THE OFFICIAL NEWSLETTER OF THE

NATIONAL COALITION OF GAY STD SERVICES

Volume 5 #3 January, 1984

* * * * * * * * *

This Newsletter is published by the National Coalition of Gay Sexually Transmitted Disease Services (NCGSTDS). Although efforts will be made to present accurate, factual information, the NCGSTDS, as a volunteer, nonprofit organization, or its officers, members, friends, or agents, cannot assume liability for articles published or advice rendered. The Newsletter provides a forum for communication among the nation's gay STD services & providers, and encourages literary contributions, letters, reviews, etc. The Editor/Chairperson reserves the right to edit as needed, unless specific requests to the contrary are received. Articles for the Newsletter, or inquiries about membership in the Coalition may be addressed to Mark P. Behar, PA-C, NCGSTDS, PO Box 239, Milwaukee, WI 53201-0239 (414/277-7671). Please credit the NCGSTDS when reprinting items from the Newsletter. We're eager to hear from you! We will try to answer all correspondence! The NCGSTDS is the proud recipient of the National Gay Health Education Foundation's JANE ADDAMS-HOWARD BROWN AWARD, for outstanding effort and achievement in creating a healthier environment for lesbians and gay men, June 12, 1983.

GAY PRESS ASSOCIATION

****

TABLE OF CONTENTS (ALPHA): STDs

* * * * * * * * *

TABLE OF CONTENTS (ALPHA): AIDS

* * * * * * * * * *

CURRENT ASPECTS OF SEXUALLY TRANSMITTED DISEASES SYMPOSIUM (CASTDS)--III

The National Coalition of Gay STD Services and the American Association of Physicians for Human Rights (NCGSTDS & AAPHR) are teaming together for a joint educational meeting at Chicago's Marriott Hotel (540 N. Michigan Av.), August 22-24, 1984. The first day, Wednesday, August 22, Current Aspects of Sexually Transmitted Diseases Symposium--III (CASTDS) will be a clinical update for the diagnosis and treatment of STDs. The course syllabus will be an outline in protocol form for the diagnosis and management of STDs, with emphasis on the special problems of gay and lesbian patients. Course faculty will include NCGSTDS members Kenneth Mayer, MD (Boston), Chris Mathews, MD (San Diego), David Ostrow, MD, PhD (Chicago), and Mark Behar, PA-C (Milwaukee). Thursday & Friday, August 23-24, AAPHR and NCGSTDS will cohost Critical Gay & Lesbian Health Problems--New Diseases, New Approaches to Persistent Problems and Prevention/Prophylaxis. The following topics & speakers have been confirmed (A = AAPHR member, N = NCGSTDS member): AIDS Diagnosis (Walter Blumenthal, A); The Immunology of AIDS (Roger Enlow, A,N); Panel on AIDS Therapeutic Trials and Alternative Treatments (Paul Volberding, Chairperson; Stephen Follansbee, A; William Siroty, A,N); Panel on "Lymphadenopathy Syndrome and its Relationship to AIDS" (Donald Abrams, A; Kenneth Mayer, A,N; Roger Enlow, A,N); The Hepatitis B Vaccine and AIDS (Cladd Stevens); Hepatitis B Infection in Gay Men (Cladd Stevens); The Etiology of AIDS & AIDS Keynote: Overview of NIH AIDS Research Program (Kenneth Sell); Panel on Psychological Aspects of AIDS (Marshall Forstein, A; Stuart Nichols, A; David Ostrow, A,N); Panel on "The Role of Gay Community Medical Organizations in AIDS Research and Prevention" (Marcus Conant; Joseph Sonnabend; David Ostrow, A,N; Neil Schram, A,N); Intestinal Syndromes in Gay Men (Thomas Quinn); Lesbian Health Issues (Patricia Robertson, A; et al.); Helping Gay and Lesbian Youth Attain Positive Self-Images (Emory Hetrick, A; Damien Martin; Paul Paroski, A,N); Stages of Gay Relationships (David McWhirter, A; Drew Mattison); Panel on Impaired Gay & Lesbian Physicians (Melvin Pohl, Chairperson, A; Max Schneider, A); Non-AIDS Keynote: Social and Political Barriers to Gay and Lesbian Healthcare (Michael Ross). Finally, Richard Krause, Director of the National Institute of Allergy & Infectious Disease, will be giving the first annual AAPHR Banquet Address on the Sociology of AIDS and Infectious Disease Research.

In addition to the invited symposium speakers and STD update/CASTDS course faculty, there will be presentations of contributed papers, videotapes, special educational materials, etc., in the form of poster sessions on both afternoons of the meeting. Several types of submissions are appropriate, although consideration for presentation will be given to any submission which contributes significantly to the educational goals of the meeting. This format has been chosen to maximize interaction between presentors and persons interested in the particular subject being presented. Abstracts chosen for presentation will be sent instructions for preparing posters or video presentations for maximum impact. The areas in which we are most interested in receiving submissions are the following: 1) Studies in any of the areas being presented in the Plenary Sessions listed above. 2) Studies highlighting other areas of gay/lesbian health concerns not already covered in the Plenary Sessions (e.g., alcoholism, aging, etc.). 3) Educational materials specifically designed for use by members of NCGSTDS or AAPHR. 4) Educational materials aimed at gay or lesbian patients. 5) Video or multi-media audio-visual programs designed for use by NCGSTDS or AAPHR members. ALL NCGSTDS & AAPHR MEMBERS WILL RECEIVE AN ABSTRACT FORM AND ADDITIONAL MATERIALS UNDER SEPARATE COVER WITHIN THE NEXT 4-8 WEEKS; IF YOU ARE NOT A MEMBER, PLEASE ADDRESS INQUIRIES OR REQUESTS FOR ABSTRACT FORMS TO MEMBERS OF THE ABSTRACT SELECTION COMMITTEE. Committee members are: David Ostrow, MD, PhD, Howard Brown Memorial Clinic, 2676 N. Halsted St., Chicago, IL 60614; Mark Behar, PA-C, NCGSTDS/CASTDS, PO Box 239, Milwaukee, WI 53201 (414/277-7671); and Bob Bolan, MD, 2252 Fillmore St., San Francisco, CA 94115.

Three major objectives will be addressed by the program: 1) To provide health practitioners with increased awareness of new medical and psychological developments related to AIDS, the emphasis will be on useful skills in meeting these challenges. 2) To provide a 2 day "homosexual health update" for leaders in the field of gay health care to increase their knowledge and skills in the areas of research and educational programs in their own communities. This will include updated material on the diagnosis and management of common health problems in the gay and lesbian community with an emphasis on fertile areas for research and education. 3) To further educate practitioners regarding the societal problems affecting themselves and their

CASTDS--III, Continued

patients. The Keynote Address, "Psychological & Political Barriers to Quality Health Care for Gay & Lesbian People," will focus on increasing the awareness of practitioners and providing them with specific skills to cope with the political and societal forces impinging on the health of gay and lesbian individuals. Ten specific objectives have been identified: 1) To familiarize the health practitioner with various diagnostic tests used in evaluating patients for AIDS. 2) To provide a general understanding of treatments used for AIDS, including non-conventional modalities and the problem of quackery. 3) To provide the health practitioner with a background to recognize and address psychological aspects of AIDS such as depression, intra-family stresses, suicide, grief reaction and denial. 4) To provide practitioners with skills and information to deal with AIDS phobias. 5) To educate practitioners in the medical, legal, and ethical issues of artificial/donor insemination and provide them with an approach to counselling patients interested in this method of reproduction. 6) To increase practitioner awareness of factors leading to impaired practitioners and to alert them to resaources available for impaired practitioners. 7) To familiarize health practitioners with the newer diagnostic tests for various venereal diseases. 8) To teach practitioners methods of assisting their patients to develop positive gay or lesbian self-identities; using available data and collecting new data. 9) To provide practitioners with a better understanding of major issues and stages in gay/lesbian relationships and how the primary practitioner can assist patients in developing positive relationships. 10) To identify and review newer issues in lesbian health care and formulate strategies for encouraging further research in women's health care.

Tentatively, the costs of the three day symposium will be as follows: NCGSTDS/AAPHR members--$75 (non-members $125, with some of that applicable to membership); housestaff members--$25; students--tentatively free; late registration charges--$25; Wednesday session only--$25; discount for those staying at the Chicago Marriott--$10. Exact costs and registration materials will be forthcoming. Profits will be split 50:50 between NCGSTDS and AAPHR for the first $5000; thereafter, 2:1, AAPHR:NCGSTDS, due to the fact that the NCGSTDS is unable to assume liabilities due to limited assets. A NCGSTDS fundraising cruise in the Lake Michigan harbor overlooking the sensational Chicago skyline is scheduled for Wednesday or Thursday evening. Details forthcoming in the next Newsletter. The symposium will also be the site of the annual meeting of AAPHR; NCGSTDS will probably hold an informal meeting--its annual meeting is scheduled for New York in June in conjunction with the International Lesbian/Gay Health Conference & Third AIDS Forum; the National AIDS Prospective Epidemiology Network (NAPEN) will also hold a business meeting in Chicago during the meeting. Mark your calendars--this NCGSTDS & AAPHR joint medical symposium promises to be one of the finest medical meetings on gay/lesbian health ever offered! Updates will be printed in future issues of the Newsletter.

* * * * *

AIDS EPIDEMIOLOGY & SURVEILLANCE UPDATE

abstracted from AIDS Weekly Surveillance Report, CDC AIDS Activity

As of January 10, 1984, the Centers for Disease Control AIDS Activity reports a total of 3157 United States cases of AIDS (CDC definition). Homosexually active men account for 71.5% of all cases; 17.3% from IV drug abusers; 4.3% from Haitians; 0.6% from Hemophiliacs; and 6.3% from those in no apparent risk group (or unknown risk). 22.2% are from individuals aged 20-29; 46.4% from ages 30-39; 21.6% from ages 40-49; 8.9% from ages 50 and over; the remainder are in all other ages. 58.1% of the individuals are white; 25.6% are black; 14.2% are hispanic; 2.1% are in other or unknown racial groups. 45 states (including Puerto Rico and the District of Columbia) have reported cases; New York and California have the most, with 44.5% and 22.7% respectively; Florida has 6.8%; New Jersey, 6.2%; Texas, 3.4%; Illinois and Pennsylvania, 1.8% each; Massachusetts, 1.6%; Georgia, 1.2%; all other areas/states have less than 1.0%. Overall case-mortality remains at about 43%; for cases diagnosed in 1983, the case-mortality is 35% during the first six months of 1983 when diagnosed, and 23% for those diagnosed in the second half of 1983. AIDS cases per million population for the entire US is 13.9, ranging from 143.4 cases per million in New York City, 116.6 in San Francisco, 80.6 in Miami, 47.3 in Newark, and 34.9 in Los Angeles, to "elsewhere" where it is 4.9 cases per million. These cases represent only those meeting the CDC's strict criteria of case definition.

* * *

NCGSTDS AT A CROSSROADS--CHAIRPERSON/EDITOR'S COMMENTS

by Mark Behar

This is the first issue of 1984 and marks the middle of volume 5 of the NCGSTDS Newsletter. Things have certainly changed in these last 5 years, especially notable in enhanced quality and increased quantity (from 2 pages in the beginning to present marathon issue!). Writing, compiling, and publishing the Newsletter has been no easy task, especially with the inability of some of our members to regularly provide and contribute information about their gay STD/AIDS programs. This partially explains why we've had to rely more upon abstractions, reprints, or rewrites of articles & features from the national gay media. We appreciate their willingness & permission to use their materials, and offer them special thanks: Chicago GayLife, Boston's Gay Community News, New York Native, Toronto Body Politic, Washington Blade, San Francisco's Bay Guardian & Coming Up!, Madison's OUT!, Denver's Colorado Gay & Lesbian News, Detroit's Cruise & Metra, Sacramento's Star & Mom Guess What, and the "mainline" Medical World News, among others. I have received many letters, lavishly praising the merits of the Newsletter. As a tool of informational exchange, it has become indispensible for many. This of course places quite a strain on the Editor, who publishes the Newsletter approximately bimonthly as a volunteer. Other Coalition responsibilities are increasing as well: distributing orders for current edition of the G&R brochure; preparing the 4th edition of the G&R brochure for May or June, in time for the International Gay/Lesbian Health Conference in New York; attending several conferences a year (my supervisors at Planned Parenthood have amazing tolerance and understanding for such leaves!); working on the Current Aspects of STD Symposium in association with AAPHR's annual medical conference in Chicago this August as a fundraiser; and trying to keep informed of the major goings-on in gay STDs and AIDS socially, politically, and organizationally for the Newsletter--no easy tasks, especially with the "quadra-coastal" competition mentalities. [The "quadra-coasts" are Pacific, Atlantic, Gulf, & Great Lakes (ie, Midwest--oh how I hate that term!!).] The lifeblood of an organization is its membership, yet there has been no time or energy to generate new members--in fact there has been an active avoidance of recruitment since this correlates with more work and time, neither of which are available nor feasible. Failure to groom new leadership to assume responsibility for the NCGSTDS has been unfortunate and must be corrected immediately. Suggestions to seek incorporation status and 501(c)(3) tax-exempt status has also been deferred due to the lack of willingness of members to share responsibility, and a type of local shortsightedness that fails to electrify members to the nationwide gay STD/AIDS perspective and objectives of the Coalition. Don't get me wrong--local issues & concerns should take priority; but the Coalition's overall national goals--of facilitating information sharing and exchange and to enhance networking could greatly assist local issues.

The Coalition is at a crossroads. As chairperson and Newsletter editor, I am unable to continue at this pace without fear of harm to the organization and to myself. No person in sane mind would now accept these responsibilities without sincere commitment from others to share in the work load. I need a sincere & committed individual and group/service to assume responsibility for each of the above projects. Management of membership/subscription and Newsletter preparation (editorial, publication, distribution) are two additional project responsibilities that are easy but time consuming tasks. What alternatives are there if there are no such volunteers? 1) Go out of business, distributing all assets to gay member STD services (a few thousand bucks--not much to go around!). This is a most distasteful option. 2) Become a for-profit business, selling subscriptions to the Newsletter. Exactly how much are members willing & able to pay? Mary Ann Liebert Publications attempted to do this with her ill-fated Homosexual Health Reports which lasted less than a year. 3) Persuading existing organizations to assume responsibility for such activities as membership, the Newsletter, or the G&R brochure. 4) Using a model similar to the Board of the National Gay Health Education Foundation, solicit a "founding" board of directors for the Coalition, delegating to each member specific responsibilities. This board could enable the NCGSTDS to seek tax-exempt agency status. Other suggestions and alternatives are welcome. Now more than ever, the NCGSTDS needs you.

* * *

BLOCK GRANT PROGRAMS: FEDERAL FUNDS AVAILABLE THROUGH THE STATES

from the National Gay Task Force

Three health care related "Block Grant" programs may be of relevance to gay & lesbian health providers & agencies providing AIDS, STDs or related services. The block grant program was initiated in 1981 to consolidate 25 health and social service programs into seven block grant programs whereby money is given to the various states who take on the responsibility for administering the grants, and for deciding who will be the recipients of the federal funds. Prior to the debut of the new programs, federal funds were provided by HHS in the form of direct grants to community-based programs in the various states. The new system reduces the federal government's role to monitoring the broad implementation of the consolidated programs. One of the stated goals of the new system is to make federal grant money "more responsive to the local needs of each state." Three block grant programs that might potentially provide funds to AIDS, STD or other gay/lesbian community health centers are Preventive Health, Alcohol & Drug Abuse, and Primary Care.

Preventive Health: $87.1 million is available to fund this block for fiscal 1984 (i.e., ending September 30, 1984!). The general purpose is to provide funds for "preventive health services for individuals and families, especially those of limited means, and for a variety of public health services to reduce preventable morbidity and mortality;" among the specific programmatic purposes is that of "providing for community-based programs to help people reduce health risks." The risk reduction education programs conducted by local AIDS & STD service organizations would appear to fall within the purview of this program.

Alcohol, Drug Abuse, and Mental Health: $462 million is available in fiscal 1984. The general purpose of this program is to "establish and maintain programs to combat alcohol & drug abuse, to care for the mentally ill, and to promote mental health." To the extent that STD/AIDS service organizations address the needs and rehabilitation of drug abusers, the psychological needs of persons with chronic diseases such as AIDS or hepatitis, or the concerns of the "worried well," they may be eligible for some of these funds.

Primary Care: #327 million is authorized for this program in fiscal 1984, however transition from firect federal grants is voluntary (not mandatory as with the other two programs above) and at the moment, participation is this program is limited to West Virginia and the Virgin Islands. Should your state convert to block grants in this area, the program provides funding to "private non-profit entitites for planning, development, and operation of community health centers."

Monitoring Administration of the Block Grant Program by Individual States: Each of these programs involves reporting requirements from the states: they must in a "required annual application...certify compliance with eight assurances of quality, fairness, and appropriateness of expenditure." More significantly from the perspective of locally-based non-profit entities in need of funding from these block grants, "legislative hearings are required beginning with the second year of block operation. The states will prepare proposed spending plans and make them available for public comment." The second year of block grant operations commenced in October, 1982, so the provisions for hearings and public comment are now in effect. Local gay/lesbian health care, STD, & AIDS service organizations are strongly encouraged to investigate the availability of these funds through their state's department of health. Local and state political organizations may wish to monitor the administration of these programs in order to determine whether the health care needs of gay men and lesbians are being adequately addressed. NGTF will make further information about government grants for which STD or AIDS-related organizations may potentially be eligible as it becomes available. Two other block grant programs, for social services and community services, are being investigated for their relevance and applicability to gay/lesbian health care needs. If you have any knowledge of or experience with block grant programs, please contact the NGTF, 80 Fifth Av., New York, NY 10011 (212/741-5800).

* * * * *

NGTF HEALTH CARE PACKET AVAILABLE

Almost 30 separate items are available to health care workers requesting the health care packet from National Gay Task Force, 80 Fifth Av., New York, NY 10011 (800/221-7044; NY State 212/741-5800). There is no charge.

They include: 1)NGTF cover letter: "Dear Health Care Worker"--general information and how to order in bulk; 2) NGTF National AIDS Resource Directory--25 pages; 3) SSI Information (NGTF press release with guidelines on back); 4) Confidentiality Statement--article on one side, form on back; 5-7) Gay Mens Health Crisis Material--Newsletter #2 (Jan., '83)--62 page booklet, Health Letter #1 (Nov., '83)--2 page color photocopy; "Overview of Psychological Issues Covering AIDS"--3 page photocopy; 8) Spanish AIDS info--LA AIDS Project 1 page photocopy; 9) French/Creole/Haitian AIDS info--6 page booklet from Haitian Coaltion on AIDS; 10) Healthworkers AIDS Guidelines--"Infection Control Guidelines for Health Care and RElated Workers"--1 page photocopy from Philadelphia AIDS Task Force; 11) Health Care Professional Advice--1 page photocopy from Chicago's Howard Brown Memorial Clinic; 12) "Infections Frequently Associated with AIDS (Manifestations/Treatment/Precautions)--1 page photocopy from NYU Med. School & GMHC: 13) AIDS Syllabus--one page photocopy (Univ. of CA Nursing Education & Research); 14) Guide for People with AIDS--3 pages from AIDS Key West; 15-16) Biographies descriptions-- . KS Foundation (1 page) & Canadian Gay Archives (2 pages); 17) Michael Callen and Bob Cecci Statements--1 page from Long Island Connection; 18) General Population AIDS pamphlets--1 page from SF Health Dept.; 19) Viral Hepatitis Risks for Gay Men: 1 page Abbott Labs pamphlet; 20) American Association of Physicians for Human Rights--one page description & membership application; 21) Health Care Packet Description--1 page from KS/AIDS Project; 22) NGTF membership application/contribution info; 23) Ten NGTF Crisisline cards; 24) Description of Crisisline/Violence Project of NGTF--1 page; 25-26) NCGSTDS Guidelines & Recommendations for Healthful Gay Sexual Activity & Fact Sheet/Membership info; 27) Guidelines for AIDS Risk Reduction from Bay Area Physicians for Human Rights.

* * * * *

GAY PEOPLE URGED TO "TALK BACK TO THE MEDIA," & ELECTRONIC NEWS

The Media Fund for Human Rights has announced a major, nationwide campaign to make gay people more critical of the media. The campaign was launched with an exhibit during the November convention of the National Association of Business Councils in Los Angeles. Convention-goers were invited to view and respond to a videotape of the media coverage of many gay issues. "Local groups have been doing incredibly successful consciousness-raising among media officials in thier communities," according to Mike Rutherford, Executive Director of the Media Fund. "Now, the time has come for us to be sending our version of breaking news stories directly into the electronic news systems of the country--and to it on a national level." The task will take full-time professionals, lots of money, and cooperation among gay groups nationwide. "If we could just match the technical facilities of the Moral Majority, we could begin to counter some of the 'media fag-bashing' which is going on," said Morgan Pinney, CPA, Chief Executive Officer for the project. The heart of the operation of the Media Fund is the computerized electronic network, established more than a year ago by the Gay Press Association and now operated by the Media Fund. The system is no accessable by any group in the country, using any of the popular home computers connected over regular telephone lines to the "host" computer in New York. Any group can leave messages for any other group or disseminate press releases to all groups. Members of special sub-groups, such as gay lawyers or gay journalists, will communicate within their special sections of the system. "All of this will result in a better and more rapidly informed gay community, and everyone will be in touch with the Media Fund as we send news and analysis directly into the electronic news systems of the country," according to Pinney. The Media Fund can be contacted through its national office in Washington, DC, 1110 Rhode Island Av., NW, zip 20005 (202/387-2430). [ED NOTE: NCGSTDS members having experiences (positive & negative) with the gay media with regards to publishing gay/lesbian health information are asked to write in to us: NCGSTDS, POB 239, Milwaukee, WI 53201.]

* * * * *

NATIONAL GAY HEALTH EDUCATION FOUNDATION SEEKS BOARD MEMBERS

In accordance with the bylaws of the National Gay Health Education Foundation (NGHEF), the NCGSTDS is being asked to submit the names of two members who would be interested in serving on the Board of Directors for a two year term. If you are interested, please send your name, resume, statement of willingness to serve on the Board, and any other materials that may be of assistance in assessing your qualifications, to Mark Behar, NCGSTDS PO Box 239, Milwaukee, WI 53201, or call 414/277-7671 evenings. Your name will be forwarded to the NGHEF.

QUALIFICATIONS: willingness to serve a two year term; ability to travel to quarterly meetings of the Board; ability to share equally with all Board members in the cost of transportation to these meetings ($75-100/meeting)--most meetings are held in New York City; willingness to raise funds for NGHEF through personal and professional sources (minimum $1000/year); willingness to give priority to NGHEF for this two year term and to promote NGHEF both locally and nationally; and ability to work on NGHEF activities, devoting substantial time and energy to at least one area of NGHEF's work.

Nominations and accompanying materials must be received no later than January 31, 1984, so act quickly! Individuals selected will be notified no later than May 10; term of office begin June 20, 1984. For more information, contact: NGHEF, PO Box 834, Linden Hill, NY 11354.

* * *

GAY STD COMPUTER NETWORK

by Scott McAdams

As the Managing Coordinator for the mostly volunteer Gay Men's Health Collective (GMHC) of Berkeley, I am interested in learning of other NCGSTDS members pursuing Apple Computer's Community Affairs Program offer of support for the formation of microcomputer networks (see August, 1983 issue of Newsletter). We are an eligible 501(c)(3) tax-exempt organization providing STD testing and treatment. If any organization is interested in establishing a network, please write to the NCGSTDS, PO Box 239, Milwaukee, WI 53201 or call 414/277-7671; the NCGSTDS will then forward your inquiry to me. At this point in time, my primary questions are: What purpose can a network among STD clinics serve? Are any STD clinic doing STD/AIDS research? A microcomputer would be an extremely beneficial asset to us, and I am therefore interested in pursuing all possibilities for obtaining one. If by networking we can achieve this end as well as communicate with other clinics, what more could we ask for (hmmm ...in these financially strapped times, plenty!)? Finally, if anyone who reads this works for a university which is a member of BITNET, please let me know: Scott McAdams, Gay Men's Health Collective, 2339 Durant Av., Berkeley, CA 94704-1670 415/644-0425.

[ED NOTE: The NCGSTDS is aware of several clinics that use, or are interested in using a computer for patient records, research, billing, or networking: Los Angeles's Clinic, Gay & Lesbian Community Services Center; Chicago's Howard Brown Memorial Clinic; Tucson's Gay Health Project; Milwaukee's Brady East STD Clinic (limited use). Are there any more? Please let me know!]

* * *

NURSING RESEARCH INSTRUMENTS ARE AVAILABLE

Researchers Genevieve M. Clavreul, MS, MPA, and Sue M. Caviness, PhD, report the availability of 4 pertinent instruments that they are offering for collecting of information. The Homophobia Index is a 14 question instrument that surveys attitudes about homosexuality. The AIDS Apprehension Index has 15 attitude multiple choice type questions and 3 open-ended essay questions about AIDS & people with AIDS. The Patient Quality Care Index--Self-Perceptio is 9 question attitude multiple-choice format survey with 5 open-ended essay type questions for people hospitalized with AIDS. These three questionnaires were developed by Clavreul & Caviness. The fourth was constructed by Elaine LaMonica, Empathy Construct Rating Scale. This instrument has 84 items that describe ways people may feel about or act towards someone. Rather than reprinting all 15 pages of these four instruments, anyone who wishes to participate in the distribution of these questionnaires among health care professionals or among people with AIDS are encouraged to correspond directly with Clavreul at: Clavreul-Caviness Management Consultants, 4119 Los Feliz Blvd., #9, Los Angeles, CA 90027 213/661-3936. Readers wishing to see the instruments may also send $1.50 for photocopying and expenses and postage to the NCGSTDS, PO Box 239, Milwaukee, WI 53201.

* * *

FIRST SOUTHEASTERN LESBIAN/GAY HEALTH CONFERENCE: CALL FOR PAPERS

by Caitlin Ryan

The First Southeastern Lesbian/Gay Health Conference, sponsored by the National Gay Health Education Foundation, will be held in Atlanta, Saturday, April 21, 1984. Proposals for workshops and presentations are now being considered. The deadline for submission is February 10, 1984. Previous national conferences which have been presented in major metropolitan areas since 1978, have brought together lesbian and gay health care providers to share information and ideas, to coordinate networking and caucusing within their respective professional organizations, and to provide a forum for professional support and development. The Atlanta-based Conference is expected to draw more than 300 health care providers, including physicians, physician assistants, nurses, social workers, psychologists, alcohol & drug specialists, physical therapists, counselors, dentists, public health workers, nutritionists, chiropractors and health care advocates. The Conference is cosponsored by the American Medical Student Association, the Emory chapter of AMSA, the American Association of Physicians for Human Rights (AAPHR), and the Georgia Association of Physicians for Human Rights. Local co-sponsors include AID Atlanta, the Memphis Gay Coalition, the Memphis and Atlanta chapters of Black & White Men Together, and the North Carolina Lesbian & Gay Health Project.

The Conference will present featured speakers who are recognized experts in aspects of lesbian/gay health care, as well as an opportunity for Board members of the National Gay Health Education Foundation to discuss activities of the Foundation and to highlight important issues in professional development and organizational growth. Keynote Speaker Bopper Deyton, MPH, former assistant to the Surgeon General, convenor of the Gay Public Health Workers Caucus of the American Public Health Association, and current National Legislative Affairs Coordinator of the American Medical Students Association, will focus on changes in perspectives in gay health care since the emergence of the AIDS epidemic and future considerations for practive and research during the next 25 years. Representatives from the Centers for Disease Control (CDC), the Federation of AIDS Related Organizations (FARO), as well as local health care providers will present a series of workshops on the medical and psychological aspects of AIDS. Approximately four workshop periods will be scheduled during the day, with a total of 20 or more workshops focusing on such topics as: lesbian/gay substance abuse, AIDS, lesbian health concerns, psychotherapy with lesbian/gay clients, health care concerns of lesbians/gays of color, aging, professional development, and others. The possibility of offering ocntinuing education credit for nurses, physicians, physician assistants, and psychologists is being investigated.

The Conference will be held at the Emory University Woodruff Medical Center Administration Building, located at 1440 Clifton Road, Atlanta. For additional information or to submit a proposal, contact: Caitlin Ryan, 550 Cresthill Av., Atlanta, GA 30306, 404/892-2459. Workshop proposals should include requests for any necessary audio-visual materials, as well as biographical information on the presentor(s). Workshop sessions will run for 1 and 1½ hours in length. Presentors will be notified of acceptance by February 25, 1984.

* * * * *

INTERNATIONAL CONJOINT STD MEETING IN MONTREAL IN JUNE: CALL FOR ABSTRACTS

An International Conjoint Meeting on STDs will be held in Montreal, June 17-21, 1984, and will highlight the first North American meeting of The International Union Against Venereal Diseases and Treponematoses (IUAVDT) which will host that group's 32nd general assembly. Other groups that are cosponsoring the Meeting include: the American Venereal Disease Association, the STD Division of the Canadian Public Health Association, the Association of Medical Microbiologists of Canada, the Canadian Infectious Disease Society, the Canadian Society for Tropical Medicine and International Health, and L'Association des Medecins Microbiologistes de la Province de Quebec. The scientific program will include the epidemiology, community health and social impact, pathogenesis, biology, diagnosis, treatment, followup and prophylaxis of STDs caused by Neisseria gonorrhoeae, Treponema pallidum, Chlamydia trachomatis, genital mycoplasmas, fungal & parasitic agents, viruses (including HSV, CMV, hepatitis, papilloma, etc.), enteric pathogens, genital ulcers, STDs in women (including vaginitis, urethral syndromes, pregnancy, PID, sterility), neoplasia and STDs, AIDS, and STDs in developing countries.

(CONTINUED)

INTERNATIONAL CONJOINT STD MEETING, Continued

Delegates wishing to present papers should submit abstracts in French or English, typewritten on the official abstract form of the Meeting, by February 15, 1984. Verbal presentations will be 12 minutes duration. Poster sessions will be organized. Official languages of the Meeting are English and French. The program committee will decide on acceptance by April 1, and wil allocate accepted papers to either verbal or poster presentations. Abstracts accepted for presentation will be printed in the Abstract Book which will be distributed at the beginning of the Meeting. All correspondence should be addressed to: International Conjoint STD Meeting, c/o Dr. Richard Morisset, 739 Dunlop Street, Montreal, Quebec H2V 2W5 Canada (514/737-9721). Registration fees are $200 (Canadian) before May 1; $250 afterwards.

* * *

PEDIATRICIANS LEARN THAT TEENS MAY BE GAY
reprinted with thanks from the BAPHRON (December, 1983)

"The Gay Adolescent in Pediatric Practice" was the title of a half-day symposium co-sponsored by the American Academy of Pediatrics and the Society of Adolescent Medicine at their Annual Meeting, October 23, 1983, in San Francisco. The speakers included former NFL football star Dave Kopay, Aaron Fricke, the Rhode Island high school student who sued to bring a male date to his senior prom and won, Dorothy Abramson, a member of the San Francisco chapter of Parents & Friends of Gays, and Bay Area Physicians for Human Rights (BAPHR) members Bill Owen, MD, and Jim Krajeski, MD. The Symposium, which was attended by over 500 MDs, was significant in that it marked the first recognition by the American Academy of Pediatrics that gay adolescents do have special needs.

Owen told the audience how to take a sexual orientation and sexual practices history from a lesbian or gay male patient in a sensitive way. He discussed the medical problems that the pediatrician might encounter in a sexually active gay male adolescent through a slide presentation of traditional venereal diseases in new locations, enteric conditions, traumatic problems and entities associated with cellular immune deficiency. He also presented a case history illustrating how obtaining a good sexual history can lead to a diagnosis more rapidly and in a more cost-effective manner. Krajeski discussed the psychological aspects of the gay adolescent. He noted that adolescents who are aware that they are gay suffer isolation that is different than that experienced by members of other minorities, since members of most other oppressed groups are visible and it is easier for those teenagers to identify peers with whom to band together for support. He urged pediatricians to be teachers who provide supportive counseling and reduce psychological stress. Krajeski also suggested that pediatricians examine their own attitudes about homosexuality, asking themselves how they feel about gay doctors & teachers, and how they would feel if their own children were gay. He further pointed out that referrals to mental health professionals with the purpose of "changing" an adolescent's sexual orientation were neither innocuous nor appropriate. Kopay tackled the popular stereotype of gay men and lesbians by talking about some of his life experiences that he had previously revealed in his book, The Dave Kopay Story. Fricke, who has also written a book about his coming out experiences, Reflections of a Rock Lobster, discussed his concept of "parental homophobia," which he feels is a forme fruste of child abuse. Abrahamson gave a moving presentation of her own lesbian daughter's and gay son's coming out story and how parents too must "come out" in accepting a child's gayness and in improving the adolescent's feelings of self-worth. A lively panel discussion with many insightful questions covering the medical, psychological and social aspects of homosexuality completed the symposium. An audio tape of Drs. Krajeski's & Owen's remarks has been prepared by the Audio Digest Foundation and will be available to physicians for purchase soon.

[For additional information/membership inquiries, contact BAPHR, PO Box 14546, San Francisco, CA 94114.]

* * *

NEWS FROM WASHINGTON, DC'S WHITMAN-WALKER CLINIC

by Jim Graham, Peter Hawley, MD, & Dusty Cunningham

This has been a successful, though very challenging year for the Whitman-Walker Clinic (WWC). We have grown with the community we serve. Our oldest program, the Gay Men's Venereal Disease Clinic (GMVDC), is about to celebrate the tenth anniversary of its founding. The WWC is approaching its sixth year mark, having been incorporated in January, 1978. Today we are doing more than ever before for the gay and lesbian community. In addition to the GMVDC, WWC is composed of several other programs--Gay Council on Drinking Behavior, Lesbian Health Center, Counseling Group, and the Gay Hotline. WWC's newest program was organized in response to the AIDS crisis, the AIDS Education Fund, which is actively providing services to the community and to persons with AIDS. WWC also prompted the District of Columbia government to establish the DC AIDS Task Force, composed of community representatives and city officials, to insure a coordinated local effort.

The problem of AIDS in our community does not appear to have significantly affected the Clinic's infection rate for STDs. In the past year, there has been only a small decline in the number of patients who have been diagnosed as having either gonorrhea or syphilis: 22.1% for 1983 to date, as compared with 24.9% in 1982. Over the past 5 years, the GMVDC has averaged 7000 patient-visits per year (the high was 7757 in 1980; 6730 patients were screened from September 1982-September, 1983). One of every three patients received treatment. The GMVDC has over 150 active volunteers working in patient services, laboratory services, phlebotomy and patient screening, with 14 physicians. There are 8 registered nurses working on the injectable program, implemented in December, 1982. Although there were 4 allergic reactions to penicillin injections, none proved to be serious thanks to the careful planning and training of medical director Peter Hawley, MD, and chief of nursing services, Kevin Rice, RN. Last winter, the GMVDC was approached by Georgetown University Medical School for allowing medical student training at the clinic. After a survey of patients indicated they were willing to participate, we proceeded, with the hope that medical students would learn about the problems facing gay male patients and thus be more sympathetic in their later practice. The experiment was a success. Thanks to an excellent training class which produced a number of very enthusiastic volunteers, we have the qualified volunteers the Clinic needs to operate. Another training class is scheduled for January, 1984. As a new program of the GMVDC, the Chronic Hepatitis B Support Group has been formed to help men recovering from hepatitis and to help friends and loved ones understand the recovery process. The GMVDC Outreach Program at the baths is hoped to be expanded to weekly screening, but must have additional trained volunteers to do so.

The AIDS Education Fund (AEF) is the Clinic's newest program. Since its inception in the spring, much has been accomplished. The AEF functions in 5 areas: Patient Support Services, Medical Services, Community Education Services, Fundraising, and Office Support and Administration. Some of our major accomplishments include:

People With AIDS Support: Our volunteers have provided support services to more than 25 persons with AIDS (PWA). These services range from advice over the telephone to long term counseling. We have buddies who visit PWAs at home or in hospitals; we provide legal advice on wills and power of attorney; we provide help in applying for Social Security Disability benefits; we have support groups for PWAs and for their loved ones. This effort is hte heart of our program, and we will be spending a great deal of time on this during the next few months, improving our system of delivery. We still have need for some particular kinds of volunteers--persons who have expertise in the public social service system; persons with free time during the day as well as the evening.

Medical Services: The Medical Services program of the AEF will starting an AIDS evaluation clinic soon. This clinic, working closely with the GMVDC, will offer low cost medical evaluation and assessment to those displaying AIDS-like symptoms. In addition, we will work closely with local research institutions to collect data which can be used in epidemiologic and laboratory studies.

Community Education: The Community Education Services program is currently developing a comprehensive public relations program so that people will be informed about AIDS and about the services the AIDS education fund provides. Among the projects accomplished are the printing of informational brochures, posters and pocket cards, the presentation of several community forums on AIDS, including one directed specifically at black and third world gay men,

(CONTINUED)

WASHINGTON'S WHITMAN-WALKER CLINIC NEWS, Continued

the issuing of an AIDS Education Fund Newsletter to keep volunteers informed and involved, and the formation of a library of books, articles, and tapes on AIDS, chronic illness and related topics. We have provided speakers at numerous events in the area, and we are currently engaged in developing a contract with the DC government to provide the AIDS Information phone line services for the whole city.

Looking Ahead: In September, 1983, our first full time program manager was hired to help organize and manage the program: John Hannay. We are still actively engaged in fund-raising, with events already scheduled into the autumn of 1984. The money raised not only pays salaries and overhead, but also contributes to the training of volunteers, printing, advertising, etc. We also have three memorial funds which are specifically for direct assistance to PWAs with financial need. We think we have come a long way in 6 months, but we see much which needs yet to be done. WWC can be proud that it responded to the AIDS crisis when it did and with programs to meet the needs as they arose. We are in the forefront in service to PWAs, to the entire Washington area.

In other areas of the WWC, the alcoholism and drug abuse program has been expanded, helping dozens of people in their recovery from alcoholism thanks to the Gay Council on Drinking Behavior. An out-patient treatment program, an aftercare program, and a concerned persons program have been implemented. Professional assessment and referral is available by appointment, and free counseling is available on walk-in basis. Despite minimal outreach, our client load has been increasing regularly. The Lesbian Health Center component of the WWC is undergoing reorganization, and is seeking volunteers. The Counseling Group is made up of 19 peer counselors of varied backgrounds. They offer individual and group counseling on a sliding scale fee-for-service. Almost thirty volunteers on the Hotline, which has recently advertised its services in the Washington Post.

The key to the WWC's success is the high quality of our volunteers. The 300 men and women involved in Clinic programs make the critical difference. But greater community service required an increase in the Clinic's professional staff. Aside from the positions of Clinic administrator and medical technologist, the Clinic added three fulltime positions in 1983: director of substance abuse services; manager of the AIDS Education Fund; and a new manager of the Gay Men's VD Clinic. We are proud of the fact that almost 70% of our total income comes directly from the gay and lesbian community. We also receive support from other sources. In 1984, the DC government will be providing financial support for our efforts on STDs, AIDS, and alcoholism, in recognition of the contribution the Clinic makes to the community. The Meyer Foundation recently granted us a contract to help support the AIDS Evaluation Clinic. Once again, we will be receiving a percentage of the "Brother Help Thyself" proceeds raised this past September. In addition, the Clinic was named the first gay beneficiary of the DC Bartenders Ball, which is held annually in February. Finally, our ability to provide direct assistance to needy persons with AIDS has been enhanced throught the creation of three memorial funds, each in memory of a local man who died of AIDS.

Next year is going to be another year of challenge for WWC. Undoubtedly, our resources are going to be taxed severely, if the AIDS crisis grows as expected. More people will be turning to WWC for assistance with problems far more serious than anything we've ever faced. The Clinic also needs to continue and enhance outreach to the black and third world communities, both in terms of AIDS and other health concerns. We are proud of what has been done. And with your support and confidence, we look forward to continued progress in the year ahead.

[ED NOTE: Apologies to the WWC staff for editing, abstracting, and rewriting their extensive, comprehensive year-end report. Thanks!!]

* * * *

NATIONAL STD CONFERENCE ANNOUNCES DATES

The 1984 National STD Conference sponsored by the VD Control Division of the Centers for Disease Control has tentatively been scheduled for May 29-June 1, 1984 in Kansas City, Missouri. Details in the next Newsletter.

* * * * *

GUIDELINES & RECOMMENDATIONS FOR HEALTHFUL GAY SEXUAL ACTIVITY

Dear NCGSTDS: I just received your November, 1983 Newsletter and wanted to encourage you to maintain the quality and explicit language in the next edition of the Guidelines brochure. Regarding its distribution, I would only mention that I have seen no mention of it anywhere but in the Newsletter. You may wish to get other groups and organizations to promote its availability. You might also want to consider trying to expand your membership. A larger group of members would reduce your printing costs (per person) but entail more work. I think that a lot of information you provide might be of interest to people other than doctors. You might even find some interest among the various governmental agencies. I have shared information from the Newsletter, as well as other groups working on this issue, with numerous coworkers, and friends. I will continue to do so, and will send you anything of interest that I come across. Thanks for all the work you have put in! --Mark Goldfield, Brooklyn, NY

[Reply:] Dear Mark: Thanks for all of your past correspondence, and your suggestions about the Guidelines brochure. The brochure is occasionally advertised elsewhere--for example, The Drummer, the leather scene magazine. And we do get requests from Drummer readers. However the biggest problem is the actual distribution of the brochure. Personally, I have neither the time nor energy to "plow ahead" with advertising the brochure or answering hundreds or thousands of requests. My energies are more useful with the compilation and distribution of the Newsletter. We must therefore rely on the assistance of gay STD clinics, services, & providers to independently push the brochure (or fasimile) for their respective communities. I really appreciate the work that individual members like yourself have put in to help share the information with friends & colleagues. Thanks for sharing your ideas & thoughts!
--Mark Behar, NCGSTDS

* * * *

COPING WITH STRESS FOR GAY & LESBIAN PHYSICIANS

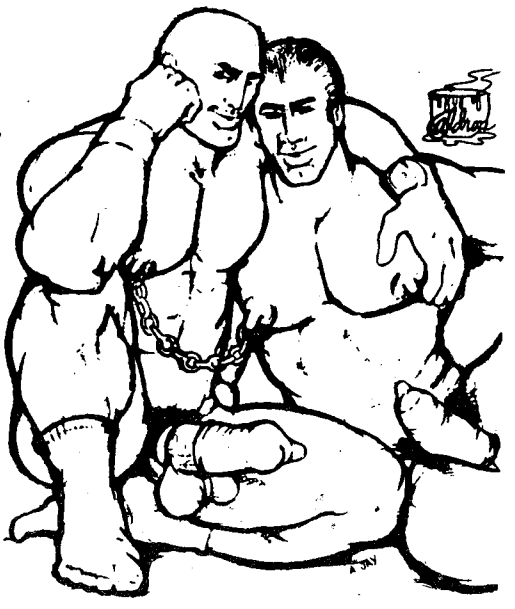
A coping with stress workshop for gay & lesbian physicinas with or without partners will be held January 13-15, 1984 at Asilomar, on California's Monterey Peninsula, overlooking the Pacific Ocean (about 160 miles from San Francisco). It is cosponsored by the California Medical Association and the Bay Area, Southern California, San Diego, and American Association of Physicians for Human Rights groups. The five faculty members for 1984 are David McWhirter, MD, psychiatrist (San Diego), Andrew Mattison, PhD, clinical psychologist (San Diego), Don Clark, PhD, clinical psychologist (San Francisco), author of Loving Someone Gay, Carol Cohen, MD, psychiatrist (Berkeley), and Hanna Bauer, EdD, licensed psychologist (Davis). The workshop is approved for up to 14 hours of Category 1 credit, and will cost $195 per person, which includes room (double occupancy), and all meals. Registration is limited to 50 people. For more information, contact SCPHR, PO Box 10672, Santa Ana, CA 92711.

* * * *

WHAT? ME? USE A CONDOM?

by Tim Burak, Seattle Gay Clinic Staff Notes (11/83)

I am compiling a notebook/kit to provide information for men who are interested in exploring the use of condoms in a gay context. Tentatively titled, "What? Me? Use a Condom?" --the kit will include samples of the various types of condoms (so far, I've collected 32 different kinds, some pretty exotic, indeed!), tips on condom use, the Consumer Reports comparative ratings on different brands of rubbers, and, I hope, some illustrations of "field" use. If you know of any photographs depicting gay sex with condoms, I'd appreciate tips on how to obtain them; or if you have any good ideas you'd like to contribute to this little project, please write or call: Tim Burak, Seattle Gay Clinic, POB 20066, Seattle, WA 98102, 206/329-0935. Condoms seem to be emerging from the closet (see ad on right from San Francisco's Caldron Baths); several thousand were passed out on the streets during the San Francisco Gay Freedom Parade in 1983; several Club Bath Chain affiliates are distributing condoms. [ED NOTE: See related article!]



* * * * *

CONDOMS AS AN STD PROPHYLACTIC--TO USE OR NOT TO USE!

[ED NOTE: The following article was written based on information from Population Reports (series H, number 6, September-October, 1982, pp. 121-156, Population Information Program, Johns Hopkins University, 624 N. Broadway, Baltimore, MD 21205), and Consumer Reports (October, 1979, pp. 583-89). These two references probably offer the most comprehensive, up-to-date information on condom use, the former having over 500 references. One thing was very clear--very little has been written about the use of condoms in male-to-male use. Please address commentary to the NCGSTDS, PO Box 239, Milwaukee, WI 53201.]

Condoms are a safe, effective, reversible method of birth control and STD prophylactic. They have no after-effects and can be used correctly without medical supervision. Yet condoms are underutilized. Only recently have condoms been promoted as useful adjuncts in the prevention of STDs and possibly AIDS among sexually active gay men. Latex rubber condoms can be inexpensively produced in large quantities, making possible the mass-marketing of condoms. The thermal conductivity of rubber is less than that of animal membranes, but rubber membranes can now be produced as thin as .03 mm, although most range from .04 to .07 mm. Rubber condoms can be produced in various styles, such as:

dry or silicon lubricated	straight-sided or contoured
plain or reservoir-tipped	smooth, textured, or rippled
colored or natural	standard thickness or extra-thin (extra-sensitive)

Rubber condoms can be produced in various sizes--an important advantage over animal-membrane condoms. The limited data available show differences in average penis size between regions as well as a wide range among men from the same region. In separate studies, the median erect penis length of Thai men was between 126 and 150 mm; of US men, between 151 and 175 mm; the median erect penis circumference of Thai men was between 101 and 112 mm; of US men, between 113 and 137 mm.

The main reason condoms are not more effective is inconsistent use and unwillingness to use. Among the reasons that people cite for not using condoms are:

1) Decreased sensitivity during sex. A US survey of 1874 men and women found that 63% of the men and 33% of the women felt that condoms reduced sensation; however 38% of the men and 14% of women saw reduced sensation as an advantage since it prolongs intercourse. Long-term users appear to be less bothered by decreased sensation. As a Philippine man said, "After some time, using the condom becomes natural. I myself have gotten used to it." Whether condoms really do reduce sensation, and if so, how much, has never been precisely measured. Presumably, the thinner the condom, the less reduction in sensation. Certainly that is what many men think. A common complaint heard by family planning programs is that the condoms they provide are too thick. For example, in Japan, the effect of thin condoms on acceptability was dramatically illustrated. Sales jumped 43% in one year after condoms advertised as having a thickness of .03 mm were introduced; these were about .02-.03 mm thinner than standard condoms. Lubricated condoms have proved more popular than unlubricated ones, perhaps because the lubrication substitutes for sensitivity.

2) Inconvenience or troublesomeness of the method. 50% of nonusers responding to a questionnaire in a popular US magazine felt that a major disadvantage of condoms was the interruption in lovemaking required to put them on. Some complained of messiness, probably due to the wet, rather than the silicone-based dry, lubrication.

3) The poor image of condoms due to their traditional association with venereal disease and prostitution. It has been reinforced for centuries by physicians and others who proclaimed condoms immoral and by laws banning their sale or mandating that they be "sold only for the prevention of disease." In the US, over 40% of 420 male adolescents felt that using a condom showed disrespect for their partner. This poor image can be changed only through promotional campaigns. The success of such campaigns in the US and Japan is evidenced by the fact that in the US, 1/3 of condoms are sold to women and in Japan, perhaps 1/5 are sold to housewives by door-to-door saleswomen.

4) Misconceptions about condom effectiveness and side-effects are widespread. In Indonesia, a pilot project that distributed condoms in answer to mail orders received many questions about how often condoms lead. Some thought that condoms should be inflated with air to test them before use. In the US as well, many young men think that condoms break easily and that each

(CONTINUED)

CONDOMS, Continued

one should be tested before use. Not only is this not necessary, but also it may damage the condom and cause it to break during use.

The use of condoms provides considerable protection against STDs. The evidence comes from both past and recent studies. For example, in the early 1970s, a French study of the sexual partners of over 700 women infected with gonorrhea or trichomoniasis revealed that less than 1% of the 302 men who claimed to have consistently used condons contracted gonorrhea, and only 2% contracted trich. Of the 480 men who did not use condoms, 97% contracted gonorrhea and 33% contracted trich. In a retrospective study of 246 sexually active Australian soldiers who served in Vietnam, none of the 55 who said that they always used condoms contracted an STD. Of the 191 who did not use condoms, 35% contracted gonorrhea or chancroid. Just how well condoms protect against STDs is difficult to gauge. The chief problem is that most studies involve retrospective interviews with military personnel or STD clinic patients. Since these studies rely entirely on written or verbal reports of condom use, it is impossible to be sure how regularly the participants used condoms. Some have argued that the protection provided by condoms is better for some STDs than for others. Specifically, it has been suggested that syphilis is more likely to be transmitted nongenitally than other STDs, and therefore condoms may provide less protection against syphilis. Others have challenged this, pointing out that cases of nongenitally transmitted syphilis are rare. It also has been suggested that the smallest disease-causing organisms--viruses, like herpes--may be able to pass through pores in condom membranes. This is unlikely however. The following compares sizes of different organisms (nanometer (nm) is one-billionth of a meter (1×10^{-9})):

sperm head	3000 nm	herpes simplex virus	120-180 nm
gonococcus	800 nm	human papilloma (wart) virus	52-55 nm
syphilis	6000-15000 x 200 nm	hepatitis B virus & dane particle	42 nm & 27 nm
chlamydia & ureaplasma	200 nm	hepatitis A virus	27 nm

Water and air molecules are about 1000 times smaller than a herpes virus. Since good quality condoms are watertight and airtight, it is unlikely that organisms such as herpes, hepatitis, or the condyloma/wart (papilloma) virus could pass through. Of the few small clinical studies addressing the effectiveness of condoms against very small microorganisms, most but not all have shown a protective effect.

Condoms may also be useful in treating women who become infertile because they produce antibodies to sperm [ED NOTE: Recall one of the factors associated with immune suppression in AIDS.]. An estimated 10-30% of unexplained infertility may occur because antibodies that incapacitate sperm develop in the cells or blood sera of women, or less commonly men. Since antibodies appear to be produced when sperm come in contact with cervical tissue, it has been suggested that using condoms should allow sperm antibody levels to drop.

All major condom-producing countries (except South Korea) and a number of importing countries have national standards for condom quality. The standards specify physical characteristics and prescribe the types of tests used to measure these characteristics. Standards generally require: visual inspection for packaging defects; measurement of length, width, thickness, and/or mass; a test for holes; a test of strength. Condoms are tested for holes in two different ways: 1) nearly all manufacturers electronically screen all condoms for pinholes; and 2) national standards require sample condoms to be tested for holes by water leakage or air inflation. Electronic screening works because rubber does not conduct electricity, so electric current cannot pass through an unflawed condom. Condoms are rolled by hand onto tube-shaped electrodes and then either passed through an electrolyte solution (wet system) or across a fine mesh screen (dry system). If current passes through a condom, it is rejected. Condoms passing the test are rerolled and sealed in foil or plastic strips. Most national standards require testing for holes by filling sample condoms with 300 ml of water and then rolling them on absorbent paper to check for leakage. Some standards specify inflating sample condoms with air to a diameter of between 125 and 167 mm and then checking for defects and holes. Testing of condom strength may also involve using the tensile test, in which small sections are cut from the middle of a condom and mechanically stretched until they break. Variations of these tests exist. In Canada, for instance, the air burst test is used. Condoms are inflated with air at a rate of 25-30 cubic decimeters per minute until it bursts. Malaysia fills condoms with 3 liters of water while supporting the closed end. While there are differences of opinion

(CONTINUED)

CONDOMS, Continued

about these tests, it is clear that current national standards are adequate to assure that condoms are of good quality. It is not certain, however, how low test readings could be and still prevent breakage during actual use of an appreciable proportion of condoms.

In November, 1978, Consumer Reports solicited 4301 requests for an 8 page condom questionnaire. Usable questionnaires were returned by 1874 male and female readers. Those 1978 brands judged to be best (i.e., fewest leakage test failures) included: Excita, Fetherlite, Horizon Stimula, Nuform, Ramses, Shiek Trojan-enz, Trojans Plus, and Trojan Ribbed. The following brands had more leakage-test failures, on the average, than the preceding brands: Conceptrol Shields, Trojan Guardian, Trojans (unlubricated), Horizon Conture, Horizon Nuda, and Horizon Prime.

Based on all of this, what recommendations can we offer sexually active gay men? Aside from the overall value of condoms as an STD and perhaps AIDS prophylactic, we should recommend that petroleum lubricants be avoided, since petroleum products are known to deteriorate latex rubber. Use plenty of water soluble lubricant (without fragrances) for comfort and to reduce the risk of breaking, preferably from a pump-operated lubricant dispensor (to prevent contamination from feces, germs, previous partners). Heat, ultra-violet and prolonged fluorescent light exposure in clear cellophane wrappers may hasten the deterioration of rubber also, so avoid storage in glove compartments of cars, etc. We should develop marketing strategies that eroticize condoms, making them sexy, as appropriate as...whatever paraphernalia usually accompnies sex!

Following are 5 condom manufacturers, minimum orders & price range, and brands that they carry, courtesy of Planned Parenthood (please confirm before ordering):

Schmid Products Co., Route 46 West, Little Falls, NJ 07424 201/256-5500
Minimum order-$125 Price range of condoms--$10.95-28/gross (144 condoms)
Brands--Sheik, Ramses, Fetherlite, Excita

Youngs Drug Products Corp., PO Box 385, 865 Centennial Av., Piscataway, NJ 08854
201/885-5777 Minimum--$25 Price range--$14.20-$26.40/gross
Brands--Trojans, Naturalube

Planned Parenthood, PO Box 397, New Windsor, MD 21776 800/223-3303
Minimum--$108 Range--$10.80/gross
Brand--Planned Parenthood

Ansell, Inc., Public Sector Sales, POB 1252, Dothan, AL 36302 800/633-0909
Minimum--$50 Range--$10.25-$18/gross
Brands--Prime, Tahiti Colors, Sultan, Hugger, Stimula

'Doc'Johnson Enterprises, PO Box 9908, North Hollywood, CA 91609 800/423-3650
Minimum--no info available
Brand--Man-to-Man

Please send any other names of condom manufacturers to the NCGSTDS, along with any comments, feedback, etc. Thanks!

* * * *

NEW CDC DIRECTOR

with thanks to the New York Native, 1/2-15/84

Dr. James O. Mason has been appointed the tenth director of the Centers for Disease Control in Atlanta, succeeding Dr. William Foege. Mason reiterated the claim that the CDC's top priority is AIDS research, however believes that the US government is doing all that can be rationally expected about AIDS. He believes that the purpose of the CDC is to control disease, and that the value of human life is not dependent upon personal characteristics. National Gay Task Force representatives Virginia Apuzzzo and Jeff Levi met with Mason, Dr. Edward Brandt, Assistant Secretary for Health, and Shellie Lengel, director of the Public Health Service's Office of Public Affairs on issues of gay/lesbian health concerns (including AIDS, alcoholism & drug abuse, hepatitis, and others). Mason pledged an openness to the gay/lesbian community; Apuzzo stated that she looked forward to future meetings with Mason, "...once he has an opportunity to establish himself in the position of director of the CDC."

* * *

GAY ALCOHOLISM & SUBSTANCE ABUSE: ISSUES FOR STD WORKERS

[ED NOTE: The NCGSTDS is cooperating with members of the National Association of Gay Alcoholism Professionals (NAGAP) to provide ongoing articles about alcoholism and substance abuse problems in gay people, and how STD workers (who frequently are the first contacts with health professionals that gay/lesbian clients may have) may learn how to recognize the problem and learn how to intervene. These articles provide only a framework that requries additional and direct assistance of preferably local NAGAP and gay/lesbian Alcoholics Anonymous/Alanon members for guidance, consultation, and staff sensitivity training and inservices. Although the articles may specify "alcohol/alcoholism," you are free to generalize to all substance abuse and addictive behaviors. Your comments and input are important--please share them with us and your local gay STD clinic/service! NAGAP's address is: 204 West 20th Street, New York, NY 10011 (212/807-0634); your membership there will be beneficial!]

Hazards of Alcohol

with thanks to Awareness Jacksonville, November, 1983

Alcoholism is a disorder characterized by repeated drinking of alcoholic beverages to an extent that it interferes with the drinker's physical & emotional health and social functioning. Most alcoholics are not derelicts, but are married, have a job and are religious. When taken as a group, the diseases associated with alcoholism constitute the third leading cause of disability and death in America. Alcoholic hepatitis is a condition characterized by fever, jaundice, swelling in the abdomen and feet. The liver is generally large, firm, tender, and infiltrated with fat. Many patients die from this disease; some recover; others progress to develop cirrhosis. Gastritis, a serious inflammation of the lining of the stomach, is usually the result of heavy drinking. The mucosa becomes reddened, with bleeding areas covered with thick, ropy mucus. Symptoms include nausea, vomiting & stomach pain. Gastric ulcers may develop or may get worse in an already existing case because of alcohol. Alcohol is extremely irritating to the stomach and causes an over-secretion of stomach acids and enzymes. This increased acidity causes ulcers and prevents healing of existing ulcers. Ulcers may hemmorhage, perforate, or obstruct passage of food. No ulcer patient should drink. Prolonged intake of alcohol has a direct poisonous effect upon the nerves of the arms & legs called neuritis. Symptoms include tingling, pins and needles sensations, burning, itching, numbness, weakness, and/or paralysis. Complete abstinence from alcohol with improved nutrition and vitamin supplementation may reverse the neuritis. Impotency refers to the inability of a man to sustain an erection satisfactory for sexual activity. Alcohol is one of the most commong causes of impotence, contrary to the myth that alcohol is an aphrodisiac or sexual stimulant. In acute alcoholism, the impotency may be caused by the depressant effect of the drug. In chronic alcoholism, impotency by be caused by neuritis, liver damage, malnutrition and other factors. Alcohol is a factor in over 60% of all suicide attempts, successful and unsuccessful. Suicide is the tenth leading cause of death in America and the third leading cause of death below the age of 30. Alcohol also plays an important role in accidents, contributing to approximately 20% of all falls, 20% of accidental asphyxiations, 20% of drownings, 20% of deaths from freezing, 25% of deaths attributed to choking on foods, 50% of all fire deaths, and well over 60% of all fatal automobile accidents. Murder is the twelfth leading cause of death in the country and the fourth leading cause of death below the age of 30; alcohol is implicated in over 70% of all murders and other violent crimes. Of interest to lesbians seeking motherhood, alcohol is an important cause of birth defects and abnormal development. Alcohol directly crosses the placental barrier to affect the developing child. Low birthweight and brain size, heart defects and cleft palate are just a few of the effects.

* * *

GAY ALCOHOLISM & SUBSTANCE ABUSE: ISSUES FOR STD WORKERS, Continued

Outline of Proposed Guidelines for Lesbian/Gay Health Workers: Screening for and Referral of Alcoholics and other Chemically Dependent Persons

prepared by Dana Finnegan & Emily McNally (NAGAP) and Tom Smith (San Francisco Alcoholism Evaluation & Treatment Center)

These guidelines are designed to help lesbian and gay health workers to identify and refer people with alcohol and/or other drug problems. Because these problems are so prevalent in the lesbian/gay community, because they are difficult to detect in their early stages, and because they are most treatable in the early stages, it is imperative that all lesbian/gay health workers learn to identify and refer appropriately.

1) Examine your own attitudes about drinking, drunkenness, the use of other drugs and addictions. For example, do you assume that liquor and/or drugs are an integral part of having a good time?
   a) Know the stresses upon lesbians & gay men that places these individuals at high risk for substance abuse and homophobia (especially internalized homophobia).

2) Examine your stereotypes about alcoholics and drug abusers. Do you, for example, believe that all alcoholics are "down & out" or do you know that 95% to 97% of all alcoholics are still functioning--hold jobs, have relationships, etc.?

3) Acquire information about alcoholism and drug abuse.
   a) Learn the definitions of alcoholism/drug abuse addictions
   b) Know that alcoholism and drug addiction are "family diseases," affecting all loved ones & significant others
   c) Learn what "enabling" is and how to avoid it.
   d) Learn biological and psychological aspects of these addictions and the biologically related aspects of treatment.
   e) Learn about the concepts of abstinence, controlled drinking/drug use, etc., the pros & cons of each concept, and how to answer questions about each topic

4) Understand the critical need to be aware of the subtle signs of early-stage alcoholism/drug addiction because of "invisibility" and denial.

5) Learn how intervention works and how to use it and limitations of its applications.

6) Know what questions to ask that detect early-stage alcoholism/drug addiction. For example:
   a) Have you ever tried to control your drinking by switching brands or kinds of alcoholic beverages?
   b) Do you socialize with people who do not drink or use drugs?
   c) Do you pride yourself on your capacity?
   d) Do you ever not do something because you are recovering from the "night before"?
   e) Do you plan your social life around alcohol and/or drugs?

7) Know what subtle hints to listen for--temporary memory loss (blackouts); rationalizing and making excuses for drinking/drugging ("I drank on an empty stomach."); any kind of trouble in the person's life (exercising poor judgement, low impulse control).
   a) Learn direct and indirect methods of work with the substance abuser's resistances, denials and ambivalences. Learn resistance utilization techniques (used with substance abusers).
   b) Learn methods of altering consciousness without the use of drugs/alcohol ("getting high without drugs," "natural highs").

8) Know your local alcoholism/drug abuse resources--and whether or not thay are gay sensitive: Alcoholics Anonymous/Alanon, National Council on Alcoholism (NCA), detox & rehabilitation units.
   a) Know local community social, recreational, political, spiritual resources for lesbians & gay men; resources that do not have a high level of pressure to drink or use drugs.

9) Know how to contact NAGAP! NAGAP, 204 West 20th St., New York, NY 10011, 212/807-0634.

(CONTINUED)

GAY ALCOHOLISM & SUBSTANCE ABUSE: ISSUES FOR STD WORKERS, Continued

Outline of Proposed Guidelines, Continued

10) Know what alcoholism/drug abuse materials are available: from NAGAP, NCA, AA

11) Know about prevention efforts focused at reduction of substance abuse in the lesbian/gay male community.

* * *

Professional Enabling Vs. Helping: Which One Are You?
by Dana Finnegan & Emily McNally

The professional enabler:

1) Overlooks obvious problems.
2) Avoids confrontations.
3) Separates slef from others.
4) Helps to remove consequences by minimizing the seriousness of the event.
5) Controls under the guise of protecting and caring.
6) Makes excuses for, covers and even defends actions.
7) Becomes frustrated because of inability to affect change.
8) Sometimes compromises own value systems.
9) Maintains the "no talk rule."
10) Labels, oversimplifies.
11) Makes judgements based upon narrow expertise.
12) Views chemical dependency as a moral issue.
13) Gossips and accuses.
14) Consistently maintains view of the chemically dependent individual as "one of those people."

The helping professional:

1) Holds the individual accountable for their behavior.
2) Talks to individual regarding specific, identified behaviors which are disruptive and disturbing.
3) Realizes limitations and accepts the fact that he cannot be "all things to all people."
4) Insures that for each negative behavior there is a specific & consistent consequence.
5) Is always aware of sudden changes in behavior.
6) Seeks appropriate help for individuals whose behavior suddenly changes.
7) Doesn't jump to conclusions or diagnose individual problems.
8) Knows when to "let go" and let someone else take over.
9) Always maintains high standards and values.
10) Expresses care and concern at all times.
11) Is open to a variety of possibilities as the cause of problems.
12) Understands and accepts chemical dependency as a disease and the process of recovery.
13) Discusses concerns with counselors, administrators, other staff members or parents about specific behaviors.
14) Is accepting and supportive of person who has been treated.
15) Works to alleviate the system of professional enablers.

* * *

Future Topics on Gay Alcoholism & Substance Abuse

In future issues of the NCGSTDS Newsletter, contributors will write about questionnaires that may be used to help screen clients; stresses that lead gay men and lesbians to abuse alcohol and other chemicals, how alcohol and other chemicals affect the immune system (in light of AIDS), and others. We invite your comments and reactions, and once again urge your establishing close ties with local and national alcoholism/substance abuse personnel & agencies. Only together can we begin to effectively deal with the gay & lesbian community's (and America's!) best kept secret & deception--alcophobia (the fear & unwillingness to confront alcoholism, etc.).

* * * * *

NCGSTDS UNRESTRICTED/NONCONFIDENTIAL MAILING LIST

The NCGSTDS regularly makes available its unrestricted/nonconfidential membership and mailing list to members to aid in the networking process. Please send corrections & updates to the NCGSTDS, PO Box 239, Milwaukee, WI 53201 (414/277-7671). Due to a fixed number of spaces allowed for the last name on the word processor, some individuals may have had their titles (MD, RN, PhD, etc.) omitted--our apologies! "Xxxxs" indicate unknown or unlisted telephone numbers. Special thanks to Don Schwamb of Milwaukee's GAMMA and Cream City Association Foundation for assistance and word processor for this compilation!

A.I.D.S. PROJECT- L.A.	MATT REDMAN	937 NORTH COLE #3	LOS ANGELES	CA 90038	213/871-1284
AID ATLANTA	JOHN KOPCHAK, PA-C	PO BOX 52785	ATLANTA	GA 30305	404/872-0600
AIDS ACTION COMMITTEE	ALLAN O'HARA	P.O. BOX 4073	KEY WEST	FL 33040	305/294-5359
AIDS-STD SERVICE/ ST. LUKES-	ROOSEVELT; MARILYN BLITZ	428 W 59TH ST	NEW YORK	NY 10019	212/
AIDS/KS FOUNDATION	RICK CRANE	54 TENTH STREET	SAN FRANCISCO	CA 94103	415/864-5855
AMERICAN ASSN PHYS HUMAN RTS	NEIL SCHRAM, MD	P.O. BOX 14366	SAN FRANCISCO	CA 94114	213/548-0491
ATLANTA GAY CENTER VD SCREENG	CLINIC; JOHN KOPCHAK	848 PEACHTREE ST N.E.	ATLANTA	GA 30308	404/876-5372
AWARENESS JACKSONVILLE	KEN HUNT	P.O. BOX 27061	JACKSONVILLE	FL 32205	/ -
BEACH AREA COMMUNITY CLINIC	TERRY CUNNINGHAM	3705 MISSION BLVD.	SAN DIEGO	CA 92109	619/488-0644
BLUE BUS CLINIC	TIM TILLOTSON	1552 UNIVERSITY AV.	MADISON	WI 53706	608/262-7440
BRADY EAST STD CLINIC		1240 E. BRADY ST.	MILWAUKEE	WI 53202	414/272-2144
COMMUNITY HEALTH PROJECT	THOMAS GRACE	208 W. 13TH ST.	NEW YORK	NY 10014	212/691-8282
DALLAS GAY ALLIANCE	TOM HATFIELD	P.O. BOX 190712	DALLAS	TX 75219	214/528-4233
FENWAY COMMUNITY HEALTH CTR	KEN MAYER, MD	16 HAVILAND ST.	BOSTON	MA 02215	617/267-7573
FND. HEALTH EDUC./NEW ORLEANS	JOSEPH NIGLIAZZO, JR/	P.O. BOX 2556	NEW ORLEANS	LA 70176	504/244-6900
GAY & LESBIAN COMMUNITY CENTER	AIDS PROJECT	1436 LAFAYETTE ST.	DENVER	CO 80218	303/831-6268
GAY & LESBIAN HEALTH ALLIANCE	OF DENVER--JEFF ADAMS	PO BOX 6101	DENVER	CO 80206	303/777-9530
GAY COMMUNITY CENTER CLINIC		241 W. CHASE ST.	BALTIMORE	MD 21201	301/837-5446
GAY MEN'S HEALTH COLLECTIVE	SCOTT McADAMS	2339 DURANT AV.	BERKELEY	CA 94704	415/524-2570
GAY MEN'S HEALTH CRISIS	PO BOX 274	132 WEST 24TH STREET	NEW YORK	NY 10011	212/685-4952
GAYLY OKLAHOMAN	RON SHAFFER	P.O. BOX 60930	OKLAHOMA CITY	OK 73146	405/528-0800
HAIGHT ASHBURY FREE MED CLINIC	TIM MESS	558 CLAYTON	SAN FRANCISCO	CA 94117	415/431-1716
HASSLE-FREE CLINIC/AIDS COMMIT	ROBERT TROW	556 CHURCH ST. #2	TORONTO, ONTARIO	M4Y 2E3	416/922-0603
HEALTH ISSUES TASK FORCE	TED WILSON	POB 14925 PUBL SQ. STA.	CLEVELAND	OH 44114	216/XXX-XXXX
HEPATITIS B PROJECT	KEN BROCK, MSW	PO BOX 160486	SACRAMENTO	CA 95816	916/453-8995
HERPES HEALTH CENTER	BRENDA JO Mc CLELLAN, RNP	1004 N. 10TH ST.	MILWAUKEE	WI 53233	414/271-1965
HOWARD BROWN MEMORIAL CLINIC	HARLEY MCMILLEN, DIREC.	2676 N. HALSTED	CHICAGO	IL 60614	312/871-5777
IOWA CITY FREE MEDICAL CLINIC	NANCY CLARK, CO-DIRECTOR	P.O. BOX 1170	IOWA CITY	IA 52244	319/337-4459
KINSEY INSTITUTE	INDIANA UNIVERSITY	416 MORRISON	BLOOMINGTON	IN 47405	
KS CLINIC	A--312	UCSF HOSPITALS & CLINICS	SAN FRANCISCO	CA 94143	415/666-1407
KS COMMITTEE OF HOUSTON	PO BOX 1155	3317 MONTROSE	HOUSTON	TX 77006	713/666-8251
LAMBDA HEALTH PROJ OF ANN ARB	3118 MICHIGAN UNION	530 S. STATE ST.	ANN ARBOR	MI 48109	313/763-4186
LESBIAN & GAY COMMUNITY	SERVICES CENTER	124 WEST LAKE ST., #E	MINNEAPOLIS	MN 55408	612/827-5614
LESBIAN & GAY PEOPLE IN	MEDICINE--AMSA	1910 ASSOCIATION DR.	RESTIN	VA 22091	703/620-6600
MAYOR'S TASK FORCE ON AIDS	BRIAN MCNAUGHT	CITY HALL	BOSTON	MA 022??	617/424-5916
METRA MAGAZINE	GARY BASSETT	2110 MISSOURI AVE	FLINT	MI 48506	313/XXX-XXXX
MONROE COUNTY HEALTH DEPT	PUBLIC SERVICE BLDG.	JR. COLLEGE ROAD	KEY WEST	FL 33040	305/294-1021
MONTREAL HEALTH PRESS	DONNA CHERNIAK, MD	POB 1000 STATION "G"	MONTREAL QUEBEC	H2W 2N1	514/272-5441
NATIONAL GAY TASK FORCE		80 FIFTH AV. #1601	NEW YORK	NY 10011	212/741-5800
NEW HAMPSHIRE FEMINIST HEALTH	CENTER	232 COURT STREET	PORTSMOUTH	NH 03801	603/436-6171
NEW YORK DEPT. OF HEALTH	YEHUDI FELMAN, MD	93 WORTH ST., #806	NEW YORK	NY 10013	212/566-7685
NEW YORK NATIVE	JAMES D'ERAMO	70 GREENWICH AVE #500	NEW YORK	NY 10011	212/925-8021
OKLAHOMANS FOR HUMAN RIGHTS	AL KRUMREY	1932 "C" S. CHEYENNE	TULSA	OK 74119	918/583-7323
PALMER CLINIC	JANICE JORDAN, DIRECTOR	22750 WOODWARD AV. #309	FERNDALE	MI 48220	313/542-7617
PEOPLES GAY ALLIANCE	413 STUDENT UNION	UNIV. OF MASS.	AMHERST	MA 01003	XXX/XXX-XXXX
PHILADELPHIA COMMUNITY HEALTH	ALTERNATIVES	PO BOX 7259	PHILADELPHIA	PA 19109	215/624-2879
PITTSBURGH FREE CLINIC		121 S. HIGHLAND AV.	PITTSBURGH	PA 15206	412/661-6604
SAN ANTONIO SAFE AIDS COMMITTE		P.O. BOX 15481	SAN ANTONIO	TX 78212	512/736-5216
SAN DIEGO PHYS FOR HUMAN RTS	CHRIS MATHEWS, MD	PO BOX 16242	SAN DIEGO	CA 92116	619/XXX-XXXX
SEATTLE AIDS ACTION COMMITTEE		113 SUMMIT AVE. E, #204	SEATTLE	WA 98102	206/323-1229
SEATTLE GAY CLINIC	TIM BUREK	PO BOX 20066	SEATTLE	WA 98102	206/329-8390
SEATTLE KING CO. AIDS PROJECT	14TH FLOOR	1200 PUBLIC SAFETY BLDG	SEATTLE	WA 98104	206/587-4999
SEX INFO CENTER	TAMMY FISHER	WWU-VIKING UNION #214	BELLINGHAM	WA 98225	206/676-3460
SIECUS	LEIGH HALLINGBY	80 FIFTH AV. #801	NEW YORK	NY 10011	212/929-2300
STD CLINIC OF ANCHORAGE	LAUREL STOLPE, RN	825 "L" STREET	ANCHORAGE	AK 99501	907/264-4611

* *

THE CLINIC--GAY & LESBIANCOMM SV CTR, TOM KURZ		1213 N. HIGHLAND AV.	LOS ANGELES	CA 90038	213/464-7480
THE DRYDEN CLINIC	FRANK BERRIER, JR.	1709 DRYDEN, SUITE 1002HOUSTON		TX 77030	713/795-0385
THE LAMBDA GROUP, INC.	JOHN TAYLOR	P.O. BOX 18302	DENVER	CO 80218	303/370-0793
THE MONTROSE CLINIC	DIRECTOR	104 WESTHEIMER	HOUSTON	TX 77006	713/528-5535
THE RESOURCE FOUNDATION	RICHARD SMITH	130 CHURCH ST.	SAN FRANCISCO	CA 94114	415/864-0550
THE SACRAMENTO STAR	TIM WARFORD, MANAGING ED.P.O. BOX 160300		SACRAMENTO	CA 95816	916/452-1476
TUCSON ALTERNATIVE HEALTH ASSNMIKE DOLORES, MD		9040 N. ORACLE RD. #B	TUCSON	AZ 85704	602/742-6863
TUCSON GAY HEALTH PROJECT	AL OBERMAIER	PO BOX 2807	TUCSON	AZ 85702	602/748-7339
VD INTERCHANGE/ TIS-CPS	CENTER FOR DIS CONT		ATLANTA	GA 30333	404/329-1819
VD NATIONAL HOTLINE	REMY LAZAROWICZ	260 SHERIDAN AVE.	PALO ALTO	CA 94306	800/227-8922
WHITMAN-WALKER GAY MEN'S VD	CLINIC JIM GRAHAM	2335 18TH ST., NW	WASHINGTON	DC 20009	202/332-5295
WIS. LESBIAN/GAY NETWORK	RICHARD NOONAN	P.O. BOX 291	APPLETON	WI 54912	414/731-4692
YALE SELF CARE NETWORK	PEACHES QUINN	17 HILLHOUSE AV.	NEW HAVEN	CT 06520	203/XXX-XXXX

ABRAMSON, MDLARY		45 CASTRO #100	SAN FRANCISCO	CA 94114	415/565-6288
ADAMS	ROBERT	2301 POST ROAD #204	MADISON	WI 53713	608/251-3394
ALLAN, RN	DEAN	PO BOX 23116 BROADWAY STASEATTLE		WA 98102	206/325-3420
AMODIA, RN	ANTHONY	324 W. 77TH ST, APT 1	NEW YORK	NY 10024	212/873-9430
ANDERSON	IAN	929 ORLEANS #6	NEW ORLEANS	LA 70116	504/568-9619
BABL	JAMES	213 FOURTH AV	VENICE	CA 90291	213/396-3575
BALES, MD	R. CRAIG	POB 49190	Austin	TX 78765	512/346-4433
BALINT	RON	235 E. 202 ST.	BRONX	NY 10458	212/220-1689
BEHAR, PA-C	MARK	PO BOX 239	MILWAUKEE	WI 53201	414/277-7671
BELLIN, MD	EUGENE	3205 GRAND CONCOURSE	BRONX	NY 10468	212/364-3322
BERRILL	KEVIN	80 FIFTH AV. #1601	NEW YORK	NY 10011	212/000-0000
BLACK	MARK	251 W. 74TH ST., #6C	NEW YORK	NY 10023	212/877-0026
BOLAN, MD	ROBERT	667 LAKEVIEW AV.	SAN FRANCISCO	CA 94112	415/587-5569
BOWERS, MD	DANIEL	897 PORTLAND AV.	ST. PAUL	MN 55104	612/227-6983
BRANSON, MD	BERNARD	101 W. READ ST. SUITE 815BALTIMORE		MD 21201	301/244-8484
BRAUNER, MD	GARY	1995 BROADWAY	NEW YORK	NY 10023	212/877-2800
BREWTON, MD	GARY	1661 HAWTHORNE	HOUSTON	TX 77006	713/522-7360
BURSAW	MIKE	1241 ESSEX ST., #10	SAN DIEGO	CA 92103	619/299-9104
CACERES, MD	CESAR	1759 Q STREET, NW	WASHINGTON	DC 20009	202/667-5041
CALDERWOOD	DERYCK	27 HARVEY DR.	SUMMIT	NJ 07901	212/273-6278
CARR, RN	GARY	222 MOULTRIE ST.	SAN FRANCISCO	CA 94110	415/821-0951
COHEN	BILL	69 WEST 9TH ST	NEW YORK	NY 10011	212/228-2800
CONTROL DIV	V.D.	CDC, Freeway Pk 179	ATLANTA	GA 30333	404/329-1819
DARROW, PhD	BILL	AIDS ACTIVITY-CID/CDC	ATLANTA	GA 30333	404/329-3162
DASSEY, MD	DAVID	P.O. BOX 12	RIVERSIDE	CA 92502	213/854-3011
DAVID, MD	HARRY S.	8733 BEVERLY BLVD. #408	LOS ANGELES	CA 90048	213/657-2202
DAVIS, MD	ROBERT	566 S. SAN VICENTE	LOS ANGELES	CA 90048	213/655-6331
DAVIS, RN	LISA	BOX 386 171 HARRISON AV	BOSTON	MA 02111	617/956-5292
DE MARCO	MIKE	28 MARINE AVE #4G	BROOKLYN	NY 11209	212/680-3408
DIETZ, RN	SUSAN	W292 N2038 ELMHURST DR	PEWAUKEE	WI 53072	414/691-3391
DIGGIN	JERRY	PO BOX 2361	DALLAS	TX 75221	214/641-1677
DISABATO	JOE	POB A OLD CHELSEA STATIONNEW YORK		NY 10011	212/242-6863
DODGE, MD	WAYNE	5763 27TH AV., NE	SEATTLE	WA 98105	206/527-1196
DONOVAN	BILL	439 16TH ST., #3R	BROOKLYN	NY 11215	212/965-4601
DOPP	STEPHEN	203 REGENT ST.	FREDERICTON, N.B. E3B 3W8506/455-1198		
DOUGLASS, MDALBERT		227 E. HILDEBRAND AV	SAN ANTONIO	TX 78212	512/826-2311
DREISBACH,MDDYAN		3822 ARMY STREET	SAN FRANCISCO	CA 94131	415/826-3198
ENLOW, MD	ROGER	125 WORTH ST,NY HEALTH D.NEW YORK		NY 10013	212/566-1879
EPSTEIN, PHDDAVID		1506 N. KINGS RD.	LOS ANGELES	CA 90069	213/656-4215
FALK, PHD	LARRY	448 N. County Rd.	Waukegan	IL 60085	312/244-4651
FILARDO, MD	THOMAS	506 S. MATHEWS	URBANA	IL 61801	217/333-8366
FISHER, MD	EVELYN	2799 W. GRAND BLVD.	DETROIT	MI 48202	313/876-2563
FONVILLE, MDTERRY		315 RIVERSIDE DR.	NEW YORK	NY 10025	212/222-7516
FOX, MD	FRED	9263 FAUNTLEROY WAY SW	SEATTLE	WA 98136	206/938-1390
GAITHER, RN	RON	6202 ESTRELLA AVE.	SAN DIEGO	CA 92120	619/265-1399
GALVIN	JOHN	8640 CROMWELL DR.	SPRINGFIELD	VA 22151	703/978-9223
GASPARD	BARRY	720 FOX	DENVER	CO 80204	303/893-5653
GAUTHIER	THOM	7981 EASTERN AV.	SILVER SPRING	MD 20910	301/565-0333

GAYLE, MD	TERRY	2443 5TH AV. WEST	SEATTLE	WA 98119	206/283-2347
GILMORE	G.M.	1003 W. CHARLES	CHAMPAIGN	IL 61821	217/XXX-XXXX
GOLDFIELD	MARK	292 PARK PLACE	BROOKLYN	NY 11238	212/789-0062
GOODMAN	BERNICE	32 E. 3RD ST.	NEW YORK	NY 10003	212/475-5307
GORMAN	MICHAEL	278D PEACHTREE HILLS	ATLANTA	GA 30305	404/237-3891
GREENBERG,MD	FRANK	1616 DRISCOLL	HOUSTON	TX 77019	713/523-5204
GREMMINGER	ROGER	929 N. ASTOR ST. #1608	MILWAUKEE	WI 53202	414/765-0849
HADDEN	STAN	STATE CAPITOL #205	SACRAMENTO	CA 95814	916/445-8390
HARISIADES	JAMES	682 WHITNEY AVE	NEW HAVEN	CT 06511	203/773-3636
HELQUIST	MICHAEL	303 COLERIDGE	SAN FRANCISCO	CA 94110	415/550-1234
HENEVADL,PAC	JOHN	1111 N. O'CONNOR RD #121	IRVING	TX 75061	214/254-6523
HICKEY, MD	TOM	435 E. 70TH ST. #9H	NEW YORK	NY 10021	212/628-8014
HILL	WILLIAM	5801 SPRING VALLEY #1712	DALLAS	TX 75240	214/386-5388
HOLDER	WILLIAM	3441 FORBES AV.	PITTSBURGH	PA 15213	412/578-8080
HUNT	KEN	2816 COLLEGE ST	JACKSONVILLE	FL 32205	904/389-8879
ISAAC, MD	RICHARD	190 ST. GEORGE ST. #605	TORONTO ONTARIO	M5R 2N4	416/968-2808
JAMES, PAC	DENNIS	320 FARMINGTON AVE. # C5	HARTFORD	CT 06105	203/527-9813
JAMES, PHD	HUGO	7 FRANKLIN ST.	TRUMBULL	CT 06611	203/261-0869
JOHNSON, PA	JOSEPH	1119 DAUPHINE APT. 10	NEW ORLEANS	LA 70116	504/524-7901
JOSHUA	JOSH	4800 FREMONT NORTH #218	SEATTLE	WA 98103	206/545-7165
KAHN, PHD	ARNOLD	1200 17TH ST., NW	WASHINGTON	DC 20036	202/833-7572
KATZ, MPH	SCOTT	8960 CYNTHIA ST #209	LOS ANGELES	CA 90069	213/550-8327
KEITH, MD	PAUL	6200 WILSHIRE BLVD #1510	LOS ANGELES	CA 90048	213/931-1463
KILLINGER	MARC	932 CHRISTIAN ST.	PHILADELPHIA	PA 19147	215/627-6733
KIMMEL	DOUG	135 EAST 94TH STREET	NEW YORK	NY 10128	212/348-1327
KISSLING,PA	ALBERT	21 REDDING ST	HARTFORD	CT 06114	203/249-2660
KLEIN, MD	TOM	4200 MARINE DR. #501	CHICAGO	IL 60613	312/472-4677
KOODEN	HAL	154 8TH AV.	NEW YORK	NY 10011	212/243-3582
KRISTAL	ALAN	316 W. 75TH ST. #4C	NEW YORK	NY 10023	212/580-2562
KRZYWICKI	BARRY	4210 E. 11TH AVE. #260	DENVER	CO 80220	303/320-8333
LEAR, MD	WALTER	206 N. 35TH ST.	PHILADELPHIA	PA 19104	215/386-5327
LEMLEY	CRAIG	225 ADAMS ST. APT 9A	BROOKLYN	NY 11201	212/522-1123
LEWIS, RN	ANGIE	POB 710	WOODACRE	CA 94973	415/488-0381
LOOMIS, PHD	MAURICE	570 61ST ST.	OAKLAND	CA 94609	415/653-3336
LORD, MD	NANCY	910 N LAKESHORE DR #1716	CHICAGO	IL 60611	312/664-2483
LOVE	MARJORIE	1432 CRESCENT DR.	NO. WATERBORO	ME 04061	207/247-6431
MALCOLM,PA-C	ZELL	636 ROCKMONT DR., N.E.	ATLANTA	GA 30324	404/876-2354
MATHEWS, MD	CHRIS	4621 VISTA ST.	SAN DIEGO	CA 92116	619/584-4958
MAYER, MD	KEN	369 TAPPAN ST. APT. 18	BROOKLINE	MA 02146	617/232-9861
MCGOVERN	JOHN	626 WEST END AV.	NEW YORK	NY 10024	212/874-0075
MCGRAW, MD	PATRICK	450 SUTTER ST. #1504	SAN FRANCISCO	CA 94108	415/391-0103
MCMILLEN	HARLEY	2676 N. HALSTED	CHICAGO	IL 60614	312/871-5777
MCSHANE, MD	DENNY	152 HEDGE RD	MENLO PARK	CA 94025	415/327-6642
MILLER	ALAN	CGA--PO BOX 639 STA. A	TORONTO ONTARIO	M5W 1G2	416/977-6320
MILLER, DO	STEPHEN	4212 KENSINGTON	DETROIT	MI 48224	313/886-4412
MILLHOFER,MD	LAWRENCE	326 WASHINGTON ST. # 2D	NORWICH	CT 06360	203/887-3565
MILLIGAN	WILLIAM	69 HADDONFIELD-BERLIN RD	CHERRY HILL	NJ 08034	609/429-4179
MOORE	JOHN	RR8, P.O.BOX 174 LOT #56	CARBONDALE	IL 62901	618/549-1482
MORRIS,CIS/	TIM	110 E. WARREN	DETROIT	MI 48201	313/833-0710
MULCAHEY	PATRICK	144 MAIN ST #5	NORWALK	CT 06851	203/847-6229
MYERS, MD	LONNY	10947 S. LONGWOOD DR.	CHICAGO	IL 60643	312/445-7656
Mc NAMARA,MD	BERNARD	1462 N. VINE	HOLLYWOOD	CA 90028	213/461-9355
NICHOLS, PHD	MARGARET	300 RARITAN AV	HIGHLAND PARK	NJ 08904	201/229-7949
NYLUND	THOMAS	4422 CLINTON ST.	LOS ANGELES	CA 90004	213/665-8943
O'HARA	ALLAN R.	P.O. BOX 4073	KEY WEST	FL 33041	305/XXX-XXXX
OLIVER, MD	DENNIS	140 WEST 71ST ST. #5B	NEW YORK	NY 10023	212/724-6832
OSTROW, MD	DAVID	155 N. HARBOR DR. #5103	CHICAGO	IL 60601	312/565-2109
OWEN, MD	WILLIAM	1580 VALENCIA ST. #202	SAN FRANCISCO	CA 94110	415/826-2400
PALMER, PA	JOHN	301 W. 22ND ST.	NEW YORK	NY 10011	212/253-3620
PAROSKI, MD	PAUL	114 WILLOUGHBY AV.	BROOKLYN	NY 11205	212/622-3000
PAYNE	KENNETH	1267 FILBERT ST. #9	SAN FRANCISCO	CA 94109	415/771-5276
PEACOCK	ROSS	985 MADISON AV.	NEW YORK	NY 10021	212/535-7200

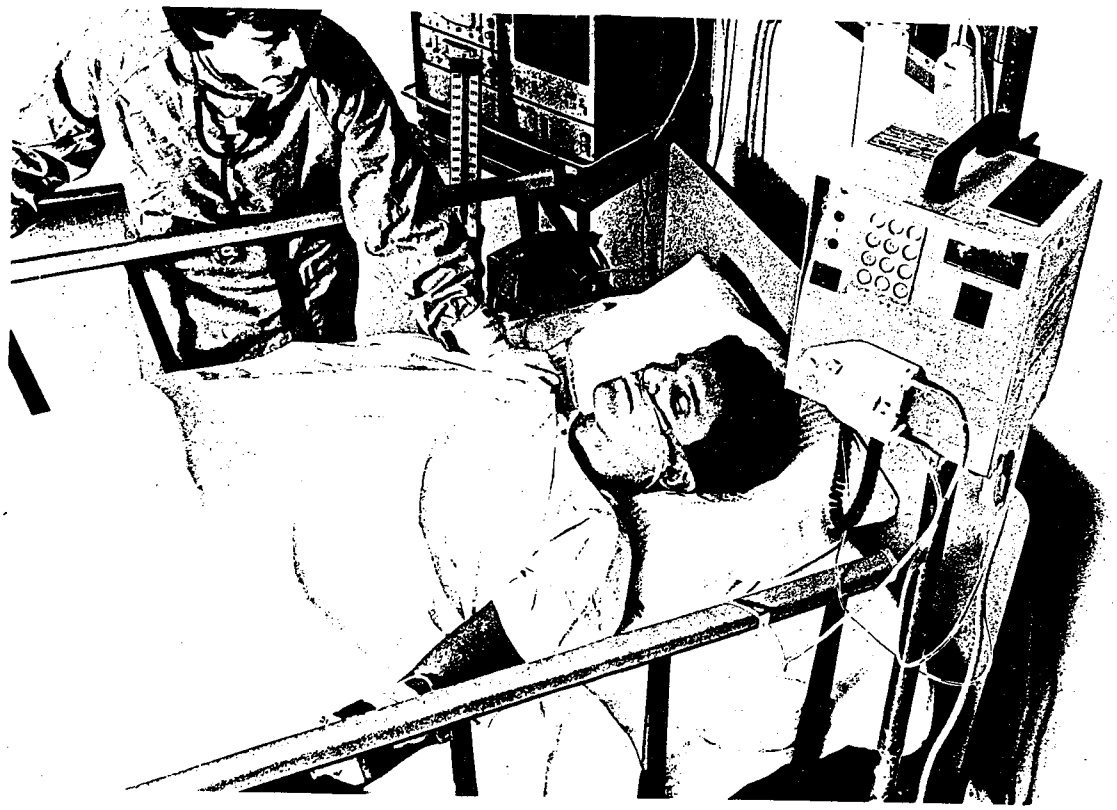
PFEFFER	DAN	300 RIVERSIDE DRIVE #11E	NEW YORK	NY 10025	212/222-5117
PICKETT,MD	ROGER	4052 N.W. 61ST ST.	OKLAHOMA CITY	OK 73112	405/942-3189
READ, MD	STAN	11 BROOKLYN AV	TORONTO ONTARIO	M4M 2X4	416/461-4371
RICE	HUGH O.	1426 N. FORMOSA AV., #2	LOS ANGELES	CA 90046	213/851-2134
RICE, RN	KEVIN	11235 OAK LEAF DR. #1713	SILVER SPRING	MD 20901	301/593-3021
RICHARDS	JEFF	41 LANDERS APT. 2	SAN FRANCISCO	CA 94114	415/861-1880
ROBERTS, MD	BOB	8315 N. BROOKLANE #801 W	BETHESDA	MD 20814	301/652-2840
ROBERTS, PA	CRAIG	343 ISLAND DR., # 4	MADISON	WI 53705	608/256-0768
ROSENSTEIN	HANAN	4617 E. 36TH ST.	MINNEAPOLIS	MN 55406	612/927-4071
RUTHERFORD	MIKE	GPA PO BOX 33605	WASHINGTON	DC 20033	202/387-2430
RYBICKI	NEAL	1709 SHATTUCK AV. #225	BERKELEY	CA 94709	415/843-4714
SABELLA	WILLIAM	BOX 7	NORTH HAVEN	CT 06473	203/239-7881
SABLE, MD	RON	3719 N. MAGNOLIA	CHICAGO	IL 60613	312/929-4439
SALLY	TIM	693 PARK AV., #8	ROCHESTER	NY 14607	716/442-7173
SCHRAM, MD	NEIL	6200 VIA SUBIDA	PALOS VERDES	CA 90274	213/548-0491
SCHUMAN, PA	ERIC	5817 S.W. 22ND TERR. #4	TOPEKA	KS 66614	913/272-5394
SCHWAMB	DON	2233 N. SUMMIT PL #702	MILWAUKEE	WI 53202	414/276-2204
SHASKEY	DALE	713 W. WRIGHTWOOD AV.	CHICAGO	IL 60614	312/000-0000
SIROTY, MD	WILLIAM	40 PARK AVE.	NEW YORK	NY 10016	212/532-6720
SMITH	ROY	1420 N ST., NW, #502E	WASHINGTON	DC 20005	202/234-7197
SMITH, MD	J.R.M.	601 CORYDON AV.	WINNEPEG MANITOBA	R3L 0P3	204/475-3540
SOLOMON, PhD	JERRY	1722 N. SEABRIGHT AVE	SANTA CRUZ	CA 95062	408/425-8785
STAEBLER	JAMES	1501 SUNSET PLAZA DR.	LOS ANGELES	CA 90069	213/854-3010
STARRETT, MD	BARBARBA	14 E. 4TH ST.	NEW YORK	NY 10012	212/982-2711
STEFFEN, PA	GEORGE	1510 W. SUNNYSIDE AVE.	CHICAGO	IL 60640	312/784-1510
STEINMAN,PHD	RICHARD	U.S.ME--96 FALMOUTH ST	PORTLAND	ME 04103	207/780-4174
STRUBE, PA	ROSEMARY	211 LAZARETTO RD., # 4F	PROSPECT PARK	PA 19076	215/237-9046
TAYLOR, MD	ROBERT	1755 BEACON ST.	BROOKLINE	MA 02146	617/232-1459
THOMAS	JOHN	PO BOX 840	ELIZABETH	NJ 07207	XXX/XXX-XXXX
THOMPSON,MD	HARVEY	912 A 21ST ST.	SACRAMENTO	CA 95814	916/441-2636
TILLOTSON	TIM	1552 UNIVERSITY AV.	MADISON	WI 53706	608/256-8476
TRUAX, MD	A. BRAD	3340 KEMPER ST. SUITE 102	SAN DIEGO	CA 92110	619/224-2921
VACHON, PA	RON	506 W. 42ND ST. #E5	NEW YORK	NY 10036	212/563-6313
VOELLER	BRUCE	MARIPOSA-66 W. 88 ST. #1D	NEW YORK	NY 10024	212/000-0000
WAITKEVICZ	JOAN	1 HAVEN PLAZA	NEW YORK	NY 10009	212/475-6030
WAKIL	AIDA	PO BOX 2901	DURHAM	NC 27705	919/286-2275
WASHBURN, MD	PETER	P.O. BOX 538	NEWPORT	RI 02840	401/846-8032
WERNER	STEPHEN	1809 E. JOHN	SEATTLE	WA 98112	206/ -
WESTMORELAND	TIM	2415 RAYBURN HOB	WASHINGTON	DC 20515	202/225-4952
WHEELER, MD	JIM	3613 FAIRMOUNT	DALLAS	TX 75219	214/559-2590
WHYTE, MD	JOHN	1831 OLIVER AV., NORTH	MINNEAPOLIS	MN 55411	612/521-0625
WILLIAM, MD	DAN	69 5TH AV., #10J	NEW YORK	NY 10003	212/924-5809
WILSON	HANK	55 MASON	SAN FRANCISCO	CA 94102	415/441-4188
WOOD, MD	BOB	3408 S. KING ST.	SEATTLE	WA 98144	206/329-3927
ZALTZBERG	ELLEN	230 JAY STREET #17A	BROOKLYN	NY 11201	212/330-0293
TRANEN,	BETH	729 S. 6th St.	Columbus	OH 43206	614/444-9434
WISNIEWSKI,	TED	835 Olga St.	New Orleans	LA 70119	504/482-9822
HODAK, MD	GREGORY	POB 39 A 57	LOS ANGELES	CA 90039	213/660-9105
VD ACTION COALN	JUDY	LIPSHUTZ 51 W. WARREN	Detroit	MI 48201	313/833-0622
INST SOC RESCH	JILL	JOSEPH POB 1248	Ann Arbor	MI 48106	313/763-3552

[Last minute additions are out of alphabetic order, at the end. Next list will be published in January, 1985 issue of Newsletter.]

* * * * * *

"HOMOPHOBIA B VACCINE"--A TONGUE & CHEEK ADVERTISEMENT
. reprinted from Madison's (WI) OUT!, November, 1983, with thanks

HE TOOK THE CHANCE OF GETTING HOMOPHOBIA B— AND LOST.



NOW THE CONSEQUENCES ARE JUST BEGINNING.

CHRONIC ACTIVE HOMOPHOBIA, MISOGYNY . . . OR DEATH.

You undoubtedly know someone who's had it. The "bad homophobia" that can keep you in bed for weeks and out of a job for months—tha can cause lifelong disability and even death from anal retention or "breeder's cancer." Where do you get it? From people who have become carriers of the virus. Today, it is estimated that at least **one million** straight men in Wisconsin alone are carriers of the homophobia B virus and spread the infection through their violent attempts at intimacy. More than half of all straight men will sooner or later become infected. **That's one major reason why many feel the world will blow up within their lifetimes.**

How can you tell who's a carrier? You probably can't. Most carriers seem to be perfectly healthy, and many are themselves unaware that they harbor the virus.

Once you get homophobia B, there's no specific treatment for it. But now there's something you can do to help protect yourself.

DON'T TAKE A CHANCE— CONTACT YOUR DOCTOR OR THERAPIST AND ASK ABOUT THE HOMOPHOBIA B VACCINE. THERE'S NO TIME TO WASTE.

It is highly effective in those who can afford to receive all three shots. Do it today because you never know where or when you'll make contact with a carrier.

If you'd like more information about homophobia B and the vaccine, call Gays and Lesbians for Life at (608) 537-2426.

This message is brought to you as a public service by Gays and Lesbians for Life.

Sexually Transmitted Diseases and Homosexuality

DAVID G. OSTROW, MD, PHD, AND NORMAN L. ALTMAN, MS

An epidemic of sexually transmitted diseases, culminating in the emergence of acquired immune-deficiency states, has developed among homosexually active men during the past ten to 15 years. This epidemic is reviewed in relation to causative factors, priorities for control, and recommendations for control and prevention. Causative factors are divided into physical, behavioral, cultural, and political factors. Given the complicated interactions of these factors and the numerous diseases epidemic in the homosexuality active population, priorities need to be established for research and control programs that take into account the overall health impact of each disease and the effectiveness of available and potential resources. Finally, educational programs must be developed that will overcome the limited effectiveness of public health control efforts in this area, or we may expect even more serious and widespread health care problems.

From the Howard Brown Memorial Clinic and the Departments of Psychiatry and Community and Preventive Medicine, Northwestern University Medical School and VA Lakeside Medical Center, Chicago, Illinois

THE PAST DECADE has seen a growing awareness that homosexually active men are at increased risk for a variety of sexually transmitted diseases (STDs). At least 11 major STDs have been identified within the homosexual community. These include viral hepatitis, syphilis, amebiasis, gonorrhea, anal warts, genital herpes, giardiasis, nongonococcal urethritis, nongonococcal proctitis, shigellosis, and scabies. The newest STD associated with homosexuality may be the recently identified acquired immunodeficiency syndrome (AIDS).[1]

This review traces the development of our awareness of the higher incidence of STDs among homosexually active men and our knowledge of the possible causes of these phenomena. It then discusses possible priorities in developing STD control programs aimed specifically at high-risk homosexual populations and describes programs that can be or have been successful in this area. Throughout this review we are referring to the homosexually active male. There is little, if any, evidence linking lesbian sexual practices to a high risk for STDs.[2] Furthermore, since most, if not all, of the studies cited in this review have utilized populations attending STD clinics, the term "homosexually active males" must be taken to refer to that subpopulation of gay men with multiple sex partners. The consideration of possible steps to improve control of STDs among homosexual men follows the general guidelines for the development of national STD control programs as outlined in the WHO Scientific Group's *Report on Nongonococcal Urethritis and Other STDs of Public Health Importance.*[3]

The Emerging Spectrum of Sexually Transmitted Pathogens in Homosexuallly Active Males

Among the first investigators to examine the prevalence and causes of STDs in homosexually active males was Fluker.[4] His study was concerned primarily with syphilis and gonorrhea among both heterosexual and homosexual males at a London hospital. He found that homosexual men experienced a higher rate of STDs than did heterosexual men. Fluker suggested that viral hepatitis, rectal disease, and "mucous colitis" were pathological conditions associated with homosexual practice. In a review of >15,000 records of patients visits to an STD clinic in Denver, Judson et al.[5] found that homosexual males were significantly more likely than their heterosexual counterparts to have gonorrhea, syphilis, or anal warts; the prevalence of these diseases was higher among homosexual men even when the investigators controlled for the effects of race and age. Ostrow[6,7] found prevalences of 6–10% for gonorrhea and 3.4% for syphilis among patients tested at a gay STD clinic in Chicago. Investigation of STD problems among homosexual males living in San Francisco showed similarly high rates of syphilis and gonorrhea

This review was undertaken for presentation to the 1981 National Sexually Transmitted Disease Training Program (Centers for Disease Control; Atlanta, Georgia) and the Pan American-World Health Organization's 1982 Scientific Working Group for Sexually Transmitted Disease Control.

The authors acknowledge the help of many persons, including the staff and volunteers of the Howard Brown Memorial Clinic. In addition, Drs. Paul Wiesner and Stephen Margolis and Mr. Akbar Zaidi of the Centers for Disease Control provided useful suggestions. Finally, we are deeply indebted to Ms. Laura Coats for her painstaking typing of this manuscript throughout its numerous versions.

Reprint requests: Dr. David G. Ostrow, Howard Brown Memorial Clinic, 2676 North Halsted, Chicago, Illinois 60614.

Received for publication on March 10, 1983, and in revised form on July 5, 1983.

and identified a greater prevalence of other conditions, including nonspecific urethritis, herpes, amebiasis, and giardiasis.[8]

In addition to the higher prevalence of conventional STDs, there has been an increase in the prevalence of a number of other conditions, both infectious and non-infectious, among homosexual men. Of particular note are enteric infections, for which sexual transmission was not previously considered to play a significant role. Because so many of these conditions are due to infection of, or trauma to, the rectum or anus, Sohn[9] coined the term "gay bowel syndrome." He reported a high incidence of amebiasis, giardiasis, shigellosis, hepatitis, proctitis, and anal warts among 260 homosexual men seen in private practice. He also cited numerous cases of concurrent infection with two or more pathogens. Shigellosis, which had been identified as sexually transmitted,[10] was found, along with amebiasis, to have increased in prevalence four- to tenfold in San Francisco during a three-year period.[11] William and Shookhoff[12] screened stool samples from 89 sexually active gay men for enteric protozoal cysts and found that approximately one-third were infected: 20% with amebiasis and 12% with giardiasis. Six men (7%) were infected with both.

Enteric viruses have also been identified as sexually transmitted pathogens among gay men. Corey and Holmes[13] identified serologic markers of past infection with hepatitis A virus in 30% of homosexual compared with 12% of heterosexual men attending an STD clinic in Seattle. Follow-up testing of patients who had originally been negative for these markers showed the rate of infection among the homosexual men to be 22%, while there were no cases in the heterosexual group. The potential role of sexual transmission in the spread of hepatitis B has been highlighted by the detection of hepatitis B surface antigen (HBsAg) in saliva[14] and semen.[15] Several studies at British hospitals and venereal disease clinics revealed a significantly higher rate of hepatitis B infection among homosexual than among heterosexual men. Fulford et al.[16] found the frequency of HBsAg and its antibody to be ten times greater among homosexual patients attending an STD clinic than among a control group of blood donors. Similar results were found in studies of mostly homosexual patients at STD clinics in London[17] and New York.[18] With the development of a sensitive measure of antibody to hepatitis B core antigen (anti-HBc) as a marker of hepatitis B infection, seropositivity rates among high-risk groups indicated that gay men and spouses of hepatitis B carriers have the highest risk for hepatitis B virus (HBV) infection, a fact further confirming the notion of sexual transmission of the virus.[19]

In a study of homosexual men, most of whom were asymptomatic and reported no history of hepatitis, Coleman[20] found rates of 5% and 40% for HBsAg and hepatitis B surface antibody (anti-HBs), respectively. Lim et al.[21] reported an association between the presence of anti-HBs and increased numbers of sexual partners as well as anorectal contact. Ostrow and Shaskey[6] reported positivity rates of 6% for HBsAg and of 68% for anti-HBs among 1,000 patients screened at a gay STD clinic in Chicago. A subsequent collaborative study of hepatitis B infection in gay men found similar rates of present and past HBV infection and demonstrated a seroconversion rate of 25–30% per year among susceptible homosexually active men.[22]

The broad clinical scope and diversity of pathogens seen in sexually transmitted proctitis among homosexual men has been most extensively demonstrated by a series of papers by Quinn and Holmes and their associates. In the first study, *Chlamydia trachomatis* was isolated from the rectums of 14 patients. Lymphogranuloma venereum (LGV) immunotypes were associated with severe granulomatous proctitis, clinically suggestive of Crohn's disease, while non-LGV immunotypes were associated with mild or asymptomatic proctitis.[23] A spectrum of clinical symptoms was also demonstrated in a series of patients with Herpes simplex proctitis, with several patients experiencing sacral paresthesias.[24] Finally, when 52 homosexually active men with anorectal symptoms and negative rectal gram stains for gram-negative diplococci were extensively tested two-thirds harbored one or more of the following potential pathogens: herpes simplex virus, 29%; *Neisseria gonorrhoeae*, 14%; *Treponema pallidum*, 12%; *Giardia lamblia*, 7%; *Entamoeba histolytica*, 7%; *Chlamydia trachomatis*, 4%; and *Neisseria meningitidis*, 2%.[25]

Causes of the Increased Scope and Incidence of STDs in Homosexually Active Men

A number of hypotheses have been suggested to explain the emergence of STDs in homosexually active men. These hypotheses can be grouped into four broad categories based on the factors thought to be primary in the transmission of STDs. The four groups are: (*1*) physical factors, such as the virulence and pathogenic characteristics of STD agents and male anatomic features, which can facilitate transmission and propagation of the pathogen, while often masking or hiding signs and symptoms; (*2*) behavioral factors, such as frequency of sexual activity and anonymity of sexual partners, and nature of specific sexual practices; (*3*) cultural factors, such as attitudes towards homosexuals on the part of health care providers, which can act as barriers to utilization of STD treatment facilities by homosexuals and may result in improper diagnosis and treatment; and (*4*) legal and political factors, such as changes in laws against homosexuality, which removed barriers against case-reporting and led to an artifactual increase in rates.

Physical Factors

Numerous biologic characteristics of infectious organisms and anatomic features of the male facilitate transmission or reception of infection with sexually transmitted agents. As Henderson[26] has pointed out,

> The male urethra is exposed to a variety of infectious agents if the penis is inserted into a mouth, rectum, or vagina during intercourse. Once infected, the male urethra is very efficient in infecting the mouth, rectum, or vagina of a partner, since the infectious agents are not only transported deep within these cavities by the penis, but large quantities are also forcefully inoculated into them during the process of ejaculation.

Although most cases of urethritis in homosexual men are due to *N. gonorrhoeae*,[27] Holmes[28] showed that the cause of nongonococcal urethritis (NGU) in gay men frequently cannot be defined. Tests for *C. trachomatis* and *Ureaplasma urealyticum*, the two most common causes of NGU in heterosexual men, are usually negative. He pointed out this this complicates diagnosis and treatment of NGU in homosexual men and results in a higher probability of recurrent infection.

The rectum has often been identified as the site of both infectious and noninfectious STDs. Five of the ten STDs discussed by Ostrow,[29] including gonorrhea, herpes, parasitic infection, rectal trauma and prolapse, and colonic perforation with sepsis, involved the rectum. Carr and William[30] suggested that the finding of a higher incidence of rectal rather than penile warts in homosexual males could be attributed to the moist, warm environment of the perirectal area. The sensitive rectal tissue has also been shown to react allergically to certain lubricants and is subject to rectosigmoid tears and other trauma as a result of the introduction of foreign objects.[8] Rectal syphilitic lesions often go unnoticed, and estimates of rates of asymptomatic rectal gonorrhea in two groups of homosexual male patients with STDs ranged from 21%[31] to 68%.[32] Judson[33] noted that asymptomatic rectal gonorrhea not only delays diagnosis but favors continued transmission. He proposed the hypothesis that anal intercourse is more likely than vaginal intercourse to transmit hepatitis B, syphilis, and genital warts. This difference may be attributable to the fact that the delicate rectal mucosa (squamous) is more subject than vaginal mucosa (cornified) to lesions and fissures that serve as a portal of entry for these pathogens. In the case of symptomatic nongonococcal proctitis, diagnosis is complicated by the presence of the nonpathogenic commensal flora of the bowel and the numerous potentially pathogenic organisms. In addition, comprehensive stool sampling is expensive and most of the culture and microscopic methods have relatively low sensitivity.[34,35]

As with the rectum, asymptomatic infection of the oropharynx with *N. gonorrhoeae* or *T. pallidum* is quite common.[5,29] Oral-anal contact facilitates transmission and ingestion of enteric pathogens including parasites and bacteria[11] and hepatitis A and B viruses.[13] William[36] points out that fecal-oral contamination is a common occurrence in homosexual activity and is not limited to direct oral-anal contact (anilingus).

Finally, the nature of antigenic variations and the complexity of the host's immune response allow for reinfection of the same individual with organisms such as *N. gonorrhoeae* and *T. pallidum*, while hampering efforts to develop effective vaccines to prevent reinfections.

It is apparent that a wide variety of agents, often difficult to diagnose and sometimes unidentified, are easily transmitted to and offered a suitable environment at the various sites of homosexual contact. Frequent asymptomatic oral and anal infection seriously compound the problem. Various anatomic attributes, such as the dual eliminative and sexual functions that the rectum serves in homosexually active men (and the ease with which these tissues can be damaged or infected), help to explain the high prevalence of STD problems among gay men.

One biologic factor that may have changed in recent years is the emergence of AIDS among a subpopulation of homosexually active men in the United States. This new phenomenon has manifested itself in a current epidemic of Kaposi's sarcoma and infections with *Pneumocystis carinii* and other opportunistic pathogens; the overall mortality rate for these diseases is 50–60%. Obviously, once the cellular immune surveillance system is severely damaged, many normally nonpathogenic organisms can cause potentially fatal infections. The actual etiologic role of AIDS of any of the well-known or newly discovered sexually transmitted organisms is unknown at this time.

Behavioral Factors

A positive association between morbidity rates due to STDs and frequency of sexual activity, as measured by numbers of different partners, has been demonstrated by numerous investigators. A recent American survey[37] canvassed a sample of men whose names were obtained from mailing lists of 1,800 gay organizations. The median number of lifetime sexual partners of the >4,000 respondents was 49.5. Many reported ranges of 300–400, and 272 individuals reported "over 1,000" different lifetime sexual partners. The number of partners was highly correlated with gonorrhea and syphilis.[38] These findings confirmed similar ones from previous studies.[5,39]

However, there is general agreement that it is not only the number of sexual partners, but certain attributes of the partner that are important, Judson[33] suggested that the higher rates of STDs experienced by the subgroup of homosexual men with larger numbers of partners may

be due to the anonymous nature of many of their sexual encounters. Henderson[26] pointed out that anonymity is a problem because it does not allow for notification of sexual contacts, the standard epidemiologic method for interrupting the chain of disease transmission. He adds that even sexual partners who are acquaintances rather than anonymous are also risks if they are not made aware of or concerned about the STD problem.

Finally, the nature of the specific sexual practices involved is highly associated with risk for the various STDs. Anal intercourse is associated with a number of rectal conditions[38] that are not seen in patients who do not engage in that practice. Similarly, rectal trauma associated with insertion of the partner's finger, fist, or large objects can result only from such activities. Several investigators[11,12] have established the relationship between oral-anal contact and transmission of enteric pathogens. The collaborative study of hepatitis B transmission sponsored by the Centers for Disease Control (Atlanta, Ga.), also identified number of nonsteady partners, oral-anal contact, and anal intercourse as the major risk factors for acquisition of hepatitis B infection.[22] Identification of these risk factors raises the question of their applicability as risk factors for other STDs. Alessi et al.[40] studied 300 patients with diagnosed cases of latent syphilis and found that their rate of hepatitis B infection was significantly higher than that among the normal population. Kryger et al.[41] found higher rates of both hepatitis A and B among homosexual patients with syphilis than among those with heterosexual or unknown sexual contacts.

The association between possible risk factors and prevalence of STDs was investigated at a gay STD clinic in Chicago. Data were collected from patients at the clinic and at two outreach sites: a mobile testing van and a gay bathhouse testing station. These three patient samples were similar both demographically and in regard to sexual preference. They were combined to examine the usefulness of the sexual-practice variables as risk factors for STDs. For each of two variables, a *t*-test was used for measurement of the significance of the difference between means for the group with a history or serologic marker for an STD ("Yes") and the group without that history ("No"). As table 1 shows, patients with a serologic or reported history of gonorrhea, syphilis, or hepatitis generally reported a higher mean number of sexual partners and had been homosexually active longer than those without a history of a given STD.

Higher rates of STDs among homosexual men may be partially explained by changes in these behaviors if it is assumed that greater numbers of contacts are now made as a result of the gay liberation movement of the 1970s, which allowed for a dramatic increase in the numbers of gay moviehouses and bathhouses, which, in turn, facilitated multiple anonymous contacts. Likewise, the greater variety of sexual practices could be due, in part, to the liberalized sexual mores that have come about as a result of the recent "sexual revolution."

TABLE 1. Differences In Number of Partners and Years of Homosexual Activity for Patients with and without History and Positive Serologic Tests for Sexually Transmitted Diseases (STDs)

STDs	No. of Partners*	Years Homosexually Active†
History of hepatitis		
No	17.4	10.8
Yes	22.7	12.6
t	3.1‡	2.4‡
History of syphilis		
No	17.2	10.4
Yes	24.6	14.9
t	3.7§	5.3§
History of oral gonorrhea		
No	18.3	7.5
Yes	24.4	10.3
t	2.2	NS#
History of urethral gonorrhea		
No	17.5	10.5
Yes	20.7	12.8
t	NS	5.9§
History of rectal gonorrhea		
No	16.5	8.6
Yes	26.4	10.5
t	5.0§	NS
Hepatitis B seropositive**		
No	14.6	8.7
Yes	22.5	12.8
t	4.7§	5.9§
VDRL reactive		
No	18.6	10.8
Yes	26.8	16.0
t	1.8	3.0§

* Measure is self-reported number of same-sex partners patient has had contact with during prior four-month period.
† Measure is self-reported number of years patient had been homosexually active on a regular basis (at least one contact per month).
‖ $P < .05$.
‡ $P < .01$.
§ $P < .001$.
# NS = not significant.
** Measure is positive if one of following is positive: HBsAg, anti-HBs, or anti-HBc.

Cultural Factors

Several investigators have proposed that angi-gay attitudes impede the reduction of morbidity due to STDs by causing underutilization of STD services by homosexually active men and improper diagnosis and treatment by health care providers. The World Health Organiza-

tion[42] asserted that higher rates of STDs among homosexuals are due to a number of complex factors including

> the tendency on the part of homosexuals to congregate in large cities to safeguard their anonymity (homosexuality being illegal in some countries), their reluctance to seek treatment owing to the stigma involved, and their propensity to form closed circles where the disease spreads rapidly and contacts are difficult to trace, partly because many homosexuals deliberately seek anonymous sexual intercourse. In the countries where figures are high, the lessening of feelings of fear and shame has resulted in a more effective tracing of contacts and in the findings of a greater number of cases.

Felman and Morrison[43] observed that homosexual men are deterred from seeking STD checkups because it requires open admission of their sexual preference, which may be accompanied by a great deal of anxiety. Judson[33] agreed that public health-care facilities are improperly utilized and emphasized that homosexual men are reluctant to trust their health to the very public officials who discriminate against them. A lack of concern and their own discomfort tends to cause many health care providers to overlook the issue of the patient's sexual preference, although such information is of vital importance to proper management of homosexual patients. Over one-third of physicians in the United States who were surveyed felt that they were "sometimes or often uncomfortable" when treating homosexual patients.[44] Although 84% felt that homosexual patients hesitate to seek medical care because of physician disapproval, 94% responded "no" when asked if their attitudes prompted referral of a male homosexual patient to another physician. Dardick[45] reported that of 602 men responding to a questionnaire printed in a local gay newspaper, only 49% indicated that they shared information regarding their sexual orientation with their primary health-care provider, and those who did not were less likely to have been checked for STDs and were more dissatisfied with their care. It would appear that anxiety about the topic deters the practitioner from approaching the subject of sexual preference and inhibits the patient from revealing such information without being probed for it.

Political Factors

Recent alterations and liberalization of statutes against homosexuality may have contributed to an apparent rise in morbidity due to STDs by removing the previous barriers to more complete reporting. Fluker[4] questioned the importance of a British act in 1968 that legalized homosexual practice, thereby leading to increased homosexual activity and increased rates of STDs. However, the British Co-operative Clinical Group[46] suggested that perhaps there was not a real overall increase in the numbers of homosexually active individuals but merely an increase in the numbers of infections admitted to be homosexually acquired. Pointing to an increase between 1969 and 1976 in rates of syphilis among men reporting same-sex contacts, Henderson[26] indicated that increased visibility resulting from liberalization of attitudes toward homosexuality had to be considered, in addition to a real increase in transmission, in explaining this rate change. Ross[47] surveyed gay males in two societies with different official positions toward homosexuality (Sweden and Australia) and found that anti-homosexual attitudes lead to underreporting of STD cases. He also concluded that removal of legal strictures has a positive effect on management of STDs.

In summary, a sizeable STD problem is associated with a subpopulation of homosexually active men; the problem appears to be due to characteristics both of organisms and of the various body sites involved, particularly the anatomic and functional properties of the rectum. The problem is compounded by a variety of sexual practices with large numbers of sexual partners, particularly among those who are indifferent about their health. Liberalization of laws against homosexuality and an increase in available sex partners may have also contributed to higher morbidity from STDs among a subpopulation of homosexual men. Anti-gay attitudes, both real and imagined, compound the problem by deterring patients from seeking care and preventing them from obtaining adequate care when they seek it. Greater visibility of STDs and increased morbidity may also be due, in part, to more comprehensive reporting and to the discovery of additional sexually transmitted pathogens, especially parasites and enteric viruses.

Priorities for Control of STDs among Homosexual Men

Setting priorities for the control of most diseases is a complicated and difficult process. Both the potential short- and long-term consequences of the disease and the resources available for its control must be taken into account. In the case of STDs among homosexual men, this process is made even more difficult by the enormous array of pathogens, the multiple sites of infection, and the lack of information on the long-term consequences (particularly immunologic) of endemic parasitic and enteric viral infections. Finally, setting priorities must be conceptualized on many levels.

In an attempt to clarify the overall priorities for STD control in the North American homosexual population, we surveyed the members of the National Coalition of Gay STD Services in 1981 and received replies from 20 clinics and practitioners. The survey asked providers to rank the 11 major STD problems for homosexuals in

relation to (*1*) overall health impact, (*2*) potential for control with existing technologies, and (*3*) need and potential for further research. The results of the survey are summarized in table 2.

As the table shows, viral hepatitis (particularly HBV) led all three priority listings. In terms of overall impact of the disease and current potential for control, syphilis, gonorrhea, and amebiasis were closely ranked for second highest priorities. Priority scores for anal warts and genital herpes infections reflected the effects of informational and technical gaps: they were ranked second in terms of research need, third in terms of health impact, but last in terms of current potential for control. Since this survey was conducted, a number of diseases associated with cellular immunosuppression, namely Kaposi's sarcoma and *Pneumocystis carinii* infection, have emerged as potential new STD problems among homosexually active males.[1] We believe that if a similar survey were conducted in late 1983, AIDS would probably rank highest in terms of health impact and research need but very low on the list in terms of current potential for control.

TABLE 2. Mean Rank of Priority for 11 Sexually Transmitted Diseases

Disease	Overall Health Impact	Current Control Potential	Research Need Potential
Viral hepatitis	1.71	2.23	3.43
Syphilis	4.14	4.25	6.14
Amebiasis	4.36	5.42	4.64
Gonorrhea	4.71	3.08	5.07
Anal warts	5.43	8.46	4.64
Genital herpes	5.50	8.92	4.43
Giardiasis	6.57	6.08	6.28
Nongonococcal urethritis	7.07	5.75	4.93
Nonspecific proctitis	7.93	7.75	7.00
Shigellosis	8.43	6.00	8.00
Scabies/pediculosis	10.14	6.62	10.07

Note. Scores represent reports from 20 clinics and practitioners. A score of 1 indicates the highest possible priority.

Recommendations for Control of STDs among Homosexual Men

Perhaps the primary requirement for effective control of STDs is for the health-care professional to approach the gay patient with an open and nonjudgmental attitude. This approach requires proper identification of the patient's sexual preference and practices. Ostrow[29] asserted that awareness of the patient's sexual preference can be the key to proper diagnosis and that a complete history of sexual practices is an essential part of primary medical care. Babb[39] urged physicians to be watchful for STDs, depending on the individual's "form and number of contacts." Owen[8] asked that physicians be nonjudgmental and understanding of the special health needs of gay patients. If the health professional feels uncomfortable with a homosexual patient, it is vital that he or she refer the patient elsewhere, rather than avoid the topic of sexual practices.[36,40]

Judson[33] argued that the public health sector in general should become more responsive to the needs of gay patients, since gay clinics do not have the funds or expertise to handle all STD problems effectively on their own. Handsfield[35] suggested that practitioners be educated in methods of nonjudgmental inquiry about alternative lifestyles, and he called for a cooperative effort between gay clinics and larger institutions such as hospitals and universities so that technically skilled and personally satisfying services can be provided. Indeed, evaluations of STD clinics operated by and for homosexual men have indicated that they can be more effective and cost-efficient in controlling STDs than many traditional sources of health care.[46,48] Homosexually active men often prefer a setting in which they can be frank and honest about their sexual activity.[6,38]

In general, since these factors are related to a higher incidence of STDs,[49] it is recommended that individuals with large numbers of anonymous partners and particularly those who often practice anal intercourse obtain routine check-ups. In addition, Ostrow[29] emphasized the importance of obtaining culture specimens from the oropharynx, urethra, and rectum, and of reculturing individuals with negative tests to rule out gonorrhea with more certainty. Evidence supporting this practice comes from a Scottish study of 278 patients screened for gonorrhea at all three sites and recultured when initial testing was negative. Fourteen of 137 cases would have been missed if all three sites had not been tested and if negative cultures had not been repeated.[50]

The above recommendations are difficult to implement, particularly in public health clinics located outside of large metropolitan areas as well as in much of the private sector. The major question confronting both the medical and gay male communities today is what forms of educational and treatment programs can best affect sexual and medical practices so as to control the increasing prevalence and seriousness of STDs among homosexually active males.

Is Education the Key to Progress in the Control of STDs among Homosexually Active Men?

It is our contention that education, on various levels, is the key to control of STDs among homosexually active men. As the previous sections of this paper have attempted to demonstrate, much of the information regarding the causes of the epidemic of STDs in this population has been gathered during the last seven to eight years. At least in the Western countries in which the high-risk homosexual male subpopulation has been shown to be af-

fected by a significant portion of the overall incidence of STDs, the problem is not availability of appropriate medical and technologic resources. Instead, the problem appears to be improper utilization and inadequate awareness of the problem. This situation exists for both the consumers and the providers of health care. A recent editorial by Handsfield[35] questioned the apparent lack of success of education of homosexual men to the types of sexual practices that place them at high risk. When this assertion is examined carefully, it is shown to reflect the inherent difficulties of integrating primary preventive education into STD control programs.[51] Rather than taking a passive, defeatist attitude, we propose that specific educational programs be developed and carefully evaluated for their effectiveness. The results of these efforts may provide answers to questions concerning the failure of STD control in a population that is generally healthy, relatively well-educated, and has access to above-average financial and medical resources. The following questions are among those that we believe must be addressed in attempts to achieve improved control of STDs.

Health Provider Educational Efforts

How can medical schools, medical residency, nurse-practitioner, and other training programs best prepare primary care providers for the diagnosis and treatment of STD problems among homosexuals? How can persons already in practice be taught the importance of obtaining complete and accurate histories of sexual practices from all patients? What methods of patient education are most appropriate to the private doctor–patient treatment setting?

Public Health Sector Educational Efforts

How can public health STD personnel be best trained to provide a setting that will promote preventive practices, such as frequent check-ups, on the part of homosexual patients? What are the most effective, productive, and appropriate roles for epidemiologic field work among the homosexual population? How can public health clinics deliver important new health care services, such as the hepatitis B vaccine, while dealing with dwindling federal and state financial support and increasing public demand for traditional services?

Educational Programs for Homosexual Men

The most important questions to be answered concerning STD control efforts in any high risk group are: What form(s) of patient education will most effectively motivate high-risk individuals to alter their sexual practices to reduce that risk, and what preventive testing or treatments are necessary to reduce the spread of STDs among the high-risk groups and their sexual contacts? We believe that the resources for answering these questions must be made available if we are to reverse an ever-worsening health crisis. It will, however, require a concerted effort to determine how best to utilize those resources.

Conclusions

The current epidemic of STDs among the gay population is the result of multiple interacting factors and circumstances operating not only at the level of the infectious agents and the individual but also within his social milieu, the health care system, and the society at large. Rather than address individual aspects of the problem, it is imperative that these interacting factors be considered. As with any population with endemic illness, it is necessary to combine education with motivation. Unfortunately, there is little emphasis on preventive medicine or patient education in most STD control programs or the medical profession in general.

STD clinics sponsored by homosexual communities have been successful in motivating patients to seek routine diagnostic and treatment services. Despite this success, STDs are epidemic in the homosexual community. New etiologic agents or presentations of disease continue to be discovered. However, even more innovative programs must be designed if we are ever to motivate a large enough proportion of the male homosexual community to preventive health action.

Programs that simultaneously increase awareness of STD problems and make testing and treatment services more accessible and attractive to the young gay person may be successful, but these require a coordinate effort involving both the community and public as well as private sectors of the health care system. Such collaborative programs would formerly have been impossible in many countries because of the fragmented nature of the health care system. In recent years, the Centers for Disease Control in the United States has sponsored, through Title 318 B grant funds, multidisciplinary outreach and education programs aimed at high-risk individuals. An example of such a program has been the multi-center hepatitis B research program described above.[22] Had it been continued, it may have ultimately produced a significant impact on the venereal spread of hepatitis B through the vaccination of high-risk individuals. The reduction in public funding of such programs has limited their immediate effects.[52] However, a significant portion of the homosexual male community is now involved in STD programs. In addition, there may be a growing appreciation by the general population of the efficacy of preventive health care. Collaborative programs involving homosexual community clinics, local board of health venereal disease control programs, and gay business establishments will continue, provided that adequate funds and interest can be developed on a local level to replace

dwindling funds from federal programs. Ultimately, it will be the education and motivation of high-risk persons that will have the greatest effect in the control of the STDs discussed in this review.

References

1. Curran J. Epidemiological aspects of Kaposi's sarcoma and opportunistic infections. N Engl J Med 1982; 306:248–52.
2. Robertson P, Schacter J. Failure to identify venereal disease in a lesbian population. Sex Transm Dis 1981; 8:75–6.
3. Report of a WHO Scientific Group. Non-gonococcal urethritis and other selected sexually transmitted diseases of public health importance. WHO Technical Report Series. no. 660. Geneva: World Health Organization, 1981.
4. Fluker J. A 10-year study of homosexually transmitted infection. Br J Vener Dis 1976; 52:155–60.
5. Judson F, Penley K, Robinson M, Smith JK. Comparative prevalence rates of sexually transmitted diseases in heterosexual and homosexual men. Am J Epidemiol 1980; 112:836–43.
6. Ostrow DG, Shaskey DM. The experience of the Howard Brown Memorial Clinic of Chicago with sexually transmitted diseases. Sex Transm Dis 1977; 4:53–5.
7. Ostrow DG, Shaskey D, Steffen G, Altman N. Epidemiology of gonorrhea infections in gay men. J Homosex 1980; 5:285–8.
8. Owen W. Sexually transmitted diseases and traumatic problems in homosexual men. Ann Intern Med 1980; 92:805–8.
9. Sohn N, Robilotti J. The gay bowel syndrome: A review of colonic and rectal conditions in 200 male homosexuals. Am J Gastroenterol 1977; 67:478–84.
10. Drusin L, Genvert G, Topf-Olstein B, Levy-Zombek E. Shigellosis: Another sexually transmitted disease. Br J Vener Dis 1976; 52:348–50.
11. Dritz SK, Ainsworth T, Back A, Boucher L, Garrard W, Palmer R, River E. Patterns of sexually transmitted enteric diseases in a city. Lancet 1977; 2:3–4.
12. William D, Shookhoff H, Felman Y, DeRamos S. High rates of enteric protozoal infections in selected homosexual men attending a venereal disease clinic. Sex Transm Dis 1977; 4:89–91.
13. Corey L, Holmes K. Sexual transmission of hepatitis A in homosexual men: Incidence and mechanism. N Engl J Med 1980; 302: 435–8.
14. Ward R, Borchert B, Wright A, Kline E. Hepatitis B antigen in saliva and mouth washings. Lancet 1972; 2:276.
15. Heathcote J, Cameron C, Dane D. Hepatitis B antigen in saliva and semen. Lancet 1974; 1:71.
16. Fulford K, Dane D, Catterall R, Woof R, Denning J. Australian antigen and antibody among patients attending a clinic for sexually transmitted diseases. Lancet 1973; 1:1470–3.
17. Jefferies D. James W, Jefferiss F. Australian (hepatitis associated) antigen in patients attending a venereal disease clinic. Br Med J 1973; 2:455–6.
18. Szmuness W. Recent advances in the study of the epidemiology of hepatitis B. Am J Pathol 1975; 81:629–49.
19. Szmuness W, Hoofnagle J, Steven C, Prince A. Antibody against the hepatitis type B core antigen: A new tool for epidemiologic studies. Am J Epidemiol 1976; 104:256–62.
20. Coleman J, Waugh M, Dayton R. Hepatitis B antigen and antibody in a male homosexual population. Br J Vener Dis 1977; 53: 132–4.
21. Lim K, Wong V, Fulford K, Catterall R, Briggs M, Dane D. Role of sexual and non-sexual practices in the transmission of hepatitis B. Br J Vener Dis 1977; 53:190–2.
22. Schreeder MT, Thompson SE, Hadler SC, et al. Hepatitis B in homosexual men: Prevalence of infection and factors related to transmission. J Infect Dis 1982; 146:7–14.
23. Quinn TC, Goodell SE, Mkrtichian E, et al. *Chlamydia trachomatis* proctitis. N Engl J Med 1981; 305:195–200.
24. Goodell SE, Quinn TC, Mkrtichian E, Schuffler MD, Holmes KK, Corey L. Herpes simplex virus proctitis in homosexual men: Clinical, sigmoidoscopic, and histopathological features. N Engl J Med 1983; 308:868–871.
25. Quinn TC, Corey L, Chaffee RG, Schuffler MD, Brancato FP, Holmes KK. The etiology of anorectal infections in homosexual men. Am J Med 1981; 71:395–406.
26. Henderson R. Improving sexually transmitted disease health services for gays: A national prospective. Sex Transm Dis 1977; 4:58–62.
27. Lee Y, Rosner B, Alpert S, Fiumara N, McCormack W. Clinical and microbiological investigation of men with urethritis. J Infect Dis 1978; 138:798–803.
28. Holmes K. Nongonococcal urethritis: General considerations and specific considerations for homosexual men. J Homosex 1980; 5:295–8.
29. Ostrow DG. Spotting and treating sexually transmitted diseases in gay men. Mo Med 1979; 47:42–7.
30. Carr G, William D. Anal warts in a population of gay men in New York City. Sex Transm Dis 1977; 4:56–7.
31. Lebedeff D, Hochman E. Rectal gonorrhea in men: Diagnosis and treatment. Ann Intern Med 1980; 92:463–6.
32. Deheragoda P. Diagnosis of rectal gonorrhea by blind anorectal swabs compared with direct vision swabs taken via a proctoscope. Br J Vener Dis 1977; 53:311–3.
33. Judson F, Miller K, Schaffnit T. Screening for gonorrhea and syphilis in the gay baths—Denver, Colorado. Am J Public Health 1977; 67:740–2.
34. Bolan B. Nonspecific proctitis. J Homosex 1980; 5:299–306.
35. Handsfield HH. Sexually transmitted diseases in homosexual men. Am J Public Health 1981; 71:989–90.
36. William DG. Sexually transmitted diseases in gay men: An insider's view. Sex Transm Dis 1979; 6:278–80.
37. Jay K, Young A The gay report. New York: Summit Books, 1979.
38. Darrow W. Social and psychological aspects of the sexually transmitted diseases: A different view. Cutis 1981; 27:307–20.
39. Babb R. Sexually transmitted infections in homosexual men. Postgrad Med J 1979; 65:215–8.
40. Alessi E, Prandi G, Pocchini A, Tassi G. The sexual transmission of Australia antigen. Boll Ist Sieroter Milan 1976; 55:340–4.
41. Kryger P, Pedersen NS, Mathiesen L, Nielsen JO. Increased risk of infection with hepatitis A and B viruses in men with a history of syphilis: Relation to sexual contacts. J Infect Dis 1982; 145: 23–6.
42. World Health Organization. Public health papers no. 65. Social and health aspects of sexually transmitted diseases. Geneva: World Health Organization, 1975.
43. Felman Y, Morrison J. Examining the homosexual male for sexually transmitted diseases. JAMA 1977; 238:2046–7.
44. Sandholzer TA. Physician attitudes and other factors affecting the incidence of sexually transmitted diseases in homosexual males. J Homosex 1980; 5:325–8.
45. Dardick L, Grady K. Openness between gay persons and health professionals. Ann Intern Med 1980; 93:115–9.
46. British Co-operative Clinical Group. Homosexuality and venereal disease in the United Kingdom. Br J Vener Dis 1980; 56:6–11.
47. Ross M. Social factors in homosexually acquired venereal disease: A comparison between Sweden and Australia. Ph.D. thesis, Flinders University, Bedford Park, Australia, 1979.
48. Merino H, Richards J. An innovative program of venereal disease case-finding, treatment and education for a population of gay men. Sex Transm Dis 1977; 4:50–3.
49. Darrow W, Barrett D, Jay K, Young A. The gay report on sexually transmitted diseases. Am J Public Health 1981; 71:104–11.
50. McMillan A, Young H. Gonorrhea in the homosexual man: Frequency of infection by culture site. Sex Transm Dis 1978; 5:146–50.
51. Ostrow DG. Letter to the editor. Am J Public Health 1982; 72:495.
52. Ostrow DG, Behar M, Baker A, et al. Preliminary report of the task force on vaccination strategies for sexually transmitted hepatitis B. Sex Transm Dis 1982; 9:151–3.

STD·84

Sexually Transmitted Diseases PREVENTION/TRAINING CLINICS

A cooperative venture among State and local health departments, selected medical schools and the Centers for Disease Control has led to the establishment of ten Sexually Transmitted Diseases (STD) Prevention/Training Clinics. Medical school faculty and clinic personnel have designed instruction and training for nurses, nurse practitioners, physician assistants and physicians who work or will soon begin to work in STD clinics. Medical update seminars are also available to clinicians, public health advisors and private physicians.

Six different courses and seminars, geared to the needs and experiences of the trainees are offered periodically at the STD Prevention/Training Clinics. The courses include:

STD CLINICIAN TRAINING COURSE—COMPREHENSIVE:
(formerly "LEVEL I") An introductory clinical training course, aimed at full-time STD nurses, physicians and physician assistants, 80 hours (2 weeks) long. The course content includes: Introduction to STD, STD Diagnosis and Management, Clinic-Patient Interaction, The Clinic Record, History and Physical Examination, Laboratory, Epidemiology, Therapeutics, Patient/Health Education and Clinic Management. The course format includes formal lectures, class discussion, audiovisual presentations and practical clinical and laboratory experience. Continuing medical education credit is granted for this course (Category I, AMA).
Course Number: 0149

STD CLINICIAN TRAINING COURSE—INTENSIVE: An introductory clinical training course aimed at STD nurses, physicians, physician assistants and other health personnel, 40 hours (1 week) long. The course content is similar to the "Comprehensive" course, but offers limited practical clinical and laboratory experience. Continuing medical education credit is granted for this course (Category I, AMA).
Course Number: 0154

STD PART-TIME CLINICIAN TRAINING COURSE—INTENSIVE: An introductory clinical training course aimed at part-time STD nurses and physician assistants, 24 hours (3 days) long. The course offers a brief overview of STD diagnosis and management. Several hours of practical clinical experience are provided. Continuing medical education credit is granted for this course (Category I, AMA).
Course Number: 0154A

STD CLINICIAN TRAINING COURSE—ADVANCED:
(formerly "Level II") A course designed for experienced clinical personnel in need of advanced training and for graduates of the "Comprehensive" course who have also had 2-4 months of applied clinical experience. The course is 40 hours (1 week) long. Course content includes: Review of STD Diagnosis and Management, Differential Diagnosis, Multiple Infections, Laboratory, Clinic-Patient Interaction and Clinic Management. The course format includes formal lectures, clinical problem-solving workshops and relevant clinical and laboratory experience. Continuing medical education credit is granted for this course (Category I, AMA).
Course Number: 0165

STD UPDATE FOR CLINICIANS: An update seminar for practicing clinicians, 16 hours (2 days) long. The seminar includes clinical problem-solving workshops, formal lectures, consultation time and supervised clinical and laboratory experience. Continuing medical education credit is offered for this seminar (Category I, AMA).
Course Number: 7008-D

STD UPDATE FOR PUBLIC HEALTH ADVISORS: An update seminar for public health advisors, 24 hours (3 days) long. The seminar provides an overview of current developments in STD diagnosis and management.
Course Number: 7008-DPHA

It is recommended that full-time clinicians with no STD experience follow this sequence: STD CLINICIAN TRAINING COURSE—COMPREHENSIVE (0149); 2-4 months of clinical experience at their place of employment; then STD CLINICIAN TRAINING COURSE—ADVANCED (0165).

Application for course or seminar enrollment should be made directly to the training site. There is no charge for tuition or for educational or laboratory supplies. Travel expenses and per diem are the responsibility of the participant or the participant's agency.

Baltimore, Maryland
Training Coordinator
Baltimore City STD Training Center
111 N. Calvert Street, Room C-223
Baltimore, Maryland 21202
Phone: (301) 396-4448, FTS: 922-0989

INTENSIVE: 1983 Oct 17-21
1984 Mar 12-16
Apr 9-13
June 18-22
Sept 10-14
Nov 12-16

CLINICIAN UPDATE: 1983 Nov 17-18
Dec 15-16
1984 Jan 19-20
Feb 16-17;
May 17-18;
Oct 4-5;
Dec 6-7

Chicago, Illinois
Training Coordinator
Municipal Social Hygiene Clinic
27 East 26 Street
Chicago, Illinois 60616
Phone: (312) 225-9598, FTS: 353-4312

COMPREHENSIVE: 1983 Oct 17-28
1984 Jan 23-Feb 3
Mar 19-30
June 11-22
Aug 20-31
Oct 29-Nov 9

ADVANCED 1983 Oct 3-7
1984 Feb 27-Mar 2
Apr 23-27
July 9-13
Sept 17-21
Nov 19-23

CLINICIAN UPDATE: 1983 Nov 17-18
1984 Feb 16-17
May 17-18
Aug 2-3
Oct 11-12

Cincinnati, Ohio
Training Coordinator
Cincinnati STD Center
3101 Burnet Avenue
Cincinnati, Ohio 45229
Phone: (513) 352-3143, FTS: 684-3240

COMPREHENSIVE: 1983 Nov 28-Dec 9
1984 Jan 23-Feb 3
Apr 30-May 11
Sept 17-28
Dec 3-14

PART-TIME INTENSIVE: 1983 Nov 7-9
1984 Feb 27-29
June 4-6
June 25-27

ADVANCED: 1983 Oct 24-28
1984 Mar 19-23
Aug 13-17
Oct 29-Nov 2

Dallas, Texas
Training Coordinator
Dallas STD Training Center
Dallas Countywide Health Department
1936 Amelia Court
Dallas, Texas 75235
Phone: (214) 920-7984, FTS: 729-7888

COMPREHENSIVE: 1983 Nov 7-18
1984 Jan 9-20;
Mar 12-23
May 14-25
July 16-27
Sept 10-21
Nov 5-16
1985 Jan 14-25

ADVANCED: 1983 Oct 17-21
1984 Feb 6-10
Oct 1-5
1985 Feb 11-15

CLINICIAN UPDATE: 1983 Dec 1-2
1984 Nov 9-10

Denver, Colorado
Training Coordinator
The Denver STD Training Center
605 Bannock Street
Denver, Colorado 80204
Phone: (303) 893-7051

INTENSIVE: 1983 Oct 7-14
1984 Mar 16-23
Oct 5-12

CLINICIAN UPDATE: 1983 Oct 7-8
1984 Mar 16-17
Oct 5-6

Los Angeles, California
Training Coordinator
Central Health Center
STD Clinic—Room 238
241 N. Figueroa Street
Los Angeles, California 90012
Phone: (213) 974-7551

COMPREHENSIVE: 1983 Oct 31-Nov 11
1984 Jan 9-20
Mar 26-Apr 6
July 9-20
Oct 8-19

INTENSIVE: 1983 Dec 5-9
1984 May 7-11
Dec 3-7

CLINICIAN UPDATE: 1984 Mar 2-3
Sept 14-15

Nashville, Tennessee
Training Coordinator
Metropolitan Health Department
311 23rd Avenue North
Nashville, Tennessee 32703
Phone: (615) 327-9313 Ext. 360
FTS: 852-7432

COMPREHENSIVE: 1983 Sept 26-Oct 7
1984 Jan 9-20
Apr 2-13
June 18-29
Aug 13-24

PART-TIME INTENSIVE: 1983 Dec 5-7
1984 Jan 30-Feb 1
May 2-4
July 25-27
Dec 5-7

ADVANCED: 1983 Oct 17-21
1984 Mar 5-9
Oct 22-26

PUBLIC HEALTH ADVISOR UPDATE:
Mar 28-30; Sept 26-28

Newark, New Jersey
Training Coordinator
Newark STD Training Center
110 Williams Street
Newark, New Jersey 07102
Phone: (201) 643-0226

COMPREHENSIVE To be announced

ADVANCED To be announced

CLINICIAN UPDATE To be announced

San Juan, Puerto Rico
Training Coordinator
Latin American STD Center
Call Box STD
Caparra Heights Station
San Juan, Puerto Rico 00922
Phone (809) 754-8127

COMPREHENSIVE 1983 Nov 7-18
1984 Jan 9-22
Mar 19-Apr 6
Apr 30-May 18
Oct 1-12

PART-TIME INTENSIVE
June 11-22; Aug 6-17

ADVANCED 1983 Oct 3-6
1984 To be announced

CLINICIAN UPDATE 1983 Dec 5-6
1984 To be announced

Seattle, Washington
Training Coordinator
STD Training Program
Mail Stop ZA-89
Harborview Medical Center
325 Ninth Avenue
Seattle, Washington 98104
Phone: (206) 223-3430, FTS: 399-2762

COMPREHENSIVE 1984: Jan 4-13
Mar 14-23
May 16-25
Sept 12-21

ADVANCED: 1983 Oct 17-21
Nov 14-18
1984 Feb 13-17
Apr 16-20
June 11-15
Oct 15-19
Nov 12-16

For more information and application forms, cut off this reply card and send it to the training site of your choice.

Name: _____

Organization: _____

Address: _____

_____

_____

Telephone: _____ Area Code: _____

Present Position in STD: _____

_____

- ☐ **STD CLINICIAN TRAINING COURSE—COMPREHENSIVE**
- ☐ **STD CLINICIAN TRAINING COURSE—INTENSIVE**
- ☐ **STD PART-TIME CLINICIAN TRAINING COURSE—INTENSIVE**
- ☐ **STD CLINICIAN TRAINING COURSE—ADVANCED**
- ☐ **STD UPDATE FOR CLINICIANS**
- ☐ **STD UPDATE FOR PUBLIC HEALTH ADVISORS**

COMMUNITY HEALTH PROJECT FORMS FROM ST. MARKS & GAY MEN'S HEALTH PROJECT

St. Marks Clinic and the Gay Men's Health Project of New York have merged to form the Community Health Project at 208 W. 13th St., just west of Seventh Avenue. The new clinic offers limited general medical care to the public, especially the gay and lesbian communities. Services include screening for sexually transmitted diseases, screening for symptoms of AIDS (chronically swollen glands, for example), and Pap smears, as well as medical diagnostic and treatment services. The STD screening is done on a first-come, first-serve basis; appointments for other medical problems should be made by calling 212/691-8282. Fees range from $5-20, with additional charges for medication and some laboratory tests. Services are provided by a staff of over 100 volunteers, including trained lay health workers and medical professionals. Daily operations are managed by a full-time clinical coordinator provided through the VD program of the New York City Health Department. Dr. Barbara Starrett, an internist associated with St. Marks for the past 10 years, is serving as medical director. CHP is supported by fees, contributions and grants, including a $25,000 grant from the Gay Men's Health Crisis. A fund-raising campaign is underway to purchase the Maritime and Food Trades High School Building, which is currently being leased from the city, for use as a gay and lesbian community center.

* * *

"POPPERS" LEGISLATION PASSES IN SAN FRANCISCO

with thanks to the New York Native, 1/2-15/84

The San Francisco Board of Supervisors have adopted a law to warn consumers about the potential health dangers of inhalable alkyl nitrite products, or "poppers." The ordinance, passed unanamously early in December, forbids sale of poppers to anyone under the age of 18 and requires merchants selling them to post warnings listing their potential hazards. The new ordinance requires the following warning to be posted wherever poppers are sold: "These products contain alkyl nitrites ('poppers'). Inhaling or swallowing alkyl nitrites may be harmful to your health. These chemicals can cause skin rashes, nasal irritation, sinus or lung infections, and rarely, severe anemia. Inhaling concentrated alkyl nitrite vapors may cause you to faint and could be very dangerous if you have a hidden heart disease. Whether continued use of alkyl nitrites may affect the immune system is not known, but several different studies have suggested that some impairment of the immune system is possible." A violation of the measure, which is the strictest law yet adopted in the nation concerning poppers, would be a misdemeanor subject to a maximum fine of $500 and/or 6 months in jail.

* * *

POPPERS AND AIDS: NEW BOOKLET

with thanks to the New York Native, 1/2-15/84

A new booklet, Poppers and AIDS, written by the San Francisco Committee to Monitor the Effects of Poppers (10 pages, $1.50, c/o Hank Wilson, 55 Mason St., SF, CA 94102) provides a clear [presumably biased?--ED NOTE] discussion of the premise that nitrite inhalents are a major risk factor in the development of AIDS. It briefly outlines findings that implicate poppers as being a possible co-factor in AIDS etiology. The booklet states, "nitrite inhalents are currently high on the list of suspects for causing AIDS, and this is sufficient reason why gay men should immediately stop using them." The booklet emphasizes, "Do not use poppers," and outlines reasons for this recommendation. A very useful, annotated 6 page bibliography is included; an afterward outlines what the authors assert is the undue influence of the poppers industry on government agencies and public opinion. "It may well be that the currently circulated rumors, to the effect that poppers have been 'exonerated,' are the result of a campaign of 'disinformation' waged by the poppers industry."

* * * * *

BURROUGHS WELLCOME PUBLISHES AIDS BOOKLET

Burroughs Wellcome Pharmaceutical Company recently has published a 27 page booklet, "AIDS Diagnosis and Management" by Abe Macher, Henry Masur, H. Clifford Lane, and Anthony Fauci. The booklet has 15 color plates and covers recognition, clinical findings, opportunistic infections and neoplasms, and lab findings and immunologic profile, among other topics. It is an excellent resource as an introduction to the AIDS crisis for medical personnel. For a complementary copy, contact your Burroughs Wellcome drug representative, contact Burroughs Wellcome, Research Triangle Park, NC 27709, or contact Allan O'Hara, Key Memorial Hospital AIDS Education Program, PO Box 4073, Key West, FL 33041 (send Allan a large format manila envelope (to accomodate 9 x 12") with $1 for postage & handling with your address).

* * *

RIGHT-WING AIMS AT GAY BUSINESSES "BECAUSE" OF AIDS

with thanks to Boston's Gay Community News, 12/24/83

A petition drive to close all homosexual establishments in response to an assumed general AIDS contagion was begun in late October, according to The Weekly News of Miami. This effort goes beyond bathhouses and bookstores to include restaurants and shops owned and operated by gay people. The American Family Association, under the signature of its president, Daniel Villanueva, has distributed about 350,000 petitions calling on US Surgeon General Dr. C. Everett Koop to shut down all gay & lesbian businesses to "quarantine all homosexual establishments," a matter crucial to the health and security of American families, according to Villanueva. The well-documented fact that AIDS is not spread by casual contact was politely ignored by the conservative group in its hysterical pitch. The chairperson of Miami's Health Crisis Network, Bill Kipp, commented, " If they close all the shops and restaurants run by gays, there won't be any left."

* * * *

SHANTI OPENS BRANCH IN SEATTLE

from Staff Notes, Seattle Gay Clinic, December, 1983

One of the principal and most humane support groups helping people in San Francisco (including, but not restricted to gay men with AIDS) has been an organization called Shanti. There is now a Shanti Seattle! Shanti focuses particularly on the emotional needs of people facing life-threatening illnesses and bereavement, and the needs of their families and companions. Shanti provides free counseling and emotional support, and, unlike some agencies and groups, is not limited to serving those with a six-month or less terminal diagnosis. Counselors and clients are carefully matched, and the relationship can be either short-term or long-term, depending on the client's needs and wants, which are always the most important consideration. Shanti counselors are caring people who are extensively trained and supervised. Shanti Seattle and Shanti San Francisco have commitments to both the gay/lesbian community and the community at large. For more information: Shanti Seattle, PO Box 1768, Seattle, WA 98111 (206/324-7920); Shanti San Francisco, 890 Hayes St., San Francisco, CA 94117 (415/849-4980).

* * *

CDC DEVELOPS EDUCATIONAL UPDATE PROGRAM ON AIDS

The Centers for Disease Control (CDC) AIDS Activity and the Division of Venereal Disease Control have collaborated to develop an educational update program on AIDS. It is being distributed to each project area to meet the increasing number of requests from STD control contituent groups interested in this problem. The package of materials includes a 20 minute videotape [ED NOTE: factual but visually unappealing, boring], a self-assessment instrument, an instructor's guide [ED NOTE: this guide offers several approaches to teaching groups about AIDS--interesting and useful set of outlines.], and slides on disease distribution. Also included is the latest version of "AIDS Questions and Answers," and all current published CDC recommendations for the prevention of AIDS. Please contact your state VD representative /public health advisor or Mr. Russ Havlak, Chief, Training, Education & Consultation Section, Division of VD Control, Center for Prevention Services, CDC, Atlanta, GA 30333 (404/329-2552).

* * *

EUROPEAN AIDS CONFERENCE

The International Gay Association (IGA) is sponsoring a European AIDS Conference, January 20-22, 1984, Amsterdam, the Netherlands, at the headquarters of the Dutch Society for Integration of Homosexuality (COC), Rozenstraat 14, Amsterdam. The Conference language is English, and is meant for all homosexual men and women currently involved with AIDS in European countries (others are welcome!). The cost is $45 (150 Dutch guilders), which includes meals. For more information or to register, write: AIDS Project Group, NVIH/COC, (Conference Secretary), Joop van der Linden and Corry Klarenbeek, Rozenstraat 8, 1016 NX Amsterdam, the Netherlands.

* * *

FLORIDA KEYS "AIDS CARING BEAR-RALPH"

by Allan O'Hara

The "AIDS Caring Bear--Ralph" is a way to educate and inform those at risk of contracting AIDS as well as a potential fundraiser. The idea to print large "Ralph" buttons & to distribute "Ralph" cards with risk reduction information was submitted to the Federation of AIDS Related Organizations as a possible fundraiser for local groups. For more information, write: Allan O'Hara, AIDS Education Program, Florida Keys Memorial Hospital, 600 Junior College Road, PO Box 990, Key West, FL 33040 (305/294-5531).

* * * * * * * *

AIDS GROUP REFUSES FUNDRAISING MONIES

[ED NOTE: The following article is excerpted from a local gay community newspaper; names are omitted or changed because it was felt that this information is a private community affair. The issues that are raised are worthy of thought and discussion, however irrespective of names. Your comments are invited.]

In a move that visibly angered some members of the committee that organized the AIDS project fundraiser, the Board of Directors of the center refused to accept a check for $7739.82, representing the net income from the event. The motion to not accept the money was introduced because of objections to the language of an accompanying letter asking that at least 50% of the funds be earmarked to help financially needy AIDS patients. The motion to not accept the money was passed with the understanding that the donation may be accepted at a later time after discussions with legal counsel, the fundraising committee, and the center's Board. (The committee and the center are two separate entities.) The committee's fundraising project "sought to project an image of unity and support...which all could point to with pride." The fundraiser was "immensely successful" however it had "become a part of a large and most disturbing schism within the community centering around the administration and leadership of the [center] and the use of AIDS monies," according to a letter submitted to the Board. As a result of some "serious questions of accountability" the group wrote that "it is both our duty and our responsibility to the community to secure" certain items from the Board. Included on this list were: 1) an accurate, detailed and comprehensive accounting of AIDS project revenues and expenses to date; 2) a review of this report with any attendant discussion or clarification as an agenda item fro the next meeting of the Board; 3) similar system of regular accounting, publication and review of AIDS project funding instituted on a quarterly basis; 4) assurances that all monies raised by the AIDS fundraiser be given to the AIDS project and that at least 50% of that money go to a restricted fund to provide direct financial assistance for people with AIDS; and 5) public access to the above guidelines through regular releases to the media. The fourth guideline was objected to strenuously, for different reasons. One feeling was that the the center Board which is most familiar with the needs of the AIDS project, should not be directed by outside groups as to how money can be spent. Another question centered on the legality of accepting the donation to the tax exempt center calling for direct monetary gifts to individuals. Many backers of the fundraiser had asked for assurances that some of the money go directly to AIDS patients rather than for paying administrative costs for the project. ***** ***** *****

FEDERATION OF AIDS-RELATED ORGANIZATIONS (FARO) UPDATE

Core Group Meets in San Francisco: Six persons with AIDS met for three days last week with representatives of twelve AIDS and AIDS-related organizations from around the country. Together, they form the steering committee for the Federation of AIDS-Related Organizations (FARO) formed June, 1983 to lobby the federal government for increased attention and research funding, and to coordinate the efforts of AIDS organizations nationwide. An emerging purpose of FARO is to facilitate communication between persons with AIDS and these organizations which are providing educational and support services in response to the AIDS crisis.

Persons with AIDS Issue Recommendations: The first agenda item was a report from persons with AIDS who spoke of the complexities of living with AIDS and issued recommendations directed at community organizations, health care providers, and government agencies. The key issue centered on the lack of involvement of persons with AIDS at both planning and decision-making levels, both within the public and private sectors. Those present indicated that their organizations do include persons with AIDS on their boards of directors and as participants at educational programs and forums. It was noted, however, that at the recent NIH conference on AIDS held in Washington, DC, there was no such participation. This type of oversight ignores the only firsthand knowledge about AIDS which is available--that of the person with AIDS. [ED NOTE: The NCGSTDS has requested editorial assistance and advise (no "board" exists, per se) from People With AIDS groups in San Francisco and New York, without reply; the offer still stands.]

Lobby Project Expands Agenda: The FARO Lobby Project, which began operation in August with the hiring of helath lobbyist Gerald Connor, reported an increased need for funding in order to expand its activities. Connor's efforts, along with those of the National Gay Task Force, the Gay Right's National Lobby, and other groups have resulted in a $48 million Congressional appropriation for AIDS research in 1984. According to Lobby Project chair, Paul Popham, it will be difficult to determine how much more is needed until the research proposals funded by that appropriation are evaluated. FARO has received a tentative committment from the American Public Health Association to undertake a review of research funding, and hopes to use the results of this study in preparing for the fight for research dollars for fiscal 1985. At the same time, the steering committee approved a proposal to hire a second consultant to lobby for improved health care services for persons with AIDS. AIDS has pointed out to thousands of Americans the myriad of problems, prejudices, and inequities in the current health care delivery system in the United States. FARO intends to add its name to those organizations already attempting to make the system for responsive to the needs of those it purposts to serve. In addition to lobbying for research funding and improved health care benefits, increased public education about AIDS will be added to the Lobby Project agenda.

National AIDS Resource Directory Presented: A preliminary draft of the Resource Directory was presented to the steering committee by Ron Vachon, Director of the FARO Resource Clearinghouse. The Directory will be available to FARO members and reference libraries, and includes information on funding, legislation, research, statistics, educational materials, services for persons with AIDS, organizational procedures, and issues relevant to AIDS such as infection control, blood banking, alternative treatments, etc. Even in draft form, the Directory represents an overview of trends, issues, and concerns from all areas in which AIDS is emerging. As a resource which catalogs information about community services including hotlines, educational programs, and emotional and financial support for persons with AIDS, as well as numbers served and dollars spent, the Directory will be a unique and important tool for use fy the Lobby Project in quantifying private sector response to the AIDS crisis. Quarterly updates will be issued based on information received from FARO members. The Resource Clearinghouse also provides immediate information flow between FARO members and the Lobby Project; and it was decided that the location be moved to Washington, DC to facilitate this exchange. Further, the basic areas of responsibility of the Resource Clearinghouse director were identified, and a job description for the position will be issued in February.

Regional Outreach Planned: The steering committee adopted a plan presented by Caitlin Ryan of AID-Atlanta which would divide the nation into 8 regions for purposes of FARO representation and outreach. Each region would hold one seat on the steering committee (except for 2 in the Northeast region, which includes New York and the northern half of New Jersey), which would also include 4 seats held by national organizations and 4 seats held by representatives of persons with AIDS, and could include floating seats if elected by the full FARO membership. It was suggested that each of the local organizations which presently occupy the regional

(CONTINUED)

FARO UPDATE, Continued

be responsible for holding a regional meeting to elect which single organization(s) will represent their region at the steering committee level. It is important to note that this program will facilitate information flow to and from the smaller communities, and identify areas of support for use in the FARO lobby effort. Specifically, each region will identify key individuals and/or organizations from those districts whose Congressional Representatives sit on the Appropriations Committees. The unified action of these constituents can potentially have substantial effect.

Funding Plan to be Developed: The concepts for an overall umbrella funding plan for FARO were presented by FARO co-chair Matt Redman of the AIDS Project/Los Angeles. ADopted were the principles of a four-tier funding program, including both general and participating levels of membership dues, a corporate donation/grant program, federal education grants, and regional support. The coordinating committee for FARO has agreed to look into hiring a consultant for grant writing and resource development.

3rd National AIDS Forum Announced: FARO co-chair Bernice Goodman presented a call for papers and a press release regarding the 3rd National AIDS Forum co-sponsored by FARO and the National Gay Health Education Foundation and held in conjunction with NGHEF's International [and 6th National] Lesbian/Gay Health Conference in New York, June 16-19, 1984. A conference committee has been established including members of both organizations to review papers, determine topics and agenda, and construct the conference.

Steering Committee to Meet in Atlanta: While the co-chairs intend a working meeting with the coordinating committee in the immediate future, the full steering committee will meet in Atlanta in February in preparation for the full FARO membership meeting which will take place at the 3rd National AIDS Forum.

* * *

THIRD AIDS FORUM, FIRST INTERNATIONAL/SIXTH NATIONAL LESBIAN/GAY HEALTH CONFERENCE: PAPERS

The National Gay Health Education Foundation announces the Sixth National Lesbian/Gay Health Conference and the First International Lesbian/Gay Health Conference, "Toward Diversity," to be held in New York City, June 16-19, 1984. The theme, "Toward Diversity," reflects the meeting's multi-focus purpose with special emphasis on Third World, international, and lesbian health concerns. The Conference will be held in conjunction with the Third National AIDS Forum, co-sponsored by the Federation of AIDS Related Organizations (FARO). The NGHEF and FARO welcome participation by those wishing to share their contributions to the field of lesbian or gay health care. Papers: A formal, written presentation followed by discussion from the floor. Panels: A topic presented from several points of view. Speaker remarks should be brief to encourage discussion among panelists and audience. Workshops: Discussion of a topic facilitated by the person(s) who submit the idea. Participation by all is encouraged. We also invite suggestions for alternative formats. Feel free to submit ideas along these lines. Be creative, but specific. Some topics have already been identified. Proposals may include or relate to such areas as: Gay Male Health Care, Gerontology, Holistic Health, Substance Abuse, Mental Health, Lesbian/Gay Families, Physically-Challenged Lesbians & Gays. Those who wish to participate should submit a narrative abstract and/or topic outline of one page (maximum) by JANUARY 15, 1984. Language requirements and other specifics will be provided upon receipt of each proposal. Notification of acceptance will be mailed after February 1, 1984. Send narratives to: ILGHC, NGHEF, 80 Eighth Av., Suite 1305, New York, NY 10011. For further information contact: Fern Schwaber or Michael Shernoff, 212/206-1009.

* * * *

AIDS PROJECT NEW-HAVEN DEVELOPS EDUCATIONAL MATERIALS
thanks to Bill Sabella

AIDS Project-New Haven has recently published 6 different informational handouts (on 8½ x 11 paper) dealing with different aspects of AIDS: 1) Affection and Sex for Persons with AIDS; 2) Reducing Risk; 3) Risk Reduction for IV Drug Users; 4) AIDS Information for the General Community; 5) Prison Guidelines; and 6) Guidelines for Emergency Medical Services. Also developed is a question & answer format brochure addressing concerns specific to Connecticut residents. For additional information, please contact: AIDS Project-New Haven, PO Box 636, New Haven, CT 06503 or call 203/624-AIDS.

* * * *

GAY COMMUNITY'S INVOLVEMENT IN CREATING SEATTLE'S AIDS ASSESSMENT PROJECT

by Tim Burak

Late in 1982, news of the first CDC-defined cases of AIDS in Seattle reached the public through a series of troubling newspaper articles, some carrying headlines that exacerbated people's fear and confusion about the new syndroms (e.g., "Deadly 'Gay' Disease Found in Heterosexual Seattle Man"). The Seattle/King County Health Department responded with corrective news releases. The Dorian Group (a statewide gay/lesbian civil rights organization) immediately called a conference of local media people to identify sources of misleading information and to educate journalists on the basics of gay health issues. And the Seattle Gay Clinic organized a public forum, "AIDS: Keeping Our Community Healthy" that drew a crowd thrice the expected size. By this time, 5 cases had been reported, community interest & anxiety was high, and gaps in the local health network were apparent--the communicable disease unit of the Health Department had no special resources to direct toward adequate case-surveillance; the Seattle Gay Clinic, with its all-volunteer staff and limited STD-screening focus was not equipped to handle increasing demands (clients were presenting for STD checkups, while really requiring full physical workups); AIDS-related services were limited to CMV/lymphadenopathy research projects in which enrollments quickly had reached their limits. In March, a member of the Clinic's Board, who also works for the Health Department, attended an AIDS workshop sponsored by the Shanti Project in San Francisco, during the week when that city's Board of Supervisors voted to provide emergency direct funding to local health agencies for AIDS-related services. San Francisco was responding under the gun, with over 200 people already identified with AIDS. Could not Seattle get a head start in establishing locally funded and controlled services for people at risk of developing AIDS? The Health Department was about to compile a list of new program initiatives for 1984. Seattle Gay Clinic staff (literally over a weekend) hammered out a model for a cooperative project that would provide surveillance, community education, and physical assessment services both at a Health Department site and at the Gay Clinic. The Clinic additionally proposed that 1) the project should begin right away, and 2) the Clinic would furnish a volunteer to staff the project and begin to develop county-wide active and passive surveillance networks while funds were being sought.

New Health Department programs in Seattle must jump two considerable hurdles: they must pass hearings and scrutiny by both City and County Councils. A community lobbying effort was begun, focusing on key Council members. A large-scale dinner/lecture on AIDS was organized, with heavy attendance by Councilmembers, staff, representatives of Congressional delegations, and the press (this, a significant election year locally, and Seattle's gay community remembering how it organized in 1977 to defeat a challenge ot the city's 10 year old fair employment & housing ordinance). Telephone and letter campaigns were coordinated, and a rally and march were scheduled downtown on the evening of the City Council's hearing on the proposal. The Council voted unanimously to recommend early funding of the project, before a full auditorium of speakers from diverse backgrounds: Northwest Physicians for Human Rights; The Dorian Group; the Freedom Socialist Party; the Office of Women's Rights; the Chemical Dependency Program; the Health Department; the Mayor's Office, Seattle Gay Clinic, Northwest AIDS Foundation, and a speaker representing gay hemophiliacs. The County Council followed suit in July. The case surveillance and information activities began immediately, and the low-cost physical assessment clinic opened in October. Project staff include a physician/epidemiologist, a nurse-practitioner, and an outreach/education specialist. Details on the purpose and the scope of the project are available on request: AIDS Project, 1400 Public Safety Building, Seattle, WA 98104 (206/587-4999).

* * *

GUIDE FOR PEOPLE WITH AIDS

The AIDS Action Committee of Key West and the AIDS Education Program of Florida Keys Memorial Hospital have recently published the 2nd edition of A Guide for People with AIDS. Some of the topics covered include: what AIDS is and is not; what to expect from others; "but they don't know I'm gay" and other problems; "what about sex?"; "how do I pay for all of this?"; the future and "preparing for the future"; and a list of resources & referrals locally and nationwide. For a free copy of the booklet, write to: Allan R. O'Hara, PO Box 4073, Key West, FL 33041 or call 305/294-8302 (a donation of $1 per copy will help defray the cost of postage & handling.)

* * *

WOMEN, AIDS, AND THE WOMEN'S AIDS NETWORK

from AID Atlanta Newsletter, September-October, 1983

While there are over 150 known cases of AIDS among women, many others of us women have close friends, relatives of lovers who have AIDS; and more of us women provide direct services for people who have AIDS; yet so often we will hear women and lesbians say, "This is not our problem." Yet politically, spiritually, and humanely, it is very much our problem. Our brothers are dying. Our sisters (though admittedly in proportionately smaller numbers) are also dying. Women have historically functioned in society as a supraconsciousness for the human race, mitigating the effects of war and environmental waste. Women are working in the forefront of the AIDS crisis in areas of research, service provisions, lobbying, networking and coordinating AIDS related organizations. As lesbians, we will be affected by the negative aspects of the disease: the paranoia and scapegoating as well as the inability of the larger society to see lesbians and gay men as separate groups. Though AIDS is not a gay disease, let me paraphrase an old adage of the women's movement: "As long as one woman is oppressed, we are all oppressed." So AIDS affects us all. The following is excerpted from a report written by Dr. Joan Waitkevicz, MD, who has long worked for New York's St. Marks' Lesbian Health Clinic (now Community Health Project).

"I'm afraid something will happen to my gay brother. He has lost three friends with AIDS. It's such an important issue. We can't divide up between men and women, people are dying in our community!" "Being the coordinator of the Kaposi's Sarcoma Clinic was very isolating. Angie (another lesbian nurse) was critical in my keeping the position. She was someone I could cry with, and talk about the sexism in the institution." "I know a lot of lesbians who are afraid of catching AIDS from their gay male friends. They need information, not rumors." "I have two concerns. Addressing our homophobic reactions to gay men's sexuality as regards AIDS. It's easy to understand where the public is coming from when we observe our own reactions. And, addressing the sexism of the gay male community as a whole. The tone of a lot of organizations is 'gay and lesbian? Why bother?'" "I am concerned about the lesbian feminist community and feminists in general, their unwillingness to get into this fight. I know someone who is a lesbian all her life and has gay male friends. When I said I was going to an AIDS meeting, she said, 'Why bother? Wait long enough and it'll be called the lesbian movement.'" These were some of the reasons 25 women attending the second National AIDS Forum in Denver (June, 1983) saw the need to be together as women. They called an impromtu meeting on June 9th, the first night of the Conference; after three meetings in three days, the Women's AIDS Network was founded. They were heterosexual women and lesbians. Many were social workers, nurses, project staff and volunteers working directly with people with AIDS. Others were friends or relatives. All expressed the wish to include women with AIDS, though none were present. Most, but not all of the women came from the two hardest hit cities, New York and San Francisco. Grace, an infection control nurse in a San Francisco hospital, had a unique story. In March, 1981, she was surprised to see a young man admitted with Pneumocystis pneumonia. "I said, this man isn't 'sick,' and went to the infectious disease committee of the hospital and said, 'What's going on?' There were three of us infection control nurses in town, and we talked with each other and found we had 5 patients. Then we called the Department of Health and asked, 'What's going on?'" The subsequent investigation showed the 5 men had AIDS. "Interesting, who gets the credit. We never heard about you," commented the women. Grace has become an educator for the public at large, an authority on AIDS. She wants to return to general infection control work. But assuring the rights of AIDS patients in the hospital, and the safety of workers and the comunity, is a full time job. Recently, she and a physician met three times with San Francisco police to assure them there was no scientific basis for them to fear catching AIDS. The police ingored their recommendations, and issued masks and gloves to be worn when handling gay men. Other nurses and social workers became invovled when they came forward, on their own, to give support as a lesbian sister to the first man with AIDS in their hospital. To some, this meant coming out on the job. Others in small towns have come out to the patients only. Some of these nurses, like Angie, are now doing two jobs, their original job, and lecturing to co-workers about gay lifestyles, about overcoming homophobia and fear to give these men proper care. Many shared feelings of grief and discouragement at seeing some of these first men suffer critical illness or die. The need for support form other women, and the hope to involve more women, were shared by all. The goals of the Women's AIDS Network include education, support, and action on a local and national level. Women are invited to join and participate: Women's AIDS Network, c/o A.J. Block, Cascade AIDS Project, 2702 NE Clackamas, Portland, OR 97232. A donation of several dollars per person will help with mailings. Thanks!

* * * *

NICE BOYS AND NEEDLES

excerpted from an article by Michael Shernoff, ACSW, reprinted with thanks from NY Native

Even "nice boys" do it--use needles to take their drugs, that is. It has become more and more apparent that intravenous (IV) drug use in the gay community is far more prevalent than has been generally appreciated. Indeed, needles--or "points," as some know them--are seldom discussed at all, at least among the uninitiated. While it is hard to get a clear picture of the extent to which needles and drug use are connected in the gay community, certain instances come to mind: a bathhouse which recently closed, used to have signs posted at the door indicating various forms of prohibited behavior--hustling, selling drugs, radio playing and shooting up. Another sex club had a regular assignment for its morning shift: sweeping the sidewalks outside the club's windows to clear off discarded hypodermic needles. The toilet stall doors at one bar were removed several years ago, not for fear of sexual goings-on, according to the owner, but to discourage patrons from shooting up and nodding out behind the latched doors. A few months ago while on a date with a regular pal who is a physical therapist, I was offered cocaine. He also asked if I'd prefer to shoot it, since he "just happened to have a syringe in the house." A client of mine with Kaposi's sarcoma admitted only after several psychotherapy sessions that he had shot drugs repeatedly over a two year period, but had made no such admissions to the CDC investigator to whom he had denied any history of IV drug use.

A reluctance to talk about--much less admit--using needles to take drugs is understandable, given the attached stigma, but this reticence makes the problem all the more difficult to recognize or confront. While it may be generally accepted that drugs, including alcohol, are part of the urban gay "lifestyle," it would come as a surprise to most that needle use has also become part of the picture--for far more people than is commonly realized. In this sense, shooting up is a kind of closet within a closet for gay people; it is a topic not easily broached, except with those who share the same fascination. Only those who shoot up seem to know who their compatriots are. One reason for this reticence is prejudice. What comes to mind when "hardcore" drugs and needles are mentioned? To many, drugs and needles mean only poor people and heroin. But to imagine that the use of needles and drugs stops at the edge of the slums is inaccurate, naive, and probably racist. And there are other myths. The use of needles to take drugs does not necessarily mean the user is addicted to or even taking heroin. Drugs that are inhaled or taken orally are also addictive. Heroin may be used recreationally without addiction. Middle class gay IV users may prefer to shoot cocaine, MDA, or methedrine.

One of the difficulties that a non-user encounters in dealing with IV drug use is the jargon and the cult of mystery surrounding it. With IV drug use, a solution of a substance is prepared (ccoked) and then injected (shot or hit up) directly into a vein. To increase the desired effect, the user may draw some blood into the syringe to mix with the drug solution, and then inject this mixture back into the vein. Known as "booting," the effect of this procedure is nearly instantaneous, and explains why some individuals lose consciousness and are observed to be "nodding out," at times with the syringe still dangling from the body. Intramuscular use occurs when a drug solution is injected into a muscle. Insulin-dependent diabetics administer medication to themselves in this fashion. The response time to drugs taken this way is slower with the effects lasting longer than with IV injections. Some needle users prefer this method if they don't want to "go all the way." Intradermal use, also called "skin-popping," is when the drug is injected just under the skin, as in under the nails. Cocaine and heroin are the recreational drugs most often used this way, but the method is also used by allergists in skin sensitivity testing. Skin-popping is often the novice's introduction to the use of needles recreationally, since most need to be taught by an experienced user how to inject themselves properly. After a tolerance is developed to drugs taken intradermally and the user desires an increased effect, the next step is intramuscular or IV use. Even is "fast-lane" gay circles, where people are sometimes jaded about drug use, needles are often taboo. Few readily admit to injecting themselves with drugs for fun. Among those who do admit to using needles, there is often a good deal of rationalization and denial about what they're doing. One or two experiments "don't count," one might rationalize. "As long as I can hold my job, my personal habits are no problem," might say a person who shoots up only on weekends.

IV drug users have been listed from the outset as one of the highrisk groups for AIDS. Until August, 1983, IV drug users were differentiated from the other major high-risk group, homosexually active men. What is slowly dawning on AIDS researchers is that more gay men belong to

(CONTINUED)

NICE BOYS AND NEEDLES, Continued

multiple-risk groups due to needle use than was originally realized. The Centers for Disease Control's epidemiology office at the New York City Health Department reports that 14-15% of gay men with the CDC criteria for AIDS admit to IV drug use, a figure that has continued to hold up since investigators began to collect these data 2 years ago. A spokesperson for the office conceded, however, that even this figure is probably low. There is really no way to determine how valid this figure is, but the foregoing suggests that is is very likely a low estimate of ther percentage of gay men with AIDS who are also (or have been) IV/needle drug users. The usual AIDS figures provided by the government indicate that about 71% of those diagnosed with AIDS are homosexually active men, and another 17% are IV drug users--classified as a separate category, exclusive of homosexually active men. But if 14% (a low estimate) of the gay men (comprising 71% of all AIDS cases) admit to having used IV drugs, the risk for contracting AIDS appears to be quite a bit higher for those using needles than has been generally understood. It may be instructive to look at the figures in another way. Suppose, for example, we take that 14% out of the homosexually active male (HAM) category altogether and instead put it into the IV category. The at-risk populations come out something like this:

HAMs--57%, IV users--31%, Others--12%

The AIDS Surveillance Update of the New York City Health Department is finally reflecting this awareness of the multiple-risk aspect of many of the gay males who have AIDS. Recent breakdowns of the high-risk groups for the period ending August 31, 1983 for New York City are broken down as follows: HAMs who report no IV use--59%; HAMs with unknown IV use--8.2%; HAMs who report IV use--8.4%; Heterosexually active IV users--16.8%; IV users, sexual orientation unknown--1.8%; and Others--5.8%. Note that the proportion of people classified as IV users seems larger as the statistical breakdown becomes more precise. Still suspicious, I telephoned the office at the Health Department that prepares the AIDS Surveillance Update to inquire whether these data applied to IV drug users in the narrow sense, or wheter "IV" was meant generically to refer to all forms of needle use. I was told that ther term was indeed defined narrowly and did not take into account other forms of needle use besides IV--e.g., intramuscular use and "skin-popping." Thus, the actual number of gay men who have AIDS and who have used needles may be considerably higher than even these figures suggest--quite apart from the namy understandable reasons for underreporting in the first place.

During the past several months I have discussed IV use with many of the people with AIDS whom I know. Some explain that once they identified themselves to epidemiologists as gay, nobody ever asked them if they had ever used needles--the assumption presumable being that nice, white, middle-class gay men wouldn't do such things. Now it seems that CDC investigators working with the New York City Health Department have begun to take more careful and complete drug histories. Other persons with AIDS informed me that, even when they were asked, the question was worded in such a way that they were able to evade it without actually lying. For example, one man told me that all he and his friends ever did was to skin-pop cocaine. So when asked about using drugs intravenously, they could honestly say, "no." Still other men explained that their distrust of the investigators had led them to deliberately conceal the truth about their use of drugs. "With the uncertainty surrounding safeguarding my confidentiality simply as a person with AIDS," one man said to me, "I'd have to be an idiot to tell those people from the federal government [CDC investigators] that I shot drugs in addition to being a fag." Given the denial and rationalization so evident among IV users, it is certainly likely that many people didn't think they were lying when they failed to own up to investigators. "After all," they might reason, "I used MDA, not heroin, and only a few times." One thing appears certain: there is some sort of connection between sharing needles and high risk for AIDS. What is needed are more sophisticated and sensitive ways of taking accurate and detailed drug histories, ways that will ascertain how many of those now with AIDS have used needles to take drugs. We must, at long last, have total access to the initial data collected in the autumn of 1981, the apparently flawed personal/sexual/drug histories taken from the first people identified with AIDS and the 1981 control group of apparently healthy gay men. This was the laundry list study that eliminated poppers as the "smoking gun." But how valid are those data? Why can't we reexamine them ourselves, subject them to alternate statistical

(CONTNUED)

NICE BOYS AND NEEDLES, Continued

analyses, or otherwise dismiss them and begin all over again? How can the CDC researchers expect us to bare our personal lives and provide blood samples in future research projects if they won't share with us what information they have (or don't have) so far? Perhaps the collection of personal/sexual/drug histories should be done by gay people or drug counselors. The taking of such histories is a specific skill that can be learned without much difficulty. In any event, it is hard to see how the outcome of such an experiment could be much worse than what the "experts" have done to date.

It was probably the pressing question of AIDS that drew me to the problem of drug abuse and needles in the gay community. But I believe this was already a problem, one growing at an alarming rate, with its own dimensions and time curve. We would have had to face it, one way or another, sooner or later. Perhaps, as a beginning, we ought to give the topic a thorough airing. Perhaps these discussions will provide helpful clues to those investigating AIDS. Perhaps more honesty will encourage those with substance-abuse problems to seek help. Perhaps the connections noted here between AIDS and all types of recreational needle use will serve as timely warnings to those who are hankering to experiment.

* * * *

MINNESOTA AIDS PROJECT
by John Whyte, MD, PhD

Since the founding of the Minnesota AIDS Project early in 1983, a large number of people have been in contact with us in a variety of ways. We've sponsored business and informational meetings on a regular basis. Our education and support groups continue to meet monthly. Our benefit concerts and individual contributions have provided sufficient revenue for our current needs, the most pressing of which is to provide emergency financial assistance to people with AIDS. Our pamphlet has been widely distributed around the state. Also, we have provided informational tables and staffed workshops at several conferences. We have provided speakers when requested and have responded to several articles in the press. Our educational outreach has taken us into hospitals, schools, and social service agencies and we have been guests on television and radio call-in shows. Nationally, there has been a falling off of media attention and a drop in general interest in AIDS. Large Congressional allocations for research and the apparent leveling off of new cases seem to be contributing to a political and social complacency. For more htan a year, there appeared to be an endless supply of energy and money coming from gay communities such as New York, San Francisco, and other cities with large numbers of people with AIDS. More recently, though, large-scale benefits and the National AIDS Vigil in Washington, DC, have had disappointingly low turn-outs. This is clearly no time to relax. Even if it's not on the cover of magazines anymore, AIDS may be with us for a long time. Researchers are not much closer to understanding the syndrome than they were 2 years ago. The political backlash is increasing, fuelled by the religious right-wing. Discrimination against people with AIDS and against gay/lesbian people in general is continuously being reported from coast to coast. In Minnesota, on a smaller scale, we have all of the same problems as the large coastal cities. We have people with AIDS who have lost jobs and who cannot afford rent and health insurance premiums. We have people with AIDS who need support and friendship, people who are feeling estranged from their community. There are several dozens and perhaps as many as a hundred people with "pre-AIDS" symptoms who need emotional support and good medical attention in their time of great uncertainty. There is a larger community of people who need and want good information and a way to participate in combatting this crisis. And, there is an even larger group that continues to deny the crisis in the completely unrealistic hope that it will all go away without affecting them. The Minnesota AIDS Project and the Lesbian & Gay Community Services will be starting support groups for some of these people. One group, on "responsible sexuality," will be for those who are healthy but interested in discussing healthy ways of expressing their sexuality. Another group is specifically to help those with symptoms of "pre-AIDS" cope with the stress and uncertainty of their illness. More information about these groups is available from the LGCS. For more information: Minnesota AIDS Project, c/o Lesbian & Gay Community Services, 124 West Lake St., Suite E, Minneapolis, MN 55408

* * *

HOUSE REPORT DOCUMENTS INADEQUATE RESPONSE TO AIDS

The Department of Health & Human Services (HHS) has failed to adequately fund Federal efforts to fight the AIDS epidemic, according to Congressman Ted Weiss (D-NY) in a report prepared by the Intergovernmental Relations and Human Resources Subcommittee which he chairs, and issues by the full House Committee on Government Operations chaired by Representative Jack Brooks (D-TX). In failing to mobilize resources for AIDS research in an urgent manner, HHS has neglected its responsibility to protect the public health during this life-threatening emergency, according to Weiss. The subcommittee investigation revealed that despite Administration claims that sufficient funds were being spent on AIDS, important surveillance, epidemiologic studies, and laboratory research at CDC and NIH were undermined because of inadequate resources. "Tragically, funding levels for AIDS investigations have been dictated by political considerations rather than by the professional judgements of scientists and public health officials who are waging the battle against the epidemic," said Weiss. "The inadequacy of funding, coupled with inexcusable delays in research activity, leads me to questions the Federal Government's preparedness for national health emergencies, as well as this Administration's commitment to an urgent resolution to the AIDS crisis." The report also concludes that NIH was needlessly slow in awarding AIDS research grants to scientists across the country. It took NIH almost 2 years after the outbreak was first reported to award major grants for AIDS research. Other NIH research initiatives on AIDS have been similarly delayed. Inadequate and ineffective planning and coordination have also hampered the Federal response to AIDS. The committee found that HHS had not developed a comprehensive plan for AIDS research, surveillance and treatment and until recently, HHS also neglected vital education and information dessmination efforts. The committee receommends three specific steps to be taken to improve the Federal Government's handling of the AIDS epidemic and other health emergencies: 1) funding of a contingency fund for research activities in health crises; 2) the development of procedures at NIH to expedite funding of research grants during emergencies; and 3) the creation of an independent expert panel to review research efforts and to develop comprehensive strategies and accompanying budgets to fight AIDS. Members of the subcommittee include: Ted Weiss, chair (D-NY); John Conyers, Jr. (D-MI); Sander Levin (D-MI); Buddy MacKay (D-FL); Edolphus Towns (D-NY); Ben Erdreich (D-AL); Robert Walker (R-PA); Alfred McCandless (R-CA); and Larry Craig (R-ID); ex-officio members are Jack Brooks (D-TX) and Frank Horton (R-NY).

* * *

AIDS BROCHURE AIMED AT STUDENTS

The University of Pennsylvania has recently published a brochure about AIDS aimed at university students. The brochure contains the typical information about what AIDS is and who gets it, associated illnesses, symptoms, prevention, and local referral names and numbers. It also addresses the issue of friends and roommates of gay men and students in the health care professions. For more information, send a self-addressed stamped envelope (SASE) to: Robert Schoenberg, ACSW, University of Pennsylvania Office of Student Life, 110 Houston Hall--CM, Philadelphia, PA 19104.

* * *

LIST OF RESEARCH ON AIDS BY PUBLIC HEALTH SERVICE

The American Association of Physicians for Human Rights (AAPHR) has recently compiled a list of all intramural and extramural research on AIDS by the U.S. Public Health Service. For more information, contact: AAPHR, PO Box 14366, San Francisco, CA 94114, or call Doug Carner, 415/558-9353 or 673-3189.

* * * * *

* *

SECRET MEMOS REVEAL AIDS FUNDS CONFLICT

by Randy Shilts, reprinted with thanks to the San Francisco Chronicle and Michael Helquist

High officials in the US Department of Health and Human Services (HHS) privately were pleading for more federal funds to conduct AIDS research while the Reagan administration insisted that federal agencies had all the money they wanted for their AIDS efforts. According to previously undisclosed documents, obtained by The Chronicle under the Freedom of Information Act, federal health officials warned last spring that important AIDS research was not undertaken this year because of the lack of federal money. To maintain a minimum level of AIDS research, the documents show, the Centers for Disease Control (CDC) diverted millions of dollars from other important health projects because funds for AIDS were not available. Scientists long have maintained that the federal government moved slowly at the outbreak of AIDS, although Reagan administration officials insisted that federal health agencies were given all the money they could use. But a review of internal memos between officials in HHS, CDC, and the Office of Management & Budget show that the rapid proliferation of AIDS left federal health agencies delaying key AIDS research and scrambling to play elaborite bureaucratic shell games with health money. "...It has now reached the point where important AIDS work cannot be undertaken because of the lack of available resources," Edward Brandt, the assistant secretary of HHS, wrote in a memo to the department's assistant secretary for management and budget. In that May 13, 1983 memo, Brandt also lists a number of important health areas other than AIDS in which work was "postponed, delayed or severely curtailed" because the CDC was diverting money to AIDS research from other federal health programs. These included studies on hepatitis, influenza among the elderly, rabies, and the restocking of "important laboratory su½plies that are being reduced to dangerously low levels." Dr. William Foege, then director of the CDC, sent Brandt a 12 page request for funds in early May, complaining that both his center and the Public Health Service were trapped "in the frustrating position of again playing 'catch up' in regards to AIDS money. Clearly, we can effectively use additional funds and positions [in 1983] and definitely should be expanding our efforts in 1984," Foege wrote. Two weeks later, however, Thomas Donnelly, the assistant HHS secretary for legislation, wrote to a senate staff member that "we are not in favor of additional appropriations" for AIDS research. Brandt, a doctor who serves as a political apointee of the administration, alsc publicly followed the administration's position that federal agencies had all the money they needed when he testified at a House subcommittee on May 9, just four days before he asked HHS for more AIDS money. Brandt testified in opposition to a proposed $40 million emergency fund to defray costs of new epidemics such as AIDS. "It is unnecessary, since we already have adequate authority to conduct the research activities that the bill would authorize, and existing budget and appropriations processes are effective in funding activities," Brandt told the House subcommittee on health and environment. Over administration objections, the House passed $12 million in additional AIDS funds for 1982-83 fiscal year, and $42 million for the 1983-84 fiscal year. In San Francisco, Representative Barbara Boxer, who sponsored the $12 million supplemental appropriation, said she would ask administration officials to explain the disparity between public statements and private memos. "What this information reveals is that there's been a lot of double-talk on the part of this administration," Boxer said. "Normally in an epidemic, the health people come begging to you for funds--here we had the reverse. We were begging them to find out if they needed funding....The highest levels of the administration were not cooperating with our needs for information. They still are not cooperating." No spokespersons for HHS were available for comment. Researchers said that the delays caused by the administration's reluctance to ask for needed money could end up costing many lives. Chicago's Dr. David Ostrow, a Northwestern University researcher who recently obtained a $3 million grant from the National Institutes of Health for AIDS studies in Chicago, stated, "We should have gotten this money two years ago."

* * *

VIDEOTAPE ON AIDS BY CHRIS MATHEWS

"AIDS: Questions & Answers" presents a discussion by Chris Mathews, MD, director of the University of California--San Diego Owen Clinic and member of the American Association of Phsycians for Human Rights. The 30 minute video covers in question & answer discussion format, the definition, epidemiology, manifestations, diagnosis, treatment, modes of transmission, and risk reduction guidelines for a rental of $15 or purchase of $50 in beta max I, II, or III, VHS, or 3/4" Umatic. Contact: UCSD School of Medicine, Office of Learning Resources (TV), La Jolla, CA 92093 or call 619/452-4134. The video has been endorsed as an excellent teaching tape directed toward high risk groups and the general public.

* * *

FUNGUS IMPLICATED IN AIDS ETIOLOGY

by James E. D'Eramo, with thanks to the New York Native (November 7-20, 1983)

A plant fungus has been identified as a possible casue of the immunosuppression typical of AIDS. A team of researchers, headed by Dr. K.W. Sell at the National Institute of Allergy and Infectious Diseases (NIAID) reported the isolation of strains of the plant and soil fungus, Thermoascus crustaceus, from the monocytes (white blood cells) of three confirmed AIDS cases. The findings were reported in a letter to the New England Journal of Medicine (October 27, 1983, page 1065). Although many researchers believe that AIDS is caused by a transmissible infectious agent--most probably a virus or viruses--the team posits a new hypothesis. "We propose a non-viral infectious agent as either a possible primary causative agent of AIDS or a secondary agent that contributes to the persistent immunosuppression." The fungus, which grows optimally at body temperature has not been previously isolated from or known to cause disease in humans. But the researchers believe that the severe impairment of the immune system in AIDS patients may be due to a potent molecule (which they call CyAIDS) which is released by the fungus. The molecule resembles a class of drugs called cyclosporins, which are used to suppress normal immunity in patients who receive tissue or organ transplants. Some of the immune deficiencies present in AIDS patients resemble the immunosuppressive effects of cyclosporin. Although the fungus was isolated from the blood of three AIDS patients, it was not found in the blood samples from six normal controls. Further, the molecule--CyAIDS--was isolated from the blood plasma of all four AIDS patients tested. One of these four patients was the same person form whom the fungus itself had been isolated. Two control blood samples proved negative for the levels of CyAIDS found in the four AIDS patients. Levels of CyAIDS in the blood of AIDS patients is significant because this finding may lead to a possible laboratory test for AIDS if the molecule can be found in a majority of AIDS patients. The researchers are careful to stress, however, that their findings are "extremely preliminary." They note that althought he fungus was cultured from the white blood cells of AIDS patients, it is not likely to be the primary source of infection in AIDS. "Nevertheless, transmission of the fungus from one person to another through a needle stick or through blood components may be possible." It is also possible that the fungus may be a contaminant in blood cell cultures, or just another of the many opportunistic infections that prey upon AIDS patients. "The fungus and the CyAIDS may also simply be cofactors with other infectious agents, not necessarily viruses, that causes the total impairment of the immune system seen in AIDS." Much more testing will be necessary to determine the importance of these findings.

* * *

CALIFORNIA AIDS ADVISORY COMMITTEE FORMED

The AIDS Advisory Committee was recently enacted by California Senate Bill 910 and signed into law by Governor Deukmejian. The Committee will advise and assist the state in addressing the public health issues associated with AIDS. The Committee will work with California Department of Health Services in statewide efforts to promote primary prevention, public education, and the advancement of knowledge regarding AIDS. Because of the serious impact of AIDS in California, and because of pressure placed on the Department of Health Services by the Legislature, the state has already begun programs to address some of the problems and issues associated with AIDS. Fifteen agencies out of 36 received $500,000 in state funding (total requested was over $2 million) for educational and outreach programs, beginning November 1, 1983. Efforts to obtain additional funding for these efforts, as well as to evaluate additional programs and ideas are already under way. The networking, communication and cooperation that is beginning to take place by public and private agencies and different levels of government is significant. Health departments, health professionals and the AIDS-related groups realize we will be dealing with AIDS for some time to come. Efforts must be continued to express your concern and to educate your elected representatives about AIDS.

* * * * *

AIDS ASSOCIATED WITH BLOOD TRANSFUSIONS

[ED NOTE: The following is a brief summary of a report scheduled for the January 12, 1984 issue of New England Journal of Medicine.]

This report, authored by James Curran, MD, of the CDC's AIDS Activity and his colleagues describes 18 adults with no known risk factors who developed Pneumocystis carinii pneumonia and AIDS [no other opportunistic infections or cancers were evaluated] following transfusion of blood (packed cells, fresh frozen plasma, whole blood, and/or platelets) and strongly suggest that blood components may transmit AIDS. As little as 1-2 units may result in transmission. The clinical and immunologic pattern observed in the 18 adults with PCP who had received transfusions during the preceding 5 years was essentially identical to that described in others with AIDS. These cases were diagnosed during approximately 12 months, a period when over 3 million persons in the US received blood trasnfusions. However, an average of 2 years elapsed between transfusion and diagnosis, donors receiving their transfusions between 1979 and early 1982, a time when the prevalence of AIDS, and presumably of potential donors affected by the putative AIDS agent was much lower than during late 1982 and early 1983. With the cooperation of the blood collection centers, investigators contacted the donors for a personal confidential interview and physical exam, and when possible, tc obtain heparinized blood for T-cell subset analyses and other immunologic studies. Public health officials checked donor names against a list of reported cases of AIDS [!!]. Altogether eight high-risk donors were identified by history or immunolgic evaluation; six or seven patients with post-transfusion associated AIDS were exposed to at least one high risk donor.

* * *

RISK OF TRANSFUSION TRANSMITTED AIDS

With public concern about AIDS occasionally approaching hysteria, fears about possible transfusion transmission of AIDS is being increasingly expressed by patients and their families. Putting this possibility in the proper perspective may be helpful in dealing with these anxieties. Dr. Joseph R. Bove, chairperson of both the FDA Advisory Committee on Blood and Blood Products and the American Association of Blood Bank's Committee on Transfusion Transmitted Diseases, has put this risk into reasonable perspective based on available current information. Since the AIDS epidemic began several years ago there have been over 10 million people who have received transfusions with products from over 30 million volunteer donors. So far there have been only approximately 20 people [excluding cases reported in January's NEJM] who have had transfusions preceding the onset of AIDS who were not in an otherwise identifiable risk group. If all of these cases were duw to blood transfusion (this is not established), then the risk would be less than one in a million. This is half (or less) the risk of death from a transfusion of the wrong unit of blood. The following table gives the risk of transfusion transmitted AIDS relative to other transfusion, medical-surgical, and life risks for the general public (i.e., not necessarily sexually active gay men).

Transfusion Related Risks	
Transfusion transmitted AIDS	1:1,000,000 (perhaps)
Transfusion transmitted hepatitis	1:20*
Transfusion transmitted malaria	1:1,000,000
Death from the wrong unit of blood	1:500,000
Surgically Related Death Rates**	
Appendectomy	1:5000
Tonsillectomy	1:10,000
Cholecystectomy (gall bladder)	1:625
Hernia repair	1:5000
General Risks (Deaths/Person/Year)***	
Automobile racing	1:10,000
Professional boxing	1:14,300
Struck by automobile	1:16,600
Earthquake (California)	1:588,000
Floods	1:455,000

Footnotes:

*Includes minimal & transient laboratory test abnormalities

**Hospital Mortality, PAS Hospitals, United States 1975

***Dinman, B.D. Journal of the American Medical Association, 1980, 244:1226-28

* * * * *

NATIONAL AIDS PROSPECTIVE EPIDEMIOLOGY NETWORK (NAPEN)

by David Ostrow, MD

The National AIDS Prospective (formerly "Pre-AIDS") Epidemiology Network (NAPEN) met November 13, 1984, in conjunction with the annual meeting of the American Public Health Association at the Dallas Hyatt Hotel. Persons attending: Viktor Andersson (Van Buren (Michigan) County Health Department), Mark Behar (NCGSTDS, Milwaukee), Gretchen Berggren (Harvard School of Public Health, Boston), Roger Detles (UCLA, Los Angeles), Brian Dobrow (Northern California Physicians for Human Rights), Peter Drotman (CDC, Atlanta), Ron Gaither (San Diego Beach Clinic), Roger Gremminger (Brady East STD Clinic, Milwaukee), Steve Helgerson (Seattle-King Dept. of Public Health), Stan Matek (APHA), and David Ostrow (Howard Brown Memorial Clinic, Chicago). Dr. Ostrow began the meeting by briefly reviewing the history and goals of NAPEN. One particular issue which arose during this discussion and elsewhere was the need to be very specific in any funding proposal in the delineation of how NAPEN's activities would further our understanding of the epidemiology of AIDS beyond what will be accomplished by the major NIH funded studies. In this regard several objectives beyond the three principle goals of NAPEN were delineated:

1) The exchange of specific information between investigators which would assist them in initiating epidemiologic studies and the tracking of study participants who may move from one city to another;

2) The providing of timely updates of trends in AIDS epidemiology which might be used to limit the effects of public fears regarding the spread of AIDS;

3) The establishment of hierarchal epidemiologic and health evaluation data bases which would allow the participation of investigators with varying levels of financial and laboratory support to participate in the overall AIDS epidemiologic research effort.

The discussion then focussed on the present status of NAPEN membership and organization. Presently, there are 34 persons identified as members of NAPEN of which 16 have actually paid the $10 initial membership fee. Including $50 in donations to NAPEN, the total funds collected is $210. $50 of this has been paid to the Federation of AIDS Related Organizations (FARO) as in initial membership fee in that organization. While the membership has approved NAPEN's membership in FARO, it was unanimously felt that further payments to FARO, which is currently requesting a $50/month fee from member organizations, be delayed until NAPEN has an established means of ongoing financial support and FARO has more clearly established how funds collected from NAPEN would be used. The NAPEN membership clearly wishes to support those specific activities of FARO which are consistent with the goals and objectives of NAPEN and will include reasonable FARO dues in its forthcoming funding proposal. The regional representatives were established as follows:

Midwest: Roger Gremminger (Milwaukee); NY/Mid-Atlantic: Open (Brett Cassens, Philadelphia, nominated); Northeast: Open; Southeast: Lisa Kaplowitz (Richmond), and Peter Katona (Atlanta) nominated; Midsouth: Frank Greenberg (Houston); Northwest: Steve Helgerson (Seattle); Northern California: Open (Marcus Conant, San Francisco, nominated); Southern California: Open (Tom Kurz, Los Angeles, nominated); Southwest: Open (Al Obermaier, Tucson, nominated); Canada: Open (Brian Willoughby, Victoria and Colin Soskolne, Toronto, nominated).

It was felt that in view of the number of AIDS investigators in both Canada and Europe expressing interest in NAPEN that additional regional representatives might have to be esablished for both sections of Canada (western, central, eastern) and Europe (Great Britain and Continent). In fact, Dr. Ostrow commented that increasing numbers of inquiries are being received from investigators in foreign countries and that an additional function of NAPEN might be in assisting foreign investigators such that cross-cultural comparisons of AIDS epidemiology could be facilitated.

The draft outlines of a NAPEN funding proposal and data base as prepared by Drs. Gremminger & Helgerson respectively, were distributed and discussed. Dr. Gremminger agreed to take on primary responsibility for drafting an actual funding proposal in collaboration with Dr. Ostrow. Dr. Ostrow will act as overall coordinator of NAPEN activities until funding for a paid coordinator can be obtained. Mark Behar of the NCGSTDS will continue to serve as secretary to NAPEN and to disseminate information about NAPEN to interested non-members through the NCGSTDS Newsletter.

(CONTINUED)

NAPEN, Continued

The NIAID epidemiological data base should be finalized by January, 1984, at which time we will determine how it can be broken down into hierarchal segments for use by investigators at various levels of support. The next meeting of NAPEN will be held during the week of April 26030 in New Orleans, concurrent with the mid-year meeting of the American Association of Physicians for Human Rights (AAPHR). By that time we hope to have initial responses to funding requests to various AIDS foundations and reports of NAPEN consultants in the following areas: Computer networking (Dennis McShane); Data pooling (Jeremiah Stamler); Confidentiality issues (To Be Determined); Data basing (Robert Gibbons).

At the conclusion of discussion of NAPEN organizational business topics, Dr. Gretchen Berggren described some of her observations during work in Haiti over the last eight years. Her observations of possible risk factors contributing to the relatively high incidence of AIDS in Haiti were seen by many of those in attendance as an excellent example of how NAPEN activities can lead to increased communication and understanding among investigators in various geographic locations. The risk factors discussed by Dr. Berggren included the use of non-sterile injections (never intravenously) by the Piquerist medicine men, the high rate of exposure to tuberculosis and intestinal parasites, and severe malnutrition occuring between the 6th and 36th months of life.

Finally, Dr. Ostrow invited all those present to participate in the APHA Symposium on AIDS to be held on November 15 at the Dallas Convention Center. At that Symposium, which was attended by about 250 persons, Dr. Ostrow described NAPEN and discussed its goals and implementation with the other panel members including Dr. James Curran, Director of AIDS Activities, Centers for Disease Control. Future meetings of NAPEN are scheduled for April 25-29 (American Association of Physicians for Human Rights Meeting, New Orleans), June 15-19 (International/ National Lesbian/Gay Health Conference & Third AIDS Forum, New York), and August 22-24 (Current Aspects of Sexually Transmitted Diseases Symposium--III, Chicago). For additional information, inquiries may be addressed to: Dr. Roger Gremminger, MD, 929 N. Astor, #1608, Milwaukee, WI 53202, or Dr. David Ostrow, MD, 155 N. Harbor Dr., #5103, Chicago, IL 60601, or Mark Behar, PA-C, PO Box 239, Milwaukee, WI 53201.

* * *

REQUESTS FOR FUNDING PROPOSALS (RFP) FOR ANTI-AIDS PHARMACEUTICALS

The molecular Microbiological & Parisitology Branch, Microbiology & Infectious Diseases Program of the National Institute of Allergy & Infectious Diseases (NIAID) is soliciting contract proposals from organizations having capabilities and facilities to develop additional drugs for the treatment of Pneumocystis carinii and Cryptosporidiosis. For PCP, the contractor shall be expected to evaluate approxiamtely 40 compounds per year using an appropriate animal to evaluate their efficacy against PCP. For Crypto, the sontractor shall be expected to develop an appropriate animal model and method for the isolation and quantification of anti-coccidial drugs as well as other potentially active drugs & compounds. To receive a copy of the RFP, request: RFP-NIH-NIAID-MIDP-84-5 for PCP, or RFP-NIH-NIAID-MIDP-84-3 for Crypto, with two self-addressed mailing labels from Mr. Robert R. Kelley, NIAID/NIH, 5333 Westbard Av. #707, Bethesda, MD 20205. The Bacteriology & Virology Branch, MIDP of the NIAID is soliciting contract proposals from organizations having the capabilities & facilities to evaluate potential anti-Candida drugs, to utilize in vitro models for initial evaluation of the antimicrobials and to evaluate the results obtained from the in vivo models, and to evaluate patential anti-M. avium and anti-M. intracellulare drugs in the same manner. To receive a copy of the RFP, request: RFP-NIH-NIAID-MIDP-84-2 for Candida, or RFP-NIH-NIAID-MIDP-84-4 for M. avium & M. intracellulare, with two self-addressed mailing labels from Mr. Gregory J. Pryor, address same as above. The Development & Applications Branch, MIDP of the NIAID is soliciting contract proposals from organizations having the capabilities & facilities to chemically synthesize 1 or more compund(s) which will inhibit the replication of human CMV. Compounds can either be targeted or new analogs of existing antiviral agents. To receive a copy of the RFP, request: RFP-NIH-NIAID-MIDP-84-6 with two self-addressed mailing labels from Ms. Toni Sutherland, address same as above. These advertisements do not commit the Government to make awards.

* * *

COSMETICS FOR PEOPLE WITH KAPOSI'S SARCOMA

with thanks to Joseph W. Bean and the New York Native, December 5-18, 1983

"Everyone has something to conceal," according to Lydia O'Leary Covermark cosmetics and describes exactly why Ms. O'Leary formulated covering makeup for scars, sores, and major blemishes more than 50 years ago. With a "port wine" birthmark over a large part of her face, she found that good jobs were closed to her, and most social events were impossible. Just so, her cosmetics solved one of the few really solvable problem of people with KS skin leasions. The heavy foundation cosmetic comes in enough tints that, straight or blended, any skin color can be matched, from the palest backroom pallor to the deepest black pigmentation. It is sold by representatives (in New York at B. Altman & Bloomindales) who train new users to apply the nearly invisible coverage over any area, from a badly timed pimple to a massive tatoo. KS lesions fall between the two in cosmetic terms, but psychologically, they share a great deal with the visible roseation (birthmarks) with which 25% of the population has. Covermark--which is often recommended by doctors and has the approval of the American Medical Association and other medical organizations--is a safe, effective, waterproof cosmetic covering, letting people with KS or other skin lesions back out of their apartments and gives them a chance to talk about something other than what's wrong with their skin. For about $50-60, a kit can be assembled that will include enough of the essential moisturizer, colors, finishing powder, removing cream, and toner for several months of regular use.

* * *

IMPAIRED IMMUNITY, INFERTILITY LINKED TO SEX PRACTICES; LYMPHADENOPATHY STUDIED

from the Journal of the American Medical Association (1/13/84)

A study from M.D. Anderson Hospital, Houston, lends support to the hypothesis that repeated exposure to sperm during anal intercourse can induce immune system abnormalities among homosexually active men. The study also suggests anal intercourse in heterosexual couples may cause a woman to develop an immune response to her partner's sperm that could lead to infertility. From a study of 30 asymptomatic, monogamously paired homosexual men, Giora M. Mavligit, MD, and colleagues report that 19 of 26 anal sperm recipients showed laboratory evidence of an immune response to their partner's sperm. In some of the men, this response was the reduced effector/suppressor T-cell ratio--a sign of immune system depression--that has been strongly associated with AIDS. No evidence of an immune system response was found in the four men who never received sperm during anal intercourse. A reduced effector/suppressor T-cell ratio, along with antibodies against her husband's sperm, were also found in the female partner of a heterosexual couple who routinely performed anal intercourse. This finding underscores the critical anatomic & structural difference between the rectum and vagina, the researchers say. Both the vagina and the oral mucosa are made up of many layers which are capable of protecting against any abrasive effect during intercourse. In contrast, the inner lining of the rectum is made of a single layer that cannot protect against abrasion and so promotes the absorption of sperm antigens into the lymphatic and blood circulation, the authors say [especially if the mucus membrane barrier is disrupted by inadequate lubrication, douching or other factors? --ED]. Applying this theory of chronic, antigen-induced immune deficiency to another area of medicine, the researchers suggest that the increased susceptibility of kidney transplant recipients to opportunistic infections and Kaposi's sarcoma--as seen in AIDS--may be due to chronic antigenic stimulation from the donor kidney rather than exclusively to the effects of immunosuppressive chemotherapy.

In a related study in the same issue of JAMA, researchers from the Centers for Disease Control report that an increase in the incidence of unexplained generalized lymphadenopathy in New York City hospitals between 1978 and 1981 paralleled the increase in incidence of AIDS. Bess Miller, MD, and colleagues studied 3139 pathology reports of lymph node biopsies performed in 7 hospitals from 1977-81. They reviewed 35 cases of unexplained generalized lymphadenopathy, representing 30 percent of patients categorized as having unexplained lymph node hyperplasia (abnormal lymph node cell growth). Of the 35 patients, 74% were males aged 16 to 44 years, most of whom were homosexual or bisexual, similar to the population at risk for AIDS. The researchers suggest that prospective studies of patients with unexplained generalized lymphadenopathy may help to define the clinical and pathological course of the syndrome and may also help to identify risk factors for the development of AIDS.

* * *

BODY POLITIC: IS THERE SAFE SEX? IS AIDS CHANGING OUR SEX LIVES? THE AGONY & THE ECSTASY

with thanks to Toronto's Body Politic, December, 1983

[ED NOTE: The following three articles from Toronto's Body Politic provide an interesting perspective about AIDS and how this syndrome is affecting our lives. You may or may not agree but the articles are bound to generate some thought and discussion. Let us know what you think! For more information about subscriptions to The Body Politic: Box 7289, Station A, Toronto, Ontario, Canada M5W 1X9 (419/977-6320). Rick Bebout authored the article, "Is There Safe Sex? Looking Behind Advise on AIDS." "The Agony and the Ecstasy--The Physiology of Turning Pain into Pleasure," was written by Geoff Mains. "Is AIDS Changing Our Sex Lives?" was published without byline.]

BODY POLITIC: IS THERE SAFE SEX? LOOKING BEHIND ADVICE ON AIDS

by Rick Bebout

THE BAR

was the Colherne, packed to the gills with men trying to get in one last pint before we all had to head out at the closing hour of 11 pm. And trying to find somebody to head out with, too, I suppose. I was, I guess, and here he was, more or less: a thin, red-haired fellow chatting eagerly beside me. We ended up later on the single bed in my room at a cheap American-style hotel — American-style because each room had its own bathroom attached. Convenient, that, especially for my red-haired friend: our tumble on that narrow bed ended abruptly with him jumping up and dashing into that bathroom for a vigorous, noisy spit and gargle. I'd just come in his mouth.

That was 1975, in London. His rush to the can didn't mean much to me then; a little jarring, maybe, but — well, I guess he just didn't like cum. In New York or San Francisco in 1983, his act would probably have meant one thing: fear of AIDS. And it would likely have meant that same fear even in cities like Vancouver, Winnipeg or Halifax, where you could count the number of diagnosed AIDS cases on the fingers of both your hands — and have one or two (or seven or eight) fingers left over.

In places both where acquired immune deficiency syndrome is a serious epidemic and where it is not, the desire for sex and the fear of deadly disease have become conflicting emotional partners, constantly seeking "expert" advice to resolve their uneasy relationship. And advice abounds, expert and otherwise, in books, on posters, from the mouths of medical professionals and in the common coin of street wisdom: limit the number of different sexual contacts; be careful choosing whom to do it with; avoid exchanges of body fluids; don't swallow cum; use a rubber for fucking or maybe don't fuck at all. Men in New York join jerk-off clubs; people in parks stand at arms-length to play. A bath in Vancouver offers free condoms (probably useful); a man in Toronto begins foreplay by popping an antiseptic lozenge (totally useless) into his trick's mouth.

All in pursuit of safe sex.

And are they finding it? Are any of these things leading to sex that will not lead to AIDS?

That question can't be answered without looking at another, larger question: what causes AIDS? And the only firm answer to that question right now is: no one knows.

Despite that lack of absolute knowledge, though, we're not totally in the dark. A lot of early speculation about direct links between the syndrome and various habits of gay life has collapsed in the face of new evidence, and with a quarter of the cases in the US and almost half in Canada occurring among heterosexuals, terms like GRID (gay-related immune deficiency) have been consigned to the ashcan of history. Poppers, once suspect, have been ruled out as a direct cause. Antibiotics such as tetracycline, widely used to treat sexually transmitted diseases and known to affect the immune system, were also suspected for a time, but people treated for years with the same drugs for other conditions, such as acne, have not developed AIDS. Having a lot of sex, partying all night or doing lots of recreational drugs — all once thought of as possible "lifestyle" causes — might wear you out or make you more susceptible to illness in general, but they won't, by themselves, give you AIDS.

The urge to find conclusive evidence of what *will* do that has led some scientists and the media (especially the gay media) to trumpet any new research wrinkle as a route to *the* answer. Some of yesterday's hot leads have led to dead ends; others are being gradually followed through and may lead to more conclusive answers.

Even though those firm answers still elude us, enough evidence has been gathered in the last two years to lead to the development of a number of theories of the cause of AIDS. According to an editorial in the September 8, 1983 issue of *The New England Journal of Medicine* by Dr James Curran of the US Centers for Disease Control in Atlanta, a key organization in AIDS monitoring and research, a consensus on the most likely cause of the syndrome began to develop in July 1982, after three cases were reported among hemophiliacs, who regularly receive injections of clotting factor concentrates prepared from the blood of thousands of donors.

"By then," Curran says, "carefully documented cases of AIDS had occurred in heterosexual men and women who were intravenous-drug abusers, suggesting a pattern of transmission reminiscent of that for infection with hepatitis B virus. ...The sudden occurrence of a new syndrome that affected primarily these three distinct populations [sexually active gay men, intravenous-drug users and hemophilia patients] who share only their susceptibility to hepatitis B convinced many investigators that a transmissible agent was the primary factor...."

THIS HAS COME

to be called the "single agent" theory, and it is by far the most generally accepted one. It assumes that AIDS is caused by an infectious agent, probably a virus, either a new one or an old one acting in new ways. The methods of transmission for hepatitis B — through intimate sexual contact or exposure to contaminated blood — are taken as a model for the likely ways in which the theorized AIDS agent is transmitted. This theory is strongly supported by the demographic distribution of the syndrome and by the appearance of clusters of related cases. It takes into account means of infection that would lead to cases not only among sexually active gay men, but among intravenous drug users (direct blood contact via contaminated needles), hemophiliacs (through injection of contaminated clotting factor) and heterosexual women (through sexual contact with infected men).

The single-agent theory assumes sexual transmission through the exchange of body fluids that might carry the theorized virus. Dr Roger Enlow, the director of the New York City Department of Health's Office of Gay and Lesbian Health Concerns, notes that there are real problems with the term "body fluids," a bit of shorthand that encompasses everything from blood, semen, urine and feces to saliva, tears and sweat. Not long after the term came into vogue, he says, "people started asking things like 'What about sweat contaminating pools and equipment in gyms?' or 'Maybe I can get AIDS if somebody sneezes on me.'" Fears that AIDS could be spread by such casual contact led to absurd homophobic reactions in the name of "public health": police in San Francisco demanded rubber gloves for dealing with gay men, and in Tulsa, Oklahoma, a public swimming pool was drained and disinfected after being rented by a gay rights group for a party.

(CONTINUED)

BODY POLITIC: IS THERE SAFE SEX? Continued

All the body's fluids can carry viruses, but each tends to carry different ones in different concentrations. Dr Randall Coates, who works in the Department of Preventive Medicine at the University of Toronto, and who has done research on hepatitis B, says that the surest vehicle for transmission of the virus for that disease is blood. It also appears in semen, and can show up in low concentrations in other fluids, especially if they are contaminated by blood (as urine, feces and saliva can be). But Coates is careful to point out that, aside from blood and semen, most body fluids are a "very inefficient" means of transmission for hepatitis B. Exposure to saliva, for instance, is very common. "If that were an easy way to get hepatitis B," he says, "we'd see a lot of people getting it that way, and we don't."

If we accept hepatitis B transmission as the likely model for the way AIDS might be passed on, we can almost certainly write off any fears about tears and sweat. Saliva might be marginally more suspect, but many investigators aren't worried about it, though some remain concerned about feces and urine. When asked on their AIDS information hot line how the syndrome is transmitted, the US Department of Public Health responds simply, "by blood and semen."

Mind you, *no one* can say for sure which fluids actually carry an AIDS virus — since we don't know for sure that there *is* an AIDS virus. But most evidence suggests that warnings about "exchange of body fluids," unspecified, are too vague to be useful in judging the risks involved in various sexual practices. As we've seen, however, they can be all too useful for those who wish to interpret them as defining all gay men as untouchables.

Even when a virus is present in a given fluid, the likelihood of it being passed on depends on what part of the body it comes in contact with. According to Dr Coates, if blood contaminated with hepatitis B were to be injected directly into your veins, you'd have more than an 80 percent chance of being infected. If the same blood fell on your skin — and if you had no microscopic cuts where it landed — the chance of infection would be almost nil. If an AIDS virus behaves in the same way, the acts most likely to pass it on are those that lead to direct contact between the most suspect fluids — blood and semen — from one person and the bloodstream of another person.

And what are those acts? Hold on — we're getting to that.

WHILE MOST

researchers and medical people accept the single-agent theory, it's not the only notion of the cause of AIDS. In a widely available booklet called *How to Have Sex in an Epidemic: One Approach*, New York AIDS activists Michael Callan and Richard Berkowitz provide advice based on what is known as the "multifactorial" or "overload" theory, which suggests that there is no single AIDS virus. What we are calling AIDS in gay men, they say, can instead be traced to repeated infections with a common existing agent called cytomegalovirus (CMV), which, according to this theory, gradually wears down the immune system. CMV can cause symptoms of its own, occasionally serious, but often mild enough to go unnoticed. Most people have been exposed to CMV at some time, but most don't remain able to pass the virus on to others for very long. Callan and Berkowitz point out that in one study of sexually active gay men in New York, one out of four were contagious for one of more forms of CMV. In a study of sexually active heterosexuals in San Francisco, the figure was one in twenty.

But there's also another factor in this theory: "The key links in AIDS in gay men," Callan and Berkowitz say in the book, "are repeated infections with CMV against a backdrop of mild immunosuppression caused by exposure to sperm." They are speaking here not about any infectious agents that may be present in semen, but about the possibility that sperm itself can mildly suppress the immune system. Tests in laboratory mice have shown that sperm can have this effect, but the extent to which this may be true in humans isn't established.

Critics of this theory point out that while AIDS is apparently a new syndrome, both CMV and sperm have been around for a long time, and so have the sexual practices that might get them together fairly often. Callan and Berkowitz respond by saying that our increasing promiscuity has been getting them together more often than ever before. Instead of a new virus, they argue, there is simply a lot more of an old one, and a lot more sex going on that can put people in repeated contact with it.

This theory would be stronger if AIDS appeared only in those who'd been very busy sexually. But as Nathan Fain pointed out in his September 15, 1983 health column in *The Advocate*, "there are now many cases of AIDS in gay men that do *not* reflect the parrotted 'fast-lane' life at all. Some, in fact, were so young they had reached only their third or fourth encounter."

Nor, of course, can sperm/CMV overload be the reason why AIDS is showing up now as a new condition among hemophiliacs, intravenous drug users and heterosexual women, or among Haitians, the other major group affected, for whom risk factors are not known. Callan and Berkowitz say that what's causing immune suppression in these people might not be the same thing that's causing it in gay men. That would mean that these unrelated groups have all developed clinically identical forms of immune deficiency for *different* reasons, but at the *same* time — by pure chance.

That's a stranger coincidence than most researchers are willing to accept. The one thing people with AIDS in these disparate groups shared — their common susceptibility to hepatitis B — very strongly suggests to most investigators that their conditions are linked, and that the most logical link is is an infectious agent that reaches these people in much the same way hepatitis B does.

All disease, however, is in some sense multifactorial. Even when a specific agent is known to be necessary to cause a disease, it alone will not determine whether the person who catches it will develop symptoms, how severe they will be or how long they will last. AIDS will probably prove to be no different: many factors will likely be shown to play a part in making some people more susceptible to immune suppression than others. But as an explanation of the *primary* cause of AIDS, the sperm/CMV overload theory remains a minority notion.

ONE FINAL

point of theoretical speculation remains if we're to understand the likely nature of AIDS well enough to be able to judge the advice we're getting about it.

What the Centers for Disease Control (CDC) defines as AIDS is not a disease. It is a *syndrome*, a group of signs or symptoms that collectively may indicate an underlying disorder. People are said to have AIDS when they have certain clearly identifiable diseases which indicate an underlying immune deficiency that cannot otherwise be explained. CDC calls these diseases "markers," and the two most common ones are a skin cancer, Kaposi's sarcoma, and pneumocystis carinii pneumonia. Immune suppression that is not accompanied by "marker" diseases is not called AIDS, and neither are cases of immune deficiency for which causes are known.

But many investigators say that the cases which qualify as AIDS under the CDC's strict definition may, in fact, be only the tip of the iceberg.

That is *not* meant as some kind of "you-ain't-seen-nothing-yet" scare talk. What it means is that the AIDS cases diagnosed so far might simply be the most serious examples of a condition that is *already* more widespread, but which in most instances isn't as serious.

Again, the hepatitis B model comes into play. Estimates of the number of sexually active urban gay men who have been infected with hepatitis B range as high as 80 percent. It can be a seriously debilitating disease, occasionally fatal. Yet, according to Dr Randall Coates, three-quarters of all those infected with it will not have symptoms serious enough to make them even aware that they've caught it. And whether they develop symptoms or not, 90 percent will go on to develop antibodies making them immune to further infection. The rest continue to carry the virus, and may be affected by it years later. Of all those who pick up hepatitis B virus, only three percent get seriously ill.

(CONTINUED)

BODY POLITIC: IS THERE SAFE SEX? Continued

Evidence is now turning up that AIDS — or the underlying disease that causes it — may act in much the same way. In September 1983, three researchers at the Royal Victoria Hospital in Montreal reported a study of 18 gay men who showed serious symptoms of immune system impairment — swollen glands, fever, night sweats and weight loss — but who did not have any of the "marker" diseases necessary to characterize their conditions as AIDS. "The implication," said Dr Norbert Gilmore, head of the national advisory committee on AIDS, "is that a lot more people get the disease, but not the full-blown syndrome." In a two-year study conducted by Dr Harry Ioachim at the Lennox Hill Hospital in New York, eight of 36 men with similar symptoms (now being called "lymphadenopathy" or "ARC"—"AIDS-related complex") later went on to develop AIDS marker diseases. So far, the rest have not.

No one can be sure yet whether lymphadenopathy and AIDS are two different manifestations of the same unidentified disease. But many of the people who accept the single-agent theory assume that the disease underlying AIDS will probably be shown to behave much like other infectious diseases, causing a spectrum of cases ranging from unnoticeably mild to fatally serious, and with many more of the former than the latter. AIDS will be no less a matter of concern if they're right, but we may at least be able to view it with some balance as a disease like many others, and not as a mysterious killer dooming everyone it touches to death.

WHAT CAN

we say, based on all this, about advice on the risks of particular sexual practices?

The first thing we can say is simple: *all advice is based on speculation*. As should be obvious by now, anything said about the causes of AIDS can only be founded on theories, assumptions and arguments by analogy with other diseases — *not* on absolute knowledge of the nature of AIDS. Keeping that in mind, let's look at some of what we've been told:

If the single-agent theory is true, this is a matter of simple logic: the fewer people you have intimate sexual contact with, the less chance you have of catching *any* infectious disease. The problem some people have with this advice is that, by itself, it doesn't tell you how you might reduce risk by deciding *what* to do with the people you do have sex with.

The question here is: choose carefully based on *what*? Obvious ill-health isn't likely to make anyone an attractive sexual prospect, but a person in apparent good health could still have — and pass on — an infectious disease like hepatitis B without showing any symptoms. There's also the danger here of subtle biases coming into play: our sense of what "looks healthy" can be warped by considerations of class, age, race or sexual style that may have no bearing at all on how likely anyone is to have a disease.

What counts is your prospective partner's sexual history — what he's done with how many people, and where. AIDS is still much more prevalent in some places than others, and while having been in those places shouldn't make a person a pariah, there is probably more risk involved in having sex with someone who has led a modestly active sex life in New York than in taking home a person who got heavily into park cruising the last time he was in Halifax. But — you won't find out any of this by looking. You have to ask.

As we've seen, this warning, unless accompanied by more specific information, is almost useless advice unless you plan to have sex in a plastic bag. Short of that, one has to look at particular fluids and the relative risks involved in exchanging them in different ways:

S U C K I N G

No one seems certain about the risks involved in sucking cock up to the moment of orgasm. Pre-orgasmic seminal fluid might carry viruses that might be able to be absorbed in the mouth, but no one has much to say about this.

Callan and Berkowitz, concerned about sperm and CMV, say one very clear thing about what to do after orgasm: don't swallow cum. Even better, they say, don't let anyone come in your mouth. But others are less sure that this entails serious risk. The single-agent theory assumes that an AIDS virus could be present in semen, and direct contact with the blood system can happen through small cuts in the mouth or minor ulcerations under the gums, which are quite common. The stomach is a less likely site of direct contact, however, since many blood-borne viruses are deactivated by stomach acids and enzymes. Swallowing cum, therefore, could be a relatively low-risk act. But this is entirely speculative. So far, no statistical correlation has been shown between oral sex and incidence of AIDS.

As long as the skin on your cock is intact, no one seems to feel that *getting* sucked involves any risk of AIDS, though you could pick up other sexually transmitted diseases, such as gonorrhea, in this way.

F U C K I N G

According to the single-agent theory, the assumed AIDS virus is most likely to be transmitted when high-risk body fluids from one person come into direct contact with the bloodstream of another person. Anal fucking can cause minor cuts and abrasions in the lining of the rectum that open up direct access to the blood system, and semen is one of the fluids thought most likely to carry the supposed virus. Semen also carries CMV, and both could be passed into the bloodstream if one partner comes in the other's ass.

This is what has led many people to advise using condoms when fucking. Recent tests on condoms indicate that they are impermeable to many viruses. But, as Dr Brian Willoughby of Vancouver notes, while wearing a rubber can help prevent transmission of other diseases, "we don't *know* if they stop an AIDS agent because we don't have any idea what an AIDS agent might be like."

Abrasions to the lining of the rectum can be minimized by making sure to use adequate, sterile and long-lasting lubrication.

One curious thing to consider in all this, though, is a report in the July 16, 1983 issue of *The Lancet*, indicating that in the major AIDS epidemiological study, no significant statistical correlation could be found between incidence of AIDS and passive anal intercourse. But most medical people remain convinced by the logic of transmission patterns in other diseases that semen-blood contact in anal sex is a likely route of AIDS infection.

Again, while other less serious diseases can be passed to the person doing the fucking, there's little feeling that he is at risk for AIDS unless he has cuts or sores on his cock.

F I S T I N G

Evidence connecting AIDS with fist-fucking is inconclusive. But there is considerable danger of damage to the lining of the rectum in fisting, making direct contact with the bloodstream likely. The context of the act is important: combining fisting with fucking, using unsterile objects or playing with a fister who's been moving from one partner to another are all seen as unwise by medical people.

R I M M I N G

Medical people generally discourage this act, since a number of diseases, including hepatitis A, pinworms and other intestinal parasites, can be transmitted in this way. The likelihood of AIDS infection through oral-anal contact is not known.

P I S S I N G

Transmission of hepatitis B through urine is not much investigated, since acts that put urine in contact with the bloodstream are fairly rare. Piss is probably a relatively low-risk fluid for the theorized AIDS agent unless contaminated by blood, though it can carry CMV. Contact with skin probably poses no risk, but the dangers of more direct contact with the bloodstream are not known.

(CONTINUED)

BODY POLITIC: IS THERE SAFE SEX? Continued

K I S S I N G

While there's some evidence that hepatitis B virus might be present in low concentrations in saliva, it is not a common route of infection for that disease. Assuming the theorized AIDS virus acts in the same way, neither simple social pecking nor deep, passionate kissing are likely to cause much risk of passing it on.

Antiseptic lozenges are not advised: they have no effect whatsoever on viruses, and can actually make some bacteria more resistant to other kinds of medication.

T O U C H I N G

Sweat is almost certainly a no-risk fluid for transmission of AIDS, and though semen is a likely carrier of the theorized virus, infection through intact skin is highly unlikely. Rubbing, squeezing, smuzzling into armpits or jerking each other off are all still as safe as they've always been.

OUT OF THIS

jumble of theories, possibilities, suppositions and occasionally conflicting evidence, health-care workers, public-health officials and activists doing AIDS-related work in the community are often obliged to come up with concise, comprehensible information to spark action or ease anxiety or steer people away from potential infection. How do they decide what to say?

The best of them are careful, sensing that authoritative statements can be misleading when so much is unknown, and that almost anything can be dangerously misinterpreted in a climate where people are eager to grasp for solid answers that don't yet exist.

Robert Trow is a paramedic at Toronto's Hassle Free Clinic, a place that deals with more gay people than any other single medical facility in Canada. Along with his fellow workers, he has to figure out not only how to advise individual patients, but what kind of information to provide to the wider community in the posters and flyers that the clinic is producing in cooperation with the City of Toronto Department of Public Health.

"There are things you can say in a one-on-one situation," says Trow, "that you can't say in a flyer or on a poster without running the risk of being misunderstood." The big "Numbers" poster that can be found in many of the city's bars and baths limits its advice to cutting down on the number of one's different sexual contacts and using condoms for anal sex. "Even there, where that poster may be the only information many people see, there's the risk of giving the impression that having a lot of sex can itself give you AIDS," something which Trow, who like most medical workers accepts the single-agent theory, doesn't believe is true. "But on a poster you have to go for the broadest and simplest advice that leads generally in the right direction."

A flyer allows more room for elaboration, but caution is still necessary. An early AIDS brochure produced by the clinic warned people to avoid exchanges of body fluids. "If you don't say any more than that," says Trow, echoing Dr Roger Enlow, "people might think you can catch AIDS off a drinking glass." A later clinic flyer dropped "body fluids" in favour of a more specific reference to blood and semen.

In Vancouver, nine people have been diagnosed with AIDS and three of them have died. Dr Brian Willoughby, who works with AIDS Vancouver and also sees many gay men in the course of his private practice, also thinks the best general advice is to cut down on the number of different partners. He gives advice on specific sexual acts only if asked about them by patients with whom he can spend time discussing their particular concerns. He has some problem with flyers that emphasize transmission by anal intercourse. "That's not inappropriate," he says, "but it tends to give the impression that that's the only way AIDS can spread, and we don't know that." In giving advice, Dr Willoughby feels, "it's better to err on the side of caution."

Dr Stephen Atkinson, a psychiatry resident who also works in general practice at Hassle Free Clinic, agrees that encouraging a reduction in numbers is a good idea, but he points out that it's still important to help people find ways to make the sex they do have safer. When his patients ask him about that, he tries not to talk about sexual acts in the abstract, but to discuss with each person the specifics of his own situation. Does he have a lover? In what kinds of settings does he have sex? What does he like to do? "I try to relate things to my own situation," he says, "to get people comfortable with talking to another gay man about what they do, and to provide whatever useful information I can through discussion, not pronouncements."

Condoms are probably a good idea, Atkinson says, but the best idea is talking to prospective sex partners, getting to know each other well enough so that you can feel comfortable sharing your mutual concerns and finding ways to deal with them.

Long-time community activist Harvey Hamburg is a lawyer, not a doctor, but as a member of the AIDS Committee of Toronto, he too has to think about the most useful ways to provide information, and has to have some conception of how AIDS works in order to do it. He cautions, though, that we shouldn't see AIDS alone as the problem. "It has to be seen in connection with things like hepatitis B, parasitic infections, lymphadenopathy and other conditions that grow out of gay-male sexual culture. As a community, we've been doing an awful job dealing with this."

If we don't get serious about finding solutions to the health problems our sexual practices tend to exacerbate, Hamburg feels, other people will move in and do it for us. The baths, for instance, "certainly shouldn't be closed," he says, "but they are an issue we have to deal with as a community, and we haven't been."

How does he think we should do this?

"We have to induce healthy changes in gay male sexual culture." This, at best, isn't a matter of telling people what they shouldn't do, but of finding ways to eroticize practices that are safer. Condoms can become a kind of sex toy, and things like circle-jerks, which people might have shied away from in the past, can be promoted as less risky ways to have fun with each other. The useful thing about *How to Have Sex in an Epidemic*, Hamburg points out, is that it is precisely about how to *have* sex, not a warning not to, and that whether AIDS is caused by CMV or by an unknown virus, most of the advice in the book could help reduce the risk of spreading the syndrome.

"We ought to be mounting a major campaign about the goodness of gay sex," he says — especially those kinds of gay sex that make the transmission of disease less likely.

In the meantime, some bottom-line advice is probably useful, and according to Hamburg that advice would be: fuck only with a condom, don't rim, and be careful when sucking.

BUT HABITS

die hard, even when we know there are risks involved. "Habit," in fact, may be a misleading word: people engage in the sexual practices they do not simply because it's what they've got used to, but also because particular acts can fill particular psychological needs for them, while other acts may not. In the midst of an impassioned sexual encounter, swallowing cum or spitting it out is not a minor technical detail, but a matter of deeply seated *desire*. Sex isn't simply a kind of pleasurable plumbing in which people don't much care how the pipes are connected as long as the juices flow when the taps are turned on. We all find some sexual encounters unsatisfying even when they result in orgasm, while we can be fulfilled by others even if we don't come. Satisfaction and fulfillment are more psychological than physiological matters, and they have have a lot to do with what particular sexual acts *mean* to each of us.

There can be a certain willful ignorance in advice that treats the psychology of desire as a simple matter of things people just happen to like, and which, with a little willpower, they can give up. Sitting in the cool, fluorescent light of a doctor's office, we might all agree on the dangers of a given act; in the burning glow of passion, we might not only *want* to do it, but will.

For those pressed to provide advice about risk reduction, this complicates things a good deal. Warnings that might make perfect sense medically could, in the end, have little to do with the ways people actually have sex. Dr Brian Willoughby's lack of enthusiasm about advising the use of condoms, he says, comes not only from uncertainty about whether they work, but also from his suspicion that "people simply won't use them."

Does this mean there's no point in trying to give advice? No, says Dr Stephen Atkinson. "You have to leave people a lot of

(CONTINUED)

BODY POLITIC: IS THERE SAFE SEX? Continued

leeway for making decisions on their own," but at the same time provide whatever useful information you can. Dr Willoughby echoes this: "Giving advice is part of my function as a doctor; making moral judgments isn't. People have the choice of whether or not to take my advice; they have to make their own decisions as responsible adults, and I try to give them information that will help them do that. In fact, I think there's a kind of abdication of responsibility involved in expecting a doctor to *tell* you what to do."

The anxiety and confusion surrounding AIDS, however, make it hard to know when we're making responsible, adult decisions and when we're not. "Much of the information and advice we're getting," Dr Atkinson notes, "is coming out of cities where a lot of people have died of AIDS, where emotions run higher and there's a greater sense of urgency. People in cities like Toronto pick up on warnings from those places and start to worry, but then they walk into a bar and everybody seems to be acting the same as ever. Despite all they've heard, the situation doesn't *look* serious, but when they go ahead and do something they've heard they shouldn't, they end up feeling guilty."

Gay men in lots of places are avid importers of cultural trends made in New York and San Francisco, even when those trends don't quite fit the local climate. Montreal and Toronto, each less than an hour by air from New York, have been affected by the worry that that city's 1,000 AIDS cases have bred. But judging risks in a given city depends very much on the local situation. Montreal has almost half of Canada's 50 AIDS cases; most of those diagnosed there are Haitians. Very few are gay men. According to Dr Ken Johnson, a staff physician at Hassle Free who also works at the Toronto General Hospital's AIDS referral clinic, nine confirmed cases have been reported in Toronto. One other is suspected; if confirmed, it will be the first new case in the city in more than four months.

Dr Johnson is quick to point out that, with numbers this small, the four-month gap can't be taken to mean anything statistically significant about the local rate of increase. Meanwhile, though, the referral clinic hasn't been very busy. It's seen some people with serious problems that, in the end, were not AIDS-related, and others who've shown symptoms such as fatigue and swollen glands but who have not gone on to develop any more serious signs. Many of the people who show up at the Toronto General clinic are there, Dr Johnson says, "because they were panicked enough to talk their doctors into referring them."

This doesn't mean we won't see more cases in these two cities, perhaps many more. But it does mean that the level of fear and worry understandable in the face of 1,000 AIDS cases might be inappropriate in places where the count is one percent of that number.

SO WHAT IS

an appropriate attitude when seeking safe sex in "the age of AIDS"?

Well, if you want my advice: don't seek advice. Seek *information*. The best sources of that information are the various gay organizations that have been set up to provide it (there's a partial list at the end of this article) and a good, gay-positive doctor.

Mind you, it's not impossible that you may already know more about AIDS than the doctor you consult, especially if he or she doesn't see many gay patients or hasn't any other reason to be keeping up with the literature. Don't be afraid to ask; doctors are not gods, and good ones don't pretend to be. And remember, too, that you certainly know more about your own sex life than any doctor. If you find yourself getting more advice than information on which to base your own decisions, *question it*: ask your doctor how she or he thinks AIDS is transmitted, and how that relates to the advice being offered.

One thing I found in researching this article is that the more medical people know about AIDS, the *less* willing they are to make firm statements about it or about which sexual acts might be likely to spread it. Unambiguous pronouncements from anyone probably indicate more bias than knowledge.

Of course, all advice is going to be biased in one way or another. Dr Stephen Atkinson points out that the most worrisome biases about AIDS might also be the hardest ones to detect — the ones that match our own. "AIDS touches on three of the strongest taboos we know," he says, "homosexuality, cancer and death, all things we're not likely to have resolved our feelings about completely, if at all. For a lot of gay men, fear of AIDS can feed into doubts about themselves and about the way they live. It's all too easy to use it as the final excuse for saying, 'gay life isn't going to work — not for me, and maybe not for anybody.'"

Doubts about the culture we've built probably do underlie much of the reaction to AIDS. One can sense more than a bit of satisfaction in the tone of Michael Callan and Richard Berkowitz when, in the concluding section of *How to Have Sex in an Epidemic*, they say, "The party that was the '70s is over." They may have reason to be glad it is: both of them say they were sick with sexually transmitted diseases through most of it. A glance at the classified ads in any gay paper will show how ready many of us are to declare our fatigue with "bars, baths and discos" once we've had our fill of them. Now such ennui can be reinforced by "science."

I'm tempted to respond to people who go on like that by pointing out that what they got out of the bars, baths and discos was probably something akin to what they brought to them in the first place. If I were to have the nerve to say that, though, I'd be wrong (in some cases; in others, merely undiplomatic). Our institutions, commercial and otherwise, are flawed; there are lots of needs and lots of people they don't serve. And we should be free to say that — and to try to figure out what to do about it — without feeling we've just poked a hole in the feeble barricades defending our right to have such institutions at all. A willingness to be critical of the things we've created for ourselves isn't the same as a desire to make those things a gladly-offered sacrifice to the vengeful gods of disease.

Just before they declare the party over, however, Richard Berkowitz and Michael Callan dare to hope that "Maybe affection is our best protection." Maybe. Caring about each other is certainly a healthier way to begin combatting AIDS than is warning each of us to suspect that every man we might desire is a walking carrier of death. "As long as we view AIDS from the perspective of each of us trying to protect himself from others," Harvey Hamburg says, "we'll run into trouble, both politically and in sexual practice. If the focus is to protect ourselves collectively, things get simpler."

Giving somebody who's about to fuck you a rubber to put on first might be taken as a rude hint that you think he's sick. Putting one on yourself before fucking someone else, however, could be taken as a sign of caring, could be a small step toward reducing the uncertainty that can keep two people afraid of each other even when they're tangled up together in one narrow bed.

HAVING WARNED

about biases, I'm obliged to admit my own.

Last November, this magazine published a ten-page, two-part feature on AIDS by Michael Lynch and Bill Lewis which, in essence, said that the syndrome might claim more of us as victims of panic than as actual casualties of disease. Illness and death, tragic as they are, were not the only possible consequences of AIDS; our collective, as well as individual, health was on the line.

Those paired articles were sharply criticized for daring to warn, even as gay men were dying, that death and the ways we choose to deal with death are matters of political as well as personal concern. There were perhaps 600 cases then; a year later there are four times that number. In that same year, we've come closer to understanding the nature of AIDS, as both a physical illness and a political issue. We have more deaths to mourn — and more evidence that the dangers to our collective life are as great as Bill Lewis and Michael Lynch warned. We have no clear answers for dealing with either, but we're learning.

And, a year later, I for one remain more afraid of AIDS as a source of communal fear than as a source of personal disease. It would be the height of disrespect for anyone to downplay the real physical suffering and death that have resulted from this crisis. No one, I'm sure, would want to. And neither would anyone say there's no reason to be worried. But we also have to be concerned about how we handle that very

(CONTINUED)

BODY POLITIC: IS THERE SAFE SEX? Continued

worry: it can shade into anxiety, into fear, into a paranoia that is itself a brand of suffering, a kind of death-in-life that can rob us of spontaneity, warmth and the sheer joy of basking in the presence of each other.

That joy is what makes my life as a gay man, here and now, worth living. And that joy can't be preserved through fear.

IS THERE

safe sex? You — and I — will have to take all we know and decide that for ourselves. If we're looking for absolute security, maybe we should admit right now that *nothing* is safe, nor has it ever been. But if we suspect that the answer, partial and tentative as it may be, lies somewhere in the direction of taking care of each other, we might just find we're on to something.

We can't cure AIDS, not yet, anyway. But we can take a crack at challenging fear. Life, however long or short, is too short to go through being afraid of the very people you'd rather desire, or trust, or maybe even love.□

For more information on AIDS, contact:

The AIDS Committee of Toronto (ACT), Box 55, Stn F, Toronto, ON M4X 2L4. Phone: (416) 926-1626.

AIDS Vancouver, c/o 19th floor, 355 Burrard Street, Vancouver, BC V6C 2J3. Phone: (604) 687-AIDS.

Collectif d'intervention communautaire auprès des gais, CP 29, Succ Victoria, Montréal, QC H3Z 2V4. Phone: (514) 484-2602

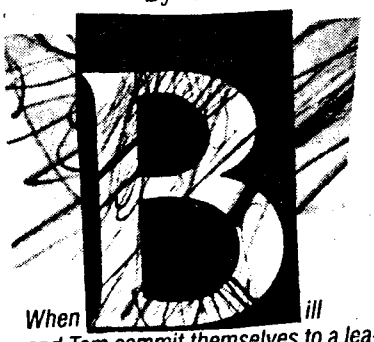
Or call your local gay organization or information line.

In the US: Gay Men's Health Crisis, Box 274, 132 West 24th St, New York, NY 10011. Hotline: (212) 685-4942, or **The National Gay Task Force** crisis line: (212) 807-6016.

Many thanks for their cooperation and advice to all the people quoted in this article, and to Jim Freston of the AIDS Committee of Toronto, who guided many manuscript drafts through the shoals of science — I hope successfully.

BODY POLITIC: THE AGONY & THE ECSTASY

by Geoff Mains



When Bill and Tom commit themselves to a leather scene, they generate a healthy dose of bewilderment. To some of their more politically-correct friends, they thoughtlessly assume the roles of male oppressors. To their acquaintances on the political left they perpetuate social violence. And whether Bill and Tom reciprocally act out the rituals of master and slave, put each other through total and prolonged bondage, or hang weights from each others' balls, they are to nearly all but their friends of the leather fraternity, truly sick.

Freud had his theories on the matter — theories that proposed masochism as a form of "normal" aggression turned abnormally against the self. Other psychoanalysts like Reich went on to concoct more abstruse theories. Thus pain is an illusion that Tom substitutes for an inability to appreciate pleasure. And for Bill, who is supposedly in flight from sexual anxiety, pain is a manageable alternative to guilt. But these theories only create further bewilderment. For it is clear to those who know them that Bill and Tom are hardly apologetic about their leather. Well-adapted, socially conscious, and self-respecting, they share a friendship based upon a fundamental equality, whatever the roles they may adopt during sexual play.

Perhaps what their friends find most perplexing is that Bill and Tom find their sexual acts pleasurable. Quite simply, pain is not enjoyable because it is a second rate substitute; it is pleasure. What has long been known as fact to leathermen has now come to have a biological basis. Deep within the structure of the central nervous systems, science has begun to disentangle the chemical knots that link pain with euphoria and that create a genuine capacity for human experience.

This understanding began in the middle seventies with the discovery of a group of chemicals found in animals and similar in their properties to opium. Named the endorphins and the enkephalins, these opioid chemicals fulfill basic biological roles. They act largely in the processes by which nerves communicate with one another. Like codeine, they act in the body's internal pain control system. Like morphine, they modulate the nervous messages to organs like the heart and intestines. And like opium, they function in the various brain centres associated with euphoria and trance.

But perhaps the most fascinating role proposed for the endorphins is that of reward. It seems that a good part of human motivation — whether an appetite for food or for social companionship — may be at least partly fueled by specific and internal addictions. These drives may well extend beneath a broad variety of human processes from excretion to sleep. In the process that underlies these drives, various nervous circuits require a regular fix of endorphin or enkephalin opioids which are generated by carrying out the activity in question. There is little doubt that these reward circuits are also modulated by physical condition and by learned behaviours (for example, apart from the opioid satisfaction induced by eating, one learns patterns and methods of dealing with hunger). Nevertheless, at least some part of many of our motivations may involve these internal rewards and the wave of euphoria that accompanies them. Feeling good is a major determinant of human behaviour and in its absence the opium drugs can serve as powerful and deadly surrogates. As well, physical and mental activities that increase the levels of opioids in blood and brain may have powerful effects.

(CONTINUED)

BODY POLITIC: AGONY & ECSTASY, Continued

essages that arrive in the brain along the channels of the nervous system often seem clear enough; for example, a stove is hot. But transmission is not always so clear. Messages shift with time, and can be modulated by other parts of the nervous system and influenced by higher centres in the brain. These are the processes by which a leather scene operates, and together, the cumulative effects can be startling.

To begin with, the scene requires a conductive, trusting mood. The mood is relaxed and open to a new experience and the partners find each other a turn-on. Successful leather play is nearly always sensualist and mutualist, whatever the psycho-drama of the roles started at a particular time. Without these real and very accepted limits, leather play would fail in its objectives as a form of love.

The methods of tit play can provide us with a model of how the internal nervous process seems likely to operate. Effective pleasures are not achieved by sudden, brutal attack but by gradual build-up. Pulling and massage may be followed by tit clamps and still later perhaps, by hot wax and alligator clips. Over time, the nipples are effectively desensitized. Far from the nipple itself,the nervous stimulation has induced a wonderful transformation in body chemistry.

A good part of the process occurs in those segments of the spinal cord where the nerves that arrive from the nipple interact with those coming and going to the brain. Here, at least two mechanisms are at work, both of which function through opioid channels.

In the first, fast-travelling and tactile messages that arrive in the spinal cord from the nipple act to suppress the transmission of slower-moving and painful messages. In the second mechanism, painful messages that do manage to pass through this "spinal gate" and climb upwards to the brain, set into motion yet further nervous actions. Acting in downward fashion from the brain into the spinal cord, these cause a release of opioids that effectively block incoming painful messages. It is by these latter actions that acupuncture appears to work, a process in which controlled pain applied to one part of the body can reduce or eliminate the perception of pain in others.

But the effects are further reaching than this. Short term and repeated painful experiences (as well as short term stress) can induce areas at the base of the brain to secrete both endorphins and even larger quantities of enkephalins. These chemicals circulate through the brain and spinal cord, where their effects are similar to a large dose of codeine. And as with codeine, these opioids not only suppress pain but also generate a feeling of euphoria.

These nervous processes form some of the molecular underpinnings of the pain-pleasure threshold and support the adage of leathermen that it is not the pain **per se** that is important but how and when it is applied. Pain applied carefully and precisely within a trusting, caring environment, can flower into a self-reinforcing high that not only suppresses subsequent pain but also increases the desire for it.

Miss iggy is the patron saint of fisters, and it is by no mean coincidence that this is so. While no physiologist has yet ventured an explanation of the nervous chemistry that underlies the success of fisting, enough information exists to sketch out some of the major links of that process. The implications lead directly to pigs in the mud.

This rather esoteric voyage could begin, perhaps, with Arnold Schwarzenegger and pumping iron — a sport which, common rumour has it, is addictive. The truth of the rumour rests somewhere in the combination of stress and muscle stretching that both appear to increase opioid levels in blood and brain and to generate a high.

That these opioids are addictive is without question. Efforts to use enkephalins and endorphins as substitutes for the opium drugs have failed. Despite their existence as an integral component of animal physiology, the internal opioids are more addictive than heroin. Rats taught to self-inject enkephalins, for example, pig out for as much as they can get.

The next stop in the path to gut-butt pleasure involves those brain areas termed the reward centres. We get rewards when we eat. When we exercise. And now it appears likely, when we shit. Despite social training that consigns the toilet to the nasty side of life, there is a clean and healthy dose of feeling good associated with the actual process of excretion. That feeling good may be the result of an internal reward of opioids.

Connections between the hypothetical reward centre associated with defecation and the nerves of the rectum have yet to be fully elucidated, but it seems likely that the rewards are generated either in response to contractions of muscles in the colon and rectum or to relaxation of the anal sphincter muscle. Recent studies of the neural connectors that wire the muscles of the butt end demonstrate that enkephalin neurotransmitters are clearly involved. In the nervous circuitry of the rectal reflex, designed to accommodate increasingly larger quantities of materials for periods of hours before ejection, there are likely processes that, when played in the requisite manner, release large quantities of opioids at the brain end. The results are relaxing and ecstatically euphoric. As with many leather activities, both the mental focus required for fisting and the opioids released as a result of fisting seem likely to induce shifts in state of consciousness. And like weight-lifting, the process is probably addictive.

There is no doubt that fisting is based on powerful physiological capacities. But the connections with pigs? With the discovery of the opioids not only in humans, but also in all higher animals, another cherished assumption of biologists appears to be under reconsideration.

(CONTINUED)

BODY POLITIC: AGONY & ECSTASY, Continued

*It now seems likely that animals have strong emotional capacities that underlie their behavior. Pigs may very well roll in the mud because they **enjoy** rolling in the mud, and very likely because there is a substantial opioid reward associated with doing so! There is not just a little similarity between this act and the pure animal indulgence of Crisco and loving fists.*

What is really so important about all of this? There are certain things that make each of us feel good, and it only seems logical that detailed workings of the nervous system should underlie them. That we are able to pinpoint those chemical processes may be interesting, but little else.

The point to be emphasized is that alternate forms of sexual pleasure, such as those involving pain, function through some fundamental and everyday capacities. The very existence of those capacities runs in the face of views commonly held by psychiatry and the general public. These groups do not view pain-pleasure as a real and very animal capacity. Rather, they see it as a warped expression of what they regard as normal capacities. The implications of recent work with opioids are thus two-fold. First, medicine has played a powerful role in justifying established values by proscribing alternate behaviors as deviant. Second, what is normal is far broader than medicine would like to have us believe.

Physical response is important. No two human beings function in identical ways and capacities for leather experience probably vary as much as does everything else human. Not all of us appear to produce opioids in response to pain. Nor do we all share desires for ritualized catharsis. Yet for those who are blessed with this blend of capacities and acculturation, the rewards include tension release, euphoria and even transcendence. More than satisfactory as pay-offs for taking the trip in the first place, there are also sufficient motivations to undertake repeat exploration. Psychology may have motivated in the first instance but these drives are soon surpassed.

Leathermen share this use of what have been suppressed or forbidden pain-pleasure capacities with many cultural groups. Yet from Dervish to flagellant, and from firewalker to Kavadi dancer, leather stands apart in exploring sexual capacities in terms of opiergic experience. To its participants, leather sex brings release and revelation. And to the world, leather becomes at once a symbol and a culture. A dark and an animal side of the soul has been rediscovered and let out.

Urban Aboriginals: Celebrations of Leather Sexuality, from which this article is extracted, will be published by Gay Sunshine Press in the fall of 1984. Geoff Mains lives in Vancouver.

(CONTINUED)

STATEMENTS SOUGHT FROM PEOPLE WITH AIDS

The National Gay Task Force is compiling a collection of open letters from people with AIDS in order to make available a more authoritative, first-person voice of the crisis. The purpose of the collection is to sensitize all those involved or concerned with the issue--health care workers, government officials & departments, the media, the straight community as well as our own community and families. Letters may be addressed to anyone in particular--your elected representatives, your families, social service agencies, the gay community, the medical establishment, a best friend--anyone. They may be in the form of a letter, a speech you prepared or article you wrote, a question and answer format, a series of journal entries, or just some random thoughts and feelings set down on paper. We definitely encourage complete expression in any aspect of the phenomenon you care to articulate, be it rage, discovery, rebirth, despair, commendation, accusation--the gamut. Our hope is to input a much more personal picture of the condition that has been availalbe thus far and to have immediately accessible a perspective (or volume of perspectives) to draw upon and a full range of voice that speak from profound familiarity and experience. Testimony need not be letter perfect; handwritten is no problem (just include phone number so we can verify text). We would like you to include full names & cities & states, but if you prefer, just a first name and initial will be accomodated (such as MARC T.--Macon, GA). As these writings will definitely be utilized by the media (both gay & straight), it's important you are comfortable with the extent of the exposure and make your name commitment based on that. Please send letters or other written contributions to NGTF, 80 Fifth Av., New York, NY 10011 by February 1, 1984. For additional information call Aubrey Wertheim (800/221-7044 toll free; NY State 212/741-5800, M-F, 3-9 pm, eastern time).

* * *

IS AIDS CHANGING OUR SEX LIVES?

Social scientists have a hard time investigating sexual habits. What people do in bed (or wherever) is likely to be altered by any suspicion that they're being observed (a point often made by critics of Masters and Johnson's sex-in-the-lab studies), and surveys asking people what they do can be affected by how willing (or able) anyone is to give an honest and accurate account. Embarrassment, pride and even simple failure of memory can colour the picture we each draw of our sex life, not only in telling someone else about it, but also in thinking about it ourselves.

Attempts to find out whether concern about AIDS has changed gay men's sex lives often end up, therefore, assessing *perceptions* rather than actual practices. Some investigators have tried to filter out this perceptual bias by looking for indicators of sexual activity that might show what people actually do, not what they think they do. A study in Denver, Colorado, for example, that showed the number of gonorrhea cases among gay men dropping by 39 percent between 1982 and 1983 has been taken as evidence that fear of AIDS was having an effect on gay sex even in a city where there weren't many cases. But if this is evidence, it isn't iron-clad, and the doctor reporting it in the July 16 issue of *The Lancet* was careful in stating his conclusion: "...it *appears* that many homosexual men *may* be opting for more conservative sexual lifestyles" [emphasis added].

Another study, reported in the September 17 *Lancet*, was based on asking gay men in Madison, Wisconsin how many sexual partners they had had over the past thirty days. In the six-month period from February to July, 1982, the mean figure was 6.8; in the same months in 1983, it was 3.2. On the face of it, that seems striking evidence of a change in sexual habits. "In the absence of other readily apparent reasons," the researchers state, "we attribute the observed decline in promiscuity to the fear of contracting AIDS, a condition which has not yet become prevalent in Madison." But while the report notes that 488 men were involved in this study, it doesn't make clear whether those asked in 1983 were the same ones questioned in 1982. Probably not: the survey was done during STD screening at a clinic and at "a bar frequented by homosexuals" in a university town with a shifting population. Unless the same people were asked, we can't be sure that gay men who acted one way in 1982 were influenced by fear of AIDS to act differently in 1983.

In September, Robert Trow and Martin Graham of the Hassle Free Clinic in Toronto prepared a questionnaire intended to assess both attitudes among gay men toward AIDS and its effect on their sexual practices. In a preliminary report taken from 90 responses, 58 percent said their sex lives had changed in the past year, and cited concern about AIDS as one reason. Sixty-eight percent said they would have gone to the baths looking for sex a year ago; less than half go now, although people seemed as likely as before to go out to bars or to cruise parks or washrooms. Of all those sampled, two-thirds said they had had less casual sex in the past year than in the year before. Yet when Trow calculated the monthly average of sexual contacts reported for the past year and compared that to the figures given for the three latest months, he found that they showed people having *more* sex recently. "Well, it was the summer," Trow notes, "or maybe it was just easier for people to remember what happened in the last three months."

The men who answered the Hassle Free survey also reported changes in what they did when they had sex. About a quarter said they had less anal sex, active or passive — though 15 percent were fucking *more* often. Seventeen percent said they'd started using condoms; 21 percent reported an increase in mutual masturbation. While, as Trow says, AIDS hasn't generated "mindless panic" in Toronto, almost two-thirds of those surveyed said they were more than a bit worried about it. Still, half of them thought their present lifestyle put them at little or no risk of picking up the syndrome.

A similar sense of relatively calm concern was noted by *TBP* reporter Jim Bartley, who recorded brief interviews with 105 men in four Toronto gay bars in late September. He asked all of them four questions to see how well-informed they were about AIDS and whether it was changing their approach to sex.

More than half of the men Bartley talked to said their sex lives had not been affected by AIDS. Three-fifths of these were monogamous. The rest said they weren't worried, some because they had few sexual contacts, others simply because they had decided worry wasn't worth the trouble: "If I'm going to get it," said one man, "then I'm going to get it."

Of the 47 men who said AIDS did have an effect on their sex lives, half had cut down on the number of their sexual partners. The rest tried to be cautious about whom they took home.

Bartley also asked each man if he knew how many AIDS cases had been diagnosed in Canada and the US. The answers seemed to indicate that most of them were relatively well-informed. Two-thirds estimated fewer than 50 Canadian cases (as of that date, there were about 40); half gave US figures ranging from 1,000 to 3,000 (there were about 2,300). When asked where they got information about AIDS, most cited the mass media. The gay press was mentioned by less than a third of them.

"Given the high profile of AIDS in the media for the last two years," Bartley says, "one might assume that most gay men would have discussed it with their doctor, or asked about it in the course of an STD check-up at a clinic. But only 39 of the men I talked to had actually done that." Of these 39, half had been advised to be cautious about choice of sexual partners or to have fewer of them; one doctor simply said, "be monogamous." Eight men were told that their risk of contracting AIDS was low, and that they shouldn't panic. But no matter what advice these men got, Bartley says, there was little apparent correlation between it and the changes — if any — that they reported in their sexual practices.

Jim Bartley says he came away from his interviews with a sense that, at least among men who go to gay bars in Toronto, "there is a predominant feeling that for the time being, anyway, the risk of catching AIDS is low, and especially low in Canada. People aren't panicking."

If he's right, we have a chance in Canada — and in many other places where the number of diagnosed cases is still small — to find ways of dealing with AIDS without giving in to unreasonable fears. The key to that process is going to be information, and the intelligent application of it. Almost a third of the men who responded to the Hassle Free survey said they had attended public forums on AIDS in Toronto, one of the three cities in Canada where gay groups exist specifically to provide information and guidance, personal and political, on dealing with the syndrome. Other groups are likely to be set up elsewhere.

We may see more changes, both in habits and in attitudes. But if we keep our heads clear, we'll be able to weigh and choose those changes for ourselves, and not have them forced on us by panic. □

NY ACADEMY OF SCIENCES CONFERENCES: LOOKING FOR THE BREAKTHROUGHS

by James E. D'Eramo, PhD, with thanks to the New York Native

AIDS has undoubtedly created new kinetics in both scientific and social realms. The mysteries of the syndrome have generated flurries of meetings from Paris to Hawaii and back. What we have been able to learn about the cause, natural history, treatment, and cure of AIDS is fragmentary; yet these fragments of immunologic findings, etiologic findings, and the array of epidemiological approaches have resulted in an embryonic body of knowledge that challenges and excites scientific minds around the world. After some answers are found, the boundaries of immunology and all related disciplines will be radically rearranged. Meanwhile, sifting through and integrating the accumulated data is a task for the strong. Ask anyone who attended the conference on AIDS sponsored by the New York Academy of Sciences (NYAS), November to 17 in New York City.

Obviously it would not be possible or appropriate to attempt to represent here the contents of such a monumental conference, but the highlights represent the roots of a new history. Never before has such an impressive group of people gathered to share their findings, to debate, to grapple with the mysteries of AIDS. There were 800 participants, and the roster of names of the speakers and many in the audience reads like the cast of a new scientific culture. The stars of the medical establishment were there; so were some of the outcasts. The politics of funding and career advancement caused friction alongside the data and hypotheses. Stocks in theories rose and fell; some of the press conferences sounded like trading on Wall Street. Self-interest stared scientific research in the face. There were a few operatic outbursts, but in general the exchanges of opinions were well-tempered. Some of those present, like Dr. David Sencer (New York City Health Commissioner), quipped that there was an epidemic of AIDS *conferences*, but everyone present knew quite well that the dialectic exchanged between formal presentations was essential to the advancement of AIDS research. For me, the repetition of information yielded greater insights. Some present were unquestionably bored; some were obviously protective of what they knew (or thought they knew). Most shared their viewpoints freely, and everyone eavesdropped to hear the candid comments at coffee breaks and lunch. Collaborations were formed, investigations planned, and remarks made about the findings that can't be found in the medical literature. Some data was preliminary, some very old. But the stirrings of the conference were orchestrated to produce a better understanding of the AIDS epidemic. And that's exactly what they produced.

Almost no AIDS topic was left unturned. The four-day conference was chaired by Dr. Irving J. Selikoff—a true gentleman and scholar—who presided over the best run press conferences I have ever seen. On Monday, Dr. W.N. Scott (President of NYAS) and Dr. David Axelrod (NY State Commissioner of Health) greeted the attendees. Dr. Axelrod's remarks left some with the impression that the number of AIDS cases in New York is slowly winding down—a notion certainly not shared by everyone. In a press conference that day, Dr. Axelrod voiced his concern that no group—including gay men—should be stigmatized by AIDS. Dr. H.W. Dickerman advised the press of the New York State AIDS Institute's purposes and outlined the research funding procedures to be followed by the Institute.

The Biology of Immunodeficiency

The first session of the conference was composed of seven presentations on the nature of immunodeficiency. Dr. M.A. Epstein (of Epstein-Barr Virus [EBV] fame) discussed his research and the possible lesson EBV holds for AIDS researchers. Dr. Epstein's attitude was not appreciated at the morning press conference: he suggested that none present could speak or understand the English language. And his joke that "AIDS was possibly retribution for the slave trade" was not humorous. Although Dr. Epstein initially insisted that EBV had no relationship to AIDS, he later came to appreciate certain links between the virus and AIDS after conversations with Dr. Donald Abrams (San Francisco).

Dr. S.F. Schlossman (Harvard) detailed the role of T-cells in immunodeficiency. Dr. M.S. Hirsch presented evidence that cytomegalovirus (CMV) induces immunosuppression that has bearing on the development of AIDS. He noted that although the role of CMV in the etiology of AIDS remains obscure, it is likely that virus-induced immunosuppression is important in the subsequent development of opportunistic infections.

Immunological Defects in AIDS

The second session of the first day focused on the various factors that may play a role in the development of AIDS, such as interferon deficiencies (Dr. C. Lopez, Mount Sinai) and genetic predisposition for Kaposi's sarcoma (Dr. P. Rubenstein, New York Blood Center). Dr. G. Shearer discussed non-infectious co-factors (semen, white blood cells, a lack of natural resistance) in the etiology of AIDS. Dr. Shearer noted that co-factors can contribute to susceptibility to the putative AIDS infectious agent(s), and that until we can isolate the etiologic agent we may have to rely on being able to identify these co-factors to initiate preventive steps. Further, he suggested that if it can be demonstrated that such co-factors definitely contribute to AIDS susceptibility, the fear associated with AIDS could be reduced. This session was chaired by Dr. James B. Wyngaarden, newly appointed director of the National Institutes of Health (NIH). Dr. Wyngaarden seemed well apprised of basic AIDS research issues at the press conference. It will be interesting to monitor his leadership at NIH.

Biologic Modifiers of the Immune Response

The importance of the three papers presented in this session revolved around possible laboratory tests for the development of AIDS and possible drugs—immunomodulators—for the restoration of deficient functions of the immune system. The role of interferon in AIDS was discussed by Dr. O.T. Preble, who first characterized acid-labile alpha interferon. Preliminary data suggests that this type of interferon is present at high levels in persons who develop AIDS.

Dr. John Hadden (Florida) discussed the uses of certain drugs (eg., isoprinosine) in restoring the T-cell mediated portion of immune response. He believes that this type of therapy will enhance resistance to viruses and other microbes, and possibly go on to ameliorate, if not cure, AIDS itself.

Dr. A.L. Goldstein (Washington, D.C.) reported that he had found it possible to identify 60 to 90 percent of persons at high risk for developing AIDS by using a simple blood test for a thymic hormone called thymosin-alpha-one. His studies may lead to the early diagnosis of AIDS, and may possibly lead to a treatment that can prevent the devastation of the immune system.

Dr. Anthony Fauci (NIH) led these discussions and pointed out in the ensuing press conference that AIDS is not casually transmitted, but has a rather low infectivity.

[CONTINUED]

NY ACADEMY OF SCIENCES, Continued

Current Research in AIDS

Monday evening 18 researchers presented their findings in a wide range of investigations. All the reports were of a preliminary nature, and several were fascinating. The evening was chaired by Dr. M. Krim (Sloan-Kettering). Dr. A.E. Davis (North Carolina) discussed his pathologic data implying that AIDS involves the destruction of thymic tissues by circulating immune complexes. These results focused on the destruction of the adult thymus tissue by an unidentified mechanism set in motion by the disease process of AIDS.

Dr. S. Witkin presented evidence that gay men possess antibodies to sperm and have circulating immune complexes containing sperm antigen. Dr. Witkin posits that these responses are due to the depositing of semen into the rectum; he has developed a rabbit model to demonstrate this.

Dr. S. Zolla-Pazner (NYU) presented evidence that a substance called Beta-2-microglobulin is present in elevated levels in the serum of patients who have AIDS, as well as in patients who have a variety of other diseases. This work may also lead to the development of a laboratory test for AIDS.

Dr. R. Kerman (Houston) reported on a comprehensive immune evaluation of hemophiliacs which suggests that they commonly display a reversed T-cell ratio directly correlated with the patient's age, the severity of their disease, and the amount of infusion treatment they have received for their hemophilia. Dr. Kerman suggests that the reversed T-cell ratios may be due to the extracted blood products they receive; in other words, the immunosuppression of hemophiliacs may be totally independent of AIDS.

Dr. C. Prakash (Ohio State University) presented a study outlining the development of Kaposi-like lesions in pigs that displayed homosexual activity. Dr. Larry Falk (Harvard) discussed the experimental infection of monkeys with Human T-cell Leukemia Virus (HTLV), a contender in the viral etiologic agents of AIDS.

AIDS Etiology

Dr. K. Sell (National Institute of Allergy and Infectious Diseases) chaired this session. He recently isolated a soil fungus from cell cultures derived from AIDS patients. He pointed out that the etiology of AIDS may be due to a non-viral agent, like a bacteria or fungus.

Dr. Fauci remarked at a subsequent press conference that he felt Dr. Sell's fungus was a mere contaminant of the cell culture, and that he believed that a retrovirus, such as HTLV, was a more plausible cause of AIDS. This position was discussed by virologist Dr. D. Francis (CDC), who presented evidence of the presence in AIDS patients of antibodies to cell membrane antigens associated with HTLV.

In another press conference, immunologist, Dr. R.A. Good, expressed his notion that "stock in HTLV" as the etiologic AIDS agent was going down, but that there is a good possibility that another retrovirus is the causative agent.

Dr. N.L. Letvin described his studies with AIDS in monkeys, asserting that the disease itself is not new, but has not previously been seen in humans. Nevertheless, the transmissible nature of immunodeficiency and lymphomas in monkeys may provide a valuable animal model for the study of AIDS.

Dr. M. Bloom (Montana) described the features of some infections caused by parvoviruses (tiny animal viruses that are dependant on other viruses for replication). Dr. Bloom holds that these parvovirus infections are reminscent of AIDS; he speculated that an as-yet-unidentified parvovirus might actually play an etiologic role in AIDS. The possible involvement of heptatitis-B virus, CMV, and herpes were also discussed in this session.

Dr. P. de Jong demonstrated a relationship between adenoviruses and 21 AIDS patients who had these viruses in their urine. Dr. G.B. de The (France) led the concluding discussion on etiology, during which it became clear that we are no closer to knowing the cause of AIDS than we were six months ago.

Other Contributory Factors

Dr. J.A. Sonnabend presented a multifactorial model for the development of AIDS. His model proposes that there is no specific AIDS agent, but rather that AIDS may have developed in gay men as a result of an interaction of the likely effects of repeated exposure to specific environmental factors, namely repeated exposure to semen, repeated CMV infection, and infection with other sexually transmitted pathogens, particularly those associated with immune complex function.

Dr. J.J. Goedert (National Cancer Institute) discussed recreational drugs as a possible contributing cause of AIDS, but the results of his studies are inconclusive with regard to nitrite inhalants (poppers), heroin, and cocaine.

Dr. G. Quinnan (Food and Drug Administration) described the interaction of CMV and EBV with other factors leading to the development of AIDS.

Dr. D.I. Abrams (San Francisco) brilliantly discussed his prospective study of 200 gay men with lymphadenopathy in San Francisco. He presented the question of whether this condition represents the endpoint of a disease process or the prodrome of AIDS. Only three of his patients have developed CDC-defined AIDS, and he believes that lymphadenopathy is an extremely mild form of the syndrome. He also speculates that for every patient he sees with lymphadenopathy, there are 20 to 30 more young gay men who have the same symptoms but haven't sought medical attention.

AIDS Research Abroad

Dr. D. Cerimele (Italy) presented results from a study in Sardinia that links Kaposi's sarcoma with genetic factors among the homogeneous population there.

Dr. David Klatzmann (Paris) presented a report describing the immune status of AIDS patients in France. Of the 100 AIDS cases in France, 18 originated in Zaire or the Congo, and none of the 18 is gay. All patients he observed had a reversed T-cell ratio. Dr. Klatzmann is part of a research team which was able to isolate a new retrovirus—called Lymphadenopathy Associated Virus (LAV)—from AIDS patients in France. Some researchers believe that LAV is a more probable contender in AIDS etiology than HTLV.

Dr. J. Desmyter (Belgium) reported that all of the 40 Belgian AIDS cases are from Zaire. The French and Belgian reports underlined the theory that AIDS originated in Africa.

Dr. J.M. Guerin (Haiti) described 150 Haitian AIDS cases that have occurred mostly in urban areas, where there is male and female prostitution; scientists from France, Belgium, and England were quick to observe that their own data did not support any observations regarding prostitution. Other Haitian researchers took exception to French reports that a French geologist died of AIDS four years after receiving a blood transfusion in Haiti. According to the Haitians, the geologist also received transfusions in Martinique.

(CONTINUED)

NY ACADEMY OF SCIENCES, Continued

Epidemiology

Dr. James W. Curran (head of the CDC's AIDS Task Force) discussed one of the major issues now becoming apparent in the CDC's definition of AIDS. There is a broadening clinical spectrum of AIDS cases that is not accounted for by the CDC's definition. Dr. Curran speculated that the nearly 3,000 cases officially counted by the CDC represent only 10 percent of the total number of AIDS cases in this country.

Dr. M.A. Fischl reported on his preliminary findings regarding AIDS in Haitian-American families.

Dr. J.B. Brunet (Paris) reported on AIDS epidemiology in France. There are nearly 100 cases reported in France—more than a third of all European cases—and they occur in nearly all of the identified risk groups, as well as in people from the various geographical areas that have cases themselves, including Haiti and Equatorial Africa.

In the subsequent discussion, Dr. Jane Teas (Harvard) presented her hypothesis that African Swine Fever Virus (ASFV) may be related to the cause of AIDS. She described the epidemiology and pathology of the disease in pigs as similar to that of AIDS in humans. She also pointed out that there have been recent epidemics of ASFV in places where AIDS has occurred, including Haiti, Zaire, Congo, and Sardinia (a focal point for the occurrence of KS).

Dr. Desmyter remarked that he hoped American researchers would attempt to resolve the questions raised by Dr. Teas' theory. Thus far, only minimal and inconclusive research has been directed at African Swine Fever Virus. In discussion, the theory was criticized as if it had been presented as a finding. It was clearly stated, however, that Dr. Teas was positing a hypothesis , not research results. Dr. Fran cis (CDC) was reported to have remarked that no matter how often Dr. Teas' theory is discounted, it keeps resurfacing.

Community Impact of AIDS

This evening session, chaired by Dr. R. Enlow, covered a wide range of topics, from the AIDS situation in NYC (Dr. D. Sencer) to a discussion of the "worried well" and the psychological implications of AIDS (Dr. M. Quadland). J.B. Eveillard spoke out against the stigmatization of Haitians. He also questioned why the U.S. government has failed to perform thorough follow-up investigations of ASFV as the cause of AIDS.

The discussion from the floor was momentarily electrified (by booing, primarily) when an Aesthetic Realist physician attempted to present guidelines for converting homosexuals into heterosexuals to save them from AIDS.

Bob Cecchi, a New York AIDS patient, delivered a very moving series of insights into the human aspects of AIDS.

The clinical manifestations of AIDS were described by Dr. Enlow, Dr. Bijan Safai (Kaposi's sarcoma), and Dr. D. Armstrong (opportunistic infections). Dr. C. Metroka presented his study of 100 homosexual and bisexual men with generalized lymphadenopathy. All his patients had imparied cellular immunity, which remained unchanged over a period of 24 months. But a small percentage of patients showed significant improvement or worsening. Dr. Metroka suggested that generalized lymphadenopathy is part of the disorder manifested by AIDS, opportunistic infections, Kaposi's sarcoma, and lymphomas.

In the press conference that followed, the researchers spoke of treatments for the various manifestations of AIDS, but all had only temporary effectiveness. Dr. Safai described a few patients who presented with no signs or symptoms of disease except KS lesions themselves. Even these patients went on to develop other diseases typical of AIDS. Some patients also died of a severe systemic form of KS.

As the conference drew to a close, many were heard to comment that they couldn't absorb one more informational tidbit or comment. But everyone seemed to be set in motion again, looking forward to further investigations. The New York Academy of Science is to be highly complimented for their sterling work in assembling such a major conference. Special acknowledgements must go to Ms. Ann E. Collins (public relations–NYAS), who organized and ran the streamlined press conferences.

The New York Academy of Science was founded in 1817 with the purposes of advancing scientific research and discovery, to provide a forum for the presentation and discussion of scientific problems, to publish and distribute the results of research, and to interpret them for the promotion of common welfare. Their address is 2 East 63rd Street, NYC 10021. ■

BILL SABELLA NAMED EPIDEMIOLOGIST/AIDS COORDINATOR IN CONNECTICUT

William Sabella, MPH, was recently appointed Epidemiologist/AIDS Coordinator in the Connecticut Department of Health to develop and coordinate active surveillance of AIDS in the state, to educate and provide up-to-date information to local and state constituencies obtained through constant review of literature, conferences, and communication with public health authorities at the CDC in Atlanta, and other cities and states. As a result of Mr. Sabella's surveillance activities, Connecticut has made the reporting of AIDS cases mandatory. In recognition of these and other concerted efforts, the CDC recently awarded a $50,000 grant to helf further develop the state's surveillance program.

* * *

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

International Notes

Acquired Immunodeficiency Syndrome (AIDS) — Europe

The following table (Table 3) summarizes the cases of AIDS reported by member countries of the European Region of the World Health Organization (WHO) as of October 1983 (*1,2*).

Reported by WHO Weekly Epidemiological Record, *1983;58:351.*

Editorial Note: As of November 21, 1983, 2,803 AIDS cases in the United States have been reported to CDC. The case definition used in other countries may differ slightly from that used by CDC.

References

1. WHO. Acquired immune deficiency syndrome (AIDS). Weekly Epidemiological Record 1983;58:227-8.
2. Based on data provided by the participants at the first meeting on AIDS organized by the WHO Regional Office for Europe (Aarhus, Denmark, October 19-20, 1983).

TABLE 3. AIDS cases reported by member countries of the European Region of WHO— as of October 20, 1983*

Country	Year of diagnosis						
	Before 1979	1979	1980	1981	1982	1983	Total
Austria						7	7
Belgium			2	4	8	24	38
Czechoslovakia					1	1	2
Denmark			1	2	4	6	13
Finland						2	2
France	6	1	5	5	30	47	94
German Democratic Republic							0
Fed. Republic of Germany	1	1			7	33	42
Greece							0
Ireland						2	2
Italy					?		2
Luxembourg							0
Netherlands					3	9	12
Norway						2	2
Poland							0
Spain				1	1	4	6
Sweden					1	3	4
Switzerland			2	3	5	7	17
United Kingdom				2	5	17	24
U.S.S.R.							0
Yugoslavia							0
Total	7	2	10	17	67	184	287

*Newly reported cases or revisions of case status according to new clinical information or better understanding of the AIDS definition.

CENTERS FOR DISEASE CONTROL December 2, 1983 / Vol. 32 / No. 47

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Current Trends

Update: Acquired Immunodeficiency Syndrome (AIDS) among Patients with Hemophilia — United States

In 1982, six hemophilia A patients who had developed *Pneumocystis carinii* pneumonia (PCP) and other opportunistic infections and who met the CDC case definition of AIDS were reported by CDC (*1,2*). As of November 30, 1983, physicians and health departments in the United States have reported a total of 21 AIDS cases among hemophilia patients—19 among patients with hemophilia A and two among patients with hemophilia B. In addition, seven cases from outside the United States meeting the CDC definition of AIDS in association with hemophilia A have been brought to CDC's attention. Of the hemophilia cases in the United States, one was diagnosed in 1981; eight, in 1982; and 12, to date in 1983 (Figure 1). Two patients are known to have had other risk factors for acquiring AIDS.

To date, no cases of Kaposi's sarcoma have been reported in association with hemophilia; each patient had an opportunistic infection suggestive of an underlying cellular immunodeficiency. PCP was the most common opportunistic infection in hemophilia patients with AIDS and has occurred in 20 (95%) of the U.S. patients. Many of these patients have had other opportunistic infections, principally candidiasis, cryptococcosis, toxoplasmosis, and histoplasmosis, or infections with cytomegalovirus and *Mycobacterium avium-intracellulare.* The geographic distribution has included 15 states, with four cases each in the Mid-Atlantic, South Atlantic, and East North Central regions, three in the East South Central region, two each in the New England and West North Central regions, and one each in the Pacific and Mountain regions. No state was the residence for more than two patients.

The National Hemophilia Foundation (NHF) and CDC have conducted a mail survey of 116 hemophilia treatment centers (HTCs) designated by the NHF in the 48 contiguous states, which estimated the prevalence of AIDS-associated diseases from 1978 to 1982 among approximately 6,700 hemophilia patients; a separate review of U.S. deaths reported to the National Center for Health Statistics as being hemophilia-related was also included in the survey. This survey failed to identify any diagnoses suggestive of AIDS occurring among hemophilia patients before the first case diagnosed in September 1981 or any cases other than those reported here. In addition to the 21 reported U.S. hemophilia patients with AIDS, some patients with hemophilia have been reported with unexplained, possibly AIDS-associated phenomena that do not fit the CDC criteria for an AIDS diagnosis, including lymphadenopathy syndrome (*3*), thrombocytopenic purpura (*4*), and Burkitt's lymphoma (*5*).

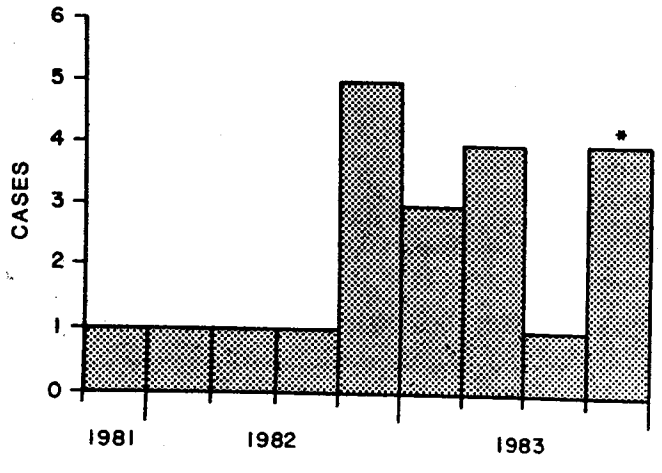
AIDS – Continued

Reported by S Karp, MS, M Shuman, MD, Moffitt Hospital, University of California—San Francisco, S Dritz, MD, City/County Health Dept, San Francisco, California; S Marchesi, MD, P McPhedrin, MD, Yale-New Haven Hospital, New Haven, Connecticut; AE Pitchenik, MD, University of Miami, Florida; P Bertagnoll, MPH, Hemophilia of Georgia, Inc., Atlanta; D Green, MD, McGaw Medical Center, Northwestern University, M Telfer, MD, Michael Reese Hospital, Chicago, G Rifkin, MD, St. Anthony's Hospital, University of Illinois, Rockford; M Serwint, MD, University of Kentucky Medical Center, Louisville; E Mohler, Jr, MD, St. Agnes Hospital, Baltimore, Maryland; D Brettler, MD, Worcester Memorial Hospital, Worcester, Massachusetts; L Rubin, MD, Children's Hospital of Long Island Jewish Hillside Medical Center, New Hyde Park, A Brownstein, MPH, Executive Secretary, National Hemophilia Foundation, New York City, New York; E Eyster, MD, Hershey Medical Center, Hershey, Pennsylvania; SL Green, MD, Riverside Hospital, Hampton, Virginia; J Craske, MD, Withington Hospital, Manchester, England; J L'Age-Stehr, Robert Koch Institut, Berlin, West Germany; Div of Host Factors, AIDS Activity, Div of Viral Diseases, Center for Infectious Diseases, Div of Field Svcs, Epidemiology Program Office, CDC.

Editorial Note: Although the etiology of AIDS remains unknown, epidemiologic evidence suggests an infectious cause (*6, 7*). The possibility of blood or blood products as vehicles for transmission of AIDS to hemophilia patients is supported by the increased risk of AIDS in intravenous drug abusers (*8*) and reports of transfusion-associated AIDS cases (*9, 10*). Patients with hemophilia receive transfusions of anti-hemophilic factor and plasma factor concentrates prepared from pools of sera from 2,000 to 20,000 donors. Cryoprecipitate and plasma factor preparations are associated with the transmission of several known viral agents, including cytomegalovirus, hepatitis B virus, and the virus(es) of non-A, non-B hepatitis (*11*). However, at least nine U.S. hemophilia-associated AIDS patients also received other blood products in the 5 years preceding their AIDS diagnoses.

The NHF's Medical and Scientific Advisory Council has issued specific recommendations for managing hemophilia patients receiving blood and blood products (*12*). In addition, the U.S. Public Health Service has requested that persons at high risk of acquiring AIDS refrain from donating plasma and/or blood and that an extensive effort be undertaken to develop and

FIGURE 1. Acquired immunodeficiency syndrome (AIDS) among patients with hemophilia, by quarter of diagnosis — United States, October 1981-November 1983



*As of November 30, 1983.

AIDS – Continued

evaluate the use of laboratory tests for screening blood or blood products obtained from individuals in high-risk groups (*13, 14*). Physicians diagnosing opportunistic infections or unusual neoplasms in hemophilia patients who have not received antecedent immunosuppressive therapy are encouraged to report these findings to local or state health departments and to CDC.

References

1. CDC. *Pneumocystis carinii* pneumonia among patients with hemophilia A. MMWR 1982;31:365-7.
2. CDC. Update on acquired immune deficiency syndrome (AIDS) among patients with hemophilia A. MMWR 1982;31:644-6, 652.
3. Gill JC, Menitove JE, Wheeler D, Aster RH, Montgomery RR. Generalized lymphadenopathy and T cell abnormalities in hemophilia A. J Pediatr 1983;103:18-22.
4. Ratnoff OD, Menitove JE, Aster RH, Lederman MM. Coincident classic hemophilia and "idiopathic" thrombocytopenic purpura in patients under treatment with concentrates of antihemophilic factor (factor VIII). N Engl J Med 1983;308:439-42.
5. Gordon EM, Berkowitz RJ, Strandjord SE, Kurczynski EM, Goldberg JS, Coccia PF. Burkitt lymphoma in a patient with classic hemophilia receiving factor VIII concentrates. J Pediatr 1983;103:75-7.
6. Special report. Epidemiologic aspects of the current outbreak of Kaposi's sarcoma and opportunistic infections. N Engl J Med 1982;306:248-52.
7. Jaffe HW, Choi K, Thomas PA, et al. National case-control study of Kaposi's sarcoma and *Pneumocystis carinii* pneumonia in homosexual men: part 1, epidemiologic results. Ann Intern Med 1983;99:145-51.
8. Masur H, Michelis MA, Wormser GP, et al. Opportunistic infection in previously healthy women: initial manifestations of a community-acquired cellular immunodeficiency. Ann Intern Med 1982;97:533-9.
9. Ammann AJ, Wara DW, Dritz S, et al. Acquired immunodeficiency in an infant: possible transmission by means of blood products. Lancet 1983;1:956-8.
10. Andreani T, le Charpentier Y, Brouet J-C, et al. Acquired immunodeficiency with intestinal cryptosporidiosis: possible transmission by Haitian whole blood. Lancet 1983;1:1187-91.
11. Enck RE, Betts RF, Brown MR, Miller G. Viral serology (hepatitis B virus, cytomegalovirus, Epstein-Barr virus) and abnormal liver function tests in transfused patients with hereditary hemorrhagic diseases. Transfusion 1979;19:32-8.
12. Medical and Scientific Advisory Council. Recommendations to prevent AIDS in patients with hemophilia (revised). New York: National Hemophilia Foundation, October 22, 1983.
13. CDC. Acquired immune deficiency syndrome (AIDS): precautions for clinical and laboratory staffs. MMWR 1982;31:577-80.
14. CDC. Acquired immunodeficiency syndrome (AIDS): precautions for health-care workers and allied professionals. MMWR 1983;32:450-1.

CENTERS FOR DISEASE CONTROL

MMWR

December 9, 1983 / Vol. 32 / No. 48

MORBIDITY AND MORTALITY WEEKLY REPORT

International Notes

Acquired Immunodeficiency Syndrome (AIDS) — Canada

As of November 25, 1983, Canada's Laboratory Centre for Disease Control (LCDC) has received reports of 51 cases of AIDS. Patients have ranged in age from 20 to 53 years, with 80% occurring in the 20- to 39-year age group. Forty-four (86%) were males. Forty-nine percent of all patients were homosexuals; however, the number of heterosexual patients (43%) is increasing; most are Haitians, and two are hemophilia patients.

Twenty-eight AIDS patients were Canadian-born; 17 were Haitian; and the remaining six were either born in other countries or of unknown birthplace. Twenty-three (45%) of these patients resided in Quebec; 17 (33%), in Ontario; six (12%), in British Columbia; two (4%), in Nova Scotia; one (2%), in Alberta; one (2%), in Manitoba; and one (2%), in Newfoundland. The onset of AIDS in three patients occurred in 1979; in four, in 1980; in eight, in 1981; in 17, in 1982; and in 17, in 1983 (up to November 25); dates of onset are unknown in the remaining two.

Symptoms, including prodromal complaints, were as follows: excessive weight loss (20%), generalized lymphadenopathy (16%), fever (15%), dyspnea (10%), oral thrush (10%), and skin lesions (5%). Kaposi's sarcoma (KS) was diagnosed in 11 (22%) patients, *Pneumocystis carinii* pneumonia (PCP) in 27 (53%), and other opportunistic infections in the remainder. KS and PCP were the only diagnoses in 14, while multiple infections with *Candida albicans*, cytomegalovirus, herpes simplex virus, *Toxoplasma gondii*, and *Cryptococcus neoformans* were found in 22 KS or PCP patients. The opportunistic infections group included combinations of these same organisms with one *Histoplasma capsulatum* infection. *Mycobacterium tuberculosis* was isolated in seven Haitian and two Canadian-born patients. One isolate each of *M. avium-intracellulare*, *M. terrae*, and *M. scrofulaceum* was reported.

The highest mortality rate (65%) occurred among patients of Haitian origin, with toxoplasmosis being the fatal infection in six of the 11 deaths. The mortality rate in the homosexual group was 48%, with PCP accounting for 50%.

Infants have not been included in these statistics because of the uncertainty in distinguishing their illnesses from previously described congenital immunodeficiency syndromes. Four such reports have reached LCDC, three involving children of Haitian origin and one possibly associated with exchange transfusions shortly after birth.

Reported in Canada Diseases Weekly Report, *1983;9:186-7, by S Handzel, MD, Bureau of Epidemiology, LCDC, Ottawa, Ontario.*

Erratum: Vol. 32, No. 47

p. 613. In the article, "Update: Acquired Immunodeficiency Syndrome (AIDS) among Patients with Hemophilia—United States," the last name in the second line of credits on p. 614 should be: P McPhedran, MD.

CENTERS FOR DISEASE CONTROL

January 6, 1984 / Vol. 32 / No. 52

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Current Trends

Update: Acquired Immunodeficiency Syndrome (AIDS) — United States

As of December 19, 1983, physicians and health departments in the United States have reported a total of 3,000 patients who meet the surveillance definition for acquired immunodeficiency syndrome (AIDS) (*1*). Of these patients, 51% were reported to have had *Pneumocystis carinii* pneumonia (PCP) without Kaposi's sarcoma (KS); 26%, KS without PCP; 7%, both KS and PCP; and 16%, opportunistic infections without either KS or PCP. A total of 1,283 (43%) of reported patients are known to have died; the proportion of patients with KS alone who have died (23%) is less than half that of other AIDS patients (50%). Of the 3,000 patients, 90% have been between 20 and 49 years old. Fifty-nine percent of the cases have occurred among whites, 26% among blacks, and 14% among persons of Hispanic origin. Women account for 7% of the cases.

AIDS was first reported in the spring of 1981 (*2,3*), although patients with diagnoses meeting the surveillance definition for AIDS were, in retrospect, seen earlier (Figure 3). Half the 3,000 reported AIDS patients have been diagnosed since February 1983.

Cases have been reported from 42 states, the District of Columbia, and Puerto Rico (Figure 4). Eighty-one percent of the patients were residents of New York, California, Florida, or New Jersey at the time of their onsets of illness. Within these states, most cases have been reported among residents of large cities. The standard metropolitan statistical areas that have reported the greatest number of cases include: New York City (42% of all AIDS patients), San Francisco (12%), Los Angeles (8%), Miami (4%), and Newark (3%).

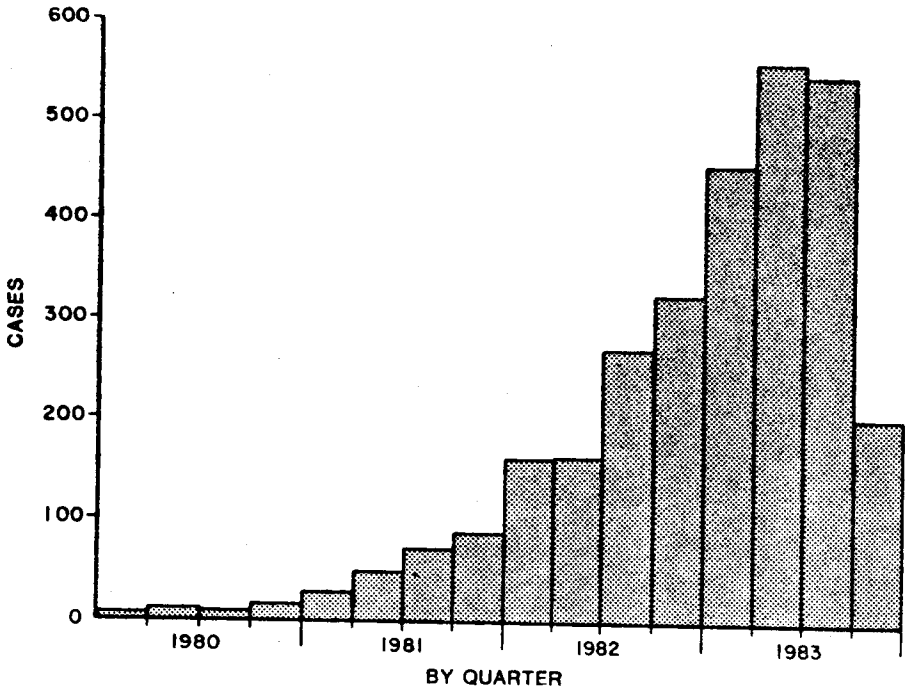
Groups at highest risk of acquiring AIDS continue to be homosexual and bisexual men (71% of cases) and intravenous drug abusers (17%); 12% of patients have other or unknown risk factors. These include persons born in Haiti and now living in the United States (5% of total cases), patients with hemophilia (1%), heterosexual contacts of persons at increased risk for acquiring AIDS (1%), and recipients of blood transfusions (1%).

The 31 patients with "transfusion-associated" AIDS include 18 men and 13 women who have no other known risk factor for AIDS and were transfused with blood or blood components within 5 years of their onsets of illness. These patients received transfusions between April 1978 and May 1983. Twelve are known to have died.

Not included in the 3,000 case reports are 42 children under the age of 5 years who meet a provisional case definition for pediatric AIDS (Table 1). All had life-threatening opportunistic infections; two also had KS (*4*). Twenty-nine (69%) are known to have died.

Twenty-nine of the children came from families in which one or both parents had a history of intravenous drug abuse (17 children) or were born in Haiti (12 children). Three of the 29 children, including one previously reported (*5*), have had a parent (two mothers, one father) with AIDS. Of the other 13 children, seven had transfusions with blood or blood components

FIGURE 3. Acquired immunodeficiency syndrome (AIDS) cases, by quarter of diagnosis—United States, first quarter 1980 through December 19, 1983*



*Excludes 15 cases diagnosed before 1980 and 7 cases for which date of diagnosis was not reported.

before their onsets of illness. One of these children received a platelet transfusion from a man who died of AIDS (*6*).

Reported by State and Territorial Epidemiologists; AIDS Activity, Center for Infectious Diseases, CDC.

Editorial Note: Although the rate of increase of diagnosed AIDS cases appears lower for the last half of 1983 than previously, trends in reported AIDS incidence must be interpreted cautiously. For example, several months often elapse between the diagnosis of an AIDS patient and the receipt of the case report at CDC; the number of reported cases lags behind the true incidence of disease. Also, during the past year, AIDS reporting has been decentralized, so that most cases are reported to state and local health departments, which forward reports to CDC. Final interpretation of trends in AIDS incidence for the last half of 1983 will, therefore, require several more months.

Because children are subject to a variety of congenital immunodeficiencies, confirmation of AIDS diagnoses in children is more complex than in adults. Laboratory testing to exclude congenital conditions is required. In future surveillance summaries, CDC will give the number of children reported to meet the provisional case definition for pediatric AIDS.

References

1. Jaffe HW, Bregman DJ, Selik RM. Acquired immune deficiency syndrome in the United States: the first 1,000 cases. J Infect Dis 1983;148:339-45.
2. CDC. *Pneumocystis* pneumonia—Los Angeles. MMWR 1981;30:250-2.
3. CDC. Kaposi's sarcoma and *Pneumocystis* pneumonia among homosexual men—New York City and California. MMWR 1981;30:305-8.
4. Buck BE, Scott GB, Valdes-Dapena M, Parks WP. Kaposi sarcoma in two infants with acquired immune deficiency syndrome. J Pediatr 1983;103:911-3.
5. CDC. Unexplained immunodeficiency and opportunistic infections in infants—New York, New Jersey, California. MMWR 1982;31:665-7.
6. Ammann AJ, Cowan MJ, Wara DW, et al. Acquired immunodeficiency in an infant: possible transmission by means of blood products. Lancet 1983;I:956-8.

FIGURE 4. Acquired immunodeficiency syndrome (AIDS) cases reported to CDC, by state—United States, as of December 19, 1983

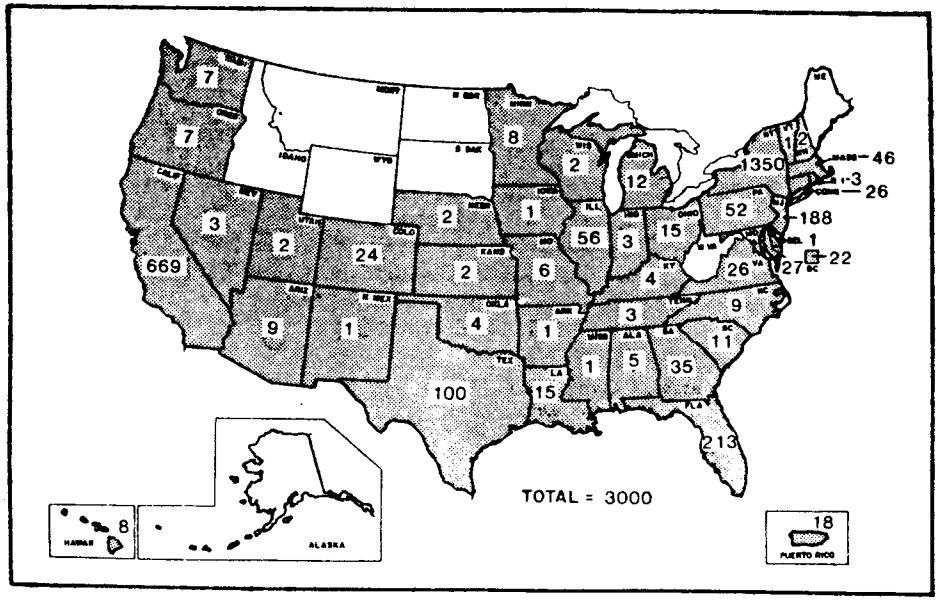


TABLE 1. Provisional case definition for acquired immunodeficiency syndrome (AIDS) in children

For the limited purposes of epidemiologic surveillance, CDC defines a case of pediatric acquired immunodeficiency syndrome (AIDS) as a child who has had:

1. a reliably diagnosed disease at least moderately indicative of underlying cellular immunodeficiency and
2. no known cause of underlying cellular immunodeficiency or any other reduced resistance reported to be associated with that disease.

The diseases accepted as sufficiently indicative of underlying cellular immunodeficiency are the same as those used in defining AIDS in adults (*1*) with the exclusion of congenital infections, e.g., toxoplasmosis or herpes simplex virus infection in the first month after birth or cytomegalovirus infection in the first 6 months after birth.

Specific conditions that must be excluded in a child are:

1. Primary immunodeficiency diseases—severe combined immunodeficiency, DiGeorge syndrome, Wiskott-Aldrich syndrome, ataxia-telangiectasia, graft versus host disease, neutropenia, neutrophil function abnormality, agammaglobulinemia, or hypogammaglobulinemia with raised IgM.*
2. Secondary immunodeficiency associated with immunosuppressive therapy, lymphoreticular malignancy, or starvation.

*Immunodeficiency. WHO Technical Report Series 1978;630:28-31.