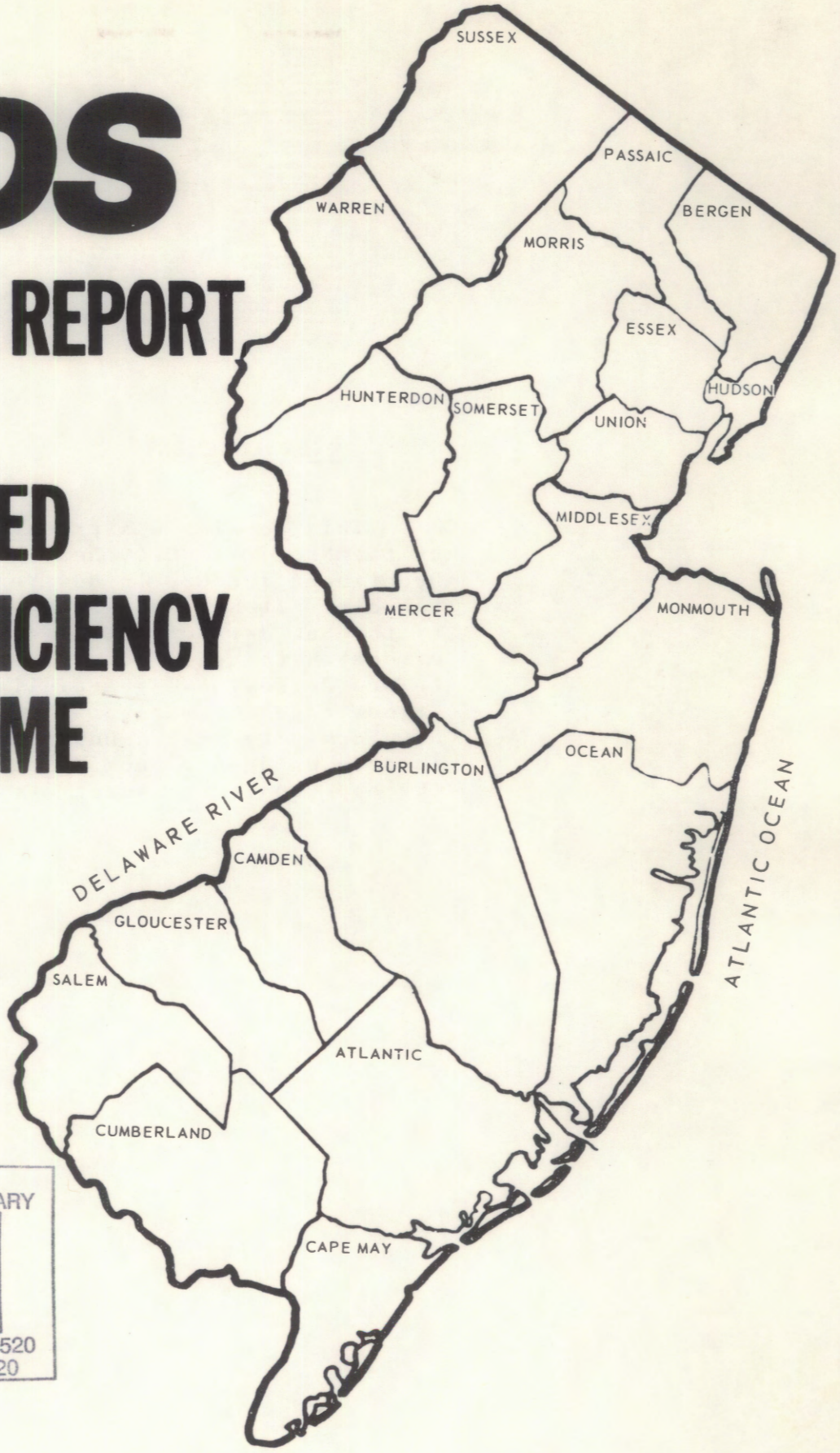
AIDS

A SPECIAL REPORT ON ACQUIRED IMMUNODEFICIENCY SYNDROME



ACKNOWLEDGEMENT

This booklet was prepared by the New York City Health Department for use in New York City Schools. It has been adapted by the New Jersey State Department of Health to apply more directly to New Jersey. We gratefully acknowledge the work of the New York City Health Department in developing the booklet and the opportunity to adapt it.

HIGHLIGHTS

Listed below are brief summaries of the main concepts which are discussed in this report.

- Acquired Immunodeficiency Syndrome (AIDS) is a disease in which the body's defense against some infections and cancers is destroyed. The retrovirus HTLV-III is the probable cause. Infections with HTLV-III may cause a wide range of outcomes from the severe disease called AIDS to asymptomatic infection. (See Section II)
- The high risk groups for AIDS are: gay and bisexual men with multiple sexual partners; male and female intravenous (IV) drug users who share needles and syringes; persons who received infected blood or blood products prior to May, 1985; sexual partners of individuals in the aforementioned categories; and infants born to parents who are at risk for AIDS. (See Section III)
- The virus is not transmitted through casual contact. The principal modes of transmission are through: sexual contact; sharing of needles among IV drug users; transfusion of contaminated blood or blood products; and in utero or during the birth process from an infected mother to the newborn. HTLV-III infection cannot be acquired through air, food, water or close nonsexual contact such as coughing, sneezing, hugging, sharing eating utensils or shaking hands. (See Section III)
- Measures can be taken to reduce the risk of transmitting AIDS. People in risk groups should: not donate blood, blood products, semen, or any other part of the body; avoid sexual practices in which blood or semen

are exchanged; reduce their number of sexual partners; not share needles or syringes; and delay pregnancy until more is known. (See Section III)

- Because HTLV-III infection is not communicable in the school setting, students with AIDS have the right to attend school if they are physically and developmentally able. (See Section V)

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I. INTRODUCTION AND BACKGROUND

This report is intended to answer the sorts of questions that people have about AIDS: What causes it? Who is at risk of contracting it? How is it spread? How infectious is it? What are its symptoms? How can one avoid transmitting or acquiring it? It will examine the virus that causes AIDS, HTLV-III, and the test to detect whether someone has been infected by it. It will explain what the results of the tests mean and don't mean. It will also explain why confidentiality is such an important issue in any discussion of AIDS.

Finally, it will set forth specific information related to the school setting. To assist the reader in understanding this often complex subject, medical terms will always be underlined and defined as they are introduced.

The disease was first noted when, between October 1980 and May 1981, five previously healthy, young homosexual men were treated for a pneumonia caused by a parasite, Pneumocystis carinii, at three different hospitals in Los Angeles. This observation was striking because P. carinii pneumonia previously had occurred almost exclusively in immunosuppressed (that is, with decreased ability to fight disease) patients, particularly those undergoing cancer treatment. During this same period, an unusual cancer, Kaposi's sarcoma, was being diagnosed with increasing frequency in young men in New York City and California. By July, 1981 26 cases of Kaposi's sarcoma had been reported in young homosexual men. Seven of these patients also had serious infections, including four patients who had P. carinii pneumonia.

These cases marked the beginning of an epidemic of a previously unknown disease, subsequently termed the Acquired Immunodeficiency Syndrome (AIDS). By May 1986, over 20,000 persons in the United States had developed AIDS. For those who have gotten AIDS, the disease is usually fatal. More than one-half of the individuals who have contracted this disease since 1981 have died.

II. DESCRIPTION OF THE DISEASE

AIDS is a condition in which the body's defenses against some infections and cancers are destroyed. These defenses are part of the body's immune system. AIDS, or Acquired Immunodeficiency Syndrome means:

A - Acquired: not hereditary;

I - Immuno: relating to the body's defense against disease;

D - Deficiency: lacking in cellular immunity;

S - Syndrome: the set of diseases that signal the diagnosis.

The infectious agent that can lead to AIDS is a retrovirus called HTLV-III (for human T - lymphotropic virus type III). Other names to describe this virus are HTLV-III/LAV ("LAV" is the French name for it), AIDS Related Virus (ARV), Human Immunodeficiency Virus (HIV), or the "AIDS virus" (a popular but incorrect term).

There are three categories of outcome resulting from infection with HTLV-III. These will be discussed below.

Acquired Immunodeficiency Syndrome (AIDS)

AIDS is the most severe form of HTLV-III infection. In this disease, a patient's immune system is so severely suppressed that he/she becomes susceptible to certain malignancies or opportunistic infections (that is, infections that would not pose a threat to persons with normal immune function but seize the opportunity to infect those with immune disfunction); these include:

- Cancers (e.g., Kaposi's Sarcoma, Primary Lymphoma [tumors] of the brain)
- Parasitic infections (e.g., toxoplasmosis, Pneumocystis carinii pneumonia)
- Fungal infections (e.g., candidiasis, histoplasmosis)

The symptoms of AIDS are often nonspecific and may be the same as in other illnesses such as a cold or the flu. However, the symptoms usually do not go away. They include:

- Prolonged fatigue that is not explained by physical activity or by other disorders
- Unexplained swollen glands lasting longer than three months
- Persistent fevers or night sweats
- Unexplained weight loss of more than ten pounds during a period of less than two months
- Recent appearance of purplish or discolored lesions of the skin or mucous membranes that do not go away and gradually increase in size
- A persistent unexplained cough
- A thick, whitish, hairy coating on the tongue or in the throat
- Easy bruising or unexplained bleeding

The incubation period (the time between becoming infected and actually developing signs of a disease) for AIDS can be quite long. In some cases, people have developed AIDS five or more years after they were thought to have been infected. Fortunately, it appears that only a minority of those infected develop symptoms, and only a fraction of these go on to develop AIDS. Of those who develop AIDS, most die from their disease within two years. Although some have survived for as long as five years it is too early to say what the prognosis of these survivors might be.

There is at present, no cure for AIDS, although most of the infections associated with the disease can be treated. Several experimental drugs are being tested on groups of people with AIDS in the United States and Europe. Studies are also being planned to treat patients who have only minimal symptoms early in the course of their disease to see if more serious symptoms can be prevented. Although development of a vaccine has received much attention in the media, it is unlikely that one will be available for several years because of the complexity of the HTLV-III virus.

AIDS-Related Complex (ARC)

There are many conditions that do not result in AIDS but are caused by infection with HTLV-III. Doctors call these conditions ARC (AIDS-Related Complex), a term for symptoms such as chronic lymphadenopathy (swollen glands), chronic diarrhea, and weight loss. Some people with ARC develop a life threatening opportunistic infection; when this happens, the person is then classified as having AIDS.

Asymptomatic Infection

Most people who have been infected with HTLV-III do not develop any symptoms. These are called asymptomatic infections and occur with all viruses; AIDS is no exception. It is estimated that as many as two million persons in the United States have been infected with HTLV-III. The number of asymptomatic but infected individuals who ultimately go on to develop AIDS or ARC can only be determined by long-term follow-up studies of persons infected by the virus. However, it is currently estimated that 6%-30% of those infected with HTLV-III will develop AIDS.

III. THE SPREAD OF AIDS

High Risk Groups for AIDS

Since AIDS was first recognized, the New Jersey State Department of Health (DOH) and the national Centers for Disease Control have been systematically gathering data on cases. Some of the most revealing information about the epidemic has come from studies of this surveillance data.

The number of new cases of AIDS has increased each year in New Jersey as well as in the rest of the country. As of May 1986, there have been 1,200 total cases of AIDS diagnosed in New Jersey of whom 62% have died; if the current rate of increase persists, the number should approximately double in the next 18 months. Eighty-four percent of cases have been male and 16% female. So far, 45 children have been diagnosed with AIDS.

The disease has been consistently prevalent in certain population groups in the four years DOH has had to study it. The data continue to show the following two groups to be at highest risk for AIDS. These two groups constitute over 80% of the cases in the State.

- o Male and female IV drug users who share needles and syringes
- o Gay and bisexual men

Other groups at risk are:

- o Female sexual partners of males at risk for AIDS
- o Infants born to parents who are at risk for AIDS
- o Persons who received infected blood or blood products in the past

The above risk groups have accounted for constant proportions of the total AIDS cases each year. This tells us that the pattern of disease transmission is quite predictable. Similarly, the percent of the total cases that has no known risk factor for AIDS (i.e., outside the risk groups discussed above) has remained constant at 6%. In fact, many of the individuals represented by this 6% probably represent members of risk groups who are reluctant to admit that they are IV drug users or homosexuals. In addition, the fact that this number remains constant at 6% excludes the possibility of transmission by casual contact. If AIDS could be transmitted by casual contact, this figure would have increased dramatically over time, as the opportunity for casual contact increased with the number of cases in the community.

How AIDS Is Transmitted

Surveillance studies have also revealed the way HTLV-III can be transmitted. HTLV-III transmission occurs in three ways: sexual intercourse with infected partners; injection of the virus directly into the body; and in utero or during the birth process from an infected mother to her newborn.

There is no doubt that the principal mode of transmission is through sexual contact where semen enters the body. Nearly 75% of the adult AIDS cases nationwide are related to sexual transmission. Most of these cases have occured among homosexual or bisexual males. Only 1.3% have occurred in females who are not themselves members of a high risk group; these women are partners of high risk males, usually drug users.

The other major mode of transmission is through sharing of needles among IV drug users where infected blood is injected into the body. This mode accounts for from 17-25% of cases nationwide and over half of the cases in New Jersey. It is also possible for a person with AIDS to be in more than one risk group.

The risk for transmission of HTLV-III through transfusion of blood or blood products has been virtually eliminated. This is because a screening test to detect whether donors have been infected by HTLV-III is now used routinely by blood banks and plasma centers. Widespread compliance with federal guidelines, which recommend that members of high risk groups voluntarily avoid donating blood and plasma, provide an added layer of protection from acquiring HTLV-III through transfused blood or blood products.

Infected mothers can also transmit the virus to their babies in the womb or at the time of birth. An asymptomatic infection in the mother can result in AIDS in the offspring. For example, IV drug use by one or both parents has been associated

with three-fourths of the pediatric AIDS cases in the nation, yet most of the mothers of these children appeared well at the time of the child's birth. The remaining cases had parents in other risk groups, were transfusion associated, or are now under investigation.

How AIDS Is Not Transmitted

Just as important as knowing how AIDS spreads is knowing how it does not spread. Although HTLV-III has been isolated in a very low percentage of samples from human saliva and tears, there is no documented case of transmission occurring through exposure to these fluids. AIDS infection is not spread in air, food, water, urine, feces, or by close nonsexual contact such as shaking hands, coughing, hugging, sneezing or sharing eating utensils.

Some of the best evidence against casual transmission comes from studies of brothers and sisters of children with AIDS. Most of these young people have shared food and drinks, used the same eating utensils and toothbrushes, slept together in the same beds, fought and wrestled, cuddled and kissed. In addition, in many cases it was not known for a considerable period of time that anyone in the family was infected and no special precautions were taken. Nevertheless, none of the siblings of these infected children have developed AIDS or shown evidence of HTLV-III infection as a result of these contacts with their ill siblings. In New Jersey this includes a set of identical twins one of whom is infected and the other uninfected. In studies of over 300 household contacts, not one person--other than a sexual contact or a child born to an infected parent--has developed AIDS or become infected with HTLV-III as a result of living with a person with AIDS. While no study or number of studies can prove that household spread never occurs, the fact that it has yet to happen after 20,000 cases indicates that the risk, if any, is beyond remote.

Studies of health care workers also provide strong evidence against casual contact as these workers have more exposure to people with AIDS than any other occupational group. In New York City alone, there are more than 200,000 health care workers and not one has developed AIDS who was not otherwise a member of a high risk group. One study followed 1,758 health care workers, including many who have been exposed to the blood of people with AIDS by sticking themselves with needles. In one case, a worker who was not previously infected and not a member of a risk group became infected after an inadvertent injection of blood from a person with AIDS. In this case the nurse actually injected blood into her hand with a full syringe° Additionally, two other health care workers, each of whom had needlestick injuries, have been reported to be infected, but in these cases there is no proof that the infection came from the needlestick or any other type of patient contact.

All of this evidence allows us to say with a high degree of certainty that HTLV-III is not spread through casual contact. This would include sharing of food, eating utensils, beds, toilets, or exposure to coughs and sneezes.

Questions have also been raised as to whether HTLV-III can be transmitted through a bite by an infected person or by exposure of open skin lesions to the blood of an infected person. While there may be a theoretical possibility that HTLV-III can be transmitted in these ways, as a practical matter, the risk of such transmission is nonexistent for the following reasons:

- There are no documented cases of HTLV-III having been transmitted in either of these ways, despite the observation of more than 20,000 cases.

- The family studies show that AIDS is not transmitted by sustained and close nonsexual contact which in the home environment would be more likely to include biting and bleeding injuries as in the school setting.
- The health care worker studies (especially those involving accidental needlestick injuries) show that the only case where infection after a needlestick was fully documented, involved an actual injection of a substantial amount of HTLV-III.
- The body's natural protective mechanisms are well developed. For protection, cuts ooze or flow outward, not inward, and quickly close over and begin to heal.

Appropriate precautions should always be followed whenever certain situations arise in the school setting to prevent transmission of various diseases. Those precautions are spelled out later. If followed, these precautions will protect against the remote theoretical risk of transmission of HTLV-III.

Reducing the Risk of Transmitting or Acquiring AIDS

There are two issues regarding preventive measures for AIDS: what people who are in risk groups can do to reduce their chances of transmitting the virus to others; and what people can do to reduce their chances of getting AIDS. Whether a person has AIDS, ARC, a positive antibody test for HTLV-III, or is only in a group at high risk of acquiring this infection, the recommendations are similar. These people should adopt the following modifications in behavior:

- Limit the number of sexual partners as each new sexual contact increases the chance of infection.

- o Do not donate blood or blood products, sperm, or any other part of the body.
- o Avoid sexual practices in which blood or semen are transferred. Specifically, avoid sexual intercourse including anal, vaginal, and oral intercourse. The use of condoms should help to prevent transmission.
- o Do not share needles or syringes.
- o Delay pregnancy until more is known about the risk of spreading the virus to the baby.
- o Ensure that soiled articles and surfaces are cleaned with soap and water after accidents involving bleeding.
- o Cover open cuts or sores with bandages.

No one should avoid contact with people who have AIDS or are infected. As already discussed, the virus is not spread through everyday, nonsexual contact.

Persons in groups considered to be at low risk for AIDS may also want to reduce the number of sexual partners and use condoms since the chance of exposure to many types of sexually transmitted diseases including HTLV-III infection and AIDS increases with the number of new contacts. Discussing the sexual history of one's partner, prior to engaging in intimate behavior, is recommended.

As will be explained in the section on AIDS in the school setting, children acquire AIDS primarily from an infected parent, through pregnancy or childbirth, or through contaminated blood or Factor VIII concentrate (for use in people with hemophilia). Therefore, the way to prevent AIDS in children is:

- o For parents with AIDS or at risk of AIDS to delay pregnancy until more is known about the transmission to newborns. (All infants born to infected mothers are not infected; however, because at least some will be infected, this caution is recommended at the present time.)
- o To screen all blood and blood products for antibodies to HTLV-III (already achieved).

Teenagers are at risk of acquiring HTLV-III infection if they are: gay males; share IV needles; females who have sexual intercourse with a bisexual male or IV drug user; or are in another high-risk group for AIDS. These teenagers should follow the same precautions as adults at high risk for this disease.

Confidentiality

Because of the seriousness of the AIDS epidemic and the absence of a cure for the disease, people with only a superficial knowledge of the disease often feel that an individual's confidentiality should take a subordinate position to protecting society as a whole from a lethal illness. However, New Jersey feels strongly that identification or promulgation of the names of people with AIDS or infected individuals serves only to feed needless panic and leads to discrimination. People with AIDS, when identified, have been fired, evicted, denied housing, socially shunned, and had their medical insurance cancelled.

To what purpose? Knowing the identity of a person with AIDS or of an infected person will not offer protection from AIDS, since these people are only a small part of the number of infected individuals. Currently, there is no treatment for persons who are infected by HTLV-III, so nothing can be offered to them after

identification. Since the disease spreads primarily through sexual intercourse and shared IV needles, infected individuals do not pose a threat to those with whom they only work or live. Anyone who participates in sexual intercourse or sharing IV needles should do so only with persons intimate enough to share information about their current state of health and past practices.

Revealing the identity of such persons to the public may make the lives of infected persons and persons with AIDS a nightmare of discrimination and hopelessness and no public gain could be expected to result. We need not identify persons because we fear casual contact. There is simply no justification to fear casual contact.

IV. THE HTLV-III ANTIBODY TEST

One immediate concern regarding AIDS is preventing its further transmission. One of the ways of preventing transmission is to ensure that the nation's blood supply is not contaminated with HTLV-III. Because of the recent development and widespread commercial availability of the HTLV-III antibody test, the risk of becoming infected in this manner has been reduced to the point of being almost nonexistent. All blood that has been donated in New Jersey and throughout the country is screened via this antibody test after the blood has been collected and before use. Any blood that repeatedly shows the presence of the HTLV-III antibody is not used for transfusion or for making blood products.

Though a great asset, this test has generated almost as much confusion as information. To understand why, it is necessary to review what the antibody test is

meant to do; what it cannot do; and what a negative, positive, or inconclusive test result means for an individual.

Antibodies are special proteins that the body produces when it comes in contact with a toxin or foreign substance (antigens). Some antibodies have the specific capacity of neutralizing, hence creating immunity to these substances.

Because of the HTLV-III antibody test, it can now be determined whether a person has antibodies to HTLV-III. If the test is positive, it means that the person, at some point, probably was infected by HTLV-III. He or she may be carrying the infection but not be ill; or he/she may be developing or may have AIDS or ARC. It is still not known what the test results mean for an individual's future health. In short, because of the limited experience with this test, it is important to note that the HTLV-III antibody test:

- o CANNOT test for AIDS
- o CANNOT predict future illness with AIDS or a related condition
- o CANNOT measure immunity to, or protection from the virus

There are some circumstances, however, in which HTLV-III antibody test results might be desirable as they may influence important decisions in an individual's life. These cases include:

- o People who are relatively certain that they are NOT at risk for AIDS but who are worried that they could be at risk because of a single or rare prior sexual experience, an ended relationship, a blood transfusion, organ transplant, or accidental puncture with a contaminated needle may seek the test to reassure themselves.

- o People who are considering pregnancy and are at risk for AIDS may seek the test to ascertain their antibody status and, if positive, defer pregnancy until more is known about the risk to their babies.
- o In individuals with symptoms the test may aid in diagnosis.

In New Jersey, persons wishing to be tested for HTLV-III antibody for these or other reasons may do so through the four counseling centers in the state in Newark, Jersey City, New Brunswick, and Atlantic City (see Appendix two). Confidentiality is assured in order to prevent wrongful discrimination. Physicians and the public should call the AIDS Information Hotline, established by the New Jersey Department of Health for up-to-date information. The Hotline number is 1-800-624-2377, Monday thru Friday, from 8:30 A.M. to 4:30 P.M.

Questions are frequently asked about interpreting the test results. The following information should provide clarification.

If a person has a positive test result, he/she probably has been infected with HTLV-III or a similar virus at some time in the past. However, knowledge about what this test means is presently limited.

- o It is probable that a positive test means that the person is currently infected with HTLV-III and able to transmit it to others.
- o It is unknown if a positive test means that the person may develop AIDS or a related condition at some time in the future.
- o It is unknown if a positive test means that the person may have recovered from infection with HTLV-III and is not infectious to others.

- o A person with a positive test result may never have been infected by the virus. This is called a false positive and is always a possibility with laboratory tests.

A person with a negative test probably has not been infected with HTLV-III. However:

- o A person tested soon after exposure to the virus might not as yet have developed antibodies, and the test may turn positive at a later date.
- o A few people infected with the virus will have a negative test. This is called a false negative and is always a small possibility with laboratory tests.
- o A negative test result is not a guarantee that a person will not become infected by HTLV-III at a later date.

A small percentage of all tests have shown inconclusive results. This means that the test result is neither positive nor negative. Inconclusive test results may be due to a number of medical factors that are not related to the presence of antibodies to HTLV-III. A person with inconclusive test results may request a repeat test. A retest may yield a positive or negative result, or may again be inconclusive.

V. AIDS IN THE SCHOOL SETTING

How Children Contract AIDS

AIDS in children under age 13 was first reported to the Centers for Disease Control in the Fall of 1982. As in adults, the disease is manifested by the

occurrence of a life-threatening infection (or, more rarely, a cancer) that is indicative of a severe immune defect. As of May 1986, reports have been received on 45 New Jersey children with AIDS. Twenty-five of these children have died; 20 are alive.

Most children born with AIDS become ill at 5 or 6 months of age and are diagnosed with a life-threatening infection by age 9 months. Very few of these children live beyond the age of 2 or 3 years.

In addition to the 45 children with AIDS, there are other children with ARC, which is frequently characterized by swollen glands, weight loss, enlarged liver or spleen, and frequent mild infections. Many pediatricians do not differentiate between AIDS and ARC. Pediatricians who treat children with AIDS and ARC estimate that for each child with AIDS, they see three to five children with ARC.

There are other children who may have the virus but who remain asymptomatic. It is <u>not</u> known how many such children are currently living in New Jersey but estimates are that they may be as many as 200.

Most children with AIDS or the virus acquired it in the womb or at the time of birth from an infected mother. The mothers have been infected by HTLV-III in various ways; largely, they have a history of IV drug use or have been sexual partners of IV drug users. A smaller number of children have acquired the illness through transfusion of contaminated blood or blood products. In one instance, a child acquired the virus through sexual abuse.

The important fact is that these children did not "catch" AIDS as they might catch influenza or chicken pox. They acquired it via direct exposure to

contaminated blood of a person in a risk group for AIDS, before, during and after birth or through blood transfusions.

The evidence against casual transmission of AIDS among children or adults is impressive. As mentioned earlier, in the twelve studies of families or households with a case of AIDS, over 300 family members have been tested and are antibody-negative. Many of those tested are children exposed to siblings who are infected. Many shared toothbrushes, beds, bottles, and eating utensils with the infected household members. In fact, two sets of twins have been studied. In each instance, one twin was infected (through a blood transfusion) and the other not; after at least 2 or 3 years of living together, the uninfected twin remained uninfected (that is, antibody negative).

Because children with AIDS acquire the disease in utero, at birth, or through blood transfusion, the ways to avoid pediatric transmission of AIDS are:

- o prevention of infection in women of childbearing age;
- o education of women in high risk groups of childbearing age to consider delaying pregnancy until more is known;
- o protection of the blood supply and of Factor VIII concentrate (used for hemophiliacs). This third method has already been achieved.

As children infected by HTLV-III become teenagers, they will need guidance and information about the risks of transmitting the virus through sexual intercourse and use of IV street drugs (see the section on Reducing One's Risk of Transmitting or Acquiring AIDS).

Because these facts about how children acquire AIDS have been little understood by the public, children with AIDS have had to face social isolation and

discrimination in day-care situations and schools. Discrimination has been extended to well children who have family or household members with AIDS. Protecting children from such isolation and discrimination has been one reason that patients' names have been kept confidential.

Right to Attend School

HTLV-III is transmissible through sexual contact with an infected person or through the exchange of contaminated blood. Thus, there is no basis to exclude from school any of the following:

- Students with AIDS
- Students with AIDS related conditions
- Students with positive test results for HTLV-III antibodies
- Students residing in a household in which a member has AIDS
- Students in risk groups for AIDS

Procedures for Review of Students Diagnosed with AIDS

Whenever there is disagreement between an infected student's physician and the school physician the case is reviewed by a special four-person panel convened by the Commissioner of Health which recommends to the Commissioner of Education whether that student can attend school or requires alternative educational placement. In making that recommendation, the panel considers the physical, developmental, neurological, and behaviorial condition of that student. The panel consists of a physician with experience in pediatric AIDS, a psychologist, a pediatrician and a physician from the Department of Health. The panel consults with the student's health care provider in making its recommendations.

Precautions in the School Setting

The risk of transmission by biting or exposure to blood is, as a practical matter, nonexistent. However, certain precautions should nevertheless be taken because other diseases may be spread by bites or by exposure to infected blood. These precautions, which are also set forth in the Appendices, are as follows:

- If blood comes into contact with skin, as occurs when a teacher or school nurse cares for a child with a bloody nose, the skin should be washed with soap and water. As an extra precaution, the skin may be wiped with an alcohol swab.
- Surfaces soiled with blood should be cleaned with soap and water followed by disinfection with rubbing alcohol or household bleach.
- Bites should be washed with soap and water and then wiped with an alcohol swab. In the event of a serious bite, the principal/school nurse should be notified so that any further medical treatment that is necessary may be sought.

Medical Supervision

As a result of the review procedure, any student with AIDS who attends school has been determined to be capable of doing so. If a child is well enough to go to school, teachers will not be called upon to undertake any special supervision of or care for those children because they have AIDS.

In some cases, the treating physician of a student with AIDS or other students who are immunosuppressed (eg. as a result of chemotherapy) may wish to request that child be exempted from certain vaccination requirements. The physician may do this by noting on the new admission exam form that such immunizations are medically contraindicated.

If a teacher observes a student who appears ill, suspects a student has AIDS or if a student's parent or guardian reports that a student may have AIDS, like any ill child, that child should be referred to the school principal/school nurse for medical attention. If, after medical attention, the student is diagnosed as having AIDS, it will be reported by the treating physician. If the school physician and the child's physician disagree about school attendance, the Department of Education will refer the case to the Panel.

Confidentiality

Unless there is a request to the contrary by the parent or legal guardian, the identity of any student with AIDS will not be revealed to anyone within the school system. There are a number of reasons for this policy of confidentiality:

- Both state and local law prohibit the Department of Health from revealing to anyone the identity of persons who have been reported as having AIDS.
- The more people who know the identity of a student with AIDS, the greater the likelihood that his/her identity will become generally known.

- If the identity of a student with AIDS becomes generally known, he/she is likely to be stigmatized, ostracized and effectively deprived of the benefits of a public school education.
- There is no benefit to either the student with AIDS or to other children from revealing his/her identity to anyone within the school system. Any medical supervision needed by the student with AIDS can be effected by his/her treating physician in cooperation with the Department of Health and any precautions should be carried generally regardless of whether there is a student with AIDS present or not.

VI. APPENDICES

- STATE RESOURCES

  Attached is information which will be useful for obtaining further information about this subject and, if required, services.

- GUIDELINES FOR HANDLING BODY FLUIDS IN SCHOOLS

  Attached are procedures for dealing with accidents resulting in body fluid spills.

STATE RESOURCES

FOR MORE INFORMATION CALL OR WRITE:

New Jersey State Department of Health
Communicable Disease Services
CN 369
Trenton, New Jersey 08625
(609) 588-3520

NJSDH Northern Regional Office
(201) 266-1910
Mon.-Fri. 8:30 am - 4:30 pm

Gay Men's Health Crisis (GMHC)
Box 274
132 West 24th Street
New York, New York 10011
(212) 807-6655

New Jersey Division of Narcotic
and Drug Abuse Control
Office of Treatment and Rehabilitation
129 East Hanover Street
CN 362, Trenton, NJ 08625
(609) 292-7232
(201) 266-1910

New Jersey AIDS Helpline
(staffed by trained volunteers)
provides general information,
medical referrals, and crisis
intervention.
(201) 596-0767
Mon.-Fri. 7:00 pm - 11:00 pm

U.S. Public Health Service Office of
Public Affairs
Room 721-H
200 Independence Ave. S.W.
Washington, D.C. 20201
(800) 342-AIDS

For printed information:

New Jersey State Department of Health
CN 369
Trenton, NJ 08625
(609) 588-3520

NJSDH Northern Regional Office
(201) 266-1910

Caribbean Haitian Council
410 Central Ave
East Orange, NJ 07018

For Counselling or HTLV-III Antibody Testing

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

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

Jersey City Medical Center
50 Baldwin Ave
Jersey City, NJ 07304
(201) 451-9800
Mrs. Gail Cook, R.N.

Sencit-Baltic Family Practice Center
Atlantic City Health Department
1325 Baltic Ave., Corner Tennessee
Atlantic City, NJ 08401
(609) 347-5200
Marilyn Budd, R.N.
Pat Dorsa, R.N.

NEW JERSEY AIDS HOTLINE
1-800-624-2377

For Physician Referral:

NJSDH
CN 369
Trenton, NJ 08625
(609) 588-3520

NJSDH Northern Regional Office
(201) 266-1910

For Support Services:

Monmouth - Ocean AIDS information
P.O. Box 834
Neptune, NJ 07753

St. Lucy's Church
615 Grove Street
Jersey City, NJ 07302
(201) 653-3366

Center for Health Awareness at
Christ Hospital
AIDS and Buddies Support Group of
Northern New Jersey
176 Palisades Avenue
Jersey City, NJ 07306
(201) 795-8444

South Jersey AIDS Alliance
1616 Pacific Avenue
Atlantic City, NJ 08404
John Marino, Chairman
(609) 641-8133
(609) 347-8799
1-800-812-2071

Philadelphia AIDS Task Force
P.O. Box 7259
Philadelphia, PA 19101
215-232-AIDS

Jersey Medical Center
149 Palisade Avenue
Jersey City, NJ 07306
Elba Ardino - (201) 451-9800
Ext. 2550

St. Michaels Medical Center
268 Dr. Martin Luther King Blvd.
Newark, NJ 07102
Eunice Pakanis - (201) 877-5220

For Counseling on Drug Abuse

ACTION/PRIDE the Natinal Family
Resource Center
1-800-241-7946

The National Federation of Parents
for Drug Feee Youth
1-800-554-KIDS

The American Council for Drug Education
6193 Executive Blvd.
Rockville, MD 20852

New Jersey Division of Narcotic and
Drug Abuse Control
Office of Treatment and Rehabilitation
129 East Hanover Street
CN 362, Trenton, NJ 08625
(609) 292-7232

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

GUIDELINES FOR HANDLING BODY FLUIDS IN SCHOOLS

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

1. Does contact with body fluids present a risk of infection?
2. What should be done to avoid contact with potentially infected body fluids?
3. What should be done if direct contact with body fluids is made?
4. How should such fluids when spilled be removed from the environment?

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

DOES CONTACT WITH BODY FLUIDS PRESENT A RISK?

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

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

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

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

WHAT SHOULD BE DONE TO AVOID CONTACT WITH BODY FLUIDS?

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

WHAT SHOULD BE DONE IF DIRECT SKIN CONTACT OCCURS?

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

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

HOW SHOULD SPILLED BODY FLUIDS BE REMOVED FROM THE ENVIRONMENT?

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

HANDWASHING PROCEDURES

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

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

DISINFECTANTS

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

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

1. Ethyl or isopropyl alcohol (70%).

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

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

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

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

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

DISINFECTION OF HARD SURFACES AND CARE OF EQUIPMENT

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

DISINFECTION OF RUGS

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

LAUNDRY INSTRUCTIONS FOR CLOTHING SOILED WITH BODY FLUIDS

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

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