Texas Preventable Disease
NEWS

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RECOMMENDED GUIDELINES FOR PROVIDING EDUCATION TO STUDENTS WITH AIDS/ARC OR HTLV-III INFECTION

The recommended guidelines for local school districts have been adapted from the State of Connecticut Departments of Education and Health Services "Information and Guidelines" published in March 1985, and the Centers for Disease Control (CDC) recommendations "Education and Foster Care of Children Infected with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus" published in the August 30, 1985 MMWR.

These recommendations apply to all school-age children known to be infected with human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV). This includes children with AIDS as defined by the CDC for reporting purposes, children who are diagnosed by their physicians as having an illness because of infection with HTLV-III/LAV but do not meet the case definition, and children who are asymptomatic but have virologic or serologic evidence of infection with HTLV-III/LAV. These recommendations do not apply to siblings of infected children unless they are also infected.

HTLV-III/LAV has been isolated from blood, semen, saliva, and tears. Transmission has only been demonstrated through intimate sexual contact or blood-to-blood contact. Transmission has not been documented from saliva and tears; in fact, the virus is present in these secretions in lower concentrations than in blood or semen.

The majority of infected children acquire the virus from their infected mothers in the perinatal period. Children may also become infected through transfusion of blood or blood products that contain the virus. None of the identified cases of HTLV-III/LAV infection in the United States is known to have been transmitted in a school, day-care, or foster-care setting or through other casual person-to-person contact. Other than the sexual partners of HTLV-III/LAV-infected patients and infants born to infected mothers, none of the family members of the over 12,000 AIDS patients reported to the CDC has been reported to have AIDS. Six studies of family members of patients with HTLV-III/LAV infection have failed to demonstrate HTLV-III/LAV transmission to adults who were not sexual contacts of the infected patients, to older children who were not likely at risk from perinatal transmission, or to younger children or twin siblings.

Children with either AIDS, AIDS-related conditions (ARC), or HTLV-III infection alone should not pose a health risk to other children or staff in a school setting.

The following guidelines are intended to provide school districts with a framework on which to develop programs to meet the needs of all children for whom the public schools are responsible.

1. All children in Texas have a constitutional right to a free, suitable program of educational experiences.

2. As a general rule, the child should be allowed to attend school in a regular classroom setting with the approval of the child's physician and should be considered eligible for all rights, privileges, and services provided by law and local policy of each school district.

3. The school nurse should function as a) the liaison with the child's physician, b) the child's advocate in the school (ie, assist in problem resolution, answer questions), and c) the coordinator of services provided by other staff.

4. The school should respect the right to privacy of the individual; therefore, knowledge that a child has AIDS/ARC or HTLV-III infection should be confined to those persons with a direct need to know (eg, principal, school nurse, child's teacher). Those persons should be provided with appropriate information concerning such precautions as may be necessary and should be aware of confidentiality requirements. It is recommended that, in general, the local health authority serve as the intermediary between the parents, child, and attending physician, on the one hand, and school officials and staff on the other.

5. Based upon individual circumstances, including those discussed below, special programming may be warranted. Special education should be provided if determined to be necessary by the Admission, [Review, and Dismissal] (ARD) Committee.

6. Under the following circumstances, the child might pose a risk of transmission to others: if the child lacks toilet training, has open sores that cannot be covered, or demonstrates behavior (eg, biting) which could result in direct inoculation of potentially infected body fluids into the bloodstream. If any of these circumstances exist, the school medical advisor, in consultation with the school nurse and the child's physician, must determine whether a risk of transmission exists. If it is determined that a risk exists, the student should be removed from the classroom.

7. The child may be temporarily removed from the classroom for the reasons stated in #6 until either an appropriate school program adjustment can be made, an appropriate alternative education program can be established, or the medical advisor determines that the risk has abated and the child can return to the classroom.

   a) A child removed from the classroom for biting or lack of toilet training should be immediately referred to the ARD Committee for assessment and, therefore, for the development of an appropriate program if warranted.

   b) A child temporarily removed from the classroom for open sores or skin eruptions which cannot be covered should be placed on homebound instruction and readmitted only with medical documentation that the risk no longer exists.

   c) Removal from the classroom under sections a) and b) above should not be construed as the only responses to reduce risk of transmission. The school district should be flexible in its response and attempt to use the least restrictive means to accommodate the child's needs.

d) In any case of temporary removal of the student from the school setting, state regulations and school policy regarding homebound instruction must apply.

8. Each removal of the child from normal school attendance should be reviewed by the school medical advisor in consultation with the student's physician at least once every month to determine whether the condition precipitating the removal has changed.

9. The child, as with any other immunodeficient child, may need to be removed from the classroom for his/her own protection when cases of measles or chickenpox are occurring in the school population. This decision should be made by the child's physician and parent/guardian in consultation with the school nurse and/or the school medical advisor.

10. Routine and standard procedures should be used to clean up after a child has an accident or injury at school. Blood or other body fluids emanating from **any** child, including ones known to have AIDS/ARC/HTLV-III infection, should be treated cautiously. Gloves should be worn when cleaning up blood spills. These spills should be disinfected with a freshly made 10% solution of household chlorine bleach in water, and persons coming in contact with them should wash their hands afterwards. Blood-soaked items should be placed in leakproof bags for washing or further disposition. Similar procedures are recommended for dealing with vomitus and fecal or urinary incontinence in **any** child. Handwashing with soap and hot water after contact with a school child is routinely recommended only if physical contact has been made with the child's blood or body fluids, including saliva.

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HBsAG CARRIERS SOUGHT AMONG INDOCHINESE REFUGEES

The International Refugee Health Screening Program, Office of Personal Health Services, Texas Department of Health, has been awarded $59,380 for a pilot project through June 1986, to offer hepatitis B intervention services to Indochinese refugees in three areas of the state with high concentrations of Indochinese refugees. Hepatitis B is endemic in Southeast Asia, and the Centers for Disease Control found that 18% to 23% of pregnant women tested in Southeast Asian refugee camps were carriers of hepatitis B surface antigen (HBsAG).

Pregnant Indochinese refugees living in Houston or Harris County may obtain intervention services from the Harris County Health Department, which will employ a full-time project coordinator. Patients may refer themselves or be referred by a local public health clinic program or an agency with special services for refugees. Low-income maternity patients of private physicians may be referred for tests and immunizations if these are unaffordable privately.

Pregnant women will be screened for HBsAG, and, if found to be carriers, their household contacts will be screened also. Those found to be at risk, as well as all newborns of mothers who carry the virus, will be provided immunizations (ie, hepatitis B immune globulin (HBIG) and hepatitis B vaccine for the newborns and only hepatitis B vaccine for older children and adults).

A similar approach will be implemented for persons in Jefferson County by the Port Arthur City Health Department. In Potter and Randall Counties, the Amarillo Bi-City-County Health Department will have a very limited supply of HBIG and hepatitis B vaccine for newborns of carriers but will not provide testing.

Project services and immunization supplies will not be available outside the three target areas, and project continuation or expansion will be contingent upon available funds which are, at present, unpredictable.

This report was prepared by Eleanor Eisenberg, MA, Director, International Refugee Health Screening Program.

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IMMUNIZATION CLINIC DELINQUENT SYSTEMS

Since the early 1970's, the Immunization Division, Texas Department of Health (TDH) has provided Clinic Delinquent Cards (Form C-64) to local health departments and public health regional offices. Clinic Delinquent Cards are also provided to Texas physicians through the Texas Osteopathic Medical Society.

During FY 1985, TDH Public Health Region 6 (PHR 6), evaluated the effectiveness of the delinquent cards for a 12-month period. During FY 1985, PHR 6 personnel identified 13,264 delinquent immunization patients, 4,521 (34.1%) of which returned to clinic after delinquency notification. A very small number of patients may have received more than one clinic delinquent card during the 12-month period. Response rates from 19 clinic sites in PHR 6 ranged from 11.8% to 75.0%.

Clinic delinquent systems are effective in reminding and encouraging patients to return for missed appointments. Each clinic site should implement a clinic delinquent system. If you need help in implementing a system, contact the Immunization Division toll-free at 1-800-252-9152. If you have questions concerning the assessment of an ongoing clinic delinquent system, contact Tommy Lee, PHR 6, 1-817-778-6744 (STS 820-2201).

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