



Aged Care Workers and HIV and Ageing



Over the last 35 years, HIV has been transformed from what was once a fatal illness to a chronic condition that people can now easily manage. Therefore, people with HIV are able to live longer and reach old age. As people living with HIV start to access aged care services, what effect will this have on the Aged Care Worker and the role they perform?

This booklet was developed for Aged Care Workers who work in a range of residential facilities and in the community providing services to clients in their own homes. The booklet provides basic information about HIV and the effect of HIV and HIV treatment on the ageing process.

Fear of ageing and aged care

Many people fear getting old and facing the possibility of needing aged care whether they have HIV or not. People living with HIV have expressed added fears directly related to HIV infection. *"I am scared of being gay and isolated in aged care and I'm scared of being HIV positive in aged care"*¹. Older gay men in particular may be worried about having to hide their sexuality in order to gain access to aged care at all. Will they be doubly judged – first for being gay and second- for having HIV? Will those with same sex partners be allowed to enter the same facility and continue their relationship emotionally and sexually? Will they still be able to access treatment and care for HIV as well as other conditions of the ageing process? What choices will there be in the type of aged care available?: *"[I] don't want to be isolated in an aged gay ghetto, but neither do [I] want to be a marginalised individual whose life and loves are regarded too risky to talk about"*.

HIV: The Facts

Human immunodeficiency virus (HIV) is a blood-borne virus (BBV). This means it is spread through contact with infected blood. HIV can also be passed on in other body fluids such as semen, bloody saliva, breast milk and vaginal fluid.

All BBVs, including HIV, can be prevented.

HIV can be treated, but if it is not, it may lead to serious health problems. See Table 1 for 'The facts about HIV'.

Table 1. The Facts About HIV

Frequency of infection	At the end of 2012, there were about 25,700 people in Australia living with diagnosed HIV infection (about 0.1% of the population) ⁱⁱ
Vaccination/Immunity	There is no vaccine for HIV. HIV infection cannot be cleared by the body and infection is for life.
How it is spread	HIV spreads through blood-to-blood contact, unprotected sexual contact and from mother to baby during pregnancy or childbirth
Signs and symptoms	<p>Early signs and symptoms may include:</p> <ul style="list-style-type: none"> ■ flu-like illness ■ rash ■ fever <p>The immune system helps protect the body from disease. HIV damages the immune system. If left untreated, HIV can progress to acquired immune deficiency syndrome (AIDS). More advanced disease symptoms may include:</p> <ul style="list-style-type: none"> ■ skin diseases ■ chest infections ■ weight loss
Treatment	<p>Antiretroviral treatment is available for HIV infection.</p> <p>Treatment does not cure HIV infection, but it stops the virus reproducing and minimises damage to the immune system and progression to AIDS.</p>

Who has HIV infection?

The most common way of spreading HIV in Australia is through sexual contact between men. From 2008 to 2012, 67% of new HIV diagnoses were in men who have sex with men (MSM).ⁱⁱ

But, in the same period, 25% of new HIV diagnoses were in the heterosexual population; 2% of cases were diagnosed in people who inject drugs; the cause of infection was uncertain in 6% of new HIV diagnoses.ⁱⁱ

People who know about their HIV infection are much less likely to pass it on.

What is the risk of getting HIV infection?

You cannot get HIV by:

- casual physical contact including hugging, kissing and shaking hands
- coughing or sneezing (through the air)
- contact with vomit, faeces or urine (if not contaminated with blood)
- sharing food or drink, plates, cutlery and glasses
- using the same shower, toilet or laundry facilities
- eating food prepared by someone living with HIV infection.

The risk of infection depends on how the person has been exposed to the virus and how much of the virus the person with the infection (the source) has in their body.

The following advice is general. It is important to get medical advice after contact with blood or body fluids. Please refer to your local policies and procedures for advice on what to do in case of a possible BBV exposure.

Exposure Type	Level of Risk
<p>Blood contact with broken skin, mouth or eyes e.g.</p> <ul style="list-style-type: none"> ■ fights/assaults: punch from a bleeding person causing a break in the skin of the other person ■ large blood splash, e.g. bleeding artery ■ bloody saliva contact to mouth from giving mouth-to-mouth resuscitation if no protective equipment used ■ open wounds ■ sports injuries involving transfer of blood through open cuts or wounds 	Low
<p>Needlestick and other skin penetrating injuries e.g.</p> <ul style="list-style-type: none"> ■ cut by a blade (or other sharp) which recently cut another person ■ recently used injecting needle piercing skin 	Moderate
<p>Tattooing/body piercing eg:</p> <ul style="list-style-type: none"> ■ sharing tattooing needles, ink ■ recently used unclean body piercing equipment 	Moderate
<p>Sharing personal hygiene products when there is a transfer of blood eg:</p> <ul style="list-style-type: none"> ■ toothbrushes ■ razors ■ tweezers ■ barbering equipment 	Moderate
Bloody saliva in mouth or eyes and bites that break the skin	Zero
Blood and saliva to unbroken skin and skin-to-skin contact	Zero
<p>Sexual exposure (no condom used):</p> <ul style="list-style-type: none"> ■ anal (receptive) ■ vaginal (receptive) ■ vaginal or anal (insertive) ■ oral 	<p>Very High</p> <p>High</p> <p>Moderate</p> <p>Very Low</p>
<p>Mother-to-baby e.g:</p> <ul style="list-style-type: none"> ■ breastfeeding ■ pregnancy (if mother is treated) ■ pregnancy (if mother is untreated) 	<p>Very Low</p> <p>Very Low</p> <p>High</p>

©ASHM. Adapted from HIV, viral hepatitis and STIs a guide for primary care 2008 Table 2.1 page 29

HIV life cycle

HIV enters the nucleus of the most vulnerable cell in the immune system (the CD4 or T4 cell), and inserts itself into the cell's DNA. HIV DNA then instructs the cell to make many copies of the original virus (virions) which leave the cell ready to infect other CD4 cells.

Treatment and antiretroviral medication (ARVs)

HIV is treated by combining different classes of drugs (usually with 3 or more drugs) that attack the virus at different parts of its life cycle. There are four different types of HIV ARV medications. Each ARV type blocks different parts of the HIV virus life cycle and stop the virus from multiplying:

- 'Entry inhibitors' work by stopping HIV getting into the CD4 cell;
- 'Nucleoside/nucleotide reverse transcriptase' (NRTIs) and 'non-nucleoside reverse transcriptase inhibitors' (NNRTIs) drugs stop HIV changing from a single strand of RNA into a double strand of DNA;
- 'Integrase inhibitors' block HIV from being combined into the cell's DNA;
- 'Protease inhibitors' work at the last stage of the HIV life cycle. They block new HIV from being cut into the right size proteins to be assembled into the final form for release from the infected CD4 cell.

The aim of taking ARVs to treat HIV is to decrease the amount of HIV in the blood (viral load) and allow the immune system to restore itself. The viral load is measured by a blood test. ARVs stop the damage that HIV does to the immune system. Ideally the viral load should be "undetectable" in the blood (which is as close to a zero level as possible).

Adherence to treatment

Once someone has started treatment with ARVs they must usually take it for the rest of their life to control the virus.

ARVs and dosing

ARVs need to be taken as prescribed (usually once or twice daily) on time. Patients must follow advice about food requirements or food restrictions.

If a person is on a once-a-day tablet and misses a dose, they can take it within the next 3-4 hours. If the person is on twice-a-day treatment, they must take it within 2 hours. If a tablet is missed completely, they must not take two doses the next time. Taking a double dose may increase the risk of more side effects.

People living with HIV who need long term aged care will usually continue with their HIV treatment. They may also be taking multiple non-HIV-related medications. Continuing to take HIV medicine will prevent HIV progressing to AIDS conditions.

The Aged Care Worker can help by checking to see if the client is taking their medication. If they suspect the client is not adhering to any treatment regime (not just for HIV) the Aged Care Worker should report it. Check the care-plan for guidance and follow the policies and procedures.

Side effects

Most people with HIV are stable on their ARV treatment. The new medications mean people are less likely to suffer with side effects. Day-to-day side effects include nausea, diarrhoea or insomnia.



Long term side effects of ARVs may be osteopenia (bone thinning) and kidney problems.

For some people there may be serious side effects with the medication. If this happens, the person may want to stop taking their drugs.

Each of the different types of ARV has its own possible side effects. More information can be found in the product information sheets or in a drug directory like MIMS.

Over time some people may change their HIV medication as newer treatments are developed. Newer medications can reduce the risk of side effects related to treatment. But some people may react badly to a change in medicines.

The Aged Care Worker should report any changes they notice in the client's behaviour e.g. if they stop eating, are vomiting, or even if they start eating when they didn't before. These behaviours may be a side effect of the medication.

Resistance to ARVs

If a person often misses a dose, stops taking ARVs for a few days or has multiple breaks off treatment, the virus has a chance to change itself (mutate), which may lead to drug resistance.

If the virus develops drug resistance the ARVs don't work as well and the virus is no longer controlled. The combination of drugs may need to be changed if this happens.

Aged Care Workers can encourage people with HIV who are on ARVs to take them as prescribed. People living with HIV need to take their medications at least 95% of the time (that's equivalent to missing one dose per month).

Prescribing ARVs/Pharmacy dispensing

Treatment with ARVs is usually organised through a specialist service. All ARVs are controlled by the federal government in a scheme called Section 100. Only specially trained doctors (some hospital based specialists and some GPs) can prescribe them. ARVs are usually only dispensed by a hospital pharmacy. Most hospital pharmacies will supply two months at a time with one repeat prescription.

People cannot usually get ARVs at the local chemist even if they have a prescription from a specialist. This means it may be difficult for some people to access HIV treatment services. They may need to travel long distances to see a doctor with specialist knowledge of HIV and pick up their medication. As the person ages, this may become more difficult or even impossible.

In some States and Territories, there may special arrangements in place for people who are not able to go to a specialist clinic at a hospital to collect their medicines. Contact local services such as the Department of Health, NAPWHA, ACON or HIV specialist centre in your State/ Territory for information for specific clients.

ARVs and drug Interactions

The combination of HIV infection, ageing and co-morbidities results in the need for multiple medications. When a new medicine is needed, the doctor must make sure that any drug they prescribe can be taken safely with all other drugs the patient may be on. This is because some drug combinations may not work as well, or may cause serious side effects.

Aged Care Workers can help by reporting any changes they notice in their client's behaviour, general health or mental health after a new medication is started. The changes might be a sign of a bad drug interaction.

Prevention, infection control and standard precautions in an aged care settingⁱⁱⁱ

Personal protective measures

Following infection-control procedures will help protect Aged Care Workers from occupational exposure to all blood-borne viruses (and other infectious diseases) not just HIV.

You cannot tell who has HIV by looking at someone. There is no reason to treat a client differently because of known or suspected



HIV (or other blood-borne virus) infection.

These work practices are the minimum requirements for infection control. They ensure a high level of protection against all blood-borne viruses and other infections. These standard precautions should be taken by all people who have contact with blood, body fluids, broken skin, and eye, nose or mouth surfaces.

Standard precautions are just that: standard for all, not just for those suspected or known to have HIV.

The rule is: treat all blood and body fluids as potentially infectious

1. Wear personal protective equipment (gloves and protective clothing)

- Wear disposable gloves in situations where you may be in contact with blood or body fluids. The gloves do not have to be sterile.
- Wear personal protective equipment, such as eyewear and face shields, when there is any chance of being splashed or sprayed in the face.

2. Avoid exposure to broken skin

- Cover your own open wounds/cuts/blisters no matter how small with waterproof dressings. This is especially important for injuries to your hands.
- Avoid creams that may cause dermatitis or broken skin.

3. Safely handle and dispose of sharp objects such as needles, blades (e.g. razor blades) and broken glass

- Hold a syringe by the barrel with a gloved hand.
- Never touch the needle.
- Do not re-cap, bend or break the needle.
- Do not remove a needle from the barrel.
- Never move your hands across your body when handling a sharp.

- Dispose of the sharp in a sharps container (a yellow, rigid walled container displaying the biohazard label and symbol).
- When away from the aged care facility, dispose of a sharp in a thick plastic drink bottle if a sharps container is not available.
- Always use long-handled tongs to pick up needles and other sharps.
- Take the sharps container to the sharp rather than carrying the sharp around.
- Do not put your hand in places you cannot see into e.g. cupboards, drawers, bags, under a mattress.

4. Clean up blood and body fluids as soon as possible

- Restrict access to the affected area.
- Wear gloves, eyewear and waterproof apron.
- Mop up spills, including those on clothing, with paper towels and dispose of the towels immediately. Change contaminated clothing as soon as possible.
- Wash the spills on hard surfaces with detergent solution then allow to air dry.
- Wash furnishings (e.g. chairs and mattresses) with detergent and cold water, and leave to dry.
- Wash uniforms (and other clothing, linen, towels etc.) in cold water. Washing in hot water will cause the bloodstain to clot and stay on the clothes. If possible, dry clothes in a clothes-dryer at the hottest temperature as this helps disinfection. Heavily contaminated clothing should be destroyed.

5. Wash your hands with soap and warm water

- *before* and *after* each new client.
- *before* touching a client.
- *after* handling blood stained clothing or linen.
- *after* going to the toilet.
- *before* and *after* preparing or eating food.

First aid for needlestick injuries and other blood exposures

- Wash exposed skin with soap and water. Use an alcohol based hand rub if water is not available. Do not suck or squeeze the wound.
- If the eyes have been exposed, thoroughly rinse them with tap water or saline with eyes open. Flush from the inside corner outwards.
- Remove contact lenses before rinsing the eyes. Clean contact lenses separately before reinserting.
- If the mouth has been exposed, spit, then rinse the mouth with water and spit again.
- Seek medical advice immediately.
- Consult a health professional immediately for a blood-borne virus risk assessment. It is preferable to seek medical advice from someone experienced in the management of blood-borne virus exposures.
- Your rights to privacy and confidentiality need to be protected and respected. You will require follow-up after a needlestick injury. You will also need to report the incident according to the organisational policy and procedures.

Testing and avoiding transmission

If you have had a blood exposure, you may be tested for blood-borne viruses as part of your risk assessment. While waiting for blood-borne virus test results it is important not to put others at risk:

- Practise safer sex, i.e. use a condom for vaginal or anal intercourse
- Cover any sores, cuts and abrasions and attend to any household blood spills yourself
- Do not share personal items such as razors and toothbrushes
- Do not share injecting equipment and dispose of used injecting equipment safely
- Do not donate blood or organs
- Seek medical advice if you are, or are planning to become, pregnant or are breastfeeding.

Post-Exposure Prophylaxis (PEP)

PEP is medication taken after exposure to HIV to reduce the risk of infection. Your health professional will assess your risk of HIV infection to determine the need for PEP. PEP for HIV is usually only offered for high-risk exposures. There may be side-effects so it is not routinely given to everyone with a possible exposure.

If PEP is recommended, it must begin within 72 hours, preferably within 24 hours, of an exposure.

HIV and ageing

Australian statistics

- The number of people over 65 living with HIV grew 10-fold between 1996 and 2006^{iv}
- By 2020, 50% of all people living with HIV in Australia will be over 50^v
- In 2012 almost 11% of new HIV diagnoses were in people aged 50-59; 3.75% were aged over 60ⁱⁱ.

For most people, HIV infection is now a chronic condition that can be managed over a long time. This is due to improved ARV medication. As a result:

- People living with HIV can expect to have the same life span as people who do not have the HIV virus.
- Many people taking ARVs for a long time do not die from causes linked to the HIV virus.
- HIV infection can cause severe damage to the immune system. For some people, this may result in much earlier heart, kidney, brain and bone disease.

Many people with HIV are starting to suffer from age-related illnesses and frailty. Frailty can occur much earlier in people with HIV infection, especially if they have advanced disease. As with the elderly, frailty can result in an increased risk of falls, hospitalisation, disability and death.

People in aged care will experience a number of symptoms due to both HIV and ageing e.g. fatigue, weight changes, memory loss, depression and malnutrition.

There are a number of conditions that make up the syndromes of ageing:

Syndromes of ageing

- Falls and gait disturbance
- Declining cognition
- Incontinence
- Altered mood
- Altered organ reserve
- Sarcopenia (loss of muscle mass)
- Polypharmacy (multiple drugs with possible interactions) (30% of hospitalisations in the elderly).

People can have more than one condition at the same time and this is known as co-morbidity. People living with HIV have an increased risk of developing co-morbidities. They may also develop them at a younger age than the general population. Long term use of ARVs can cause a number of these co-morbidities and this is known as ARV toxicity (see Figure 1).

Medical management

Special needs of people living with HIV

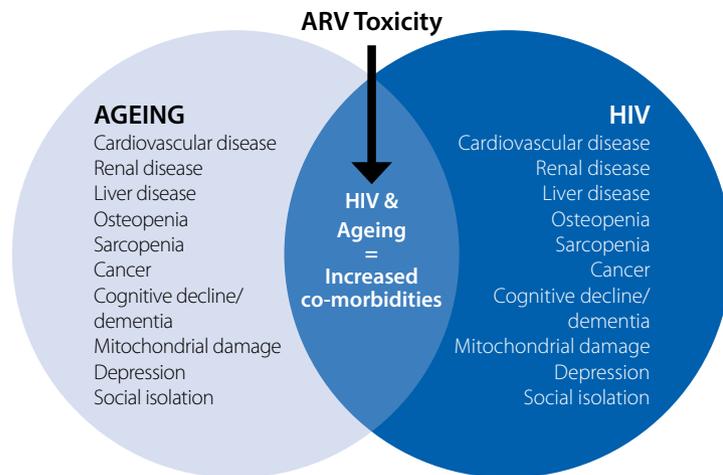
1. Complex care needs

Most people with HIV admitted to residential aged care facilities, will also have a number of non-HIV medical conditions e.g. dementia, diabetes, heart disease, chronic lung disease, osteoporosis and possibly cancer.

It is still unclear whether people living with HIV experience these co-morbidities related to their age at higher rates and earlier than the general population. It is also unclear why non-AIDS co-morbidities such as diabetes, high blood pressure, heart disease and cancer more often affect people living with HIV.

Although there are no clear answers as to what causes premature ageing of people living with HIV, there are a number of factors that may contribute as shown in Figure 2.

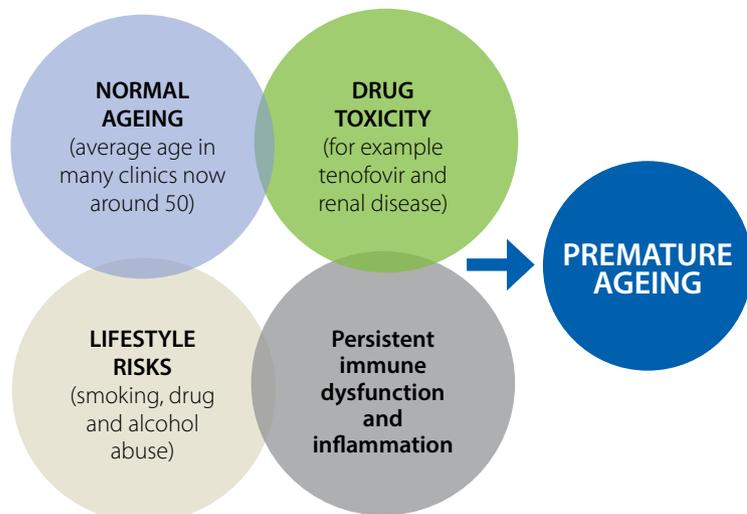
Figure 1: ARV Toxicity



People with HIV in residential or community aged care services therefore, may have complex care needs. Care delivery should include, but not be limited to:

- a Shared Care Plan, co-ordinated by a case manager to bring together all support people such as the GP, specialists, other clinicians, support agencies, family and carers
- ongoing review of medical needs
- support of the person to take their medication correctly
- looking out for drug interactions
- help with access to specialist services when necessary
- access to legal advice such as:
 - guardianship
 - advance directives (e.g. living will, power of attorney)
 - end of life care (e.g. palliative care, 'Do not resuscitate' orders)

Figure 2: Causes of Premature Ageing



Deeks, S. G et al. BMJ 2009;338:a3172

All HIV care providers need to address the multiple co-morbidities that are already common in the ageing population, and will now be seen in people living long term with HIV. The person's GP can manage non-HIV-related medical illnesses.

2. Mental health issues

A recent report shows that older people living with HIV are five times more likely to suffer with depression than people of the same age without HIV. Depression can have a negative impact on quality of life, self-care, social life, medication adherence and physical health.

The risk of suicide increases with age and HIV. It is important to be aware of people in care expressing comments relating to hopelessness, despair or suggestive of self-harm.

In addition, older people with HIV are more likely to experience stigma, rejection, and abandonment. This will make anxiety, isolation and drug and alcohol dependence worse. Many older people with HIV are members of minority groups (e.g. gay men, transgender, people who inject drugs). They may experience additional stigma, isolation and discrimination because of this with their mental health being affected.

Aged care providers should be able to arrange mental health assessments. They should refer people to appropriate specialist services.

Aged Care Workers have a close relationship with their clients. They are well placed to notice changes in their client's mental health. Aged Care Workers should raise any changes to or concerns about their client's mental health with their supervisor.

3. Cardiovascular disease

The risk of cardiovascular disease increases with age, and includes both coronary heart disease and cerebrovascular disease (stroke). Some of the risk factors for developing cardiovascular disease can't be changed e.g. ageing, gender (males), family history of heart disease. Other risk factors can be modified e.g. stopping smoking, treating high blood pressure and high cholesterol. Men are more at risk than women until after menopause.

People with HIV are at higher risk than those without HIV, even after controlling for traditional cardiovascular risk factors. Smoking, high blood pressure and diabetes are all associated with the risk of death during treatment for HIV infection.

4. Osteopenia/osteoporosis

As people age there is a higher risk of developing osteopenia (bone thinning) and osteoporosis (porous bones, with holes). In people with HIV infection, the use of ARVs increase this risk. Some women with HIV may experience a premature menopause which will increase their risk, at a younger age, for osteopenia or osteoporosis. Falls resulting in hip and wrist fractures are the most common injuries associated with ageing and osteoporosis.

5. Neurocognitive abnormalities

Ageing can lead to a reduction in the ability of a person to memorise information and learn new skills. Ageing also decreases reaction time. The effects of this will vary from person to person. These processes can be exaggerated by HIV infection through HIV associated neurological disorder or HAND. Up to 40% of people with HIV will experience HAND.

Early intervention of HAND may improve signs and symptoms such as memory and concentration problems. In addition some people living with HIV may develop other dementias such as Alzheimer's disease or vascular dementia.

Aged Care Workers should report any changes they notice in the client's memory or concentration.

Other blood borne viruses: Hepatitis B and Hepatitis C

People with HIV infection may also have a viral hepatitis co-infection. An estimated 6% of people living with HIV also have hepatitis B^{vii}. Approximately 12% of people living with HIV also have hepatitis C^{viii}. Finally about 5% of people living with hepatitis B have hepatitis C co-infection^{ix}. Hepatitis viruses cause inflammation (hepatitis) of the liver and over a long time, may lead to liver damage and liver cancer.

Hepatitis B is a viral infection that is passed on through blood or body fluids. Like HIV, infection occurs through contact with infected blood, body fluids or unprotected sexual contact. Hepatitis B is also passed on from mother-to-child. Household contact is considered low risk. People should avoid contact with blood and other body fluids. Do not share grooming equipment such as razors, which may have blood on them.

Hepatitis B can be prevented by vaccination. The vaccination is recommended for all health care workers, including Aged Care Workers. Hepatitis B can be treated but treatment does not cure the infection. Two of the ARV drugs used for HIV infection also treat chronic hepatitis B infection.

Hepatitis C is spread through blood-to-blood contact. The most common way of getting hepatitis C is by sharing injecting drug equipment. Transmission through unprotected sexual contact is possible but not common. People should avoid sharing personal grooming equipment such as toothbrushes and razors. They should not share any injecting drug equipment.

There is no vaccine for hepatitis C. Treatment is available for hepatitis C that may clear (cure) current infection and prevent further liver damage and transmission. It is successful for up to 90% of people.

Treatment (or previous infection) does not stop someone from getting a new hepatitis C infection in the future.



Stigma and discrimination

Stigma and discrimination lead to people not being treated with dignity and respect.

“How do I know that I’m going to be treated compassionately and with understanding? Will my story as an old ‘poofter’ be treated respectfully? What will it be like in aged care with HIV – it’s still very stigmatised, new protocols notwithstanding?”

HIV is an infection that many people have fears, prejudices or negative attitudes about. This can result in people living with HIV being insulted, rejected, gossiped about and excluded. They may also be verbally and/or physically abused. People do not always recognize their own behaviour as discriminatory. Some common examples of discriminatory behaviour towards people with HIV are:

- not making eye contact
- speaking sharply or abruptly
- using different infection control precautions depending on known or suspected HIV status
- physical abuse
- refusing care or providing substandard care, e.g. not spending enough time on their needs
- blaming the person for their HIV status

- avoiding touching people living with HIV or only touching when wearing disposable gloves
- making assumptions about risk behaviours (e.g. sexuality, injecting drugs, unsafe sex practices) based on the patient’s HIV status
- disclosing the person’s HIV status without their consent

The Aged Care Worker may need to challenge their own beliefs and attitudes towards such issues as sex and sexuality (including same sex relationships, transgender and intersex people), injecting drug use, fears of and knowledge of HIV/AIDS in order to provide the best possible care for people with HIV.

“HIV is still stigmatised even now and its complex territory tangled up in things like Criminal Codes and the Health Act. I expect enlightenment and compassion from staff within a health facility but the reality is their knowledge of HIV may well be suspect”ⁱ

Legal rights and responsibilities – Disclosure

“Disclosure” means telling someone you have (or someone else has) HIV infection. There are very few situations where, by law, someone must tell you if they have HIV (or when you must tell someone else about your own HIV status).

A person with HIV using aged care services would not have to tell the Aged Care Worker about their HIV status. The service provider would not need to tell the Aged Care Worker if a particular client had HIV either. The result is Aged Care Workers may be providing services to a client in residential or community care who does not tell them their HIV status. Everyone has the right not to disclose their HIV status in this situation.

The person with HIV also has a right to confidentiality. This means if the person tells you they have HIV, or you find out in the course of your work, the Aged Care Worker cannot discuss this with anyone else, including family or carers, except in very limited situations - see below.

Duties of confidentiality on Aged Care Workers

Both State and Federal Privacy laws, impose confidentiality on people working in healthcare services. This means an Aged Care Worker must not collect information that is unnecessary or intrusive. They must not disclose information without the consent of the person concerned.

The health worker may disclose information if it is **directly necessary for the treatment or care of that person**. One example might be disclosure of medications where a patient was transferred to hospital which may be “necessary for the treatment and care of the person”. But the Aged Care Worker should not disclose the patient’s HIV status to a paramedic when the ambulance was used just as a form of transport. It would not fall under the “directly necessary for the treatment or care of the person”.

There would be very few situations where another person’s health or safety is at risk. The risk of harm must be imminent and is unlikely to happen in the context of HIV. Remember that standard infection control precautions must be used when dealing with all blood and body fluids. This must be kept in mind when deciding whether disclosure is necessary.

When to disclose if you have HIV?

There may be laws in your State and Territory that say when someone must disclose their HIV status.

Work:

A person only has to disclose they have HIV if it means the person cannot do their job or part of their job. There are only three occupations where disclosure is mandatory:

1. Healthcare workers who engage in Exposure Prone Procedures (EPPs) must know their HIV status and refrain from performing EPPs if they are HIV-positive. (An exposure-prone procedure is one in which there is potentially a high risk of transmitting a blood-borne disease between an aged care worker and a patient during a medical or dental procedure.)
2. The Defence Force will not accept members who test HIV-positive. The Defence Force may terminate the employment of any serving member who tests HIV-positive.
3. There may be restrictions on the types of commercial pilot licenses that a person with HIV can get.

Other situations:

- In some States and Territories a person must tell a sexual partner about their HIV-positive status before engaging in sexual activity. If they do not, they may be prosecuted under either criminal or public health laws.
- Insurance where a person's HIV status is relevant, for example, health insurance, or life insurance.

Disclosure in any other situation is **not** legally required, and decisions made because of a person's HIV-status may be against State or Federal Anti-Discrimination laws. Aged Care Workers should check the laws in their State or Territory.

For more information on disclosure or discrimination contact HALC or the National Antidiscrimination Gateway. (See contacts and resources)

Glossary

AIDS: Acquired Immunodeficiency Syndrome

ARV: antiretroviral medication

BBV: blood-borne virus

Cardiovascular disease: heart disease

Cerebrovascular disease: stroke

Discrimination: treatment of a person or group of people in a way that is worse than the way people are usually treated because of their race, colour, gender, sexual preference, age, religion etc

Exposure-Prone Procedure (EPP): An exposure-prone procedure is one in which there is potentially a high risk of transmitting a blood-borne disease between an aged care worker and a patient during a medical or dental procedure.

HIV: Human immunodeficiency virus

Post-Exposure Prophylaxis (PEP): medication taken after exposure to HIV to reduce the risk of infection.

Osteopenia: thinning of the bones

Osteoporosis: bones that have holes and become porous

Sarcopenia: loss of muscle mass

Stigma: can be defined as "the shame or disgrace attached to something seen as socially unacceptable". Stigma is often attached to something people are afraid of.

References

- i What's Next: Thoughts and Fears of moving into Aged Care with HIV: Jim Lillicrap, QPP Alive Autumn 2014
- ii The Kirby Institute (2013). The University of New South Wales, Sydney, NSW, HIV, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report. Accessed 29 April 2014 at: <http://www.kirby.unsw.edu.au/surveillance/2013-annual-surveillance-report-hiv-viral-hepatitis-stis>
- iii Australian Government. Department of Health and Ageing; Australian Guidelines for the Prevention and Control of Infection in Healthcare (2010) National Health and Medical Research Council. Accessed 28 April 2014 at: www.nhmrc.gov.au/node/30290
- iv UNSW, Mapping HIV outcomes: geographical and clinical forecasts of numbers of people living with HIV in Australia page 50 accessed 2 June 2014 at: <http://www.kirby.unsw.edu.au/sites/default/files/hiv/attachment/FinalModHIVoutcomesAusRep.pdf>
- v HIV and Ageing: Research findings, personal perspectives, clinical complications and future planning. Edited by Sean Slavin and Adrian Ogier 2011 page 3 accessed on 2 June 2014 at: <http://napwa.org.au/files/HIV%20and%20Ageing.pdf>
- vi Cysique LA1, Vaida F, Letendre S, Gibson S, Cherner M, Woods SP, McCutchan JA, Heaton RK, Ellis RJ. Dynamics of cognitive change in impaired HIV-positive patients initiating antiretroviral therapy. *Neurology*. 2009 Aug 4;73(5):342-8.
- vii Petoumenos K, Ringland C and Australian HIVOD. Antiretroviral treatment change among HIV, hepatitis B virus and hepatitis C virus co-infected patients in the Australian HIV Observational Database. *HIV Med* 2005;6:155-63.
- viii Lincoln D, Petoumenos K, Dore GJ. HIV/HBV and HIV/HCV coinfection, and outcomes following highly active antiretroviral therapy. *HIV Med*. 2003;4(3):241-9.
- ix Body A, Hoy J, Cheng A, Giles M. Incident Hepatitis B virus (HBV) infection subsequent to the diagnosis of HIV infection in a Melbourne cohort; missed opportunities for prevention. *Sexual health*. 2013

Additional references

- Cummins D et al for Working Party "HIV Information for Residential and Aged Care Facilities" 2008
- Applebaum A.B. & Brennan M 2009 In Brennan M et al eds. *Older adults in HIV: An in-depth examination of an emerging population*, New York: Nova Pubs, 38-47.
- Grov C, Golub, SA, Parsons JT, et al 2010. *AIDS Care* 22 (5) 630-39.

Contacts and resources

NATIONAL	Telephone/Fax	Email	Website
ASHM	T: 02 8204 0700	ashm@ashm.org.au	www.ashm.org.au
Australian Federation of AIDS Organisations (AFAO)	T: 02 9557 9399 F: 02 9557 9867		www.afao.org.au
Australian Government National Health and Medical Research Council			www.nhmrc.gov.au/ guidelines/publications/cd33
Australasian Society for Infectious Diseases	T: 02 9256 5475	asid@racp.edu.au	www.asid.net.au
HIV/AIDS Legal Centre Inc (NSW)	T: 02 9206 2060 F: 02 9206 2053	halc@halc.org.au	www.halc.org.au/
Human Rights and Equal Opportunity Commission – Commonwealth	T: 02 9284 9600		www.humanrights.gov.au
National Antidiscrimination Gateway The National Antidiscrimination Gateway provides a snapshot of each anti-discrimination system, including information about the grounds and areas of public life on which a complaint can be made in each jurisdiction. Individuals and businesses can also find contact details for each antidiscrimination commission, anti-discrimination board or human rights commission, through this Gateway			www.antidiscrimination.gov.au
National Guidelines for PEP after non-occupational exposure to HIV These guidelines outline the management of individuals who have been exposed (or suspect they have been exposed) to HIV in the non-occupational setting.			www.ashm.org.au/images/ publications/ The guidelines are available at: guidelines/2007 nationalnpepguidelines2.pdf
National Association of People with HIV Australia (NAPWHA)	T: 02 8568 0300 or Freecall 1800 259 666	admin@napwha.org.au	www.napwha.org.au
ACT	Telephone/Fax	Email	Website
AIDS Action Council of the ACT (AACACT)	T: 02 6257 2855 F: 02 6257 4838	enquiries@aidsaction.org.au or aidsaction@aidsaction.org.au	www.aidsaction.org.au
ACT Department of Health and Community Care for infection control guidelines			www.health.act.gov.au/ policiesandplans
NSW	Telephone/Fax	Email	Website
ACON ACON is NSW's and Australia's largest community based gay, lesbian, bisexual and transgender (GLBT) health and HIV/AIDS organisation	T: 02 9206 2000 Freecall: 1800 063 060		www.acon.org.au
NSW Elder Abuse Helpline	T: 1800 628 221		
Multicultural HIV and Hepatitis Service (MHAHS)	T: 02 9515 1234	info@mhahs.org.au	www.mhahs.org.au
NSW Health for HIV resources	T: 02 9391 9000 F: 02 9391 9101		http://www.health.nsw.gov.au/ endinghiv/Pages/tools-and-data.aspx
NSW Health Infection Control Policy			www.health.nsw.gov.au/policies/ pd/2007/PD2007_036.html
POZHET – Heterosexual HIV Service	T: 1800 812 404	pozhet@pozhet.org.au	www.pozhet.org.au
Positive Life NSW	T: 02 9206 2177 Freecall: 1800 245 677		www.positivelife.org.au
The Albion Centre Enhanced Medication Access (EMA)	T: 02 9332 9650 F: 02 9331 6519	info@thealbioncentre.org.au	www.thealbioncentre.org.au
NT	Telephone/Fax	Email	Website
Northern Territory AIDS and Hepatitis Council	T: 08 8953 3172 (Alice Springs) T: 08 8944 7777 (Darwin)		www.ntahc.org.au
Northern Territory Department of Health Centre for Disease Control for resources			http://health.nt.gov.au/ Centre_for_Disease_Control/ Publications/index.aspx

QLD	Telephone/Fax	Email	Website
Elder Abuse Prevention Unit – helpline	T: 1300 651 192	eapu@uccommunity.org.au	www.eapu.com.au
Positive Directions	T: 07 3028 4730 Freecall: 1800 422 313		www.positivedirections.org.au
Queensland AIDS Council Inc.	T: 07 3017 1777 M: 0412 301 496 F: 07 3852 5200		www.quac.org.au
Queensland Health for resources and guidelines			www.health.qld.gov.au/chrisp/
Queensland Positive People (QPP)	T: 07 3013 5555 F: 07 3891 1830	info@qpp.org.au	www.qpp.net.au/
Seniors Enquiry Line	T: 1300 135 500		www.seniorenquiryline.com.au
SA	Telephone/Fax	Email	Website
Aged Rights Advocacy Service	T: 1800 700 600		
MOSAIC HIV Support Services	T: 08 8245 8100 or 1800 182 325		www.rasa.org.au/wp-content/uploads/2013/06/MOASIC-HIV-Brochure-July-2013-OUTLINES1.pdf
Positive Life SA	T: 08 8293 3700 or 1300 854 887 F: 08 8293 3900	reception@hivsa.org.au	www.hivsa.org.au/campaigns/resource-list.html
Relationships Australia HIV/AIDS and the Law in South Australia – A resource for workers			www.rasa.org.au/resources/booklets/
South Australian Department of Human Services for infection control guidelines			www.health.sa.gov.au/Default.aspx?tabid=47
TAS	Telephone/Fax	Email	Website
Department of Health and Human Services Tasmania for infection control guidelines			www.dhhs.tas.gov.au/peh/tasmanian_infection_prevention_and_control_unit/information_for_healthcare_workers/guidance_and_policies_for_healthcare_workers
Tasmanian Council on AIDS, Hepatitis and Related Diseases (TasCAHRD)	T: 03 6234 1242		www.tascahrd.org.au
Tasmanian Elder Abuse Helpline	T: 1800 441 169		
VIC	Telephone/Fax	Email	Website
Department of Health Victoria HIV/AIDS Your questions answered - resource	T: 1300 651 160 F: 03 9096 9174		ideas.health.vic.gov.au/diseases/hiv-aids-your-questions-answered.asp
HIV-Hepatitis-STI Education and Resource Centre	T: 03 9076 6993	erc@alfred.org.au	www.hivhepsti.info
Living Positive Victoria	T: 03 9863 8733	info@livingpositivevictoria.org.au poslink@livingpositivevictoria.org.au	www.livingpositivevictoria.org.au
Positive Women Victoria	T: 03 9863 8747	info@positivewomen.org.au	www.positivewomen.org.au
Senior Rights Victoria	T: 1300 368 821		
Straight Arrows	T: 03 9863 9414 F: 03 9863 9421	information@straightarrows.org.au	www.straightarrows.org.au/
Victorian AIDS Council – Gay Men’s Health Centre Health promotion, counselling & operations	T: 03 9865 6700 or Freecall: 1800 134 840		www.vicaids.asn.au
Victorian Department of Human Services, Public Health Division The Blue Book – Guidelines for the Control of Infectious Diseases			www.ideas.health.vic.gov.au/publications.asp
WA	Telephone/Fax	Email	Website
Advocare	T: 08 9479 7566		
Health Department of Western Australia for infection control guidelines			www.health.wa.gov.au
The WA AIDS Council	T: 08 9482 0000		www.waids.com
WA Sexual Health Network			www.washn.org.au

ASHM resources

ASHM resources are available from the ASHM website:
www.ashm.org.au/publications

Profession-Based Booklets

- Aboriginal and Torres Strait Islander Health Workers and Blood-Borne Viruses (BBVs)
- Antenatal Testing and Blood-Borne Viruses (BBVs)
- Correctional Officers and Blood-Borne Viruses (BBVs)
- Dental and Orofacial Health and Hepatitis C
- Dentists and HIV
- Emergency Services Providers and Blood-Borne Viruses
- General Practitioners and Hepatitis C
- General Practitioners and HIV
- Hepatitis B and Primary Care Providers
- Nurses and Hepatitis C
- Pharmacy and Hepatitis C
- Police and Blood-Borne Viruses

Factsheets

- Decision Making in Hepatitis B
- Decision Making in Hepatitis C
- Decision Making in HIV
- Hepatitis B Factsheet: for people newly diagnosed
- Hepatitis C in Brief – patient factsheet
- HIV Patient Fact Sheet

Monographs

- B Positive: all you wanted to know about hepatitis B – a guide for primary care providers
- Co-infection: HIV & viral hepatitis – a guide for clinical management
- HIV, Viral Hepatitis and STIs: a guide for primary care

Distance-learning Kit

- Clinical Science of HIV Medicine CD
- C Me, Hear Me DVD
- B Seen, B Heard DVD

Manuals

- Australasian Contact Tracing Manual Available in hardcopy and online at www.ashm.org.au/ctm

Online resources

- ASHM Directory of HIV, Viral Hepatitis and Sexual Health Services
- Australian STI Management Guidelines. Available at www.sti.guidelines.org.au
- Guide to Australian HIV Laws and Policies for Healthcare Professionals. Available online only at www.ashm.org.au/HIVlegal
- Testing Policy available online <https://testingportal.ashm.org.au>
- Managing Aboriginal and Torres Strait Islander patients with hepatitis B and hepatitis C
- Introduction to Blood-Borne Viruses

HIV and Ageing Resources

Ahead of time, A practical guide to growing older with HIV

NAPWHA, ACON, AFAO

W: www.afao.org.au/__data/assets/pdf_file/0013/4702/AheadOfTime.pdf

Living with HIV in aged care

W: www.afao.org.au/library/hiv-australia/volume-8/number-3/living-with-hiv-in-aged-care#.U4vcFv6KCUk

HIV Information for aged care facilities

W: www.nurseuncut.com.au/hiv-information-for-aged-care-facilities/

Hospital and Aged Care

Aged care providers need early ageing HIV awareness

W: www.hospitalandagedcare.com.au/news/aged-care-providers-need-early-ageing-hiv-awareness

The Department of Health

National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI)

Ageing and Aged Care Strategy

W: www.health.gov.au/internet/main/publishing.nsf/Content/ageing-lgbti-national-aged-care-strategy-html

Ageing and HIV disease – a client's perspective Denise Cummins; Gary Trotter

W: www.ajan.com.au/Vol25/AJAN_25-3_Cummins.pdf

Aged Care on-line

Understanding Aged Care: It's a Tough Road for Seniors living with HIV –

W: www.agedcareonline.com.au/2013/11/Understanding-Aged-Care-It-s-a-Tough-Road-for-Seniors-living-with-HIV

Health Direct

Better aged care for sexual minority groups (LGBTI)

W: www.healthdirect.gov.au/news/better-aged-care-sexual-minority-groups-lgbti

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Writers: Dr Virginia Furner, Albion Centre and Indraveer Chatterjee, HALC

ASHM Staff: Karen Seager, Senior Project Officer, NPED

For additional copies of this resource please contact:

ASHM

T +61 2 8204 0700 F +61 2 9212 2382

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ASHM

LMB 5057 Darlinghurst NSW 1300
Tel +61 2 8204 0700
Fax +61 2 9212 2382
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