Children at school and problems related to AIDS.

CHILDREN at SCHOOL and problems related to AIDS

Department of Education and Science and Welsh Office

This booklet has been produced as a guide for schools, teachers and school health personnel, by the Department of Education and Science and the Welsh Office.

Foreword

This booklet incorporates advice from a specially convened DHSS Working Group including medical experts and has been approved by the Expert Advisory Group on AIDS (Acquired Immune Deficiency Syndrome) appointed by the Secretary of State for Social Services. It draws extensively on guidance issued by the US Centers for Disease Control.

The first known case of AIDS in the United Kingdom was reported in 1981. A number of cases had been identified earlier in the USA. The disease is therefore a comparatively new one in the western world, and there still exists much misunderstanding about it and about infection with the virus which has been identified as its cause.

It is important that all those concerned with the education and care of children should be properly informed about AIDS and the Human-T-Lymphotropic Virus Type III/Lymphadenopathy Associated Virus (HTLV-III/LAV), whether or not they are directly concerned with an infected person.

The recommendations in this booklet apply to all children known to be infected with HTLV-III/LAV and include children with positive HTLV-III/LAV antibody test, with AIDS-related conditions and full clinical AIDS.

This booklet has been prepared for the information and guidance of local education authorities, school governing bodies, school staff and parents. It is also being issued to doctors including general practitioners, paediatricians and haematologists, to assist them when advising children and their families.

March 1986

BACKGROUND

1. As in many virus diseases, infection with Human-T-Lymphotropic Virus Type III/Lymphadenopathy Associated Virus (HTLV-III/LAV) has a wide spectrum of clinical expressions. Most infected people show no symptoms, and can be identified only by a test for the presence of virus antibodies in their blood. A minority are severely affected and develop AIDS (Acquired Immune Deficiency Syndrome) and then succumb to infections which take advantage of the resulting lowered immunity of the body. It is important to point out that the majority of individuals infected with HTLV-III/LAV, although they show no symptoms and may never develop AIDS, are carriers of the virus, and, in certain circumstances described in paragraph 3 below, may transmit it to other people.

2. The first case of AIDS in the UK was reported in 1981. At present the number of cases which have been reported to the Communicable Disease Surveillance Centre is small, although the number of people who have been exposed to the virus is thought to be significantly greater. Over the next few years, new cases of AIDS and AIDS-related conditions will arise out of those already infected with HTLV-III/LAV. Recent studies in the United States of America would suggest that in adults about 10 per cent of such carriers have gone on to develop the full blown AIDS but in people who have haemophilia the figure would seem to be very much smaller.

MODE OF SPREAD

3. HTLV-III/LAV is transmitted principally by:

- sexual intercourse with an infected person – predominantly between male homosexuals;
- the transfusion or inoculation of infected blood and blood products;
- the sharing of contaminated needles and syringes among injecting drug misusers.

4. There is no evidence to date that there is a risk of transmission of infection from:

- normal social contact;
- airborne droplets from coughing and sneezing;
- sharing washing or toilet facilities;
- sharing eating and drinking utensils;
- living in the same house.

Although the virus has been isolated in saliva and tears there is no documented evidence of the spread of infection from these

secretions. There is a theoretical risk of transmission through exposure of open skin lesions or mucous membranes to the blood or body fluids of an infected person.

Infected mothers and blood transfusion

5. The number of infected children is at present small, but is likely to increase, the major cause of the increase being in the numbers of children born to infected mothers. Infected women may transmit the virus to their infants during pregnancy or birth or possibly through breast milk.

6. The risk of a child becoming infected as a result of a blood transfusion is extremely low and this risk has been reduced even further by the screening of all blood donations for the virus antibody.

Haemophilic HTLV-III/LAV antibody positive children

7. Children with haemophilia, almost all of whom are male, suffer from a clotting defect which causes bleeding into joints and also soft tissues after knocks rather than external bleeding. Any cuts to haemophilic HTLV-III/LAV antibody positive children do not present a significant hazard to others providing they are managed promptly as suggested in the Annex.

8. HTLV-III/LAV infection has occurred in some of these children as a result of some batches of Factor VIII and IX preparations (blood-clotting agents used in their treatment) being infected with the virus. All Factor VIII and IX in use in this country is now heat treated; this should eliminate any future risk of transmission from these agents. The great majority of haemophilic children (who total just over 700 in the UK) have now been tested for the HTLV-III/LAV antibody; of these, 35 per cent have been found to be antibody positive and carriers of the virus. As these children reach school leaving age, the number of infected haemophilic children in schools will gradually diminish.

Is there any risk of transmission in school?

9. None of the identified cases of HTLV-III/LAV infection in the United States or in the UK are known to have been transmitted in the school setting or through other casual personal contact or in families.

10. Studies of the known cases in the USA and UK have shown no evidence that infection has been transmitted by casual person-to-person contact such as occurs in schools. Furthermore, research has shown that intimate contact in a family setting with children

(including haemophiliacs) who are infected with HTLV-III/LAV or who have AIDS has not led to infection spreading to other members of the family.

THE CHILD IN SCHOOL

11. Since there is no apparent risk on all present evidence of transmitting HTLV-III/LAV in the school setting, and since the benefits for an infected child attending school and enjoying normal social relationships far outweigh the risk of a child with AIDS acquiring harmful infections (see paragraph 17 below), infected children should be allowed to attend school freely and be treated in the same way as other pupils.

12. It follows from this that the fact of HTLV-III/LAV infection should not, in the Department's view, be a factor taken into account by local education authorities, governing bodies and head teachers in discharging either their various duties concerning school admissions, transfers and attendance (in respect of an infected child or otherwise), or their powers of exclusion from school.

Counselling and confidentiality

13. It is understandable that, as a result of inaccurate publicity, parents whose children attend the same school as an HTLV-III/LAV infected child may be afraid that their own will become infected, and they are likely to need reassurance from professionals. Parents of HTLV-III/LAV infected children need to be aware of the potential for social isolation if the child's condition becomes known to others in the school. Those involved in educating and caring for these children should be sensitive to their need for confidentiality and their right to privacy. It must be emphasised, too, that both the parents and the child will need support and counselling and this is likely also to be needed by teachers and others involved in the direct care of the child at school. The number of people, including teachers, who are aware that a child is infected should be restricted, and should be rigorously confined to those who need to know in order to ensure the proper care of the child when conditions arise such as bleeding injury, where the potential for transmission may increase.

Young and handicapped children

14. Studies of the risk of transmission of the virus through contact between young children and neurologically handicapped children who lack control of their body secretions are very limited. In the light of experience with other infectious diseases the theoretical potential for transmission would be greatest among these children.

15. If a child is developmentally delayed or handicapped, this fact will be taken into account along with information on his or her HTLV-III/LAV antibody status, in medical and nursing advice to the local education authority when assessing the educational needs of each individual child under the requirements of the Education Act 1981.

16. There is no reason why children who are not handicapped and are HTLV-III/LAV infected should not be considered, in the light of medical and nursing advice, for placement in nursery schools or nursery classes within ordinary schools or in whatever other provision would be appropriate.

Risks to the child with HTLV-III/LAV infection

17. Most HTLV-III/LAV infected children show no symptoms. Children with AIDS suffer a lowering of their immunological defences. At present there are no children with AIDS in the UK. Such children may have a greater risk of catching infections at school than at home and may also suffer severe complications, due to their lack of natural defences (immunodeficiency) from the common childhood infections such as chicken pox, measles or herpes simplex (cold sore virus). Assessment of possible risk to, and management of, these immunodeficient children would be for their general practitioner, dentist, school doctor and school nurse together with the consultant paediatrician or haematologist involved. A very small number of children with HTLV-III/LAV infection may deteriorate in health, and therefore may need to be medically reassessed. Such reassessment should be the responsibility of the doctor who is in charge of the clinical care of the child.

18. Some people with AIDS and some with less severe manifestations of the infection may develop impaired mental functions. Alteration in intellectual performance or physical difficulties in an HTLV-III/LAV antibody positive child should alert school staff to the possibility of encephalopathy (neurological/developmental problems). There is no reason to think that such disorders would necessarily require removal from school but psychological and medical advice should be sought since special educational provision may be needed.

Incontinence

19. If an infected child is incontinent staff should follow the hygiene procedures set out in the Annex, paragraph 5.2.

Sucking, mouthing and chewing

20. The sucking of thumbs or mouthing of toys or chewing of pens or pencils is not considered a risk.

Biting

21. Habitual biters of any age will pose problems. Some will be in community care and most will be severely mentally handicapped. These children should be assessed individually as detailed in paragraph 15 above.

Soiled materials and management of accidents

22. Incontinence has already been dealt with in paragraph 19 above. Where an infected schoolgirl has passed puberty the question of disposal of soiled menstrual materials also arises. Guidance is given in the Annex, paragraphs 1.3 and 1.4. Where an accident occurs which leads to bleeding such as a nosebleed, or a child becomes ill with vomiting and/or diarrhoea, it will be necessary to clean up clothing and dispose of waste. Details of procedures to be followed are contained in the Annex, paragraph 5.

Particular school subjects or activities where risk may occur and where guidance is required

23.	Craft, Design and Technology	normal safety precautions should be taken;
	Home Economics	normal safety precautions should be taken;
	Music lessons	the sharing of wind instruments presents no risk. The usual hygienic practices should be observed;
	Science subjects	no HTLV-III/LAV antibody positive person should give blood for class use;
	Sport and outdoor pursuits	i may be freely allowed provided there is no other medical condition which prevents the child participating; ii swimming pools should be chlorinated or suitably treated according to standard practice. Normal precautions should be taken; iii barefoot work presents no risk.
24.	First Aid	When teaching mouth-to-mouth resuscitation it is sound hygienic practice for children to be taught the use of the specially designed device incorporating a valve and mask. No cases of AIDS have

arisen as a result of direct mouth-to-mouth resuscitation. In an emergency direct mouth-to-mouth resuscitation should not therefore be withheld.

Children's games and social practices

25. There are some games and social practices which schools and head teachers should discourage to prevent the spread of infection not only of HTLV-III/LAV but also other conditions such as hepatitis (infectious jaundice). These include:

- Blood brothers/sisters

  Sometimes it is fashionable for children to confirm friendship by cutting or pricking the skin so that two or more children can become blood brothers or sisters with the mingling of blood.

- Ear piercing

  Many girls and some boys have their ears pierced. Unless the ear piercing equipment is properly sterilised there is a risk of transfer of infection.

- Tattooing

  Similar considerations apply as for ear piercing.

HEALTH EDUCATION

26. It is of great importance that there should be adequate knowledge and understanding about AIDS and HTLV-III/LAV among the public generally as well as among those who are directly involved with infected people. The education service should ensure that school staff and pupils are informed about the virus and its transmission. The Chief Medical Officer is writing separately to District Health Authorities.

27. Schools can contribute to the general level of knowledge and awareness about AIDS through the health education which they offer to their pupils. The majority of secondary schools include some teaching about sexually transmitted diseases within their programme of health education, generally in the context of sex education. Other secondary schools and primary schools usually address the issue as it arises in the course of other work, e.g. in response to questions from pupils. Local education authorities and individual schools should now consider how such approaches might be extended to cover HTLV-III/LAV, bearing in mind that the publicity given to the disease is bound to have reached schoolchildren and that this is an issue about which many parents will have strong feelings.

28. This will be a difficult and delicate task. Some consideration of the nature of HTLV-III/LAV and of the circumstances associated with its incidence within the community are appropriate topics for the classroom, although considerable care and sensitivity are needed to match the teaching to the maturity of the pupils involved. The basis of any teaching offered should be the presentation of straightforward, factual information about the virus and about modes of transmission of infection – along the lines of the information provided in the early part of this document – in order to balance the incomplete and inaccurate impression which pupils may have gained from other sources. In particular it should be made clear that on current epidemiological evidence normal social and occupational contact such as occurs in schools, or living in the same house with an AIDS sufferer or HTLV-III/LAV carrier, poses no risk of infection to others provided normal hygiene precautions are followed (see the Annex).

29. Schools should see it as part of their task, in the context of personal and social education, to consider with pupils some of the broader questions associated with the transmission of infection, including the health risks of promiscuous sexual behaviour, whether heterosexual or homosexual. Pupils should not, however, be left with the impression that AIDS and HTLV-III/LAV infection can be contracted only through particular forms of sexual behaviour. There should be reference to the risks to injecting drug misusers – possibly linked with teaching aimed specifically at preventing drug misuse – and also to the possibility of haemophiliacs and others having acquired the virus through contaminated blood products. With more senior pupils it may be possible and desirable to introduce a balanced discussion about the implications of AIDS for society at large and for the lifestyles of individuals.

FURTHER ADVICE AND INFORMATION

30. Further advice on the care and treatment of an HTLV-III/LAV infected child within the school environment may be sought from the District Health Authority medical, dental and nursing staff responsible for the child and school health services, and local Haemophilia Centres. Literature produced by the Health Education Council, 78 New Oxford Street, London WC1 1AH, may be helpful to teachers and health professionals.

ANNEX
HTLV-III/LAV – Infection control guidelines for local education authorities, schools and health staff

This guidance applies to HTLV-III/LAV infected children.

1. Personal hygiene

1.1 Razors, toothbrushes or other implements which could become contaminated with blood must not be shared.

1.2 Minor cuts, open or weeping skin lesions and abrasions should be covered with waterproof or other suitable dressings.

1.3 Sanitary towels must be burnt in an incinerator or the procedure for disposal of infected waste followed (see below*).

1.4 Tampons may be flushed down the toilet.

2. Accidents involving external bleeding

2.1 Normal First Aid procedures should be followed, which should include the use of disposable gloves where possible.

2.2 Wash the wound immediately and copiously with soap and water. Apply a suitable dressing and pressure pad if needed.

2.3 As soon as possible seek medical advice.

2.4 Splashes of blood from HTLV-III/LAV antibody positive child on to another child:

- splashes of blood on the skin should be washed off immediately with soap and water.
- splashes of blood into the eyes or mouth should be washed out immediately with copious amounts of water.

2.5 After accidents resulting in bleeding, contaminated surfaces, e.g. tables or furniture, should be cleaned liberally with household bleach, freshly diluted 1:10 in water. Such solutions must not come into contact with the skin.

NB: Bleach can corrode metal and burn holes in fabrics if used for too long or in the wrong concentration, and must never be used on skin.

2.6 Complete an accident form in the usual manner.

3. General hygiene

3.1 Cleaning:

- normal cleaning methods should be used. No special disinfectants are necessary for either the bath or toilet.
- use disposable cloths.
- use separate cloths for kitchen, for bathroom, and for toilet.

3.2 Spillages of blood and vomit should be cleared up as quickly as possible. Ordinary household bleach freshly diluted 1:10 in water (preferably hot) should be gently poured over the spill and covered with paper towels. (See warning in paragraph 2.5.)

3.3 If practical the diluted bleach should be left for 30 minutes before being wiped up with disposable paper towels. (See warning in paragraph 2.5.) Disposable gloves and apron should be worn.

3.4 Individual paper towels may be discarded down the toilet. However, if many are used, it is preferable to treat them as infected waste. Gloves and aprons should be discarded as infected waste. (See paragraph 5.2.)

3.5 Clothes and linen that are stained with blood or semen should be washed in a washing machine at 95 degrees centigrade for 10 minutes or boiled before handwashing.

*See *The Safe Disposal of Clinical Waste*, Health and Safety Commission, Health Services Advisory Committee, HMSO. ISBN 0 11 883641 2.

3.6 Crockery and cutlery can be cleaned by handwashing with hot soapy water or in a dishwasher or dish steriliser.

4. Staff precautions

As a general policy, if staff giving physical care to infected children have cuts and abrasions, these should be covered with waterproof or other suitable dressings.

5. Waste disposal

5.1 Urine and faeces should be eliminated or discarded into the toilet in the normal manner. Potties should be washed and dried with paper towels after use. Disinfectant is not necessary.

5.2 Soiled waste, i.e. nappies and pads, should be burnt. If this cannot be done in the school, the rubbish including protective disposable gloves or aprons should be "double bagged' in yellow plastic bags and effectively secured. Arrangements should be made with the responsible local authority for collection of this waste for incineration.

5.3 Non-infected waste is discarded into bin liners or dustbins. This should be collected and disposed of in the usual manner by the local authority cleansing department.

5.4 When work is completed wash and dry your hands.

6. Uniformed youth organisations, clubs and discos

There is no risk in HTLV-III/LAV antibody positive children attending such groups or social activities. These children may attend and partake in all such gatherings freely.

7. School and public libraries

Libraries may be used in the normal way.

A limited stock of this booklet is held by the Department of Education and Science and the Welsh Office; copies are obtainable from:

DES — Publications Despatch Centre, Canons Park, Middlesex HA7 1AZ

Welsh Office — Information Division, Cathays Park, Cardiff CF1 3NQ

(A Welsh Language version will be available on request)

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