



**DIRECTIVE FOR A CLIENT POPULATION  
REGISTERED NURSE SPECIALTY PRACTICE**

**SEXUAL HEALTH PROGRAM**

**SEXUALLY TRANSMITTED INFECTIONS**

**Gonorrhea, Chlamydia, and Syphilis**

**&**

**BLOOD BORNE ILLNESSES**

**Hepatitis B, Hepatitis C and HIV**

**Updated: April 24, 2023**

### DIRECTIVE FOR CLIENT POPULATION ORDERS SEXUAL HEALTH PROGRAM

This RN Clinical Protocol and Medical Directive provides the authority and direction for RNs working in NITHA Partnership Communities to:

Screen, test and treat for the following sexually transmitted infections (STI's) for any client presenting for sexual health:

- Gonorrhea
- Chlamydia
- Syphilis


Screen, test and assist with case management for the following blood-borne infections (BBI's)

- Hepatitis B
- Hepatitis c
- HIV

The NITHA Sexual Health Program is overseen by the MHO through a collaborative, and interdisciplinary approach.

- If there is a discrepancy between this RN Specialty Practice and the current treatment guidelines from the Saskatchewan Communicable Disease Control (SCDC) Manual on Sexually Transmitted Infections, the SCDC Manual shall supersede this protocol.
- All Health Care Providers (HCP) are expected to adhere to all policies/procedures relating to the parameter of the Sexual Health Program that the overseeing MHO has communicated through the attached Medical Directive.
- Presumptive diagnosis for gonorrhea and chlamydia can be made based on history and physical findings. Definite diagnosis is confirmed with laboratory testing,
- RNs are authorized to provide a beta-HCG (pregnancy) test in conjunction with the above STI testing
- RN's are authorized to initiate pretest counselling and testing for STI's and BBI's based on risk factor, contact tracing or general screening. Pre and post test counselling is an essential part of effective sexual health programs.
- Any positive blood borne infection must be reported to the NITHA MHO and referred to an Infectious Disease Specialist (preferred) or Physician.
- An RN may give the initial Benzathine Penicillin (Bicillin-LA) IM dose for Syphilis if no contraindications.
- For Hepatitis B, C and HIV, an RN must refer to the NITHA MHO, Infectious Disease Specialist and/or Physician. This pertains to Hepatitis B, Hepatitis C and HIV.
- This directive is consistent with the overarching policy.
- Pre and post test counselling is an essential part of sexual health programs.

Submitted from: NITHA Nursing Specialty Practice Working Group

Authorized by:   
Dr Nnamdi Ndubuka, MHO NITHA

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**HIGH ALERT:**

- The reviewing of lab results and follow-up for positive STIBBI's is an area of risk management that must meet standards of care. Employer policy must be in place for the management of lab tests and required follow-up. HCP's must adhere to employer policy surrounding it.
- Refer to the SCDC manual for the interpretation and management of STI and BBI lab tests and required follow-up.
- There is a legal obligation to report sexual activity to Child and Family Services or the RCMP (depending on your regional resources) in individuals under the age of consent or unable to provide consent. See agency policy and procedure for course of action (see Appendix A – Age of Consent for Sexual Activity). Mental health resources should be considered in cases of children and youth.
- An RN should seek immediate consultation from a physician or NP when any of the following circumstances exist;
  - clients presenting with signs and symptoms of pelvic inflammatory disease (PID) such as severe abdominal and pelvic pain, abnormal vaginal bleeding or perineal pain
  - victims of sexual assault –with incident occurring in past 100 hrs
  - pediatric clients under 12 years of age
  - clients with acute clinical symptoms (e.g. severe testicular pain, enlarged lymph nodes, conjunctivitis, fever, rashes, etc.)
- Prenatal, infants and immunocompromised
- For best practice, HCP's are required to thoroughly fill out the lab requisitions to include the MHO's name, date of sample collected, client demographic information.
- For the out of province lab results, you must ensure a copy of lab results are sent to NITHA CDC at 1(306) 953-5020.

**OBJECTIVE**

- To provide timely screening, testing, treatment and/ or case management for clients presenting with concerns regarding sexual health, STIBBI's throughout the NITHA Partnership communities.
- To increase accessibility to STIBBI services in the NITHA Communities.

**RN COMPETENCY REQUIREMENTS**

- This RN Specialty Practice protocol requires the RN to have been certified in phlebotomy as per NITHA training package or similar from an accredited institution.
- RNs must familiarize themselves with the Sexual Health Program and maintain competency in the screening, testing, treatment and management of STIs/BBIs.
- RNs must review this Medical Directive and RN Clinical Protocol annually.
- RNs must have access to recommended resources as indicated:
- Government of Saskatchewan. (2007). The Public Health Act, 1994. Regina, SK: Queens Printer Saskatchewan.

Roy Romanow Provincial Laboratory Compendium of Tests (2023)<https://rrpl-testviewer.ehealthsask.ca/>

Saskatchewan Ministry of Health (2023). *Communicable Disease Control Manual*  
<https://www.ehealthsask.ca/services/Manuals/Pages/CDCManual.aspx>

## Chlamydia

- Definite diagnosis is confirmed with laboratory testing (Public Health Agency of Canada, 2018)
- Presumptive diagnosis for chlamydia can be made based on history and physical findings.

### Testing Guidelines:

Source: SDCD Manual

Genital infection:

- NAAT should be performed on first void urine because of greater sensitivity than culture.
- Culture and Gram stain are recommended for the following specimens:
  - urethra in young and adult males with or without meatal discharge;
  - cervix in young and adult females.
- Culture is recommended for the following specimens:
  - rectum in females and males who have sex with men (colonization can occur without anal intercourse);
  - vagina in prepubertal girls or women without cervix.

Extra-genital infection:

- Culture:
  - pharynx in those with a history of oral-genital contact;
  - conjunctiva for ocular infections.
- Disseminated infection:
- genital testing as outlined above;
- blood culture
- synovial fluid for culture and gram stain if arthritis;
- Gram stain and culture of skin lesion.

Special considerations:

- Cultures obtained less than 48 hours after exposure may be negative.
- Culture is especially important in the following cases:
  - sexual abuse of children (rectal, pharyngeal, vaginal);
  - sexual assault;
  - treatment failure;
  - evaluation of pelvic inflammatory disease (PID);
  - infection acquired overseas or in areas with recognized antimicrobial resistance.

NAAT should not be used for test of cure.

**Chlamydia Treatment Guidelines**

In the absence of any contraindications, the following treatment options are recommended;

<i>Adults (non-pregnant and non-lactating): Urethral, endocervical, rectal, conjunctival infection</i>	
<b>Preferred</b>	<b>Alternative</b>
Azithromycin 1 g PO in a single dose if poor compliance is expected *  <b>If allergic to Azithromycin, give:</b> Doxycycline 100mg PO BID for 7 days. *Doxycycline is contraindicated in pregnancy	Erythromycin 2g/day PO in divided doses for 7 days <b>OR</b> Erythromycin 1g/day PO in divided doses for 14 days ** <b>OR</b> Ofloxacin 300mg PO BID for 7 days

Adapted from the SDC MANUAL (2023)

<i>Pregnant women and nursing mothers: Urethral, endocervical, rectal infection</i>
Amoxicillin 500 mg PO tid for 7 days* <b>OR</b> Erythromycin 2 g/day PO in divided doses for 7 days <sup>*†</sup> <b>OR</b> Erythromycin 1 g/day PO in divided doses for 14 days <sup>*†</sup> <b>OR</b> Azithromycin 1 g PO in a single dose, only if poor compliance is expected <sup>†</sup>

Adapted from the SDC MANUAL (2023)

**Notes:**

- <sup>\*†</sup>Erythromycin dosages refer to the use of erythromycin base. Equivalent dosages of other formulations may be substituted (with the exception of the estolate formulation being contraindicated in pregnancy). Gastrointestinal side effects are more severe with erythromycin than amoxicillin.
- †If vomiting occurs more than 1hour post-administration, a repeat dose of Azithromycin is not required.
- Topical therapy alone for adult chlamydial conjunctivitis is **NOT** effective for cure and is unnecessary when systematic treatment is used.
- <sup>\*†</sup>Test of cure should be performed 4 weeks after the completion of treatment in all pregnant women.
- In Saskatchewan azithromycin is generally the preferred treatment for non-prenatal due to poor compliance of multiday treatments.

- Advise that test of cure for chlamydia is not routinely indicated if a recommended treatment has been completed, signs and symptoms resolve, and there has been no re-exposure to an untreated partner.
- Test of cure for chlamydia is only recommended when:
  - treatment completed but signs and symptoms persist,
  - compliance to therapy is suboptimal,
  - client is pre-pubertal,
  - client is pregnant,
  - previous treatment failure, or
  - client is diagnosed with PID or disseminated gonococcal infection

### **Children (12-18 years old) Chlamydia Treatment**

Preferred	Alternative
Azithromycin 12-15 mg/kg (max. 1 g) PO in a single dose if poor compliance is expected  <b>If allergic to Azithromycin, give:</b> Doxycycline 5 mg/kg/day PO in divided doses (max. 100 mg bid) for 7 days	Erythromycin 40 mg/kg/day PO in divided doses (max. 500 mg qid for 7 days or 250 mg qid for 14 days*

Adapted from the SCDC Manual (2023)

A physician must be consulted and orders obtained prior to treating any client under the age of 12. See Appendix A for Age of Consent to Sexual Activity

### **Notes for neonates diagnosed with chlamydial infection:**

- For neonates born to mothers who've tested positive to chlamydia, should be closely monitored for signs of chlamydial infection (e.g., conjunctivitis, pneumonitis) as per hospital protocols. This should be Reported to the NITHA MHO.

\*If erythromycin or sulfamethoxazole has been used for treatment, repeat testing 4 weeks after completion of therapy is advisable.

## Gonorrhoea

- Definite diagnosis is confirmed with laboratory testing (Public Health Agency of Canada, 2018)
- Presumptive diagnosis for gonorrhoea can be made based on history and physical findings.

### **Testing Guidelines for Gonorrhoea:**

Source: SDCD Manual

#### Genital infection:

- NAAT should be performed on first void urine because of greater sensitivity than culture.
- Culture and Gram stain are recommended for the following specimens:
  - urethra in young and adult males with or without meatal discharge;
  - cervix in young and adult females.
- Culture is recommended for the following specimens:
  - rectum in females and males who have sex with men (colonization can occur without anal intercourse);
  - vagina in prepubertal girls or women without cervix.

#### Extra-genital infection:

- Culture:
  - pharynx in those with a history of oral-genital contact;
  - conjunctiva for ocular infections.

#### Disseminated infection:

- genital testing as outlined above;
- blood culture
- synovial fluid for culture and gram stain if arthritis;
- Gram stain and culture of skin lesion.

#### Special considerations:

- Cultures obtained less than 48 hours after exposure may be negative.
- Culture is especially important in the following cases:
  - sexual abuse of children (rectal, pharyngeal, vaginal);
  - sexual assault;
  - treatment failure;
  - evaluation of pelvic inflammatory disease (PID);
  - infection acquired overseas or in areas with recognized antimicrobial resistance.

NAAT should not be used for test of cure.

Antimicrobial resistant gonorrhoea (AMR-GC) continues to be of concern in Canada and globally. In order to determine the most appropriate treatment individuals must be assessed for the following specific risk factors and sexual behaviours prior to being treated for gonorrhoea:

- history of MSM (men who have sex with men),
- history of oral sex,

- history of anal sex,
- sex with a person outside of Saskatchewan or Canada.

Treatment with the following **MUST** be given if the patient answers **yes** to any of the identified risk factors above **OR** if the assessment is not completed:

Ceftriaxone 250 mg IM (lidocaine 1% is the preferred diluent)

**AND**

Azithromycin 1 gram orally.

The following treatment is **only appropriate** when the above risk factors have been ruled out:

Cefixime 800 mg orally;

**AND**

Azithromycin 1 gram orally.

\*In the absence of a contraindication, the following tables outline treatment options that should be considered in conjunction with the above guidelines for gonorrhea.

#### ***Anogenital and Pharyngeal Gonorrhea Infections***

***Recommended treatment of uncomplicated anogenital and pharyngeal infection in adults and youth 12 years of age and older (for MSM, see below)***

<u><i>Urethral, endocervical, vaginal, rectal gonorrhea</i></u>	
<b>Preferred</b>	<b>Alternatives</b>
Ceftriaxone 250 mg IM in a single dose*† <b>PLUS</b> Azithromycin 1 g PO in a single dose‡  <b>OR</b> Cefixime 800 mg PO in a single dose*§ <b>PLUS</b> Azithromycin 1 g PO in a single dose	Gentamicin 240 mg IM in 2 separate 3 mL injections of 40 mg/mL solution <b>PLUS</b> Azithromycin 2 g PO in a single dose‡

<u><i>Pharyngeal gonorrhea</i></u>	
<b>Preferred</b>	<b>Alternatives</b>
Ceftriaxone 250 mg IM in a single dose*† <b>PLUS</b> Azithromycin 1 g PO in a single dose‡	Cefixime 800 mg PO in a single dose*§ <b>PLUS</b> Azithromycin 1 g PO in a single dose‡

Source: Adapted from SCDC Manual

*Treatment of Uncomplicated anogenital and pharyngeal Gonorrhoea infection  
in MSM Urethral, rectal*

Preferred	Alternatives
Ceftriaxone 250 mg IM in a single dose*† <b>PLUS</b> Azithromycin 1 g PO in a single dose‡	Cefixime 800 mg PO in a single dose*§ <b>PLUS</b> Azithromycin 1 g PO in a single dose‡ <b>OR</b>  Gentamicin 240 mg IM in 2 separate 3 mL injections of 40 mg/mL solution <b>PLUS</b> Azithromycin 2 g PO in a single dose ‡

*Treatment of Uncomplicated anogenital and pharyngeal Gonorrhoea infection in MSM  
Pharyngeal gonorrhoea*

Preferred	Alternatives
Ceftriaxone 250 mg IM in a single dose*† <b>PLUS</b> Azithromycin 1 g PO in a single dose	Cefixime 800 mg PO in a single dose*§ <b>PLUS</b> Azithromycin 1 g PO in a single dose‡

**A physician MUST be consulted and orders obtained prior to treating any client under the age of 12. See Appendix A –Age of Consent for Sexual Activity**

**Footnotes:**

\* Cefixime and ceftriaxone should not be given to persons with a cephalosporin allergy or a history of immediate and/or anaphylactic reactions to penicillins.

† The preferred diluent for ceftriaxone is 1% lidocaine without epinephrine (0.9 mL/250 mg, 0.45 mL/125 mg) to reduce discomfort.

‡ Alternate combination therapy: Azithromycin 1 g PO is preferred over the alternative of doxycycline 100 mg PO bid X 7 days, due to significant rates of tetracycline-resistant gonorrhoea and concerns regarding compliance with a 7-day treatment regimen. **Doxycycline is contraindicated in pregnant and breastfeeding women.**

**Additional Guidelines for Gonorrhoea**

- Perform test of cure three to four weeks after the completion of therapy. Tests should not be done sooner to avoid false-positive results due to the presence of non-viable organisms (Anti-Infective Review Panel, 2019; Government of Saskatchewan, 2018; Public Health Agency of Canada, 2019).
- If using a urine test (NAAT) for test of cure, wait three to four weeks after completion of treatment. However, if the client's symptoms improved but then worsened again, they may have been reinfected and retesting for both Chlamydia and GC is recommended (Government of Saskatchewan, 2018; Public Health Agency of Canada, 2019).

**General Guidelines for clients positive for Chlamydia and/or Gonorrhea**

- Complete contact tracing and submit Confidential Notification of Sexually Transmitted Infections to NITHA CDC Nurse via Confidential Fax
- For clients diagnosed with nongonococcal urethritis including Chlamydia, or clients diagnosed with Gonorrhea the RN should:
  - Follow-up in seven days when the course of antibiotics is completed to ensure symptom resolution, adherence to the medication, and to determine if there has been re-exposure, and/or if there are new sexual partners.
  - Treat current sexual partner(s) and those within the past 60 days even if asymptomatic.
    - Complete contact tracing and submit Confidential Notification of Sexually Transmitted Infections to NITHA CDC Nurse via Confidential Fax

The RN provides client and caregiver education as follows:

- Counsel client about appropriate use of medications (dose, frequency, importance of compliance, etc.).
- Counsel that both the index case and partner(s) should avoid unprotected sexual contact for at least seven days after completion of therapy.
- Recommend barrier protection for all sexual activity as it may reduce the risk of contracting an STI. (i.e., male and female condoms, dental dams)
- It's good practice to review immunization records. The HCP may recommend human papilloma virus (HPV) and hepatitis B vaccinations if eligible.
- Review risk factors related to STI transmission and ways to mitigate these.
- Recommend human papilloma virus (HPV) and -Review follow-up timelines with client (i.e. test of cure for parentals or if symptoms persist)
- Advise that currently in Saskatchewan, STIs must be reported to the Medical Officer of Health and that all sexual contacts during the 60 days preceding the onset of symptoms should be tested and empirically treated, regardless of clinical findings (Government of Saskatchewan, 2018; Public Health Agency of Canada, 2019).
- Complete contact tracing and submit Confidential Notification of Sexually Transmitted Infections to NITHA CDC Nurse via Confidential Fax.

## Syphilis

In the absence of contraindication, the following treatment options are recommended;

### Non-pregnant adults' treatment:

**\*The usual treatment administration is to administer 2 doses of the 1.2 long-acting Benzathine penicillin G (Bicillin® L-A) 2.4 million units at the same time on right and left upper outer quad of buttocks. GIVE INJECTION OVER 3 MINUTES**

Stage	Preferred Treatment
All non-pregnant adults who are not co-infected with HIV <ul style="list-style-type: none"> <li>• Primary</li> <li>• Secondary</li> <li>• Early Latent (&lt;1 yr duration)</li> </ul>	Long-acting Benzathine penicillin G (Bicillin® L-A) 2.4 million units IM STAT  1 vial= 1.2 Long-acting Benzathine penicillin G 2.4 million units
Epidemiological treatment of sexual contacts in the preceding 90 days to primary, secondary and early latent syphilis	Long-acting Benzathine penicillin G (Bicillin® L-A) 2.4 million units IM STAT
All non-pregnant adults <ul style="list-style-type: none"> <li>• Late latent syphilis</li> <li>• Latent syphilis of unknown duration</li> <li>• Cardiovascular syphilis and other tertiary syphilis not involving the central nervous system</li> </ul>	Long-acting Benzathine penicillin G (Bicillin® L-A) 2.4 million units IM weekly for 3 doses Give initial IM dose and consult MHO if unsure as to latency. Week #1 (2.4 million units IM STAT) Week #2 (2.4 million units IM STAT) Week #3 (2.4 million units IM STAT)
All adults <ul style="list-style-type: none"> <li>• Neurosyphilis</li> </ul>	Requires consult/referral

### Pregnant adults' treatment:

Stage	Preferred Treatment
Pregnant women <ul style="list-style-type: none"> <li>• Primary</li> <li>• Secondary</li> <li>• Early latent (&lt;1 yr duration)</li> </ul>	Long-acting Benzathine penicillin G (Bicillin® L-A) 2.4 million units IM do require 2 doses at 7 days apart Week #1 (2.4 million units IM STAT) Week #2 (2.4 million units IM STAT)
Pregnant women <ul style="list-style-type: none"> <li>• Late latent syphilis</li> <li>• Latent syphilis of unknown duration</li> <li>• Cardiovascular syphilis and other tertiary syphilis not involving the central nervous system</li> </ul>	Benzathine penicillin G 2.4 million units IM Long-acting weekly for 3 doses Give initial IM dose and consult MHO if unsure as to latency. Week #1 (2.4 million units IM STAT) Week #2 (2.4 million units IM STAT) Week #3 (2.4 million units IM STAT)
Cardiovascular syphilis and other tertiary syphilis not involving the central nervous system	Week #3 (2.4 million units IM STAT)

**\*Ensure Benzathine Penicillin (Bicillin-LA) is utilized, DO NOT USE the short acting Pen G**

**\*If Penicillin allergy –MUST consult with MHO for alternative treatment regime**

### **General Guidelines for Syphilis Management**

- Treat current sexual partner(s) and those within the past 90 days prior to onset of symptoms, all contacts should be offered presumptive treatment with a single dose of Long-acting Benzathine penicillin G (Bicillin® L-A) 2.4 million units IM STAT (if no penicillin allergy) at their initial visit. Baseline serology should also be collected at this first visit.
- For secondary syphilis, early latent and late latent refer to [Communicable Disease Control Manual – Sexually Transmitted Infections](#) (ehealthsask.ca)
- Assess marital or other long-term partners or infants to positive mothers as appropriate.
- Congenital Syphilis – consult with Physician
- **Complete contact tracing and submit Confidential Notification of Sexually Transmitted Infections** to NITHA CDC Nurse via Confidential Fax to 1(306)953-5020
- Refer to Physician or Infectious Diseases (ID) specialist for staging and necessary follow-up
- Serology will be ordered by family physician or NP, but RN can instruct client of the following guidelines:
  - Primary, secondary early latent (1), 3, 6, 12 months after treatment.
  - Late latent, tertiary 12 and 24 months after treatment.
  - HIV-infected (any stage) (1), 3, 6, 12 and 24 months after treatment and yearly thereafter.

Source: Canadian Guidelines on Sexually Transmitted Infections, 2023.

- 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 and timing of follow-up 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.
- Referral - Refer symptomatic individuals to their primary care provider or to an ID Specialist.
- Period of Abstinence
  - Clients should be encouraged to abstain from all sexual contact with others for a full 2 weeks following the final treatment. The use of condoms is not an exemption to the 2-week abstinence recommendation.
  - If the client has any lesions, the 2-week period of abstinence should be extended until all lesions have healed.
- Condoms should be advised and encouraged for all sexual encounters.

## Hepatitis B

### Testing:

Specimen Collection and Transport

Specimen: Serum

Request testing for hepatitis B surface antigen (HBsAg).

- Anti-HBc IgM positive indicates acute infection, usually disappears within 6 months but can persist in some HBV carriers (Heymann, 2008).
- Anti-HBc IgG positive indicates past infection.
- Consider the client's history and consult with the MHO as necessary.

### Immunization

- Immunize infants, children, and adults according to the recommended schedule in the Saskatchewan Immunization Manual Chapters 5 and 76,7
- Safer sex practices and other healthy lifestyle choices (piercings, tattooing, drug use).
- Standard precautions and routine precautions for handling blood and body fluids and biomedical waste management. Refer to the Saskatchewan Biomedical Waste Management Guidelines, 2008.

**Treatment: Mandated per Physician or ID Specialist. There is no treatment for Hepatitis B, but antiviral therapy may be indicated for some clients.**

<b>Interpretation of Hepatitis B laboratory results</b>				
<b>HBsAg</b>	<b>Anti-HBs</b>	<b>Total anti-HBc (IgM / IgG)</b>	<b>Possible Interpretation</b>	<b>Recommendation</b>
( - )	( - )	( - )	<ul style="list-style-type: none"> <li>• Never infected</li> <li>• Susceptible, if never vaccinated</li> <li>• Vaccine failure</li> </ul>	Immunize
( + )	( - )	IgM (+)	Early acute infection	Refer to MHO / ID Specialist
( - )	( + )	( + )	Past infection and immune	
( + )	( - )	IgG (+)	Chronic HBV infection	
( - )	( + )	( - )	Vaccinated / immune	

## Hepatitis C

### Testing:

Specimen Collection and Transport

Specimen: Serum

- Anti-HCV (antibody to hepatitis C) – marker for acute or chronic infection. This test does not distinguish between current and past infection.
- HCV RNA (RNA polymerase chain reaction [PCR] assay – ribonucleic acid) – Indicates active ongoing viral replication. Used to confirm active HCV infection and to measure viral load.

\*Reactive (positive) antibody tests require additional confirmatory RNA testing to diagnose current infection.

*Window period:* It may take 5 to 10 weeks for HCV antibodies to be detected in the blood following exposure. Repeat anti-HCV testing may be required.

### Treatment:

Hepatitis C is considered a curable infection.

Clients who test positive for Hepatitis C must be reported to the NITHA MHO and the treatment of hepatitis C infections is prescribed by or in consultation with a specialist with expertise in HCV treatment. A referral to nearest *Positive Care Program* in Prince Albert or Saskatoon is important (if client is agreeable) so that the processes for treatment can be initiated.

### Immunization:

Refer to Chapter 7: section 2.8 in the Saskatchewan Immunization Manual for immunization information.

## Human Immunodeficiency Virus (HIV)

### **Testing:**

Specimen Collection and Transport

Specimen: Serum or Plasma

- HIV combination test (which detect both HIV antibodies and the HIV p24 antigen). If a reactive result is present, the laboratory will conduct specialized confirmatory testing to ensure correct diagnosis of an HIV infection.
- HIV RNA (Viral Load test) - Can be used to assess patient prognosis by measuring baseline HIV-1 RNA level and as an aid in assessing viral response to antiretroviral treatment (<https://www.publichealthontario.ca/en/laboratory-services/test-information-index/hiv-viral-load>).
- CD4 – If client is HIV positive, a CD4 test may be ordered by physician. This test will identify the number of CD4/CD8 cells present and is an indicator of the strength of immune system. Viral replication depletes the CD4+ T cells to the level of profound immunosuppression, leading to opportunistic infections (<https://www.canada.ca/en/public-health/services/diseases/hiv-aids/health-professionals.html>).

*Window period:* Some patients will have a positive result as early as 15 to 20 days after HIV exposure. While most people will have an accurate test result three to six weeks after exposure, for a small number of people the window can be up to 12 weeks. This is why it is essential to advise patients to retest approx. 90 days after their exposure ([https://www.canada.ca/en/public-health/services/infectious-diseases/sexual-health-sexually-transmitted-infections/canadian-guidelines.html?utm\\_source=link&utm\\_medium=email&utm\\_content=en&utm\\_campaign=hc-sc-stbbi-21-22](https://www.canada.ca/en/public-health/services/infectious-diseases/sexual-health-sexually-transmitted-infections/canadian-guidelines.html?utm_source=link&utm_medium=email&utm_content=en&utm_campaign=hc-sc-stbbi-21-22))

### **Treatment:**

All patients that are HIV positive, after being given their diagnosis, should be referred to Prince Albert or Saskatoon's Positive Care Clinic for follow up care and treatment. Here they will be overseen by nurses and physicians experienced in HIV care or an infectious diseases specialist. Clients need to be agreeable to this referral as well.

Effective HIV treatment can be an important prevention strategy. People who adhere to ART and who achieve and maintain an undetectable viral load have effectively no risk of transmitting HIV sexually. Effective ART can also help prevent perinatal transmission of HIV (<https://www.canada.ca/en/public-health/services/diseases/hiv-aids/health-professionals.html>).

### **Immunization:**

Refer to Chapter 7; section 3.3 in the Saskatchewan Immunization Manual for immunization information.

Contact NITHA and ask for the HIV Strategy Coordinator or CD Nurse if needing support or information not covered in this directive: (306)953.5000

**Appendix A - Age of Consent to Sexual Activity**

The age of consent is the age at which a young person can legally agree to sexual activity. Age of consent laws apply to all forms of sexual activity, ranging from kissing and fondling to sexual intercourse.

All sexual activity without consent is a criminal offence, regardless of age.

These are serious offences that carry serious penalties, including mandatory minimum penalties.

Canada's age of consent

The age of consent to sexual activity is 16 years. In some cases, the age of consent is higher (for example, when there is a relationship of trust, authority or dependency).

In other words, a person must be at least 16 years old to be able to legally agree to sexual activity.

Close in age exceptions

A 14- or 15-year-old can consent to sexual activity as long as the partner is less than five years older and there is no relationship of trust, authority or dependency or any other exploitation of the young person. This means that if the partner is 5 years or older than the 14- or 15-year-old, any sexual activity is a criminal offence.

There is also a "close in age" exception for 12- and 13-year-olds. A 12- or 13-year-old can consent to sexual activity with a partner as long as the partner is less than two years older and there is no relationship of trust, authority or dependency or any other exploitation of the young person. This means that if the partner is 2 years or older than the 12- or 13-year-old, any sexual activity is a criminal offence.

Sexual exploitation

A 16- or 17-year-old cannot consent to sexual activity if:

- their sexual partner is in position of trust or authority towards them, for example their teacher or coach
- the young person is dependent on their sexual partner, for example for care or support
- the relationship between the young person and their sexual partner is exploitative

The following factors may be taken into account when determining whether a relationship is exploitative of the young person:

- the young person's age
- the age difference between the young person and their partner
- how the relationship developed (for example, quickly, secretly, or over the internet)
- whether the partner may have controlled or influenced the young person

Retrieved from <https://www.justice.gc.ca/eng/rp-pr/other-autre/clp/faq.html> April 27, 2023.

**REFERENCES:**

Department of Justice (2023). Age of Consent for Sexual Activity.

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