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Dr. Lee from Dr. Bander
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Merle Bander
Medicine

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PEF

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September 22, 1986

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Philip Sowa, M.D.
Executive Administrator
San Francisco General Hospital
1001 Potrero Avenue, 2-A-11
San Francisco, CA 94110

ADMINISTRATION
SAN FRANCISCO GENERAL HOSPITAL

u (9/25)
T.F.

Dear Dr. Sowa:

As you may know, the Department of Public Health has developed guidelines for the control of perinatally-transmitted human immunodeficiency virus (HIV) infection and care of HIV-infected mothers, infants, and children. The Department developed these guidelines in cooperation with the San Francisco Medical Society; the San Francisco Gynecologic Society; the Northern California Chapter of the American Academy of Pediatrics; San Francisco General Hospital; the University of California, San Francisco; the San Francisco AIDS Foundation; the Juvenile Court; the Department of Social Services; and other concerned agencies.

I have enclosed these guidelines for your reference. Copies have already been mailed to all practicing pediatricians, obstetricians and gynecologists, internists, family practitioners, and general practitioners in San Francisco. They are now being specifically re-distributed to chiefs of pediatrics, obstetrics and gynecology, medicine, and family practice of all acute care hospitals; chiefs of staff and hospital administrators of all acute care hospitals; and to medical directors of all prenatal, family planning, sexually transmitted disease, and substance abuse clinics in San Francisco.

The guidelines recommend both general and clinic-based risk reduction education for all women of childbearing age in San Francisco and, in specific high-risk situations, HIV antibody testing. There are specific recommendations for the care of HIV-infected women in the prepartum and intrapartum periods, and for evaluation and care of HIV-exposed infants and children.

The guidelines call for a perinatal coordinator within the Department of Public Health to deal with issues of foster placement and adoption of HIV-exposed and infected infants. I have appointed Geraldine E. Oliva, M.D., M.P.H., the Director of the Bureau of Family Health, to serve as Perinatal AIDS Coordinator.

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Dr. Oliva, her staff, and the Department's Perinatal Forum Medical Advisory Committee have developed a suggested protocol for implementing the guidelines, "Practical Applications of Perinatal Guidelines". The protocol is enclosed for your information. A protocol for evaluating infants for foster care placement is also available and can be obtained on request from Dr. Oliva's office at 558-3684. A resource list for services and health education materials is also included for your information.

We encourage all health care institutions in San Francisco to review and implement these guidelines. We suggest that you share the enclosed materials with your entire medical staff as a first step. Dr. Oliva and her staff are available to assist you and to answer any questions you may have. We are anxious to arrange relevant education and information sessions at appropriate institutions upon request.

Thank you for your help with this important project.

Sincerely yours,

A handwritten signature in dark ink, reading "David Werdegan". The signature is written in a cursive, flowing style.

David Werdegan, M.D., M.P.H.
Director of Health

DW:roas

ENCLOSURES (3)

Practical Application of Perinatal Guidelines for HIV Infected
High Risk Mothers, Infants, and Preschool Age Children
by Medical Advisory Committee of the Perinatal Forum

In February of 1986, a special task force of the Department of Public Health recommended guidelines for the care of the infected/high risk mother, infant and preschool age children with HIV infection/exposure. This short summary addresses the practical applications of these recommendations.

Pre-Pregnancy and Prenatal Care

1. All women seen in clinical settings should be given written, audio-visual and/or oral information about AIDS and about the HIV antibody test in their own language at an appropriate reading level.
2. All women planning pregnancy in high risk groups for HIV infection should be encouraged to be tested. For women already pregnant, testing should occur at the first prenatal visit. Women who are members of the following groups or who have sexual partners who are members of these groups are considered risk for HIV infection (all risk categories refer to behavior since 1979).
 - A. Intravenous drug users or sexual partners of intravenous drug users.
 - B. Sexual contacts of AIDS patients or bisexual men.
 - C. Multiple sex partners in areas with a high incidence of AIDS.
 - D. Recipients of blood products between January 1, 1979 and June 1, 1985.
 - E. Donor inseminated women since January 1, 1979 unless donor has been screened.
 - F. Mothers of perinatally infected children.
 - G. Residence in AIDS endemic areas (Haiti, Burundi, Rwanda, Zaire, Congo, Tanzania, Kenya).
 - H. Anyone requesting the antibody test for any reasons even though they admit no risk factors.
3. For prepregnant women, testing can be done through the regular provider or at an alternative test site. If done by the provider, written consent must be obtained which specifies release of information.
4. For pregnant women, the test should be ordered through the regular provider where possible, but clients who wish should be referred to alternative testing sites. A client's written consent must be obtained prior to testing, which includes a release of information to specified providers, including the pediatrician where known.

5. If a woman is in a high risk group, the problem list in her chart should be marked (suggested notation is "H/A precautions"). When testing has been done, results should be reviewed by the primary provider or by a specific clinician designated as on-site AIDS coordinator. If the test result is positive, or the woman refuses the test, this problem will remain active and the problem list will be sent with the rest of the record to the delivery room staff, obstetrician, and the baby's clinician. (The staff will assume HIV infection where no other infection is noted on the problem list and a lab slip for hepatitis is in the chart and negative). If the test is negative, the problem will be inactivated.
6. The actual test results will not be in the chart unless the client agrees, but should be kept in a separate locked file box.
7. The client should be informed in person as to the results of the test and provided with ongoing psychosocial support services and risk reduction counseling.
8. Antibody positive women should be informed of the risk of intrauterine transmission of AIDS and the options open to them.
9. Asymptomatic antibody positive women can be safely followed by their usual provider.
10. Pregnancy women who were antibody negative at first screening and continue to remain at risk should be encouraged to have a retest in the third trimester.

Intrapartum/Postpartum Care

1. For women who are documented antibody positive or who are in a high risk group, labor and delivery should take place in a labor room if appropriate for easier infection control. All personnel who are having direct contact with a potentially infected mother or newborn during delivery should wear gloves and gowns. Those exposed to the potential splash of infectious material, e.g., the delivering person (or all personnel at Cesarean section) should strongly consider wearing protective eyewear. Disposal of materials following the birth should follow hospital infection control precautions (e.g., the room should be disinfected with 1:10 hypochloride solution). The placenta of a high risk woman or an antibody positive woman should not be released for commercial use and should be labeled with "H/A precautions" before being sent to pathology for disposal or research.
2. For postpartum care, mothers should be given full access to their infants unless they have untreated pulmonary tuberculosis. If possible, mothers who are high risk or antibody positive should be in private rooms or in semi-private rooms if the room is being shared by a mother who is also HIV antibody positive. Mothers who are positive antibody status should not breast feed as transmission through breast milk of the AIDS virus has occurred.

Newborn Care

1. "H/A precautions" should be entered on the chart of antibody positive or high risk untested infants.
2. Nursery care for exposed and infected infants: It is strongly discouraged that circumcision be carried out on infants who are antibody positive or infants of high risk mothers. These infants should have their umbilical stumps cleaned meticulously until they are evulsed and hospital procedures for HIV infection control should be followed for infants of positive or high risk mothers.
3. Antibody positive mothers should not breast feed since viral transmission by this route has occurred.
4. With the high risk mother's written consent, cord blood or infant blood will be sent for an AIDS antibody test. Infants born to mothers who are high risk for HIV should be tested before two months of age for the HIV antibody and, if positive, be retested at one year of age when passively transferred antibody should have disappeared. Obviously, if there is a clinical indication the test can be repeated earlier.

Pediatric Care

1. The infant should be followed, at least monthly, for signs of: failure to thrive, yeast infections, growth failure, developmental delay, adenopathy, and other signs of immunodeficiency.
2. Live virus vaccines should not be administered to the infant until it is clear that the child is not infected. However, inactivated polio vaccine (SALK) should be given at 2, 4 and 6 months.
3. Antibody positive or symptomatic children of high risk mothers should have an evaluation by a pediatrician experienced in the care of HIV infected patients.

CURRENT SUPPORT GROUPS AND ASSISTANCE
FOR WOMEN EXPOSED TO AIDS
compiled 6/86

AIDS HEALTH PROJECT - 626-6637

333 Valencia Street, 4th Floor
San Francisco, CA 94103

First appointment is an intake with an individual worker. Groups for women will be set up when there has been interest indicated after intakes. Call to see if there is currently a group or one happening soon.

Many ongoing groups for gay men: support groups, groups for those at risk, for persons with AIDS recovering from substance abuse, and other groups form as needed. There are cases of women participating in some of these groups when they would like to be in a group with gay men (she must be referred by an intake worker.)

AIDS PROJECT OF THE EAST BAY - 420-8181

400 40th Street, suite 200
Oakland, CA 94609
(a program of the Pacific Center)

A weekly drop-in support group for women partners of men with AIDS is forming and will begin in 6/86. Call for dates and times.

Other groups that include women: grief group; parents group; family, friends, and lovers group; individual counseling regarding AIDS.

New groups start based on interest. Call for information.

SHANTI PROJECT - 558-9644

890 Hayes Street
San Francisco, CA 94117

Shanti sees three client groups: people with AIDS, people anticipating a loss from AIDS, and those who have already experienced a loss from AIDS. Women are incorporated in all support groups; there are no groups specifically for women. Call for current listing of groups, dates, and times.

WOMEN'S AIDS NETWORK - 864-4376 (ask for Nancy Shaw)

c/o Women's Program - San Francisco AIDS Foundation
333 Valencia Street, 4th Floor
San Francisco, CA 94103

A Northern California Network of health care providers, activists, and concerned women who meet monthly to address current AIDS issues affecting women. Activities: committees, outreach/newsletter, coordination and monitoring of resources, and political action. Call for more information.

Current Support Groups and Assistance
For Women Exposed to AIDS

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SAN FRANCISCO AIDS FOUNDATION - 864-4376

333 Valencia Street, 4th Floor
San Francisco, CA 94103

For women with AIDS or ARC: Social Services department provides assistance with AFDC, Medi-Cal, Social Security, Disability, Food Stamps, Housing, and Insurance. Contact Debbie or Catherine for an appointment.

Informal Network of Women exposed to AIDS: A list of names of women with AIDS, ARC, or exposed to AIDS who are willing to talk with others like themselves. Contact Nancy Shaw for more information.

Women's Program: Resources, referrals, information, research updates, opportunity to do volunteer work. Contact Nancy Shaw for more information.

MARIN AIDS SUPPORT NEWORK - 457-2437

4 - G Street, Suite I
San Rafael, CA 94903

Male and female peer counseling (similar to Shanti). Groups are forming for men with AIDS or ARC; groups for women will form based on interest.

TASK FORCE II - 885-9533 (as for Juliet Traynor)

964 Eddy Street
San Francisco, CA 94109

For people dealing with problems associated with AIDS; also for contact with women who have AIDS, ARC, or have been directly exposed to AIDS.

Prepared by:
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SAN FRANCISCO EPIDEMIOLOGIC BULLETIN

CITY AND COUNTY OF SAN FRANCISCO • DEPARTMENT OF PUBLIC HEALTH • BUREAU OF COMMUNICABLE DISEASE CONTROL

Vol. 2, Supplement 1

April 1986

Guidelines for Control of Perinatally Transmitted Human T-Lymphotropic Virus-Type III/Lymphadenopathy-Associated Virus Infection and Care of Infected Mothers, Infants, and Children

City and County of San Francisco
Department of Public Health
Perinatal and Pediatric AIDS Advisory Committee

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

These recommendations apply to all infants, children, and women of child-bearing age known to be infected or at high risk of being infected with human T-lymphotropic virus-type III/lymphadenopathy-associated virus (HTLV-III/LAV). This includes persons with Centers for Disease Control (CDC)-defined acquired immunodeficiency syndrome (AIDS), persons with lesser clinical manifestations of HTLV-III/LAV infection such as AIDS-related complex (ARC), and persons with asymptomatic HTLV-III/LAV infection.

These guidelines are intended to supplement previously published national guidelines for the education and foster care of HTLV-III/LAV-infected children¹ (Attachment I) and for the prevention of perinatal HTLV-III/LAV infection (Attachment II).² They were approved by the Health Commission on February 4, 1986, and are being distributed to health care providers, clinics, hospitals, and interested individuals.

BACKGROUND

Perinatal HTLV-III/LAV Infection and Pediatric AIDS

The transmission of HTLV-III/LAV from infected mothers to infants, either in utero or perinatally, has been well established.³⁻¹² Infection in these infants can be asymptomatic or cause a variety of clinical syndromes including AIDS.¹³

It is not, however, conclusively known what proportion of infants exposed in utero or perinatally will become infected and what proportion of infected infants will develop clinical disease.² As of December 1, 1985, 217 cases of pediatric AIDS had been reported to CDC (CDC, unpublished data). Forty-eight percent of these children were born to intravenous-drug-using mothers, 17 percent to Haitians, and 10 percent to mothers who either had AIDS or were sexual partners of men with AIDS or at risk for AIDS. An additional 39 (18 percent) children were infected through transfusions of infected blood or blood products, and 13 (6 percent) had unknown sources of infection. Thus, 165 (76 percent) of the cases had been exposed to HTLV-III/LAV in utero or perinatally.

Perinatally infected infants who go on to develop AIDS first develop symptoms at a median age of four months, and approximately one-half of these infants will be diagnosed as having AIDS by their first birthday.¹³ Typical prodromal symptoms include failure to thrive, recurrent or persistent thrush, chronic interstitial pneumonitis, hepatosplenomegaly, chronic or recurrent diarrhea, lymphadenopathy, and severe recurrent bacterial infections such as sepsis and meningitis. When frank clinical AIDS develops in these patients, the most common diagnosis is Pneumocystis carinii pneumonia (62 percent) and the second most common are other opportunistic infections without Kaposi's sarcoma or Pneumocystis carinii pneumonia (33 percent).¹³

HTLV-III/LAV Infection in Women of Child-Bearing Age

In the United States, approximately 7 percent of adult cases of AIDS involve women. Fifty-three percent of these women are intravenous drug users, 15 percent are sexual partners of men in risk groups (primarily heterosexual intravenous drug users), and 9 percent have received infected blood or blood products. Eighty percent are between 20 and 49 years old. Twenty-two percent of these women are white, 55 percent black, and 23 percent Hispanic (CDC, unpublished data). In San Francisco, as of January 31, 1986, there had been 10 cases of

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AIDS reported in adult women. Three of these women were intravenous drug users, one was a sexual partner of a man in a high prevalence group, four had received transfusions, and two had no identified risk. Four were between 20 and 49 years old; two of these were white, one black and one Asian.

HTLV-III/LAV Transmission in Households

None of the identified cases of HTLV-III/LAV infection in the United States are known to have been transmitted in school, day-care, or foster-care settings or through casual person-to-person contact.¹ Other than sexual partners of HTLV-III/LAV-infected patients, infants born to infected mothers, or a single case involving nosocomial transmission from a child to a mother providing nursing care¹⁴, none of the family members of the over 17,000 AIDS patients reported to CDC have developed AIDS. Five studies of family members of patients with HTLV-III/LAV infection have failed to demonstrate HTLV-III/LAV transmission to adults who are not sexual contacts of the infected patients or to children who are not already infected perinatally.¹⁵⁻¹⁹ However, if casual person-to-person transmission of HTLV-III/LAV infection does exist, it should theoretically be greatest among young children. This 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. We emphasize that there is no evidence of this type of transmission occurring in any setting at this time.

GENERAL RECOMMENDATIONS

Education

1. **Risk-Reduction Education.** All sexually active homosexual, bisexual, and heterosexual adults with multiple sexual partners since 1979 should be aware that they are potentially at risk of HTLV-III/LAV infection, and sexually active women with multiple sexual partners since 1979 should understand that, if they have been infected, they are at risk of transmitting HTLV-III/LAV perinatally. To this end, widespread health education campaigns

should address the risk of infection and the ways to prevent sexual transmission among heterosexuals and, more specifically, to women of child-bearing age. Additionally, women in recognized risk groups (Table 1) should be the target of more intensified educational campaigns and, if indicated, special educational programs to decrease their ongoing risk of parenterally or sexually acquiring HTLV-III/LAV infection, such as referral for substance abuse or sexual risk reduction counseling. These campaigns should be culturally and linguistically appropriate for these risk groups.

2. **Provider Education.** In order to provide a high standard of care for HTLV-III/LAV-infected women, infants, and children, obstetricians, pediatricians, foster parents and agencies, and other providers need to be educated about the virus, its modes of transmission, its prevention, and the special issues of confidentiality and counseling surrounding the infection. Focus should be placed on educating and training those providers serving patients at highest risk of infection. We recommend that providers assess each patient's history of potential exposure to HTLV-III/LAV and not assume that membership in a risk group implies *de facto* infection and, conversely, that non-membership implies non-infection.

Laboratory

We recommend that more than one method of anti-HTLV-III antibody determination be used for testing pregnant women, women in risk groups, and children of women in risk groups for HTLV-III/LAV infection. Such methods include enzyme-linked immunosorbent assay (ELISA), indirect fluorescent antibody, and Western blot. Because of the complexity of prenatal testing, especially that involving intravenous-drug-using women, laboratory testing should be done in a single reliable and experienced facility. Submission of specimens identified only by code number to this laboratory will greatly decrease the chances of inadvertent disclosure.

Pre-Conception Recommendations

Whenever possible, women infected with HTLV-III/LAV should be confidentially

identified and educated about the risks of perinatal transmission. Infected women should be advised to postpone pregnancy until more is known about the specific risks of perinatal transmission. Detailed contraceptive counseling should be offered to these women. Infected women should also be counseled to avoid unsafe sexual practices. Regardless of other contraceptive methods used, they should use barrier methods of contraception (e.g., condom or condom plus a diaphragm with a nonoxynol-9-containing spermicide) during intercourse in order to diminish the chances of transmitting HTLV-III/LAV to their sexual partners.

We recommend that women who believe themselves to be at high risk for HTLV-III/LAV infection (Table 1) be confidentially or anonymously tested for anti-HTLV-III antibody if they are planning to become pregnant. Testing can be offered through private physicians, alternate test sites, or through clinics, especially those used by women in risk groups, such as family planning clinics, drug treatment programs, and sexually transmitted disease clinics. Testing of these women, although strongly recommended, must be voluntary and confidential. We do not recommend that women who are not in risk groups be tested at this time. However, because of possible sexual contact with men in high-incidence groups, it may be prudent for women with multiple sexual partners in areas with high incidence of AIDS to consider themselves at risk and obtain pre-conception counseling and testing if indicated. Regardless of test results, women and their children should continue to have access to all health and social services for which they are eligible.

MATERNAL RECOMMENDATIONS

Identification of Infected Pregnant Women

Routine histories taken at clinical facilities serving women potentially at high risk for HTLV-III/LAV infection should include confidential questions designed to elucidate their risk of infection. Such clinics include physicians' offices, family planning clinics, sexually transmitted disease clinics, drug treatment clinics, WIC clinics, and prenatal clinics. Written and/or audiovisual materials regarding HTLV-III/LAV infection

should be available at all sites where these women are seen.

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

Care of Infected Pregnant Women

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

1. **Prenatal Care.** We recommend that any seropositive woman be retested using two different anti-HTLV-III antibody determinations to insure accuracy. We recommend that women confirmed to be seropositive be carefully counseled regarding the risk of perinatal HTLV-III/LAV infection and the options open to them.

Erratum

Page 4 S, second column, fourth full sentence should read:
However, as the benefits of breast feeding in all likelihood
outweigh the potential risks of postnatal transmission of
the virus, we do not recommend that breast feeding be restricted
unless the mother is known to be infected.

Such options include continuation of the pregnancy or termination of pregnancy if early enough in gestation. Infected women should also be specifically counseled to postpone subsequent pregnancies until more is known about perinatal transmission of the virus. They should be medically evaluated to rule-out any incipient opportunistic infections or malignancies. Specifically, the possibility of infection with Mycobacterium tuberculosis should be evaluated by chest x-ray and PPD, and chronic infection with hepatitis B virus, cytomegalovirus, and Herpes simplex virus should be excluded. Teratogenic drugs, including trimethoprim and most antivirals, should be avoided except in the face of life-threatening maternal illness.

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

3. **Postpartum Care.** In the postpartum period, regular hospital infection control procedures for HTLV-III/LAV infection

should be followed. Isolation of asymptomatic seropositive women is not recommended. Mothers should be given full access to their infants unless they have untreated pulmonary tuberculosis. Until more is known about potential transmission of virus in breast milk, infants of mothers known to be infected should not be breast fed. However, as the benefits of breast feeding in all likelihood outweigh the risks of virus transmission, we do not recommend that breast feeding be restricted unless the mother is known to be infected. Because the potential for exposure to large amounts of infectious material decreases markedly after delivery, information regarding the woman's antibody status should not be transmitted beyond the labor and delivery area, including to social workers, law enforcement, or correctional personnel.

Special Considerations

1. **Women at High Risk of Infection who are not Screened.** We recommend that women at high risk of HTLV-III/LAV infection who have not been tested during pregnancy be presumed to be positive for purposes of intrapartum infection control procedures.

2. **Intravenous-Drug-Using Mothers.** In order to prevent further parenteral transmission of HTLV-III/LAV through needle sharing and further perinatal transmission, we recommend that women in this risk group be specially targeted for substance abuse treatment and risk reduction education.

INFANT AND PRE-SCHOOL-AGED CHILD RECOMMENDATIONS

Identification of Exposed Infants

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

Identification of Infected Infants

1. Infants of Seropositive Mothers.

Infants born to mothers who are known to have been infected during pregnancy should be retested for anti-HTLV-III antibody at approximately one year of age when passively acquired maternal antibody has disappeared. Infants presenting before one year of age with symptoms suggestive of HTLV-III/LAV infection should be retested at that time. If an IgM-specific anti-HTLV-III antibody test or other method of early diagnosis becomes available, these infants should be tested for HTLV-III/LAV infection at birth.

2. Infants and Children of High-Risk

Mothers with Unknown Serologic Status.

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

3. Infants and Children at Risk for Parenterally Acquired Infection. Infants and children at risk for parenterally-acquired HTLV-III/LAV infection should be tested only (a) if they received blood or blood products from a donor identified as HTLV-III/LAV-infected and will receive live virus vaccines; (b) if they were transfused with non-heat-treated Factor VIII and will receive live virus vaccines; or (c) if clinically indicated.

4. Infants and Children of Non-High-Risk Mothers. Infants and children born to mothers not at high risk of HTLV-III/LAV infection and not at risk for parenterally acquired HTLV-III/LAV infection should not be tested.

Care of Exposed and Infected Infants and Children

1. Nursery and In-Hospital Care.

Regular hospital infection control procedures for HTLV-III/LAV infection and regular hospital procedures for inpatient care of immunosuppressed patients should be followed in the nursery and during subsequent inpatient admissions. In order to prevent potential sources of infection, circumcision of exposed male infants should be strongly discouraged and only done with informed consent. Umbilical stumps should be meticulously cleaned daily until they are evulsed.

2. Routine Home Care. Caregivers who are exposed to the body fluids and excrement of exposed infants and infected children should be aware of the potential for infection and the modes of HTLV-III/LAV transmission. Good handwashing after exposure to body fluids and excrement should be observed and any open lesions, either on caregivers' hands or on children, should be covered.

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

Exposed infants and infected children should not receive live virus vaccines or BCG until more is known about vaccination of HTLV-III/LAV-infected persons. Inactivated vaccines, including *Haemophilus influenzae* type b and pertussis vaccines and diphtheria and tetanus toxoids, are not contraindicated and should be given as regularly scheduled. Inactivated polio vaccine should be substituted for oral polio vaccine and be given in conjunction with diphtheria and tetanus toxoids and pertussis vaccine at 2, 4, 6, and 18 months and 4-6 years of age.

Measles, mumps, and rubella vaccine should not be administered to these children at the present time.

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

Special Considerations

1. **Foster Care.** In each decision involving foster care placement, a mother's history of potential exposure to HTLV-III/LAV infection should be individually assessed to determine if she and her child are truly at risk of infection. These decisions can be made in consultation with a perinatal coordinator within DPH or, if necessary, with the Perinatal and Pediatric AIDS Advisory Committee. For the purposes of foster care decisions, the Committee will also include consumer advocates representative of ethnic and socio-economic populations at high risk for perinatally transmitted infection.

If a child whose mother has been tested for HTLV-III/LAV infection comes to foster care, we recommend that the DSS caseworker assigned to the case request that the mother's obstetrical provider release the results of her test to the perinatal coordinator with the mother's consent. A sample release of information form is included in Appendix II. Based on the results of these tests the perinatal coordinator will specify if the infant will need medical foster

care placement or routine foster care placement. Medical placement will be required for infants of mothers with positive anti-HTLV-III antibody test. The Perinatal and Pediatric AIDS Advisory Committee. Routine placement will require that the mother be seronegative. The perinatal coordinator will also inform the caseworker assigned to follow the child of the reasons for medical placement and also be responsible, in conjunction with the caseworker, for informing the foster parent and the child's pediatrician of the reason for medical placement. Additional release of information will be required for each subsequent disclosures.

Children less than three years old currently in foster care and children entering foster care in the future whose mother has not been tested for HTLV-III/LAV infection should be tested for HTLV-III/LAV infection only if their mother has been determined to be at risk of infection. Testing in this setting is indicated on medical grounds alone and should be done with the consent of the mother. A sample consent form is included in Appendix I. If the mother refuses to consent to testing, the caseworker should recommend that the case be reviewed by the Perinatal and Pediatric AIDS Advisory Committee and, if indicated, confidential testing of the child and release of the test results be ordered as part of dependency proceedings. Once results of the test are available they will be released by the caseworker to the perinatal coordinator in the case of voluntary testing or reported directly by the laboratory to the perinatal coordinator in the case of court-ordered testing. The perinatal coordinator will then indicate whether the child is in need of medical placement or routine placement. If the mother is in need of medical placement, the perinatal coordinator will follow procedures as outlined above. If, for whatever reason, the child is not tested, the mother's exposure history will be reviewed and appropriate placement recommended by the Perinatal and Pediatric AIDS Advisory Committee.

Children in foster care three years old and older, born after January 1, 1979, and born to a mother determined to be at risk for HTLV-III/LAV infection should be tested

only if they have significant neurodevelopmental delay and lack control of their body secretions or display aggressive behavior, such as biting, or who have uncoverable, oozing lesions. Such testing should occur only after careful medical review by the Perinatal and Pediatric AIDS Advisory Committee to determine if such behaviors truly increase the theoretical risk of casual HTLV-III/LAV transmission. Again, the consent of the child's mother should be obtained for testing and release of information, or, if consent is not available, testing and release of information should be ordered by the court if indicated.

Under Section 199.21 of the Health and Safety Code of the State of California (AB 403) (Attachment III), it is unlawful to disclose the results of a blood test to detect antibodies to the probable causative agent of AIDS to any third party except pursuant to a written authorization of the person who is tested. Therefore, if written releases of information are unavailable, specific waivers will need to be obtained so that prenatal testing results can be made available by the mother's obstetric care provider to the perinatal coordinator and so that the perinatal coordinator can make either prenatal or postnatal screening results available to the DSS caseworker, the child's foster family, and the child's pediatrician. Additionally, under Section 199.22, no person shall test a person's blood for evidence of antibodies to the probable causative agent of AIDS without the written consent of the subject of the test. We feel that all prenatal testing should be done on a voluntary basis and that the mother should freely consent both to being tested and to release the test results in order to assure better medical care of her children. However, in the event that a mother determined to be at risk of infection has not been tested prenatally, refuses to be tested prenatally, or refuses to consent to release the results of her prenatal test, as it is our opinion that testing of high-risk children for HTLV-III/LAV infection is medically indicated, we recommend that, if these children are to be placed in foster homes, such testing be obtained and, if necessary, be specifically ordered by the court having jurisdiction over the child. However, prior to any court-ordered testing, the case must be reviewed by the Perinatal and Pediatric AIDS Advisory Committee to

determine if testing is indeed indicated.

2. Adoption. We recommend that infants and children (a) whose mothers were at high risk of HTLV-III/LAV infection, (b) who were born on or after January 1, 1979, and (c) who have not been previously tested be tested for HTLV-III/LAV infection prior to placement. We recommend that the HTLV-III/LAV status of all children at high risk of infection be made available to adopting parents prior to final placement so that they can consider the possible social and psychological effects on their families.

CONCLUSIONS

We reemphasize that these are interim guidelines which will need to be reviewed as more information becomes available on perinatal transmission, the natural history of HTLV-III/LAV infection in pregnancy and childhood, and household transmission and also as vaccine and definitive antiviral therapy become available. Finally, it should be clearly stated that all evidence suggests that there is no risk for casual transmission of HTLV-III/LAV and that the primary intent of these guidelines is to assure appropriate medical care for infected pregnant women, infants, and children.

TABLE 1. Groups in Which HTLV-III/LAV Infection Has Been Reported, Females

Mode of Transmission	Group
Sexual	Sexual contacts of AIDS patients or men in risk groups
	Artificially inseminated women (donor insemination) between January 1, 1979, and June 1, 1985
Parenteral	Intravenous drug users
	Recipients of blood or blood products between January 1979, and June 1, 1985
Either	Mothers of perinatally infected children

* Women with multiple sexual partners in areas with high incidence of AIDS should possibly consider themselves in this category.

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APPENDIX I

MODEL

INFORMED CONSENT TO DO TEST FOR AIDS VIRUS
(HTLV-III/LAV) ANTIBODY

IMPORTANT INFORMATION REGARDING THIS TEST

The AIDS virus (HTLV-III/LAV) antibody test detects the presence of antibodies, naturally occurring substances in the blood produced by the body following infection with the AIDS virus, by using a simple blood test. This is not a test for AIDS. The test does not tell you if you have AIDS or an AIDS-related condition (ARC); it does show whether you have been infected with the virus that can cause AIDS. For further information regarding AIDS or the AIDS virus antibody test, consult your physician or call the San Francisco AIDS Foundation Hotline (415-863-AIDS).

I understand that this test result will be part of my medical record and my baby's medical record. I have been informed about the AIDS virus (HTLV-III/LAV) antibody test (see reverse). I have had a chance to ask questions which were answered to my satisfaction. I believe that I understand the benefits and risks of the test.

Date: _____ 19____

(Patient's Signature)

(Patient's Printed Name)

(Witness)

HTLV-III ANTIBODY TEST - LIMITATIONS AND IMPLICATIONS

- A. This test will not tell you:
- if your child has AIDS or ARC (AIDS related condition);
 - if your child will develop AIDS or ARC;
 - if your child is immune to AIDS or ARC;
 - if your child is healthy.
- B. A negative test result indicates that the antibody has not been found in your child's blood. If your child tests negative, there are three possible explanations:
- your child has not been infected with the virus; or
 - your child has been exposed to the virus but has not become infected; or
 - your child has been infected by the virus but has not yet produced antibodies.
- Research indicates most people produce antibodies within 2-8 weeks after infection. Some people will not produce antibodies for six months or more. A very small number of people will never produce antibodies.
- C. A positive test result indicates that your child has probably been infected with the AIDS virus, and his or her body has produced antibodies. Researchers have shown that most people with AIDS antibodies have active virus in their bodies. A positive result does not mean:
- that your child has AIDS or ARC;
 - that your child will necessarily get AIDS or ARC;
 - that your child is immune to AIDS.
- D. Not everyone infected with the virus will develop AIDS.
1. The majority of infected children will develop antibodies to the virus yet remain healthy. They will display none of the symptoms of AIDS.
 2. A smaller group of children who also have antibodies will develop some of the symptoms of AIDS. These children are diagnosed as having ARC (AIDS-related condition).
 3. An unknown percentage of infected, antibody-positive children will develop AIDS. A diagnosis of AIDS is made only after finding specific life-threatening infections or malignancies that do not normally occur in healthy children.
- E. NOTE ABOUT CONFIDENTIALITY - Parents of children taking the test should be aware that there may be some risk associated with letting others know about their child's test results. While using test results as grounds for discrimination in insurance or employment is prohibited by California law, the burden of proof is on the person discriminated against.

MODEL

AUTHORIZATION TO RELEASE THE RESULTS OF A BLOOD TEST
TO DETECT ANTIBODIES TO THE AIDS RELATED VIRUS (HTLV-III)

A. EXPLANATION:

Permission to release the results of your blood test to detect antibodies to the AIDS related virus (HTLV-III) is being asked of you to fulfill the terms of the Confidentiality of Medical Information Act, Civil Code Section 56 et seq. and Health and Safety Code, Section 199.21 (f,g,h).

Written permission must be given for each separate release of AIDS antibody test results by a person or institution who did the test. Release of your test results without your consent is punishable by fine (Health & Safety Code, Section 199.21 (a,b,c,d,e)).

B. AUTHORIZATION:

I hereby authorize _____
(Name of person or institution)

to release to _____
(Name of the person who is to receive the results)

the results of blood tests to detect antibodies to the AIDS virus (HTLV-III/LAV).

C. USES:

The results of the test cannot be used to deny insurance or employment. The information will be used only for the medical care [and foster-care placement]* of your baby.

D. DURATION:

This authorization shall be effective immediately and shall remain in effect indefinitely or until _____ 19 ____.

E. RESTRICTIONS:

I understand that the requester may not further use or release my test results unless another authorization is obtained from me.

F. ADDITIONAL COPY:

I further understand that I have a right to receive a copy of this authorization upon my request.

Date: _____ 19 ____ _____
(Patient's Signature)

(Patient's Printed Name)

Original to Medical Record
Copy to Patient
Copy to person who is to receive the results.

MODEL

INFORMED CONSENT TO DO TEST FOR AIDS VIRUS
(HTLV-III/LAV) ANTIBODY

IMPORTANT INFORMATION REGARDING THIS TEST

The AIDS virus (HTLV III/LAV) antibody test detects the presence of antibodies, naturally occurring substances in the blood produced by the body following infection with the AIDS virus, by using a simple blood test. This is not a test for AIDS. The test does not tell you if your child has AIDS or an AIDS-related condition (ARC); it does show whether your child has been infected with the virus that can cause AIDS. For further information regarding AIDS or AIDS virus antibody test, consult your child's physician or call the San Francisco AIDS Foundation Hotline (415-863-AIDS).

I understand that this test result will be part of my child's medical record. I have been informed about the AIDS virus (HTLV-III/LAV) antibody test (see reverse). I have had a chance to ask questions which were answered to my satisfaction. I believe that I understand the benefits and risks of the test.

Date: _____ 19____ _____
(Parent's or Guardian's Signature)

(Patient's Printed Name)

(Witness)

HTLV-III ANTIBODY TEST -- LIMITATIONS AND IMPLICATIONS

- A. This test will not tell you:
- if you have AIDS or ARC (AIDS related condition);
 - if you will develop AIDS or ARC;
 - if you are immune to AIDS or ARC;
 - if you are healthy.
- B. A negative test result indicates that the antibody has not been found in your blood. If you test negative, there are three possible explanations:
- you have not been infected with the virus; or
 - you have had contact with the virus but have not become infected; or
 - you have been infected by the virus but have not yet produced antibodies.

Research indicates most people produce antibodies within 2-8 weeks after infection. Some people will not produce antibodies for six months or more. A very small number of people will never produce antibodies.

- A negative result does not mean:
- that you are immune to the virus;
 - that you have not been infected with the virus. You may have been infected and have not yet produced antibodies.

- C. A positive test result indicates that you have probably been infected with the AIDS virus and your body has produced antibodies. Researchers have shown that most people with AIDS antibodies have active virus in their bodies. You may therefore assume you are contagious and capable of passing the virus on to others including your baby. A positive result does not mean:

- that you have AIDS or ARC;
- that you will necessarily get AIDS or ARC;
- that you are immune to AIDS.

- D. Not everyone infected with the virus will develop AIDS.
1. The majority of infected people will develop antibodies to the virus yet remain healthy. They will display none of the symptoms of AIDS.
 2. A smaller group of people who also have antibodies will develop some of the symptoms of AIDS. These people are diagnosed as having ARC (AIDS-related condition).
 3. An unknown percentage of infected people will develop AIDS. A diagnosis of AIDS is made only after finding specific life-threatening infections or malignancies that do not normally occur in healthy people.

- E. NOTE ABOUT CONFIDENTIALITY - People taking the test should be aware that there may be some risk associated with letting others know about their test results. While using test results as grounds for discrimination in insurance or employment is prohibited by California law, the burden of proof is on the person discriminated against. There are benefits associated with telling your physician, dentist, and sexual partners. You should ascertain first, however, what they will do with the information and who they will share it with.



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Education and Foster Care of Children Infected with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus

The information and recommendations contained in this document were developed and compiled by CDC in consultation with individuals appointed by their organizations to represent the Conference of State and Territorial Epidemiologists, the Association of State and Territorial Health Officers, the National Association of County Health Officers, the Division of Maternal and Child Health (Health Resources and Services Administration), the National Association for Elementary School Principals, the National Association of State School Nurse Consultants, the National Congress of Parents and Teachers, and the Children's Aid Society. The consultants also included the mother of a child with acquired immunodeficiency syndrome (AIDS), a legal advisor to a state education department, and several pediatricians who are experts in the field of pediatric AIDS. This document is made available to assist state and local health and education departments in developing guidelines for their particular situations and locations.

These recommendations apply to all children known to be infected with human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV). This includes children with AIDS as defined for reporting purposes (Table 1); 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 August 20, 1985, 183 of the 12,599 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.

The 183 AIDS patients reported to CDC represent only the most severe form of HTLV-III/LAV infection, i.e., those children who develop opportunistic infections or malignancies (Table 1). As in adults with HTLV-III/LAV infection, many infected children may have milder illness or may be asymptomatic.

Legal Issues. Among the legal issues to be considered in forming guidelines for the education and foster care of HTLV-III/LAV-infected children are the civil rights aspects of public

HTLV-III/LAV — Continued

TABLE 1. Provisional case definition for acquired immunodeficiency syndrome (AIDS) surveillance of children

For the limited purposes of epidemiologic surveillance, CDC defines a case of pediatric acquired immunodeficiency syndrome (AIDS) as a child who has had:

1. A reliably diagnosed disease at least moderately indicative of underlying cellular immunodeficiency, and
2. No known cause of underlying cellular immunodeficiency or any other reduced resistance reported to be associated with that disease.

The diseases accepted as sufficiently indicative of underlying cellular immunodeficiency are the same as those used in defining AIDS in adults. In the absence of these opportunistic diseases, a histologically confirmed diagnosis of chronic lymphoid interstitial pneumonitis will be considered indicative of AIDS unless test(s) for HTLV-III/LAV are negative. Congenital infections, e.g., toxoplasmosis or herpes simplex virus infection in the first month after birth or cytomegalovirus infection in the first 6 months after birth must be excluded.

Specific conditions that must be excluded in a child are:

1. Primary immunodeficiency diseases—severe combined immunodeficiency, DiGeorge syndrome, Wiskott-Aldrich syndrome, ataxia-telangiectasia, graft versus host disease, neutropenia, neutrophil function abnormality, agammaglobulinemia, or hypogammaglobulinemia with raised IgM.
2. Secondary immunodeficiency associated with immunosuppressive therapy, lymphoreticular malignancy, or starvation.

school attendance, the protections for handicapped children under 20 U.S.C. 1401 et seq. and 29 U.S.C. 794, the confidentiality of a student's school record under state laws and under 20 U.S.C. 1232g, and employee right-to-know statutes for public employees in some states.

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 care or educational setting. School, day-care, and social service 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 and Transmission. 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 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 are 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 parent had AIDS or was a member 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.

HTLV-III/LAV -- Continued

Risk of Transmission in the School, Day-Care or Foster-Care Setting. None of the identified cases of HTLV-III/LAV infection in the United States are known to have been transmitted in the school, day-care, or foster-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 over 12,000 AIDS patients reported to CDC have 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 or 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. The risk of acquiring some infections, such as chickenpox, may be reduced by prompt use of specific immune globulin following a known exposure.

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 are best made using the team approach including the child's physician, public health personnel, the child's parent or guardian, and personnel associated with the proposed care or educational setting. 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. Children infected with HTLV-III/LAV should be cared for and educated in settings that minimize exposure of other children to blood or body fluids.

HTLV-III/LAV -- Continued

4. Care involving exposure to the infected child's body fluids and excrement, such as feeding and diaper changing, should be performed by persons who are aware of the child's HTLV-III/LAV infection and the modes of possible transmission. In any setting 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 gloves should be worn if open lesions are present on the caretaker's hands. Any open lesions on the infected person should also be covered.
5. Because other infections in addition to HTLV-III/LAV can be present in blood or body fluids, all schools and day-care facilities, 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 the disinfectant. Those who are cleaning should avoid exposure of open skin lesions or mucous membranes to the blood or body fluids.
6. The hygienic practices of children with HTLV-III/LAV infection may improve as the child matures. Alternatively, the hygienic practices may deteriorate if the child's condition worsens. Evaluation to assess the need for a restricted environment should be performed regularly.
7. Physicians caring for children born to mothers with AIDS or at increased risk of acquiring HTLV-III/LAV infection should consider testing the children for evidence of HTLV-III/LAV infection for medical reasons. For example, vaccination of infected children with live virus vaccines, such as the measles-mumps-rubella vaccine (MMR), may be hazardous. These children also need to be followed closely for problems with growth and development and given prompt and aggressive therapy for infections and exposure to potentially lethal infections, such as varicella. In the event that an antiviral agent or other therapy for HTLV-III/LAV infection becomes available, these children should be considered for such therapy. Knowledge that a child is infected will allow parents and other caretakers to take precautions when exposed to the blood and body fluids of the child.
8. Adoption and foster-care agencies should consider adding HTLV-III/LAV screening to their routine medical evaluations of children at increased risk of infection before placement in the foster or adoptive home, since these parents must make decisions regarding the medical care of the child and must consider the possible social and psychological effects on their families.
9. Mandatory screening as a condition for school entry is not warranted based on available data.
10. 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 increase (e.g., bleeding injury).
11. All educational and public health departments, regardless of whether HTLV-III/LAV-infected children are involved, are strongly encouraged to inform parents, children, and educators regarding HTLV-III/LAV and its transmission. Such education would greatly assist efforts to provide the best care and education for infected children while minimizing the risk of transmission to others.

HTLV-III/LAV - Continued

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Current Trends

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

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

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

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

Currently available data indicate that most pediatric HTLV-III/LAV infections and AIDS are acquired perinatally from infected women, but additional studies are needed to better quantify the risk of transmission from an infected pregnant woman to the fetus or newborn.

The recommendations below pertain to women. However, men who are HTLV-III/LAV-antibody positive should also be counselled regarding the risks of sexual and perinatal transmission, so they can refer for counselling and testing their sex partners who may be pregnant or considering pregnancy.

BACKGROUND

Pediatric AIDS Cases due to Perinatal Transmission. As of December 1, 1985, 217 (1%) of the 15,172 AIDS cases reported to CDC occurred among children under 13 years of age. Sixty percent of these children are known to have died. These 217 cases represent only the more severe manifestations of HTLV-III/LAV infection. Less severe manifestations, often described as AIDS-related complex (ARC), are not reported to CDC, so the number of children with clinically significant illness attributable to HTLV-III/LAV infection is greater than the reported cases of pediatric AIDS. In addition, a number of infected children are probably asymptomatic.

HTLV-III/LAV — Continued

Of the 217 reported pediatric AIDS patients, 165 (76%) have as their only known factor a mother belonging to a group with increased prevalence of HTLV-III/LAV infection; additional 18% of the pediatric cases are attributable to transfusions of blood or blood products, while risk factor information is missing or incomplete on the remaining 6%. Of the 2 children with AIDS, 48% had mothers who were intravenous (IV) drug abusers; 17% had mothers who were born in Haiti; and 10% had mothers who were sex partners of either drug abusers or bisexual men.

Of the patients with perinatally acquired AIDS, 45% resided in New York City, while Florida and New Jersey accounted for an additional 32%.

Mechanisms of Perinatal Transmission. It is believed that HTLV-III/LAV is transmitted from infected women to their fetuses or offspring during pregnancy, during labor and delivery or perhaps shortly after birth. Transmission of the virus during pregnancy or labor and delivery is demonstrated by two reported AIDS cases occurring in children who had no contact with their infected mothers after birth. One was delivered by Cesarean section (1,2).

Transmission of the virus after birth has been implicated in one case of HTLV-III/LAV infection in a child born to a mother reported to have acquired the infection from a postpartum blood transfusion. Since she breastfed the child for 6 weeks, the authors suggested breastfeeding as the possible mode of transmission (3). Recently, HTLV-III/LAV has been isolated from the breast milk of infected women (4).

Risk of Perinatal Transmission from Infected Mothers. The rate of perinatal transmission of HTLV-III/LAV from infected pregnant women is unknown; however, available data suggest a high rate. In one study of 20 infants born to infected mothers who had already delivered one infant with AIDS, 13 (65%) had serologic and/or clinical evidence of infection with HTLV-III/LAV several months after birth (5,6). Since these women were selected on the basis of having previously transmitted HTLV-III/LAV perinatally, this study may overestimate the average risk of transmission for all infected pregnant women.

Perinatal transmission from an infected mother to her newborn is not inevitable. Of three children born to women who became infected with HTLV-III/LAV by artificial insemination from an infected donor, all were in good health and negative for antibody to the virus more than 1 year after birth (7). Another child, born to a woman who was already pregnant at the time of AIDS diagnosis and was demonstrated to be viremic, was seronegative, culture negative, and healthy at birth and at 4 months of age (8). In a retrospective study evaluating nine children under 5 years of age whose mothers were later diagnosed with AIDS, two (22%) had antibody to HTLV-III/LAV (9). The infection status of these women during pregnancy was unknown.

In these studies, the rate of transmission ranged from 0% (0/3) to 65% (13/20). Additional studies are needed to better define the rate of transmission and variables associated with it.

Risk of Illness among Infected Pregnant Women. Pregnancy is associated with suppression of cell-mediated immunity and increased susceptibility to some infections (10). The T-helper to T-suppressor ratio is decreased during normal pregnancy, being lowest in the third trimester, and returns to normal approximately 3 months postpartum (10). It is not known whether pregnancy increases an infected woman's risk of developing AIDS or ARC, but one study suggests it does (6). Fifteen infected women who were well at time of delivery were followed an average of 30 months after the births of their children. Five (33%) subsequently developed AIDS; seven (47%) developed AIDS-related conditions; and only three (20%) remained asymptomatic. These results may not apply to all infected pregnant women, but they do suggest an increased likelihood of developing disease when an HTLV-III/LAV infection occurs in association with pregnancy.

HTLV-III/LAV — Continued

Prevalence of HTLV-III/LAV Infection. Counselling and testing for antibody to HTLV-III/LAV when indicated, to reduce perinatal transmission of AIDS will be most beneficial in populations of women with increased prevalence of the virus (Table 1). These include: women who have used drugs intravenously for nonmedical purposes; women who were born in countries where heterosexual transmission is thought to play a major role (11, 12); women who have engaged in prostitution, and women who are or have been sex partners of men who abuse IV drugs, are bisexual, have hemophilia, were born in countries where heterosexual transmission is thought to play a major role (11, 12), or have evidence of HTLV-III/LAV infection.

The prevalence of antibody to HTLV-III/LAV in U.S. populations of men and women ranges from less than 0.01% in female blood donors to as high as 74% in men with hemophilia (13-15). Among heterosexual IV drug abusers, the prevalence of HTLV-III/LAV infection ranges from 2% to 59% in various geographic areas (16, 17). Seroprevalence among the heterosexual partners of persons at increased risk for AIDS varies from 10% in female partners of asymptomatic, seropositive hemophilia patients to 71% in the female partners of men with AIDS or ARC (18-20). Among prostitutes, the HTLV-III/LAV antibody prevalence varies from 5% to 40%, depending on geographic area, with most of the women with positive tests relating histories of IV drug abuse (21). Among female blood donors in Atlanta, Georgia, who

TABLE 1. Prevalence of HTLV-III/LAV antibody in heterosexual populations — United States

Populations	Location	No. tested	Prevalence (%)
Intravenous drug abusers (16, 17)	New York City	274	59
	NJ* < 5 miles from NYC†	204	56
	NJ 5-10 miles from NYC	124	43
	NJ > 100 miles from NYC	55	2
	San Francisco	53	9
Persons with hemophilia (13, 14)		234	74
Factor VIII concentrate recipients		36	39
Factor IX concentrate recipients		15	40
Cryoprecipitate only recipients			
Female prostitutes (21)	Seattle, Washington	92	5
	Miami, Florida	25	40
Female sex partners of men with AIDS or ARC (two separate studies) (19, 20)		7	71
		42	47
Female sex partners of men with asymptomatic HTLV-III/LAV infection (18)		21	10
Haitians (12)	New York City	97	4
	Miami, Florida	129	8
Female blood donors (15)	Atlanta, Georgia	28,354	0.01

*New Jersey

†New York City

HTLV-III/LAV — Continued

denied belonging to high-risk groups, 0.01% had repeatedly reactive enzyme-linked immunosorbent assays (ELISAs) followed by reactive Western blot tests (15).

Commercially available tests to detect antibody to HTLV-III/LAV are ELISAs using antigens derived from whole disrupted HTLV-III/LAV. When the ELISA is reactive on initial testing, it is standard procedure to repeat the test on the same specimen. Repeatedly reactive tests are highly sensitive and specific for antibody to HTLV-III/LAV. However, when the ELISA is used to screen populations in which the prevalence of infection is very low (such as blood donors or women not in high-risk groups), the proportion of repeatedly reactive results that are falsely positive will be higher. For that reason, an additional test, such as a Western blot, is recommended following repeatedly reactive ELISA results, especially in low-prevalence populations. In populations with high prevalence of infection (e.g. homosexual men or IV drug abusers), most repeatedly reactive ELISAs are reactive by Western blot or another test. For example, among 109 IV drug abusers whose sera were repeatedly reactive by ELISA, over 85% were reactive by Western blot (22). In contrast, in a low-prevalence population of 69 female blood donors whose sera were repeatedly reactive by ELISA, only 5% were reactive by Western blot (15).

Due to the seriousness of the implications of HTLV-III/LAV-antibody reactivity, it is recommended that repeatedly reactive ELISAs be followed by an additional test, such as the Western blot. Women with sera repeatedly reactive by ELISA and reactive by Western blot should have a thorough medical evaluation. HTLV-III/LAV has been isolated from a single specimen in 67%-95% of persons with specific antibody (23, 24). Because infection has been demonstrated in asymptomatic persons, the presence of specific antibody should be considered presumptive evidence of current infection and infectiousness.

RECOMMENDATIONS

Women Who Should be Offered Counselling and Testing. Counselling services and testing for antibody to HTLV-III/LAV should be offered to pregnant women and women who may become pregnant in the following groups: (1) those who have evidence of HTLV-III/LAV infection; (2) those who have used drugs intravenously for nonmedical purposes; (3) those who were born in countries where heterosexual transmission is thought to play a major role (11, 12); (4) those who have engaged in prostitution; (5) those who are or have been sex partners of: IV drug abusers, bisexual men, men with hemophilia, men who were born in countries where heterosexual transmission is thought to play a major role (11, 12), or men who otherwise have evidence of HTLV-III/LAV infection. If data become available to show that HTLV-III/LAV-antibody prevalence is increased in other groups or settings, counselling and testing programs should be extended to include them. Routine counselling and testing of women who are not included in the above-mentioned groups is not recommended due to low prevalence of infection and concern about interpretation of test results in a low-prevalence population. However if a woman requests it, the service should be provided in accordance with these recommendations.

Settings for Offering Counselling and Testing. Counselling and testing for antibody to HTLV-III/LAV to prevent perinatal transmission is recommended in the setting of any medical service in which women at increased risk are commonly encountered. These include services for treating IV drug abuse (i.e., detoxification and methadone maintenance), comprehensive hemophilia treatment centers, sexually transmitted disease clinics, and clinics that serve female prostitutes. In addition, services related to reproduction, such as family planning and infertility services, gynecologic, premarital, or preconceptual examinations, and prenatal and

HTLV-III/LAV -- Continued

obstetric services should also consider offering counselling and testing if high-risk women are seen at these facilities. Testing for antibody to HTLV-III/LAV should be performed with the woman's consent after counselling is provided regarding risk factors for infection, the interpretation of test results, the risks of transmission, and the possible increased likelihood of disease among women infected with HTLV-III/LAV in association with pregnancy. The counselling and testing must be conducted in an environment in which confidentiality can be assured. In settings where confidential counselling and testing cannot be assured, information should be provided and referrals made to appropriate facilities.

Frequency of Testing. Detectable antibodies to HTLV-III/LAV may not develop until 2-4 months after exposure. This, and whether the woman is continuously exposed, should be taken into account when considering the need for, and frequency of, repeat testing. High-risk women should be offered counselling and testing before they become pregnant. During pregnancy, counselling and testing should be offered as soon as the woman is known to be pregnant. If the initial test is negative, repeat testing may be indicated near delivery to aid in the clinical management of the pregnant woman and newborn. If this final test is negative and the mother's risk of exposure no longer exists, she may safely consider breastfeeding the child, and management of the child need not include the same concerns that would be appropriate if the woman had had a positive test or if she were at high risk and had not been tested at all.

Counselling Women with Positive Results. Women with virologic or serologic evidence of HTLV-III/LAV infection should be counselled regarding their own risk of AIDS and the risk of perinatal and sexual transmission of HTLV-III/LAV. Infected women should be counselled to refer their sex partners for counselling and testing. If the partners of these women are not infected, both members of the couple should be counselled on how they may modify their sexual practices to reduce the risk of HTLV-III/LAV transmission to the uninfected partner. In addition, the couple should be told not to donate blood, organs, or sperm and should be discouraged from using IV drugs and advised against sharing needles and syringes. When seeking medical or dental care for intercurrent illness, they should inform those responsible for their care of their positive antibody status so appropriate evaluation can be undertaken. Recommendations for providing information and advice to individuals infected with HTLV-III/LAV have been published (25).

Infected women should be advised to consider delaying pregnancy until more is known about perinatal transmission of the virus. Pregnant infected women may require additional medical and social support services due to an enhanced risk of opportunistic infections and psychosocial difficulties during and after pregnancy. Obstetric-care providers should be alert to signs and symptoms of HTLV-III/LAV and related opportunistic infections in these pregnant women and to the need for specialized medical care.

HTLV-III/LAV-infected women should be advised against breastfeeding to avoid postnatal transmission to a child who may not yet be infected. The child should receive follow-up pediatric evaluations to determine whether he/she has HTLV-III/LAV infection, and to diagnose and treat promptly any diseases that may be secondary to HTLV-III/LAV infection. Recommendations for educating and providing foster care for infected children have been published (26).

Counselling Women with Negative Test Results. A negative ELISA for HTLV-III/LAV antibody in women who have no clinical or laboratory evidence of HTLV-III/LAV infection is evidence that they have probably not been infected. However, uninfected women who have sex

HTLV-III/LAV -- Continued

partners with evidence of HTLV-III/LAV infection or with an increased risk of becoming infected should be informed that sexual intercourse increases their risk of infection. These women should be informed of the risks associated with pregnancy if they become infected and advised to consider delaying pregnancy until more is known about perinatal transmission of virus or until they are no longer considered to be at risk for acquiring the virus. In addition, preventing pregnancy, the consistent and proper use of condoms can offer some protection against HTLV-III/LAV infection.

High-risk women, even if seronegative, should be told not to donate blood or organs, decrease their risk of becoming infected, IV drug abusers should be encouraged to seek treatment for their drug abuse. Persons counselling IV drug abusers should know that IV drug abuse is often strongly ingrained and compulsive. Despite educational efforts and encouragement for treatment, some addicts will continue to abuse drugs or relapse after treatment. If drug abuse continues, they should be advised not to share needles or syringes and to use only sterile equipment.

HTLV-III/LAV - Continued

Additional Considerations. These recommendations will be revised as additional information becomes available. It is recognized that provision of the recommended professional counselling, HTLV-III/LAV-antibody testing and associated specialized medical services will take time to implement and may stress available resources, particularly in public facilities, which are most greatly affected. Health-care providers, social-service personnel, and others involved in educating and caring for HTLV-III/LAV-infected persons should be aware of the potential for social isolation and should be sensitive to the need for confidentiality. They should be familiar with federal and state laws, regulations, and policies that protect the confidentiality of clinical data and test results. Each institution should assure that specific mechanisms are in place to protect the confidentiality of all records and to prevent the misuse of information. Anonymous testing would not be appropriate if it prevents adequate counselling and medical follow-up evaluation.

Hospital precautions for managing infected women and infants should be patterned after those for caring for patients with HTLV-III/LAV infection (27,28). Additional recommendations will follow.

DEVELOPMENT OF THESE RECOMMENDATIONS

The information and recommendations contained in this document were developed and compiled by CDC and the U.S. Public Health Service in consultation with individuals representing the Conference of State and Territorial Epidemiologists, the Association of State and Territorial Health Officials, the American Public Health Association, the United States Conference of Local Health Officers, the American Medical Association, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the Planned Parenthood Federation of America, the American Venereal Disease Association, the Division of Maternal and Child Health of the Health Resources and Services Administration, the National Institute on Drug Abuse of the Alcohol, Drug Abuse, and Mental Health Administration, the National Hemophilia Foundation, the Haitian Medical Association, the American Bar Foundation, and the Kennedy Institute of Ethics at Georgetown University. The consultants also included representatives of the departments of health of the areas with the largest number of perinatally transmitted pediatric AIDS cases: New York City, Florida, and New Jersey. These recommendations may not reflect the views of all individual consultants or the organizations they represented.

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CHAPTER 22

An act to add Chapter 1.11 (commencing with Section 199.20) to Part 1 of Division 1 of the Health and Safety Code, relating to health, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor April 3, 1985. Filed with Secretary of State April 4, 1985.]

LEGISLATIVE COUNSEL'S DIGEST

AB 403, Agnos. Health.

(1) Existing law provides that the results of specified blood tests shall be confidential and not open to public inspection.

This bill, in addition to existing law, would provide that no person shall be compelled, as specified, to identify any individual who is the subject of a blood test to detect antibodies to the probable causative agent of acquired immune deficiency syndrome. The bill would provide penalties for disclosure, as defined, of the results of the blood test, as defined, except as specified, including the assessing of civil penalties and the creation of a new misdemeanor. It would establish a right of action for actual damages. Creation of a new misdemeanor constitutes a state-mandated local program.

This bill would permit the State Department of Health Services to require blood banks and plasma centers to submit reports summarizing data concerning tests to detect the presence of viral hepatitis and antibodies to the probable causative agent of AIDS, as specified.

It would prohibit a person, except as specified, from testing a person's blood for evidence of antibodies to the probable causative agent of AIDS without the written consent of the subject.

This bill would prescribe that the results of the blood test not be used in any instance for the determination of insurability or suitability for employment.

It would also prescribe that neither the state department nor any blood bank or plasma center, including a blood bank or plasma center operated by a public entity, be liable for any damages resulting from a specified notification of test results.

(2) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates which do not exceed \$500,000 statewide and other procedures for claims whose statewide costs exceed \$500,000.

This bill would provide that no reimbursement shall be made from the State Mandates Claims Fund for costs mandated by the state

pursuant to this act, but would recognize that local agencies and school districts may pursue any available remedies to seek reimbursement for some of these costs.

This bill would provide that, notwithstanding Section 2231.5 of the Revenue and Taxation Code, this bill does not contain a repealer, as required by that section; therefore, the provisions of the bill would remain in effect unless and until they are amended or repealed by a later enacted bill.

The bill would take effect immediately as an urgency statute.

The people of the State of California do enact as follows:

SECTION 1. Chapter 1.11 (commencing with Section 199.20) is added to Part 1 of Division 1 of the Health and Safety Code, to read:

CHAPTER 1.11. MANDATED BLOOD TESTING AND
CONFIDENTIALITY TO PROTECT PUBLIC HEALTH

199.20. To protect the privacy of individuals who are the subject of blood testing for antibodies to the probable causative agent of acquired immune deficiency syndrome (AIDS) the following shall apply:

Except as provided in Section 1603.1 or 1603.3, as amended by AB 488 of the 1985-86 Regular Session, no person shall be compelled in any state, county, city, or other local civil, criminal, administrative, legislative, or other proceedings to identify or provide identifying characteristics which would identify any individual who is the subject of a blood test to detect antibodies to the probable causative agent of AIDS.

199.21. (a) Any person who negligently discloses results of a blood test to detect antibodies to the probable causative agent of acquired immune deficiency syndrome to any third party, except pursuant to a written authorization, as described in subdivision (g), or except as provided in Section 1603.1 or 1603.3, as amended by AB 488 of the 1985-86 Regular Session, shall be assessed a civil penalty in an amount not to exceed one thousand dollars (\$1,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(b) Any person who willfully discloses the results of a blood test to detect antibodies to the probable causative agent of the acquired immune deficiency syndrome, to any third party, except pursuant to a written authorization, as described in subdivision (g), or except as provided in Section 1603.1 or 1603.3, as amended by AB 488 of the 1985-86 Regular Session, shall be assessed a civil penalty in an amount not less than one thousand dollars (\$1,000) and not more than five thousand dollars (\$5,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(c) Any person who willfully or negligently discloses the results of

a blood test to detect antibodies to the probable causative agent of acquired immune deficiency syndrome to a third party, except pursuant to a written authorization, as described in subdivision (g), or except as provided in Section 1603.1 or 1603.3, as amended by AB 488 of the 1985-86 Regular Session, which results in economic, bodily, or psychological harm to the subject of the test, is guilty of a misdemeanor, punishable by imprisonment in the county jail for a period not to exceed one year or a fine of not to exceed ten thousand dollars (\$10,000) or both.

(d) Any person who commits any act described in subdivision (a) or (b) shall be liable to the subject for all actual damages, including damages for economic, bodily, or psychological harm which is a proximate cause of the act.

(e) Each disclosure made in violation of this chapter is a separate actionable offense.

(f) The results of a blood test to detect antibodies to the probable causative agent of acquired immune deficiency syndrome shall not be used in any instance for the determination of insurability or suitability for employment.

(g) "Written authorization," as used in this section, applies only to the disclosure of test results by a person responsible for the care and treatment of the person subject to the test. Written authorization is required for each separate disclosure of the test results, and shall include to whom the disclosure would be made.

(h) Nothing in this section limits or expands the right of an injured subject to recover damages under any other applicable law.

(i) Nothing in this section shall be construed to impose liability or criminal sanction for disclosure of a blood test to detect antibodies to the probable causative agent of AIDS in accordance with any reporting requirement for a diagnosed case of AIDS by the state department or the Centers for Disease Control under the United States Public Health Services.

(j) The state department may require blood banks and plasma centers to submit monthly reports summarizing statistical data concerning the results of tests to detect the presence of viral hepatitis and antibodies to the probable causative agent of AIDS. This statistical summary shall not include the identity of individual donors or identifying characteristics which would identify individual donors.

(k) "Disclosed," as used in this section, means to disclose, release, transfer, disseminate, or otherwise communicate all or any part of any record orally, in writing, or by electronic means to any person or entity.

(l) "Results of a blood test," as used in this section, means to identify or provide identifying characteristics of the person to whom the results apply.

199.22. No person shall test a person's blood for evidence of antibodies to the probable causative agent of AIDS without the written consent of the subject of the test, and the person giving the

test shall have a written statement signed by the subject confirming that he or she obtained the consent from the subject.

This requirement does not apply to a test performed at an alternative site, as established pursuant to Article 8 (commencing with Section 1630) of Chapter 4 of Division 2. This requirement also does not apply to any blood and blood products specified in paragraph (2) of subdivision (a) of Section 1603.1, as amended by Assembly Bill 488 of the 1985-86 Regular Session.

199.23. Neither the state department nor any blood bank or plasma center, including a blood bank or plasma center owned or operated by a public entity, shall be held liable for any damages resulting from the notification of test results, as set forth in paragraph (3) of subdivision (a) of, and in subdivision (c) of, Section 1603.3, as amended by AB 488 of the 1985-86 Regular Session.

SEC. 2. (a) No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because part of the costs which may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, changes the definition of a crime or infraction, changes the penalty for a crime or infraction, or eliminates a crime or infraction.

(b) No reimbursement shall be made from the State Mandates Claims Fund pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code for costs mandated by the state pursuant to this act. It is recognized, however, that a local agency or school district may pursue any remedies to obtain reimbursement available to it under Part 7 (commencing with Section 17500) and any other provisions of law.

SEC. 3. Notwithstanding Section 2231.5 of the Revenue and Taxation Code, this act does not contain a repealer, as required by that section; therefore, the provisions of this act shall remain in effect unless and until they are amended or repealed by a later enacted act.

SEC. 4. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to protect the confidentiality of persons undergoing a blood test for the detection of antibodies to acquired immune deficiency syndrome, and to encourage individuals who are stricken with the disease to undergo treatment which would ultimately benefit the health and welfare of all citizens of the State of California, it is necessary that this act take immediate effect.

CITY AND COUNTY OF SAN FRANCISCO
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BUREAU OF COMMUNICABLE DISEASE CONTROL
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