

Certified Practice

DST 900 Assessment and Diagnostic Guideline: Sexually Transmitted Infections (STI)

Registered Nurses who hold Certified Practice designation (RN(C)) in **Reproductive Health (Sexually Transmitted Infections)** are authorized to manage, diagnose, and/or treat the following STI conditions:

- Chlamydia Trachomatis
- Neisseria Gonorrhoea
- Mucopurulent Cervicitis
- Trichomoniasis
- Bacterial Vaginosis
- Urethritis
- Recurrent Urethritis
- Lower Urinary Tract Infection
- Genital Warts

In addition to the above conditions, RN(C)s with **Reproductive Health (Sexually Transmitted Infections)**, are authorized to treat contacts of sexually transmitted infections. This Guideline supports RN(C)s in conducting assessments and screening and/or diagnostic tests to manage, diagnose, and treat STI conditions under the Certified Practice framework. A glossary of terms can be found in *Appendix A*.

RN(C)s must ensure they complete and document their clinical reasoning through assessments according to regulatory practice standards and their practice setting requirements.

Within the scope of nursing practice with clients of all genders experiencing or at risk for STI, comprehensive assessment includes a sexual health history, a risk assessment, a physical assessment, and screening and/or diagnostic tests. Use of an interpreter is recommended in instances where the clinician does not adequately speak the language of the client.

Guided by three foundational principles, this document applies an equity lens to STI assessment. Through these three principles, the DST takes a new direction toward accommodating and providing more equitable, inclusive, and affirming care for all clients, especially for transgender, gender-diverse, sexually diverse and two-spirit peoples. This is of particular importance as inequities are associated with negative stereotypes often leading to higher rates of STIs and non-disclosure of information. As a consequence, this may hinder relevant

testing, diagnosis, treatment, and the provision of targeted client education. The principles below aim to direct clinician-consideration of the diversity in bodies, of the client, their culture, their gender, their sexuality, and their context-specific needs when providing services.

- Cultural safety that is trauma- and violence-informed
- Knowledge and understanding of the burden of disease as it relates to the social determinants of health (SDOH) and syndemics
- Creative and flexible service provision

The decision to perform a sexual health history may be client-initiated (e.g., client-request, client-reported symptoms, or concerns) or clinician-initiated. If a pelvic examination is required as part of the physical assessment, RN(C)s must follow [PHSA's Pelvic Exam DST](#) (indicated for clients aged 14 years and up). The following criteria apply when providing STI certified practice care:

- Consultation and/or referral with a physician or nurse practitioner (NP) is required for:
 - All clients 11 years and under
 - Symptomatic clients aged 12-13 years
 - All pregnant clients
 - All breast/chest-feeding clients, depending on required and recommended treatment (see *Consultation and/or Referral* section of the applicable DST)

Visual Summary of Guideline

1. STI History (pages 3-6)

- Factors associated with STI acquisition
- Signs and symptoms associated with STIs
- Sexual health history
- Risk assessment

2. Physical Assessment (when indicated) (pages 6-7)

- Head to toe
- Additional physical assessments

3. Screening and Diagnostic Tests (pages 7-15)

- Methods of specimen collections
- Site-based STI testing options

STI History

Factors Associated with STI Acquisition

Listed below are factors associated with STI acquisition based on syndemic and epidemiological data, and/or social conditions that sustain vulnerability and likelihood of exposure to STI.

- Any sexual activity with blood and/or body fluid exchange
- Any sexual activity with skin-to-skin contact
- Non-use or failure of barriers for oral, genital, and/or anal sex (e.g., condoms, dental dams, etc.)
- Sharing sex toys without condoms and/or not cleaning between use
- Sexual activity where there is possibility of oral-fecal transmission (e.g., rimming, anal play, etc.)
- Previous history of STI
- Sexual contact with someone with an STI
- Anonymous sexual partner(s) (e.g., internet, bath house, play parties, etc.)
- Trade of money, goods, drugs, food, and/or shelter for sex
- Rough sex causing mucosal tearing
- Survivors of sexual assault and sexual abuse
- Sexually active youth under 25 years of age
- Substance use, such as alcohol or chemicals, in association with having sex
- Sharing drug use paraphernalia: pipes, intra-nasal, and injecting equipment

Signs and Symptoms Associated with STIs

- Often asymptomatic presentation
- Abnormal urethral, genital and/or rectal discharge
- Pain with intercourse (dyspareunia)
- Urinary abnormality – dysuria, frequency, urgency, colour, odour
- Anogenital irritation and inflammation
- Anogenital lesions
- Bleeding with intercourse or between menstrual cycles
- Fever, lower back pain, deep dyspareunia

Sexual Health History

A sexual health history is the first component of a comprehensive assessment. When conducting a sexual health history, it is necessary to consider the potential for past and present experiences of bias, judgement, violence, and trauma, both from an interpersonal and a systemic perspective. Assessments are tailored-based

on the information a client discloses (implicit or explicit) about their experiences, exposures, sexual activities, and other risk identifiers. The sexual health history focuses on information relevant to sexual health, and may include:

- Client concerns
- Demographic information and methods of contacting client
- Assessment of signs and symptoms
- Onset
- Duration and frequency
- Location
- Symptom radiation to adjacent areas
- Severity
- Precipitating and aggravating factors
- Relieving factors
- Associated symptoms
- Effects on daily activities
- Previous treatments and outcomes
- Immunization history (e.g., hepatitis A, B, and HPV)
- Recent antibiotic use (i.e., date of last dose, reason for use)
- Other medications: prescription and over the counter (OTC)
- Allergies (e.g., latex, antibiotics, and other medications)
- Medical conditions (i.e., renal or liver diseases, GI disease, cardiac, etc.)
- Sexual contact(s)
- Barrier use (e.g., condoms, dental dams, etc.)
- Body sites of possible exposure
- Sexual partners (number, sites of exposure, gender, and most recent sexual contact)
- Previous STI testing and results
- Previous HIV testing and results
- Drug and alcohol use/practices
- Named as an STI contact
- Surgical history (e.g., hysterectomy, vaginoplasty, metoidioplasty, genital cutting, etc.)
- Use of gender-affirming hormones
- Recent (within 28 days) history of sexual assault (refer to [PHSA's Prophylaxis Post Sexual Assault DST](#))
- Previous and/or current use and/or knowledge of HIV post-exposure prophylaxis (PEP) and/or pre-exposure prophylaxis (PrEP)

- Reproductive health history
- Pap/cervical screening and results
- Date of last menstrual period
- Regularity of menses, signs and symptoms associated with menses, was last menses normal?
- Pregnancy (risk, intent or current)
- Contraception and emergency contraception (including satisfaction with contraception)
- Testicular health
- Breast/chest health

Risk Assessment

Building on information collected in the sexual health history, risk assessments provide information regarding the likelihood of exposure to STI. This type of assessment supports clinical judgment regarding:

- Screening and diagnostic tests
- Body sites for specimen collection
- Partner notification and referral services
- Client education
 - Risk assessment draw from essential knowledge regarding modes of STI transmission, and in particular, the relationships between modes of transmission, sites of exposure (e.g., rectum, oropharynx, genitals), and syndemic evidence for specific populations. While sexual orientation and/or gender may be helpful to clarify sexual behaviours and sites of exposure, they should not be the primary means by which to inform clinical judgement. In and of themselves, they are not risk factors for STI acquisition.

In addition to sexual health history, components of the risk assessment include:

- Date of last sexual contact (to inform window periods and potential need for future testing) and whether this was consensual or not
- Frequency of partners and nature of relationship (e.g., casual, regular, anonymous, etc.)
- Gender of contacts (e.g., male, female, transgender, two-spirit, gender-diverse, unsure/questioning, prefer not to answer, etc.)
- Feasibility of contacting sexual partners should they require notification, testing and/or treatment
- How sexual contacts are met (e.g., internet, commercial sex establishments, mobile phone apps, bath houses, etc.) and safety measures when meeting
- Sexual and drug use practices of sexual contacts (if known)
- STI and HIV status of sexual contacts (if known)

- Possible exposure to blood borne infections (e.g., needle stick, shared drug paraphernalia) and/or accidental exposures (i.e., exposure to blood during a fight)
- Candidate for and/or client-request for HIV PrEP (see <https://www.bccfe.ca/hiv-pre-exposure-prophylaxis-prep>)
- Candidate for PEP with high-risk exposure within past 72 hours (see <https://www.bccfe.ca/post-exposure-prophylaxis>)

Physical Assessment (when indicated)

The physical assessment is a head-to-toe approach in which the clinician uses inspection and palpation to assess potential sites of infection. Physical assessment may include:

- Inspection of the mouth and throat (e.g., for lesions, redness, swelling)
- Inspection of the trunk, forearms and palms (e.g., for signs of rash, lesions)
- Inspection of the external genital, pubic, and perianal areas, (e.g., for bleeding, discharge, irritation, lesions, rash, etc.)
- Palpitation of the inguinal nodes (for swelling/tenderness)

Additional Physical Assessments

Penile and Scrotal Anatomy (if applicable)

- Inspection of urinary meatus for:
 - Redness and/or swelling
 - Discharge (e.g., mucoid, mucopurulent, purulent)
- Palpitation of testicles for tenderness or abnormal lumps
- If the client is symptomatic or urethral discharge is noted at the meatus, refer to applicable *Care and Treatment Plan* and the Site-based STI Testing Options table in this document.

Vulvar and Vaginal Anatomy (if applicable)

For internal pelvic exams, refer to [PHSA's Pelvic Exam DST](#)

- Inspect vulva (e.g., redness, swelling, lesions, etc.), introitus, and vagina (e.g., redness, swelling, lesions, hypergranulation)
- Assess vaginal discharge for:
 - Amount, consistency, colour, and odour (e.g., copious, mucoid, purulent, thick, frothy, malodorous, amine odour)

- pH if indicated
- Presence of foreign object (i.e., tampon, condom, drugs, etc.)
- Bimanual exam:
 - Cervical motion tenderness (CMT)
 - Adnexal tenderness and or masses
 - Fundal tenderness and or fullness

Screening and Diagnostic Tests

As part of routine screening, all clients should be offered gonorrhea, chlamydia, syphilis, and HIV testing. In addition to this routine screening, further diagnostic testing is completed based on a client's sexual health history, risk assessment, and presentation of symptoms, such as abnormal genital/urethral symptoms (e.g., discharge, irritation), genital ulcers, lesions, and the sites of the body potentially exposed to infection.

For hepatitis serology refer to *Appendix B: Hepatitis A, B, & C Serology*

Methods of Specimen Collections

1. Throat swabs

- Clinician- or client-collected

2. Urine specimens

GC/CT and/or trichomonas vaginalis (T. vaginalis or TV) (for further information on testing requirements, refer to *DST 909: Care and Treatment Plan – Trichomoniasis*)

- Client should not have voided in the previous 1-2 hours
- Collect approximately 10-20ml of first-pass urine
- Used when cervical or vaginal specimens are not desired or appropriate
- Preferred for clients who have undergone vaginoplasty or hysterectomy
- Urine dipstick, urinalysis (micro and/or macroscopic), and/or urine culture & sensitivity (C&S) as indicated by the *DST 910: Care and Treatment Plan – Uncomplicated Lower UTI*
- Urine pregnancy test if indicated

3. Urethral specimens

- When visible discharge is present at the meatus, collect discharge (ask client to milk if necessary); insertion of the swab into the urethra is not required

Collect smear for typical intracellular diplococci (TID) and polymorphonuclear leukocytes (PMNs) (if immediate microscopy available) and GC C&S, for symptomatic clients with visible meatal discharge

4. Vaginal specimens

- Clinician- or client-oriented
- Depending on agency lab kits, validation, and facility guidelines, any of the following diagnostic tests may be used for vaginal specimens:
 - Nugent score/gram stain for bacterial vaginosis (BV)
 - Vaginal smear for BV and yeast
 - Gram stain or culture for yeast and/or *T. vaginalis*
 - *T. vaginalis* NAAT
 - *T. vaginalis* antigen detection (if available)
 - *T. vaginalis* C&S (if applicable)
 - Wet-mount of *T. vaginalis*; wet-mount and/or clue cells, BV, and/or yeast if immediate microscopy available
 - GC/CT NAAT
 - Vaginal pH
 - Vaginal KOH whiff test (if available, see *Safe Use of 10% Potassium Hydroxide in STI Screening* located in the *BCCDC Communicable Disease (CD) Manual Chapter 5: Sexually Transmitted Infections*)
- Vaginal specimens are indicated with any of the following:
 - Abnormal odour
 - Abnormal vaginal discharge
 - Vaginal irritation and/or inflammatory disease
 - Symptoms of pelvic inflammatory disease (PID)
 - Clients determined to be at potential higher risk (based on risk assessment)

5. Cervical Specimens

- May be indicated in the following:
 - Pap/cervical screening test
 - Symptoms (e.g., lesion)
 - GC C&S
 - Pelvic or internal exam

6. Rectal Swabs

- Clinician- or client-collected

Site-Based STI Testing Options

Certified Practice Testing Options for Site-Based STI Screening			
<p>All clients testing for STIs should be offered tests for the following:</p> <ul style="list-style-type: none"> • Gonorrhea (GC) • Chlamydia (CT) • Syphilis • HIV 			
Site	Asymptomatic	Symptomatic	Notes
Throat	GC/CT NAAT (when indicated; see notes)	GC C&S	Collect C&S first, then NAAT for contacts to GC (asymptomatic and symptomatic clients).
		GC/CT NAAT	Indicated for clients who have given oral sex on a penis.
Site	Asymptomatic	Symptomatic	Notes
Penile urethra (with or without phalloplasty or metoidioplasty with urethral lengthening)	GC/CT NAAT urine	GC C&S	Collect visible discharge from the meatus (ask client to <i>milk</i> if necessary); insertion of the swab into the urethra is <i>not</i> required.
		Smear (of meatal discharge) for TID and PMN	Recommended but may not be offered in all clinical settings (only where immediate microscopy is available).
		GC/CT NAAT urine	
Site	Asymptomatic	Symptomatic	Notes
Vagina with cervix	GC/CT/Trich NAAT: vaginal (preferred) OR cervical OR urine	GC C&S: cervical (preferred) OR vaginal	Collect C&S first, then NAAT for contacts to GC

<p>Refer to PHSA’s non-certified practice, Pelvic Exam DST</p>	<p>Pap/cervical screening if indicated</p>	<p>GC/CT/Trich NAAT vaginal (preferred) OR cervical OR urine</p>	<p>(asymptomatic and symptomatic clients)</p>
		<p><i>T. vaginalis</i> NAAT vaginal (preferred) OR cervical OR urine</p>	<p>Samples that are obtained for <i>T. vaginalis</i> NAAT and processed by the BCCDC Public Health Laboratory (BCCDC PHL), will be done using the same sample (cervical/vaginal swab or urine) submitted for GC and CT testing. NB: refer to <i>DST 909: Care and Treatment Plan: Trichomoniasis</i> for further testing options if indicated</p>
		<p>Vaginal smear for BV and yeast</p>	<p><i>If on testosterone:</i> Refer for comprehensive yeast and bacterial culture. <i>If not on testosterone:</i> Nugent score/gram stain or clue cells (Amsel’s Criteria).</p>
		<p>Vaginal pH</p>	<p>pH strips are ineffective in the presence of blood.</p>
		<p>Vaginal KOH whiff test</p>	<p>For BV, clinical diagnosis can be by either a positive KOH whiff test OR if obvious amine odour in the absence of such a test.</p>
		<p>Testing options if applicable/indicated:</p>	
		<p>Urine dipstick and/or urinalysis</p>	<p>Refer to <i>DST 910: Care and Treatment Plan:</i></p>

		with suspected lower UTI	<i>Uncomplicated Lower UTI</i> to rule-out complicated lower UTI for consultation/referral information. If pt is menstruating, RBCs will be inaccurate.
		Pap/cervical screening	Cannot do when patient is menstruating
		Urine pregnancy test	Consider window periods. Possible false positive within 4 weeks of therapeutic abortion, spontaneous abortion, and delivery.
Site	Asymptomatic	Symptomatic	Notes
Vaginal after hysterectomy (no cervix) Refer to PHSA’s non-certified practice Pelvic Exam DST and the BCCA <i>Screening of the Cervix</i> to determine recommendations for clients with removal of cervix	GC/CT/Trich NAAT: urine (preferred) OR vaginal	GC C&S: vaginal	Collect C&S first, then NAAT for contacts to GC (asymptomatic and symptomatic clients).
		GC/CT/Trich NAAT: urine (preferred) or vaginal	
		<i>T. vaginalis</i> NAAT (if not done with GC/CT) vaginal OR urine	Samples obtained for <i>T. vaginalis</i> NAAT, and processed by the BCCDC PHL, will be done using the same sample (cervical/vaginal swab or urine) submitted for GC and CT testing. NB: Refer to the <i>DST 909:Care and Treatment Plan: Trichomoniasis</i> for further testing options.

		Vaginal smear for BV and yeast	<p><i>If on testosterone:</i> Refer for comprehensive yeast and bacterial culture.</p> <p><i>If not on testosterone:</i> Nugent score/gram stain or clue cells (Amsel’s Criteria).</p>
		Vaginal pH	pH strips are ineffective in the presence of blood.
		Vaginal KOH whiff test	For BV, clinical diagnosis can be by either a positive KOH whiff test OR obvious amine odour in the absence of such a test.
		Testing options if applicable/indicated:	
		Urine dipstick and/or urinalysis with suspected lower UTI	Refer to <i>DST 910: Care and Treatment Plan: Uncomplicated Lower UTI</i> to rule-out complicated lower UTI for consultation/referral information.
Site	Asymptomatic	Symptomatic	Notes
<p>Vagina after vaginoplasty</p> <p>If pain, discharge, or bleeding occur in the early post-operative period, consult with an experienced clinician:</p> <ul style="list-style-type: none"> • RACE line: 604.696.2131 or 	GC/CT/Trich NAAT urine	GC/CT/Trich NAAT urine	
		<i>T. vaginalis</i> NAAT (if not done with GC/CT NAAT) urine	Samples that are obtained for <i>T. vaginalis</i> NAAT, and processed by the BCCDC PHL, will be done using the same sample (urine) submitted for GC and CT testing.

toll-free 1.877.696.2131; select “Transgender Health” <ul style="list-style-type: none"> • Trans Care BC: 1.866.999.1514 or transcareteam@p hsa.ca 		Testing options if applicable/indicated:	
		Urine dipstick and/or urinalysis with suspected lower UTI	Refer to <i>DST 910: Care and Treatment Plan:</i> <i>Uncomplicated Lower UTI</i> to rule-out complicated lower UTI for consultation/referral information.
		Refer and/or consult for comprehensive yeast and bacterial culture	Clients who have had vaginoplasty require a comprehensive yeast and bacterial culture to diagnose bacterial vaginosis.
Site	Asymptomatic	Symptomatic	Notes
Rectum	GC/CT NAAT	GC C&S	Collect C&S first, then NAAT for contacts to GC (asymptomatic and symptomatic clients).
		GC/CT NAAT	Indicated for clients who have had receptive anal penetration (including penetrative sex with toys).
		HSV PCR	
Site	Asymptomatic	Symptomatic	Notes
Genital and/or oral ulcers or lesions Note: All syphilis lesion specimens should be accompanied by serology (see below).		HSV PCR swab of the lesions(s)	
		CT NAAT for LGV	Refer to a physician or NP for all clients who present with suspected LGV.
		Syphilis PCR (for oral or genital lesions) swab of the lesion(s)	Write “for T. Pallidum PCR” on the requisition.

		Direct fluorescent antibody testing (DFA) (not appropriate for oral lesions)	Secretions from a lesion mounted onto a slide and sent to the lab for examination.
		Dark-field microscopy	Only available at specific sites.
Site	Asymptomatic	Symptomatic	Notes
Venipuncture (blood draw)	Syphilis EIA	Syphilis EIA	Serology for syphilis screening is indicated on the lab requisition as syphilis (non-prenatal), syphilis antibody TPE. The diagnostic platform is an enzyme immune assay (EIA). If the EIA is reactive, further confirmatory testing will be automatically completed by the lab.
	HIV Ag/Ab (4 th generation)	HIV (Ag/Ab 4 th generation)	If acute HIV infection is suspected, contact the medical microbiologist on call at BCCDC (604.661.7033) to discuss if HIV RNA testing is an option.
	HIV point-of-care (POC) (Ab 3 rd generation)	HIV POC (Ab 3 rd generation)	POC involves finger-prick blood specimen (not venipuncture per se); see BC Point of Care HIV Testing Program website for further information.
		HSV IgG; HSV type-specific serology (TSS)	Please refer to the Herpes Simplex Virus (HSV) DST for more information and specific indications in serologic screening for the following:

			<p>HSV IgG: Indicates HSV antibodies only and does not differentiate between HSV 1 and HSV 2 HSV TSS: some areas may have access to HSV TSS through their local labs (generally there is a fee charged to clients by the lab for this test).</p>
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More recent editions of any of the items in the References List may have been published since this DST was published. If you have a newer version, please use it.

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Appendix A

Glossary of Terms

Accommodation: A principle about structuring and designing for inclusiveness, adjustments made to policies, programs, and/or practices to enable individuals to benefit from and participate in the provision of services equally.

Equity: The practice of ensuring fair, inclusive, and respectful treatment of all peoples, with consideration of individual and group diversities. Equity honours and accommodates the specific needs of individuals/groups.

Gender: Socially and culturally constructed roles, behaviours, actions, expressions, roles, and identities linked to girls, women, boys, men, transgender, gender-diverse, and two-spirit peoples.

Gender-diverse: Gender roles and/or expressions that do not follow social and cultural expectations, norms, and stereotypes of gender. People who are gender-diverse may or may not identify as transgender; sometimes also referred to as gender nonconforming, gender-variant, etc.

Hypergranulation: Occurs when there is an extended inflammatory response and characterised by the appearance of light red or dark pink flesh that can be smooth, bumpy, or granular. Most commonly present beyond the surface of incision sites post-vaginoplasty.

Hysterectomy: A surgical procedure to remove all or part of the uterus, and sometimes the cervix; is also a gender-affirming, masculinizing lower surgery.

Inclusive: an approach that aims to reach-out to and include all people, honouring the diversity and uniqueness, talents, beliefs, backgrounds, capabilities, and ways of living of individuals and groups.

Metoidioplasty: A gender-affirming, masculinizing, lower surgery to create a penis and scrotum, done by cutting ligaments around the clitoris to add length to the shaft, grafting skin around the shaft to create added girth, lengthening the urethra so one can urinate from the shaft, and creating a scrotum.

Phalloplasty: A multi-phase gender-affirming, masculinizing, lower surgery to create a penis and scrotal sac, testicular implants, and implants to obtain rigidity/erection.

Syndemic: For the purpose of this guideline, syndemics is the presence of two or more epidemics interacting and creating an increase in disease burden based on social conditions that sustain vulnerability. Syndemics generally occur when health-related changes cluster by person, place, or time.

Transgender: An umbrella term used to describe anyone whose gender identity differs from the gender they were assigned at birth, including transgender people with binary and non-binary identities.

Two-spirit: Taken during colonization, two-spirit is being reclaimed as a term used within some Indigenous communities to encompass sexual, gender, cultural, and/or spiritual identities. It reflects complex understandings of gender and sexuality, and the long history of sexual- and gender-diversity that is specific to each nation. Two-spirit is different than identifying as LGBTQ+ and being indigenous due to the cultural, spiritual, and historical contexts of this identity.

Vaginoplasty: A gender-affirming, feminizing, lower surgery to create a vagina and vulva (mons, labia, clitoris, and urethral opening) by inverting the penis, scrotal sac, and testes.

Appendix B

The decision to test for acute or chronic infection or immunity should take into consideration past or current risk factors, risk for future exposure, and/or prior testing and vaccination history.

Hepatitis A, B, & C Serology

Hepatitis A Serology: General Information

- HAV infection is primarily transmitted by the fecal-oral route. The most common transmission pathway is through the consumption of food or water contaminated with infected feces. Transmission can also occur through close physical contact resulting in the oral ingestion of contaminated feces (e.g., rimming).
- HAV serologic testing is only recommended in the following scenarios where there has been no prior hepatitis A vaccine series:
 - Presenting with signs and symptoms suggestive of acute hepatitis
 - Chronic hepatitis B or hepatitis C infection
 - Chronic liver disease (e.g., cirrhosis)
 - Individuals with haemophilia A or B receiving plasma-derived replacement clotting factors and testing negative for anti-HAV IgG
- Include the following serologic tests:
 - Signs and symptoms: anti-HAV Total and anti-HAV IgM
 - Screening: anti-HAV Total

For further information, see [BCCDC CDC Manual: Chapter 1 - Hepatitis A](#) and [BCCDC CDC Manual: Chapter 2 - Immunization](#).

Hepatitis B Serology: General Information

- HBV is a blood-borne virus that is highly transmissible via perinatal, percutaneous or sexual exposure to a HBV infected person's blood and/or body fluids. HBV infection is most commonly acquired through sexual contact, injection drug use, and perinatal exposure from mother-to-infant.
- Indications for HBV serologic testing in the absence of a prior full hepatitis B vaccine series includes:
 - HIV or HCV infection
 - Individuals who engage in illicit drug use
 - Sexual partner or household contact of someone with acute or chronic HBV infection
 - Recent sexual assault (refer to PHSA's [Prophylaxis Post Sexual Assault DST](#))
 - Unprotected sex and/or multiple sex partners
- Include the following serologic tests:
 - HBsAg
 - Anti-HBs
 - Anti-HBc Total

For further information, see [BCCDC CDC Manual: Chapter 1 – Hepatitis B](#) and [BCCDC CDC Manual: Chapter 2 - Immunization](#).

Hepatitis C Serology: General Information

- HCV is a blood-borne virus that is highly transmissible via percutaneous exposures to infectious blood. Per mucosal transmission may occur if blood is present but is not as efficient.
- Indications for testing in a sexual health/harm reduction context may include:
 - Sharing of injection and/or non-injection drug equipment (e.g., crack pipes, cocaine straws)
 - Diagnosis of HBV (chronic or acute), HIV, or STIs where sores and lesions are present such as Lymphogranuloma venereum (LGV) and syphilis
 - Repeated condomless sexual contact with person(s) where there is a possibility of blood exchange (e.g., rough sex causing mucosal tearing)
 - Tattooing, body piercing, and/or acupuncture in unregulated premises where unsterile equipment and/or improper technique is used
 - Recent sexual assault (refer to PHSA's [Prophylaxis Post Sexual Assault DST](#))
- For individuals with ongoing hepatitis C related risk factors, annual screening is recommended. Include the following serologic tests:
 - Anti-HCV
 - HCV RNA – only if previous anti-HCV positive

For further information on HCV, screening, risk factors and/or laboratory and testing information, refer to the [BCCDC CDC Manual: Chapter 1 - Hepatitis C](#)