FINAL REPORT OF THE

PROBATION COMMITTEE ON AIDS

Administrative Office of the Courts
Probation Services
Justice Complex, CN-987
Trenton, NJ 08625

July 1987

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Executive Summary

-Acquired Immunodeficiency Syndrome (AIDS) poses a significant public health problem in the United States and in New Jersey.

-AIDS attacks the body's immune system, making it vulnerable to diseases that would normally be repelled.

-AIDS can be carried and transmitted by persons who do not show symptoms.

-AIDS is very difficult to transmit; the only known vehicles for transmission are blood and semen.

-There is no evidence that AIDS can be transmitted through casual contact.

-Intravenous drug users account for 46% of the reported cases in New Jersey.

-Probation supervision should continue to be provided to those persons with AIDS. Some modifications to standard operating procedures may need to be incorporated on a case-by-case basis.

-Probation staff should encourage persons suspected of being infected to be tested for the AIDS antibody. Those with the infection should be referred for treatment.

-All probationers should be provided with educational material about AIDS, especially those who engage in high risk behaviors, e.g., intravenous drug use and bisexual or homosexual relations.

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INTRODUCTION

A significant and frightening public health problem confronts society today--Acquired Immunodeficiency Syndrome or AIDS. Since its appearance in 1981, it has had a devastating impact on its victims, creating widespread fear and trepidation among the citizenry. The Centers for Disease Control and the New Jersey Department of Health are actively maintaining statistics which reveal that New Jersey is ranked fifth, surpassed only by New York, California, Florida, and Texas in known or diagnosed AIDS cases.

As of June 1, 1987, 35,769 cases have been reported nationally. Of those, 2,173 or 6% are in New Jersey. It is estimated that as many as 100 times that number of people are infected with the virus. The New York City/Northern New Jersey area is considered the epicenter for AIDS cases related to intravenous drug use; 75% of such cases identified in the country are in this region. In fact, over 50% of all drug users in New Jersey are probably infected.

Probation has not been insulated from this grave problem. In fact, the situation is exacerbated by the fact that intravenous drug users are the largest group of AIDS sufferers in New Jersey and also make up a significant portion of the population with whom probation officers have court related contact.

This heightened probability of involvement with AIDS sufferers coupled with a fundamental concern for the health and well-being of probation personnel prompted the formation of a committee of Chief Probation Officers, line probation personnel and Administrative Office of the Courts staff to prepare probation's response to the AIDS challenge. The committee would like to acknowledge the invaluable advice and assistance provided by Patricia A. Nisler of the Communicable Disease Operations Program, New Jersey Department of Health.

This document presents a brief description of the disease's medical aspects, a discussion of implications for probation, a recommended training program, and recommended policies for supervision.

MEDICAL ASPECTS OF THE DISEASE

AIDS is the acronym for Acquired Immunodeficiency Syndrome.[1] This relatively new disease, first described in 1980, has no known cure and in its most active state claims 100% mortality. AIDS is transmitted through intimate physical contact; semen and blood have been isolated as vehicles for transmission. Newborn infants can also be infected by mothers at birth.

Contrary to popular belief, AIDS does not kill its victim. What it does is invade and undermine the human body's natural immune system by destroying certain white blood cells. The victim then becomes susceptible to a range of infections and diseases which would not be life threatening to someone with a healthy immune system. Those secondary diseases are often highly contagious, the most prevalent in New Jersey being tuberculosis. Nationally, the most common causes of death are Kaposi's Sarcoma and Pneumocystics Carinii Pneumonia which develop in the infected individual as a result of a breakdown in the immune system. (Statistics of mortality from these diseases are presented in Appendix A.)

The Virus

In 1983 and 1984, French and American scientists identified the probable cause of AIDS. Called Human Immunodeficiency Virus (HIV)[2], it is generally believed to be an indispensable requirement to the development of AIDS. It has not been firmly established as the sole cause; there may be co-factors which contribute to the process.

A person can be infected with HIV for years, even decades, without ever developing overt symptoms. The virus can be transmitted by these persons who are asymptomatic.

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1 The commonly used acronym AIDS was derived from the earlier name for the disease, Acquired Immune Deficiency Syndrome. The accepted spelling is now Acquired Immunodeficiency Syndrome, but the AIDS acronym is still used.

2 HIV was previously known as Human T-Cell Lymphotropic Virus Type III or HTLV-III. The International Committee for the Taxonomy of Viruses has designated Human Immunodeficiency Virus (HIV) as the appropriate name. The New Jersey Department of Health and many other health-related agencies have adopted HIV as the official name they will use for the AIDS virus.

Transmission of AIDS

AIDS is difficult to transmit.

"There is absolutely no evidence of its transmission through casual contact, such as coughing, hugging, handshaking, sharing eating and drinking utensils, or using the same toilet facilities."[3] The chances of having the virus transmitted through biting are less than zero percent.[4]

The virus is not very hardy outside the human body. It is susceptible to heat, common disinfectants and detergents, and to washing with simple soap and water.

According to the Centers for Disease Control, the HIV virus appears to be transmitted exclusively through exposure to contaminated blood and semen. This occurs primarily through sexual relations including vaginal intercourse, anal intercourse, oral-genital and oral-anal contact and through needle sharing in drug use.

A number of studies have examined the transmission of AIDS among family members. All have shown that the disease is not passed to others living in the same household regardless of length of exposure, so long as there has been no exchange of blood or semen. The same is true for the medical profession. If AIDS were an easily transmitted disease, its occurrence would be rampant among those who provide daily care to AIDS sufferers; clearly that is not the case.

AIDS Risk Groups

The latest available data shows that AIDS most frequently occurs in homosexual/bisexual males and intravenous (IV) drug users. These two groups account for 90% of the cases known nationally. While IV drug users in the national data account for 17%, in New Jersey, they total 46% of the reported cases.

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3 Hammett, Theodore M. AIDS in Prisons and Jails: Issues and Options. (Washington, D.C.; National Institute of Justice, February 1986) Page 2. See Appendix B.

4 One letter to the British medical journal "Lancet" suggests the possibility that the infection may have been transmitted by a bite. In that situation, a brother of an infected person developed the HIV infection, and no other means (other than a bite) of transmission was identified.

Progression of AIDS

Clinically, it is impossible to ascribe discrete stages to the illness resulting from HIV infection. Schematically, however, the disease process can be described as follows.

...Infection of the Human Immunodeficiency Virus (HIV) follows exposure via the routes of transmission described above.

...A seronegative period lasts for six to twelve weeks following infection. Although infection has already occurred, antibody levels have not yet reached a point where they would be termed "reactive". Test results during this window period would be deemed non-reactive or negative.

...Seropositivity brings positive test results because adequate antibody levels to HIV have been developed. After initial infection, seropositivity lasts indefinitely and does not indicate whether the disease is currently active.

...ARC (AIDS-Related Complex) signifies the presence of a combination of factors indicative of AIDS:

a. unusual prolonged fatigue (not explained by physical activity or other disorders) which may be combined with headache, dizziness, or light headedness;

b. rapid weight loss of 10 to 15 pounds or 10% of body weight in less than two months not due to dieting or exercise;

c. persistant fever of 100° or more;

d. recurrent drenching night sweats;

e. chronic, unexplained swollen lymph nodes or glands in neck, armpits or groin lasting longer than three months; and

f. chronic, unexplained diarrhea.

The usual criteria for ARC include any two of these clinical signs that have persisted for more than three months plus two of the following laboratory abnormalities:

a. suppressed helper T-cell counts;

b. depressed helper/suppressor cell ratio;

c. elevated serum globulin;

d. leukopenia, thrombocytopenia, absolute lymphopenia, or anemia;

e. depressed blastogenesis; and

f. abnormal skin tests (using multitest).

Persons with ARC may appear to get better, but since there is no cure for the virus, they remain infected.

...Acquired Immunodeficiency Syndrome is the end stage illness caused by HIV infection. It includes the onset of opportunistic infections and cancers which would not otherwise affect a healthy body. AIDS is characterized by the symptoms of ARC with these additional possibilities associated with some of the opportunistic illnesses:

a. persistent dry cough unrelated to smoking, colds, or flu;

b. shortness of breath;

c. thick, whitish coating on the tongue, throat, or inside mouth (oral thrush);

d. unexplained bleeding from any body opening or from growths on the skin or mucous membranes;

e. bruises which appear more readily than usual but which do not heal easily; and

f. appearance of brownish, reddish, bluish skin spots, usually painless, especially on ankles, or on mucous membranes (mouth, nasal passages, eyelids, around rectum) which do not go away but gradually increase in size.

HIV may also attack the nervous system causing delayed damage to the brain. Symptoms of this eventuality include memory loss, forgetfulness, confusion, indifference, loss of coordination, changes in gait, partial paralysis, blurring of vision and/or hearing, slurred speech, delusions, and mental disorder.

Progression through these phases is reductionary in nature. In other words, fewer people are found at any given stage of the disease than at the previous one. For example, it is estimated that for every person who has AIDS, there may be as many as 100 more who are HIV infected. Current predictions are that as many as 65% of asymptomatic HIV infected individuals will get sick at some level, be it AIDS or ARC. Between 25% and 50% of the asymptomatically infected will progress to AIDS. These percentages have been changing over time as the disease has been followed in research cohorts for longer periods.

An individual who exhibits seropositivity can and should do a number of things which may slow the progression of the disease and delay the onset of ARC or AIDS:

...maintain good nutrition;

...get adequate exercise and rest;

...reduce stress;

...avoid drug use - steroids, nicotine, alcohol, marijuana, other illicit substances;

...do not receive vaccinations which use live materials;

...take extra precautions against all types of infection;

...avoid pregnancy until testing and medical advice is sought;

...know the signs and symptoms of ARC/AIDS and see a physician immediately if any of them occur;

...refrain from donating blood, plasma, sperm, body organs, or tissue; and

...have a physical check-up every six months.

Antibody Testing

In 1985, a commercial test for the antibody to HIV became available. The presence in the blood of antibodies to HIV gives evidence of the immune system's attempt to fight off infection. It is important to note that the HIV antibody test does not test directly for AIDS, will not predict future illness from AIDS or a related condition, and cannot measure immunity to or protection from the virus.

A person with negative test results probably has not been infected with HIV. However, a person tested soon after exposure to the virus might not have developed antibodies as yet, and the test could show positive results at a later date. Also, a few people who are actually infected with the virus will have negative test results nonetheless. (Such false negatives are a possibility with any laboratory test.) Further, a negative test result is never a guarantee that the individual will not become infected by HIV at some time in the future.

Positive test results indicate that the individual probably was infected with HIV or similar virus at some time in the past. Although certainty is not possible, it is likely the person who tests positive for HIV antibodies is currently infected and able to transmit the infection to others. (However, it is also possible that the individual has recovered from HIV and is not

currently infectious.) It cannot be predicted from the positive test results whether that person will develop ARC or AIDS at some time in the future. In an extremely small percentage of cases, false positive results are possible, meaning that the person has never actually been infected although the test indicates otherwise.

Since the antibody test does not necessarily indicate current infection, it is advisable to follow up on positive outcomes with a more specific secondary test, the Western Blot. This combination of tests is especially reliable in predicting current HIV infection for people who have engaged in high risk behaviors since 1977.

In spite of the uncertainties which surround the results, it is usually desireable to administer the HIV antibody test to obtain information which will influence important decisions. For example, people who are relatively certain they are not generally at risk for AIDS may want reassurances because of a single or rare prior sexual experience (including rape), a blood transfusion or organ transplant, or accidental exposure such as a puncture by a contaminated needle or knife. Secondly, people at risk who are considering pregnancy should be tested to ascertain their antibody status and seek medical advice since the disease can be passed from mother to fetus. Finally, when people are exhibiting symptoms of ARC or AIDS, testing is helpful to diagnosis.

Because of the seronegative period in the disease's progression, testing should be done in series as long as negative results are obtained. Specifically, an antibody test should be done immediately after an incident which raises the possibility of HIV infection (such as rape, needle stick accident, etc.). As long as there are negative results, the test should be repeated after six weeks, three months, and six months. Any positive result should be followed by a Western Blot test. (While each HIV antibody test costs only about $6.00, the Western Blot test costs about $70.00.)

DISCUSSION

The best available scientific information indicates that AIDS is transmitted through exchange of internal body fluids (blood and semen) in intimate sexual relations or activities engaged in by a small subgroup of IV drug users. These behaviors do not occur during the regular conduct of probation supervision. Since the risk of transmission at the work place is very low, few change in probation policies are warranted.

While there is no reason to make extraordinary modifications in procedures, any risk at all is a cause for concern given the fact that AIDS is almost always fatal. Probation administrators must take prudent action to develop policies consistent with the best scientific knowledge, agency priorities and social conscience. A prominent researcher has noted..."right now, our only tools [for controlling AIDS] are education and behavior change."[5]

Probation's response to the challenge of AIDS must balance several competing interests, all compelling in their own right. The safety of staff must be protected by reducing the risk of exposure. The rights of the person with AIDS to services and to a degree of dignity must be protected. Persons with AIDS could easily become social outcasts. The rights of society to enforcement of court orders and protection through supervision cannot be forgotten.

Because of the long incubation period for AIDS, infected persons are able to carry and transmit the virus without themselves showing symptoms. Those who have contracted the disease or carry the virus may remain quite able to continue behavior associated with transmission for some time. If they still use intravenous drugs and probation does not take appropriate steps to stop them, probation is not only remiss in its duty but indirectly contributes to the spread of the disease. In that regard, probation is obligated to work toward assuring the discontinuation of intravenous drugs use.

Probation also has a role to educate persons under its supervision about AIDS and high risk behavior and to locate and make available the appropriate services for infected probationers. Historically, probation has located and provided services for those in much less severe need. The person with AIDS is an individual in the most desperate need. Probation has a moral obligation to respond.

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5 Dr. Harold Jaffe of the Centers for Disease Control, addressing a NIC-sponsored meeting of correctional administrators, November 6, 1985.

RECOMMENDED STRATEGY TO RESPOND TO AIDS

Probation's response to AIDS includes procedural changes and education. Modified supervision policies for infected probationers and training for staff are designed to achieve safety without sacrificing the integrity of supervision.

Training

Staff training will educate probation personnel about the disease and reduce the level of fear and anxiety which exists. In turn, probation staff will be able to provide accurate information to others, including probationers and court personnel.

The New Jersey Department of Health has been providing training about AIDS for some time and has maintained the most up to date information. In order to provide quality training in a timely fashion, the AOC Training Unit has utilized trainers from the Department of Health to conduct sessions for probation staff.

The AOC Training Unit staff will maintain a liaison with staff of the Department of Health to monitor developments in this area, and provide additional training and/or information as it becomes appropriate.

Verification and Medical Treatment

A probation staff member may learn of AIDS infection from a probationer or other reliable source. Those with AIDS will probably be getting medical treatment. Therefore, the simplest and most reliable way of verifying an HIV infection is through the medical provider who informed the probationer of the infection, e.g., the doctor, clinic, the HIV antibody testing site, etc.

The medical provider should be contacted in writing, either directly or by having the probationer hand-carry a written request for information, to verify an AIDS diagnosis or other stage of HIV infection. The provider should respond in writing on letterhead or prescription form. Because of the highly confidential nature of this information, the first step must be to have the probationer sign a specific records release authorization, a copy of which would accompany any written communication to the medical provider. (Having the probationer hand-carry such a request may expedite matters by allowing the provider to receive personal verification of permission to release the information.)

If this process is unsuccessful, for whatever reason, and the HIV infection reported by the probationer or some other source is still suspected, then an HIV antibody test should be considered as an alternative means to verify infection. The need for

an HIV antibody test should be carefully discussed with the probationer. Information should be provided about the potential for discriminatory use of test results should they become known, for example, in the insurance and housing markets. (New Jersey has no state law safeguarding against such discrimination.) Then a referral should be made to either a state-funded counselling and testing site where confidentiality is strictly guarded, or to another medical provider mutually agreed upon, where confidentiality may or may not be securely preserved. (See Appendix C for a listing.)

If a probationer is reluctant or refuses to submit to antibody testing, the probation staff should make every effort to convince the probationer of the need for testing for personal and public health reasons. Should these efforts fail to persuade the probationer, the case should be referred to the sentencing judge for action in obtaining cooperation.

If probationers with HIV infection are not getting adequate medical treatment, probation staff should encourage them to do so and assist with referrals to appropriate facilities. (See Physicians' Referral List in Appendix C.) This is very important because life-threatening symptoms can develop very quickly. If the probationer's permission is given, medical personnel may be able to provide information to the probation staff which will assist in supervision.

Confidentiality

Persons with AIDS, ARC, or HIV infection run a significant risk of becoming social outcasts. Probation staff should exercise caution in revealing information about infected persons. Normal restrictions apply, but the potentially damaging nature of this information requires careful exercise of discretion. Therefore, information on AIDS infection should be revealed only to those individuals who absolutely must know to effect successful supervision.

Urine Monitoring

Screening for drug use gains importance due to the high risk of transmission of the virus through sharing of needles. Probation staff involved with urine monitoring should follow the procedures developed for use by the Centers for Disease Control, as adopted by the state Intensive Supervision Program. (See Appendix D.) THESE PROCEDURES SHOULD BE FOLLOWED FOR ALL URINE SPECIMENS BECAUSE THEY ARE EFFECTIVE CONTROLS FOR ANY COMMUNICABLE DISEASE. (See also Appendix E.)

Education

With the overlap of one high risk AIDS group (IV drug users) and the probation population, educational materials should be readily available in the probation offices including informational brochures and posters. Staff should be knowledgeable

about AIDS, but when they are unable to answer probationers' specific questions, referral should be made to the New Jersey AIDS Hotline (1-800-624-2377) or other reliable sources listed in Appendix F.

Supervision

Policy Statement

The probation departments and their employees shall provide supervision and services to all persons placed under their jurisdiction by the courts, despite a suspected or confirmed diagnosis of AIDS or HIV infections.

Probation supervision activities should not be eliminated in the face of AIDS, but some modifications may need to be incorporated into standard operating procedures on a case-by-case basis.

Supervision Contacts

Probation staff should continue to provide supervision to persons verified to be HIV infected. If an HIV infected person's medical condition would rule out or prevent benefiting from a face-to-face personal contact (e.g., probationer is bedridden or hospitalized due to secondary illness), collateral contacts should be an option.

Testing

A variety of questions remaining about HIV antibody testing lend themselves to resolution through policy promulgation by the courts. These issues include the following.

...Can the courts compel testing?
...If so, should they?
...For whom?
...Where should testing be done?
...Who should pay for it?

Probation officers and other appropriate judicial employees need to be trained about the advantages and disadvantages of testing. They should also be given the skills and sensitivity needed to counsel probationers on this subject and the knowledge of where to refer for testing and counseling.

Although there is no known cure for AIDS, testing is still advisable for a number of reasons. If the individual to be tested does not have AIDS, the test can provide reassurances. The results are not foolproof, but they are accurate enough to relieve some of the fear and anxiety associated with the disease. On the other hand, if positive test results are found, certain medications may be beneficial while new ones could be discovered at any time. Also, modifications of certain behaviors may slow the progress of the disease or help

to prevent the onset of opportunistic infections. Equally important, changes in habits or life styles could help significantly in limiting the spread of infection to others. (See Appendixes G and H.)

The most reasonable stance to take on this issue seems to be an avoidance of wholesale testing in favor of a selective approach based on individual case circumstances. One important criterion should be to conduct tests whenever an individual is put at risk by another person's actions. In such cases as rape or other type of assault where the possibility of infection is present, testing should be done on the perpetrator if at all possible and the results shared with the victim if that person wants to know them. If for any reason the perpetrator cannot be tested, then the victim should be counseled about the advisability of being tested.

RESOURCES

This document draws heavily on the work on AIDS sponsored by the National Institute of Justice (NIJ) and the National Academy of Sciences (NAS). The NIJ reports are available from the National Criminal Justice Reference Service (1-800-851-3420). The remaining documents are available from the publishers.

1.) Gong, Victor, M.D. and Norman Rudnick, eds. AIDS: Facts and Issues. New Brunswick: Rutgers University Press, 1987.

2.) Hammett, Theodore M. AIDS in Prisons and Jails: Issues and Options (Research in Brief). Washington, D.C.: National Institute of Justice. February 1986.

3.) Hammett, Theodore M. AIDS in Correctional Facilities: Issues and Options (Full Report) Washington, D.C.: National Institute of Justice. April 1986. NCJ-100126.

4.) Institute of Medicine, National Academy of Sciences. Confronting AIDS. Washington, D.C.: National Academy Press, 1986.

5.) Institute of Medicine, National Academy of Sciences. Mobilizing Against AIDS. Cambridge: Harvard University Press, 1986.

6.) U.S. Department of Health and Human Services. Surgeon General's Report on Acquired Immune Deficiency Syndrome. Washington, D. C. 1986.

The resource list from the full report by Hammett is included in Appendix G. The Research in Brief is included in Appendix B.

APPENDICES

A. Department of Health Statistics

B. AIDS in Prisons and Jails: Issues and Options

C. Questions and Answers About the HTLV-III Antibody Test

D. Physician Referral List

E. ISP Urine Collection Protocol

F. Guidelines for Handling Body Fluids

G. Resource List

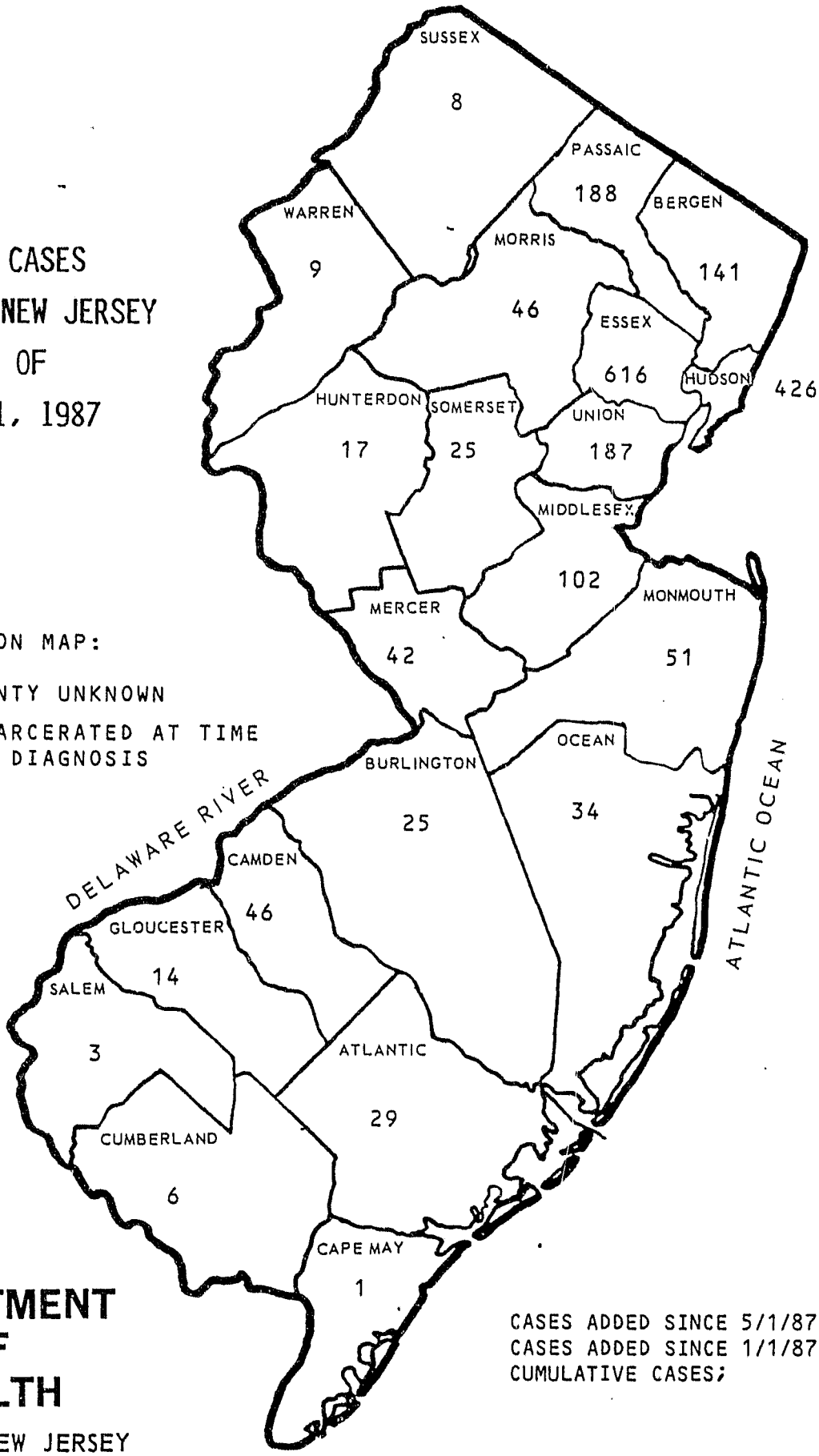
H. Infection Precautions

I. Recommendations for Preventing Transmission of Infections

J. Department of Health Information Clearinghouses

APPENDIX A

AIDS CASES
STATE OF NEW JERSEY
AS OF
JUNE 1, 1987



NOT INCLUDED ON MAP:

8 CASES COUNTY UNKNOWN

149 CASES INCARCERATED AT TIME OF AIDS DIAGNOSIS

	NJ	US
CASES ADDED SINCE 5/1/87:	60	1256
CASES ADDED SINCE 1/1/87:	426	6765
CUMULATIVE CASES;	2173	35769

DEPARTMENT OF HEALTH

STATE OF NEW JERSEY

CASES OF AIDS BY TRANSMISSION CATEGORY REPORTED TO CENTERS FOR DISEASE CONTROL (CDC)
AS OF MAY 18, 1987 AND THE NEW JERSEY STATE HEALTH DEPARTMENT AS OF JUNE 1, 1987

TRANSMISSION CATEGORIES[1]	ADULT/ADOLESCENT											
	MALES				FEMALES				TOTAL			
	U.S.	(%)	N.J.	(%)	U.S.	(%)	N.J.	(%)	U.S.	(%)	N.J.	(%)
Homosexual/Bisexual Male	23174	(71)	707	(40)	0	(0)	0	(0)	23174	(66)	707	(34)
Intravenous Drug Abuser (IVDA)	4660	(14)	769	(44)	1218	(50)	215	(61)	5878	(17)	984	(47)
Homosexual Male and IVDA	2673	(8)	122	(7)	0	(0)	0	(0)	2673	(8)	122	(6)
Hemophilia/Coagulation Disorder	318	(1)	22	(1)	8	(0)	0	(0)	326	(1)	22	(1)
Heterosexual Cases[2]	661	(2)	51	(3)	704	(29)	97	(28)	1365	(4)	148	(7)
Tranfusion, Blood/Components	455	(1)	28	(2)	256	(11)	17	(5)	711	(2)	45	(2)
None of the Above	892	(3)	51	(3)	249	(10)	22	(6)	1141	(3)	73	(3)
Sub-Total	32833	(100)	1750	(100)	2435	(100)	351	(100)	35268	(100)	2101	(100)

	CHILDREN[3]											
	MALES				FEMALES				TOTAL			
	U.S.	(%)	N.J.	(%)	U.S.	(%)	N.J.	(%)	U.S.	(%)	N.J.	(%)
Hemophilia/Coagulation Disorder	23	(8)	3	(7)	2	(1)	0	(0)	25	(5)	3	(4)
Parent With/At Risk of AIDS[4]	200	(73)	36	(84)	194	(86)	27	(93)	394	(79)	63	(88)
Tranfusion, Blood/Components	40	(15)	3	(7)	21	(9)	2	(7)	61	(12)	5	(7)
None of the Above	12	(4)	1	(2)	9	(4)	0	(0)	21	(4)	1	(1)
Sub-Total	275	(100)	43	(100)	226	(100)	29	(100)	501	(100)	72	(100)
TOTAL	33108		1793		2661		380		35769		2173	

1 Cases with more than one risk factor other than the combinations listed in the tables or footnotes are tabulated only in the group listed first.

2 Includes 109 persons (18 men, 91 women) who have had heterosexual contact with a person with AIDS or at risk for AIDS and 39 persons (33 men, 6 women) without other identified risks who were born in countries in which heterosexual transmission is believed to play a major role although precise means of transmission have not yet been fully defined.

3 Includes all patients under 13 years of age of time of diagnosis

4 Epidemiologic data suggest transmission from an infected mother to her fetus or infant during the perinatal period.

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS),
KAPOSI'S SARCOMA (KS), PNEUMOCYSTIS CARINII PNEUMONIA (PCP)
AND OTHER OPPORTUNISTIC INFECTIONS (OI)
CASES REPORTED TO CENTERS FOR DISEASE CONTROL (CDC)
AS OF MAY 18, 1987 AND NEW JERSEY STATE HEALTH DEPARTMENT
AS OF JUNE 1, 1987

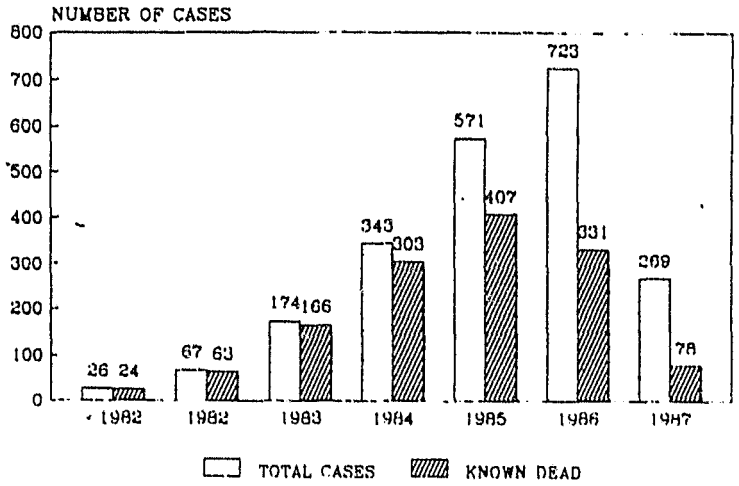
	TOTAL CASES				KNOWN DEATHS			
	U.S.	(%)	N.J.	(%)	U.S.	(%) (DEAD)	N.J.	(%) (DEAD)
PCP	23143	(65)	1409	(65)	13534	(58)	898	(64)
OI WITHOUT KS OR PCP	8056	(23)	601	(28)	5044	(63)	378	(63)
KS	4570	(13)	163	(8)	2105	(46)	96	(59)
TOTAL	35769	(100)	2173	(100)	20683	(58)	1372	(63)

RACIAL/ETHNIC DISTRIBUTION OF AIDS CASES
REPORTED TO CDC AS OF MAY 18, 1987 AND THE NEW JERSEY
STATE HEALTH DEPARTMENT AS OF JUNE 1, 1987

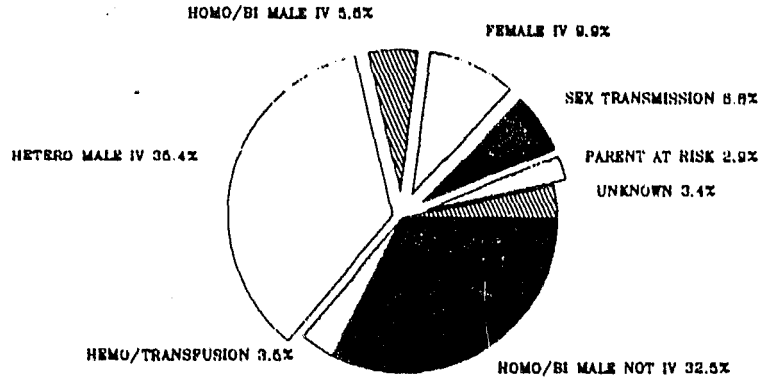
RACIAL/ETHNIC GROUP	ADULT/ADOLESCENT				CHILDREN*				TOTAL			
	U.S.	(%)	N.J.	(%)	U.S.	(%)	N.J.	(%)	U.S.	(%)	N.J.	(%)
WHITE, NOT HISPANIC	21446	(61)	815	(39)	100	(20)	15	(21)	21546	(60)	830	(38)
BLACK, NOT HISPANIC	8566	(24)	1012	(48)	276	(55)	44	(61)	8842	(25)	1056	(49)
HISPANIC	4911	(14)	268	(13)	122	(24)	13	(18)	5033	(14)	281	(13)
OTHERS & UNKNOWN	345	(1)	6	(0)	3	(1)	0	(0)	348	(1)	6	(0)
TOTAL	35268	(100)	2101	(100)	501	(100)	72	(100)	35769	(100)	2173	(100)

* Includes all patients under 13 years of age at time of diagnosis.

NEW JERSEY AIDS CASES
BY YEAR OF DIAGNOSIS AS OF 6/1/87



NEW JERSEY AIDS CASES
BY RISK FACTOR AS OF 6/1/87



AGE AT DIAGNOSIS OF AIDS CASES REPORTED TO CDC
AS OF MAY 18, 1987 AND THE NEW JERSEY STATE HEALTH DEPARTMENT
AS OF JUNE 1, 1987

AGE GROUP	U.S. NO.	U.S. (%)	N.J. NO.	N.J. (%)
UNDER-5 YEARS	442	(1)	62	(3)
5 - 12	59	(0)	10	(0)
13 - 19	144	(0)	10	(0)
20 - 29	7519	(21)	487	(22)
30 - 39	16692	(47)	1089	(50)
40 - 49	7401	(21)	337	(16)
OVER 49	3512	(10)	178	(8)
TOTAL	35769	(100)	2173	(100)

AIDS CASES BY STATE OF RESIDENCE AND DATE OF REPORT TO CDC - As of May 18, 1987

CUMULATIVE TOTAL SINCE JUNE 1981

STATE OF RESIDENCE	Adult/Adolescent Number	Adult/Adolescent Percent	Children Number	Children Percent	Total Number	Total Percent
New York	10506	29.8%	184	36.7%	10690	29.9%
California	7939	22.5%	30	6.0%	7969	22.3%
Florida	2340	6.6%	60	12.0%	2400	6.7%
Texas	2286	6.5%	14	2.8%	2300	6.4%
New Jersey	2076	5.9%	68	13.6%	2144	6.0%
Illinois	903	2.6%	11	2.2%	914	2.6%
Pennsylvania	817	2.3%	9	1.8%	826	2.3%
Massachusetts	744	2.1%	12	2.4%	756	2.1%
Georgia	720	2.0%	11	2.2%	731	2.0%
District of Columb	650	1.8%	8	1.6%	658	1.8%
Maryland	557	1.6%	9	1.8%	566	1.6%
Washington	454	1.3%	1	0.2%	455	1.3%
Louisiana	418	1.2%	6	1.2%	424	1.2%
Connecticut	401	1.1%	14	2.8%	415	1.2%
Virginia	398	1.1%	6	1.2%	404	1.1%
Colorado	365	1.0%	2	0.4%	367	1.0%
Puerto Rico	339	1.0%	21	4.2%	360	1.0%
Ohio	350	1.0%	2	0.4%	352	1.0%
Remainder of U.S.	3005	8.5%	33	6.6%	3038	8.5%
TOTAL	35268	100.0%	501	100.0%	35769	100.0%

CASES OF AIDS IN THE U.S. PER MILLION POPULATION IN THE TEN METROPOLITAN AREAS OF RESIDENCE WITH THE HIGHEST RATES AND AT LEAST 10 CASES (FROM CDC REPORT, MAY 11, 1987)

OBS	SMSA	CASES	POP	RATE	ADULTS	KIDS	PERCENT KIDS
1	NEW YORK CITY	9722	9120046	1065.97	9552	170	1.7%
2	SAN FRANCISCO	3404	3250630	1047.18	3399	5	0.1%
3	JERSEY CITY	416	556972	746.90	409	7	1.7%
4	MIAMI	1043	1625781	641.54	1006	37	3.5%
5	NEWARK, NJ	853	1965969	433.88	815	38	4.5%
6	LOS ANGELES	3106	7477503	415.38	3089	17	0.5%
7	FT LAUDERDALE	422	1018200	414.46	416	6	1.4%
8	PATERSON	181	447585	404.39	171	10	5.5%
9	HOUSTON	1134	2905353	390.31	1126	8	0.7%
10	WASHINGTON DC	1039	3060922	339.44	1029	10	1.0%

P9140

NEW JERSEY STATE
DEPARTMENT OF HEALTH
CN 360
TRENTON, N.J. 08625-0360

APPENDIX B

U.S. Department of Justice
National Institute of Justice

NIJ

National Institute of Justice / Research in Brief

February 1986

AIDS in Prisons and Jails:
Issues and Options

The study summarizes the latest medical information on AIDS, presents statistics on the incidence of AIDS in correctional facilities, and enumerates the key issues and options facing correctional administrators as they formulate policy responses to this complex problem. This Research in Brief summarizes the major findings and conclusions of that report.

Cause and transmission of AIDS

AIDS is a serious communicable disease that undermines the human body's ability to combat infections. In 1983 and 1984, the probable cause of AIDS—variously called human t-cell lymphotropic virus type III (HTLV-III) and lymphadenopathy-associated virus (LAV)—was identified. Thus far, most cases in the United States have been among homosexuals and intravenous drug abusers, with cases primarily concentrated in large metropolitan areas on the east and west coasts.

End-stage AIDS is almost always fatal. However, a range of milder forms of illness, sometimes called AIDS-Related Complex (ARC), may also appear among those infected with the AIDS virus.

Infection with HTLV-III is transmitted through contaminated blood and semen, primarily during sexual activity and needle-sharing related to intravenous drug abuse. The virus is difficult to transmit and there is absolutely no evidence of its transmission through casual contact, such as coughing, hugging, handshaking, sharing eating and drinking utensils, or using the same toilet facilities.

In 1985, a test was developed and made widely available to detect the presence of antibodies (evidence of the body's attempt to fight off an infection) to HTLV-III. While the test does not detect the presence of the virus itself, seropositivity (i.e, presence of antibodies) means that an individual has been infected with the AIDS virus at some time, although the body may have subsequently fought off the infection.

The likelihood that HTLV-III seropositivity means current infection with the virus is considered much greater for individuals in identified AIDS risk groups (e.g., homosexual or bisexual males, intravenous drug abusers). Nevertheless, seropositive individuals may never develop any symptoms, let alone develop end-stage AIDS.

Currently, the Centers for Disease Control (CDC) estimate that 5 to 6 percent of seropositive individuals will develop end-stage AIDS while another 25 percent will develop ARC. However, recent research suggests that the percentage of seropositive individuals who will develop AIDS may be somewhat higher. Moreover, CDC cautions that seropositive individuals may be able to transmit the infection to others, even if they never develop symptoms themselves. Exhibit 1 summarizes the relationships among exposure, infection, seropositivity, ARC, and AIDS.

AIDS in the correctional population

Responses to the study questionnaire reveal that, since 1981, there have been a cumulative total of 455 confirmed AIDS cases in 25 State and Federal prison systems. Twenty large city and county jail systems reported 311 cases of AIDS among inmates. These figures represent *cumulative* total cases since the responding jurisdictions began keeping records.

As of the period November 1985 to January 1986, there were 144 cases of

Exhibit 1

Relationships among exposure, infection, HTLV-III seropositivity, and development of ARC or AIDS

Stage	Meaning	Relationship to previous stage(s)
Exposure	Individual has contact with HTLV-III in a way that makes transmission possible (e.g., sexual contact or needle-sharing activity)	—
Infection	Individual is infected with HTLV-III. Infection may be permanent or body may successfully combat the virus.	Unknown, although multiple exposures probably increase the risk of infection.
Seropositivity	Individual has antibodies to HTLV-III. Infection has occurred at some time in the past, but date of infection or whether individual remains infected cannot be determined.	CDC considers the HTLV-III antibody test a reliable indicator that infection has occurred at some time. Repeat and confirmatory testing increase reliability.
ARC	A combination of conditions that together give evidence of infection with AIDS virus.	About 25 percent of seropositive individuals will probably develop ARC (CDC estimate). This estimate is uncertain due to the lengthy incubation period.
AIDS	Illness characterized by one or more opportunistic infections at least moderately indicative of underlying cellular immunodeficiency.	About 5 to 6 percent of seropositive individuals will probably develop AIDS. (CDC estimate). Recent studies place the fraction as high as one-third. Again, all estimates are uncertain due to the lengthy incubation period.

Opinions or points of view expressed in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

AIDS among State and Federal inmates in 19 systems and 35 cases among city and county inmates in 11 systems.

No known AIDS cases have occurred among correctional staff as a result of contact with inmates. Questionnaire respondents reported nine cases of AIDS among current or former staff, but none of these individuals had been involved in an incident with an inmate in which transmission of the AIDS virus might have occurred. Indeed, most were known or suspected to have been in AIDS risk groups.

The distribution of AIDS cases across correctional systems is highly skewed (Exhibit 2). Fifty-one percent of the prison systems have had *no* cases and 80 percent have had fewer than four cases. Among responding city and county jail systems, 39 percent have had no cases and 70 percent have had fewer than four cases.

At the other extreme, two State prison systems and only one of the responding city and county jail systems have had more than 50 cases. The regional distribution is also highly uneven. Over 70 percent of the cases, both in State prison systems and in city and county jail systems, have occurred in the mid-Atlantic region, with all other parts of the United States contributing much smaller percentages.

The vast majority of correctional AIDS cases, particularly in jurisdictions with large numbers of cases, are believed to be associated with prior intravenous drug abuse. There is substantial debate, but little hard data, on the extent to which the AIDS virus is being transmitted within correctional institutions. The two primary means of transmission are prohibited behavior in all corrections systems. However, logic and common sense suggest that, even in the best-managed correctional facilities, there may be at least some transmission of the infection occurring among inmates.

Correctional policy issues and options

The major policy areas involved in the correctional response to AIDS are education and training; HTLV-III antibody testing; and medical, legal, and correctional management issues.

Exhibit 2

Distribution of cumulative total AIDS cases among inmates, by type of system

Range of total AIDS cases	State/Federal prison systems				City/county jail systems			
	n systems	%	n cases	%	n systems	%	n cases	%
0	26	51%	0	0%	13	39%	0	0%
1-3	15	29	24	5	10	30	16	5
4-10	5	10	30	7	7	21	43	14
11-25	2	4	42	9	1	3	12	4
26-50	1	2	33	7	1	3	40	13
51-100	1	2	95	21	0	0	0	0
> 100	1	2	231	51	1	3	200	64
TOTAL	51	100%	455	100%	33	99%[a]	311	100%

Source: NIJ/ACA questionnaire responses

[a] Due to rounding

Education and training

Because there is no vaccine or cure for the disease, education and training programs are the cornerstone of efforts to curb the spread of AIDS in prisons and jails, as well as in the population at large. Education and training programs also provide the opportunity to counteract misinformation, rumors, and fear concerning the disease. For example, the majority of systems responding to the questionnaire reported that inmates and staff worried about the possibility of contracting AIDS; many responses referred to fear of casual contact or types of contact not actually associated with transmission of the virus.

As a result, many correctional administrators feel strongly that education and training are not options but absolute requirements. Ninety-three percent of the responding jurisdictions currently offer or are developing AIDS educational programs for staff; 83 percent offer or are developing such programs for inmates.

Among respondents whose educational programs have operated for some time, the vast majority believe these programs to be effective in reducing the fears of staff and inmates. Several jurisdictions reported that timely educational efforts had successfully averted threatened job actions by correctional staff unions.

Experience suggests that training and education programs should be instituted before deep-seated fears have developed, and repeated periodically so that the latest medical information can be presented and new staff and inmates can be reached on a timely basis.

Effective education programs may include live presentations by training teams, printed materials, and videotapes. Program curricula and materials should be brief, clear, and straightforward and tailored to the particular knowledge gaps and concerns of the audience. They should discuss the means of transmission of the AIDS virus and emphasize everyone's responsibility to avoid behaviors known to be associated with transmission. They should also guard against encouraging a false sense of security in

any group. At the same time, programs should not create needless fear by advocating unnecessary precautionary measures.

HTLV-III antibody testing

There is substantial debate, both in corrections and in society at large, surrounding the uses of the HTLV-III antibody test and the meaning of the test results. The most controversial testing application in corrections is mass screening: the testing of all inmates or all new inmates, regardless of the presence of symptoms or other clinical indications.

Correctional policies on HTLV-III antibody testing. Only four State correctional systems (Nevada, Colorado, Iowa, and Missouri) have implemented or plan to implement mass screening programs for inmates; no city or county systems responding to the questionnaire have instituted or planned such programs. However, almost 90 percent of the responding jurisdictions do employ testing for more limited purposes. These include testing of risk-group members, testing in support of diagnoses of AIDS or ARC, testing in response to incidents in which the AIDS virus might have been transmitted, testing on inmate request, and testing carried out as part of anonymous epidemiological studies. Exhibit 3 summarizes study findings on correctional testing policies.

Mass screening: the debate. The debate over mass screening for antibody to HTLV-III in correctional institutions involves the following major questions:

- *Should correctional systems take steps not being taken in the community at large?*

Proponents of testing argue that rates of HTLV-III seropositivity are higher among inmates and that the virus is likely to be transmitted within institutions; they believe that screening is necessary to identify infectious individuals and to target prevention programs.

Opponents argue that there is no proof of higher rates of HTLV-III transmission in prison and therefore there is no legitimate reason to screen.

Exhibit 3

Summary of responding jurisdictions' HTLV-III antibody testing policies for inmates[a]

Policy category	State/Federal prison systems		City/county jail systems	
	n	%	n	%
• Mass screening (all or all new inmates)	4	8%	0	0%
• Screening of risk groups	2	4	7	21
• Testing *only* for diagnoses, incident response, or epidemiological studies	39	77	20	61
• Testing *only* on inmate request	1	2	1	3
• No testing	5	10	5	15
TOTAL	51	101%[b]	33	100%

[a]Includes actual and planned policies. This is a hierarchical categorization. That is, jurisdictions that do mass screening are placed in that category, regardless of whether they also do testing for other purposes; jurisdictions that do screening of all members of at least some risk groups, but no mass screening, are placed in the "screening of risk groups" category regardless of whether they also do testing for diagnosis, incident response, or epidemiology studies.

[b]Due to rounding.

- *What are the policy implications of identifying seropositive individuals?*

Proponents of screening argue that seropositive individuals must be identified so they can be given special supervision, counseling, and other programming.

Opponents argue that mass identification of seropositives would serve no purposes not better addressed by educational programs and would, in fact, create significant correctional management problems—particularly if large numbers of seropositives were identified and there was irresistible pressure to segregate them.

- *How would mass screening affect education and prevention programs?*

Proponents argue that screening is necessary to inform and target education and prevention programs.

Opponents argue that screening needlessly and misleadingly divides the inmate population into a stigmatized class and a "safe" class, thereby undermining the important educational message that everyone should be careful.

- *Is it possible to develop a reliable and confidential screening program?*

Proponents argue that the antibody test is reliable and that confidentiality of results can be maintained.

Opponents argue that the test results are often unreliable and that real and rumored results would inevitably become known to the inmate population and others outside the institution, potentially subjecting actual or supposed seropositives to threats and intimidation while in prison and to discrimination in housing, employment, and insurability after discharge.

- *What are the legal implications of screening?*

Proponents argue that mass screening is legal and proper and, in fact, that failure to conduct mass screening may result in serious legal liabilities.

Opponents point out that laws and policies requiring subjects' informed consent for HTLV-III antibody testing preclude mandatory mass screening and suggest that liability issues can be effectively managed.

- *What are the costs of mass screening?*

Proponents of screening argue that the test can be economically administered.

Opponents argue that when the costs of repeat and confirmatory tests and the costs of separate correctional programming for seropositives are included, the total price could become prohibitive, particularly for large systems and/or those likely to identify large numbers of seropositive inmates.

- *Will mass screening allay or inflame fears?*

Proponents argue that screening could help to calm the concerns of inmates and staff if it found low rates of seropositivity. Moreover, regardless of the seropositivity rates, failure to screen could cause serious public relations problems.

Opponents argue that mass screening will needlessly inflame fears, particularly if the seropositivity rate is found to be high.

- *Are there feasible alternatives to screening?*

Proponents argue that screening is the best method of obtaining the necessary information on HTLV-III seropositivity and transmission.

Opponents argue that there are better ways to identify high-risk individuals and diagnose AIDS and ARC that avoid the negative consequences of mass screening. These include astute medical surveillance and alternative laboratory work for diagnoses.

In addition, anonymous epidemiological studies may permit estimation of HTLV-III seropositivity and transmission rates while avoiding the correctional management and confidentiality problems of mass screening.

Implementation issues. Correctional administrators who decide to implement any mass or selective testing program face a range of issues, including when and where to administer the test, and whether testing should be voluntary, mandatory, or on request.

In 60 percent of the responding jurisdictions, all testing is either voluntary or on inmate request. In 15 percent of the jurisdictions, all testing is mandatory.

There are serious legal and ethical issues involving both whether inmates can be compelled to submit to testing and whether they have a right to testing on request. Laws in some jurisdictions (e.g., California and Wisconsin) prohibit HTLV-III antibody testing without the informed consent of the subject.

Those who oppose mandatory testing argue that, because of the potentially serious negative effects of testing (e.g., discrimination in housing, employment, insurability), medical ethics require that there be a right of refusal, regardless of law or policy.

Some also argue that correctional systems have an obligation to provide the test to any or all inmates who request it. However, if such testing is provided, many physicians believe that inmates should be fully and accurately informed of the potential personal and psychological effects of testing before they make any decisions and that those who are tested be counseled on the meaning and implications of the results.

Medical, legal, and correctional management issues

Correctional administrators responding to the challenging problem of AIDS in prisons and jails must balance medical considerations and medical advice against complex correctional management factors. Decisionmaking is further complicated by legal and cost concerns. The following section discusses these issues.

Medical issues. Perhaps the highest priority in the correctional response to AIDS is providing timely, professional, and compassionate medical care to inmates who become ill with the disease. As in society at large, prompt detection and diagnosis are needed to minimize spread of the disease and alleviate the suffering of patients.

Whether or not HTLV-III testing is used, appropriate diagnostic workups are necessary to identify immunosuppression, ARC, and AIDS. Also, certain tests may be able to detect early evidence of opportunistic infections typically seen in AIDS patients.

Careful surveillance and regular followup are extremely important for patients with AIDS, ARC, and HTLV-III seropositivity, since life-threatening symptoms can develop very quickly. Because AIDS patients experience serious psychological as well as physical problems, counseling and support systems involving correctional staff and family members are also considered important components of care.

Correctional management issues. Ironically, the medical treatment of AIDS patients may be the simplest issue confronting correctional administrators. Other questions—where to house and treat the inmate, how to prevent the spread of the disease, and how to pay for medical care—are likely to be even more difficult to resolve.

Housing policies. One of the most critical and difficult decisions for correctional administrators is where to house and treat inmates with AIDS, ARC, or HTLV-III seropositivity. Of course, medical considerations dictate many of these decisions. Most jurisdictions place inmates with confirmed diagnoses of AIDS in a medical facility either within the correctional system or in the community, although the duration of such hospitalization varies considerably.

Preventing the spread of AIDS within the prison and protecting affected inmates from intimidation and violence are important considerations. Other factors in treatment and housing decisions include availability and location of facilities able to provide appropriate care, costs of any new construction or renovations necessary to prepare special units, and staffing of any special AIDS units (correctional as well as medical).

Correctional administrators have a number of options concerning treatment and housing placements for inmates with AIDS, ARC, or HTLV-III seropositivity. The key options are the following:

1. maintaining inmates in the general population;

2. returning inmates to the general population when their illnesses are in remission;

3. administratively segregating inmates in a separate unit or relying on single-cell housing;

4. hospitalization; and

5. case-by-case determination of all housing and treatment decisions.

Exhibit 4 summarizes the housing policies of the responding systems. Two-thirds of the Federal and State systems, and 70 percent of responding city and county systems have written policies in place or in development for managing inmates with AIDS, ARC, and HTLV-III seropositivity.

Most jurisdictions hospitalize or administratively segregate at least some of the three AIDS-related inmate categories.

City and county jurisdictions are more likely to use segregation: 39 percent of responding city and county jail systems segregate all three AIDS-related inmate categories, as opposed to only 16 percent of State and Federal prison systems. Almost one-third of all responding systems have basic policies involving case-by-case determination of treatment and housing programs.

While Exhibit 4 indicates the wide variation in correctional policies on housing and treatment of inmates with AIDS, the four jurisdictions with almost 75 percent of the correctional AIDS cases (New York State, New York City, New Jersey, and Florida) all follow the same combination of policies:

1. medical segregation of AIDS patients, but no segregation of inmates with ARC or HTLV-III seropositivity;

2. careful evaluation and ongoing monitoring of inmates suspected of having ARC or AIDS;

3. no mass screening for antibody to HTLV-III; and

4. extensive staff and inmate educational programs.

All four of these systems report that equilibrium has been reached on the AIDS issue, with no widespread fear among staff or inmates regarding transmission of the virus within the institutions.

Precautionary measures. Correctional agencies have adopted a wide range of precautionary measures to control spread of AIDS within institutions; many are based on Centers for Disease Control guidelines for clinical staff.[1] The CDC guidelines advise clinical and laboratory staff "to use the same precautions when caring for patients with AIDS as those used for patients with hepatitis-B virus infection...Specifically, patient-care and laboratory personnel should take precautions to avoid direct contact of skin or mucous membranes with blood, blood products, excretions, secretions, and tissues of persons judged likely to have AIDS."

Several physicians interviewed for this study believe that, since the AIDS virus is less hardy and more difficult to transmit than the hepatitis-B virus, precautions designed to prevent transmission of hepatitis-B should more than suffice to prevent transmission of AIDS.

Some correctional agencies have instituted precautionary measures which go far beyond those recommended by CDC. Many of these measures are designed to limit exposure under extremely unusual circumstances or to prevent exposure through casual contact. However, all evidence indicates that AIDS cannot be transmitted by a single exposure of any kind or through casual contact. This is a major theme in most AIDS education programs.

Precautionary measures addressing very rare or casual modes of contact, even if implemented in a good faith effort to reduce the fears of staff and inmates, may ultimately increase those fears by encouraging the view that the disease is spread by the very sort of unusual or casual contacts they seek to prevent. Such a conflict between educational messages and practical measures may not only increase fear within the institution, but also may foster suspicion of the correctional

Exhibit 4

Summary of responding jurisdictions' housing policies[a] for inmates with AIDS, ARC, and HTLV-III seropositivity

Policy combination	State/Federal prison systems		City/county jail systems	
	n	%	n	%
• Segregate AIDS cases; ARC cases and seropositives maintained in general population	3	6%	3	9%
• Segregate AIDS and ARC cases; seropositives maintained in general population	10	20	3	9
• Segregate all categories	8	16	13	41
• No segregation of any categories	2	4	0	0
• No policy	8	16	1	3
• Combinations involving case-by-case determination	16	31	10	30
• Other policy combinations	4	8	3	9
TOTAL	51	101%[b]	33	101%[b]

[a]For the purposes of this categorization, segregation means that the *basic* policy is to hospitalize (either within or outside the correctional system) or to segregate administratively the particular category of inmate, regardless of whether these inmates are returned to the general population when their symptoms subside. Single-celling is also included in segregation.

[b]Due to rounding.

[1]CDC, *Morbidity and Mortality Weekly Report* (*MMWR*) 1982; 31:577-580; see also *MMWR* 1985; 34: 681-695.

system for, in effect, saying one thing about the transmission of AIDS but doing something else.

Notification and confidentiality. One of the most difficult and sensitive issues regarding AIDS in corrections is who receives information on the medical status of inmates with AIDS, ARC, or HTLV-III seropositivity. Decisions regarding who should receive HTLV-III antibody test results and who should be notified of AIDS or ARC diagnoses may be dictated by precise legal and policy standards such as requirements for written authorization to release test results or other medical records.

Two-thirds of State and Federal prison systems and 91 percent of responding city and county jail systems have general or specific confidentiality policies covering AIDS-related medical information.

Some argue that decisions regarding disclosure versus confidentiality of medical information in cases of AIDS or ARC should be based solely on legal requirements—that is, no information should be reported to anyone unless it is required by law. This position is based on the premise that correctional systems should bear no greater responsibility for notification than do institutions in the community at large.

Where law or policy allows any discretion, decisions regarding disclosure versus confidentiality invariably raise the question of which should take precedence: the inmate's right to have medical information kept confidential or the correctional system's perceived legal and moral responsibility to protect its staff and other inmates, as well as the public, from HTLV-III infection.

There are valid claims on both sides. On the one hand are arguments that correctional staff have a right to know when they are dealing with inmates who may be infectious or who have a serious communicable disease, and that other inmates, spouses, or sexual partners have a right to know who may be carrying a sexually transmitted disease. Notification to public health departments and inmates' former and/or subsequent correctional systems may also be considered important to facilitate treatment, prevention measures, and contact tracing. Such disclosures may also be designed to reduce or eliminate the correctional system's legal liability should a released or transferred inmate transmit AIDS to others.

On the other hand, the most compelling reason for maintaining confidentiality is that persons known to have AIDS, ARC, or HTLV-III seropositivity may suffer ostracism, threats, and possibly violent intimidation while in prison, and discrimination in employment, housing, and insurance availability after they are discharged.

Because of their rapid population turnover rates, jails face even more difficult policy decisions and logistical problems regarding disclosure and confidentiality of medical information.

The most notable study finding regarding disclosure is that a relatively small number of systems provide test results to inmates (31 percent of State and Federal systems and 52 percent of responding city and county systems). No State or Federal system and a small fraction of city-county systems (19 percent) disclose results to inmates *only*. Seventy percent of State and Federal systems and 61 percent of responding city and county systems provide results to medical staff.

No jurisdictions responding to the questionnaire specifically reported that spouses or sexual partners or previous correctional facilities of seropositive inmates are notified of test results.

Costs of care and associated services. Questionnaire responses showed that correctional systems are almost universally concerned about the costs of medical care and associated services for inmates with AIDS. Questions regarding range of costs elicited widely varying estimates, but all agreed that medical care for AIDS patients is extremely expensive, whether it is provided in a correctional medical facility, in another public medical facility, or in a hospital in the community, particularly because correctional inmates are ineligible for Medicaid reimbursement.

Correctional systems should plan on spending anywhere from $40,000 to over $600,000 for hospitalization and associated medical costs of caring for each inmate with AIDS.[2] The costs will vary depending on the amount of acute care required; they will also probably be higher if inmates are placed in hospitals in the community than if they are retained in correctional medical facilities or other public medical facilities.

To the figures for hospitalization and medical care must be added costs of ancillary services such as counseling, possible legal assistance, increased insurance (unless the system is self-insured), and funerals. Obviously, medical care and associated services for inmates with AIDS could have serious budgetary implications for correctional systems.

Legal issues. There is currently very little law specifically on correctional systems' policies regarding AIDS cases, though several cases have been filed in New York and other States. Otherwise, specific AIDS-related legal concerns remain largely hypothetical. Still, there is substantial caselaw on correctional medical care in general, which is important for administrators to consider in developing policies regarding AIDS.

Suits on the quality of correctional medical care[3] may be brought on the basis of Federal constitutional standards, State law, or common law. There are three constitutional principles relevant to correctional medical care.

First, under the eighth amendment, inmates are entitled to a safe, decent, and humane environment.[4] Second, in *Estelle v. Gamble*,[5] "deliberate indifference to serious medical need" was held to violate the eighth amendment protection against "cruel and unusual punishment." Finally, the constitutional guarantee of "equal protection of the laws" applies to correctional medical care cases, and particularly to

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[2]The low figure is from "Special Report: The AIDS Epidemic," *New England Journal of Medicine* 1985; 312:523; the high figure is based on 2 years at New York City's annual estimate of $300,000 for patients requiring acute care.

[3]This discussion is based largely on the presentation of Clair Cripe, Esq., of the Federal Bureau of Prisons, at a meeting of Correctional Commissioners on AIDS, sponsored by the National Institute of Corrections, Atlanta, Georgia, November 6, 1985.

[4]See, e.g., *Rhodes v. Chapman*, 452 U.S. 337 (1981).

[5]429 U.S. 97 (1976).

cases involving AIDS inmates, because of the segregation issues.

Medical care in correctional institutions is usually governed by the same State laws (e.g., medical practice and nursing practice acts) that apply to care in the community at large. Finally, in some States, correctional medical care may be subject to suits for common law torts such as negligence. Medical malpractice suits are also a possibility.

Existing caselaw on AIDS in correctional facilities falls into the following three major categories:

*1. **Equal protection.*** Cases filed by inmates alleging denial of equal protection based solely on the fact that they had AIDS (e.g., *Cordero v. Coughlin*).[6] This case was decided in favor of the correctional department.

*2. **Quality of care.*** Cases filed by inmates alleging inadequacies in medical care and associated services (e.g., *Storms v. Coughlin*).[7]

*3. **Failure to protect others from AIDS.*** Cases filed by inmates and potentially also by staff alleging inadequate protective measures and seeking additional steps such as mass screening of inmates and segregation of inmates with AIDS, ARC, or HTLV-III seropositivity (e.g., *Mtr La Rocca v. Dalsheim*).[8] The *La Rocca* case was decided in favor of the correctional department; other cases on these issues are still pending.

AIDS poses complex and difficult problems for correctional systems. The only certainty is that the problems will not disappear. Every correctional system should develop comprehensive policies and procedures for managing the AIDS problem in its institutions. The information provided here and in the full report can help correctional administrators consider the range of options available and the strengths and weaknesses of each.

Theodore M. Hammett was project director for Abt Associates, Inc., in the urgent 4-month study that led to this condensed report. To learn about availability of the full report, call the National Institute of Justice/ NCJRS at 800–851–3420 and give the title and identifying number, NCJ 100126. (From Alaska, Maryland, and the Metropolitan Washington, D.C., area, call 301–251–5500.)

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[6] 607 F Supp 9 (S.D.N.Y., 1984)

[7] *Storms v. Coughlin* was filed in U.S. District Court for the Southern District of New York. Some of the issues may be mooted by new State regulations, but the plaintiff's attorney believes that there are a number of important quality-of-care issues to litigate. See also *Thagard v. County of Cook*, unreported opinion: No. 85 C 4429 (N.D. Ill., May 20, 1985).

[8] 120 Misc 2d [illegible] (N.Y. 1983). See also *Herring v. Keeney* (U.S.D.C., Oregon, filed September 17, 1985); *Sheppard v. Keeney* (U.S.D.C., Oregon, filed October 7, 1985); *Malport v. Keeney* (U.S.D.C., Oregon, filed October 11, 1985); *Telepo et al. v. Kean et al.* Civil Action 85-1742A(U.S.D.C., New Jersey, filed May 1985).

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APPENDIX C

PHYSICIAN REFERRAL LIST

Sparticus Bellomo, M.D.
330 Clinton Street
Hoboken, NJ
201-656-7824

Roger Cooper, M.D.
St. Michael's Medical Center
306 Martin Luther King Blvd.
Newark, NJ 07102
201-877-5000

Allen Lin Greenberg, M.D.
c/o Department of Medicine
Jersey City Medical Center
50 Baldwin Avenue
Jersey City, NJ 07304
201-451-9800

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Old Marlton Pike Medical Building
16 West Main Street
Marlton, NJ 08054
609-723-4221, x228

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185 Central Avenue
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201-675-8545

Albert Klainer, M.D.
Morristown Memorial Hospital
100 Madison Avenue
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201-540-5136

Steven Manocchio, M.D.
330 Clinton Street
Hoboken, NJ
201-656-7824

John R. Middleton, M.D.
Raritan Bay Medical Center
530 New Brunswick Avenue
Perth Amboy, NJ 08861
201-442-3700

Anthony Minnefor, M.D.
St. Joseph's Hospital & Medical Center
703 Main Street
Paterson, NJ 07503
201-977-2000

James Oleske, M.D.
Department of Pediatrics
UMDNJ-NJMS
Medical Sciences Building F-532
100 Bergen Street
Newark, NJ 07103
201-456-5066

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Room I-248 - 100 Bergen St.
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201-456-6076

Philip Paparone, M.D.
Atlantic City Medical Center
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609-344-4081

Richard Porwancher, M.D.
St. Francis Medical Center
601 Hamilton Avenue
Trenton, NJ 08629
609-599-5000

Purnendu Sen, M.D.
Jersey Shore Medical Center
1945 Corlies Avenue
Neptune, NJ 07753
201-775-5500

John S. Salaki, M.D.
60 Franklin St.
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201-676-1000, x532

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Jeremias Murillo, M.D.
Beth Israel Medical Center
201 Lyons Avenue
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201-926-7000

Melvin Weinstein, M.D.
Middlesex General University Hospital
180 Somerset Street
New Brunswick, NJ 08903
201-828-3000

Steven Wrigley, M.D.
Atlantic City Medical Center
1925 Pacific Avenue
Atlantic City, NJ 08406
609-344-4081, Beeper 701

AIDS
Alternate Test Sites
And Clinic Hours

Saint Michaels Hospital
Infectious Disease Department
306 Martin Luther King Blvd.
Newark, NJ 07102
(201) 877-5525

Tues. (9-12 noon)
Thurs. (1- 4 pm)

Ms. Elena Perez

Jersey City Medical Center
50 Baldwin Ave.
Jersey City, NJ 07304
(201) 451-9800

Wed. (9-12 noon)
Thurs. (9-12 noon)

Mrs. Gail Cook, R.N.

Middlesex General University Hospital
Ambulatory Care Services
180 Somerset Street
New Brunswick, NJ 08901
(201) 828-3000

Mon. (4:30-7pm)
Wed. (4:30-7pm)

Doris Connolly, R.N.

Sencit-Baltic Family Practice Ce .er
Atlantic City Health Department
1325 Baltic Ave., Corner Tennessee
Atlantic City, NJ 08401
(609) 347-5200
Wed. (8:30-11:00 am)
Fri. (8:30-11:00 am)

Marilyn Budd, R.N.
Pat Dorsa, R.N.

P7792

APPENDIX D

ADMINISTRATIVE OFFICE OF THE COURTS

Intensive Supervision Program

Protocol for Collection of Urine Specimens

Urine specimens should be collected and stored according to the following instructions to insure that direct contact with any specimen does not occur or is limited.

1. All urine specimens should be collected in the approved paraphernalia (consisting of specimen bottle, cap, plastic bag) supplied by ISP.

2. When obtaining a urine specimen, ISP personnel shall hand the participant the plastic bottle with cap.

3. Participant shall be instructed to void specimen into the plastic bottle, securely cap it and thereupon place it in the plastic bag and secure or optionally return it to the officer to secure it in the bag.

4. Under all circumstances, ISP personnel shall wear disposable plastic gloves while handling any urine specimens even when enclosed in the plastic bag. Gloves shall be disposed of immediately after use.

5. Upon receipt of the specimen, it should be placed in a secured container until it is brought to the regional office for transfer to a central holding cooler until retrieved by the laboratory courier.

6. Urine specimens must be retained under control of ISP staff at all times to preserve the chain of evidence and avoid any opportunities for tampering. In the field, the specimens must be kept in a container in the officers' locked vehicle. At a group community service work site, specimens must be secured by being kept in officers' locked vehicle. Specimens cannot be left unattended at any time. In regional office, specimens must be kept in a locked cooler or refrigerator until retrieved by lab courier.

APPENDIX E

Appendix E

This appendix describes information on handling body fluids in a safe manner. It was prepared for a school setting, but is applicable to probation. The work of the New Jersey Department of Health and the Connecticut Department of Health Services and Education is acknowledged by this inclusion of their work.

ADAPTED FROM: STATE OF CONNECTICUT, DEPARTMENTS OF EDUCATION AND HEALTH SERVICES

GUIDELINES FOR HANDLING BODY FLUIDS IN SCHOOLS

Recent concern about how children with AIDS should be educated has raised several questions regarding exposure of teachers and children to potentially infectious body fluids from children with communicable diseases in the school setting:

1. Does contact with body fluids present a risk of infection?

2. What should be done to avoid contact with potentially infected body fluids?

3. What should be done if direct contact with body fluids is made?

4. How should such fluids when spilled be removed from the environment?

The following guidelines are meant to provide simple and effective precautions against transmission of disease for all persons, including pregnant women, potentially exposed to the blood or body fluids of any student. No distinction is made between body fluids from students with a known disease or those from students without symptoms or with an undiagnosed disease.

DOES CONTACT WITH BODY FLUIDS PRESENT A RISK?

The body fluids of all persons should be considered to contain potentially infectious agents (germs). The term "body fluids" includes: blood, semen, drainage from scrapes and cuts, feces, urine, vomitus, respiratory secretions (e.g., nasal discharge) and saliva. Contact with body fluids presents a risk of infection with a variety of germs. In general, however, the risk is very low and dependent on a variety of factors including the type of fluid with which contact is made and the type of contact made with it.

Table 1 provides examples of particular germs that may occur in body fluids of children. It must be emphasized that with the exception of blood, which is normally sterile, the body fluids with which one may come in contact usually contain many organisms, some of which may cause disease. Furthermore, many germs may be carried by individuals who have no symptoms of illness. These individuals may be at various stages of infection: incubating disease, mildly infected without symptoms, or chronic carriers of certain infectious agents including the AIDS and hepatitis viruses. In fact, transmission of communicable diseases is more likely to occur from contact with infected body fluids of unrecognized carriers than from contact with fluids from recognized individuals because simple precautions are not always carried out.

TABLE 1
TRANSMISSION CONCERNS IN THE SCHOOL SETTING
BODY FLUID SOURCE OF INFECTIOUS AGENTS

BODY FLUID-SOURCE	ORGANISM OF CONCERN
Blood -cuts/abrasions -nosebleeds -menses -contaminated needle	Hepatitis B. virus AIDS virus Cytomegalovirus
Feces -incontinence	Salmonella bacteria Shigella bacteria Rotavirus Hepatitis A virus
Urine -incontinence	Cytomegalovirus
Respiratory Secretions -saliva -nasal discharge	Mononucleosis virus Common cold virus Influenza AIDS virus Hepatitis B virus
Vomitus	Gastrointestinal viruses, e.g., (Norwalk agent Rotavirus)
Semen	Hepatitis B AIDS virus Gonorrhea

WHAT SHOULD BE DONE TO AVOID CONTACT WITH BODY FLUIDS?

When possible, direct skin contact with body fluids should be avoided. Disposable gloves should be available in at least the office of the custodian, nurse, or principal. Gloves are recommended when direct hand contact with body fluids is anticipated (e.g., treating bloody noses, handling clothes soiled by incontinence, cleaning small spills by hand). If extensive contact is made with body fluids, hands should be washed afterwards. Gloves used for this purpose should be put in a plastic bag or lined trash can, secured, and disposed of daily.

WHAT SHOULD BE DONE IF DIRECT SKIN CONTACT OCCURS?

In many instances, unanticipated skin contact with body fluids may occur in situations where gloves may be immediately unavailable (e.g., when wiping a runny nose, applying pressure to a bleeding injury outside the classroom, helping a child in the bathroom). In these instances, hands and other affected skin areas of all exposed persons should be routinely washed with soap and water after direct contact has ceased. Clothing and other nondisposable items (e.g. towels used to

wipe up body fluid) that are soaked through with body fluids should be rinsed and placed in plastic bags. If presoaking is required to remove stains, (e.g. blood, feces), use gloves to rinse or soak the item in cold water prior to bagging. Clothing should be sent home for washing with appropriate directions to parents/teachers (see page 4). Contaminated disposable items (e.g., tissues, paper towels, diapers) should be handled as with disposable gloves.

HOW SHOULD SPILLED BODY FLUIDS BE REMOVED FROM THE ENVIRONMENT?

Most schools have standard procedures already in place for removing body fluids (e.g., vomitus). These procedures should be reviewed to determine whether appropriate cleaning and disinfection steps have been included. Many schools stock sanitary absorbent agents specifically intended for cleaning body fluid spills (e.g., ZGOOP, Parsen Mfg. Co., Philadelphia, PA). Disposable gloves should be worn when using these agents. The dry material is applied to the area, left for a few minutes to absorb the fluid, and then vacuumed or swept up. The vacuum bag or sweepings should be disposed of in a plastic bag. Broom and dust pan should be rinsed in a disinfectant. No special handling is required for vacuuming equipment.

HANDWASHING PROCEDURES

Proper handwashing requires the use of soap and water and vigorous washing under a stream of running water for approximately 10 seconds.

Soap suspends easily removable soil and microorganisms allowing them to be washed off. Running water is necessary to carry away dirt and debris. Rinse under running water. Use paper towels to thoroughly dry hands.

DISINFECTANTS

An intermediate level disinfectant should be used to clean surfaces contaminated with body fluids. Such disinfectants will kill vegetative bacteria, fungi, tubercle bacillus and viruses. The disinfectant should be registered by the U.S. Environmental Protection Agency (EPA) for use as a disinfectant in medical facilities and hospitals.

Various classes of disinfectants are listed below. Hypochlorite solution (bleach) is preferred for objects that may be put in the mouth.

1. Ethyl or isopropyl alcohol (70%).

2. Phenolic germicidal detergent in a 1% aqueous solution (e.g., Lysol*).

3. Sodium Hypochlorite with at least 100 ppm available chlorine (1/2 cup household bleach in 1 gallon water, needs to be freshly prepared each time it is used).

4. Quaternary ammonium germicidal detergent in 2% aqueous solution (e.g., Tri-quat*, Mytar* or Sage*).

5. Iodophor germicidal detergent with 500 ppm available iodine (e.g., Wescodyne*).

*Brand names used only for examples of each type of germicidal solution and should not be considered an endorsement of a specific product.

DISINFECTION OF HARD SURFACES AND CARE OF EQUIPMENT

After removing the soil, a disinfectant is applied. Mops should be soaked in the disinfectant after use and rinsed thoroughly or washed in a hot water cycle before rinse. Disposable cleaning equipment and water should be placed in a toilet or plastic bag as appropriate. Non-disposable cleaning equipment (dust pans, buckets) should be thoroughly rinsed in the disinfectant. The disinfectant solution should be promptly disposed down a drain pipe. Remove gloves and discard in appropriate receptacles.

DISINFECTION OF RUGS

Apply sanitary absorbent agent, let dry and vacuum. If necessary, mechanically remove with dust pan and broom, then apply rug shampoo (a germicidal detergent) with a brush and revacuum. Rinse dust pan and broom in disinfectant. If necessary, wash brush with soap and water. Dispose of nonreusable cleaning equipment as noted above.

LAUNDRY INSTRUCTIONS FOR CLOTHING SOILED WITH BODY FLUIDS

The most important factor in laundering clothing contaminated in the school setting is elimination of potentially infectious agents by soap and water. Addition of bleach will further reduce the number of potentially infectious agents. Clothing soaked with body fluids should be washed separately from other items. Presoaking may be required for heavily soiled clothing. Otherwise, wash and dry as usual. If the material is bleachable, add 1/2 cup household bleach to the wash cycle. If material is not colorfast add 1/2 cup nonclorox bleach (e.g., Clorox II, Borateem) to the wash cycle.

GUIDELINES FOR HANDLING BODY FLUIDS IN SCHOOLS was prepared by Elaine Brainerd, M.A., R.N., State Department of Education, in consultation with James Hadler, M.D., M.P.H., Chief, Epidemiology Section, Patricia Checko, M.P.H., Epidemiology Program, and William Sabella, AIDS Coordinator, Connecticut State Department of Health Services. December, 1984.

APPENDIX F

INFECTION PRECAUTIONS FOR PEOPLE WITH AIDS

LIVING IN THE COMMUNITY

People with diagnosed AIDS who are able to care for themselves at home can safely live with both healthy individuals who do not have AIDS or with other persons with AIDS. Certain common sense hygienic measures protect both the persons with AIDS as well as their housemates.

1. Care should be taken to not share body secretions, particularly blood or semen. In order for secretions to be shared, there must be a point of entry into another persons body. Preventing this transfer of body secretions while still maintaining one's sexuality requires foresight and common sense. Risk reduction counseling for those who wish to remain sexually active is available through the Gay Men's Health Crisis (New York (212) 807-6655). This is important both to prevent possible transmission of AIDS to others and also to prevent acquiring other infections which may not be well tolerated by the person with AIDS.

   There is no reason why persons with AIDS should not continue to have the usual casual social contacts with people that they have had in the past.

2. Maintaining a state of personal cleanliness is helpful to both the person with AIDS and others. This includes bathing regularly, washing hands after the use of bathroom facilities or contact with one's own body fluids such as semen, mucus, or blood, and washing hands before preparing food.

3. Kitchen and bathroom facilities may be shared with others. Normal sanitary practices in any household will prevent the growth of fungi and bacteria that may potentially cause illness to both immunocompromised and immuno-competent people. These include:

   - Clean kitchen counters with scouring powder to remove food particles. Sponges used to clean in the kitchen where food is prepared should NOT be the same sponges used to clean up bathroom-type spills. Dirty looking sponges should not be used to wash dishes or clean food preparation areas.

APPENDIX G

RESOURCE LIST

1. Sources for Current Medical Information

- AIDS Program
  Center for Infectious Diseases
  Centers for Disease Control
  Atlanta, GA
  (404) 329-3651

  Contact: David Collie
  Senior Public Health Advisor

  CDC produces a weekly publication, Morbidity and Mortality Weekly Report, which contains frequent updates on medical and epidemiological research on AIDS. A bound collection of articles entitled Reports on AIDS Published in the Morbidity and Mortality Weekly Report includes all MMWR articles relating to AIDS since 1981 and is available from CDC.

- National Cancer Institute
  National Institutes of Health
  Building 31
  9000 Rockville Pike
  Bethesda, Maryland 20205
  (301) 496-5583

- National Institute of Allergy and Infectious Diseases
  National Institutes of Health
  Building 31
  9000 Rockville Pike
  Bethesda, Maryland 20205
  (301) 496-5717

- U.S. Public Health Service
  Room 721-H
  200 Independence Avenue, S.W.
  Washington, D.C. 20201
  (202) 245-6867
  (800) 342-AIDS — National AIDS Hotline provides recorded message for general public 8:30 a.m. to 5:30 p.m.

- State and local public health departments may be contacted for more information.

2. Sources of Additional Information Related to AIDS in Corrections

- American Correctional Association
  4321 Hartwick Road, Suite L-208
  College Park, Maryland 20740
  (301) 699-7600

- American Correctional Health Services Association
  5530 Wisconsin Avenue, N.W., Suite 745
  Washington, D.C. 20815
  (301) 652-1172

- National Institute of Corrections
  320 First Street, N.W.
  Washington, D.C. 20534
  (202) 724-3106

- National Institute of Corrections
  Information Center
  1790 30th Street
  Boulder, Colorado 80301
  (303) 444-1101

- National Institute of Corrections
  Jail Division
  1790 30th Street
  Boulder, Colorado 80301
  (303) 497-6700

- National Institute of Justice
  National Criminal Justice Reference Service
  Box 6000
  Rockville, Maryland 20850
  (301) 251-5520
  (800) 851-3420

- National Institute on Drug Abuse
  5600 Fishers Lane
  Rockville, Maryland 20857
  (301) 443-6500

- American Civil Liberties Union
  National Prison Project
  1616 P Street, N.W.
  Washington, D.C. 20036
  (202) 331-0500

  Contact: Ms. Urvashi Vaid
  Staff Attorney

3. **Printed Information Materials**

This section lists AIDS information resources and cites a number of document currently available.

- "AIDS Update," "AIDS Fact Sheet"

  American Federation of State, County and
  Municipal Employees, AFL-CIO
  1625 L Street, N.W.
  Washington, D.C. 20036
  (202) 429-1000

- "Information and Procedural Guidelines for Providing Health and Social Services to Persons with AIDS," September 1, 1985, HRS Pamphlet #150-3.

  Florida Department of Health and Rehabilitative Services
  Tallahassee, Florida

- "Questions and Answers about the HTLV-III Antibody Test," pamphlet developed by HERO and other local agencies, March, 1985.

  "DRUG USERS: Do Not Share Needles," pamphlet.

  HERO (Baltimore Health Education Resource Organization)
  Medical Arts Building, Suite 819
  Cathedral and Read Streets
  Baltimore, Maryland 21201
  (301) 945-AIDS Information and Referral Line on AIDS

- AIDS Legal Guide, A Professional Resource on AIDS-Related Issues and Discrimination, 1984.

  Lambda Legal Defense and Education Fund, Inc.
  132 West 43 Street
  New York, New York 10036
  (212) 944-9488

- Designing an Effective AIDS Prevention Campaign Strategy for San Francisco: Results from the Second Probability Sample of an Urban Gay Male Community, June 28, 1985. Report prepared for the San Francisco AIDS Foundation.

  Research and Decisions Corporation
  375 Sutter Street, Suite 300
  San Francisco, CA 94108
  (415) 989-9020

- The San Francisco AIDS Foundation has published several dozen pamphlets and bulletins, and has designed 14 advertisements.

  San Francisco AIDS Foundation
  333 Valencia Street, 4th Floor
  San Francisco, CA 94103
  (415) 864-4376

- "What Everyone Should Know About AIDS;"

  "Why You Should Be Informed About AIDS;"

  "What Gay and Bisexual Men Should Know About AIDS;"

  "Lo que TODOS deben saber sobre AIDS" (in Spanish);

  "Facts About AIDS," January 1985.

  The U.S. Public Health Service produces AIDS information bulletins and periodic updates on AIDS for general and professional audiences. Brochures used in many state and county correctional facilities incorporate material from the titles listed above.

  Office of Public Affairs
  U.S. Public Health Service
  Room 721-H
  200 Independence Avenue, S.W.
  Washington, D.C. 20201
  (202) 245-6867

4. **Audio-Visual Materials**

   Staff and Inmates

   - "AIDS Videotape"

     The Department of Corrections in New York City produced two different videotapes on AIDS. The more recent 1985 program is intended for inmates and provides general information about the illness. The other videotape, made in 1982-83, is for staff. (These are discussed in Chapter Two of the report.)

     New York City Department of Corrections
     100 Centre Street
     14th Floor
     New York, New York 10013
     (212) 374-4541

     Contact: Assistant Commissioner for Program Services
     Health Services

- "AIDS Videotape"

  This videotape for inmates and staff addresses general issues involving AIDS in prisons and work environments. Developed for the Corrections Service Division of Canada by The University of British Columbia's Department of Medicine, the program is also being used by the Washington State Department of Corrections.

  Time: approximately 25 minutes

  Constructional Resources Center
  University of British Columbia
  AV-TV Media Library
  Vancouver, British Columbia
  V6T1W5
  (604) 228-3467

  Contact: Ms. Lee McCarvill
  Biomedical Communications

- "What If the Patient Has AIDS?"

  This videotape was produced in association with the National Institutes of Health and is intended for health care workers.

  "AIDS and Your Job"

  This videotape was produced in association with the Centers for Disease Control and is intended for such workers as policemen and firemen.

  These videotapes are currently being updated and will soon be available for distribution.

  Time: 45 minutes

  National Audio Visual Center
  (301) 763-1896

- "AIDS: Key Facts for Correctional Staff"

  This package includes a brochure, poster and leader's guide.

  Time: 35 minutes

  "AIDS: Key Facts for Inmates"

  This also includes a brochure, poster and leader's guide.

  Time: 30 minutes

Capital Communications Systems developed these two videotapes and accompanying literature for the Federal Bureau of Prisons.

Capitol Communications Systems
19 Chelsea House
2411 Crofton Lane
Crofton, Maryland 21114
(301) 261-6770

Contact: Tom Sutty

Corrections Policymakers and Practitioners

- "AIDS: An Overview with Dr. Harold Jaffe"

This videotape records the presentation of Dr. Harold Jaffe of CDC at the NIC-sponsored November 6, 1985 meeting of State Directors of Corrections in Atlanta, Georgia. The videotape provides a medical update on AIDS and is available to all departments of corrections and correctional practitioners.

Time: 35.5 minutes

National Institute of Corrections
Information Center
1790 30th St.
Boulder, CO 80301
(303) 444-1101

APPENDIX H

1985 Nov 15;34:681–86, 691–95

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 280 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.

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Recommendations for Assisting in the Prevention of Perinatal Transmission of Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus and Acquired Immunodeficiency Syndrome

The information and recommendations in this document are intended to assist health-care providers and state and local health departments in developing procedures to prevent perinatal transmission of human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III LAV), the virus that causes acquired immunodeficiency syndrome (AIDS).

This document contains recommendations for providing counselling and, when indicated, testing for antibody to HTLV-III LAV for women who are at increased risk of acquiring the virus and who are either pregnant or may become pregnant. It is important that these women know they are at risk, as well as know and understand their HTLV-III/LAV-antibody status, so they can make informed decisions to help prevent perinatally acquired HTLV-III LAV.

Through counselling, uninfected women can learn how to avoid becoming infected, and infected women can choose to delay pregnancy until more is known about perinatal transmission of the virus. If already pregnant, infected women can be provided information for managing the pregnancy and caring for the child.

APPENDIX I

AIDS Information Clearinghouses

The Department of Health has established regional clearinghouses for the distribution of AIDS literature.

If you wish to obtain information, contact the closest clearinghouse to ensure that the information is available. Clearinghouses are for pick up of materials only. They do not mail.

NEW JERSEY SUSTANCE ABUSE INFORMATION CLEARINGHOUSES

Northern Locations:

1. Paterson Counseling Center, Inc.
   319-321 Main Street
   Paterson, NJ 07505
   Contact - Mr. Robert Alexander
   (201) 523-8316

2. Regional Curriculum Services Unit-North
   15 South Munn Avenue
   East Orange, NJ 07018
   Contact - Mr. Robert Goger or Ms. Sharon Orlando
   (201) 266-8660/8665

3. Learning Resource Center
   Normandy Park Administration Bldg.
   Normandy Parkway
   Morristown, NJ 07960
   Contact - Ms. Carol Novick or Ms. Roberta Wohle
   (201) 539-0331/0337

Central Locations:

1. Regional Curriculum Services Unit-Central
   200 Old Matawan Road
   Old Bridge, NJ 08857
   Contact: Mr. Barry Ward
   (201) 390-6030

2. Discovery Institute for Addictive Disorders
   PO Box 177
   Marlboro, NJ 07746
   Contact: Nancy Horowitz
   (201) 946-9444

Southern Locations:

1. Institute for Human Development
   1315 Pacific Avenue
   Atlantic City, NJ 08401
   Contact: Mr. Franco Acquaviva
   (609) 345-4035

2. Regional Curriculum Services Unit - South
   RD 5 - Box 635
   635 North Black Horse Pike
   Williamstown, NJ 08094
   Contact: Mr. John Edwards
   (609) 629-3133/5900

3. NJ Division of Narcotic Division
   1012 Haddonfield Rd.
   Cherry Hill, NJ 08002
   (609) 663-9256