

Approved _____

Date 2-4-88
sh

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE

The meeting was called to order by Marvin L. Littlejohn at
Chairperson

1:30 /a.m./p.m. on February 2, 1988 in room 423-S of the Capitol.

All members were present except:

Committee staff present:

Emalene Correll, Research
Bill Wolff, Research
Norman Furse, Revisor
Sue Hill, Committee Secretary

Conferees appearing before the committee:

Representative Frank Buehler
Representative Max Moomaw
Representative Susan Roenbaugh
Dennis Moore, Johnson County District Attorney
Jim Clark, Douglas County District Attorney
Dr. Jack Walker, Lt. Governor of Kansas
Brenda Braden, Attorney General's Staff
Dr. Richard Parker, Director of Bureau/Epidemiology/Dept.H.& E.
Chip Wheelen, Ks. Medical Society
Elizabeth Taylor, Ks. Association/Local Health Departments
Keith Landis, Christian Science Committee on Publications for KS.
Harold Riehm, Ks. Assn. of Osteopathic Medicine
William Dean, Merrell Dow Chemical Company

Chairman called meeting to order, noting Staff briefing would be given on HB 2614, HB 2653, HB 2659.

Ms. Correll began with briefing on HB 2614. This bill places restrictions on newly developed homes' number of beds licensed. She explained the exceptions, i.e., paragraphs (b)(c)(e). From a technical standpoint, she suggested there might need to be clarification in this regard. She answered questions.

Briefing on HB 2659 began.

Ms. Correll cited the list of crimes that would call for mandated testing of AIDS and other communicable diseases by sex offenders. She defined statutes in regard to paragraph (b) in that the courts would be required to order that person convicted of such crimes to have a test for AIDS, and if positive, the results reported to the Secretary of Health and Environment. She explained who was qualified to perform the testing, and further explained the confidentiality language, fines for breach of such confidentiality. She answered questions.

Briefing on HB 2653 began.

Mr. Furse spoke to technical aspects of rules and Regulations; fees of \$25.00 for duplicate license; new language that would stagger registration so it will allow for a two year period of authorization of practice.

Briefing on HB 2654:

Mr. Furse explained the new fees fixed by the Board of Rules and Regs for Mental Health Technicians.

Chair thanked staff for their comprehensive briefing on all bills.

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE

room 423-S, Statehouse, at 1:30 // a.m./p.m. on February 2, 1988

Hearings began on HB 2659:-

Representative Buehler, who had introduced this legislation explained the bill would mandate AIDS virus testing for convicted sex offenders, provide for a fine for breach of confidentiality and would provide counseling for the victim of such crimes. We now know AIDS is fatal, contagious, and it is an epidemic. We must address the matter of protecting the innocent public from this disease. He explained he had served on Task Force in the Midwestern Legislative Conference of the Council of State Governments. They have met and studied and been educated, and at the close of summer conferences, he made the decision to introduce this legislation. He agrees education is vital, but sex offenders are not prone to accepting education. He cited the importance of counseling, spoke to fiscal impact that will plague our society in years to come. We must move forward in the protection of our citizens. (Attachment No.1)

Representative Max Moomaw stated Kansas needs to address the side of the victim in regard to this problem. Counseling is vital and HB 2659 covers this. He urged for support. He answered questions, i.e., perhaps language will need to be clarified in confidentiality section.

Representative Susan Roenbaugh spoke in support of HB 2659. This is an unfortunate disease, and we all know it won't go away. HB 2659 won't solve the problem, but it is a step forward. Education, counseling, are vital, and mandatory testing of sex offenders would speak to the victim's rights. She indicated (Attachment No.2) would allow those interested to send for literature on AIDS Issues, Care Policies/ Research, and other information.

Dennis Moore, Johnson County District Attorney gave hand-out, (see Attachment No.3) for details. He cited SB 517 is very much like HB 2659, and he praised language in this bill for the counseling sections. He has worked hard on victims rights, and feels we must protect innocent victims of criminal assault. He cited specific cases of victims, i.e., one of a brutal rape, and when she asked to have the perpetrator tested for AIDS, he had to tell her there were no statutes to authorize such testing. While drafting a proposed statute, he explained there were many things to be considered, i.e., that a person is entitled to presumption of innocence until proven guilty. A balancing of privacy rights of a person convicted of a sex crime against the right to know for the innocent victim of the sexual assault is what we are working for. Peace of mind for the innocent victim is important, and he urged for support of both HB 2659 and SB 517. He answered numerous questions, i.e., He isn't trying to lay blame, only trying to protect innocent victims; the perpetrator has given up some of his rights when he commits a terrible crime; we are trying to give the victim and families of victims all the information that we can; yes, he does urge the victims to also undergo testing for AIDS; yes, after a criminal is incarcerated there can be problems.

At this point Dr. Walker, stated a member of the Task Force was an individual representing the Corrections Institutions, and he suggested this committee might wish to hear her speak about what is being done in the prisons.

Jim Clark, Douglas County District Attorney, agreed with Mr. Moore in his testimony, then yielded his time for other conferees.

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-SStatehouse, at 1:30 a.m. on February 2, 1988

Hearings continued on HB 2659:--

Brenda Braden, Attorney General's staff stated their Department supports the passage of HB 2659, however she cited their concerns. There are things covered in the bill that need not be, i.e., battery, and indecent liberties with a child that includes fondling. It was suggested there might be a need to insert language to cite only crimes that could transmit the AIDS virus and not those just mentioned. Discussion and questions followed, i.e., perhaps a Judge might give a discretion order in cases where there are special circumstances; yes, each case is individual.

Dr. Richard L. Parker, Department of Health and Environment gave hand-out, (see Attachment No.4) for details. He stated their Department does not support HB 2659 because tests on the perpetrator are not useful in determining if transmission has occurred. Not all sex acts committed by an infected person will transmit the HIV virus 100% of the time. Because the perpetrator might become infected after the crime, and because there may be a period of time between the crime and conviction, the information obtained may be of little value. There is no test for AIDS. There is a test which detects the presence of antibody against the HIV in blood, and could indicate the presence of infection, but not the disease. they oppose this bill on technical grounds, certainly not on the intent to protect the victim.

Chip Wheelen, Kansas Medical Society gave hand-out, (Attachment No.5). He noted there is a large attachment that has been supplied from Centers for Disease Control Guidelines. (This is recorded as part of Attachment No.5) The Kansas Medical Society is neither in favor of, nor against HB 2659, but he speaks to this committee for the purpose of their Society's position on AIDS. Their membership has studied the medical side of this problem, not the criminal side the bill speaks to. They propose testing be done voluntarily and with informed consent/that a positive ELISA test be confirmed with Western Blot test/that testing be administered only if trained personnel are available for pre and post-test counseling. He spoke to their interest in the exemption from immunity for liability found in the bill.

At this point Dr. Walker stated there are 30-40 testing places in Kansas, and none is permitted to test without also giving counseling. Many of these tests are done free of charge. Counseling is an integral part of testing.

Elizabeth Taylor, Kansas Association of Local Health departments, gave hand-out, (Attachment No.6). Their Association is in these testing sites spoken of earlier. However, they will not speak this date for, nor against HB 2659, but would like to indicate their position on AIDS prevention and control. All this is outlined in Attachment No. 6.

Keith Landis, Christian Science Committee on Publications, (Attachment NO.7) spoke to HB 2659, saying their people believe an individual should be allowed to select the type of health care he wishes. In this bill those required to be tested would be convicted sex offenders, and barring the remote possibility of an innocent person being convicted, they feel would not be practicing their teachings. Present wording of the bill allows a victim to reject counseling if they wish to do so. We have no problem with this legislation, he said.

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,
room 423-S Statehouse, at 1:30 a.m. on February 2, 1988

Hearings continued on HB 2659:--Harold E. Riehm, Executive Director, Ks. Assn. Osteopathic Medicine, furnished hand-out, (see Attachment No.8) as testimony presented by Dr. William Wade, D.O., on SB 445. This part of his testimony, Mr. Riehm stated is pertinent to contents of HB 2659, i.e., medically he said, it makes little sense to test the perpetrator of these mentioned offenses. Whether or not they test positive, they could still be infected and must be assumed to be so. They feel the only way to offer peace of mind to the victim of sexual assaults is to provide counseling and free, confidential testing for them 12 weeks after the incident. He answered numerous questions.

Brief remarks were made by Mr. Bill Dean, Merrell Dow at the invitation of Chair. He stated he supports the position taken in HB 2659, everyone convicted should be tested routinely.

Meeting adjourned 3:00 p.m.

FRANK BUEHLER

REPRESENTATIVE, ONE HUNDRED THIRTEENTH DISTRICT
BARTON COUNTY
P.O. BOX 317
CLAFLIN, KANSAS 67525-0317



TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS

VICE CHAIRMAN PUBLIC HEALTH AND WELFARE
MEMBER JUDICIARY
LABOR AND INDUSTRY

HOUSE BILL 2659

Feb. 1, 1988

Mandated Aids Virus Testing for Convicted Sex offenders.
Provides a Fine for Breach of Confidentially and Provides
Counseling for the Victim.

There are three things we know for certain about Aids.
IT IS FATAL - IT IS CONTAGIOUS - IT IS EPIDEMIC.
We just simply have to address the matter of protecting the
innocent public from this fatal disease.

I have been privileged to be a member of a Task Force on
Health Care for The Midwestern Legislative Conference of The
Council of State Governments. Kansas is one of the 12 states
that make up the Midwestern Conference.

This Task Force has twice met to address the Aids crisis.
In Feb. of 1987, we met in St. Louis and most recently in
Nov. we met in Chicago. At the conclusion of the Chicago
meeting my decision to introduce HB 2659 was made. At that
meeting we discussed this catastrophic disease with Illinois
Free Community Based Services. With Illinois Correction
Officials, American Civil Liberties Union and Illinois
Legislators.

At the conclusion of this meeting as I discussed the problem
with our Task Force Chairperson, Senator Patricia Miller of
the Indiana Senate, she stated that she was introducing
legislation similar to HB 2659 in Indiana this year and urged
me to do likewise in Kansas and bring this issue squarely
before the Kansas Legislature for a decision.

Heretofore, the emphasis has been on education. I find no
fault with education as a method of addressing Aids.
However, the time has come when we need to become more
positive in protecting the innocent of society. I offer for

*Attn. #1
2-2-8
P&W*

your consideration that SEX OFFENDERS ARE NOT PRONE TO ACCEPTING EDUCATION.

Please let me press that we have positive access to Convicted Sex Offenders and they can hardly move underground to escape observation. This legislative proposal contains a severe penalty for breach of confidentiality and the provision for victim counseling if of prime importance. Because of these provisions, I think that HB 2659 is necessary for protection of society.

In 1979 I received two transfusions, This was prior to testing of all blood for Aids Virus. I have always been an advocate for testing of persons who may have been exposed to the virus. It is my opinion that those who advocate testing should set an example. I used the fact that I had been transfused as justification to ask for aids virus testing for myself. I was so impressed with the counseling that was a part of the testing that I just know that any who may have been exposed to this fatal disease should realize the necessity of caution in protecting others as well as for their own future health.

At the last Task Force Meeting we addressed costs to society. We learned that costs to the public are underestimated by 20% at this time. This is calculated on cases identified in 1981 but as time goes by, we may find new ways to identify this disease and the numbers will increase and the costs as well. Estimated full cost per patient now are considered to be from \$20,320 to \$43,000 per year. By 1991, costs per patient will be recorded as high as \$270,000 and could reach \$500,000. Lifetime hospital costs will be from 25 to 50 thousand dollars per person. Currently, medicaid pays for 40% of the cases but only 25% of the costs. In 1987 Medicaid expenses were expected to reach 400 to 800 million. San Francisco alone in 1987 spent over 17 million.

I am anxious for you to hear from the other conferees and I will be prepared to actively and aggressively participate in the dialogue as we debate this issue in committee. If you have any questions that will not hold until later, I'll be glad to respond at this time, but in the interest of time, perhaps you'd rather hear from the other interested parties.

Frank Buehler
State Representative

AIDS: A Public Health Challenge To The States

A State Policymaker's Guidebook

The Intergovernmental Health Policy Project at the George Washington University will publish **AIDS: A Public Health Challenge To The States**. This report will identify and analyze key policy issues of concern to state health policymakers, suggest courses of action for these concerns, and describe in detail the most innovative programs underway in the states. State legislation and reports of state AIDS task forces will also be described.

This comprehensive, broad-based policy guidebook should be of immense help to those states which have just begun to address some of the AIDS-related policy issues. The guidebook should also help states that have AIDS programs underway by highlighting innovative ways to enhance their existing efforts.

ISSUES

- **Screening/Testing** (special populations, informed consent, counseling, alternative test sites, protocols)
- **Managing the Needs of Special Populations** (women, mothers, children, minorities, persons at increased risk)
- **Confidentiality** (legal strategies to protect private and public information, medical record laws, physician responsibilities)
- **Research** (funding, types, state models)
- **Medical Care** (infection control procedures, transplants, comprehensive systems of care, designated centers)
- **Financing Care and Service Programs** (federal, state and private financing, qualifying for financing innovative programs)
- **Surveillance** (AIDS/ARC/HIV reporting, comparisons of state contact tracing and notification programs, cost-benefit considerations)
- **Potential Discrimination** (in employment/insurance; HIV infection as a handicap)
- **Education** (for public schools/colleges, persons at increased risk, minorities, health professionals and the public)
- **Support Services** (types, funding, availability)
- **Administrative/Organization** (policymaking bodies, program organization, planning efforts)

FEATURES

- Outlines major policy questions
- Describes state programs and policies in response to AIDS-related problems
- "Insight Sections" on special policy issues or background information
- Summarizes major policy considerations and commonly recognized advantages and disadvantages
- Identifies key elements that help or impede the implementation of state programs
- Resource Listings

See Other Side For Order Form

*Attn #2
2-2-88
PRD*

AIDS: A Public Health Challenge To The States will be available in July 1987. To order, please complete this form and return to:
IHPP, 2100 Pennsylvania Avenue, N.W., Suite 616, Washington, D.C. 20037

Name/Title _____

Organization _____

Address _____

City/State/Zip _____

The publication will be released in three volumes. Each volume will cost \$30.00. The complete set can be purchased for \$80.00. Make checks payable to IHPP.

STATE OF KANSAS
Tenth Judicial District

OFFICE OF DISTRICT ATTORNEY

DENNIS W. MOORE
DISTRICT ATTORNEY

JOHNSON COUNTY COURTHOUSE
P.O. Box 728, 6TH FLOOR TOWER
OLATHE, KANSAS 66061
913-782-5000, EXT. 333

February 2, 1988

Dear Senate/House Committee Member:

I appreciate the opportunity to be here today to testify in support of SB 517 and HB 2659.

In 1981 the United States Centers for Disease Control (CDC) recognized Acquired Immune Deficiency Syndrome (AIDS) as a disease. The CDC reports that as of February, 1987 there were approximately 30,000 cases of persons with AIDS in this country and that as many as 1.5 million persons are carriers of the AIDS virus, although they have not developed the disease. We are told by the CDC that AIDS can only be spread by blood transfusions (contaminated blood), intimate sexual contact and sharing needles for intravenous drug injections. The public's awareness and concern about the AIDS epidemic has spread almost as rapidly as the number of cases. There is much information and misinformation in the public domain. While we must not respond in a hysterical manner to concerns about AIDS, we have a right to use reasonable and legitimate means to protect and provide information to persons who are innocent victims of the criminal acts of others who may be infected with AIDS.

I was contacted several weeks ago by a young woman who was the victim of a brutal rape. She awoke in the middle of the night to find a man in her bed with a knife at her throat. He proceeded to have vaginal sex with her and attempted anal intercourse. He forced her to perform oral sex on him.

Through the investigation that followed, the young woman's assailant was identified, charged and the defendant entered a plea of guilty to rape and aggravated criminal sodomy. The woman contacted me and asked if we might test the defendant's blood to determine if he was a carrier of the AIDS virus. She was concerned that she might have been exposed to AIDS.

The woman's inquiry presented two legal questions: (1) is there legal authority to conduct a test for the AIDS virus on the blood of a person charged or convicted who does not consent to the test? and (2) is there legal authority to disclose the

*Attn. # 3
PNW
2-2-8*

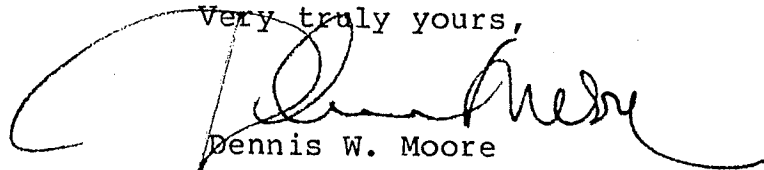
results of that test to the crime victim? My legal research indicated that the answer to both questions is "No".

It is common for prosecutors in a sexual assault case to obtain a search warrant to obtain known samples of body evidence from a person charged with a crime for comparison with evidence found at the scene of the crime. The tests are used to establish identification of the person charged with the crime. However, even though it is legal with a search warrant to draw blood from a defendant for purposes of evidence comparison, there is no specific legal authority in Kansas that permits prosecutors to use that blood to test for AIDS or any other disease. And even assuming that there was authority for such testing, there are substantial personal and constitutional privacy considerations as to whether, absent consent by the defendant, results of such a test could be provided to anyone, including the victim of a forced sexual attack. I advised the victim in this rape case of my findings. She was disappointed.

In drafting a proposed statute, I considered whether there might be circumstances where it would be appropriate to test a person charged with a sex crime, prior to conviction. But under our system of laws, a person is entitled to a presumption of innocence until the State proves his guilt beyond a reasonable doubt. In my opinion, a statute which permits testing the blood of a defendant convicted of a sex crime has a much greater chance of being upheld on appeal. What is involved, of course, is a balancing of the privacy rights of a person convicted of a sex crime against the right to know for the innocent victim of a sexual assault. While a person accused of a crime has important constitutional rights which must be protected, once that person has been convicted then perhaps the balance should shift in favor of the victim's right to know. I believe there is a strong societal interest in providing some measure of peace of mind (hopefully by a negative test result) if a victim asks if she has been exposed to the AIDS virus by a forced sexual assault.

I urge your support of SB 517 and HB 2659.

Very truly yours,

A handwritten signature in cursive script, appearing to read "Dennis W. Moore". The signature is written in dark ink and is positioned above the printed name.

Dennis W. Moore

DWM:JH

P.S. Enclosed is a letter from the victim in the rape case I mentioned.

Dear Dennis,

1/4/88

Thank you again for your help. I appreciate the efficient and sensitive way my case was handled. It was such a relief not to have to go to trial. Enclosed is the letter you requested. If I can be of further assistance, please let me know.

Sincerely,

M. J. ...

December 30, 1987

To the Kansas State Legislature:

I am writing this letter to plead for mandatory AIDS testing. This summer, I was the victim of a sexual assault. A man broke into my house on August 2, 1987 at two o'clock in the morning and raped me. As a medical student my first concern was for my health and the possibility of contracting AIDS. The disease process of AIDS is such that it may not manifest itself for a significant amount of time such as months to even years. I could potentially be a carrier and unknowingly infect others, such as loved ones.

By violating and abusing my rights the rapist is relinquishing his own rights. Coping with the whole ordeal of being violated and putting your life back together is difficult enough without having to also live with the fear of AIDS.

Requiring AIDS testing of the rapist will put my mind at ease as well as enable me to put the whole event in the past. I was fortunate in that the man who raped me consented to be tested for AIDS. But, even at this it took several months before this arrangement was made.

Most rape victims are not as fortunate and must live with the anxiety of whether or not they were exposed to the AIDS virus. If we can insist on our soldiers being tested how can you turn your back on the rights of the innocent victim and let them live with not only the permanent scars of an assault, but also the fear that they may have AIDS.

Sincerely,

A Victim

Executive Board

Sergeant Craig Hill, President
Detective, Investigations Division
Leawood Police Department
Sergeant Richard King, Exec VP
Gladstone Dept Public Safety
Detective Mike Smitley, Sec
Lee's Summit Police Department
Officer Brenda Haupt, Treas
Kansas City Police Department
Sergeant Steve Jensen, VP
Kansas Highway Patrol
Sergeant Curt Mathews, VP
Missouri State Highway Patrol
Don Cahail
Applause Video
Theresa Donaldson
Children's Mercy Hospital
Larry Moore
KMBC-TV

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James Mallow
Linda Mallow
Harry McLearn
Stan Rose
Tricia Scott
David Stallings
Robert T. Stephan
John Walsh
William L. Webster
George Weyrauch II
Phil Witt
Lisa Valenti

December 29, 1987

87 DEC 30
RECEIVED
JOHNSON COUNTY
DISTRICT ATTORNEY

RE: AIDS Task Force

Dear :

Working in the field of missing and sexually abused children, I was confused and concerned after reading the attached article wherein the Task Force declined to recommend mandatory testing for AIDS on sex offenders.

I would appreciate receiving an explanation regarding the "high cost". I would also like to receive a copy of the Task Force's recommendations.

I am attaching two other articles, one titled "Aids calls double" and the other "Specter of AIDS looms in sexual abuse of children". Also, please see 1985 F.B.I. Crime Clock and supporting documentation which covers "reported" rape of female adults only.

I strongly support District Attorney Moore's position that all rape victims (and their families) have a right to know if they have been exposed to the deadly AIDS disease.

THE LOST CHILD NETWORK
...in partnership
to protect
our children

Joanna Engel
Joanna Engel, Admin. Coordinator

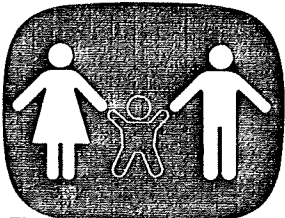
je

Attachments

bcc: District Attorney Dennis Moore
Representative Gene Amos
Governor Mike Hayden
Attorney General Bob Stephan

bps: This letter sent to AIDS Task Force members per attached list.

Education, Awareness, Recovery



The Lost Child Network.

• 8900 STATE LINE ROAD • SUITE 351 • LEAWOOD, KANSAS 66206 • 913 649-6723

STATE OF KANSAS



DEPARTMENT OF HEALTH AND ENVIRONMENT

Forbes Field
Topeka, Kansas 66620-0001
Phone (913) 296-1500

Mike Hayden, Governor

Stanley C. Grant, Ph.D., Secretary
Gary K. Hulett, Ph.D., Under Secretary

Testimony Presented to
House Public Health and Welfare Committee
by
The Kansas Department of Health and Environment

House Bill 2659

This bill calls for testing of persons convicted of certain sex crimes. We do not support this because tests on the perpetrator are not useful in determining if transmission has occurred. Not all sex acts committed by an infected person will transmit the HIV virus all of the time. Because the perpetrator might become infected after committing the crime, and because some period of time might elapse before conviction, the information obtained would be of little value to the victim. The numbers would not be great (approximately 144 convictions per year) and the public health impact would be minimal.

The fundamental question is whether or not the victim has been infected. As an alternative, counseling and voluntary testing of the victim is recommended.

The definition of "AIDS Test" is technically inexact (there is no laboratory test for AIDS; there is, however, a test which detects the presence of antibody against the HIV in blood and is therefore presumptive of the presence of infection but not of disease).

Presented by:
Richard L. Parker, DVM, MPH
Director, Bureau of Epidemiology
February 2, 1988

*Attn #4
2-2-8
P.H.U.*



KANSAS MEDICAL SOCIETY

1300 Topeka Avenue · Topeka, Kansas 66612 · (913) 235-2383

Position Statement on AIDS

The Kansas Medical Society recognizes the impact that virally transmitted AIDS and AIDS-related complex have on our state and country. Projected medical and economic concerns increase daily, reflecting the growing number of cases reported to the Centers for Disease Control.

Consistent with KMS policy that all patients should have competent and humane medical care, no patient should be discriminated against or denied medical care on the basis of a known or suspected diagnosis. All physicians and surgeons, nurses, other health care professionals, and hospitals should either render services to patients with AIDS or AIDS-related complex, or promptly refer to another physician who is competent to care for such patients.

In the area of professional and public education, the Kansas Medical Society will strive to keep its members informed by disseminating information on AIDS in a timely manner, to reprint information about AIDS in KANSAS MEDICINE, and to promote continuing education on AIDS to KMS members.

Additionally, KMS will help establish a speakers bureau for health care professionals that can help educate both professionals and lay people concerning AIDS. The Kansas Medical Society also supports appropriate educational efforts which will enable all citizens of Kansas to become informed about AIDS.

In the area of HIV testing, the KMS suggests that testing be: 1) voluntary and with informed consent; 2) that a positive ELISA test be confirmed with a Western Blot test; and 3) that testing be administered only if trained personnel are available for pre- and post-test counselling.

The KMS also adopts by reference the guidelines and recommendations contained in the following Center for Disease Control publications:

1. CDC Recommendations for Control of AIDS and for the Protection of Health Care Workers and Their Patients.
2. CDC Perspectives in Disease Prevention and Health Promotion.
3. CDC Guidelines for the Control of Perinatal Transmission of HIV.
4. CDC Revision of CDC Surveillance Case Definition for AIDS of August, 1987.

Finally, KMS endorses the recommendations, findings and guidelines for physicians contained in the following AMA reports: 1) AMA Board of Trustees Report YY (A-87); and 2) Council on Ethical and Judicial Affairs Report A (I-87).

*Attm # 5
2-2-8
P.H.W.*

REPORT OF THE BOARD OF TRUSTEES

Report: YY
(A-87)

Subject: Prevention and Control of AIDS -
An Interim Report

Presented by: Alan R. Nelson, M.D., Chairman

Referred to: Reference Committee E
(Alfred J. Clementi, M.D., Chairman)

1 Introduction
2

3 Responding sensitively, intelligently, and effectively to the
4 growing AIDS crisis is one of the crucial public health problems
5 facing the nation. Prevention and control of the disease must be an
6 essential part of that response because there is, at present, no
7 known cure for AIDS patients.
8

9 Recommendations in this report have as their foundation an
10 overriding concern for a judicious balance between the well-being of
11 HIV positive patients and the protection of the public health.
12 These recommendations are based upon the best information and data
13 available at present. The AMA will continuously monitor and analyze
14 developments in AIDS and update AMA policy and recommendations as
15 dictated by advances in knowledge.
16

17 Education continues to be the major weapon against spread of
18 HIV infection. Physicians should assume the leadership role in
19 educating themselves, their patients and the public. Individuals in
20 society also must assume responsibility for being well-informed and
21 for actions that affect their own health and the health of others.
22 In developing this report, the Board emphasizes the need for
23 concerted and cooperative efforts by all members of society in the
24 fight against AIDS. The recommendations outlined below are designed
25 to help in successfully confronting this challenge to society's
26 well-being.
27

28 I. Background
29

30 A. The Current Climate
31

32 It is estimated that five to ten million people are
33 infected with HIV virus worldwide. AIDS has been reported in more
34 than one hundred countries. In the United States HIV-infected
35 individuals may number one and one-half (1.5) million, approximately
36 35,000 of whom have been reported to suffer from AIDS and more than
37 20,000 of whom are dead.

1 The U.S. Public Health Service has projected that by 1991 there
2 may be 323,000 reported patients with AIDS and as many as 200,000 of
3 them may be dead by that time. In addition, conversion rates of
4 seropositive people to AIDS status now appear to be higher than
5 early preliminary estimates. Originally under 20% were thought to
6 convert. It now appears that, without treatment advances, a much
7 higher percentage will develop the disease.

8
9 Seventeen percent of the AIDS cases have been intravenous drug
10 abusers; 66% have been homosexual/bisexual men; 8% have been
11 homosexual male IV drug users; female, heterosexual male, and
12 pediatric victims infected by the transfusion of blood or blood
13 products, sexual contact, or prenatally in the case of infants,
14 account for the bulk of the balance.

15
16 Polls indicate that AIDS has become the highest priority health
17 concern of the American public, ahead of heart disease and cancer.
18 It has already caused changes in a variety of public attitudes.
19 Sexual abstinence, monogamous relationships, and the use of condoms
20 are being widely promoted in the media by public officials and many
21 private organizations. IV drug abusers are being counseled to use
22 clean needles and to avoid sharing needles. Education on the sexual
23 transmission of the AIDS virus is being extended to school
24 children. The nation is more sensitive to the rights of those
25 afflicted with the disease to be free from discrimination,
26 regardless of the manner by which they became infected.

27
28 B. Historical Control Measures for Infectious Diseases

29
30 A primary mode of transmission of AIDS is through sexual
31 contact, and the control efforts for sexually transmitted diseases
32 (STD) that have been instituted in the past are sources of analogies
33 for prevention and control of AIDS. National programs to control
34 STDs were established during the beginning of World War I. For the
35 following 50 years the focus was almost exclusively on the control
36 of syphilis and its complications. During World War II rapid
37 treatment centers for syphilis and gonorrhea were established.
38 Public health officials instituted limited contact-tracing, had the
39 authority to close sex bars and clubs, to order tests for
40 prostitutes, and, most importantly, had effective therapy to offer.
41 Widespread availability of penicillin led to the dissolution of the
42 rapid treatment centers and of the clinical speciality,
43 syphilology. Every state in the Union at one time required all
44 persons seeking marriage licenses to be tested for syphilis. During
45 the 1950s and 1960s federal assistance programs continued to support
46 contact-tracing, serological screening, and patient education.

47
48 In the late 1960s public health officials were concerned about
49 the rapidly escalating cases of gonorrhea, and projects were
50 instituted to increase case-finding and contact-tracing. In 1972

1 financial assistance for STD control by the federal government was
2 dramatically increased and by 1982 gonorrhea accounted for nearly
3 three-fourths of the federal STD dollar. During the 1970s gonorrhea
4 control efforts evolved through overlapping phases that included
5 objectives to lower disease incidence and the occurrence of
6 drug-resistant bacteria, focused screening on high-risk patients,
7 intensified follow-up of treatment failures, and used patient
8 counseling as a means of increasing compliance with therapy and
9 improving contact-tracing. The latter was deemed especially
10 important since the large numbers of gonorrhea cases precluded the
11 intensive follow-up of each infected case that had been
12 characteristic of the syphilis era.

13
14 In 1982 the World Health Organization/Pan American Health
15 Organization (WHO/PAHO) identified the following key objectives for
16 intervention to reduce STDs:

- 17
18 1. To minimize disease exposure by reducing sexual
19 intercourse with persons who have a high probability
20 of infection.
21
22 2. To prevent infection by increasing the use of condoms
23 or other prophylactic barriers.
24
25 3. To detect and cure disease by implementing screening
26 programs, providing effective diagnostic and
27 treatment facilities, and promoting health-seeking
28 behaviors.
29
30 4. To limit complications of infections by providing
31 early treatment to symptomatic and asymptomatic
32 infected individuals.
33
34 5. To limit disease transmission within the community
35 through the above efforts.
36

37 These objectives were used as a framework for the current
38 United States program regarding STDs, which consists of the
39 following components:

- 40
41 1. Health education and promotion.
42
43 2. Disease detection through testing and other means.
44
45 3. Appropriate treatment.
46
47 4. Contact tracing and patient counseling.
48
49 5. Clinical services.

1 6. Training.

2
3 7. Research.

4
5 C. The Challenge of AIDS Control

6
7 It might seem reasonable to extend the experience in
8 preventing the spread of other STD infections to AIDS. The
9 objectives established by WHO/PAHO and the components of the current
10 national STD program are certainly applicable to AIDS. However,
11 AIDS presents a much different social problem than other STD
12 infections. Since there is no cure for AIDS and no protection
13 beyond avoiding or making safer intimate contact with infected
14 individuals, those infected with the virus must be sexually isolated
15 from uninfected persons. A condom barrier offers some but not
16 complete protection. Avoidance of sexual contact and use of shared
17 needles are the only sure protections.

18
19 Further, the stigma that accompanies a diagnosis of AIDS, based
20 on fear and society's attitude toward IV drug abusers and
21 homosexuals, presents a factor beyond the control of the infected
22 individual or medicine. An HIV-seropositive individual who might
23 live five years or much longer with no overt health problems, once
24 identified in a community, may be subject to many and varied
25 discriminations—by family and loved ones, by neighbors and friends,
26 by employers and fellow employees, and by other providers of
27 services.

28
29 As with prevention and control of all contagious diseases,
30 prevention and control of AIDS involves two, sometimes competing,
31 concerns. First, the person who is afflicted with the disease needs
32 compassionate treatment, and both those who have the disease and
33 those who have been infected with the virus should not be subjected
34 to irrational discrimination based on fear, prejudice or
35 stereotype. Second, and of critical importance, the uninfected must
36 be protected; those individuals who are not infected with the AIDS
37 virus must have every opportunity to avoid transmission of the
38 disease to them.

39
40 II. The Need for a National Policy on Aids

41
42 Given the growing dimensions of the crisis and given limited
43 national resources, it is imperative that a national policy be
44 developed jointly by the public and private sectors. Such a policy
45 must seek, in a cost-effective way, to achieve fundamental national
46 goals: prevention, treatment, and cure — and adequate research in
47 all three areas. A coherent national approach to this modern killer
48 is needed: a comprehensive blue print for a national response, not
49 piecemeal solutions. Knowledge of the disease is now more than six
50 years old and the growing magnitude of the problem has been apparent
51 for nearly that long.

1 Such a national policy must have certain characteristics:
2

- 3 • The policy must be comprehensive, proceeding
4 simultaneously on the fronts of prevention, treatment, and
5 research.
6
- 7 • The policy must be coordinated between public and private
8 sectors and between the different levels of government. A
9 national policy does not necessarily mean a federal
10 policy: there are important roles at all levels of the
11 health care systems and at all levels of government. Nor
12 does it necessarily mean uniformity: on certain issues
13 different approaches should be tried to determine efficacy.
14
- 15 • The policy must be carefully balanced. For example,
16 concern for the person with the disease must be balanced
17 with concern for those who do not have the disease but who
18 may become infected. Similarly, careful consideration
19 must be given to directing scarce resources to increased
20 prevention, even as increasingly large resources are
21 necessarily devoted to research and treatment.
22
- 23 • The policy must be based on scientific information and
24 medical judgments. Although policy choices must
25 inevitably be made, they should be formed on the best
26 available information and on the extensive public health
27 experience in dealing both with AIDS and with other
28 contagious diseases.
29
- 30 • The policy should be nonpartisan. Although it may be
31 tempting to play on fears and prejudices, public figures
32 and officials both inside and outside the health community
33 should avoid exploiting the crisis for partisan political
34 advantage.
35
- 36 • The policy should be capable of continuous review and
37 modification as more and better information becomes
38 available.
39

40 RECOMMENDATION 1:
41

42 A Commission, modeled after the commission which made recom-
43 mendations on the problems of Social Security financing in the early
44 1980s, should be constituted with representatives from the Executive
45 branch of the federal government, the Congress, state and local
46 government, and the private sector and directed to develop a
47 consensus position for consideration by the Congress, the Executive,
48 state and local governments and private associations and
49 institutions. The presidential commission announced, but not yet

1 appointed, by the Administration could be broadened to implement
2 this recommendation. A high-level body with representatives from
3 the different branches and levels of government, but operating to
4 the side of the more formal political processes, may have the best
5 chance of forging the necessary national consensus which can then
6 become the basis for concerted and coordinated action by both the
7 public and private sectors.

8
9 III. The Special Role of Physicians and Other Health Care Counselors

10
11 Because there is no cure for AIDS, effective preventive
12 techniques are vital. This involves both those who are infected and
13 those who are not. Those who are infected must be identified so
14 that they will not unknowingly transmit the disease to others. Many
15 who are not infected will need to change their behavior
16 substantially to minimize their risk of infection by the AIDS virus.

17
18 The key to changed behavior is public education coupled with
19 counseling which must be given by physicians and other health care
20 counselors.

21
22 A. Public Awareness

23
24 The public is well aware of AIDS in a general sense. The
25 attention of the media has been intensively focused on the disease.
26 Translating general awareness into modifications of behavior is the
27 challenge.

28
29 The groups that are most at risk for AIDS, e.g., IV drug
30 abusers, homosexuals, bisexuals, and prostitutes, have reason to
31 know they are at risk. Their contacts, however, may not know they
32 are at risk and hence spouses, unborn babies, and premarital and
33 extramarital sexual partners may become infected. Education and
34 counseling aimed at the high-risk groups must be the first
35 priority. The education should urge immediate counseling with a
36 physician or other health care counselor about the risk of AIDS, the
37 uses of antibody testing and preventive measures.

38
39 Also, it must be recognized that persons in these groups may
40 not respond to education and counseling and, when they do not, more
41 aggressive programs--such as expanded methadone maintenance programs
42 or penalties for knowingly exposing others--must be considered.

43
44 Education aimed at the more general population is difficult for
45 at least two reasons. First, reaching all Americans with an
46 effective message can be expensive and not all people respond in the
47 same way or to the same method of learning. Messages must therefore
48 be tailored to the target audience in question. Second, preventive
49 messages must necessarily deal with controversial subject matter.
50 Widespread use of the electronic media -- especially television --

1 appears to be the most effective way to reach the general public.
2 Accordingly, public service advertising on the electronic media must
3 be greatly increased and these announcements must be shown at times
4 and in places where they will be viewed by those who need the
5 message most.
6

7 The AMA will continue its efforts to place its own public
8 service ads on national television. AMA's Tony Danza public service
9 advertisement (PSA) directed at teenagers about abstinence and
10 condoms, and other PSAs which the networks have agreed to use, are
11 significant first steps. But, more must be done and it must be
12 nationally coordinated.
13

14 RECOMMENDATION 2: 15

16 The communications industry must develop voluntary guidelines for
17 public service advertising regarding AIDS in consultation with the
18 health care community and government officials. The AMA intends to
19 be a catalyst in this effort to immediately bring the communications
20 and health care communities together.
21

22 B. Counseling--And Educating Counselors 23

24 Perhaps the greatest need at the present time is effective
25 counseling of both low-risk and high-risk populations by physicians
26 or other health care counselors. A massive education effort for
27 physicians and other counselors is necessary as a first step.
28 Complete and accurate information on the disease, the modes of
29 transmission, the appropriate application of antibody testing, and
30 effective ways to change behavior must be understood by counselors
31 if it is to be properly communicated to patients. In conjunction
32 with face-to-face counseling, printed materials--like the Surgeon
33 General's recent 36-page report on AIDS--should be widely
34 disseminated.
35

36 Even more challenging than preparing physicians and others for
37 generic counseling on AIDS is preparing these counselors to assist
38 those who test positive and are infected with the virus. It is at
39 that time that a change of behavior on the part of the person
40 infected is most critical, and it is then that the most
41 sophisticated counseling is required due to the emotional impact of
42 the test results. There is no higher prevention priority than
43 ensuring that the community of individuals who provide health care
44 counseling be given adequate tools to be effective. And the AMA, as
45 the largest organization of physicians in the world, must take a
46 leading role in this undertaking.
47

48 RECOMMENDATION 3: 49

50 A conference should be immediately held between the AMA, other

1 physician organizations and public health officials at all levels of
2 government to determine:

- 3
4 1. The types of education and training that are necessary for
5 effective counseling.
6
7 2. The people in the health care community who should receive
8 this education and training.
9
10 3. The current resources available for such education and
11 training.
12
13 4. Recommendations for providing additional resources,
14 including consideration of the respective roles of medical
15 associations and government at all levels.
16
17 5. Recommendations on how to update information continually
18 as new scientific data are developed.
19
20 6. Recommendations as to alternative measures to prevent the
21 spread of AIDS where education and counseling are not
22 likely to be effective, particularly among IV drug users,
23 through such programs as expanded methadone maintenance.
24

25 The AMA will promptly and widely report on the conference findings
26 and assist in the implementation of the conference recommendations.
27

28 C. Voluntary and Mandatory Testing
29

30 Knowledge that a person is infected with the AIDS virus
31 can be the crucial predicate to changing behavior. Thus, testing
32 for an antibody to the AIDS virus, when used in conjunction with
33 appropriate counseling (and when offered in the context of
34 appropriate anti-discrimination and confidentiality protections
35 discussed below), serves the important public health purpose of
36 providing impetus for behavior changes that minimize the risk of
37 transmitting the AIDS virus.
38

39 Clearly, the need for HIV-antibody testing has expanded beyond
40 its original purpose, the screening of blood donors. Guidelines for
41 the appropriate use of HIV-antibody testing must center on the
42 following justifications:
43

- 44 1. To identify infected persons and to offer treatment
45 where possible and to protect uninfected third
46 parties.
47
48 2. To offer education and counseling that would modify
49 high risk behavior.

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3. To solicit patient cooperation for locating and referring sex partners.
4. To obtain broadened epidemiological statistics on the prevalence of HIV infection in the population.

In addition, in considering the merits of voluntary versus mandatory testing, these facts about AIDS must be kept in mind:

1. AIDS is caused by an infectious agent, and therefore is an infectious disease. Appropriate precautions, procedures, and policies should be applied to protect the community from the spread of the disease.
2. The extent to which the AIDS virus already has spread into the general population is not completely understood. Current projections are based on a number of unverified assumptions.
3. The transmission of the AIDS virus does not occur through casual contacts. Sexual contact, septic intravenous equipment, and the administration of infected blood and blood products are the main modes of transmission.
4. Heterosexual transmission of the AIDS virus, especially from males to females, does occur.
5. Seropositive pregnant females will transmit the virus to their babies in a high percentage of cases.
6. Health care workers, especially those who perform invasive surgical procedures, and emergency room and laboratory personnel, are at some risk when caring for AIDS patients.
7. No patient with a clinical case of AIDS has survived the disease. The disease has been uniformly fatal.
8. The disease, not its victims, is the threat from which society must be protected.
9. The confidentiality of the doctor-patient relationship is vitally important but not absolute.
10. Physicians have an ethical and professional obligation to behave in a scientifically responsible manner.

1 All of these considerations guided the Board of Trustees as it
2 considered the issues that have been raised by the wide variety of
3 proposals for HIV-antibody testing that are being discussed in
4 society.
5

6 General Conclusions
7

8 Except for individuals in the limited categories listed in
9 Recommendation 5 below (blood, organ and semen donors, immigrants,
10 military personnel, prison inmates) with regard to whom testing
11 serves well-established and well-accepted protection goals, manda-
12 tory national testing should not, at present, be broadly extended.
13

14 Military personnel have traditionally been subject to mandatory
15 immunizations and our defense forces, of course, must be as strong
16 as possible. Prison inmates, because they are confined and have a
17 higher incidence of high-risk individuals than the general
18 population, require special protection. Immigrants should be tested
19 so that we can focus on the AIDS problem already here, and the
20 nation certainly has the right to bar entrants with communicable
21 diseases. The need to test donors of blood, organs and semen has
22 never been questioned.
23

24 Public health authorities have advanced a plausible premise for
25 their opposition to mandatory testing of homosexuals and drug
26 abusers: such testing will only drive people underground and away
27 from the health care system. Public health authorities also have
28 advanced a premise for not requiring mandatory testing of large
29 segments of the general population, such as all those seeking
30 marriage licenses or all those admitted to hospitals: such testing
31 in low prevalence populations would result in a high proportion of
32 false positives, and would not be cost-effective, given the demand
33 for voluntary testing and the shortage of testing and counseling
34 resources for those who want them voluntarily or who will want them
35 following effective public awareness campaigns.
36

37 Until those premises are shown by superior studies to be
38 incorrect, a policy regarding mandatory testing which has been
39 rejected by the vast majority of public health officials, including
40 the Centers for Disease Control and the Surgeon General, cannot be
41 recommended.
42

43 But certain high risk groups should be regularly tested, with a
44 right to informed consent and to refuse the test. Those groups are
45 defined in Recommendation 6.
46

47 In addition, physicians and other hospital personnel involved
48 in invasive surgical procedures who necessarily and unavoidably come
49 in contact with the blood of patients, need to be aware of their
50 risks. Limited regular testing of patients will assure that the CDC

1 guidelines for the protection of hospital personnel are followed
2 rigorously and will further assure that all patients receive prompt
3 and full treatment. The Board emphasizes here that physicians have
4 a long and honored tradition of tending to patients afflicted with
5 infectious diseases with compassion and courage. That tradition
6 must and will be continued throughout the AIDS epidemic.
7

8 Because the risk to health care personnel will be slight in
9 most areas, any effort at mandatory testing of certain kinds of
10 patients should be instituted after voluntary testing has failed and
11 where a variety of factors, e.g. the costs and availability of
12 proper testing and counseling as measured against the risk presented
13 by the relative presence of a high risk patient population, weigh in
14 favor of mandatory testing.
15

16 The AMA does not believe it appropriate at this time to extend
17 regularly offered testing to persons other than those listed, e.g.,
18 recommended testing should not be extended to all individuals
19 anywhere who are considering marriage or to all persons in hospi-
20 tals. Decisions about whether there should be generally recommended
21 testing to other types of individuals should, at this time, be left
22 to the decision of the local community depending on its own
23 circumstances and the judgments of its own public health officials.
24

25 At present, each case of AIDS must be reported by the
26 individual physician to state public health authorities either by
27 name or identifier. Anonymous, or if carefully implemented,
28 confidential reporting should also be extended to all confirmed
29 instances of persons infected with AIDS virus but not afflicted with
30 ARC or AIDS. Individuals who are seropositive for the HIV antibody
31 are infected with the virus and can spread the disease as certainly
32 as those with symptoms of AIDS. A sound epidemiologic understanding
33 of the potential impact of AIDS on society requires the reporting of
34 those who are confirmed as testing positive for the antibody to the
35 AIDS virus.
36

37 Testing Recommendations

38 RECOMMENDATION 4:

39 Tests for the AIDS virus should be readily available to all who wish
40 to be tested. The tests should be routinely subsidized for
41 individuals who cannot afford to pay the cost of their test.
42
43
44

45 RECOMMENDATION 5:

46 Testing for the AIDS virus should be mandatory for donors of blood
47 and blood fractions, organs and other tissues intended for
48 transplantation in the U.S. or abroad, for donors of semen or ova
49 collected for artificial insemination or invitro fertilization, for
50

1 immigrants to the United States, for inmates in federal and state
2 prisons and for military personnel.

3
4 RECOMMENDATION 6:

5
6 Voluntary testing should be regularly provided for the following
7 types of individuals who give an informed consent:

- 8
9 1. Patients at sexually transmitted disease clinics.
10
11 2. Patients at drug abuse clinics.
12
13 3. Pregnant women in high risk areas in the first trimester
14 of pregnancy.
15
16 4. Individuals who are from areas with a high incidence of
17 AIDS or who engage in high-risk behavior seeking family
18 planning services.
19
20 5. Patients who are from areas with a high incidence of AIDS
21 or who engage in high risk behavior requiring surgical or
22 other invasive procedures. If the voluntary policy is not
23 sufficiently accepted, the hospital and medical staff
24 should consider a mandatory program for the institution.
25

26 RECOMMENDATION 7:

27
28 As a matter of medical judgment, physicians should encourage
29 voluntary HIV testing for individuals whose history or clinical
30 status warrant this measure.
31

32 RECOMMENDATION 8:

33
34 Individuals who are found to be seropositive for the AIDS virus
35 should be reported to appropriate public health officials on an
36 anonymous or confidential basis with enough information to be
37 epidemiologically significant.
38

39 RECOMMENDATION 9:

40
41 Physicians should counsel patients before tests for AIDS to educate
42 them about effective behaviors to avoid the risk of AIDS for
43 themselves and others. In public screening programs, counseling may
44 be done in whatever form is appropriate given the resources and
45 personnel available as long as effective counseling is provided.
46

47 RECOMMENDATION 10:

48
49 Physicians should counsel their patients who are found to be
50 seropositive regarding (a) responsible behavior to prevent the
51 spread of the disease, (b) strategies for health protection with a

1 compromised immune system, and (c) the necessity of alerting sexual
2 contacts, past (5-10 years) and present, regarding their possible
3 infection by the AIDS virus. Long-term emotional support should be
4 provided or arranged for seropositive individuals.
5

6 RECOMMENDATION 11:
7

8 Patients should knowingly and willingly give consent before a
9 voluntary test is conducted.
10

11 IV. Resources
12

13 Only recently has Congress and the Administration begun to
14 seriously consider the vast resources needed to deal effectively
15 with AIDS. Federal funding for 1988 is expected to reach \$1
16 billion. But that amount will not be enough. The AMA endorses the
17 bill introduced by Congressman Waxman to increase resources for
18 testing and counseling.
19

20 Testing for the HIV virus in America will require substantially
21 more resources than are currently being made available. Trained
22 counselors, materials for counseling, and research on effective
23 counseling approaches, for the variety of population groups that
24 need these services, are urgently required. Also, dependable
25 testing facilities with sufficient capacity to respond to the
26 epidemic are needed now. In addition, funds for research and care
27 must be increased to fully exploit the nation's capacity to respond
28 effectively to this crisis.
29

30 The key premise of a prevention strategy, when there is no
31 vaccine, is behavioral change on the part of those infected and
32 those at risk of infection by AIDS virus. It is therefore crucial
33 that there be immediate and systematic studies conducted of how
34 behavior of affected groups may have changed in recent years, and if
35 possible, what factors caused the changes. Most particularly, it is
36 necessary to study and evaluate the types of counseling that have
37 been effective so that the techniques may be replicated widely.
38 There can be little question that in a free society suasion and
39 voluntary change, if effective, are far preferable to compulsion.
40

41 RECOMMENDATION 12:
42

43 Public funding must be provided in an amount sufficient (1) to
44 promptly and efficiently counsel and test for AIDS (2) to conduct
45 the research necessary to find a cure and develop an effective
46 vaccine, (3) to perform studies to evaluate the efficiency of
47 counseling and education programs on changing behavior and (4) to
48 assist in the care of AIDS patients who cannot afford proper care or
49 who cannot find appropriate facilities for treatment and care.

1 V. Protection Against Discrimination

2
3 A. Anti-Discrimination

4
5 The AMA believes strongly that AIDS victims and those who
6 test positively for the antibody to the AIDS virus should not be
7 treated unfairly or suffer from arbitrary or irrational
8 discrimination in their daily lives. Last year, the AMA filed a
9 friend of the court brief in School Board of Nassau County v.
10 Arline, a case before the Supreme Court which addressed the question
11 of how the federal handicapped anti-discrimination laws should apply
12 to persons afflicted with contagious diseases. The AMA set forth a
13 framework for the application of the law which the Supreme Court
14 adopted, quoting verbatim from the AMA brief in its key holding.
15

16 A sound anti-discrimination approach does not allow reflexive
17 discrimination against AIDS victims based on fear or stereotype or
18 prejudice. Nor does it require that all employers or other federal
19 fund recipients automatically accommodate a person afflicted with a
20 communicable disease. Instead, based on an individualized analysis
21 of the nature and duration of the handicap and the nature and
22 duration of the communicability, a federal fund recipient must make
23 a reasonable accommodation based on reasonable medical judgments,
24 given the state of medical knowledge at the time. This sound
25 framework for carefully balancing the two competing concerns -- the
26 right of the victim to be free from irrational acts of prejudice and
27 the right of others to be protected against an unreasonable risk
28 from disease -- should also guide state anti-discrimination efforts.
29

30 A key question left open by the Supreme Court is whether a
31 person who is not afflicted with AIDS or AIDS Related Complex, but
32 who nonetheless tests positive for the antibody, is protected by the
33 federal anti-discrimination law.
34

35 In order to encourage people to seek counseling, and testing if
36 necessary, the AMA strongly urges that anti-discrimination laws at
37 both the federal and state levels be clarified either by regulatory
38 interpretation or statutory amendment to cover those who test HIV
39 antibody positive. Allowing irrational discrimination against those
40 who test positive serves no useful purpose: it only has the
41 destructive effect of removing those who are otherwise productive
42 members of society from the work force or otherwise denying them
43 access to an important aspect of normal life. While the federal law
44 should continue to apply only to federal fund recipients, state laws
45 should be sought to prevent irrational discrimination by entities or
46 individuals within those jurisdictions.
47

48 RECOMMENDATION 13:

49
50 Anti-discrimination laws must be clarified or amended to cover those
51 who test positive for the antibodies to the AIDS virus.

1 B. Confidentiality

2
3 The ability of the health care community to maintain the
4 confidentiality of patient information and restrict its use to only
5 those purposes essential for maintenance of health is, like
6 clarification of anti-discrimination laws, vital to an effective
7 program of preventing and controlling AIDS. Even if anti-
8 discrimination laws were completely effective, which unfortunately
9 is not likely, persons who test positive (such as those with ARC or
10 AIDS), will suffer stigma. Thus, confidentiality is crucial.

11
12 The basic principle should be that access to patient
13 information should be limited only to health care personnel who have
14 a legitimate need to have access to the information in order to
15 assist the patient or to protect the health of others closely
16 associated with the patient.

17
18 As with anti-discrimination laws, laws protecting the
19 confidentiality of patient information should be on both federal and
20 state agendas.

21
22 RECOMMENDATION 14:

23
24 Model confidentiality laws must be drafted which can be adopted at
25 all levels of government to encourage as much uniformity as possible
26 in protecting the identity of AIDS patients and carriers, except
27 where the public health requires otherwise.

28
29 V. Questions for the Future

30
31 As the national debate on prevention and control of AIDS
32 continues, other important issues will need to be addressed.

33
34 A. Research and Data

35
36 There is an urgent and critical need for more scientifi-
37 cally sound data on the prevalence and spread of virus in the
38 general population. At the present time only those cases that meet
39 the current CDC surveillance definition of AIDS are reported to that
40 institution. Since AIDS is the terminal and fatal stage of HIV-
41 infection, it represents only the tip of the huge HIV-infection
42 iceberg. There are protean manifestations of HIV-infection ranging
43 from infected asymptomatic to full-blown AIDS. How large the base
44 of that iceberg really is—that is, how many people are actually
45 infected—can only be estimated from the number of reported AIDS
46 cases. That has been done by using a multiple (50 to 100 times the
47 number of AIDS cases) that has been extracted largely from surveys
48 done in high-prevalence areas. Yet this same multiple has been used
49 to estimate the number of current and potential HIV-infected persons
50 in low-prevalence areas and for that matter the entire country and
51 even the world. The CDC itself is unsure about the accuracy of its

1 estimates. Yet if economic and medical plans are to be made for the
2 future, reliable projections must be available. How sufficient or
3 exaggerated these plans may be depends upon the accuracy of current
4 and future estimates of HIV-infected persons, particularly as to the
5 extent of its spread into the low-risk heterosexual population.
6

7 Not only are accurate estimates of HIV-infected persons needed,
8 but so too are reliable data on the rate conversion of asymptomatic
9 seropositive persons to clinical illness, including AIDS, that
10 requires increased medical care. This information is important for
11 the formulation of plans for the future cases of potentially
12 hospitalizable patients and the economic consideration thereof.
13 HIV-infection has protean manifestations and death can result not
14 only from AIDS itself, but from severe ARC or progressive CNS
15 disease as well. In order to obtain accurate information in HIV
16 infected persons on the rate of conversion from asymptomatic to
17 clinically severe illness, baseline data on their serologic status
18 must be obtained as early as possible--not after clinically manifest
19 disease is present. The presence of HIV antibodies indicates not
20 only current infection with the virus, but also that the patient is
21 potentially capable of transmitting the disease. This follows from
22 the fact that HIV integrates its genome into the host cell genome
23 with the result that once infected, the patient remains infected for
24 life and is, therefore, capable of life-long transmission of the
25 agent. The earlier the infected person is detected, the earlier he
26 or she may be advised of this contagious state and counseled on how
27 to avoid further transmission of this lethal virus.
28

29 RECOMMENDATION 15:
30

31 Consistent with the proposal by the Secretary of Health and Human
32 Services, a national study in various areas of the country must be
33 immediately undertaken to determine the prevalence and conversion
34 rate of the virus in the United States population, and the study
35 must be repeated at appropriate intervals to gauge the spread of the
36 disease.
37

38 B. Warning to Third Parties
39

40 One of the more difficult issues for society is how to
41 warn unsuspecting spouses or sexual partners of persons who test HIV
42 positive. Such a warning would allow the third party to practice
43 "safer" sex or to abstain from sexual relations with the infected
44 person altogether. Given the life-or-death consequences, the
45 unsuspecting third party should, as a general matter, be warned
46 because there is no cure and because it may not be responsible to
47 rely solely on the infected person to provide a suitable warning.
48

49 Physicians who have reason to believe that there is an
50 unsuspecting sexual partner of an infected individual should be
51 encouraged to inform public health authorities. The duty to warn

1 the unsuspecting sexual partner should then reside in the public
2 health authorities as well as the infected person and not in the
3 physician to the infected person.
4

5 The AMA believes that mechanisms, analogous to those used by
6 public health authorities to warn sexual partners about other
7 sexually transmitted diseases, should be put in place to warn
8 unsuspecting third parties about an infected sexual partner. Such
9 warning may be appropriate whether the infected person is bisexual,
10 heterosexual or homosexual.
11

12 This problem raises the general question of whether anonymous
13 reporting should continue to be the standard for persons who test
14 seropositive. Our recommendation at this time is limited to
15 situations where physicians or health officials already know the
16 identity of the AIDS carrier and have reason to believe a risk to
17 third parties exists.
18

19 RECOMMENDATION 16:
20

21 Specific statutes must be drafted which, while protecting to the
22 greatest extent possible the confidentiality of patient information,
23 (a) provide a method for warning unsuspecting sexual partners, (b)
24 protect physicians from liability for failure to warn the
25 unsuspecting third party but (c) establish clear standards for when
26 a physician should inform the public health authorities, and (d)
27 provide clear guidelines for public health authorities who need to
28 trace the unsuspecting sexual partners of the infected person.
29

30 C. Sanctions for Reckless Disregard for the Safety of Others
31

32 A related question which must be explored is whether an
33 infected person, who knows he or she is infected and who knowingly
34 fails to warn a sexual partner of the infection, should be subject
35 not just to tort suits, but to a proceeding brought by state
36 authorities to sanction the individual.
37

38 RECOMMENDATION 17:
39

40 Given the risk of infection being transmitted sexually, and given
41 the dire potential consequences of transmission, serious
42 consideration should be given to sanctions, at least in
43 circumstances where an unsuspecting sexual partner subsequently
44 finds out about a partner's infection and brings a complaint to the
45 attention of authorities. Pre-emptive sanctions are not being
46 endorsed by this recommendation.
47

48 CONCLUSION
49

50 The Board intends to review its evaluation of the developing
51 AIDS epidemic on a constant basis. Modifications of the AMA's
52 positions will be made as the situation warrants.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

Report: A
(I-87)

Subject: Ethical Issues Involved in the Growing AIDS Crisis
Presented by: John H. Burkhardt, M.D., Chairman
Referred to: Reference Committee on Amendments to
Constitution and Bylaws
(Julius Michaelson, M.D., Chairman)

1 The Council on Ethical and Judicial Affairs of the American
2 Medical Association recognizes the growing AIDS crisis as a crucial
3 health problem involving the physician's ethical responsibility to
4 his patients and to society. The House of Delegates adopted Report
5 YY (A-87) of the Board of Trustees which provides excellent guidance
6 for a responsible public policy. As stated therein, AIDS patients
7 are entitled to competent medical service with compassion and
8 respect for human dignity and to the safeguard of their confidences
9 within the constraints of the law. Those persons who are afflicted
10 with the disease or who are seropositive have the right to be free
11 from discrimination.

12

13 A physician may not ethically refuse to treat a patient whose
14 condition is within the physician's current realm of competence
15 solely because the patient is seropositive. The tradition of the
16 American Medical Association, since its organization in 1847, is
17 that: "when an epidemic prevails, a physician must continue his
18 labors without regard to the risk to his own health." (See
19 Principles of Medical Ethics, 1847, 1903, 1912, 1947, 1955). That
20 tradition must be maintained. A person who is afflicted with AIDS
21 needs competent, compassionate treatment. Neither those who have
22 the disease nor those who have been infected with the virus should
23 be subjected to discrimination based on fear or prejudice, least of
24 all by members of the health care community. Physicians should
25 respond to the best of their abilities in cases of emergency where
26 first aid treatment is essential, and physicians should not abandon
27 patients whose care they have undertaken. (See Section 8.10 of
28 Current Opinions of the Council on Ethical and Judicial Affairs of
29 the American Medical Association, 1986).

30

31 Principle VI of the 1980 Principles of Medical Ethics states
32 that "A physician shall in the provision of appropriate patient
33 care, except in emergencies, be free to choose whom to serve, with
34 whom to associate and the environment in which to provide medical
35 services." The Council has always interpreted this Principle as not

1 supporting illegal or invidious discrimination. (See Section 9.11
2 of Current Opinions, 1986). Thus, it is the view of the Council
3 that Principle VI does not permit categorical discrimination against
4 a patient based solely on his or her seropositivity. A physician
5 who is not able to provide the services required by persons with
6 AIDS should make an appropriate referral to those physicians or
7 facilities that are equipped to provide such services.
8

9 At its 1987 Annual Meeting, the House of Delegates adopted
10 Substitute Resolution 18 which asked the Council on Ethical and
11 Judicial Affairs to address "the patient confidentiality and ethical
12 issues raised by known HIV antibody positive patients who refuse to
13 inform their sexual partners or modify their behavior." Physicians
14 have a responsibility to prevent the spread of contagious diseases,
15 as well as an ethical obligation to recognize the rights to privacy
16 and to confidentiality of the AIDS victim. These rights are
17 absolute until they infringe in a material way on the safety of
18 another person or persons. Those who are not infected with the
19 virus are entitled to protection from transmission of the disease.
20 Thus, the societal need for accurate information and public health
21 surveillance must also be respected. As the Board of Trustees
22 stated in Report YY (A-87), "A sound epidemiologic understanding of
23 the potential impact of AIDS on society requires the reporting [on
24 an anonymous or confidential basis to public health authorities] of
25 those who are confirmed as testing positive for the antibody to the
26 AIDS virus."
27

28 In those jurisdictions in which the reporting of individuals
29 infected with the AIDS virus to public health authorities is not
30 mandated, a physician who knows that a seropositive patient is
31 endangering a third party faces a dilemma. The physician should
32 attempt to persuade the infected individual to refrain from
33 activities that might result in further transmission of the
34 disease. When rational persuasion fails, authorities should be
35 notified so that they can take appropriate measures to protect third
36 parties. Ordinarily, this action will fulfill the physician's duty
37 to warn third parties; in unusual circumstances when all else fails,
38 a physician may have a common law duty to warn endangered third
39 parties. However, notification of any third party, including public
40 health authorities without the consent of the patient may be
41 precluded by statutes in certain states. Therefore, the Council
42 reiterates and strongly endorses Recommendations 16 and 17 of Board
43 Report YY (A-87). They are:
44

45 RECOMMENDATION 16:
46

47 Specific statutes must be drafted which, while
48 protecting to the greatest extent possible the
49 confidentiality of patient information, (a)
50 provide a method for warning unsuspecting sexual

1 partners, (b) protect physicians from liability
2 for failure to warn the unsuspecting third party
3 but, (c) establish clear standards for when a
4 physician should inform the public health
5 authorities, and (d) provide clear guidelines for
6 public health authorities who need to trace the
7 unsuspecting sexual partners of the infected
8 person.

9
10 RECOMMENDATION 17:

11
12 Given the risk of infection being transmitted
13 sexually, and given the dire potential
14 consequences of transmission, serious consi-
15 deration should be given to sanctions, at least
16 in circumstances where an unsuspecting sexual
17 partner subsequently finds out about a partner's
18 infection and brings a complaint to the attention
19 of authorities. Pre-emptive sanctions are not
20 being endorsed by this recommendation.

21
22 The civil rights and liberties of those who are infected with
23 the AIDS virus, as well as those who are not, are entitled to
24 protection. The ethical challenge to the medical profession is to
25 maintain a judicious balance in this regard, including the issue of
26 whether physicians who are HIV-infected must inform their patients
27 or whether they may continue in patient care at all. The Council's
28 new opinion on PHYSICIANS AND INFECTIOUS DISEASES is:

29
30 A physician who knows that he or she has an
31 infectious disease should not engage in any
32 activity that creates a risk of transmission of
33 the disease to others.

34
35 In the context of the AIDS crisis, the application of the Council's
36 opinion depends on the activity in which the physician wishes to
37 engage.

38
39 The Council on Ethical and Judicial Affairs reiterates and
40 reaffirms the AMA's strong belief that AIDS victims and those who
41 are seropositive should not be treated unfairly or suffer from
42 discrimination. However, in the special context of the provision of
43 medical care, the Council believes that if a risk of transmission of
44 an infectious disease from a physician to a patient exists,
45 disclosure of that risk to patients is not enough; patients are
46 entitled to expect that their physicians will not increase their
47 exposure to the risk of contracting an infectious disease, even
48 minimally. If no risk exists, disclosure of the physician's medical
49 condition to his or her patients will serve no rational purpose; if
50 a risk does exist, the physician should not engage in the activity.

1 The Council recommends that the afflicted physician disclose his or
2 her condition to colleagues who can assist in the individual
3 assessment of whether the physician's medical condition or the
4 proposed activity poses any risk to patients. There may be an
5 occasion when a patient who is fully informed of the physician's
6 condition and the risks that condition presents may choose to
7 continue his or her care with the seropositive physician. Great
8 care must be exercised to assure that true informed consent is
9 obtained.

10
11 In summary, the Council on Ethical and Judicial Affairs believes
12 that:

13
14 ● A physician may not ethically refuse to treat a patient whose
15 condition is within the physician's current realm of competence
16 solely because the patient is seropositive. Persons who are
17 seropositive should not be subjected to discrimination based on
18 fear or prejudice.

19
20 ● Physicians are dedicated to providing competent medical
21 service with compassion and respect for human dignity.

22
23 ● Physicians who are unable to provide the services required by
24 AIDS patients should make referrals to those physicians or
25 facilities equipped to provide such services.

26
27 ● Physicians are ethically obligated to respect the rights of
28 privacy and of confidentiality of AIDS patients and seropositive
28 individuals.

30
31 ● Where there is no statute that mandates or prohibits the
32 reporting of seropositive individuals to public health
33 authorities and a physician knows that a seropositive individual
34 is endangering a third party, the physician should: (1) attempt
35 to persuade the infected patient to cease endangering the third
36 party; (2) if persuasion fails, notify authorities; and (3) if
37 the authorities take no action, notify the endangered third
38 party.

39
40 ● A physician who knows that he or she is seropositive should
41 not engage in any activity that creates a risk of transmission
42 of the disease to others.

43
44 ● A physician who has AIDS or who is seropositive should
45 consult colleagues as to which activities the physician can
46 pursue without creating a risk to patients.

47
48 The Council on Ethical and Judicial Affairs requests that this
49 report be filed.



Supplement

MORBIDITY AND MORTALITY WEEKLY REPORT

Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome

AIDS Program Center for Infectious Diseases Centers for Disease Control Atlanta, Georgia 30333

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Attach. 4

Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome

Reported by
Council of State and Territorial Epidemiologists;
AIDS Program, Center for Infectious Diseases, CDC

INTRODUCTION

The following revised case definition for surveillance of acquired immunodeficiency syndrome (AIDS) was developed by CDC in collaboration with public health and clinical specialists. The Council of State and Territorial Epidemiologists (CSTE) has officially recommended adoption of the revised definition for national reporting of AIDS. The objectives of the revision are a) to track more effectively the severe disabling morbidity associated with infection with human immunodeficiency virus (HIV) (including HIV-1 and HIV-2); b) to simplify reporting of AIDS cases; c) to increase the sensitivity and specificity of the definition through greater diagnostic application of laboratory evidence for HIV infection; and d) to be consistent with current diagnostic practice, which in some cases includes presumptive, i.e., without confirmatory laboratory evidence, diagnosis of AIDS-indicative diseases (e.g., *Pneumocystis carinii* pneumonia, Kaposi's sarcoma).

The definition is organized into three sections that depend on the status of laboratory evidence of HIV infection (e.g., HIV antibody) (Figure 1). The major proposed changes apply to patients with laboratory evidence for HIV infection: a) inclusion of HIV encephalopathy, HIV wasting syndrome, and a broader range of specific AIDS-indicative diseases (Section II.A); b) inclusion of AIDS patients whose indicator diseases are diagnosed presumptively (Section II.B); and c) elimination of exclusions due to other causes of immunodeficiency (Section I.A).

Application of the definition for children differs from that for adults in two ways. First, multiple or recurrent serious bacterial infections and lymphoid interstitial pneumonia/pulmonary lymphoid hyperplasia are accepted as indicative of AIDS among children but not among adults. Second, for children <15 months of age whose mothers are thought to have had HIV infection during the child's perinatal period, the laboratory criteria for HIV infection are more stringent, since the presence of HIV antibody in the child is, by itself, insufficient evidence for HIV infection because of the persistence of passively acquired maternal antibodies < 15 months after birth.

The new definition is effective immediately. State and local health departments are requested to apply the new definition henceforth to patients reported to them. The initiation of the actual reporting of cases that meet the new definition is targeted for September 1, 1987, when modified computer software and report forms should be in place to accommodate the changes. CSTE has recommended retrospective application of the revised definition to patients already reported to health departments. The new definition follows:

1987 REVISION OF CASE DEFINITION FOR AIDS FOR SURVEILLANCE PURPOSES

For national reporting, a case of AIDS is defined as an illness characterized by one or more of the following "indicator" diseases, depending on the status of laboratory evidence of HIV infection, as shown below.

I. Without Laboratory Evidence Regarding HIV Infection

If laboratory tests for HIV were not performed or gave inconclusive results (See Appendix I) and the patient had no other cause of immunodeficiency listed in Section I.A below, then any disease listed in Section I.B indicates AIDS if it was diagnosed by a definitive method (See Appendix II).

A. Causes of immunodeficiency that disqualify diseases as indicators of AIDS in the absence of laboratory evidence for HIV infection

1. high-dose or long-term systemic corticosteroid therapy or other immunosuppressive/cytotoxic therapy <3 months before the onset of the indicator disease
2. any of the following diseases diagnosed <3 months after diagnosis of the indicator disease: Hodgkin's disease, non-Hodgkin's lymphoma (other than primary brain lymphoma), lymphocytic leukemia, multiple myeloma, any other cancer of lymphoreticular or histiocytic tissue, or angioimmunoblastic lymphadenopathy
3. a genetic (congenital) immunodeficiency syndrome or an acquired immunodeficiency syndrome atypical of HIV infection, such as one involving hypogammaglobulinemia

B. Indicator diseases diagnosed definitively (See Appendix II)

1. candidiasis of the esophagus, trachea, bronchi, or lungs
2. cryptococcosis, extrapulmonary
3. cryptosporidiosis with diarrhea persisting >1 month
4. cytomegalovirus disease of an organ other than liver, spleen, or lymph nodes in a patient >1 month of age
5. herpes simplex virus infection causing a mucocutaneous ulcer that persists longer than 1 month; or bronchitis, pneumonitis, or esophagitis for any duration affecting a patient >1 month of age
6. Kaposi's sarcoma affecting a patient < 60 years of age
7. lymphoma of the brain (primary) affecting a patient < 60 years of age
8. lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia (LIP/PLH complex) affecting a child <13 years of age
9. *Mycobacterium avium* complex or *M. kansasii* disease, disseminated (at a site other than or in addition to lungs, skin, or cervical or hilar lymph nodes)
10. *Pneumocystis carinii* pneumonia
11. progressive multifocal leukoencephalopathy
12. toxoplasmosis of the brain affecting a patient >1 month of age

I. With Laboratory Evidence for HIV Infection

Regardless of the presence of other causes of immunodeficiency (I.A), in the presence of laboratory evidence for HIV infection (See Appendix I), any disease listed

case definition. For reporting purposes, the revision adds to the definition most of those severe non-infectious, non-cancerous HIV-associated conditions that are categorized in the CDC clinical classification systems for HIV infection among adults and children (4,5).

Another limitation of the old definition was that AIDS-indicative diseases are diagnosed presumptively (i.e., without confirmation by methods required by the old definition) in 10%-15% of patients diagnosed with such diseases; thus, an appreciable proportion of AIDS cases were missed for reporting purposes (6,7). This proportion may be increasing, which would compromise the old case definition's usefulness as a tool for monitoring trends. The revised case definition permits the reporting of these clinically diagnosed cases as long as there is laboratory evidence of HIV infection.

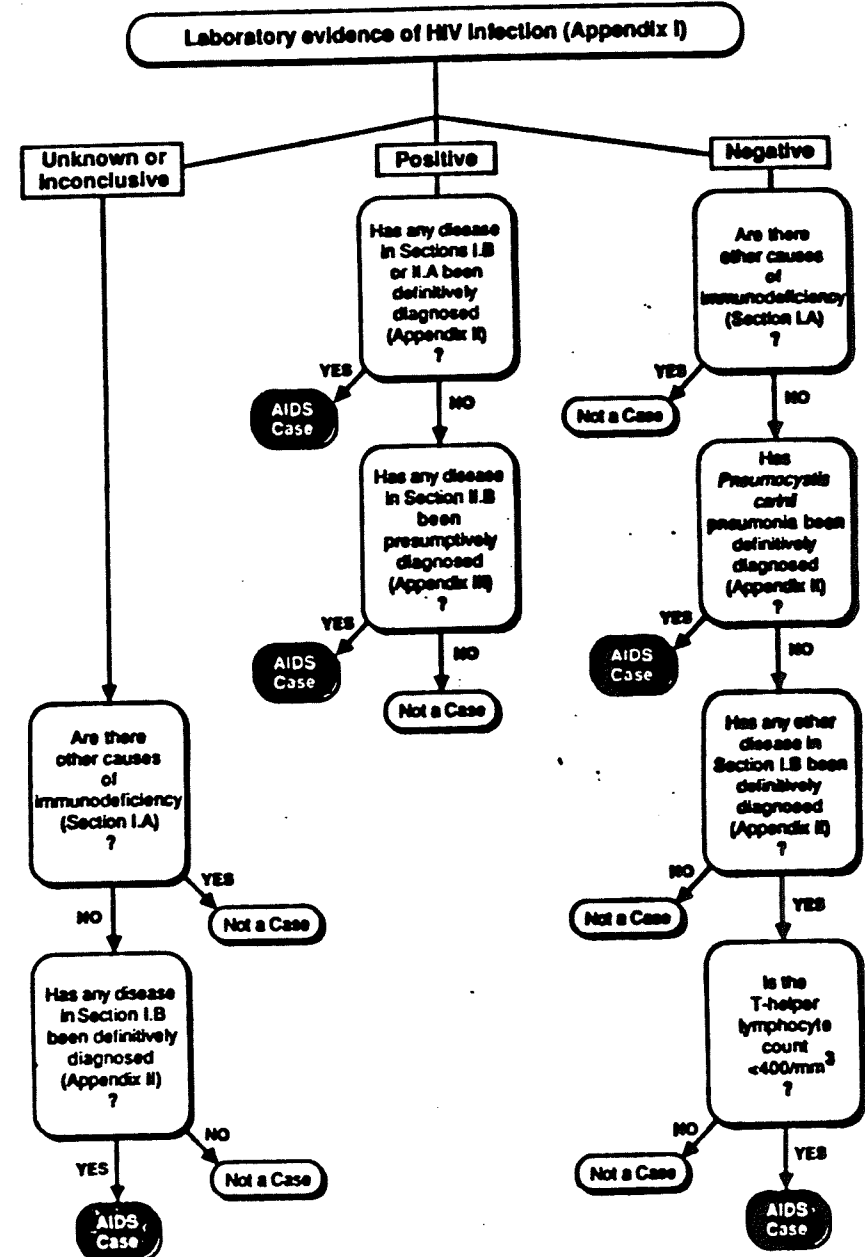
The effectiveness of the revision will depend on how extensively HIV-antibody tests are used. Approximately one third of AIDS patients in the United States have been from New York City and San Francisco, where, since 1985, < 7% have been reported with HIV-antibody test results, compared with > 60% in other areas. The impact of the revision on the reported numbers of AIDS cases will also depend on the proportion of AIDS patients in whom indicator diseases are diagnosed presumptively rather than definitively. The use of presumptive diagnostic criteria varies geographically, being more common in certain rural areas and in urban areas with many indigent AIDS patients.

To avoid confusion about what should be reported to health departments, the term "AIDS" should refer only to conditions meeting the surveillance definition. This definition is intended only to provide consistent statistical data for public health purposes. Clinicians will not rely on this definition alone to diagnose serious disease caused by HIV infection in individual patients because there may be additional information that would lead to a more accurate diagnosis. For example, patients who are not reportable under the definition because they have either a negative HIV-antibody test or, in the presence of HIV antibody, an opportunistic disease not listed in the definition as an indicator of AIDS nonetheless may be diagnosed as having serious HIV disease on consideration of other clinical or laboratory characteristics of HIV infection or a history of exposure to HIV.

Conversely, the AIDS surveillance definition may rarely misclassify other patients as having serious HIV disease if they have no HIV-antibody test but have an AIDS-indicative disease with a background incidence unrelated to HIV infection, such as cryptococcal meningitis.

The diagnostic criteria accepted by the AIDS surveillance case definition should not be interpreted as the standard of good medical practice. Presumptive diagnoses are accepted in the definition because not to count them would be to ignore substantial morbidity resulting from HIV infection. Likewise, the definition accepts a reactive screening test for HIV antibody without confirmation by a supplemental test because a repeatedly reactive screening test result, in combination with an indicator disease, is highly indicative of true HIV disease. For national surveillance purposes, the tiny proportion of possibly false-positive screening tests in persons with AIDS-indicative diseases is of little consequence. For the individual patient, however, a correct diagnosis is critically important. The use of supplemental tests is, therefore, strongly endorsed. An increase in the diagnostic use of HIV-antibody tests could improve both the quality of medical care and the function of the new case definition, as well as assist in providing counselling to prevent transmission of HIV.

FIGURE 1. Flow diagram for revised CDC case definition of AIDS, September 1, 1987



**HIV encephalopathy*
(dementia)**

clinical findings of disabling cognitive and/or motor dysfunction interfering with occupation or activities of daily living, or loss of behavioral developmental milestones affecting a child, progressing over weeks to months, in the absence of a concurrent illness or condition other than HIV infection that could explain the findings. Methods to rule out such concurrent illnesses and conditions must include cerebrospinal fluid examination and either brain imaging (computed tomography or magnetic resonance) or autopsy.

HIV wasting syndrome*

findings of profound involuntary weight loss >10% of baseline body weight plus either chronic diarrhea (at least two loose stools per day for ≥ 30 days) or chronic weakness and documented fever (for ≥ 30 days, intermittent or constant) in the absence of a concurrent illness or condition other than HIV infection that could explain the findings (e.g., cancer, tuberculosis, cryptosporidiosis, or other specific enteritis).

*For HIV encephalopathy and HIV wasting syndrome, the methods of diagnosis described here are not truly definitive, but are sufficiently rigorous for surveillance purposes.

APPENDIX III

Suggested Guidelines for Presumptive Diagnosis of Diseases Indicative of AIDS

Diseases	Presumptive Diagnostic Criteria
candidiasis of esophagus	<p>a. recent onset of retrosternal pain on swallowing; AND</p> <p>b. oral candidiasis diagnosed by the gross appearance of white patches or plaques on an erythematous base or by the microscopic appearance of fungal mycelial filaments in an uncultured specimen scraped from the oral mucosa.</p>
cytomegalovirus retinitis	<p>a characteristic appearance on serial ophthalmoscopic examinations (e.g., discrete patches of retinal whitening with distinct borders, spreading in a centrifugal manner, following blood vessels, progressing over several months, frequently associated with retinal vasculitis, hemorrhage, and necrosis). Resolution of active disease leaves retinal scarring and atrophy with retinal pigment epithelial mottling.</p>

mycobacteriosis

microscopy of a specimen from stool or normally sterile body fluids or tissue from a site other than lungs, skin, cervical or hilar lymph nodes, showing acid-fast bacilli of a species not identified by culture.

Kaposi's sarcoma

a characteristic gross appearance of an erythematous or violaceous plaque-like lesion on skin or mucous membrane.

(Note: Presumptive diagnosis of Kaposi's sarcoma should not be made by clinicians who have seen few cases of it.)

lymphoid interstitial pneumonia

bilateral reticulonodular interstitial pulmonary infiltrates present on chest X ray for ≥2 months with no pathogen identified and no response to antibiotic treatment.

Pneumocystis carinii pneumonia

- a history of dyspnea on exertion or nonproductive cough of recent onset (within the past 3 months); AND
- chest X-ray evidence of diffuse bilateral interstitial infiltrates or gallium scan evidence of diffuse bilateral pulmonary disease; AND
- arterial blood gas analysis showing an arterial pO₂ of <70 mm Hg or a low respiratory diffusing capacity (<80% of predicted values) or an increase in the alveolar-arterial oxygen tension gradient; AND
- no evidence of a bacterial pneumonia.

toxoplasmosis of the brain

- recent onset of a focal neurologic abnormality consistent with intracranial disease or a reduced level of consciousness; AND
- brain imaging evidence of a lesion having a mass effect (on computed tomography or nuclear magnetic resonance) or the radiographic appearance of which is enhanced by injection of contrast medium; AND
- serum antibody to toxoplasmosis or successful response to therapy for toxoplasmosis.

Patient's Name _____ Telephone No: _____
 Address _____

**ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)
 PEDIATRIC CONFIDENTIAL CASE REPORT**
 (Patients <13 years of age at time of diagnosis)

Physician's Name: _____ Telephone No: _____
 Hospital: _____ Medical Record No: _____
 Person Completing Form: _____ Telephone No: _____

DEPARTMENT OF HEALTH AND HUMAN SERVICES
 PUBLIC HEALTH SERVICE
 CENTERS FOR DISEASE CONTROL
 AIDS PROGRAM, CID, ATLANTA, GEORGIA 30333

**ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)
 PEDIATRIC CONFIDENTIAL CASE REPORT**
 (Patients <13 years of age at time of diagnosis)

This report is authorized by law (Sections 304 and 306 of the Public Health Service Act, 42 USC 242b and 242f). Response in this case is voluntary for federal government purposes, but may be mandatory under state and local statutes. Your cooperation is necessary for the understanding and control of AIDS. Information in the surveillance systems that would permit identification of any individual or establishment is collected with a guarantee that it will be held in confidence, will be used only for the purposes stated in the assurance on the reverse of the form, and will not otherwise be disclosed or released without the consent of the individual or the establishment in accordance with Section 308 of the Public Health Service Act (42 USC 242m).

HEALTH DEPARTMENT USE ONLY

DATE FORM COMPLETED Mo Day Year [][] [][] [][]	SOUNDEX NAME CODE [][][][]	STATUS OF THIS REPORT 1 New Case 2 Update Report	REPORTING HEALTH DEPARTMENT State _____ City/County _____	STATE PATIENT NUMBER [][][][][][][][][]	CITY/COUNTY PATIENT NUMBER [][][][][][][][][][][][][]
--	--------------------------------------	--	---	---	---

I. BASIC PATIENT INFORMATION

DATE OF BIRTH Mo Day Year [][] [][] [][][][]	AGE AT DIAGNOSIS OF AIDS Years Mos [][] [][]	CURRENT STATUS 1 Alive 2 Dead 3 Unknown	DATE OF DEATH Mo Day Year [][] [][] [][][][]	SEX 1 Male 2 Female
RACE/ETHNICITY 1 White (not Hispanic) 2 Black (not Hispanic) 3 Hispanic 4 Asian/Pacific Islander 5 American Indian/Alaskan Native 9 Not Specified		COUNTRY OF BIRTH 1 U.S. 2 Canada 3 Dominican Republic 4 Haiti 5 Mexico 8 Other (specify) _____		
RESIDENCE AT ONSET OF ILLNESS SUGGESTIVE OF AIDS: City _____ County _____ Zip Code _____ State/Country _____		HOSPITAL WHERE DIAGNOSIS OF AIDS ESTABLISHED: Name _____ City _____ State/Country _____		

II. SOCIAL AND RISK FACTORS

AFTER 1977 AND PRECEDING THE DIAGNOSIS OF AIDS, HAS THIS CHILD: (check all that apply)

Received any blood products (i.e., factor VIII or IX, cryoprecipitate, or fibrinogen) for the treatment of a coagulation disorder?	Yes	No	Unk
- If yes, specify disorder: 1 Hemophilia A (factor VIII) 2 Hemophilia B (factor IX) 8 Other, specify: _____	1	0	9
Received a transfusion of blood/blood components?	1	0	9
- If yes, and this is only risk factor, give date of first and last transfusion: First Mo Yr [][] [][] Last Mo Yr [][] [][]			

AFTER 1977, HAS THIS CHILD'S MOTHER: (check all that apply)

Used needles for self injection of drugs not prescribed by a physician?	Yes	No	Unk
Received any blood products (i.e., factor VIII or IX, cryoprecipitate, or fibrinogen) for the treatment of a coagulation disorder?	1	0	9
- If yes, specify disorder: 1 Hemophilia A (factor VIII) 2 Hemophilia B (factor IX) 8 Other, specify: _____			
Received a transfusion of blood/blood components?	1	0	9
Been diagnosed as having AIDS, ARC, or documented HIV infection?	1	0	9
Had heterosexual relations with any of the following: (check all that apply)	1	0	9
- IV drug abuser	1	0	9
- Bisexual man	1	0	9
- Man with hemophilia/coagulation disorder	1	0	9
- Blood transfusion recipient with AIDS or documented HIV infection	1	0	9
- Man with unknown risk factors, but has AIDS, ARC, or documented HIV infection	1	0	9
- Man born in a country where heterosexual transmission predominates, (e.g., African or Caribbean country) Specify country: _____	1	0	9

MOTHER WAS BORN IN: 1 U.S. 2 Canada 3 Dominican Republic 4 Haiti 5 Mexico 8 Other (specify) _____

FATHER WAS BORN IN: 1 U.S. 2 Canada 3 Dominican Republic 4 Haiti 5 Mexico 8 Other (specify) _____

III. DISEASES INDICATIVE OF AIDS (check all that apply)

DISEASE	DIAGNOSIS		DISEASE	DIAGNOSIS	
	Definitive*	Presumptive		Definitive*	Presumptive
Bacterial infections, multiple or recurrent (including Salmonella septicemia)	1	NA	Kaposi's sarcoma	1	2
Candidiasis, bronchi, trachea, or lungs	1	NA	Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia	1	2
Candidiasis, esophageal	1	2	Lymphoma, Burkitt's (or equivalent term)	1	NA
Coccidioidomycosis, disseminated or extrapulmonary	1	NA	Lymphoma, immunoblastic (or equivalent term)	1	NA
Cryptococcosis, extrapulmonary	1	NA	Lymphoma, primary in brain	1	NA
Cryptosporidiosis, chronic intestinal	1	NA	Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary	1	2
Cytomegalovirus disease (other than in liver, spleen, or nodes) onset at >1 mo. of age	1	NA	M. tuberculosis, disseminated or extrapulmonary	1	2
Cytomegalovirus retinitis (with loss of vision)	1	2	Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary	1	2
HIV encephalopathy	1	NA	Pneumocystis carinii pneumonia	1	2
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or pneumonitis or esophagitis onset at >1 mo. of age	1	NA	Progressive multifocal leukoencephalopathy	1	NA
Histoplasmosis, disseminated or extrapulmonary	1	NA	Toxoplasmosis of brain, onset at >1 mo. of age	1	2
Isosporiasis, chronic intestinal (>1 mo. duration)	1	NA	Wasting syndrome due to HIV	1	NA

*Refer to instructions on back for definition of definitive diagnosis.

Of diseases checked above, date first disease diagnosed: Mo Yr [][] [][]

IV. LABORATORY DATA

1. HIV SERUM ANTIBODY TESTS:

• ELISA	Pos	Neg	Inc*	Not Done	Test Date Mo Yr [][] [][]
• Western blot/immunofluorescence assay	1	0	8	9	[][] [][]
• Other (specify) _____	1	0	8	9	[][] [][]

*Inc = Inconclusive

2. HIV DETECTION TESTS: (Applicable only if serum antibody tests are not positive.)

• Culture of HIV confirmed by both specific HIV antigen test and reverse transcriptase detection	Pos	Neg	Inc*	Not Done
• HIV serum antigen test	1	0	8	9
• Other HIV test (specify) _____	1	0	8	9

*Inc = Inconclusive

3. If HIV tests were not positive, were not done, or the patient is <15 months of age, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition?

Yes	No	Unk
1	0	9

4. IMMUNOLOGIC LAB TEST: (If >15 months of age or if antibody negative at any age, has this patient had any of the following?)

• Low lymphocyte count, (e.g., <1000 cells/mm ³)	Yes	No	Unk
• T-helper cell count <400 cells/mm ³	1	0	9
• Low T-helper/T suppressor (e.g., <1.0)	1	0	9
• Total serum immunoglobulins (mg/dl)	1 <1500	2 1500 to 2500	3 >2500
Test date of highest immunoglobulin level	Mo Yr [][] [][]		

V. ADDITIONAL INFORMATION OR COMMENTS

**ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)
ADULT CONFIDENTIAL CASE REPORT**
(Patients ≥13 years of age at time of diagnosis)

Physician's Name: _____ Telephone No.: () _____
Hospital: _____ Medical Record No.: _____
Person Completing Form: _____ Telephone No.: () _____

Patient's Name: _____ Telephone No.: () _____
Address: _____

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL
AIDS PROGRAM, CID, ATLANTA, GEORGIA 30333

**ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)
ADULT CONFIDENTIAL CASE REPORT**
(Patients ≥13 years of age at time of diagnosis)

FORM APPROVED
OMB NO. 0920-0049

This report is authorized by law (Sections 304 and 306 of the Public Health Service Act, 42 USC 242b and 242c). Response in this case is voluntary for federal government purposes, but may be mandatory under state and local statutes. Your cooperation is necessary for the understanding and control of AIDS. Information in the surveillance system that would permit identification of any individual or establishment is collected with a guarantee that it will be held in confidence. It will be used only for the purposes stated in the assurance on the reverse of the form, and will not otherwise be disclosed or released without the consent of the individual or the establishment in accordance with Section 308(b) of the Public Health Service Act (42 USC 242m).

DATE FORM COMPLETED Mo Day Year [][] [][] [][]	HEALTH DEPARTMENT USE ONLY		
	SOUNDEX NAME CODE [][][][][][]	STATUS OF THIS REPORT 1 New Case 2 Update Report	REPORTING HEALTH DEPARTMENT State _____ City/County _____
CDC PATIENT NUMBER [][][][][][][][][][]	STATE PATIENT NUMBER [][][][][][][][][][]		CITY/COUNTY PATIENT NUMBER [][][][][][][][][][]

I. BASIC PATIENT INFORMATION

DATE OF BIRTH Mo Day Year [][] [][] [][]	AGE AT DIAGNOSIS OF AIDS Years [][]	CURRENT STATUS 1 Alive 2 Dead 9 Unknown	DATE OF DEATH Mo Day Year [][] [][] [][]	SEX 1 Male 2 Female
RACE/ETHNICITY 1 White (not Hispanic) 2 Black (not Hispanic) 3 Hispanic 4 Asian/Pacific Islander 5 American Indian/Alaskan Native 9 Not Specified		COUNTRY OF BIRTH 1 U.S. 2 Canada 3 Dominican Republic 4 Haiti 5 Mexico 8 Other (specify) _____		
RESIDENCE AT ONSET OF ILLNESS SUGGESTIVE OF AIDS: City _____ County _____ Zip Code _____ State/Country _____		HOSPITAL WHERE DIAGNOSIS OF AIDS ESTABLISHED: Name _____ City _____ State/Country _____		

II. SOCIAL AND RISK FACTORS

AFTER 1977 AND PRECEDING THE DIAGNOSIS OF AIDS, DID THIS PATIENT: (check all that apply)

• Have sexual relations with a male partner?	Yes	No	Unk
• Have sexual relations with a female partner?	1	0	9
• Use needles for self-injection of drugs not prescribed by a physician?	1	0	9
• Receive any blood products (i.e., factor VIII or IX, cryoprecipitate, or fibrinogen) for the treatment of a coagulation disorder?	1	0	9
• If yes, specify disorder: 1 Hemophilia A (factor VIII) 2 Hemophilia B (factor IX) 8 Other, specify _____			
• Have heterosexual relations with any of the following: (check all that apply)			
• I.V. drug abuser	1	0	9
• Bisexual man	1	0	9
• Person with hemophilia/coagulation disorder	1	0	9
• Blood transfusion recipient with AIDS or documented HIV infection	1	0	9
• Person with AIDS or documented HIV infection	1	0	9
• Person born in a country where heterosexual transmission predominates, (e.g., African or Caribbean country) Specify country _____	1	0	9
• Has patient received a transfusion of blood/blood components?	1	0	9
• If yes, and this is only risk factor, give date of first and last transfusion: First Mo Yr [][] [][] Last Mo Yr [][] [][]			
• Work in a health-care or clinical laboratory setting?	1	0	9
• If yes, specify occupation: _____			

III. DISEASES INDICATIVE OF AIDS (check all that apply)

DISEASE	DIAGNOSIS		DISEASE	DIAGNOSIS	
	Definitive*	Presumptive		Definitive*	Presumptive
Candidiasis, bronchi, trachea, or lungs	1	NA	Kaposi's sarcoma	1	2
Candidiasis, esophageal	1	2	Lymphoma, Burkitt's (or equivalent term)	1	NA
Coccidioidomycosis, disseminated or extrapulmonary	1	NA	Lymphoma, immunoblastic (or equivalent term)	1	NA
Cryptococcosis, extrapulmonary	1	NA	Lymphoma, primary in brain	1	NA
Cryptosporidiosis, chronic intestinal	1	NA	Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary	1	2
Cytomegalovirus disease (other than in liver, spleen, or nodes)	1	NA	M. tuberculosis, disseminated or extrapulmonary	1	2
Cytomegalovirus retinitis (with loss of vision)	1	2	Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary	1	2
HIV encephalopathy	1	NA	Pneumocystis carinii pneumonia	1	2
Herpes simplex, chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis, or esophagitis	1	NA	Progressive multifocal leukoencephalopathy	1	NA
Histoplasmosis, disseminated or extrapulmonary	1	NA	Salmonella septicemia, recurrent	1	NA
Isosporiasis, chronic intestinal (>1 mo. duration)	1	NA	Toxoplasmosis of brain	1	2
			Wasting syndrome due to HIV	1	NA

*Refer to instructions on back for definition of definitive diagnosis.

Of diseases checked above, date first disease diagnosed: Mo [][] Yr [][]

IV. LABORATORY DATA

1. HIV SERUM ANTIBODY TESTS:

• ELISA	Pos	Neg	Inc*	Not Done
• Western blot/immunofluorescence assay	1	0	8	9
• Other (specify) _____	1	0	8	9

*Inc = Inconclusive

2. HIV DETECTION TESTS:
(Applicable only if serum antibody tests are not positive.)

• Culture of HIV confirmed by both specific HIV antigen test and reverse transcriptase detection	Pos	Neg	Inc*	Not Done
• HIV serum antigen test	1	0	8	9
• Other HIV test (specify) _____	1	0	8	9

*Inc = Inconclusive

3. If HIV tests were not positive or were not done, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition?

Yes	No	Unk
1	0	9

4. IS ABSOLUTE T-HELPER LYMPHOCYTE COUNT <400 per mm³?
(Applicable only if tests results are negative for HIV infection.)

Yes	No	Unk
1	0	9

V. ADDITIONAL INFORMATION OR COMMENTS

Guidelines for the Control of Perinatally Transmitted Human Immunodeficiency Virus Infection and Care of Infected Mothers, Infants and Children

GEORGE W. RUTHERFORD, MD; GERALDINE E. OLIVA, MD, MPH; MOSES GROSSMAN, MD; JAMES R. GREEN, MD; DIANE W. WARA, MD; NANCY S. SHAW, PhD; DEAN F. ECHENBERG, MD, PhD; CONSTANCE B. WOFSEY, MD; DANIEL H. WEINSTEIN, LLB; FLORENCE STROUD, MSN, MPH; EDWIN S. SANSFIELD, MSW, and DAVID WERDEGAR, MD, MPH, *San Francisco*

The transmission of the human immunodeficiency virus (HIV) from infected mothers to infants, either in utero or perinatally, has been well established.¹⁻¹⁰ Infection in these infants can be asymptomatic or cause a variety of clinical syndromes including the acquired immunodeficiency syndrome (AIDS).¹¹ It is not, however, conclusively known what proportion of infants exposed in utero or perinatally will become infected and in what proportion of infected infants clinical disease will develop.¹² As of December 1, 1985, there were 217 cases of pediatric AIDS reported to the Centers for Disease Control (CDC) (unpublished data). Of these children, 48% were born to intravenous-drug-using mothers, 17% to Haitians and 10% to mothers who either had AIDS or were sexual partners of men with AIDS or at risk for AIDS. An additional 39 (18%) children were infected through transfusions of infected blood or blood products, and 13 (6%) had unknown sources of infection. Thus, 165 (76%) of the cases had been exposed to HIV in utero or perinatally.

HIV Infection in Women of Child-Bearing Age

In the United States, approximately 7% of adult cases of AIDS are women. Nearly 53% of these women are intravenous drug users, 15% are sexual partners of men in risk groups (primarily heterosexual intravenous drug users) and 9% have received infected blood or blood products. In all, 80% are between 20 and 49 years old, 22% of these women are white, 55% black and 23% Latino (CDC, unpublished data). In San Francisco, as of January 31, 1986, there had been ten cases of AIDS reported in adult women. Three of these women were intravenous drug users, one was a sexual partner of a man in a high-prevalence group, four had received transfusions and two had no identified risk. Four were between 20 and 49 years old; two of these were white, one black and one Asian.

HIV Transmission in Households

None of the identified cases of HIV infection in the United States are known to have been transmitted in school, day-care or foster-care settings or through casual person-to-person

contact.¹³ Other than sexual partners of HIV-infected patients, infants born to infected mothers or a single case involving nosocomial transmission from a child to a mother providing nursing care,¹⁴ none of the family members of the more than 17,000 AIDS patients reported to CDC have had the development of AIDS. Five studies of family members of patients with HIV infection have failed to show HIV transmission to adults who are not sexual contacts of the infected patients or to children who are not already infected perinatally.¹⁵⁻¹⁹ If, however, casual person-to-person transmission of HIV infection does exist, it should theoretically be greatest among young children. This theoretic transmission would most likely involve exposure of open skin lesions of mucous membranes to blood and possibly other body fluids of an infected person. We emphasize that there is no evidence of this type of transmission occurring in any setting at this time.

General Recommendations

Education

Risk-reducing education. All sexually active homosexual, bisexual and heterosexual adults with multiple sexual partners since 1979 should be aware that they are potentially at risk of HIV infection, and sexually active women with multiple sexual partners since 1979 should understand that, if they have been infected, they are at risk of transmitting HIV perinatally. To this end, widespread health education campaigns should address the risk of infection and the ways to prevent sexual transmission among heterosexuals and, more specifically, to women of child-bearing age. Additionally, women in recognized risk groups (Table 1) should be the target of more intensified educational campaigns and, if indicated, special educational programs to decrease their ongoing risk of parenterally or sexually acquiring HIV infection, such as referral for substance abuse or sexual risk-reducing counseling. These campaigns should be culturally and linguistically appropriate for these risk groups.

Provider education. To provide a high standard of care for HIV-infected women, infants and children, obstetricians, pediatricians, foster parents and agencies and other providers

(Rutherford GW, Oliva GE, Grossman M, et al: Guidelines for the control of perinatally transmitted human immunodeficiency virus infection and care of infected mothers, infants and children. *West J Med* 1987 Jul; 147:104-108)

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Attach. 3

ABBREVIATIONS USED IN TEXT

- AIDS = acquired immunodeficiency syndrome
- ARC = AIDS-related complex
- CDC = Centers for Disease Control
- ELISA = enzyme-linked immunosorbent assay
- HIV = human immunodeficiency virus

need to be educated about the virus, its modes of transmission, its prevention and the special issues of confidentiality and counseling surrounding the infection. Focus should be placed on educating and training those providers serving patients at highest risk of infection. We recommend that providers assess each patient's history of potential exposure to HIV and not assume that membership in a risk group implies de facto infection and, conversely, that nonmembership implies noninfection.

Laboratory Testing

We recommend that more than one method of anti-HIV antibody determination be used for testing pregnant women, women in risk groups and children of women in risk groups for HIV infection. Such methods include enzyme-linked immunosorbent assay (ELISA), indirect fluorescent antibody and Western blot. Because of a possible increased incidence of false-positive ELISA results during pregnancy, especially among intravenous-drug-using women, laboratory testing should be done in a single reliable and experienced facility. Submission of specimens identified only by code number to this laboratory will greatly decrease the chances of unintentional disclosure.

Preconception Recommendations

Whenever possible, women infected with HIV should be confidentially identified and educated about the risks of perinatal transmission. Infected women should be advised to postpone pregnancy until more is known about the specific risks of perinatal transmission. Detailed contraceptive counseling should be offered to these women. Infected women should also be counseled to avoid unsafe sexual practices and to inform previous and prospective sexual partners about their possible exposure. Regardless of other contraceptive methods used, they should use barrier methods of contraception—such as a condom or a condom plus a diaphragm with a nonoxynol-9-containing spermicide—during intercourse to diminish the chances both of transmitting HIV to their sexual partners and of being reinfected with it.

We recommend that women who believe themselves to be at high risk for HIV infection (Table 1) be confidentially or

anonymously tested for anti-HIV antibody if they are planning to become pregnant. Testing can be offered through private physicians, alternate test sites or through clinics, especially those used by women in risk groups, such as family planning clinics, drug treatment programs and sexually transmitted disease clinics. Testing of these women, although strongly recommended, must be voluntary and confidential. We do not recommend that women who are not in risk groups be tested at this time. Because of possible sexual contact with men in high-incidence groups, however, it may be prudent for women with multiple sexual partners in areas with a high incidence of AIDS to consider themselves at risk and to obtain preconception counseling and testing if indicated. Regardless of test results, women and their children should continue to have access to all health and social services for which they are eligible.

Recommendations for Mothers

Identification of Infected Pregnant Women

Routine histories taken at clinical facilities serving women potentially at high risk for HIV infection should include confidential questions designed to elucidate their risk of infection. Such clinics include physicians' offices, family planning clinics, sexually transmitted disease clinics, drug treatment clinics, women, infants and children clinics and prenatal clinics. Written or audiovisual materials, or both, regarding HIV infection should be available at all sites where these women are seen.

We recommend that women in risk groups be educated about HIV infection and that women determined to be at risk be tested at the time they present for prenatal care. Such testing must be voluntary and confidential. We do not recommend routine testing of all pregnant women. High-risk women who are seronegative in the first or second trimester should be retested in the late third trimester to rule out intercurrent HIV infection. Because quality obstetric care requires that the obstetrical provider know if an individual patient is infected, we recommend that, whenever possible, the test be obtained through the provider. Before such testing occurs, however, each provider should institute procedures that guarantee patient confidentiality. A release-of-information form authorizing the newborn's medical provider access to the mother's test result should also be obtained at this time. Because of the unique potential for exposure of health care workers to large amounts of possibly infectious blood and amniotic fluid during the course of labor and delivery, we recommend that labor and delivery personnel be notified of the need for appropriate infection control procedures on a strictly controlled basis. Ideally this information should be transmitted directly to labor and delivery personnel and through a mechanism other than the permanent medical record.

Care of Infected Pregnant Women

These recommendations apply specifically to women who are known to be infected. Guidelines for women at high risk of infection who have not been tested for HIV infection are found under "Special Considerations" below.

Prenatal care. We recommend that any seropositive woman be retested using two different anti-HIV antibody determinations to ensure accuracy. We recommend that women confirmed to be seropositive be carefully counseled regarding the risk of perinatal HIV infection and the options open to

TABLE 1.—Women in Whom Human Immunodeficiency Virus Infection Has Been Reported

Mode of Transmission	Group
Sexual	Sexual contacts of AIDS patients or men in risk groups* Artificially inseminated women (donor insemination) between January 1, 1979, and June 1, 1985
Parenteral	Intravenous drug users Recipients of blood or blood products between January 1, 1979, and June 1, 1985
Either	Mothers of perinatally infected children
AIDS = acquired immunodeficiency virus	
*Women with multiple sexual partners in areas with high incidences of AIDS should possibly consider themselves in this category.	

them. Such options include continuing the pregnancy or terminating it if early enough in gestation. Infected women should also be specifically counseled to postpone subsequent pregnancies until more is known about the perinatal transmission of the virus. They should be medically evaluated to rule out any incipient opportunistic infection or malignancy. Specifically, the possibility of infection with *Mycobacterium tuberculosis* should be evaluated by chest x-ray film and purified protein-derivative test, and chronic infection with hepatitis B virus, cytomegalovirus and herpes simplex virus should be excluded. The use of teratogenic drugs, including trimethoprim and most antivirals, should be avoided except in the face of a life-threatening maternal illness.

Intrapartum care. We recommend that hospitals review their procedures for infection control during the intrapartum period and that hospital personnel exercise caution when dealing with any potentially infectious body fluid. For HIV these fluids include blood of either maternal or fetal origin, amniotic fluid and the placenta and membranes. Grossly contaminated linens and disposables, as well as blood and amniotic fluid specimens, should be handled according to the hospital infection control procedures. The choice of location for delivery—delivery room versus labor room—may be dictated by circumstance, but consideration should be given to a labor room delivery to minimize the need for disinfection of two locations. All personnel expected to have direct contact with an infected mother or newborn during delivery should wear gloves and gowns. Those exposed to the possibility of a splash of infectious materials should strongly consider wearing a mask and protective eyewear during the delivery itself. Disposal of all materials should follow hospital infection control procedures. The labor room, delivery room and all instruments should be disinfected with a 1:10 sodium hypochlorite solution. The placenta of a seropositive woman or of a high-risk woman of unknown status should be labeled with "Blood Precautions" or the equivalent before routing for pathologic examination or disposal.

Postpartum care. In the postpartum period, regular hospital infection control procedures for HIV infection should be followed. Isolation of asymptomatic seropositive women is not recommended. Mothers should be given full access to their infants unless they have untreated pulmonary tuberculosis. Until more is known about the possible transmission of virus in breast milk, mothers known to be infected should not breast-feed their infants. Because the potential for exposure to large amounts of infectious material decreases substantially after delivery, information regarding the woman's antibody status should not be transmitted beyond the labor and delivery area, including to social work, law enforcement or correctional personnel.

Special Considerations

Women at high risk of infection who are not tested. We recommend that women at high risk of HIV infection who have not been tested during pregnancy be presumed to be positive for purposes of intrapartum infection control procedures. As the benefits of breast-feeding may outweigh the possible risk of postnatal transmission of the virus, however, breast-feeding by mothers at risk of infection who have not been tested is not absolutely contraindicated. Rather, recommendations regarding the safety of breast-feeding should be individualized and based on a mother's estimated risk of infection.

Intravenous-drug-using mothers. To prevent further parenteral transmission of HIV through needle sharing and further perinatal transmission, we recommend that women in this group be specially targeted for substance abuse treatment and risk-reducing education.

Recommendations for Infants and Children

Identifying Exposed Infants

We recommend that identification of HIV-exposed infants begin in utero. If women in high-incidence groups are not tested during pregnancy, we recommend that for medical reasons their infants be tested as early as possible—such as testing the cord blood—and definitely before 2 months of age. Such testing should be done confidentially and with the voluntary consent of the child's parent or guardian.

Identifying Infected Infants

Infants of seropositive mothers. Infants born to mothers who are known to have been infected during pregnancy should be retested for anti-HIV antibody at about 1 year of age when passively acquired maternal antibody has disappeared. Infants presenting before 1 year of age with symptoms suggestive of HIV infection should be retested at that time. If facilities are available, peripheral mononuclear cells should be cultured for HIV to definitely establish a diagnosis of HIV infection.

Infants and children of high-risk mothers with unknown serologic status. Infants born to mothers at high risk of HIV infection whose prenatal anti-HIV antibody status is not known should be tested before 2 months of age for exposure to HIV and retested at 1 year of age or earlier if clinically indicated. Older children who were born on or after January 1, 1979, and whose mothers were at risk of HIV infection should be tested only if they have not completed a primary series of oral polio vaccine and have not received a measles-mumps-rubella vaccination or if clinically indicated. Because of possible complications of live virus vaccines, we recommend that older high-risk children be tested for HIV exposure or infection before receiving live virus vaccines. In the event that the parent or guardian refuses testing, the infant or child should not receive live virus vaccines.

Infants and children at risk for parenterally acquired infection. Infants and children at risk for parenterally acquired HIV infection should be tested only if they received blood or blood products from a donor identified as HIV-infected and will receive live virus vaccines, or if they were transfused with non-heat-treated factor VIII and will receive live virus vaccines or if clinically indicated.

Infants and children of non-high-risk mothers. Infants and children born to mothers not at high risk of HIV infection and not at risk for parenterally acquired HIV infection should not be tested.

Care of Exposed and Infected Infants and Children

Nursery and in-hospital care. Regular hospital infection control procedures for HIV infection and regular hospital procedures for inpatient care of immunosuppressed patients should be followed in the nursery and during subsequent inpatient admissions. To prevent possible portals of entry for infection, circumcision of exposed male infants should be strongly discouraged and only done with informed consent. Umbilical stumps should be meticulously cleaned daily until they are evulsed.

Routine home care. Care-givers who are exposed to the body fluids and excrement of exposed infants and infected children should be aware of the potential for infection and the modes of HIV transmission. Good handwashing after exposure to body fluids and excrement should be observed and any open lesions, either on care-givers' hands or on children, should be covered.

Medical care. Exposed infants who remain anti-HIV positive beyond 1 year of age or who have documented positive HIV cultures at any age should be considered at risk for the development of AIDS or AIDS-related complex (ARC) and, therefore, potentially immunodeficient. Infants and children either at risk for the development of AIDS or ARC or who have clinical AIDS or ARC should be assumed to have a secondary combined immunodeficiency, be followed closely for problems with growth and development and be given prompt and aggressive therapy for infections and exposure to potentially lethal infections, such as varicella and measles.

Exposed infants and infected children should not receive live virus vaccines or bacille Calmette Guérin until more is known about vaccinating HIV-infected persons. Inactivated vaccines, including *Hemophilus influenzae* type b and pertussis vaccines and diphtheria and tetanus toxoids, are not contraindicated and should be given as regularly scheduled. Inactivated polio vaccine should be substituted for oral polio vaccine and be given in conjunction with diphtheria and tetanus toxoids and pertussis vaccine at 2, 4, 6 and 18 months and 4 to 6 years of age. Measles, mumps and rubella vaccine should not be administered to these children at the present time.

Infants or children with clinical AIDS or ARC should be evaluated and cared for as if they have combined immunodeficiency disease. Because these children potentially have a significant cellular immunodeficiency, all blood products should be irradiated to avoid graft-versus-host disease. Until more is known about the natural history of disease in infants who remain anti-HIV positive beyond 1 year of age, the immune status of these children should be sequentially evaluated with the consultation of a pediatrician experienced in the care of HIV-infected children. The increased risk of *Pneumocystis carinii* pneumonia in these children may be modified by the prophylactic use of trimethoprim-sulfamethoxazole. As these children do not make normal specific antibodies to new antigens, their increased risk of infection with bacterial agents may be altered by monthly administration of immune globulin, either intramuscularly or intravenously.

Special Considerations

Foster care. In each decision involving foster-care placement, a mother's history of possible exposure to HIV infection should be individually assessed to determine if she and her child are truly at risk of infection. In San Francisco these decisions can be made in consultation with a designated perinatal coordinator within the Department of Public Health or, if necessary, with the Perinatal and Pediatric AIDS Advisory Committee. For the purposes of foster-care decisions, the committee in San Francisco also includes consumer advocates representative of ethnic and socioeconomic populations at high risk for perinatally transmitted infection. (For a list of the committee members, see footnote at end of article.)

If a child whose mother has been tested for HIV infection comes to foster care, we recommend that the social worker assigned to the case request that the mother's obstetrical pro-

vider release the results of her test to the perinatal coordinator with the mother's consent. Based on the results of these tests, the perinatal coordinator will specify if the infant will need medical foster-care placement or routine foster-care placement. Medical placement will be required for infants of mothers with a positive anti-HIV antibody test and in San Francisco entails review of the placement decision by the Perinatal and Pediatric AIDS Advisory Committee. Routine placement will require that a mother be seronegative. The perinatal coordinator will inform the social worker assigned to follow the child of the reasons for medical placement and will also be responsible, in conjunction with the social worker, for informing the foster family and the child's pediatrician of the reasons for medical placement. Additional authorizations to release information will be required for each of these subsequent disclosures.

Children younger than 3 years currently in foster care and children entering foster care in the future whose mothers were not tested for HIV infection prenatally should be tested for HIV infection only if their mothers have been determined to be at risk of infection. Testing in these cases is indicated on medical grounds alone and should be done with the consent of the mother. In San Francisco, if a mother refuses to consent to testing or refuses to release the results of her test, we recommend that the case be reviewed by the Perinatal and Pediatric AIDS Advisory Committee and, if indicated, confidential testing of the child and release of the test results be done as part of dependency proceedings. Once results of the test are available, they will be released by the child's provider to the perinatal coordinator in the case of voluntary testing or reported directly by the laboratory to the perinatal coordinator in the case of court-ordered testing. The perinatal coordinator will then indicate whether the child is in need of medical placement or routine placement. If the child is in need of medical placement, the perinatal coordinator will follow procedures as outlined above. If, for whatever reason, the child is not tested, the mother's exposure history will be reviewed and appropriate placement recommended by the perinatal and pediatric AIDS advisory committee.

Children in foster care 3 years of age and older, born after January 1, 1979, and born to a mother determined to be at risk of HIV infection should be tested only if they have significant neurodevelopmental delay and lack control of their body secretions or display aggressive behavior, such as biting, or who have uncoverable, nozing lesions. Such testing should occur only after careful medical review by a perinatal and pediatric AIDS advisory committee to determine if such conditions truly increase the theoretic risk of casual HIV transmission. Again, the consent of the child's mother should be obtained for testing and release of information, or, if consent is not available, testing and release of information should be ordered by the court if indicated. We feel that all prenatal testing should be done on a voluntary basis and that the mother should freely consent both to being tested and to release the test results (required by law in California²⁰) to assure better medical care of her children. In the event, however, that a mother determined to be at significant risk of infection has not been tested prenatally, refuses to be tested prenatally or refuses to consent to release the results of her prenatal test, as it is our opinion that testing of high-risk children for HIV infection is medically indicated, we recommend that, if these children are to be placed in foster homes, such testing be done and, if necessary, be specifically ordered by the court having

jurisdiction over the child. Before any court-ordered testing, however, the case must be reviewed by the Perinatal and Pediatric AIDS Advisory Committee to determine if testing is indeed indicated.

Adoption. We recommend that infants and children whose mothers were at high risk of HIV infection, who were born on or after January 1, 1979, and who have not been previously tested be tested for HIV infection before placement. We recommend that the HIV status of all children at high risk of infection be made available to adopting parents before final placement so that they can consider the possible social and psychological effects on their families.

Conclusions

The information and recommendations contained in this report were developed and compiled by the Perinatal and Pediatric AIDS Advisory Committee, a special task force of the Department of Public Health, City and County of San Francisco, which included representatives of the Departments of Obstetrics, Gynecology and Reproductive Sciences, Medicine and Pediatrics and the AIDS Activities Unit, San Francisco General Hospital; the Department of Pediatrics, University of California, San Francisco; the San Francisco Medical Society; the American Academy of Pediatrics; the San Francisco Gynecologic Society; the San Francisco AIDS Foundation; Bay Area Addiction Research and Treatment, Inc. and the Department of Social Services, the City Attorney's Office and the Superior Court of the City and County of San Francisco.*

These recommendations apply to all infants, children and women of child-bearing age known to be infected or at high risk of being infected with HIV. This includes persons with CDC-defined acquired immunodeficiency syndrome, persons with lesser clinical manifestations of HIV infection such as ARC and persons with asymptomatic HIV infection. They are intended to supplement previously published national guidelines for the foster care and adoption of HIV-infected children and for the prevention of perinatal HIV infection.

We reemphasize that these are interim guidelines that will need to be reviewed as more information becomes available

*Members of the committee were Moses Grossman, MD, chair; Jeffrey W. Amory, Arthur F. Bach, DrPH, Paul E. Barnes, Martin C. Carr, MD, Wayne W. Clark, PhD; Daniel E. Collins, JD; Nancy G. Corser, RN, FNP; Dean F. Echenberg, MD, PhD; James R. Green, MD; Marty Jessup, RN, MS; Alan C. Johnson, MD; Ron Kletter, PhD; Craig M. McCabe, JD; Larry Meredith, PhD; Glenn Molyneaux, MD; Geraldine F. Oliva, MD, MPH; Ann O'Reilly, MSW; Nancy H. Rubin, MSW; George W. Rutherford, MD; Edwin S. Sarsfield, MSW; Janet Snalowitz, MD; Nancy S. Straw, PhD; Florence M. Stroud, MSN, MPH; John R. Vera, MSW; Diane W. Waza, MD; Daniel H. Weinstein, LLB; David Werdegar, MD, MPH; Constance B. Wotsy, MD; Donald F. Wong, MD; and Mark M. Young, MA.

on perinatal transmission, the natural history of HIV infection in pregnancy and childhood and household transmission and also as vaccine and definitive antiviral therapy become available. Finally, it should be clearly stated that all evidence suggests that there is no risk of casual transmission of HIV and that the primary intent of these guidelines is to assure appropriate medical care for infected pregnant women, infants and children.

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Perspectives in Disease Prevention and Health Promotion

Public Health Service Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS

These guidelines are the outgrowth of the 1986 recommendations published in the *MMWR* (1); the report on the February 24-25, 1987, Conference on Counseling and Testing (2); and a series of meetings with representatives from the Association of State and Territorial Health Officials, the Association of State and Territorial Public Health Laboratory Directors, the Council of State and Territorial Epidemiologists, the National Association of County Health Officials, the United States Conference of Local Health Officers, and the National Association of State Alcohol and Drug Abuse Directors.

Human immunodeficiency virus (HIV), the causative agent of acquired immunodeficiency syndrome (AIDS) and related clinical manifestations, has been shown to be spread by sexual contact; by parenteral exposure to blood (most often through intravenous [IV] drug abuse) and, rarely, by other exposures to blood; and from an infected woman to her fetus or infant.

Persons exposed to HIV usually develop detectable levels of antibody against the virus within 6-12 weeks of infection. The presence of antibody indicates current infection, though many infected persons may have minimal or no clinical evidence of disease for years. Counseling and testing persons who are infected or at risk for acquiring HIV infection is an important component of prevention strategy (1). Most of the estimated 1.0 to 1.5 million infected persons in the United States are unaware that they are infected with HIV. The primary public health purposes of counseling and testing are to help uninfected individuals initiate and sustain behavioral changes that reduce their risk of becoming infected and to assist infected individuals in avoiding infecting others.

Along with the potential personal, medical, and public health benefits of testing for HIV antibody, public health agencies must be concerned about actions that will discourage the use of counseling and testing facilities, most notably the unauthorized disclosure of personal information and the possibility of inappropriate discrimination.

Guidelines – Continued

Priorities for public health counseling and testing should be based upon providing ready access to persons who are most likely to be infected or who practice high-risk behaviors, thereby helping to reduce further spread of infection. There are other considerations for determining testing priorities, including the likely effectiveness of preventing the spread of infection among persons who would not otherwise realize that they are at risk. Knowledge of the prevalence of HIV infection in different populations is useful in determining the most efficient and effective locations providing such services. For example, programs that offer counseling and testing to homosexual men, IV-drug abusers, persons with hemophilia, sexual and/or needle-sharing partners of these persons, and patients of sexually transmitted disease clinics may be most effective since persons in these groups are at high risk for infection. After counseling and testing are effectively implemented in settings of high and moderate prevalence, consideration should be given to establishing programs in settings of lower prevalence.

Interpretation of HIV-Antibody Test Results

A test for HIV antibody is considered positive when a sequence of tests, starting with a repeatedly reactive enzyme immunoassay (EIA) and including an additional, more specific assay, such as a Western blot, are consistently reactive.

The *sensitivity* of the currently licensed EIA tests is 99% or greater when performed under optimal laboratory conditions. Given this performance, the probability of a false-negative test result is remote, except during the first weeks after infection, before antibody is detectable.

The *specificity* of the currently licensed EIA tests is approximately 99% when repeatedly reactive tests are considered. Repeat testing of specimens initially reactive by EIA is required to reduce the likelihood of false-positive test results due to laboratory error. To further increase the specificity of the testing process, laboratories must use a supplemental test—most often the Western blot test—to validate repeatedly reactive EIA results. The sensitivity of the licensed Western blot test is comparable to that of the EIA, and it is highly specific when strict criteria are used for interpretation. Under ideal circumstances, the probability that a testing sequence will be falsely positive in a population with a low rate of infection ranges from less than 1 in 100,000 (Minnesota Department of Health, unpublished data) to an estimated 5 in 100,000 (3,4). Laboratories using different Western blot reagents or other tests or using less stringent interpretive criteria may experience higher rates of false-positive results.

Laboratories should carefully guard against human errors, which are likely to be the most common source of false-positive test results. All laboratories should anticipate the need for assuring quality performance of tests for HIV antibody by training personnel, establishing quality controls, and participating in performance evaluation systems. Health department laboratories should facilitate the quality assurance of the performance of laboratories in their jurisdiction.

*Guidelines – Continued***Guidelines for Counseling and Testing for HIV Antibody**

These guidelines are based on public health considerations for HIV testing, including the principles of counseling before and after testing, confidentiality of personal information, and the understanding that a person may decline to be tested without being denied health care or other services, except where testing is required by law (5). Counseling before testing may not be practical when screening for HIV antibody is required. This is true for donors of blood, organs, and tissue; prisoners; and immigrants for whom testing is a Federal requirement as well as for persons admitted to state correctional institutions in states that require testing. When there is no counseling before testing, persons should be informed that testing for HIV antibody will be performed, that individual results will be kept confidential to the extent permitted by law, and that appropriate counseling will be offered. Individual counseling of those who are either HIV-antibody positive or at continuing risk for HIV infection is critical for reducing further transmission and for ensuring timely medical care.

Specific recommendations follow:

1. *Persons who may have sexually transmitted disease.* All persons seeking treatment for a sexually transmitted disease, in all health-care settings including the offices of private physicians, should be routinely* counseled and tested for HIV antibody.
2. *IV-drug abusers.* All persons seeking treatment for IV-drug abuse or having a history of IV-drug abuse should be routinely counseled and tested for HIV antibody. Medical professionals in all health-care settings, including prison clinics, should seek a history of IV-drug abuse from patients and should be aware of its implications for HIV infection. In addition, state and local health policy makers should address the following issues:
 - Treatment programs for IV-drug abusers should be sufficiently available to allow persons seeking assistance to enter promptly and be encouraged to alter the behavior that places them and others at risk for HIV infection.
 - Outreach programs for IV-drug abusers should be undertaken to increase their knowledge of AIDS and of ways to prevent HIV infection, to encourage them to obtain counseling and testing for HIV antibody, and to persuade them to be treated for substance abuse.
3. *Persons who consider themselves at risk.* All persons who consider themselves at risk for HIV infection should be counseled and offered testing for HIV antibody.

*"Routine counseling and testing" is defined as a policy to provide these services to all clients after informing them that testing will be done. Except where testing is required by law, individuals have the right to decline to be tested without being denied health care or other services.

Guidelines – Continued

4. *Women of childbearing age.* All women of childbearing age with identifiable risks for HIV infection should be routinely counseled and tested for HIV antibody, regardless of the health-care setting. Each encounter between a health-care provider and a woman at risk and/or her sexual partners is an opportunity to reach them with information and education about AIDS and prevention of HIV infection. Women are at risk for HIV infection if they:
- Have used IV drugs.
 - Have engaged in prostitution.
 - Have had sexual partners who are infected or are at risk for infection because they are bisexual or are IV-drug abusers or hemophiliacs.
 - Are living in communities or were born in countries where there is a known or suspected high prevalence of infection among women.
 - Received a transfusion before blood was being screened for HIV antibody but after HIV infection occurred in the United States (e.g., between 1978 and 1985).

Educating and testing these women before they become pregnant allows them to avoid pregnancy and subsequent intrauterine perinatal infection of their infants (30%-50% of the infants born to HIV-infected women will also be infected).

All pregnant women at risk for HIV infection should be routinely counseled and tested for HIV antibody. Identifying pregnant women with HIV infection as early in pregnancy as possible is important for ensuring appropriate medical care for these women; for planning medical care for their infants; and for providing counseling on family planning, future pregnancies, and the risk of sexual transmission of HIV to others.

All women who seek family planning services and who are at risk for HIV infection should be routinely counseled about AIDS and HIV infection and tested for HIV antibody. Decisions about the need for counseling and testing programs in a community should be based on the best available estimates of the prevalence of HIV infection and the demographic variables of infection.

5. *Persons planning marriage.* All persons considering marriage should be given information about AIDS, HIV infection, and the availability of counseling and testing for HIV antibody. Decisions about instituting routine or mandatory premarital testing for HIV antibody should take into account the prevalence of HIV infection in the area and/or population group as well as other factors and should be based upon the likely cost-effectiveness of such testing in preventing further spread of infection. Premarital testing in an area with a prevalence of HIV infection as low as 0.1% may be justified if reaching an infected person through testing can prevent subsequent transmission to the spouse or prevent pregnancy in a woman who is infected.

Guidelines – Continued

6. *Persons undergoing medical evaluation or treatment.* Testing for HIV antibody is a useful diagnostic tool for evaluating patients with selected clinical signs and symptoms such as generalized lymphadenopathy; unexplained dementia; chronic, unexplained fever or diarrhea; unexplained weight loss; or diseases such as tuberculosis as well as sexually transmitted diseases, generalized herpes, and chronic candidiasis.

Since persons infected with both HIV and the tubercle bacillus are at high risk for severe clinical tuberculosis, all patients with tuberculosis should be routinely counseled and tested for HIV antibody (6). Guidelines for managing patients with both HIV and tuberculous infection have been published (7).

The risk of HIV infection from transfusions of blood or blood components from 1978-1985 was greatest for persons receiving large numbers of units of blood collected from areas with high incidences of AIDS. Persons who have this increased risk should be counseled about the potential risk of HIV infection and should be offered antibody testing (8).

7. *Persons admitted to hospitals.* Hospitals, in conjunction with state and local health departments, should periodically determine the prevalence of HIV infections in the age groups at highest risk for infection. Consideration should be given to routine testing in those age groups deemed to have a high prevalence of HIV infection.
8. *Persons in correctional systems.* Correctional systems should study the best means of implementing programs for counseling inmates about HIV infection and for testing them for such infection at admission and discharge from the system. In particular, they should examine the usefulness of these programs in preventing further transmission of HIV infection and the impact of the testing programs on both the inmates and the correctional system (9). Federal prisons have been instructed to test all prisoners when they enter and leave the prison system.
9. *Prostitutes.* Male and female prostitutes should be counseled and tested and made aware of the risks of HIV infection to themselves and others. Particularly prostitutes who are HIV-antibody positive should be instructed to discontinue the practice of prostitution. Local or state jurisdictions should adopt procedures to assure that these instructions are followed.

Partner Notification/Contact Tracing

Sexual partners and those who share needles with HIV-infected persons are at risk for HIV infection and should be routinely counseled and tested for HIV antibody. Persons who are HIV-antibody positive should be instructed in how to notify their partners and to refer them for counseling and testing. If they are unwilling to notify their partners or if it cannot be assured that their partners will seek counseling, physicians or health department personnel should use confidential procedures to assure that the partners are notified.

*Guidelines — Continued***Confidentiality and Antidiscrimination Considerations**

The ability of health departments, hospitals, and other health-care providers and institutions to assure confidentiality of patient information and the public's confidence in that ability are crucial to efforts to increase the number of persons being counseled and tested for HIV infection. Moreover, to assure broad participation in the counseling and testing programs, it is of equal or greater importance that the public perceive that persons found to be positive will not be subject to inappropriate discrimination.

Every reasonable effort should be made to improve confidentiality of test results. The confidentiality of related records can be improved by a careful review of actual record-keeping practices and by assessing the degree to which these records can be protected under applicable state laws. State laws should be examined and strengthened when found necessary. Because of the wide scope of "need-to-know" situations, because of the possibility of inappropriate disclosures, and because of established authorization procedures for releasing records, it is recognized that there is no perfect solution to confidentiality problems in all situations. Whether disclosures of HIV-testing information are deliberate, inadvertent, or simply unavoidable, public health policy needs to carefully consider ways to reduce the harmful impact of such disclosures.

Public health prevention policy to reduce the transmission of HIV infection can be furthered by an expanded program of counseling and testing for HIV antibody, but the extent to which these programs are successful depends on the level of participation. Persons are more likely to participate in counseling and testing programs if they believe that they will not experience negative consequences in areas such as employment, school admission, housing, and medical services should they test positive. There is no known medical reason to avoid an infected person in these and ordinary social situations since the cumulative evidence is strong that HIV infection is not spread through casual contact. It is essential to the success of counseling and testing programs that persons who are tested for HIV are not subjected to inappropriate discrimination.

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Supplement

MORBIDITY AND MORTALITY WEEKLY REPORT

**Recommendations for
Prevention of HIV
Transmission in Health-Care
Settings**

U. S. Department of Health and Human Services
Public Health Service
Centers for Disease Control
Atlanta, Georgia 30333

Attach. 1

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Recommendations for Prevention of HIV Transmission in Health-Care Settings

Introduction

Human immunodeficiency virus (HIV), the virus that causes acquired immunodeficiency syndrome (AIDS), is transmitted through sexual contact and exposure to infected blood or blood components and perinatally from mother to neonate. HIV has been isolated from blood, semen, vaginal secretions, saliva, tears, breast milk, cerebrospinal fluid, amniotic fluid, and urine and is likely to be isolated from other body fluids, secretions, and excretions. However, epidemiologic evidence has implicated only blood, semen, vaginal secretions, and possibly breast milk in transmission.

The increasing prevalence of HIV increases the risk that health-care workers will be exposed to blood from patients infected with HIV, especially when blood and body-fluid precautions are not followed for all patients. Thus, this document emphasizes the need for health-care workers to consider all patients as potentially infected with HIV and/or other blood-borne pathogens and to adhere rigorously to infection-control precautions for minimizing the risk of exposure to blood and body fluids of all patients.

The recommendations contained in this document consolidate and update CDC recommendations published earlier for preventing HIV transmission in health-care settings: precautions for clinical and laboratory staffs (1) and precautions for health-care workers and allied professionals (2); recommendations for preventing HIV transmission in the workplace (3) and during invasive procedures (4); recommendations for preventing possible transmission of HIV from tears (5); and recommendations for providing dialysis treatment for HIV-infected patients (6). These recommendations also update portions of the "Guideline for Isolation Precautions in Hospitals" (7) and reemphasize some of the recommendations contained in "Infection Control Practices for Dentistry" (8). The recommendations contained in this document have been developed for use in health-care settings and emphasize the need to treat blood and other body fluids from all patients as potentially infective. These same prudent precautions also should be taken in other settings in which persons may be exposed to blood or other body fluids.

Definition of Health-Care Workers

Health-care workers are defined as persons, including students and trainees, whose activities involve contact with patients or with blood or other body fluids from patients in a health-care setting.

Health-Care Workers with AIDS

As of July 10, 1987, a total of 1,875 (5.8%) of 32,395 adults with AIDS, who had been reported to the CDC national surveillance system and for whom occupational information was available, reported being employed in a health-care or clinical laboratory setting. In comparison, 6.8 million persons—representing 5.6% of the U.S. labor force—were employed in health services. Of the health-care workers with AIDS, 95% have been reported to exhibit high-risk behavior; for the remaining 5%, the means of HIV acquisition was undetermined. Health-care workers with AIDS were significantly more likely than other workers to have an undetermined risk (5% versus 3%, respectively). For both health-care workers and non-health-care workers with AIDS, the proportion with an undetermined risk has not increased since 1982.

AIDS patients initially reported as not belonging to recognized risk groups are investigated by state and local health departments to determine whether possible risk factors exist. Of all health-care workers with AIDS reported to CDC who were initially characterized as not having an identified risk and for whom follow-up information was available, 66% have been reclassified because risk factors were identified or because the patient was found not to meet the surveillance case definition for AIDS. Of the 87 health-care workers currently categorized as having no identifiable risk, information is incomplete on 16 (18%) because of death or refusal to be interviewed; 38 (44%) are still being investigated. The remaining 33 (38%) health-care workers were interviewed or had other follow-up information available. The occupations of these 33 were as follows: five physicians (15%), three of whom were surgeons; one dentist (3%); three nurses (9%); nine nursing assistants (27%); seven housekeeping or maintenance workers (21%); three clinical laboratory technicians (9%); one therapist (3%); and four others who did not have contact with patients (12%). Although 15 of these 33 health-care workers reported parenteral and/or other non-needlestick exposure to blood or body fluids from patients in the 10 years preceding their diagnosis of AIDS, none of these exposures involved a patient with AIDS or known HIV infection.

Risk to Health-Care Workers of Acquiring HIV in Health-Care Settings

Health-care workers with documented percutaneous or mucous-membrane exposures to blood or body fluids of HIV-infected patients have been prospectively evaluated to determine the risk of infection after such exposures. As of June 30, 1987, 883 health-care workers have been tested for antibody to HIV in an ongoing surveillance project conducted by CDC (9). Of these, 708 (80%) had percutaneous exposures to blood, and 175 (20%) had a mucous membrane or an open wound contaminated by blood or body fluid. Of 396 health-care workers, each of whom had only a convalescent-phase serum sample obtained and tested ≥ 90 days post-exposure, one—for whom heterosexual transmission could not be ruled out—was seropositive for HIV antibody. For 425 additional health-care workers, both acute- and convalescent-phase serum samples were obtained and tested; none of 74 health-care workers with nonpercutaneous exposures seroconverted, and three (0.9%) of 351

with percutaneous exposures seroconverted. None of these three health-care workers had other documented risk factors for infection.

Two other prospective studies to assess the risk of nosocomial acquisition of HIV infection for health-care workers are ongoing in the United States. As of April 30, 1987, 332 health-care workers with a total of 453 needlestick or mucous-membrane exposures to the blood or other body fluids of HIV-infected patients were tested for HIV antibody at the National Institutes of Health (10). These exposed workers included 103 with needlestick injuries and 229 with mucous-membrane exposures; none had seroconverted. A similar study at the University of California of 129 health-care workers with documented needlestick injuries or mucous-membrane exposures to blood or other body fluids from patients with HIV infection has not identified any seroconversions (11). Results of a prospective study in the United Kingdom identified no evidence of transmission among 150 health-care workers with parenteral or mucous-membrane exposures to blood or other body fluids, secretions, or excretions from patients with HIV infection (12).

In addition to health-care workers enrolled in prospective studies, eight persons who provided care to infected patients and denied other risk factors have been reported to have acquired HIV infection. Three of these health-care workers had needlestick exposures to blood from infected patients (13-15). Two were persons who provided nursing care to infected persons; although neither sustained a needlestick, both had extensive contact with blood or other body fluids, and neither observed recommended barrier precautions (16,17). The other three were health-care workers with non-needlestick exposures to blood from infected patients (18). Although the exact route of transmission for these last three infections is not known, all three persons had direct contact of their skin with blood from infected patients, all had skin lesions that may have been contaminated by blood, and one also had a mucous-membrane exposure.

A total of 1,231 dentists and hygienists, many of whom practiced in areas with many AIDS cases, participated in a study to determine the prevalence of antibody to HIV; one dentist (0.1%) had HIV antibody. Although no exposure to a known HIV-infected person could be documented, epidemiologic investigation did not identify any other risk factor for infection. The infected dentist, who also had a history of sustaining needlestick injuries and trauma to his hands, did not routinely wear gloves when providing dental care (19).

Precautions To Prevent Transmission of HIV

Universal Precautions

Since medical history and examination cannot reliably identify all patients infected with HIV or other blood-borne pathogens, blood and body-fluid precautions should be consistently used for all patients. This approach, previously recommended by CDC (3,4), and referred to as "universal blood and body-fluid precautions" or "universal precautions," should be used in the care of all patients, especially including those in emergency-care settings in which the risk of blood exposure is increased and the infection status of the patient is usually unknown (20).

1. All health-care workers should routinely use appropriate barrier precautions to prevent skin and mucous-membrane exposure when contact with blood or other body fluids of any patient is anticipated. Gloves should be worn for touching blood and body fluids, mucous membranes, or non-intact skin of all patients, for handling items or surfaces soiled with blood or body fluids, and for performing venipuncture and other vascular access procedures. Gloves should be changed after contact with each patient. Masks and protective eyewear or face shields should be worn during procedures that are likely to generate droplets of blood or other body fluids to prevent exposure of mucous membranes of the mouth, nose, and eyes. Gowns or aprons should be worn during procedures that are likely to generate splashes of blood or other body fluids.
2. Hands and other skin surfaces should be washed immediately and thoroughly if contaminated with blood or other body fluids. Hands should be washed immediately after gloves are removed.
3. All health-care workers should take precautions to prevent injuries caused by needles, scalpels, and other sharp instruments or devices during procedures; when cleaning used instruments; during disposal of used needles; and when handling sharp instruments after procedures. To prevent needlestick injuries, needles should not be recapped, purposely bent or broken by hand, removed from disposable syringes, or otherwise manipulated by hand. After they are used, disposable syringes and needles, scalpel blades, and other sharp items should be placed in puncture-resistant containers for disposal; the puncture-resistant containers should be located as close as practical to the use area. Large-bore reusable needles should be placed in a puncture-resistant container for transport to the reprocessing area.
4. Although saliva has not been implicated in HIV transmission, to minimize the need for emergency mouth-to-mouth resuscitation, mouthpieces, resuscitation bags, or other ventilation devices should be available for use in areas in which the need for resuscitation is predictable.
5. Health-care workers who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient-care equipment until the condition resolves.
6. Pregnant health-care workers are not known to be at greater risk of contracting HIV infection than health-care workers who are not pregnant; however, if a health-care worker develops HIV infection during pregnancy, the infant is at risk of infection resulting from perinatal transmission. Because of this risk, pregnant health-care workers should be especially familiar with and strictly adhere to precautions to minimize the risk of HIV transmission.

Implementation of universal blood and body-fluid precautions for all patients eliminates the need for use of the isolation category of "Blood and Body Fluid Precautions" previously recommended by CDC (7) for patients known or suspected to be infected with blood-borne pathogens. Isolation precautions (e.g., enteric, "AFB" [7]) should be used as necessary if associated conditions, such as infectious diarrhea or tuberculosis, are diagnosed or suspected.

Precautions for Invasive Procedures

In this document, an invasive procedure is defined as surgical entry into tissues, cavities, or organs or repair of major traumatic injuries 1) in an operating or delivery

room, emergency department, or outpatient setting, including both physicians' and dentists' offices; 2) cardiac catheterization and angiographic procedures; 3) a vaginal or cesarean delivery or other invasive obstetric procedure during which bleeding may occur; or 4) the manipulation, cutting, or removal of any oral or perioral tissues, including tooth structure, during which bleeding occurs or the potential for bleeding exists. The universal blood and body-fluid precautions listed above, combined with the precautions listed below, should be the minimum precautions for all such invasive procedures.

1. All health-care workers who participate in invasive procedures must routinely use appropriate barrier precautions to prevent skin and mucous-membrane contact with blood and other body fluids of all patients. Gloves and surgical masks must be worn for all invasive procedures. Protective eyewear or face shields should be worn for procedures that commonly result in the generation of droplets, splashing of blood or other body fluids, or the generation of bone chips. Gowns or aprons made of materials that provide an effective barrier should be worn during invasive procedures that are likely to result in the splashing of blood or other body fluids. All health-care workers who perform or assist in vaginal or cesarean deliveries should wear gloves and gowns when handling the placenta or the infant until blood and amniotic fluid have been removed from the infant's skin and should wear gloves during post-delivery care of the umbilical cord.
2. If a glove is torn or a needlestick or other injury occurs, the glove should be removed and a new glove used as promptly as patient safety permits; the needle or instrument involved in the incident should also be removed from the sterile field.

Precautions for Dentistry*

Blood, saliva, and gingival fluid from all dental patients should be considered infective. Special emphasis should be placed on the following precautions for preventing transmission of blood-borne pathogens in dental practice in both institutional and non-institutional settings.

1. In addition to wearing gloves for contact with oral mucous membranes of all patients, all dental workers should wear surgical masks and protective eyewear or chin-length plastic face shields during dental procedures in which splashing or spattering of blood, saliva, or gingival fluids is likely. Rubber dams, high-speed evacuation, and proper patient positioning, when appropriate, should be utilized to minimize generation of droplets and spatter.
2. Handpieces should be sterilized after use with each patient, since blood, saliva, or gingival fluid of patients may be aspirated into the handpiece or waterline. Handpieces that cannot be sterilized should at least be flushed, the outside surface cleaned and wiped with a suitable chemical germicide, and then rinsed. Handpieces should be flushed at the beginning of the day and after use with each patient. Manufacturers' recommendations should be followed for use and maintenance of waterlines and check valves and for flushing of handpieces. The same precautions should be used for ultrasonic scalers and air/water syringes.

*General infection-control precautions are more specifically addressed in previous recommendations for infection-control practices for dentistry (8).

3. Blood and saliva should be thoroughly and carefully cleaned from material that has been used in the mouth (e.g., impression materials, bite registration), especially before polishing and grinding intra-oral devices. Contaminated materials, impressions, and intra-oral devices should also be cleaned and disinfected before being handled in the dental laboratory and before they are placed in the patient's mouth. Because of the increasing variety of dental materials used intra-orally, dental workers should consult with manufacturers as to the stability of specific materials when using disinfection procedures.
4. Dental equipment and surfaces that are difficult to disinfect (e.g., light handles or X-ray-unit heads) and that may become contaminated should be wrapped with impervious-backed paper, aluminum foil, or clear plastic wrap. The coverings should be removed and discarded, and clean coverings should be put in place after use with each patient.

Precautions for Autopsies or Morticians' Services

In addition to the universal blood and body-fluid precautions listed above, the following precautions should be used by persons performing postmortem procedures:

1. All persons performing or assisting in postmortem procedures should wear gloves, masks, protective eyewear, gowns, and waterproof aprons.
2. Instruments and surfaces contaminated during postmortem procedures should be decontaminated with an appropriate chemical germicide.

Precautions for Dialysis

Patients with end-stage renal disease who are undergoing maintenance dialysis and who have HIV infection can be dialyzed in hospital-based or free-standing dialysis units using conventional infection-control precautions (21). Universal blood and body-fluid precautions should be used when dialyzing all patients.

Strategies for disinfecting the dialysis fluid pathways of the hemodialysis machine are targeted to control bacterial contamination and generally consist of using 500-750 parts per million (ppm) of sodium hypochlorite (household bleach) for 30-40 minutes or 1.5%-2.0% formaldehyde overnight. In addition, several chemical germicides formulated to disinfect dialysis machines are commercially available. None of these protocols or procedures need to be changed for dialyzing patients infected with HIV.

Patients infected with HIV can be dialyzed by either hemodialysis or peritoneal dialysis and do not need to be isolated from other patients. The type of dialysis treatment (i.e., hemodialysis or peritoneal dialysis) should be based on the needs of the patient. The dialyzer may be discarded after each use. Alternatively, centers that reuse dialyzers—i.e., a specific single-use dialyzer is issued to a specific patient, removed, cleaned, disinfected, and reused several times on the same patient only—may include HIV-infected patients in the dialyzer-reuse program. An individual dialyzer must never be used on more than one patient.

Precautions for Laboratories[†]

Blood and other body fluids from all patients should be considered infective. To supplement the universal blood and body-fluid precautions listed above, the following precautions are recommended for health-care workers in clinical laboratories.

[†]Additional precautions for research and industrial laboratories are addressed elsewhere (22,23).

1. All specimens of blood and body fluids should be put in a well-constructed container with a secure lid to prevent leaking during transport. Care should be taken when collecting each specimen to avoid contaminating the outside of the container and of the laboratory form accompanying the specimen.
2. All persons processing blood and body-fluid specimens (e.g., removing tops from vacuum tubes) should wear gloves. Masks and protective eyewear should be worn if mucous-membrane contact with blood or body fluids is anticipated. Gloves should be changed and hands washed after completion of specimen processing.
3. For routine procedures, such as histologic and pathologic studies or microbiologic culturing, a biological safety cabinet is not necessary. However, biological safety cabinets (Class I or II) should be used whenever procedures are conducted that have a high potential for generating droplets. These include activities such as blending, sonicating, and vigorous mixing.
4. Mechanical pipetting devices should be used for manipulating all liquids in the laboratory. Mouth pipetting must not be done.
5. Use of needles and syringes should be limited to situations in which there is no alternative, and the recommendations for preventing injuries with needles outlined under universal precautions should be followed.
6. Laboratory work surfaces should be decontaminated with an appropriate chemical germicide after a spill of blood or other body fluids and when work activities are completed.
7. Contaminated materials used in laboratory tests should be decontaminated before reprocessing or be placed in bags and disposed of in accordance with institutional policies for disposal of infective waste (24).
8. Scientific equipment that has been contaminated with blood or other body fluids should be decontaminated and cleaned before being repaired in the laboratory or transported to the manufacturer.
9. All persons should wash their hands after completing laboratory activities and should remove protective clothing before leaving the laboratory.

Implementation of universal blood and body-fluid precautions for all patients eliminates the need for warning labels on specimens since blood and other body fluids from all patients should be considered infective.

Environmental Considerations for HIV Transmission

No environmentally mediated mode of HIV transmission has been documented. Nevertheless, the precautions described below should be taken routinely in the care of all patients.

Sterilization and Disinfection

Standard sterilization and disinfection procedures for patient-care equipment currently recommended for use (25,26) in a variety of health-care settings—including hospitals, medical and dental clinics and offices, hemodialysis centers, emergency-care facilities, and long-term nursing-care facilities—are adequate to sterilize or disinfect instruments, devices, or other items contaminated with blood or other body fluids from persons infected with blood-borne pathogens including HIV (21,23).

Instruments or devices that enter sterile tissue or the vascular system of any patient or through which blood flows should be sterilized before reuse. Devices or items that contact intact mucous membranes should be sterilized or receive high-level disinfection, a procedure that kills vegetative organisms and viruses but not necessarily large numbers of bacterial spores. Chemical germicides that are registered with the U.S. Environmental Protection Agency (EPA) as "sterilants" may be used either for sterilization or for high-level disinfection depending on contact time.

Contact lenses used in trial fittings should be disinfected after each fitting by using a hydrogen peroxide contact lens disinfecting system or, if compatible, with heat (78 C-80 C [172.4 F-176.0 F]) for 10 minutes.

Medical devices or instruments that require sterilization or disinfection should be thoroughly cleaned before being exposed to the germicide, and the manufacturer's instructions for the use of the germicide should be followed. Further, it is important that the manufacturer's specifications for compatibility of the medical device with chemical germicides be closely followed. 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, SW, Washington, D.C. 20460.

Studies have shown that HIV is inactivated rapidly after being exposed to commonly used chemical germicides at concentrations that are much lower than used in practice (27-30). Embalming fluids are similar to the types of chemical germicides that have been tested and found to completely inactivate HIV. In addition to commercially available chemical germicides, a solution of sodium hypochlorite (household bleach) prepared daily is an inexpensive and effective germicide. Concentrations ranging from approximately 500 ppm (1:100 dilution of household bleach) sodium hypochlorite to 5,000 ppm (1:10 dilution of household bleach) are effective depending on the amount of organic material (e.g., blood, mucus) present on the surface to be cleaned and disinfected. Commercially available chemical germicides may be more compatible with certain medical devices that might be corroded by repeated exposure to sodium hypochlorite, especially to the 1:10 dilution.

Survival of HIV in the Environment

The most extensive study on the survival of HIV after drying involved greatly concentrated HIV samples, i.e., 10 million tissue-culture infectious doses per milliliter (31). This concentration is at least 100,000 times greater than that typically found in the blood or serum of patients with HIV infection. HIV was detectable by tissue-culture techniques 1-3 days after drying, but the rate of inactivation was rapid. Studies performed at CDC have also shown that drying HIV causes a rapid (within several hours) 1-2 log (90%-99%) reduction in HIV concentration. In tissue-culture fluid, cell-free HIV could be detected up to 15 days at room temperature, up to 11 days at 37 C (98.6 F), and up to 1 day if the HIV was cell-associated.

When considered in the context of environmental conditions in health-care facilities, these results do not require any changes in currently recommended sterilization, disinfection, or housekeeping strategies. When medical devices are contaminated with blood or other body fluids, existing recommendations include the cleaning of these instruments, followed by disinfection or sterilization, depending on the type of medical device. These protocols assume "worst-case" conditions of

extreme virologic and microbiologic contamination, and whether viruses have been inactivated after drying plays no role in formulating these strategies. Consequently, no changes in published procedures for cleaning, disinfecting, or sterilizing need to be made.

Housekeeping

Environmental surfaces such as walls, floors, and other surfaces are not associated with transmission of infections to patients or health-care workers. Therefore, extraordinary attempts to disinfect or sterilize these environmental surfaces are not necessary. However, cleaning and removal of soil should be done routinely.

Cleaning schedules and methods vary according to the area of the hospital or institution, type of surface to be cleaned, and the amount and type of soil present. Horizontal surfaces (e.g., bedside tables and hard-surfaced flooring) in patient-care areas are usually cleaned on a regular basis, when soiling or spills occur, and when a patient is discharged. Cleaning of walls, blinds, and curtains is recommended only if they are visibly soiled. Disinfectant fogging is an unsatisfactory method of decontaminating air and surfaces and is not recommended.

Disinfectant-detergent formulations registered by EPA can be used for cleaning environmental surfaces, but the actual physical removal of microorganisms by scrubbing is probably at least as important as any antimicrobial effect of the cleaning agent used. Therefore, cost, safety, and acceptability by housekeepers can be the main criteria for selecting any such registered agent. The manufacturers' instructions for appropriate use should be followed.

Cleaning and Decontaminating Spills of Blood or Other Body Fluids

Chemical germicides that are approved for use as "hospital disinfectants" and are tuberculocidal when used at recommended dilutions can be used to decontaminate spills of blood and other body fluids. Strategies for decontaminating spills of blood and other body fluids in a patient-care setting are different than for spills of cultures or other materials in clinical, public health, or research laboratories. In patient-care areas, visible material should first be removed and then the area should be decontaminated. With large spills of cultured or concentrated infectious agents in the laboratory, the contaminated area should be flooded with a liquid germicide before cleaning, then decontaminated with fresh germicidal chemical. In both settings, gloves should be worn during the cleaning and decontaminating procedures.

Laundry

Although soiled linen has been identified as a source of large numbers of certain pathogenic microorganisms, the risk of actual disease transmission is negligible. Rather than rigid procedures and specifications, hygienic and common-sense storage and processing of clean and soiled linen are recommended (26). Soiled linen should be handled as little as possible and with minimum agitation to prevent gross microbial contamination of the air and of persons handling the linen. All soiled linen should be bagged at the location where it was used; it should not be sorted or rinsed in patient-care areas. Linen soiled with blood or body fluids should be placed and transported in bags that prevent leakage. If hot water is used, linen should be washed

with detergent in water at least 71 C (160 F) for 25 minutes. If low-temperature (≤ 70 C [158 F]) laundry cycles are used, chemicals suitable for low-temperature washing at proper use concentration should be used.

Infective Waste

There is no epidemiologic evidence to suggest that most hospital waste is any more infective than residential waste. Moreover, there is no epidemiologic evidence that hospital waste has caused disease in the community as a result of improper disposal. Therefore, identifying wastes for which special precautions are indicated is largely a matter of judgment about the relative risk of disease transmission. The most practical approach to the management of infective waste is to identify those wastes with the potential for causing infection during handling and disposal and for which some special precautions appear prudent. Hospital wastes for which special precautions appear prudent include microbiology laboratory waste, pathology waste, and blood specimens or blood products. While any item that has had contact with blood, exudates, or secretions may be potentially infective, it is not usually considered practical or necessary to treat all such waste as infective (23,26). Infective waste, in general, should either be incinerated or should be autoclaved before disposal in a sanitary landfill. Bulk blood, suctioned fluids, excretions, and secretions may be carefully poured down a drain connected to a sanitary sewer. Sanitary sewers may also be used to dispose of other infectious wastes capable of being ground and flushed into the sewer.

Implementation of Recommended Precautions

Employers of health-care workers should ensure that policies exist for:

1. Initial orientation and continuing education and training of all health-care workers—including students and trainees—on the epidemiology, modes of transmission, and prevention of HIV and other blood-borne infections and the need for routine use of universal blood and body-fluid precautions for all patients.
2. Provision of equipment and supplies necessary to minimize the risk of infection with HIV and other blood-borne pathogens.
3. Monitoring adherence to recommended protective measures. When monitoring reveals a failure to follow recommended precautions, counseling, education, and/or re-training should be provided, and, if necessary, appropriate disciplinary action should be considered.

Professional associations and labor organizations, through continuing education efforts, should emphasize the need for health-care workers to follow recommended precautions.

Serologic Testing for HIV Infection

Background

A person is identified as infected with HIV when a sequence of tests, starting with repeated enzyme immunoassays (EIA) and including a Western blot or similar, more specific assay, are repeatedly reactive. Persons infected with HIV usually develop antibody against the virus within 6-12 weeks after infection.

The sensitivity of the currently licensed EIA tests is at least 99% when they are performed under optimal laboratory conditions on serum specimens from persons infected for ≥ 12 weeks. Optimal laboratory conditions include the use of reliable reagents, provision of continuing education of personnel, quality control of procedures, and participation in performance-evaluation programs. Given this performance, the probability of a false-negative test is remote except during the first several weeks after infection, before detectable antibody is present. The proportion of infected persons with a false-negative test attributed to absence of antibody in the early stages of infection is dependent on both the incidence and prevalence of HIV infection in a population (Table 1).

The specificity of the currently licensed EIA tests is approximately 99% when repeatedly reactive tests are considered. Repeat testing of initially reactive specimens by EIA is required to reduce the likelihood of laboratory error. To increase further the specificity of serologic tests, laboratories must use a supplemental test, most often the Western blot, to validate repeatedly reactive EIA results. Under optimal laboratory conditions, the sensitivity of the Western blot test is comparable to or greater than that of a repeatedly reactive EIA, and the Western blot is highly specific when strict criteria are used to interpret the test results. The testing sequence of a repeatedly reactive EIA and a positive Western blot test is highly predictive of HIV infection, even in a population with a low prevalence of infection (Table 2). If the Western blot test result is indeterminant, the testing sequence is considered equivocal for HIV infection.

TABLE 1. Estimated annual number of patients infected with HIV not detected by HIV-antibody testing in a hypothetical hospital with 10,000 admissions/year*

Beginning prevalence of HIV infection	Annual incidence of HIV infection	Approximate number of HIV-infected patients	Approximate number of HIV-infected patients not detected
5.0%	1.0%	550	17-18
5.0%	0.5%	525	11-12
1.0%	0.2%	110	3-4
1.0%	0.1%	105	2-3
0.1%	0.02%	11	0-1
0.1%	0.01%	11	0-1

*The estimates are based on the following assumptions: 1) the sensitivity of the screening test is 99% (i.e., 99% of HIV-infected persons with antibody will be detected); 2) persons infected with HIV will not develop detectable antibody (seroconvert) until 6 weeks (1.5 months) after infection; 3) new infections occur at an equal rate throughout the year; 4) calculations of the number of HIV-infected persons in the patient population are based on the mid-year prevalence, which is the beginning prevalence plus half the annual incidence of infections.

When this occurs, the Western blot test should be repeated on the same serum sample, and, if still indeterminate, the testing sequence should be repeated on a sample collected 3-6 months later. Use of other supplemental tests may aid in interpreting of results on samples that are persistently indeterminate by Western blot.

Testing of Patients

Previous CDC recommendations have emphasized the value of HIV serologic testing of patients for: 1) management of parenteral or mucous-membrane exposures of health-care workers, 2) patient diagnosis and management, and 3) counseling and serologic testing to prevent and control HIV transmission in the community. In addition, more recent recommendations have stated that hospitals, in conjunction with state and local health departments, should periodically determine the prevalence of HIV infection among patients from age groups at highest risk of infection (32).

Adherence to universal blood and body-fluid precautions recommended for the care of all patients will minimize the risk of transmission of HIV and other blood-borne pathogens from patients to health-care workers. The utility of routine HIV serologic testing of patients as an adjunct to universal precautions is unknown. Results of such testing may not be available in emergency or outpatient settings. In addition, some recently infected patients will not have detectable antibody to HIV (Table 1).

Personnel in some hospitals have advocated serologic testing of patients in settings in which exposure of health-care workers to large amounts of patients' blood may be anticipated. Specific patients for whom serologic testing has been advocated include those undergoing major operative procedures and those undergoing treatment in critical-care units, especially if they have conditions involving uncontrolled bleeding. Decisions regarding the need to establish testing programs for patients should be made by physicians or individual institutions. In addition, when deemed appropriate, testing of individual patients may be performed on agreement between the patient and the physician providing care.

In addition to the universal precautions recommended for all patients, certain additional precautions for the care of HIV-infected patients undergoing major surgical operations have been proposed by personnel in some hospitals. For example, surgical procedures on an HIV-infected patient might be altered so that hand-to-hand passing of sharp instruments would be eliminated; stapling instruments rather than

TABLE 2. Predictive value of positive HIV-antibody tests in hypothetical populations with different prevalences of infection

	Prevalence of infection	Predictive value of positive test*
Repeatedly reactive enzyme immunoassay (EIA) [†]	0.2%	28.41%
	2.0%	80.16%
	20.0%	98.02%
Repeatedly reactive EIA followed by positive Western blot (WB) [‡]	0.2%	99.75%
	2.0%	99.97%
	20.0%	99.99%

*Proportion of persons with positive test results who are actually infected with HIV.

[†]Assumes EIA sensitivity of 99.0% and specificity of 99.5%.

[‡]Assumes WB sensitivity of 99.0% and specificity of 99.9%.

hand-suturing equipment might be used to perform tissue approximation; electrocautery devices rather than scalpels might be used as cutting instruments; and, even though uncomfortable, gowns that totally prevent seepage of blood onto the skin of members of the operative team might be worn. While such modifications might further minimize the risk of HIV infection for members of the operative team, some of these techniques could result in prolongation of operative time and could potentially have an adverse effect on the patient.

Testing programs, if developed, should include the following principles:

- Obtaining consent for testing.
- Informing patients of test results, and providing counseling for seropositive patients by properly trained persons.
- Assuring that confidentiality safeguards are in place to limit knowledge of test results to those directly involved in the care of infected patients or as required by law.
- Assuring that identification of infected patients will not result in denial of needed care or provision of suboptimal care.
- Evaluating prospectively 1) the efficacy of the program in reducing the incidence of parenteral, mucous-membrane, or significant cutaneous exposures of health-care workers to the blood or other body fluids of HIV-infected patients and 2) the effect of modified procedures on patients.

Testing of Health-Care Workers

Although transmission of HIV from infected health-care workers to patients has not been reported, transmission during invasive procedures remains a possibility. Transmission of hepatitis B virus (HBV)—a blood-borne agent with a considerably greater potential for nosocomial spread—from health-care workers to patients has been documented. Such transmission has occurred in situations (e.g., oral and gynecologic surgery) in which health-care workers, when tested, had very high concentrations of HBV in their blood (at least 100 million infectious virus particles per milliliter, a concentration much higher than occurs with HIV infection), and the health-care workers sustained a puncture wound while performing invasive procedures or had exudative or weeping lesions or microlacerations that allowed virus to contaminate instruments or open wounds of patients (33,34).

The hepatitis B experience indicates that only those health-care workers who perform certain types of invasive procedures have transmitted HBV to patients. Adherence to recommendations in this document will minimize the risk of transmission of HIV and other blood-borne pathogens from health-care workers to patients during invasive procedures. Since transmission of HIV from infected health-care workers performing invasive procedures to their patients has not been reported and would be expected to occur only very rarely, if at all, the utility of routine testing of such health-care workers to prevent transmission of HIV cannot be assessed. If consideration is given to developing a serologic testing program for health-care workers who perform invasive procedures, the frequency of testing, as well as the issues of consent, confidentiality, and consequences of test results—as previously outlined for testing programs for patients—must be addressed.

Management of Infected Health-Care Workers

Health-care workers with impaired immune systems resulting from HIV infection or other causes are at increased risk of acquiring or experiencing serious complications of infectious disease. 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., measles, varicella). Any health-care worker with an impaired immune system should be counseled about the potential risk associated with taking care of patients with any transmissible infection and should continue to follow existing recommendations for infection control to minimize risk of exposure to other infectious agents (7,35). Recommendations of the Immunization Practices Advisory Committee (ACIP) and institutional policies concerning requirements for vaccinating health-care workers with live-virus vaccines (e.g., measles, rubella) should also be considered.

The question of whether workers infected with HIV—especially those who perform invasive procedures—can adequately and safely be allowed to perform patient-care duties or whether their work assignments should be changed must be determined on an individual basis. These decisions should be made by the health-care worker's personal physician(s) in conjunction with the medical directors and personnel health service staff of the employing institution or hospital.

Management of Exposures

If a health-care worker 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 or has a cutaneous exposure involving large amounts of blood or prolonged contact with blood—especially when the exposed skin is chapped, abraded, or afflicted with dermatitis—the source patient should be informed of the incident and tested for serologic evidence of HIV infection after consent is obtained. Policies should be developed for testing source patients in situations in which consent cannot be obtained (e.g., an unconscious patient).

If the source patient has AIDS, is positive for HIV antibody, or refuses the test, the health-care worker should be counseled regarding the risk of infection and evaluated clinically and serologically for evidence of HIV infection as soon as possible after the exposure. The health-care worker should be advised to report and seek medical evaluation for any acute febrile illness that occurs within 12 weeks after the exposure. Such an illness—particularly one characterized by fever, rash, or lymphadenopathy—may be indicative of recent HIV infection. Seronegative health-care workers should be retested 6 weeks post-exposure and on a periodic basis thereafter (e.g., 12 weeks and 6 months after exposure) to determine whether transmission has occurred. During this follow-up period—especially the first 6-12 weeks after exposure, when most infected persons are expected to seroconvert—exposed health-care workers should follow U.S. Public Health Service (PHS) recommendations for preventing transmission of HIV (36,37).

No further follow-up of a health-care worker exposed to infection as described above is necessary if the source patient is seronegative unless the source patient is at high risk of HIV infection. In the latter case, a subsequent specimen (e.g., 12 weeks following exposure) may be obtained from the health-care worker for antibody

testing. If the source patient cannot be identified, decisions regarding appropriate follow-up should be individualized. Serologic testing should be available to all health-care workers who are concerned that they may have been infected with HIV.

If a patient has a parenteral or mucous-membrane exposure to blood or other body fluid of a health-care worker, the patient should be informed of the incident, and the same procedure outlined above for management of exposures should be followed for both the source health-care worker and the exposed patient.

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KANSAS ASSOCIATION OF LOCAL HEALTH DEPARTMENTS

“... Public Health in Action”

FY 1989

AIDS PREVENTION AND CONTROL

I. Issue Definition

The public health aspects of acquired immunodeficiency syndrome (AIDS) should be handled as other communicable diseases in that positive blood tests should be reported to health departments and contact follow-up should take place. Mandatory blood tests should be required under some circumstances and all medical information should be kept confidential as it is with other communicable diseases.

II. Background

AIDS is a fatal disease caused by a virus that is transmitted by sexual intercourse and blood, the latter usually is through sharing of contaminated needles by intravenous drug abuse. Since AIDS was first reported in the United States in mid. 1981, public health services has received reports of about 36,058 cases with a case fatality ratio of 58%. Approximately 70% of the cases has occurred in homosexual/bisexual men and 17% have occurred in intravenous drug abusers. While the percent of cases in these groups has remained constant, there has been a significant increase in heterosexual cases. AIDS is a public health problem that merits serious concern and is a major priority of the U.S. Public Health Service. The AIDS virus is spread by sexual contact and needle sharing and may be transmitted from infected mother to infant during pregnancy or birth, or shortly after birth (probably through breast milk). The risk of infection with the virus is increased by having multiple sexual partners, either homosexual or heterosexual. Through June 18, 1987 there have been 74 AIDS cases in Kansas with a case fatality ratio of 64%.

The current recommendations for the prevention and control of AIDS is through education in schools, the workplace and the general public and through anonymous testing of individuals in high risk groups. There is no contact follow-up. Positive blood tests are not reported to local or State health officials and no contact follow-up is made. The number of people estimated to be infected with the AIDS virus in the

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United States is about 1.5 million. All of these individuals are assumed to be capable of spreading the virus sexually (heterosexually or homosexually) or by sharing needles and syringes or other implements for intravenous drug use. Scientists predict that 20%-30% of those infected with the AIDS virus will develop AIDS within five years. Traditionally the control of communicable diseases has been to report known cases to official public health agencies, so their contacts can be investigated. Also, individuals who are infected and capable of transmitting the infection are reported to public health officials so their contacts can be investigated.

III. Options

- A. Continue with education and anonymous testing and hope that it diminishes further spread of the AIDS virus.
- B. Continue education and voluntary anonymous testing of high risk individuals and mandate testing of immigrants and prisoners in local jails and State prisons.
- C. Supply increased funding for AIDS with the following priorities.
 - 1. Support the continued testing, counseling, and education of individuals with high-risk behaviors.
 - 2. Support public health departments in their effort to do contact follow-up of cases and those with positive HIV test results.
 - 3. Offer voluntary testing in clinics for family planning and sexually transmitted diseases and for anyone thought to be at risk.
 - 4. Mandate testing in prisons and jails.
 - 5. Provide voluntary testing for individuals not in high-risk groups.
 - 6. Continue with education about AIDS in schools, workplaces, and for the general public.

IV. Recommendation

The Kansas Association of Local Health Departments recommends option C. AIDS is a sexually transmitted disease and testing, counseling, education and follow-up are necessary public health components. Testing in prisons and jails would be productive in segregating positive individuals from those who tested negative. Because drug abuse and homosexual activity occurs during incarceration, separation of the prisoners could prevent transmission of the infection and prevent the

treatment costs which will fall back on local or State governments operating the prisons and jails.

Many of the patients attending family planning and sexually transmitted disease clinics may be in high risk categories and therefore testing should be offered and followed by counseling about the risks of promiscuity. The follow-up of positive HIV tests will help public health authorities control the spread of this infection. These practices have been successful in syphilis and other communicable diseases.

V. Fiscal Impact

The cost of performing the procedures under option C would be high but case treatment costs are extremely high. The cost to draw the blood for the test and provide counseling is estimated at \$15.00 per person. The number of positive tests will probably be small and the number of contacts to be followed should not be overwhelming.

VI. Legislative Implications

Legislation would be needed to mandate testing in prisons and jails. There may be the need to strengthen the anti-discrimination laws to protect individuals who are found to be positive on mandated and voluntary testing.

VII. Impact on Other Agencies

Option C and accompanying legislation would have an impact on the KDHE laboratory and epidemiology unit, local health departments that would test and counsel individuals, State Prisons and County jails, and private physicians that would do voluntary testing.

VIII. Supporting Documents

Surgeon General's report on Acquired Immune Deficiency Syndrome. Facts about AIDS-winter 1987-U.S. Public Health Service. Public Health and the Law-AIDS Screening, Confidentiality, and the Duty to Warn. Larry Gostin, J.D. and William J. Curran, J.D., LLM, SMHYG. APHA 77;361-365, 1987.

Christian Science Committee on Publication For Kansas

820 Quincy Suite K
Topeka, Kansas 66612

Office Phone
913/233-7483

To: House Committee on Public Health and Welfare

Re: House Bill 2659

Members of this committee have asked that I explain why we are not requesting an amendment to this bill as it is presently drafted.

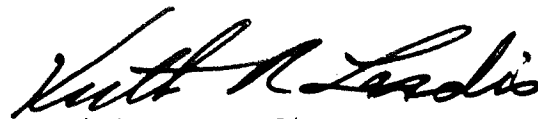
We believe an individual should be allowed to select the type of health care he wishes to receive. Because spiritual healing is a part of the practice of Christian Science, we request amendments which will allow adherents of our religion to be free of mandatory medical requirements, including treatment, diagnosis, examination, immunization, psychiatric or psychological treatment or counseling.

We do not make these requests because we fear medical practitioners and their associates or because we don't appreciate their unselfish efforts to relieve mankind's suffering. We make these requests because the approach to healing in Christian Science is so different from that of medical practice that it is unfair to both to try to combine them.

Those required to be tested under the provisions of this bill would be convicted sex offenders. Barring the remote possibility of an innocent person being convicted, a person convicted of such a crime would not be practicing the teachings of our religion. That person should not, then, be able to raise a religious objection to the test.

Present wording of the bill allows a victim to reject the offered counseling if the victim chooses to do so.

You may recall that we have requested consideration of our religious beliefs and provision for them in pending bills which would mandate premarital blood testing.



Keith R. Landis
Committee on Publication
for Kansas

*Attn. #7
2-2-8
PH&W*

Kansas Association of Osteopathic Medicine

Harold E. Riehm, Executive Director

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Topeka, Kansas 66612
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To: Members, House Public Health Committee
Reg: H.B. 2569

Below is testimony presented by William Wade, D.O. on S.B. 445. This part of his testimony is pertinent to the contents of 2569.

Section 22 mandates HIV testing for individuals convicted of sexual crimes. Individuals who have been subjected to involuntary sexual assault must have free counseling and testing made available to them. Medically, it makes little sense to test the perpetrator of these offenses. Whether or not the perpetrator tests positive, they could still be infected and must be assumed to be so. We do not test the perpetrators of sexual offenses for fertility, but rather we always counsel the female rape survivors about the chance of pregnancy, and provide testing for it. Likewise, the ONLY way to offer peace-of-mind to the victim of involuntary sexual assaults is to provide counseling and free, confidential testing for them twelve weeks after the incident (see Fig. 1). If the perpetrator tested positive or negative, the status of infection of the victim can only be assessed by testing the victim, not the perpetrator. Punitively, if HIV testing is to be made part of the sentencing, that is a different story. S.B. 445 makes no provisions as to the responsibility of the victim or the victim's family with the information of the perpetrator's HIV status. Conceivably, the irate victim or family could spread the perpetrator's HIV test results to the media, employers, and other "interested" parties with blatant disregard to the rights of the perpetrator. Would this be a just punishment for the perpetrators of such crimes? I think not. Mandatory testing of convicted sex offenders has no medical or ethical purpose.

Attm #8
2-2-8
PAK