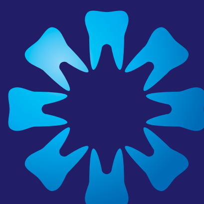
HIV

Guidelines for dentists



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THE SOUTH AFRICAN DENTAL ASSOCIATION

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This publication of the South African Dental Association is intended to provide general background information on HIV management in a dental practice. It does not constitute policy or recommendations of SADA, nor is it intended to provide legal, ethical or professional advice. Appropriate professionals must be contacted from such services.

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Acronyms and abbreviations

ACQUIRED Something you get that is not your own. In the case of AIDS you get the HIV virus from the blood or body fluids of somebody else.

AIDS (Acquired Immunodeficiency Syndrome)

ART (anti-retroviral treatment): Medicine that stops retroviruses from making a person sick.

BACTERIA A very small bug (too small to see) that makes you ill. It is easier to fight bacteria than it is to fight a Virus. (see VIRUS)

DEFICIENCY When something is missing or not present. HIV takes away the body's immune system and that is why we say the body has an immune 'deficiency' (see IMMUNE).

EXPOSURE When a person has come into contact with HIV, they have been 'exposed' to it.

HIV (Human Immunodeficiency Virus): (see IMMUNO, DEFICIENCY, and VIRUS)

HIV-POSITIVE A person who has been infected with the HI-Virus is said to be HIV-positive.

IMMUNE A system in the blood of a human that fights against infection and sickness.

HCW Healthcare workers

OHCW Oral Healthcare Workers.

PEP (Post-exposure Prophylaxis): Medicine taken by a person after they have been exposed to HIV to prevent becoming infected.

TRANSMISSION When HIV is passed from one person to another.

VIRUS A very small bug (too small to see) that infects the body, causes a breakdown in the immune system and leaves the person vulnerable to opportunistic infections..

Abbreviation	Full name	Principal Disease
HIV 1	Human immunodeficiency virus - Type 1	AIDS
HIV 2	Human immunodeficiency virus - Type 2	AIDS
HBV	Hepatitis B virus	Hepatitis
HCV	Hepatitis C virus	Hepatitis

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Foreword by SADA Chairman

The proportion of South Africans infected with HIV has increased from 10.6% in 2008 to 12.2% in 2012, according to the Human Sciences Research Council's (HSRC) National HIV Prevalence, Incidence and Behaviour Survey. The total number of infected South Africans now stands at 6.4-million; 1.2-million more than in 2008.

Dentists and other oral health care professionals have a critical role to play now more than ever in the national response to the HIV epidemic through the provision of quality oral health services.

Unfortunately for many patients, obtaining the proper oral health care they need is not as easy, especially for those living with HIV/AIDS. Many HIV positive patients still perceive that they are being discriminated and victimised and therefore do not attend to their regular oral health as they should.

The development of new therapies for management and treatment of HIV infection has provided renewed hope for HIV positive patients. Comprehensive dental care will become a routine part of their health care regime.

Early detection of oral conditions by oral healthcare professionals found in HIV positive patients will be critical in patients seeking early interventions and thus preventing costly treatment of complications of such illnesses.

The South African Dental Association has produced these guidelines to help build knowledge and skills required to provide an empathetic environment for the personal, social and health challenges faced by many individuals living with HIV/AIDS as well as any other communicable diseases. These guidelines although not absolute will assist the healthcare professional in the legal, ethical and clinical management of both personnel and patients on issues regarding HIV, AIDS and other infectious diseases.

It must be remembered that the law is fluid, and blanket guidance is neither available nor appropriate. The profession's understanding of their ethical obligations is continually evolving and these guidelines must be read as such.

The South African Dental Association (SADA) would like to thank Professor Sudeshni Naidoo and Mr Punkaj Govan for the effort and time spent in producing this valuable guidelines for our members.

Dr R Vermeulen
SADA Chairman

Introduction

"A virus is a piece of nucleic acid surrounded by bad news." M.B.A. Oldstone: Viruses, Plagues and History

1. The Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS) are serious public health problems which have socio economic, employment and human rights implications.

2. HIV knows no social, gender, age or racial boundaries, but it is accepted that socio-economic circumstances influence disease patterns. HIV thrives in an environment of poverty, rapid urbanisation, violence and destabilisation.

3. Despite the availability of scientific evidence and information, HIV/AIDS remains a disease surrounded by ignorance, prejudice, discrimination and stigma. In the workplace unfair discrimination against people living with HIV and AIDS has been perpetuated through practices such as pre-employment HIV testing, dismissals for being HIV positive and the denial of employee benefits.

4. Oral health is an integral part of general health and plays a role in the prevention, treatment and care of HIV-infected people. Oral health care workers (OHCWs) are an important resource in the country's fight against the epidemic. Dentistry is at the forefront of infection control procedures and patients' health and well-being are primary concerns. The procedures and practices that have now become standard in dentistry have served as models for other health care providers. It has played, and continues to play, a major role in establishing state-of-the-art infection control protocols for the small surgery environment.

5. The mouth remains an important indicator of the progression of HIV disease and studies have shown that 60-70% of HIV/AIDS patients will have an oral manifestation of the disease at any one time. Oral health care workers are often the first carer to identify an oral manifestation of HIV, even in patients who are unaware of their status. It is crucial, therefore, that general dental practitioners OHCWs' have the knowledge, skills and confidence to diagnose and manage patients with HIV.

6. In the absence of a cure, early diagnosis can have a profound impact in curbing the spread of HIV infection and on patients' prognosis through the early institution of prophylactic medication and antiretroviral therapy. The ability to detect the oral manifestations of HIV is invaluable, given the impracticability of serological screening of patients, particularly in resource poor settings. OHCW are in an ideal situation to diagnose oral lesions.

7. The benefits of early identification of oral lesions and consequently early diagnosis are:
   - 7.1. early counselling can be initiated and health education messages provided;
   - 7.2. it permits early administration of prophylactic medication and antiretroviral therapy where it is available;
   - 7.3. early detection of immunological changes and
   - 7.4. it can be used to monitor the efficacy of antiretroviral therapy.

8. The Health Professions Council of South Africa (HPCSA) ethical rules provide that no dentist may ethically refuse to treat any patient solely on the grounds that the patient is, or may be, HIV seropositive. No dentist may withhold normal standards of treatment from any patient solely on the grounds that the patient is HIV seropositive, unless such variation of treatment is determined to be in the patient's interest and not by perceived potential risk to the oral health care worker.

9. It must also be recognised that the HIV/AIDS epidemic will affect every workplace, with prolonged staff illness, absenteeism and death, impacting on productivity, employee benefits, occupational health and safety, production costs and workplace morale. Organised dentistry must continue to meet these challenges.

10. The dental surgery is an ideal environment for cross-infection with pathogens other than HIV including cytomegalovirus, hepatitis B and C viruses, herpes simplex virus types 1 and 2, Mycobacterium Tuberculosis (TB), staphylococci, streptococci, and other viruses and bacteria that colonize or infect the oral cavity and respiratory tract. The risk of transmitting hepatitis B virus is about 30% per encounter, whereas the transmission of HIV with known contaminated blood is 0.3%

11. It exposes OHCW and patients to a variety of microorganisms that are transmitted via blood, oral or respiratory secretions. Occupational exposures can occur percutaneously, i.e., through needlesticks or injuries from sharp instruments contaminated with infected blood or through contact of the eye, nose or mouth with infected blood. Cross infection can be from patient to OHCW, from OHCW to patient or from patient to patient.

12. Dentists in South Africa have a professional duty to cause no harm to their patients, and to provide a safe working environment for the other OHCW in their practice. Transmission of infectious diseases before, during or after dental and oral health care is possible.

13. One of the most effective ways of reducing and managing the impact of HIV/AIDS in the workplace is through the implementation of an HIV/AIDS policy and programme. Addressing aspects of HIV/AIDS in the workplace will enable employers, trade unions and government to actively contribute towards local, national and international efforts to prevent and control HIV/AIDS. In view of the above, this Code has been developed as assist OHCWs, employers, trade unions and employees.

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Modes of Transmission

There are many rumors or myths about how HIV is transmitted.

1. HIV is transmitted primarily in 3 ways:
   1.1. Sexual (usually heterosexual, by sexual contact with an infected person).
   1.2. Perinatal (babies born to HIV-infected women may become infected before or during birth or through breast-feeding after birth).
   1.3. Blood-borne (eg. sharing of equipment, sharing needles and/or syringes (primarily for injecting drug use) with someone who is infected.
2. Less common modes of transmission include:
   2.1. Being "stuck" with an HIV-contaminated needle or other sharp object. This risk pertains mainly to healthcare workers.
   2.2. Receiving blood transfusions, blood products, or organ/tissue transplants that are contaminated with HIV. This risk is extremely rare due to the testing of the blood supply and donated organs/tissue.
   2.3. Contact between broken skin, wounds, or mucous membranes and HIV-infected blood or blood-contaminated body fluids. These reports have also been extremely rare.
   2.4. There is an extremely rare chance that HIV could be transmitted during oral sex, "French" or deep, open-mouth kissing with an HIV-infected person if the HIV-infected person's mouth or gums are bleeding.
3. Although HIV transmission is possible in healthcare settings, it is extremely rare. Medical experts emphasize that the careful practice of infection control procedures, including universal precautions (i.e. using protective practices and personal protective equipment to prevent transmission of HIV and other blood borne infections), protects patients as well as healthcare providers from possible HIV transmission in medical and dental settings.
4. The risk of OHCWs being exposed to HIV while at work is very low, especially if they carefully follow universal precautions (i.e., using protective practices and personal protective equipment to prevent HIV and other blood-borne infections). It is important to remember that casual, everyday contact with an HIV-infected person poses no risk to health care workers or anyone else to HIV. For health care workers on the job, the main risk of HIV transmission is through accidental injuries from needles and other sharp instruments that may be contaminated with the virus; however, even this risk is very small. It has been estimated that the risk of infection from a needle-stick is less than 1 percent, a figure based on the findings of several studies of health care workers who received punctures from HIV-contaminated needles or were otherwise exposed to HIV-contaminated blood.
5. It is generally accepted that the oral health team is far more at risk from the hepatitis B virus than from HIV (Table 1).
6. HIV may also be transmitted through unsafe or unsanitary injections or other medical or dental practices. However, the risk is rare.
7. Eating food that has been pre-chewed by an HIV-infected person. The contamination occurs when infected blood from a caregiver's mouth mixes with food while chewing. This appears to be a rare occurrence and has only been documented among infants whose caregiver gives them pre-chewed food.
8. Being bitten by a person with HIV. Each of the very small number of cases documented has included severe trauma with extensive tissue damage and the presence of blood. There is no risk of transmission if the skin is intact.
9. Tattooing or body piercing present a potential risk of HIV transmission, but no cases of HIV transmission from these activities have been documented. Only sterile equipment should be used for tattooing or body piercing.
10. Universal precautions against blood-borne infections should therefore be adhered to in all health care encounters to minimise exposure of health care workers and their patients.In the oral health care setting, there is little risk of an OHCW contracting HIV through clinical contact with an HIV positive individual, or through contact with environmental surfaces.
11. Some people fear that HIV might be transmitted in other ways; however, there is no scientific evidence to support any of these fears. Thus there is no risk of HIV transmission from casual contact in a normal working environment (Table 2).
12. Preventing occupational blood exposures is the primary way to prevent transmissions of hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV) in oral health care settings.

Table 1: Infectious and non-infectious body fluids

Infectious body fluids	Non-infectious body fluids
• All body fluids containing blood • Vaginal secretions • Semen • Pericardial fluid • Pleural fluid • Cerebrospinal fluid • Amniotic fluid • Peritoneal fluid • Synovial fluid	• Tears • Faeces • Urine • Saliva • Nasal secretions • Sputum • Vomit • Sweat

Table 2: Risk of Transmission

Virus	Risk
HIV percutaneous	0.3%
HIV mucosal exposure	0.1%
Hepatitis B – eAg negative	2%
Hepatitis B – eAg positive	20-40%
Hepatitis C	1-10%

HIV/AIDS disclosure - keep it confidential!

The South African Constitution gives every person a right to privacy and dignity. In the context of HIV/AIDS, this means an individual has the right, and is entitled to have his or her HIV status kept confidential.

HIV/AIDS is not a notifiable disease, and therefore, except in rare instances, HIV-positive people cannot be forced to disclose their HIV status to anyone. Accordingly, a HCW does not have to report to the health authorities when a person is diagnosed with HIV or AIDS, or when someone dies of AIDS.

Privacy is defined as the right of an individual to restrict availability by others to certain attributes of their person. This refers not only to physical places such as the human body, the home or private property, but also to certain kinds of decisions. In other words:

a. The right to privacy leads to the freedom to choose whether or not to disclose one's HIV and AIDS status and how to disclose.
b. The right to privacy also means that a person has the right to control information about themselves, such as one's HIV status, by keeping it confidential.

Right to Dignity

The Constitutional Court has stated that there is nothing shameful about suffering from HIV and AIDS because it is a chronic disease like any other. It is an affront to the person living with HIV and AIDS's dignity for another person to disclose details about a person's HIV status or any other private medical information without their consent. In other words, the fact that a person is HIV positive does not compromise their right to human dignity; what compromises this right is when disclosure is made about HIV status to a third party without their consent.[1]

Right to confidentiality

1. Confidentiality is central to trust between dentists and patients. Dentists have access to information about patients that is private and sensitive. Without assurances about confidentiality, patients may be reluctant to disclose information they need in order to provide appropriate care. Patients have a right to expect that information about them will be held in confidence by dentists.
2. The National Health Act (Act No. 61 of 2003) requires that health care providers (which include oral health care workers) and health care establishments are responsible for personal information about their patients and must make sure that such information is effectively protected against improper disclosure at all times. For example, this means that employees such as clerks and receptionists must also be trained to respect the confidentiality of patients when dealing with personal information.[2]
3. Justice Madala from the Constitutional Court held that the lack of respect for private medical information and its subsequent disclosure might result in fear, jeopardising an individual's right to make certain fundamental choices that he/she has a right to make. Especially with regard to the disclosure of an individual's HIV/AIDS status, the court held that confidentiality was important as it would encourage individuals to seek treatment and divulge information encouraging disclosure of HIV, and that it may also result in the improvement of public health policies on HIV/AIDS.

DISCLOSURE

Non-consensual disclosure

Rule 13 of the Ethical Rules of the HPCSA states that, where practitioners divulge verbally or in writing patient information in terms of statutory provisions, court instructions or if it is justified in the public interest, it must be divulged with the express consent of the patient and in case of minor under 12 years, with the express consent of the parent or guardian.[3]

Non-consensual disclosure: by a health practitioner to an intimate partner and/or family member

1. This issue was raised in the case of VRM v Health Professions Council of South Africa[4] whether or not to disclose the HIV-status of a patient to that patient's spouse/partner. The ethical conflict between the healthcare practitioner's duties to respect the patient's right to privacy and confidentiality weighs heavily in such circumstances against the general duty of all healthcare practitioners to inform individuals of possible health risks. Of particular concern for dentists is whether or not to disclose the HIV-status of a patient to that patient's spouse/partner. The ethical conflict between the dentist's duties to respect the patient's right to privacy against the general duty of all healthcare practitioners to inform individuals of possible health risks. The UNAIDS, the Canadian Advisory Committee and the American Medical Association provides for partner notification - first with the source patient's informed consent and in limited circumstances without such consent – no comparable partner notification programmes or guidelines exist in South Africa.

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[1] NM v Smith para 2007 (5) SA 250 (CC) 48.
[2] HPCSA Booklet 11 "Confidentiality: Protecting and Providing Information" (Second Edition)
[3] HPCSA Guidelines for the Management of Patients with HIV Infection or AIDS", Booklet 11, May 2008
[4] VRM v Health Professions Council of SA & others [2003] JOL 11944 (T)

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2. Rule 10 of the HPCSA guidelines provides for situations where an HIV-infected patient refuses to inform his/her intimate partner of his or her status. The decision by the practitioner to divulge the information to other parties involved with the patient must be in consultation with the patient. If the patient's refuses to make this disclosure, practitioners should use their discretion on whether or not to divulge the information to other parties involved who are at clear risk or danger.[5]
3. If the dentist decides on disclosure to the patient's sexual partner, the practitioner should:-
   3.1. counsel the patient on the importance of disclosing to his or her sexual partner and for taking other measures to prevent HIV transmission; and
   3.2. providing support to the patient to make this disclosure.
4. If the patient still refuses to disclose his or her HIV status or refuse to consider other measures to prevent infection.
5. The pre-disclosure procedure entails that the patient is counselled and where the importance of disclosure to the intimate partner is emphasised, as well as the behavioural changes the patient is required to make. Support must be offered to the patient throughout the disclosure process and only if the patient continues to refuse to disclose status to the intimate partner himself or herself is the dentist allowed to disclose the HIV status of the patient to the intimate partner without the patient's consent.
6. Dentist must inform the patient of this action, it must be explained that it is the dentist's ethical duty to divulge the information, and the patient must also be counselled on the possible adverse consequences of the disclosure.
7. It is unclear whether or not a dentist's general ethical duty to protect others from harm and inform them of possible health risks will be a justifiable limitation of the patient's right to privacy and confidentiality in terms of the patient's HIV/AIDS.
8. There is a possibility that the dentist can be sued by a sexual partner for failure to have informed them they were at risk of HIV. The person at risk of HIV could institute a civil claim against the dentist for not warning them.

Disclosure of Health Care Worker (HCW) who are HIV positive

1. Rule 11 of the HPCSA Guidelines provides that, no doctor or HCW is obliged to disclose his or her HIV status to an employer nor may any employee be unfairly discriminated against or dismissed as a result of his or her HIV status.[6]
2. HCWs should be informed about the benefits of voluntary HIV testing and if agreeable be encouraged to seek counselling from an appropriate professional source. Counsellors should be familiar with recommendations such as those of the Centre for Disease Control (CDC) so that unnecessary, onerous, and scientifically unjustifiable restrictions are not placed on the professional activities of an HIV positive doctor.
3. Infected doctors may continue to practise. However, they must implement the counsellor's advice on the extent to which they should limit or adjust their professional practice in order to protect their patients. Dentists must rely on their personal physicians and attorneys for medical and legal advice.
4. The CDC suggests that health care professionals who perform such invasive procedures should know their HIV status and, if positive, they should not perform exposure-prone procedures unless they have sought counsel from an expert review panel. The guidelines do not mandate that HIV-infected health care workers notify to patients or stop working. Rather, the CDC guidelines support case by case evaluation of what practice restrictions, if any, should be imposed on the provider in question.

Disclosure to employers

Employers cannot request a person's HIV status, or require that a person take an HIV test when applying for a job or while in employment unless Labour Court has given permission. The Employment Equity Act also provides that a person cannot be dismissed arbitrarily because they have HIV/AIDS.

Disclosing the HIV/AIDS status of deceased patients

Rule 13 of HPCSA ethical rules provide that, the confidential information about a deceased patient (including his or her HIV-status) may be disclosed only with the written consent of that deceased person's next-of-kin or with the written permission of the executor of the deceased person's estate. The exception from this general principle is if the deceased's personal information must be disclosed in terms of a statute or a court order, or justified in the public interest. Therefore there is no special protection for the deceased's right to privacy and confidentiality.[7]

Disclosure to Medical Aids

People do not have to take an HIV test to receive medical aid and they do not have to pay a higher premium if they are HIV-positive.

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[5]HPCSA Guidelines for the Management of Patients with HIV Infection or AIDS, Booklet 11, May 2008
[6] HPCSA Guidelines for the Management of Patients with HIV Infection or AIDS, Booklet 11, May 2008
[7]HPCSA Guidelines for the Management of Patients with HIV Infection or AIDS, Booklet 11, May 2008

Disclosure to insurance companies

Insurance companies usually ask for an HIV test. A person's HIV status is a "material fact" that can affect the insurance company's assessment of someone's risk and have a duty to keep people's HIV-status confidential.

Disclosure and the HIV status of minors

1. While it has already been established that the disclosure of an adult's HIV status is a contentious issue, the disclosure of the status of a minor is even more complex and multi-faceted
2. Section 130(1) of the Children's Act 38 of 2005 provides that no child may be tested for HIV unless it is in the best interest of the child and that consent is given.
3. Consent may be given by the child if 12 years of age or older and is of sufficient maturity to understand the benefits, risks and social implications of such a test.
4. Where the child is under the age of 12 and is not of sufficient maturity to understand the benefits, risks and social implications of the test the child's parent or caregiver, the Provincial head of social development, a designated child protection organisation arranging the placement of the child and the superintendent or person in charge of a hospital if the child has no parent or caregiver and there is no designated child protection organisation arranging for the placement of the child.
5. The children's court may give consent on behalf of the child only if the consent by the role players referred to above is unreasonably withheld or the child or the parent or the caregiver of the child is incapable of giving consent.
6. The Act furthermore provides for required counselling before and after testing, as well as for the confidentiality of the information on the HIV/AIDS status of children.
7. Section 133 prohibits anybody from disclosing the HIV status of a child without the consent given by the child if the child is 12 years of age or older or is under the age of 12 years and is of sufficient maturity to understand the benefits, risks and social implications of such disclosure.
8. With regard to the treatment of minors specifically for HIV/AIDS the Children's Act is silent.

Practitioner disclosing to another dentist or health care worker about patient's HIV status

1. In South Africa, a doctor cannot disclose (give) the HIV status of a patient to other doctors without the consent of the patient unless there is a clear legal duty to do this. The need for transmission of clinical data to other health care workers directly involved with the care of the patient should be discussed with the patient in order to obtain his or her consent for disclosures considered to be in the patient's best interest in terms of treatment and care.
2. If the health care worker explains why other doctors and nurses need to know a patient's HIV status, most patients will consent to this information being given out when it is in their best interests to get proper medical treatment.
3. Some patients may stipulate the extent and nature of the disclosure, for example, patients may consent to their status being disclosed to particular people such as the specialist and the team involved in a surgical intervention.
4. If a patient refuses to agree to this information being given to other health care workers, then the health care worker must respect this decision. But the health care worker must warn the patient if this may lead to the patient getting unsuitable medical or dental treatment, and if this may be dangerous for their health. The health care worker also has a right to refer the patient to another practitioner.
5. If the patient's consent cannot be obtained, ethical guidelines recommend that the health care worker should use his or her discretion whether or not to divulge the information to other parties involved who are at clear risk or danger. Such a decision must be made with the greatest care, after explanation to the patient and with acceptance of full responsibility at all times.
6. The report of HIV test results by a laboratory, as is the case with all laboratory test results, should be considered confidential information.
7. To take a person's blood for HIV testing without consent may amount to an invasion of the right to privacy which could result in the dentist being prosecuted for assault or crimen injuria through the criminal courts or held liable for damages in a civil action.

EXAMPLE

*I*n the landmark case of Jansen van Vuuren v Kruger (1993) a medical practitioner had disclosed the HIV status of his patient — after an explicit request by the patient to keep the information confidential — to other health practitioners during the course of a game of golf. The patient/plaintiff instituted proceedings claiming that the medical practitioner owed him a duty of confidentiality in regard of their doctor-patient relationship and regarding any knowledge of the plaintiff's medical and physical condition. The plaintiff argued that he had suffered an invasion of privacy and had been injured in his rights of personality. The medical practitioner, however, argued that the disclosure had been made on a privileged occasion, that it was the truth, and made in the public interest, and that it was objectively reasonable in the public interest in the light of the boni mores. The medical practitioner contended that he had a social and moral duty to make the disclosure to the other health practitioners and that they had a reciprocal social and moral right to receive the information and apply due diligence when again dealing with or treating the plaintiff.

Practitioner ordered by court to give confidential information

If a dentist is called to give evidence in court, they should tell the judge that they under an ethical obligation to keep patient information confidential. If the judge instructs that the dentist must give the court this information and that the

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dentist may be charged for contempt of court, then they may have to breach the confidential relationship between patient and dentist. They should inform the judge that they are disclosing this information because the court has ordered them to do so.

Sick Certificates

Patients have the right to keep HIV status confidential and the dentist issuing a sick certificate must not disclose this information on the certificate. They can simply write that the patient is sick and not injured. The Basic Conditions of Employment Act states that the person who completes the certificate must put down the reason for the absence – in other words, sickness or injury. Again there is no legal duty on the dentist to write 'HIV or AIDS' on the certificate.

A medical certificate for being off sick must be drawn up after discussion with the patient because it gives an employer confidential information on the person's medical condition. You can ask for private information to be left off the certificate.

Forms that require patients to complete personal information and their medical history should avoid questions requesting information regarding their HIV status in any form.

The Constitution of South Africa of 1996[8]

The Constitution provides for everyone's right to fair labour practices, as well as rights to equality, human dignity and not to be subjected to unfair discrimination. Although HIV status is not specifically listed as a ground for unfair discrimination in the Constitution, it has previously been held to be an analogous ground in a 2000 Constitutional Court case.

National Health Act of 2003[9]

The National Health Act addresses the issue of medical confidentiality without expressly mentioning HIV and AIDS.

The Medical Schemes Act of 1998[10]

The Act is designed to ensure compliance with the constitutional obligations which include confidentiality of a person's medical records and other related matters.

Labour Relations Act 66 of 1995[11]

The Labour Relations Act does not specifically mention HIV and AIDS. It does, however, deal with privacy, stating that employees have a right to privacy with regard to their personal and private information, including any personal medical information. The Act also prohibits the employer from disclosing an employee's personal information (including HIV status) without the employee's written consent. HIV and AIDS have also been established as an analogous ground for automatically unfair dismissal linked to unfair discrimination.

Code of Good Practice on HIV and AIDS[12]

1. A Code of Good Practice on HIV and AIDS and Employment has been added to both the Labour Relations Act and the Employment Equity Act. It provides a general guide on how employers, employees and trade unions manage and respond to HIV and AIDS in the workplace.
2. The Code prohibits unlawful disclosure of one's HIV status without written consent. An employee is under no obligation to disclose his or her HIV status to an employer or to other employees.

Basic Conditions of Employment Act (No. 75 of 1997)[13]

This Act sets standards for employers and all employees have a right to sick leave and an employer has no right to discriminate against or dismiss an employee who uses these rights. Sick employees can ask employers to have more sick leave for less pay.

The Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 (PEPUDA)[14]

Although HIV and AIDS are not expressly listed under the seventeen grounds for non-discrimination in PEPUDA, it has taken a step further to ensure that people living with HIV and AIDS are protected from unfair discrimination by recognising that the HIV and AIDS status, whether real or perceived, leads to discrimination.

Policy on HIV and AIDS and Sexual Transmitted Diseases in the Workplace, November 2000

The Department of Health has developed a policy on HIV and AIDS and Sexual Transmitted Diseases in the Workplace, and provides that employees have the right to confidentiality with regard to their HIV and AIDS status. This policy also prohibits unlawful disclosure by the employer without written consent from the employee.

The Department of Education - Policy on HIV and AIDS for Learners and Educators in Public Schools and Students and Educators in Further Education and Training Institutions

The policy provides that all information pertaining to the medical condition of a learner, student or educator with HIV/AIDS must be kept confidential and that disclosure to third parties can be authorised only with the individual's informed consent. It also prohibits the mandatory testing of learners, students or educators and dismisses the notion of routine

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[8] Access Act at www.parliament.gov.za
[9] Access Act at www.polity.org.za/article/national-health-act-no-61-of-2003-2003-01-01
[10] Access Act at www.medicalschemes.com
[11] Access Act at www.labour.gov.za

testing as there is said to be no medical justification for such programmes. This policy encourages voluntary disclosure of one's status and prohibits mandatory disclosure.

The National Patients' Rights Charter[15]

1. During November 1999, the Department of Health launched a National Patients' Rights Charter. The Charter lists the rights and duties of all patients that attend government hospitals and clinics.
2. It is not a law but it sets out guidelines which health care workers and patients are expected to follow. It provides rights amongst others right to a healthy and safe environment and enjoy confidentiality and privacy about their medical treatment.
3. The Charter states that all health care workers, like nurses and doctors, must treat all patients with human dignity, respect, courtesy, patience and tolerance.

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[12]Access document at www.labour.gov.za
[13]Access document at www.labour.gov.za
[14]Access document at www.justice.gov.za
[15]Access document at www.hpcsa.co.za/downloads/.../booklet3patientsrightscharter

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HIV Testing & Informed Consent

Everyone has the right to make their own decisions about their body so no patient can be given dental treatment without their consent. Consent to dental treatment is elicited in two parts: information (understanding) and permission (agreeing). With an HIV test, patients must know what the test is, why it is being done and what the result will mean for patients before they agree to the blood sample being taken. This is called pre-test counselling. After the HIV test results have been received patients must be counselled again to help them understand and accept the effect that a negative or a positive result will have on their life. This is called post-test counselling.

Rules on consent

1. The right to an informed consent flows from the South African Constitution, the National Health Act, various other statutes, the common law and the HPCSA Guidelines. Health care practitioners are expected to be aware of the law in this regard.
2. Successful relationships between dentists and patients depend upon mutual trust. To establish that trust dentists must respect patients' autonomy - their right to decide whether or not to undergo any dental or medical intervention, even where a refusal may result in harm to themselves or in their own death. Patients must be given sufficient information in a way that they can understand including the costs of each treatment option, to enable them to exercise their right to make informed decisions about their care. This is what is meant by an '*informed*' consent.
3. The South African courts held that legally for a proper informed consent the patient must have:
   - 3.1. knowledge of the nature or extent of the harm or risk;
   - 3.2. appreciated and understood the nature of the harm or risk;
   - 3.3. consented to the harm or assumed the risk; and
   - 3.4. the consent must have been comprehensive, (i.e. extended to the entire transaction, inclusive of its consequences).
4. A dentist providing treatment or investigation treatment has the responsibility to discuss it with the patient and obtain consent, as the practitioner will has comprehensive understanding of the procedure or treatment, how it is to be carried out, and the risks attached to it.
5. Informed consent can be either oral or in writing. In some cases, the nature of the risks that the patient is exposed to make it important that a written record as part of the patient's consent and other wishes in relation to the proposed investigation and treatment. This helps to ensure later understanding between dentist, the patient and anyone else involved in carrying out the procedure or providing care.
6. Dentists should be careful about relying on a patient's apparent compliance with a procedure as a form of consent. Submission in itself may not necessarily indicate consent. For example, the fact that a patient lies down on the dental chair does not indicate that the patient has understood what the dental practitioner proposes to do and why.[16]

Ethical Guidelines

1. Rule 2 of the HPCSA Guidelines provides that HIV testing can only take place with the voluntary, informed consent of the individual. Routine or universal testing of patients in the health care settings is unjustifiable. However, patients may be requested to consider HIV testing when certain well-defined high risk procedures are to be undertaken.
2. Rule 7 of the HPCSA Guideline provides a patient may be tested for HIV-infection only if he or she gives informed consent.
3. Such informed consent should provide the patient with information regarding:
   - 3.1. purpose of the test;
   - 3.2. advantages or disadvantages testing may hold for him or her as patient;
   - 3.3. why this information is required by the doctor;
   - 3.4. what influence the result of such a test will have on his or her treatment; and how his or her medical protocol will be altered by this information. The psychosocial impact of a positive test result should also be addressed.[17]
4. All such communication with the patient should be conducted in a language that is easily understood by the patient. Furthermore, the patient should clearly understand the information provided, so that he or she may agree to the HIV test, based on such understanding.
5. The dentist must, therefore, ensure that the patient is directed to appropriate facilities that will oversee his or her further care and, if possible, counsel his or her family and/or sexual partners.
6. Rule 8 of the HPCSA Guidelines provides it may be justifiable to test for HIV without the patient's consent, but only:
   - 6.1. in the circumstances set out in the National Policy on Testing for HIV. This would include as part of unlinked and anonymous testing for epidemiological

[16]HPCSA Booklet 10 "Seeking Patients' Informed Consent: the Ethical Considerations", 30th May 2007
[17]HPCSA Guidelines for the Management of Patients with HIV Infection or AIDS, Booklet 11, May 2008

purposes undertaken by the national, provincial or local health authority or an agency authorised by any of these bodies, provided that HIV testing for epidemiological purposes is carried out in accordance with national legal and ethical provisions regarding such testing.

6.2. where statutory provision or other legal authority exists for testing without informed consent.[18]

7. Patients can indicate their informed consent either orally or in writing as stated above. In some cases, risks may be such it is important to have a written record of the consent. Dentists should be careful about relying on a patient's apparent compliance with a procedure as a form of consent. Written informed consent is recommended at all times.

Adults

1. All adults who have legal capacity (the ability to make a legal decision) and who are of "sound and sober mind" can give valid consent to treatment (consent recognised by law).
2. Adults without legal capacity (eg people who are mentally ill or have a mental disability) cannot give consent without assistance.
3. Couples must consent to treatment individually – one partner in a relationship cannot consent to treatment on behalf of the other partner.

Children and youth

1. Section 130(1) of the Children's Act 38 of 2005 provides that no child may be tested for HIV unless it is in the best interest of the child and consent was given in terms of section 130(2) of the Act or if the test is necessary to establish if a healthcare worker (or any other person) may have contracted HIV due to contact with any substance from the child's body that may transmit HIV.
2. Section 130(2)(a) of the Act states that consent for an HIV test on a child may be given by the child only if the child is 12 years of age or older or under the age of 12 years but is of sufficient maturity to understand the benefits, risks and social implications of such a test.
3. Where the child is under the age of 12 and is not of sufficient maturity to understand the benefits, risks and social implications of the test the following persons may give consent on behalf of the child: the child's parent or caregiver, the provincial head of social development, a designated child protection organisation arranging the placement of the child, and the superintendent or person in charge of a hospital if the child has no parent or caregiver and there is no designated child protection organisation arranging for the placement of the child. The children's court may give consent on behalf of the child only if the consent by the roleplayers referred to above and in Section 130(2)(a) to (d) of the Act is unreasonably withheld or the child or parent or the caregiver of the child is incapable of giving consent.

HIV TESTING IN THE WORKPLACE

Due to the growing prevalence of HIV in society, dentists as employers are experiencing an increasing impact on the workplace. Absenteeism is increasing and speculation about the risks to non-infected persons is rife. Dentists as employers are concerned that the nature of their business is such that an employee infected with HIV could place others at risk of being infected and affect their business.

Prohibition

1. The Employment Equity Act of 1998 prohibits medical testing of employees, including prospective employees, unless it is permitted by legislation or where it is justifiable on certain specified grounds. The Act further prohibits the testing of an employee for his/her HIV status, unless the Labour Court determines that such testing is justifiable. An employee is under no obligation to disclose his or her HIV status to an employer, any other employee or anyone associated with the organisation.
2. The purpose of these prohibitions and limitations is to prevent employers from discriminating against employees and job applicants on the basis of their medical status. Persons infected with HIV are particularly vulnerable to prejudice, hence the provision that only the court, and not the employer, may determine whether it is justifiable to test an employee for this condition.

Voluntary testing

In the same case above, the courts were of the view that the prohibitions and limitations applied only to compulsory HIV testing. In other words, it is quite in order for employees to undergo voluntary testing without the court's permission, provided that the testing is truly voluntary. It does not matter whether the initiative for testing has come from the employer or the employee. When is testing truly voluntary? It would, for example, not be truly voluntary where a person agrees to be tested for HIV in order to be considered for a job.

[18] HPCSA Guidelines for the Management of Patients with HIV Infection or AIDS, Booklet 11, May 2008

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Testing when there is a needlestick injury

1. Testing of an existing blood sample is only permitted if the patient (or mandated person if the patient is unable to) consents. It may be required to test a patient in an emergency situation in order to protect other persons. In such cases, in order to pass the tests of reasonability and justifiability, consideration should be had for the nature of the injury(ies) and the source patient has to be evaluated to determine the likelihood of HIV.
2. However, the person must be informed that the blood sample was tested, and if he/she, after pre-test counseling wishes to know the results, the principles of post-test counseling have to be adhered to.

Constitution of the Republic of South Africa Act, No.108 of 1996

The Constitution provides that every person has the right to privacy and bodily integrity. This means that no person may be treated (including HIV testing) without informed consent and they have the right to privacy regarding their HIV status.

Employment Equity Act, No. 55 of 1998

The Employment Equity Act prohibits testing of an employee for HIV without authorisation by the Labour Court. This means employers are required to apply to the Labour Court for a Court Order granting permission to test for HIV before requiring employees to submit to such a test.

Code of Good Practice on HIV and AIDS

The Code provides that employers may not require employees or applicants for employment to undertake an HIV test to ascertain their status. They may apply to Labour Court to obtain authorisation for testing.

EXCEPTIONS TO THE RULE OF INFORMED CONSENT

There may be instances when a dentist does not have to get informed consent to do an HIV test and these include:

Emergencies

1. In an emergency, health care workers can only do an HIV test if the test is necessary to save the patient's life.
2. If a patient needs emergency treatment, the doctor or hospital does not need to get consent before carrying out essential treatment (treatment that will save the patient's life).
3. The law says that doctors can only treat a patient in an emergency situation if:
   - 3.1. there is a real emergency which makes the treatment necessary.
   - 3.2. the patient is unaware of the treatment required because he/she is unconscious.
   - 3.3. the doctor tries to get consent from the patient's relatives or loved ones.
   - 3.4. the treatment is not against the wishes of the patient, (e.g. Jehovah's Witnesses believe that they should not be given blood at any time – this means in an emergency, a hospital may not give a Jehovah's Witness a blood transfusion as this would be against their wishes.)
   - 3.5. the treatment is in the best interests of the patient.
4. It is unlawful to do an HIV test for 'protecting' a health care worker operating on a patient.
5. It is unlikely that an HIV test can ever be part of emergency life-saving medical treatment.

Testing done on blood donations

1. The voluntary donation of blood at a Blood Transfusion Service Centre is usually preceded by a request to fill in a form. You will answer questions which are used to find out if your blood is likely to have any viruses or infections.
2. After the blood is taken, it is screened and tested for HIV, Hepatitis B and C, and sexually transmitted diseases. If any of these tests are positive, the blood donor will be informed of the results.

Mentally ill patients

1. In the case of a mentally ill person who is unable to consent to treatment or testing, consent can be obtained from their:
   - 1.1. Curator (person appointed by law to look after them)
   - 1.2. Spouse (husband or wife)
   - 1.3. Parent
   - 1.4. Child (if the child is 21 or older)
   - 1.5. Brother or sister.
2. If the person is in a mental institution, the medical superintendent can, in serious cases, consent on behalf of the patient if the next-of-kin (e.g. child) cannot be found.
3. But, the patient can only be tested for HIV if this information is necessary for his/her medical treatment. The medical superintendent is not allowed to consent on the patient's behalf if the results are going to be used to unfairly discriminate against the patient.

Anonymous, unlinked testing

1. Testing is sometimes done for research purposes and it is usually:
   - 1.1. anonymous (no names are used), and
   - 1.2. unlinked (it cannot be traced back to the person who was tested).
2. The annual survey of the number of pregnant women with HIV is an example of this kind of testing, which can be done without informed consent.
3. A recent Labour Court case considered the question whether permission from the court was required if testing was done on an anonymous and voluntary basis. The view was if the identity of the person being tested remains unknown, the risk of discrimination is absent.

In this case it was the employer's aim to assess the potential impact of HIV/Aids, to do proper manpower planning, provide support structures for those living with HIV/Aids, to take proactive steps to prevent employees becoming infected, etc. Given these circumstances, the anonymous testing of employees fell outside the ambit of the Act and no permission was required.

Compulsory HIV-testing

Chapter 5 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 provides for the compulsory HIV testing of alleged sex offenders. Sections 30 and 28 make provision for the victim of a sexual offence (or any interested person on behalf of such a victim, who obtained the required consent from the victim) to apply to a magistrate for an order that the alleged offender be tested for HIV and that the results thereof be disclosed to the victim or the interested person, as well as the alleged offender.

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Universal Infection Control Measures

1. Universal precautions [UP] refer to a set of principles that is based on the likelihood of contact with blood or other potentially infectious material, not on the likelihood of contact with an infected individual.
2. This means all patients are treated equally in terms of infection control as every patient is seen to be potentially infectious. Dentists must thus apply the same infection control protocols. UP is designed to protect the health and safety of OHCW and in doing so, also protects the patient.
3. There is consensus that adherence to universal precautions is one of the most important actions that will significantly protect health care workers against infection by HIV and other bloodborne pathogens. (The exception is immunisation against hepatitis B.)
4. Dentistry is at the forefront of infection control procedures, and affirms the fact that patients' health and well-being are our primary concerns. Compliance with infection control standard of care is an ethical obligation and is at the core and key to quality care and excellence in dentistry.
5. The procedures and practices that are now standard and routine in dental practice have served as models for other health care providers.
6. Universal infection control measures /Standard precautions are the best practices that must be adopted by all oral healthcare workers (OHCW) when potentially coming into contact with any patient's blood, tissue or body fluid.
7. As a general principle, disposable instruments should only be used once, and re-usable items should be sterilised.
8. Emphasis should be placed on consistent adherence to recommended infection control strategies, including the use of protective barriers and appropriate methods of sterilisation.
9. Each dental practice or facility should develop a written protocol for infection control including instrument processing, operatory clean up and management of injuries.
10. Dentists as employers are obliged to provide and maintain, as far as is reasonably practicable, a workplace that is safe and without risk to the health of employees.
11. The following are key elements of universal/standard infection control precautions:
    - 11.1. Hand hygiene.
    - 11.2. Personal protective equipment.
    - 11.3. Sharps disposal.
    - 11.4. Waste disposal.
    - 11.5. Blood and body fluid spillage procedure.
    - 11.6. Decontamination of equipment and the environment.
    - 11.7. Autoclave Use.
    - 11.8. Handpiece Sterlisation.
    - 11.9. Personal protection in the form of vaccinations and immunisations.

Hand Hygiene

1. Hand decontamination is the most effective means of preventing cross infection. Bacteria and viruses cannot penetrate intact skin. It is vital to maintain skin in a good condition and prevent cracking, chapping and drying of the skin.
2. The following activities are examples of when hands **must** be washed using detergent and water:
    - 2.1. Whenever hands are visibly dirty;
    - 2.2. Prior to and following examination of a patient;
    - 2.3. Prior to handling patient equipment;
    - 2.4. On entering and leaving the clinical environment;
3. After removal of gloves;
    - 3.1. Following any handling of blood or body fluids;
    - 3.2. After visiting the bathroom;
    - 3.3. After handling hand pieces and instruments;

This is not an exhaustive list.

Personal Protective Equipment (PPE)

1. Personal Protective Equipment (PPE) consists of aprons, gloves, masks and eye protection.
2. The primary use of PPE is to protect staff and reduce opportunities for transmission of micro-organisms.
3. Dentists are responsible for ensuring that staff has access to appropriate PPE. Staff also has a responsibility to use PPE in appropriate situations.
4. The selection of the PPE is based on a risk of transmission of micro-organisms to the patient and the risk of contamination of the OHCW clothing and skin by the patient's blood and body fluids.
5. At all times when an OHCW is likely to be splashed in the face with blood or body fluids;
6. At all times when an OHCW is working in close proximity to a patient who is coughing.
7. When an OHCW has acne or dermatitis.
8. During restorative work using a high-speed hand piece for example when preparing a tooth or polishing a crown.
9. Body fluids dirtying clothes - Wear a plastic apron or gown during procedures where body fluids may dirty clothes.

Gloves

1. The use of gloves can reduce the risk of acquiring infection through direct skin contact between OHCW and patients. Gloves should not be worn unnecessarily or as a substitute for hand decontamination as prolonged and indiscriminate use may cause adverse reactions and skin sensitivity.
2. Gloves are a single use item.
3. Gloves can reduce the likelihood of contact dermatitis in staff exposed to chemical agents.

4. Gloves must be worn when direct contact with contact with blood, body fluids, non-intact skin or mucus-membranes is anticipated.
5. Gloves must be changed between patients and different procedures on the same patient.
6. Gloves must be disposed of in a clinical waste bin.
7. Hands must be decontaminated with soap and water immediately on removal of gloves.

Sterile gloves

1. Training on the correct procedure for donning and removing sterile gloves must be provided for staff to prevent the contamination of the outer surface of the glove and the hands.
2. If OHCW has a latex allergy or sensitivity to specific chemicals in gloves, they must report this to the dentist as alternative gloves must be made available in the person's area of work.
3. Where a patient is known to be allergic to latex, staff must use non-latex gloves.

Disposable aprons and gowns

1. Plastic aprons must be worn to reduce the level of contamination of uniforms/clothing where direct patient care is given and there is potential for the dispersal of pathogens.
2. The type of apron or gown to be worn depends on an assessment of risk of contact with body fluids. Aprons:
   - 2.1. Must be worn where there is a risk of blood or body fluid contamination of the uniform,
   - 2.2. Must be changed between patients and different procedures on the same patient,
   - 2.3. The apron must be disposed in an orange clinical waste bin. as clinical waste,
   - 2.4. May be worn for decontamination activities, including cleaning and disinfection.

Eye protection

1. Mucous membranes of the eyes and mouth must be protected when there is a risk of blood splashes.
2. Eye protection may be achieved through the use of goggles, visors or spectacles with side pieces. They must be comfortable to wear, fit correctly and allow for clear vision.
3. Eye protection that is designed for multi-use must be cleaned with detergent between each task and patient.

Masks and respirators

1. Masks are worn to protect the wearer from potential exposure to micro-organisms via splashes of blood or body fluid.
2. The use of a mask must be based on an assessment of risk of body fluid exposure. Staff may select a face mask depending on the level of protection required.
3. Where a mask is required it should be applied prior to entering the surgery area.
4. Masks must be worn correctly and be close fitting.
5. Handled as little as possible.
6. Changed between operations or patients.
7. Changed if wet.
8. Discarded immediately after removal in an orange clinical waste bin.
9. Hands must be washed on removal of mask.

Sharps Disposal

1. Use of appropriate PPE.
2. Used sharps must be discarded into a sharps container at the point of use. Needles and syringes must not be disassembled by hand prior to disposal.
3. Do not re-sheath needles.
4. Do not carry loose sharps in your own hands - use a plastic tray.
5. Sharps must not be passed directly from hand to hand, use a tray so that the same sharp device is not touched by more than one person.
6. Sharps containers must not be filled above the mark indicating they are full.
7. Temporary closure mechanisms should be used when sharps boxes are not in use.
8. Sharps containers should be located in a safe position.
9. Report all incidents (including near misses) involving contaminated sharps at the time of occurrence, or as soon as possible afterwards.

Disposal of Waste Materials

1. In terms of the Code of Practice of the South African Bureau of Standards on the Handling and Disposal of Waste Materials within Health Care Facilities (SABS 0248:1993), health care waste is identified as hazardous waste.
2. It is the responsibility of all dentists to have a health care waste management system in place or to have access to such a system.
3. Such a system should be provided by an accredited waste service provider and be conducted in accordance with the SABS code 0248:1993.
4. Blood, suctioned fluids or other liquid waste may be poured carefully into a drain connected to a sanitary sewer system.
5. Disposable needles, scalpels or other sharp items should be placed intact into puncture resistant containers before disposal.
6. Solid waste contaminated with blood or other body fluids should be placed in sealed, sturdy impervious bags to prevent leakage of the contained items.

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7. The independent practitioner should be able to provide demonstrable evidence of compliance with an acceptable protocol for the management of health care waste. Such a protocol should provide for an audit trail on the management of waste generated by the practice.
8. Sharps bins must be kept separate from other clinical waste and MUST NOT be put into clinical waste bags.

Blood and body fluid spillage procedure

1. For spillages on the floor or a large surface area use PPE, wear gloves and apron.
2. Use paper roll to remove the spillage and place in a in an orange clinical waste bag.
3. Wash area with detergent and water.
4. Dispose of PPE in a clinical waste bin.
5. Decontaminate hands using soap and water.

Decontamination of equipment and the environment

1. After treatment of each patient and at the completion of daily work activities, countertops and dental unit surfaces that may have become contaminated with patient material should be cleaned.
2. Use PPE, wear gloves and apron.
3. Spilled blood - Clean up spilt blood immediately and wipe the surface with disinfectant.
4. Wear sturdy utility gloves when cleaning up.
5. Covering to be changed with a gloved hand after each patient;
6. Rubber dams to be used as appropriate;
7. High speed evacuation should be used at all times.
8. Surfaces should be disinfected with a suitable chemical germicide.
9. Clean the area with detergent and water.
10. Surfaces or equipment contaminated with blood should be disinfected with a chlorine based disinfectant.
11. Dispose of waste in a clinical waste bin.
12. Dispose of PPE as in a clinical waste bin.
13. Decontaminate hands using soap and water.

Autoclave Use

1. The sterilisation of instruments is one the most important infection control precautions in dental practice.
2. Sterilisation by heat is superior to any other form of sterilisation.
3. Professional Associations recommend flushing of dental unit waterlines each day before work, and before and after each patient.
4. Autoclaves must be tested regularly to ensure they are operating efficiently.
5. Disinfection of dental impressions and appliances
6. All impressions and appliances that need to be sent to the laboratory for processing are required to be adequately disinfected to prevent any cross infection.

Hand piece Sterlisation

1. Most modern hand pieces make use of ceramic bearings and thus heat-treating hand pieces between each patient should be considered an essential component of standard procedures.
2. Dentists can autoclave their hand pieces as often as possible as modern hand pieces can withstand the rigours of autoclaving between patients.

Hepatitis B Immunisation

1. It is recommended that all OHCW who might be exposed to blood or blood-contaminated substances in a dental setting be vaccinated for Hepatitis B.
2. Check every 5-10 years whether immunity is still protective. If not, revaccination or a booster vaccination may be required.

Duties of OHCW

Introduction

1. The SA Constitution grants every person the right to access health care services, the right to equality and to be free from unfair discrimination, the right to freedom and security of person, the right to privacy and to emergency medical treatment.
2. In terms of the South African Constitution no patient may be refused emergency treatment. This rule binds both private and public health facilities. In the former case, a patient has to be stabilized at least before being transferred to a state facility.
3. The Health Professions Council of South Africa (HPCSA) Rule 2.4 provides that no health worker can:
   - 3.1. refuse to treat patient solely because the patient is or may be HIV seropositive;
   - 3.2. treat HIV-positive people differently to other patients by withholding normal standards of treatment unless treatment difference is in the patient's interest (e.g. for fear of getting infected with HIV).[19]
4. Treatment cannot be suboptimal because of a perceived potential risk to health care workers. It is accepted that a health care worker will examine or treat a patient only with the informed consent of the patient.
5. When managing a HIV patient, the OHCW has a primary responsibility towards the individual patient. OHCW has certain responsibilities to other health care workers, and other persons that might be in danger of contracting the disease from the patient.
6. OHCW are reminded that an HIV diagnosis, without further examination (such as measuring viral load or CD4 cell counts), provides no information about a person's prognosis or actual state of health.
7. There is persuasive scientific evidence that knowledge of the HIV status of a patient does not provide additional protection to OHCW treating the patient. Nevertheless, there is a perception amongst some OHCW that under exceptional circumstances, the knowledge of the HIV status of a patient may be useful in order to ensure the use of 'extended' universal precautionary measures such as special gloves, clothing and face masks, and that inexperienced personnel should not be allowed to perform surgery on such patients.
8. OHCW should realise that there are factors which make it unrealistic to rely on HIV testing of patients to protect themselves against occupational exposure. Thus, OHCW must appreciate the significance of the window period of infectivity; the ever-increasing prevalence of HIV infection, especially among hospital patients; the time and cost it takes to obtain a reliable HIV test result and the need to treat, under less than ideal conditions, patients outside hospitals and in emergency care units.
9. These factors are not under the control of the OHCW and strengthen the view that, to minimise the risk of infection, health care workers should adopt appropriate universal precautions in all clinical situations rather than rely on knowledge of the HIV status of patients.
10. Where certain well defined high risk or exposure prone procedures are considered, the patient should be informed of the concerns and requested to consent to HIV testing. This should not be used routinely for all patients or patients informed that HIV testing is compulsory.
11. Patients always retain the right to refuse HIV testing and where it is refused, the patient may not be refused treatment on this basis. Where the patient decline to be tested such patient should be managed as if the patient is HIV positive.

[19]HPCSA Guidelines for the Management of Patients with HIV Infection or AIDS, Booklet 11, May 2008

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OHCW infected with HIV

1. Although the Bill of Rights in the Constitution and the Employment Equity Act, censures stigma and discrimination, it is still prevalent.
2. Although the Employment Equity Act declares that discrimination on the basis of HIV status is unlawful, it also provides exclusion of any person on the basis of an inherent requirement of the job is not unfair discrimination and if the Labour Court deems it justifiable, then testing of an employee to determine HIV status is not prohibited. This implies that as a consequence of their HIV status, limitations may be placed on employees with regard to the nature of the work they may undertake.
3. The laws regarding infected practitioners should be driven by science. The same reasons that provide that HIV infected patients have certain rights to treatment, HIV infected health care providers also have certain rights to practice.
4. No dentist or OHCW is obliged to disclose his or her HIV status to an employer nor may any employee be unfairly discriminated against or dismissed as a result of his or her HIV status. Disclosure of HIV status by an infected practitioner in the climate of fear surrounding AIDS is tantamount to withdrawing from practice.
5. Rule 11 of the HPCSA guidelines provide that no dentist or OHCW is obliged to disclose his or her HIV status to an employer nor may the employee be unfairly discriminate against or dismissed based on HIV status.
6. Any OHCW who finds himself or herself to be HIV positive, should be encouraged to seek counselling from an appropriate professional source, preferably one designated for this purpose by a medical academic institution. Counsellors must of course be familiar with recommendations such as those of the Centres for Disease Control so that unnecessary, onerous, and scientifically unjustifiable restrictions are not placed on the professional activities of an HIV positive dentist.
7. The benefits of voluntary HIV testing should be explained to all OHCW and they should be encouraged to consider HIV testing.
8. Infected dentists may continue to practice. However, they must seek and implement the counsellor’s advice on the extent to which they should limit or adjust their professional practice in order to protect their patients. The counsellor must make individual risk assessments and decide on a case by case basis what practice restrictions, if any, should apply to a particular practitioner.
9. Universal precautions are an effective and adequate means of preventing the transmission of HIV from OHCW to patient and patient to OHCW.

Dentists as Employers

1. It must be recognised that the HIV/AIDS epidemic will affect every workplace with possible prolonged staff illness, absenteeism, and death impacting on productivity, employee benefits, occupational health and safety, production costs and workplace morale.
2. From a business perspective, employees should be encouraged to voluntarily disclose their HIV seropositivity status. This would enable their conditions to be monitored so that the secondary support systems, consisting of superiors, peers and subordinates can assist HIV infected individuals in their tasks and help them to maintain a sense of reality.
3. However, individuals (including healthcare workers) are under no legal obligation to disclose their HIV status. The way in which employees with HIV or AIDS are treated in the workplace has a multitude of legal obligations.
4. Employers should be aware of possible liabilities if wrongful action is taken against employees with HIV or AIDS.

The South African Constitution

The SA Constitution grants all people the right to equality and non-discrimination. It also gives employees the right to be treated fairly at work. The Bill of Rights provides for every person has the right to fair labour practices.

National Health Act

1. The National Health Act provides that health establishments must implement measures that minimize injury or damage to the person or property of health care workers. This means that health care workers must be protected from physical harm, their working environment made safe and free from any hazardous incidents.
2. Health care workers must be provided with protective clothing against airborne viruses.
3. If a health care worker accidentally pricks him or herself with a needle containing blood from a person who may be HIV positive, the necessary measures must be taken to ensure that the worker has access to post-exposure prophylaxis (PEP) to reduce the risk of HIV transmissions.
4. To ensure compliance with these policies by health establishments the National Health Act establishes an Inspectorate for Health Establishments. The provisions of the National Health Act should be read with the Occupational Health and Safety Act and labour legislation governing working conditions.

Employment Equity Act (EEA)

1. The EEA was the first law to directly provide that employers may not unfairly discriminate against employees because of their HIV status. It is the only legislation that specifically refers to HIV/AIDS. The EEA aims at ensuring equality and non-discrimination in the workplace through anti-discrimination measures and affirmative action. It also provides specific provisions regarding HIV/AIDS.
2. A person's HIV status is something private. It has nothing to do with their work and employees are under no legal duty to tell their employer whether they are HIV negative or positive.
3. Any information employees share with their employers about their HIV status may only be disclosed to other people with consent. Telling other employees without an employee's consent is a breach of confidentiality and it could mean the employer is liable for damages.
4. Any dentist who tells a patient's employer about their HIV status without their consent or knowledge is acting against the law.
5. The EEA provides that an employer may not force an employee to take an HIV test except in certain circumstances. Making employees undergo HIV tests is expressly prohibited, unless deemed justifiable by the Labour Court. An employer cannot force a job applicant to have an HIV test. Practitioners that do this are acting unlawfully.
6. If an employer wants to test employees for HIV and the employer thinks that HIV testing may be important and reasonable for whatever reason, the employer must ask the Labour Court to allow for HIV testing. The Labour Court will then have to decide whether HIV testing is justified in the employer's workplace.
7. Basically, employees with HIV/AIDS must be treated in exactly the same manner as other employees with life-threatening illnesses.

Testing Employees In Terms Of Eea	
Authorised testing	**Permissible testing**
Employers must approach the Labour Court in the following circumstances: i. during an application for employment; ii. as a condition of employment; iii. during procedures related to termination of employment; iv. as an eligibility requirement for training or staff development programmes; and v. as an access requirement to obtain employee benefits.	An employer may provide testing to an employee who has requested a test in the following circumstances: i. As part of a health care service provided in the workplace; ii. In the event of an occupational accident carrying a risk of exposure to blood or other body fluids; iii. For the purposes of applying for compensation following an occupational accident involving a risk of exposure to blood or other body fluids. Furthermore, such testing may only take place within the following defined conditions: i. At the initiative of an employee; ii. Within a health care worker and employee-patient relationship; iii. With informed consent and pre- and post-test counselling, as defined by the Department of Health's National Policy on Testing for HIV; and iv. With strict procedures relating to confidentiality of an employee's HIV status as described in section 6 of this Code.

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Labour Relations Act (No.66 of 1995)

1. In accordance with Section 187(1)(f) of the Labour Relations Act, No. 66 of 1995, an employee with HIV/AIDS may not be dismissed simply because he or she is HIV positive or has AIDS. However where there are valid reasons related to their capacity to continue working and fair procedures have been followed, their services may be terminated in accordance with Section 188(1)(a)(i).
2. The employer can be taken to the CCMA or Labour Court and be forced to re-employ the employee or give him/her compensation stipulated by the Court.
3. Where employees can no longer do their work, an employer should first investigate what the extent of the employee's capability to do their job is and what alternatives are available apart from dismissal. These alternatives can include extended sick leave without pay, adapted duties and possible means of accommodating the employee's disability.
4. An employer may refuse to employ a person who is clearly too ill to work (for whatever reason). But to refuse to employ any person simply because they are known or suspected to have HIV unfairly discriminates against that person on the grounds of HIV status and is therefore unlawful.
5. An employer could only refuse to employ a person with HIV if being HIV negative was an inherent requirement of the job.
6. An employee no longer able to work must be provided with an incapacity hearing before they can be dismissed.
7. A Code of Good Practice on Key Aspects of HIV/AIDS and Employment has been added to both the LRA and the EEA. The Code is a general guide on how employers, employees and trade unions should respond to HIV/AIDS in the workplace.
8. The Code provides that should employees no longer have the capacity to perform their functions, employers must examine the extent of the incapacity. Alternatives to dismissal must be examined, which may include short time, extended unpaid sick leave and adapted duties. Furthermore, employers are required to investigate possible ways to accommodate employees' disabilities. The Code also requires that employees be given the chance to voice their opinions on the possible alternatives or accommodations during the process.
9. If dismissal still seems the only tenable solution, the Code prescribes that employees must be given an incapacity hearing before they are dismissed.
10. If an employee who is found incapable has an AIDS related illness, dismissal can be fair provided that the employer follows the steps laid down by the Code of Good Practice on Dismissal.

DISMISSAL OF A PERSON WHO HAS AIDS

Illness and incapacity

1. Eventually, many people with HIV start to become ill with AIDS. During this time, an employee may use up a lot of sick leave, and his/her capacity may be affected.
2. All employees have a right to sick leave and an employer has no right to discriminate against or dismiss an employee who uses these rights. However, an employer is allowed to dismiss an employee on the grounds of incapacity and poor work performance, even if the employee has not used all their sick leave.
3. The LRA Code of Good Practice sets out very clear procedures for employers and employees when dealing with dismissals for incapacity.
4. The principle of the Code is that employers and employees "should treat one another with mutual respect".

Dismissal without incapacity

It is unlawful for an employer to dismiss an employee simply because he/she suspects that you may have AIDS, but cannot show any evidence of incapacity.

Duties of an employer to make a dismissal for incapacity fair

1. Investigate the extent of the incapacity or injury.
2. Decide if it is likely to be permanent (long-term) or temporary (short term).
3. Investigate alternatives to dismissal.
4. Consider the possibility of "adapting the duties or work circumstances of the employee to accommodate the employee's disability".

Promotion of Equality and Prevention of Unfair Discrimination (No.4 of 2000)

The Promotion of Equality and Prevention of Unfair Discrimination Act also sees to it that there is no unfair discrimination in the workplace, especially with things like insurance. This means that an employee with HIV/AIDS must be treated in exactly the same way as all the other employees in the organization in all matters.

Occupational Health and Safety Act (No. 85 of 1993) (OHSA)

1. Sometimes an accident at work can cause a bleeding injury. If the injured person is HIV-positive and someone who tries to help the person also has an open wound, there is a small chance of the helper becoming infected if the wound comes into contact with the injured person's blood. The employer has a responsibility to make sure that the workplace is safe and that employees are not at risk of HIV infection at work.

2. OHSA requires that employers create a safe working environment as far as they can.
3. Regarding HIV/AIDS, the employer has the duties to ensure that steps are taken to minimize the risk of occupational HIV infection:
   3.1 ensure that the risk of possible HIV infection is minimised;
   3.2. ensure that appropriate first-aid equipment is readily available to deal with spilt blood and body fluids;
   3.3. ensure that staff training is undertaken on safety steps to be taken following an accident, and
   3.4. ensure that universally accepted infection control procedures are used in any situation where there is possible exposure to blood or blood products.
4. Furthermore, the occupational transmission of HIV/AIDS should be placed on the agenda of companies' Health and Safety Committees to ensure that proper control measures are followed.

Compensation for Occupational Injuries and Disease Act (No.130 of 1993)

1. The Compensation for Occupational Injuries and Diseases Act (COIDA) gives every employee the right to compensation for accidents and illness that they get while working. If an employee gets infected with HIV because of a workplace accident, they can claim for compensation.
2. An "occupational accident" is an accident arising out of and in the course of a person's employment, which results in a personal injury, illness or death.
3. To get compensation, an employee needs to show that HIV infection was the result of the occupational accident. There are no formal guidelines from the Compensation Commissioner on occupational accidents involving exposure to HIV.
4. Employees can demand more compensation if they can show that:
   4.1. Personal protective equipment was not available, and
   4.2. their infection was due to the negligence (carelessness) of the employer, who did not provide a fully safe workplace.
5. If an accident is not reported to an employer or the Compensation Commissioner within 12 months, an employee loses the right to claim for compensation.

The Unemployment Insurance Act (UIF)

1. The Unemployment Insurance Act offers a range of benefits to South Africans, which include Illness benefits are offered to contributors who are incapable of working due to their illness and have been unemployed as a result for longer than two weeks.
2. Through the introduction of this Act, it is evident that the Department of Labour has taken note of the increased incidence of AIDS related unemployment.
3. Indirectly, it is also a safety net to business organisations with HIV positive and AIDS affected employees, since if such employees are dismissed from service due to the inability to work, they can be provided with money from the Government. Furthermore, employees who take extended sick leave have the option of resigning and also obtaining funds from the UIF.

The Medical Schemes Act No 131 of 1998

The Act prohibits discrimination based on "state of health". Therefore, it is an illegal act to discriminate against anyone with HIV or AIDS.

Summary of the rights of people living with hiv and aids in the workplace

RIGHT	LAW
Right to fair labour practices	Constitution and Labour Relations Act (LRA)
Right not to be unfairly dismissed because you have HIV	LRA
Right not to be unfairly discriminated against on the basis of your HIV status	Employment Equity Act (EEA)
Right not to be tested for HIV unless your employer has applied to the Labour Court for authorisation	EEA
Right to a safe working environment	Occupational Health and Safety Act, and Mine Health and Safety Act
Right to compensation if infected with HIV at work	Compensation for Occupational Injuries and Diseases Act (COIDA)
Right to certain basic standards of employment, including 6 weeks of paid sick leave over a 3-year period	Basic Conditions of Employment Act (BCEA)
Right to no unfair discrimination in giving employee benefits	Medical Schemes Act
Right to privacy about your HIV status at work	Common law right

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Needle stick Injuries

The Occupational Health and Safety Act (No. 85 of 1993), which covers all employees, provides that employers must provide and maintain if an accident happens and blood is spilt, there is a as far as is reasonably practicable, a working environment that is safe and without risk to the health of his employees. This means that all employers must make sure that the workplace is safe, and that employees are not at risk of getting infected with HIV in the workplace.

New regulations require that employers have a duty to see that safety equipment such as rubber gloves are in every first aid box. Furthermore, all staff must be trained in universal precautions and should have access to the equipment needed to use these precautions.

NEEDLE STICK INJURIES

1. A sharp is defined as any object or instrument, which may cause a puncture or incisional wound in the skin.
2. Needlestick injuries can be defined as any piercing wound caused by a needle, or by other sharp instruments or objects such as scalpels, mounted needles, broken glassware, etc. The needlestick injury is one of the most stressful workplace accidents that happen to HCWs.
3. OHCWs are frequently exposed to blood borne pathogens. These include HIV, HBV, HCV, all of which can be contracted through needle stick and sharps injuries or mucosal splashes.
4. The average risk of HIV infection after being exposed to HIV infected blood via needle stick injury or cut is:

HIV	0.3%
Hepatitis B	> 30%
Hepatitis C	0-10%

5. The amount of blood on a used dental hypodermic syringe is extremely small which is further reduced by friction as the needle is withdrawn from the oral mucosa further as it penetrates the rubber glove and superficial layer of the skin.
6. The amount of blood deposited subcutaneously in the OHCW is insufficient to contain a pathogenic dose of HIV and the local anaesthetic solution may have a deleterious effect on the viability of HIV. At present infection by the hepatitis B virus poses a greater risk.
7. The emotional impact of a needlestick injury can be severe and long lasting, even when no infection is transmitted. Not knowing the infection status of the source patient can accentuate the OHCW's stress. It is important that all OHCW are well informed about the exposure risks and educated regarding the appropriate measures to take following an injury.
8. In the United Kingdom, standard precautions exist to help prevent needlestick injuries where all blood and body fluids, regardless of its source, are considered to contain infectious agents, and treated as such. It is recommended that dentists in South Africa operate on the same basis.
9. The main risk posed by needlestick injuries is exposure to blood-borne viruses (BBV), particularly Hepatitis B (HBV), Hepatitis C (HCV) and Human Immunodeficiency Virus (HIV). Needlestick injuries can also cause psychological distress, as the injured person may have to cope with the fear that they have been infected.

Prevention of occupational exposure

Prevention of occupational exposures is the responsibility on both the employer and the employee. The employer is obliged to provide, as far as is reasonably practicable, a safe working environment. OHCW is required to work safely within that environment, and standard precautions should apply wherever infectious fluid contact is possible.

1. Gloves (in appropriate sizes) and protective eyewear must be readily available and ppromote safety awareness in the work environment.
2. Needles should not be recapped and handling of needles after withdrawal from a patient should be kept to an absolute minimum. If possible, eeliminate the use of needles where safe and effective alternatives are available.
3. All needles and sharp objects should be disposed of in dedicated sharps bins. Syringes and other blunt instruments should not be placed in these bins.
4. Sharps bins must be sealed and disposed of once three quarters full. Overfull bins are a risk factor during use and disposal.
5. Keep a detailed report of all needlestick and other sharps-related injuries in your workplace and analyse them to identify hazards and injury trends.
6. Establish procedures for and encourage the reporting and timely follow-up of all needlestick and other sharps related injuries.
7. Report all needlestick and other sharps-related injuries promptly to ensure that they receive appropriate follow up care.
8. Inform the employer about the hazards from needles or other sharp instruments that they observe in their work environment.
9. Participate in infection control training and recommended infection prevention practices, including hepatitis B vaccination.
10. Emphasis should therefore be on PREVENTION OF EXPOSURE through the adoption of safe work practices and following a policy of applying "universal infection control", when handling ALL blood or blood-stained body fluids.

Risk Assessment

1. When an OHCW has sustained an occupational exposure, the situation must be handled sensitively. This may involve asking some highly personal and embarrassing personal questions.The patient must not be approached by the injured OHCW. There is no single approach that will cover every interview, but the following should be observed.
2. The discussion should take place where proper privacy can be maintained.
3. The patient should be informed that someone has been injured in an accident involving their blood/body fluid. Injuries of this kind can cause considerable anxiety and worry for OHCWs because of infections such as hepatitis B, hepatitis C and HIV can be transmitted in this way.
4. Source patient may be asked if they willing to provide a sample of blood to test since positive or negative result will determine the management of the OHCW's injury, potentially over a period of six months. It is important that undue pressure is not applied and the decision lies entirely with the patient and this must clearly be explained to the patient to comply with this request. Emphasise that the questions are very personal and might very well not apply to them, but they are now asked routinely, for example by blood transfusion services. The outcome of the discussions should be recorded in the patient's notes.
5. Inform source patient he or she will be notified of the result.
6. If it is not possible to identify the source patient for a particular needle or sharp instrument or the source patient does not consent to a test, a risk assessment should be carried out to determine the likelihood that the needle may have been used on a patient with blood borne virus (BBV) infection.
7. The decision to implement post-exposure prophylaxis (PEP) will be determined on a case specific basis, after carefully weighing the potential risks and benefits of providing PEP based on the risk assessment of the exposure incident. PEP should be initiated by the physician appointed by the practitioner.
8. HIV PEP should be initiated within two to four hours of exposure for maximum efficacy. As the time period from exposure to initiation of PEP increases, the likelihood of the virus establishing infection and spreading beyond the local site.
9. Baseline and follow-up testing of the exposed OHCW is recommended in situations where risk assessment of the exposure incident has concluded that HIV PEP is indicated, but a decision has been made not to initiate HIV PEP.
10. If HIV PEP was appropriate but not initiated for the exposed OHCW at the time of exposure and the source patient is subsequently discovered to be HIV positive, HIV PEP should be started as soon as possible, if the exposure occurred less than 72 hours prior. In this case, HIV PEP should be initiated upon receipt of the first positive HIV antibody screening test, before confirmatory test results are available.
11. If the exposed OHCW has begun an HIV PEP regimen and the source patient is later determined to be HIV-negative, HIV PEP should be discontinued regardless of number of days of prophylaxis completed. In these situations, it should be emphasised that continuation of PEP might be considered in rare instances where there is realistic concern that the source patient is in the window period of infection (seroconversion phase). At all times consultation with the physician is recommended.
12. In addition, the employer must provide for psychological and counselling support for the OHCW. There should be an open door policy for the affected person to discuss new and ongoing concerns.

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Management after Exposure

Immediate Care to Exposure site

1. Dispose of the sharp/needle immediately and safely.
2. Stop all operative procedures and immediately institute first aid.
3. For wounds: wash the exposed site thoroughly with running water.
4. Eye or mouth exposure: irrigate with copious quantities of water or saline.
5. Skin: Wash with soap and water and rinse
6. DO NOT: panic, put the pricked finger in the mouth, squeeze the wound to bleed it, scrub the wound, and do not use bleach, chlorine, alcohol, bethadine, iodine or any other antiseptics or detergents to wash the wound.
7. The incident should immediately be reported to the practice owner or practice manager.
8. Dry the wound and cover it with a waterproof plaster or dressing.
9. Clothing contaminated by blood/body fluids should be removed.
10. A thorough assessment of the exposure is then required to determine the risk of disease transmission (type of fluid, type of needle, amount of blood on the needle, etc).
11. Reassure the employee and the patient that it is only rarely that blood exposures result in infection.

Reporting incident

1. Document the circumstances and record the source of the exposure, the patient's name, and number, date of birth if details are known etc, type of body fluid and type of injury.
2. OHCW should be given time to talk about their concerns following the incident and discuss the available information about risks from the exposure. Discuss the practical implications of the test and its result (positive or negative). Discuss possible routes of transmission of HIV, Hepatitis C Virus (HCV) and Hepatitis B Virus (HBV).
3. Employees should be instructed and educated to immediately report exposure incidents to the dentist employer to permit timely medical follow up.
4. The exposure source should be evaluated. A blood sample may not be taken from the patient for the purposes of an HIV test without the patient's consent. The dentist or designated doctor should make arrangements to approach a source patient whose HIV status is not known and ask for their informed consent to HIV testing. This should not be undertaken by the exposed worker.
5. If HIV post-exposure prophylaxis is medically indicated it should be initiated promptly within 1-2 hours after exposure incident.
6. Immediate reporting also enables the dental employer to evaluate the circumstances surrounding the exposure incident to try to find ways to prevent such a situation arising again.

Referral to a Health Care Professional

1. Refer exposed employee to a health care professional immediately and follow-up to perform all medical evaluation and procedures with the employee's consent to be tested for HIV, HBV and HCV.
2. The designated doctor should first assess if the exposure report was significant i.e. with the potential to transmit HIV. Some OHCW may have occupational exposures which, after careful assessment, are not considered significant i.e. they do not have the potential for HIV transmission.

Information Provided to the Health Care Professional

1. The practice owner must provide the HCP with a copy of:
   - 1.1. the blood-borne pathogens standards
   - 1.2. the employee's job duties as they relate to the incident
   - 1.3. report of the specific exposure incident
   - 1.4. results of the source patient's blood testing if available subject to specific consent to release the information.

HIV Status of Source Person

1. An attempt should be made as soon as possible to determine the HIV status of the source person. It is recommended that a reliable rapid HIV test be used.
2. Where source patient agree to be test for HIV antibodies, careful pre-test discussion will be needed, as will informed consent.
3. As part of pre-test discussion, the source patient should be informed about the incident and the reason for the enquiry and request for a test. The difficulties of the exposed health care worker's situation should be discussed.
4. Testing of the source person should be done in a proper and ethical manner i.e. with informed consent.
5. If the source person refuses to have his or her blood taken then it must be assumed he or she is HIV positive.
6. The Department of Health guidelines suggest where an existing blood sample is available, an HIV test may be conducted on that sample with the consent of the source person. It may be required to test a patient in an emergency situation in order protect other persons. In such cases, in order to pass the tests of reasonability and justifiability, consideration should be had for the nature of the injury(ies) and the source patient has to be evaluated to determine the likelihood of HIV.
7. However, the person must be informed that the blood sample was tested, and if s/he, after pre-test counseling wishes to know the results, the principles of post-test counseling have to be adhered to.

Counselling

1. Counselling is a vital component of the required post exposure follow-up procedures [See Appendix 2].
2. The employee needs to be counselled regarding his or her infectious status, including results of and interpretation of all tests, and discuss with the employee the possible risks of infection, the need for post-exposure prophylaxis and the protection of personal contacts.

Exposure Report

1. The dental employer must prepare a report of the:
   - 1.1. exposure incident;
   - 1.2. date and time of exposure;
   - 1.3. type route of exposure (puncture, laceration, mucous membrane, splash);
   - 1.4. mechanism of exposure, details of the procedure being performed; where, how and type of device used;
   - 1.5. source of exposure: material patient history and stage of disease;
   - 1.6. type of fluid that the employee was exposed to (blood, visibly bloody fluid, other potentially infectious fluid or tissue, concentrated virus);
   - 1.7. whether gloves, eye protection and masks were used at the time of exposure.

Table 3: Assessing Risk

Exposure Type	Type of device	Visible blood	Depth of injury
Lower Risk	Solid instrument	No	Superficial or moderate
Higher Risk	Hollow needle Visibly contaminated with the patient's blood Needle placed in vein or artery	Yes / No	Superficial, moderate or deep
	Any instrument	Yes / No	Deep
		Yes	Superficial, moderate or deep

Post-Exposure Prophylaxis (PEP)

1. PEP is an antiviral therapy designed to reduce the possibility of an individual becoming infected with HIV after a known exposure to the virus. However, currently PEP guidelines lack a substantive evidence base to guide advice ie. efficacy has NOT been demonstrated by randomized controlled trials
2. Our current decision-making with regards to PEP is guided by evolving basic science and biological plausibility, supported by animal data and retrospective case-control studies utilizing several ARV PEP regimens
3. After an occupational exposure, the source patient and the exposed OHCW should be evaluated to determine the need for PEP. Assess the risk to the health care worker (Table 3).
4. PEP is recommended for any high risk exposure including percutaneous [skin perforating needle stick injury, involving:
   - 4.1. Visible blood on the needle;
   - 4.2. Needle having been used in a vein or artery of source person.
   - 4.3. Any deep intra-muscular injury or injection into the body where large volumes of blood or body fluids are involved and prolonged contact with them.
   - 4.4. Exposure to broken skin and to mucous membranes.
   - 4.5. PEP should be initiated as soon as possible, preferably within one to two hours after the exposure and within 24 hours.
   - 4.7 In order to avoid delays in starting PEP, "starter packs" [first three days' supply of a 28 day treatment] of PEP drugs should be made available while steps are being taken to assess the source patient's HIV status or where it is known to be HIV positive. If after conclusive testing the source patient is found to be HIV negative, PEP should be discontinued.
   - 4.8 Consult with a HIV clinician for the most current ARV drug regimen options.

If the OHCW is HIV positive or the source patient is negative.	No prophylactic medication for HIV is required.
If the source patient is HIV positive and the staff member is negative.	It is recommended that prophylactic medication be taken.
If the source patient status is unknown and the staff member is negative.	No prophylaxis is required. It is however recommended that it be taken.

Monitoring

Drug toxicity should be monitored at baseline and two weeks after commencement of treatment.

Baseline screening should include a complete blood count, renal and hepatic function tests.

Serum glucose should be tested in individuals receiving a protease inhibitor. If toxicity is noted, modification of the regimen should be considered after expert consultation and further diagnostic tests may be required.

HIV antibody testing should be done at 6 weeks, 12 weeks and 6 months.

Follow up

OHCW with occupational exposure to HIV should receive follow-up counselling, post-exposure testing and medical evaluation regardless of whether they receive PEP.

This will include the possibility of HIV seroconversion, the importance of starting prophylaxis and behavioural changes that will have to be made for at least six months to prevent transmission of HIV to others.

HIV-exposed OHCW should be advised to: use sexual abstinence or condoms, avoid pregnancy, cease breast feeding, and refrain from donating blood, plasma, organs, tissue or semen.

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Appendix 1

Example of Reporting Procedure Form		
Reporting procedure	Signature of responsible person	Date & time
1. Immediate management and completion of exposure report form		
2. Report the incident immediately to person in charge		
3. Institute pre-test counselling		
4. Obtain written, informed consent from the source patient to draw blood for HIV, HBV, HCV		
5. Obtain written, informed consent from the OHCW to draw blood for HIV, HBV, HCV		
6. Contact virologist to arrange for urgent blood tests		
7. Give initial dose of PEP medication		
8. Give prescription for further medication		
9. Report incident to all concerned		
10. Arrange for follow-up blood tests at 6 weeks, 3 months & 6 months		
11. Assess exposure reports for recommendations for future actions (modifying work practices)		

Appendix 2

Guidelines for basic counselling skills

- It is required by law that everyone who has to undergo an HIV test receives pre-test counselling. Every client who contemplates HIV testing should ideally be fully counselled by a professionally trained counsellor.
- Most health facilities do not have trained counsellors and patients often have to be referred. Due to the fact that oral health care workers are increasing being faced with this situation, it is imperative that they have at least basic counselling skills. It is preferable that all oral health care workers undergo professional training in counselling.

Why is counselling necessary?

A person who has tested HIV-positive may never have the same quality of life again. The stigma surrounding the diagnosis of HIV, as well as its associated mortality, poses a challenge for any health care worker who has to break the news to a patient. HIV positive individuals who are given support and help at the time of testing cope better with their situations and are able to talk about their fears and feelings more openly and to plan for the future.

The aims of counselling HIV counselling aims to:

- Provide a supportive environment;
- Help clients manage their problems;
- Explore coping skills that clients may have used before and help them develop new ones;
- Empower clients to become self-sufficient in dealing with emerging issues and problems;
- Counsel clients on how to avoid re-infection and how to prevent infection of others; and
- Explore options with clients that will help them bring about necessary changes in behaviour.

Pre-test Counselling

- When giving pre-test counselling, one needs to focus on what the client is feeling and experiencing. In busy practices this may be very difficult, but all reasonable efforts should be made to ensure privacy, a session free of interruptions and where confidentiality is assured.
- Clients should be assured that both counselling and testing are confidential procedures;
- Discuss possibility of referral to a trained professional counsellor in the event of a positive result;
- Provide information about HIV infection and transmission and its links to AIDS, sexually transmitted infections and tuberculosis
- Provide information on the technical aspects of testing i.e., window period, what ‘positive’ and ‘negative’ mean
- Discuss the implications of a positive and negative diagnosis;
- Provide information about legal rights. Clients should consider whom to tell (sexual partner/s) and whom not to tell (employer/third party). Clients are not obliged to tell anyone apart from their sexual partners;
- Evaluate risk behaviour and discuss steps that they should take to prevent future infection and transmission;
- Determine whether clients have coping resources and support systems in the event of a positive result;
- Provide clients with a sense of support and hope;
- It is advisable to document the patient’s consent.

Post-test Counselling

Post-test counselling assists clients to work through the crisis and other issues after learning of their HIV status.

For an HIV-positive result, a few sessions are required:

- Containment (preparation phase);
- Questions and concerns (discussion phase);
- Integration (reviewing the situation).

For an HIV-negative result:

- Discuss the window period;
- Reinforce prevention and safer sexual practice messages;
- Discuss referral if necessary;

Ongoing counselling may be necessary if the patient indulges in risky behaviour, needs ongoing support, and needs to be counselled for anxiety or depression.

Ongoing Counselling

- Ongoing counselling helps the client deal with issues such as partner notification, relationship difficulties, queries about health and treatment and disclosure to others.
- With written permission from the client, the counsellor may liase with other caregivers.
- The counsellor is often a crucial source of support, since clients often feel that they cannot share the diagnosis with others and they are initially very vulnerable.

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