Guidelines for developing policies and procedures for UK based organisations or UK churches sending staff or volunteers overseas in relation to HIV infection.

Approved by International HR Forum July 2007

INTRODUCTION

The Global Connections HIV Infection Guidelines are designed to give guidance to any UK based organisation or UK church sending staff or volunteers overseas. The principles should be applied to all types of staff such as mission partners, volunteers working overseas, national/local staff of UK mission agencies and UK staff visiting field locations. Agencies and churches should also apply them in all contexts, both long and short-term, although different procedures might be needed in each context. These guidelines have been formed specifically with cross-cultural contexts in mind, but can also be useful in UK situations, both same-culture and cross-cultural.

They are also designed to help national churches and agencies with whom the UK agency or UK church partners.

These are guidelines of good practice. Our motivation in producing them is based on our desire that God is glorified in all that we do. We recognise the risks to our staff and our responsibility as Christians in protecting and safeguarding them to the highest standards possible.

They are not guidelines for health professionals or for projects relating to people working with HIV infected people. Their primary function is to provide a framework for HR, personnel and member care staff in helping to develop agreed policies relating to the following:

- Information, education and preventative health measures
- Ways to protect mission partners, staff and their families
- Voluntary testing, counselling and confidentiality
- Terms of appointment and service
- Living with HIV
- Caring for carers

All UK agencies should appoint a representative who is responsible throughout the organisation for ensuring that their agency develops, completes and implements its HIV policies and that they are consistent with the required standards set out in these guidelines. Agencies that are part of an international structure should ensure the Head Office has appropriate policies and procedures in place and that the UK office is an integral part of any procedures.

Section 1

AIMS AND OBJECTIVES OF AN HIV INFECTION POLICY

An HIV Infection Policy is a statement of intent that demonstrates a responsibility and commitment to staff and national workers of agencies and churches based in the UK but sending staff or volunteers overseas. It helps to create the safest and most positive environment for staff and to show that the agency/church is taking its responsibilities seriously.

The guidelines are based on two clear principles:

1. The avoidance of discrimination against people who are HIV positive during selection. HIV infection is not a reason for rejecting candidates per se.

2. Ensuring that HIV positive people are not placed at unacceptable risk to their health by sending them into environments where they are more prone to lethal infections. To do so would be a failure to provide an acceptable standard of care, and that will only happen if the status of HIV positive persons is known.

The following principles are also important to note:

1. AIDS is the name of the disease caused by advanced HIV infection and is widely used internationally. However in the UK, AIDS is a dated term and concept which is rarely used by health care workers.

2. All UK agencies and churches should have a policy on recruitment and employment of HIV positive people regardless of whether or not they work directly with people affected by HIV.

3. The policy should be written clearly and understood by its users at every level.

4. The policy should be given to all staff and volunteers who work in or visit overseas locations. It should be a part of the staff handbook, orientation and training programme.

5. Dealing with HIV issues should also be a necessary part of personnel and member care practice. It should also be an integral part of risk management analysis. Therefore the policy should be reviewed on a regular basis, preferably every year, in view of continual change in legal legislation, or when there is a significant change in the UK agency/church.

6. In situations where a staff member is seconded to a local partner, the local partner should also be encouraged to develop HIV policies and guidelines.

7. Clear overall procedures should be developed and then adapted as appropriate for each overseas location and be based on the overall policies.

Section 2

BEING PREPARED

It is easy to assume that everyone knows about HIV and AIDS. Indeed the opposite is often the case and ignorance should be assumed. Clear information and guidance needs to be given to staff on these issues.

- All staff should be made aware of basic information relating to HIV infection including how it is transmitted and not transmitted and how to protect oneself from infection.

- Information on universal precautions for infection control should be provided in brief to all staff and in detail to staff working in medical programmes.

- Staff orientation should include discussion about sexual life including, how to deal with temptation and loneliness on the field for both married and single staff. Frank discussions of sexuality and risk with the opportunity for individual private discussion with a counsellor or nurse should be offered to all staff prior to departure. This can be part of a travel health consultation, now seen as good practice before any but the shortest overseas missions when immunisations, malaria, HIV etc can be discussed). Information about how to use and where to get condoms should be provided.

- Agency obligations and individual responsibilities in relation to possible risks of HIV infection should be clearly communicated to staff.

- Before an international assignment, all mission partners and their families should receive health clearance.

- Agencies/churches should provide adequate health and evacuation insurance cover. Local insurance options for local staff should also be sought.

- Each agency or church should appoint a specialist to advise on HIV infection who has overall responsibility for developing, completing and implementing its HIV policies and procedures. Churches in particular will not usually have the resources for this, but it can be contracted out to health providers.

Section 3

INFORMATION, EDUCATION AND OTHER PREVENTATIVE HEALTH MEASURES

1. All new staff should have pre-departure briefing for all HIV related issues.

2. All staff should take extra care of their health in the course of their duties.

3. All staff and their families should be provided with sufficient updated information to enable them to protect themselves from HIV infection including accurate information on condom use especially in areas of high HIV infection rates.

4. All staff should be made aware of where safe blood may be obtained. To accomplish this, an up-to-date list of reliable and operational blood transfusion centres should be available. If agencies decide to operate a "safe donor pool" in a particular location then they should ensure that potential donors have been screened for blood borne viruses to the same standard as in the UK. Alternatively it is possible to join the Blood Care Foundation which gets blood to most areas of the world within 24 hours.

5. All staff should exercise their responsibility to adopt measures to reduce the frequency of road traffic accidents as they can represent a particular risk for HIV infection in those localities lacking safe blood supplies. The following measures for reinforcement or for general adoption should be considered and circulated to all personnel together with instructions on the use of public transport:
   - The fitting and compulsory use of seat belts
   - Proper training in off-road use of 4-wheel drive vehicles
   - Provision of first aid kits in vehicles including strong leather gloves
   - Compulsory use of helmets for all riders of motorbikes
   - Prohibition against substance abuse, including alcohol consumption, by vehicle drivers
   - Appropriate first aid training

6. All staff and their families should be supplied with disposable syringes and needles or a fuller HIV kit containing macromolecular solutions (plasma expanders) or Hartmann's solution, where there is no guarantee of the proper sterilisation of such materials. This should be accompanied by a certificate indicating why these items are being carried.

7. Staff and their families should be aware of procedures relating to access to treatment for needle stick injury and other post exposure or post rape prophylaxis. The agency/church should look at what it should stock itself in settings where suitable treatment is unavailable, with clear criteria and procedures for use. Full guidelines on the use of PEP are available from heath providers.

Section 4

TESTING, COUNSELLING AND CONFIDENTIALITY

In ascertaining whether to test for HIV at any stage of recruitment or employment, it is important to bear in mind that untreated HIV infection, which has been present for long enough to have progressed, may:

- Impair immunity
- Render the infected person more prone to serious infections like TB
- Rule out the use of live vaccines (e.g. yellow fever or BCG)
- Render some vaccinations less effective, (e.g. for rabies)

Agencies/churches have an obligation to make sure that steps are taken to maintain and improve the health of employees and should discourage HIV infected employees from travelling to areas which might place them at increased risk of lethal infection. This will only be possible if HIV status is known and the agency/church is able to take steps to ensure that the HIV positive person receives the best possible therapy, regular health checks and takes the appropriate prophylactic measures to prevent opportunistic infections.

As well as the general principles above, the following should be noted:

1. Voluntary testing with pre-test discussion, post-counselling and assured confidentiality should be made available to all staff members and their families as an integrated part of any health check.

2. Where HIV testing is a pre-requisite for obtaining visas and residence permits, this requirement must appear in the vacancy notice or job description and where this applies to a particular candidate they should be informed as early in the application process as possible.

3. Specific procedures must be developed by agencies/churches to maintain confidentiality with respect to negative as well as positive results from an HIV test, including whether such a test has been taken. It should be clear in the policy and procedures that only the person tested has the right to release information concerning his/her status.

4. Adequate consideration on matters relating to HIV infection should be given for general healthcare, maternity, dental and surgical care in the field.

Section 5

TERMS OF APPOINTMENT AND SERVICE

Pre-recruitment and employment prospects:

Whilst employment law states that no-one should be rejected for employment because of a medical condition, if an applicant has a disabling medical condition then an occupational health doctor should assess the risk that this poses for the candidate. If the doctor believes that the risk is too great then an employer may be justified in rejecting the disabled person.

Whilst agencies should not insist on HIV testing of all candidates before accepting them for employment, HIV tests may sometimes be justified during a pre-employment medical examination. If the examining doctor thinks that the history and/or medical examination suggests that HIV infection may be present or is a significant risk, an HIV test should be performed with the consent of the applicant.

An agreed strategy should then be formulated by the medical examiner with the applicant regarding disclosure, which may or may not take place to the recruiting agency/church. Disclosure should not be required, but if the medical examiner concludes that an HIV+ applicant will be at serious health risk in a particular location overseas and the applicant has not given permission for disclosure of HIV status, the medical examiner will need to inform the agency/church that there are medical issues which he/she is not at liberty to divulge, that justify rejection of the applicant for that particular location.

- HIV testing should not be required as a condition of eligibility for national social security schemes, health/general insurance policies and occupational schemes.
- As stated earlier, in special circumstances where HIV testing is required as part of the process for obtaining visas and residence permits, this requirement must appear in the vacancy notice or job description as relevant. The reason should have been made clear to any candidate as early in the process as possible.

Continuity of employment:

- HIV infection, whether early or more advanced, should not be considered as a basis for termination of employment.
- If fitness to work is impaired by HIV related illness, reasonable alternative working arrangements should be made.
- All agencies/churches should have a long term sickness policy.
- Staff members with progressed HIV should enjoy health and social protection in the same manner as other employees suffering from serious illness.
- Confidentiality regarding all medical information, including HIV status, must be maintained.
- Whilst there should be no obligation on the part of the employee to inform the employer regarding his or her HIV status, it is usual practice for an employee to inform occupational health or its equivalent.
- Information should be available for all employees, which makes them aware that HIV infection is a condition which, with expert medical help, may be consistent with normal health and life expectancy.
- People in the workplace affected by, or perceived to be affected by HIV, must be protected from stigmatisation and discrimination by co-workers, employers or clients.
- HIV-infected employees and those with advanced HIV should not be discriminated against, including access to and receipt of benefits from statutory social security programmes and occupationally-related schemes.
- Agencies/churches should clarify who is responsible for providing antiretroviral medication for HIV infected staff. The administrative, personnel and financial implications of these principles under terms of appointment and service should be monitored and periodically reviewed.

Section 6

LIVING AND WORKING WITH HIV

When a person learns they have been infected with HIV, the change in their life may be dramatic. They may experience a wide range of emotions – fear, loss, grief, depression, denial, anger and anxiety. No matter how reassuring the doctor is concerning the efficacy of current and future drug therapies, how minimal the physical impact of the infection, or how intellectually prepared they may be, their need for counselling and support will be great.

The psychological issues faced by most persons with HIV infection revolve around uncertainty. Their future hopes and expectations, their relationships and their career will require some adjustment in order for them to learn to cope with their illness and lead a fulfilling and productive life.

The agency or church needs to ensure that its policies and procedures fully appreciate these psychological issues and that appropriate action can be taken to minimise them.

All organisations should actively encourage people living with HIV to take part in policy setting and decision-making around HIV issues and should provide support to those who choose to disclose their status. We need to talk about in-reach before outreach – putting our own house in order and making it a welcoming place for people living with HIV to live and work.

Section 7

CARING FOR THE CARERS

As member care providers, it is important that agencies and churches help carers to manage the stress of working with people with HIV. There should be clear policies and procedures in place concerning this issue.

1. **The most commonly reported causes of stress among carers working with HIV programmes include:**
   - Financial hardship
   - Oppressive workloads
   - Secrecy and fear of disclosure among people with HIV
   - Over involvement with people with HIV and their families
   - Personal identification with the suffering of people with progressed HIV infection
   - The unmet needs of their own children
   - Lack of an effective voice in decisions that affect them and their work
   - Lack of clarity about what the care giver is expected to do
   - Lack of referral mechanisms
   - Lack of medication and health care materials

2. **Those working as family level carers will additionally be exposed to:**
   - Isolation, insecurity and fear for the future
   - The effects of HIV on personal relationships and family dynamics
   - Difficulties in communication (especially with children)

3. **Symptoms of stress:** These are very similar to stress and burnout from other causes and will be familiar. The specifics of the HIV situation may be reflected in an over-involvement with clients or in withdrawal and complete detachment. This may be exaggerated if the counsellor himself or herself is HIV positive and facing future personal issues as they watch their carers suffer.

A common list of signs of stress would not differ significantly from those amongst general mission partners and care workers. For example:

- Loss of interest in and commitment to work
- Loss of punctuality and neglect of duties
- Feelings of inadequacy, helplessness and guilt
- Loss of confidence and self esteem
- A tendency to withdraw – from both clients and colleagues
- Loss of sensitivity in dealing with clients
- Irritability
- Difficulty in getting on with people
- Tearfulness
- Loss of concentration
- Sleeplessness and/or excessive fatigue
- Depression
- Bowel disturbance

4. **Responsibility for monitoring levels of stress:** Clear systems should be put in place relating to responsibility for monitoring levels of stress and burnout in field staff. After identification, the treatment and management of staff with symptoms of stress and burnout would not differ from treating stress and burnout from other causes.

Section 8

OTHER MATTERS TO BE CONSIDERED

General matters

- The different needs of staff should be addressed (e.g. marital status, isolation, location)
- How to deal with non-discrimination towards people living with HIV or AIDS and disciplinary measures for sexual misconduct?
- How much is assumed about the sexual behaviour of staff
- What criteria are used for changing the responsibilities of staff or for repatriating staff due to their HIV status and how these line up with non-discrimination policies?
- To what extent are staff at risk of rape as a weapon of terror/control/war?
- Are there guidelines in place for emergencies and evacuation of personnel?
- Is there training for staff in emergency procedures?
- Do policies and training include reference to HIV and AIDS in emergency settings?

Provision of HIV post-exposure prophylaxis

The agency/church needs to have a clear policy on the provision of HIV post-exposure prophylaxis (HIV PEP).

HIV PEP is normally delivered by the simultaneous administration of two or three anti-retroviral drugs, given daily for one month. There is sound evidence that HIV PEP will reduce transmission after occupational exposure. When a 'sharps' incident, or possible transmission by another route such as rape, has occurred HIV PEP should be started as soon as possible, preferably within one hour of the exposure incident. See guidelines from health provider.

All employers, but especially those running medical programmes, have a responsibility:

- To research and define current access to HIV PEP at each work location. In areas where this is not locally available, to make every effort to ensure its availability
- To ensure that this is available without delay
- To ensure that trained staff can assess the transmission risk and make an appropriate decision about delivery of HIV PEP to the employee
- To educate their workforce about what constitutes a significant risk of transmission
- To consider staff having their own PEP

There has been a dramatic change in attitudes to HIV infection as a disease and testing for HIV infection over the last 10 years. In particular, HIV infection is no longer regarded as an illness with the same prognosis and severity as malignancy.

Doctors are however concerned about high death rates in newly diagnosed HIV infected patients. This occurs because the infection has been present for sufficiently long to have seriously damaged immunity, placing the patient at risk of life-threatening opportunistic infections.

A paradigm shift in HIV testing practice is taking place. Whereas HIV antibody testing was considered an exceptional test to be accompanied by detailed pre-test counselling, HIV testing should be, and is, increasingly viewed as equivalent to other laboratory tests for serious diseases. In antenatal care and in the screening of patients with sexually transmitted

diseases, an HIV test is now one of several tests that are performed routinely although patients may elect to opt out.

Normalising HIV tests is important. The British HIV Association recommends:

- That more widespread availability of HIV testing is an important means to improve patient outcome and reduce transmission of HIV
- Previous protocols for testing that include detailed pre-test counselling are less relevant in most situations
- That clinical healthcare professionals should be alert to the symptoms, signs and histories that denote possible risk, and then offer testing
- That an offer to undertake an HIV test should be within the competence of all doctors….'*there is no need for special counselling skills outside those which all clinicians (nurses and doctors) require for their daily practice'*.
- Patients need to be informed that strict rules of confidentiality apply to medical practitioners[1]

The following should also be noted:

- Testing for HIV should not be carried out at the workplace unless there is an occupational health clinic and then only if strict guidelines preserving confidentiality are followed by the staff of the occupational health clinic. Otherwise test results may be revealed and misused, and the informed consent of workers may be compromised, not be freely given, or be given on the basis of incomplete understanding of the implications of disclosure. It is appreciated however that in some situations this may be the only solution.

[1] http://www.bhiva.org/ - HIV Treatment Guidelines 2005 and 2006

Appendix 1

WHAT IS AIDS?

AIDS stands for Acquired Immunodeficiency Syndrome, a pattern of devastating infections caused by the Human Immunodeficiency Virus, or HIV, which attacks and destroys certain white blood cells that are essential to the body's immune system. However AIDS is now considered an outdated term and concept, which is rarely used by healthcare workers in the UK today although it is still widely used worldwide.

When HIV infects a cell, it combines with that cell's genetic material and may lie inactive for years. After a variable period of time, the virus becomes activated and the impaired immunity associated with destruction of important immune cells then leads progressively to the serious infections and other conditions that characterise advanced HIV. In general, about 50 percent of HIV-infected adults are likely to develop advanced HIV within 10 years after first becoming infected. A few people infected with HIV remain healthy and live for years with no symptoms or only minor illness. Although they are HIV+ they do not have advanced HIV infection or what was previously referred to as AIDS.

It is likely that modern treatment will allow at least a majority of people living with HIV to achieve a normal life expectancy if treatment is taken regularly and doses are not missed. However HIV may still cause death if patients seek medical help when their infection is already advanced and serious life threatening disease develops. Research continues on vaccines which may either prevent infection or assist with treatment. Although researchers hope for a cure this goal remains elusive. For the moment, therefore, prevention of transmission remains the only method of control.

The symptoms of progressed HIV infection are varied and complex but can include: Fever, enlarged lymph glands, skin rash, persistent diarrhoea, cough, severe weight loss, fatigue skin lesions, loss of appetite.

How HIV is transmitted

- Sexual intercourse
- Contaminated blood and blood products, tissues and organs
- Contaminated needles, syringes and other piercing instruments
- From mother-to-child at birth or during breast feeding
- Blood transfusions

How HIV is not transmitted by:

- Shaking hands, hugging or kissing
- Coughing or sneezing
- Using a public phone
- Visiting a hospital
- Opening a door
- Sharing food, eating or drinking utensils
- Using drinking fountains
- Sharing communion cups
- Using toilets, showers or public swimming pools
- Getting a mosquito or insect bite

Appendix 2

USEFUL ADDRESSES AND RESOURCES

UNAIDS
20 Avenue Appia, 1211 GENEVA 27, Switzerland
Tel: +41 22 791 36 66
Email: unaids@unaids.org Website: www.unaids.org

UK Consortium on AIDS & International Development
Grayston Centre, 28 Charles Square, London N1 6HT
Tel: 020 7324 4780
Email: info@aidsconsortium.org.uk Website: www.aidsconsortium.org.uk

ACET (AIDS Care, Education and Training
1 Carlton Gardens, Ealing, LONDON W5 2AN
E-mail: patrickdixon@globalchange.com

PEOPLE IN AID
Development House, 56-64 Leonard Street, LONDON EC2A 4JX
Tel: 020 7065 0900
Email: info@peopleinaid.org Website: www.peopleinaid.org

INTERHEALTH
111 Waterloo Road, London SE1 7HR
Tel: 020 7902 9000
Email: info@interhealth.org.uk Website: www.interhealth.org.uk
(for members we provide a full range of advice and services with regard to HIV)

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