LEGISLATIVE

RESEARCH COMMISSION

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

REPORT TO THE
1989 GENERAL ASSEMBLY
OF NORTH CAROLINA
1989 SESSION

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STATE OF NORTH CAROLINA

LEGISLATIVE RESEARCH COMMISSION

STATE LEGISLATIVE BUILDING

RALEIGH 27611

December 14, 1988

TO THE MEMBERS OF THE 1989 GENERAL ASSEMBLY:

The Legislative Research Commission herewith submits to you for your consideration its final report on the acquired immune deficiency syndrome. The report was prepared by the Legislative Research Commission's Committee on Acquired Immune Deficiency Syndrome AIDS pursuant to Section 2.1(2) of Chapter 873 of the 1987 Session Laws.

Respectfully submitted.

Liston B. Ramsey

J. J. (Monk) Harrington

Cochairmen
Legislative Research Commission

December 14, 1988

TO THE MEMBERS OF THE 1989 GENERAL ASSEMBLY:

The Legislative Research Commission herewith submits to you for your consideration its final report on AIDS. The report was prepared by the Legislative Research Commission's Committee on Acquired Immune Deficiency Syndrome - AIDS pursuant to Section 2.1(2) of Chapter 873 of the 1987 Session Laws.

Respectfully submitted,

Liston B. Ramsey

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Legislative Research Commission

1987-1988

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PREFACE

The Legislative Research Commission, established by Article 6B of Chapter 120 of the General Statutes, is a general purpose study group. The Commission is co-chaired by the Speaker of the House and the President Pro Tempore of the Senate and has five additional members appointed from each house of the General Assembly. Among the Commission's duties is that of making or causing to be made, upon the direction of the General Assembly, "such studies of and investigations into governmental agencies and institutions and matters of public policy as will aid the General Assembly in performing its duties in the most efficient and effective manner" (G.S. 120-30.17(1)).

At the direction of the 1987 General Assembly, the Legislative Research Commission has undertaken studies of numerous subjects. These studies were grouped into broad categories and each member of the Commission was given responsibility for one category of study. The Co-chairs of the Legislative Research Commission, under the authority of G.S. 120-30.10(b) and (c), appointed committees consisting of members of the General Assembly and the public to conduct the studies. Co-chairs, one from each house of the General Assembly, were designated for each committee.

The study of Acquired Immune Deficiency Syndrome - AIDS was authorized by Section 2.1(2) of Chapter 873 of the 1987 Session Laws 1987 Session. That act states that the Commission may consider House Bill 72 in determining the nature, scope and aspects of the study. The relevant portions of Chapter 873 and House Bill 72 are included in Appendix A. The Legislative Research Commission grouped this study in its Human Resources area under the direction of Senator James Richardson. The Committee was chaired by Senator Helen Rhyne Marvin and Representative Sidney A. Locks. The full membership of the Committee is listed in Appendix B of this report. A Committee notebook containing the Committee minutes and all information presented to the Committee is filed in the Legislative Library.

GLOSSARY OF TERMS*

AIDS is an acronym for the Acquired Immunodefiency Syndrome: this disease occurs as the end result of infection with the AIDS retrovirus. This virus is known as the human immunodefiency virus, or HIV; previously it was called HTLV-III (human T-cell lymphotrophic virus or LAV (lymphadenopathy virus, by the French). Virus persistence. Infection with HIV is thought to lead to persistent infection--that is, once a person becomes infected with HIV, he or she will remain infected with the virus for life. There is no evidence at present that natural body defenses are able to overcome the infection or totally destroy the virus. A corollary of this is that infected individuals will remain potentialy infectious for others indefinitely.

Antibody. Infection with the AIDS virus leads to development of antibody in the blood: this represents a chemical response to the virus as an attempted body defense mechanism. The presence of antibody can be ascertained by several tests (see below). Although often referred to as indicated by exposure to virus, most experts feel that the presence of antibody means that infection has occurred and that the person harbors the virus.

Disease due to HIV infection. Infection with the AIDS virus may lead to several kinds of very different diseases. Shortly after infection, there may be a brief illness, at times resembling infectious mononucleosis or other virus infections affecting the tissue covering the brain (so- called viral meningitis). This illness is self-limited and patients usually totally recover. There then follows a long period of continuing infection during which there may be no evidence of illness whatsoever. This is called

asymptomatic infection. During this period, which usually lasts from ten to fourteen years, the virus grows in certain cells (called T helper cells) that are essential for natural protection against the myriad of germs with which all persons are normally in contact. Over a period of many months, the virus progressively destroys these T helper cells leading eventually to a failure of the natural body defenses which normally ward off common germs. These germs then begin to cause serious secondary infections of many different types (so-called opportunistic infections)--this is AIDS. In addition, because these impaired body defenses also protect against different kinds of cancers, some patients may develop opportunistic cancers. In the months preceding the onset of opportunistic infections and AIDS, there may be non specific symptoms such as fever, weight loss, swollen glands and/or diarrhea. This is termed AIDS-related complex or ARC. Of all infected persons, at the present time, only about 1% have full-blown clinical AIDS, while 5-30% may have ARC. Thus, most infected persons have no evidence of disease at all--the iceberg effect. Once AIDS develops, it is invariably fatal. The average life span following diagnosis of AIDS is on the order of 6 to 12 months. Newborn infants infected with the virus may live longer. The virus also infects the brain and may cause brain degeneration in the absence of other signs of AIDS. Progressive deterioration of brain function may lead to a severely demented state. Ultimately, this effect of the AIDS virus may prove of greater medical and sociological consequences than the disease that is now perceived as AIDS.

Transmission of virus from person to person occurs through three major routes:

Sexual Transmission--The virus is found in semen and female genital secretions, and can be transmitted during almost any sexual act which results in an exchange of body fluids. Virus transmission occurs between men engaged in homosexual activities, but also occurs from man to woman and probably woman to man

during heterosexual intercourse. Condoms, by preventing exchange of infected fluids, may greatly decrease the odds of infection following sexual exposure.

Blood (parenteral) transmission--The virus is present in blood, and will be transmitted among drug abusing individuals if they share needles and other injection devices. The risk of transmission following blood transfusion has been greatly reduced by the institution of screening tests for blood donors.

Transmission to babies (perinatal transmission)--The virus is commonly transmitted to babies by infected mothers; this may occur while the baby is in the womb, during the birth process, or even after birth.

Casual transmission of virus during everyday-type contact between persons has been carefully researched for and has not been found to occur. HIV is not transmitted by casual contacts, including hugging or handshaking, using bathroom facilities, sneezing, coughing, spitting, sharing dishes or utensils, or through insect bites. It is not spread through normal daily contact at work, in school, or through regular household contact.

Testing for HIV infection can be accomplished by a test for antibody called an ELISA test. Importantly, this test was not developed for diagnosite purposes, but rather as a tool to screen units of blood being used for transfusion. This test may cost as much as $20 to $60 depending on where it is performed. No antibody test is perfect, and the HIV ELISA test has shortcomings. About 1 in every 100 normal persons will react falsely with this test. Thus, the odds of a positive test correctly indicating the presence of HIV infection will vary with the proportion of persons being tested who really are infected. For example, suppose the ELISA test is used to screen 1000 persons, of whom only one truly has HIV infection.

About 11 persons will test positive: 1 true positive, and 10 false positive. On the other hand, if the test is used to screen 100 persons, each of whom is a homosexual man living in an urban setting and among whom the true proportion of infected persons is 30%, 31 persons will be found positive by ELISA (30 true positve and 1 false positive). In the former situation, the odds of a positive ELISA test indicating true infection is about 10% whereas it is 97% in the second case. This feature of testing needs to be considered whenever a screening program is considered. ELISA test results can be established as true positive or false positive by a confirmatory antibody test known as a Western blot. This is an expensive, time-consuming and technically demanding procedure not suited to large numbers of specimen.

* Presented to members of the North Carolina General Assembly in a Seminar on AIDS, Wednesday, April 29, 1987, by Doctors Stanley Lemon and Joseph Pagano, UNC-CH School of Medicine and the Lineberger Cancer Research Center.

BACKGROUND

North Carolina has been justifiably proud of its public health efforts of the past 75 years. We have been the leader in establishing local public health structures, and in establishing public health graduate education and research for the rest of the nation. We have witnessed unprecedented success in controlling communicable diseases.

However, the fight against communicable diseases is not finished. A spectre from the past has been visited upon us. In 1981, a few alert physicians recognized a new disease in a few patients. Vague ill health developed in previously healthly men in the prime of life. Laboratory testing quickly revealed that critical components of these patients' immune systems had been destroyed for no apparent reason. Medical researchers agreed on the name "Acquired Immune Deficiency Syndrome" to define this new complex disease. In only a few years the communicable disease epidemic of human immunodeficiency virus (HIV) and AIDS has shaken our confidence and revived fears associated with plagues. There have been past epidemics. Each is unique to its own time and place. Scientists suggest that there are important differences between AIDS and past epidemics, and between AIDS and other current diseases. AIDS is fatal. There is no cure for AIDS. Its sufferers appear to remain infectious for life. HIV infection and AIDS strike primarily the most productive members of society - young adults. Some of the differences between AIDS and other well-known communicable diseases are:

1) its symptoms may not reveal themselves for years: and

2) it is not transmitted by casual contact or air borne germs.

The HIV virus has been isolated from blood, semen, bone marrow, tears, saliva, cervical secretions, urine, and feces. To date, however, the disease is known to have been transmitted only by sexual contact, by shared contaminated needles, by infected blood or blood products, by infected organ or tissue transplants, and from mother to infant across

the placenta or during delivery. Therefore, blood, tissue and genital secretions are the only known vehicles of HIV transmission.

By July of this year, the Center for Disease Control reported a total of 66,464 AIDS cases in adults and children. Of these, 37,353 have died, including more than 80% of the patients diagnosed as of 1985. Since AIDS reporting began, 63% of the victims of the disease in the United States have been homosexual or bisexual men without a history of intraveneous drug abuse, 7% were homosexual or bisexual with a history of IV drug abuse, and 19% were heterosexual men and women who were IV drug users. In addition, almost 3% were associated with transfusions of contaminated blood; roughly 1% of the adults who contracted AIDS were hemophiliacs.

Nationwide, morbidity and mortality due to AIDS will increase within the next few years, as some of the 1 to 1.5 million Americans who are already infected with the HIV virus develop AIDS. Approximately 1 in 25 American men between the ages of 20 and 50 are infected with HIV. The doubling time for the number of reported AIDS cases in the United States has gradually lengthened from five months in 1981 and 1982 to 14 months currently. This time frame is approximately 13 months in North Carolina.

In North Carolina, as of September 1988, 597 cases of AIDS have been reported to the Division of Health Services. More than 50%, or 305, of these cases were reported in the last year; the rest occurred during the last 7 years. The usual estimate given of the number of HIV infected persons who have not developed AIDS is 25 times the number of AIDS cases or 15,000 cases in North Carolina. Most of these infected patients will later develop AIDS.

The day to day protection and promotion of public health has traditionally been a state function. Therefore, the HIV and AIDS epidemic caused great concern to the 1987 North Carolina General Assembly. Many different measures were proposed, including mandatory testing, education, and a revision of the communicable disease laws. (See Appendix C).

The issue of mandatory testing for AIDS became extremely controversial in the 1987 Session. Questions were asked about the accuracy of the tests, the costs of testing in relation to pay-off, and the handling of the results of the test. All testing bills were rejected by the 1987 session.

However, three bills relating to AIDS survived the close scrutiny of the 1987 Session. These bills included HJR 72, creating a Legislative Research Commission study; HB 666, related to AIDS education in the schools, and HB 458, amending the law pertaining to communicable diseases.

HB 666 enacted a new subsection to GS 115C-81(a)(2) which reads:

> "Instruction in the prevention of Acquired Immune Deficiency Syndrome (AIDS) virus infection and other communicable diseases shall be offered in the public schools and shall be conducted under guidelines to be developed by the State Board of Education emphasizing parental involvement, abstinence from sex and drugs, and other accurate and appropriate information to prevent the spread of the disease."

The State Board of Education has already responded to this legislation by giving approval to a curriculum guide for an AIDS education program. This curriculum was implemented in the spring session of the 1988 school year in the school systems throughout North Carolina, and will be taught in the seventh grade in succeeding years.

HB 458 rewrote the Communicable Disease Control Law to clarify and strengthen control measures and to clarify confidentiality provisions. The definitions of communicable diseases to be regulated by the State were expanded to cover "communicable conditions," since control measures may be needed for individuals who carry certain viruses, but do not have the "disease", such as AIDS virus carriers.

AIDS is the most serious public health epidemic in this century. Our government's ability to respond effectively to immediate public need will be a crucial test of the State's

ability to respond to the AIDS epidemic. Already, traditional public health measures - screening, testing, reporting, contact tracing, isolation and quarantine - have been involved. Will these measures be adequate in the case of AIDS, which is complicated by the large numbers of healthy carriers perhaps infectious for life? The vast majority of HIV-positive people are healthy, functioning members of society. Sound legislative policy on HIV infection needs to protect the rights of these individuals and allow them to continue their contribution, instead of becoming a drain on society. Coping with AIDS will be a severe test of oursocial values and resources before the epidemic is controlled.

COMMITTEE PROCEEDINGS

The Acquired Immune Deficiency Syndrome Study Committee met seven times in the course of its deliberations: November 13, 1987, February 25, 1988, March 31, 1988, August 29, 1988, October 13, 1988, October 14, 1988, and November 9, 1988. The October 13 meeting was a public hearing, in which almost 50 persons participated. Lists of those attending Committee meetings, as well as Committee minutes, are contained in the Committee's record on file in the Legislative Library.

The following statement by Cochair, Senator Helen Rhyne Marvin set the tone of all meetings held by the Committee:

> "Certainly, no one needs to tell the Committee that AIDS has been a topic that has been in the forefront of public discussion at least for the past year. Much has been written, and even more has been said, about the subject. It is the intent of this Commission to look at all of the available facts, to hear opinions from the experts who understand and analyze these facts, and then to ponder this information and determine what, if any, recommendations this Commission needs to make to the 1989 General Assembly in regard to new legislation or modification to current legislation. We solicit your input and we promise to hear opinions of persons representing all sides of the issue. But, I would like to point out that our decisions will be reached only after careful reflection and discussion of the information that is presented to this Commission, and then made in an atmosphere of calm deliberation that considers the human needs and the financial implications of both victim and the general public. Representative Locks and I intend to ensure that decisions will not be made as fear-triggered reactions to

emotion-charged arguments which ignore the facts and are oblivious to the plight of victims, many of whom are children or other innocent persons."

Since AIDS is such a new topic in which new scientific and behavioral information is being generated almost daily, the Committee by necessity spent much time and energy at every meeting educating itself about AIDS. This information has served as a background for analysis and will not be repeated to any great extent in this report. It is contained in Appendix D.

The Committee had great interest in the development of the AIDS public school curriculum, as mandated by HB 666. Portions of three meetings - November 13, 1987, February 25, 1988, and October 14, 1988, were devoted to this topic. The Committee had the opportunity to witness the development of the curriculum and to see the final product. At the meeting on November 13, 1987, the Committee was given the principles upon which the curriculum would be based. On February 25, 1988, a draft was presented, and on October 14, 1988, the Committee viewed the final product and heard a report on the use of the curriculum in North Carolina public schools. Cochair Locks made some observations about the draft and his suggestions were heeded.

Negative comments concerning some of the content in the curriculum were presented to the Committee by several parents and interested citizens at the public hearing. There was concern by these witnesses that abstinence from sexual intercourse was not stressed enough and that there were alternatives to abstinence presented in the curriculum. At a later meeting, Department of Public Instruction officials told the Committee that they believe that abstinence had been fully stressed. (See Appendix E).

Although HB 458 was ratified by the 1987 Session, the Committee followed the development and adoption of rules for this legislation. Dr. Ronald Levine, Director of the Division of Health Services, reported on the activity of his Division in the development of these rules. After extensive public hearing, the rules were adopted in late 1987.

The Office of Legal Assistance, Division of Health Services, reported on issues related to HB 458. From Committee discussion, it seems that two issues remain unresolved:

1) Provisions in the original bill requiring consent prior to AIDS testing; and

2) Antidiscrimination. HB 458 did not include specific antidiscrimination language. The North Carolina Handicapped Law may cover AIDS victims, but there is lack of clarity in the law. An additional problem emerges in that North Carolina law applies only to employers of 15 or more persons.

A question of great concern to the Committee was how the State's institutional structure has responded to the onslaught of this epidemic. The Committee heard from a number of these institutions, such as Division of Prisons, local public health departments, and Department of Public Instruction.

A few correctional officers in the prison system expressed concern to the Committee that a range of job-related functions may place them at risk of being infected with AIDS. The incidence of AIDS in prisons and correctional facilities is critically important and is likely to be a growing problem, given the number of incarcerated people who have already been intravenous drug abusers. There have been a total of 22 AIDS cases in the North Carolina Prison System since 1983.

The Committee heard from Correction officials including the Health Director, Division of Prisons. Testing in the prison system is not done on a mass basis, but only on inmates who are recommended by physicians for a medical reason. Inmates may also request testing subject to approval of a unit physician. The prison system, with a very limited health budget, is making every effort to conduct an educational program for both inmates and correctional officers.

Questions were raised about testing all inmates and segregating those testing positive into one unit. Newly developed procedures by the Department of Correction do not require these measures. (See Appendix F).

The North Carolina Local Health Directors Association reported to the Committee. The Committee also heard from local health directors and from counties in which successful AIDS programs are being conducted.

In a presentation by the Local Health Directors' Association, it was suggested that testing, counseling, and education are the necessary elements to control AIDS. Local health departments are busy with these activities. Over 1600 tests and counseling sessions are being provided each month. Each test includes extensive education, averaging 30 minutes before the test and 45 minutes after the test results are obtained. Local public health departments respond to many requests. For example:

- In Cleveland County, the Health Department approached the local ministers' group. Together they have provided AIDS related education to parents and youths.

- In Robeson County, the Health Department has not only provided counseling and testing for 134 persons, but has also given 22 education programs on AIDS for all teachers and county employees in Robeson County, as well as for members of the First Baptist Church.

- In Sampson County, the Health Department has organized AIDS education forums for teenagers and their parents at local high schools.

- In Cabarrus County, the Health Department has provided AIDS education for the general public through billboards, public forums, and information sent to local businesses.

- In Pitt County, the Health Department has provided AIDS education sessions for the schools, law enforcement officers, county employees, day care operators, hair stylists, and social service workers.

- In Wake County, the Health Department, with assistance from the hospitals and commissioners, has organized health care for AIDS patients using health providers and resources.

- In New Hanover, Brunswick, Pender, and Bladen Counties, the Health Directors have organized a multi-county AIDS Task Force with broad community representation to provide AIDS education to the citizens of these counties.

- In Durham County, the Health Department has constructed AIDS prevention activities to reach IV drug users, especially those in the jails and those not attending drug rehabilitation centers. In addition, educational sessions have been provided all teachers and all seventh and twelfth graders.

- In Gaston County, the Health Department, with the support of the United Way, the Board of Health, and County Commissioners, is providing the leadership necessary to build a local AIDS community education program.

- In Guilford County, the County Commissioners, with the leadership of the Board of Health and Health Department, adopted a model AIDS policy for County Government as an example for all businesses. The policy states that county employees will provide county services to all citizens of the County, including those with AIDS. AIDS training is required for all county employees. An AIDS fact sheet was sent to all employees.

That is the good news. The bad news is that many requests for AIDS-related education from schools, workplaces, high-risk groups, and the general public go unanswered for lack of personnel. Local health departments are being forced to use staff from other important programs. For example, forty percent of one staff person in Cabarrus County and over fifty percent in Pitt County are being used for AIDS testing. In Durham County, over 1000 additional clinic visits are being made annually. Many health departments have extended waiting lists for testing. As a consequence, people are foregoing their testing and are missing their appointments.

Through testimony from the Division of Social Services and from pediatricians involved in care of children with AIDS, the Committee learned that infants and children with AIDS are a growing problem. Most of them have been infected by their mothers either before birth or at birth, and yet they share the general public infamy frequently cast on affected patients. Parents who are infected with AIDS are usually physically unable to care for their children. Currently, there are 13 cases in North Carolina identified as AIDS in children (7 in foster care, as wards of the State). The disease progresses more rapidly in infants - approximately 18 months until death. Children with AIDS also have neurological problems and are developmentally disabled. North Carolina is already experiencing problems in placement of medically-dependent children, including HIV infected children. This constitutes both a financial burden and a social problem. The experts stressed the following things are needed:

1) adequate medical care; and

2) adequate community-support programs

Social Services representatives believe that provision must be made in the foster care system to provide adequate training and additional pay for foster parents who care for children with AIDS. The two basic policy issues brought to the attention of the Committee were whether:

1) To commit to a decision that home care is better than institutional care and to make the necessary funds available for home care; and

2) To expand the concept of dependent children in community to include other than abuse or neglect and make provisions to assist parents who are trying to care for their children in the home, but who, despite their best intentions, cannot.

Another issue raised by pediatricians that is particularly important with regard to children is children's right to health care. Unlike adults, children do not have the right to consent or the privilege of deciding about their own health care. Provisions of health care for children are at the request of and with the consent of appropriate parent or guardian. Unfortunately, the responsible adult may not have the health care of the child at the top of his or her priority list. The adult may be ill and compromised, unable to make appropriate decisions about the child, or may justifiably fear discrimination and/or ostracism if the child's condition became public knowledge.

Testimony from experts on the financial aspects of AIDS care suggests that implications of such an epidemic will have a dramatic effect on the cost of care and on the operation of the health care system. Testimony from the UNC AIDS working group pointed to the fact that defining and identifying costs of health care for people with AIDS in North Carolina, both today and in the future, is not simple and straight forward. Generally, health care for most illness is readily definable. Yet, AIDS patients may have severe disabilities that require custodial care and/or social support services, which some insurers and governmental agencies do not consider health-related.

Data presented to the Committee suggest that in 1989 AIDS care will cost a total of $20 million for patient care in North Carolina. By 1992, the patient care costs could reach as high as $100 million. This estimate does not cover the full range of costs, such as home health care. Further, the cost will fall disproportionately on a small number of institutions

that are especially equipped to care for AIDS patients, and on a small number of counties with a limited resource base.

A number of distinct health care questions were raised about the social and economic consequences of AIDS that will ultimately have to be faced by the General Assembly:

1) How much will uncompensated care costs increase because of AIDS? What effect will AIDS costs have on Medicaid expenditures?

2) Will the cost of AIDS care place an intolerable burden on selected institutions or counties?

3) Will the number or distribution of AIDS patients place new strains on the capacity of the health care system to care for these patients? Will there be sufficient services available for home health care and custodial care? Will the spread of AIDS further exacerbate the difficulties in recruiting health care professionals and increase staff turnover?

4) Can effective means be found to ensure that insurance companies do not discriminate against AIDS patients, thereby shifting the financial burden to public funds?

5) Can adequate State resources be made available for AIDS care without decreasing funds for existing health programs?

Fear has driven both action and inaction regarding AIDS. Society fears AIDS, and people with AIDS fear potential discrimination and the inability to live, or die, with dignity. A large majority of those who testified before the Committee indicated that addressing discrimination should be the first critical step in this State's response to the epidemic. Otherwise, as long as discrimination occurs, without legal remedies, individuals who are infected with HIV will be reluctant to come forward for testing, counseling and care.

Throughout the Committee meetings and the public hearing, the Committee heard testimony about discrimination against individuals with HIV seropositivity and of the

problems of individuals with all stages of HIV infection, including AIDS. People who confessed to having AIDS, AIDS service organizations, lawyers, public health officials, and personnel organizations told their stories. These accounts attested to discrimination problems that persons with HIV infection face, ranging from job dismissal to refusal by health professionals to render care.

The following examples are cases brought to the Governor's Advocacy Council for Persons with Disabilities within the past year and were presented to the Committee on October 14:

- The first request of our Office of which I have personal knowledge was from a social worker who was trying to find an apartment for a person who was in a hospital in the final stages of AIDS. The disabled person wished to die with dignity with care from friends in the community. No one would rent him an apartment. There was no law to protect his rights.

- A restaurant worker called. He had been terminated from his job at a restaurant in a shopping mall. He said his roommate had AIDS and that his employer had cautioned him not to tell people in the mall about it. He said that he had told some people and that rumors had spread about him and that the restaurant's business had decreased. He decided not to pursue any remedy against the restaurant.

- A caller reported that he worked in a truck manufacturing plant. He was concerned because he has been tested and found to be HIV positive. There had been an accident in the plant where another worker was injured. The caller noticed that there was a great deal of bleeding involved in that injury and that persons assisting the injured person had not taken any precautions to protect

themselves against exposure to the blood. He was concerned that if he were injured , people should take care not to be exposed to his blood in case they could become infected. He was reluctant to report the fact that he had tested positive to HIV because he feared he would lose his job. We discussed what recourse he would have if he were terminated after reporting the fact of his HIV exposure.

We also discussed alternatives he might have, such as suggesting that safety precautions always be taken in cases of injury with bleeding. We discussed whether he had a duty to identify himself to his employer. He did not identify himself to us and did not call back.

- A hairdresser called and stated that he had AIDS. When he told the district manager about this, his job was terminated. He already had a private attorney. We suggested that his attorney call us if he had any questions. He did not.

- A manager of a fast food restaurant called. He stated that his employer was threatening to terminate his employment unless he would take an AIDS test. He was not sure whether he wanted to take the test. It was not clear after discussing the problem with him for some time why the employer wanted him to take the test. Later the employee notified us that he had taken the test and received a positive result. The employer terminated his employment after discussions with their own attorney and with us about the requirements of the law regarding employment discrimination and the company's possible liability for employment discrimination. The employer's representative was extremely concerned about the possibility for infection of the public through food handling.

- A social worker from North Carolina Memorial Hospital called on behalf of a mother whose son had died of AIDS. We talked with the mother and gave her some advice concerning her right to information concerning her son's benefits from his employer since she was administrator of his estate. The employer had refused to provide payment under the company medical plan and had refused to discuss it with the mother.

- A social worker from a hospital called on behalf of a woman and her young child who are both HIV positive. There had been a breach of confidentiality alleged. Information had been given to the district attorney for investigation and action. The social worker was concerned that this woman would not be able to cope with questioning from the district attorney without someone to help her understand what was going on. We agreed to provide assistance if the woman would contact us directly. She did not do so. The social worker later informed us that the woman had backed away from involvement with the whole issue for a while.

- An attorney called who was representing a man who had been terminated from his job one day after his employer learned that he had AIDS. We gave the attorney some suggestions to look at GS 168A and some other information.

- A man called who had been arrested for driving while impaired. He said that he had a head injury and had been a little unsure what all was going on while he was being requested to take a breathalyzer test. He said that he told the officer that he had AIDS and was afraid that he would contaminate the machine. He said this had been interpreted as a refusal to take the breathalyzer test. He

had been assisted by an attorney in his locality so we call his attorney and referred it back to him for follow up.

- A woman called who was employed in a textile mill. She knew an individual whom others reported had AIDS. Her co-workers in the textile plant stated their concern that she might have AIDS also and feared working with her. She was transferred to another job in the company, but was told by her supervisor that she must get tested for AIDS at the company's expense and the results of the test reported to him, or she would be terminated. We advised her of her right not to be tested, of confidentiality, and to possible coverage under GS 168A if she were terminated.

- A hairdresser who had AIDS called us. He stated that he had been fired at the shop where he had been working. He also stated that after his termination his employer had been telling his previous customers that he had AIDS and lately had told them that he had died. As he had an attorney, we advised him to inform his attorney about the confidentiality laws.

Excerpted from "Remarks of Lockhart Follin-Mace for AIDS Study Commission," October 14, 1988.

I. FINDINGS

The Legislative Research Commission's Committee on AIDS makes the following findings:

A. Our society and State are at the beginning of a long roadin the fight against AIDS. Many problems related to AIDS must be addressed and solved, such as problems related to children with AIDS, the allocation of health resources for persons with AIDS, and other important issues. AIDS issues are contemporaneous, ever-changing, and deeply political. Therefore, there needs to be a forum to address issues particularly suited for legislative solutions.

B. Educational and control efforts to foster behavioral changes are the only means now available to stem the spread of HIV infection. Yet the amount of education the public receives is woefully inadequate. Education works to prevent the spread of AIDS by altering the behavior through which the virus is transmitted. Because AIDS cannot be contained by medical means, such as vaccine, people must be taught how to contain the virus through their own activity. The AIDS epidemic is too big, too complex, too costly, and too emotional for any one group or agency to control or stop. But it is obvious that two of the major organizations that the State must depend upon are the public school system and the system of local health departments in every county. Unfortunately, State financial assistance has been minimal in support of these institutions. The National Academy of Sciences has determined that to confront AIDS adequately at least $1.00 per capita must be committted to educational activities. Currently less than 10% of that figure has been committed by the North Carolina General Assembly.

Our health and educational institutions must reach out and focus on high-risk groups. Government at all levels should encourage and fund effective educational programs

designed to foster behavioral changes. Candid presentations, utilizing sound educational principles and geared to the unique characteristics of different constituencies, are necessary to get the message across.

In the 1987 Session, the General Assembly provided some of the structural steel to control AIDS in North Carolina. Now the bricks and mortar, the windows and the roof, must be provided. The effectiveness of AIDS prevention depends not only upon education, but also upon the availability of HIV testing and counseling. Control measures will require financial support from the General Assembly if AIDS is to be effectively controlled in North Carolina.

C. Arguments for antidiscrimination legislation may be based upon arguments of moral responsibility and social justice, but the simple overriding fact for the Committee has been that discrimination undermines the two major tools available to fight HIV infection:

1) tracking the epidemic; and

2) providing counseling and testing When HIV-infected persons face the loss of a job, schooling, housing, insurance, medical care, and other support services, how can they risk coming forward to be counted, or to receive counseling and testing? Discrimination also undermines the progress we have made in education by renewing community fears based on misinformation.

The Committee was moved and impressed by the large number of persons and organizations throughout the hearing that, without reservation, supported the need for State antidiscrimination legislation. The call for such legislation was not limited to AIDS patients and their families, but also included such groups and individuals as the North Carolina Medical Society Committee on Sexually Transmitted Diseases and AIDS, the Association of Local Health Directors, the State Employees Association of North Carolina, private attorneys, religious leaders, and other advocacy groups.

The message is clear that discrimination against persons with HIV infection in the workplace setting or in the area of housing, schools, and public accomodations, is

unwarranted because it has no public health basis. Nor is there any basis to discriminate against those who care for or associate with such individuals.

The Committee heard from some witnesses that there were protections afforded persons with HIV infection under Section 504 of the Rehabilitation Act of 1973 and GS 168A, the North Carolina Handicapped Persons Protection Act. The Committee believes that these acts are limited in scope inasmuch as it does not:

1) cover workers employed in businesses employing 15 or less;
2) extend protection necessary to entire institutions, corporations, schools, hospitals, etc. Protection is only extended to programs on activities receiving federal funds; and
3) indicate either in language or through regulations whether contagious diseases are excluded or included in the definition of "handicaps".

Therefore, North Carolina should enact a more far-reaching measure that would protect all persons with AIDS or HIV infection.

The Presidential Commission's Report on HIV Infection states we are fighting two fights--one against the HIV virus and one against discrimination. We may not win the first fight until we have won the second.

D. Legislators may easily view screening and testing programs as a way to provide immediate results and to show that they are doing something positive in the fight against AIDS. However, the essential policy question is what level of public resources should be allocated to testing relative to other interventions, such as expanding public education programs. The Committee believes that this State should not mandate screening for low-risk groups, especially since the State is putting almost no funds into more basic strategies. Moreover, in other states with this type of mass testing, it has not proven to be worth the social and economic costs involved.

E. Under current State laws, there is no prohibition against HIV testing being performed under blanket consent that does not specifically mention the test. The policy

question is whether health care providers should be required to obtain informed consent prior to testing a patient's blood for HIV.

The Committee believes that the answer to this question must be "yes" when an HIV test is performed for any reason other than anonymous epidemiologic studies.

F. The relatively sudden appearance of large numbers of patients with a disease notable for its medical complexities and thorny social issues has caused problems within our health care and social services systems. But this is just the beginning. AIDS patients have medical, psychological, and social needs that cover the entire range of human requirements. Failure to make adjustments in the provision of health care for this epidemic will result in large amounts of care being provided in hospitals, the most expensve place to provide care. The Committee has spent much time listening to concerns and efforts related to control measures. The preliminary focus was necessary, but now is the time to begin to shift focus to thehuman dimensions of AIDS patients and their families. This State has a little time, if we act now, to develop health and support systems that are the least restrictive and most supportive. We must begin to shift care, where possible, from the hospital to the home, and community case management must be an integral part of all care given.

G. It is estimated that as of 1987-88, a total of 12 North Carolina children and youth have AIDS, and 100 more have HIV infection with no symptoms. Of this number, at least .05% are in foster care. If predictions are correct that by 1991 the problem may be ten times worse, 1120 children will be infected. If .05% are in foster care, county departments of social services will provide foster care to 56 youngsters in 1991.

The Committee believes that there is a special need to increase the foster care assistance payment beyond the maximum payment of $215 per month. This payment will not cover the cost of the specialized care and services required. Accepting responsibility for a child with an ultimately fatal illness is extremely difficult and attracts only special

people. The goalfor these children should be to provide a normal and dignified home life for as long as possible.

H. As has been stated previously, there is no cure for AIDS. There is a prescription drug that increases survival time and reduces opportunistic infections. This drug, AZT, blocks the virus' ability to reproduce. In recognition of these facts, the Federal government funded the purchase of this antiretroviral drug because of its great cost at about $8,600 per patient per year. The final grant has been made to the states. The expectation is that the states will continue the funding after federal funds are expended. The expectation is that North Carolina will have enough funds to continue through this fiscal year.

The Committee believes that North Carolina should continue the funding of this drug and any other antiretroviral drugs that become available for this therapy. Such policy is not only humane, but it also allows HIV infected persons to delay the onset of some severe symptoms. It allows these persons to continue to be contributing members of society, thus reducing the public cost of caring for such persons.

The Committee believes that the Appropriations Committees should carefully review the needs of the program. The Appropriations Committees should review the medical criteria for participation and the income eligibility scale. As of October 20, 1988, there were 30 patients being funded with an average cost of approximately $600 per month.

II. RECOMMENDATIONS

The Legislative Research Commission's Committee on AIDS makes the following Legislative recommendations to the 1989 General Assembly:

A. THE 1989 GENERAL ASSEMBLY SHOULD ESTABLISH A STATEWIDE AIDS PREVENTION AND EDUCATION PROGRAM, AND PROVIDE $6.5 MILLION FOR EACH YEAR OF THE BIENNIUM TO FUND EDUCATION AND CONTROL MEASURES AT THE LOCAL AND STATE LEVELS. (Appendix G).

B. THE 1989 GENERAL ASSEMBLY SHOULD AUTHORIZE THE LEGISLATIVE RESEARCH COMMISSION TO CONTINUE ITS STUDY OF AIDS AND REPORT TO THE 1991 GENERAL ASSEMBLY. (Appendix H).

C. THE 1989 GENERAL ASSEMBLY SHOULD ENACT LEGISLATION THAT PROHIBTS DISCRIMINATION FOR PERSONS WHO ARE INFECTED WITH HIV FOREMPLOYMENT, HOUSING, PUBLIC SERVICES, PUBLIC ACCOMODATIONS, AND PUBLIC TRANSPORTATION UNLESS NECESSARY TO PROTECT THE PUBLIC HEALTH AS DETERMINED BY THE COMMISSION FOR HEALTH SERVICES. (Appendix I).

D. THE 1989 GENERAL ASSEMBLY SHOULD ENACT LEGISLATION TO REQUIRE THAT INFORMED CONSENT BE OBTAINED BEFORE ANY HIV TESTING BE PERFORMED. (Appendix I).

E. THE NORTH CAROLINA GENERAL ASSEMBLY SHOULD ENACT LEGISLATION TO PREVENT SYMPTOMATIC HIV INFECTION FROM BEING

TREATED DIFFERENTLY THAN ANY OTHER DREAD DISEASE UNDER HEALTH INSURANCE POLICIES. (Appendix J).

F. THE NORTH CAROLINA GENERAL ASSEMBLY SHOULD APPROPRIATE $480.000 FOR FISCAL YEAR 1989-90 AND $1.120.000 FOR FISCAL YEAR 1990-91 FOR FOSTER CARE PLACEMENT FOR HIV INFECTED CHILDREN. (Appendix K).

G. THE NORTH CAROLINA GENERAL ASSEMBLY SHOULD APPROPRIATE $200.000 IN EACH YEAR OF THE BIENNIUM FOR THE PURCHASE OF ANTIRETROVIRAL DRUGS FOR HIV INFECTED PERSONS. (Appendix L).

APPENDIX A

GENERAL ASSEMBLY OF NORTH CAROLINA
1987 SESSION
RATIFIED BILL

CHAPTER 873
HOUSE BILL 1

AN ACT TO AUTHORIZE STUDIES BY THE LEGISLATIVE RESEARCH COMMISSION, TO CREATE AND CONTINUE VARIOUS COMMITTEES AND COMMISSIONS, TO MAKE APPROPRIATIONS THEREFOR, AND TO AMEND STATUTORY LAW.

The General Assembly of North Carolina enacts:

PART I. TITLE

Section 1. This act shall be known as "The Study Commissions and Committees Act of 1987."

. . .

PART II.-----LEGISLATIVE RESEARCH COMMISSION

Sec. 2.1. The Legislative Research Commission may study the topics listed below. Listed with each topic is the 1987 bill or resolution that originally proposed the issue or study and the name of the sponsor. The Commission may consider the original bill or resolution in determining the nature, scope and aspects of the study. The topics are:

(2) Acquired Immune Deficiency Syndrome--AIDS (H.J.R. 72 Jones). "...."

APPENDIX B

MEMBERSHIP OF LRC COMMITTEE ON ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

President Pro Tem's Appointments	Speaker's Appointments
Sen. Helen R. Marvin, Cochair	Rep. Sidney A. Locks, Cochair
Sen. Ollie Harris	Rep. Howard C. Barnhill
Sen. William N. Martin	Rep. Walter B. Jones, Jr.
Dr. Mahan Siler	Rep. Coy C. Privette
Dr. Harry Adams	Rep. Sharon Thompson

APPENDIX C

AIDS BILLS - 1987 GENERAL ASSEMBLY

HB 61 AIDS Marital Partner Protection
Defeated in House Health Committee
Minority Report - Failed

HB 63 Marital Blood Test for AIDS
Reported Unfavorable

HB 292 AIDS Test for Prostitute
Minority Report - Failed

HB 438 Test Prisoners for AIDS
Minority Report - Failed

HB 458 Communicable Disease Law
Amended - Ratified Chapter 782

HB 490 AIDS Prevention/Education

SB 228 Approximately $10 million requested
Not funded

HB 1091 Public Health Protection
Held in committee

HB 666 AIDS Prevention Instruction
Ratified Chapter 630

DISEASE and EPIDEMIOLOGY

HISTORY

First recognized 1981, Los Angeles--5 young health men developed PCP

Risk Groups: Homosexual males
IV Drug Users
Transfusion recipients
Hemophiliacs

Same as for Hepatitis B

Surmised transmissible agent/transmission same as Hepatitis B

Early recommendations to prevent spread:
Limit number of sexual partners
Avoid IV drug use/needle-sharing
Limit use of blood transfusions
Self-deferral of high-risk blood donors ('83)

Virus Isolated:

Late 1983--Montagne, Pasteur Institute: Lymphadenopathy Associated Virus (LAV)

early 1984--Gallo, NIH Human T-Lymphotropic Virus, Type III (HTLV-III)

mid-1984--Levy, San Francisco: Adenopathy-Related Virus (ARV)

1986--Renamed Human Immunodeficiency Virus (HIV) by International Cmte for Toxonomy of Viruses

Antibody test licensed by FDA to screen blood supply, April, 1985

April/May, 1985--Blood banks beginning screening donated blood
93 Alternate Testing Sites est. in NC

Viral and antibody studies confirmed suspected modes of transmission:
Sexual
Parenteral
Perinatal
Not Casual

Recommendations to prevent transmission reaffirmed:

Limit number of sexual partners

Avoid exchange of body fluids during sex (Use condoms)

Avoid use of IV drugs/needle-sharing

Avoid sharing other potentially blood-contaminated items, e.g. razors, toothbrushes

Notify sexual partners, health care providers, dentist if Ab positive

Females in high risk groups/Ab positive should avoid child-bearing until more known about risk of perinatal transmission

NATURAL HISTORY OF INFECTION

Infection (? infective dose)
Seroconversion (Ab production)
6-12 weeks usually
as long as 8 months or more
rarely virus positive/seronegative for years
Within 5 years:
90% immunologic abnormalities

1985: SF Cohort Study:
(33 homosexual men/seropositive since 1978-90/avg follow-up 68.2 months)
15% AIDS
27% PGL
24% Hematologic abnormalities
39% No clinical abnormalities

1985/86: CDC est. 20-30% infected will have AIDS within 5 years of infection
IOM/NAS est. 25-50% infected will have AIDS within 10 years after infection

1987: By 7 years after infection approximately 70% have AIDS or ARC (SF Cohort and Multicenter Men's Study)

TRANSMISSION

Requires 5 basic elements:
1) Infected source
2) Vehicle or mechanism of spread
3) Susceptible host
4) Appropriate site of exit from infected host
5) Appropriate site of entry into susceptible host

Body fluids from which HIV isolated:
Blood
Semen
Vaginal fluid
Saliva
Tears
-suggests possible routes of transmission, but does not imply that transmission by that route occurs
-interpretation must be tempered by other evidence of transmission

Epidemiologic data indicate transmission:
Sexual
Male to male
Male to female
Female to male
Parenteral
Needle-sharing by IDUs
Transfusion
Needlestick injury by HCWs
Percutaneous
Perinatal
At or before birth
Breast-feeding

US: more than 44,000 cases (11-87)
NC: 313 cases (11-87)

Risk Group - Adult (>13 yrs)	% US	% NC
Homosexual/Bisexual male	66	61
Intravenous drug user (IDU)	17	14
Homosexual male & IDU	8	5
Hemophilia/Coagulation disorder	1	4
Heterosexual contacts*	4	4
Transfusion	2	5
None of the above (NIR)	3	7

*55% of persons in this category are from central Africa and Haiti

Males	93	91
Females	7	9
White	61	55
Black	25	43
Other	15	2

Risk Group - Children (<13 yrs)	% US	# US	# NC
Parent at risk for AIDS	77	482	2
Transfusion	12	77	1
Hemophilia/Coagulation disorder	6	36	1
None of above (NIR)	5	33	0
Total	100	628	4
Males	53		3
Females	47		1
White	21		3
Black	54		1
Other	25		0

NC Seroprevalence Data:

Blood donors	0.018%	
Military recruits (10/85-6/87)		
All	0.13%	
Women	0.025%	(1/3983)
Men	0.15%	(33/22,737)
Blacks	0.22%	(21/9,578)
Family Planning Clinics (87)	0.00%	(0/200)
Maternal Health Clinics (87)	0.00%	(0/200)
STD Clinics (87)	0.97%	(5/515)
Counseling & Test Sites (86)	10.6%	(213/2004)
(1/87 thru 9/87)	3.6%	(345/9621)

PARENTERAL TRANSMISSION

Current risk from transfusion:
Factors to consider -
1) Sensitivity of screening test
2) Prevalence & duration of viremia prior to seroconversion
3) Likelihood of donation prior to seroconversion
4) Number of units received
10 million units transfused/yr in US
risk of tranmission reduced >95% by Ab testing
Estimate approx. 100 infected units/yr (instead of 4,000)
approx. half transfusion recipients die from other causes
Page 8

PERINATAL TRANSMISSION

Breast feeding

Risk of transmission uncertain:
13/20 (65%) infants born to mothers with previous AIDS infant seropositive several months after birth

Other studies: 0-22% transmission
Current estimate: About 50%

Risk to mother:
Higher incidence of developing AIDS following pregnancy in small group of infected women.

Cautions: HIV IgG antibody crosses placenta
Antibody testing in newborn of uncertain significance until 9 - 15 months

CASUAL TRANSMISSION

Household studies:
CDC - No AIDS in household contacts (without own risk factor) of AIDS cases reported to CDC

9 studies (>100 HIV infected persons, >316 family contacts):
Includes 21 infected children >5 yr and >71 family members
(16 under 5 yr and 9 from 6-18 yr)

Healthcare workers:
Rate HCWs among AIDS cases same as rate in population

OCCUPATIONAL EXPOSURE:

	Exposures	Seropositives	Paired Sera	Seroconversion
CDC Study				
Needle/scapel	969	2	298	1*
Open Wounds	70	0		0
Mucous Membrane	58	0	82	0
	1097			
NIH Study				
Needle/Scapel	103	0		
Mucous Membrane	229	0		
	332			
Univ. California				
Open Wounds/mucous membranes	63	0		
TOTAL	1492	2		1

Reported Seroconversions in literature:

US:
- 1 Needlestick* (Stricof, Morse, NEJM 1986; 314:1115)
- 1 Person who provided care (MMWR 1986;35:76)
- 3 Skin exposures (MMWR 1987;36:285)

Outside US:
- 3 Needlestick
- 1 Person who provided care

AIDS PROGRAM UPDATE FOR AIDS STUDY COMMITTEE
R. A. Meriwether, M.D.
August 29, 1988

598 cases reported through August 8, 1988 (includes 14 children)

54% (325) dead
44% Black
90% Male
87% Between 20 and 49 years old
18% IV Drug Users

Risk Factors:

Adults (>13 yrs.)	Children (<13 yrs)
60% homosexual/bisexual males	50% parent at risk
18% IV drug users	29% transfusion
5% bi/homosexual males AND IV drug user	7% hemophiliac
4% hemophiliac	14% unknown
5% heterosexual contact high risk person	
4% transfusion	
3% unknown	

Current Program:

Surveillance:

- Reported cases, data analysis
- Active surveillance- approx. 20 sites (large hospital/clinics) - to ensure full reporting.
- Anticipate Seroprevalence Studies - expect funding from NIH for blinded screening of newborn filterpaper blood specimens to determine prevalence in childbearing women as a reflection of prevalence in general population.

Counseling & Testing:

- All 100 local health departments
- Increasing testing of high-risk patients attending prenatal, family planning, STD, and TB clinic patients.
- Developed risk factor form to give us more information about who is being tested and prevalence of infection among different risk groups being tested.
- Clarifying how to do confidential vs. anonymous testing.

Partner Notification/Control:

- Now have eleven staff working on partner notification.
- Highly emotional encounters.
- Isolation orders.

Health Education/Risk Reduction:

- Minority Initiatives:
  - One staff member working with Minority Community.
  - Conference "The Black Community Responds to AIDS," Chapel Hill, October 10, 1988.
  - Funding five minority initiative projects with $150,000 in federal funds:

    1. Durham Committee Institute, Durham County. A clearinghouse and networking center for AIDS education in the Black community in 10 northern piedmont and northeastern counties. Will utilize existing networks and organizations and develop new ones.

    2. Teens Against AIDS, Wake County. Cooperative effort of Wake Co. Health Department, Strengthening the Black Family, Inc., NCSU, St. Augustine's College. Will conduct and evaluate the effectiveness of peer based education utilizing social gatherings and radio communication.

    3. In the Know, Orange County Health Department. Will utilize existing "natural helpers" network to provide AIDS education within the Black community in Orange County.

    4. Operation Sickle, Inc., Cunberland County. Will utilize existing educational network and experience to provide AIDS education to sickle cell patients who may be at risk for HIV infection due to blood transfusions and to the Black community at large.

    5. AIDS Awareness in the Black Community, New Hanover County Health Department. Through a contract with an individual who has been involved in AIDS education for some time, this project will target Black women, teens, IV drug users and their sex partners, and gay men.

- High Risk Groups:
  - Expect to hire three staff members soon - 1 to work with gay men to develop educational initiatives to prevent transmission.
  - Knowledge, Belief, Behavior Survey of gay men to be completed by October.
  - Two staff members to work with drug treatment programs to establish risk reduction programs and counseling and testing sites and to develop innovative outreach programs to bring drug users into treatment and to provide risk reduction education.
  - Community-Based Risk Reduction Grants:
    - $200,000 will be distributed to six local risk reduction projects with emphasis on high prevalence groups:

      1. Durham County Health Department. To provide AIDS education to drug users with special emphasis on Blacks in two residential areas of Durham known to have high rates of drug use and hepatitis B, in the county jail, and through Drug Counseling and Evaluation Services.

      2. Drug Action of Wake County. To establish a program in a predominantly Black lower income community utilizing recovered drug users to educate and bring drug users into treatment.

      3. AIDS Task Force of Winston Salem and Step One, Forsyth County. A cooperative effort to utilize recovered drug users to educate and bring minority drug users into treatment and to prevent drug use by those at high risk of becoming drug users.

      4. AIDS Services Project, Durham County. To provide risk reduction education to gay men in the Triangle through gay bars and other gathering spots.

      5. Western North Carolina AIDS Project, Buncombe County. To provide risk reduction education and to reinforce and maintain risk reducing behaviors among gay men in Western NC through gay bars and other gathering spots.

      6. Mecklenburg County Health Department. To provide through a subcontract with the Metrolina AIDS Project education and outreach programs utilizing peer counselors to obtain and maintain risk reduction behaviors among gay men, with special efforts directed toward the minority community.

- General Public:
  - Have a staff member responsible for these educational efforts. Will soon hire media specialist to utilize the media to provide more effective educational programs.

Funding:

- CDC grant $1.6 million for 8 month project period. Includes $200,000 for local community-based risk reduction projects $150,000 for local minority initiatives, and $247,500 for eleven local health department counseling and testing sites ($22,500 for each; selection based on number of persons tested):
  Buncombe, Cabarrus, Cleveland, Durham, Forsyth, Gaston, Guilford, Mecklenburg, New Hanover, Orange, Wake
- $219,000 appropriated by General Assembly for administrative staff in AIDS Control Program, including a physician, administrator, and health education program supervisor. Recruitment underway.
- $150,000 allocated last year for six (6) health departments doing most counseling and testing:
  Cumberland, Durham, Forsythe, Guilford, Mecklenburg, Wake (account for 53% of reported AIDs cases) - funding continuing.
- $250,000 newly appropriated for local health departments for AIDS education and counseling. Mechanism for equitable and cost effective distribution worked out with NC Health Directors Association. Funding will be based on a needs formula (including population, non-white population, number of AIDS cases, number of tests done) and funding already received. $12,500 will be distributed to each of 17 health departments scoring highest, and $500 each to 81 health departments.
- $176,303 Federal funds for purchase of AZT Through July 31, 1988 60 persons had applied for assistance; 51 had received assistance; 45 are currently receiving assistance; 7 were denied due to ineligibility; 4 applications pending. Program expires 9/30. We will be able to continue paying for drug for persons on program beyond 9/30 until funds fully spent (est. 12/31/88). No new applicants can be accepted after 9/30/88.

Cost, Provision, & Financing	-utilization of public and private resources to provide optimal care at lowest possible cost. -AIDS Task Force will report on this to Secretary Flaherty by December 1, 1988. Have endorsed concept and developed a model system for case management as a mechanism to provide appropriate care at reasonable cost.

New Developments:

1. Vaccine: Much further off than we had hoped. Chimps have been given vaccine and have developed antibody in several classes, including neutralizing antibody. Yet, when they were challenged with virus, they became infected and ill.

2. Incubation period: Average time from infection to disease now appears to be between 8 and 14 years.

3. Deep latent infection: Approximately 0.4% of infected persons develop antibody and subsequently lose it as virus is fully integrated into the DNA of the host cell and no virus products are made. These individuals are thought to begin expressing antibody once more as the virus begins to reproduce and they develop symptoms.

4. Variable infectivity: Suggestions that infected individuals transmit most efficiently shortly before they develop symptoms and thereafter have been supported by further research. The actual efficiency of transmission in different stages of infection and for different modes of transmission remains uncertain.

5. Predicting the epidemic: Predictions of how many cases of AIDS will occur are relatively accurate over two to three years. Predictions beyond this period are difficult due to changing behaviors. It is thought by many that the number of infected people will soon level off and HIV infection will become "endemic," while the number of AIDS cases will continue to grow rapidly for another five years or more.

6. Modes of transmission: It was pointed out at the Fourth International AIDS Conference that in spite of intensive work on AIDS, none of the over 7,000 participants had suggested in over 3,100 scientific presentations at the meeting that there were any new modes of transmission. Conference participants clearly felt that HIV is transmitted sexually, through injection of or non-intact skin exposure to infected blood, and from infected mother to infant at or before birth but not in other ways.

DRAFT

Preventing AIDS:

HEALTH EDUCATION

Curriculum Supplement for Middle Level Schools

Abstinence from Sexual Intercourse and Intravenous Drug Use is the Surest, Safest, Best Way for Young People to Avoid AIDS!

North Carolina Department of Public Instruction

STATE OF NORTH CAROLINA DEPARTMENT OF CORRECTION DIVISION OF PRISONS	SUBJECT: AIDS and HIV Infection	
HEALTH CARE PROCEDURES	TAB: GENERAL MEDICAL	NO. 214.3

POLICY REGARDING ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) AND HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION

I. General. To insure the orderly operation of the prison system and to protect the health, safety, and welfare of the public, staff, and inmates, the Division of Prisons will take reasonable action to prevent the spread of AIDS/HIV infection. As a standard operating procedure, correctional staff should observe blood and body fluid precautions with all inmates. Further, the Division will provide diagnostic and treatment services for those inmates who become sick with AIDS or HIV infection.

II. Definitions

A. AIDS
Illness characterized by one or more opportunistic infection at least moderately indicative of underlying cellular immunodeficiency.

B. ARC
Presence of a combination of conditions together giving evidence of infection with AIDS virus.

C. Seropositivity
Individual has antibodies to HIV, meaning that infection has occurred at some time in the past. ELISA test cannot pinpoint date of infection or determine whether individual remains infected.

D. Infection
Individual is infected with HIV. Infection may be permanent or body may successfully combat the virus.

E. Exposure
Individual has contact with HIV in a way that makes transmission possible (e.g., sexual contact activity).

III. Testing Procedures
The Division of Prisons will take measures to generate data which will be used to address important correctional and medical management issues, including housing, programs, work assignment, behavior management, medical supplies and equipment, and personnel needs.

Epidemiologic studies may be conducted in conjunction with the Department of Human Resources - Division of Health Services (DHR-DHS), and public health professionals, to

inmate population.

a. General Testing - When clinically indicated upon presentation of symptoms of HIV infection or after exposure to contaminated blood or body fluids, or as otherwise determined by the unit health authority, inmates will be tested for HIV infection. Confirmation testing will be performed for inmates admitted with a suspected history of HIV antibody infection.

During admission processing or upon referral, inmates will be interviewed by health staff to identify those who may be HIV infected. Specific questions will be asked and responses documented, regarding any history of high risk behavior, such as homosexual activity, intravenous substance abuse, contact with prostitutes. Medical signs and symptoms such as unexplained fever, weight loss, persistent lymphadenopathy, persistent diarrhea, night sweats, persistent thrush on tongue or throat and pink or purple blotches under skin or inside mouth, nose, eyelids, or rectum, will be documented on the HIV/HTLV III Screening Report.

b. Validation of Tests - An inmate shall not be considered seropositive until all initially reactive tests have been repeated at least once, and all repeatedly reactive tests have been confirmed by the Western Blot method or a method approved by the Director of the State Public Health Laboratory.

Tests results shall be filed in the inmate's medical record. A copy of all HIV screening reports will be forwarded to the Director of Health Services in a sealed envelope marked Confidential.

Any confirmed case of AIDS shall be reported to the local health director by the unit physician.

c. Notification - The unit health authority shall notify the Director of Health Services, through the medical chain of command, and the prison facility administrator of any HIV-infected inmate.

d. Self-Requested Testing - The Division will provide self-requested testing, subject to the approval of the unit physician. Inmates will be allowed to undergo voluntary HIV testing provided they receive counseling by the unit health authority. Testing will be performed no more frequently than every twelve (12) months, unless otherwise determined by the Unit Physician.

[illegible] to submit to ordered testing. Although consent should be sought in all cases, HIV testing may be accomplished when an inmate refuses to consent, pursuant to procedures set forth in Section 701.2 of the Health Care Procedures Manual.

When an inmate refuses to submit to an ordered diagnostic test, the following priority actions will be performed by prison authorities:

(1) Counseling - Reasonable efforts will be made to convince the inmate to voluntarily submit to testing. Counseling will be documented in the medical record.

(2) Disciplinary Sanctions - If counseling proves to be ineffective, the inmate shall be informed that the act of refusal is subject to disciplinary action. Refusal constitutes grounds for charging the inmate with the major offense - Disobeying a Direct Order.

(3) Compulsory Testing - Continued inmate refusal to submit to ordered diagnostic testing will result in compulsory testing. When testing is exercised, the following conditions will apply:
   (A) Appropriate medical personnel will be present when use of force is necessary.
   (B) Only that degree of force reasonable to perform the diagnostic test is to be applied. The degree of force used shall be documented on a Use of Force Report.
   (C) Unacceptable behavior by the inmate under these conditions may subject the inmate to other administrative and/or disciplinary sanctions.

IV. Control Measures and Counseling

The unit health authority shall give the infected inmate control measures for AIDS and HIV infection.

a. Control measures are as follows:
   (1) Infected persons shall:
      (A) refrain from sexual acts while in the custody of the Department;
      (B) never share needles or syringes;
      (C) not donate or sell blood, plasma, platelets, other blood products, semen, ova, tissues, organs, or breast milk;
      (D) have a skin test for tuberculosis;
      (E) notify future sexual intercourse partners of the infection; if the time of initial infec-

sexual intercourse and needle partners since the date of infection; and, if the date of initial infection is unknown, notify persons who have been sexual intercourse and needle partners for the previous year.

(2) The unit health authority shall:

(A) give the inmate the control measures and document this session on the "Verification of Counseling People with Seropositive HIV Antibody Test Results", which will be placed in Section 2 of the Out-patient Health Record;

(B) give the inmate a form to be provided by the Department of Human Resources for use in listing partners for whom notification is required. (The form will then be returned by the unit health authority to DHR - Division of Health Services AIDS counselors who will notify and counsel the partners. This will include notification of known victims of sex offenses when the perpetrator of the crime has tested positive for HIV infection.) If the inmate refuses to complete the form, such refusal shall be noted on the form and then returned to the source agency; if the identity of the spouse of an infected inmate is known, the unit health authority shall list the spouse on a form provided by the Department of Human Resources Division of Health Services and return the form to the source agency. The DHR Division of Health Services will undertake to counsel the spouse. The unit health authority's responsibility for notification of potentially exposed persons is satisfied by fulfilling the requirements of (2) (B) and (C) above;

(D) advise infected inmates of proper clean-up of blood and body fluids; and

(E) advise infected inmates of the risk of perinatal transmission.

b. Counseling - The counseling program will include the provision of informational materials available within the Division of Prisons. A copy of the Division's "Information for Persons with a Positive HIV Antibody Test Result" shall be given to each HIV positive inmate who is counseled. Counseling sessions will be documented on the "Verification of Counseling People

be placed in Section 2 of the Out-Patient Health Record, along with a copy of the completed DHR-DHS partner notification form.

V. Management

a. General - AIDS/HIV infected inmates who do not require inpatient care will be eligible for general population housing at any facility which meets the health, security, and programmatic needs of the inmate.

Inmates who have been identified by local law enforcement authorities as suspected AIDS/HIV-infected will have their HIV status confirmed and will be admitted at the appropriate processing center, as designated by the Director of Health Services and the Chief of Classification. This designation will provide the inmate with greater access to health care services.

b. Behavior Management - The Division shall attempt to reduce the frequency of inmate behavior which might transmit HIV infection through education, surveillance, appropriate supervision, discipline and classification. The unit health authority and the facility administrator will consult promptly when either party discovers an infected inmate or one engaged in high-risk behavior. Each facility administrator will assemble a list of HIV-infected persons and by utilizing incident reports, disciplinary reports and other appropriate sources will identify HIV infected persons who are or may be engaging in high risk behavior.

The following behaviors are considered high risk: sexual activity; intravenous substance abuse; tatooing; nose and ear piercing; aggressive behavior toward staff or inmates which may transmit the HIV virus or other blood born virus, such as scratching, biting, throwing blood or body fluids.

An inmate who is believed to have been engaging in high-risk behavior may be placed in administrative segregation, in accordance with 5 NCAC 2C .0300, in order to protect other inmates and staff from the risk of HIV transmission. Other management may include changes in programming, level of surveillance, security, classification, disciplinary segregation or transfer to a facility that can better provide the necessary supervision.

c. Transportation - HIV-infected inmates may be transferred routinely on regular transportation, except as their health condition or behavior might otherwise require. If the inmate's health condition warrants, the unit superintendent/institution head, in consultation with the unit health authority, will determine the method of transportation. Special transfers shall be managed under conditions which provide the degree of security necessary to protect staff and other inmates.

d. Medical Isolation of Inmates Suffering From AIDS - The purpose of medical isolation is to provide inmates with AIDS greater access to health care services. These inmates are referred for in-patient care for follow-up treatment and medical isolation as their clinical condition requires.

Inmates confirmed as AIDS cases will be medically isolated at an appropriate Division of Prisons in-patient medical facility. Patients shall be medically isolated for so long as the condition persists, or the patient is released from the custody of the Division of Prisons.

e. Death of Inmate - Upon release of the body to another agency, the unit health authority attending any deceased HIV-infected inmate shall provide written notification to observe blood and body fluid precautions.

VI. Program Eligibility

HIV-infected inmates will be eligible for on-site and community based programs which are available to the general population, except as specified below, or where the health grade or behavior of the inmate does not permit participation.

a. Marriage Requests - A request by an HIV-infected inmate will be processed according to the following procedure:

(1) When the HIV-infected inmate makes a marriage request, pre-marriage counseling will be mandatory with the inmate, the prospective spouse, and a designated prison official.

(2) The inmate shall complete the form provided by DHR-Division of Health Services for notification of future sexual intercourse partners. The form shall be returned by the unit health authority to

the double agent) for notification and counseling of the prospective spouse.

(3) Only after such notification and counseling of the prospective spouse will the marriage request be considered.

b. Home-Leave Program - An inmate recommended for participation in the home-leave program will be processed according to the following procedure:

(1) In order to be eligible for home leave, the inmate must be recommended for participation in the program through established classification procedures;

(2) The home leave coordinator, as designated by the unit superintendent, will initiate the investigation and will determine the potential sponsor for the inmate.

(3) Prior to final approval for initial program participation, the inmate will be tested for HIV infection by appropriate medical authorities. In the interest of protecting the public, refusal to submit to HIV testing will result in denial of home leave participation.

(4) For inmates who test seropositive or have been previously known to be positive, home leave will not be approved until notification and counselling of the responsible sponsor have been completed.

(5) Following removal from the home leave program, retesting for reinstatement will not be required unless there is evidence that high-risk behavior has occurred.

VII. Work Assignments

HIV-infected inmates may be assigned to any institutional work assignment for which their health grade warrants, except for assignments to the barber shop, canteen, cosmetology, food processing, and food service. These exceptions are to facilitate the maintenance of unit order and to allay fears within the inmate population.

Work assignments for HIV-infected inmates will be reviewed on a case-by-case basis by the unit superintendent, in consultation with the unit health authority.

VIII. Education and Training

a. General. A centralized AIDS information source will be established an maintained in order to insure that the information provided is current and consistent throughout the Division.

of up-to-date information concerning AIDS. Staff will be informed of those aspects of HIV infection that would be of use in the conduct of duties and in minimizing risk of infection.

Training on AIDS/HIV infection will be provided during Officer Basic Training, as well as during in-service activities. All employees assigned to prison units will receive informational materials explaining the known ways in which AIDS/HIV infection are transmitted and the precautions that should be taken when their duties require them to work around seropositive inmates. Materials will be given to each employee during orientation and will be made available upon request thereafter.

c. Inmates. Inmates shall be provided with information about AIDS/HIV infection in order to allay their fears and to minimize their risk of exposure. Inmates will receive informational materials explaining the known ways of transmission of AIDS/HIV infection and actions which should be avoided to lessen risk of exposure. This information will be provided at the Diagnostic Centers upon admission and periodically to the general population.

d. Other Staff. Agents of the Division, volunteers, and contractual staff shall be provided information about AIDS/HIV infection in order to minimize the risk of exposure.

All personnel, including emergency responders and correctional staff, shall follow blood and body fluid precautions with all inmates.

IX. Release of Information

All information and records that identify an inmate who has HIV infection shall be strictly confidential. The inmate's HIV status shall not be released to anyone, except as specifically authorized by this policy or the Chief of Health Services under the following circumstances:

a. Release is made for statistical purposes and in no way identifies the inmate;

b. Release is made with written consent of the inmate or the inmate's legal guardian;

c. Release is made to health care personnel providing care to the inmate;

d. Release is made pursuant to subpoena or court order; or

e. Release is made by the Chief of Health Services or his designee and the prison facility administrator by referral to the appropriate classification authorities in accordance with Section V herein.

An unauthorized release of information will be considered unacceptable personal conduct and will result in disciplinary action.

X. Staff Exposure Testing

Staff who believe they have had an on the job related blood or body fluid exposure that poses a risk of transmission shall report such exposure immediately to the unit health authority and the prison facility administrator. The Industrial Commission form No. 19 shall be required to be completed by the employee, as will an incident report.

The unit health authority will determine the nature of the exposure and whether HIV antibody testing will be recommended. Should testing be recommended, the employee may visit a physician of their choosing. When indicated, testing shall be performed at reasonable intervals for up to one year. The Department will reimburse for such tests as are necessary to determine the HIV seropositivity status.

XI. Correctional Staff Protective Devices

The Division of Prisons will insure that the following equipment is available, as appropriate for use by correctional staff having direct contact with inmates:

a. Gloves

b. Masks

c. Gowns

d. Ventilation Devices

e. Chemical Germicide

f. Hard walled containers for needles/sharps

g. Plastic Bags

Director of Health Services for the Division of Prisons.

Protective devices and other equipment shall serve the dual purpose of staff protection and facilitating the provision of appropriate medical assistance to the inmate population. Each unit/institution shall be supplied with equipment and supplies in sufficient quantities to accomplish this objective.

XII. Central Office Resources

The Division of prisons AIDS Program is coordinated through the Office of Health Services by a work group of senior correctional professionals appointed by the Director of the Division. This group is responsible for the development, monitoring and implementation of policies and programs to address the problems of inmates who test seropositive for HIV infection or those who have AIDS.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1989

S D

89-LF-23
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: AIDS Prevention/Education Program. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH A STATEWIDE AND A COMMUNITY-BASED AIDS PREVENTION AND EDUCATION PROGRAM.

The General Assembly of North Carolina enacts:

Section 1. Chapter 130A of the General Statutes is amended by adding a new G.S. 130A-148 to read as follows:

"§ 130A-148. AIDS Prevention and Education Program.--(a) The Department shall establish and administer a Statewide AIDS Prevention and Education Program. In administering the program, the Department shall:

(1) Use health education and other methods that do the following:

a. Improve the awareness of individuals, communities and high risk group members about how Acquired Immune Deficiency Syndrome (AIDS) is transmitted and how to avoid acquiring or transmitting infection, and

b. Promote changes in behavior that reduce the risk of acquiring or transmitting this infection;

(2) Establish, finance, coordinate, and administer contracts with local health departments to provide community-based AIDS education and risk reduction, and antibody test counseling. In awarding contracts under this subdivision, the Department shall provide an equal base amount to each county and an additional amount to be allocated on the needs of the general population;

(3) Establish, finance, coordinate, and administer a system for awarding and monitoring competitive contracts for local AIDS education and risk reduction projects and support services. Local health departments and public and private organizations, institutions, and agencies shall be eligible to compete for these contracts, which shall include:

a. Model community-based projects, each involving a local health department, and AIDS service organization, substance abuse and mental health services, schools, and other services and organizations as appropriate to coordinate and provide AIDS education and risk reduction, and antibody test counseling to promote risk reducing behaviors in the general public and AIDS high risk groups;

b. Innovative projects for defined populations, including projects involving one or more local public or private organizations, institutions, or agencies to provide AIDS education and risk reduction counseling to one or more AIDS high risk groups or the general public;

c. Projects providing coordination and training of volunteers to provide support services to persons with AIDS virus infection to minimize health care costs by keeping patients at home as long as possible;

(4) Seek and encourage funding from other public and private sources for the purpose of expanding the nature, scope, and impact of services and activities provided under the program;

(5) Encourage contractors to subcontract parts of local program services and activities to other public and private organizations, institutions, and agencies that can effectively provide these services and activities;

(6) Promote, encourage, and support participation of volunteers in appropriate aspects of the program;

(7) Provide technical assistance, management, evaluation, consultation, and training to contractors and communities, including provision of educational materials, coordination of a statewide media campaign, and support to the AIDS Task Force;

(9) Develop a statewide AIDS resource referral center and case management services to facilitate and coordinate medical and support services for AIDS; and

(10) Perform such other actions it considers necessary to administer the program.

(b) The Commission shall adopt rules necessary to implement the program."

Sec. 2. There is appropriated from the General Fund to the Department of Human Resources the sum of six million five hundred thousand dollars ($6,500,000) for the 1989-90 fiscal year and the sum of six million five hundred thousand dollars ($6,500,000) for the 1990-91 fiscal year to establish and administer the statewide and community-based program of AIDS

Prevention and Education established by Section 1 of this act. No more than twenty percent (20%) of the total allocation shall be used for statewide programs and no less than ten percent (10%) of the total allocation shall be used for grants to AIDS service organizations for training and support of volunteers.

Sec. 3. The Commission for Health Services shall adopt temporary rules pursuant to the authority of G.S. 130A-148(b) and of G.S. 150B-13 to implement the provisions of this act.

Sec. 4. This act shall become effective July 1, 1989.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1989

H D

HOUSE JOINT RESOLUTION 89-LF-22
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Sponsors: .

Referred to:

A JOINT RESOLUTION AUTHORIZING THE LEGISLATIVE RESEARCH COMMISSION TO STUDY THE IMPACT OF ACQUIRED IMMUNE DEFICIENCY SYNDROME ON PUBLIC HEALTH AND HEALTH CARE IN NORTH CAROLINA.

Whereas, Acquired Immune Deficiency Syndrome (AIDS) is a virulent disease that causes a complex of health problems deriving from a defect in a person's natural immunity against disease; and

Whereas, the first cases of the disease were first diagnosed in 1981 and there has been a rapid rate of increase in the incidence of new cases in a very short period of time; and

Whereas, no state has been immune from the epidemic of AIDS; and

Whereas, North Carolina needs to protect itself from the insidious nature of the virus and the modes of transmission; Now, therefore, be it resolved by the House of Representatives, the Senate concurring:

Section 1. The Legislative Research Commission may study the following issues concerning the control of AIDS:

(1) The need for funding for Aids control activities, public education, counselling, medical care, and social support systems;

(2) The adequacy of reporting requirements for AIDS virus infection;

(3) The need for legislation requiring any particular subgroup of the State's population to undergo mandatory testing for AIDS; and

(4) Any additional issues relevant to the control of AIDS in North Carolina.

Sec. 2. The Commission may submit an interim report to the 1989 General Assembly (Second Session 1990) and may report its findings and recommendations on these issues to the 1991 General Assembly.

Sec. 3. This resolution is effective upon ratification.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1989

S D

89-LF-24
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Communicable Disease Law Change. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO AMEND THE COMMUNICABLE DISEASE LAW.

The General Assembly of North Carolina enacts:

Section 1. G.S. 130A-148 reads as rewritten:

"§ 130A-148. Laboratory tests for AIDS virus infection.--(a) For the protection of the public health, the Commission shall adopt rules establishing standards for the certification of laboratories to perform tests for Acquired Immune Deficiency Syndrome (AIDS) virus infection. The rules shall address, but not be limited to, proficiency testing, record maintenance, adequate staffing and confirmatory testing. Tests for AIDS virus infection shall be performed only by laboratories certified pursuant to this subsection and only on specimens submitted by a physician licensed to practice medicine. This subsection shall not apply to testing performed solely for research purposes under the approval of an institutional review board.

(b) Prior to obtaining consent for donation of blood, semen, tissue or organs, a facility or institution seeking to obtain blood, tissue, semen or organs for transfusion, implantation,

transplantation or administration shall provide the potential donor with information about AIDS virus transmission, and information about who should not donate.

(c) No blood or semen may be transfused or administered when blood from the donor has not been tested or has tested positive for AIDS virus infection by a standard laboratory test.

(d) No tissue or organs may be transplanted or implanted when blood from the donor has not been tested or has tested positive for AIDS virus infection by a standard laboratory test unless consent is obtained from the recipient, or from the recipient's guardian or a responsible adult relative of the recipient if the recipient is not competent to give such consent.

(e) Any facility or institution that obtains or transfuses, implants, transplants, or administers blood, tissue, semen, or organs shall be immune from civil or criminal liability that otherwise might be incurred or imposed for transmission of AIDS virus infection if the provisions specified in subsections (b), (c), and (d) of this section have been complied with.

(f) Specimens may be tested for AIDS virus infection for research or epidemiologic purposes without consent of the person from whom the specimen is obtained if all personal identifying information is removed from the specimen prior to testing.

(g) Persons tested for AIDS virus infection shall be notified of test results and counseled appropriately. This subsection shall not apply to tests performed by or for entities governed by Article 34 of G.S. Chapter 58, the Insurance Information and Privacy Protection Act, provided that said entities comply with the notice requirements thereof.

(h) No test for AIDS virus infection may be performed without consent of the person being tested except as provided in any law that specifically requires testing for AIDS virus infection. The Commission may authorize or require laboratory tests for AIDS virus infection when necessary to protect the public health.

(i) Except as provided in subsection (h) of this section, no test for AIDS virus infection shall be required, performed, or

used to determine suitability for employment, housing, or public services, or for the use of places of public accommodation, as defined in G.S. 168A-3(8), or public transportation. It shall be further unlawful to discriminate against persons to determine suitability for employment, housing, or public services, or for the use of places of public acccommodation, as defined in G.S. 168A-3(8), or public transportation who has or is perceived to have AIDS virus infection. Any person so aggrieved shall be entitled to institute a civil action pursuant to G.S. 168A-11.

Sec. 2. This act is effective upon ratification.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1989

S/H D

BILL-F
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: No HIV Insurance Discrimination. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT DISCRIMINATION AGAINST HIV INFECTED PERSONS UNDER HEALTH INSURANCE POLICIES.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-54.4(7) reads as rewritten:

"(7) Unfair Discrimination.

a. Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

b. Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

c. Making or permitting any unfair discrimination between or among individuals or risks of the same class and of essentially the same hazard by refusing to issue, refusing to renew, cancelling, or limiting the amount of insurance coverage on a property or casualty risk because of the geographic location of the risk, unless:

1. The refusal or limitation is for the purpose of preserving the solvency of the insurer and is not a mere pretext for unfair discrimination, or

2. The refusal, cancellation, or limitation is required by law.

d. Making or permitting any unfair discrimination between or among individuals or risks of the same class and of essentially the same hazard by refusing to issue, refusing to renew, cancelling, or limiting the amount of insurance coverage on a residential property risk, or the personal property contained therein, because of the age of the residential property, unless:

1. The refusal or limitation is for the purpose of preserving the solvency of the insurer and is not a mere pretext for unfair discrimination, or

2. The refusal, cancellation, or limitation is required by law.

e. Treating symptomatic HIV infection differently than any other dread disease under policy provisions and applications."

Sec. 2. This act is effective upon ratification.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1989

S D

89-LF-25
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: HIV Child Foster Care Funds. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR FOSTER CARE PAYMENTS FOR HIV INFECTED CHILDREN.

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to The Division of Social Services, Department of Human Resources, the sum of four hundred eighty thousand dollars ($480,000) for the 1989-90 fiscal year and the sum of one million one hundred twenty thousand dollars ($1,120,000) for the 1990-91 fiscal year, to provide twenty thousand dollars ($20,000) in foster care payments for each of 24 children in 1989-90 and 56 children in 1990-91, who are infected with the HIV virus.

Sec. 2. This act shall become effective July 1, 1989.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1989

S D

89-LF-26
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Antiretroviral Drugs Funds. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR THE PURCHASE OF ANTIRETROVIRAL DRUGS.

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to the Division of Health Services, Department of Human Resources, the sum of two hundred thousand dollars ($200,000) for the 1989-90 fiscal year and the sum of two hundred thousand dollars ($200,000) for the 1990-91 fiscal year, for the purchase of antiretroviral drugs needed for the treatment of HIV infected people.

Sec. 2. This act shall become effective July 1, 1989.