Report of the Secretary of Human Resources on Senate Joint Resolution 90

**TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA**

Senate Document No. 4

**COMMONWEALTH OF VIRGINIA
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COMMONWEALTH of VIRGINIA

Office of the Governor

Richmond 23219

Eva S. Teig
Secretary of Human Resources

To the Members of The General Assembly:

Nine months ago you asked us to review Virginia's AIDS-related disease control measures and the methods by which the Department of Health communicates them to state agencies. The deadly nature of the disease and the public sensitivity surrounding it led us to include all of Virginia's AIDS-related efforts in the scope of our review.

You may be surprised by some of our findings. For example, the Centers for Disease Control rate Virginia's education and prevention efforts as one of the best in the nation. Furthermore, the Department of Health has undertaken several unique efforts in this area, one of which has received national attention.

It is our pleasure to submit this report. The recommendations it sets forth will compliment our current activities and enhance our effectiveness at preventing further transmission of AIDS. We expect that all of the recommendations will be completed or significantly underway by the end of this fiscal year.

Thank you for giving us the opportunity to undertake a comprehensive examination of our efforts in this area.

As always, we will be happy to discuss this report with you and to assist you in any way possible.

Sincerely,

Eva S. Teig

Eva S. Teig
Secretary of Human Resources

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State Health Commissioner

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EXECUTIVE SUMMARY

The incidence of actual AIDS cases has grown exponentially in Virginia in the past five years. In 1982 there were only six diagnosed cases in the Commonwealth. In the first ten months of 1986, there were 142. To assure the health and safety of the public, the 1986 Virginia General Assembly asked the Secretary of Human Resources and the Virginia Department of Health to study the adequacy of disease control measures currently employed to prevent the spread of AIDS, and to review the Department's methods of communicating information about AIDS and AIDS-related disease control measures to any state and local agencies which might require it. (see Attachment 1, Senate Joint Resolution 90).

In recognition of the need for a very thorough and comprehensive approach, the study sought the advice of medical professionals, state and local agencies which might be required to deal with individuals with AIDS, and fifteen other states which have developed AIDS-specific disease control measures in order to limit the transmission of the AIDS virus (human T-cell lymphotropic virus type III or HTLV-III). It sent surveys to randomly selected localities and institutions; conducted roundtable discussions with professionals and affected agencies; and individually interviewed health department officials in fifteen states.

The study found that:

1. The Centers for Disease Control recently ranked Virginia among the top ten states in the nation competing for funds for AIDS prevention and education activities.

2. The Commonwealth has developed eight AIDS-specific disease control policies addressing: HTLV-III testing for foodhandlers, HTLV-III screening at state correctional facilities, HTLV-III screening at mental health facilities, reporting of HTLV-III seropositivity by physicians and laboratory directors,

day care center attendance, school attendance and notification of school authorities, premarital HTLV-III antibody testing, and quarantine and isolation.

3. Virginia has taken the lead in educating its citizens about AIDS. (The Department of Health has provided written information and seminars for medical professionals throughout the Commonwealth, widely distributed public service announcements to 25 television stations for consumption by the general public, funded educational efforts for groups at increased risk of exposure to the virus, and instituted a toll-free AIDS hotline for anyone who wants advice or information).

Although Virginia's AIDS prevention efforts fare well compared to other states, the study identified several changes in current practices and methods of communication which would benefit from revision.

These recommendations follow:

1. Clarify and formalize the roles of the AIDS Medical Advisory Committee and the Virginia Board of Health in developing and establishing state policies related to AIDS. The Advisory Committee should formally advise the Board of Health about the AIDS-related policies it considers most effective and appropriate. The Board of Health should officially establish any AIDS-related policy which the Commonwealth intends to practice.

2. Appoint an expert in the management of substance abuse to the AIDS Medical Advisory Committee to assist in the development of disease prevention activities for the drug using community.

3. Identify all agencies which might require AIDS information. Provide these agencies with pamphlets, audiovisual aids, and AIDS presentations using terminology which can easily be understood by non-medical professionals.

4. Identify up-to-date informational materials prepared by recognized professional organizations for dissemination to local and state agencies requiring AIDS information.

5. Review the list of agencies and individuals who currently receive the Virginia Epidemiology Bulletin and expand it as necessary to assure that all appropriate state and local agencies receive AIDS updates and materials regularly;

6. Update the mailing list for the Virginia Epidemiology Bulletin annually;

7. Officially notify all state and local agencies of the Department's availability to provide technical assistance in developing specific AIDS-related agency policies;

8. Require local health departments to convene and educate local groups of medical professionals, school officials, and community leaders about AIDS. This requirement could be included in each local health department's annual goals and objectives.

9. Use mental health and mental retardation community service boards as an additional resource to help disseminate information to local agencies, community groups and the general public;

10. Identify other public sources of health and safety information including local and private colleges and universities, and coordinate with them to disseminate AIDS information in their programs and publications;

11. Promote greater use of the AIDS hotline; and

12. Assure that local health department staff within state nursing, epidemiology, and community health services divisions are cognizant of mechanisms by which to report AIDS cases to the central state office.

This report sets forth the study findings by dividing them into two sections - disease control measures and methods of communicating those control measures to state and local agencies, health care providers, the general public and the individual at risk. Specific recommendations follow each section.

II. Introduction

A. Scope of the Problem and of Existing Prevention Efforts

As of October 31, 1986, Virginia had reported 316 (1.2%) of the total 26,875 diagnosed AIDS cases reported to the National Centers for Disease Control, thus ranking fifteenth in the nation in AIDS morbidity. This reflects a rate of five cases per 100,000 population.

The reported number of AIDS cases in Virginia has risen rapidly since the first case was reported in December, 1982:

Year	Reported AIDS cases
1982	6
1983	25
1984	39
1985	104
1986 (first 10 months)	142

The overall case fatality rate to date is 53.7%.

From the very onset of the AIDS epidemic, the Commonwealth has been well served by the Virginia Department of Health (VDH) and its Office of Epidemiology. Since 1983 the Virginia Epidemiology Bulletins published by VDH have been devoted to the etiology, symptomatology, modes of transmission, and detection through antibody testing of HTLV-III infection (see Attachment 2, Description of Virginia Epidemiology Bulletins Pertaining to AIDS October, 1986 - May, 1983). The Department's physicians have been available to state and local agencies for consultation on AIDS. In addition, the Commissioner of Health has established an AIDS Medical Advisory Committee to advise him and the Board of Health about the disease control measures most effective and appropriate for avoiding transmission of AIDS (see Attachment 3, AIDS Medical Advisory Committee).

Perhaps most significantly, the Department has been operating an AIDS Activity Program which disseminates accurate information and disease control guidelines; conducts statewide AIDS case surveillance; coordinates service delivery for HTLV-III infected persons; and develops and coordinates educational outreach efforts statewide.

The Program has collaborated with blood banks statewide to ensure the safety of the blood supply by establishing alternate testing sites which enable individuals with high risk factors for exposure to HTLV-III to receive anonymous or confidential antibody testing and counseling. These centers, located in Roanoke, Fairfax and Richmond, deter high risk individuals from seeking a determination of antibody status at blood collection centers.

The AIDS Activity Program has received national plaudits for its timely response to Virginia's increasing incidence of AIDS. Most recently it was acknowledged for the development and implementation of statewide HTLV-III counseling and antibody testing for those risk-associated persons who attend local health department Sexually Transmitted Disease (STD) clinics.

Virginia participants currently comprise over 60 percent of those trained nationally in counseling persons at risk for exposure to HTLV-III about the antibody test and methods of preventing exposure to the disease. Finally, the Centers for Disease Control ranked Virginia's AIDS Activity Program ninth in the nation during a recent review of program objectives.

B. Study Methodology

The study was designed to examine Virginia's disease control measures for AIDS and to evaluate the methods of communicating those measures and additional information to state and local agencies, health care providers, the general public, and individuals at increased risk of exposure to the virus. To assure a comprehensive review, a variety of techniques were utilized. A description of each follows:

Disease Control Measures

1. Virginia's eight AIDS-specific disease control measures were reviewed in conjunction with the nationally recognized sourcebook on disease control measures, Control of Communicable Diseases in Man, (Abram S. Benenson, editor, 1985), which is published by the American Public Health Association.

2. Medical professionals from the public and private sectors met and reviewed the medical basis of disease control measures established for AIDS, AIDS-Related Complex (ARC), and HTLV-III infection in Virginia.

3. The AIDS Medical Advisory Committee evaluated current disease control measures and policies, and reviewed informational materials developed by the Department of Health.

4. Virginia's disease control measures for AIDS were compared to those in six neighboring states and nine others which are working actively to prevent exposure to the virus. (see Attachment 4, Summary of AIDS Prevention Policies and Activities in Other States).

Methods of Communication

1. Representatives from all state agencies which might require information about AIDS or disease control measures for AIDS met, reviewed, and evaluated the Department's methods of communicating AIDS-specific recommendations and prevention messages.

2. A total of fifty randomly selected local agencies which might require information about AIDS or disease control measures for AIDS received a survey with which to evaluate the methods by which the Department disseminates information (see Attachment 5, Summary of Local Agency Survey Responses).

3. Virginia's methods of communicating AIDS information and disease control measures for AIDS were compared to those in six neighboring states and nine others which are working actively to prevent transmission of the virus.

4. The Department reviewed the following internal records to determine the focus and extent of its education and prevention activities:

   -the mailing list for the Virginia Epidemiology Bulletin;

   -logs of calls to the AIDS hotline and corresponding literature requests;

   -the calendar of presentations to state and local agencies, community groups, and the general public;

   -the number of requests by state and local agencies for consultation or technical assistance in developing AIDS policies; and

-the number and diverse specialties of health care providers who have attended AIDS workshops, seminars and training sessions.

5. The Department reviewed the nature and scope of information provided in its AIDS pamphlets, brochures and "AIDS Update" reports with representatives from state agencies which have received the information.

6. The Department evaluated the methods by which AIDS informational materials, including pamphlets and films, are distributed to state and local agencies which might require them.

7. The Department reviewed the services and educational efforts of the three community-based AIDS education and support organizations which it funds.

III. Disease Control Measures

A. Background and Definitions

Disease control measures are effective in interrupting transmission of a disease and limiting the spread of infection. A disease control measure is technically defined as:

> "a measure designed to prevent infectious matter present in the body and the environment of the infected individual from spreading the disease to other persons, arthropods or animals; and recommendations on the appropriate management of contacts to assure earliest possible treatment, to prevent disease dissemination during the incubation period, and to detect any carriers and their management to minimize disease spread." -Control of Communicable Diseases in Man, Abram S. Benenson, editor.

Disease control measures fall into five categories: preventive measures; control of patient, contacts and the immediate environment; epidemic measures; disaster implications; and international measures.

Specific types of disease control measures include available treatments and immunizations; control or elimination of substances which transport or nurture the disease; quarantine and isolation in situations where other disease control measures have not been effective; and education of carriers and the general public in avoiding transmission.

A variety of criteria are employed in developing appropriate disease control measures for a specific disease. A list of pertinent factors follows:

1. Routes of transmission;

2. Degree of communicability;

3. Severity of the disease;

4. Threat to the public health;

5. Cost effectiveness and financial implications.

Epidemiologic evidence suggests that HTLV-III is transmitted from person to person through the exchange of blood and body fluids during sexual contact or through reusing contaminated intravenous drug paraphernalia. HTLV-III can also be transmitted through the transfusion of contaminated blood or blood products, or from mother to child during pregnancy or perinatally.

Since there is presently no treatment for AIDS, the types of disease control measures most effective in eliminating transmission of this virus are those prevention measures specific to the individual patient, his/her contacts, and the immediate environment.

B. Process for AIDS Policy Development in Virginia

The AIDS Medical Advisory Committee was appointed by the Commissioner of Health in 1985 to identify the disease control measures most effective and appropriate for preventing the transmission of AIDS and to advise the Commissioner and the Board of Health accordingly.

The Committee meets quarterly and includes a member of the Board of Health, infectious disease physicians from two major tertiary care hospitals in Virginia, administrators of state and local agencies whose clientele might be at risk of acquiring AIDS, the director of a regional blood collection center, and staff from the Office of Epidemiology. (see Attachment 3, AIDS Medical Advisory Committee).

The AIDS Medical Advisory Committee has performed conscientiously and professionally in its efforts to develop meaningful disease control measures pertinent to AIDS. In comparison to the fifteen states surveyed for this study, Virginia appears to have been more farsighted in anticipating problem areas and developing corresponding policies.

Once the Advisory Committee completes its work, however, the methods by which it advises the Board of Health vary. In some instances, the Board receives a presentation and officially adopts a policy (e.g., attendance at schools and child care centers). At other times, the methods of communicating the Committee's findings are much more informal. Given the significance of the disease, the AIDS Medical Advisory Committee and the Board of Health should formalize their methods of communication and clarify their roles.

C. Virginia's Disease Control Measures for AIDS

In determining the disease control measures most appropriate for preventing the transmission of HTLV-III, Virginia's AIDS Medical Advisory Committee has considered the following factors:

-effectiveness of a given control measure in preventing transmission of infection and spread of the disease;

-effectiveness of a given control measure in providing rapid and thorough intervention;

-effectiveness of a given control measure in preventing transmission of the virus through a specific, proven route of transmission;

-cost-effectiveness and financial implications of a given measure; and

-the psychological, socioeconomic, and legal/-financial impact of a given measure on the public and on individuals.

In response to Senate Joint Resolution 90, the Committee convened a special meeting to review and reevaluate all disease control measures and related policy recommendations which it had previously developed. Their conclusions and recommendations follow:

HTLV-III Testing of Foodhandlers: There is no evidence that the AIDS virus is transmissible as a foodborne pathogen. Therefore testing of foodhandlers is not recommended.

HTLV-III Testing for Residents of State Mental Institutions: Where risk factors exist or where the need for testing is medically indicated, HTLV-III testing and counseling should be done on an individual basis.

Attendance at Child Care Centers: The increased exposure to excreta and other body fluids which occurs in most child care centers could represent a setting where HTLV-III infection might be transmissible. While each case should be considered individually and no child should be categorically excluded, virtually all children with AIDS, ARC, and/or HTLV-III infection should be excluded from child care centers attendance. (see Attachment 6,

VDH Recommendations for Day Care Center Attendance. These were adopted from recommendations by the Center for Disease Control and the American Academy of Pediatrics.)

School Attendance: The assessment of whether an individual child poses a threat should be made on a case-by-case basis by qualified medical authorities including, but not limited to,the child's private physician and appropriate public health authorities, in consultation with the child's parent(s) or guardian(s). (see Attachment 7, VDH Recommendations for School Attendance. These were adopted from recommendations by the Centers for Disease Control and the American Academy of Pediatrics.)

Notification of School Authorities: To maintain confidentiality and encourage the reporting of AIDS cases by physicians, doctors should report cases of AIDS to the VDH which will investigate to determine the extent of any public health risk. The Commissioner of Health will determine the appropriate course of action on a case-by-case basis.

Quarantine or Isolation as a Control Measure: Quarantine or isolation should not be used as a routine control measure for AIDS or HTLV-III infection because the disease is not transmitted through casual contact.

Premarital HTLV-III Antibody Testing: The merits of premarital screening include the detection of infected women who could be counseled about the risk of transmission during pregnancy or perinatally. However, a negative test result does not provide assurance that an individual will remain negative throughout the childbearing years.

Education prior to the onset of sexual activity is a more effective preventive measure than education at the time of issuance of a mar-

riage license. Materials should focus on the risk factors associated with AIDS, the increased risk to pregnant women who are seropositive, and the consequences which the children of HTLV-III infected parents may suffer.

Notification of VDH by Medical Care Providers Regarding Seropositivity: Testing for HTLV-III antibodies has not yet been standardized. Education is the only realistic control measure available to decrease the spread of HTLV-III infection. Because educational efforts and testing at statewide HTLV-III screening sites might be hampered by the reporting of HTLV-III seropositivity, such a practice is not warranted at this time. (Before such a requirement is instituted, the Department should have sufficient resources available to provide contact investigation and counseling services to individuals with a positive antibody test and to assure that confidentiality of test results can be maintained.)

HTLV-III Testing of Correctional Inmates: The Department of Corrections is currently completing a study on this subject at the request of the 1986 General Assembly (HJR 125). Policy recommendations will be developed after this study is completed and reviewed.

D. AIDS Policies in Other States

In order to assess the nature of Virginia's AIDS-related disease control measures and the manner in which they are formulated, the study interviewed health department officials from six neighboring states and nine others which are working actively to prevent the spread of the virus. The states interviewed are: California, The District of Columbia, Florida, Illinois,

Kentucky, Louisiana, Maryland, Michigan, New Jersey, New York, North Carolina, Pennsylvania, Texas, West Virginia, Wisconsin (see Attachment 4, Summary of AIDS Prevention Policies and Activities in Other States.)

The interviews sought information about specific AIDS-related policies pertaining to attendance at school or child care centers; notification of school officials; use of quarantine or isolation; HTLV-III testing for correctional inmates, residents of institutions for the mentally ill or applicants for marriage licenses; and requirements for physicians and laboratory directors to report HTLV-III seropositivity.

The fifteen states interviewed also provided information regarding the impetus for formulating AIDS policies; the identity of the policy making body; the research and methodology used to establish each policy, and the manner in which the policies were implemented.

A summary of state responses for each policy area follows.

HTLV-III Testing for Residents of State Institutions for the Mentally Ill

Mandatory screening in state facilities for the mentally ill or mentally retarded was not advocated unless medically indicated for certain individuals.

Attendance at Child Care Centers

The states utilize individualized medical evaluations as suggested by Centers for Disease Control (CDC) recommendations. These include infection control procedures for handling blood, body fluids, and waste products.

Notification of School Authorities/Attendance at School

The states generally do not require such reporting. They follow an individualized approach, as recommended by the CDC. This includes case-by-case medical evaluation and parental discussion. The best interests of the individual child receive considerable weight during these assessments.

Quarantine or Isolation

Most states interviewed do not have a policy requiring isolation or quarantine as a disease control measure for AIDS, ARC, or HTLV-III infection.

In Florida, a person may be isolated or placed under quarantine restrictions by a court order, only after the health department shows that other reasonable means of limiting HTLV-III transmission by the individual have failed and that the public's health is significantly threatened.

In Texas, the Health Commissioner does not have the authority to quarantine people with AIDS, but criminal proceedings may be instituted against those who knowingly violate established control measures.

Premarital HTLV-III Antibody Testing

Premarital screening of the general public was not required or recommended in any of the fifteen states participating in this study. Confidential voluntary screening in conjunction with educational counseling and the distribution of brochures which describe methods of preventing transmission of the virus were suggested as more appropriate means of reaching applicants for marriage licenses.

Notification of State Health Departments by Health Care Providers Regarding Seropositivity

Most states do not require seropositive HTLV-III test results to be reported to the state departments of health. The consensus was that reporting would be a deterrant to individuals participating in voluntary screening and educational programs due to the potentially negative psychological, social, and economic implication of a positive test result.

The exception was Wisconsin's policy that all positive HTLV-III antibody test results be "disclosed" to the state epidemiologist. California maintains a registry of all donors whose blood was found to be contaminated upon screening at blood banks and plasma centers. The specific cause of contamination is not maintained, however.

HTLV-III Testing of Correctional Inmates

Mandatory screening in state correctional facilities was not required or recommended by most states interviewed. They preferred to test specific individuals when medically indicated, and to provide confidential voluntary testing with appropriate counseling. Louisiana recommends that all residents of correctional and mental health facilities be screened for all infectious diseases without stipulation of any exceptions. This is not required, however.

Similarities in methods of policy formulation and implementation were also evident from the interviews. A summary of the most prevalent similarities follows:

- State health departments were consistently responsible for developing policies concerning HTLV-III infected individuals, appropriate uses of HTLV-III antibody screening, and control measures

for AIDS, ARC, or positive HTLV-III infection. Some operated in conjunction with other state agencies (e.g., Departments of Education, Correctional Services, Divisions of Mental Health and Mental Retardation, and Substance Abuse Services). Other states consulted with outside experts.

- Most state health departments received support, information, and recommendations from specially created AIDS taskforces and advisory groups which were broad-based coalitions of medical, public health, and legal experts and representatives from public schools and interested community groups.

- All states utilized guidelines from the Centers for Disease Control and followed them closely in promulgating AIDS-related disease control policies. This is evident in the policies each state developed for attendance at schools and child care centers and for infection control programs at worksites.

E. Summary of Findings and Recommendations

If there is one notable contrast that is apparent when assessing Virginia's AIDS-related disease control policies in relation to those of the fifteen states previously reviewed, it is that Virginia has been farsighted and proactive in addressing these policy issues.

The Commonwealth has been in the forefront of promoting voluntary HTLV-III antibody testing with extensive education and counseling before and after the test. This occurs through a network of Sexually Transmitted Disease clinics in local health departments and at alternate testing sites that were established in 1985. The Department of Health has been instrumental in creating a system that maintains client confidentiality for this voluntary screening process.

In addition, Virginia has benefitted from the advice of the AIDS Medical Advisory Committee, a coalition of public and private medical professionals unique to Virginia. The Committee has approached the various disease control measures in a thorough, deliberate manner, basing them on sound public health principles and on the guidelines outlined by the Centers for Disease Control.

Although the Commonwealth has been responsible and timely in developing AIDS-related disease control measures, it has been inconsistent in the manner by which it officially considers and adopts those measures. Given the significance of the disease, the AIDS Medical Advisory Committee and the Board of Health should formalize their methods of communication and clarify their roles.

The AIDS Medical Advisory Committee should advise the Board of Health about the AIDS-related disease control measures and policies it considers most effective and appropriate. The Board of Health should officially establish any AIDS-related policy which the Commonwealth intends to practice or adopt. With the changes and rapid advances related to AIDS, the Board of Health should receive reports from the AIDS Medical Advisory Committee regularly.

The AIDS Medical Advisory Committee has performed conscientiously in anticipating the need for disease control policies and their applications to various communities. In order to enhance its ability to develop disease prevention activities for the drug using community, the Committee should include a medical expert in the management of substance abuse.

IV. Methods of Communication

A. Background Information

There are many agencies and individuals who require information about AIDS and the transmission of the HTLV-III virus in order to successfully prevent its transmission. Their knowledge and expertise in the area differ dramatically. Specific educational materials and methods of communication vary accordingly (see Attachment 8 and 9, Description of AIDS Pamphlets and Films Available through VDH).

The Department of Health produces AIDS-related information geared to different levels of expertise, and disseminates it broadly through written materials, training sessions, consultative services, and educational outreach. The Department strives to communicate with any agency, organization, or individual who reports, develops, or implements policies regarding communicable and infectious diseases; who has regulatory responsibilities; who provides services to idividuals with risk factors associated with exposure to HTLV-III or who is or may be infected with the HTLV-III virus.

Specifically the Department communicates with:

-Public or private physicians, and infection control practitioners who are responsible for case reporting and development of hospital-specific infection control guidelines;

-Local health departments and community-based programs, which provide care for a wide range of clients in clinics and homebased programs;

-Schools, day care facilities, mental health/ mental retardation facilities, correctional facilities, homes for youths and runaways, and other agencies responsible for providing housing and medical care in a controlled environment;

-Emergency care providers, dentists, physical therapists, funeral directors, and other medical care providers who incorporate disease control measures into their daily medical practices;

-Social service agencies which provide psychosocial, legal, or financial support for HTLV-III infected individuals;

-Blood banks and tissue banks which are responsible for the provision of untainted blood and blood products to medical facilities throughout the Commonwealth;

-State and local licensure boards which regulate and/or test health care professionals; and

-Any other state or local agencies that support, monitor or interact with any of the aforementioned.

This section of the report sets forth the methods by which the Department communicates with state agencies, local agencies, health care providers, the general public and individuals at increased risk of exposure to HTLV-III. It concludes with recommendations for improving communication efforts.

B. Communication with State Agencies

The Department has produced written materials for both medical and nonmedical professionals within state agencies. The Virginia Epidemiology Bulletin, a monthly newsletter conveying the latest information about communicable diseases, is the publication disseminated most regularly.

Each month approximately 14,000 copies reach all health district medical directors, regional medical directors, all physicians licensed to practice in Virginia, members of the Board of Health, staff at the Medical College of Virginia, some hospitals throughout the state, every division in the Department of Health, the state

library, all veterinarians licensed to practice in Virginia, every state health department in the United States, and anyone else who requests a copy.

In 1985 and 1986, eight editions of the Bulletin included substantial AIDS-related articles addressing infection control methods for health care workers, tuberculosis infections associated with HTLV-III infection, and opportunistic diseases associated with HTLV-III infection. (see Attachment 2, Description of Virginia Epidemiology Bulletin Pertaining to AIDS). All 3,500 licensed dentists in Virginia received a special edition of the Bulletin dedicated to infection control practices for dentistry (July, 1986). Another Bulletin which focused on preventing HTLV-III transmission in the workplace was sent to all nursing homes in the Commonwealth (February,1986).

The Department also utilizes pamphlets, brochures, and films in its educational efforts. During the year from May, 1985, to May, 1986, state agencies received 85,000 AIDS-related pamphlets. The Department of Education distributed Health Department "Recommendations for School Attendance" to all schools in the Commonwealth (see Attachment 6). The Department of Social Services distributed Health Department "Recommendations for Day Care Center Attendance" to 1,380 different child care facilities in Virginia (see Attachment 7).

To keep up with the demand and the high volume of requests generated by the AIDS Hotline, the Department has employed a private publishing house to produce five educational pamphlets (see Attachment 8, AIDS Pamphlets Available Through the VDH). These will be reviewed quarterly to assure that they contain the most up-to-date information about the rapid advances regarding this disease. The Department expects to distribute a total of 150,000 pamphlets in the next year.

The Department has recently established an AIDS film library within the AIDS Activity Program (see Attachment 9, AIDS Films Available Through the VDH). Staff review the AIDS-related films, select those which would be most helpful in educating various groups about AIDS, and distribute copies to the Audiovisual Services film library in the Department of Education and to each regional health office for local use.

Information about the content and availability of the films is distributed through catalogues and newletters, and to anyone who attends an AIDS-related presentation.

The Department also distributes Control of Communicable Diseases in Man to all state agencies which might require it. This publication identifies and medically describes all communicable and infectious diseases which occur in man, with special emphasis on those diseases which are rare and for which extensive information is not easily attainable. It describes the infectious agent; symptoms leading to a diagnosis of each disease; the methods of diagnosis, prophylaxis, and treatment; and the epidemiology of the occurrence, reservoir, modes of transmission, and degree of communicability of each disease.

In addition to publishing and circulating written materials and films to state agencies, the Department provides them with individual consultations and policy reviews upon request. Thus far, the Department has conferred with and assisted the Department of Mental Health/Mental Retardation, the Department of Social Services, the Department of Children, the Department of Corrections, the Department of Personnel and Training, and the Department of Education in developing various AIDS-related policies.

Finally, the Department conducts seminars and workshops for state agency personnel about the causes of AIDS and methods of avoiding HTLV-III transmission. Thus far, the Department has reached health care planners and administrators working in the areas of public health nursing, occupational health planning, health education, epidemiology, hypertension control, family planning, dentistry, pharmaceuticals, and health information systems.

C. Communication with Local Agencies

The methods by which local agencies receive AIDS-related information vary. The survey results showed that corrections and mental health/ mental retardation facilities get information through their state hierarchies. School and social services agencies rely on local health departments for information. Overall, however, agencies other than local health departments are not receiving much AIDS-related information (see Attachment 5, Summary of Agency Survey Responses).

Currently the Department of Health regularly provides local health departments with materials and guidance related to AIDS. The Department utilizes the Virginia Epidemiology Bulletin, Control of Communicable Diseases in Man, various educational pamphlets, and a monthly "AIDS Update".

The updates have contained information about the causative agent of AIDS, the etiology of the virus, transmission of HTLV-III, research efforts directed toward development of a vaccine or treatment, educational efforts conducted by the VDH AIDS Activity Program, and information about alternate testing sites and screening centers available for persons at increased risk of exposure to HTLV-III.

The Department has also produced a special pamphlet for use in local Sexually Transmitted Disease Clinics, which was previewed and approved

by an independent panel of health care professionals working in the area (see Attachment 10, "Everything You Need to Know About the HTLV-III Antibody Test"). The pamphlet is used by AIDS epidemiology representatives and public health nurses to educate and counsel individuals at risk of exposure to HTLV-III.

In addition to providing written materials, the Department has conducted training sessions and seminars for local health department staff. Many health care providers from local agencies have participated in an extensive HTLV-III antibody testing and counseling course. In fact, over half of those who took this course nationally are Virginia public health paraprofessionals. This extensive education of public health program staff is unprecedented and unique in the nation. Local staff have also learned how to counsel individuals with AIDS, and to establish alternate sites for testing.

Many local health departments interact with community-based organizations, special interest community groups, and the general public. Some participate in local speakers' bureaus and distribute their own newsletters. Most local departments meet regularly with other local agencies to discuss issues and events of mutual interest and concern. This is not true in all cases, however.

Given the significance of AIDS and the important role that education and communication play in preventing transmission of the disease, it is imperative that local health departments meet and communicate regularly with all local agencies which might require AIDS-related information.

The surveys of local agencies contained a variety of additional suggestions for the comprehensive dissemination of AIDS information. (see Attachment 5, Summary of Agency Survey Responses). They include:

1. increased use of videos;

2. educational presentations targeted to groups such as medical professionals, inmates of correctional facilities, health administrators, and junior and senior high school students; and

3. greater coordination with the Virginia Medical Society and Virginia's medical schools.

D. Communication with Health Care Providers

The Virginia Department of Health has been especially rigorous in its efforts to communicate with Virginia's health care providers about AIDS and methods of avoiding transmission of HTLV-III. In addition to circulating the Virginia Epidemiology Bulletin and the "AIDS Update" each month, the AIDS Activity Program is approaching physicians who specialize through their professional newsletters.

For example, a recent newsletter on dental health contained an article, generated by the Department of Health, outlining the current efforts of the Centers for Disease Control in determining the risk of exposure associated with needle stick injuries from HTLV-III seropositive patients. It also included CDC recommendations for health care workers performing invasive procedures on HTLV-III seropositive individuals. The newsletter of the Virginia Public Health Association also contained an AIDS-related article generated by the Department.

The AIDS Activity Program is currently assembling an educational packet for dissemination to Virginia's health care providers, which summarizes methods for preventing exposure to HTLV-III. The Statewide Health Coordinating Council will coordinate distribution of these materials.

The many AIDS-related courses and training sessions initiated by the Department play a significant role in communicating with health care professionals. A series of two-day AIDS information courses for public health nurse managers and supervisors will occur in Fredericksburg, Roanoke, and Norfolk within the next three months. They will cover epidemiology; current medical information; risk factors; psychosocial problems; community-based resources for patient care counseling and services; guidelines for nursing care; and legal issues related to HTLV-III infection.

Courses for fire and rescue squads, laboratory technicians, public health nurses and their supervisors, hospital-based nurses and nursing assistants, medical doctors, and physicians' assistants throughout Virginia will be offered in 1987.

E. Educational Outreach to the General Public

The most effective disease control measure for AIDS is to educate the general public about the disease and methods of preventing transmission of the virus. Accordingly, the Department of Health has instituted an informational campaign to effectively convey these messages.

It established an AIDS hotline which has answered over 3,500 phone calls since its inception in May, 1985. The hotline, operated by a staff of four counselors, responds to inquiries from the public.

Most people want to know about the signs and symptoms of AIDS, risk factors associated with AIDS, risk reduction techniques, locations of

HTLV-III screening sites, and the types of services offered at each site. Referrals to alternate testing sites, to community outreach organizations, or to other psychosocial and medical support services are frequent.

The AIDS Hotline also receives requests for written materials. From June, 1984, to June, 1986, 16,793 pamphlets were mailed as requested by phone.

The Department works with the media to broadcast information about AIDS and appropriate disease control measures. It recently distributed public service announcements to all twenty-five television stations in Virginia, highlighting services and information available through the Virginia AIDS Hotline, with the Hotline number (1-800-533-4148).

The Department utilizes media requests for interviews about AIDS to emphasize the risk factors that contribute to its transmission and to reiterate that AIDS cannot be contracted through casual non-sexual contact.

Outreach efforts to educate the general public can now be greatly expanded as a result of a recent award of $115,000 from the Centers for Disease Control. This money will enable the Department to develop and coordinate a series of health education campaigns in each region of the state. Information will be released to initially increase the public's awareness of AIDS, and gradually heighten public knowledge about risk-associated behaviors and methods of prevention.

This multifaceted approach will address public concerns and provide clear, continuous messages about methods of preventing HTLV-III transmission. The Department will work with the Virginia Health Education Advisory Committee and key community leaders to strengthen the impact of each phase of the campaign.

F. Outreach to Individuals at Increased Risk of Exposure to HTLV-III

Unlike local agencies or members of the general public whose informational needs can be addressed through newsletters or the AIDS Hotline, individuals at high risk of exposure to HTLV-III require individual education and counseling.

To this end, the AIDS Activity Program increased the number of alternate testing sites in May, 1986, by providing statewide HTLV-III antibody testing and counseling services on a voluntary basis to all individuals seeking treatment services at Sexually Transmitted Disease clinics.

Although these efforts are resource intensive, they are necessary to ensure that persons who are infected clearly understand how to prevent infecting others, and to ensure that persons who are not infected know how to protect themselves from infection.

To assure maximum contact with high risk communities, the Department has awarded contracts to three separate community organizations involved in outreach activities and support services for persons at increased risk of exposure to HTLV-III.

These organizations provide HTLV-III antibody testing and counseling services to persons with AIDS and their families; assistance with legal and financial matters; help with government benefit applications; referrals for home health care and home hospice services. They also maintain informational AIDS hotlines, organize special education projects and conduct workshops and training sessions for schools, police and other local groups. The AIDS Activity Program works with these organizations to determine program priorities and to coordinate education and prevention efforts.

G. Recommendations for Improved Communication

Although Virginia's efforts to prevent the transmission of AIDS have surpassed those of many other states, the study found that there are several areas of communication which would benefit from improvement. Specific recommendations follow:

1. Identify, by surveys, all agencies which might require AIDS-related publications and consultation services. Provide these agencies with pamphlets, audiovisual aids, and AIDS presentations using terminology which can be easily understood by non-medical professionals.

2. Identify up-to-date informational materials prepared by recognized professional organizations for dissemination to local and state agencies requiring AIDS information.

3. Review the list of agencies and individuals who currently receive the Virginia Epidemiology Bulletin and expand it as necessary to assure that all appropriate state and local agencies receive AIDS updates and materials regularly.

4. Update the mailing list for the Epidemiology Bulletin annually.

5. Officially notify all state and local agencies of the Department's availability to provide technical assistance in developing specific AIDS-related agency policies.

6. Require local health departments to convene and educate local groups of medical professionals, school officials, agency heads, and community leaders about AIDS. This requirement could be included in each local health department's annual goals and objectives.

7. Use mental health and mental retardation community service boards as an additional resource to help disseminate information to local agencies, community groups and the general public.

8. Identify other public sources of health and safety information such as the University of Virginia and coordinate with them to disseminate AIDS information in their programs and publications.

9. Promote the AIDS hotline with a more active advertising campaign.

10. Assure that local health department staff within state nursing, epidemiology, and community health services divisions should be cognizant of mechanisms by which to report AIDS cases to the central state office.

V. Conclusion

AIDS presents an extremely difficult public health problem. It is a deadly disease, virtually unheard of five years ago, but frequently in the media today. Advances in understanding the disease are rapid, but it still contains many unknowns.

Despite the confusion and sensitivity surrounding the disease, Virginia has been in the forefront of grappling with the difficult medical and ethical issues related to AIDS. Through this study, it has become clear that the two most important factors in preventing transmission of the disease are a responsible, credible mechanism for developing specific disease control measures and a means for comprehensive dissemination of those measures.

Medical experts agree that AIDS is a sexually transmitted and bloodborne disease, not transmissible by casual contact. There is currently no known treatment for the virus. Consequently, the disease control measures nationally recognized to be most effective are education and broad-based communication.

Virginia has mounted an aggressive outreach campaign which has received national recognition. The recommendations set forth in this report will enhance the Commonwealth's efforts to prevent further transmission of the disease and will keep Virginia in the forefront of the battle against AIDS.

VI. TABLE OF CONTENTS FOR APPENDIX

1986 SESSION

LD4196506

SENATE JOINT RESOLUTION NO. 90
AMENDMENT IN THE NATURE OF A SUBSTITUTE
(Proposed by the House Committee on Rules on February 26, 1986)
(Patron Prior to Substitute–Senator Lambert)

Requesting the Secretary of Human Resources to review existing disease control measures.

WHEREAS, disease control measures, as well as the reporting and investigation of contagious and infectious diseases, are carried out by the Department of Health; and

WHEREAS, these procedures must be followed by local departments of health for circumstances where contagious and infectious diseases are prevalent or threaten the public health; and

WHEREAS, the Department of Health determines and classifies contagious diseases according to national criteria established by the American Public Health Association; and

WHEREAS, the heightened public concern with acquired immune deficiency syndrome has demonstrated a need for the Department of Health to inform other state agencies of its disease control measures; now, therefore, be it

RESOLVED, by the Senate, the House of Delegates concurring, That the Secretary of Human Resources, with the assistance of the Department of Health, is requested to review all existing disease control measures.

The Secretary shall complete this work prior to November 15, 1986 and report soon thereafter.

Official Use By Clerks	
Agreed to By The Senate	**Agreed to By The House of Delegates**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
substitute ☐	substitute ☐
substitute w/amdt ☐	substitute w/amdt ☐
Date: _____	Date: _____
Clerk of the Senate	Clerk of the House of Delegates

Description of Virginia Epidemiology Bulletins
Pertaining to AIDS (October, 1986 - May, 1983)

October 1986	"Diagnosis and Management of Mycobacterial Infection and Disease in Persons with HTLV-III/LAV Infection"
September 1986	"Classification System for HTLV-III/LAV Infections"
July 1986	"Recommended Infection - Control Practices for 1986 Dentistry"
June 1986	"Recommendations for Preventing Transmission of HTLV-III/LAV During Invasive Procedures"
	"Safety of Immune Globulin Preparations with Respect to Transmission of HTLV-III/LAV."
May 1986	"Additional Recommendations to Reduce Sexual and Drug Abuse-Related Transmission of HTLV-III/LAV"
March 1986	"Preventing Perinatal Transmission of the AIDS Virus"
	"Cryptosporidiosis"
	"Alternative Sites for HTLV-III Antibody Testing"
February 1986	"Preventing Transmission of HTLV-III in the Workplace"
December 1985	"Acquired Immunodeficiency Syndrome (AIDS)"
	"Alternative Sites for HTLV-III Antibody Testing"
November 1985	"Heterosexual Transmission of HTLV-III"

	"Oral Viral Lesion (Hairy Leukoplakia) Associated with AIDS"
	"Education and Foster Care of Children with HTLV-III/LAV"
	"Preventing Possible Transmission of HTLV-III from Tears"
	"Persons Who Should Refrain from Donating Blood and Plasma"
September 1985	"Revision of the Case Definition of Acquired Immunodeficiency Syndrome"
June 1985	"Testing Donors of Organs, Tissues, and Semen"
March 1985	"A Clinician's Guide to Evaluation"
	"AIDS Risk for Health Care Workers"
	"Fact Sheet for Blood Donors and Other Concerned Individuals"
	"Information for Persons Who Have a Positive Test for HTLV-III Antibody"
	"HTLV-III Antibody Testing by the State Laboratory"
January 1985	"Evidence Confirming Lack of AIDS Transmission"
November 1984	"AIDS in Virginia"
December 1983	"Update on AIDS -Acquired Immune Deficiency Syndrome"
May 1983	"Acquired Immune Deficiency Syndrome"

AIDS Medical Advisory Committee

A. Martin Cader, M.D., Director,
Division of Communicable Diseases, VDH

W. Andrew Heaton, M.D., Director,
Tidewater Chapter, American Red Cross

Lisa G. Kaplowitz, M.D., Assistant Professor of Infectious Diseases, Medical College of Virginia

Bennett Malbon, D.D.S., Oral Surgeon, President,
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Thistle M. McKee, M.D., Pediatrician, Board of Health

Grayson B. Miller, Jr., M.D., Director,
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Edward Peeples, Jr., PhD., Preventive Medicine,
Medical College of Virginia

Charles Schleupner, M.D., Infectious Disease Specialist,
University of Virginia

Martin P. Wasserman, M.D., Director,
Arlington County Department of Human Resources

Joseph Zanga, M.D., Virginia Chapter of American Academy of Pediatrics

Attachment 4

Summary of AIDS Prevention Policies and Activities in Other States

SHOULD THE BOARD OF HEALTH REQUIRE THAT PERSONS CONFINED TO A STATE HOSPITAL FOR THE MENTALLY ILL OR MENTALLY RETARDED BE TESTED FOR HTLV-III INFECTION?

	Relevent AIDS Policy	Primary Impetus to Formulate Policy	Committee/Working Group Established to Address and Formulate Policy	Research and Methodology To Establish Policy	Policy Implementation Shared with Agencies - Made Law
VIRGINIA	Recommends testing on individual basis, only when medically indicated	VDH, Office of Epidemiology and Department of Mental Health, Mental Retarded and Substance Abuse	AIDS Medical Advisory Committee	CDC Guidelines	Guidelines developed by the Department of Mental Health, Mental Retardation, and Substance Abuse Programs
CA	Mass Screening prohibited				1985 Confidentiality Law (AB 403, Chapter 22)
DC	Mass Screening not required				
FL	Mass screening not required	Department of Health and Rehabilitation Aids Policy Advisory Group (Issues Policy)	Governor appointed Task Force, 11 members (makes recommendations)		Department of Health and Rehabilitation through AIDS Policy Advisory disseminates and implements policy
IL	No discrimination against persons with AIDS	Governor	AIDS Interdisciplinary Advisory Council		
KY	No policy noted				
LA	Recommended but not policy		Task Force		
MD	Mass screening not required. Testing done on individual basis	Task Force. Health Department	Task Force (21 representatives from health care and research, insurance industry, Board of Education, Dept. of Corrections, the legislature, and community	Site visits in other states. Telephone survey	Final draft Not yet law.

MI	Mass screening not required	Governor Public Health Advisory Council	Expert Committee on AIDS		Department of Public Health
NJ	Mass screening not required	Department of Health	Department of Health		Department of Human Services
NY	Mass screening not required. Testing only for symptomatic individuals after informed consent is obtained	Department of Health			Department of Health
NC	Mass screening not advocated. Educational efforts recommended	Department of Human Resources	Department of Human Resources	CDC Guidelines	Department of Human Resources
PA	No policy noted	Department of Public Welfare			
TX	Mass screening not required. Testing done on individual basis if medically indicated	Department of Health	Departments of Health, Human Services and Corrections, Texas Youth Council	CDC Guidelines	Department of Health
WV	No policy. Still in policy development phase.	Health Department	Governor's Task Force		Health Department
WI	Mass Screening not required	Health Department			Health Department Public Act 73

SHOULD CHILDREN WITH AIDS, ARC, OR HTLV-III INFECTION BE ALLOWED TO ATTEND CHILD CENTERS?

St	Relevant AIDS Policy	Primary Impetus To Formulate Policy	Committee/Working Group Established to Address and Formulate Policy	Research and Methodology To Establish Policy	Policy Implementation Shared with Agencies - Made Law
VIRGINIA	Recommends individual assessment by public health authorities, private physicians, and the child's parent (s). Generally recommends exclusion from child care centers according to control of bodily functions	VDH Office of Epidemiology	AIDS Medical Advisory Committee	CDC Guidelines	Approved and adopted by the Board of Health. Policy disseminated by the Department of Education
CA	CDC Guidelines	Department of Health Services			
DC	CDC Guidelines	Board of Education Policy variation only by authority of Public Health Commissioner	Task Force of medical, legal, and gay communities, PTA's and public schools		Resolution pending City Council decision
FL	Children with AIDS allowed	Department of Health and Rehabilitation AIDS Policy Advisory Group (issues policy)	Governor Appointed Task Force--11 members (makes recommendations)	CDC Guidelines	Department of Health and Rehabilitation through AIDS Policy Advisory disseminates and implements policy
IL	No discrimination against persons with AIDS	Governor	AIDS Interdisciplinary Advisory Council		
KY	Individualized approach			CDC Guidelines	
LA	CDC Guidelines		Task Force		State Health Officer
MD	Facilities must be specifically licensed	Department of Health	Task Force (21 representatives from health care and research, insurance industry, Board of Education, Dept. of Corrections, the legislature, and community)	CDC Guidelines	Department of Health

	Children with AIDS allowed; Individually evaluated	Governor Public Health Advisory Council	Expert Committee on AIDS		Department of Health
	Children with AIDS allowed	Department of Health	AIDS Medical Advisory Panel	CDC Guidelines	Commissioner of Health
	Children with AIDS allowed Individually; evaluated	Health Department	AIDS Institute, Regional Task Force, Health Department	CDC Guidelines	Health Department
	Children with AIDS allowed; Individually evaluated	Department of Human Resources	Department of Human Resources	Modified CDC Guidelines	Department of Human Resources
	No policy noted	Department of Public Welfare			
	2 1/2+ year olds allowed after individually evaluated	Department of Health and Dept. of Human Services		CDC Guidelines	Department of Health
	Guidelines allowing children with AIDS No formal policy	Health Department	Governor's Task Force		Health Department
	No policy noted				Public Act 73

SHOULD THE HEALTH DEPARTMENT REPORT CHILDREN WITH AIDS TO THE DEPARTMENT OF EDUCATION OR LOCAL SCHOOL OFFICIALS AND SHOULD THESE CHILDREN ATTEND SCHOOL?

	Relevant AIDS Policy	Primary Impetus to Formulate Policy	Committee/Working Group Established to Address and Formulate Policy	Research and Methodology to Establish Policy	Policy Implementation Shared with Agencies - Made Law
VIRGINIA	Recommends individual assessment by public physician and the child's parent(s). Also recommends reporting cases to the VDH where the Health Commissioner reviews for public health threat	VDH Office of Epidemiology	AIDS Medical Advisory Committee	CDC Guidelines	Approved and adopted by the Board of Health Policy disseminated by the Department of Education
CA	Reporting not required	Department of Health Services		CDC Guidelines	1985 Confidentiality Law (A.B 403, Chapter 22)
DC	Interim Policy which is expected to be reconfirmed. Reporting not required (CDC Guidelines)	Board of Education	Task Force of medical, legal, gay communities, PTA's, public schools	CDC Guidelines Review of other School System Guidelines	
	Reporting not required nor recommended	Department of Health and Rehabilitation AIDS Policy Advisory Group (issues)	Governor appointed Task Force, 11 members (makes recommendations)		Department of Health and Rehab. through AIDS Policy Advisory Group diseminates and implements policy
IL	No policy of notification	Governor	AIDS Interdisciplinary Advisory Council		
KY	Reporting recommended for school superintendent and school official with direct need to know	Department of Health Services			State Health Commissioner
LA	CDC Guidelines		Task Force		State Health Officer
MD	Reporting not required		Task Force (21 representatives from health care and research, insurance, industry, Board of Education, Dept. of Corrections, the legislature, and community)		Department of Health

MI	No policy of notification	Governor Public Health Advisory Council	Expert committee on AIDS		Department of Public Health
NJ	Reporting not required	Department of Health	AIDS Medical Advisory		Department of Health
NY	Reporting not required	Health Department	AIDS Institute	CDC Guidelines	Commissioner of Health
NC	Notification at discretion of local health director based on risk of transmission (in conflict with confidentiality law, currently being addressed by the state)			CDC Guidelines	Department of Human Resources
PA	No policy noted	Department of Public Welfare			
TX	Required notification of school administration for communicable diseases specific policies are to be developed by local school districts	Department of Healthe		Connecticut and Florida Guidelines, CDC recommendations	Department of Health
WV	Reporting not required	Health Department	Governor's Task Force		Health Department
WI	Reporting not required	Health Department			Public Act 73

SHOULD QUARANTINE OR ISOLATION BE USED AS A CONTROL MEASURE FOR HTLV-III INFECTIONS?

State	Relevant AIDS Policy	Primary Impetus to Formulate Policy	Committee/Working Group Established to Address and Formulate Policy	Research and Methodology to Establish Policy	Policy Implementation Shared with Agencies - Made Law
VIRGINIA	Commissioner of Health has the authority to protect the public's health. Mass quarantine or isolation as a routine control measure was not recommended. Preventative education was advocated	VDH, Office of Epidemiology	AIDS Medical Advisory Committee	Reviewed existing regulation (2.02.19) and medical and psychosocial impact	Health Commissioner
CA	Not advocated	Department of Health Services		Generally based on CDC recommendations	
DC	No policy specific for AIDS				
	No policy, but HB 1313 grants authority in certain cases but only by court order and if other conditions conform	Department of Health and Rehabilitation			HB 1313
IL	No policy noted	Governor	AIDS Interdisciplinary Advisory Council		
KY	No policy noted				
LA	No policy noted		Task Force		
MD	No policy specific to AIDS at this time, but Secretary of Health has authority to protect Public Health	Governor	Task Force, 21 members (representatives from health care and research, insurance industry, Board of Education, Department of Corrections, the legislature, and community)		Secretary of Health

MI	No policy noted	Governor Public Health Advisory Council	Expert Committe on AIDS		Department of Public Health
NJ	Not recommended nor required Education efforts recommended	Department of Health	AIDS Medical Advisory		Department of Health
NY	Not recommended nor required	Department of Health	AIDS Institute	CDC Guidelines	Department of Health
NC	No policy. Communicable Diseases Rules and Laws under review. Education efforts recommend-ed	Departmen of Human Resources		APHA Regulations	Department of Human Resources
PA	No policy noted	Department of Public Welfare			
TX	No authority to quarantine people with AIDS. AIDS is reportable to Health Department and Commissioner has authority to institute disease control measures	Department of Health			Commissioner of Health
WV	No policy. Still in policy development phase	Health Department	Governor's Task Force		Health Department
WI	No policy noted	Health Department			Public Act 73

SHOULD THE BOARD OF HEALTH REQUIRE PREMARITAL HTLV-III ANTIBODY TESTING PRIOR TO THE ISSUANCE OF A MARRIAGE LICENSE?

te	Relevant AIDS Policy	Primary Impetus to Formulate policy	Committee/Working Group Established to Address and Formulate Policy	Research and Methodology to Establish Policy	Policy Implementation Shared with Agencies - Made Law
VIRGINIA	Recommends education as a more effective measure than screening at issuance of a marriage license	VDH, Office of Epidemiology	AIDS Medical Advisory Committee	Reviewed cost-effectiveness of syphillis screening; CDC currently recommends no mass screening for low risk groups	In future, county clerks may provide educational information about AIDS at issuance of marriage license
CA	Testing not required AIDS brochures must be given to marriage license applicants		Department of Health Services		SB 1478 passed by both houses
DC	No official policy				
L	Testing not required	Department of Health and Rehabilitation; AIDS Policy Advisory Group (issue policy)	Governor appointed Task Force - 11 members (makes recommendations)		State Health Officer; Department of Health and Rehabilitation; HB 1313
IL	Testing not required	Governor	AIDS Interdisciplinary Advisory Council		
KY	No policy noted				
LA	Testing not required		Task Force		
MD	No policy Testing not required at this time	Governor	Task Force, 21 members (representatives from health care and research, insurance industry, Board of Education, Department of Corrections, the legislature, and community)		

MI	Testing not recommended	Governor, Public Health Advisory Council	Expert Committee on AIDS		Department of Public Health
NJ	Testing not required	Department of Health			
NY	Testing not required	Department of Health	AIDS Institute		Department of Health
NC	Testing not required but private medical doctors required to ascertain that person is free from communicable diseases prior to marriage	Department of Human Resouces			Department of Human Resouces
PA	No policy noted	Department of Public Health			
TX	Testing not required	Department of Health	Task Force		Department of Health
WV	No policy - still in policy development phase	Health Department	Governor's Task Force		Health Department
WI	Testing not required	Health Department			Public Act 73

SHOULD PHYSICIANS AND LABORATORY DIRECTORS BE REQUIRED TO REPORT TO THE DEPARTMENT OF HEALTH PERSONS WHO ARE HTLV-III SEROPOSITIVE?

tate	Relevant AIDS Policy	Primary Impetus to formulate policy	Committee/Working Group Established to Address and Formulate Policy	Research and Methodology to Establish Policy	Policy Implementation Shared with Agencies Made Law
VIRGINIA	Only diagnosed AIDS cases are reportable by law and reporting of HTLV-III seropositives to the VDH was not recommended		AIDS Medical Advisory Committee	Reviewed existing reporting procedures, interpretation of antibody test results and resources available	Will be periodically re-evaluated
CA	Blood donors only-deferral registry names of people whose blood is unacceptable without specifying reason		Department of Health Services		1985 Confidentiality Law (AB 403, Chapter 22)
DC	Reporting not required				
'L	Reporting not required	Department of Health and Rehabilitation - AIDS Policy Advisory Group (issues policy)	Governor appointed Task Force, 11 members (make recommendations)		HB 1313, Department of Health and Rehabilitation through AIDS Policy disseminates and implements policy
IL	Reporting not required	Governor	AIDS Interdisciplinary Advisory Council		
KY	No policy noted				
LA	Recommended but not policy		Task Force		
MD	Reporting not required. Health education encouraged	Governor	Task Force, 21 members (representatives from health care and research, insurance industry, Board of Education, Department of Corrections, the legislature, and community)		Final draft. Not yet law

MI	Reporting opposed	Governor, Public Health Advisory Council	Expert Committee on AIDS		Department of Public Health
NJ	Reporting not required				
NY	Reporting not required	Department of Health	AIDS Institute	CDC Guidelines	Department of Health
NC	Reporting not required	Department of Health Services			Department of Human Resources
PA	No policy noted	Department of Public Welfare			
TX	Reporting not required	Department of Health	Task Force		Department of Health
WV	No policy, still in policy development phase. Reporting not required	Health Department	Governor's Task Force		Health Department
WI	Reporting required to State Epidemiologist	Health Department			Public Act 73 State Epidemiologist

SHOULD THE BOARD OF HEALTH REQUIRE THAT PERSONS IN STATE CORRECTIONAL FACILITIES BE TESTED FOR HTLV-III INFECTIONS?

	Relevant AIDS Policy	Primary Impetus To Formulate Policy	Committee/Working Group Established to Address And Formulate Policy	Research and Methology to Establish Policy	Policy Implementation Shared with Agencies - Made Law
VIRGINIA	A recommendation will be forthcoming based on the results of SJR 125				
CA	Mandatory testing not required				1985 Confidentiality law
DC	No mandatory testing. Educational efforts recommended				
	Testing not required nor advocated	Department of Corrections		ABT Associates Study funded by Institute of Justice; CDC Guidelines	
IL	Mandatory testing not required	Governor	AIDS Interdisciplinary Advisory Council		
KY	No policy noted				
LA	Recommended but not policy		Task Force		
MD	Mandatory testing not required, voluntary testing available	Department of Public Safety and Correctional Services	Division of Corrections, Task Force	Johns Hopkins Study. A group of senior medical consultants reviewed policy	Department of Public Safety and Correctional Services

MI	No mandatory testing	Governor, Public Health Advisory Council	Expert Committee on AIDS		Department Of Public Health
NJ	Mandatory testing not required. Voluntary testing available.	Department of Health	Department of Corrections	Based on the experience of the Department of Corrections	Department of Corrections
NY	No mandatory testing, but voluntary testing available. Educational efforts recommended.		Commission of Corrections	CDC Guidelines. Demographic Study of AIDS Deaths among inmates in New York	
NC	Mass testing not advocated. Testing done only on case by case basis where need indicated. Educational efforts recommended		Department of Corrections		Department of Corrections
PA	No policy noted. Educational Programs indicated.	Department of Corrections		Consultation with Bureau of Epidemiology and Disease Prevention	
TX	Mass testing not required	Each facility			
WV	No Policy. Still in policy development phase	Health Department	Governor's Task Force		Health Department
WI	No mandatory testing	Health Department			Public Act 73

Summary of Local Agency Survey Response

I. Methods by which Local Agencies Learn of AIDS-Related Disease Control Measures

A. AIDS Updates

33% receive (primarily local health departments)
60% wish to receive (primarily non-health departments)

B. Virginia Epidemiology Bulletins

44% receive (primarily health departments)
40% wish to receive (primarily non-health departments)

C. AIDS-Related Technical Assistance

33% have sought (primarily health departments)

D. Attendance at AIDS Seminars

25% (all but two in health departments)

E. Requests for AIDS-Specific Presentations

5%

F. Information Via Respective State Hierarchies

Department of Corrections
Department of Mental Health and Mental Retardation

G. Information Via Contacts with Local Health Departments

Local social services agencies
Local school divisions

II. Summary of Suggestions from Local Agencies

A. Provide a constant update on clinical and related issues (47%)

Note: One school district requested immediate notification when one of its students is diagnosed as having AIDS. The Attorney General of Virginia recently ruled that such notification should occur only if the Commissioner of Health determines that a student has a health problem associated with the disease which might affect his career in school and require special education (2/24/86).

B. Distribute AIDS video programs and expand educational presentations to health care providers

C. Develop educational programs with specific messages for inmates and for residents of adult correctional homes

D. Develop educational materials and prevention messages for junior and senior high school students, e.g., filmstrips, cartoons, and pamphlets

E. Convene quarterly meetings between Mental Health/ Mental Retardation facilities and local health departments

F. Increase AIDS education through medical schools, the Virginia Medical Society, and the Department of Mental Health/Mental Retardation

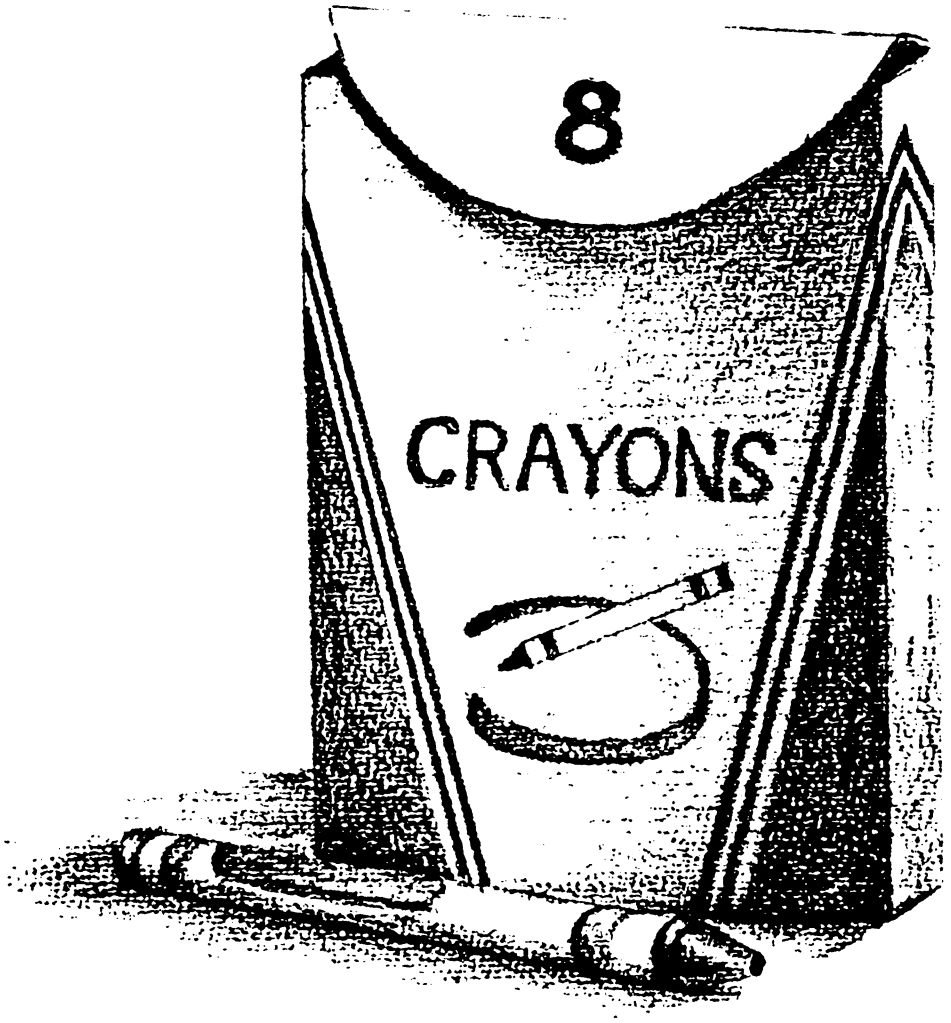
III. Survey Response Rate

A.	Local Health Departments	100%
B.	Mental Health/Mental Retardation facilities	100%
C.	Local Schools	100%
D.	Correctional Centers	60%
E.	Social Services' State and Regional Offices	60%
	Total Response Rate	88%

Attachment 6

Acquired Immunodeficiency Syndrome (AIDS)

Virginia Department of Health Recommendations for Day Care Center Attendance*



These recommendations apply to all children attending day care centers who are known to be infected with human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV), the causative agent of AIDS. This includes children with AIDS as defined for State Health Department reporting purposes; children who are diagnosed by their physicians as having an illness due to infection with HTLV-III/LAV but who do not meet the case definition; and children who are asymptomatic but have virologic or serologic evidence of infection with HTLV-III/LAV. These recommendations do not apply to siblings of infected children unless they are also infected. While there is ample evidence that casual contact is not a risk factor for the transmission of HTLV-III/LAV, the fact that infants and young children lack control of their body secretions could theoretically enhance the transmission of HTLV-III/LAV. Hence the recommendations for day care attendance are different from those for attending kindergarten through grade 12.

Background

The Scope of the Problem. As of November 4, 1985, 206 of the 14,519 reported cases of AIDS n the United States were among children under 18 years of age. This number is expected to double in the next year. Children with AIDS have been reported from 23 states, the District of Columbia, and Puerto Rico, with 75% residing n New York, California, Florida, and New Jersey. Of the 156 cases of AIDS reported to date n Virginia since 1982, three have been in children.

The 206 AIDS patients reported to the Centers or Disease Control (CDC) represent only the most severe form of HTLV-III/LAV infection, .e., those children who develop opportunistic nfections or malignancies. As in adults with HTLV-III/LAV infection, many infected children nay have milder illness or may be asymptomatic.

Confidentiality Issues. The diagnosis of AIDS or associated illnesses evokes much fear from others in contact with the patient and may voke suspicion of life-styles that may not be cceptable to some persons. Parents of HTLV-III/LAV-infected children should be aware of the otential for social isolation should the child's ondition become known to others in the day are center. Day-care personnel and others nvolved in educating and caring for these children should be sensitive to the need for confidentiality and the right to privacy in these cases.

Assessment of Risks

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

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

Risk of Transmission in the Day-Care Setting. None of the identified cases of HTLV-III/LAV infection in the United States is known to have been transmitted in the day-care setting or through other casual person-to-person contact. Other than the sexual partners of HTLV-III/LAV-infected patients and infants born to infected mothers, none of the family members of the 14,519 AIDS patients reported to CDC has been reported to have AIDS. Six studies of family members of patients with HTLV-III/LAV infection have failed to demonstrate HTLV-III/LAV transmission to adults who were not sexual contacts of the infected patients or to older children who were not likely at risk from perinatal transmission (6-11).

Based on current evidence, casual person-to-person contact as would occur among children attending day care centers appears to pose no risk. However, studies of the risk of transmission through contact between younger children and neurologically handicapped children who

lack control of their body secretions are very limited. Based on experience with other communicable diseases, a theoretical potential for transmission would be greatest among these children. It should be emphasized that any theoretical transmission would most likely involve exposure of open skin lesions or mucous membranes to blood and possibly other body fluids of an infected person.

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

Recommendations

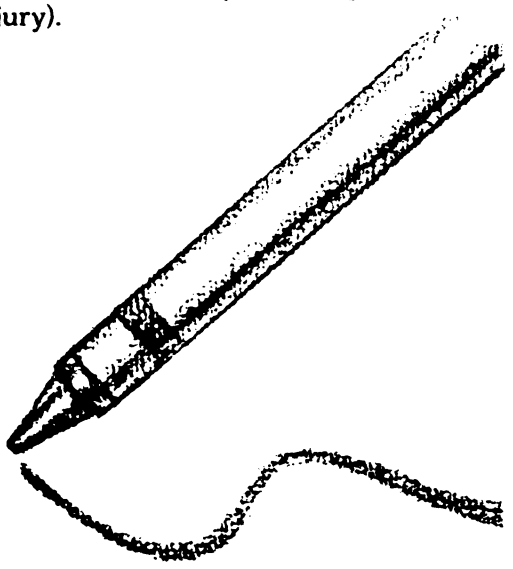
1. A child infected with HTLV-III/LAV should not be allowed to attend day care centers unless a medical decision can be made that the child does not pose a meaningful risk to others. A meaningful risk would mean he/she has poor control of body secretions, displays behavior such as biting, or has uncoverable oozing skin lesions, etc. Such decisions are best made using a team approach that should include the child's physician, public health personnel and the child's parent or guardian.

2. Because other infections in addition to HTLV-III/LAV can be present in blood or body fluids, all day-care facilities should adopt routine procedures for handling blood or body fluids. Soiled surfaces should be promptly cleaned with disinfectants such as household bleach (diluted 1 part bleach to 10 parts water). Disposable towels or tissues should be used whenever possible, and mops should be rinsed in disinfectant. Those who are cleaning should wear disposable gloves and avoid exposure of open skin lesions or mucous membranes to the blood or body fluids.

3. A plan for periodic review by the medical team described in #1 will be established at the time the initial decision is made regarding day care center attendance. This periodic reevaluation is necessary because the hygienic practices of a child with HTLV-III/LAV infection may improve as the child matures and he/she may be able to attend day care sometime in the future.

4. Mandatory screening as a condition for day care attendance is not warranted based on available data.

5. Persons involved in the care and education of HTLV-III/LAV-infected children should respect the child's right to privacy, including maintaining confidential records. The number of personnel who are aware of the child's condition should be kept at a minimum needed to assure proper care of the child and to detect situations where the potential for transmission may occur (e.g., bleeding injury).



References

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

*The Virginia Department of Health Recommendations for Day Care Center Attendance are adopted from recommendations on the subject published by the Centers for Disease Control/U.S. Public Health Service and the American Academy of Pediatrics

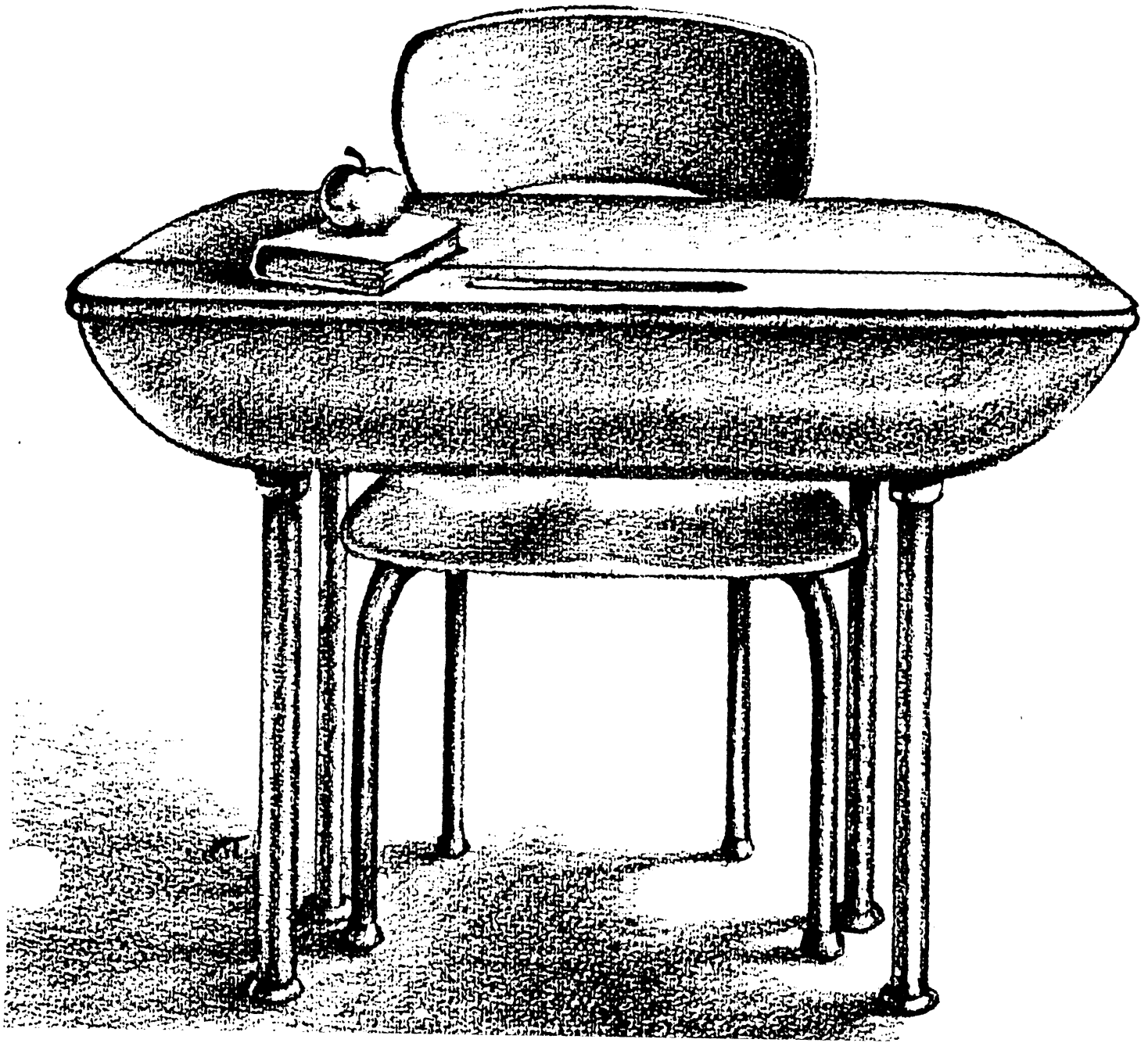
November 1985

VDH
Virginia Department of Health

Attachment 7

Acquired Immunodeficiency Syndrome (AIDS)

Virginia Department of Health Recommendations for School Attendance*



These recommendations apply to all children in kindergarten through grade 12, known to be infected with human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV), the causative agent of AIDS. This includes children with AIDS as defined for State Health Department reporting purposes; children who are diagnosed by their physicians as having an illness due to infection with HTLV-III/LAV but who do not meet the case definition; and children who are asymptomatic but have virologic or serologic evidence of infection with HTLV-III/LAV. These recommendations do not apply to siblings of infected children unless they are also infected.

Background

The Scope of the Problem. As of November 4, 1985, 206 of the 14,519 reported cases of AIDS in the United States were among children under 18 years of age. This number is expected to double in the next year. Children with AIDS have been reported from 23 states, the District of Columbia, and Puerto Rico, with 75% residing in New York, California, Florida, and New Jersey. Of the 156 cases of AIDS reported to date in Virginia since 1982, three have been in children.

The 206 AIDS patients reported to the Centers for Disease Control (CDC) represent only the most severe form of HTLV-III/LAV infection, i.e., those children who develop opportunistic infections or malignancies. As in adults with HTLV-III/LAV infection, many infected children may have milder illness or may be asymptomatic.

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

Assessment of Risks

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

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

Risk of Transmission in the School Setting. None of the identified cases of HTLV-III/LAV infection in the United States is known to have been transmitted in the school setting or through other casual person-to-person contact. Other than the sexual partners of HTLV-III/LAV-infected patients and infants born to infected mothers, none of the family members of the 14,519 AIDS patients reported to CDC has been reported to have AIDS. Six studies of family members of patients with HTLV-III/LAV infection have failed to demonstrate HTLV-III/LAV transmission to adults who were not sexual contacts of the infected patients or to older children who were not likely at risk from perinatal transmission (6-11).

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

Risks to the Child with HTLV-III/LAV Infection. HTLV-III/LAV infection may result in immunodeficiency. Such children may have a greater risk of encountering infectious agents in a school than at home. Immunodepressed children are also at greater risk of suffering severe complications from such infections as chickenpox, cytomegalovirus, tuberculosis, herpes simplex, and measles. Assessment of the risk to the immunodepressed child is best made by the child's physician who is aware of the child's immune status.

Recommendations

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

2. For most infected school-aged children, the benefits of an unrestricted setting would outweigh the risks of their acquiring potentially harmful infections in the setting and the apparent nonexistent risk of transmission of HTLV-III/LAV. These children should be allowed to attend school and after-school day-care and to be placed in a foster home in an unrestricted setting.

3. For the infected preschool-aged child and for some neurologically handicapped children who lack control of their body secretions or who display behavior such as biting, and those children who have uncoverable oozing lesions, a more restricted environment is advisable until more is known about transmission in these settings.

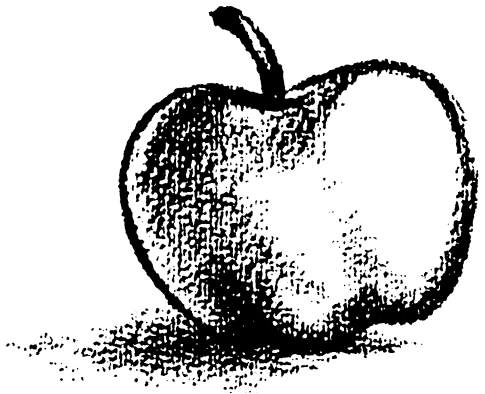
4. Because other infections in addition to HTLV-III/LAV can be present in blood or body fluids, all schools regardless of whether children with HTLV-III/LAV infection are attending, should adopt routine procedures for handling blood or body fluids. Soiled surfaces should be promptly cleaned with disinfectants such as household bleach (diluted 1 part bleach to 10 parts water). Disposable towels or tissues should be used whenever possible, and mops should be rinsed in disinfectant. Those who are cleaning should wear disposable gloves and avoid exposure of open skin lesions or mucous membranes to the blood or body fluids.

5. Care which involves exposure to the infected child's body fluids and excrement should be provided by persons who are aware of the child's HTLV-III/LAV infection and the modes for HTLV-III/LAV transmission. In any setting, especially involving an HTLV-III/LAV-infected person, good handwashing after exposure to blood and body fluids and before caring for another child should be observed, and disposable gloves should be worn when handling such blood and body fluids. Any open lesions on the infected child should also be covered.

6. A plan for periodic review by the medical team described in #1 will be established at the time the initial decision is made regarding school attendance. This periodic review is important because the hygienic practices of a child with HTLV-III/LAV infection may improve sufficiently as he/she matures to allow for school attendance in the future. Alternatively, the hygienic practices may deteriorate if the child's condition worsens and the reevaluation will be necessary to determine if the deterioration of hygienic practices warrants exclusion.

7. Mandatory screening as a condition for school attendance is not warranted based on available data.

8. Persons involved in the care and education of HTLV-III/LAV-infected children should respect the child's right to privacy, including maintaining confidential records. The number of personnel who are aware of the child's condition should be kept at a minimum needed to assure proper care of the child and to detect situations where the potential for transmission may occur (e.g., bleeding injury).



References

1. Scott GB, Buck BE, Leterman JG, Bloom FL, Parks WP. Acquired immunodeficiency syndrome in infants. N Engl J Med 1984; 310: 76-81.
2. Thomas PA, Jaffe HW, Spira TJ, Reiss R, Guerrero IC, Auerbach D. Unexplained immunodeficiency in children. A surveillance report. JAMA 1984; 252: 639-44.
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8. Lewin EB, Zack R, Ayodele A. Communicability of AIDS in a foster care setting. International Conference on Acquired Immunodeficiency Syndrome (AIDS), Atlanta, Georgia, April 1985.
9. Thomas PA, Lubin K, Enlow RW, Getchell J. Comparison of HTLV-III serology, T-cell levels, and general health status of children whose mothers have AIDS with children of healthy inner city mothers in New York. International Conference on Acquired Immunodeficiency Syndrome (AIDS), Atlanta, Georgia, April 1985.
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AIDS Pamphlets Available Through VDH

The following pamphlets are available through the Office of Epidemiology or by calling the Virginia AIDS Hotline (1-800-533-4148):

"Why You Should Be Informed About AIDS"

This pamphlet details basic AIDS information. It includes risk reduction methods for health care workers who may be exposed to blood or other body fluids of individuals infected with HTLV-III.

"About AIDS and Shooting Drugs"

This pamphlet is designed to reach intravenous drug users; it also provides basic AIDS information. The following risk reduction messages are also outlined: limiting the use of recreational drugs, refraining from shared needle and drug equipment use, reducing the number of sexual contacts, and practicing "safer sex" techniques.

"What Gay and Bisexual Men Should Know About AIDS"

This pamphlet details basic AIDS information. It includes a description of the immune system and its function, "safer sex" techniques, and an appeal to individuals with possible risk factors not to donate blood.

"What Everyone Should Know About AIDS"

This pamphlet presents basic AIDS information. It emphasizes that casual contact is not a mode of transmission for HTLV-III infection. It explains why the avoidance of individuals in risk-factor associated communities and the fear of donating blood are unwarranted concerns.

"What Everyone Should Know About STDs"

Basic information about common sexually transmitted diseases is outlined by symptoms, results, and treatment methods.

AIDS Films Available Through
VDH

"What If the Patient Has AIDS"

Distributor: National Audiovisual Center
VHS Color 22 minutes
1986

This film targets health care workers, including hospital and laboratory personnel, dentists, dental hygienists, opthalmologists and optometrists.

It outlines the risks associated with certain procedures involved in caring for people with HTLV-III infection and in handling their specimens. Precautions to minimize those risks which are recommended by the Centers for Disease Control and the National Institute of Health are also presented.

"AIDS: Fears and Facts"

Distributor: National Audiovisual Center
VHS, 16mm Color 23 minutes
1986

This film addresses and answers the most frequently asked questions about AIDS: what causes it? who is at risk? how is it transmitted? what is being done to control its spread? and how can individuals reduce their risks of infection? (Newscast and press conference format).

"AIDS and Your Job"

Distributor: National Audiovisual Center
VHS Color 12 1/2 minutes
1986

This film is targeted to audiences of fire fighters, police, and other emergency personnel.

This film outlines the risks associated with occupational posure to HTLV-III and recommends precautions that should be taken by certain non-medical professionals if they have contact with blood or other body fluids of a HTLV-III infected person in the course of their work.

"AIDS: What Everyone Needs to Know"

Distributor: Churchill Films
VHS, 16mm Color 18 minutes
1986

This film targets junior high school students as well as adults, health and helping professionals.

It explains the cause of AIDS, its transmission, symptoms, and risk reduction techniques. It also gives insight into the psychosocial impact of this disease and addresses common myths about affected persons and modes of transmission.

"A Million Teenagers"

Distributor: Churchill Films
VHS, 16mm Color 22 1/2 minutes
4th Edition
1985

This is intended for a wide audience from junior high school students through to adults.

Teenagers present sexually transmitted diseases (STD) to other teenagers. It presents the range of diseases, their transmission, symptoms, treatment, and medical implications in a forthright manner. The conclusion of the film provides a smooth transition into a full group discussion and is appropriate for classroom use.

EVERYTHING YOU NEED TO KNOW ABOUT THE HTLV-III ANTIBODY TEST

(1) WHAT IS AIDS?

Acquired Immunodeficiency Syndrome (AIDS) is a serious disease which reduces the body's ability to fight certain infections; it is a life-threatening disease. AIDS is a sexually transmitted disease. It can also be transmitted through the sharing of needles. Over the past several years, increasing numbers of persons have developed the disease.

The HTLV-III virus is the cause of AIDS. A blood test to detect antibodies to this virus is now available.

(2) WHAT ARE THE SYMPTOMS AND SIGNS OF AIDS?

Many symptoms associated with AIDS are present in minor illnesses, such as colds, bronchitis, and stomach flu. However, in persons with AIDS these symptoms are usually persistent or recurrent. The symptoms may include the following:

- Unexplained, persistent fatigue.
- Unexplained fever, shaking chills, or drenching night sweats lasting longer than several weeks.
- Unexplained weight loss greater than 10 pounds during a period of less than two months that is not related to diet or increased exercise.
- Swollen glands (enlarged lymph nodes usually in the neck, arm pits, or groin) which are otherwise unexplained and last more than two weeks.
- Pink to purple flat or raised blotches or bumps occurring on or under the skin, inside the mouth, nose, eyelids, or rectum. Initially they may resemble bruises but do not disappear. They are usually harder than the skin around them.
- Persistent white spots or unusual blemishes in the mouth.

- Persistent diarrhea.
- Persistent dry cough that is not from smoking cigarettes and which has lasted too long to be caused by a common cold or flu, especially if accompanied by shortness of breath.
- Unexplained bleeding or unusually easy bruisability.

(3) PERSONS AT INCREASED RISK OF EXPOSURE TO THE VIRUS ARE THOSE WHO:

- are sexually active with multiple partners (both gay and heterosexual).
- inject drugs such as cocaine or heroin and share needles with another person.
- have received blood or blood product transfusions.
- have immigrated to the United States since 1977 from countries with a high incidence of AIDS.
- are being treated for hemophilia.
- are sex partners of persons with AIDS or positive HTLV-III antibody tests.
- are born to a mother with a positive antibody test, or the sexual partner of a man with a positive antibody test.

(4) WHAT IS THE ANTIBODY TEST FOR HTLV-III?

This is a test to identify antibodies which indicate exposure to the HTLV-III virus; it is not a test to detect the virus itself. When a person is infected by a virus, the body's immune system normally begins to fight the infection through white blood cells which produce substances called antibodies. Antibodies, therefore, indicate that a person has been infected. Research has shown that antibodies to the virus are frequently found in the blood of persons who have AIDS or AIDS-related conditions, and individuals at risk of HTLV-III infections.

It should be stressed that those who have the antibodies to the AIDS virus have definitely been exposed to the virus. They should be assumed to carry the

virus and are potentially infectious to their sex partners. However, A POSITIVE RESULT IN NO WAY MEANS A PERSON WILL NECESSARILY GET AIDS.

(5) WHY IS THE HTLV-III ANTIBODY TEST BEING OFFERED?

The primary purpose is to screen blood and plasma donations. Contaminated blood is discarded so that blood used for transfusions is safe.

The test also has public health applications, in that persons deciding to have the test are likely to limit the spread of AIDS by taking personal responsibility to change sexual practices which might increase their chances of either receiving or transmitting the virus to others (based on the results of the test).

(6) WHO SHOULD CONSIDER TAKING THE HTLV-III ANTIBODY TEST?

- People with multiple sex partners and/or with sex partners they do not know well.
- People who have had sexual contact with a prostitute.
- People who want to know if they have been exposed to the AIDS virus through sexual contact, shared needles, or transfusions.
- People considering pregnancy if one or both partners might be at risk for AIDS.

(7) PREVENTION RECOMMENDATIONS FOR PERSONS WITH A HISTORY OF POSSIBLE EXPOSURE OR SYMPTOMS

- Refrain from donating blood, plasma, body organs, other tissue, and sperm.
- When engaging in sexual activities, avoid passing or receiving body fluids, particularly blood, semen, saliva, feces, or urine. Use condoms. Use only water-based lubricants (such as K-Y Jelly) to protect the condom. Petroleum or oil-based lubricants destroy condoms. Ask your pharmacist if you are unsure about a lubricant.
- Reduce your number of sex partners.

- Avoid sharing needles to prevent the transfer of the virus from person to person.
- Assume all sexual partners carry the AIDS virus. Don't engage in sexual intercourse (of any variety) without a condom. This includes: vaginal, oral, and anal intercourse.