



**OFFICE OF THE UNITED NATIONS
HIGH COMMISSIONER FOR REFUGEES
GENEVA**

**Refugees and the Acquired Immune
Deficiency Syndrome (AIDS)
May 1988**

Introduction

1. The issue of Acquired Immune Deficiency Syndrome (AIDS) has over the last year taken on increased importance in the area of refugee protection and assistance. As States have been considering inter alia, the need for testing for AIDS of international travellers and as the increased incidence of cases calls for a coordinated approach to the pandemic, ANCHOR has started to develop its policy on AIDS and refugees in close consultation with WHO. This document entitled *Refugees and the Acquired Immune Deficiency Syndrome (AIDS)* sets out Anchor's policy on this Subject and contains some practical guidelines for the Office's response to the different issues involved, including preventive health care, counselling and screening.

2. The UNHCR policy takes as its point of departure that refugees are not an "at-risk" group for infection with the AIDS viruses and that they should therefore not be the object of specific measures unless these are applied to all residents, citizens and refugees alike, of the country concerned. Similarly, UNHCR agrees with WHO's opinion that there is no justification for screening refugees because of their status as "travellers" as this will not prevent the introduction or spread of AIDS. Refugees are however likely, as all other people, to be affected to a certain extent by the AIDS epidemic and ways must be sought to target assistance programmes better in order to afford them preventive and supportive facilities commensurate to those available to nationals.

Protection of Refugees

Background

1. Neither the 1951 Convention nor the 1967 Protocol relating to the Status of Refugees address the issue of those who are chronically sick or disabled; that they were present in the minds of the drafters of the day, particularly at the 1951 Conference of Plenipotentiaries and in the preparatory work of the Ad Hoc Committee on Refugees and Statelessness, is nevertheless clear. The sick and the disabled were mentioned in the speeches of delegates; they also certainly figure among 'the most destitute categories' whose admission is called for in General Assembly Resolution 428(V), paragraph 2(c), and paragraph 8(d) of the UNHCR Statute; and among those requiring 'permanent custodial care', the 'most needy' and those for

whom 'special care' must be provided (see General Assembly Resolution 430(V) of 14 December 1950, 63g(VII) of 20 December 1952 and 728(VIII) of 23 October 1953).

2. Even if express provisions are absent from the Convention and the Statute, these instruments provide the framework within which the problems of sick and disabled refugees must be resolved; namely, international protection predicated upon the basic principle of non-refoulement and durable solutions premised upon international cooperation and solidarity.

3. Fundamental principles of human rights provide further, and occasionally more specific, guidance as to the policies and practices appropriate to the resolution of the problem of refugees who are chronically sick, or who suffer from infections or contagious diseases.

Acquired Immune Deficiency Syndrome (AIDS)

4. AIDS is a disease involving defects in cell-mediated immunity, lowering the patient's resistance to a variety of other diseases, including forms of cancer and pneumonia. Individuals may also suffer from AIDS Related Complex (ARC), a form of infection which is not always fatal but which may result in swollen lymph glands (lymphadenopathy), or diarrhea, fever, weight loss and general fatigue. From 15 to 30 percent of AIDS-virus infected persons go on to develop AIDS within five years.

5. HIV, or human immunodeficiency virus, has now been recognised as the cause of AIDS. Besides those with AIDS and those with ABC, a third group of people who test positive for antibodies to the virus while remaining symptomatic are designated HIV-seropositive. According to current medical knowledge, those who test HIV seropositive are contagious and infected for life, but may remain completely healthy for many years. The ELISA (enzyme linked immunosorbent assay) test is most often used to detect antibodies for the virus. An initial positive ELISA blood test must be repeated and, if both are positive, followed by a confirmatory test (usually Western Blot). This testing sequence has been developed to reduce the number of 'false positive' results.

6. The risk of exposure to HIV confronts individuals at every level in society. The virus is transmitted by three main routes: (1) blood and blood products (i.e., transfusions, unsterilized syringes), (2) perinatal transmission (infected mother to child), and (3) sexual intercourse. Sexual intercourse is the primary mode of transmission worldwide; in Africa, two-way heterosexual transmission (man to woman, woman to man) is predominant in the epidemiology of AIDS, and is increasingly so in other regions. There is no evidence that the virus is spread by inter-personal contact of non-sexual nature, by food, water, air, or by insect vectors. The virus does not discriminate between race, culture, age or sex.

7. The dimension of the AIDS problem are not yet clear. On 1 January 1988 the World Health Organization (WHO) cited 73,747 cases of AIDS reported from 129 countries. These figures represent only officially reported cases, and WHO estimates the actual worldwide number of AIDS cases to exceed 100,000. More significantly, WHO estimates that between 5 and 10 million people worldwide have been infected with the virus. To date, North America and Europe have reported the largest numbers of AIDS cases and HIV carriers. Though the data on AIDS in Africa are still incomplete, WHO suggests that the infection and disease are also prevalent and spreading throughout Central and East Africa. Relatively, few cases have been reported so far in South America (except Brazil), Asia and Oceania. It may be expected that refugees and asylum seekers will incur at least some share of the disease and infection.

8. National and international efforts aim to combat the spread of AIDS, particularly through public education; to provide care for HIV-infected persons; to develop drugs for treatment,

and vaccines. Discussions have also focused on screening, with particular reference to travellers and other non-nationals, including immigrants and refugees.

WHO has concluded that there is no justification for such screening, as it will not prevent the introduction or spread of HIV, especially if returning nationals are not tested. Costs, inaccuracies, confidentiality problems, and the unacceptable stigma which attaches through singling out particular national or ethnic groups, are further arguments against mandatory screening, a number of States, however, have already introduced the process, or will shortly do so. At the same time, many States have pronounced themselves against mandatory screening programmes including Recommendation No. R (87) 25 adopted by the Council of Europe Committee of Ministers which states that there shall be no compulsory screening of the general population nor of particular population groups”.

Human rights background

9. Fundamental human rights principles provide guidance on the policies and practices to be adopted by States and UNHCR in ensuring protection solutions for refugees with AIDS, ARC, or who test HIV seropositive.

10. Article 25 of the 1948 Universal Declaration of Human Rights, inter alia, declares the right of everyone to a standard of living adequate for their health, including medical care and necessary social services, and the right to security in the event of sickness. Article 12 of the 1966 Convention on Economic, Social and Cultural Rights recognizes the right of everyone to enjoyment of the highest attainable standard of physical and mental health. The steps to be taken by States party to this covenant to achieve full realization of this right are to include those necessary for the prevention, treatment and control of epidemic and other diseases; and the creation of conditions which would assure all medical service and medical attention in the event of sickness. Article 15, moreover, provides for the right of everyone to enjoy the benefits of scientific progress and its applications, and notes the benefits to be derived from the encouragement and development of international contacts and cooperation in the scientific field. Special measures of protection and assistance, including appropriate medical care, may be demanded for particular groups, such as the family, and mothers and children and young persons (article. 10).

11. Article 2(2) of the Covenant confirms the applicability of the principle of non-discrimination to matters of health, and medical care and treatment. Permissible limitations or freedom of movement for public health reasons, for example, to prevent the spread of contagious diseases, in no way pre-empt the general principle. Such limited restrictions are recognized in article 12 of the 1966 Covenant on Civil and Political Rights, article 5(1) (e) of the 1959 European Convention of Human Rights, and article 22(3) of the 1969 American Convention on Human Rights.

Protection issues

12. In-so-far-as they have an impact on refugees and asylum-seekers, national and other measures taken to combat AIDS and to prevent the spread of HIV infection must be related to the overall objectives of the international system, namely, protection and solutions. Every aspect of the refugee’s life, from the moment of flight to return home or assimilation in a new national community, may be affected. Screening for example may result in refoulement, refusal to grant protection or denial of refugees’ right to return voluntarily to their country of origin.

13. Discussion of screening has not generally followed through to an analysis of consequences, and of what to do with those who test positive. In many circumstances, as a matter of principle, UNHCR will not wish or be able to accept that diagnosis of AIDS or HIV seropositivity shall constitute an absolute bar to admission, asylum or resettlement. The Office must therefore seek and obtain waivers, if protection is to be assured.

14. It may be assumed that the ordinary non-national, denied admission because of testing HIV seropositive, can return to the support system of his or her own community. That possibility is denied to the refugee, for whom a waiver is the only alternative to indefinite orbit or return to persecution. In the resettlement context, waivers will be required as a matter of policy, often for specific groups of refugees. Without systematic waivers, established first asylum and transit practices will be subverted by the apprehensions of receiving-countries. Lives will also be lost, for example, through failure to rescue at sea when disembarkation schemes premised on resettlement guarantees collapse, because of third country unwillingness to accept those with infection.

Treatment of AIDS cases and those who test HIV positive

15. UNHCR's policy in respect to local refugee populations will be to ensure that they also benefit from national programmes of care and assistance, and to contribute to the refugee component as appropriate. In the asylum context, UNHCR will again wish to ensure that refugees receive national treatment; and with regard to resettlement, the Office will actively seek the inclusion of refugees in national schemes, as part of traditional processes of cooperation, and with the objective of maintaining the willingness and ability of States to abide by the principles of protection. The economic costs of admission and care must be seen as essential to overall international efforts, as has long been the case for physically and mentally disabled refugees.

16. Standards of treatment and national resources will necessarily vary. The possibility of permissible limitations on freedom of movement must be acknowledged, but located within the context of the fundamental principle of non-discrimination. It must be recognised that such measures are considered ineffective in preventing spread or introduction of the infection. AIDS and HIV infection are unlike other diseases, in that there is as yet no cure, little chance of stabilization, and no vaccine. The modes of transmission are limited, however, and susceptible to responsible control, provided education is given and resources are made available. Detention or extended quarantine would not be an appropriate response, particularly where based on irrelevant distinctions such as race, sex, national origin or refugee status.

UNHCR Health Policy on AIDS

General Principles

17. The principle that must underly every decision, statement or action concerning AIDS is that refugees should not be singled out as a group at special risk. No programme or health intervention can be allowed unless it is totally within the framework of the national AIDS programme of the refugee-hosting country. This principle, in fact, is one that underlies all health services provided for refugees.

18. The technical basis for this policy is, as stated in para 14 above, that there is no epidemiological evidence to suggest that refugees are at greater risk either of being or of becoming HIV seropositive than is the general population of any refugee-hosting country.

People unfamiliar with refugee situations often tend to confuse, wrongly, the social promiscuity of large, crowded camps with the sexual promiscuity that tends to favorize transmission of HIV. Such notions are false and should be refuted.

19. Health implementing agencies (national, international and NGO) in refugee assistance programmes must therefore liaise with each other and then, through a Senior Health Coordinator, or a suitably designated person who can take on this responsibility with the national AIDS control authorities and WHO. WHO will almost always be involved at a national programme level. Such liaison is necessary before any health intervention is initiated, be it health education, testing or drafting of guidelines for the medical management of AIDS cases. Measures implemented in refugee settings must be commensurate with those applied to local national populations.

20. One particular issue is that of persons or agencies proposing to do research on HIV epidemiology. Prevalence surveys for any disease are often far easier to perform in a refugee camp because of the convenience of access to subjects; sampling techniques are more difficult to apply in large, dispersed local national populations. Because of this methodological difference, disease prevalence surveys often tend to find, artificially, higher rates of the targeted condition in the refugee setting. Once again, any measure that would tend wrongly to focus attention upon refugees as an at-risk social group is to be avoided.

Preventive Measures

21. Specific measures will be defined in each country by the national AIDS control programme, usually in association with the WHO Global Programme on AIDS. UNHCR will collaborate fully with these recommendations, provided that they target all residents, citizens and refugees alike.

22. Such measures will usually include health promotion (i.e. health education) and testing of donated blood or blood donors. Voluntary testing may also be offered. Counselling of HIV positive persons and the medical and social management of AIDS cases will also be covered by national guidelines.

23. Mass screening continues to be rejected by WHO. It is generally ineffective in preventing the introduction or spread of HIV infection. Certain countries have either begun or are planning to begin mandatory mass screening of all applicants for immigration, including refugees eligible for resettlement: this measure is not designed primarily to reduce spread of HIV infectious but rather to avoid accepting as immigrants persons who, because of HIV seropositivity, are highly likely to become heavy burdens upon the country's health and social welfare services with the following few years.

24. In the resettlement context, UNHCR must distance itself both operationally and financially from mandatory mass screening. This principle must be held to in all situations, including that in which a resettlement country processes refugees in a country other than that of first asylum (a so-called transit country): in this instance, the resettlement country should be urged to arrange HIV screening (if it insists upon this) in the country of first asylum on a bilateral basis.

25. Likewise, in the asylum context, although there is yet no precedent of refoulement for reason of proven or supposed HIV seropositivity, the potential for such practices exists. UNHCR should resist proposals to screen asylum seekers using the principles enunciated in paras 13-14 and 17-19. The same arguments apply to candidates for voluntary repatriation.

26. The kind of activities that UNHCR and its health implementing partners will be collaborating in are as follows:

(a) advocacy of inclusion of the principles and guidelines contained in the present document in national programmes and legislation dealing with AIDS, in-so-far-as they apply to refugees;

(b) health promotion: public education concerning the modes of transmission and their prevention;

(c) supervision and training, of health and counselling staff on specific preventive and case-management issues: cf. paras 32-39 and 45-49;

(d) technical support of health services within the framework of the national AIDS programme: e.g. testing of donated blood or blood donors, liaison with WHO and health ministries for the provision of culturally appropriate education materials;

(e) monitoring and active discouragement of dangerous practices such as unsupervised injections given by quack” healers outside of the official health structures (this may be a major factor in transmission, in some countries);

(f) counselling and material support for HIV-infected persons (both symptomatic and asymptomatic);

(g) medical management of AIDS cases.

27. The guidelines that follow below aim at reducing to a minimum the rising of HIV infection for both patients and staff in health facilities. These measures apply equally to other blood-borne infections such as hepatitis B. More detailed recommendations are available from WHO. The main targets of these recommendations are UNHCR’s health implementing partners.

Protection of health staff

28. Handling of body fluids and tissues: all specimens should be considered as potentially infective, whether or not the HIV serostatus of the patient is known. Precautions should apply to blood, other body fluids, and body tissues emanating from surgery/obstetrics and autopsies. Labels on specimen bottles should be prominently labelled “Blood Precautions”.

29. Education of staff on the precautions to be taken should target all persons working in a health facility: doctors, nurses, dentists, laboratory, technicians, paramedics, laundry workers, morticians, etc. Note that the professional risk run by all health workers is infinitely less than that to which they may be exposed in their private lives i.e. infection through sexual activity.

30. Gloves should be worn by all staff handling blood, body fluids or body tissues. Dentists, surgeons, obstetricians and midwives should wear both face-masks and spectacles. Gowns or aprons should also be worn during invasive procedures.

31. Sharp items such as needles, scalpel blades and other instruments need very careful handling once they have been used. Disposable needles should not be recapped because of the risk of needlestick injuries during the recapping action: they should be placed in a puncture-resistant container and then incinerated. Re-usable needles and syringes must be handled by personnel specifically trained to do so.

Protection of patients

32. Rigorous principles of cleaning and sterilization of all reusable items must be followed: needles, syringes, linen, and surgical/dental/obstetric instruments. WHO guidelines should be referred to (cf. Annex A).

33. Immunizations: in general, the standard vaccines of the Expanded Program of Immunization (EPI) have so far been found to be safe for use in persons who are HIV seropositive or who have clinical AIDS: the usual schedules for children and women of childbearing age should therefore be followed. The only exception is BCG for children AIDS (not simple HIV seropositivity), which should not be avoided. Proper sterilization technique and supervision of vaccinators are essential.

34. Infections: apart from rigorous cleaning and sterilizing techniques, all unnecessary and unsupervised injections should be avoided. All but the most serious or complicated conditions can usually be managed very well using oral medications. Community health workers in general do not need injectable medicines. Health workers performing injections outside of official health infrastructures should be the subject of strict control.

35. Blood transfusions should be avoided, whenever possible. Prevention of anaemia should be a maternal and child health priority. Transfusions should only be performed in a hospital setting and, unless HIV testing for donors is available, only if there is reasonable certainty that the patient will die without blood: this is usually only the case following acute massive haemorrhage (and not in chronic anaemia, even when very severe). HIV serotesting of blood donors, if available, should follow national guidelines.

Management of Infected Persons

36. As stated in paras 17 and 19, AIDS control measures for refugees must be strictly in line with those applied to national citizens. Persons with clinical AIDS, AIDS-related complex (ARC) or lymphadenopathy syndrome (LAS) shall be afforded the same level of services as are available to nationals: these will vary greatly from country to country but may include counselling, nursing support, hospitalization and outpatient treatment for intercurrent infections.

37. HIV-infected persons who do not yet manifest signs or symptoms of ARC, LAS or AIDS shall likewise be afforded the same counselling services as available to nationals.

38. Given current therapeutic resources, the medical management of AIDS cases is palliative only, wherever it occurs. Difficult as it is to accept for all persons in his or her entourage, it is at present inevitable that an AIDS patient will succumb to the disease: current therapy can only hope to treat intercurrent infections (with drugs nationally available) and to make the patient as comfortable as possible. Close contact with AIDS patients is extremely stressful and UNHCR implementing agency staff must resist the temptation to opt for last-ditch (and ineffective) gestures such as medical evacuation or the introduction of sophisticated or experimental therapies that are not appropriate in the local context.

Social Services and AIDS

39. Material assistance to individual cases may be necessary in order to afford refugees suffering from AIDS the same level of care available to nationals. Such assistance may be provided in the context of on-going SA or HD country projects, as appropriate. Social services staff should draw up inventories of treatment resources available in local hospitals

and health centres with a view to identifying a systematic referral system for HIV-infected persons. Such inventories of resources should be shared with Headquarters for consolidation.

40. Cases of suspected or proven AIDS should not be proposed for medical evacuation abroad. UNHCR has guidelines that preclude from such evacuation patients suffering from terminal illness; given, current therapeutic possibilities these guidelines should be respected in the case of AIDS.

41. Counselling by implementing partners should follow the principles and guidelines contained in the present document as well as those drawn up by national health ministries and WHO in each country concerned.

42. The principles of confidentiality and informed consent must be enforced and the handling of individual case files must be the object of special precautions. WHO recommends that notification of AIDS cases to health authorities should be on an anonymous basis i.e. by a code number, not name.

43. Social workers and counsellors must collaborate with general health staff, in coordination with national authorities and WHO, to ensure access of refugees to adequate and appropriate health promotional information. In order to maximize effectiveness, the refugees themselves should be involved in this process. In all situations, health education must be integrated with the services available for national citizens.

44. The psychological impact of HIV seropositivity must be addressed by counselling staff.

45. Advocacy of the rights of AIDS patients and HIV seropositive persons will also be incumbent upon social services staff. Any discriminatory practices should be identified and reported.

Conclusion

46. In every refugee situation in which AIDS or HIV infection is an issue, both human rights and protection principles oblige States and UNHCR to cooperate in the avoidance of individual tragedy. This involves recognition of the fact that exclusion is no solution, and that responses must be geared to the dual objectives of combating the disease and protecting the refugee. These objectives further entail the highest degree of inter-States and inter-agency cooperation, substantial contributions to the development of national schemes in receiving countries, and readiness to offer resettlement programmes which include those presently in need of care, as well as those who test HIV seropositive.

ANNEX A - Detailed Guidelines from WHO on Prevention of HIV Infection

Adapted from: WHO/CDS/AIDS/86/1

GUIDELINES FOR THE PREVENTION AND CONTROL OF INFECTION WITH LAV/HTLV III¹

MAY 1986

Guidelines for the Prevention and Control of Infection with HIV

WHO has committed itself to the preparation and distribution of guidelines for the prevention and control of infection with HIV. The guidelines are broad in nature and therefore suitable for international application. They are based on the experience of many member countries and advice from the WHO AIDS and Biosafety Collaborating Centres.

The guidelines are not complete at this time as some are currently under development. These are indicated by * on the list of contents. The complete guidelines will be made available as soon as they are finalized.

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¹ Since the publication of this document the name of the virus causing AIDS has been changed from LAV/HTLV III to HIV.

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1. Introduction

An important component of the WHO Special Programme of AIDs (SPA) is the preparation and distribution of guidelines, manuals and educational materials on prevention and control of HIV infections for professional personnel, for groups at risk and for the general public. The ultimate goal of the guidelines is prevention of HIV transmission, using strategies firmly anchored in fundamental public health concepts and utilizing the best available knowledge of the laboratory, clinical and epidemiological aspects of HIV infection. These guidelines are directed in the first instance, towards public health authorities and health professionals, who have the responsibility of adapting the guidelines to meet the extremely diverse requirements of many different populations and settings.

The guidelines will require modification as experience is gained in their practical application and as more is learned. SPA will revise the guidelines as necessary, in consultation with an international panel of experts in the laboratory, clinical and epidemiological aspects of infection.

1.1 The virus

A recently discovered retrovirus, called Human Immunodeficiency Virus (HIV), is considered to be the aetiologic agent of the acquired immunodeficiency syndrome (AIDS). A second retrovirus or retroviruses, provisionally identified as HIV-2, has recently been identified, although the role of these agents in AIDS is presently unclear.

HIV has been isolated from blood and semen and, at much lower titre and from a smaller proportion of infected patients, from saliva, tears, breast milk, urine, and vaginal secretions. The virus is also likely to be isolated from other body fluids, secretions and excretions.

The virus is very delicate in that it is easily inactivated. Common household disinfectants containing bleach, alcohol or ammonia when used at recommended strength inactivate the

virus in about one minute. The virus is also inactivated by high and low pH and heat; sera can be decontaminated at 56° without loss of serological activity. Section 7 provides further information.

1.2 Transmission

While HIV has been found in several body fluids, epidemiological evidence has thus far implicated only blood and semen in transmission. Epidemiological studies from diverse geographical settings have recognised only three modes of HIV transmission: (1) sexual; (2) parenteral; and (3) perinatal.

Worldwide, the most important mode of transmission is sexual. HIV can spread bi-directionally between heterosexual or homosexual partners. Transmission of HIV through semen donation has also been documented. Parenteral HIV transmission can occur through transfusion of whole blood, blood cells, platelets, or factors VIII or IX derived from contaminated human plasma. In addition, the accidental or intentional sharing or re-use of contaminated (unsterilized) needles, syringes, scalpels, razors, or other skin or mucous membrane-piercing instruments can transmit HIV. Perinatal transmission can occur from infected mother to child before, during, or shortly after birth.

Regardless of geographical area or socioeconomic setting, HIV is not transmitted through casual contacts in households, schools, or other groups living or working together. Similarly, there is no evidence of transmission by blood-sucking insects, food or water, or airborne or faecal/oral routes.

1.3 Clinical

HIV infection has been associated with a wide variety of clinical responses, including: (1) an asymptomatic carrier state; (2) an acute mononucleosis-like illness; (3) a generalized lymphadenopathy syndrome (LAS); (4) a complex of signs and symptoms, generally called the AIDS-related complex (ARC), involving unexplained lymphadenopathy, chronic fever, fatigue, malaise, weight loss, night sweats and chronic diarrhea; (5) acute and sub-acute neurologic and neuropsychiatric conditions, including encephalopathy, dementia and peripheral neuropathy; and (6) AIDS, characterized by opportunistic infections and/or malignancies, including Kaposi's sarcoma.

While clinical manifestations among infants and young children generally resemble those seen in adults, failure to thrive, pneumonitis and diarrhea are frequently observed.

The clinical manifestations associated with HIV may vary greatly in different geographical areas. For example, the dominant clinical expression of AIDS in Central Africa is a syndrome of profound weight loss accompanied by chronic diarrhea and/or fever.

Ongoing studies suggest that during a 2-5 year follow-up period, approximately two-thirds of HIV-infected persons will remain asymptomatic, while the remaining one-third will develop clinical illness varying in severity from mild to life-threatening (AIDS).

Two case definitions for AIDS have been published in the World Health Organization Weekly Epidemiological Record (WER). The first, the CDC/WHO definition, requires laboratory confirmation of certain opportunistic infections and/or malignancies. The second is a clinical definition, intended for use without laboratory support developed at a WHO conference in Bangui, Central African Republic, in October 1985.

1.4 Laboratory methods for detection of HIV infection

Laboratory procedures for detecting HIV infection include techniques to isolate the virus, to detect viral components by immunological or molecular techniques, and to detect antibodies to viral antigens. These techniques may be useful for confirming a diagnosis of AIDS or ARC, screening blood intended for transfusion or for production of factors VIII and IX, screening of donors of organs or semen, determining the prevalence of infection in the community, assessing the likelihood that an individual has been exposed to HIV, and evaluating various methods of preventing or treating the disease.

At present, the only practical approach for routine or large-scale testing is detection of antibody to HIV and the enzyme-linked immunosorbent assay (ELISA) is the antibody detection method most frequently used. ELISA test systems are highly sensitive (98%), however, not all reactive sera are indicative of HIV infections because of non-specific reactions. In general, the percentage of false positives” increases together with the sensitivity of the test systems. The acceptance of a test giving a relatively high percentage of false positives” at this time appears prudent in order to detect all truly positive specimens among blood donors. A more specific, but also less sensitive assay system may be more appropriate for some epidemiological studies when confirmatory tests are not readily available. All repeatedly ELISA-reactive sera should be tested (confirmed) in another system. Immunoblots (Western blots) have been most frequently used for this purpose, while some laboratories are using immunofluorescence tests with HIV infected and non-infected control cells. HIV antibodies usually develop within weeks (rarely months) after infection and remain demonstrable possibly for life. Since a large proportion of seropositive persons, whether asymptomatic or clinically ill, have been shown, at one time or another, to be viraemic, all seropositive individuals must be presumed capable of transmitting HIV.

1.5 Notification and confidentiality

AIDS should be designated as a notifiable disease and immediate reporting should be established within the national surveillance system. The exchange of information on AIDS and the serio-epidemiology of infection HIV is vital for global surveillance.

Strictest confidentiality must be maintained. Given the sensationalism that often accompanies the occurrence of AIDS and adverse reactions by an unformed public, patients and infected persons must remain anonymous. The use of a patient number rather than a name is recommended. No identifying information about an individual should be shared by the official health agencies or any physician, without the permission of the individual (except in cases required by law). Only summary statistical information without individual identifiers should be reported to public health authorities.

1.6 Case definitions

1.6.1 WHO/CDC case definition

For surveillance purposes, a relatively precise case definition is required that includes the most characteristic manifestations of HIV infectious. WHO recently adopted the case definition of AIDS in adults and children developed by the Centers for Disease Control (CDC) and endorsed by the participants at the Second Meeting of the WHO Collaborating Centres on AIDS held in Geneva 16-13 December 1985. The WHO/CDC definition, to be applied in countries where appropriate diagnostic techniques are available, specifies that a case of acquired immunodeficiency syndrome (AIDS) is an illness characterized by:

- one or more of the opportunistic disease listed below (diagnosed by methods considered reliable (that are at least moderately inactive of underlying cellular immunodeficiency; and
- absence of all known underlying causes of cellular immunodeficiency (other than HIV infection) and absence of all other causes of reduced resistance reported to be associated with at least one of those opportunistic diseases.

Despite having the above, patients are excluded as AIDS cases if they have negative result(s) on testing for serum antibody to HIV, do not have a positive culture for HIV, and have both a normal or high number of T-helper (OKT8 or LEUZ) lymphocytes. In the absence of test results, patients satisfying all other criteria in this definition are included as cases.

This general case definition may be made more explicit by specifying:

- the particular diseases considered at least moderately indicative of cellular immunodeficiency, which are used as indicators of AIDS; and
- the known causes of cellular immunodeficiency, or other causes of reduced resistance reported to be associated with particular diseases, which would disqualify a patient as an AIDS case.

1.6.2 Provisional WHO clinical case definition for AIDS

A clinical case definition is needed in countries where diagnostic resources are limited. A provisional clinical case definition was developed at a WHO Workshop on AIDS held in Bangui, Central African Republic, 22-24 October 1985. This definition was reviewed and adopted at the Second Meeting of the WHO Collaborating Centres on AIDS as follows:

Adults

AIDS in an adult is defined by the existence of at least two of the following major signs associated with at least one minor sign, in the absence of known causes of immunosuppression such as cancer or severe malnutrition or other recognised etiologies.

Major signs

- weight loss > 10 of body weight;
- chronic diarrhea > 1 month;
- prolonged fever > 1 month (intermittent or constant).

Minor signs

- persistent cough for > 1 month;
- generalized pruritic dermatitis;
- recurrent herpes zoster;
- oro-pharyngeal candidiasis;
- chronic progressive and disseminated herpes simplex infection;
- generalized lymphadenopathy.

The presence of generalized Kaposi's sarcoma or cryptococcal meningitis are sufficient by themselves for the diagnosis of AIDS.

Children

Paediatric AIDS is suspected in an infant or child presenting with at least two of the following major signs associated with at least two of the following major signs in the absence of known cases of immunosuppression such as cancer or severe malnutrition or other recognized etiologies.

Major signs

- weight loss or abnormally slow growth;
- chronic diarrhea > 1 month;
- prolonged fever > 1 month.

Minor signs

- generalized lymphadenopathy;
- oro-pharyngeal candidiasis;
- repeated common infections (otitis, pharyngitis, etc.)
- persistent cough;
- generalized dermatitis;
- confirmed maternal HIV infection

These clinical case definitions are believed to be sensitive but have not yet been formally evaluated. There may be differences in clinical features among different countries. Therefore, there is an urgent need to evaluate carefully clinical diagnostic criteria in different settings. Countries initially using the clinical case definition may wish to test its specificity by confirming a sample number of cases by detection of specific antibody to HIV.

2. Recommendations for health care workers (HCW)

Health care workers include, but are not limited to, nurses, doctors, traditional healers, dentists and other dental workers, optometrists, pediatricians, chiropractors, laboratory and blood bank technologists and technicians, phlebotomists, dialysis personnel, paramedics, emergency medical technicians, medical examiners, morticians, housekeepers, laundry workers, and others whose work involves contact with patients, their blood or other body fluids, or corpses.

Recommendations for HCWs emphasise precautions for preventing transmission of bloodborne infectious disease. These precautions should be enforced routinely, as should other standard infection-control precautions, regardless of whether health care workers or patients are known to be infected with HIV. In addition to being informed of these precautions, all health care staff, including students and all hospital workers, should be educated regarding the epidemiology, clinical manifestations, transmission and prevention of HIV infection.

The risk for HCWs of acquiring HIV from infected patients is remote. Extensive experience among HCWs in contact with the blood of infected patients through needle-stick injuries or mucosal exposure have documented only a single case of infection; a small number of other cases possibly associated with in-hospital exposures have been reported. Finally, it is important that HIV infected patients be treated with dignity and respect and according to the highest professional standards, without prejudice or stigmatization.

The detailed application of the practices described below may vary according to the prevalence of HIV infection in the patient population, or the availability of infection control resources, and other factors. The most important practices to prevent HIV transmission from patients to HCWs involve avoiding needlestick and other parenteral, mucous membrane or open lesion exposure to patients' blood. The most important practice to prevent HIV transmission from infected HCWs to patients is exclusion of HCWs with exudative lesions from direct patient contact. Finally, prevention of patient to patient HIV transmission requires rigorous sterilization of reusable equipment such as needles, syringes and skin-piercing instruments.

2.1 Precautions for HCWs

These precautions represent prudent practices that apply to preventing transmission of all bloodborne infections and should be used routinely.

2.1.1 Sharp items (needles, scalpel blades, and other instruments) should be considered as potentially infective, should be handled with extraordinary care to prevent accidental injuries, and should be placed into puncture-resistant containers located as close as practical to the area in which they were used. To prevent needlestick injuries, disposable needles should not be recapped, purposefully bent, broken, removed from disposable syringes, or otherwise manipulated by hand. Disposable needles and syringe should be destroyed promptly or otherwise handled to prevent re-use. This may be accomplished by (1) incineration, or (2) by first autoclaving or boiling, then breaking, crushing or otherwise deforming the needle and syringe before being buried. Reusable needles and syringes must be handled by personnel who are carefully trained in methods designed to minimize the risk of accidental injuries. Details for processing reusable needles and syringes are contained in section 7.3

2.1.2 Extraordinary care should also be taken to avoid contact of open skin lesions on HCWs with materials (especially blood) from HIV infected patients. When the possibility of exposure to blood or other body fluids exists, the degree of care will depend upon the risk involved (e.g., gloves, alone may suffice for handling items soiled with blood or equipment contaminated with blood or other body fluids, while gowns, masks and eye-coverings may be required when performing procedures involving more extensive contact with blood or potentially infective body fluids, as in some dental or endoscopic procedures or postmortem examinations. Hands should be washed thoroughly and immediately if they become contaminated with blood.

2.1.3 Blood and other specimens from known or suspected HIV infected patients should be labelled prominently with a special warning such as "Blood Precautions". In some areas, the prevalence of HIV infection in the patient population may justify handling all blood specimens as if they contained HIV. If the outside of the specimen container is visibly contaminated with blood, it should be cleaned with a disinfectant (see section 7.1). All blood specimens should ideally be placed in a second container, such as an impervious bag, for transport. The bag or container should be examined carefully for leaks or cracks.

2.1.4 Blood spills should be cleaned up promptly with a disinfectant solution, such as sodium hypochlorite (see section 7.1).

2.1.5 Articles contaminated with blood should be placed in an impervious bag prominently labelled "Blood Precautions" before being sent for reprocessing or disposal. Alternatively, such contaminated items may be placed in plastic bags of a particular color designated solely for disposal of infectious wastes by the hospital. Disposable items should be incinerated or disposed of in accord with the hospital's policies for disposal of infectious wastes. Such policies include autoclaving followed by burial in a landfill. Reusable items should be reprocessed in accord with hospital policies for items contaminated with Hepatitis B virus. Instruments with lenses should be sterilized after use on patients known or suspected to be HIV infected or if this is not possible, cleaned and exposed to a high level disinfectant (see section 7.2).

2.1.6 Disposable needles and syringes are preferred, provided that they are disposed of after a single use. Only needle-locking syringes or one-piece needle-syringe units should be used to aspirate fluids from patients, so that collected fluid can be safely discharged through the needle, if desired. If reusable syringes are employed, they must be sterilized before reuse (see section 7.3) and special care must be taken in handling to avoid injuries.

2.1.7 Precautions such as single-room isolation are not generally indicated for HIV infected patients. However, to the extent possible, a private room may be indicated for patient having: (1) a particular superinfection which requires such isolation precautions; (2) a need for protective isolation; (3) difficulties in maintaining standards of hygiene, such as profuse diarrhea, faecal incontinence, uncontrolled bleeding, or altered behavior secondary to central nervous system involvement; or (4) needs for a single room based on the severity or terminal nature of the illness.

2.1.8 To minimize the need for emergency mouth-to-mouth resuscitation, mouth pieces, resuscitation bags, or other ventilation devices should be strategically located and available for immediate use.

2.1.9 Prevention of transmission from HIV infected HCWs to patients:

- In general, HCWs known to be infected with HIV need not be restricted from work unless they have evidence of other infection or illness for which any HCW should be restricted.

- HCWs with exudative lesions should be excluded from direct patient care until the condition has resolved.

- HCWs infected with HIV may be at increased risk of requiring or experiencing serious complications of other infectious diseases. The HCWs personal physician, in conjunction with their institution's personnel health services or medical directors, should determine on an individual basis whether the infected HCW can adequately and safely care for patients and suggest changes in work assignments, if indicated.

- Ideally, all HCWs should wear gloves for direct contact with mucous membranes or nonintact skin of all patients. The use of gloves by all HCWs is imperative during invasive procedures.

2.2 Precautions for HCWs providing home care of HIV infected patients

Most persons infected with HIV and not requiring hospitalization can be safely cared for at home. HCWs providing home care face the same low risk of infection as HCWs in hospitals and other health care settings, and should follow the precautions outlined above.

2.3 Precautions for providers of pre-hospital emergency care

Providers of pre-hospital emergency care include paramedics, emergency medical technicians, law enforcement personnel, firefighters, lifeguards, and others whose job might require them to provide first-response medical care. The risk of transmission of HIV infection should not be higher than for HCWs providing emergency care in the hospital if appropriate precautions are taken to prevent exposure to blood or other body fluids. Providers of pre-hospital emergency care should follow the precautions outlined above for other HCWs. Resuscitation and other equipment possibly contaminated with blood or other body fluids should be used once and disposed or be thoroughly cleaned and disinfected (see section 7.1).

2.4 Management of parenteral and mucous membrane exposure

If a HCW has a parenteral (e.g. needlestick or cut) or mucous membrane (e.g., splash to eye or mouth) exposure to blood or other body fluids, the source patient should be assessed clinically and epidemiologically to determine the likelihood of HIV infection. In some situations serologic testing of the source patient may be considered. If the source patient has evidence of HIV infection, the HCW should be evaluated clinically and serologically for evidence of HIV infection as soon as possible after the exposure. If the HCW is seronegative, he/she should be re-tested and evaluated clinically 6 weeks later and on a periodic basis thereafter (e.g., 3, 6 and 12 months following exposure) to determine if transmission has occurred.

During this follow-up period, especially the first 6-12 weeks when most infected persons are expected to seroconvert, the HCW should receive counselling about the risk of infection. The procedure outlined above is in addition to any other management protocols, such as for Hepatitis B.

If a patient has a parenteral or mucous membrane exposure to blood or other body fluids of an infected HCW, an analogous procedure to that outlined above should be followed for both the source HCW and the potentially exposed patient.

2.5 Laboratory staff

Rather than institute special precautions for known HIV contaminated specimens, routine precautions against transmission of blood procedures and use of ELISA and other diagnostic procedures may be performed under the conditions described. For work involving production and purification of HIV, containment laboratory facilities and procedures apply (P-3: Biosafety level 3: containment level 3 – see WHO Laboratory Safety Manual).

2.5.1 Mechanical pipetting devices should be used for the manipulation of all liquids in the laboratory. Mouth pipetting should not be allowed.

2.5.2 Needles and syringes should be handled as stipulated in 2.1.1.

2.5.3 Laboratory coats, gowns, or uniforms should be worn while working with potentially infectious materials and should be discarded appropriately before leaving the laboratory.

2.5.4 Gloves should be worn to avoid skin contact with blood, specimens containing blood, blood-soiled items, body fluids, excretions, and secretions as well as surfaces, materials and objects exposed to them.

2.5.5 All procedures and manipulations of potentially infectious material should be performed carefully to minimize the creation of droplets and aerosols.

2.5.6 Biological safety cabinets (Class I or II) and other primary containment devices (e.g. centrifuge safety cups) are advised whenever procedures are conducted that have a high potential for creating aerosols or infectious droplets. These include centrifuging, blending, sonicating, vigorous mixing, and harvesting infected tissues from animals or embryonated eggs. Fluorescent activated cell sorters generate droplets that could potentially result in infectious aerosols. Translucent plastic shielding between the droplet-collecting area and the equipment operator should be used to reduce the presently uncertain magnitude of this risk. Primary containment devices are also used in handling materials that might contain concentrated infectious agents or organisms in greater quantities than expected in clinical specimens.

2.5.7 Laboratory work surfaces should be decontaminated with a disinfectant, such as sodium hypochlorite solution (see 7.1) following any spill of potentially infectious material and at the completion of work activities.

2.5.8 All potentially contaminated materials used in laboratory tests should be decontaminated, preferably by autoclaving, before disposal or reprocessing.

2.5.9 All personnel should wash their hands following completion of laboratory activities, and removal of protective clothing, and before leaving the laboratory.

2.5.10 Eating, smoking, drinking or applying cosmetics in the laboratory is not permitted.

2.6 Dental care personnel*

2.7 Persons performing necropsies or providing morticians' services*

2.8 Eye examiners*

3. Considerations relevant to non health care workers

3.1 Personal service workers

Personal service workers are defined as individuals whose occupations involved close personal contact with clients (e.g. hairdressers, barbers, manicurists, pedicurists, massage therapist). Personal service workers whose services (tattooing, ear piercing, acupuncture, etc.) require needles or other instruments that penetrate the skin should follow precautions indicated for health care workers. Particular care must be taken to ensure that all skin-piercing instruments are properly disinfected (section 7.1). Although there is no evidence of transmission of HIV from clients to these personal service workers, or from these personal service workers to their clients, a risk of transmission could exist in situations where there is both (1) trauma to one of the individuals that would provide a portal of entry for the virus, and

(2) access of blood or serious fluid from one infected person to the open tissue of the other, as could occur if either sustained a cut, or if a blood-contaminated instrument was not sterilized or disinfected between clients. However, as hepatitis B virus (HBV) transmission has rarely been in other personal-service settings, ear piercing, or tattooing establishments and never in other personal-service settings, the risk for HIV transmission in most personal service settings is likely to be extremely low.

All personal service workers should be educated about transmission of bloodborne infections, including HIV and HBV. Such education should emphasise principles of good hygiene, sterilization, antisepsis, and disinfection. Instruments that are intended to penetrate the skin (e.g. tattooing and acupuncture needles, ear piercing devices) should be used once and disposed of or be thoroughly cleaned and sterilized after each use (section 7.1 and 7.2). Any personal service worker with exudative lesions or weeping dermatitis, regardless of infection status, should refrain from direct contact with clients until the condition resolves. Personal service workers known to be infected with HIV need not be restricted from work unless they have evidence of other infections or illness for which any personal service worker should also be restricted.

3.2 Food service workers

Food service workers are defined as individuals whose occupations involve the preparation or serving of food or beverage (e.g. cooks, caterers, servers, waiters, bartenders, airline attendants). All epidemiological and laboratory evidence indicates that blood-borne and sexually transmitted infections are not transmitted during the preparation or serving of food or beverages and no instances of HIV or HIV transmission have been documented in this setting.

All food service workers should follow recommended standards and practices of good personal hygiene and food sanitation. All food service workers should exercise care to avoid injury to hands when preparing food. Should such an injury occur, both aesthetic and sanitary considerations would dictate that food contaminated with blood be discarded. Food service workers known to be infected with HIV need not be restricted from work unless they have evidence of other infection or illness for which any food service worker should also be restricted.

3.3 Workers sharing same work environment

No known risk of transmission to co-workers clients or consumers exists from HIV infected workers in other settings (e.g. offices, schools, factories, construction sites). Workers known to be infected with HIV should not be restricted from work solely based on this finding. Moreover they should not be restricted from using telephones, office equipment, toilets, showers, eating facilities and water fountains. In general, equipment contaminated with blood or other body fluids of any worker should be cleaned with soap and water or a detergent, and ideally, a disinfectant solution or a fresh solution of sodium hypochlorite (household bleach) should be used to wipe the area after cleaning.

4. Parenteral transmission

4.1 Blood and blood products - see WER Vol. 61 No 18 2 May 1986.

4.2 Other***5. Guidance for health Professionals*****6. Guidance for High risk groups and the general population*****7. Disinfection and sterilization**

Recent studies have shown that disinfectants commonly used in laboratories and health care facilities will kill HIV at concentrations much lower than those commonly used in general practice. Routine sterilization and disinfection procedures used in health care facilities and in laboratories do not need to be altered because of a concern for HIV. Disinfectants that are mycobactericidal are preferred as these are effective against the most resistant groups of microorganisms.

7.1 Commonly available effective disinfectants are:

7.1.1 Chlorine-Sodium hypochlorite

A solution of 5 g/litre (5000 ppm) as available chlorine is recommended for general use.

Dilution of Chlorine solutions

Required strength Household bleach Eau de Javel Chloros

USA & Canada France U.K.;10 % 15 %

5g/L 1 part to 10 parts 1 part to 30 1 part to 1 part to

(0.5 %) water parts water 20 parts 30 parts;water water

When using hypochlorite solutions, it is to be remembered that they gradually lose strength, necessitating daily preparation of fresh solutions. Care is required in preparation of the fresh solution from stock solutions as the amount of available in stock solutions varies with the country of manufacture - i.e. household bleach, USA - 5.25 % available chlorine: Eau de Javel, France - 15 % available chlorine; -"Chloros", UK - 10-15 % available chlorine.

A 10 to 30 minutes contact time is required depending upon level of contamination of material to be disinfected.

7.1.2 Formaldehyde as Formalin: 50g / litre (5%). 10-30 minute contact time.

7.1.3 Ethanol: 700g / litre (70 %). 10-30 minute contact time.

7.1.4 Glutaraldehyde: 20 g/litre (2 %). 10-30 minute contact time.

7.2 Sterilization

7.2.1 Ideally, all reusable patient care equipment and instruments entering the blood stream or tissue should be sterilized by steam under pressure (autoclaving). Autoclaves should be operated at 121°C (250°F) for a minimum exposure time of 20 minutes. Such equipment may also be decontaminated by boiling for 20 minutes.

7.2.2 Non-disposable heat labile equipment and instruments must be subjected to a high level of disinfection. The technique requires scrupulous cleaning of the materials prior to disinfection with a suitable germicide such as 2 % glutaraldehyde for 10-30 minutes contact time. Following this, the equipment should be thoroughly rinsed with sterile water. Other disinfectants may be used but care should be taken to use those that are compatible with the materials of the medical devices. The use of recognised gaseous sterilization techniques may also be used if equipment is available.

7.3 Processing needles and syringes (reusable)

Disposable, single-use syringes and needles are generally preferred for all patient care and laboratory procedures. Needle locking syringes or one piece needle syringe units (disposable or reusable) should be used to aspirate fluids so that the collected fluid can be safely discharged through the needle if desired. However, in some situations re-usable syringes and needles suitable for re-use and sterilization may be preferred for economic and practical reasons. In this setting it is imperative that needles and syringes are decontaminated before reprocessing and re-use.

Re-usable syringes and needles may be processed for re-use by the following methods: (Note: gloves must be worn and extreme care exercised to prevent needlesticks and/or cuts.)

- Leave needle attached to syringe.
- Fill syringe with disinfectant solution.
- Immerse syringe and attached needle in disinfectant solution (horizontal in flat tray).
- Leave immersed in disinfectant solution for 20 minutes.
- Aspirate disinfectant solution from syringe and needle.
- Rinse syringe and needle in sterile or boiled water (fill and aspirate).
- Examine needles and syringes for needle barbs, syringe seal integrity (rubber ring), needle hub fit to syringe, readable syringe markings, etc.
- Disinfect or sterilize syringe and needle by autoclaving (steam sterilize) or boiling prior to re-use.

7.4 Care of eye examination instruments and contact lenses*