



16 February 2017

Standing Committee on Law and Safety
NSW Legislative Assembly

Sent by email: lawsafety@parliament.nsw.gov.au

Dear Law and Safety Committee,

Re: Inquiry into Violence Against Emergency Services Personnel

Thank you for the opportunity to write to the Law and Safety Committee on the Inquiry into Violence Against Emergency Services Personnel.

We represent six organisations with decades of experience working in the area of blood borne viruses (BBVs), including supporting community, the medical profession and research. A summary of our organisations is attached to this letter.

We are aware that the NSW Police Association recently made a submission to the Law and Safety Committee on the health of emergency workers in NSW that proposes mandatory testing of people whose bodily fluids, including saliva, may come into contact with police officers.

We are concerned that some aspects of the Police Association's submission do not equate with the current medical and scientific evidence concerning the transmission of blood borne viruses, including HIV and hepatitis C. Any legislative or policy response to this issue should, we believe, be based on evidence.

This letter provides the Committee with the current evidence-base and policy framework on BBV transmission. In our expert opinion, the mandatory testing of people whose body fluids may come into contact with emergency services is neither an effective, necessary nor viable option for reform.

We appreciate the need for police officers and other emergency service workers to operate in as safe an environment as possible. However, the mandatory testing proposal is based on outdated notions of HIV

and other BBV transmission risk. Scientific understanding of the risk of BBV transmission from occupational exposure is now highly developed and based on rigorous evidence.

Based on this scientific evidence, our organisations share a number of concerns about any proposal to move to mandatory screening. We draw your attention to the following:

1. There have been no cases of saliva being a transmission route for HIV in Australia. While infectious HIV can be detected in the saliva, it is present in substantially reduced quantities and contains HIV-specific antibodies. The risk of Hepatitis B, Hepatitis C and HIV transmission from a known positive source through blood and saliva to unbroken skin and skin-to-skin contact is zero. The proposal is based on, and perpetuates, misunderstanding about how HIV and other BBVs can be transmitted.
2. Testing for HIV and other BBVs has a window period during which an infection cannot be detected. Even in those rare cases where there is a significant risk of transmission, antibody testing on the prospective source person could only be considered preliminary. A negative result will not be conclusive, as the person may have seroconverted recently and is still within the window period. The officer/emergency service worker would still need to be tested and treated. Even if a positive BBV result is returned by the prospective source person, it would not establish whether the officer/worker had contracted a BBV unless they were tested themselves.
3. Mandatory testing conflicts with state and national guidelines that indicate testing should be voluntary except in exceptional circumstances. Given that saliva is not considered a risk for BBVs, this act would not reach the threshold for mandatory testing under current policy settings. It is unclear how mandatory testing would be enforced if a person resists because taking blood from someone without consent would constitute assault.
4. Mandatory testing would contribute to and amplify the significant stigma and discrimination for people living with HIV and viral hepatitis B and C in the community, which limits the ability of health services to target and engage people at risk of these blood borne viruses. Stigma and discrimination are exacerbated because many of the affected populations (including gay men, people who inject drugs, sex workers, people from culturally and linguistically diverse backgrounds and Aboriginal and Torres Strait Islander people) already experience stigma and discrimination on the basis of these other attributes.
5. The implementation of mandatory testing would have a detrimental impact on the ability of NSW specifically, and Australia more broadly, to address viral hepatitis. This includes weakening our ability to eliminate hepatitis C, because increased discrimination may dissuade people from engaging with health care services. It would also undermine campaigns for increased testing for viral hepatitis B.
6. In South Australia and Western Australia, where mandatory testing legislation has been introduced, it has faced active criticism from the health sector. Delegates at Australia's national HIV/AIDS conference in November 2016 issued a joint statement expressing their 'profound disappointment' at the laws so completely removed from the evidence-base.
7. Calls to implement mandatory BBV testing appear to originate from Police Associations, rather than qualified medical professionals with an understanding of BBV transmission. In some cases the legislation and guidelines provide for a senior police officer to determine whether it is 'likely' that exposure occurred or for police to override a doctor's recommendation as to the need for testing. In this instance the risk would be assessed by an unqualified person and undermine Australia's

best-practice policy framework for addressing BBVs, which addresses risks from within an evidenced based framework.

The proposed mandatory testing regime will do little to address stress for police (or their families) who believe they've been put at risk of BBV infection, as it is based on a misunderstanding of BBV transmission. Such laws will, however, mark a fundamental shift in the rights of individuals to privacy and to the integrity of their own selves, and a fundamental change to the established, successful and globally-respected Australian policy which is founded on the principle of voluntary consent for HIV and other BBV testing.

NSW has an opportunity to lead the way in the elimination of BBV transmission and demonstrate leadership in this area by implementing an evidence-based response. Over the last six years the NSW Government has led the Australian HIV response with progressive and adaptive policy settings. It is our firm belief that the pursuit of mandatory testing would be a backwards step for NSW, and would jeopardise much of the excellent work that has occurred under the current and former NSW HIV Strategies.

It is essential that laws enacted to address this issue are firmly grounded in evidence. For the Committee's reference we attach a series of documents featuring in-depth research about BBV transmission and analysis of existing mandatory testing laws.

We urge the Committee to consider alternative measures to ensure that police, emergency services and corrections personnel are educated about the true risk of occupational exposure to HIV and other BBVs.

Should you require any further information please contact Nicolas Parkhill on 9206 2122 or at nparkhill@acon.org.au.

Kind regards



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Levinia Crooks
CEO, ASHM



Stuart Loveday
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Dr Mary Harrod
CEO, NUAA



Craig Cooper
CEO, Positive Life NSW



Cameron Cox
CEO, SWOP

Attached:

- *Spitting and Mandatory Testing for HIV and Other Blood Borne Viruses*, Australian Federation of AIDS Organisations, October 2015.
- *Mandatory Testing for BBVs for alleged offenders in South Australia and Western Australia*, Australian Federation of AIDS Organisations, September 2015.

- *Emergency Service Providers and Blood Borne Viruses*, Australasian Society of HIV Medicine, March 2012.
- 'Back to the Future? HIV, Spitting and Perceptions of Risk', *HIV Australia*, Vol 14:1, March 2016.
- *HIV not transmitted via spitting*, Australasian Society of HIV Medicine Position Statement, March 2015.
- 'HIV Conference Slams Spitting Laws' Australasian Society of HIV Medicine, Media Release, November 2016.

Signatories to this letter

ACON is NSW's largest community-based lesbian, gay, bisexual, transgender and intersex (LGBTI) health and HIV organisation. ACON provides a range of information and services in the areas of HIV and STI prevention, HIV care and support, health promotion, advocacy, counselling, and housing. ACON also has a focus on issues such as mental health, alcohol and other drugs use, violence and ageing within the LGBTI community via a harm minimisation framework to address issues that can contribute to risk behaviours which increase the possibility of HIV/STI transmission.

ASHM is a peak organisation of health professionals in Australia and New Zealand who work in HIV, viral hepatitis and sexually transmissible infections. ASHM draws on its experience and expertise to support the health workforce and to contribute to the sector, domestically and internationally. ASHM supports its members, sector partners and collaborators to generate knowledge and action in clinical management and research, education, policy and advocacy in Australasia and internationally. It is committed to quality improvement, and its products and services are sought after by governments, members, health care workers and affected people. ASHM's dedicated membership, high-calibre staff and commitment to partnership assure its effectiveness in achieving its mission.

Hepatitis NSW (HNSW) is an independent, community-based, non-government health promotion charity. It provides information, support, referral and advocacy for people affected by hepatitis C in NSW along with workforce development and education services to improve services for those affected by it. HNSW strives to be representative of people affected by hepatitis C and works actively in partnership with other organisations and with the affected communities themselves to bring about improvements in quality of life, information, support and treatment, and to prevent HCV transmission. Although HNSW's focus is largely on hepatitis C, it also provides information and support for people affected by chronic hepatitis B as well as advocating for communities either affected by or at risk from chronic viral hepatitis in general. HNSW is part of a broader federated structure that has Hepatitis Australia at its peak and an independent hepatitis organisation in each State and Territory.

The **NSW Users & AIDS Association (NUAA)** is a not-for-profit NSW-based community controlled organisation advocating for people who use drugs, particularly those who inject drugs. The peak drug user organisation in NSW, NUAA was formed in 1989 in the face of a growing HIV epidemic. Funded primarily by the NSW Health Department, NUAA provides peer education, practical support, information and advocacy to people who use and inject illicitly, their friends, and allies. NUAA has often led the way in

developing innovative approaches to peer education and community development, and has contributed to Australia having one of the lowest HIV rates amongst people who inject in the world.

Positive Life NSW is a not-for-profit community organisation representing the interests of people with HIV, their partners and family in NSW. It was founded in 1988 and incorporated in July 1989. Positive Life NSW is a membership organisation with an elected board of directors. All Board members and staff are either living with/or personally affected by HIV. Positive Life NSW works to promote a positive image of people living with and affected by HIV with the aim of eliminating prejudice, isolation, stigmatisation and discrimination. It provides information and targeted referrals, outreach and community development, publications, education and community awareness, peer support programs, health promotion, policy development and systemic advocacy related to health and community support services.

SWOP is Australia's largest and longest established community based peer education sex worker organisation focused on HIV, STI and Hepatitis C prevention, education and health promotion for sex workers in NSW. A key element in the success of SWOP's work is the building of strategic, collaborative and multidisciplinary working relationships with sex workers, other key health, government and non-government organisations, and advocating for an equitable and holistic approach to services provided to sex workers.



Spitting and Mandatory Testing for HIV and other Blood Borne Viruses

October 2015

Key Points

1. SA and WA legislation now provides for forced BBV testing of an individual who is considered to have potentially exposed a police officer to the risk of contracting a BBV. Although the specifics of the legislation differ, in both states the legislation includes provision for forced testing for BBVs of a person who has spat¹ at a police officer. In both states introduction of the legislation followed concerted Police Association advocacy.
2. Presented as protecting police, these laws will in fact serve to fuel officers' unfounded fears regarding HIV transmission risk, while doing nothing to address legitimate police health concerns.
3. These forced testing laws and media regarding introduction of the legislation serve to perpetuate the common misconception that HIV can be transmitted by contact with saliva, such as through spitting. They also confuse issues about HIV risk and third party transmission.

Background and context

- In both WA and SA, the legislation was introduced as a result of advocacy on the part of local police associations.
- This briefing paper is premised on the understanding that HIV infection is a very serious matter with serious, life-long implications, and that there is a need for guidelines and procedures to minimise the risk of an officer contracting HIV following an exposure risk.
- AFAO, Western Australian AIDS Council and Gay Men's Health South Australia advocated against these laws because the provisions for forced testing do not in fact protect police from HIV infection. They instead serve to reinforce common misunderstandings of the ways in which HIV is transmitted, and will fuel rather than address unfounded anxieties experienced by police who have been spat at or bitten.
- The new laws flout Australia's National HIV Testing Policy which generally requires consent for HIV testing.
- **Key concerns about these laws are that they:**
 - **Perpetuate HIV transmission myths:** The new laws perpetuate the common misunderstanding that HIV can be transmitted through contact with saliva, such as through spitting and will no doubt fuel police officers' misapprehensions regarding risk of contracting a BBV, rather than allay general anxiety and specific concerns. As clearly stated in the Australian Society of HIV Medicine's guiding document entitled *Police and Blood-Borne Viruses*², there are only certain body fluids that contain HIV in sufficient concentration to be implicated in HIV transmission (i.e. blood, semen, pre-ejaculate, vaginal fluids and breast milk), and spit is not one of them.
 - **Conflate third party status with likelihood of transmission:** The rationale for forcibly testing a third party for BBVs is misconceived. Even if a positive BBV result is returned, it cannot establish whether a police officer has contracted the BBV. Conversely, as there is a window period for HIV tests, a negative test result from a third party is not conclusive. Application of the new laws will likely fuel unnecessary anxiety for some, while creating a false sense of security for others.

¹ Or other bodily/biological fluid has come in contact with a police officer.

² Australasian Society for HIV Medicine (ASHM), *Police and Blood-Borne Viruses*, June 2011, accessible at: http://www.ashm.org.au/images/pdfs/publications/1976963382_POLICE_Booklet_V2.0.pdf



Spitting and Mandatory HIV and other Blood Borne Virus Testing

September 2015

- **Completely ignore thresholds set by the National HIV Testing Policy:** The National HIV Testing Policy³ states:

Informed consent is required for HIV testing, except for rare occasions when a legal order is made for compulsory testing or in emergency settings (see Section 3.0 Indications for HIV Testing).

In both SA and WA, a 'senior police officer' will decide whether exposure to a BBV has occurred and will be able to order forced testing of a person, without requiring permission from a court or to obtain external scientific or medical expert opinion on HIV transmission risk.

- **Undermines the National HIV Strategy:** The National BBV Strategies are premised on a partnership between Government, the community, clinicians and researchers. The Seventh National HIV Strategy identifies the negative impact of criminalisation on priority populations through perpetuating isolation and marginalisation and limiting their ability to seek information, support and health care. Laws that potentially criminalise people with HIV and other affected communities run contrary both to the letter and spirit of these Strategies.
- **Undermine basic legal principles of assault:** The new laws represent a significant challenge to Australian legal principles. Generally, taking blood from a person without their consent involves the criminal offence of assault and civil trespass.
- **Provide no threshold at which the intervention of a court should be sought:** Of particular concern is the provision in the Western Australian legislation which states that "A police officer may apprehend and detain the suspected transferor for as long as is reasonably necessary to enable to determination of the application". This suggests that a person may be held indefinitely while they continue to resist forced testing. The South Australian states that "For the avoidance of doubt, a forensic procedure may be carried out on a person under this Division whether or not the person is in lawful custody".
- **May be frequently applied:** A WA Police media release noted that in 2013, 147 WA Police were exposed to bodily fluids - implying that mandatory testing may have been imposed in these cases had the legislation been in place at the time. Such statements fuel groundless anxieties: there are no recorded Australia cases of HIV transmission attributed to biting or spitting.
- **Fail to differentiate risk associated with different BBVs:** The new laws group BBVs together. It is unclear whether in each instance an assessment will be made about the likelihood of transmission associated with each different BBV, or whether a full 'set' of tests will be run regardless of risk.
- **Risk of criminalisation of those who test positive for HIV:** There is a chance that individuals who test positive under the new laws may potentially be charged under general criminal laws for exposure and transmission of HIV. Criminalisation of HIV transmission and exposure is very problematic and further extending the scope of criminalisation of great concern.
- **May be replicated in other states:** Following the prompt promulgation of these laws in South Australian and Western Australia, we are concerned that laws such as these may be adopted in other states and territories. Once in place, the repeal of such laws is notoriously difficult.

³ <http://testingportal.ashm.org.au/hiv/informed-consent-for-testing>

Briefing Paper

September 2015



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Mandatory testing for BBVs for alleged offenders in South Australia & Western Australia

The South Australian and Western Australian governments recently introduced legislation that allows for forced testing for blood borne viruses (BBVs) of individuals accused of certain offences, with the scope of these laws differing somewhat in each jurisdiction. These laws have been introduced as a result of the local Police Association's advocacy. AFAO, WAAC and Gay Men's Health South Australia have been actively engaged in advocacy against these laws.

These forced testing laws are of great concern. They perpetuate the common misconception that HIV can be transmitted through contact with saliva, such as through spitting. They also confuse issues about HIV risk and third party transmission. It could be argued that we are seeing the introduction of laws based in dated, 30-year old notions of HIV and other BBV transmission risk.

This paper provides:

- an explanation of what those supporting these laws seek to achieve
- where the legislation sits in relation to expert HIV medical guidance on HIV transmission risk and policing, the Australia HIV Testing Policy and the HIV legal framework more broadly
- policy solutions
- the advocacy AFAO, its members and partners have undertaken in response to the introduction of these laws.

Several annexures are included: a letter sent by AFAO to the South Australian Deputy/Premier (Annexure A), the letter received in response (Annexure B), the letter received by Gay Men's South Australia, Relationships Australia South Australia (Annexure C), the letter sent by WAAC to the Western Australia Attorney General (Annexure D) and the letter received in response (Annexure E).

South Australia

In 2012 the South Australian Police Association passed a resolution at its annual conference calling for laws that require a person or persons who assault a police officer to undergo blood tests to check for communicable diseases. In the lead up to the South Australian state election in early 2014, the Labor party announced its intention to pass such a law if re-elected. The re-elected Labor

Government introduced the Bill into Parliament – the *Criminal Law (Forensic Procedures) (Blood Testing for Diseases) Amendment Bill 2015*¹.

The Bill allows Police to test someone who has spat at or bitten police. The circumstances in which Police are able to require a BBV test are defined as where “the person is suspected of a prescribed serious offence” (this covers assault, causing harm and serious harm), and “it is likely that a person engaged in prescribed employment came into contact with, or was otherwise exposed to, biological material of the person as a result of the suspected offence”². A senior police officer determines whether exposure occurred and can order forced testing for BBVs.

The SA Opposition supports the measure but wants to broaden the scope of the law to cover firefighters, paramedics, emergency service workers, surf lifesavers, nurses, midwives, doctors and hospital emergency department staff.

The SA Government, Opposition and the Police Association argue that passing of the Bill would provide ‘peace of mind’ to police who might be exposed to a BBV. The Police Association’s President, Mark Carroll, has advocated for the law by arguing that the “incubation periods for diseases such as hepatitis and HIV cause the police and their families to endure stress while waiting months before knowing whether the officers involved are infected or healthy.”³ He has also recounted instances when police have been exposed to blood or other bodily fluids - many of which do not include risk of HIV transmission. South Australia’s Premier, Jay Weatherill, has supported forced testing, arguing that,

"While officers are already blood tested in these situations, some diseases are not detectable for months. This means officers can be left waiting for a considerable amount of time, which can be stressful for them and their families."⁴

Western Australia

In October 2014, the WA Government passed the *Mandatory Testing (Infectious Diseases) Act 2014*. This law allows for mandatory testing for certain infectious diseases of persons reasonably suspected

¹<http://www.legislation.sa.gov.au/LZ/B/CURRENT/CRIMINAL%20LAW%20%28FORENSIC%20PROCEDURES%29%20%28BLOOD%20TESTING%20FOR%20DISEASES%29%20AMENDMENT%20BILL%202015.aspx>

²s20A definition of biological material “means the person's blood or bodily fluids or any other biological material of the person that is capable of communicating or transmitting a disease”

³<http://www.thebody.com/content/69495/australia-push-for-police-assailants-to-undergo-ma.html>

⁴New blood test law to protect those who protect us, South Australian Premier Jay Weatherill and Deputy Premier John Rau Attorney-General joint News Release, Tuesday, October 15, 2013, available at: <http://www.agd.sa.gov.au/sites/agd.sa.gov.au/files/documents/Initiatives%20Announcements%20and%20News/Oct%202013%20-%20Media%20Releases/New%20blood%20test%20law%20to%20protect%20those%20who%20protect%20us%20%28PDF%20304.8KB%29.pdf>

of having transferred bodily fluids to police and other related public officers (related to policing) acting in the course of duty.

The Police Union WA has stated that before the new "spitters and biters" legislation was passed, officers faced "an anxious three to six months" for blood tests results to see if they had caught an infectious disease (ignoring the reality that most BBVs can be diagnosed in less than six months). According to police union boss, George Tilbury, "under the new [law], police officers will now only have to wait a few days ... one officer was reluctant to kiss his soon-to-be wife after their wedding, because he feared he could transfer an infectious disease after he was spat in the mouth by a woman." Mr Tilbury said the union has been lobbying the state government for years to have mandatory testing for offenders who bite and spat at officers:

"This issue has been on our agenda since it was first raised at the 2008 Annual Conference...and was resurrected again in 2012 after an executive motion".⁵

Police Minister, Liza Harvey, has stated that the legislation, which was an election commitment, meant that a person who exposed a police officer to the risk of infectious disease would be required to undergo blood testing:⁶

"Currently, the police officer has to wait an anxious three to six months for test results to confirm whether they have contracted a disease. This legislation will allow for the taking of bodily samples from the offender which will help with early diagnosis, clinical management and treatment of the exposed police officer. We need to protect officers who are on the frontline protecting us." (Underlining ours)

Interaction with proposed new WA public health legislation: *Public Health Bill 2014 (WA)*

Clause 105 of the Western Australian *Public Health Bill 2014* - in Part 8, Division 4, "Test orders" - provides a framework for test orders to be made, stating:

105. Division not limited by Mandatory Testing (Infectious Diseases) Act 2014

Nothing in the Mandatory Testing (Infectious Diseases) Act 2014 limits or affects this Division.

Division 4. Part 8, Division 4 provides the Chief Medical Officer with the authority to make test orders. According to the explanatory memorandum, the Chief Health Officer may make a test order if four criteria are established relating to the circumstances of possible transmission, the provision of counselling, the absence of consent and the need for the test for clinical or public health purposes.

⁵Biting and spitting bill' will bring police officers relief: union, WA Today, Article 24 October 2014, available at: <http://www.watoday.com.au/wa-news/biting-and-spitting-bill-will-bring-police-officers-relief-union-20141024-11b92l.html#ixzz3HK3Pbd4q>

⁶ New blood test laws protect police, Hon Liza Harvey MLA, Police Minister, Media Statement 15 May 2014, also available at: <http://www.mediastatements.wa.gov.au/Pages/StatementDetails.aspx?listName=StatementsBarnett&StatId=8325>

Clause 97, allows an authorised officer to take action to enforce a test order. An authorised officer may request the assistance of a police officer.

AFAO does not believe that the Public Health Bill will limit in anyway the exercise of powers under the *Mandatory Testing (Infectious Diseases) Act 2014* to order a mandatory test.

Problems with the laws

This briefing paper is based on the understanding that HIV infection is a very serious matter with serious, life-long implications. It also acknowledges that it is extremely regrettable that police and others serving the community should ever be put at risk of HIV infection while in the line of duty.

Unfortunately, the mechanisms proposed in the legislation will do little to address stress for Police or their families who believe they've been put at risk of HIV infection, much of which is based on misunderstanding of the ways in which HIV is transmitted. The new laws will, however, mark a fundamental shift in the rights of individuals to privacy and to the integrity of their own bodies and a fundamental change to Australian policy which generally requires consent for HIV testing.

These laws are deeply problematic because they:

- **Perpetuate HIV transmission myths:** The new laws perpetuate the common misunderstanding that HIV can be transmitted through contact with saliva, such as through spitting and potentially consolidate police officers' misapprehensions regarding risk of contracting a BBV, rather than allay general anxiety and specific concerns. As clearly stated in the Australian Society of HIV Medicine's guiding document entitled *Police and Blood-Borne Viruses*⁷, there are only certain body fluids that contain HIV in sufficient concentration to be implicated in HIV transmission (i.e. blood, semen, pre-ejaculate, vaginal fluids and breast milk), and spit is not one of them. This position was clearly stated in the July 2014 the US Center for Disease Control (CDC) statement on HIV transmission risk⁸: risk of HIV transmission risk from biting and spitting is negligible. Likewise, the US Center for HIV Law & Policy's⁹ *Spit Does Not Transmit Fact Sheet for Law Enforcement Professionals on the Risk of HIV Transmission in the Line of Duty* clearly states that "Contact with saliva, tears, or sweat has never been shown to result in HIV transmission".

Unfortunately, Australia lacks such expert scientific and legal statements by comparable authorities. In the absence of such statements by Australian authorities the new laws will only compound current misunderstandings and myths regarding transmission risks associated with spitting and biting.

- **Conflate third party status with likelihood of transmission:** The rationale for forcibly testing a third party for BBVs is misconceived. Even if a positive BBV result is returned, it cannot

⁷ Australasian Society for HIV Medicine (ASHM), *Police and Blood-Borne Viruses*, June 2011, accessible at: http://www.ashm.org.au/images/pdfs/publications/1976963382_POLICE_Booklet_V2.0.pdf

⁸ <http://www.cdc.gov/hiv/policies/law/risk.html>

⁹ As well as the Organisation of Black Law Enforcement Executives and Association of Prosecuting Attorneys

establish whether a police officer has contracted the BBV. Conversely, as there is a window period for HIV tests, a negative test result from a third party is not conclusive. Execution of the new laws will likely fuel unnecessary anxiety for some, while creating a false sense of security for others.

- **Completely ignore the thresholds set by the National HIV Testing Policy:** The National HIV Testing Policy¹⁰ states:

Informed consent for testing means that the person being tested agrees to be tested on the basis of understanding the testing procedures, the reasons for testing and is able to assess the personal implications. Informed consent is required for HIV testing, except for rare occasions when a legal order is made for compulsory testing or in emergency settings (see Section 3.0 Indications for HIV Testing).

In both South Australia and Western Australia, a 'senior police officer' will decide whether exposure to a BBV has occurred and will be able to order forced testing of a person. The senior police officer is not required to seek permission from a court or to obtain external scientific or medical expert opinion on HIV transmission risk. This broad brush approach ignores HIV transmission science and fails the National HIV Testing Policy's threshold which requires that testing without a person's informed consent can only occur if a legal order is obtained or the actions are carried out in an emergency setting.

- **Undermines the National HIV Strategy:** The National BBV Strategies are premised on a partnership between Government, the community, clinicians and researches. The Seventh National HIV Strategy identifies the negative impact of criminalisation on priority populations through perpetuating isolation and marginalisation and limiting their ability to seek information, support and health care. New laws that potentially further criminalise people with HIV and other affected communities run contrary both to the letter and spirit of these Strategies.
- **Undermine basic legal principles of assault:** The new laws represent a significant challenge to Australian legal principles. Generally, taking blood from a person without their consent involves the criminal offence of assault and civil trespass. HIV testing exceeds the legal boundaries of 'examining' a person, as it requires the subcutaneous drawing of blood: skin penetration constituting bodily harm. It is a marked infringement on an individual's human rights and civil liberties. AFAO is analysing how the new legislation will interact with each state's public health legislation – particularly the proposed new legislation for WA, the *Public Health Bill 2014 (WA)*.
- **Provide no threshold at which the intervention of a court should be sought:** Of particular concern is the provision (at section 9) in the Western Australian Act that states that "A police officer may apprehend and detain the suspected transferor for as long as is reasonably necessary to enable to determination of the application'. This suggests that a person may be held indefinitely while they continue to resist forced testing. There is no time limit at which

¹⁰ <http://testingportal.ashm.org.au/hiv/informed-consent-for-testing>

the matter may be referred to a court for adjudication. There is no opportunity for a court to intervene to consider whether there is a genuine risk that HIV transmission could possibly have occurred and there is no appeal mechanism for a person who does not wish to be tested. AFAO is analysing how WA's *Mandatory Testing (Infectious Diseases) Act 2014* would interact with WA's proposed new public health legislation, the *Public Health Bill 2014* (WA).

- **May be frequently applied:** The WA Police have released a statement to the media that in 2013, 147 WA Police were exposed to bodily fluids, implying such cases should come under the scrutiny of the new law. Despite the large numbers of people alleged to have exposed police to bodily fluids, we have not been able to identify a single recorded case of HIV transmission by biting or spitting in Australia. Introduction of forced testing laws is clearly legislative over-reach, responding to instances of spitting and biting rather than to evidence of exposure to transmission risk.
- **Fail to differentiate risk associated with different BBVs:** The new laws group BBVs together. It is unclear whether in each instance an assessment will be made about the likelihood of transmission associated with each different BBV, or whether a full 'set' of tests will be run regardless of risk.
- **Risk of criminalisation of those who test positive for HIV:** There is a chance that individuals who test positive under the new laws may potentially be charged under general criminal laws for exposure and transmission of HIV. Criminalisation of HIV is very problematic, and extending the scope of its application is of great concern.
- **May be replicated in other states:** Following the prompt promulgation of these laws in South Australian and Western Australia, we are concerned that laws such as these may be adopted in other states and territories. Once in place, the repeal of such laws is notoriously difficult. Consequently, it is crucial to act immediately to prevent the further adoption of such laws.

Policy remedies to ameliorate the impact of the new laws

Given that laws have now been introduced in both South Australia and Western Australia, it is essential to ensure the reasonable and consistent application of these laws. This should be done in the framework of an operating procedures protocol that outlines the appropriate application of these laws. Such a procedure document should, among other things, limit the application of new laws requiring/permitting non-consensual testing for communicable (SA) or infectious (WA) diseases *only* to circumstances where there is a real/reasonable possibility of transmission, and ensure that any overriding protections and rights of appeal contained in each state's public health legislation are reflected in procedural guidelines and policies, and complied with.

The SA and WA Bills were introduced in a context of fear of BBV transmission risk. The new laws neither address real transmission risk nor provide mechanisms to address the fears articulated by the police in both states. Ironically, these laws may serve to undermine the wellbeing of those officers first seeking to utilise them by giving effect to formerly vague fears. Where the legislation is applied and a forced test is undertaken, the officer involved may well draw conclusions/inferences from the results of alleged offenders that are not relevant to understanding their own BBV status.

A concerted, coordinated approach is required to respond to the serious deficit in understanding of HIV transmission risk, as evidenced by the rationales provided in SA and WA for these laws. This should be based on scientific, evidence-based processes, as laid out in ASHM's guiding document entitled Police and Blood-Borne Viruses. All police officers who have been put at actual risk of HIV infection should be offered access to Post-Exposure Prophylaxis (as per appropriate jurisdictional and national guidelines). They should also be offered referral to professional and expert post-exposure counselling. These evidence-based responses must occur in a context of increased education/awareness of first responders to actual BBV transmission risk.

We note that the Police Association of NSW has also recently called for powers to force anyone who "transmits" a bodily fluid to emergency workers, to be tested for infectious diseases, including blood-borne viruses – see: <http://www.news.com.au/national/breaking-news/cops-union-calls-for-new-spitting-offence/story-e6frku9-1227258410585> .



Emergency Service Providers and Blood-Borne Viruses



Emergency Service Providers can be exposed to a person's blood or other body fluids in the course of their work. Several studies show that the incidence of occupational exposure to blood or other body fluids among Emergency Service Providers is higher than that in the general public and is second only to that in healthcare workers.¹⁻⁵ This resource is intended for Emergency Service Providers in Australia.

This resource provides general information about blood-borne viruses specific to Emergency Service Providers; this includes Paramedics, Fire Service workers, First Aid providers and State Emergency Services personnel. It is designed for use throughout the country, and it is therefore necessarily broad in content and advice. The resource focuses on blood-borne viruses and the principles of transmission, prevention and management. This document is supplementary to the policies and procedures of each emergency agency and its purpose is to provide information and guidance rather than being mandatory. Where jurisdictional detail is required, reference must be made to local policies and procedures.

The Facts

The three major blood-borne viruses – hepatitis B virus (HBV), hepatitis C virus (HCV) and human immunodeficiency virus (HIV) – are different viruses and are not related to each other. They can all be transmitted by blood. HBV and HIV can also be transmitted by other body fluids. Many people with HBV and HCV, and some people with HIV, are unaware that they have the infection and may unknowingly pass the virus on to others. These infections can be prevented. They can all be treated, but if left untreated, can lead to serious health problems (Table 1).

Table 1. The Facts About HBV, HCV and HIV

	HBV	HCV	HIV
Prevalence	An estimated 170,000 people in Australia have chronic HBV infection. ⁶	An estimated 222,100 people in Australia have chronic HCV infection. ⁶	An estimated 21,391 people in Australia are living with HIV infection. ⁶
Vaccination/ Immunity	HBV can be prevented by vaccination.	There is no vaccine for HCV.	There is no vaccine for HIV.
	95% of adults infected with HBV naturally clear the virus and become immune for life.	25% of adults infected with HCV clear the virus naturally, but do not become immune.	HIV infection cannot be cleared by the body and infection is for life.
Transmission	<p>Blood-to-blood contact:</p> <ul style="list-style-type: none"> ■ injecting equipment ■ needle-stick injury ■ open wounds ■ tattooing and body piercing equipment. <p>Sexual contact (unprotected anal or vaginal sex).</p> <p>Mother to baby.</p> <p>Saliva in the mouth, eyes and bites that break the skin.</p> <p>Infected blood products (all blood in Australia has been screened since 1970).</p>	<p>Blood-to-blood contact:</p> <ul style="list-style-type: none"> ■ injecting equipment ■ needle-stick injury ■ open wounds ■ tattooing and body piercing equipment. <p>Not considered sexually transmitted unless blood contact occurs.</p> <p>Mother to baby.</p> <p>Infected blood products (all blood in Australia has been screened since 1990).</p>	<p>Blood-to-blood contact:</p> <ul style="list-style-type: none"> ■ injecting equipment ■ needle-stick injury ■ open wounds ■ tattooing and body piercing equipment. <p>Sexual contact (unprotected anal and vaginal sex).</p> <p>Mother to baby.</p> <p>Infected blood products (all blood in Australia has been screened since 1985).</p>
Signs and symptoms	<p>Initial signs and symptoms may include:</p> <ul style="list-style-type: none"> ■ feeling unwell ■ loss of appetite ■ dark urine ■ yellow skin known as jaundice ■ right upper abdominal pain. 	<p>Initial signs and symptoms may include:</p> <ul style="list-style-type: none"> ■ tiredness ■ nausea ■ right upper abdominal pain ■ intolerance to fatty foods and alcohol. 	<p>Initial signs and symptoms may include:</p> <ul style="list-style-type: none"> ■ flu-like illness ■ rash ■ fever. <p>HIV damages the immune system. If left untreated, HIV can progress to AIDS.</p>
Treatment	<p>Long-term antiviral treatment is available for chronic HBV to prevent liver damage.</p> <p>Treatment does not cure HBV infection.</p>	<p>Antiviral treatment is available for chronic HCV and may clear (cure) HCV infection.</p>	<p>Antiretroviral treatment is available for HIV infection.</p> <p>Treatment does not cure HIV infection, but minimises damage to the immune system and progression to AIDS.</p>

HBV: hepatitis B virus

HCV: hepatitis C virus

HIV: human immunodeficiency virus

AIDS: acquired immune deficiency syndrome

Prevention, Infection Control and Standard Precautions in a Community Setting

The following section addresses how Emergency Service Providers can protect themselves from exposure to blood-borne viruses.

Emergency Service Providers should be HBV vaccinated as a means to protect themselves and others, both personally and professionally.



Vaccination

It is recommended that Emergency Service Providers should be vaccinated against HBV if they are assigned to duties which may involve exposure to a person's blood and other body fluids.⁷

Vaccination involves three doses of HBV vaccine over 6 months. A blood test after completion of the vaccination course can confirm immunity. If immunity is achieved, no booster doses are required.⁷ If immunity cannot be confirmed following the primary course of vaccination, further vaccination may be required. People who fail to develop immunity after vaccination must be aware that they are an unvaccinated person and have no protection against HBV.

Personal Protective Measures

The following work practices are minimum requirements needed for effective infection control. If correctly followed, they will ensure a high level of protection against transmission of infection including blood-borne viruses. Standard precautions are taken by all personnel having contact with blood, other body fluids, non-intact skin, and the eye, nose or mouth surfaces. Standard precautions are just that: standard for all, not just those suspected or known to have a blood-borne virus.⁸

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

a) Personal protective equipment (gloves and protective clothing)

- Emergency Service Providers should wear disposable gloves in situations where they may be exposed to blood or other body fluids. The gloves do not have to be sterile.
- Personal protective equipment, such as eyewear and face shields, should be worn when there is the chance of being splashed or sprayed in the face and eyes with blood or body fluids.

b) Avoiding exposure to broken skin

- Cover all your open wounds/cuts/blisters with waterproof dressings and check the dressings are intact and adherent. This is especially important for any injuries on the hands and palms where dressings are hard to stick.
- Maintain good hand care; moisturise hands with a good hand cream and avoid irritants that may cause dermatitis (and therefore broken skin).

c) Proper handling and disposal of sharp objects such as needles, blades and glass

- Gloves should be worn when handling sharp objects (sharps). The safest way to hold a syringe is by the barrel, with a gloved hand. Do not handle the metal needles. Never recap a needle, bend or break it by hand or remove the needle from the barrel or disposable syringe.
- Sharp objects should be handled as little as possible. Avoid crossing your hands when handling a sharp.
- Only one person should handle the sharp object until it is disposed of in a sharps container or specifically designed evidence containers.
- A sharps container is a yellow, rigid-walled container displaying the biohazard label and symbol. It should be available in work places that are likely to involve the handling of sharps. In the field, other containers may do, such as thick plastic drink bottles.
- Take the sharps containers to the sharp object, rather than carrying the sharp object to the container.

d) Prevention of needle stick and sharps injuries when doing searches

- Employ a slow systematic approach to searching.
- Do not put your hands in places where you cannot see.
- Do not slide your hand when searching, pat your hand instead.

- Use tools instead of your hand, to assist with hard-to-access areas.
- Empty the contents of bags and containers onto a flat surface for inspection, rather than putting your hands in to feel when searching.
- Perform the search in a well lit area or use mirrors and torches to assist with the search.

e) Environmental blood and body substance spills

- Blood and other body-fluid spills should be dealt with as soon as is practicably possible.
- A 'spills kit' should be easily available for blood spills.
- Wear personal protective equipment (gloves, goggles, waterproof apron).
- Soak up spills, including those on clothing, with paper towels.
- Wash the spills down with detergent and water, and then allow to air dry.
- For larger spills, confine and contain the spill, clean visible matter with disposable absorbent material and discard in appropriate waste container.
- Furnishings such as chairs and mattresses can be washed with water and detergent and should be allowed to dry.
- Leather goods (belts, shoes) can be washed with soap and water.
- Uniforms can be commercially laundered. Hot temperatures in a clothes dryer assists disinfection. Heavily contaminated clothing should be destroyed.

Workplace Protective Measures

Emergency Service Provider's work can be very unpredictable when in the field; however it is important that, where possible, all appropriate measures be taken to ensure safety. Safe Work Australia⁹ advises the following:

- **Hazard identification:** identify activities in the workplace that may put you, your colleagues or members of the public at risk of transmission of blood-borne viruses as a result of work activities.
- **Risk assessment:** evaluate the risk to yourself and colleagues from blood or other body fluid exposures. Risk assessments need to be consistently monitored, reviewed and evaluated to take into account the specific duty.

■ Risk control, including:

1. Limiting exposure to sharps
2. Safe working environment
3. Standard precautions in place, as outlined above
4. Access to personal protective equipment
5. Education and training about blood-borne viruses for staff
6. Post-exposure procedures in place (see Table 2).

Risk Assessments

Emergency Service Providers are less likely to experience an exposure than hospital workers, and the exposures that do occur tend to be less significant and carry less risk.¹⁰ Needlestick injuries (NSIs) carry the highest risk for infection compared to all other types of exposures. An American study found that emergency service personnel receive 87–370 NSIs per 1,000 workers each year, compared to 50–2,000 NSIs/1,000 doctors/yr.¹¹

Since the introduction of a vaccine for HBV, the risks of HBV infection to vaccinated Emergency Service Providers is negligible.¹⁰

The whole-of-career risk of acquiring HCV through work has been estimated to be less than 1 in 1000 for US Emergency Services Personnel.¹²

Table 2 presents an estimate of risk of infection by various exposures from a person who is known to have a blood-borne virus. It includes the risk for sexual exposures as a comparison. Risk estimates are approximate and will vary according to individual circumstances.

The risk is many times lower when the person is not known to have HBV, HCV or HIV. As an estimate, the risk from a person not known to have HBV or HCV would be approximately 200 times less for HBV, and 100 times less for HCV. The risk of HIV transmission from a person not known to have HIV would be 1000 times less. These estimates are based on the prevalence of blood-borne viruses in the community and the following equation:

$$\text{Risk of transmission} \times \text{likelihood of source having a BBV} = \text{Risk of exposure}$$

There are many factors that determine the likelihood of transmission. Each exposure needs to be independently evaluated by an experienced health professional, so it is important to seek medical advice when exposure to blood or other body fluids occurs.

Potential Blood-borne Virus Exposure Management

The following advice is general. Please refer to your local policies and procedures for advice on the management of a potential blood-borne virus exposure.

It is important to act immediately on the following:

Table 2. Risk of HBV, HCV and HIV Transmission From a Known Positive Source

Exposure type	Known Positive Source Status		
	HBV+	HCV+	HIV+
Blood contact with broken skin, mouth or eyes <ul style="list-style-type: none"> ■ e.g. Punch from bleeding person to body causing break in skin ■ Large blood splash, e.g. arterial bleed ■ Blood contact to mouth from giving mouth-to-mouth resuscitation if no protective equipment used 	moderate	low	low~
Needle stick injury and other penetrating injuries <ul style="list-style-type: none"> ■ e.g. Cut by a blade which recently penetrated another person ■ Recently used needle penetrating skin 	very high#	high^	moderate*
Saliva in mouth or eyes and bites that break the skin	very low	zero	zero
Blood and saliva to intact skin and skin-to-skin contact	zero	zero	zero
Sexual exposure (no condom used) <ul style="list-style-type: none"> ■ Anal (receptive) ■ Vaginal or anal (insertive) ■ Oral 	high high moderate	very low very low zero	very high moderate very low

~ Risk of HIV from blood contact to broken skin is estimated by US CDC at less than 1 in 1000 chance

Risk of HBV from needle stick injury estimated at 1/3

^ Risk of HCV from needle stick injury estimated at 1/30

* Risk of HIV from needle stick injury estimated at 1/300

zero = less than 1 in 1 000 000

First Aid Measures

- Wash exposed skin with soap and water. Use an alcohol-based hand rub if no water is available.
- If the eyes have been exposed, thoroughly rinse them with tap water or saline (0.9% or normal saline), with eyes open.
- If the mouth has been exposed, spit, then rinse the mouth with water and spit again.
- Seek medical advice immediately. If available, call the designated hotline for your service (contact details for each state and territory can be found on page 7).

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.

The Source of the Exposure

- Often it is not possible to determine the source of an exposure e.g. a needle stick injury from a discarded needle and syringe.
- Where the identity of the source is known, the source may claim to have, or deny having, a blood-borne virus. Neither assertion can be relied upon unless the source has been, or is tested for, blood-borne viruses. Testing of the source is possible in some jurisdictions through a Disease Testing Order. Testing and results in relation to the source should not delay seeking medical care as treatment may need to commence as soon as possible.

Testing and Avoiding Transmission

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

- Practice safer sex, i.e. use a condom for vaginal or anal intercourse. As HCV is rarely transmitted by sex, this precaution is not required if your only risk is HCV infection.
- Cover any sores, 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 breast feeding.

For HBV, no further testing is required if you are immune. If you are in the middle of a vaccination course at the time of the exposure, it is recommended that you are tested 4 weeks after the third dose of vaccination.

For HCV, blood tests are recommended at 12 and 24 weeks after the exposure. A negative HCV test at 24 weeks means you did not contract HCV.

For HIV, you will generally be offered HIV tests at 6 and 12 weeks after the exposure. If you were not placed on HIV post-exposure prophylaxis (PEP), a negative blood test at 12 weeks means you did not contract HIV. If you were placed on HIV PEP, it is recommended that you have a test 24 weeks after the exposure. A negative test at this time means you did not contract HIV.



Post Exposure Prophylaxis (PEP)

PEP is medication taken after exposure to a blood-borne virus to reduce the risk of infection. Your health professional will assess your risk of HIV or HBV infection to determine the need for PEP. PEP is not available for HCV.

For HBV, PEP is not required if you have been fully vaccinated. A blood test to confirm immunity may be recommended.

If you have not been vaccinated against hepatitis B, or your blood test shows you are not immune, you may be offered HBV PEP with vaccination. Non HBV-immune people experiencing a significant exposure such as a needle stick injury or blood splash to broken skin, mouth or eyes, are advised to have a vaccination against hepatitis B. The first dose is given as soon as possible after the exposure, and further doses are given over the next 6 months. If in addition the source is known to have HBV, you may be offered hepatitis B immunoglobulin (HBIG) within 72 hours of an exposure.

For HCV there is no PEP but it is still important to seek medical advice for an assessment of the risk and follow-up procedure.

For HIV there are jurisdictional and national guidelines for PEP. These guidelines are applicable to the community setting. For contact details of services that can provide information on PEP if you have experienced a blood-borne virus exposure, refer to Table 3 Helplines for Emergency Services Providers. Alternatively, refer to the national PEP guidelines¹³ for further information.

PEP for HIV consists of two or sometimes three antiretroviral medications taken daily for 28 days.

These medications are the same as those used to treat people with HIV. It is critical that PEP is commenced no later than 72 hours following an exposure. The effectiveness of PEP has not been accurately measured. PEP may cause side-effects such as headache, tiredness and nausea. Emergency Departments at major public hospitals and sexual health clinics are likely to provide PEP medications. Most states have a 24-hour PEP Hotline that you can contact to find locations which dispense PEP and to discuss the exposure (see Table 3 Helplines for Emergency Services Providers for contact details).

Providing Support

Experiencing an exposure to a blood-borne virus can be stressful. Your health professional and your designated employee assistance or counselling services are available to provide support during this period (Table 3).

Duty of Care

Emergency Service Providers or members of the public who are potentially exposed to blood-borne viruses require medical assessment as soon as possible following an exposure.

Discrimination

HBV, HCV and HIV are highly stigmatised conditions and many people living with these viruses experience discrimination. Policies and practices that protect privacy and confidentiality are important. Legislation prohibits discrimination against people with a blood-borne virus, and there are also privacy laws protecting people's health information. Education is also vital, enabling Emergency Services Providers to understand how blood-borne viruses are transmitted and how to reduce the risk of exposure.

There is no need to isolate a person or deal with that person any differently because he or she is known to have, or is suspected of having, a blood-borne virus. Standard precautions provide protection and should be used in all situations regardless of whether a person has an infection. A person's suspected blood-borne virus status or sexual orientation must not be noted in any records unless it is directly relevant to a crime or the person's health state. There may be occasions where Emergency Services Providers may learn of a person's blood-borne virus status. In this case, the information will need to be regarded as confidential and it is essential that every effort is made to protect the privacy rights of the person concerned.

Emergency Services Providers With a Blood-borne Virus Infection

All Emergency Services Providers should adhere to standard precautions to avoid transmitting blood-borne virus in the workplace.⁹ Emergency Services Providers are encouraged to be vaccinated against hepatitis B. It is recommended that Emergency Services Providers, as with the general public, know their own status with regard to blood-borne viruses. Knowing your status means you can get the right health care for yourself.

Emergency Services Providers are generally not required to disclose their blood-borne virus status to their employer. In some jurisdictions, healthcare workers who carry a blood-borne virus are legally obliged to declare their Infectious status.¹⁴ Employers must not unlawfully discriminate against their employees on the basis of their blood-borne virus status.

Emergency Services Providers who have a blood-borne virus should consult a suitably qualified medical practitioner to assess their risk of disease transmission during the performance of their normal duties. That assessment of risk should take into consideration the nature of the duties and refer to section B 5.3 of the NHMRC (2010) *Australian Guidelines for the Prevention and Control of Infection in Healthcare* on Exposure Prone Procedures (EPP). The Guidelines provide categories of Exposure Prone Procedures. Exposure Prone Procedures (EPPs) are invasive procedures where there is potential for direct contact between the skin, usually finger or thumb and sharp surgical instruments, needles, or sharp body parts (e.g. fractured bones), spicules of bone or teeth in body cavities or in poorly visualised or confined body sites, including the mouth of the patient. During an EPP there is an increased risk of transmitting a blood-borne virus from the Emergency Services Provider to the patient.¹⁵

If you have a blood-borne virus and your status becomes known to other Emergency Services Providers either from your disclosure, or as a result of testing (e.g. following an exposure or as part of a vaccination program), they must keep this information confidential and not disclose it to anyone without your consent.

Glossary of Terms

Antibody test: An initial screening blood test that looks for antibodies to the virus and not for the virus itself.

Cirrhosis: Extensive and permanent scarring of the liver.

Hepatitis: Inflammation of the liver. It can be caused by alcohol, drugs and viruses including hepatitis B and C.

Immunity: The condition of being immune, or protected, from infection.

Post-exposure prophylaxis (PEP): Drugs and vaccines given as soon as possible but within 72 hours of exposure to HIV or HBV in an attempt to prevent infection.

Standard Precautions: Minimum required work practices to protect against transmission of infection including blood-borne viruses. Standard precautions should be used with all people and with any blood, body fluids, non-intact skin, and eye or mouth surfaces.

Detailed References

Detailed references are available on the ASHM website at www.ashm.org.au/publications

Resources

Table 3. Helpline Resources for Emergency Services Providers

State	Service	Telephone	Service Provided	Further Information
ACT*	Canberra Sexual Health Centre	02 6244 2184	Advice about being exposed to blood or body fluids and counselling services	It is recommended that Emergency Services Providers contact their local emergency department outside of operating hours.
NSW	Needle Stick Injury Hotline	1800 804 823	Information about the need for and access to post-exposure prophylaxis (PEP)	This service is available 24 hours, 7 days a week. However it is recommended that Emergency Services Providers contact their local emergency department following an exposure to blood or body fluids for advice.
	NSW PEP Hotline	1800 737 669	Information about the need for and access to PEP	This service is available 24 hours, 7 days a week
	Employee Assistance Program (NSW Govt workers only)	1300 667 197	Counselling services	This service is available 24 hours, 7 days a week.
NT	Health Direct**	1800 022 222	Expert health advice from Registered Nurses	This service is available 24 hours, 7 days a week. However it is recommended that Emergency Services Providers contact their local emergency department following an exposure to blood or body fluids for advice.
Qld*	Blood and Body fluids Hotline	1800 010 461	Advice for Emergency Services Providers and their immediate family about a blood or body fluid exposure from qualified doctors.	This service is available 24 hours, 7 days a week.
SA*	SA PEP Hotline	1800 022 226	Information about the need for and access to PEP.	This service is available 24 hours, 7 days a week.
Tas*	Department of Health and Human Services, Sexual Health Clinical Services	1800 675 859	Advice about being exposed to blood or body fluids and counselling services	This service operates week days, 8:30am-5:00pm. It is recommended that Emergency Services Providers contact their local emergency department outside of operating hours.
Vic	Medical Services Hotline	1800 004 464	Advice about being exposed to blood or body fluids and counselling services	This service is available 24 hours, 7 days a week.
	Vic PEP Helpline	1800 889 887	Information about the need for and access to PEP	
WA	WA PEP Line	1300 767 161	Information about the need for and access to PEP.	This service is available 24 hours, 7 days a week. However it is recommended that Emergency Services Providers contact their local emergency department following an exposure to blood or body fluids for advice.

* If a post-exposure prophylaxis (PEP) helpline is not available in your state or territory, it is recommended that you seek advice from the emergency department of your closest major hospital or public sexual health clinic.

** Health Direct is also available in the ACT, NSW, Tas, SA and WA.

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 anti-discrimination commission, anti-discrimination board or human rights commission, through this Gateway: www.antidiscrimination.gov.au

National Guidelines for Post-Exposure Prophylaxis 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. The guidelines are available at: <http://www.ashm.org.au/images/publications/guidelines/2007nationalnpepguidelines2.pdf>

Safe Work Australia

Safe Work Australia (formerly known as the National Occupational Health and Safety Commission) began operating in 2009 as an independent statutory agency with primary responsibility to improve occupational health and safety and workers' compensation arrangements in Australia. Workers can access the National Code of Practice for the Control of Work-related Exposure to Hepatitis and HIV (blood-borne) Viruses by visiting: www.safeworkaustralia.gov.au.

Register of Public Sexual Health Clinics in Australia and New Zealand

A directory of Public Health Clinics in Australia and New Zealand can be found at: <http://www.racp.edu.au/page/sexual-health-publications>.

ASHM resources

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

Profession Based Booklets

- An Overview of Hepatitis C: Clinical management in opiate pharmacotherapy settings
- Antenatal Testing and Blood-Borne Viruses (BBVs)
- Correctional Officers and Hepatitis C
- Dental Health and Hepatitis C
- Dentists and HIV
- General Practitioners and Hepatitis C
- General Practitioners and HIV
- Nurses and Hepatitis C
- Pharmacy and Hepatitis C
- Police and Blood-Borne Viruses

Factsheets

- Decision Making in Hepatitis B
- Hepatitis B Factsheet: for people newly diagnosed
- Hepatitis C in Brief – patient factsheet
- Hepatitis C Management and Treatment for Clients of Pharmacotherapy Services
- HIV Patient Fact Sheet

Monographs

- B Positive: all you wanted to know about hepatitis B – a guide for primary care
- Co-infection: HIV & viral hepatitis – a guide for clinical management
- Hepatitis C: clinical management in opiate pharmacotherapy settings
- HIV and Viral Hepatitis C: policy, discrimination, legal and ethical issues
- HIV Management in Australasia: a guide for clinical care
- HIV, Viral Hepatitis and STIs: a guide for primary care

Distance-learning Kit

- Clinical Science of HIV Medicine CD

Manuals

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

Online resource

- ASHM Directory of HIV, Viral Hepatitis and Sexual Health Services
- Guide to Australian HIV Laws and Policies for Healthcare Professionals. Available online only at www.ashm.org.au/HIVLegal

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ASHM offers training in HIV, viral hepatitis and blood-borne viruses for general practitioners, nurses and allied health care workers around Australia.

For further information on upcoming courses:

Visit www.ashm.org.au/courses or contact the ASHM National Policy and Education Division on education@ashm.org.au or phone 02 8204 0720.

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Online Learning Module

An accompanying online education module covering the most important aspects of this printed resource and incorporating interactive self-assessment activities has been developed. The aim of the online module is to discuss the potential exposure management of blood-borne viruses in the work place. To access this online education module, visit the ASHM website at: www.ashm.org.au/esp.

Further resources and support information is available from the following organisations:

ASHM T 02 8204 0700 E ashm@ashm.org.au W www.ashm.org.au	Human Rights & Equal Opportunity Commission – Commonwealth T 02 9284 9600 W http://www.humanrights.gov.au/
Australian Injecting and Illicit Drug Users League (AIVL) T 02 6279 1600 E info@aivl.org.au W www.aivl.org.au	Gastroenterological Society of Australia T 1300 766 176 E gesa@gesa.org.au W www.gesa.org.au
Australian Drug Foundation T 03 9278 8100 or 1300 858 584 (Infoline) E adf@adf.org.au W www.adf.org.au	Hepatitis Australia T 02 6232 4257 F 02 6232 4318 E achinfo@hepatitisaustralia.com W www.hepatitisaustralia.com
Australian Federation of AIDS Organisations (AFAO) T 02 9557 9399 F 02 9557 9867 W www.afao.org.au	HIV-Hepatitis-STI Education and Resource Centre T 03 9076 6993 E erc@alfred.org.au W www.hivhepsti.info
Australasian Society for Infectious Diseases (ASID) T 02 9256 5475 E asid@racp.edu.au W www.asid.net.au	National Association of People With AIDS T 02 8568 0300 or Freecall 1800 259 666 F 02 9565 4860 W www.napwa.org.au

Most states and territories provide information about their infection control guidelines and policies through their websites:

Australian Government	
National Health and Medical Research Council W http://www.nhmrc.gov.au/guidelines/publications/cd33	ACT Department of Health and Community Care W www.health.act.gov.au/policiesandplans
NSW Health Infection Control Policy W www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007_036.pdf	Department of Health and Community Services – Northern Territory W www.nt.gov.au/health/
Queensland Health W http://www.health.qld.gov.au/chrisp/	Health Department of Western Australia W www.health.wa.gov.au
Department of Health and Human Services Tasmania W www.dhhs.tas.gov.au/publichealth/communicablediseases/	Victorian Department of Human Services, Public Health Division Guidelines for the Control of Infectious Diseases W www.health.vic.gov.au/ideas
South Australian Department of Human Services W http://www.health.sa.gov.au/Default.aspx?tabid=47	
New Zealand	
The Hepatitis Foundation W www.hepfoundation.org.nz	New Zealand AIDS Foundation W www.nzaf.org.nz

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Supporting the HIV, Viral Hepatitis and Sexual Health Workforce

www.ashm.org.au



Emergency Service Providers and Blood-Borne Viruses SUPPLEMENTARY

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BACK TO THE FUTURE? HIV, SPITTING AND PERCEPTIONS OF RISK

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Warning: this article may evoke a spooky, back to the 1980s feeling ... a past/future Australia where councils seriously proposed draining swimming pools frequented by gay men to protect swimmers from 'catching AIDS ...'.

But this is not a story of past ignorance; it's about recent developments, policy challenges, and a very serious question: how do we preserve hard won legal protections against HIV-related discrimination and laws that stigmatise people with HIV?

Introduction

In 2014 the South Australian (SA) and Western Australian (WA) parliaments passed legislation providing for forced testing for blood borne viruses (BBVs) of people who are considered to have potentially exposed police, hospital staff or emergency workers to a BBV.

In both states, the laws were introduced following concerted advocacy on the part of police unions. This article looks at what drove the introduction of these laws, discusses implementation issues, and proposes some policy solutions.

Before looking at the detail, let's be clear: police officers face challenging and dangerous situations daily, and it is perfectly understandable that an officer who has been bitten, jabbed, bled on or spat at will want workplace policies in place to minimise the risk of contracting an infectious disease as a result of potential exposure.

The problem is that for HIV and other BBVs, these new forced-testing laws represent a knee-jerk response that:

- a. undermines Australia's best-practice policy framework for addressing BBV risks to public health in a way that responds to actual risk, and
- b. does nothing to educate the public or police about BBV transmission and exposure risk, or allay unfounded fears and stigmatisation of people living with BBVs in the community.

It is the view of the Australian Federation of AIDS Organisations (AFAO) that these laws in fact serve to reinforce misinformation about how BBVs are transmitted; heighten police officers' anxieties; and fuel community stigma associated with HIV and other BBVs.

The concerns raised in this article focus on HIV, but the basic issues apply for all BBVs.

South Australia

In the lead up to the 2014 South Australian election, the Police Association of SA successfully lobbied the SA Labor Government for laws to provide that a person who assaults a police officer can be required to undergo blood tests to check for 'communicable diseases' – including HIV and other BBVs.

This resulted in Labor announcing its intention to pass such a law if re-elected. The SA Premier and Attorney-General's media statement announcing the proposed legislation described it as 'a new community safety measure' designed to 'protect those who protect us'.¹

The re-elected Labor Government subsequently fulfilled its promise, with the *Criminal Law (Forensic Procedures) (Blood Testing for Diseases) Amendment Bill 2014*.²

The Opposition, the Police Association and the Law Society of SA were all at one with the government on the issue, agreeing that the legislation would provide 'peace of mind' to police who might have been exposed to a BBV or communicable disease.

The SA Opposition not only supported the measure but proposed to broaden its scope to include firefighters, paramedics, emergency service workers, surf lifesavers, nurses, midwives, doctors and hospital emergency department staff.³ Representations made to the SA Attorney-General, including from AFAO, argued strongly against the legislation, went unheeded and in 2015 the Bill was passed.

The SA legislation provides for forced testing for 'communicable diseases', including HIV and other BBVs where a person is 'suspected of a prescribed serious offence' (this covers assault, causing harm and serious harm), and 'it is likely that' a person engaged in 'prescribed employment' came into contact with, or was otherwise exposed to, 'biological material of the person as a result of the suspected offence'. People in 'prescribed employment' are:

- a. police officers
- b. emergency workers
- c. medical practitioners in a hospital
- d. nurses or midwives in a hospital, and
- e. people providing assistance or services in a hospital.

Under the legislation, a senior police officer determines whether it is 'likely' that exposure occurred, and can order that an alleged offender provide a blood sample for BBV testing.

The scope of this legislation is extremely broad, allowing for testing to be carried out 'whether or not the person is in lawful custody', and clarifying that these amendments apply 'whether the relevant offence was committed before, on or after the commencement of the law'.

Western Australia

And so to the west ... and another election commitment. In October 2014, the WA Parliament passed the *Mandatory Testing (Infectious Diseases) Act 2014*⁴, its intended purpose being:

'to help ensure that a police officer or other public officer who, in the course of duty, is exposed to the risk of transmission of certain infectious diseases receives appropriate medical, physical and psychological treatment ...'.

Under the legislation, persons reasonably suspected of having transferred bodily fluids to a police officer (or other public officer) may be required to test for BBVs/specified STIs. Other than for children/incapable persons, the decision to require a person to test is made by a 'senior police officer'.

It is particularly concerning that the guidelines supporting the implementation of this legislation enable the police to 'request to override' an attending doctor's recommendation as to the need for testing.⁵

This extraordinary process prioritises the expertise of police over attending doctors when making decisions about testing, and begs the question of what infection and disease expertise do WA Police have that is more relevant than that of a medical professional?

As in South Australia, the introduction of the legislation was the result of concerted police union advocacy, with similar hyperbole providing fodder for sensationalist media reports.

A WA News report in March 2014 says it all when quoting WA Police Union Boss George Tilbury:

'Members have told harrowing stories about withdrawing from family and friends because they feared they would infect them ...

*'This legislation will allow for the taking of blood samples from the offender which helps in diagnosis, clinical management and treatment of the exposed police officer.'*⁶

Peppered with inaccuracies and factual errors, the report uses the same emotive language as we heard from SA, when Police Association of SA president Mark Carroll stated: 'Incubation periods for serious diseases such as hepatitis C and HIV mean that police and their families must endure the horrible stress of waiting months before their health is cleared'.⁷

Misguided rationale

The rationale presented for introducing these laws has been variously stated as 'protecting' the police, and helping to address officers' anxieties while they wait for their own test results.

The legislation fulfils neither rationale. A fundamental flaw is the broad-brush approach of both the SA and the WA legislation, covering various BBVs and contagious diseases; and covering various types of exposure to bodily fluids, ranging from contact with saliva, to blood co-mingling, including during an assault.

Rather than serving to address real exposure risks faced by police officers, this broad coverage reinforces misplaced anxieties and common misconceptions about modes of transmission of HIV – as is apparent in the media statements about the laws.^{8, 9} Government, opposition and trade union policy announcements and associated media have served to perpetuate the common misunderstanding that HIV can be transmitted through contact with saliva, such as through spitting. This will reinforce rather than allay general anxiety about the risk of contracting a BBV, both among police and the wider community.

What if there has been an actual exposure risk?

In cases of actual potential exposure risk, the rationale for forcibly testing the source of the potential exposure is misconceived.

If a positive BBV result is returned for an offender, it cannot establish whether a police officer has contracted a BBV unless they are themselves tested, allowing for the relevant BBV window periods.

While a positive result may unduly alarm the officer, a negative test result from the offender is not conclusive, given that they may have seroconverted but still be in the test window period.

The new laws also group BBVs together. It is unclear whether in each instance an assessment will be made about the likelihood of transmission associated with each different BBV, or whether a full 'set' of tests will be run regardless of risk.

The best-practice approach for any police officer who has had an actual potential exposure to a BBV – e.g. they've been jabbed with a blood-filled syringe – is to get immediate access to post-exposure prophylaxis (PEP) and ongoing support, including accurate information resources and referral to professional and expert counselling.

The logistics of forcibly obtaining a blood sample

The legislation does not meet the threshold criteria for compulsory testing set by the National HIV Testing Policy, which states:

'Informed consent is required for HIV testing, except for rare occasions when a legal order is made for compulsory testing or in emergency settings.' (Section 3.0)¹⁰

In both SA and WA, a 'senior police officer' will be able to order forced testing of a person. The senior police officer is not required to obtain external scientific or medical expert opinion on HIV transmission risk.

The legislation fails to specify how testing will be enforced where a person refuses to be tested. The WA Act states that: 'A police officer may apprehend and detain the suspected transferor for as long as is reasonably necessary to enable determination of the application'.

This suggests that a person may be held indefinitely while they continue to resist forced testing.

Alternatives to forced testing

In AFAO's view, the SA and WA legislation should be repealed, or at least substantially amended to require that exposure risks for particular BBVs and contagious conditions are taken into account when determining whether a test is to be required.

Clear processes for supporting police who have been exposed to risk need to be developed, as laid out in ASHM's guiding document, *Police and Blood-Borne Viruses*.¹¹

In the meantime, robust procedural protocols are needed, both to limit application of these laws and ensure that overriding protections and rights of appeal in other legislation are observed.

The need for federal leadership

There is a risk that these laws may be replicated around the country, with police unions in other jurisdictions making calls for similar 'protection'.¹²

The Commonwealth has an overarching responsibility to identify and respond to jurisdictional issues of national significance.

The SA and WA laws clearly flout the *Seventh National HIV Strategy*¹³, and established national policy guidelines which state that BBV testing must be voluntary and with informed consent; however, the Commonwealth has to date taken a hands-off approach, arguing that these are jurisdictional issues.

This perspective ignores the real potential for further policy replication across the jurisdictions – particularly given the political expediency of responding to ongoing pressure from state police unions regarding what is painted as a law and order issue.

The legislation has been presented by governments as workforce protection without regard to actual BBV transmission risks, and without proper consultation with jurisdictional health departments. In SA and WA it seems that political expediency overrode expert advice.

The result is that we are now seeing the introduction of laws based on misguided understandings of HIV transmission risk that were rife in 80s, but are now well and truly discredited.

Once in place, the repeal of such laws is notoriously difficult. The National HIV Strategy notes the importance of entering into 'a respectful dialogue with other sectors to discuss impacts of wider decisions on the health of priority groups'.¹⁴

It's time for the Commonwealth to establish 'a respectful dialogue' with WA, SA and the police unions to reform the laws now in place, and prevent the replication of bad laws around the country.

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- ² Available at: www5.austlii.edu.au. This Bill is yet to come into operation, with the date of proclamation currently unknown. Under the South Australian Acts Interpretation Act 1915, it will come into operation on the second anniversary of the assent date, i.e. 9 July 2017, in the absence of any date of proclamation being announced.
- ³ Novak, L. (2014, 14 October). SA Liberals want mandatory blood tests for offenders who bite or spit at emergency service workers. *The Advertiser*. Retrieved from: www.adelaidenow.com.au
- ⁴ Available at: www5.austlii.edu.au
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- ⁷ News.com.au editorial feature. (2012, 21 October). *Push for police assailants to undergo mandatory blood tests*. Retrieved from: www.news.com.au
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- ⁹ News.com.au editorial feature. (2012, 21 October). op. cit.
- ¹⁰ See: section 3.0 'Indications for HIV testing' in: National HIV Testing Policy Expert Reference Committee. (2011). *National HIV Testing Policy 2011 v1.1*. Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM), Sydney. Retrieved from: testingportal.ashm.org.au/hiv/indications-for-hiv-testing
- ¹¹ ASHM, Australia New Zealand Policing Advisory Agency (ANZPAA). (2015). *Police and Blood-Borne Viruses*. ASHM, Sydney. Retrieved from: www.ashm.org.au
- ¹² AAP editorial feature. (2015, 15 March). Cops union calls for new spitting offence. *The Advertiser*. Retrieved from: www.adelaidenow.com.au
- ¹³ Department of Health (DoH). (2014). *Seventh National HIV Strategy 2014–2017*. Commonwealth of Australia, Canberra. Section 7.2 states that: 'The principles of voluntary testing, informed consent and confidentiality underpin high rates of HIV testing in Australia, and these principles remain central to the management of HIV. The National HIV Testing Policy ... provides guidance to those involved in testing and is reviewed regularly to accommodate changing epidemiology and technology and to reflect the needs of the sector.'
- ¹⁴ *ibid.*

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ASHM Position Statement

HIV not transmitted via spitting

HIV is not transmitted by spitting and there has been no case of transmission of HIV from having been spat upon. ASHM does not endorse or support HIV testing of an individual because they have been spat upon by a person with HIV or a person of unknown HIV status.

Background:

HIV is the Human Immunodeficiency Virus. HIV is a retrovirus which is

“transmitted following contact with infected bodily fluids. The typical routes of transmission are unprotected sex, blood-to-blood contact (including needle-stick injuries, sharing injecting equipment and contaminated blood products) and vertical transmission (from mother to child before, during and after birth). Less common routes include tattooing, organ and tissue transplantation, artificial insemination and semi-invasive medical procedures.”

ASHM (2009) HIV Management in Australasia, p37

However iatrogenic transmission is not seen in Australia since the blood supply commenced screening all samples in 1984.

HIV is not spread by other bodily fluidsⁱ, “HIV cannot be spread through saliva, and there is no documented case of transmission from an HIV-infected person spitting on another person”ⁱⁱ.

“While infectious HIV is detected in the saliva, it is present in substantially reduced quantities compared with blood or genital secretions. Furthermore, the saliva contains endogenous antiviral factors including HIV-specific antibodies and a number of soluble factors such as secretory leukocyte protease inhibitorⁱⁱⁱ. Saliva may alter gp120 structure and lyse HIV-infected cells secondary to the inherent hypotonicity of the saliva”.^{iv}

ASHM (2009) HIV Management in Australasia, p39

Date adopted:

March 2015

Author and review:

Levinia Crooks (a)

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Evidence:

ⁱ <https://www.aids.gov/hiv-aids-basics/hiv-aids-101/how-you-get-hiv-aids/>

ⁱⁱ <http://www.cdc.gov/hiv/basics/transmission.html>, can I get HIV from being spit on?

ⁱⁱⁱ Turville SG, Cameron PU, Handley A, Lin G, Pohlmann S, Doms RW, et al. Diversity of receptors binding HIV on dendritic cell subsets. Nat Immunol 2002; 3: 975-83.

^{iv} ASHM (2009) HIV Management in Australasia, p39

HIV Conference slams spitting laws

Media Release

Adelaide: Friday, 18 November 2016

Delegates at Australia's national HIV/AIDS conference have condemned the governments of South Australia, Western Australia and Northern Territory over laws that force people accused of criminal offences to undergo mandatory HIV and blood-borne virus testing.

The conference passed a resolution this afternoon expressing its 'profound disappointment' in the laws, which make it mandatory for people to undergo blood tests if they are accused of spitting on or biting law enforcement personnel. The laws were passed in South Australia and Western Australia in 2014, and in the Northern Territory in 2016.

"Australia has a proud record of basing its HIV response on evidence-based policy," said Adjunct Associate Professor Levinia Crooks CEO of the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM). "These laws are antiscientific — the risk of transmission of HIV or other blood-borne viruses from saliva is practically zero. There is no justification for invading the privacy of people in custody by forcing them to undergo blood tests when there is no risk to the officer."

"We understand the considerable risks faced by police and emergency services when they go about their jobs, but this is not the solution. There has never been a case of HIV transmission from spitting or biting in Australia."

The full text of the resolution passed by the conference is:

As researchers, clinicians, and civil society representatives, we are united in our commitment to a HIV response grounded in evidence and protective of the human rights of people living with and affected by HIV. This conference expresses its profound disappointment in the governments of South Australia, Western Australia and the Northern Territory for enacting anti scientific and counterproductive laws mandating HIV testing for people accused of spitting on law enforcement personnel, in the face of overwhelming evidence that such laws are neither effective nor necessary. HIV is not transmitted in saliva and these laws only serve to further marginalise and criminalise people with HIV. We call on all governments to establish evidence-based protocols that protect the wellbeing of police and emergency workers and the rights of people living with HIV.

The [Australasian HIV & AIDS Conference](#) is the premier medical/scientific conference in the Australasian HIV and related diseases sector. The 2016 Conference was held in Adelaide from 16–18 November, in conjunction with the [Australasian Sexual Health Conference](#).

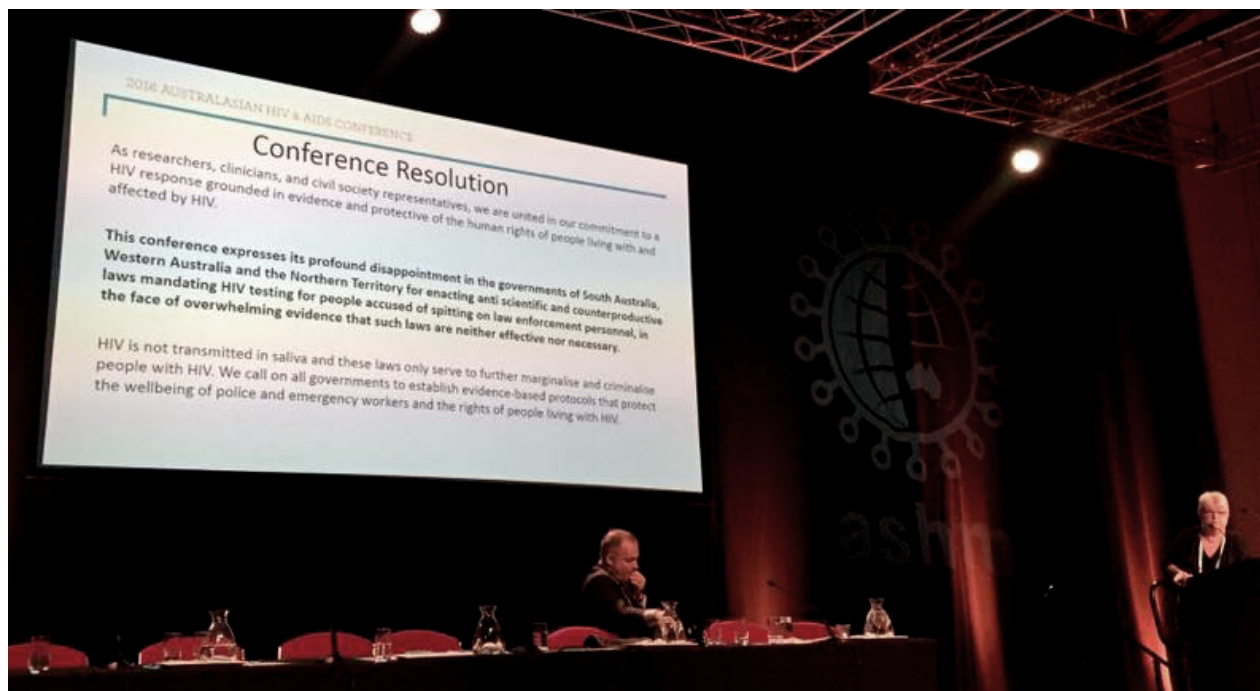


Photo credit: [Paul Kidd](#)

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See also

- [ASHM Position Statement: HIV not transmitted via spitting](#)
- Back to the future? HIV, spitting and perceptions of risk – HIV Australia article March 2016:
<https://www.afao.org.au/library/hiv-australia/volume-14/vol-14-no-1/back-to-the-future-hiv,-spitting-and-perceptions-of-risk#.V6giTjWDsm0>
- Background Briefing: Spitting and Mandatory Testing for HIV and other BBVs – October 2015
https://www.afao.org.au/library/topic/public-health/background_briefing_mandatory_testing_for_spitting_October_2015.pdf
- Briefing Paper: Mandatory testing for BBVs for alleged offenders in South Australia & Western Australia – September 2015
https://www.afao.org.au/library/topic/public-health/afao_briefing_state-based_mandatory_bbv_testing_laws_september_2015.pdf

More about the Australasian HIV&AIDS Conference

The [Australasian HIV & AIDS Conference](#) is the premier medical/scientific conference in the Australasian HIV and related diseases sector. The 2016 Conference was held in Adelaide from 16–18 November, in conjunction with the [Australasian Sexual Health Conference](#).

The conference was first launched in 1989 in response to the emerging area of clinical care for HIV. Since its inception as a small meeting of medical practitioners brought together under the umbrella of ASAP (the Australian Society of AIDS Physicians) the HIV&AIDS Conference has grown into the region's premier

medical/scientific conference in the HIV and related diseases sector, attracting speakers and delegates from around the world.

Since 2005 the Conference has been held back-to-back with the [Australasian Sexual Health Conference](#) with one full day of overlap, providing a unique opportunity to look at HIV in the broader context of sexual health. Together, the conferences attract more than 1000 delegates from across the region.

Delegates to the conference come from a range of professional backgrounds including basic science, clinical medicine, community programs, education, epidemiology, indigenous health, international and regional issues, nursing and allied health, policy, primary care, public health and prevention, and social research.

Visit the conference website www.hivaidconference.com.au