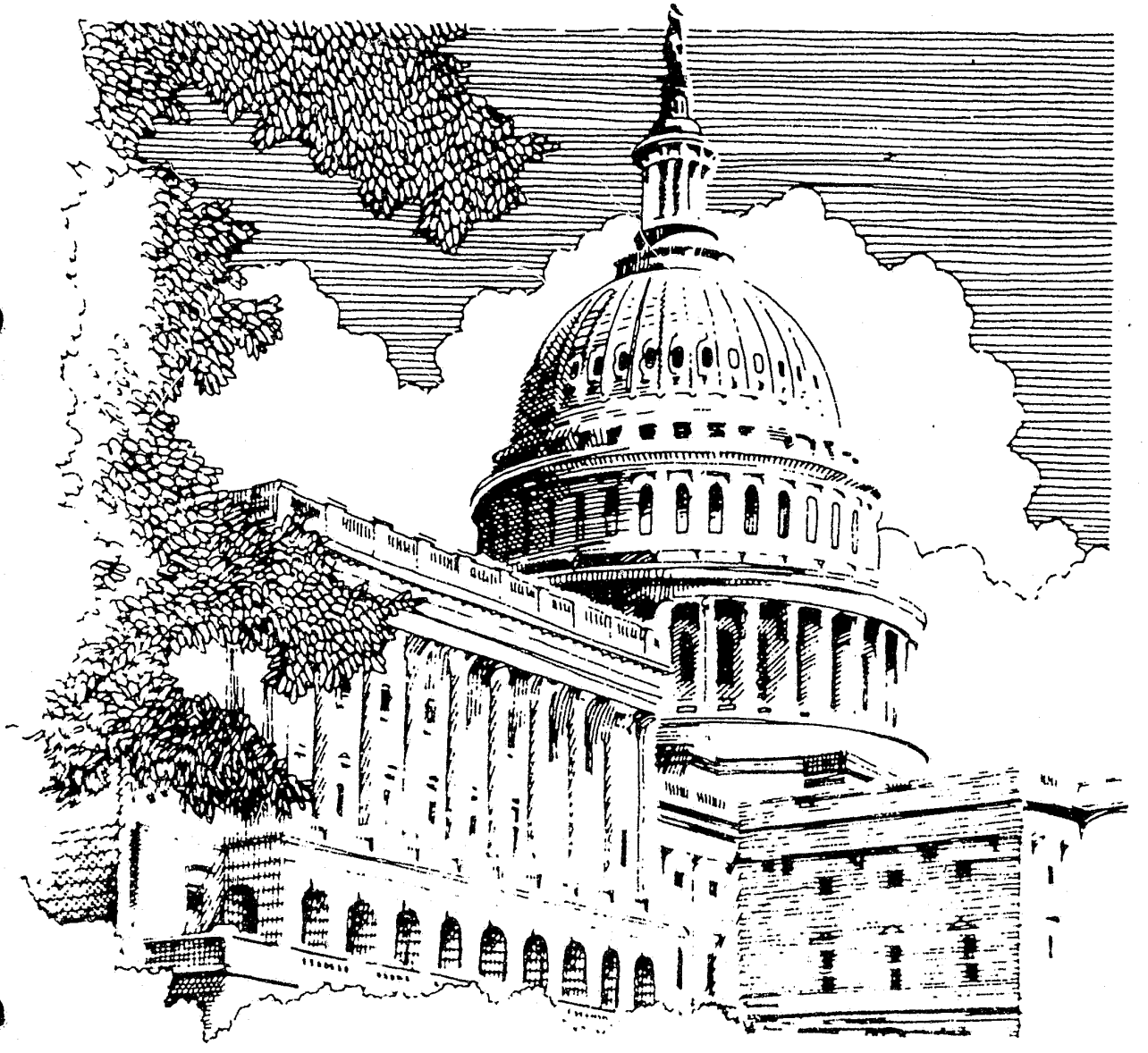
AIDS Policy Reports

A series of public policy papers from your Seattle-King County Department of Public Health



CONTENTS

INTRODUCTION

AIDS Policy Reports is, to the best of our knowledge, the first project of its kind in the nation. It represents a concerted effort by the Seattle-King County Public Health Department to clarify and communicate to the local public information about policies affecting the control of HIV/AIDS in our community. As the epidemic enters its second decade, the policy issues it raises are growing increasingly complex. At the same time, the public's sophistication and interest in these often controversial issues is on the rise.

The policy papers that follow are not comprehensive inventories of department procedures and protocols. Rather, they are brief, readable summaries of the AIDS policy issues most frequently asked about and debated in our community. These reports are intended for use by Health Department staff, AIDS educators, hotline and speakers' bureau volunteers, community agencies, policymakers, the media, and the general public.

The public is increasingly curious about subjects such as needle exchange and HIV partner notification. We think they deserve accurate answers to these policy questions just as much as they need accurate information on the medical issues related to HIV/AIDS. We feel we have a progressive state law on AIDS in Washington and local policies which are forward-thinking, balanced and fair. These reports aim to promote public understanding and support of sensible public health policy, which is essential to the effective control of this epidemic in Seattle-King County.

Additional papers in the *AIDS Policy Reports* series will be published and distributed as new issues and controversies arise. All papers will be reviewed and revised annually. Comments on these papers as well as suggestions for future topics are encouraged. Address comments, suggestions, or requests for in-service training on public policy issues to me at the AIDS Prevention Project, 1116 Summit Avenue, Suite 200, Seattle, WA 98101; (206) 296-4649.

-- John Leonard
Series Editor

AIDS Policy Reports

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Number 1 **December 1990**

HIV ANTIBODY TESTING

BACKGROUND:

In April of 1985, the HIV antibody test became available for screening the nation's blood supply for human immunodeficiency virus, the virus that causes AIDS. Testing has since become widely available for persons wishing to learn their HIV status, and has proven to be a valuable AIDS prevention strategy when combined with counseling.

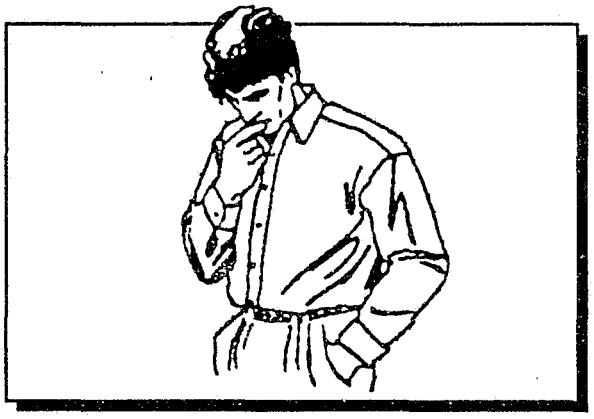
Voluntary HIV testing creates an opportunity to provide counseling and education aimed at reducing future risky behavior and, where necessary, to begin medical intervention. It also enables the voluntary notification of sexual partners who may be at risk for HIV infection.

Coercive approaches to testing, on the other hand, foster a climate of distrust which negatively affects voluntary behavior change. Compulsory testing creates an undesirable public health impact by deterring those persons in greatest need of counseling, testing, and care from seeking needed services. The recommendations below outline key factors to be considered with regard to risk assessment, voluntary, and mandatory testing.

CURRENT LAW:

Washington state law mandates that HIV antibody testing be voluntary and with the informed consent of the patient.

For all persons seeking voluntary HIV testing, state regulations require counseling to accompany testing. (Counseling requirements and procedures are detailed in the state publication HIV/AIDS Counseling & Partner Notification Guide.)



All regions in the state are required to make HIV testing available anonymously as well as confidentially.

HIV test results must be held in the strictest of confidence. Health care workers are permitted to exchange information about a patient's HIV status only when necessary to provide appropriate health care services to the patient.

Under Washington state law, some exceptions exist to voluntary testing. Mandatory testing is required for the screening of human organs, tissues, and blood prior to transplantation, transfusion, or artificial insemination. Mandatory counseling and testing also is required for persons convicted of:

- certain sex-related offenses; and
- drug offenses involving the use of a hypodermic needle.

State law allows the local public health officer to order HIV counseling and testing of:

- a source patient when certain categories of public service workers have been substantially exposed on the job to certain bodily fluids of the patient; and

- individuals who, based on reasonable evidence, are recklessly behaving in ways that could spread HIV.

In both of these situations, the person who is the subject of the public health order has the right to appeal the order in a court of law.

In addition, the federal government currently requires mandatory pre-employment testing for:

- all U.S. military services,
- the Peace Corps,
- the Job Corps,
- the diplomatic corps (the State Department).

Several countries, including the U.S., require HIV testing for international travel and immigration.

POLICY RECOMMENDATIONS:

Since HIV infection is increasingly treatable, voluntary testing and early identification of infection is more important than ever in preventing or delaying progression of the disease. The Health Department strongly recommends testing and counseling for anyone at risk of HIV infection. Persons at **high risk** of HIV infection include:

- men who have had sex with other men (whether or not identified as homosexual or bisexual) since 1978;
- persons who have shared needles to use drugs intravenously since 1978;
- persons who have traded sex for money or drugs;
- persons receiving multiple transfusions of blood or blood products between 1978 and 1985;
- sexual partners of persons engaging in any of the behaviors noted above.

Persons at **low to moderate risk** of HIV infection include those without the above risk factors but who have had multiple sexual partners, are being seen for sexually transmitted diseases, or are health care workers with substantial occupational exposures to HIV (see *AIDS Policy Reports* No. 10).

Otherwise, persons are generally at no or negligible risk and do not need testing.

The Seattle-King County Health Department provides anonymous and confidential HIV counseling and testing on a sliding fee scale for anyone concerned about HIV, regardless of his or her risk.

The Health Department currently sees no significant public health justification for mandatory pre-employment HIV testing or mandatory testing of immigrants or international travelers. However, the Department complies with all state and federal laws regarding HIV testing.

Persons subject to HIV testing for screening purposes (e.g., blood, organs, tissues) should always be informed of the test requirement.

RESOURCES:

For HIV risk assessment information and referrals for testing, call the AIDS Information Line, 296-4999 (TTY 296-4843 for deaf access). For information about substantial occupational exposure to HIV, call Health Department HIV Program Coordinator, Frank Chaffee, at 296-4649 (TTY 296-4843).

REFERENCES:

WAC 248-100-016 Confidentiality

HIV/AIDS Counseling & Partner Notification Guide. Washington State Responds to AIDS. 1989.

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Number 2 December 1990

HIV/AIDS AND QUARANTINE

BACKGROUND:

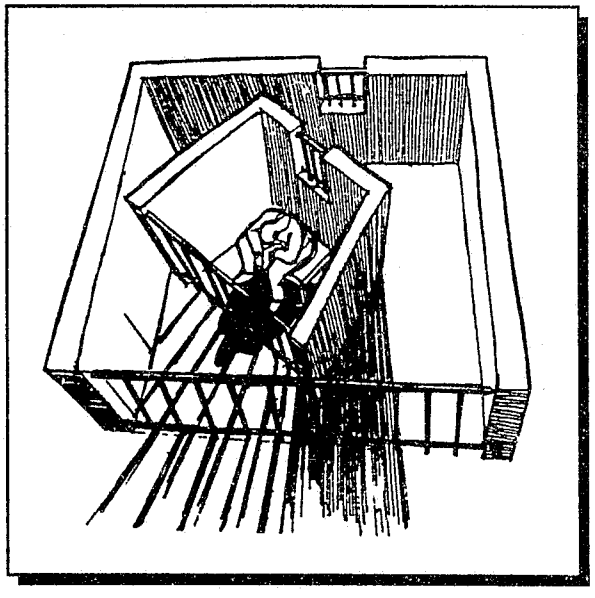
"Quarantine" means the separation or restriction of activities of a person who has been exposed to or infected with an infectious agent, in order to prevent disease transmission (WAC 248-100-011 (30)). Historically, quarantine has been employed as a public health measure in numerous epidemics. Quarantine measures have usually been imposed during epidemics of diseases that are (or were believed to be) spread through casual social contact, such as diseases caused by airborne microbes (e.g. measles, tuberculosis, smallpox). The effectiveness of quarantine has been questioned by several public health historians.

Although quarantining people with HIV and AIDS has never been seriously considered by responsible public health officials in the U.S., some individuals have suggested this option. Proponents of quarantine have argued that:

- The traditional public health strategy of separating infected people from susceptible people is necessary to prevent the further spread of the infection.
- Public health authorities, as representatives of society as a whole, have an obligation to protect uninfected people even if the means of doing so entails summary restrictions on the liberty of one group (i.e., people infected with HIV).

Opponents have argued against quarantine on both practical and ethical grounds. Practical factors limiting the usefulness of quarantine include:

- The prolonged (10 or more years) asymptomatic phase of HIV infection. Identifying and isolating all people with HIV infection would require regular, universal HIV testing of the entire population, an impractical and unwise use of resources.



- The large number of people with HIV in the US. It is currently estimated that about 1 million people are infected with HIV. Identifying and indefinitely restricting that many people is beyond the scope of public resources.
- Restrictive policies drive people into hiding. Quarantine policies would encourage people, especially those at highest risk, to avoid public health HIV programs, HIV testing, and basic health care.

Ethical objections include:

- The loss of individual liberty implicit in quarantine is only justified when used to protect people who cannot protect themselves, as in the case of

casually transmitted diseases, such as tuberculosis. HIV is almost exclusively spread through private, consensual adult behavior (e.g., unprotected sex and needle-sharing). Uninfected people can normally choose to avoid behaviors that carry a risk of HIV infection. Quarantine measures cannot be justified on the basis of protecting people from the adverse consequences of their own behavior.

- Routine quarantine measures would effectively restrain a person's activities based on the presumption of "guilt." Such a policy would presume that no person with HIV infection could be trusted to avoid behaviors that spread the infection. This reasoning is contrary to numerous constitutional principles.

CURRENT LAW:

Under Washington law, state and local public health officers are granted broad discretion to implement measures to control the spread of diseases. Their authority includes the imposition of quarantine (WAC 248-100-036-1d) when doing so is deemed appropriate and consistent with prevailing public health practices as defined by the American Public Health Association. The consensus of public health professionals to date has been that quarantine of people with HIV infection is not an appropriate or effective strategy for the control of HIV.

Exceptions are granted for temporary restriction of specific individuals who, based on reasonable evidence, are recklessly behaving in ways that could spread HIV (RCW 70.24.024, RCW 70.24.034, and WAC 248-100-206). Periods of restricted activity are limited to 90 days, designed to help the individual modify risk-taking behavior, and subject to judicial review.

POLICY RECOMMENDATIONS:

The Seattle-King County Department of Public Health strongly opposes quarantine of people with HIV infection. The Department, however, recognizes the necessity of occasionally imposing temporary restrictive measures on specific individuals who are found through due process to be behaving in ways that pose imminent danger to the public health. Such restrictive measures shall only be imposed when necessary and in a manner consistent with the principles and procedures detailed in Washington state law.

RESOURCES:

For information or consultation regarding Department policy on "behaviors endangering the public health," call the AIDS Information Line at 296-4999 (TTY 296-4843 for deaf access) or the HIV Program Coordinator, Frank Chaffee, at 296-4649 (TTY 296-4843).

REFERENCES:

Benenson, Abram S., ed., Control of Communicable Diseases in Man, American Public Health Association, 1985.

Brandt, Allan M. No Magic Bullet, New York: Oxford University Press, 1987, p. 201.

Revised Code, Washington (RCW), 70.24.024 and 70.24.034.

Washington Administrative Code (WAC) 248-100-011, 248-100-036, 248-100-041, 248-100-206.

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Number 3 December 1990

HIV/AIDS EDUCATION

BACKGROUND:

As of December 1990, more than 1600 people in King County had been diagnosed with AIDS and 10,000 persons in the Seattle area may be infected with HIV, the virus that causes AIDS.

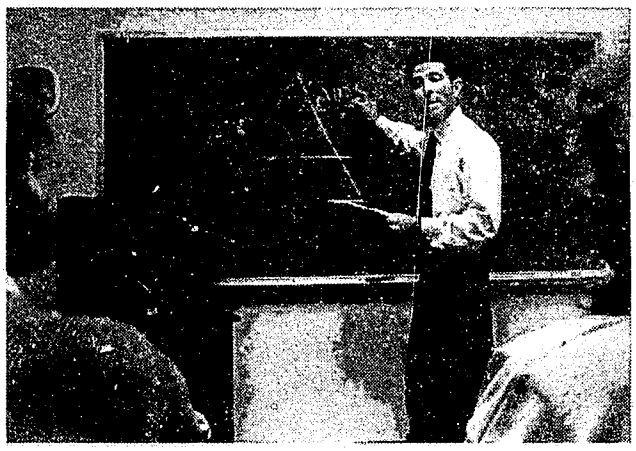
Because HIV infection is preventable, educating people about the virus and how it is transmitted is of paramount importance. Education is the best means to prevent AIDS, and it is the first step toward any behavior change. HIV/AIDS education is important for people at increased risk as well as for the general public. People at increased risk for HIV include:

- men who are sexually active with other men
- intravenous drug users
- hemophiliacs
- sexual partners of the above

Youth are also at increased risk for HIV because of high levels of sexual activity and multiple sex partners. Additionally, the high rates of sexually transmitted diseases and pregnancy indicate that youth are not taking precautions against HIV.

Educating the general public is important as well. Not only are we fighting the epidemics of AIDS and HIV, we are also fighting the epidemic of fear and misunderstanding that leads to risk denial and lack of compassion for those impacted by the disease.

AIDS education is controversial. Controversy has centered around such questions as who should be targeted, how much should be spent, and especially issues related to content, emphasis, and explicitness.



CURRENT LAW:

There are two laws that significantly impact content and provision of AIDS education in Washington State:

A. Federal Regulations: Since 1985, the Centers for Disease Control has required that all recipients of CDC funds for HIV prevention programs establish a Program Review Panel to review all educational materials and program activities. In 1988, the regulation was revised to include the following regulation:

"AIDS education programs funded by the Centers for Disease Control...shall not be designed to promote or encourage directly, intravenous drug abuse or sexual activity, homosexual or heterosexual, and...shall provide information on health risks of promiscuous sexual activity, and intravenous drug use."

In addition, the Program Review Panel is responsible for determining that the materials will be inoffensive to a majority of the intended audience, or to a majority of persons outside of the intended audience.

B. The 1988 Washington State AIDS Omnibus Act requires the following for education activities financed with public monies:

- All materials targeted to the general public shall emphasize the importance of sexual abstinence, sexual fidelity and avoidance of substance abuse in controlling disease.
- All materials directed to children in grades kindergarten through 12 shall give emphasis to the importance of sexual abstinence outside marriage and avoidance of substance abuse in controlling disease.

In addition, the bill requires education for the following groups of people:

- Public school students in grades 5 through 12 must receive AIDS education at least once a year.
- Community colleges and four year universities must make AIDS information available to all newly matriculated students.
- All licensed health providers, emergency medical personnel, day care providers and people who work in licensed facilities must receive AIDS education.
- Public school employees must receive AIDS education as part of their present continuing education requirements.

POLICY RECOMMENDATIONS:

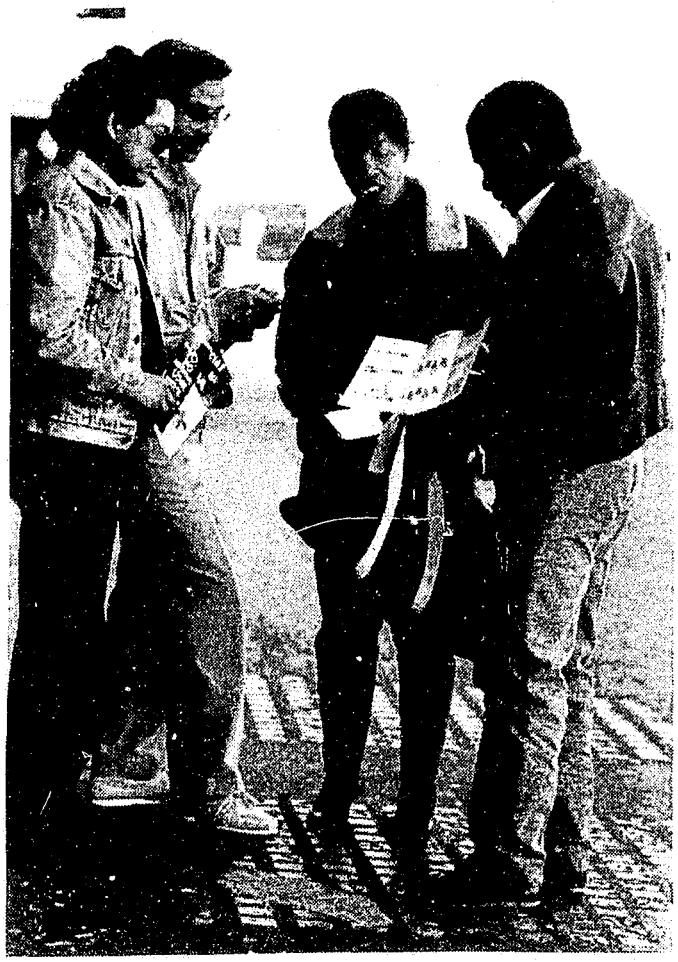
The Department of Public Health's overall HIV/AIDS education policy is to provide factual information to people at risk and the general public. All educational materials and activities should be nonjudgmental, reflect a wide range of values, include referrals for additional information and services, and be culturally appropriate to the population being targeted.

Specifically:

Education directed to **men who have sex with other men** should provide explicit information, tools for making behavior change (e.g. condoms), and skill building around making behavior changes (e.g. how to use condoms, how to negotiate safer sex).

Education directed to **intravenous drug users** (IVDUs) should provide factual information and tools for change (e.g. bleach, condoms, access to needle exchange programs). Skill building around making behavior changes is also essential. Additionally, educational activities should be nonjudgmental and should work with IVDUs according to where they are on the continuum of change. Referrals to drug treatment should be part of all educational activities (see *AIDS Policy Reports* No. 6).

Education directed to **health professionals** should promote universal precautions for infection control and compassionate care for people with HIV/AIDS. State education requirements for licensure should be followed, and attention paid to self-care issues for the avoidance of burnout among AIDS health care workers.



Education directed to **people in the workplace** should be proactive and foster compassion as well as increased knowledge (see *AIDS Policy Reports* No. 3).

Education targeted to **youth in the schools** should be presented in the context of comprehensive sexuality education and should be appropriate to students' age and developmental level. Parental involvement in AIDS education is essential. Educational materials should stress abstinence as the best means of prevention, but also should provide risk reduction information for those youth for whom abstinence is not a realistic choice. Educational approaches which incorporate peer education are encouraged.

Education targeted to **out-of-school youth** (e.g. street kids) must reach youth where they are, in a variety of institutional and non-institutional settings. Information should be frank and explicit, and appropriate to the social and cultural realities of these youth.

Education targeted to **people of color** must recognize social, cultural and economic factors, and the way these factors influence design and delivery of AIDS education activities. Educational messages should be delivered by appropriate messengers, and when possible, peer education should be incorporated into educational strategies.

RESOURCES:

Seattle-King County Department of Public Health
- AIDS Information Line 296-4999
- TTY for deaf access 296-4843
- Seattle School Liaison 296-4780
- King County School Liaison 296-4879

Washington State Office on HIV/AIDS,
- Education Coordinator 1-586-3886

Northwest AIDS Foundation 329-6923

Northwest Regional AIDS Education
- & Training Center (health care workers) . 543-9750

Washington Employers'
- AIDS Prevention Alliance 287-4326

Washington State Office of the
- Superintendent for Public Instruction,
- AIDS Education Specialist 1-753-2744

YouthCare 282-1288

People of Color Against AIDS
- Network (POCAAN) 322-7061

Health Information Network 784-5655

REFERENCES:

Chapter 70.24 RCW AIDS Omnibus Law

Frendenberg, Nicholas. Preventing AIDS. American Public Health Association. Washington, D.C.: 1989.

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Number 4 **December 1990**

HIV/AIDS PREVENTION AMONG INTRAVENOUS DRUG USERS

BACKGROUND:

It has been estimated that Seattle and King County have as many as 12,000 intravenous drug users. About five percent are believed to be infected with HIV, and the virus may be spreading faster in this group than in any other. Intravenous drug use is involved, directly or indirectly, in the majority of cases of AIDS among heterosexual men, among women, and among infants.

HIV is transmitted among intravenous drug users through sharing contaminated syringes and through unprotected sex. The fact that intravenous drug users are involved in illicit activity makes intervention difficult, and the establishment of trust especially important.

Some risk reduction interventions, such as bleach distribution for cleaning syringes and exchanging sterile syringes for contaminated ones, have raised controversy because they may seem to condone drug use. Such programs, however, are offered in the context of education that clearly identifies the dangers of drug use, and offers help in quitting. These programs also help greatly to establish trust with the population at risk, and offer the chance to keep people healthy until they are successful in conquering their addiction.

CURRENT LAW:

In early 1990, a Pierce County, Washington, Superior Court judge ruled that needle exchange, when operated by a department of public health, was an appropriate and legal response to the epidemic of HIV infection and AIDS among intravenous drug users, and that the staff

of such an exchange are not in violation of state law against the possession or delivery of drug paraphernalia.

State law requires mandatory HIV testing and counseling of all persons convicted of drug offenses involving the use of a hypodermic needle.

POLICY RECOMMENDATIONS:

The Health Department makes the following recommendations:

- Financial and other barriers to entry to drug treatment should be minimized.
- Communities with demonstrable concentrations of injection drug users should develop risk reduction outreach programs, including education, encouragement in behavior change, referral to drug

treatment and social and health services, provision of risk reduction materials, and needle exchange.

- Bleach and condoms should be made freely available at clinics, drug treatment agencies, and other sites where they may be encountered by drug users.

- Free, confidential, and anonymous HIV counseling and antibody testing should be made available at sites likely to be convenient and accessible to intravenous drug users and their sexual partners.

- It should be realized that total abstinence from drugs, while the ultimate and healthiest goal for all, is not immediately realizable for many. Programs of risk reduction should be instituted for those who have not yet achieved it.

RESOURCES:

For more information on HIV/AIDS control among intravenous drug users, call the Health Department's Community AIDS Services Unit at 296-4568, or the AIDS Information Line at 296-4999 (TTY 296-4843 for deaf access).

REFERENCES:

Allen vs. City of Tacoma, Superior Court of the State of Washington, Pierce County. 89-2-09067.3

Buning, EC. "The role of the needle exchange project in preventing HIV infection among drug users in Amsterdam." International Drug Abuse Treatment and Prevention Research Conference. New York, 1989.

Des Jarlais, et al. "Safer injection among participants in the first North American syringe exchange program." Fifth International Conference on AIDS. Montreal, 1989.

Donoghoe, et al. "Changes in HIV risk behavior in clients of syringe exchange schemes in England and Scotland." AIDS, 3(5), 267.

Fuchs, et al. "Successful preventive measures in a community of IV drug addicts." Fourth International Conference on AIDS. Stockholm, 1988.

Phua, et al. "The control of the spread of HIV infection among IV drug users in New South Wales, Australia." International Conference on the Global Impact of AIDS. London, 1988.

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Number 5 December 1990

HIV/AIDS IN THE WORKPLACE

BACKGROUND:

By December 1990, more than 1600 persons in King County had been diagnosed with AIDS (Acquired Immune Deficiency Syndrome). The Health Department estimates that approximately 10,000 additional people in the Seattle area may be infected with HIV (human immunodeficiency virus). People with HIV infection and AIDS come from all walks of life and represent many different careers and occupations. They are our co-workers, clients, and customers. Many workplaces in King County have already been touched by AIDS, and many more will be affected as the epidemic grows in the coming years.

Because HIV is not transmitted through casual contact, there is little or no risk of HIV transmission in most workplace settings. In workplaces where some occupational risk exists (e.g., health care), infection control guidelines should be followed carefully. All workplaces should be sites for AIDS prevention education and support for affected workers.

This paper outlines existing laws pertaining to AIDS in the workplace, and additional Health Department policy recommendations.

CURRENT LAW:

In Washington state, it is illegal to discriminate against persons with AIDS, persons with HIV infection, and persons perceived to be HIV infected. Discrimination is expressly prohibited in the following areas:

- employment;
- rental, purchase or sale of apartment houses or real estate;

- places of public accommodation (restaurants, theaters, etc.);
- health care, legal services, home repairs and other personal services;
- applying for a loan or credit card, or other credit transactions;
- certain insurance transactions.

Specifically, employers may not discriminate in:

- recruitment,
- hiring,
- transfers,
- layoffs,
- terminations,
- rate of pay,
- job assignments, and
- leaves of absence, sick leave, or other fringe benefits.

Federal law requires employers to provide "reasonable accommodation" for disabled workers, including those with HIV and AIDS. This means making adjustments or modifications such as:

- providing special equipment
- allowing flex-time
- providing frequent rest breaks.

State law prohibits employers from:

- Asking employees or job applicants about their lifestyle, sexual orientation, or HIV status (unless absence of HIV infection is a "bona fide occupational qualification" for the job).
- Requiring employees or job applicants to take a physical exam to identify HIV or AIDS, or to take an HIV antibody blood test.

Managers and supervisors are required by law to hold in the strictest confidence all medical information provided to them about persons who have HIV infection or AIDS. Health care workers may exchange information about a patient's HIV status only when necessary to provide appropriate health care services to the patient.

POLICY RECOMMENDATIONS:

The Health Department makes the following recommendations to workplaces:

- Employers and unions should establish HIV/AIDS non-discrimination policies.
- Employers should provide employees with accurate and up-to-date education about AIDS and HIV risk reduction.
- Workplace AIDS education should occur before the first on-site case of HIV infection becomes known, to avoid work disruption due to ignorance and unwarranted fear.
- In those special occupational settings in which there may be a potential risk of exposure to HIV (for example, in health care, where workers may be exposed to blood), employers should provide specific, ongoing training, as well as the necessary equipment to reinforce appropriate infection control procedures and ensure that they are implemented.
- Any worker who believes he or she has been exposed to HIV on the job should immediately notify his or her supervisor and contact the AIDS Information Line for information on risk assessment and testing (see *AIDS Policy Reports* No. 10).

RESOURCES:

For more information about HIV/AIDS in the workplace, educational programs, and policy development, call:

AIDS Prevention Project Information Line . . 296-4999
TTY for deaf access 296-4843
Washington Employers'
AIDS Prevention Alliance: 287-4326
To report HIV-related discrimination, contact:
Seattle Department of Human Rights . 684-4500
WA State Human Rights Commission . 464-6500

REFERENCES:

Chapter 49.60 RCW Human Rights Law of Washington State

Section 504 of the Federal Rehabilitation Act of 1973

Chapter 70.24 RCW AIDS Omnibus Act

Citizen's Commission on AIDS, Responding to AIDS: 10 Principles for the Workplace.

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Number 6 December 1990

HIV/AIDS IN CORRECTIONAL FACILITIES

BACKGROUND:

HIV/AIDS issues in the correctional setting are often controversial. Correctional facilities face issues about inmate housing, correctional management, occupational exposure risks, education, and training, as well as HIV antibody testing and medical and psychosocial care for HIV-infected individuals.

In response to those issues, the Department of Adult Detention and the Seattle-King County Department of Public Health have formulated policy and procedure for HIV/AIDS issues.

The King County Jail Health HIV/AIDS Program was developed to provide:

- education to jail staff, inmates, and Jail Health Services staff;
- HIV counseling and testing for high risk individuals and those mandated to receive testing, and
- clinical services to people with HIV infection.

From a public health perspective, the jail provides a unique opportunity to reach individuals who are at high risk for HIV infection. It is estimated that more than three-quarters of intravenous drug users (IVDUs) eventually pass through correctional facilities. Contrast this with the fact that only one in six IVDUs can be found within a treatment program at any given time and nearly half have never experienced a treatment program. Individuals in jail other than IVDUs may be at high risk due to other drug use, sex industry work, or sexual contact with persons at high risk. Thus, correctional facilities may be one of the best places to reach high risk populations with HIV education, counseling and testing.

CURRENT LAW:

Washington state law mandates HIV testing at the time of sentencing for all persons convicted of the following crimes:

- A sexual offense involving sexual intercourse or the transmission of body fluids.
- A felony offense relating to prostitution involving sexual intercourse or the transmission of body fluids.
- A drug offense associated with the use of hypodermic needles.

State law allows the local public health officer to order HIV counseling and testing of:

- a source patient when certain categories of public service workers (e.g., police, firefighters, paramedics) have been substantially exposed on the job to body fluids of the patient; and
- individuals who, based on reasonable evidence, are recklessly behaving in ways that could spread HIV.

In both of these situations, the person who is the subject of the public health order has the right to appeal the order in a court of law.

State law requires that AIDS risk assessment counseling be provided to pregnant women and to individuals seeking treatment for sexually transmitted diseases.

Washington law authorizes jail administrators to order HIV testing for persons detained in jail, if the local health officer determines that actual or threatened behavior presents a possible risk to staff. When actual

exposures occur, the substantial exposure procedures should be utilized, to assure that both the exposed person and the source individual receive counseling and follow up.

POLICY RECOMMENDATIONS:

In cooperation with the King County Department of Adult Detention, the Seattle-King County Department of Public Health has adopted the following HIV/AIDS policies for the King County Correctional Facility.

HIV Education

- Inmates will be offered group HIV/AIDS education at frequent and regular intervals to promote maximal reduction of the risk of HIV transmission. Education will be offered in the appropriate language, respecting cultural differences.
- Correctional and health staff will receive AIDS training on prevention, transmissions and treatment annually, and as needed.

HIV Counseling and Testing

- HIV counseling and testing will be made available to inmates on a confidential basis (or using fictitious names) to the extent possible. It will be offered to all inmates with identified risk for HIV infection.
- The identities of all persons who require mandatory HIV counseling and testing will be communicated to Jail Health staff so that this service can be performed in a timely fashion.
- Partner notification services will be provided for all persons testing HIV seropositive (see *AIDS Policy Reports* No. 8).

Clinical Services

- HIV seropositive inmates and those with AIDS will receive the community standard of medical care which their condition requires, with backup by Harborview Medical Center.

Risk Reduction

- We will attempt to assure that all inmates are provided appropriate HIV risk reduction materials and referral to community resources at or around the time of release from the correctional facility.

Housing Issues

- Segregated housing, based on HIV status alone, is unnecessary from a public health perspective and is a breach of confidentiality. Segregated housing is medically indicated only for persons with special needs and who require frequent access to medical staff.

Universal Precautions

- Universal blood and body fluid precautions will be the standard of practice for medical and correctional staff in the King County Correctional Facility.

RESOURCES:

For more information on HIV/AIDS in correctional facilities, call King County Jail Health Services at 296-1082, or call the AIDS Information Line at 296-4999 (TTY 296-4843 for deaf access).

REFERENCES:

Jail Health Services, "HIV/AIDS Services" Policy.

King County Department of Adult Detention, "Infectious Disease Safety Measures" Policy, No. 9200.1.

Revised Code, Washington (RCW) 70.24.340, 70.24.340(4), 70.24.095, 70.24.360, 70.24.370.

Washington Administrative Code (WAC) 248-100-206(10), 248-100-208(1).

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AIDS Policy Reports

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Number 7 **December 1990**

ACCESS TO HIV/AIDS CARE

BACKGROUND:

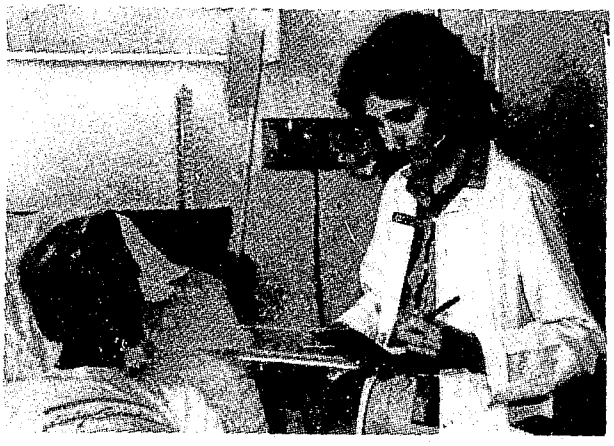
The HIV/AIDS epidemic has put tremendous stresses on the health care delivery system in the United States and focused attention on its many shortcomings. Chief among these is the lack of adequate access to quality health care services for all persons, including people with HIV/AIDS and those at risk.

Although denial of access based on age, sex, ethnic, religious, or racial status is illegal and discriminatory, such barriers still occur. Denial of access based on other factors, such as sexual orientation or irrational fear of AIDS contagion continues to occur commonly.

Service availability varies by geographic location and by ability to pay. As many as 15% of the U.S. population are believed to have no public or private health insurance and another 20% are underinsured; that is, they have inadequate insurance protection for major hospital and medical expenses.

Existing federal and state programs, such as Medicaid, endeavor to assure access to the most necessary health care for low income people. Nevertheless, service availability varies considerably from state to state, and from time to time within any state, based on available funds. Hospitalization costs are generally covered, but services to prevent disease or to substitute for hospitalization may not be reimbursed. Also, funding levels are so low that many physicians are reluctant to provide outpatient care to eligible persons.

The lack of adequate access to health care in the U.S. significantly impacts AIDS prevention and care. Lack of access to primary care providers who do HIV risk evaluation, counseling, and testing severely hampers this important AIDS control strategy.



Persons seeking HIV evaluation must be willing to confront life and death issues and potential stigmatization and discrimination. The potential benefit of knowing one's HIV status depends on access to basic medical care such as immune system monitoring and therapy with such expensive drugs as AZT. Without assured access to care, it is easy to understand why many persons are reluctant to seek HIV testing.

Without access to a variety of care options, providers must frequently hospitalize patients with HIV/AIDS who could be managed more efficiently in lesser care settings. Lack of comprehensive social and medical services, therefore, can substantially increase health care costs, in addition to being less humane and compassionate.

CURRENT LAW:

A variety of federal and state laws have established and provided funding for programs to improve access to health care for underserved populations.

- **Medicaid**

  Federal program for the poor and disabled; covers physicians, hospitalization, drugs, long term care, and equipment.

- **Medicare**

  Federal program for the elderly and disabled; covers hospitalization, skilled nursing, home health, and rehabilitation services.

- **State Health Insurance Pool**

  For persons who have been denied coverage, issued restrictive riders, or an increased premium for health reasons.

- **State HIV/AIDS Insurance Continuation Program**

  Pays part or all of health insurance premiums for eligible persons with Class IV HIV/AIDS.

- **AIDS Prescription Drug Program**

  State/federal program; pays all or part of costs for AZT, aerosolized pentamidine, or alpha interferon for eligible persons.

- **Coordinated Community AIDS Service Alternatives** (CCASA) Program

  Provides skilled nursing, attendant care, respite care, psychosocial services, nutrition consultation, home delivered meals, and transportation for eligible low income persons with Class IV HIV/AIDS.

- **State HIV Intervention Program**

  Medical coverage for office visits and lab tests for eligible HIV-positive persons who do not have advanced infection or AIDS.

POLICY RECOMMENDATIONS:

The Seattle-King County Department of Public Health believes that every person should have access to a full range of needed health care services, regardless of ability to pay, race, color, national origin, ancestry, religion, sex, sexual orientation, marital status, age, or handicap. It is in the public's interest to assure that all persons at risk for or with HIV infection have access to primary health care, including testing and counseling, medications, out-patient care, hospitalization, and long-term care. The Health Department is working with local hospitals, community clinics, private providers, community agencies, professional organizations, and policymakers to improve access and further the goal of compassionate, comprehensive, continuous, and coordinated health care for all the people of the region.

RESOURCES:

Northwest AIDS Foundation 329-6923 x241
(Information and Referral)

Washington State Office on HIV/AIDS . 206/586-0426

AIDS Prevention Project Information Line . . 296-4999
TTY for Deaf Access 296-4843

REFERENCES:

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Number 8 December 1990

HIV PARTNER NOTIFICATION

BACKGROUND:

Partner notification is the process by which individuals who may have been exposed to a sexually transmitted disease (STD), including HIV/AIDS, are notified about their risk of infection and treatment options.

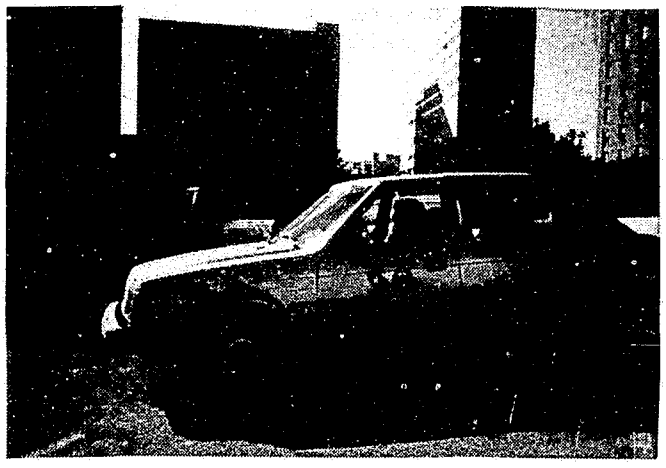
Since the 1930's, partner notification has been a standard public health intervention for treatable STD's (e.g. syphilis, gonorrhea), yielding personal health benefit for those who are notified and treated, as well as public health benefit in stopping the spread of the infection. Since the mid-1980's, most local public health jurisdictions in the United States have also established HIV partner notification programs, generating controversy.

Opponents of partner notification for HIV infection argue that:

- there is high potential for government misuse of sensitive information acquired in the course of identifying and locating partners;
- fear of potential privacy violations would keep people from obtaining the benefits of HIV testing;
- because there is no treatment to render a person with HIV non-infectious, notifying partners cannot definitively interrupt the chain of infection.

Proponents of partner notification for HIV infection argue that:

- health care providers and public health officials have an ethical obligation to warn identified third parties of their exposure to a serious infection;



- knowledge of exposure to HIV, and especially knowledge of actual infection, often leads to reduced risk-taking behavior, thereby decreasing the potential for spreading the infection;
- evidence of beneficial medical interventions for asymptomatic HIV infection (e.g., treatment with AZT or drugs to prevent opportunistic infections) obligate public health workers to locate people who may be unaware of their infection and to provide access to the benefits of medical and psychosocial interventions;
- public health partner notification programs have an excellent record of preserving confidentiality.

CURRENT LAW:

Washington state law requires health care providers to offer partner notification assistance to persons with HIV infection (RCW 70.24.320(2)). Washington state administrative code establishes rules for providing such assistance (WAC 248-100-076), which include privacy protection specific to HIV, including:

- names and addresses of partners may be reported by health care providers to public health for partner notification;

- seropositive patients may be referred by providers to public health for partner notification assistance; the names of people with HIV infection need not be reported to public health for this purpose, except for those persons who refuse to comply with prescribed infection control measures [WAC 248-100-021 ((2)(d))] including partner notification;

- records of names used in partner notification must be destroyed after three (3) months or after the partner is notified, whichever occurs first.

POLICY RECOMMENDATIONS:

To prevent potential transmission of HIV by persons who may be infected unknowingly and to encourage more timely medical interventions for such persons, it is the policy of the Seattle-King County Department of Public Health to:

- counsel and educate all persons with HIV infection about the need for partners to be notified;

- provide persons with assistance in notifying their partners in a confidential, timely, and effective manner; and

- assume the responsibility for notifying and counseling those partners when an infected person cannot or will not personally notify his/her partners.

For the purpose of this policy, "partners" are persons who have shared needles, engaged in any insertive sexual practices, or received blood or other tissues or organs from an HIV-infected individual. This policy will be applied on a case-by-case basis, recognizing the need to balance the public health concern for stopping the spread of HIV with the legitimate concerns of privacy, discrimination, stigmatization, and criminal prosecution.

- Confidentiality and discretion will be maintained at every point in this process, in accord with Washington law.

- To interfere least in persons' intimate relationships, several options will be offered. These include notification of the partner by the client, notification by the provider, and notification by Health Department personnel.

- Partner notification services will be provided in a manner that respects differences in language, culture, and lifestyle.

- Partner notification is inherently voluntary, and coercive measures (e.g., criminal prosecution or penalties) could be counterproductive to AIDS control. Except as required by law, such measures are not proposed, nor should they be inferred, from any part of this policy statement.

RESOURCES:

For information or assistance, call the SKCDPH Program Coordinator for HIV Counseling, Frank Chaffee, at 296-4649 (TTY 296-4843 for deaf access). Consultation does not require revealing the identity of the parties involved.

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Number 9 December 1990

HIV SEROPOSITIVE REPORTING

BACKGROUND:

Standard public health practice involves many strategies. One of these is the requirement for health care providers to report certain diseases and conditions to the local public health officer. Such reporting requirements serve three primary functions:

- **Epidemiology**: the science of understanding disease trends. This understanding contributes to the design of rational disease control programs.
- **Partner Notification**: assures that people who may have been exposed are notified, provided treatment, and given information to reduce transmission of infection to other persons. From a public health perspective, this is especially effective if the available treatment leaves the treated individual non-infectious, thereby breaking the cycle of disease transmission.
- **Treatment Decisions**: assures that each person with the disease receives prompt and proper treatment.

In Washington, health care providers have been required to report all AIDS cases since 1984. Reporting of all CDC Class IV HIV infections (AIDS plus AIDS-related conditions) began in 1987. This requirement has helped monitor the impact of the epidemic and project resource needs.

Tests for HIV infection (including asymptomatic HIV infection) became widely available in 1985. Since that time thirty-one states have implemented various forms of required reporting of non-AIDS HIV infection. Nineteen of those states require reporting of the identities of individuals with non-AIDS HIV infection (that is, all persons with positive tests for HIV).[1]

Should the identities of people with asymptomatic HIV infection be routinely reported to public health authorities?

To date, various professional organizations have endorsed conflicting policies on whether to recommend mandatory reporting of the identities of HIV seropositive persons to local public health authorities. For example, the American Medical Association supports reporting while the Washington State Medical Association opposes it.

Proponents argue that reporting the identities of seropositive persons:

- Would improve the documentation of epidemic trends. Current reporting of only AIDS cases reflects infections that occurred 3-10 years ago. Reporting asymptomatic seropositives would provide a more accurate reflection of recent infections and trends. Including the names is necessary to avoid duplication in counting the case numbers.
- Would allow for the development and maintenance of a confidential public health "register" of people with HIV infection. Such a register could:

a) improve the operation of HIV partner notification programs by avoiding duplication of effort on the same case (e.g. partner notification of a sex partner who was already known to be HIV seropositive and aware of his/her status);

b) facilitate enforcement of laws prohibiting behaviors that endanger the public health by providing documentation of when a person became aware of his/her HIV infection;

c) allow public health authorities to inform people with HIV infection about beneficial programs and treatments.

- Would not pose significant risks to the civil rights of people with HIV infection. Proponents cite the excellent public health record of maintaining the confidentiality of reports of other diseases.

Organizations that oppose mandatory reporting of the identities of HIV seropositive persons include the American Public Health Association, the National Academy of Sciences and the Institute of Medicine, the American Psychiatric Association, and the Washington State and California Medical Associations.

Opponents argue that identity reporting would be counterproductive because:

- Reporting is a deterrent to voluntary HIV testing. Multiple reported studies show that the threatened implementation of reporting[2] or lack of anonymous services can substantially reduce willingness to seek HIV counseling and testing.[3,4,5]

- Self-selection bias in requests for voluntary HIV testing compromises the validity of extrapolating disease trends from such data. Blinded probability samples are a more reliable way of monitoring disease trends. Such sampling does not require reporting the names of people who are seropositive.

- Keeping accurate registers is very expensive. The current annual cost of maintaining the Washington State AIDS/Class IV HIV registry is $500,000. A registry of asymptomatic seropositives is likely to be larger and more expensive, thereby depleting limited funds.

- The success of partner notification programs depends on the voluntary disclosure of the identities of sex or needle-sharing partners. A registry of seropositive persons is not essential to the success of an HIV partner notification program.

CURRENT LAW:

Under Washington state law, the State Board of Health determines which conditions are reportable to health authorities. Health care providers must report, with names, all cases of CDC Class IV HIV infection, including AIDS (WAC 248-100-076). Health care providers may not report the names of people with class I, II or III HIV infection (WAC 248-100-072(4)), except to request public health assistance in locating and personally notifying an individual who has not been informed of his/her positive HIV test result and to report individuals who are recklessly behaving in ways that could spread HIV.

POLICY RECOMMENDATIONS:

At present, the Seattle-King County Department of Public Health opposes the reporting of people with asymptomatic HIV infection. Such policies discourage voluntary HIV testing and do not appear to offer significant public health benefit in other areas of HIV control.

Because our understanding of HIV infection changes rapidly, this recommendation may change in the future. Reporting the identities of seropositive persons may be considered an effective and acceptable policy in the future, dependant upon some or all of the following conditions:

- Evidence of beneficial treatments that would further alter disease progression for people with asymptomatic HIV infection.

- Improved access to such treatments for all people who need them.

- Promptly enforceable antidiscrimination laws to protect people who have, or are perceived to have or be at risk for, AIDS or HIV infection (gay men, IV drug users, etc).

- If or when a treatment is developed that alters the chain of infection and renders an HIV-positive person non-infectious. This is not likely in the foreseeable future.

RESOURCES:

For information on current HIV/AIDS reporting requirements, contact the Health Department AIDS Surveillance Unit at 296-4645.

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4) Fordyce EJ, Sambula S, Stoneburner R. Mandatory reporting of human immunodeficiency virus testing would deter blacks and hispanics from being tested. JAMA, July 21, 1989; 262; pp 349.

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Number 10 **December 1990**

SUBSTANTIAL OCCUPATIONAL EXPOSURE TO HIV

BACKGROUND:

From 1981 to October 31, 1989 approximately 25 cases of occupationally acquired HIV infection had been documented in health care workers in the United States.[1] Eighteen of these cases involved needlestick exposures to HIV-infected blood. Seven cases resulted from exposure of mucous membranes or non-intact skin to HIV-infected blood.[1] The CDC has estimated that the risk of acquiring HIV infection following a single needlestick exposure to infected blood is approximately 0.4 percent.[1] Although this risk is low, it of legitimate concern to workers who may risk such exposures.

In-vitro and animal studies with other retroviruses have suggested that immediate post-exposure prophylaxis (preventive treatment) with the anti-retroviral agent, AZT (zidovudine), may decrease the chance of infection following exposure to a retrovirus.[2,3,4] However, because infection occurs so rarely following occupational exposures, because AZT prophylaxis failures have been documented,[5,6,7] and because long-term toxicity of AZT is not known, the value of this intervention is uncertain. Still more recently, a study showed that infection of monkeys with the simian immunodeficiency virus, which is related to HIV, was not prevented by AZT or other anti-retroviral drugs, even when treatment was started well before inoculation with the virus.

Despite these limitations, some exposed workers may want to consider post-exposure AZT prophylaxis. Current recommendations advise initiating prophylactic therapy within hours of the exposure. Because AZT can have serious side effects, it is reasonable for exposed workers to continue post-exposure AZT prophylaxis only after an exposure to someone who is definitely known to have HIV infection. These factors contribute to the worker's legitimate "need to know" the

HIV status of the person who was the source of the exposure; that information can significantly influence theworker's decisions regarding personal health care and sexual activity.

Except in special circumstances, testing for HIV infection is voluntary. The decision often involves the consideration of multiple psychological, medical and social factors. Following an accidental occupational exposure, the worker's "need to know" the HIV status of the person who was the source can conflict with the principle of respect for the autonomy of the source. This conflict is exacerbated when the person who is the source of the exposure does not want to undergo testing for HIV infection.

CURRENT LAW:

Washington law empowers the local Public Health Officer to order a person to undergo HIV testing when a law enforcement officer, firefighter, health care provider, or a person working in a health care facility is substantially exposed on the job to that person's blood or certain other body fluids (RCW 70.24.340). "Substantial exposure" and "exposure presenting

possible risk" have been defined by the State Board of Health (WAC 248-100-206).

POLICY RECOMMENDATIONS:

The Department recognizes that the need to inform the exposed health or public safety worker must be balanced by the need to protect the rights of the person to whom the worker was exposed.

Therefore, the Department will order involuntary testing only after reasonable attempts have been made to obtain voluntary consent from 1) the source, or when the patient is incompetent or deceased, 2) the source's legal guardian, or 3) the source's next of kin.

Because immediate post-exposure prophylaxis with AZT may be considered, a timely response is critical. Therefore, the Department expects that reasonable attempts to obtain voluntary consent will not unduly delay testing. An agency or person requesting an order to test should make three attempts over a 12-hour period to obtain cooperation from the source or his/her guardian or next of kin. However, the Department may waive or expand this requirement. If voluntary consent cannot be obtained and testing is still requested, then the supervisor or employee must contact the Public Health Department within seven (7) days.

RESOURCES:

Health Department staff is available 24 hours a day to offer advice and assistance following substantial exposures. For information or to request a testing order, call the HIV Program Coordinator at the AIDS Prevention Project at 296-4649 (TTY 296-4843 for deaf access). After hours, call 386-8900 and ask for the AIDS Project and give your name and phone number.

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