Ministry of Health

Ontario Public Health Standards:
Requirements for Programs, Services and Accountability

Infectious Diseases Protocol

Appendix 1: Case Definitions and Disease-Specific Information

Disease: Acquired Immunodeficiency Syndrome (AIDS)

Effective: June 2025

Ontario

Acquired Immunodeficiency Syndrome (AIDS)

☒ Communicable

☐ Virulent

Health Protection and Promotion Act (HPPA)[1]
Ontario Regulation (O. Reg.) 135/18 (Designation of Diseases)[2]

Provincial Reporting Requirements

☒ Confirmed case

☐ Probable case

As per Requirement #3 of the "Reporting of Infectious Diseases" section of the *Infectious Diseases Protocol, 2018* (or as current), the minimum data elements to be reported for each case are specified in the following:

- O. Reg. 569 (Reports) under the HPPA;[3]
- The iPHIS User Guides published by Public Health Ontario (PHO); and
- Bulletins and directives issued by PHO.

Type of Surveillance

Case-by-case

Case Definition

Confirmed Case of Human Immunodeficiency Virus (HIV) Infection

Children < 18 months:

- Detection of HIV nucleic acid (proviral deoxyribonucleic acid (DNA) and/or ribonucleic acid (RNA) or p24 antigen (p24 Ag) in two separate samples collected at different times.

OR

- Isolation of HIV in culture

Adults, Adolescents and Children ≥18 months:

- Detection of HIV antibody with confirmation by a validated laboratory-based method

OR

- Detection of HIV RNA by qualitative nucleic acid test

OR

- Detection of p24 antigen by serology

OR

- Isolation of HIV in culture

Confirmed Case of Acquired Immunodeficiency Syndrome (AIDS)

- Meets the case definition for a confirmed case of HIV

AND

- Definitive diagnosis of one or more AIDS indicative diseases (See Clinical Evidence section)

Clinical Presentation

HIV

HIV infection can generally be broken down into three distinct stages: primary acute infection, chronic asymptomatic stage, and chronic symptomatic infection, before progression to AIDS.[4] Depending on the stage of infection, an individual infected with HIV may be asymptomatic, may present with non-specific symptoms, or may present with an AIDS indicative disease.

Early testing, diagnosis and treatment for HIV are important factors in reducing morbidity and mortality associated with HIV infection and preventing disease progression to AIDS. Due to the high risk of transmission of HIV during the primary acute infection stage, clinicians should maintain a high index of suspicion in individuals with a non-specific febrile illness and/or a history of high-risk behaviour(s).[4,5]

AIDS

AIDS is a severe, life-threatening clinical condition and an advanced HIV-related disease. This syndrome represents the late clinical stage of HIV infection resulting from immune system exhaustion and chronic inflammation, leading to one or more opportunistic infections and cancers, of which bacterial pneumonia is one of the common presentations.[6] Indicator diseases for AIDS are listed under Clinical Evidence.

Clinical Information

Clinical Evidence

HIV

Primary acute infection - If present, symptoms generally appear 2 to 4 weeks after exposure and can last up to two weeks. Symptoms may include: fever, fatigue, myalgia (muscle pain), arthralgia (joint stiffness), rash, headache, sore throat, generalized lymphadenopathy (swollen lymph nodes), night sweats, oral ulcers and/or genital ulcers, weight loss, and gastrointestinal symptoms (e.g., nausea, vomiting or diarrhea).[7]

Chronic asymptomatic infection - Viral replication and plasma viremia are more controlled by the immune response represented by the level of CD4+ T cells. Individuals may be free of clinical signs or symptoms, though generalized lymphadenopathy and/or thrombocytopenia may be present. Disease progression varies but can last years.

Chronic symptomatic infection – This stage is characterized by high levels of viral replication, plasma viremia, a depressed CD4+ T cell count, and viral shedding from mucosal sites. Symptoms and conditions include: oral hairy leukoplakia, unexplained fever, fatigue or lethargy, unexplained weight loss, chronic diarrhea, unexplained lymphadenopathy, cervical dysplasia, dyspnea and dry cough, loss of vision, recurrent or chronic candida infection (oral, vaginal), dysphagia, red/purple nodular or mucosal lesions, herpes zoster (especially if severe, multidermatomal or disseminated), unexplained “anemia of chronic disease,” and increased frequency or severity of mucocutaneous herpes simplex infection.[8]

AIDS

AIDS Indicative Diseases for Adult and Pediatric Cases:

- Bacterial pneumonia (recurrent)*
- Candidiasis (bronchi, trachea or lungs)
- Candidiasis (esophageal)
- Cervical cancer (invasive)
- Coccidioidomycosis (disseminated or extrapulmonary)

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* These conditions may be diagnosed presumptively; otherwise, definitive diagnosis is required.

- 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 virus: 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
- Lymphoma, immunoblastic (or equivalent term)
- Lymphoma (primary in brain)
- *Mycobacterium avium* complex or *M. kansasii* (disseminated or extrapulmonary)
- *Mycobacterium* of other species or unidentified species
- *M. tuberculosis* (extrapulmonary or pulmonary)
- *Pneumocystis jirovecii* pneumonia* (formerly known as *Pneumocystis carinii*)
- Progressive multifocal leukoencephalopathy
- *Salmonella* septicemia (recurrent)
- Toxoplasmosis of brain
- Wasting syndrome due to HIV

AIDS Indicative Diseases that only apply to Pediatric Cases (<15 years old):

- Bacterial infections (multiple or recurrent, excluding recurrent bacterial pneumonia)
- Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia

Laboratory Evidence

Laboratory Confirmation

For laboratory confirmation, refer to Case Definition section.

Approved/Validated Tests

- Antibody detection: Anti-HIV-1/Anti-HIV-2
    - Laboratory based tests (e.g., chemiluminescent microparticle immunoassay [CMIA], enzyme immunoassay [EIA], line immunoassay [LIA], immunochromatographic test)
- Non-laboratory based tests (e.g., point-of-care [POC], rapid tests)
- Qualitative nucleic acid test (e.g., PCR)
- Antigen detection: HIV p24 Ag test
- Proviral DNA PCR assay
- Standard HIV culture

Indications and Limitations

In children <18 months of age born to a person living with HIV, nucleic acid testing should be done within 2 weeks (or within 48 hours for those at high risk of perinatal transmission) after birth and, if negative, repeated at 1 to 2 months and at 3 to 4 months of age. If any of these test results are positive, a second specimen should be collected as soon as possible for confirmation. For infants born to a person living with HIV, maternal antibodies persist for up to 18 months, thus antibody testing should not be used for HIV diagnosis for children <18 months of age.[9,10]

The time after which HIV is detectable in blood following initial infection varies depending on the test that is used.[4,7]

- Point of care tests are able to detect HIV-antibodies as early as three to four weeks and in 99.6% of people 3 months after exposure.
- Fourth-generation antigen/antibody combination tests reduce the window period to two to three weeks and can detect >99% of people infected with HIV six weeks after exposure.
- HIV PCR tests can detect HIV RNA ~10 days after infection and may be useful to support an HIV diagnosis in specific scenarios.

For further information about HIV diagnostic testing, contact Public Health Ontario and/or refer to PHO Laboratory HIV Test Information Sheet.[11]

Case Management

In addition to the requirements set out in the Requirement #2 of the “Management of Infectious Diseases – Sporadic Cases” and “Investigation and Management of

Infectious Disease Outbreaks" sections of the *Infectious Diseases Protocol, 2018* (or as current), the board of health shall primarily focus on:

- Encouraging the case to connect to care in order to initiate highly active antiretroviral therapy (ART) and achieve viral suppression (if not already on ART).
- Counselling the case on the importance of attending medical appointments and assessing potential barriers to remaining engaged in care.
- Referral(s) to community support agencies and mental health services as required.
- Counselling on strategies to lower the risk of onward HIV transmission (e.g., treatment as prevention, condom use) and offer support and resources when barriers to utilizing these strategies exist.
- Counselling on disclosure of HIV status when there is a "realistic possibility of transmission" including to sexual and drug equipment sharing partners.[12] Offer support and resources when barriers to disclosure have been identified. Health units may also offer information on legal resources available to people living with HIV in Ontario.[13]
- Counselling against donating blood or blood products.

For case management refer to the following documents:

- PIDAC Sexually Transmitted Infections Case Management and Contact Tracing Best Practice Recommendations (2009, or as current);[14]
- *Sexual Health and Sexually Transmitted/Blood-Borne Infections Prevention and Control Protocol, 2018* (or as current);[15]
- Complementary resources and professional development - HIV;[16] and
- Canadian Guidelines on Sexually Transmitted Infections (2018, or as current).[17]

Contact Management

For identified contacts of an HIV case, the board of health shall primarily focus on:

- Counselling on post-exposure prophylaxis (PEP) and referral to a healthcare provider as appropriate.
- Counselling on post-exposure testing for HIV and other sexually transmitted and blood borne infections as per clinical guidelines.[7]
- Counselling on pre-exposure prophylaxis (PrEP) for future HIV exposure prevention and referral to care if appropriate.[18]

For contact management and the development of partner notification strategies with individuals, refer to the following documents:

- PIDAC Sexually Transmitted Infections Case Management and Contact Tracing Best Practice Recommendations (2009, or as current);[14]
- *Sexual Health and Sexually Transmitted/Blood-Borne Infections Prevention and Control Protocol, 2018* (or as current);[15]
- Canadian Guidelines on Sexually Transmitted Infections (2018, or as current);[17] and
- Ontario Guidelines for Providers Offering HIV Testing (2023, or as current).[7]

Outbreak Management

Not applicable.

Prevention and Control Measures

Personal Prevention Measures

Measures include:[7,19]

- Persons at risk for HIV should be counselled regarding HIV pre-exposure prophylaxis (PrEP) and/or post-exposure prophylaxis (PEP) and offered a referral to a healthcare provider as appropriate.
- Provide education and communicate positive messaging to persons, especially those presenting with concerns about HIV infections, about HIV transmission, the benefits of early diagnosis, available treatments and improved disease prognosis for those who achieve viral suppression.
- Provide counselling on safer sex/drug use practices, including proper use of barrier (e.g. condom) methods, use of HIV PrEP, and risk reduction with injection drug use (e.g. use of clean needles, avoid sharing needles).
- Persons with known risk behaviors and clinical indications should be offered HIV screening, with appropriate pre and post-test counselling, and referral if necessary. People at high risk of acquiring HIV should be counselled to test more frequently.[7] Counselling should be age appropriate and individualized to the person being tested.
- All pregnant people should be offered confidential HIV testing and counselling as part of a routine prenatal care for each pregnancy.
- Treatment as Prevention (TasP): individuals diagnosed with HIV should be

referred to a healthcare provider to initiate treatment, with the goal of viral suppression and prevention of sexual transmission of HIV.

For recommendations on testing and contact management refer to the following documents:

- *Sexual Health and Sexually Transmitted/Blood-Borne Infections Prevention and Control Protocol, 2018* (or as current);[15]
- Canadian Guidelines on Sexually Transmitted Infections (2018, or as current);[17] and
- Ontario Guidelines for Providers Offering HIV Testing (2023, or as current);[7]

For more information on counselling and education refer to the following documents:

- Ontario Guidelines for Providers Offering HIV Testing (2023, or as current);[7]
- PIDAC Sexually Transmitted Infections Case Management and Contact Tracing Best Practice Recommendations (2009, or as current);[14]
- *Sexual Health and Sexually Transmitted/Blood-Borne Infections Prevention and Control Protocol, 2018* (or as current);[15]
- Canadian Guidelines on Sexually Transmitted Infections (2018, or as current);[17] and
- *Substance Use Prevention and Harm Reduction Guideline, 2018* (or as current).[20]
- Canadian guideline on HIV pre-exposure prophylaxis and nonoccupational postexposure prophylaxis (2017, or as current).[18]

Infection Prevention and Control Strategies

- Routine practices are recommended for contact with bodily fluids., including with needlestick injuries.[21]

Disease Characteristics

Aetiologic Agent - Human immunodeficiency virus (HIV) is a retrovirus of which two types have been identified: type 1 (HIV-1) and type 2 (HIV-2). They are serologically and geographically distinct but have similar epidemiological characteristics.[6]

Modes of Transmission - Person to person transmission through: condomless sexual intercourse; mucosal contact with infected body fluids including: vaginal, seminal, and anal fluids, blood, breast milk and cerebral spinal fluid (CSF); the use of HIV-contaminated needles and syringes and some drug paraphernalia, including sharing by people who inject drugs and accidental contact with contaminated sharps (e.g., needlestick injuries); transfusion of infected blood or its components; organ and tissue transplants; mother to child transmission; and contact of broken skin or mucosa with body secretions such as blood, CSF or semen.[6]

Certain exposures are more likely to result in HIV transmission than others. A more detailed description of HIV transmission is available in “HIV Transmission: A Summary of the Evidence.”[22] Updated information with a focus on biological risk and transmission through sexual activity is available in the Canadian AIDS Society publication, “HIV Transmission: Factors that Affect Biological Risk”; as well as in the other resources and references listed below.[23]

Incubation Period - HIV and AIDS,

Symptoms of an acute HIV infection typically appear 2 to 4 weeks after exposure.[7]

In the absence of treatment, the time from HIV infection has an observed range of less than one year to 15 years or longer.[6]

Period of Communicability – Communicability begins early after HIV infection, highlighting the importance of initiating treatment as soon after diagnosis as possible. Highly active antiretroviral therapy (ART) can be started prior to receiving drug-resistance testing (i.e. therapy can be later modified based on drug-resistance results).

Infectivity during the early stages of infection is considered to be high and increases with higher viral load, worsening clinical status and with the presence of other sexually transmitted infections (STIs).[6]

Advances in HIV treatment have slowed disease progression to the degree that HIV infection is now understood to be a chronic, manageable condition, in which people can live healthy, long and active lives. Early diagnosis and initiation of treatment can lead to reduced communicability associated with HIV infection and disease progression.[4]

Individuals living with HIV who are on treatment and achieve viral load suppression <200 copies/mL ***cannot*** sexually transmit HIV to others. This is the basis for the health promotion campaigns of "U=U" (which stands for "Undetectable† = Untransmittable") and more recently "U = 0" (which stands for "Undetectable = Zero transmission risk").[24,25] Untransmittable or zero-transmission risk status is achieved after two consecutive viral load tests of < 200 copies/mL over a 6-month period. To retain this status, an individual living with HIV needs to maintain their viral load below 200 copies/mL by continuing treatment and ensuring that they have a viral load test every 4 to 6 months that continues to show a viral load of < 200 copies/mL. By openly discussing the U=U/U=0 message as part of general sexual health messaging, public health professionals can dismantle HIV-related stigma and discrimination, and help normalize and promote sexual health.[24]

Reservoir - Humans

Host Susceptibility and Resistance - Presumed to be general. Inflammation and/or mucous membrane micro-tears at the site of HIV exposure may increase host susceptibility. This includes the presence of other STIs, especially if ulcerative (e.g., herpes, syphilis, lymphogranuloma venereum).[6]

Epidemiology

Please refer to Public Health Ontario's Infectious Disease Trends in Ontario and the Ontario HIV Epidemiology and Surveillance Initiative for the most up-to-date information on HIV trends in Ontario.[26,27]

For additional national and international epidemiological information, please refer to the Public Health Agency of Canada and the World Health Organization.

† An undetectable viral load means that the level of HIV in a person's blood cannot be detected using standard laboratory tests. While a threshold of 200 copies/mL is used to define "undetectable" in the context of U=U, advances in testing have allowed for viral detection below 200 copies/mL.

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Document History

Revision Date	Document Section	Description of Revisions
March 2025	Entire Document	Case Definitions: Updated to reflect new testing algorithms. HIV – Children <18 months: Change from two separate samples collected “at one month and four months after delivery’ to “at different times”. HIV - Adults, Adolescents and Children ≥ 18 months: Addition of “Detection of HIV RNA by qualitative nucleic acid test”. AIDS: Change from “A positive test for HIV infection with confirmation” to “Meets the case definition for a confirmed case of HIV”. Clinical Presentation: Updated Clinical Evidence: Minor updates Laboratory Evidence: Updated Indications and Limitations: Updated Case Management: Updated Contact Management: Updated Prevention and Control Measures: Updated Infection Prevention and Control Strategies: Updated Disease Characteristics: Updated References: Updated
April 2022	Entire Document	New template. Appendix A and B merged. No material content changes.

Revision Date	Document Section	Description of Revisions
April 2022	Epidemiology: Occurrence section	Removed.
April 2022	ICD Codes	Removed.