

A STUDY OF
ISSUES OF ACQUIRED IMMUNODEFICIENCY SYNDROME
HPELS 6010

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CHAPTER I

ACQUIRED IMMUNE DEFICIENCY SYNDROME

BACKGROUND

In 1981 an epidemic of a severe form of acquired immune deficiency, now known as acquired immunodeficiency syndrome (AIDS), began in homosexual men and intravenous drug abusers in New York City, San Francisco and Los Angeles.⁸ Since that time, states Martha Rogers, M.D., over 7000 cases from 45 states and 32 foreign countries had been reported to the Center for Disease Control. The disease affects primarily the cellular immune system and in its severe form results in repeated opportunistic infections and malignancies.

By April 27, 1987, 634 cases of AIDS in children and adolescents had been reported to CDC.⁷ Children with AIDS present a number of difficult problems to educators regarding diagnosis, management and psychosocial problems. Therefore the basic purpose of this paper is to review some of these issues.

DEFINITION

AIDS (Acquired Immune Deficiency Syndrome) is a devastating, fatal disease that destroys some of the immune system's key white blood cells, thereby crippling an individual's ability to fight off life-threatening infections and diseases such as pneumonia, tuberculosis and certain types

of cancer. It can also attack the nervous system, eventually causing permanent neurological damage. The first case of AIDS in the United States was reported in 1981.

The virus that causes AIDS was identified in 1983, and is referred to by any of the three acronyms, LAV (Lymphadenopathy Associated Virus), HTLV-III (Human T-Lymphotropic Virus Type III) and HIV (Human Immunodeficiency Virus) or simply as the AIDS virus. It is estimated that three to eight percent of persons infected with the virus develop full-blown AIDS; fifteen to thirty percent develop a related but rarely fatal syndrome called ARC (called AIDS Related Complex). It is emphasized, however, that anyone infected with the AIDS virus is capable of transmitting it to another person.

When an individual becomes infected with the AIDS virus, the virus multiplies in certain T-lymphocytes, the white blood cells that help fight off infection, and destroys them. It may enter other types of cells as well. Some individuals become ill within weeks after an AIDS-virus infection; others only after five or more years.

The CDC describes those that slip into a chronic debilitating condition called ARC experience symptoms that include loss of appetite and weight, fever, "night sweats," skin rashes, swollen glands, diarrhea, fatigue and decreased resistance to infection.

The most common initial symptoms of AIDS are a dry cough, shortness of breath, weight loss and oral candidiasis or thrush (a fungal mouth infection characterized by white patches). A disease commonly associated with AIDS is Kaposi's sarcoma, in which a cancer or tumor of the blood or lymph system causes purplish skin lesions of the body. Sometimes the AIDS virus enters the brain tissue where it may cause devastating emotional and behavioral changes.⁴

CASE DEFINITION

A report by CDC In 1984 gives a case definition for AIDS developed before the discovery of the etiology of AIDS based on clinical signs and symptoms.⁶ A case is defined as a child diagnosed as having an opportunistic infection or malignancy indicating an underlying cellular immunodeficiency. Other causes of immunodeficiency such as congenital immunodeficiencies, congenital infections, medications, lymphoreticular malignancy and starvation must be ruled out. Because this definition requires the presence of an opportunistic infection or malignancy, the cases of AIDS retrovirus infection reported to CDC are the most severe. CDC further explains less severe forms of the illness which occur. Symptoms associated with AIDS such as generalized lymphadenopathy, chronic diarrhea, weight loss or failure to thrive, recurrent infections, persistent oral candidiasis, interstitial pneumonitis and hepatosplenomegaly have

occurred in patients belonging to high risk groups. This constellation symptoms has been called AIDS-related complex and has been used to describe patients in high risk groups who have symptoms that are associated with AIDS but who have not developed an opportunistic infection or malignancy. Since development of the serologic tests for measuring antibody to the AIDS virus, antibody to HTLV III/LAV has been found in patients with AIDS-related complex and asymptomatic members of high risk groups.⁶ HTLV III/LAV has been isolated from these asymptomatic seropositive persons suggesting that a chronic carrier state can exist. In a recently reported study, virus was also isolated from four persons who were seronegative. Long-term follow-up of these individuals have been planned to clarify the relationship between antigen and antibody production and clinical symptoms.²⁰

DEFINITION OF TERMS²⁶

Agammaglobulinemia: An immunological deficiency state characterized by an extremely low level of generally all classes of gamma globulin in the blood, resulting in heightened susceptibility to those infectious diseases vulnerable to immunoglobulin-associated defense mechanisms.

Atasia-telangiectasia: Severe progressive cerebellar ataxia, associated with oculocutaneous telangiectasia, sino-pulmonary disease with frequent respiratory infections

and abnormal eye movement, a.k.a., Louis Bare Syndrome.

Concanavalin: Substance which agglutinate the blood of mammals.

DiGeorge Syndrome: Congenital syndrome in which absence of the thymus and parathyroids due to defective development of the 3rd and 4th embryonic pharyngeal pouches is associated with impairment of cell-mediated immunity and normal levels of immunoglobulins.

Hypogammaglobulinemia: a.k.a., agammaglobulinemia.

Immunoglobulins: Active antibodies, synthesized by lymphocytes and plasma cells, responsible for humoral aspects of immunity.

Neutropenia: Decrease in the number of neutophilic leukocytes susceptibility to infection, occasionally anemia and thrombocytopenia and hypercellular bone marrow.

Phytohemagglutinin: A hemagglutinin of plant origin. (Hemagglutin: agglutination of erythrocytes).

Recombinant DNA: DNA that has been artificially introduced into a cell so that it alters the genotype and phenotype of the cell and is replicated along with natural DNA.

Thrombocytopenia: Decrease in the number of platelets. Therefore, decreases the clotting time since the platelets function is chiefly in blood coagulation.

Wiskott-Aldrich Syndrome: A condition characterized by chronic exzema, chronic suppurative otitis media, anemia,

and thrombocytopenic purpura; transmitted as a sex-linked recessive trait called also Aldrich's syndrome.

ETIOLOGY

Recent evidence strongly suggests a retrovirus as the cause of AIDS. Two prototype viruses were initially identified independently by investigators at the Institut Pasteur in France and at the National Cancer Institute in the United States.¹⁰ Evidence indicates that these two viruses are the same.

In 1983 investigators at the Institut Pasteur in Paris isolated a retrovirus from a homosexual man with lymphadenopathy syndrome, a syndrome thought to be a mild form or precursor to AIDS.² This virus, morphologically different from the known human retroviruses was termed the lymphadenopathy associated virus (LAV). This virus was subsequently isolated from other AIDS Patients, including one patient with transfusion-associated AIDS and one of the donors of the transfused blood.⁹ A seroepidemiologic study showed that antibody to this virus was present in more than 70% of patients with AIDS or with symptoms strongly suggestive of AIDS, in only 1% of healthy blood donors and in none of their patients with congenital immunodeficiencies.¹³

In 1984, investigators at the National Institutes of Health, United States, isolated a retrovirus, termed the human T-lymphotrophic retrovirus, type III (HTLV III), from

a number of patients with AIDS, from patients with symptoms strongly suggestive of AIDS and from asymptomatic homosexual men.¹⁰ The virus was not isolated from healthy heterosexual subjects. A seroepidemiologic study found antibody to the retrovirus in similar populations.²¹

Retroviruses are RNA viruses which contain an enzyme, reverse transcriptase, that transcribes DNA from RNA, a process used in the replication of these viruses. Although retroviruses infect many animal species, only two other human retroviruses are known: (1) human T cell leukemia/lymphoma virus (HTLV) type I which has been isolated from patients with malignancies of the thymus-derived lymphocytes¹⁸ and (2) HTLV type II which has been isolated from a patient with a T cell variant of hairy cell leukemia.¹⁹

The AIDS retrovirus, like other human retroviruses, primarily infects the lymphocytes derived from the thymus (T lymphocytes), which are responsible for cellular immunity. The AIDS virus preferentially infects the subset of T lymphocytes known as helper T lymphocytes which augment the immune response. The subset of T lymphocytes which suppresses the immune response, the suppressor T lymphocytes is relatively spared and outnumbers the helper T cells. The bone marrow-derived lymphocytes (B lymphocytes), which are responsible for antibody production, are also relatively spared.⁸

EPIDEMIOLOGY

In adults and adolescents over 95% of cases have occurred in persons belonging to four high risk groups: Group 1, homosexual or bisexual men; Group 2, intravenous drug abusers; Group 3, hemophiliacs; and Group 4, the sexual partners of infected persons. This epidemiologic evidence indicated that, in adults and adolescents, AIDS is transmitted through sexual contact (both heter- and homosexual contact) or through parenteral (intravenous) exposures such as the sharing of needles used for injecting illicit drugs or through blood transfusions.

There are two risk factors in children that are primarily associated with infection: (1) receiving blood or blood products; and (2) birth to a mother who has AIDS, is a member of a high risk group or is a sexual partner of a member of a high risk group.

The route of transmission in those children born to high risk parents is unknown, but the retrovirus may be acquired in utero, from infective maternal blood at the time of birth or postnatally. Data from cases reported to CDC suggest that children born to high risk parents may acquire infection in utero. The median time interval between birth and onset of symptoms in children of high risk parents is four months. This is shorter than the median time interval

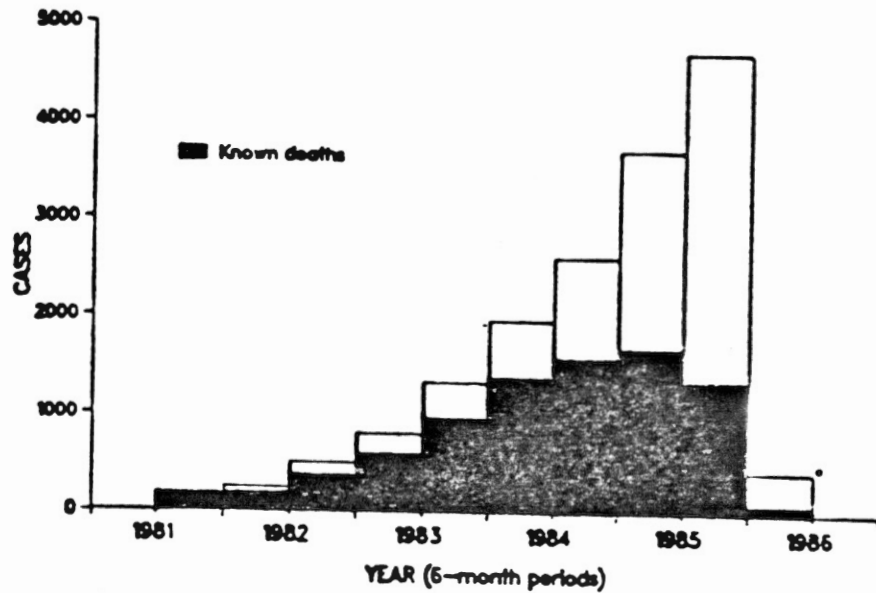
of transfusion-associated illness in which the time between transfusion and onset of symptoms is eight months.

Postnatal transmission, through infected breast milk or close contact between the mother and baby, could theoretically occur. However, none of the 7408 cases reported to the CDC as of December 13, 1984, has occurred in individuals who were household contacts (nonsexual) of other AIDS patients, suggesting that transmission through casual person-to-person contact, if it occurs, is rare. All the patients reported to CDC with no identifiable risk of exposure deny contact with a known AIDS patient. Breast milk from infected mothers has not been cultured.⁵

INCUBATION PERIOD

Based upon a report by Dr. David Sencer the incubation period (the time between becoming infected and actually developing signs of a disease) for AIDS can be quite long. In some cases, people have developed AIDS five or more years after they were thought to have been infected. Fortunately, it appears that only a minority of those infected develop symptoms, and only a fraction of these go on to develop AIDS. Of those who develop AIDS, most die from their disease within two years. Although some have survived for as long as five years, it is too early to say if these people will become ill again. There is at present, no cure for AIDS, although most of the infections associated with the disease can be treated.²⁵

FIGURE 1. Acquired immunodeficiency syndrome cases and known deaths, by 6-month period of report to CDC — United States, through January 13, 1986



*Data incomplete

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES / PUBLIC HEALTH SERVICE

TABLE 1. Acquired immunodeficiency syndrome cases, by date of report and doubling time — United States, through January 13, 1986

Cumulative cases reported	Date	Doubling time (months)
129	September 1981	—
257	February 1982	5
514	July 1982	5
1,029	January 1983	6
2,057	August 1983	7
4,115	April 1984	8
8,229	February 1985	10
16,458	January 1986	11

DIAGNOSTIC CHARACTERISTICS

AIDS must be differentiated from other causes of immune deficiency such as treatment with immuno-suppressive drugs, congenital immunodeficiencies, congenital infections and starvation. A careful history and physical examination should rule out immunodeficiency secondary to recent oral or parenteral use of steroids or cytotoxic agents and starvation. Malignancies that are associated with immunodeficiency, particularly lymphomas, must be considered. Congenital infections and immunodeficiencies may be more difficult to differentiate.

Cellular immunodeficiency can be associated with some congenital infections, such as cytomegalovirus infection or rubella. However, this immunodeficiency is temporary and is usually less severe than that associated with AIDS. Unlike most congenital infections, symptoms associated with AIDS do not usually occur in the neonatal period, and developmental defects such as cardiac abnormalities have not been reported in children with AIDS. Infants with AIDS can acquire infections such as cytomegalovirus and toxoplasmosis as a result of AIDS, but acquisition is usually not in the neonatal period, and these infections are generally much more severe than acquired infection in the immunocompetent child.

Congenital immunodeficiencies to be considered include severe combined immunodeficiency, DiGeorge syndrome, Wiskott Aldrich syndrome, ataxia-telangiectasia, graft versus host disease, neutropenia, neutrophil function abnormality, agammaglobulinemia and hypogammaglobulinemia with elevated IgM. Unlike patients with severe combined immunodeficiency and immunoglobulin deficiencies, patients with AIDS usually have markedly elevated immunoglobulins. Unlike children with DiGeorge syndrome, children with AIDS have normal facies and do not have hypocalcemic tetany. Although thrombocytopenia may be seen in children with AIDS, bleeding episodes do not usually occur as with Wiskott-Aldrich syndrome. Wiskott-Aldrich syndrome, an X-linked recessive disease, occurs almost exclusively in boys, whereas about 40% of children with AIDS are girls. AIDS may be differentiated from neutrophil disorders by its primary effect on lymphocytes rather than on granulocytes. Ataxia is not a common feature of AIDS.²⁴

TREATMENT

Although some therapies have resulted in temporary improvement and prolonged survival, to date no effective therapy for AIDS exists. Intravenous gammaglobulin is being used in some centers with variable success in preventing recurrent episodes of sepsis and meningitis.¹⁸ Bone marrow transplantation and lymphocyte transfusion have resulted in

partial immunologic reconstitution in some cases, but without clinical improvement.²⁴ Recombinant alpha-2-interferon therapy has been reported to reduce the size of the lesions of Kaposi's sarcoma in some cases but did not produce change in immunologic characteristics.¹¹ Suramin, an inhibitor of reverse transcriptase in vitro,¹⁵ and ribavirin, a reported suppressor of replication of LAV in culture, are being assessed.¹⁶ Early diagnosis and treatment of opportunistic infections and malignancies associated with AIDS may prolong survival. Careful attention to the nutritional and the emotional needs of patients and their families is helpful.¹⁸

PROGNOSIS

The prognosis for HTLV III/LAV infected patients who develop opportunistic infections or malignancies is poor. Of the 7408 patients reported to the CDC since the epidemic began, over 40% have died. Of those patients diagnosed prior to 1983, over 80% have died. Of the 103 children age 18 years or younger with outcome reported to the CDC, 65% have died. Although the long-term prognosis of infection with HTLV III/LAV has not been determined, a few longitudinal studies of high risk patients with symptoms of AIDS but without opportunistic infections have revealed that as many as 20% develop AIDS within three years of onset of symptoms¹⁴ and up to 50% of adult patients with oral candidiasis

develop AIDS.¹¹ Similar longitudinal studies in children have not been reported.¹⁸

OCCURRENCE

Of the 7408 cases of AIDS reported to CDC as of December 1984, 107 (1.4%) were in children and adolescents 18 years of age or younger. The number of cases of AIDS in the pediatric population has been steadily increasing since diagnosis in 1979 of the earliest case reported to CDC. The apparent decrease in cases reported in the latter half of 1984 probably reflects the lag time between diagnosis and receipt of case reports.

Of the 107 children, 71 (66%) had P.carinii pneumonia, 5 (5%) had Kaposi's sarcoma, 2 (2%) had both and, 29 (27%) had some other opportunistic infection. There were 1.6 times as many cases in males (66) as in females (41). A greater proportion of cases occurred in black (54%) and Hispanics (19%) than in whites (27%). The 107 cases were reported from 18 states and Puerto Rico with 79% residing in New York, New Jersey, Florida or California.

The majority of pediatric patients with AIDS were preschool-aged children. Of the 107 children and adolescents with AIDS, 84 (79%) were younger than six years of age at the time of diagnosis of AIDS. All of these children, in whom investigations have been completed, acquired AIDS either from a blood transfusion (12 children) or because

they were born to a mother who had AIDS, was a member of a high risk group or was a sexual partner of someone in a high risk group (60 children).⁷

PREVENTION

Since a large proportion of children with AIDS acquire the disease through exposure to their parents, prevention of AIDS in adults would be expected to prevent cases in children as well. Behavior modification in adults and adolescents such as reduction of the number of sexual partners, especially those in high risk groups, participation in drug rehabilitation programs and avoiding the use of nonsterile needles may help reduce cases.

Prevention of congenital cases through birth control and abortion are also important; however, the risk of AIDS in infants born to infected mothers is unknown. In 11 mothers who had already delivered one child with AIDS, 12 subsequent pregnancies produced four affected infants, suggesting that the risk of transmission of the agent is a continuing one and that each pregnancy may be at high risk for infection. Infected mothers are often asymptomatic before and during the pregnancy and at the time of birth, making any intervention such as avoidance of pregnancy or abortion impossible.²³

CHAPTER II

SCHOOL MANAGEMENT AND RESPONSIBILITY

Considerable concern about how children with AIDS should be educated has stimulated questions regarding exposure of teachers and children to potentially infectious body fluids from infected children in the school setting. The best answer I think was the message emphasized repeatedly at an AIDS conference (National School Board Association), that the risk of becoming infected with AIDS virus is not greater in school than anywhere else. Schools can plan an important role in reducing fear and helping prevent the spread of this viral disease by educating students and parents about how AIDS is transmitted.¹⁵

PLACEMENT

In the event that a school-age child is known to be infected with HIV, a team should be developed on an individual basis to determine advisability of school admission and need for any special precautions. Most of my readings suggest that this team should include the student's physician and parents, public health and school personnel. Confidentiality should remain an important priority.

The remote risks of transmission in an educational setting are far less than the significant risks of general screening and misidentification of children as a result of

false positive serological tests in a low incidence population. Serological testing is recommended only for children in high-risk groups (mother with HIV infection, hemophilia, sexual contact of individuals with HIV infection, intravenous drug abuser).

It is further suggested that a child with HIV infection who has uncontrolled behavior primarily as manifested by biting, poses a theoretical risk to other children, even though transmission by biting has not been documented.

Any child, including one with HIV, with uncoverable open sores should remain out of school until the sores heal or can be adequately covered.

Employees should be instructed in risks of transmission of HIV as well as other infectious agents. They should use appropriate decontamination measures routinely, including dilute hypochlorite solutions to clean environmental surfaces and proper handwashing techniques.

There are theoretical risks of transmission of HIV infection by intense contact sports in which bleeding is common or by shared use of band instruments. It is stressed that no data exist to support such a mode of transmission, therefore it is felt to be a remote risk. It would be prudent to counsel a known HIV-infected student to abstain from such sports or from sharing band instruments. Band instructors should be instructed in proper decontamination

procedures which should be used routinely if band instruments are shared.

Children with HIV-induced immunosuppression are at increased risk of severe complications from a number of infectious diseases (Chickenpox, Tuberculosis, Measles, etc.) and from live vaccines. The risks to the child of exposure to other children should be periodically reassessed in determining appropriateness of school attendance; they should not be required to receive live vaccines as a condition of school attendance.

PHYSICAL PROTECTION

Reported by a panel of AIDS experts at a recent conference sponsored by the National School Boards Association and N.S.B.A. Council of School Attorneys, legal as well as medical issues surround the disease AIDS. The decision whether to exclude a student with AIDS or AIDS antibodies should be determined by the proper medical authorities, said Gwendolyn Gregory, deputy general counsel. As long as school officials rely on appropriate medical opinions about whether a child is infectious in a classroom setting, they might avoid legal liability.³

Although some states have classified AIDS as a communicable disease, the relevant legal issue concerning AIDS is whether it's classified as communicable in the classroom. Because no evidence suggests that the virus can be

transmitted through casual contact, excluding students with AIDS on the basis of state communicable disease laws would be unwarranted.

CONFIDENTIALITY

A physician's unauthorized disclosure of information given him by a patient in the course of a professional relationship may result in both professional and legal sanctions. A hospital has a duty to release a patient's privileged information only to the patient, the patient's authorized representative, the attending physician, and hospital staff members with a legitimate interest. Hospital personnel departments should review the hospital's disciplinary rules to make sure that they adequately protect the privacy rights of AIDS patients. These disciplinary rules should be distributed to new employees in a systematic fashion and should remind current employees of the current rules regarding confidentiality. However, the existence of these rules will not provide you with legal protection if they are not enforced.¹

LEGAL ASPECTS

Okla. Stat. 2503 State the Physician and Psychotherapist/Patient Privilege. (4.A) A communication is confidential if not intended to be disclosed to third persons,...

Okla. Stat. 503 Suspension or revocation of license for unprofessional conduct...

Okla. Stat. 509 Unprofessional conduct. 509-4
Willfully betraying a professional secret to the detriment
of the patient...

Okla. Stat. 1-1709 Information concerning condition
and treatment of patients - Restrictions - Exemptions from
liability - Review committees...

Assembly Bill No. 403 Existing law provides that the
results of specified blood tests shall be confidential...

Assembly Bill No. 488 Ref. to Blood banks and plasma
centers... (Appendix)

ENVIRONMENTAL PROTECTION

Elaine Brainerd suggested the following guidelines to
provide simple and effective precautions against transmis-
sion of disease for all people potentially exposed to the
blood or body fluids of any student. No distinction is made
between body fluids from students with a known disease or
those from students without symptoms or with an undiagnosed
disease.

To Avoid Contact with Body Fluids

Whenever possible, avoid direct contact with body
fluids. Gloves are recommended. Gloves used for this
purpose should be put in a plastic bag or lined trash can,
secured and disposed of daily.

Direct Skin Contact

In the instance an un-anticipated skin contact with body fluids may occur and gloves are not immediately available (for example, when wiping a runny nose, applying pressure to a bleeding injury outside the classroom). Hands and other affected skin areas of all exposed persons should be routinely washed with soap and water.

Handwashing Procedures

Proper handwashing requires the use of soap and water and vigorous washing under a stream of running water for approximately 10 seconds. Soap suspends easily removable soil microorganisms, allowing them to be washed off.

Disinfectants

An intermediate-level disinfectant should be used to clean surfaces contaminated with body fluids. Bleach (hypochlorite solution) is preferred for objects that may be put in the mouth. A 1:10 solution of sodium hypochlorite solution will need to be freshly prepared each day to be used for clean-up of body fluids.

Care of Equipment

Mops should be soaked in disinfectant after use and rinsed thoroughly and washed in a hot water cycle before rinsing. Disposable cleaning equipment should be placed in a plastic bag, sealed and disposed of appropriately.³

CHAPTER III

SUMMARY

AIDS has invaded the human population of the twentieth century with a devastating impact that is second to none. The recognition and diagnosis of AIDS have aroused the concerns of more people about health care and wellness than ever before. This elevated level of suspicion by health care providers will ensure the diagnosis, reporting and monitoring of the incidence of communicable diseases, especially AIDS and encourage a consistent surveillance of new risk groups for epidemiological concerns.

A search of literature has defined AIDS as a life-threatening disease that damages the immune system of usually normal, healthy individuals; leaving the body defenseless to protect itself from communicable diseases. AIDS is non-selective to any socioeconomic group. Any person who is exposed to body fluid and/or blood of a person infected with AIDS is at risk of becoming infected with AIDS also, unless precaution is maintained to prevent it.

Reported high risk individuals are children who have many social problems in addition to the ones associated with AIDS. Children with hemophilia may require transfusions that could have been contaminated with the AIDS virus. Teenagers, men and women may have contacted AIDS through

homosexual or heterosexual relationships or through the use of intravenous drug paraphernalia.

The possibility of a student transmitting the AIDS virus through casual contact in a school setting is remote according to research. Available research reports that the majority of schools across the nation are without restriction in permitting their students with AIDS to attend regular classes. However, if a student is prone to biting or other such behavior, incontinence, drooling, etc, a more restrictive environment was suggested to minimize the exposure of other students to body fluids at least until research can be more definitive.

It is the duty of the employer to inform the employee of diagnosis of a student in his/her charge. It is also an obligation to caution the employee of the responsibility to maintain confidentiality.

Health education will be the most significant avenue to alleviate the fears of students and the public and to prevent the spread of Acquired Immunodeficiency Disease Syndrome.

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APPENDIX

Enrolled House Bill No. 1476

Bill 2503 - Civil Procedure

Bill 503 - Profession and Occupation

Bill 509 - Profession and Occupation

Bill 1709 - Public Health Code

Assembly Bill 403 - Mandatory Blood Testing

Assembly Bill 488 - AIDS - Blood Banks and Plasma Centers

United States AIDS - Monthly Report

Oklahoma AIDS - Monthly Report

ENROLLED HOUSE
BILL NO. 1476

BY: WHITE, HAMILTON (Jeff),
BASTIN, DAVIS (Guy),
HUTCHCROFT, LARASON,
LASSITER, LITTLEFIELD,
THOMPSON, WILLIAMS
(Freddie), HOBSON,
SNIDER, LEWIS, HARRIS
(Robert), GLENN, MORGAN
(Jim), HOLT, VANATTA,
ROSS, ANDERSON and
STOTTLEMYRE of the HOUSE

and

STIPE, HERBERT, TAYLOR,
BROWN, CAIN, HANEY,
HORNOR, RIGGS and
DICKERSON of the SENATE

AN ACT RELATING TO EDUCATION; MANDATING AIDS
PREVENTION EDUCATION FOR STUDENTS; PROVIDING
PROCEDURES AND REQUIREMENTS FOR SUCH EDUCATION;
PROVIDING FOR CODIFICATION; PROVIDING AN OPERATIVE
DATE; AND DECLARING AN EMERGENCY.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 11-103.3 of Title 70, unless there is created a duplication in numbering, reads as follows:

A. Acquired immune deficiency syndrome (AIDS) prevention education shall be taught in the public schools of this state. AIDS prevention education shall be limited to the discussion of the disease AIDS and its spread and prevention. Students shall receive such education:

1. at the option of the local school district, a minimum of once during the period from grade five through grade six;
2. a minimum of once during the period from grade seven through grade nine; and
3. a minimum of once during the period from grade ten through grade twelve.

B. The State Department of Education shall develop curriculum and materials for AIDS prevention education in conjunction with the State Department of Health. A school district may also develop its own AIDS prevention education curriculum and materials. Any curriculum and materials developed for use in the public schools shall be approved for medical accuracy by the State Department of Health. A school district may use any curriculum and materials which have been developed and approved pursuant to this subsection.

C. School districts shall make the curriculum and materials that will be used to teach AIDS prevention education available for inspection by the parents and guardians of the students that will be involved with the curriculum and materials. Furthermore, the curriculum must be limited in time frame to deal only with factual medical information for AIDS prevention. The school districts, at

any classroom, shall conduct for the parents and guardians of the students involved during weekend and evening hours at least one presentation concerning the curriculum and materials that will be used for such education. No student shall be required to participate in AIDS prevention education if a parent or guardian of the student objects in writing to such participation.

D. AIDS prevention education shall specifically teach students that:

1. engaging in homosexual activity, promiscuous sexual activity, intravenous drug use or contact with contaminated blood products is now known to be primarily responsible for contact with the AIDS virus;

2. avoiding the activities specified in paragraph 1 of this subsection is the only method of preventing the spread of the virus;

3. sexual intercourse, with or without condoms, with any person testing positive for human immunodeficiency virus (HIV) antibodies, or any other person infected with HIV, places that individual in a high risk category for developing AIDS.

E. The program of AIDS prevention education shall teach that abstinence from sexual activity is the only certain means for the prevention of the spread or contraction of the AIDS virus through sexual contact. It shall also teach that artificial means of birth control are not a certain means of preventing the spread of the AIDS virus and reliance on such methods puts a person at risk for exposure to the disease.

F. The State Department of Health and the State Department of Education shall update AIDS education curriculum material as newly discovered medical facts make it necessary.

SECTION 2. This act shall become operative July 1, 1987.

SECTION 3. It being immediately necessary for the preservation of the public peace, health and safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

§ 2503. Physician and Psychotherapist-Patient Privilege

A. As used in this section:

1. A "patient" is a person who consults or is examined or interviewed by a physician or psychotherapist;

2. A "physician" is a person authorized to practice medicine in any state or nation, or reasonably believed by the patient to be so authorized;

3. A "psychotherapist" is:

- a. a person authorized to practice medicine in any state or nation, or reasonably believed by the patient to be so authorized, while engaged in the diagnosis or treatment of a mental or emotional condition, including alcohol or drug addiction, or
- b. a person licensed or certified as a psychologist under the laws of any state or nation, or reasonably believed by the patient to be so licensed or certified, while similarly engaged; and

4. A communication is "confidential" if not intended to be disclosed to third persons, except persons present to further the interest of the patient in the consultation, examination or interview, persons reasonably necessary for the transmission of the communication, or persons who are participating in the diagnosis and treatment under the direction of the physician or psychotherapist, including members of the patient's family.

B. A patient has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications made for the purpose of diagnosis or treatment of his physical, mental or emotional condition, including alcohol or drug addiction, among himself, his physician or psychotherapist, and persons who are participating in the diagnosis or treatment under the direction of the physician or psychotherapist, including members of the patient's family.

C. The privilege may be claimed by the patient, his guardian or conservator or the personal representative of a deceased patient. The person who was the physician or psychotherapist at the time of the communication is presumed to have authority to claim the privilege but only on behalf of the patient.

D. The following shall be exceptions to a claim of privilege:

1. There is no privilege under this section for communications relevant to an issue in proceedings to hospitalize the patient for mental illness, if the psychotherapist in the course of diagnosis or treatment has determined that the patient is in need of hospitalization;

2. Communications made in the course of a court ordered examination of the physical, mental or emotional condition of a patient, whether a party or a witness, are not privileged under this section when they relate to the particular purpose for which the examination is ordered unless the court orders otherwise; or

3. The privilege under this Code as to a communication relevant to the physical, mental or emotional condition of the patient in any proceeding in which the patient relies upon that condition as an element of his claim or defense or, after the patient's death, in any proceeding in which any party relies upon the condition as an element of his claim or defense, is qualified to the extent that an adverse party in said proceeding may obtain relevant information regarding said condition by statutory discovery.

Laws 1978, c. 285, § 503, eff. Oct. 1, 1978. Laws 1980, c. 113, § 1, eff. Oct. 1, 1980.

Witnesses ⇨ 208 *et seq.*

Construction and application

Overton v. State, Okl.Cr., 606 P.2d 586 (1979).

Hospital records

City of Edmond v. Parr, Okl., 587 P.2d 56 (1978).

§ 2504. Husband-Wife Privilege

A. A communication is confidential for purposes of this section if it is made privately by any person to his spouse and is not intended for disclosure to any other person.

B. An accused in a criminal proceeding has a privilege to prevent his spouse from testifying as to any confidential communication between the accused and the spouse.

C. The privilege may be claimed by the accused or by the spouse on behalf of the accused. The authority of the spouse to do so is presumed.

D. There is no privilege under this section in a proceeding in which one spouse is charged with a crime against the person or property of:

1. The other;
2. A child of either;
3. A person residing in the household of either;

or

4. A third person when the crime is committed in the course of committing a crime against any other person named in this section.

Laws 1978, c. 285, § 504, eff. Oct. 1, 1978.

Witnesses ⇨ 188 *et seq.*

§ 503. Suspension or revocation of license for unprofessional conduct

The State Board of Medical Examiners may suspend or revoke the license or certificate of any physician or surgeon holding license or certificate to practice in the State of Oklahoma for unprofessional conduct, but no such suspension or revocation shall be made until such licentiate be cited to appear for hearing. No such citation shall be issued except upon sworn complaint filed with the Secretary of said Board, charging the said licentiate with having been guilty of unprofessional conduct and setting forth the particular act or acts alleged to constitute such unprofessional conduct. In the event it comes to the attention of said Board that a violation of the rules of professional conduct may have occurred, even though a formal complaint or charge may not have been filed, said Board may conduct an investigation of such possible violation, and may upon its own motion institute a formal complaint. In the course of such investigation persons appearing before the Board may be required to testify under oath. Upon the filing of such complaint, either by an individual or the Board as provided herein, such citation must forthwith be issued by the Secretary of the Board over his signature and seal of the Board, setting forth the complaint of said unprofessional conduct, and giving due notice of the time and place of the hearing thereof by the Board of Medical Examiners. The said citation shall be made returnable at the next regular meeting of the Board occurring at least thirty (30) days next after the service of said citation. The accused shall file his written answer thereto under oath with the Secretary of said Board within twenty (20) days after the service upon him of said citation and therewith shall deposit with the Secretary his license or certificate authorizing him to practice medicine and surgery within this State and unless such answer with such license or certificate be filed as herein set forth, the accused shall be considered in default and his license or certificate suspended or revoked, if the charges be deemed sufficient by the Board; provided, that the Secretary of the Board may extend the time of answer upon satisfactory showing that the defendant is for reasonable cause, unable to make answer within the said twenty (20) days, but in no case shall the time be extended beyond the date of the next regular meeting of the Board, unless continuance thereof be granted by the Board.

Laws 1923, ch. 59, p. 108, § 23. Amended by Laws 1955, p. 328, § 1.

§ 509. Unprofessional conduct—Definition

The words "unprofessional conduct" as used in this Act are hereby declared to mean:

First. Procuring, aiding or abetting a criminal operation or abortion.

Second. Advertising in any manner, either in his own name or under the name of another person, firm, association or corporation, in any newspaper, pamphlet, circular, or other written or printed paper or document, the treatment of or the curing of venereal diseases, or the private diseases peculiar to men and women, or the advertising, or holding himself out to the public, in any manner as a specialist in the diseases of the sexual organs, or diseases caused by sexual weakness, self-abuse or excessive indulgence, or in any disease of like nature produced by like causes, or the restoration of "lost manhood," or the advertising of any medicine, or any means whatsoever, whereby the monthly periods of women can be restored or regulated or the menses be re-established, if suppressed, or being employed by, or in the service of, any person, firm, association or corporation so advertising.

Third. The obtaining of any fee or offering to accept any fee, present, or other form of remuneration whatsoever, on the assurance or promise that a manifestly incurable disease can or will be cured.

Fourth. Wilfully betraying a professional secret to the detriment of the patient.

Fifth. Habitual intemperance or the habitual use of habit-forming drugs.

Sixth. Conviction of a felony or of any offense involving moral turpitude.

Seventh. The employment of what is commonly known as "Cappers" or "Steerers" in procuring practice.

Eighth. All advertising of medical business in which statements are made which are grossly untrue or improbable and calculated to mislead the public.

Ninth. Conviction or confession of a crime involving the violation of the anti-narcotic or prohibition laws and regulations of the Federal Government, or the Board of Health laws and regulations of the State of Oklahoma.

Tenth. Dishonorable or immoral conduct.

Laws 1923, ch. 59, p. 110, § 29. Amended by Laws 1925, ch. 63, p. 96, § 5.

§ 1-1709. Information concerning condition and treatment of patients—Restrictions—Exemption from liability—Review committees

Any authorized person, hospital, sanatorium, nursing home or rest home, or other organization may provide information, interviews, reports, statements, memoranda or other data relating to the condition and treatment of any person to any of the following for use in the course of studies for the purpose of reducing morbidity or mortality: The State Board of Health; the Oklahoma State Medical Association, or any committee or allied society thereof; the American Medical Association, or other national organization approved by the State Board of Health, or any committee or allied medical society thereof; or any in-hospital staff committee. No liability for damages or other relief shall arise or be enforced against any authorized person, institution or organization by reason of having provided such information or material, or by reason of having released or published the findings and conclusions of such groups to advance medical research and medical education, or by reason of having released or published generally a summary of such studies. The recipients shall use or publish such information or material only for the purpose of advancing medical research or medical education in the interest of reducing morbidity or mortality, except that a summary of such studies may be released by any such group for general publication. In all events, the identity of any person whose condition or treatment has been studied shall be confidential and shall not be revealed under any circumstances. Any information furnished shall not contain the name of the person upon whom information is furnished and shall not violate the confidential relationship of patient and doctor. All information, interviews, reports, statements, memoranda, or other data furnished by reason of this section, and any findings or conclusions resulting from such studies, are declared to be privileged communications which may not be used or offered or received in evidence in any legal proceeding of any kind or character, and any attempt to use or offer any such information, interviews, reports, statements, memoranda or other data, findings or conclusions, or any part thereof, unless waived by the interested parties, shall constitute prejudicial error in any such proceeding. Physicians and others appointed to hospital utilization review committees for the purpose of determining the optimum use of hospital services shall be immune from liability with respect to decisions made as to such utilization and actions thereunder so long as such physicians or others act in good faith; provided, however, that nothing in this section shall be construed to relieve any patient's personal physician of any liability which he may have in connection with the treatment of such patient.

Laws 1963, c. 13, § 1. Laws 1968, c. 215, § 1, eff. April 23, 1968.

AIDS—MANDATORY BLOOD TESTING—CONFIDENTIALITY

Assembly Bill No. 403

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.

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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 and 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.

**AIDS—BLOOD BANKS AND PLASMA CENTERS—
ANTIBODY TESTING**

Assembly Bill No. 488

CHAPTER 23

An act to amend Sections 199.21 and 1603.1 of, to add Sections 1603.3 and 1603.4 to, and to add Article 8 (commencing with Section 1630) to Chapter 4 of Division 2 of, the Health and Safety Code, relating to health, making an appropriation therefor, 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 488, Roos. Blood banks and plasma centers: AIDS.

(1) Existing law requires each blood bank, as defined, to make tests of all human whole blood received to detect the presence of viral hepatitis.

This bill would require each blood bank and plasma center, as defined, to test for the probable causative agent for acquired immune deficiency syndrome, except as specified. It would prohibit blood or blood components to be used in vivo for humans, unless the blood or blood components have been so tested and labeled nonreactive, except as specified. It would require all blood donors to be given a specified written notice and to sign a written confirmation of this notification. It would require blood banks and plasma centers to utilize self-deferral and callback procedures. It would require blood banks and plasma centers, after a confirmation test, to report information to the State Department of Health Services to be included in a Donor Deferral Register, as specified. It would require laboratories which make the antibody test to be specially approved

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ACQUIRED IMMUNODEFICIENCY SYNDROME

MONTHLY SURVEILLANCE REPORT

CUMULATIVE TOTALS

April 27, 1987

UNITED STATES CASES REPORTED TO CDC

<u>PRIMARY DISEASE REPORTED</u>	<u>Cases</u>	<u>Known Deaths</u>	<u>% Dead</u>	<u>Reported Since 1-1-87</u>
<u>Pneumocystis carinii</u> Pneumonia	22692	13246	58%	3979
Other Opportunistic Infections	7858	4910	62%	1450
Kaposi's Sarcoma	<u>4518</u>	<u>2085</u>	<u>46%</u>	<u>609</u>
Total	35068	20241	58%	6038

AGE

Under 5	435	1%
5-12	58	0%
13-19	141	0%
20-29	7357	21%
30-39	16388	47%
40-49	7259	21%
Over 49	<u>3430</u>	<u>10%</u>
Total	35068	100%

RACE

White	21118	60%
Black	8662	25%
Hispanic	4950	14%
Other & Unknown	<u>338</u>	<u>1%</u>
Total	35068	100%

SEX

Male	32459	93%
Female	<u>2609</u>	<u>7%</u>
Total	35068	100%

TRANSMISSION CATEGORIES

	<u>Cumulative</u>		<u>Since 1-1-87</u>	
Homosexual or Bisexual Men	22705	65%	3972	66%
I.V. Drug User	5793	17%	880	15%
Homosexual Male and IV Drug User	2634	8%	390	6%
Blood Transfusion	745	2%	171	3%
Hemophilia/Coagulation Disorder	330	1%	61	1%
Parent w/AIDS or increased risk	389	1%	66	1%
Heterosexual Contact	1335	4%	216	4%
None of the above/Other	<u>1137</u>	<u>3%</u>	<u>282</u>	<u>5%</u>
Total	35068	100%	6038	100%

ACQUIRED IMMUNODEFICIENCY SYNDROME
MONTHLY SURVEILLANCE REPORT - OKLAHOMA

CUMULATIVE TOTALS

April 30, 1987

OKLAHOMA CASES REPORTED

	<u>Cases</u>	<u>Known Deaths</u>	<u>% Dead</u>	<u>Reported Since 1-1-87</u>
<u>Pneumocystis carinii</u> Pneumonia	70	45	64%	17
Other Infections	32	17	53%	3
Kaposi's Sarcoma	<u>13</u>	<u>5</u>	<u>38%</u>	<u>3</u>
	115	67	58%	23

AGE

Under 5	1	1%
5-12	--	--
13-19	--	--
20-29	34	30%
30-39	51	44%
40-49	14	12%
Over 49	<u>15</u>	<u>13%</u>
Total	115	100%

RACE

White	100	87%
Black	11	10%
Indian	2	2%
Hispanic	2	2%
Other	<u>--</u>	<u>-- %</u>
Total	115	100%

SEX

Male	109	95%
Female	<u>6</u>	<u>5%</u>
Total	115	100%

(Mean age 35 years)

TRANSMISSION CATEGORIES

	<u>Cumulative</u>		<u>Since 1-1-87</u>	
Homosexual or Bisexual Male	84	73%	18	78%
I.V. Drug User	5	4%	--	--
Homosexual Male and I.V. Drug User	12	10%	3	13%
Blood Transfusion	5	4%	--	--
Parent w/HIV Infection	1	1%	--	--
Heterosexual Contact	2	2%	1	4%
None of the above/Other	<u>6</u>	<u>5%</u>	<u>1</u>	<u>4%</u>
Total	115	100%	23	100%

Addendum:

I. Policy: Communicable Diseases

Admission and Management of Students with AIDS

Students with AIDS

II. Curriculum Guide for Teachers

Tulsa Public Schools	EPS Code: JHCC
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Communicable Diseases

Any student afflicted with a communicable or contagious disease will be prohibited from attending school in this district until he/she is free from such a disease, or until a plan for management of the case has been determined which will adequately protect others in the school environment against transmission of the disease.

Adopted:

Legal Reference: Title 70, O.S. 1210.194

Admission and Management of Students with
Acquired Immune Deficiency Syndrome (AIDS)

Acquired Immune Deficiency Syndrome (AIDS) is one of a number of communicable diseases which require special precautions to prevent their transmission in the school environment. However, because there is no cure for AIDS and because it is a life-threatening disease, it is imperative that very specific procedures be followed in the management of any case of a student with AIDS.

Nature of the AIDS Virus

AIDS is a disease which disables the body from fighting infection. The cause of the disease is infection by the Human T-Lymphotropic Virus, Type III (HTLV-III), also known as Human Immunodeficiency Virus (HIV). Three categories of outcomes result from infection by HTLV-III. The first, AIDS, is the most severe form of the infection and most victims die within two years. The second form of infection is AIDS-Related Complex (ARC), a milder form with less severe symptoms. The third and most common form of infection by HTLV-III causes the affected person to be an Asymptomatic Carrier, having no symptoms but still believed capable of transmitting the virus to others. Based upon the medical evidence available, it must be assumed that each of the three levels or stages of HTLV-III infection is contagious under certain conditions.

Transmission of AIDS

Fortunately, AIDS, unlike many other communicable diseases, is not believed by most medical authorities to be transmissible through the casual contact which would typify the normal school environment. AIDS is acquired by the introduction of the virus into the blood stream through sexual contact, sharing of hypodermic needles among intravenous drug users, receiving blood transfusions from infected individuals, or at birth. Pending further research, however, any spill of body fluid--blood, tears, semen, saliva, vomitus, urine or excrement--by an AIDS infected individual should be considered as a possible source of infection.

Cleanup of Body Fluids

Since it is not always known which children may be infected with the HTLV-III virus, rubber gloves and a 1 to 10 solution of household bleach in water are to be used in cleaning up a spill of body fluid by any student. Insofar as possible, paper towels or other disposable products are to be used. Following cleanup, the rubber gloves

and paper towels are to be sealed in a plastic bag and discarded. Other materials used in the cleanup, such as mop heads, rags, or clothing, are to be thoroughly rinsed in a bleach and water solution or washed separately in hot water. Band instruments which are shared among students are to be thoroughly decontaminated between uses. Thorough hand washing with soap and water is also advised. These precautions will help to guard against the spread of not only AIDS but other more communicable, though less deadly, diseases.

Referral to Health Evaluation Team

Any student found to be infected with the HTLV-III virus, even if no symptoms are evident, should be reported immediately in writing to the Superintendent of Schools. The Superintendent will appoint a Health Evaluation Team consisting of the following individuals:

- Director of Elementary, Middle or High School Education (Chairperson)
- Principal of the student's school
- Director of Health Services
- Representative of Tulsa City County Health Department
- Student's physician
- Student's parent(s) or guardian(s)

The Health Evaluation Team will consider all available data regarding the student and will recommend to the Superintendent the most appropriate educational environment for that student, as well as any special conditions or precautions. The Team will review the case at least annually, or more often as needed.

Right of Appeal

A parent who disagrees with the assignment and/or conditions of attendance prescribed for an HTLV-III student may send a written request to the Superintendent of Schools describing the reasons for the appeal. The Superintendent will refer the case to a Health Review Board for hearing and disposition. The members of this Board shall include the following:

- Consulting Physician to the Tulsa Public Schools
- Representative of the Division of Instruction
- Representative of the Division of Instructional Support Services
- Representative of the Division of Business and Personnel Services

The Health Review Board will send a written report of their conclusions and recommendations to the Superintendent of Schools who will respond to the parent(s).

Protection of Other Students

The first consideration must be the protection of other students from infection by the AIDS student. Since the possibility of spreading the HTLV-III virus through casual contact such as occurs in a school situation is "remote," according to medical researchers, most AIDS students can continue without restriction in the regular classroom, except that such students are not to be allowed to participate in contact sports. But if a child is prone to biting or other similarly aggressive behavior, is incontinent, has open skin lesions, or is subject to drooling, a more restrictive environment which minimizes the exposure of other children to his/her body fluids will be prescribed by the Health Evaluation Team. Any employee assigned to work with this type of child must be informed of the potential contagiousness of the student.

Protection of AIDS Students

A second consideration is the physical well-being of the AIDS afflicted child. Since AIDS severely depresses the immune system, any of the minor infections or childhood diseases which are common among children could be life threatening to a child afflicted with AIDS. It may thus be advisable to recommend a restricted educational environment, either permanently or temporarily, for the protection of the AIDS student.

Confidentiality Requirements

Protection of the confidentiality of information regarding HTLV-III infected students is of utmost importance. Only those employees who have an absolute need to know are to be made aware of the identity of AIDS students. The Health Evaluation Team will identify by name those employees who are to be given this information. This list will be given to the principal who will be responsible for ensuring that only authorized employees are made aware of the student's condition, and that they are informed of the potential legal liabilities of revealing that information. When an HTLV-III student is identified, the principal is to establish a separate file on that student to which only he and those identified employees are to have access. No entry regarding the AIDS condition is to be made on the student's cumulative record, health card, the computerized student data base or other record.

Issued: Waiting on legal opinion

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

PREVENTION EDUCATION

**Curriculum Guide
For Teachers**

**Oklahoma State Department of Education
John M. Folks, Ed.D.
State Superintendent of Public Instruction**

**Oklahoma State Department of Health
Joan K. Leavitt, M.D.
Commissioner of Health**

PROPOSED

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) PREVENTION EDUCATION

GENERAL OBJECTIVE: Be aware of the forms of the disease, the methods of transmission, and prevention of Acquired Immune Deficiency Syndrome (AIDS).

EXPECTED OUTCOMES:

- 1. Understand origin and history of Acquired Immune Deficiency Syndrome.**
- 2. Define AIDS.**
- 3. Name the cause of AIDS.**
- 4. List the methods of transmission of AIDS.**
- 5. List the methods of prevention.**
- 6. List and describe the forms of the HIV infections.**
- 7. Identify tests for the HIV infections.**
- 8. Describe methods of care and treatment.**
- 9. List the groups at high risk for acquiring the HIV infection.**
- 10. Understand that a woman who is infected with the HIV and becomes pregnant, is more likely to develop ARC or classic AIDS.**
- 11. Identify misconceptions about AIDS.**
- 12. Identify authoritative sources of information about AIDS.**

In order for our staff to assist local schools in the preparation for the implementation of Acquired Immune Deficiency Syndrome (AIDS) Prevention Education, the State Board of Education hereby declares that an emergency exists with imminent peril to the public health, safety, or welfare.

GLOSSARY

- abstinence -** (Sexual abstinence) Refraining from all types of sexual intercourse (oral, anal, and vaginal).
- acquired -** Resulting from events which occur after birth; not inherited.
- addiction -** To feel unable to do without something, such as drugs or cigarettes; to be "hooked" on something.
- AIDS -** Acquired Immune Deficiency Syndrome. A fatal illness caused by a virus that damages the body's immune system.
- AIDS-Related Complex (ARC) -** A condition in which a person infected with human immunodeficiency virus (HIV) has a set of specific symptoms, but has not developed AIDS.
- anal intercourse -** Insertion of the penis into the rectum.
- antibiotic -** Substance which kills or prevents multiplication of bacteria.
- antibodies -** Substances in the blood made by the immune system to fight against germs.
- antiviral -** Substance which prevents multiplication of viruses.
- anus -** The rear opening of the digestive tract. Bulk waste (feces, stool) passes out of the body through this opening.
- ARC -** See "AIDS-Related Complex"
- artificial -** Not natural. Artificial methods of birth control include chemical and mechanical methods.
- AZT -** Azidothymidine. A drug which may help to prevent opportunistic infections in some patients with AIDS.
- birth control -** A substance or material used to prevent pregnancy, such as condoms, spermicides, and oral contraceptives ("the pill").
- bisexual -** A person who has sexual intercourse with both men and women.

casual contact -	Nonsexual body contact including touching, hugging, handshaking, and sitting closely together.
chemotherapy -	Medications used to treat certain viruses, bacteria, or cancer cells.
chlamydia -	A sexually transmitted disease caused by bacteria that can infect males and females, often without causing symptoms. If left untreated, may cause sterility.
communicable disease -	Disease that can be passed from person to person caused by bacteria, viruses, and other organisms.
condom -	A rubber cover or sheath worn over the penis. Used during sexual activity to prevent AIDS, other sexually transmitted diseases, and pregnancy.
contaminated -	Come in contact with or made impure by exposure to material or organisms such as bacteria or viruses.
coordination -	Control over body movements.
counseling -	To help an individual better understand a situation or problem so that he or she can make decisions and take appropriate actions.
deficiency -	Lack of or insufficient amount of.
diagnose -	Identifying the disease which a patient has.
disease organism -	Living thing which causes disease.
disruption -	Upset, disturbance.
Factor VIII -	A blood protein that stops bleeding.
feces -	Bulk waste made by the body that leaves the body through the anus (bowel movement).
genitals -	The external sex organs.
gonorrhoea -	A type of sexually transmitted disease (STD) caused by a bacteria that can infect males and females, often without causing symptoms. If left untreated, may cause sterility.
hemophilia -	A hereditary clotting disorder characterized by excessive, sometimes spontaneous bleeding.

heterosexual -	A person who prefers sexual intercourse with someone of the opposite sex.
HIV -	Human Immunodeficiency Virus. This is the virus that causes AIDS. It has other names: HTLV-III, LAV, ARV are some.
homosexual -	A person who prefers sexual intercourse with someone of the same sex.
immune -	Resistance to a disease.
immunodeficiency -	Weakness of the immune system; the body cannot fight germs properly.
infection -	A disease caused by germs, such as viruses and bacteria.
intravenous -	Injected into a vein.
Kaposi's sarcoma -	A rare form of skin cancer which is common in persons with AIDS.
lymph node -	Part of the immune system which can sometimes be felt near the surface of the body; "glands".
misconceptions -	Mistaken idea or incorrect notion.
mucous membrane -	The soft, moist skin that lines the body cavities such as the mouth, vagina, urethra, eyelids, and rectum.
opportunistic diseases -	Cancers and infections that invade a person whose immune system is weakened.
organism -	Any living thing.
paralysis -	Inability to move.
plasma -	Liquid part of the blood which does not contain cells.
pneumocystis carinii pneumonia -	Severe form of lung infection commonly seen in AIDS patients.
precautions -	Steps to prevent something.
promiscuous -	Frequent change of sexual partners or multiple sexual partners.
radiation -	A form of treatment for certain types of cancers using X-rays.

saliva -	The clear liquid in the mouth, also called "spit".
screen -	To test, especially when testing a large number of people, such as all blood donors for HIV antibody.
sexual partner -	A person with whom another person has sexual intercourse.
sexual intercourse -	Sexual union with the penis in the vagina (vaginal sex), penis in the rectum (anal intercourse), or penis in the mouth (oral intercourse).
sign -	Measured or objective evidence of a disease as determined by a physician.
spermicide -	A substance which kills sperm. Some spermicides may also kill viruses and bacteria. Certain spermicides may also kill the HIV.
STD -	Sexually transmitted disease caused by organisms which are usually transmitted person-to-person; including bacteria, fungi, protozoa, and viruses.
symptoms -	Changes in a person's health that can be seen or felt. Subjective evidence of an illness.
syndrome -	A pattern of signs and symptoms.
syphilis -	A sexually transmitted disease which can infect men, women, and unborn babies. If not treated, it can cause severe damage to many organs.
syringe -	Holds substance to be injected.
therapeutic -	Useful in treating a disease.
transmitted -	Passed from one person or place to another.
urine -	Liquid waste matter of the body excreted by the kidneys, a yellowish, watery fluid.
vagina -	The tube that leads from a woman's uterus (womb) to the outside of her body. Also called the birth canal.
vaginal secretions -	Fluids that can be found in the vagina.
virus -	The smallest organism that can cause diseases.

**ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) PREVENTION EDUCATION
ADVISORY COMMITTEE**

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United Methodist Church**

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Milburn Public Schools**

**Bill Hicks, Principal
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School Board Representative**

**The Reverend Richard Virtue
St. John's Episcopal Church**

**Representative Vickie White
Norman**

**Gae Wilson, Superintendent
Glenpool Public Schools**

AIDS Testing Sites

Anonymous AIDS testing is offered free of charge at these sites:

AIDS Task Force
Oklahoma Blood Institute
1001 Lincoln Boulevard
Oklahoma City, OK (405) 232-0670

The Comanche County Health Dept.
1010 S. Sheraton Rd., Lawton, OK
(405) 248-5890

The Garfield County Health Dept.
2502 Mercer Dr., Enid, OK (405) 233-0650

The Oklahoma City/County Health Dept.
921 NE 23, OKC, OK (405) 427-8651

The Tulsa City/County Health Dept.
4616 E. 15th, Tulsa, OK (918) 744-1000

Toll Free Hotline: 800-342-AIDS--taped message; 800-447-AIDS--Counselor

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) PREVENTION EDUCATION

EXPECTED OUTCOMES:

- 1. Understand origin and history of Acquired Immune Deficiency Syndrome.** AIDS was not recognized or described as a disease until 1981. The tracing of AIDS only began when doctors had seen enough of it to recognize that they were faced with a serious, previously unknown disease. In 1981, 316 people in the United States had AIDS. By June, 1987, there were over 35,908 reported cases of Acquired Immunodeficiency Syndrome (AIDS) in the United States. Of these cases, about 145 were among teenagers (13-19 years old), and some 7,563 cases were among young adults (20-29 years old). The incidence of AIDS continues to grow at an alarming rate. IT IS PROJECTED THAT BY THE END OF 1991, 270,000 PERSONS WILL HAVE BEEN DIAGNOSED WITH AIDS IN THE UNITED STATES WITH A TOTAL OF 179,000 DEATHS. SEVENTY-FOUR THOUSAND CASES WILL BE DIAGNOSED AND FIFTY-FOUR THOUSAND PEOPLE WILL DIE IN THAT YEAR ALONE!

The exact origin of AIDS is not known. It is either a new human disease which developed recently, or it is a disease that was until recently isolated in a particular geographic group of people. There is much debate about where AIDS originated with some researchers suggesting it began in Africa. The disease was first noted in Africa in the late 1970's and early 1980's, about the same time it came to attention in the United States.

Eighty percent of people with AIDS have died within two years of diagnosis. So far no one is known to have survived the disease for more than five years.

There is no vaccine, no cure, and no treatment which actually stops the progression of the disease. The only sure method of slowing the expansion of AIDS is to prevent infection in the first place. To do this, people need clear and accurate information on AIDS, and if necessary, support in changing behaviors which could increase their likelihood of contracting the disease.

Adolescents are at an age at which they are beginning to explore their sexual options and attitudes, may experiment with drugs and are establishing habits and behaviors they will carry into early adulthood. It is essential that youth have the necessary information to understand how AIDS is spread and how to prevent getting the disease.

For teenagers, one of the best sources of information is their school. As a group, they are more likely to get good information about AIDS from thoughtfully taught classes than from newspapers, television, or radio. Teaching AIDS prevention is an essential part of a successful battle against the disease. It is important to have an ongoing parental involvement in AIDS education. Knowledge of modes of transmission and methods of prevention is the main tool against the spread of AIDS. The goal is to prevent the occurrence of future cases of AIDS in Oklahoma. (A more in-depth medical history of AIDS may be found in the appendices.)

- 2. Define AIDS.** AIDS is an abbreviation for Acquired Immune Deficiency Syndrome. AIDS is a life-threatening disease that damages the immune systems of otherwise healthy persons. (1)

Acquired means that AIDS is not inherited, but rather is passed from person to person.

Immune refers to the body's natural mechanism to protect itself from disease.

Deficiency means that the immune system is not working.

Syndrome indicates that a pattern of symptoms has developed. (1)

- 3. Name the cause of AIDS.** Acquired Immune Deficiency Syndrome (AIDS), identified in 1981, is caused by a virus that attacks the body's immune system. Many rare infections and cancers can then attack the defenseless body. Many of the infections and cancers are treatable, but the underlying immune problem is not. The virus is called Human Immunodeficiency Virus (HIV). (1)

- 4. List the methods of transmission of AIDS.** People do not become infected with the HIV in day-to-day, casual contact with family, friends, acquaintances, or the population at large, unless that contact involves sexual encounters or the sharing of needles or syringes from intravenous drug use contaminated by an infected person.

The virus that causes AIDS lives in certain body fluids, especially blood and semen. People most commonly become infected with HIV after their blood system has come into direct contact with the semen, blood, or vaginal secretions of someone else who is infectious. Although the HIV has been isolated from other body fluids such as saliva, tears, perspiration, or urine, transmission has never been proven to have occurred in contact with these.

Transmission occurs through:

- a. Sexual contact--male to male, male to female, female to male--often with several persons, and most commonly in the form of anal intercourse, as has usually been the case in homosexual men. (77% of reported cases) (4)
- b. Shared use of needles or syringes for intravenous drug use (and possibly the use of nonprofessional tattoo needles). (17% of reported cases) (1) (3) (4)
- c. From infected mother to child before or during birth. (1)
- d. Contact with contaminated blood products. (4)

5. List the methods of prevention.

"AIDS prevention education shall specifically teach students that engaging in homosexual activity, promiscuous sexual activity, intravenous drug use or contact with contaminated blood products is now known to be primarily responsible for contact with the AIDS virus." Title 70 O.S. 1987 Supp § 11-103.3

- a. **Abstinence.** Practice abstinence. Since HIV can be transmitted by either heterosexual or homosexual intercourse, the avoidance of sexual intercourse is the most effective manner of not contracting or spreading the HIV. Abstinence from sexual activity is the only certain means for the prevention of the spread or contraction of the HIV through sexual contact. Learn to say "NO!" (4)
- b. **Artificial means of Birth Control.** Know that artificial means of birth control such as condoms and spermicides are not a certain means of preventing the spread of the HIV and reliance on such methods puts a person at risk for exposure to the disease. Sexual intercourse, with or without condoms, with any person testing positive for human immunodeficiency virus antibodies, or any other person infected with the HIV, places that individual in a high risk category for developing AIDS. (4)
- c. **Don't share needles and syringes.** Sharing needles and syringes to inject heroin, cocaine, and other drugs is directly related to the risk of getting AIDS.

All drugs and alcohol reduce the ability of the body to resist infection. More importantly, drugs and alcohol may alter the user's judgment, making the person more likely to participate in sex activities.

- d. **Promote blood supply safety.** Persons in high risk groups should not donate blood. Because of sophisticated screening and processing, the chances are about one in one million of getting AIDS from a blood transfusion. A person cannot contract AIDS while donating blood because new and sterile equipment is used.

6. List and describe the forms of the HIV infections.

- a. **No Signs.** Some people remain apparently well after infection with the HIV. They may have no physically apparent symptoms of illness. These infected individuals can spread the virus to others through sexual intercourse or sharing needles. Anyone who thinks he or she is infected or involved in high risk behaviors should not donate his or her blood, organs, tissues, or sperm because they may now contain the HIV.
- b. **ARC.** AIDS-Related Complex (ARC) is a condition caused by the HIV in which the patient tests positive for HIV infection and has a specific set of clinical symptoms. However, ARC patients' symptoms are often less severe than those with the disease called classic AIDS. Signs and symptoms of ARC may include loss of appetite, weight loss, fever, night sweats, diarrhea, tiredness, lack of resistance to infection, or swollen lymph nodes. These are also signs and symptoms of many other diseases and a physician should be consulted.
- c. **AIDS.** Only a qualified health professional can diagnose AIDS, which is the result of a natural progress of infection by the HIV. AIDS destroys the body's immune (defense) system and allows otherwise controllable infections to invade the body and cause additional diseases. These opportunistic diseases would not otherwise gain a foothold in the body. These opportunistic diseases may eventually cause death. A woman who is infected with the HIV and becomes pregnant, is more likely to develop ARC or classic AIDS.

Some symptoms and signs of AIDS and the "opportunistic infections" may include a persistent cough and fever associated with shortness of breath or difficult breathing. These may be the symptoms of pneumocystis carinii pneumonia. Multiple purplish blotches and bumps on the skin may be a sign of Kaposi's sarcoma. HIV in all infected people is essentially the same; the reactions of individuals may differ.

- d. **Long term.** The HIV may also attack the nervous system and cause delayed damage to the brain. This damage may take years to develop and the symptoms may show up as memory loss, indifference, loss of coordination, partial paralysis, or mental disorder. These symptoms may occur alone, or with other symptoms mentioned previously. (2)

7. Identify tests for the HIV infections. As with most other infections, there is no single test for diagnosing AIDS. There is now a test for antibodies (substances produced in the blood to fight disease organisms) to the virus that causes AIDS. Presence of the HIV antibodies means that a person has been infected with the HIV. The antibody test is used to screen donated blood and plasma and to assist in the prevention of cases of AIDS that result from blood transfusions or the use of blood products, such as Factor VIII, needed by people with hemophilia. The test is available through private physicians and community organizations. The Oklahoma State Department of Health has established testing sites in five County Health Departments for people who feel they may have been exposed to AIDS. Counseling before and after the test is available at these sites. Test results will not be given over the telephone. (A list of these testing sites is given in the appendices.) (1) (3)

8. Describe methods of care and treatment. Casual contact with AIDS patients or persons who might be at risk for the illness does NOT place others at risk for getting the illness. No cases have been found where AIDS has been transmitted by casual household contact with AIDS or persons at high risk for getting the illness. Although the HIV has been found in saliva, there have been no cases in which exposure was shown to have resulted in transmission. Ambulance drivers, police, and fire-fighters who have assisted AIDS patients have not become ill. Nurses, doctors, and health care personnel have not developed the HIV infection from caring for persons with the HIV, except when care givers have been in direct contact with the HIV.

Everyone should follow safety procedures carefully when handling blood and tissue specimens from persons with potentially transmissible diseases, including AIDS. School districts should also have guidelines for dealing with accidents involving blood or other body fluids to prevent the spread of the disease.

Currently there are no antiviral drugs available anywhere that have been proven to cure AIDS, although the search for such a drug is being pursued vigorously. Some drugs like azidothymidine (AZT) have been found that inhibit the virus, but they do not cure the infection. Though no treatment has yet been successful in restoring the immune system of an AIDS patient, doctors have had some success in using drugs, radiation, and surgery to treat the various illnesses of AIDS patients. Therapeutic agents are needed for all stages of AIDS infections, to block action of the virus once infection has occurred, and to build up immunity in patients who have developed AIDS symptoms. (3)

9. List the groups at high risk for acquiring the HIV infection.

AIDS does not discriminate by race, sex, or age. Although the initial discovery was in the homosexual community, AIDS is not a disease only of homosexuals. AIDS is found in heterosexual people as well. AIDS is not just a male disease. AIDS is found in women; it is found in children. AIDS is found in all races. In the future AIDS will probably increase and spread among people who are not homosexual or intravenous drug abusers in the same manner as other sexually transmitted diseases like syphilis and gonorrhea.

- a. **Men who have sexual relations with other men are especially at risk.** About 70 percent of people with AIDS throughout the country are male homosexuals and bisexuals. This percentage probably will decline as heterosexual transmission increases. Infection results from a sexual relationship with an infected person.

The risk of infection increases according to the number of sexual partners one has, male or female. The more partners you have, the greater the risk of becoming infected with the HIV.

- b. **Drug abusers who inject drugs into their veins are another population group at high risk and with high rates of infection by the HIV.** Users of intravenous drugs make up 25 percent of the cases of AIDS throughout the country. The HIV is carried in contaminated blood left in the needle, syringe, or other drug-related implements and the virus is injected into the new victim by reusing dirty syringes and needles. Even the smallest amount of infected blood left in a used needle or syringe can contain live HIV to be passed on to the next user of those dirty implements.
- c. **Some persons with hemophilia (a blood clotting disorder that makes them subject to bleeding) have been infected with the HIV either through blood transfusion or the use of blood products that help their blood clot.** Now that we know how to prepare safe blood products to aid clotting, this is unlikely to happen. This group represents a very small percentage of the cases of AIDS throughout the country.
- d. **Some people may have had a blood transfusion prior to March, 1985 before blood was screened for safe transfusion and may have become infected with the HIV.** Blood that has been collected for use is tested for the presence of antibody to the HIV. Fortunately, there are not now a large number of these cases. With routine testing of blood products for antibody to the HIV, the blood supply for transfusion is now safer than it has ever been with regards to AIDS. Persons who have engaged in homosexual activities or have injected street drugs since 1977 should never donate blood. If they admit to such activities, they are not allowed to donate.

- e. **Heterosexual partners of persons infected with the HIV also are at high risk for developing HIV infections.** As of now, most cases of heterosexual-acquired cases of AIDS have occurred among sex partners of intravenous drug users. HIV infection occurs from male to male, male to female, or female to male sexual contact.
- f. **Children born to HIV-infected mothers, may be infected.** The mother can pass the HIV to her unborn child. Approximately one third of the babies born to AIDS infected mothers will also be infected with the HIV. Most of the infected babies will eventually develop the disease and die. Several of these babies have been born to wives of hemophiliac men infected with the HIV by way of contaminated blood products. Some babies have also been born to women who became infected with the HIV by bisexual partners who had the virus. Almost all babies with AIDS have been born to women who were intravenous drug users or the sexual partners of intravenous drug users who were infected with the HIV. More such babies can be expected. (2)

10. Understand that a woman who is infected with the HIV and becomes pregnant, is more likely to develop ARC or classic AIDS. Studies have shown if a woman is infected with HIV, and becomes pregnant, she is twice as likely to develop classic AIDS.

11. Identify misconceptions about AIDS. There are no known medically documented cases caused by:

- a. donating blood
- b. sharing food or drinks
- c. touching or hugging someone
- d. insect bites
- e. riding buses
- f. toilet seats
- g. sinks
- h. swimming pools
- i. hot tubs
- j. drinking fountains
- k. sharing telephones
- l. sharing pencils
- m. sharing paper
- n. from someone coughing or sneezing on you
- o. shaking hands
- p. sharing tools
- q. social kissing
- r. crying
- s. sharing bed linens, towels, cups, straws, dishes, or any other eating utensils
- t. doorknobs
- u. office machinery
- v. household furniture

(1) (2) (3)

12. Identify authoritative sources of information about AIDS used in the development of this publication.

(1) "AIDS Update" pamphlet distributed by Oklahoma State Department of Health, 1000 NE 10th, Oklahoma City, Oklahoma 73152.

(2) Surgeon General's Report on Acquired Immune Deficiency Syndrome distributed by the U.S. Department of Health and Human Services.

(3) AIDS Acquired Immune Deficiency Syndrome, Junior High School Program, Dade County Public Schools, Miami, Florida.

(4) Title 70 O.S. 1987 Supp. § 11-103.3 (A complete copy of this legislation is found in the appendices.)

AIDS EDUCATION RESOURCES
GRADES 5-6

TYPE OF RESOURCE	VENDOR	AREAS OF EMPHASIS			
		General Information	Transmission-symptoms	Prevention	Societal Impact
		*	*	*	*
PRINT RESOURCES					
<u>About AIDS</u> (booklet)	Scriptographic	X	X	X	
<u>Choosing Good Health</u> (texts, tests, posters)	Scott Foresman	X		X	
NONPRINT RESOURCES					
<u>AIDS</u> (video)	SVE	X			
<u>AIDS: The Facts</u> (video)	Guidance Assoc.	X	X	X	
<u>Triangle of Health</u> (filmstrip)	Walt Disney	X			X

AIDS EDUCATION RESOURCES
GRADES 7-9

TYPE OF RESOURCE	VENDOR	AREAS OF EMPHASIS			
		General Information	Transmission-symptoms	Prevention	Societal Impact
		*	*	*	*
PRINT RESOURCES					
<u>About AIDS</u> (booklet)	Scriptographic	X	X	X	X
<u>About AIDS and Shooting Drugs</u> (booklet)	Scriptographic	X	X	X	
<u>AIDS</u> (pamphlet)	Amer. Red Cross	X	X		
<u>AIDS</u> (posters)	Amer. Red Cross	X	X	X	
<u>AIDS: Beyond Fear</u> (booklet)	Amer. Red Cross	X	X	X	X
<u>AIDS: The Facts</u> (pamphlet)	Amer. Red Cross	X		X	
NONPRINT RESOURCES					
<u>AIDS</u> (video)	SVE	X			
<u>AIDS: Acquired Immune Deficiency Syndrome</u> (film)	Walt Disney	X	X	X	X
<u>AIDS: Beyond Fear</u> (video)	Amer. Red Cross	X	X		X

AIDS EDUCATION RESOURCES
GRADES 10-12

TYPE OF RESOURCE	VENDOR	AREAS OF EMPHASIS			
		General Information	Transmission-symptoms	Prevention	Societal Impact
		*	*	*	*
PRINT RESOURCES					
<u>About AIDS</u> (booklet)	Scriptographic	X	X	X	
<u>About AIDS and Shooting Drugs</u> (booklet)	Amer. Red Cross	X	X	X	
<u>AIDS</u> (poster)	Amer. Red Cross	X	X	X	
<u>AIDS--Beyond Fear</u> (brochure)	Amer. Red Cross	X	X	X	
<u>AIDS: The Facts</u> (pamphlet)	Amer. Red Cross	X	X	X	
<u>AIDS, Sex and You</u> (pamphlet)	Amer. Red Cross	X	X	X	
<u>Coping With AIDS</u> (pamphlet)	R. I. Dept. of Health	X	X	X	X
<u>Facts About AIDS</u> (pamphlet) (Spring, 1986)	Office of Public Affairs	X			
<u>Facts About AIDS</u> (pamphlet)	R. I. Dept. of Health	X	X	X	
<u>Facts About AIDS and Drug Abuse</u> (pamphlet)	Amer. Red Cross	X	X	X	
<u>Surgeon General's Report on AIDS</u> (pamphlet)	R. I. Dept. of Health	X	X	X	X
<u>When a Friend Has AIDS</u> (pamphlet)	R. I. Dept. of Health		X		X

TYPE OF RESOURCE	VENDOR	AREAS OF EMPHASIS			
		General Information	Transmission-symptoms	Prevention	Societal Impact
		*	*	*	*
NONPRINT RESOURCES					
<u>AIDS</u> (video)	SVE	X			
<u>AIDS: Acquired Immune Deficiency Syndrome</u> (filmstrip)	Walt Disney	X	X	X	X
<u>AIDS: Beyond Fear</u> (video)	Amer. Red Cross	X	X	X	X
<u>AIDS: The Disease and What We Know</u> (video)	Sunburst	X			
<u>The AIDS Movie</u>	New Day Films	X	X	X	X
<u>AIDS, Sex and Drugs</u> (video)	Amer. Red Cross	X	X	X	X
<u>AIDS - What Everyone Needs to Know</u> (film)	Churchill.Films	X			
<u>Profile of an Epidemic</u> (video)	R.I. Dept. of Health	X	X	X	X
OTHER RESOURCES					
<u>AIDS Education for Youth</u> (video)	Amer. Red Cross	X			
<u>AIDS: Learn for Your Life</u> (video)	All Media Prod.	X			
<u>AIDS: The Plague That Knows No Boundaries</u> (special report-- June, 1987)(question and answer guide available)	Reader's Digest	X			
<u>AIDS: What Young Adults Should Know</u> (student and instr. guide)	Amer. Alliance	X			
<u>Schools Without Drugs: The Challenge</u>	U.S. Dept. of Educ.	X			

TEACHER RESOURCES

PRINT RESOURCES

About AIDS and Shooting Drugs (booklet)

AIDS (guide)

AIDS: 100 Questions and Answers (article)

AIDS and Children: Information for Teachers and School Officials (brochure)

AIDS and the Safety of the Nation's Blood Supply

AIDS and Your Job--Are There Risks?

AIDS: Deadly But Hard to Catch (article)

AIDS in Children: A Review of Clinical Epidemiologic and Public Health Aspects (article)

AIDS Instruction and Local Control (article)

AIDS Instruction Becomes a Troubling Test of Courage for Local School Boards (article)

The AIDS Movie

AIDS: Protect Your Health, Know the Facts (brochure)

AIDS Update (brochure)

AIDS: What You Need to Know, What You Should Do (article)

Answers about AIDS (brochure)

VENDOR

Channing L. Bete Company

Dade County Florida

Oklahoma State Department of Health

American Red Cross, U.S. Public Health
OK County Chapter
323 N.W. 10th
Oklahoma City, OK 73102

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Consumer Reports (November, 1986)

U. S. Public Health

Wall Street Journal (May, 1987)

American School Board Journal
(March, 1987)

New Day Films

Wisconsin Division of Health

Oklahoma State Department of Health

U. S. News and World Report
(January 12, 1987)

American Council on Science and Health

Bibliography on Books Available on AIDS (bibliography)	Pamela Sidnell
Federal Guidelines for AIDS Courses Stress Abstinence (article)	Education Week (March 25, 1987)
Guidelines for Implementing the Critical Health Problems and Comprehensive Health Education Act (article)	Illinois Department of Education
If Your Test for Antibody to the AIDS Virus is Positive . . . (brochure)	American Red Cross, U.S. Public Health
Impairment Due to Infectious Disease Ruled A Handicap: Supreme Court Decision as Applying to AIDS (article)	Education Week (March 11, 1987)
Lo Que Todos Deben Saber Sobre El Sida (booklet) (Everything You Need to Know About AIDS)	Channing L. Bete Company
More Help for Your Fight Against AIDS (article)	American School Board Journal
Network Publications (catalog)	Network Publications
Preventing Aids Through Education (brochure)	Minnesota Department of Education
Some Questions and Answers About HIV Infections and AIDS (brochure)	American Social Health Association
Surgeon General's Report on AIDS (pamphlet)	U. S. Public Health Service
Teaching AIDS (resource guide)	Marcia Quackenbush and Pamela Sargent
What Parents Should Know About AIDS (article)	PTA Today (February, 1987)

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American Red Cross	OK County Chapter 323 N.W. 10th	Oklahoma City, OK 73102	
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Acquired Immunodeficiency Syndrome: Review of Epidemiology

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Acquired Immunodeficiency Syndrome: Review of Epidemiology

H. DAN CAMERON, JR., MPH

The AIDS epidemic began in relative obscurity with initial disease reports to the Centers for Disease Control in June 1981. By August 1985, over 12,000 cases have been reported. The total cases have doubled in the past year, with public concern and scientific knowledge of the disease increasing at even greater rates. This article will review the epidemiology of AIDS, current statistics, and public health intervention programs.

The acquired immunodeficiency syndrome (AIDS) was first described during the spring of 1981. The Centers for Disease Control (CDC) published the first recognition of an unusual pattern of disease in young homosexual men during June and July 1981.^{1,2} These initial reports of 26 patients with Kaposi's sarcoma and 15 patients with *Pneumocystis carinii* pneumonia spurred the subsequent reporting of an additional 70 cases within six weeks.³

Surveillance for this apparently new syndrome was initiated in June 1981, reaching 1,000 reported cases by February 1983. By August 1985, over 12,000 cases had been reported, twice the total of just one year earlier. Public concern has increased at a rate comparable to the increase of reported cases. A significant fatality rate and the potential for disease transmission through blood or blood products has fueled the increasing public

demand for research and control measures by public health agencies.

This article will review the epidemiology of AIDS within the United States and in Oklahoma. The geographic distribution and patient characteristics are remarkably similar between this state and the nation. A companion article⁴ will describe the clinical manifestations and management of the AIDS patient.

Case Definition

The case definition for AIDS was established by the CDC for the purpose of disease surveillance. The primary criteria are: (1) The presence of a reliably diagnosed disease at least moderately indicative of cellular immune deficiency and (2) the absence of an underlying cause for the immune deficiency or of any defined cause for reduced resistance to the disease. A serologic test for antibodies to the virus has been added to the surveillance criteria. In spite of this, the definition remains primarily clinical and is further discussed in the accompanying article.⁴

Disease Trends

Cases of AIDS reported in the United States and Oklahoma are presented in the figure. The epidemic curve for the United States shows a sharp increase in reported cases over the past four years. The first case of AIDS in Oklahoma was reported in January 1983 and reporting has not increased as dramatically as the national reports. Through August 31, 1985, a

From the Oklahoma State Department of Health.

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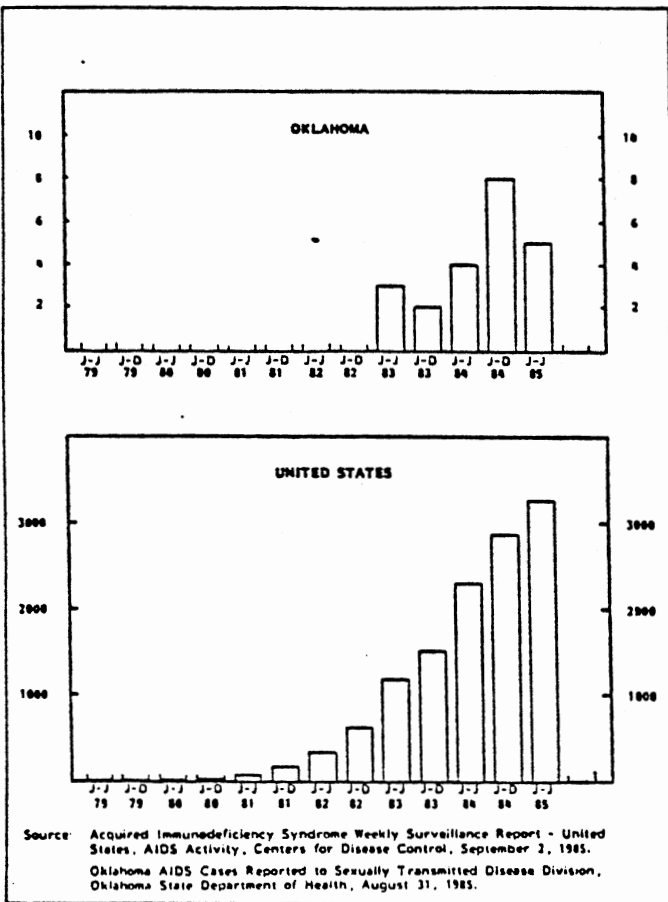


Figure.—Reported AIDS cases in Oklahoma and the United States by six-month periods 1979-1985.

total of 26 cases were reported in persons with onset of symptoms occurring while they were living in Oklahoma. Physicians have reported an additional 15 cases among Oklahoma residents whose onset of symptoms occurred while the individuals were residents of another state. Most frequently, these latter patients have returned to Oklahoma to be closer to family after a diagnosis of AIDS in California (6 patients) and New York (4 patients). Of the 41 total cases, 28 have died. The 68% mortality reported in Oklahoma is higher than the nationally reported mortality rate of 50% (6,481 deaths among the total 12,932 reported cases) through September 2, 1985.

Among those who died, the average time from date of diagnosis to date of death has been 5.6 months in Oklahoma. Those patients returning to this state after a diagnosis of AIDS had an average of 8.2 months. Differences may be attributable to a selection bias, as more severe cases may not survive long enough to make the transition to another state.

Geographic Distribution

The majority of cases are reported from larger metropolitan areas, primarily New York City, San Francisco, and Los Angeles (Table 1). Distribution of cases

by state reveals 36% of the cases have been reported in New York and 23% in California, with Florida, New Jersey, and Texas ranked third through fifth respectively. In Oklahoma, 34% of the cases are reported from the Tulsa metropolitan area and 50% from the Oklahoma City metropolitan area.

Risk Characteristics

Distribution of individuals within the identifiable risk groups has remained fairly constant since the first 1,000 cases were reported. Table 2 presents the major patient characteristics listed as a hierarchy of mutually exclusive groups. Data for Oklahoma closely resemble the national trends, with homosexual or bisexual men representing the majority (73%) of cases. The second major group (17%) consists of intravenous drug abusers.

Age distribution is clustered in the third decade of life, with a mean age in Oklahoma of 35 years. Comparison of age distribution for Oklahoma and the nation is presented in Table 3.

Racial and ethnic distribution in the United States and Oklahoma has remained fairly constant. Differences between Oklahoma trends and national trends may be attributed to relative differences in racial makeup of the primary reporting cities. Oklahoma has reported 21 cases in whites (81%) and 5 cases in blacks (19%). Nationally, 60% of cases have been in whites and 25% in blacks.

The vast majority of cases occur in males. Although 100% of Oklahoma cases are male, 93% of nationally reported cases are male.

Transmission Patterns

Initially, the described patterns of infection were remarkably similar to those of hepatitis B infection and suggested a similarly transmissible agent. Risk of infection increases with the number of sexual partners.⁵⁻⁷ While the greatest risk occurs among homosexual or bisexual men, heterosexual transmission has occurred.^{8,9}

Drug abuse is second in the hierarchy of risk characteristics. Use of inhalant drugs such as amyl and butyl nitrite is associated with AIDS; however, it appears to be a coincidental association with frequent receptive anal intercourse.¹⁰⁻¹² The use of parenteral drugs has been implicated and the primary risk appears to be the sharing or reuse of contaminated needles.¹¹ Greatest risk from this activity is reflected by incidence in New York City and New Jersey where "shooting galleries," apartments, or other secure locations frequented by addicts are greatest in number.

Hemophiliacs have been at increased risk for AIDS due to treatment of their disease with concentrated clotting factors derived from pooled plasma. A single lot of this clotting factor concentrate is produced from donations of 2,500 to 25,000 commercial donors. Recipients of Factor VIII concentrate began to show seropositivity to human T-cell lymphotropic virus type III (HTLV-III) antibody in 1979, with substantial increases in antibody prevalence during the past six years.¹⁴ Recommendations to replace therapy with heat-treated concentrates should significantly reduce the risk of AIDS among hemophiliacs.

Transmission of AIDS by blood transfusion or use of blood products was first reported in December 1982.¹⁵ This led to the March 1983 Public Health Service recommendations advising members of groups at risk for AIDS to refrain voluntarily from donating blood.¹⁶ Relatively long intervals, sometimes exceeding four years, between a suspect blood transfusion and subsequent diagnosis of AIDS in the transfusion recipient have been reported.¹⁷ This suggests that the impact of voluntary donor deferral might not be evident for several years. The availability of a serologic test in March 1985 should further enhance the safety of the blood supply and virtually eliminate transfusion-associated AIDS cases in the future.

Table 1. — All AIDS Cases Per Million Population (from the 1980 Census), by Standard Metropolitan Statistical Area (SMSA) of Residence, Reported from June 1, 1981 to September 2, 1985 — United States

SMSA of residence	Cases	Percentage of total	Cases per million population
New York, NY	4286	33	469.9
San Francisco, CA	1463	11	450.1
Miami, FL	430	3	264.5
Newark, NJ	319	2	162.3
Los Angeles, CA	1092	8	146.0
Elsewhere (irrespective of SMSA)	5342	41	26.2
Total — United States	12932	100	56.8
Oklahoma City, OK	13	50	15.6
Tulsa, OK	9	35	13.1
Elsewhere	4	15	2.7
Total — Oklahoma	26	100	8.6

Source: Acquired Immunodeficiency Syndrome Weekly Surveillance Report — United States, AIDS Activity, Centers for Disease Control, September 2, 1985.
Oklahoma AIDS Cases reported to Sexually Transmitted Disease Division, Oklahoma State Department of Health, August 31, 1985.

Acquisition of AIDS by infants and children occurs by two predominant routes: (1) Infection as a result of blood transfusion or blood products, and (2) infection as a result of birth to a mother who has AIDS or is in a high-risk category.¹⁸ Transmission to infants by an infected mother appears to occur in utero, but does not necessarily occur in all subsequent births.¹⁹ Transfusion-associated cases in children have shorter intervals — 8 months — between transfusion and onset of symptoms, when compared to adults.²⁰

Transmission by casual person-to-person contact has never been shown to occur. There are no documented cases of transmission to household non-sexual contacts of AIDS victims.

Etiology

The variety of factors that contribute to the risk characteristics and occurrence of disease in recipients of blood suggests the existence of a transmissible agent.²¹ In Paris, isolation of a new human retrovirus from a homosexual male experiencing persistent lymphadenopathy was reported in 1983 as lymphadenopathy-associated virus (LAV).²² The identification of an apparently similar virus in the United States was reported in 1984 and labeled as human T-cell lymphotropic virus type III²³⁻²⁵ or AIDS-associated retrovirus (ARV).²⁶ The HTLV-III infects and kills T-lymphocytes called helper cells. Several studies have reported population groups with a high percentage of individuals with seropositivity for HTLV-III antibody, though current prevalence of AIDS is low^{27,28}; these observations suggest that host defenses against this virus may exist.

This virus has been isolated from semen, blood, saliva, tears, and lymph nodes of infected individuals.^{22-24,29-31} Greatest risk of transmission appears to relate to blood and semen. Transmission by saliva and tears has not been demonstrated. Further research may clarify the mechanism of disease development more precisely. A potential for cofactors in disease development has been suggested.³² While additional research will expand the knowledge surrounding the development of AIDS, adequate information already exists to establish some effective control measures.

Serologic Testing

The Food and Drug Administration (FDA) licensed the first serologic test for HTLV-III antibody on March 2, 1985. An enzyme-linked immunosorbent assay (ELISA) is both highly sensitive (97.3%) and

specific (98.6%).³³ Specificity can be further confirmed using a Western Blot electrophoresis technique.³⁴ These assays are being applied for confirmation of clinical diagnosis, for screening of blood products, and for epidemiologic purposes. However, it must be stressed that these are not tests for AIDS. These tests identify antibodies to HTLV-III, indicating only that an individual has been exposed to the virus and may be potentially infectious. It appears that a minority of seropositive patients develop AIDS.³⁵

Blood Banking

Following FDA licensure of an ELISA, the blood banking community began a nationwide effort to test all units of blood donated within the United States. Notification of the blood bank donors with positive tests is made only after repeatedly positive ELISAs (two tests of the specimen to eliminate nonspecific reactions) and confirmation by Western Blot. Plasma centers may notify a donor prior to availability of the Western Blot results since these individuals tend to donate more frequently.

Table 2. — Patient Characteristic Groups — United States and Oklahoma

Patient groups	United States				Total	
	Adult/Adolescent				Cases	(%)
	Males	(%)	Females	(%)		
Homosexual or bisexual men	9365	(79)	—	(—)	9365	(73)
Intravenous (IV) drug user	1733	(15)	425	(53)	2178	(17)
Hemophilia/coagulation disorder	82	(1)	4	(0)	86	(1)
Heterosexual Contact [†]	15	(0)	114	(14)	129	(1)
Transfusions with blood/blood products	113	(1)	82	(10)	195	(2)
None of the above/other [‡]	618	(5)	196	(23)	814	(6)
Total	11926	(100)	841	(100)	12767	(100)
Patient groups	Pediatric*				Total	
	Males	(%)	Females	(%)	Cases	(%)
Hemophilia/coagulation disorder	9	(9)	0	(0)	9	(5)
Parent with AIDS/or at increased risk for AIDS [§]	62	(63)	54	(81)	116	(70)
Transfusion with blood/blood products	18	(18)	7	(10)	25	(15)
None of the above/other	9	(0)	6	(9)	15	(9)
Total	98	(100)	67	(100)	165	(100)
Oklahoma						
Patient Groups	Cases	(%)				
Homosexual or bisexual men	21	81%				
IV drug abuser	2	8%				
Blood transfusion	1	3%				
None/other	2	8%				
Total	26	100%				

Groups listed are ordered hierarchically; cases with multiple characteristics are tabulated only in the group listed first.

*Includes patients under 13 years of age at time of diagnosis

†With a person with AIDS or at risk for AIDS

‡Includes 341 persons born in countries in which most AIDS cases have not been associated with known risk factors

§Epidemiologic data suggest transmission from infected mother to child before, at, or shortly after the time of birth

Source: Acquired Immunodeficiency Syndrome Weekly Surveillance Report — United States, AIDS Activity, Centers for Disease Control, September 2, 1985. (Oklahoma AIDS Cases Reported to Sexually Transmitted Disease Division, Oklahoma State Department of Health, August 31, 1985.

Nationally, reports from American National Red Cross indicate 1,593,969 units have been tested, and 3,209 (0.20%) were found repeatably positive for HTLV-III antibody from March through June. Oklahoma blood banks have tested 77,445 units through August 1985 and found 171 units (0.22%) repeatably positive.

Public Health Intervention

Public health intervention begins with an accurate description of the disease morbidity and mortality. The extend of AIDS morbidity and mortality has brought this epidemic to national attention. The public concern has been that an uncontrollable epidemic will spread to the general population and not remain limited to the recognized risk categories. The toll on society has been great, even though limited within a few high-risk categories.

Oklahoma began development of an AIDS program with the establishment of AIDS as a reportable disease in July 1983. Surveillance includes the voluntary reporting by physicians of patients with AIDS. This cooperative relationship between public health personnel and practicing physicians is crucial to an accurate description of the extent of the problem in Oklahoma.

Sites have been established to provide testing for HTLV-III antibody to individuals in high-risk categories and to persons concerned about possible exposure to AIDS. These "alternative" testing sites were established to further safeguard the blood supply. They allow individuals to be tested without donating blood and provide strict confidentiality to persons tested.

While an effective treatment or cure for AIDS is not currently available, control programs can have an impact through professional and public education. The potential for spread of this epidemic beyond the recognized risk groups in the United States is real. Transmission of this disease in homosexual and bisexual men appears to be related to sexual promiscuity among members of these groups. In Africa, the same disease, apparently, is frequently spread among promiscuous heterosexual populations.³⁶⁻³⁸ Successful control measures may depend on the ability to modify sexual behavior through public education efforts. Selected studies have reported modifications in sexual behavior among homosexual and bisexual men,³⁹ and changes can be measured by the reduction of associated diseases, such as reports of rectal gonorrhea in San Francisco. Knowledge of risk is not always enough to effect behavior modification, as

Table 3.—Age Distribution — Oklahoma and United States

Age	Oklahoma		United States	
	Cases	(%)	Cases	(%)
Under 13	—	(—)	165	(1)
13 - 19	—	(—)	61	(0)
20 - 29	8	(31)	2726	(21)
30 - 39	13	(50)	6069	(47)
40 - 49	2	(8)	2701	(21)
<u>Over 49</u>	<u>3</u>	<u>(11)</u>	<u>1184</u>	<u>(9)</u>
Total	26	(100)	12932	(100)
(Mean age 35 years)				

Source: Acquired Immunodeficiency Syndrome Weekly Surveillance Report — United States, AIDS Activity, Centers for Disease Control, September 2, 1985.
Oklahoma AIDS Cases Reported to Sexually Transmitted Disease Division, Oklahoma State Department of Health, August 31, 1985.

demonstrated by seat-belt use and alcohol consumption, but further research into educational methods may improve the public response in AIDS risk-reduction efforts.⁴⁰

The pervasive nature of public concern over AIDS has extended the boundaries beyond the initial concern with high-risk groups. Careful and deliberate planning is necessary to establish recommendations or guidelines for situations where legitimate concerns for disease transmission exist. Through careful planning, recommendations may be formulated that give due consideration to individual civil rights, the patients' rights to confidentiality, and the rights of the public at large in the protection of public health. The Centers for Disease Control provided "Precautions for Clinical and Laboratory Staffs" in November 1982.⁴¹ Guidelines for children in public schools and day-care facilities were issued August 1985.⁴² These recommendations suggest exclusion of children with AIDS from day-care facilities. A confidential panel should be convened to make a decision regarding school attendance for each child with AIDS. These decisions should be based on the child's behavior, neurologic development, and physical condition. In each case, risks and benefits to both the infected child and other school children or employees should be carefully considered. □

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An Act

ENROLLED HOUSE
BILL NO. 1476

BY: WHITE, HAMILTON (Jeff),
BASTIN, DAVIS (Guy),
HUTCHCROFT, LARASON,
LASSITER, LITTLEFIELD,
THOMPSON, WILLIAMS
(Freddie), HOBSON,
SNIDER, LEWIS, HARRIS
(Robert), GLENN, MORGAN
(Jim), HOLT, VANATTA,
ROSS, ANDERSON and
STOTTLEMYRE of the HOUSE

and

STIPE, HERBERT, TAYLOR,
BROWN, CAIN, HANEY,
HORNER, RIGGS and
DICKERSON of the SENATE

AN ACT RELATING TO EDUCATION; MANDATING AIDS
PREVENTION EDUCATION FOR STUDENTS; PROVIDING
PROCEDURES AND REQUIREMENTS FOR SUCH EDUCATION;
PROVIDING FOR CODIFICATION; PROVIDING AN OPERATIVE
DATE; AND DECLARING AN EMERGENCY.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in
the Oklahoma Statutes as Section 11-103.3 of Title 70, unless there
is created a duplication in numbering, reads as follows:

A. Acquired immune deficiency syndrome (AIDS) prevention
education shall be taught in the public schools of this state. AIDS
prevention education shall be limited to the discussion of the
disease AIDS and its spread and prevention. Students shall receive
such education:

1. at the option of the local school district, a minimum of once
during the period from grade five through grade six;
2. a minimum of once during the period from grade seven through
grade nine; and
3. a minimum of once during the period from grade ten through
grade twelve.

B. The State Department of Education shall develop curriculum
and materials for AIDS prevention education in conjunction with the
State Department of Health. A school district may also develop its
own AIDS prevention education curriculum and materials. Any
curriculum and materials developed for use in the public schools
shall be approved for medical accuracy by the State Department of
Health. A school district may use any curriculum and materials which
have been developed and approved pursuant to this subsection.

C. School districts shall make the curriculum and materials that
will be used to teach AIDS prevention education available for
inspection by the parents and guardians of the students that will be
involved with the curriculum and materials. Furthermore, the
curriculum must be limited in time frame to deal only with factual
medical information for AIDS prevention. The school districts, at
least one (1) month prior to teaching AIDS prevention education in

any classroom, shall conduct for the parents and guardians of the students involved during weekend and evening hours at least one presentation concerning the curriculum and materials that will be used for such education. No student shall be required to participate in AIDS prevention education if a parent or guardian of the student objects in writing to such participation.

D. AIDS prevention education shall specifically teach students that:

1. engaging in homosexual activity, promiscuous sexual activity, intravenous drug use or contact with contaminated blood products is now known to be primarily responsible for contact with the AIDS virus;

2. avoiding the activities specified in paragraph 1 of this subsection is the only method of preventing the spread of the virus;

3. sexual intercourse, with or without condoms, with any person testing positive for human immunodeficiency virus (HIV) antibodies, or any other person infected with HIV, places that individual in a high risk category for developing AIDS.

E. The program of AIDS prevention education shall teach that abstinence from sexual activity is the only certain means for the prevention of the spread or contraction of the AIDS virus through sexual contact. It shall also teach that artificial means of birth control are not a certain means of preventing the spread of the AIDS virus and reliance on such methods puts a person at risk for exposure to the disease.

F. The State Department of Health and the State Department of Education shall update AIDS education curriculum material as newly discovered medical facts make it necessary.

SECTION 2. This act shall become operative July 1, 1987.

SECTION 3. It being immediately necessary for the preservation of the public peace, health and safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.