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(Revised Edition)



British HIV Association
BHIVA

HIV: A GUIDE FOR POLICE FORCES

How to address HIV in
police occupational health policies
and blood-borne virus (BBV) training

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NAT is the UK's leading charity dedicated to transforming society's response to HIV.

We provide fresh thinking, expertise and practical resources.

We champion the rights of people living with HIV and campaign for change.

A) Introduction

This guide has been drawn up by NAT (National AIDS Trust) and endorsed by BHIVA (British HIV Association). It is intended to help police occupational health staff, trainers, individual police officers and other police staff have a better understanding of HIV, including routes of HIV transmission and levels of HIV risk.

It is designed to be used in the development of police occupational health guidance and blood-borne virus (BBV) policies. It addresses some of the common myths about HIV which can have an impact on how the police view the risk of HIV transmission, policing practice, and the way people living with HIV are treated by police personnel.

This resource draws on NAT's recent review of occupational health policies and BBV training in fifteen police constabularies across the UK and NAT's subsequent report: 'Police occupational health policies and blood borne virus training: protecting health?'¹

That review found in many instances inaccuracies and errors in police guidance and policies. This can lead to an inflated assessment of the risk of HIV transmission in common policing scenarios. This causes unnecessary anxiety amongst police officers and may have an impact on how people living with HIV are treated by the police.

The recommendations in this guide provide police officers and staff with the information they need if they are potentially exposed to HIV at work and also address unfounded fears by providing up-to-date information about HIV. This should also ensure that when people living with HIV come into contact with police officers and staff they are treated with understanding and respect.

Other blood-borne viruses, in particular hepatitis B and hepatitis C, are significantly more infectious than HIV (for example, the World Health Organisation notes that hepatitis B is fifty to one hundred times more infectious than HIV²).

This guide does not attempt to provide guidance or information on these other blood-borne viruses. It is important when informing and training police officers and staff about risks from blood-borne viruses, that they are distinguished and not 'lumped together', for example, in terms of transmission risk. It is hoped that further guidance on hepatitis B and C will be produced for use by police officers in the near future. Although these two viruses are more infectious than HIV, it is as important to inform police officers and staff based on evidence and the facts, and to avoid any stigmatising or discriminatory approach to people who have these viruses.

1 NAT (June 2012)

http://www.nat.org.uk/media/Files/Policy/2012/Policy_Briefings/June-2012-Police-occupational-health-policies-report.pdf

2 WHO <http://www.who.int/mediacentre/factsheets/fs164/en/>

B) What is HIV?

HIV or Human Immunodeficiency Virus is a virus that attacks and damages the body's immune system.

In the UK, HIV is no longer a death sentence, and for people diagnosed in good time and on treatment, HIV is a long-term manageable condition and people are likely to have a normal life span. Due to improvements in treatment, most people living with HIV can lead active lives (for example, working, having long-term relationships, having children if they wish to), and will not go on to develop AIDS. It is important to remember this when thinking about HIV. Policies and training should provide accurate information about HIV today. This will reduce anxiety about HIV transmission and ensure police officers and staff treat people living with HIV appropriately.

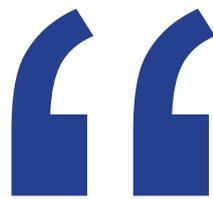
There are approximately 100,000 people living with HIV in the UK according to the latest statistics.³ Around 77% of people living with HIV are diagnosed and receiving specialist care, but over 20% remain undiagnosed and unaware of their HIV status. While HIV continues to disproportionately affect gay and bisexual men, African communities, and people who inject drugs, HIV rates are rising amongst the heterosexual population. It would be wrong

to make simple and potentially stigmatising assumptions about HIV status based, for example, on someone's sexuality or lifestyle.

The difference between HIV and AIDS

Historically, and even now on occasion in the media and in

as people with HIV are diagnosed and start treatment when they need to, it is very unlikely that people living with HIV will develop AIDS. It is incorrect to describe someone living with HIV as having AIDS. Similarly, when speaking of risk of transmission, it is HIV which is transmitted, and never AIDS.



It will rarely, if ever, be appropriate and accurate for police officers to use the term AIDS in relation to someone with HIV.

public discussion, the terms 'HIV' and 'AIDS' (Acquired Immunodeficiency Syndrome) are used interchangeably. This is incorrect, very misleading and can be sensationalist and alarmist in tone. HIV if left untreated can lead to the development of AIDS, which is a collective term for one or more conditions which occur in someone whose immune system has been seriously damaged by untreated HIV.

Since the development of effective HIV treatment, as long

It should also be noted that even if you do get an AIDS diagnosis you will probably now recover as a result of effective treatment and care for the specific AIDS-defining condition(s), and so no longer have AIDS (though you will of course still have HIV).

In brief, it will rarely, if ever, be appropriate and accurate for police officers to use the term AIDS in relation to someone with HIV.

HIV symptoms

Most of the time that someone is living with HIV there will be no symptoms of their condition. However, for a short period after transmission, between 70-90% of people will experience symptoms of early HIV infection known as 'primary infection'.⁴ Primary infection usually occurs around 10 days after transmission and can present as a combination of symptoms, such as fever, sore throat, rash, fatigue, headaches, diarrhoea and loss of appetite. These symptoms are unusual in otherwise healthy people and would be identified as potential signs of primary HIV infection if they occurred soon after a sexual risk incident. The symptoms last only for a few weeks and then disappear as the individual enters the chronic, asymptomatic stage of HIV infection, which can last for many years.

Impact of HIV treatment on risk of transmission

It is now known that HIV treatment has an immense impact in reducing infectiousness and risk of transmission.⁵ If someone has been diagnosed with HIV, is adhering to their daily treatment as prescribed, and has, as a result, a very low level of virus in their body (known as

'an undetectable viral load'), it is extremely unlikely they can pass on HIV to others. Recent data from Public Health England found that in 2010, 85% of HIV patients had an undetectable viral load (<50 copies/ml) one year after beginning HIV treatment (often

termed antiretroviral therapy).⁶ Someone living with HIV and on treatment represents an extremely low infection risk, even in instances of unprotected sex - by far the most significant route for HIV transmission.

HIV treatment has an immense impact in reducing infectiousness.

Key messages:

- There are approximately 100,000 people living with HIV in the UK, with over 20% of them undiagnosed.
- As long as someone with HIV is diagnosed in good time and takes HIV medication as prescribed, they should have a healthy life and normal lifespan.
- 'HIV' and 'AIDS' are not the same thing and should not be confused. It is only very rarely that it would be correct to use the term 'AIDS'.
- Most people on HIV treatment have a very low level of HIV in their body - this means they are effectively non-infectious. The vast majority of HIV transmissions are from people who are undiagnosed.

4 NAT (2008) <http://www.nat.org.uk/Media%20library/Files/PDF%20documents/primary%20infection%20final.pdf>

5 BHIVA/EAGA Position statement on the use of antiretroviral therapy to reduce HIV transmission January 2013

6 Health Protection Agency (2011) HIV in the United Kingdom: 2011 report http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317131685847

C) How is HIV transmitted? And how is it not transmitted?

Introduction

There has been no known case of occupational HIV transmission to a police officer or member of staff in the UK, yet HIV remains one of the viruses police are most concerned about contracting at work. In reality HIV is difficult to pass on, and over 95% of cases in the UK are transmitted through sexual contact. Whilst it is important that police officers and staff have the information they need to protect themselves from HIV at work, it is vital that occupational health policies and training materials do not overstate the risk of HIV transmission and cause unnecessary concern. All police training and occupational health materials should state clearly how HIV can be transmitted and how it is not transmitted.

Making clear how HIV is and is not transmitted will avoid concern

that police or the general public may be able to contract HIV from ordinary policing activity or social situations. It will also reduce the anxiety that can arise from unnecessary HIV testing and the possible taking of Post-exposure Prophylaxis (PEP). More details about PEP can be found below.

The main routes of HIV transmission

HIV can be transmitted through semen, anal mucus and vaginal fluid, blood, and breast milk. It is important to remember, even if your skin is in contact with one of these fluids, if your skin is intact there is no risk of transmission.

HIV is transmitted through anal or vaginal intercourse without a condom or through the sharing of injecting equipment. In the UK the vast majority of transmissions (well over 98%) are through these transmission routes.

It is possible to transmit HIV through unprotected oral sex, in particular where ejaculation takes place in the mouth and where the mouth has sores or bleeding gums, but the risk is significantly lower.

It is also possible for a mother with HIV to transmit HIV to her child during pregnancy or childbirth or when breastfeeding. However, in the UK, effective screening of pregnant women for HIV and provision of HIV treatment to those who have HIV has reduced mother-to-child HIV transmission to below 1%. Blood transfusion is also a possible route for HIV transmission - but again, in the UK, effective screening processes for donors means that nowadays HIV transmission from blood transfusion is extremely unlikely.

Scenarios where there is not a risk of HIV transmission

- HIV is not transmitted through contact with other bodily fluids such as saliva, urine, faeces or vomit.
- You cannot get HIV from social contact such as touching, kissing, superficial scratching, coughing, sneezing or sharing toilet seats, handling or lifting someone, toothbrushes, or cutlery.

There has been no known case of occupational HIV transmission to a police officer or member of staff in the UK.

“ You cannot get HIV from spitting.

- You cannot get HIV from spitting.
- There is also no risk from cuts or grazes from broken glass, other sharp materials, or knives if there is no blood on them.

Extremely low risk scenarios

There are some situations where there may be a theoretical risk of HIV transmission but it is extremely low, or may indeed not exist at all, and where there have been no, or hardly any, incidents of HIV transmission either in the UK or globally. For all these scenarios - biting, puncture wound from a discarded needle, blood in the eye, or resuscitation where there is blood in the mouth of the person resuscitated and no shield/mask used - it is advisable to get medical advice but mainly to address other possible infection risks or health issues. Any HIV risk would be assessed on a case-by-case basis by a qualified medical practitioner but PEP (see section D) is generally not recommended following, for example, biting or a puncture wound from a discarded needle outside a healthcare setting, because the risk is so low.

Biting

Biting presents a theoretical risk if a bite is so severe as to puncture

the skin, and if the person biting has HIV, has his/her own blood in his/her mouth, and s/he is highly infectious either because they are recently infected or because s/he has a late stage HIV illness. But there has never been a reported case in the UK of infection from biting and only a handful of possible cases around the world. If biting is included in advice and guidance as a possible transmission route it needs to be made clear that it presents extremely low risk of transmission and even then only in very exceptional circumstances.

HIV risk from a discarded needle outside a healthcare setting

Although HIV infection from a discarded needle outside a healthcare setting is theoretically possible, there has never been a known case in the UK or elsewhere. You may see documents which quote the statistic, “1 in 300 needlestick injuries result in HIV infection.” This is actually the statistic for needlestick injuries in a healthcare setting where the patient is known to be HIV positive. Injuries from discarded needles in the community are far less likely to lead to HIV infection because:

- HIV is a fragile virus which does not survive for long in an

external environment,

- needles rarely contain fresh blood,
- the injury does not occur immediately after the needle was used, and,
- any virus present has been exposed to drying and environmental temperatures.

In addition, given the relatively low level of HIV prevalence amongst injecting drug users (estimated at about 1% in the UK), the blood in a discarded needle is not likely to contain HIV.⁷

There may, however, be risks of other infections including hepatitis B or C so it is, of course, advisable for someone who has had a puncture wound from a needlestick (or from any other sharp object which may have had blood on it) to seek medical advice.

Blood in the eye

There is a very low risk of HIV transmission from blood which comes into contact with a ‘mucous membrane’. For policing purposes this will usually be caused by a splash of blood into the eye. If blood comes into contact with someone’s eye then it is important to quickly follow universal precautions and rinse the eye with water

⁷ Public Health England estimates that around 1 in 100 people who inject drugs are living with HIV. http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317140236856

or saline solution. While this will not eliminate risk of HIV transmission, it is good practice. It is then important to seek further medical advice as to the level of HIV transmission risk involved in the incident. Transmission of HIV through a splash of blood in the eye is very unusual, and is very low risk. A risk assessment would need to be made to decide whether PEP is required. Any assessment is likely to include a look at risk factors such as the amount of blood involved, if the blood is from someone known to be living with HIV, and also if it is, whether or not they are on treatment.

Resuscitation

The risk of infection from mouth-to-mouth resuscitation is extremely low. Resuscitation is normally required because of cardiac arrest and the Police College, formally National Policing Improvement Agency (NPIA), guidance states that mouth-to-mouth resuscitation should not be delayed because of concerns around contracting a BBV.⁸ It states that if blood is present in the mouth then a Resusci-shield or Pocket Mask should be used if available, but if not, resuscitation should continue regardless.

Importance of universal precautions

Police officers or staff working with the public should already be following universal precautions such as using gloves when searching someone or when cleaning up blood or bodily fluids and making

sure any cuts or skin infections are properly covered. There is no need for extra precautions when in contact with someone living with HIV.

Key messages:

- **It is extremely unlikely that HIV could be transmitted to a police officer or member of staff in the course of police duties.**
- **There is no risk from spitting, from bodily fluids if they are only in contact with intact skin, and from normal social interaction such as sharing of cutlery, shaking hands etc.**
- **Universal precautions should always be used as directed to exclude or minimise risks of blood-borne virus transmission.**
- **The risk of HIV transmission through resuscitation is extremely low and resuscitation should never be delayed or denied because of concerns around HIV or other BBV risk.**
- **The risks of HIV transmission from biting, puncture wounds from a discarded needle outside of a healthcare setting, or blood splash in the eye are extremely low, or theoretical, but any concerns should be raised with a healthcare professional.**

⁸ National Policing Improvement Agency (now the Police College), (October 2011), p6, 'Blood-Borne Viruses: Guidance to the Police Services' http://www.college.police.uk/en/docs/NPIA_Circular_05-2011_Blood_Borne_Viruses_guidance.pdf

D) What to do if you think you may have been exposed to HIV

PEP (Post-exposure prophylaxis)

Police officers and staff may be concerned about contracting HIV and want to access Post-exposure Prophylaxis (PEP) to avoid HIV transmission after a possible exposure incident. PEP is a month-long course of HIV medication to be taken daily (known as antiretroviral therapy or ART), which if started very soon, and no longer than 72 hours after exposure to HIV, can prevent someone becoming infected with HIV. There can be side-effects from taking PEP. Given the possible side-effects and increased levels of anxiety whilst taking PEP, additional support for staff taking PEP from police forces might be appropriate.

It will only be in very rare circumstances that PEP would be recommended to a police officer as a result of possible occupational exposure to HIV. Recent PEP guidance from the British Association for Sexual Health and HIV (BASHH) states that in general PEP should not be provided for needlestick injuries when a needle has been discarded outside a healthcare setting, or in instances of biting, because of the extremely low risk of HIV transmission. Of course, if on the basis of appropriate training around occupational health and blood-borne virus risk, a police officer is concerned about an

exposure incident, they should seek medical advice straight away (procedures will be set down by individual police forces) and discuss the matter with a qualified medical practitioner. It is recommended that police officers follow clinical advice as to whether PEP is really necessary.

HIV testing

It is always advisable to have an HIV test if you are concerned about risk of HIV transmission and a reliable test result is possible after four weeks.

Information about HIV testing can be a common source of confusion, with information often out-of-date. Up-to-date information on HIV testing is important to reassure officers and staff who may have been subject to an exposure incident. Your local sexual health clinic will be able to provide detailed

advice. The website HIVAware www.hivaware.org.uk also provides clear and useful information on HIV and HIV tests. The HIV tests available in sexual health clinics and A&E are able to reliably test for HIV from four weeks after an exposure incident, though in some circumstances the clinic may advise a further confirmatory test to absolutely rule out transmission three months from the exposure incident. Test results can be available quickly, but waiting times are dependent on the type of test. Results of blood tests in a GU clinic or A&E are usually provided within forty-eight hours.

Key messages:

- An HIV test in a sexual health clinic or A&E can provide a reliable test result from four weeks after a possible exposure to HIV (though sometimes there may be a further confirmatory test three months from exposure).
- Anyone who has reason to believe they have been at risk of HIV transmission should seek medical advice as soon as possible. If PEP is recommended, you will need to start no later than 72 hours from the possible exposure.
- PEP is in general not recommended for incidents of biting or a puncture wound from a discarded needle outside a healthcare setting. Nevertheless, if concerns remain, discussion should be had with a healthcare professional.

E) How to treat someone living with HIV

People living with HIV are protected under the Equality Act 2010 (HIV is defined as a disability from the point of diagnosis for the purposes of legal protection from discrimination), which means it is a legal requirement to treat people living with HIV fairly and with respect. It means it is unlawful to single out someone living with HIV for different treatment or to decline to offer goods or services to them. Unlawful discrimination also includes 'harassment' which means violating someone's dignity or 'creating an intimidating, hostile, degrading, humiliating or offensive environment' for an individual.

As part of treating people living with HIV with respect, it is important to make sure that language used to speak, write about, and describe HIV and people living with HIV, is appropriate and doesn't increase fear and stigma. Language such as 'homosexuals', 'prostitutes' and 'drug abusers' is stigmatising - these phrases are now considered out-dated and offensive. Instead the terms 'gay and bisexual', 'sex workers' and 'people who inject drugs' are more appropriate. As highlighted above, materials should refer to HIV rather than AIDS, as thanks to the huge advances in treatment, very few people in the

“ People living with HIV are protected under the Equality Act 2010. ”

UK will develop AIDS. Language such as 'deadly disease', 'HIV carrier', and 'AIDS sufferers' should also be avoided as this paints an out-of-date image of what it is actually like to live with HIV and the health risk associated with living with HIV. 'People living with HIV' is the appropriate term for people who have HIV.

Members of the public living with HIV are entitled to respect and equal treatment, whether they are reporting a crime, a witness or a suspect in an investigation. When engaging with someone who may identify themselves as living with HIV, it is important to remember that someone who knows their own HIV positive status is very likely to be on treatment, and so usually the risk of HIV transmission is extremely low.

In custody people living with HIV should not be segregated or singled out, or if it isn't general practice for everyone, given disposable cutlery or bedding. In relation to universal precautions, the use of two layers of latex gloves which is sometimes called

'double-gloving' should not be used for people known to have HIV as it is unnecessary and stigmatising. Many people with HIV (over 20% - approximately 22,000 people) remain undiagnosed and are actually likely to be more infectious than someone diagnosed and on treatment, so therefore universal precautions should apply and all members of the public should be treated in the same way.

In addition, it would be discriminatory to treat someone living with HIV in a less favourable way than people who are not HIV positive. There is no need to dispose in any different way of something that has been in contact with someone living with HIV, nor would a cell need to be specially disinfected just because someone living with HIV may have occupied it. Guidance should also apply to any civilian staff that may be supporting police officers or coming into contact with people in custody.

Access to HIV treatment

If someone in custody has disclosed their HIV status to a police officer or a member of staff, it is important to ascertain whether that individual is taking HIV medication and, if they are, for that person to have timely access to their treatment, because strict adherence to treatment is vital for its success. HIV medication has to be taken at least once a day. Even missing one prescribed dose in a month can risk the treatment becoming ineffective. Arrangements may need to be made, in consultation with the person in custody, to access their medication. You should not assume that close relatives or friends know about the HIV positive status of the individual, and care should be taken and consent sought from the person in custody before disclosing their HIV status or raising the need for medication with anyone else. It may be safer sometimes to contact her/his HIV clinic.

Key messages:

- People with HIV are protected against discrimination and harassment under the disability-related provisions of the Equality Act 2010 in England, Scotland and Wales, and the Disability Discrimination Act 1995 in Northern Ireland.
- People with HIV should not be singled out, segregated or treated differently as a result of their HIV status. There is almost no risk of HIV transmission from dealing with someone living with HIV. Universal precautions should in any event be used for all people police come in contact with.
- It is extremely important that anyone with HIV who is on HIV medication (ART) has access to their drugs and can take them on a daily basis as prescribed.
- Language do's and don'ts:
 - Use 'HIV' rather than 'AIDS'.
 - Do not use 'homosexuals', 'prostitutes', 'drug abusers', 'HIV or AIDS sufferers'.
 - Use instead 'gay and bisexual', 'sex workers', 'people who inject drugs', 'people living with HIV'.



It would be discriminatory to treat someone living with HIV in a less favourable way than people who are not HIV positive.

F) The importance of maintaining HIV confidentiality

Recognising the right to confidentiality of someone living with HIV is essential, as unfortunately HIV remains a stigmatised condition. For that reason, if someone discloses their HIV status it is important that their confidentiality is maintained, and that their status is not disclosed to a third party without their explicit consent. The Police College (formally NPIA) guidance makes this clear: “Sensitive information about a person’s health should be treated as confidential. It is unnecessary, insensitive and a serious breach of confidentiality and the Data Protection Act 1998 to label or mark a detainee’s cell, cutlery, crockery etc. to denote their infectious status”.⁹

This extends to discussing openly the HIV status of an individual with police force colleagues, or in earshot of third parties. Whilst police officers investigating a possible offence, supporting someone in custody, or someone who is otherwise in contact with the police, may need to know the individual’s HIV status, that information should be communicated in private and on a confidential basis.

“ Sensitive information about a person’s health should be treated as confidential.”

Key messages:

- It is immensely important, and a legal obligation, to respect and protect the confidentiality of people living with HIV.

⁹ National Policing Improvement Agency (now the Police College), (October 2011), p7, ‘Blood-Borne Viruses: Guidance to the Police Services’ http://www.college.police.uk/en/docs/NPIA_Circular_05-2011_Blood_Borne_Viruses_guidance.pdf

G) Criminal prosecution for transmission of HIV

NAT has worked with the Association of Chief Police Officers (ACPO) to produce 'ACPO Investigation Guidance relating to the Criminal Transmission of HIV'.

The Guidance aims to end inappropriate police investigations and ensure, when they are considered necessary, that police forces and officers investigate allegations of criminal HIV transmission in a way which is:

- consistent with Crown Prosecution Service (CPS) prosecution policy,
- appropriately informed about HIV from both a clinical and a social perspective,
- respectful of human rights and confidentiality, and
- which does not prolong an investigation longer than necessary.

The Guidance is available to all police officers in England, Wales and Northern Ireland via the Police Online Knowledge Area (POLKA) hosted by the Police College. It is also available on the NAT website at <http://www.nat.org.uk/Our-thinking/Law-stigma-and-discrimination/Police-investigations.aspx>

“ The Guidance aims to end inappropriate police investigations

NAT has produced a leaflet for people with HIV explaining the Guidance: 'Police Investigation of HIV Transmission' which can also be downloaded using the above link.

The Crown Office and Procurator Fiscal Service (COPFS) in Scotland has also produced guidance on prosecution policy for cases of possible transmission

of or exposure to sexually transmitted infections. There is not as yet ACPOS guidance on relevant police investigations in Scotland. NAT's leaflet for people with HIV in Scotland explaining COPFS prosecution policy might in the interim be a useful resource also for police officers, in addition to the COPFS guidance itself.¹⁰

Key messages:

- It is possible for people to be prosecuted for reckless HIV transmission (and in Scotland also for exposure to the risk of HIV transmission). The law is, however, very complex and if an allegation is made of criminal behaviour around HIV transmission, police officers should immediately access the ACPO Investigation Guidance for advice (or in Scotland read the COPFS policy and NAT's guide for people with HIV).

¹⁰ NAT (February 2013), 'Prosecutions for HIV & STI Transmission or Exposure: A guide for people living with HIV in Scotland' <http://www.nat.org.uk/media/Files/Publications/scottishprosecutions2013.pdf>

H) Working with someone who is HIV positive

Serving police officers and police staff living with HIV are also protected from discrimination by the Equality Act 2010.

Police officers and staff may not just be coming into contact with members of the public who are living with HIV, but also colleagues who have HIV. They may, or may not, have disclosed their HIV status to colleagues or to staff in the human resources team. There are no health and safety risks associated with working with someone with HIV, and for most people HIV has no impact on their working life. It is important to remember that the use of stigmatising language about HIV may also have an impact on colleagues living with HIV, and can be considered unlawful harassment, so this is an additional reason why it should be avoided.

Colleagues have no need to know the HIV status of an individual except if the employee wishes to ask for reasonable adjustments in which case they would need to disclose their status to a relevant member of staff. If an employee does disclose their HIV status, they have a right for this information to be kept confidential within the workplace. The Data Protection Act 1998 specifies that written consent is needed for personally sensitive information to be passed on.

Key messages:

- You may well have colleagues living with HIV - do not assume simply because they have not told you that they are HIV positive that you don't know anyone who has HIV.
- You have an ethical and legal obligation to treat any colleague with HIV fairly and with respect, maintaining their confidentiality.
- Pejorative and discriminatory comments about HIV and people with HIV contravene police force equality policies, may be a disciplinary offence and may also constitute unlawful harassment of colleagues or members of the public living with HIV.

NAT has produced guidance for both employers and employees living with HIV around addressing HIV appropriately in the workplace.

For more information please use the link in the footnotes below.¹¹

Serving police officers and police staff living with HIV are also protected from discrimination by the Equality Act 2010.

¹¹ NAT (June 2012) 'HIV@work: advice for employers'
http://nat.org.uk/media/Files/Policy/2012/Jul_2012_HIV@Work_Advice_for_employers.pdf

I) Guide to further information and reading

If someone is a trainer of police officers or staff, it is important to know where to signpost people for more information on HIV. Equally if you are a police officer or member of staff and want to know more, please look at our suggestions below:

All the key facts about HIV: www.hivaware.org.uk

NAT (National AIDS Trust): www.nat.org.uk

BHIVA (British HIV Association): www.bhiva.org

NAM: www.aidsmap.com

THT (Terrence Higgins Trust): www.tht.org.uk or call THT Direct on 0808 802 1221

Police College Guidance:

http://www.college.police.uk/en/docs/NPIA_Circular_05-2011_Blood_Borne_Viruses_guidance.pdf

Other BBVs -

For hepatitis C: www.hepctrust.org.uk

For hepatitis B: www.britishlivertrust.org.uk

J) Blood-Borne Virus Training and Occupational Health Policy Checklists



Does your Blood-Borne Virus Training:



Distinguish between HIV, hepatitis B and hepatitis C, setting out separately key facts about each virus, how each virus is and is not transmitted, details of their respective testing and treatment, as well as other relevant clinical, social and legal information.



Contain basic information on HIV, including -

- The numbers living with HIV in the UK, and the proportion undiagnosed
- The difference between HIV and AIDS
- The effectiveness of HIV treatment, resulting in normal lifespans and reducing infectiousness to extremely low levels.



Explain clearly how HIV is and is not transmitted, including -

- That HIV is not transmitted by everyday social interaction, by spitting, touching, handling, superficial scratches, coughing or sneezing, use of toilet seats, sharing of cutlery
- That biting, puncture wounds from a discarded needle, blood in the eye and resuscitation procedures would only involve any HIV risk in the most exceptional circumstances
- That universal precautions should always be followed and are sufficient to protect from almost all risk of HIV transmission in a work setting.



Does your Blood-Borne Virus Training:



Explain where to have an HIV test, how long after exposure an HIV test can reliably detect HIV infection, and how soon after being tested one can receive the result.



Emphasise the importance of ensuring anyone being detained/in custody who has HIV and is on treatment has uninterrupted daily access to their HIV medication.



State that people with HIV are protected in law from discrimination, harassment and breaches of confidentiality -

- Providing examples of how different treatment can be unlawful
- Explaining how to protect confidentiality
- Reminding that colleagues may be living with HIV, even if they have not disclosed this fact to you.



Signpost to guidance on how to deal with allegations of criminal HIV transmission - these are very complex cases which need to be handled with great care.



Does your occupational health policy:



Contain basic information on HIV, including -

- The numbers living with HIV in the UK, and the proportion undiagnosed
- The difference between HIV and AIDS
- The effectiveness of HIV treatment, resulting in normal lifespans and reducing infectiousness to extremely low levels.



Explain clearly how HIV is and is not transmitted, including -

- That HIV is not transmitted by everyday social interaction, by spitting, touching, handling, superficial scratches, coughing or sneezing, use of toilet seats, sharing of cutlery
- That biting, puncture wounds from a discarded needle, blood in the eye and resuscitation procedures would only involve any HIV risk in the most exceptional circumstances
- That universal precautions should always be followed and are sufficient to protect from almost all risk of HIV transmission in a work setting.



Explain the common symptoms of early HIV infection, as well as the fact that after the first few weeks HIV may be without symptoms for many years.



Explain PEP (Post-exposure Prophylaxis), how and when to access it (as soon as possible after exposure and certainly no more than 72 hours from the possible exposure to HIV), and that PEP would be advisable following an incident at work only in very exceptional circumstances if recommended by a clinician.



Explain where to have an HIV test, how long after exposure an HIV test can reliably detect HIV infection, and how soon after being tested one can receive the result.

About BHIVA

BHIVA (British HIV Association) has become the leading UK professional association representing professionals in HIV care. Founded in 1995, it is a well-established organisation which is committed to providing excellence in the care of those living with and affected by HIV. It acts as a national advisory body to professions and other organisations on all aspects of HIV care. BHIVA also provides a national platform for HIV care and contributes representatives for international, national and local committees dealing with HIV care. In addition, BHIVA works to promote undergraduate, postgraduate and continuing medical education within HIV care. For more information go to www.bhiva.org



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www.nat.org.uk

New City Cloisters, 196 Old Street, London EC1V 9FR

T: +44 (0)20 7814 6767 F: +44 (0)20 7216 0111

E: info@nat.org.uk

SM: Twitter @Nat_AIDS_Trust and Facebook

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Registered Office: NAT, New City Cloisters, 196 Old Street
London, EC1V 9FR

