(b)the name, age, sex and address of the infected person, and (c)appropriate details if the disease reported is epidemic or shows unusual features. A report made under section 3 shall include (a) the name of the disease,(b)the name, age, sex and address of the patient, and (c)the name and address of the physician or other person who is or has been attending the patient. (4)All reports referred to in this section shall include any further relevant information requested by the medical health officer. 5) A report made under section 2 (2) or (3) or 3 respecting a person who voluntarily submitted to testing for Human Immunodeficiency Virus must omit the name and address of the person if that person so chooses. **British Columbia uses PHAC guidelines for HIV:** http://www.phac-aspc.gc.ca/std-mts/sti-its/cgsti-ldcits/section-5-8-eng.php Reporting and Partner Notification HIV infection is reportable in all provinces and territories; such reporting may be nominal or non-nominal, depending on the jurisdiction. AIDS is reportable by physicians to local public health authorities in all provinces and territories.

	Partner notification must be undertaken in all cases of AIDS and HIV infection. Local public health authorities are available to assist with partner notification and help with appropriate referral for clinical evaluation, testing, treatment and health education. The treating physician is responsible for ensuring that partner notification is initiated. All children born to mothers who are or may be HIV-infected need to be evaluated (see Pregnancy chapter). All HIV-positive persons who have previously received or donated blood should be reported in confidence to the local Canadian Blood Services.
Manitoba	http://www.gov.mb.ca/health/publichealth/cdc/protocol/hiv.pdf **HIV** *Contact Notification* Notification of contacts regarding their HIV exposure may be Public Health initiated, practitioner/physician initiated or case initiated. Public Health should ensure that a plan is in place for contact notification, using at a minimum, one of these approaches. It is preferable that the client agrees to the involvement of Public Health and/or practitioners in contact notification. However, if it is believed that there is a significant exposure risk to the contact and the client will not inform the contact directly, then the case's practitioner and/or Public Health should inform a contact without obtaining consent from the HIV-positive client. All health care practitioners have the legal and ethical responsibility to assure the confidentiality of cases and contacts to the extent possible; to ensure that there is a plan in place to advise the contacts of their risk for infection; and to assist contacts in accessing medical attention if they desire. **Timelines** Contact notification should generally include sexual and/or injection equipment-sharing partners with whom the client has had contact within the year prior to the client's first HIV-positive laboratory report If the exposure has been within three months of the client's first positive HIV serology, and the contact has a negative serology test, the testing of the contact should be repeated at least three months after the last exposure. Although the recommended interview period is generally not more than one year, there may be situations where more distant contact identification and notification may be required depending on the period of infectivity, the significance of the exposure, the feasibility of notification and a prioritization of contacts at risk. Testing of contacts for HIV antibody should be performed as soon as possible **Information Required** HIV-positive clients/patients must be advised that pertinent information about their contacts will be confidentially forwarded to Manitoba Health.

	The information for each contact must be recorded on a separate Manitoba Health HIV Contact Notification Form and all of the information for each contact must be submitted to Manitoba Health as soon as possible for surveillance and public health referral purposes. • All of the information for each contact will be referred by Manitoba Health to the health jurisdiction in which the contact resides. *Contact Notification Options* .2.2.1 Public Health Initiated Contact Notification With this option of contact notification, Regional Public Health notifies the contact(s) of the HIV-positive client. The region will attempt to notify contacts within four weeks of receiving the referral from Manitoba Health. The HIV- positive client will provide contacts' names and their locating information to a health professional. The identity of the HIV-positive client will not be disclosed to his/her contacts. 7.2.2.2 Practitioner/Physician Initiated Contact Notification The practitioner will notify the contact(s) of the HIV-positive client. The HIV-positive client will provide contact names/identifiers and locating information to the practitioner who ordered the HIV testing. The practitioner will attempt to notify contacts regarding their exposure to HIV, once contact information is obtained. It is recommended that the practitioner notify the contact within four weeks of obtaining contact locating information. Alternatively, the practitioner can defer contact notification to Public Health. The identity of the HIV-positive client will not be disclosed to his/her contacts. 7.2.2.3 Case Initiated Contact Notification This is a strategy through which the HIV-positive client commits to notify his/her contacts regarding their possible exposure to HIV. The health care practitioner should consult with Public Health to agree on a process to confirm that the contact(s) were notified by the case and to discuss any additional follow-up required. The health care practitioner should ensure the case is aware of the information that needs to be communicated to their contacts. The minimum requirement for the HIV-positive client is to inform contacts of their exposure to HIV, their need for HIV testing (either through their own health care provider or Public Health) and their need to contact their own health care provider for follow- up. The health care practitioner should negotiate a time period with the HIV-positive client (up to four weeks) within which the index case will inform their contacts. If the contacts have not been notified of their exposure to HIV after the agreed- upon time period, either the practitioner or Public Health should intervene as determined during the initial consultation process. 7.2.3 Infant Contact Children born to a woman known to be HIV-positive at time of delivery should be tested for HIV (refer to Section 6 for testing information). If the mother's date of seroconversion is unknown, all her children should be assessed and considered for HIV testing. Women should be informed that the lack of signs and symptoms suggestive of HIV infection in older children does not exclude HIV infection. Some perinatally infected children can remain asymptomatic for several years.

	To ensure that infants at risk receive appropriate care, Manitoba Health will refer all infants testing positive for HIV antibody to regional Public Health authorities, even though this result may result from maternal antibody transfer and not infant infection. The attending practitioner/physician must be contacted by regional Public Health authorities and collaboration sought in identifying the infant and family. All infants born to HIV-positive mothers should be referred to a pediatric HIV specialist for appropriate follow-up antibody and NAT testing. Positive test results will be referred to the appropriate jurisdiction
New Brunswick	Unable to locate online
Newfoundland	http://www.health.gov.nl.ca/health/publichealth/cdc/STBBI_Sept2010.pdf **HIV** **Mandated** Partner notification may be done by the client, public health or physician as decided by the attending health care professional in consultation with office of the Regional Medical Officer of Health (RMOH). Investigations and reporting are the responsibility of the office of the Regional Medical Officer of Health (RMOH). As the lead in the region the RMOH collaborates with family physicians, Communicable Disease Control (CDC) and public health staff to provide effective and confidential follow-up of laboratory confirmed cases of STIs and BBPs or sexually transmitted infections (STIs) and bloodborne pathogens Communicable disease control nurse (CDCNs) or community health nurses (CHNs) educated in communicable disease and nurse practitioners (NPs) are permitted to undertake testing for STIs or BBP at selected sites within a regional health authority under direction/designation of their MOH. **Timelines** (BBPs) contact follow up and notification is required and is completed in a confidential and timely manner at the local or regional level Laboratory: Routine reporting to CMOH, RMOH and attending physician within four working days for all list B STIs. RMOH or designate: Assign and initiate investigation within four working days Every attempt must be made to identify, locate, examine and treat partners/contacts; of cases If physicians/HCP of the case other than the MOH or the CDCN,CDN or NP completes the follow up of contacts then they are to notify the RHA that this follow up has been taken place If a physician/HCP may choose to have the assistance of the MOH or the CDCN, CDN or NP to do contact tracing and follow up for the notifiable STI case then the physician /HCP shall advise the RHA of this within two weeks of receiving notification of the case

	In absence of a response from the physician/HCP within the two week time frame to the RHA then the appropriate STI services will be initiated by the MOH or the CDCN,CDN or NP Partner notification should include appropriate referral for clinical evaluation, testing, treatment and health education as needed *Management of Contacts:* Pre-test and post-test counseling should be offered to those who are at risk. This should be done in a confidential manner by an individual who has training or experience in this area. This opportunity should also be used to provide education about prevention strategies. This should include safer sex practices and harm reduction strategies. Contracts may require testing for other STIs and BBIs If suspected occupational exposure to potential blood or body fluids occurs in a health care facility, baseline testing should be performed. Occupational exposure must be reported to your occupational health department for follow up and recommended action. The baseline testing should include screening for exposure to hepatitis B & C as well as HIV. Consideration must be given to using HIV post exposure prophylaxis as antiretroviral agents can have severe side effects, careful consideration must be given to the benefits and risks of this prophylaxis. **Reporting Process** Physicians, laboratories and communicable disease control nurses (CDCNs) and Infection Control Practitioners (ICPs) must report confirmed cases of HIV infection to the Regional Medical Officer of Health .The RMOH or designate are responsible for follow-up of identified cases of HIV, infection and for the electronic reporting to the provincial office of CMOH. The RMOH or designate must contact the primary health care provider to determine the need for education, pre-test and post-test counseling and contact tracing. The primary health care provider must complete the national HIV/AIDS report form provided by the office of the RMOH. When completed it is forwarded to RMOH for review and then forwarded to the CMOM. CDCN enters the case into the electronic reporting system Provincial Disease Control forwards completed national HIV/AIDS report form to Public Health Agency of Canada, reports and confirms aggregate case information to Public Health Agency of Canada quarterly, provides an analysis of the case/s with reports in the Communicable Disease Report (CDR) **Newfoundland/Labrador Policy** All laboratory confirmed reportable STIs and BBPs are to be reported to the RMOH or designate, appropriately treated and case follow-up completed. Reports from the provincial public health laboratory are sent to the office of the RMOH, CMOH (Chief Medical Officer of Health) as well as the attending physician. Reporting of these infections allows for public health agencies to monitor the prevalence and incidence of these infections in the community and thus help to plan prevention and intervention programs to reduce the risk of infection and disease.
Northwest Territories	http://www.hss.gov.nt.ca/sites/default/files/cdcmanfulldoc.pdf http://www.hss.gov.nt.ca/sites/default/files/hiv_aids_manual.pdf

	Mandated Partner notification, treatment and counseling are indicated for any infection or syndrome that is predominantly transmitted sexually. Patient referral: Patients inform their own partners without the direct involvement of health care providers or public health authorities. Provider referral**:** Health care providers and/or public health authorities notify partners of the patient. Staff of the OCMHO will assist with partner notification, when they reside outside the NWT is required. All confirmed cases of HIV Infection must be reported to the Office of the Chief Medical Health Officer. **Partner Notification and Contact Tracing** Partner notification and contact tracing must begin immediately following an HIV positive result. The NWT Public Health Act gives the health care provider authority to undertake contact tracing, and to inform those exposed to the virus. *Steps for Contact Tracing* 1. Inform the patient of what must occur. For some individuals, issues of disclosure and/or concern for others can cause anxiety and stress. Patients who test positive for HIV should be advised of their responsibility to disclose their HIV status to anyone they have engaged within activities that had a significant risk of HIV transmission. For further information, refer to Section IV, Support For Those Living With HIV. 2. Suggested statements: "We have a responsibility to ensure that all sexual contacts of HIV be notified so they can be tested and treated. This is important because people can be HIV positive and not know it. They could unknowingly pass the infection to others." "I need to collect information on all your partners in the past 6 months (or more) so I can notify them help them get tested." "Your identity will be protected. We never reveal who named a person or the date of the sexual contact." 3. Record contact information on the NWT Sexually Transmitted Diseases Report. 4. Give the patient the option to notify their own contacts. The patient must provide confirmation that notification has occurred. If notification has not occurred within 1 week, the health care professional will undertake notification of contacts. **Methods of Notification**

	Telephone Verify you are speaking to the right person. Identify yourself State what you have to discuss is personal and confidential. Ask if it is an appropriate time to talk. *Written Notice* A simple note consisting of a name and telephone number to call for an urgent personal message. Because mail is often opened by others, no mention of HIV contact should be made. The return address on the envelope should not identify the nature of the content. *Visit* Identify yourself only to the contact, if possible. Verify you are speaking to the right person
Nova Scotia	Comprehensive manual, unable to copy http://www.gov.ns.ca/hpp/publications/cdc_manual.pdf
Nunavut	http://www.canlii.org/en/nu/laws/regu/rrnwt-nu-1990-c-p-13/latest/rrnwt-nu-1990-c-p-13.html **Mandated in Regulations for all reportable Communicable Diseases** Where a medical practitioner or nurse has received a positive test result for one of his or her patients or a medical practitioner, nurse or dentist has reason to believe or suspect that one of his or her patients is infected with a communicable disease, the medical practitioner, nurse or dentist shall (a) in the case of a disease listed in Item I of (i) immediately notify the Chief Medical Health Officer by telephone, and (ii) within 24 hours, send a written report to the Chief Medical Health Officer in a form approved by the Chief Medical Health Officer;(b) in the case of a disease listed in Item II of Schedule A, within seven days send a written report to the Chief Medical Health Officer in a form approved by the Chief Medical Health Officer;(c) advise the patient to adopt the specific control measures for the communicable disease in question; d) provide the patient with the necessary information to comply with paragraph (c); and (e) within seven days of giving notice under paragraph (a) or (b),(i) in accordance with guidelines provided by the Chief Medical Health Officer, carry out contact tracing or surveillance of those aspects of the occurrence and spread of the communicable disease that are pertinent to the effective control of the disease, or (ii) request the Chief Medical Health Officer to carry out the contact tracing or surveillance.
Ontario	http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/sexual_health_sti.pdf **HIV** **Mandated** The board of health shall ensure that the medical officer of health or designate receives reports of sexually transmitted infections and blood-borne infections and responds in accordance with

	the Health Protection and Promotion Act and the Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol, 2008 (or as current). Laboratory confirmed cases shall be reported to the medical officer of health by persons required to do so under the Health Protection and Promotion Act, R.S.O. 1990. **Timelines** HIV; Start with the most recent contacts. Consider the outer time limit as the start of risk behaviour or to last known negative test. Report only case classifications specified in the case definition to PHD. Cases shall be reported using the integrated Public Health Information System (iPHIS), or any other method specified by the Ministry within five (5) business days of receipt of initial notification **Contact Tracing** If previous negative result, include all contacts from 12 weeks prior to the last negative result. If no previous negative result, consider the outer time limit as the start of risk behaviour and include all contacts since. **Information Required** Lab Confirmed Case: b) Include as much relevant information as possible to facilitate location, counselling, and treatment of cases of reportable STIs/BBIs. A laboratory report alone is insufficient. Case information shall include as much of the following, as described in disease-specific iPHIS user guides or any other documentation or any other method specified by the ministry: i) Infection/diagnosis; ii) First name, last name (with the exception of anonymous HIV testing); iii) Birth date or birth year if date of birth not available; and iv) Gender. Other data elements to be collected and reported for cases of reportable STIs/BBIs could include: v) Address/telecommunications; vi) Case/encounter date (e.g., onset date, reported date, etc.); vii) Treatment; and viii) Risk factors (e.g., exposure setting, medical risk factors, and behavioural/social factors). Contact information; c) Include as much relevant information as possible to facilitate the location, counselling and treatment of contacts .Information shall include as much of the following information as possible as described in disease-specific iPHIS user guides or any other documentation or any other method specified by the ministry: infection/diagnosis; ii) First name, last name; iii) Birth date or birth year if date of birth not available; and iv) Gender. Other data elements to be collected and reported on contacts could also include :v) Address/telecommunications; iv) Contact (e.g., sexual, maternal, household, etc.); vii) Case/encounter date (e.g., onset date, reported date, etc.); viii)

	Treatment; and, ix) Risk factors (e.g., exposure setting, medical risk factors, behavioural/social factors). The board of health shall also include collection of as much of the following information as described in disease-specific iPHIS user guides or any other documentation or any other method specified by the ministry: First name, last name of contact(s); Birth date or birth year; Gender; Address/telecommunication; Contact (e.g., sexual, casual, etc.); Relevant case/encounter date; and risk factors . Ensure that contact tracing is completed when partner notification is done by the health care provider or the case. **Reporting Process** The board of health shall: use the integrated Public Health Information System (iPHIS) or any other method specified by the Ministry of Health and Long-Term Care (the "ministry") to notify the ministry of cases and contacts of reportable STIs including BBIs. It is required to include all disease-specific information specified in O. Reg. 5692 under the HPPA.1 The board of health shall conduct surveillance of: Sexually transmitted infections; Blood-borne infections; Reproductive outcomes; Risk behaviours; and Distribution of harm reduction materials/equipment in accordance with the *Population Health* Assessment and Surveillance Protocol, 2008 (or as current)and the Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol, 2008(or as current).
Prince Edward Island	Unable to locate online
Quebec	Unable to locate online
Saskatchewan	http://www.health.gov.sk.ca/cdc-section5 The hyperlink provided by the CDC manual does not exist anymore here is the general info. *Who Performs Partner Notification?* The client, health care provider, MHO or their designate may notify the partner. When the person with the STI chooses to notify his or her contacts, they must inform the contact of the exposure, explain their duty to get tested and take all reasonable measures to reduce the risk of exposing others. *Reporting and Partner Notification* Reporting must occur from the correctional facility to the local Public Health office.

	Partner notification is a major component of STI follow-up but inmates may be reluctant to disclose information about contacts or behaviours that may be deemed inappropriate, illegal or be stigmatized. This highlights the importance of confidentiality and a non-coercive approach to partner-notification process. Inmates view Public Health as an outside agency and therefore may be more willing to disclose information about contacts to Public Health.
Yukon	Unable to locate online
PHAC	http://www.phac-aspc.gc.ca/std-mts/sti-its/cgsti-ldcits/section-5-8-eng.php **Reporting and Partner Notification** HIV infection is reportable in all provinces and territories; such reporting may be nominal or non-nominal, depending on the jurisdiction. AIDS is reportable by physicians to local public health authorities in all provinces and territories. Partner notification must be undertaken in all cases of AIDS and HIV infection. Local public health authorities are available to assist with partner notification and help with appropriate referral for clinical evaluation, testing, treatment and health education. The treating physician is responsible for ensuring that partner notification is initiated. All children born to mothers who are or may be HIV-infected need to be evaluated (see *Pregnancy* chapter). All HIV-positive persons who have previously received or donated blood should be reported in confidence to the local Canadian Blood Services.

7. Appendix A – Reportable Disease Forms

Province/Territories	Reportable Disease Forms
Alberta	http://www.health.alberta.ca/documents/ND-Report-Manual.pdf
British Columbia	http://www.bccdc.ca/discond/CDSurveillanceForms/default.htm#heading5
Manitoba	http://www.gov.mb.ca/health/publichealth/cdc/protocol/form2.pdf http://www.gov.mb.ca/health/publichealth/cdc/protocol/hepbc_caseform.pdf http://www.gov.mb.ca/health/publichealth/surveillance/forms.html http://www.gov.mb.ca/health/publichealth/cdc/protocol/form3.pdf
New Brunswick	Unable to locate online
Newfoundland	http://www.health.gov.nl.ca/health/publications/diseasecontrol/DCM_Introduction_May_2010.pdf Appendix C&E
Northwest Territories	http://www.hss.gov.nt.ca/sites/default/files/nwt_sexually_transmitted_diseases_report.pdf http://www.hss.gov.nt.ca/sites/default/files/hepatitis_b_and_c_case_investigation_form.pdf http://www.hss.gov.nt.ca/sites/default/files/hiv_case_investigation_form.pdf http://www.hss.gov.nt.ca/sites/default/files/syphilis-investigation-form.pdf
Nova Scotia	http://www.gov.ns.ca/hpp/publications/13118_Comm.DiseaesRptFrm_Oct07_En.pdf
Nunavut	Unable to locate online

Ontario	Unable to locate online
Prince Edward Island	Unable to locate online
Quebec	http://msssa4.msss.gouv.qc.ca/intra/formres.nsf/36e747f5dc7d0d6585256e1a006ba727/64631465d0d5c09085256ecf006b4afd/$FILE/AS-770_DT9070(2013-03)D.pdf
Saskatchewan	Unable to located online
Yukon	Unable to locate online

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NCCID gathers, distils and disseminates current information, technology and resources on infectious diseases and ensures they reach practitioners to the benefit of all Canadians. NCCID's work ultimately informs public policy and better equips public health practitioners in their role of preventing and controlling emerging and re-emerging infectious diseases.

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