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REPORT OF

THE GOVERNOR'S TASK FORCE ON AIDS

(Acquired Immune Deficiency Syndrome)

January 6, 1986
Tallahassee, Florida

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The Florida AIDS Hotline provides information to the public about AIDS, including methods of transmission and the availability of testing programs and local experts and speakers. It can be reached toll-free by calling (800) FLA-AIDS.

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REPORT OF THE GOVERNOR'S TASK FORCE ON AIDS
(Acquired Immune Deficiency Syndrome)
January 5, 1986

SUMMARY

Acquired Immune Deficiency Syndrome (AIDS), while only recognized as a clinical entity in 1981, has become a major killer. Over 15,000 Americans have been diagnosed as having AIDS, while many more than that number have a related but less lethal form of the disease known as AIDS related complex or ARC. Approximately one-half of those diagnosed as having AIDS are now dead. More than one million individuals in the United States may be infected with the virus known to spread the disease, the human t-lymphotropic virus type III, or HTLV-III.

Thus far, AIDS has appeared to inevitably result in death, usually within two to five years after original diagnosis. It is spread through intimate sexual contact, the sharing of intravenous needles, and exchange of bodily fluids, particularly in the transfusion of contaminated blood and blood products. The disease in the United States has appeared predominately in homosexual men (73 percent) and intravenous drug users (17 percent).

More than 1,000 Floridians have contracted AIDS in the last five years, with another 1,000 expected to be diagnosed in 1986 alone. Florida has the third highest number of cases of AIDS in the country, predominately in Dade, Broward and Palm Beach counties. Florida's unique and highly heterogeneous socio-demographic characteristics may account, in part, for the high number of AIDS cases in the state.

Because of medical uncertainties about the disease and the lack of an immunization or effective treatment against its fatal course, AIDS has stirred considerable public anxiety. The Governor convened this task force of experts to weigh the available evidence about the disease, evaluate current Florida programs designed to combat it, answer difficult medical and ethical questions as they relate to appropriate public policy, and to make recommendations to the Governor and the Legislature about the future course of action the State of Florida should take against AIDS. This

document summarizes their actions and recommendations since the group was formed in October, 1985.

In general, the Task Force believes there is sufficient epidemiologic evidence about the disease to end many uncertainties about appropriate public protection in schools, the workplace and elsewhere. However, until an immunization or treatment is developed through additional research, the only effective method to prevent spread of HTLV-III is through appropriate education about the sexual and drug use practices implicated in spreading the disease. For those patients who now have AIDS and ARC, significant additional resources are needed to provide for their care and treatment.

POLICY RECOMMENDATIONS

The Governor's Task Force on AIDS recommends:

PUBLIC HEALTH

1. That health cards have no practical use in the control of AIDS.

2. That the CDC guidelines on handling AIDS in the workplace become state policy. These guidelines state that AIDS is not transmitted through the usual person-to-person contact that generally occurs among workers and clients or consumers in the workplace. Additions to these guidelines will be made at a future date.

3. That bath houses and peep shows are public places where there is a high probability of transmitting HTLV-III. Legal notice should be served to these places requiring the cessation of sexual activity because it increases the risk of HTLV-III transmission.

4. That the FMA and CDC guidelines on children attending school be adopted as state policy. These guidelines state that each case should be reviewed independently and in concert with the child's physician. The guidelines also outline appropriate health care procedures in the classroom.

5. That no public interest is served by routine screening of low risk populations with the EIA test, and strongly recommends against routine EIA screening for insurance or employment purposes. The Task Force recommends that state law on this issue be strengthened.

PUBLIC EDUCATION

1. That groups with a special need to know about AIDS be identified and educational packages be presented that are tailored to their needs. Suggested groups include: professional health care providers, industrial and personal service workers, judicial groups, schools, detention centers, mental health institutions, the general public and high risk groups;

2. That health care facilities appoint one spokesperson for AIDS to work as liaison with the community. This person should be responsible for disseminating information to the facility and the community, and relating to local and state experts on AIDS;

3. That a full-time staff position for education be developed to work with HRS and the Task Force;

4. That the Task Force serve as a clearing house for policy issues on AIDS;

5. That $1 million be appropriated for education and information programs;

6. That the HRS pamphlet concerning AIDS be widely disseminated to health care facilities and others throughout the state because of its excellence and comprehensive treatment of the subject.

PATIENT SERVICES

1. That the $6.8 million patient care network proposed by Jackson Memorial Hospital in Miami be funded by the state and federal government. This program requires a network with other Florida hospitals, nursing and foster homes, social services and support groups to provide total care for AIDS patients, to decrease hospitalization and medical costs, and to provide more community-oriented treatment.

2. That the legislature fund additional patient care programs in other counties ($2 million); model research, treatment, and education programs in three medical universities ($1 million); and care for children with AIDS through Children's Medical Services ($400,000).

3. That the following statement adopted by the Task Force be widely distributed: The risk of acquiring HTLV-III through blood transfusion is virtually eliminated with the present HTLV-III antibody screening test and continued use of self-exclusion criteria for high risk donors. There is no risk to donors, and never has been.

RESEARCH AND EPIDEMIOLOGY

1. That three P-3 level laboratories for HTLV-III investigation, at an approximate cost of $150,000 each for renovation, be established in Florida.

2. That $450,000 be appropriated to conduct virological and clinical research on HTLV-III, including development and testing of new antiviral compounds.

3. That $480,000 be appropriated for increased case surveillance and investigation, and special epidemiologic studies of HTLV-III infection

Budget Recommendations of The Governor'S Task Force on AIDS

I. CURRENT FEDERAL PROGRAMS	
AIDS Surveillance	$ 186,000
Information and Education	194,000
Alternate Test Site	967,000
II. CURRENT STATE APPROPRIATION	576,000
III. AIDS INFORMATION AND EDUCATION	
Media and materials	600,000
Community organizations	350,000
Professional staff	50,000
IV. PATIENT TREATMENT PROGRAMS	
Jackson Memorial Hospital	6,800,000
Other Counties	2,000,000
Model University Programs	1,000,000
Pediatric Foster Care	400,000
V. AIDS Research	
Virology Laboratory Improvement	450,000
Virological and Clinical Research	450,000
VI. AIDS Surveillance and Management	
Special Epidemiological Studies	200,000
Increased Surveillance	280,000
TOTAL	$14,503,000

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January 6, 1985

I. INTRODUCTION

A. AIDS IN THE UNITED STATES

Acquired Immune Deficiency Syndrome (AIDS) is a newly recognized disease in man, first noted as a clinical entity in 1981. As of December 9, 1985, 15,581 persons in the United States have been diagnosed as having AIDS, of whom 8,002 have died. Approximately three-quarters of these cases occurred in homosexual or bisexual men, while 17 percent occurred in heterosexual men and women who use intravenous drugs. An additional 4 percent of reported AIDS cases received transfusions with contaminated whole blood or blood components, while the remaining 6 percent were in no known risk groups. Of persons in no known risk group, many were from countries with a large number of AIDS cases not associated with known risk factors.

AIDS is caused by a retrovirus, human T-lymphotropic virus type III (HTLV-III), that infects especially the cells of the immune system called T-4 helper cells. These cells are responsible for starting the immune response against a virus or other infective agent. When HTLV-III attacks the T-4 cell, the body's ability to produce antibody against infections is destroyed, leaving the patient vulnerable to infection. AIDS patients are particularly susceptible to certain "opportunistic" infections and cancers that are the hallmark of AIDS. Some of these opportunistic diseases are pneumocystis carinii pneumonia, Kaposi's sarcoma, candidiasis, cryptococcosis and cytomegalovirus infections. The average life expectancy of an AIDS patient once an opportunistic disease occurs is 2-5 years.

It is estimated that at least one million people in the United States are seropositive for the HTLV-III antibody, indicating prior exposure to the virus. For those persons who are seropositive, it is believed they will probably have a lifelong infection. While it is estimated that 10-30% of these people may develop AIDS (based on current studies), it is believed that most persons with the antibody are also

capable of transmitting the virus. The number of cases of AIDS projected to be diagnosed next year is 1-2% of those currently seropositive for the HTLV-III antibody. The total number of cases of AIDS is expected to double next year and each following year until it reaches a plateau in 1990.

B. AIDS IN FLORIDA

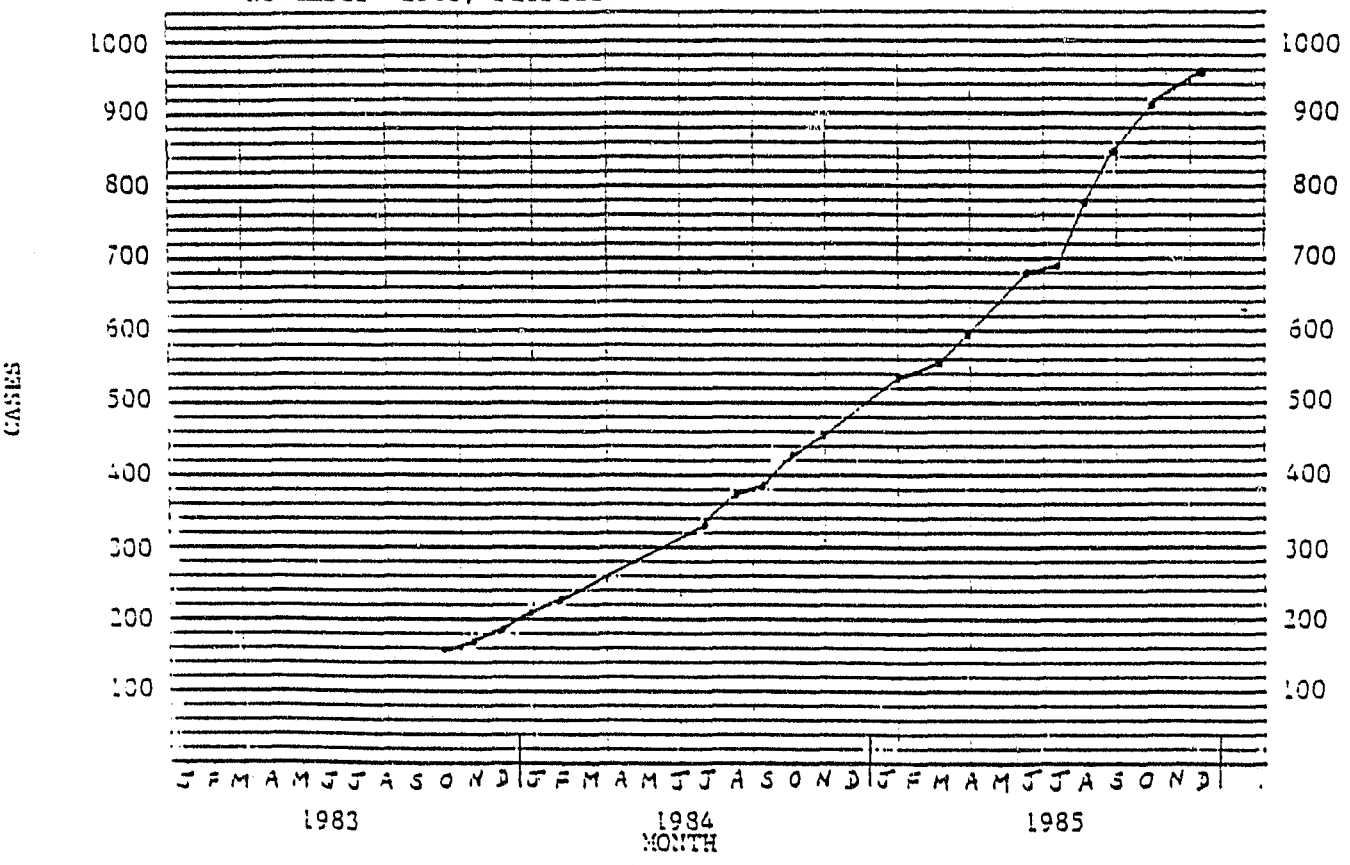
Florida has the third largest number of AIDS cases in the country, behind California and New York. AIDS was recognized early as an important public health threat in Florida.

On September 30, 1983, the State Health Officer wrote to over 18,000 physicians requesting that they report all cases of AIDS to the Department of Health and Rehabilitative Services (HRS). At that time there were 165 cases in Florida. Since then, the total number has grown to 959 adults and 33 children as of November 23, 1985. The rate of growth in AIDS cases in Florida is expected to parallel the doubling of cases predicted nationwide (i.e., 1,000 in 1986, and 2,000 in 1987).

Dade county has the largest number of AIDS cases, totaling 442 as of November 23, 1985. Broward and Palm Beach counties have 126 and 112 cases respectively. The remaining cases are distributed throughout the state with the greatest concentrations in the larger cities. The distribution of cases in Florida counties has remained relatively stable since the onset of the disease.

Florida appears to have some unique problems regarding AIDS. It has a large transient population composed of vacationers and migrant workers, and has a disproportionately large number of visitors and immigrants. In addition to a large homosexual community living in Miami, drug abuse is widespread in many parts of Florida.

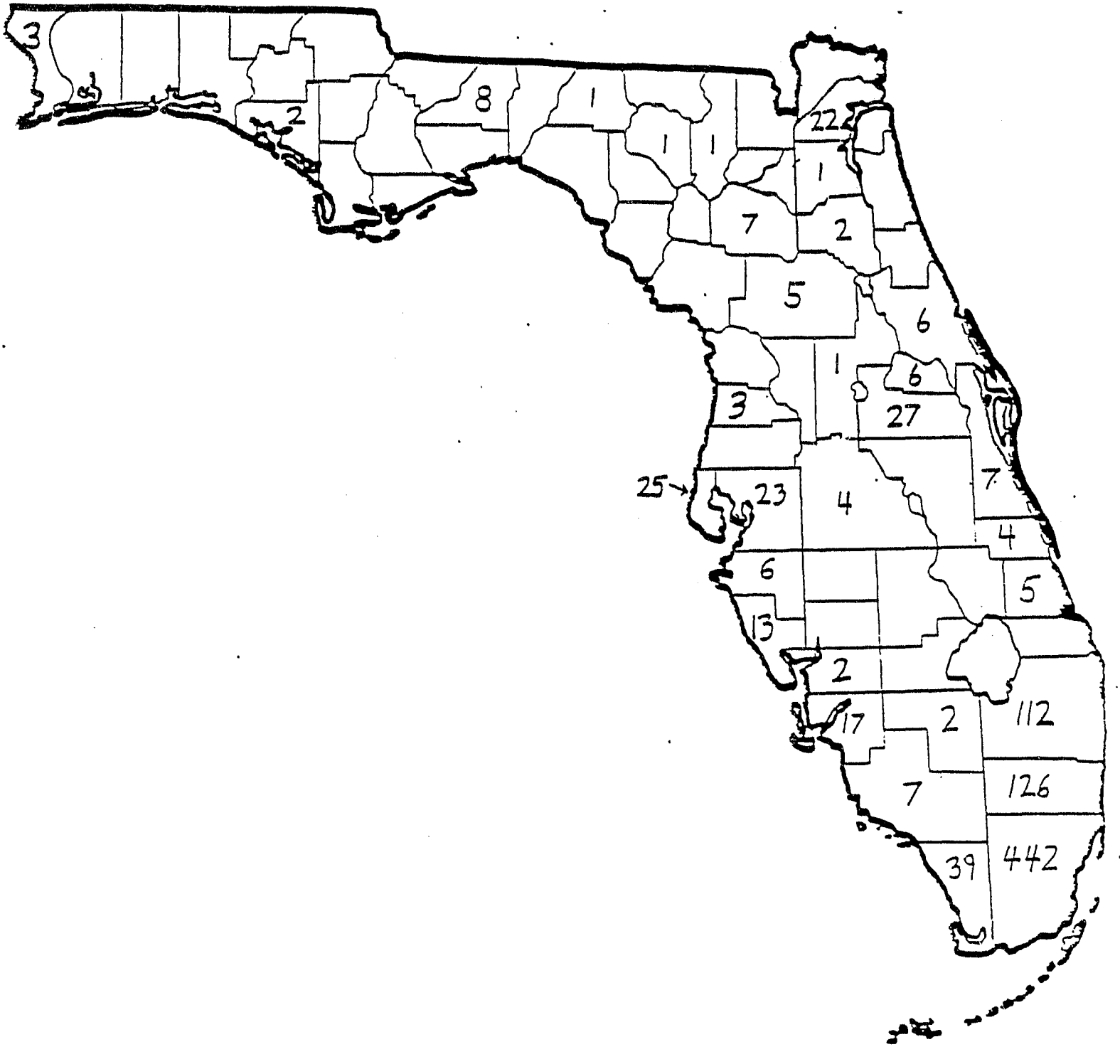
FIGURE 1. Cases of AIDS, by month of surveillance report, September 1983 through November 1985, Florida.



II. EXECUTIVE AND LEGISLATIVE RESPONSE

The Governor and the Legislature has recognized the need to address these problems. During the 1985 session, the Legislature enacted and the Governor signed Laws of Florida, Chapter 85-52, creating Section 381.606 of Florida Statutes. This statute permits the Secretary of the Department of Health and Rehabilitative Services to declare a public health emergency; to establish a series of alternate testing sites; to safeguard information; and to prohibit discrimination in employment or insurance through uses of serologic testing. In response to this statute, the Secretary did declare an emergency with regard to AIDS, and the Department has established a series of alternate testing sites and other measures designed to combat the AIDS problem. In addition, the Legislature appropriated $576,000, which together with approximately $1.4 million in federal funding form the basis for current Florida programs.

Figure 2: Cumulative AIDS Cases by County
Confirmed by the Centers for Disease Control
1980 through 11-23-85



In response to the growing concerns of the public and the Legislature about AIDS, the Governor appointed a Task Force of 11 experts to provide recommendations on the changes, improvements and resources needed in programs in public health, public education, patient care, and research as they pertain to AIDS. This report is a summary of their recommendations.

III. CURRENT PROGRAMS IN FLORIDA CONCERNING AIDS

Florida currently has a number of programs designed to address the AIDS problem. Most are funded by the Centers for Disease Control (CDC). Recent funding by the state legislature has made it possible for HRS to expand the programs described below, including the addition of new personnel and equipment in HRS laboratories, district offices, county public health units, and at headquarters.

A. SURVEILLANCE

AIDS surveillance in Florida was initiated in 1982. State-level surveillance activities are funded by a cooperative agreement with the CDC which totaled $122,277 in Federal Fiscal Year (FFY) 1984-85. The FFY 85-86 agreement is for $185,947.

The AIDS surveillance and investigation program is designed to identify and report cases of AIDS, through county public health units, to the Health Program Office in Tallahassee, and then to the Centers for Disease Control in Atlanta. AIDS surveillance staff in Tallahassee and Dade County have: 1) established essential communications with key diagnostic clinicians and medical institutions involved in diagnosing, treating and reporting cases of AIDS; 2) trained county public health unit staff who are responsible for reporting of AIDS cases; 3) provided consultation to state mental institutions; and 4) provided information and periodic reports to persons involved in statewide reporting of AIDS.

In addition, the AIDS program staff have worked closely with the CDC in Atlanta to develop protocols for anonymity and confidentiality of the state case registry. See Appendix A for a copy of a monthly surveillance report produced as a result of this cooperative agreement. These and other surveillance activities are ongoing.

B. INFORMATION/EDUCATION

In February 1985, the Centers for Disease Control awarded a cooperative agreement of $141,903 to HRS for Information and Education on Acquired Immune Deficiency Syndrome. The purpose of this project is to provide information about AIDS for members of high risk groups and the general population, as well as health professionals.

The objectives of this project are accomplished using several strategies. The first is the establishment of a 24-hour Hotline for dissemination of AIDS-related information. Use of the hotline has been heavy since its inception in May, 1985 and has increased to over 2,000 calls monthly. A second strategy is the design, printing and distribution of three informational brochures covering such topics as disease transmission, antibody testing, signs and symptoms and risk reduction methods. Numerous educational workshops and meetings are addressed in the course of this project, and a symposium for over 250 HRS personnel was conducted in October 1985. In addition, four organizations have been provided with special funds to target education for high risk groups in their communities.

C. ALTERNATE TEST SITE PROGRAM FOR HTLV-III ANTIBODIES

The Alternate Site Program offers the HTLV-III antibody test to individuals who suspect exposure to HTLV-III. The purpose of the program is to divert potential high risk donors from blood banks to "alternate sites" to screen their blood for HTLV-III antibody.

Through a cooperative agreement with the CDC, $967,000 of federal start-up funds were awarded for the program. These "alternate sites" have developed County Public Health Unit (CPHU) and HRS laboratory capability to carry out its functions. Testing, counseling, and referral are carried out through 17 County Public Health Units, chosen for equitable geographic distribution and number of AIDS cases. Actual testing of the blood is performed by HRS laboratories in Jacksonville, Tampa and Miami.

The client counseling about lifestyles changes is considered as important as the testing. In addition, clients at the alternate sites are assured of anonymity. Recently, the program has expanded its activities to include community education and prevention work.

D. BELLE GLADE STUDY

Belle Glade has the highest incidence of AIDS in the country, yet in many of these cases investigators have not been able to establish a risk factor at this time. An epidemiological study is presently underway in Belle Glade to determine the prevalence of HTLV-III infection and

identify risk factors for HTLV-III transmission; to document the extent of heterosexual transmission of HTLV-III; to document living conditions and develop recommendations to limit the spread of HTLV-III in this community.

This cross-sectional study will include at least 500 randomly recruited participants. In each household selected, all adult residents and children from ages 2-10 will be educated about AIDS, interviewed using a detailed standardized questionnaire, have a blood sample drawn, and will receive a physical examination.

The study is estimated to take four months and is funded by a CDC cooperative agreement for $127,000.

E. PROSTITUTE STUDY

A CDC research grant -- one of five awarded in a national competition among states -- will provide funds for a study of the prevalence of antibody to the HTLV-III virus in prostitutes in Miami. This study, which is being conducted in cooperation with the Dade County Public Health Unit and Dade County Prison Medical Services personnel, will involve extensive laboratory work, interviewing and counseling for prostitutes identified in the Dade County Women's Detention Center, as well as through clinics for sexually transmitted diseases conducted by the Dade CPHU. The investigation also seeks to determine what, if any, behavioral risk factors are associated with seropositivity for HTLV-III antibody..The study was designed and will be managed by existing HRS AIDS staff. (Annual award: $92,999)

HRS Public Health Programs re:
Acquired Immune Deficiency Syndrome

	Current Federal Grant Annual Award	State Fiscal Year 1984-85 Actual	State Fiscal Year 1985-86 Estimated
I. AIDS Surveillance and Investigation			
9/84 - 10/85	$122,277	$75,082	$185,947
II. AIDS Information and Education			
2/85 - 3/86	141,903	12,631	194,413
III. AIDS Alternate Site Screening, Counseling and Referral			
4/85 - 4/86	967,138	17,358	903,750
III. AIDS Epidemiological Research			
Belle Glade Study 10/85 - 4/86	92,322	-0-	92,322
Miami Prostitute Study 10/85 - 9/86	92,999	-0-	69,750
V. State Appropriations			576,666
TOTALS	$1,416,639	$105,071	$2,022,848

IV. TASK FORCE DELIBERATIONS

A. PUBLIC HEALTH

The Department of Health and Human Services, Public Health Service has declared AIDS as the number one public health problem today. It touches on every aspect of our society, including education, religion, economics, health care, law and social structure. All of these aspects need to be considered when dealing with the control of AIDS.

Classically, public health authorities have used a number of means to control communicable diseases in the community. Such measures include quarantine, isolation, contact tracing and treatment, involuntary hospitalization and compulsory immunization. The goal of any measure taken by public health authorities with regard to HTLV-III is to control the spread of the infection in the community. While the individual concern of each patient is always important, public health authorities are obligated to protect the population from disease.

The task force has addressed certain public health issues as they relate to the control of AIDS and HTLV-III infection. These include disease reporting, health cards, "bath houses" and "peep shows", school attendance, HTLV-III infection in the workplace, uses of the HTLV-III antibody test, and contact investigation.

1. DISEASE REPORTING

AIDS is officially listed as a reportable disease in Florida and physicians have been reporting it since 1982. Currently, results of the HTLV-III antibody test are not reportable, although all test results from the 17 county alternate testing sites are recorded on an anonymous basis. As of November 23, 1985, Florida had 959 verifiable adult cases of AIDS and 33 pediatric cases. By December 5,1985, the 17 county health department alternate sites had tested 4,526 individuals for HTLV-III antibody.

Presently, there are no plans to require that HTLV-III positive tests or ARC be reported. Because there is no vaccine or treatment, the purpose for reporting HTLV-III positive tests would be to gather information on the demographics of the disease and possibly keep track of seropositive people who go on to develop AIDS.

2. HEALTH CARDS

A health card is a certification that a worker has been examined by a physician and is free from communicable disease. Health cards are not a practical guarantee of public health safety from HLTV-III for several reasons: 1) HTLV-III is not known to be transmitted through food or by casual contact; 2) the HTLV-III antibody test is not reliable in low risk populations; 3) the cost of antibody testing, confirmation and medical examinations would be immense; and 4) a health card issued at one time would not guarantee that the employee will not become infectious soon thereafter (a negative blood test has validity only for the moment the blood sample was taken).

3. SCHOOL ATTENDANCE

The Florida Medical Association (FMA) and the Centers for Disease Control have published guidelines concerning school children and AIDS. The FMA states that students should be allowed to attend with their physician's approval (see Appendix B).

The CDC's guidelines also agree that children of school age should be allowed to attend school and outlines health care procedures for children with AIDS in the classroom.

These two publications thoroughly consider the issue of children with AIDS in the classroom and the Task Force, which adopted the FMA guidelines, agrees that these documents are comprehensive and appropriate recommendations.

4. BATH HOUSES AND PEEP SHOWS

Because HTLV-III is known to be transmitted sexually, any measure which might prevent unsafe sexual practices will prevent the transmission of the virus. The Task Force endorses appropriate and necessary legal action to eliminate such practices.

5. AIDS AT THE WORKSITE

During the Task Force's deliberations, the CDC published guidelines stating that HTLV-III is not transmissible through usual activity in worksites i.e., industry, office, food, most personal services, and schools. As a result, the guidelines conclude that workers with AIDS should not be prohibited from employment in these places. However, because there is a risk of HTLV-III transmission in health care facilities, specific precautions should be observed in these institutions to prevent the transmission of HTLV-III and protect those people with AIDS. The Task Force specifically endorses these recommendations made by the CDC(attached as Appendix C).

6. SCREENING FOR HTLV-III ANTIBODY

The present test used for detecting HTLV-III antibody is the EIA (enzyme-linked immunosorbent assay). This test is only sensitive to the presence of antibody to the HTLV-III, and does not indicate if a person currently has the virus or is infectious. While a good screening test, the EIA test has a high false-positivity rate in low risk populations and costs $4-6/test. The confirmatory test used on positive EIA tests is the Western blot, costing $40-80/test. Because of these cost and reliability factors, it is not financially or medically reasonable to screen the general population for HTLV-III antibody. In addition, the virus is not transmitted through casual contact or food.

Screening selected "high risk" groups may be useful for the purposes of education and disease detection. Such screening must be conducted in the most carefully controlled conditions, to avoid abuse and misinterpretation of results and to insure that sensitive, informative counseling is provided.

7. CONTACT INVESTIGATION

Contact investigation (i.e., locating and evaluating contacts of infected people), is used routinely for the control of such communicable diseases as syphilis and tuberculosis. Presently, there is a divergence of opinion among experts regarding the usefulness of this technique with AIDS. Obstacles include limited knowledge of the natural history of HTLV-III infection, as well as the high expense and effort required in contact investigations. The Task Force believes that routine contact investigation would not be helpful at this time. However, limited contact investigation for certain groups, such as women of childbearing age who are at increased risk for the disease, could be effective. Currently, health education is the only method to control the spread of the disease in the absence of specific treatments.

B. PUBLIC EDUCATION

The task force recognizes that information and education are the primary preventive measures available today to control AIDS. Because there is no treatment or immunization for AIDS, the public must be made aware of the known modes of transmission, signs and symptoms, and risk factors involved with AIDS. An informed public will also have a more rational approach to AIDS, reducing unwarranted discrimination and unfounded fears. The task force recommends a comprehensive educational program to inform public and health profession groups, high risk populations, legal groups, schools, detention centers, and prison

personnel about AIDS, its methods of transmission, and ways to control the spread of this deadly disease. To achieve these goals, the Task Force recommends a total allocation of $1 million.

1. HIGH RISK GROUPS

A recent study in San Francisco demonstrated that increasing public awareness of the transmission and risk factors associated with AIDS helped to decrease the incidence of some sexually transmitted diseases by 74 percent, and altered the sexual habits of homosexual men in that city. A nation-wide decrease in the incidence of anal gonorrhea also may be attributed to the public awareness and concern about AIDS. Despite this encouraging news, a successful public education program must overcome several difficult barriers. Because AIDS is primarily a sexually transmitted disease, sexual habits and lifestyles must be changed in order to reduce transmission. These changes relate not only to homosexuals, but also to prostitutes and promiscuous heterosexuals. Many people view their sexual habits as very private and personal choices, and are not easily swayed by public education, health advisories, and religious teachings. In addition, many individuals in high risk groups may have a fatalistic attitude about AIDS and refuse to take necessary precautions.

Another risk group more difficult to reach is intravenous (I.V.) drug users. In Florida there has been a steady increase in the number of intravenous drug users who have AIDS, ARC (AIDS Related Complex), or are positive for HTLV-III antibody. HTLV-III is transmitted when an infectious person uses a needle and shares this blood-contaminated needle with others. To further complicate the problem, many I.V. drug users are also prostitutes, further increasing their chances of contracting HTLV-III.

Educational programs in Florida need to address these groups through mass media and individual counseling. In addition, specific programs that reach these high risk groups should be increased.

2. HEALTH CARE PROFESSIONALS

Medical and other health care professionals, and other workers in hospitals, nursing homes, other health care facilities, schools, detention centers and prisons should be provided with continuous and updated education about AIDS and how to care for AIDS patients. Most health care facilities provide routine in-service training programs for their staff to educate them concerning sanitary precautions and treatment procedures. This training should include appropriate management of patients with HTLV-III infection. To ensure consistent and safe care, each health care

facility in Florida should have a copy of HRS pamphlet 150-3, which provides complete instructions on handling AIDS patients.

Each facility should also appoint a spokesperson to serve as liaison between the community and the facility to communicate information about AIDS. In addition, an HRS staff position should be created to act as a coordinator to work with the Task Force, health care facilities, schools, detention centers and prisons. This will ensure that updated information is delivered promptly in a complete and accurate form.

3. LEGAL PROFESSION

The legal profession will have an increasing role in determining how people with AIDS are managed in Florida. There is an important need for judges and attorneys to understand how HTLV-III is transmitted. Information should be available to all judges and prosecuting and defending attorneys that explains the virology of HTLV-III, how the virus is transmitted, the latency period of the infection, and what diagnostic tests are available and how to interpret these tests. These groups should be provided new information on developments in AIDS technology and the Florida Statutes dealing with AIDS.

C. RESEARCH

AIDS is caused by a virus that has only recently been found in man. The virus is one of three human retroviruses that have been discovered to date. In the short time since its discovery, investigators have made remarkable strides in understanding how the virus works. A blood test has been developed to detect the antibody. Millions of dollars are invested in research designed to produce a vaccine and to discover an effective treatment for AIDS, but many more questions remain. Florida has unique problems concerning AIDS. If answers to some of these problems can be found here, they may provide valuable solutions worldwide .

Florida would benefit greatly from enhanced epidemiological studies and increased surveillance of HTLV-III. Florida's hetereogenous demographic characteristics require specific inquiries to determine if unique factors may be attributed to the high number of cases in this state. In addition, with as many cases expected next year as in the previous five years cumulatively, additional assistance will be needed at the county public health unit level for investigation and followup, especially of individuals who are in no known risk group. It is recommended that $480,000 be appropriated for these activities.

To accomplish research into the virology of HTLV-III, including investigation of new anti-viral compounds to inhibit HTLV-III in vitro, several P-3 (protection level 3) laboratories must be established. A P-3 level laboratory is constructed to provide the highest level of protection against viral or bacterial contamination, accidents, or leakage outside of the laboratory. An existing laboratory may be converted into a P-3 laboratory for a cost of $50,000 to $150,000 or more, depending on the current design of the facility. At this time, Florida does not have a single P-3 level laboratory, but such laboratories are recommended by the National Institutes of Health to perform research with high concentrations of retroviruses, such as HTLV-III. At least three P-3 laboratories are recommended by the Task Force in order for Florida to effectively compete for Federal funds for AIDS virological research.

D. PATIENT CARE

Patient care resources are the most pressing need with AIDS. This disease is expected to affect as many people during 1986 as the total number affected in the 5 years since discovery of the disease. As we increase our knowledge of the disease, we also need to increase our ability to treat the disease most cost-effectively and prolong the lives of the patients. Although AIDS is a fatal disease, more people will be living longer and will need a greater scope of care than ever before.

San Francisco has developed a comprehensive patient care network that is worth emulating, and the Task Force believes Florida should develop a similar model. This plan calls for a network between hospitals, foster homes, nursing homes, home health care and hospice organizations, social services and support groups. Because this plan utilizes resources other than hospitals for much of the patient care, health care is better directed and costs are decreased.

Jackson Memorial Hospital in Miami has proposed a networking plan for Florida. This hospital treats a majority of Florida AIDS patients -- both because it is a public hospital and because of its excellent treatment and research programs in AIDS. The hospital has been overburdened financially and physically by this responsibility. Jackson Memorial presented the Task Force with a networking patient care proposal for $6.8 million. Of this amount, is is hoped that the federal government would subsidize a share, with the remainder coming from the Florida legislature. These funds would pay for indigent care in hospitals, nursing and foster homes, home health

care services, hospice services, outpatient living quarters, support groups and referral services.

The task force believes that most of the medical and other health care needs of AIDS patients would be answered with this program and endorses it as a cost effective and humanitarian approach to patient care.

In addition, the Task Force endorses providing such care in additional communities in Florida, although lesser funding would be required because of the smaller number of cases in other counties. The Task Force believes that $2 million should be appropriated to these other communities, to be distributed through HRS.

The Task Force also endorses an appropriation of $1 million, to be divided equally to the three medical schools affiliated with universities in the state, to develop model protocols for treatment, research, and education concerning AIDS. Also, the Task Force supports a special provision for care of children with AIDS in medically supervised foster homes through Children's Medical Services (CMS). Approximately $400,000 would be necessary next year to remove these children from their present hospital environment.

E. LEGAL, LEGISLATIVE, AND REGULATORY ISSUES

The Governor's Task Force on AIDS spent a good deal of its efforts considering the interaction of the law and public health policy related to AIDS. It has been concerned about several legal issues confronting physicians and patients, and expressed its reservations about the passage of restrictive legislation without more definitive scientific and medical research. More specifically, the committee expressed its concern over the following issues:

- Confidentiality of patient information
- Confidentiality of research information
- Inappropriate uses of the EIA blood screening test for employment and insurance purposes
- The need to transmit better information to the judicial system about AIDS, ARC, and HTLV-III positive antibody status
- Inappropriate uses of the ELISA blood screening test in schools for employees and students
- The sufficiency and appropriateness of public health

laws to deal with AIDS and other sexually transmitted diseases.

The AIDS Task Force discussed legal issues at three of its meetings. It also met with Judge Wetherington, Chief Judge of the 11th Circuit, to discuss better ways of educating the judiciary about AIDS and all its various aspects. The Task Force resolved to request HRS to work with the judiciary, prosecutors, and public defenders on a continuing basis to inform them about the disease, necessary precautions, and advisable actions based on informed medical judgment.

The Task Force also requested that HRS work with these groups at their regularly scheduled statewide meetings, to include information in statewide newsletters, and to work with judges individually, particularly the Chief Justice of the Supreme Court and the chief judges of the circuit and county courts on a localized basis. In addition, HRS agreed to designate a chief spokesman to deal with the judiciary concerning the AIDS problem.

A major discussion of the Task Force concerned revisions to current statutes concerning sexually transmitted diseases (STDs). The Task Force reviewed the current statute and found it considerably out of date, covering only three diseases -- syphilis, gonorrhea and chancroid. As a result, the Task Force recommended a revision and modernization of this statute (Chapter 384, F.S.), to include all generally recognized sexually transmitted diseases, including AIDS.

A modernized statute concerning sexually transmitted diseases was submitted by HRS for consideration by the Task Force. This statute would give public health authorities (the Department of Health and Rehabilitative Services and respective county public health units) broad authority to control sexually transmitted diseases through a number of powers, including

- The authority to order a person to submit to an examination
- The requirement that all physicians and other health care providers report all cases of an STD to the Department
- The authority to isolate and quarantine persons with an STD by initiation of the Health Officer
- The authority to write rules and regulations to carry out the provisions of the STD law
- The authority to establish by rule, subject to

certain criteria, those diseases that are sexually transmitted

- o The authority to invoke administrative penalties for failure to follow the rules or statutes related to STDs

- o The imposition of criminal penalties for a person knowingly infected with an STD to have sexual contact with another person without that person being informed of the infected person's status

- o Authority for minors to consent to treatment for a sexually transmitted disease without parental consent

- o Statutory protection of the confidentiality of information gathered in investigating, reporting or treating a STD. (It should be noted that many of these powers are contained in current law, but apply to only three diseases).

The Task Force took no position on the issue of quarantine, believing there was insufficient time and information to make a definitive recommendation. Nonetheless, the Task Force believed that the Department should have full statutory authority to deal with whatever public health emergency should arise, and that the Department should consult with other experts on the disease prior to taking such drastic action.

The Task Force also recommended that action be taken to clarify Laws of Florida, Chapter 85-52 (Section 381.606(5) F.S.), which outlaws use of serologic blood screening tests for purposes of employment or insurance, and prohibits discrimination based on test results. Task Force members were unanimous that the EIA test by itself should not be used for employment, school or insurance screening, and that state law should be clarified on this point.

The Task Force took notice of the provisions of Chapter 381.231(4) establishing confidentiality of information provided to the Department for diseases designated as "reportable." The Task Force recommended that these provisions, and other provisions relating to confidential medical information be strengthened to require such information be sealed by the courts in any litigation to which such information is relevant and has been produced by subpoena, unless the party to which the information applies has made it an issue in any judicial or administrative proceeding.

A number of legislative proposals concerning AIDS have been advanced by local jurisdictions, and in the state

legislature, which the Task Force has taken notice of and made recommendations. Specifically, the Task Force has recommended that statutory requirements for screening restaurant workers and other persons who handle food not be implemented. HTLV-III is not transmitted by food, and these proposals are costly and misleading to the public.

Similarly, the Task Force also notes that screening of school children and school employees is not necessary to protect the public health. Persons with AIDS, ARC and HTLV-III may come in social contact with other persons without risk of spreading the disease. Rather, the Task Force, like the Florida Medical Association and the CDC, recommends that each child (and employee) be evaluated individually, without a blanket prohibition on admission to school or employment.

The Task Force urged that careful consideration be given to any statutory changes the Legislature might consider, noting the need to balance individual privacy with broader needs to protect the public's health. The Task Force noted that the rapidly changing state of the science related to this disease may quickly outdate blanket policy statements. Because it is inevitably fatal, AIDS poses a unique public challenge in terms of both education and control. While legislation may assist in these efforts, it is on better education, treatment and research that our current efforts must focus.

APPENDIX A

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) SURVEILLANCE REPORT

DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
EPIDEMIOLOGY PROGRAM, PREVENTIVE HEALTH SERVICES, HEALTH PROGRAM OFFICE
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(904) 488-2905, SC 278-2905; Compiled by Deborah Holtzman, Ph.D.

Table 1. Cases of AIDS by place of residence at diagnosis, 09/24/85 - 11/23/85 and cumulative, Florida.

DISTRICT/ County		State-Confirmed[1]	CDC-verified[2] This Period (09/24-11/23/85)	CDC-verified[2] No. (%) Cumulative (1980 thru 11/23/85)	Non-Case[3]
I	Escambia	3	--	3 (0.3)	1
	Okaloosa	1	--	--	-
II	Bay	--	--	2 (0.2)	1
	Gadsden	1	--	--	-
	Jackson	--	--	--	1
	Leon	1	--	8 (0.8)	-
	Madison	--	--	1 (0.1)	-
	Taylor	--	--	--	1
III	Alachua	--	--	7 (0.7)	-
	Columbia	--	--	1 (0.1)	-
	Hernando	1	--	3 (0.3)	-
	Lake	--	--	1 (0.1)	-
	Marion	--	--	5 (0.5)	-
	Putnam	--	--	2 (0.2)	-
	Suwannee	--	--	1 (0.1)	1
IV	Clay	--	--	1 (0.1)	-
	Duval	1	2	22 (2.3)	2
	Volusia	--	--	6 (0.6)	-
V	Pinellas	3	4	25 (2.6)	1
	Pasco	1	--	--	-
VI	Hillsborough	4	1	23 (2.4)	4
	Manatee	--	1	6 (0.6)	2
	Polk	--	--	4 (0.4)	-
VII	Brevard	1	--	7 (0.7)	-
	Orange	1	2	27 (2.8)	3
	Seminole	--	--	6 (0.6)	-
VIII	Charlotte	--	--	2 (0.2)	-
	Collier	--	1	7 (0.7)	1
	Hendry	--	--	2 (0.2)	-
	Lee	1	2	17 (1.8)	2
	Sarasota	--	1	13 (1.4)	1
IX	Indian River	--	--	4 (0.4)	1
	Palm Beach	5	21	112 (11.7)	5
	St. Lucie	--	--	5 (0.5)	-
X	Broward	3	1	126 (13.1)	4
XI	Dade	39	12	442 (46.1)	22
	Monroe	1	--	39 (4.1)	1
DEPARTMENT OF CORRECTIONS		--	4	24 (2.5)	11
UNKNOWN		--	--	5 (0.5)	2
TOTAL		67	52	959(100.0)	67

[1]Diagnosis confirmed by the Health Program Office, pending verification by the Centers for Disease Control (CDC).
[2]Diagnosis verified by CDC.
[3]Diagnosis reported as AIDS via State or by other reporter, but does not meet CDC criteria.

NOTE: Pediatric cases not included in Tables 1 and 2.

Table 2. Cases of AIDS*, by sex and patient characteristic, through 11/23/85, Florida.

Characteristic	Male No. (% of males)	Female No. (% of females)	Total No. (% of total)
Homosexual (HO)	448 (52.0)	0 (0.0)	448 (46.7)
IV Drug User (IV)	102 (11.8)	31 (31.6)	133 (13.9)
Bisexual (BI)	69 (8.0)	0 (0.0)	69 (7.2)
HO & IV	30 (3.5)	0 (0.0)	30 (3.1)
BI & IV	15 (1.7)	0 (0.0)	15 (1.6)
Blood Transfusion	6 (0.7)	6 (6.1)	12 (1.3)
Hemophiliac	5 (0.6)	0 (0.0)	5 (0.5)
Sex Contact**	3 (0.3)	14 (14.3)	17 (1.8)
None Apparent/Unknown			
U.S. Born	46 (5.3)	12 (12.2)	58 (6.0)
Non-U.S. Born***	137 (15.9)	35 (35.7)	172 (17.9)
Total	861(100.0)	98(100.0)	959(100.0)

*Diagnosis verified by CDC.
**With a person with AIDS or a member of a group at high risk for AIDS.
***Includes persons born in countries in which most AIDS cases have not been associated with known risk factors.

PEDIATRIC AIDS IN FLORIDA: As of November 23, 1985 there were 33 CDC-confirmed pediatric cases of AIDS in Florida. Of these cases 20 (61.0%) have died. A breakdown of pediatric cases by race, sex and patient characteristic, and age at diagnosis is shown in Tables 3 - 5.

Table 3. Cases of Pediatric AIDS, by race, through 11/23/85, Florida.

Race	No. (% of total)
White, non-hispanic	2 (6.1)
Black, non-hispanic	28 (84.8)
Hispanic	3 (9.1)
Total	33(100.0)

Table 4. Cases of pediatric AIDS, by sex and patient characteristic, through 11/23/85, Florida.

Characteristic	Male	Female	Total (%)
Mother with AIDS	2	1	3 (9.1)
Mother uses IV Drugs	3	2	5 (15.2)
Blood Transfusion	3	2	5 (15.2)
None Apparent/Unknown			
U.S. Born	1	3	4 (12.1)
*Non-U.S. Born	7	9	16 (48.5)
Total	16	17	33 (100.0)

*Includes persons whose parent(s) are from countries in which most AIDS cases have not been associated with known risk factors.

Table 5. Cases of pediatric AIDS, by sex and age at diagnosis, through 11/23/85, Florida.

Age (years)	Male	Female	Total (%)
Less than 1 year	10	9	19 (57.6)
1 year	2	1	3 (9.1)
2 years	2	2	4 (12.1)
3 years	--	3	3 (9.1)
4 years	1	1	2 (6.1)
5 years	1	1	2 (6.1)
Total	16	17	33 (100.0)

HTLV-III INFECTION AMONG HEALTH CARE WORKERS: Weiss, et. al. (JAMA 1985;254:2089-2093) recently reported on the occurrence of HTLV-III infection among health care workers who had sustained on-the-job needlestick injuries (or other percutaneous exposures) while caring for AIDS patients. Health care and clinical laboratory personnel from seven metropolitan areas in the United States were studied. Participants were interviewed for potential risk for AIDS and tested for antibody to HTLV-III. Of the 361 participants tested, ten were seropositive for HTLV-III antibody. Of these 10 seropositive individuals, six were members of recognized high risk groups, three were not, and one remains to be fully investigated. Possible heterosexual HTLV-III transmission could not be ruled out for two of the three individuals with no apparent risk factor. In sum, it appears that HTLV-III infection was related to percutaneous exposure for at least one of the studied health care workers; however, the risk in general remains low for health care workers.

HETEROSEXUAL TRANSMISSION OF AIDS: A major issue in AIDS research is the role of heterosexual transmission. Related to this issue is whether female-to-male transmission is a significant factor in the epidemiology of AIDS in the United States. One study by Redfield, et. al. (JAMA 1985;254: 2094-2096) addresses both issues. Forty-one patients with AIDS or ARC (AIDS related complex) were evaluated at Walter Reed Army Medical Center in Washington, D.C. HTLV-III infection was documented either by virus isolation or by detection of antibody. All participants were interviewed to determine possible risk factors for AIDS. Results of the interview showed that 15 (ten males, five females) of the 41 patients appeared to have acquired HTLV-III infection through heterosexual contact. Three of the 15 patients reported recurrent heterosexual contact with a person AIDS or ARC; three reported heterosexual contact with a sexual partner, who was a member of a high-risk group for AIDS; and nine reported multiple heterosexual contacts with prostitutes. These results support heterosexual transmission of the disease and also support both male-to-female and female-to-male transmission of AIDS.

However, as the authors point out, the population under study which is comprised of military personnel, who may be less likely to report homosexuality or IV drug use, may not be representative of the general heterosexual community. Further, while this study supports heterosexual transmission of AIDS, the data for the United States continue to show that the incidence in the heterosexual community is small.

Outside the United States, particularly in some developing countries in Africa, heterosexual transmission of AIDS appears to play a more important role in the spread of the disease (MMWR, September 20,1985,Vol. 34.,No. 37). A case-control study by Clumeck, et. al. (JAMA 1985;254: 2599-2602) examined the prevalence of HTLV-III antibody in African patients with AIDS or ARC, in African female prostitutes, in a group of healthy African controls, and in a group of African blood donors. The majority of the patients and controls were from Zaire or Rwanda. None of the study participants reported IV drug use and all reported that they were heterosexual. Demographically, these study groups showed a low male-to-female ratio and a mean age from 26 to 32. The rate of seropositivity in each group was as follows: 87% (46 of 53) in the patients with ARC, 80% (67 of 84) in the female prostitutes, 12.5% (5 of 40) in the healthy controls and 15.5% (8 of 51) in the blood donors. Seropositivity for HTLV-III antibody was significantly higher in the patients with AIDS or ARC than in the controls. HTLV-III seropositivity was also significantly higher in female prostitutes (80%) than in female (9%) controls. These results support the role of HTLV-III in the etiology of African AIDS. Futher, the demographic data of the patients with AIDS and ARC, and the lack of recognized risk factors suggest that the disease was probably transmitted through heterosexual contact. Supporting this method of transmission are the results of infection in the group of female prostitutes, who in all probability contracted the disease sexually. While this study does not show that female prostitutes are transmitting the disease to men in Africa, the lack of other risk factors in relation to the AIDS in the male patients under study does point to heterosexual transmission via females.

One important factor affecting the impact of AIDS on the heterosexual community is the behavior of individuals who are infectious. Any behavior which reduces the transmission of this bloodborne, sexually transmitted disease will affect the spread of AIDS. Some indication that changes in sexual practices of gay and bisexual men was shown in a recent survey in San Francisco. In a phone survey in August 1984, 500 men, who identified themselves as gay or bisexual, were asked about their sexual practices. In particular, they were asked 1) whether they had engaged in monogamous, celibate, or no unsafe (unsafe = anal sex without condom and oral sex with exchange of semen) sexual activity outside a primary relationship and, 2) whether they had more than one sexual partner during the last 30 days. In April of 1985, 301 of the original 500 men surveyed in 1984 agreed to be re-interviewed by phone. Sixty-nine percent of those first surveyed in 1984 said that they had engaged in monogamous, celibate, or no unsafe sexual activity outside a primary relationship. This percentage increased to 81% on re-interview. And while 49% of those first surveyed in 1984 said that they had more than one sexual partner during the last 30 days, 36% responded positively to this question in 1985. These results indicate that modification of sexual practices has occurred by some gay and bisexual men in an effort to reduce the transmission of AIDS.

AIDS SYMPOSIUM: On October 28 and 29, 1985, a symposium on AIDS was held for state health care workers in Orlando, Florida. The symposium was presented by the Office of the Assistant Secretary for Program Planning and the Health Program Office, and included presentations from medical experts in Florida and around the nation. Up-to-date information on AIDS was provided and a number of issues concerning the care and treatment of AIDS patients were discussed. Results of the symposium, including policy recommendations, will be forthcoming.

GOVERNOR'S TASK FORCE: The Governor's Task Force on AIDS held their first meeting on October 27, 1985, in Tampa, Florida. Dr. Robert Good was selected as chairman and two additional members were added to the group. Subcommittees were established to address AIDS-specific issues. A second meeting was held on November 10, 1985, in Tampa. At the meeting, four issues were voted upon and passed as policy recommendations to be presented to Governor Graham. They are as follows:

1) Health Cards are **not** recommended for restaurant workers, foster homes, or school employees because the blood test for antibody to AIDS is not 100% reliable and no evidence is available that AIDS is passed through casual contact.
2) The Task Force adopted the Florida Medical Association's policy on immunodeficient children and the Centers for Disease Control's guidelines on children in school as their recommendation. (These statements basically say that each child who is positive for AIDS antibody should be reviewed individually to determine if he should go to school and that mass screening for AIDS antibody in schools is not recommended).
3) The Task Force agreed to set up an ad hoc committee to examine issues that deal with Florida's laws as they pertain to AIDS.
4) The new pamphlet on HRS Guidelines for AIDS will be sent to all primary health care facilities in Florida.

On November 24, 1985, a third meeting was held in Miami. Eight additional issues were voted upon and passed as policy recommendations. Four of these issues are related to public health and are as follows:

1) Bath houses were not thought to pose a major public health problem in Florida. (This was amended to read that legal notice be given to places where anonoymous sex occurs to reduce the transmission of AIDS.)
2) The Centers for Disease Control guidelines for handling AIDS in the workplace were adopted by the task force (pending modifications to be discussed at a future meeting).
3) Screening by ELISA test for HTLV-III antibody for insurance purposes or to determine suitability for, or discharge from, employment was not recommended.
4) The task force determined that an immediate need was present to meet with state legal associations to develop guidelines for local judicial systems to be consistent when dealing with AIDS cases through the judicial process.

Four recommendations relating to public education were also adopted as follows:

1) The task force will serve as a clearing house for information on AIDS.
2) A full-time staff position will be established for public education to work with HRS and the task force.
3) Target groups for education will be selected, including professional health care providers; industry, judicial, school, and prison personnel; the general public; and high risk groups for AIDS.
4) Health care facilities will be encouraged to appoint one spokesperson for AIDS and this person will be regularly updated on task force activities.

For further information, please contact Janice Rousseau at SUNCOM 278-2905 or (904) 488-2905.

Current Trends 1985 Aug 30;34:517-521

Education and Foster Care of Children Infected with Human T-Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus

The information and recommendations contained in this document were developed and compiled by CDC in consultation with individuals appointed by their organizations to represent the Conference of State and Territorial Epidemiologists, the Association of State and Territorial Health Officers, the National Association of County Health Officers, the Division of Maternal and Child Health (Health Resources and Services Administration), the National Association for Elementary School Principals, the National Association of State School Nurse Consultants, the National Congress of Parents and Teachers, and the Children's Aid Society. The consultants also included the mother of a child with acquired immunodeficiency syndrome (AIDS), a legal advisor to a state education department, and several pediatricians who are experts in the field of pediatric AIDS. This document is made available to assist state and local health and education departments in developing guidelines for their particular situations and locations.

These recommendations apply to all children known to be infected with human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV). This includes children with AIDS as defined for reporting purposes (Table 1); children who are diagnosed by their physicians as having an illness due to infection with HTLV-III/LAV but who do not meet the case definition; and children who are asymptomatic but have virologic or serologic evidence of infection with HTLV-III/LAV. These recommendations do not apply to siblings of infected children unless they are also infected.

BACKGROUND

The Scope of the Problem. As of August 20, 1985, 183 of the 12,599 reported cases of AIDS in the United States were among children under 18 years of age. This number is expected to double in the next year. Children with AIDS have been reported from 23 states, the District of Columbia, and Puerto Rico, with 75% residing in New York, California, Florida, and New Jersey.

The 183 AIDS patients reported to CDC represent only the most severe form of HTLV-III/LAV infection, i.e., those children who develop opportunistic infections or malignancies (Table 1). As in adults with HTLV-III/LAV infection, many infected children may have milder illness or may be asymptomatic.

Legal Issues. Among the legal issues to be considered in forming guidelines for the education and foster care of HTLV-III/LAV-infected children are the civil rights aspects of public school attendance, the protections for handicapped children under 20 U.S.C. 1401 et seq. and 29 U.S.C. 794, the confidentiality of a student's school record under state laws and under 20 U.S.C. 1232g, and employee right-to-know statutes for public employees in some states.

TABLE 1. Provisional case definition for acquired immunodeficiency syndrome (AIDS) surveillance of children

For the limited purposes of epidemiologic surveillance, CDC defines a case of pediatric acquired immunodeficiency syndrome (AIDS) as a child who has had:

1. A reliably diagnosed disease at least moderately indicative of underlying cellular immunodeficiency, and
2. No known cause of underlying cellular immunodeficiency or any other reduced resistance reported to be associated with that disease.

The diseases accepted as sufficiently indicative of underlying cellular immunodeficiency are the same as those used in defining AIDS in adults. In the absence of these opportunistic diseases, a histologically confirmed diagnosis of chronic lymphoid interstitial pneumonitis will be considered indicative of AIDS unless testing for HTLV-III/LAV are negative. Congenital infections, e.g., toxoplasmosis or herpes simplex virus infection in the first month after birth or cytomegalovirus infection in the first 6 months after birth must be excluded.

Specific conditions that must be excluded in a child are:

1. Primary immunodeficiency diseases—severe combined immunodeficiency, DiGeorge syndrome, Wiskott-Aldrich syndrome, ataxia-telangiectasia, graft versus host disease, neutropenia, neutrophil function abnormality, agammaglobulinemia, or hypogammaglobulinemia with raised IgM.
2. Secondary immunodeficiency associated with immunosuppressive therapy, lymphoreticular malignancy, or starvation.

Confidentiality Issues The diagnosis of AIDS or associated illnesses evokes much fear from others in contact with the patient and may evoke suspicion of life styles that may not be acceptable to some persons. Parents of HTLV-III LAV-infected children should be aware of the potential for social isolation should the child's condition become known to others in the care or educational setting. School, day-care, and social service personnel and others involved in educating and caring for these children should be sensitive to the need for confidentiality and the right to privacy in these cases.

ASSESSMENT OF RISKS

Risk Factors for Acquiring HTLV-III/LAV Infection and Transmission In adults and adolescents, HLTV-III/LAV is transmitted primarily through sexual contact (homosexual or heterosexual) and through parenteral exposure to infected blood or blood products. HTLV-III/LAV has been isolated from blood, semen, saliva, and tears but transmission has not been documented from saliva and tears. Adults at increased risk for acquiring HTLV-III/LAV include homosexual/bisexual men, intravenous drug abusers, persons transfused with contaminated blood or blood products, and sexual contacts of persons with HTLV-III LAV infection or in groups at increased risk for infection.

The majority of infected children acquire the virus from their infected mothers in the perinatal period (*1-4*). In utero or intrapartum transmission are likely, and one child reported from Australia apparently acquired the virus postnatally, possibly from ingestion of breast milk (5). Children may also become infected through transfusion of blood or blood products that contain the virus. Seventy percent of the pediatric cases reported to CDC occurred among children whose parent had AIDS or was a member of a group at increased risk of acquiring HTLV-III/LAV infection, 20% of the cases occurred among children who had received blood or blood products; and for 10% investigations are incomplete.

Risk of Transmission in the School, Day-Care or Foster-Care Setting None of the identified cases of HTLV-III/LAV infection in the United States are known to have been transmitted in the school, day-care, or foster-care setting or through other casual person-to-person contact. Other than the sexual partners of HTLV-III/LAV-infected patients and infants born to infected mothers, none of the family members of the over 12,000 AIDS patients reported to CDC have been reported to have AIDS. Six studies of family members of patients with HTLV-III/LAV infection have failed to demonstrate HTLV-III/LAV transmission to adults who were not sexual contacts of the infected patients or to older children who were not likely at risk perinatal transmission (*6-11*).

Based on current evidence, casual person-to-person contact as would occur among schoolchildren appears to pose no risk. However, studies of the risk of transmission through contact between younger children and neurologically handicapped children who lack control of their body secretions are very limited. Based on experience with other communicable diseases, a theoretical potential for transmission would be greatest among these children. It should be emphasized that any theoretical transmission would most likely involve exposure of open skin lesions or mucous membranes to blood and possibly other body fluids of an infected person.

Risks to the Child with HTLV-III/LAV Infection HTLV-III/LAV infection may result in immunodeficiency. Such children may have a greater risk of encountering infectious agents in a school or day-care setting than at home. Foster homes with multiple children may also increase the risk. In addition, younger children and neurologically handicapped children who may display behaviors such as mouthing of toys would be expected to be at greater risk for acquiring infections. Immunodepressed children are also at greater risk of suffering severe complications from such infections as chickenpox, cytomegalovirus, tuberculosis, herpes simplex, and measles. Assessment of the risk to the immunodepressed child is best made by the child's physician who is aware of the child's immune status. The risk of acquiring some infections, such as chickenpox, may be reduced by prompt use of specific immune globulin following a known exposure.

RECOMMENDATIONS

1. Decisions regarding the type of educational and care setting for HTLV-III/LAV-infected children should be based on the behavior, neurologic development, and physical condition of the child and the expected type of interaction with others in that setting. These decisions are best made using the team approach including the child's physician, public health personnel, the child's parent or guardian, and personnel associated with the proposed care or educational setting. In each case, risks and benefits to both the infected child and to others in the setting should be weighed.

2. For most infected school-aged children, the benefits of an unrestricted setting would outweigh the risks of their acquiring potentially harmful infections in the setting and the apparent nonexistent risk of transmission of HTLV-III LAV. These children should be allowed to attend school and after-school day-care and to be placed in a foster home in an unrestricted setting.
3. For the infected preschool-aged child and for some neurologically handicapped children who lack control of their body secretions or who display behavior, such as biting, and those children who have uncoverable, oozing lesions, a more restricted environment is advisable until more is known about transmission in these settings. Children infected with HTLV-III/LAV should be cared for and educated in settings that minimize exposure of other children to blood or body fluids.
4. Care involving exposure to the infected child's body fluids and excrement, such as feeding and diaper changing, should be performed by persons who are aware of the child's HTLV-III LAV infection and the modes of possible transmission. In any setting involving an HTLV-III LAV-infected person, good handwashing after exposure to blood and body fluids and before caring for another child should be observed, and gloves should be worn if open lesions are present on the caretaker's hands. Any open lesions on the infected person should also be covered.
5. Because other infections in addition to HTLV-III/LAV can be present in blood or body fluids, all schools and day-care facilities, regardless of whether children with HTLV-III LAV infection are attending, should adopt routine procedures for handling blood or body fluids. Soiled surfaces should be promptly cleaned with disinfectants such as household bleach (diluted 1 part bleach to 10 parts water). Disposable towels or tissues should be used whenever possible, and mops should be rinsed in the disinfectant. Those who are cleaning should avoid exposure of open skin lesions or mucous membranes to the blood or body fluids.
6. The hygienic practices of children with HTLV-III LAV infection may improve as the child matures. Alternatively, the hygienic practices may deteriorate if the child's condition worsens. Evaluation to assess the need for a restricted environment should be performed regularly.
7. Physicians caring for children born to mothers with AIDS or at increased risk of acquiring HTLV-III LAV infection should consider testing the children for evidence of HTLV-III LAV infection for medical reasons. For example, vaccination of infected children with live virus vaccines, such as the measles-mumps-rubella vaccine (MMR), may be hazardous. These children also need to be followed closely for problems with growth and development and given prompt and aggressive therapy for infections and exposure to potentially lethal infections, such as varicella. In the event that an antiviral agent or other therapy for HTLV-III LAV infection becomes available, these children should be considered for such therapy. Knowledge that a child is infected will allow parents and other caretakers to take precautions when exposed to the blood and body fluids of the child.
8. Adoption and foster-care agencies should consider adding HTLV-III/LAV screening to their routine medical evaluations of children at increased risk of infection before placement in the foster or adoptive home, since these parents must make decisions regarding the medical care of the child and must consider the possible social and psychological effects on their families.
9. Mandatory screening as a condition for school entry is not warranted based on available data.
10. Persons involved in the care and education of HTLV-III LAV-infected children should respect the child's right to privacy, including maintaining confidential records. The number of personnel who are aware of the child's condition should be kept at a minimum needed to assure proper care of the child and to detect situations where the potential for transmission may increase (e.g., bleeding injury).
11. All educational and public health departments, regardless of whether HTLV-III LAV-infected children are involved, are strongly encouraged to inform parents, children, and educators regarding HTLV-III LAV and its transmission. Such education would greatly assist efforts to provide the best care and education for infected children while minimizing the risk of transmission to others.

References

1 Scott GB, Buck BE, Leterman JG, Bloom FL, Parks WP. Acquired immunodeficiency syndrome in infants. N Engl J Med 1984;310:76-81.
2 Thomas PA, Jaffe HW, Spira TJ, Reiss R, Guerrero IC, Auerbach O. Unexplained immunodeficiency in children: A surveillance report. JAMA 1984;252:639-44.
3 Rubinstein A, Sicklick M, Gupta A, et al. Acquired immunodeficiency with reversed T4/T8 ratios in infants born to promiscuous and drug-addicted mothers. JAMA 1983;249:2350-6.
4 Oleske J, Minnefor A, Cooper R Jr, et al. Immune deficiency syndrome in children. JAMA 1983;249:2345-9.
5. Ziegler JB, Cooper DA, Johnson RO, Gold J. Postnatal transmission of AIDS-associated retrovirus from mother to infant. Lancet 1985;i:896-8.
6. CDC. Unpublished data.
7 Kaplan JE, Oleske JM, Getchell JP, et al. Evidence against transmission of HTLV-III/LAV in families of children with AIDS. Pediatric Infectious Disease (in press).
8. Lewin EB, Zack R, Ayodele A. Communicability of AIDS in a foster care setting. International Conference on Acquired Immunodeficiency Syndrome (AIDS), Atlanta, Georgia, April 1985.
9. Thomas PA, Lubin K, Enlow RW, Getchell J. Comparison of HTLV-III serology, T-cell levels, and general health status of children whose mothers have AIDS with children of healthy inner city mothers in New York. International Conference on Acquired Immunodeficiency Syndrome (AIDS), Atlanta, Georgia, April 1985.
10. Fischl MA, Dickinson G, Scott G, Klimas N, Fletcher M, Parks W. Evaluation of household contacts of adult patients with the acquired immunodeficiency syndrome. International Conference on Acquired Immunodeficiency Syndrome (AIDS), Atlanta, Georgia, April 1985.
11 Friedland GH, Saltzman BR, Rogers MF, et al. Lack of household transmission of HTLV-III infection. EIS Conference, Atlanta, Georgia, April 1985.

Current Trends

1985 Aug 30;34:533-534

Recommendations for Preventing Possible Transmission of Human T-Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus from Tears

Human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV), the etiologic agent of acquired immunodeficiency syndrome (AIDS), has been found in various body fluids, including blood, semen, and saliva. Recently, scientists at the National Institutes of Health isolated the virus from the tears of an AIDS patient (*1*). The patient, a 33-year-old woman with a history of *Pneumocystis carinii* pneumonia and disseminated *Mycobacterium avium-intracellulare* infection, had no ocular complaints, and her eye examination was normal. Of the tear samples obtained from six other patients with AIDS or related conditions, three showed equivocal culture results, and three were culture-negative.

The following precautions are judged suitable to prevent spread of HTLV-III/LAV and other microbial pathogens that might be present in tears. They do not apply to the procedures used by individuals in caring for their own lenses, since the concern is the possible virus transmission between individuals.

1 Health-care professionals performing eye examinations or other procedures involving contact with tears should wash their hands immediately after a procedure and between patients. Handwashing alone should be sufficient, but when practical and convenient, disposable gloves may be worn. The use of gloves is advisable when there are cuts, scratches, or dermatologic lesions on the hands. Use of other protective measures, such as masks, goggles, or gowns, is *not* indicated.
2. Instruments that come into direct contact with external surfaces of the eye should be wiped clean and then disinfected by (a) a 5- to 10-minute exposure to a fresh solution of 3% hydrogen peroxide; or (b) a fresh solution containing 5,000 parts per million (mg/L) free available chlorine—a 1:10 dilution of common household bleach (sodium hypochlorite); or (c) 70% ethanol, or 70% isopropanol. The device should be thoroughly rinsed in tap water and dried before reuse.
3 Contact lenses used in trial fittings should be disinfected between each fitting by one of the following regimens.
   a. Disinfection of trial hard lenses with a commercially available hydrogen peroxide contact lens disinfecting system currently approved for soft contact lenses. (Other hydrogen peroxide preparations may contain preservatives that could discolor the lenses.) Alternatively, most trial hard lenses can be treated with the standard heat

APPENDIX B

AIDS POLICY

The following substitute recommendation was approved by the FMA Board of Governors at its meeting on October 17-18, 1985.

The various school systems should address the overall needs of immuno-compromised children, including those with AIDS or ARC, those with congenital anomalies of the immune system, those on immuno-suppressive drugs for the therapy of various clinical entities such as collagen-vascular diseases and malignancies, and those children on immuno-suppressive drugs after an organ transplantation.

The complexity of the clinical status of these children, including an assessment of the emotional impact of the disease on the child, requires an individual decision for each child regarding his/her involvement in the educational system.

Thus, with each child who falls into one or more of these categories, the child's physician and a physician representing each school system, should jointly review all the aspects of a child's health problems and develop a protocol that emphasizes the particular needs of each child.

In the event that such physicians are not available, the school system will be represented by the county health officer or his designee; and the child will be represented by a physician appointed by the local county medical society.

In the event of a disagreement between the involved physicians, the protocol to be followed should emphasize the totality of the health needs of all the children in that particular school, including the child under review.

The guidelines and recommendations of the Center for Disease Control (CDC) in regard to all types of actual or potentially infectious diseases, including AIDS or ARC, should be utilized as one component in the decision-making process regarding each individual child.

All educational and public health departments, regardless of whether AIDS-infected children are involved, are strongly encouraged to inform parents, children and educators regarding AIDS and its transmission. Such education would greatly assist efforts to provide the best care and education for infected children while minimizing the risk of transmission to others.

Command? R32 32

Posted: Thu Nov 14, 1985 12:03 PM EST Msg: LGIF-2310-1687
From: ASTHO.FDN
To: ADVANCE.MMWR
C ASTHO.FDN
Subj: OCCUP. AIDS GUIDELINES
Forwarded message:

Posted: Thu Nov 14, 1985 10:30 AM EST Urgent Msg: NGIF-2309-8691
From: CDC.BOARD
To: sha.alert.cdc, reg.all
Subj: MMWR 11/15

Please check CDC Information for revised MMWR article 'Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace.' To access CDC Information Service, at command prompt enter c cdc.

Action?

Please enter one of the following:
1, 2, 3a, 3b, 3c, 3d, 4, or 5

Please enter your selection: 1

Msg posted Nov 14, 1985 1:21 PM EST MSG: IGIF-2310-2500

Following is an electronic reprint of Morbidity and Mortality Weekly Report dated November 15, 1985. The printed version has tables, figures, and certain scientific symbols that are not included here.--CDC

Only one article this week:

MORBIDITY AND MORTALITY WEEKLY REPORT--November 15, 1985

Current Trends

Summary:

Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus in the Workplace

The information and recommendations contained in this document have been developed with particular emphasis on health-care workers and others in related occupations in which exposure might occur to blood from persons infected with HTLV-III/LAV, the 'AIDS virus.' Because of public concern about the purported risk of transmission of HTLV-III/LAV by persons providing personal services and those preparing and serving food and beverages, this document also addresses personal-service and food-service workers. Finally, it addresses 'other workers'--persons in settings, such as offices, schools, factories, and construction sites, where there is no known risk of AIDS virus transmission.

Because AIDS is a bloodborne, sexually transmitted disease that is not spread by casual contact, this document does not recommend routine HTLV-III/LAV antibody screening for the groups addressed. Because AIDS is not transmitted through preparation or serving of food and beverages, these recommendations state that food-service workers known to be infected with AIDS should not be restricted from work unless they

have another infection or illness for which such restriction would be warranted.

This document contains detailed recommendations for precautions appropriate to prevent transmission of all bloodborne infectious diseases to people exposed--in the course of their duties--to blood from persons who may be infected with HTLV-III/LAV. They emphasize that health-care workers should take all possible precautions to prevent needlestick injury. The recommendations are based on the well-documented modes of HTLV-III/LAV transmission and incorporate a 'worst case' scenario, the hepatitis B model of transmission. Because the hepatitis B virus is also bloodborne and is both hardier and more infectious than HTLV-III/LAV, recommendations that would prevent transmission of hepatitis B will also prevent transmission of AIDS.

Formulation of specific recommendations for health-care workers who perform invasive procedures is in progress.

Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus in the Workplace

Persons at increased risk of acquiring infection with human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV), the virus that causes acquired immunodeficiency syndrome (AIDS), include homosexual and bisexual men, intravenous (IV) drug abusers, persons transfused with contaminated blood or blood products, heterosexual contacts of persons with HTLV-III/LAV infection, and children born to infected mothers. HTLV-III/LAV is transmitted through sexual contact, parenteral exposure to infected blood or blood components, and perinatal transmission from mother to neonate. HTLV-III/LAV has been isolated from blood, semen, saliva, tears, breast milk, and urine and is likely to be isolated from some other body fluids, secretions, and excretions, but epidemiologic evidence has implicated only blood and semen in transmission. Studies of nonsexual household contacts of AIDS patients indicate that casual contact with saliva and tears does not result in transmission of infection. Spread of infection to household contacts of infected persons has not been detected when the household contacts have not been sex partners or have not been infants of infected mothers. The kind of nonsexual person-to-person contact that generally occurs among workers and clients or consumers in the workplace does not pose a risk for transmission of HTLV-III/LAV.

As in the development of any such recommendations, the paramount consideration is the protection of the public's health. The following recommendations have been developed for all workers, particularly workers in occupations in which exposure might occur to blood from individuals infected with HTLV-III/LAV. These recommendations reinforce and supplement the specific recommendations that were published earlier for clinical and laboratory staffs (1) and for dental-care personnel and persons performing necropsies and morticians' services (2). Because of public concern about the purported risk of transmission of HTLV-III/LAV by persons providing personal services and by food and beverages, these recommendations contain information and recommendations for personal-service and food-service workers. Finally, these recommendations address workplaces in general where there is no known risk of transmission of HTLV-III/LAV (e.g., offices, schools, factories, construction sites). Formulation of specific recommendations for health-care workers (HCWs) who perform invasive procedures (e.g., surgeons, dentists) is in progress. Separate recommendations are also being developed to prevent HTLV-III/LAV transmission in prisons, other correctional facilities, and

institutions housing individuals who may exhibit uncontrollable behavior (e.g., custodial institutions) and in the perinatal setting. In addition, separate recommendations have already been developed for children in schools and day-care centers (3).

HTLV-III/LAV-infected individuals include those with AIDS (4); those diagnosed by their physician(s) as having other illnesses due to infection with HTLV-III/LAV; and those who have virologic or serologic evidence of infection with HTLV-III/LAV but who are not ill.

These recommendations are based on the well-documented modes of HTLV-III/LAV transmission identified in epidemiologic studies and on comparison with the hepatitis B experience. Other recommendations are based on the hepatitis B model of transmission.

COMPARISON WITH THE HEPATITIS B VIRUS EXPERIENCE

The epidemiology of HTLV-III/LAV infection is similar to that of hepatitis B virus (HBV) infection, and much that has been learned over the last 15 years related to the risk of acquiring hepatitis B in the workplace can be applied to understanding the risk of HTLV-III/LAV transmission in the health-care and other occupational settings. Both viruses are transmitted through sexual contact, parenteral exposure to contaminated blood or blood products, and perinatal transmission from infected mothers to their offspring. Thus, some of the same major groups at high risk for HBV infection (e.g., homosexual men, IV drug abusers, persons with hemophilia, infants born to infected mothers) are also the groups at highest risk for HTLV-III/LAV infection. Neither HBV nor HTLV-III/LAV has been shown to be transmitted by casual contact in the workplace, contaminated food or water, or airborne or fecal-oral routes (5).

HBV infection is an occupational risk for HCWs, but this risk is related to degree of contact with blood or contaminated needles. HCWs who do not have contact with blood or needles contaminated with blood are not at risk for acquiring HBV infection in the workplace (6-8).

In the health-care setting, HBV transmission has not been documented between hospitalized patients, except in hemodialysis units, where blood contamination of the environment has been extensive or where HBV-positive blood from one patient has been transferred to another patient through contamination of instruments. Evidence of HBV transmission from HCWs to patients has been rare and limited to situations in which the HCWs exhibited high concentrations of virus in their blood (at least 100,000,000 infectious virus particles per ml of serum), and the HCWs sustained a puncture wound while performing traumatic procedures on patients or had exudative or weeping lesions that allowed virus to contaminate instruments or open wounds of patients (9-11).

Current evidence indicates that, despite epidemiologic similarities of HBV and HTLV-III/LAV infection, the risk for HBV transmission in health-care settings far exceeds that for HTLV-III/LAV transmission. The risk of acquiring HBV infection following a needlestick from an HBV carrier ranges from 6% to 30% (12,13), far in excess of the risk of HTLV-III/LAV infection following a needlestick involving a source patient infected with HTLV-III/LAV, which is less than 1%. In addition, all HCWs who have been shown to transmit HBV infection in health-care settings have belonged to the subset of chronic HBV carriers who, when tested, have exhibited evidence of exceptionally high concentrations of virus (at least 100,000,000 infectious virus particles per ml) in their blood. Chronic carriers who have substantially lower concentrations of virus in their blood have not been implicated in transmission in the health-care setting (9-11,14). The HBV model thus represents a 'worst case' condition in regard to transmission in health-care and other related settings. Therefore, recommendations for the control of HBV infection should, if followed,

also effectively prevent spread of HTLV-III/LAV. Whether additional measures are indicated for those HCWs who perform invasive procedures will be addressed in the recommendations currently being developed.

Routine screening of all patients or HCWs for evidence of HBV infection has never been recommended. Control of HBV transmission in the health-care setting has emphasized the implementation of recommendations for the appropriate handling of blood, other body fluids, and items soiled with blood or other body fluids.

TRANSMISSION FROM PATIENTS TO HEALTH-CARE WORKERS

HCWs include, but are not limited to, nurses, physicians, dentists and other dental workers, optometrists, podiatrists, chiropractors, laboratory and blood bank technologists and technicians, phlebotomists, dialysis personnel, paramedics, emergency medical technicians, medical examiners, morticians, housekeepers, laundry workers, and others whose work involves contact with patients, their blood or other body fluids, or corpses.

Recommendations for HCWs emphasize precautions appropriate for preventing transmission of bloodborne infectious diseases, including HTLV-III/LAV and HBV infections. Thus, these precautions should be enforced routinely, as should other standard infection-control precautions, regardless of whether HCWs or patients are known to be infected with HTLV-III/LAV or HBV. In addition to being informed of these precautions, all HCWs, including students and housestaff, should be educated regarding the epidemiology, modes of transmission, and prevention of HTLV-III/LAV infection.

Risk of HCWs acquiring HTLV-III/LAV in the workplace. Using the HBV model, the highest risk for transmission of HTLV-III/LAV in the workplace would involve parenteral exposure to a needle or other sharp instrument contaminated with blood of an infected patient. The risk to HCWs of acquiring HTLV-III/LAV infection in the workplace has been evaluated in several studies. In five separate studies, a total of 1,498 HCWs have been tested for antibody to HTLV-III/LAV. In these studies, 666 (44.5%) of the HCWs had direct parenteral (needlestick or cut) or mucous membrane exposure to patients with AIDS or HTLV-III/LAV infection. Most of these exposures were to blood rather than to other body fluids. None of the HCWs whose initial serologic tests were negative developed subsequent evidence of HTLV-III/LAV infection following their exposures. Twenty-six HCWs in these five studies were seropositive when first tested; all but three of these persons belonged to groups recognized to be at increased risk for AIDS (15). Since one was tested anonymously, epidemiologic information was available on only two of these three seropositive HCWs. Although these two HCWs were reported as probable occupationally related HTLV-III/LAV infection (15,16), neither had a preexposure nor an early postexposure serum sample available to help determine the onset of infection. One case reported from England describes a nurse who seroconverted following an accidental parenteral exposure to a needle contaminated with blood from an AIDS patient (17).

In spite of the extremely low risk of transmission of HTLV-III/LAV infection, even when needlestick injuries occur, more emphasis must be given to precautions targeted to prevent needlestick injuries in HCWs caring for any patient, since such injuries continue to occur even during the care of patients who are known to be infected with HTLV-III/LAV.

Precautions to prevent acquisition of HTLV-III/LAV infection by HCWs in the workplace. These precautions represent prudent practices that apply to preventing transmission of HTLV-III/LAV and other bloodborne infections and should be used routinely (18).

1. Sharp items (needles, scalpel blades, and other sharp instruments) should be considered as potentially infective and

be handled with extraordinary care to prevent accidental injuries.

2. Disposable syringes and needles, scalpel blades, and other sharp items should be placed into puncture-resistant containers located as close as practical to the area in which they were used. To prevent needlestick injuries, needles should not be recapped, purposefully bent, broken, removed from disposable syringes, or otherwise manipulated by hand.
3. When the possibility of exposure to blood or other body fluids exists, routinely recommended precautions should be followed. The anticipated exposure may require gloves alone, as in handling items soiled with blood or equipment contaminated with blood or other body fluids, or may also require gowns, masks, and eye-coverings when performing procedures involving more extensive contact with blood or potentially infective body fluids, as in some dental or endoscopic procedures or postmortem examinations. Hands should be washed thoroughly and immediately if they accidentally become contaminated with blood.
4. To minimize the need for emergency mouth-to-mouth resuscitation, mouth pieces, resuscitation bags, or other ventilation devices should be strategically located and available for use in areas where the need for resuscitation is predictable.
5. Pregnant HCWs are not known to be at greater risk of contracting HTLV-III/LAV infections than HCWs who are not pregnant; however, if a HCW develops HTLV-III/LAV infection during pregnancy, the infant is at increased risk of infection resulting from perinatal transmission. Because of this risk, pregnant HCWs should be especially familiar with precautions for the preventing HTLV-III/LAV transmission (19).

Precautions for HCWs during home care of persons infected with HTLV-III/LAV. Persons infected with HTLV-III/LAV can be safely cared for in home environments. Studies of family members of patients infected with HTLV-III/LAV have found no evidence of HTLV-III/LAV transmission to adults who were not sexual contacts of the infected patients or to children who were not at risk for perinatal transmission (3). HCWs providing home care face the same risk of transmission of infection as HCWs in hospitals and other health-care settings, especially if there are needlesticks or other parenteral or mucous membrane exposures to blood or other body fluids.

When providing health-care service in the home to persons infected with HTLV-III/LAV, measures similar to those used in hospitals are appropriate. As in the hospital, needles should not be recapped, purposefully bent, broken, removed from disposable syringes, or otherwise manipulated by hand. Needles and other sharp items should be placed into puncture-resistant containers and disposed of in accordance with local regulations for solid waste. Blood and other body fluids can be flushed down the toilet. Other items for disposal that are contaminated with blood or other body fluids that cannot be flushed down the toilet should be wrapped securely in a plastic bag that is impervious and sturdy (not easily penetrated). It should be placed in a second bag before being discarded in a manner consistent with local regulations for solid waste disposal. Spills of blood or other body fluids should be cleaned with soap and water or a household detergent. As in the hospital, individuals cleaning up such spills should wear disposable gloves. A disinfectant solution or a freshly prepared solution of sodium hypochlorite (household bleach, see below) should be used to wipe the area after cleaning.

Precautions for providers of prehospital emergency health care.

Providers of prehospital emergency health care include the following: paramedics, emergency medical technicians, law enforcement personnel, firefighters, lifeguards, and others whose job might require them to provide first-response medical care. The risk of transmission of infection, including HTLV-III/LAV infection, from infected persons to providers of prehospital emergency health care should be no higher than that for HCWs providing emergency care in the hospital if appropriate precautions are taken to prevent exposure to blood or other body fluids.

Providers of prehospital emergency health care should follow the precautions outlined above for other HCWs. No transmission of HBV infection during mouth-to-mouth resuscitation has been documented. However, because of the theoretical risk of salivary transmission of HTLV-III/LAV during mouth-to-mouth resuscitation, special attention should be given to the use of disposable airway equipment or resuscitation bags and the wearing of gloves when in contact with blood or other body fluids. Resuscitation equipment and devices known or suspected to be contaminated with blood or other body fluids should be used once and disposed of or be thoroughly cleaned and disinfected after each use.

Management of parenteral and mucous membrane exposures of HCWs. If a HCW has a parenteral (e.g., needlestick or cut) or mucous membrane (e.g., splash to the eye or mouth) exposure to blood or other body fluids, the source patient should be assessed clinically and epidemiologically to determine the likelihood of HTLV-III/LAV infection. If the assessment suggests that infection may exist, the patient should be informed of the incident and requested to consent to serologic testing for evidence of HTLV-III/LAV infection. If the source patient has AIDS or other evidence of HTLV-III/LAV infection, declines testing, or has a positive test, the HCW should be evaluated clinically and serologically for evidence of HTLV-III/LAV infection as soon as possible after the exposure, and, if seronegative, retested after 6 weeks and on a periodic basis thereafter (e.g., 3, 6, and 12 months following exposure) to determine if transmission has occurred. During this follow-up period, especially the first 6-12 weeks, when most infected persons are expected to seroconvert, exposed HCWs should receive counseling about the risk of infection and follow U.S. Public Health Service (PHS) recommendations for preventing transmission of AIDS (20,21). If the source patient is seronegative and has no other evidence of HTLV-III/LAV infection, no further follow-up of the HCW is necessary. If the source patient cannot be identified, decisions regarding appropriate follow-up should be individualized based on the type of exposure and the likelihood that the source patient was infected.

Serologic testing of patients. Routine serologic testing of all patients for antibody to HTLV-III/LAV is not recommended to prevent transmission of HTLV-III/LAV infection in the workplace. Results of such testing are unlikely to further reduce the risk of transmission, which, even with documented needlesticks, is already extremely low. Furthermore, the risk of needlestick and other parenteral exposures could be reduced by emphasizing and more consistently implementing routinely recommended infection-control precautions (e.g., not recapping needles). Moreover, results of routine serologic testing would not be available for emergency cases and patients with short lengths of stay, and additional tests to determine whether a positive test was a true or false positive would be required in populations with a low prevalence of infection. However, this recommendation is based only on considerations of occupational risks and should not be construed as a recommendation against other uses of the serologic test, such as for diagnosis or to facilitate medical management of patients.

Since the experience with infected patients varies substantially among hospitals (75% of all AIDS cases have been reported by only 200 of the more than 6,000 acute-care hospitals in the United States), some hospitals in certain geographic areas may deem it appropriate to initiate serologic testing of patients.

TRANSMISSION FROM HEALTH-CARE WORKERS TO PATIENTS

Risk of transmission of HTLV-III/LAV infection from HCWs to patients. Although there is no evidence that HCWs infected with HTLV-III/LAV have transmitted infection to patients, a risk of transmission of HTLV-III/LAV infection from HCWs to patients would exist in situations where there is both (1) a high degree of trauma to the patient that would provide a portal of entry for the virus (e.g., during invasive procedures) and (2) access of blood or serous fluid from the infected HCW to the open tissue of a patient, as could occur if the HCW sustains a needlestick or scalpel injury during an invasive procedure. HCWs known to be infected with HTLV-III/LAV who do not perform invasive procedures need not be restricted from work unless they have evidence of other infection or illness for which any HCW should be restricted. Whether additional restrictions are indicated for HCWs who perform invasive procedures is currently being considered.

Precautions to prevent transmission of HTLV-III/LAV infection from HCWs to patients. These precautions apply to all HCWs, regardless of whether they perform invasive procedures: (1) All HCWs should wear gloves for direct contact with mucous membranes or nonintact skin of all patients and (2) HCWs who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient-care equipment until the condition resolves.

Management of parenteral and mucous membrane exposures of patients. If a patient has a parenteral or mucous membrane exposure to blood or other body fluids of a HCW, the patient should be informed of the incident and the same procedure outlined above for exposures of HCWs to patients should be followed for both the source HCW and the potentially exposed patient. Management of this type of exposure will be addressed in more detail in the recommendations for HCWs who perform invasive procedures.

Serologic testing of HCWs. Routine serologic testing of HCWs who do not perform invasive procedures (including providers of home and prehospital emergency care) is not recommended to prevent transmission of HTLV-III/LAV infection. The risk of transmission is extremely low and can be further minimized when routinely recommended infection-control precautions are followed. However, serologic testing should be available to HCWs who may wish to know their HTLV-III/LAV infection status. Whether indications exist for serologic testing of HCWs who perform invasive procedures is currently being considered.

Risk of occupational acquisition of other infectious diseases by HCWs infected with HTLV-III/LAV. HCWs who are known to be infected with HTLV-III/LAV and who have defective immune systems are at increased risk of acquiring or experiencing serious complications of other infectious diseases. Of particular concern is the risk of severe infection following exposure to patients with infectious diseases that are easily transmitted if appropriate precautions are not taken (e.g., tuberculosis). HCWs infected with HTLV-III/LAV should be counseled about the potential risk associated with taking care of patients with transmissible infections and should continue to follow existing recommendations for infection control to minimize their risk of exposure to other infectious agents (18,19). The HCWs' personal physician(s), in conjunction with their institutions' personnel health services or medical directors, should determine on an individual basis whether the infected HCWs can adequately and safely perform patient-care duties and suggest changes in work assignments, if

indicated. In making this determination, recommendations of the Immunization Practices Advisory Committee and institutional policies concerning requirements for vaccinating HCWs with live-virus vaccines should also be considered.

STERILIZATION, DISINFECTION, HOUSEKEEPING, AND WASTE DISPOSAL TO PREVENT TRANSMISSION OF HTLV-III/LAV

Sterilization and disinfection procedures currently recommended for use (22,23) in health-care and dental facilities are adequate to sterilize or disinfect instruments, devices, or other items contaminated with the blood or other body fluids from individuals infected with HTLV-III/LAV. Instruments or other nondisposable items that enter normally sterile tissue or the vascular system or through which blood flows should be sterilized before reuse. Surgical instruments used on all patients should be decontaminated after use rather than just rinsed with water. Decontamination can be accomplished by machine or by hand cleaning by trained personnel wearing appropriate protective attire (24) and using appropriate chemical germicides. Instruments or other nondisposable items that touch intact mucous membranes should receive high-level disinfection.

Several liquid chemical germicides commonly used in laboratories and health-care facilities have been shown to kill HTLV-III/LAV at concentrations much lower than are used in practice (25). When decontaminating instruments or medical devices, chemical germicides that are registered with and approved by the U.S. Environmental Protection Agency (EPA) as 'sterilants' can be used either for sterilization or for high-level disinfection depending on contact time; germicides that are approved for use as 'hospital disinfectants' and are mycobactericidal when used at appropriate dilutions can also be used for high-level disinfection of devices and instruments. Germicides that are mycobactericidal are preferred because mycobacteria represent one of the most resistant groups of microorganisms; therefore, germicides that are effective against mycobacteria are also effective against other bacterial and viral pathogens. When chemical germicides are used, instruments or devices to be sterilized or disinfected should be thoroughly cleaned before exposure to the germicide, and the manufacturer's instructions for use of the germicide should be followed.

Laundry and dishwashing cycles commonly used in hospitals are adequate to decontaminate linens, dishes, glassware, and utensils. When cleaning environmental surfaces, housekeeping procedures commonly used in hospitals are adequate; surfaces exposed to blood and body fluids should be cleaned with a detergent followed by decontamination using an EPA-approved hospital disinfectant that is mycobactericidal. Individuals cleaning up such spills should wear disposable gloves. Information on specific label claims of commercial germicides can be obtained by writing to the Disinfectants Branch, Office of Pesticides, Environmental Protection Agency, 401 M Street, S.W., Washington, D.C., 20460.

In addition to hospital disinfectants, a freshly prepared solution of sodium hypochlorite (household bleach) is an inexpensive and very effective germicide (25). Concentrations ranging from 5,000 ppm (a 1:10 dilution of household bleach) to 500 ppm (a 1:100 dilution) sodium hypochlorite are effective, depending on the amount of organic material (e.g., blood, mucus, etc.) present on the surface to be cleaned and disinfected.

Sharp items should be considered as potentially infective and should be handled and disposed of with extraordinary care to prevent accidental injuries. Other potentially infective waste should be contained and transported in clearly identified impervious plastic bags. If the outside of the bag is contaminated with blood or other

body fluids, a second outer bag should be used. Recommended practices for disposal of infective waste (23) are adequate for disposal of waste contaminated by HTLV-III/LAV. Blood and other body fluids may be carefully poured down a drain connected to a sanitary sewer.

CONSIDERATIONS RELEVANT TO OTHER WORKERS

Personal-service workers (PSWs). PSWs are defined as individuals whose occupations involve close personal contact with clients (e.g., hairdressers, barbers, estheticians, cosmetologists, manicurists, pedicurists, massage therapists). PSWs whose services (tattooing, ear piercing, acupuncture, etc.) require needles or other instruments that penetrate the skin should follow precautions indicated for HCWs. Although there is no evidence of transmission of HTLV-III/LAV from clients to PSWs, from PSWs to clients, or between clients of PSWs, a risk of transmission would exist from PSWs to clients and vice versa in situations where there is both (1) trauma to one of the individuals that would provide a portal of entry for the virus and (2) access of blood or serous fluid from one infected person to the open tissue of the other, as could occur if either sustained a cut. A risk of transmission from client to client exists when instruments contaminated with blood are not sterilized or disinfected between clients. However, HBV transmission has been documented only rarely in acupuncture, ear piercing, and tattoo establishments and never in other personal-service settings, indicating that any risk for HTLV-III/LAV transmission in personal-service settings must be extremely low.

All PSWs should be educated about transmission of bloodborne infections, including HTLV-III/LAV and HBV. Such education should emphasize principles of good hygiene, antisepsis, and disinfection. This education can be accomplished by national or state professional organizations, with assistance from state and local health departments, using lectures at meetings or self-instructional materials. Licensure requirements should include evidence of such education. Instruments that are intended to penetrate the skin (e.g., tattooing and acupuncture needles, ear piercing devices) should be used once and disposed of or be thoroughly cleaned and sterilized after each use using procedures recommended for use in health-care institutions. Instruments not intended to penetrate the skin but which may become contaminated with blood (e.g., razors), should be used for only one client and be disposed of or thoroughly cleaned and disinfected after use using procedures recommended for use in health-care institutions. Any PSW with exudative lesions or weeping dermatitis, regardless of HTLV-III/LAV infection status, should refrain from direct contact with clients until the condition resolves. PSWs known to be infected with HTLV-III/LAV need not be restricted from work unless they have evidence of other infections or illnesses for which any PSW should also be restricted.

Routine serologic testing of PSWs for antibody to HTLV-III/LAV is not recommended to prevent transmission from PSWs to clients.

Food-service workers (FSWs). FSWs are defined as individuals whose occupations involve the preparation or serving of food or beverages (e.g., cooks, caterers, servers, waiters, bartenders, airline attendants). All epidemiologic and laboratory evidence indicates that bloodborne and sexually transmitted infections are not transmitted during the preparation or serving of food or beverages, and no instances of HBV or HTLV-III/LAV transmission have been documented in this setting.

All FSWs should follow recommended standards and practices of good personal hygiene and food sanitation (26). All FSWs should exercise care to avoid injury to hands when preparing food. Should such an injury occur, both aesthetic and sanitary considerations would dictate that food contaminated with blood be discarded. FSWs known to be

infected with HTLV-III/LAV need not be restricted from work unless they have evidence of other infection or illness for which any FSW should also be restricted.

Routine serologic testing of FSWs for antibody to HTLV-III/LAV is not recommended to prevent disease transmission from FSWs to consumers.

Other workers sharing the same work environment. No known risk of transmission to co-workers, clients, or consumers exists from HTLV-III/LAV-infected workers in other settings (e.g., offices, schools, factories, construction sites). This infection is spread by sexual contact with infected persons, injection of contaminated blood or blood products, and by perinatal transmission. Workers known to be infected with HTLV-III/LAV should not be restricted from work solely based on this finding. Moreover, they should not be restricted from using telephones, office equipment, toilets, showers, eating facilities, and water fountains. Equipment contaminated with blood or other body fluids of any worker, regardless of HTLV-III/LAV infection status, should be cleaned with soap and water or a detergent. A disinfectant solution or a fresh solution of sodium hypochlorite (household bleach, see above) should be used to wipe the area after cleaning.

OTHER ISSUES IN THE WORKPLACE

The information and recommendations contained in this document do not address all the potential issues that may have to be considered when making specific employment decisions for persons with HTLV-III/LAV infection. The diagnosis of HTLV-III/LAV infection may evoke unwarranted fear and suspicion in some co-workers. Other issues that may be considered include the need for confidentiality, applicable federal, state, or local laws governing occupational safety and health, civil rights of employees, workers' compensation laws, provisions of collective bargaining agreements, confidentiality of medical records, informed consent, employee and patient privacy rights, and employee right-to-know statutes.

DEVELOPMENT OF THESE RECOMMENDATIONS

The information and recommendations contained in these recommendations were developed and compiled by CDC and other PHS agencies in consultation with individuals representing various organizations. The following organizations were represented: Association of State and Territorial Health Officials, Conference of State and Territorial Epidemiologists, Association of State and Territorial Public Health Laboratory Directors, National Association of County Health Officials, American Hospital Association, United States Conference of Local Health Officers, Association for Practitioners in Infection Control, Society of Hospital Epidemiologists of America, American Dental Association, American Medical Association, American Nurses' Association, American Association of Medical Colleges, American Association of Dental Schools, National Institutes of Health, Food and Drug Administration, Food Research Institute, National Restaurant Association, National Hairdressers and Cosmetologists Association, National Gay Task Force, National Funeral Directors and Morticians Association, American Association of Physicians for Human Rights, and National Association of Emergency Medical Technicians. The consultants also included a labor union representative, an attorney, a corporate medical director, and a pathologist. However, these recommendations may not reflect the views of individual consultants or the organizations they represented.

References

1. CDC. Acquired immune deficiency syndrome (AIDS): precautions for clinical and laboratory staffs. MMWR 1982;31:577-80.
2. CDC. Acquired immunodeficiency syndrome (AIDS): precautions for health-care workers and allied professionals. MMWR 1983;32:450-1.

3. CDC. Education and foster care of children infected with human T-lymphotropic virus type III/lymphadenopathy-associated virus. MMWR 1985;34:517-21.
4. CDC. Revision of the case definition of acquired immunodeficiency syndrome for national reporting--United States. MMWR 1985;34:373-5.
5. CDC. ACIP recommendations for protection against viral hepatitis. MMWR 1985;34:313-24, 329-335.
6. Hadler SC, Doto IL, Maynard JE, et al. Occupational risk of hepatitis B infection in hospital workers. Infect Control 1985;6:24-31.
7. Dienstag JL, Ryan DM. Occupational exposure to hepatitis B virus in hospital personnel: infection or immunization? Am J Epidemiol 1982;115:26-39.
8. Pattison CP, Maynard JE, Berquist KR, et al. Epidemiology of hepatitis B in hospital personnel. Am J Epidemiol 1975;101:59-64.
9. Kane MA, Lettau LA. Transmission of HBV from dental personnel to patients. JADA 1985;110:634-6.
10. Hadler SC, Sorley DL, Acree KB, et al. An outbreak of hepatitis B in a dental practice. Ann Intern Med 1981;95:133-8.
11. Carl M, Blakey DL, Francis DP, Maynard JE. Interruption of hepatitis B transmission by modification of a gynaecologist's surgical technique. Lancet 1982;i:731-3.
12. Seeff LB, Wright EC, Zimmerman HJ, et al. Type B hepatitis after needlestick exposure: prevention with hepatitis B immune globulin. Ann Intern Med 1978;88:285-93.
13. Grady GF, Lee VA, Prince AM, et al. Hepatitis B immune globulin for accidental exposures among medical personnel: Final report of a multicenter controlled trial. J Infect Dis 1978;138:625-38.
14. Shikata T, Karasawa T, Abe K, et al. Hepatitis B e antigen and infectivity of hepatitis B virus. J Infect Dis 1977;136:571-6.
15. CDC. Update: evaluation of human T-lymphotropic virus type III/lymphadenopathy-associated virus infection in health-care personnel--United States. MMWR 1985;34:575-8.
16. Weiss SH, Saxinger WC, Rechtman D, et al. HTLV-III infection among health care workers: association with needle-stick injuries. JAMA 1985;254:2089-93.
17. Anonymous. Needlestick transmission of HTLV-III from a patient infected in Africa. Lancet 1984;ii:1376-7.
18. Garner JS, Simmons BP. Guideline for isolation precautions in hospitals. Infect Control 1983;4:245-325.
19. Williams WW. Guideline for infection control in hospital personnel. Infect Control 1983;4:326-49.
20. CDC. Prevention of acquired immune deficiency syndrome (AIDS): report of inter-agency recommendations. MMWR 1983;32:101-3.
21. CDC. Provisional Public Health Service inter-agency recommendations for screening donated blood and plasma for antibody to the virus causing acquired immunodeficiency syndrome. MMWR 1985;34:1-5.
22. Favero MS. Sterilization, disinfection, and antisepsis in the hospital. In: Manual of Clinical Microbiology. 4th ed. Washington, D.C.: American Society for Microbiology, 1985;129-37.
23. Garner JS, Favero MS. Guideline for handwashing and hospital environmental control, 1985. Atlanta Georgia: Centers for Disease Control, 1985. Publication no. 99-1117.
24. Kneedler JA, Dodge GH. Perioperative patient care. Boston: Blackwell Scientific Publications, 1983:210-1.
25. Martin LS, McDougal JS, Loskoski SL. Disinfection and inactivation of the human T-lymphotropic virus type III/lymphadenopathy-associated virus. J Infect Dis 1985;152:400-3.
26. Food Service Sanitation Manual 1976. DHEW publication no. (FDA)