THE OFFICIAL NEWSLETTER OF THE

NATIONAL COALITION OF GAY STD SERVICES

Volume 6 #1 August-September, 1984

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* 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 or subscriptions may be addressed to Mark P. Behar, PA-C, Chairperson, 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, and will try to answer all correspondence! The NCGSTDS is the proud recipient of the National Lesbian/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.

GPA GAY PRESS ASSOCIATION

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NCGSTDS SIXTH ANNUAL MEETING: REPORT

from notes compiled by Roger Gremminger & Mark Behar

The 6th Annual Meeting of the NCGSTDS was convened at the 6th National/1st International Lesbian/Gay Health Conference, Sunday, June 17, 1984, at New York University's Loeb Student Center in New York City by Mark Behar, Chairperson. Roger Gremminger, MD, volunteered to be the recording notetaker for the meeting. After a brief welcome, introduction, and history of the NCGSTDS, the 4th edition of the Guidelines & Recommendations for Healthful Gay Sexual Activity brochure, and the latest Newsletter (volume 5:5) was distributed. Coalition members from New York; San Francisco; Long Beach (Nassau County), NY; Milwaukee; Boston; Hartford; New Haven; and Los Angeles were in attendance.

Financial Report and Membership: Total income for the period July 1, 1983-June 30, 1984 is $9966.59, with membership accounting for 54.4% of that total, the Guidelines brochure, 29.7%, donations and Newsletter advertisement-donations, 9.8%, and miscellaneous, 6.1%. Expenses amounted to $8817.09, with the Newsletter (publication & postage) accounting for 45.9% of total expenses, Guidelines brochure, 25%, postage and telephone expenses, 9.7%, and miscellaneous (including airfare expenses, membership in other organizations & newspaper subscriptions, typewritter supplies, etc.), 19.4%. End of year bank account balance--$3281.92. There are approximately 213 paid members/subscribers. A physician member from Washington, DC requested that the membership category, "For Profit" Physician be changed to something more accurate, such as "Private Practice." A motion to change category 3 to: "Individual Practicing Physician: an individual, private practice physician providing health care services." was approved unanimously. Coalition forms will reflect this change in their next printing.

Current Aspects of STD Symposium--III. In light of last year's plans to host a Current Aspects of Sexually Transmitted Diseases Symposium (CASTDS) in Seattle,

Current Aspects of Sexually Transmitted Diseases Symposium--III (CASTDS). After last year's plans to host CASTDS-III in Seattle were aborted, it was decided that the NCGSTDS should coordinate the Symposium this year in Chicago, with the American Association of Physicians for Human Rights. The agreement between the two groups was to split profits from the Conference 50:50 for the first $2500 of profit, and thereafter, a 67:33 split with AAPHR receiving the greater percentage due to their greater liability. Both groups are sponsoring fundraisers--AAPHR, their annual banquet dinner meeting; NCGSTDS, an elevated trainride fundraiser. The cost for renting the four-car train that can hold almost 200 passengers is $1200; at least 60 people paying $20 each is needed to break even. Profits generated by the trainride and CASTDS will help finance a computer system that will help eliminate much of the time-consuming busy work that organizations are plagued with. It was reccommended that the computer system be able to tie into those systems planned for the National AIDS Prospective Epidemiology Network (NAPEN) and the Computerized AIDS Information Network (NAPEN). It was unanamously approved that funds from these events be used to acquire such a computer system. The chairperson was asked to attend the April Board Meeting of AAPHR in New Orleans to work out details for the August meetings (CASTDS/AAPHR Medical Symposium); the chair asked for and received authorization for reimbursement of the $330 roundtrip airfare.

The need for a Board of Directors/Advisors or Steering Committee was discussed. The chairperson voiced concern over lack of guidance and assistance in making decisions about finances, purchases, and other issues, including incorporation. A five member interim board was chosen until Volume 6:1 of the Newsletter, where an appeal to the membership for participation as Board members will be made [see related article]. The five interim board members are: Eric Bjorklund and Hugh Rice (Los Angeles), Dennis James (Boston), Bert Kissling (Hartford), and John Palmer (New York). Board members must be able to meet at least once yearly at a national lesbian/gay health conference or other mutually agreed upon site (at their own expense), and be available for conference calls with other Board members and the chairperson from one to three times yearly (at the expense of the Coalition).

Site of the next NCGSTDS meeting was chosen to coincide with the American Public Health Association's Annual Meeting in Anaheim, November 11-15, exact time, date, and place to be announced later. The seventh annual meeting will tentatively be held in the late spring/early

(CONTINUED)

NCGSTDS SIXTH ANNUAL MEETING, Continued

summer in association with the 7th National Lesbian/Gay Health Conference in Washington, DC.

Membership and support of the Federation of AIDS Related Organizations was discussed after an NCGSTDS meeting recess; as FARO has reorganized into the FARO Action Council, a lobbying group, it was decided that NCGSTDS will continue to support those efforts with $50 annual "membership dues." [See related article on FARO.] The meeting concluded with the reelection of Mark Behar as chairperson and editor of the Newsletter.

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LETTER TO THE EDITOR FROM AMSTERDAM

Dear NCGSTDS: Thanks very much for your very kind letter...which you send us. Thanks also for your congratulations on our recent honor of receiving the Jane Addams-Howard Brown Award. We really are very honored by receiving the award. As we know the National Coalition of Gay STD Services received the award in 1983, so we sure are in very good company. The Newsletter you send us contains really a lot of very useful information we also can use in the Netherlands. So if possible we should like to receive it in the future. Because our own funds are very limited we should be very grateful if you could request the National Lesbian and Gay Health Education Foundation for financial assistance in the postal costs...If you or one of your friends of the NCGSTDS is planning to visit Europe and the Netherlands, feel free to contact and visit us. Or perhaps we will see each other at the next year's Lesbian & Gay Health Conference in Washington. With kind regards and in gay solidarity, Joop van der Linden and Corry Klarenbeek, Nederlandse Vereniging Tot Integratie Van Homoseksualiteit COC, Amsterdam.

[EDs Explanation: Cost of international membership/subscriptions is $55, due to the high cost of international postage. The NLGHEF is unable to provide financial support because, according to Frank Greenberg, president, "...If we were to support COC membership, we would be committed to do the same for other international groups and we do not have the funding base necessary to do this...." If any of our readers would like to sponsor the COC's membership in the NCGSTDS, please send us a note with your donation: NCGSTDS, PO Box 239, Milwaukee, WI 53201. Thanks!!]

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JANE ADDAMS-HOWARD BROWN AWARD PRESENTED IN NEW YORK

The National Gay Health Education Foundation recently announced the recipients of the 1984 Jane Addams-Howard Brown Award at the First International/Sixth National Lesbian/Gay Health Conference in New York. The Award was presented to the newly created National People With AIDS Project and the Nederlandse Vereniging Tot Integratie Van Homosexualiteit (COC) [The Dutch Society for Integration of Homosexuality (Cultural Leisure (i.e., Ontspanning) Centre)] for their significant impact on the health care delivery to lesbians & gay men. The Award was created by the National Gay Health Coalition in 1978 to honor individuals and/or organizations that have made significant contributions to the lesbian/gay health care community.

The Award carries the names of Jane Addams, a lesbian, who as founder of the Chicago Hull House, demonstrated her great social concern, and Howard Brown, a gay physician, who publically acknowledged his homosexuality while serving as health commissioner for the City of New York and provided an awareness of the special needs of gay/lesbian individuals in the process of health care delivery. The Award has traditionally been granted at the National Lesbian/Gay Health Conference. Since the take over of the production of these Conferences by the National Gay health Education Foundation, Inc., the granting of the Award has become the responsibility of the board of directors of the Foundation. Previous recipients of the Jane Addams-Howard Brown Award include Evelyn Hooker and Walter Lear; in 1983, to the National Coalition of Gay STD Services and the National Association of Gay Alcoholism Professionals (in Denver). Ideas for nominations for the 1985 Awards may be directed to Frank Greenberg, President, NGHEF, PO Box 784, New York, NY 10036.

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NCGSTDS ISSUES CALL FOR HELP; "BOARD OF ADVISORS" NEEDED

At the NCGSTDS' recent annual meeting in New York [see adjoining article], chairperson Mark Behar outlined the need for a small group of individuals interested in the goals & objectives of gay STD services and gay/lesbian health issues to be available for consultation on issues of direct import to the Coalition. Five individuals volunteered to serve as an "interim" board of advisors/steering committee, to assist in the decision-making responsibilties that may have long-term ramifications to the NCGSTDS. Some of the issues that require action by this Board: 1) decision to become incorporated and to develop articles of incorporation; 2) investigate whether official IRS tax-exempt status is a desireable long-ranger goal; 3) to review and oversee budgetary concerns (one person shouldn't have to be stuck with a $20,000/year cash flow!); 4) to assist and authorize purchase of computer system; 5) other tasks as agreed upon. Can you think of any additional issues? The responsibilities of this Board include: 1) Meet at least once yearly, at a national lesbian/gay health conference or some other mutually agreed upon site, expenses borne by individuals; 2) Be available for rearranged conference calls with other Board Members and the Chairperson from one to three times per year, expenses to be the responsibility of the NCGSTDS; 3) To offer guidance to chariperson about NCGSTDS business & affairs, as needed (as in above issues).

PLEASE, PLEASE, PLEASE!! The Coalition needs you to assist in those short & long range goals. Please volunteer as a member of this Board! Address your letter of interest to: NCGSTDS, PO Box 239, Milwaukee, WI 53201. Help to expand the leadership base to ensure the continued health and prosperity of the NCGSTDS. Write today.

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NCGSTDS SEEKS DONATIONS

The NCGSTDS is seeking donations to help pay for the acquisition of a new computer system. Previous lamentations involving increasing correspondence, paperwork, and the production of the Newsletter, among other tasks are rapidly depleting Mark Behar's energy stores as chairperson & editor. A computer system to assist in the production in the Newsletter, maintenance of membership lists and forms, etc. is thought to dramatically reduce the work load. A major fundraiser scheduled for Chicago this month, is expected to fall short of the goal. Current Aspects of STDs Symposium, cosponsored with the American Association of Physicians for Human Rights will be held August 22-24. A trainride fundraiser aboard the Chicago Transit Authority's elevated train/subway system will tour the downtown Loop and north and south sides, and is also expected to generate funds. However at least 60 people will be needed to pay for the train, which is costing $1200. The train will be able to hold almost 200 people. If you are not planning to attend the Chicago Conference or Trainride fundraiser, please consider sending a $20 contribution (or more if you can afford it) to the NCGSTDS, PO Box 239, Milwaukee, WI 53201. Thanks!

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SPECIAL THANKS TO ALL WHO HELPED WITH NCGSTDS

As we begin our 6th year of existance and publication of this Newsletter, we must reflect on the accomplishments of our first five years, and gratefully acknowledge the help and assistance of our friends and members. Special thanks to all the gay newspapers that have kindly allowed NCGSTDS to reprint articles. Your appreciation can best be expressed by support of those papers: Boston's Gay Community News, The Washington Blade, the New York Native, Toronto's Body Politic, Detroit's Cruise, among others. Those gay STD services and AIDS foundations also deserve and need your support--they have provided the NCGSTDS with inspiration as well as information. To those who have wrote articles and sent wishes of support, my gratitude is deeply expressed. Let us rededicate ourselves to gay & lesbian health in our respective communities and nationally, and continue to foster the growing networks (printed, phone, electronic, and otherwise) of information sharing among our groups.

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SOURCEBOOK, DIRECTORY, & CASSETTES AVAILABLE ON GAY/LESBIAN HEALTH CARE

The National Lesbian/Gay Health Education Foundation, cosponsor of the recently well-attended First International/Sixth National Lesbian & Gay Health Conference and Third AIDS Forum in New York, are offering several important and valuable "mementos" from the June meetings. The Sourcebook on Lesbian/Gay Health Care is an indispensable tool for health care providers and consumers alike, and is the only national publication devoted to both examining the issue of access to quality health care for lesbians and gay men and listing sources of services around the country who are specialists in lesbian/gay health care. Cost of the Sourcebook is $10 for individuals ($20 for institution/organization rate). The Directory of AIDS Services is a compendium of educational materials, services to people with AIDS, services to populations at risk, information about networking with people with AIDS, AIDS hotlines, infection control guidelines, confidentiality and other issues along with information about community-based AIDS organizations. The Directory is the only listing of current services by the affected communities on medical, psycho-social, legal, advocacy, and financial information. It is over 250 pages in length in a loose-leaf binder format, with quarterly updates for one year (provided with purchase price). The cost is $25 for individuals ($50 for institutions/organizations). Over fifty audio cassette tapes of selected panels and presentations from the Conference are available, dealing with such topics as lesbian sexuality, parenting, alcoholism, AIDS, gynecologic health, health care for the elderly, incest, healthful sex, homophobia, anorexia, youth, death & dying, and others. For more information and ordering forms, contact: NLGHEF, PO Box 784, New York, NY 10036 (212/563-6313).

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NATIONAL LESBIAN GAY HEALTH EDUCATION FOUNDATION HIGHLIGHTS CHANGES

The National Gay Health Education Foundation has recently announced several new changes and policies. The most noticeable change, is in the Foundation's name, incorporating "Lesbian;" the group is now known as the National Lesbian Gay Health Education Foundation, Inc. (NLGHEF), and will be displayed on appropriate letterheads, etc., as soon as the group relocates to Washington, DC, the second major change. The Foundation is presently searching for an office manager for the new Washington office. Ron Vachon has resigned as executive director; search for a new chief executive will take place after future directions of the Foundation are more clearly defined. New Board members include the NCGSTDS' Ron Sable, MD (Chicago), Margie Nichols, clinical psychologist (Jersey City), and Walter Batchelor, lobbiest with the American Psychological Association (Washington, DC). The Board will elect a person with AIDS to serve at their next meeting, September 7. New Board officers include: Frank Greenberg, MD, President; Caitlin Ryan, MSW, President-Elect; Jeff Richards, Secretary; and Paul Paroski, Jr., MD, Treasurer. The Lesbian Health Care Survey is now being distributed all over the country, thanks in part to a grant from the Ms. Foundation. Special emphasis on reaching women of color and low income are being made. The 7th National Lesbian/Gay Health Conference will be held in Washington, DC, in 1985. Exact dates and places will be announced later. For more information about the Foundation, contact: NLGHEF, P.O. Box 784, New York, NY 10036.

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FEDERAL LESBIANS AND GAYS FORMS

An organization for gay men and lesbians working within the federal government has formed in New York and San Francisco, and is dedicated to not only provide a much needed social support for federal employees but also to help change the laws that perpetuate discrimination and harassment among gay & lesbian federal employees. The groups hope to hold a national conference in 1985. For more information, contact: FLAG, 584 Castro St., Suite #464, San Francisco, CA 94114-2588 or FLAG, 496 LaGuardia Pl., Box 217, New York, NY 10012.

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TENTH ANNIVERSARY CELEBRATION SCHEDULED FOR CHICAGO'S HOWARD BROWN MEMORIAL CLINIC

This fall marks the tenth anniversary celebration for an outstanding gay clinic--Chicago's Howard Brown Memorial Clinic. The Brown Society is planning events to commemorate ten years of gay health service according to GayLife. A fundraising dinner and casino party are planned to raise money to supplement the Clinic's operating expenses for testing, treatment, and research into the sexually transmitted diseases. Persons wishing to help support HBMC are asked to help underwrite weekend expenses, advertise in the program booklet, donate prizes for the casino auction, or purchase tickets for the dinner, scheduled for September 22, or the casino, scheduled for September 23. For more information, contact the HBMC, 312/871-5777.

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ADVOCATE 400 HONORS MANY

To help celebrate the 400th issue and 16th year of publication of The Advocate, the national gay newsmagazine, 400 individuals who have made and are continuing to make significant contributions to the gay rights movement in the nation were honored. Eleven of those 400 are members of the NCGSTDS: Daniel William, MD, New York; A. Brad Truax, MD, San Diego; Harvey Thompson, MD, Sacramento; Caitlin Conor Ryan, MSW, Atlanta; William Owen, Jr., MD, San Francisco; David Ostrow, MD, PhD, Chicago; Allan O'Hara, Key West; Roger Gremminger, MD, Milwaukee; Roger Enlow, MD, New York; Susan Dietz, RN, Pewaukee (Wisconsin); and Mark Behar, PA-C, Milwaukee.

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BARTENDER AS GAY HEALTH EDUCATOR

Ohio Department of Health AIDS Newsletter, August, 1984

Bartenders in gay bars have access to great numbers of gay men, many of whom engage in sexual practices that put them at high risk for AIDS and other STDs. Given the correct information and the incentive to disseminate it, bartenders could be a major force in educating gay men about health and healthful sexu practices. To this aim, the Ohio Department of Health has designated a 4 hour training program titled, "The Bartender as a Gay Health Educator." The program will be implemented this fall and presented in 5 Ohio cities. Topics will be: 1) Common STDs; 2) AIDS Update; 3) Healthful Sex Practices; and 4) Local Referral Sources. For additional information, contact: Alan Ford, Ohio Dept. of Health, Div. of Communicable Diseases, 246 N. High St., Columbus, OH 43215.

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CORRECTION

In the last issue of the Newsletter (Volume 5:5) the NCGSTDS incorrectly named the Gay Community Blade, a nonexistant entity, rather than the Gay Community News as the source of an article on an inexpensive hepatitis B vaccine being developed. Sorry for the error!

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GAY NURSES ALLIANCE ELECTS OFFICERS

The National Gay Nurses' Alliance (GNA) is pleased to announce the election of its new steering committee: B. Kevin Rice, RN, National Coordinator (2006 Columbia Rd., NW, Washington, DC 20009, 202/232-6984), Michael J. White, RN, Secretary (Houston); Andrew J. White, RN, Treasurer (Seattle), and William Donovan, RN Nominations & Bylaws Chair (New York). GNA is a national organization founded in 1973 to promote a national mutual support system for lesbian & gay nurses as well as advocacy for lesbian & gay patients. GNA seeks to educate nurses, nursing students, and the general public about health care needs and lifestyles of lesbians & gays. The organization openly communicates with the American Nurses Association, other nursing professional groups, and lesbian & gay health care groups. Additional information is available from the National Coordinator.

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LESBIAN HEALTH

by Caitlin Ryan

By now, many gay men are aware of the contributions made by lesbians to hay male health concerns, especially in the area of AIDS. Now many of you will have a chance to reciprocate by helping us develop a national contact network for the lesbian health care survey. If you have friends or colleagues who are lesbians, please show them this article. The National Lesbian/Gay Health Education Foundation is actively expanding our network of women concerned witht the health care needs of lesbians to prepare for a national survey of lesbian health care needs. We are beginning with a pilot study, funded largely by a grant from the Ms. Foundation, and carried out by lesbian health care providers, researchers, and interested volunteers. Questionnaires will be distributed beginning mid-August and must be returned by November 30, 1984. While the research coordinator, Dot Parkel, and project coordinator, Caitlin Ryan, are based in Atlanta, the study will be conducted nationwide. We are currently seeking women who would be interested in working with us to distribute questionnaires in their communities and make sure they are returned to us. We are attempting to reach as broad a group of lesbians as possible, including: women of color, women with diverse educational and class backgrounds, different occupations, different political attitudes, women who visit women's health clinics and women who have never used them, women who participate openly in lesbian communities and women who do not, women with varied income levels, lesbian mothers, lesbians who are married, lesbians of different ages and experiences. Since our population is so diverse, the questionnaire will be worded to appeal to as broad a spectrum of experience as possible. Some of the questionnaires will be printed in Spanish.

In order to make this study as representative as possible of our diverse community, we need your help: to locate women who would be interested in participating in this study; to develop networks through friends (and friends of friends); to use the resources in your communities such as bulletin boards, newsletters, women's centers and clinics, therapist's offices, social groups, and lesbian/gay organizations. We need to receive as many completed questionnaires as possible from many different parts of the country and from many different kinds of women. It is our experience that women who do not usually respond to questionnaires or who have never participated in a study, will often do so when asked by a friend. Questionnaires will be kept confidential and only the overall results of the study will be published. Completed questionnaires will be mailed to a post office box in Atlanta where the core research team will code the data for computer entry and analysis. The results will be available to people from all over the country and will be used to develop appropriate health care services for lesbians and to provide basic information for education and further study. If you would like to participate, please contact any of the individuals listed below. Thanks for your support in this exciting, vital, and essential work with lesbians thoughout the country. For more information or copies of the survey, please contact: Caitlin C. Ryan (404/892-2459), Margie Nichols (201/246-8439); Pat Maher (212/566-6110 w, 499-6023 h); Weeza Matthias (802/863-1386 w, 658-3061 h); Judy Bradford (804/257-1043/8371 w, 353-4097 h); Fran Miller (415/457-2464 w, 658-7485 h); Kathy Kilbane (312/874-9346 h); Allida Black (202/463-6982); if from Wisconsin, write to the Wisconsin Governor's Council on Lesbian & Gay Issues, PO Box 7863, Madison, WI 53707-7863; or write to: Caitlin Ryan, 550 Cresthill Av., Atlanta, GA 30306 or the National Lesbian/Gay Health Education Foundation, PO Box 784, New York, NY 10036.

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SANTA CRUZ WOMEN'S HEALTH CENTER ANNOUNCES LESBIAN HEALTH PUBLICATIONS

The Santa Cruz Women's Health Center hopes to change the health care system to meet people's health needs. Several publications have been written that specifically address lesbian needs. Lesbian Health Matters! is a comprehensive, heavily illustrated, 106 page book on all aspects of health care relating to lesbians ($4); "Lesbian Health Issues" is a reprint of an article appearing in Science for the People, with an overview of lesbian health issues, annotated bibliography, and illustrations ($1). Several other pamphlets on women's health issues: pelvic inflammatory disease, slef-examination, menopause, patients' rights, gynecologic exam check list, the collective process, and pregnancy. Mail request or prepaid order to: Santa Cruz Women's Health Center, 250 Locust St., Santa Cruz, CA 95060 (408/427-3500).

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INSURANCE REIMBURSEMENT FOR COST OF HEPATITIS B VACCINE

by Pierson, Ball & Dowd, Attorneys At Law, for Merck, Sharp & Dohme Pharmaceuticals

Two components of the US Department of Heatlh and Human Services (the Health Care Financing Administration (HCFA) and the Office of Health Maintenance Organizations (OHMO)) addressed questions concerning reimbursement of costs and requirements for coverage associated with the hepatitis B vaccine (Heptavax).

*For hospitals still reimbursed by Medicare under the retrospective reasonable cost-based system, Medicare will cover under Part A the hospital's reasonable administrative costs incurred in vaccinating employees who are at high risk of contracting hepatitis B and whose private health insurance does not cover the immunization. The Medicare retrospective system applies to hospitals with current cost report periods that began prior to October 1, 1983.

*For cost reporting periods beginning on or after October 1, 1983, the new Medicare prospective payment system applies and the costs incurred would not be directly recoverable for hospitals paid on that basis. Certain types of hospitals will continue to be reimbursed under the retrospective cost-based system. These include psychiatric, rehabilitation, alcohol and drug treatment hospitals (including separately certified units), and long term care and children's hospitals.

*If the hospital treats Medicaid patients, and the state in which the hospital is located utilizes a Medicaid reimbursement system for inpatient hospital services that follows Medicare's retrospective cost-based system, Medicaid would also pay a share of the hospital's cost of administering Heptavax to at-risk employees. As with Medicare, the state Medicaid program's payment of these costs would be based on the hospitals' percentage of Medicaid patients and any overall cost limitations.

*To illustrate these cost recovery opportunities, assume that Hospital X is on a cost-reporting period beginning July 1 so that the new Medicare prospective payment system will not be effective until July 1, 1984. Assume further that Hospital X is located in a state whose Medicaid program reimburses hospitals for inpatient services on a Medicare retrospective cost-based system. Hospital X's patient population consists of 50% Medicare patients, 20% Medicaid patients, and 30% self-pay patients. In April, 1984, the hospital identifies 80 employees who are at-risk of contracting hepatitis B and purchases Heptavax for each of those employees, the total cost of administering costing $8000. Medicare will reimburse the hospital 50% of its costs ($4000), and Medicaid will cover an additional 20% of the costs ($1600).

*OHMO Program Information Letter 83-06 requires federally qualified health maintenance organizations (HMO) to make immunizations with Heptavax available, without additional cost, to plan members who are determined to be in an at-risk category for contracting hepatitis B. At risk groups would usually include health care workers, hospital staff, clients and staff of institutions for the mentally retarded. [AND NOT HOMOSEXUALLY ACTIVE MEN??!!!--ED]

*The need for vaccinations are to be determined on a case-by-case basis in keeping with accepted medical practice.

[Wish to write your comments to the company or its lawyers? Merck Sharp, & Dohme, West Point, PA 19486 (215/661-6412); Pierson, Ball & Dowd, 1200 18th St., NW, Washington, DC 20036, 202/331-8566.]

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LIVER CANCER TEST DEVELOPED

with thanks from Cruise Magazine, July 6, 1984

Scientists at Boston's Massachusetts General Hospital have found a fast, inexpensive test for the early detection of liver cancer, according to an article in the Proceedings of the National Academy of Science. The test was developed by using sophisticated genetic engineering methods, using a chemical that can spot substances in the blood to determine whether a tumor is present. The simple test will cost about $1-2, and will take about 1 hour to process. No sophisticated equipment will be necessary and it will be possible to conduct the test in the simplist of medical laboratories, requiring only a blood sample. Liver cancer is one of the World's most common cancers and is fatal almost 100% of the time, mainly because there has not been a method for early detection. Chronic carriers of hepatitis have a risk 273 times greater than that of the general population of contracting liver cancer. Homosexually active men have a lifetime risk of 80% or more of contracting hepatitis; 6-10% of the approximately 200,000 new cases of hepatitis B contracted each year in the U.S. become chronic carriers, with almost 1000 deaths due to liver cancer.

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"BEST" WAY TO GET MONEY INTO HEPATITIS SCREENING & VACCINATION PROGRAM

by Doug Johnson, RN

Shortly after the availability of the hepatitis B vaccine, the Brady East STD (BEST) Clinic in Milwaukee began instituting a testing and vaccination program based on a sliding-scale fee ability to pay [see Newletter, Volume 4:3, December, 1982, pages 8-11 for a comparison of how 24 communities are dealing with hepatitis B--ED.] Unfortunately but expectedly, a greater proportion of higher income patients (who would have paid more) were found to be antibody positive, making the vaccine unnecessary. Lower income individuals tended to require the vaccine, and paid a smaller amount. Like other communities, there has not been an overwhelming demand or interest in hepatitis screening and vaccination, probably in part due to the AIDS crisis overshadowing hepatitis as a health problem, probably also due to the unattractive cost (even with our sliding scale fees) and inconvenience of repeated appointments for screening, three vaccinations, and a post-test, and lastly, probably most importantly, the poor public relations image and "unfashionablity" of even thinking about hepatitis. While BEST Clinic staff and others from around the country are working on these problems, there was a more immediate need--for funding to keep the program solvent. Recently, however, BEST's hepatitis program was used by the employees of Milwaukee's New Concept Foundation, a social service agency providing services for the mentally retarded, a group where hepatitis B is also endemic. Seven people were tested and immunized, and BEST received approximately $1200 from the Foundation's employee health insurance company. The insurance company stated that the BEST Clinic provided a cost effective service, and plans to refer additional individuals to us for testing & vaccination. Gay health clinics are well advised to investigate this avenue for an important influx of funds. For more information, write: Doug Johnson, RN, BEST Clinic, 1240 E. Brady St., Milwaukee, WI 53202.

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HEPATITIS B AWARENESS WEEK IN NEW YORK PROCLAIMED BY MAYOR

by James D'Eramo, PhD, with thanks to the New York Native, May 21-June 3, 1984

New York City Mayor Ed Koch declared May 20-26 "Hepatitis B Awareness Week" in the city. The proclamation was presented to Jerry Meltzer, founder and president of the American Hepatitis B Association (AHBA). The AHBA was established during the winter of 1983 in response to the public's need to know more about the disease and to provide support and outreach to hepatitis B carriers. Hepatitis B Awareness Week inaugurated a two-month program of low cost blood screening for hepatitis B by the Community Health Project and ten private sponsoring physicians. According to Meltzer, "The significance of this proclamation is to take hepatitis B out of the closet--where it's always been--and to create the awareness essential to overcoming this terrible disease. Hepatitis B, unlike some diseases, can be prevented through proper blood screening, education, vaccination, and the practice of safer sex guidelines. For the hepatitis B carrier, there is no longer a reason to be alone, depressed, and ostracized." For additional information about the group, contact: 212/340-8986, AHBA, 208 W. 13th St., New York, 10011.

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CHICAGO RESOURCE CENTER AWARDS MONEY TO FLORIDA KEYS MEMORIAL HOSPITAL FOR AIDS WORK

Florida Keys Memorial Hospital has recently been granted $10,000 by the Chicago Resource Center to continue its AIDS Education Programs. This grant supplements a basic grant awarded last year for $7500 to help initiate the program. Sarah Bradley, Program Manager for the Chicago Resource Center (CRC) commended the Hospital and Allan R. O'Hara, coordinator of the project, for developing an exemplary program that she said has provided extremely effective services, not only for Key West, but for the state of Florida and the nation as well. O'Hara spends much of his day answering questions about AIDS by phone or letter. Often, it is family, and friends who call, concerned about a loved one. He also answers calls from other hospitals, doctors, dentists, health care providers, and most recently, from several infection control nurses in federal prisons. In addition to booklets, pamphlets, and reprints of articles, the office has videotapes and films that provide information to help understand the disease. For more information, contact: Allan O'Hara, FKMH, PO Box 4073, Key West, FL 33041 (305/294-5531).

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CRISISLINE HAS FUNDING CRISIS

by Steven C. Arvanette, with thanks to the New York Native, July 2-15, 1984

The National Gay Task Force's AIDS Crisisline, a toll-free telephone service which has taken over 15,000 calls from across the country, is experiencing a funding crisis that threatens to shut off the phones. After failing to secure additional grant money, an NGTF membership group recently turned to soliciting donations on New York's Christopher Street, in attempts to keep the lines operating. NGTF started the service in October, 1982 with two national lines but soon expanded to four, with a single line for New York State callers (who pay their toll costs). Peak demand came during last summer's heightened media coverage of the AIDS medical crisis, according to Aubrey Wertheim, coordinator of the crisisline. Monthly telephone bills then ran $3000, but have since dropped to around $1800. The line began as a "resource and reporting tool for anti-gay violence," Wertheim said. Most calls now are inquiries about AIDS, reports of anti-gay violence and attacks, or young people, whom NGTF has especially been directing ads towards, attempting to deal with coming out. "The line has always been a financial problem for NGTF," Wertheim noted. That problem was compounded when money from a September 1983 grant of $12,000 from the Gay Men's Health Crisis was exhausted. A further request for $17,000 from GMHC was denied, due to that group's own financial difficulties. Rodger MacFarlane, GMHC's executive director, said his organization has experienced a serious decline in donations from unsolicited funds and outside benefits, and may experience a $150,000 financial shortfall before the end of the year. NGTF is searching for additional funding sources in the meanwhile.

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COMPUTER INFORMATION RECEIVED

In response to the Coalition's call for information about computers to help in the selection of a system that would facilitate NCGSTDS business, one important communication was received from Mark Goldfield from Brooklyn. His 7 page letter (actually 2 letters) reviews important things to consider before purchasing a system. Topics covered: software & hardware, word-processing, computer keyboards, monitors, disk drives, printers, modems, and other things to think about. If interested in reviewing this easy to understand document, please write to the NCGSTDS, PO Box 239, Milwaukee, WI 53201, and send $1 to cover reproduction & postage.

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CHICAGO'S HOWARD BROWN MEMORIAL CLINIC SEEKS NEW DIRECTOR

Chicago's Howard Brown Memorial Clinic, a pioneer and one of the leading gay health care centers in the country, has announced a national search for a new chief executive officer, after the resignation of Harley McMillen due to illness. The Clinic has grown since its founding in 1974 from a totally volunteer organization serving 1100 patients annually, to a volunteer and professionally staffed facility serving 14,000 patients and providing research, education, and support services. The new executive director will manage a staff of approximately 20 paid employees and 350 active volunteers, and will be responsible for an annual budget in excess of $1.2 million. Candidates should forward resumes and salary requirments to David DuPre, Chairperson, CEO Search Committee, 2850 N. Sheridan, #1109, Chicago, IL 60657. Applications will be accepted through September 15, 1984.

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APPLE COMPUTERS AWARDED TO WASHINGTON, BALTIMORE & PHILADELPHIA GAY GROUPS

from Newsletter of the AIDS Education Fund, Whitman-Walker Clinic, Washington, DC

One year ago, the NCGSTDS Newsletter (volume 5:1, August, 1983, page 7) reported about the availability of free Apple computer systems through their Community Affairs Program, to promote formation of microcomputer networks among nonprofit organizations. The grant includes an Apple IIE computer and monitor, double disk drive, modem, word processing program and printer, and other related software, costing about $4000. The grant was made to the AIDS Education Fund of Washington's Whitman-Walker Clinic, Baltimore HERO, the Baltimore Gay Community Center, and the Philadelphia AIDS Task Force. This consortium of groups, named the Mid-Atlantic AIDS Network (MAAN), will share among its members and other research institutions in the area data on AIDS, AIDS research, and epidemiology. As a side benefit, the equipment will also help keep mailing lists up to date. Special thanks go to Apple Computers and to Gary Hensler for his role in shepherding this grant through the process.

For more information about developing a microcomputer network and applying for a grant to acquire Apple's hardware and software, write: Apple Computer Community Affairs Program, 20525 Mariani Av., M/S 9L, Cupertino, CA 95014, or phone 408/996-1010.

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WARTS STUDIED IN CDC TRIAL

A two phase clinical study of condyloma accuminata, the venereal wart, is finally planned by the Centers for Disease Control, according to Ward Cates and Tom Becker of the STD Control Division. Phase one will evaluate the efficacy and safety of three common treatment modalities--podophyllin, 25% in tincture of benzoin; cryotherapy (liquid nitrogen); and electrocautery (with local anesthesia). All therapies will be offered weekly for a maximum of 6 consecutive weeks, with follow-up evaluations periodically for one year. Use of laser as a treatment modality will not be tested, probably because it is not yet commonly available to most clinicians. Treatment will only be offered to warts found on the penis, vulva, and perianal area. The second phase of the study is expected to begin a year or two later, and will attempt to evaluate viral- (human papilloma virus) induced cervical changes with colposcopic techniques. When asked about the possibility of a multi-clinician collaborative study, Dr. Becker replied that it would be too difficult to plan and beyond their resources.

[ED NOTE: Clinicians providing STD services to homosexually active men have been using a multitude of therapeutic modalities against venereal warts. Although podophyllin (25% in tincture of benzoin) has been the mainstay, efudex, cantharin, bi- & trichloroacetic acid, cryotherapy, electrocautery, laser, immunotherapy (with the patient's own homogonized warts), and surgery have been used with varying success on penile, anal, and intrarectal (vulvovaginal if you also see women patients) condylomata. Certain strains of HPV are known to be associated with cervical carcinoma; is there also increased risk of anorectal carcinoma from similar exposure to certain strains of HPV? Jim Curran of the CDC's AIDS Activity (and previously with the VD Control Division) predicted "...an epidemic of anorectal cancer in homosexually active men by the year 2000...." If any readers are interested in studying these problems (effective treatment for intrarectal warts, use of colposcopic techniques for evaluating anorectal warts, association of warts & HPV with rectal carcinoma, etc.) in a collaborative study, please contact the NCGSTDS, PO Box 239, Milwaukee, WI 53201.]

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"VENEREAL WARTS--A NEW EPIDEMIC?"

abstracted with thanks to the Hotliner, VD National Hotline Newsletter, Spring, 1984

[ED NOTE: The above headline was taken from the feature article of the Spring issue of the Newsletter of the VD National Hotline. One of the biggest problems in public health has been public hysteria by injudicious use of inflamatory words like "epidemic;" we do not dispute the fact that warts are becoming a major problem, but in order to avoid the massive misunderstandings from the public as occured with herpes and AIDS, public health educators must chose their words carefully.]

Although by no means a new disease, venereal warts have recently been making the news. Like other STDs, warts have steadily increased in incidence, with an estimated half a million persons acquiring the condition annually in the US. Once viewed as a relatively benign, though troublesome condition, warts have attracted attention and concern because of the mounting evidence that they are linked to the development of cancer. Also known as condylomata accuminata, venereal warts are caused by the human papilloma virus (HPV). Symptoms may appear anywhere from 6 weeks to eight months after exposure, but the average incubation period is three months. While the relationship is not firmly established, research findings suggest a link between laryngeal warts and throat cancer. Numerous studies have also shown a link between anogenital HPV infection and cancer. Condyloma may be associated with 5% of vulvar carcinoma and 15% of penile carcinoma. A recent study indicates that 91% of women with cervical neoplasia showed evidence of HPV infection in the form of wart virus particles. Warts may be viewed as a premalignant lesion with a long latency period. Warts are contagious during the incubation period, so partners may not show signs simultaneously. Even with treatment, a cycle of reinfection can occur. Use of condoms can help decrease the risk of transmitting the virus.

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NORTH CAROLINA HEALTH SURVEY RESULTS RELEASED BY DURHAM'S LESBIAN & GAY HEALTH PROJECT

As one of the first projects of the newly formed North Carolina Lesbian & Gay Health Project--Durham, was a broad-based health survey to help determine the quality of health care available to gay people in the state. Ignorance of possible gay-related health problems, among both health care providers and consumers, also seemeda major interest. Questions of provider sensitivity to gay problems and, indeed, overt discrimination were also raised. The AIDS crisis gave these issues a compelling new urgency. Over 450 people completed the survey, with a preponderance to young (under age 46), white (94%), and highly educated (almost 68% were college grads). Men worry much more than women (77.5% vs. 21.17%) about STDs, and apparently for good reasons. First, men are far more sexually active than women. 23.2% of the male respondents reported 4 or more different sex partners per month; none of the female respondents reported this many. Second, as is commonly reported, men reported much lengthier histories of STDs than women; of the men, 39.19% have had gonorrhea, 10.76% syphilis, and 13.53% hepatitis; of the women, 29.5% had gonorrhea, 1.47% syphilis, and 6.67% hepatitis. On the other hand, women reported more concerns with mental health issues and more mental health counseling experiences than men. Some 76.47% of female respondents have sought counseling vs. 54.09% of the men. As for mental health problems, 44.12% of the women reported chronic sadness or depression and 31.86% reported chronic anxiety or fear as either current or past problems. The figures for alcohol problems were 20.75% and for weight problems 45.59%. For men, the figures were: depression, 35.76%; anxiety, 24.45%; alcohol, 14.34%, and weight, 33.22%; considerably less, but still substancial. As for assault and abuse, 21.74% of the women and 6.71% of the men reported being sexually abused as children and 23.48% of women and 15.25% of the men report being physically abused as children. But asked if they had ever been attacked or abused for being homosexual, 9.82% of the women and 16.32% of the men answered yes. Additional results are being compiled. For more information, contact: LGHP, PO Box 11013, Durham, NC 27703.

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PHYSICIAN ASSISTANT NEEDED IMMEDIATELY IN CHICAGO

Applications are now being accepted for the position of Physician Assistant for the National Institutes of Health Immune Function Research Study at Chicago's Howard Brown Memorial Clinic. This represents an entry level position which reports to the Senior Physician Assistant assigned to the project for job orientation and daily supervision. Medical direction will be provided by the Principal Investigator assigned to the project. Responsibilities of the Physician Assistant will include: 1) Administration of the NIH Study Baseline Physical Exam; 2) Provision of health education, encouragement and support through the examination and as needed thereafter; 3) Make appropriate referral to clinical staff at Northwestern University Medical School for more extensive followup; 4) Review all laboratory results and designate an approriate medical status regarding the need for any additional testing or followup care in addition to routine NIH clinical visits; and 5) Review all clinical impressions with the Study Principal Investigator. Candidates must be certified Physician Assistants or be board eligible. Salary competitive. Forward resume and names of three references to: James P. Harisiades, MPH, NIH Project Coordinator, Howard Brown Memorial Clinic, 2676 N. Halsted, Chicago, IL 60614. Howard Brown is an equal opportunity employer.

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MINNEAPOLIS SEARCHING FOR EXECUTIVE DIRECTOR

with thanks to Equal Time, June 27, 1984, and J.C. Ritter

The Minneapolis Lesbian & Gay Community Services (LGCS) is searching for a new executive director after the resignation of Morris Floyd, who had been with the center since July, 1981. The executive director will manage a volunteer telephone staff of almost 50 with a budget of over $300,000. The position will pay $25-30,000. For more information, contact Ann Richtman, President of the Board, LGCS, 124 West Lake St., #E, Minneapolis, MN 55408.

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BOOK: HOMOSEXUALITY AND SOCIAL WORK

The Haworth Press has recently announced the publication of the monograph, Homosexuality and Social Work (previously published as the Journal of Social Work & Human Sexuality, Volume 2:2-3), edited by Robert Schoenberg and Richard Goldberg, with David Shore. The 156 page comprehensive volume provides an introduction, overview and exploration of social work services for homosexual men and women. It is available in hardbound ($19.95) and softbound ($12.95) from your book seller or The Haworth Press, 28 East 22nd St., New York, NY 10010.

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BOOK: BISEXUAL & HOMOSEXUAL IDENTITIES: CRITICAL THEORETICAL ISSUES

The Haworth Press recently announced the publication of the 8th book in their series, Research on Homosexuality--Bisexual and Homosexual Identities: Critical Theoretical Issues, by editors John DeCecco and Michael Shively. This 174 page book was also published in the Journal of Homosexuality (Volume 9:2-3), and addresses questions about the possible ingredients of homosexual and bisexual identities and their conceptual bases in cultural history, moral philosophy, biology and social psychology. It is only available in hardbound ($22.95) from your book dealer or The Haworth Press, 28 East 22nd St., New York, NY 10010.

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"LOVE MASK" PROVIDES LATEST IN STD PREVENTION!
with thanks to Cruise and Tony Rome Enterprises

[The following ad was recently seen in a recent issue of Cruise magazine from Detroit. It is reprinted here for your amusement!--Ed.]

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DECLINING RECTAL & PHARYNGEAL GONORRHEA AMONG NEW YORK CITY MEN DUE TO SAFE SEX?
with thanks from CHI, New York City Health Information, June 13, 1984

The rate of rectal and pharyngeal gonorrhea in New York City among men aged 15-44 years has declined from 129 per 100,000 in 1980, to 74 per 100,000 in 1983, the lowest level in the past 7 years. In comparison, gonorrhea rates among women aged 15-44 have risen over the same period from 587 to 624 per 100,000. The most compelling explanation for these trends is a decline in the effective transmission of gonorrhea among gay men. Declines in gonorrhea incidence among homosexually active men have also been reported by Frank Judson in Denver. Since 1980, there have been many alterations in the gay lifestyle possibly due to concern about AIDS; this has resulted in a reduction in the number of sexual partners and probably adoption of "lower risk" & "safe sex" activities. These voluntary changes coincide with the decreases observed in gonorrhea rates. Maintenance of these efforts should help reduce the transmission of AIDS.

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OHIO SPONSORS AIDS CONFERENCE

An AIDS conference geared to social workers, health care providers, and publich health personnel is being sponsored by the Ohio Department of Health, September 25, 1984, at the Sanese Services Conference Center, 6465 Bush Blvd., Columbus. There will be a limited enrollment, and an immediate RSVP is required, by not later than September 10: write or call: Lois Hall, Ohio Dept. of Health, 246 N. High St., PO Box 118, Columbus, OH 43215, 614/466-0265. There is no registration fee, and lunch will be provided. A cocktail reception hosted by the Columbus AIDS Task Force will follow the conference. Topics to be covered include: Screening/Medical Protocol; AIDS Update; Ohio Epidemiology; Community Response; and the AIDS Experience.

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AIDS EPIDEMIOLOGY/SURVEILLANCE UPDATE

abstracted from AIDS Weekly Surveillance Report, CDC AIDS Activity

As of July 30, 1984, the Centers for Disease Control AIDS Activity reports a total of 5394 cases of AIDS in the United States (CDC definition). Homosexually active men account for 71.9% of all cases; 17.6% from IV drug users; 3.9% from Haitians; 0.8% from hemophiliacs; and 5.9% from those in no apparent risk/unknown risk group. [The CDC has received much criticism for this atypical "hierarchical" listing--some of the homosexually active men may also be IV drug users, but are only counted in the top (i.e., homosexually active men) category. This confuses and misrepresents the data, which the CDC has admitted.--ED] 22.9% are from individuals aged 29 or less; 47.0% from ages 30-39; 21.3% from ages 40-49; and 8.8% from ages 50 or older; the remainder are in unknown age groups. 58.2% of the individuals are white; 25.2% are black; 14.6% are hispanic; 2.1% belong to other/unknown racial/ethnic backgrounds. Forty-eight states including the District of Columbia and Puerto Rico have reported cases to the CDC; New York and California have the most cases, with 41.0% and 22.1%, respectively; Florida, 7.2%; New Jersey, 6.4%; Texas, 4.3%; Illinois, 2.1%; all other states have less than 2.0% each. Overall mortality has remained high--45.6%, which reflects an increased case mortality since the last Newsletter (Volume 5:5, date of update, May 28; mortality was 43.3%). AIDS cases per million of population for the entire US is 23.8, ranging from 225.3 cases per million in New York City, and 187 cpm in San Francisco, 135.9 cpm in Miami; 77.8 cpm in Newark; 58.4 cpm in Los Angeles; and 9.5 cpm elsewhere in the nation. These figures represent only those cases meeting the CDC's strict criteria of case definition.

As of May 30, 1984, Canada has recognized 88 adult cases of AIDS (77 males, 11 females), of whom 40 are alive and 48 deceased; 49 homosexuals, 39 heterosexuals or unknown. Provincial ackground: Quebec, 41; Ontario, 30; British Columbia, 8; Alberta, 4; Nova Scotia, 2; Manitoba, Newfoundland and Saskatchewan, all 1 each. [Thanks to Toronto's The Body Politic, July-August, 1984, for these Canadian AIDS statistics.]

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AIDS PATIENTS WIN THANKS TO NATIONAL GAY RIGHTS ADVOCATES

reprinted with thanks to Cruise, volume 6:27, July 13, 1984

The California Department of Health Services Medi-Cal program has backed down on its refusal to pay for costs associated with the treatment of certain AIDS patients. Medi-Cal was refusing to pay when patients with pneumocystis pneumonia were treated with the drug pentamidine. The National Gay Rights Advocates (NGRA), a public interest law firm involved with gay & lesbian civil rights litigation, threatened the state agency with a lawsuit if they didn't change their policy. Medi-Cal claimed they could not approve of pentamidine treatment because it was "experiemntal." NGRA asserted that position was unfounded because the Centers for Disease Control distributes the medication and until a few years ago it was the first medication of choice for the illness. It is still used for those who are unable to receive trimethoprim-sulfamethoxazole. NGRA won a total victory when Medi-Cal agreed to start providing pentamidine and to conduct retroactive reviews of earlier cases that were not certified for funding.

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COMPUTERIZED AIDS INFORMATION NETWORK

Included with this Newsletter is a brochure outlining CAIN, California's Computerized AIDS Information Service. CAIN is designed to provide a central, computerized data-base of AIDS related information; CAIN addresses the need for an up-to-date source of AIDS related information, readily available to all interested individuals and organizations. CAIN is a project which has received funding from the California Department of Health Services and is administered by the Gay and Lesbian Community Service Center of Los Angeles and the San Francisco AIDS Foundation. For more information, contact: CAIN, Greg Elmore, Vice President, Marketing, J.R. Tellum, 8033 Sunset Blvd., #934, Los Angeles, CA 90046 (213/222-7222).

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TEMPORARY HOUSING FOR PEOPLE WITH AIDS IN WASHINGTON, DC

from Newsletter of the AIDS Education Fund, Whitman-Walker Clinic, Washington, DC

Work continues on the establishment of the Robert Schwartz, MD Memorial Home, which will provide temporary housing for persons with AIDS who have none of their own or who are unable to live alone. The project was established March, 1984, following Dr. Schwartz's sudden death in February. Dr. Schwartz had been the first director of Patient Support Services for the AIDS Education Fund. As of June 20, close to $9000 had been raised for the project. It is projected that the Home will open sometime during the fall of the year.

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BOSTON HIKERS RAISE $9000 FOR AIDS ACTION COMMITTEE

with thanks to Boston's Gay Community News, July 14, 1984

Seventy-one hikers raised over $9000 to benefit Boston's AIDS Action Committee at the Chiltern Mountain Club's second annual Hike for Life, June 23. The eight mile trek took men and women hikers through the Blue Hills Reservation. The Chiltern Mountain Club sponsored a similar event at Meriden Mountain in Connecticut, June 17. Fifty hikers raised $3000 to support AIDS related work of the Hartford Gay Collective and the AIDS Project of New Haven.

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HOUSTON'S KS/AIDS FOUNDATION ISSUES SECOND ANNUAL REPORT & FINANCIAL STATEMENT

The second Annual Report and Financial Statement for the KS/AIDS Foundation of Houston has recently been released, and is available for $1 plus self-addressed stamped envelope with 37¢ postage (or alternatively, if you wish to include a donation, just send $2) from: KS/AIDS Foundation of Houston, Inc., 1001 Westheimer, Suite 193, Houston, TX 77006. Please specify "second ARFS" for the latest, 1984 report, or "first ARFS" for the 1983 report.

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HOUSTON KS/AIDS FOUNDATION: ADAPT, ENJOY, AND SURVIVE

The KS/AIDS Foundation of Houston began developing and implementing "safe sex" and "adapt, enjoy, and survive" campaigns back in 1983, patterning programs & philosophies in complement with similar groups in New York, San Francisco, Los Angeles, and other cities. The campaign themes have emphasized fun and fashion rather than the fear already inherent in the disease. An educational evaluation survey completed April, 1984, shows that gay men in Houston now know what "safe sex" is and they report it makes them feel more confident and less afraid of AIDS, but a majority also report they are unaware of how to use "safe sex" advice practically. The average gay man wants to play safely, but doesn't know how to identify a "safe sex" partner, how to negotiate a "safe sex" contract with a potential partner, nor how to control an encounter to make it "safe." There are also psychosocial, emotional, affectual, as well as practical considerations to overcome if "safe sex" education is to ever prevent disease and save lives. The media hype is over, the panic is fading, but the reality is growing. For more information, contact the KS/AIDS Foundation of Houston, 1001 Westheimer, Suite 193, Houston, TX 77006, 713/524-AIDS. [Thanks to Michael Wilson!]

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MORE AIDS MONEY REQUESTED FROM HEALTH & HUMAN SERVICES

by Dave Walter, with thanks from the Washington Blade, volume 15:28, July 13, 1984

A top federal health official has sent a memo to Health & Human Services Secretary Margaret Heckler saying that millions of dollars in additional funds for AIDS-related research are needed if scientists are to "seize the opportunities which the recent breakthroughs have provided us...." Assistant Secretary for Health Dr. Edward Brandt, Jr. said in a "confidential" May 25 memo obtained by The Washington Blade that a supplemental appropriation of more than $20 million is needed for fiscal year 1984 and that the Administration must hike its FY 1985 AIDS budget request by nearly $36 million, which is needed as a result of recent research advances including the discovery of LAV/HTLV-III as the "probable" cause of AIDS, and the probable development of a blood test for AIDS. If granted, the FY 1984 supplemental would boost the 1984 appropriation to the the Public Health Service to more than $68 million. The amendment to the Administration's FY 1985 request would hike the proposed 1985 figure to slightly more than $91 million. In his memo to Heckler, Brandt said, "Although I realize the general policy would discourage supplemental and amendment requests at this time, I believe that the unique situation with respect to AIDS justifies our forwarding the requests at this time....I ask your favorable consideration of the PHS proposals and respectfully request you forward it to the Office of Management and Budget." Brandt's request has not been forwarded to the OMD; in fact, Heckler herself hasn't yet seen the memo, according to HHS spokesman Campbell Gardett. Gardett said it is "not unusual" for documents to be circulated in the Secretary's office before being sent to her. Heckler has repeatedly referred to AIDS as the nation's "number one health priority" and has promised to be responsive to funding requests from government health officials. As recently as June 18, Heckler told reporters, "If it requires a supplemental appropriation, of course, I will naturally request it." But she added, "I cannot prejudge the need for funding; it may not be necessary." Jeff Levi, Washington representative of the National Gay Task Force, which has worked closely with the Reagan Administration on AIDS-related matters, said he was "disappointed" and "angry" that more than 6 weeks have passed without action by Heckler. Levi added, however, that he is pleased that the amount of extra funding requested by Brandt is "so substantial" and said he was particularly glad that the request includes $2.5 million for risk reduction and prevention.

Brandt's memo includes requests for funding for the following agencies:

The Centers for Disease Control. For the remainder of FY 1984, which runs through September 30, $3.2 million in additional funds is requested for the CDC, including $1.7 million which would be used partially to initiate basic studies for vaccine development. Another $437,000 would be used to improve diagnosis and treatment of opportunistic infections. Most of the rest of the money would be used to expand current efforts. The FY 1985 request for an additional $11.2 million seeks money to continue 1984 projects including a study of sexual partners of people with AIDS in Boston to determine "transmission risk factors." In addition, the CDC wants to use $2.5 million of the funds to expand existing agreements with state and local health departments "to include risk reduction (information/education) programs for high risk groups."

National Institutes of Health. Brandt is seeking a total of $13.1 million more for FY 1984. Some of the funds would go to the National Cancer Institute for accelerated efforts "to produce a vaccine and to prevent AIDS and to develop other ways to halt its development." Among other things, NCI also seeks to expand its search for an effective treatment for AIDS. Other FY 1984 funds would go to the National Institute of Dental Research, the Division of Research Resources, and the National Institute of Allergy and Infectious Diseases for a variety of projects including animal studies. For FY 1985, an additional $18 million is saught, primarily to continue projects initiated this year.

Food & Drug Administration. Brandt's request for the FDA is for $2.6 million more for FY 1984, to be used for facility renovations and equipment. However, he noted that if the money were not made available by July 1 it would have to be added to the FY 1985 request. Brandt seeks $5.75 million more for the FDA in FY 1985, some of which would be used "to assess the impact on the national blood supply if those who are screened as positive for the AIDS agent are excluded from further donation...."

Alcohol, Drug Abuse, and Mental Health Administration. Approximately $1.2 million would be added in FY 1984 and $822,000 in FY 1985 to the ADAMHA budget to support research on "the psychological and behavioral factors related to AIDS victims and the relationship of AIDS to drug use." Congressional appropriations subcommittees have been working on FY 1984 supplemental and FY 1985 appropriations for AIDS-related projects without the benefit of an Administration

(CONTINUED)

MORE AIDS MONEY, Continued

request incorporating Brandt's figures. However, Shirley Barth, a spokesperson for Brandt, acknowledged that there is informal communication between Capitol Hill staffers and PHS officials. The AIDS-related funding levels being considered by Congress have not been made public, but an informed source said the House appropriations panel is considering an amount that is "about half" of the amount contained in Brandt's request. The source said the Senate subcommittee is considering a CDC funding level that is at least equal to the Administration's FY 1985 request and an NIH funding level that is higher than the Administration's request. According to Brandt's memo, the PHS received $5.5 million in AIDS-related funding in FY 1982 and $28.7 million in FY 1983, and has received $48.3 million so far in FY 1984. He wants the FY 1984 appropriation increased to $68.4 million and the FY 1985 figure set at $91 million.

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"MORE AIDS MONEY" WORKED OVER BY CONGRESSIONAL COMMITTEE

by Mark Scott, with thanks to The Washington Blade, July 27, 1984

The House Appropriations Committee approved $8.3 million for additional AIDS-related funding for fiscal year (FY) 1984, substantially less than the $20 million that Assistant Secretary for Health Dr. Edward Brandt, Jr. said was needed to capitalize on recent research gains. Jeff Levi, Washington director of the National Gay Task Force, said he was "disappointed" by the FY 1984 supplemental appropriation but believes the National Institutes of Health will have a "blank check" for AIDS research in FY 1985. Levi said the FY 1984 supplemental, which includes $1.75 million for the Centers for Disease Control and $6.55 million for the NIH, is "not enough." The supplemental did include $150,000 to be used for public education about AIDS in a national effort directed by the National Hemophilia Foundation and community based AIDS educational organizations such as Washington, DC's Whitman-Walker Clinic, Levi said.

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OKLAHOMA AIDS AWARENESS

with thanks to The Gayly Oklahoman, August, 1984, and author Lynn Robert Kennington

In a relentless drive to educate the Oklahoma City gay community about the AIDS crisis, the Oklahoma City AIDS Task Force, Oklahoma Blood Instititute, HealthGuard, and the Gay Helpline are realigning their roles in what has been called one of the nation's "model" AIDS-awareness efforts. Working together, the groups have devised a plan to maximize resources and services to AIDS-risk groups, while remaining cost effective. The AIDS Task Force, a non-profit group consisting of medical, non-medical, gay and non-gay professionals, has served as the primary source of AIDS-related information. The Task Force has maintained a constanct rapport with the local news media to help dispel myths about the disease and to defuse any AIDS anxiety, as seen in other parts of the country. The group has also assisted in the production and distribution of nearly 5000 pamphlets and has previously been responsible for the AIDS Hotline, a free phone line where callers could receive AIDS-related information. Recently, the Oklahoma City Gay Helpline took control of the Hotline, which can be reached by dialing 405/232-1312. The Gay Helpline, which has been a source of information about the gay community for several years, hopes to raise additional revenue to expand AIDS informational services to the entire state, via a toll-free, 800 line. The AIDS Task Force holds an AIDS screening clinic at the Blood Institute. When AIDS was initially recognized, several areas of the country were considering legislation to bar homosexuals from donating blood. The Institute followed the example by the Blood Center of Southeastern Wisconsin and others by intituting a voluntary "self-deferral" or "face-saving" policy--one of the firsts in the nation. The AIDS screening clinic is staffed by volunteers and professional services are provided free of charge, however there are small costs for laboratory testing, which includes a complete blood count, hepatitis A and B and cytomegalovirus antibody testing, and if requested, a T4T8 test of immune function. The fourth group to contribute to the AIDS-awareness campaign is HealthGuard, a gay, non-profit group which is raising funds to help produce health related literature for distribution to the gay community. At a recent fund-raiser, "Gay Family Feud," HealthGuard raised over $1500. HealthGuard is planning to produce a complete series of health-related brochures relaying information aobut common STDs, AIDS, and guidelines for more healthful sexual activity.

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POLITICS OF AIDS: REQUEST FOR IDEAS FROM AUTHOR DENNIS ALTMAN

I am working on the politics of AIDS for a book that will examine, in particular, the symbolic ways in which AIDS is being viewed. I am particularly interested in anything readers might know of which discusses how AIDS has affected the way we think about community, spirituality, medicine, sexuality, and politics as a result of the epidemic. I would be very interested in hearing from people who might have relevant comments or material. Please write to: Dennis Altman, 1326 Third Avenue, San Francisco, CA 94143. [Thanks to Toronto's The Body Politic, June, 1984.]

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RESEARCH SQUELCHED BY AIDS PANIC IN LABORATORY

by Ken Popert, with thanks to Toronto's The Body Politic, June, 1984

A University of Alberta (Edmonton) medical researcher has been denied access to university laboratories for AIDS research, apparently because laboratory staff feared they might contract the condition. John Krowka, who is completing his doctoral work in the Department of Immunology, was told April 30 that permission to use the department's containment facility, granted earlier, was being revoked by department chair Dr. Erwin Diener. Permission to use a similar lab in the Department of Medical Microbiology had also been withdrawn. Krowka was denied access even though the university's biosafety committee, which determines the conditions under which possibly dangerous research may be conducted, had approved the project. Permission to use the facility had been withdrawn after an unusual departmental meeting at which staff fears about AIDS were expressed and could not be allayed. Dr. Stan Read, a member of an AIDS research team in Toronto, described the incident as one instance of "a serious problem that comes up everywhere." Nils Clausson, civil rights director of Edmonton's Gay Alliance Toward Equality, said, "The issue here is hysteria among staff and technicians. The university seems unwilling to surmount the obstacle or confront it openly."

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SOCIAL SECURITY DISABILITY INSURANCE

from the Division of Preadjudicative Policy, Office of Disability (No. 11-84-OD, 7/18/84)

This information is being issued to ensure that all Social Security and disability determination services' (DDS) adjudicators have a clear understanding of the nature of AIDS and the proper aproach to the documentation and evaluation of AIDS cases. The documentation of AIDS requires adequate description of teh clinical findings and information providing the results of serological testing, microbiologic cultures, or tissue biopsy. To confirm a diagnosis of AIDS, SSA uses the CDC definition. Once an individual has a confirmed diagnosis of AIDS, the level of severity of AIDS is such that he or she will be found to have an impairment which meets or equals the Listing of Impairments. It should be noted, however, that individuals should not be denied merely because their impairment does not meet the CDC definition. It cannot be assumed that individuals who have evidence of immune system dysfunction but do not have a confirmed diagnosis of AIDS are not disabled. Such individuals must be assessed on a case-by-case basis. As with all medically determinable impairments, the rating of severity must take into account signs, symptoms and laboratory findings. An assessment of the individual's residual functional capacity (RFC) should be made, and a decision should then be made as to whether, based on the RFC, the individual retains the capability to perform past relevant work. If he or she cannot perform any past relevant work, then age, education, and past work experience should be considered to determine if there is any other work that the individual can perform.

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POPPERS & AIDS

by Hank Wilson, San Francisco Committee to Monitor Poppers

The US Public Health Service is now distributing a "scriptographic" pamphlet, "What Gay and Bisexual Men Should Know About AIDS," and it has serious errors with respect to comments written about inhalant nitrites (poppers). Although there is increasing concern about the role of poppers as a possible cofactor in the development of AIDS, the booklet authoritatively states: "Nitrite inhalants or "poppers," used by some homosexuals to enhance sexual excitement, were thought to affect the immune system. (This theory has been ruled out.)" [Emphasis added.] Contact Mr. Seaborg, US Public Health Service, AIDS Hotline (202/245-6867) if you'd like to comment about that statement. San Francisco recently implimented an educational strategy rather than a prohibitive one, and passed an ordinance mandating the posting of a warning anyplace inhalant nitrites are sold. For more information: Hank Wilson, CMP, 55 Mason, San Francisco, CA 94102 (415/441-4188).

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AMERICAN NURSES ASSOCIATION ADDRESS AIDS

with thanks to the New York Native, July 30-August 12, 1984

The American Nurses Association (ANA) recently issued a statement addressing health care and social supports for persons with AIDS, during their June 22-28 meeting in New Orleans. The statement points to "widespread social stigmatization of lesbian and gay persons" and acknowledges that "when seeking care" members of this group "find themselves socially vulnerable --ostracized and punished," and goes on to affirm the "right to equitable and humanistic health care," including "quality treatment; non-discriminatory use of current isolation procedures; full explanations of research procedures, treatments, and risks involved; informed choice of treatment/research modalities; confidentiality of medical record; and respect for privacy and significant relationships." The statement was issued by the ANA board, which also endorsed a five-part plan of implementation including issuance of the public statement; making funding for gay and lesbian health care a priority in their lobbying efforts; endorsing the work done by the National Gay/Lesbian Health Foundation; setting up a liaison between ANA and the Foundation; and urging all state nurses associations to lend appropriate support. The meeting also featured a program on "AIDS: Nursing Responsibilities," attended by nearly 600 people.

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POPPERS AS AIDS COFACTOR--AN OPINION

by Charles L. Ortleb, Publisher & Editor-in-Chief, with thanks to the New York Native, July 30-August 12, 1984

There are a lot of gay people who think that they have never inhaled poppers [amyl/butyl/isobutyl nitrites]; in reality they've been inhaling them for years. How? Simply by dancing next to people who are inhaling them. And having sex while a partner inhales them, supposedly by himself. In 1983, the Centers for Disease Control (CDC) gassed 10 mice with isobutyl nitrite for up to 18 weeks. The results of the study have been interpreted by many lay and medical people as an indication that poppers have been ruled out as a cause of AIDS. The report of the isolation of LAV/HTLV-3 may have sustained the notion that poppers are an innocent bystander. But in the CDC's report on the effects of poppers, they did not rule them out as a co-factor in the development of the syndrome. We believe they may be a critical co-factor. The report on the poppers study in the Morbidity & Mortality Weekly Report [Sept. 9, 1983, volume 32:35, reprinted in NCGSTDS Newsletter, volume 5:2, November, 1983] notes: "None of animals exposed to isobutyl nitrite showed any evidence of immunotoxic reactions. Methemaglobinemia was noted in animals exposed to 300 parts per million of isobutyl nitrite, and some evidence of thymic atrophy, possibly stress-related, was found in this group." This "thymic atrophy" was not disturbing to the CDC because the CDC misunderstands the importance of the thymus's role in the immune system....A prominent AIDS researcher reports that a scientist at the CDC told him, "Everybody knows that the thymus is not functional in an adult." Everyone except that researcher and many other prominent scientists in the country. Our readers should keep in mind that autopsies of AIDS patients have revealed that the thymus is destroyed in this syndrome. We think that gay people should not wait for the CDC to straighten out the controversies of contemporary anatomy before extrapolating a warning from the thymuses of those mice-on-poppers. Our readers should also remember that [in past issues of the Native] we reported on a study that revealed that poppers do indeed alter the [immune system functioning] of people with bronchial asthma. How to create poppers-free zones for gay people who are concerned about their thymuses and [immune system functioning]?...Can't we have a voluntary ban on poppers in public places like discos? If Dioxin were a recreational drug, we'd demand that the Environmental Protection Agency prevent such hazards. If [sexual secretions] contain temporary viral hazards, surely we can at least keep dancing safe and pristine. Let individuals jeopardize their thymuses and [immune systems] in the privacy of their own homes; where poppers are concerned, it's too difficult to separate the dancer from the dance.

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WANTED FOR FRAUD AND MISINFORMATION

[The following ad is reprinted with thanks from The Baltimore Gay Paper, June, 1984, and Baltimore HERO; although some of the information may be inaccurate, it is still worthy in its political comment.--ED]

WANTED

For Fraud and Misinformation

At a press conference April 23, 1984, Secretary Margaret Heckler announced:

"We now have a blood test for **AIDS** which we hope can be widely available within about six months. With this blood test, we can now identify **AIDS** victims with essentially 100 percent certainty."

Ms. Heckler also stated that a vaccine would be available within two years.

Margaret Heckler
Secretary, U.S. Department of
Health and Human Services

These statements on the newly discovered Virus (HTLV-3) which *may be* the cause of **AIDS** was brought to you by the same people who brought us the Swine flu vaccine. You know what happened to it. Let's set the record straight.

Heckler: "We now have a blood test for **AIDS**."

Fact: Only 36 percent of **AIDS** patients tested showed evidence of HTLV-3, this new, supposed "cause" of **AIDS**. Among other things, people who demonstrate presence of this agent also show evidence of lots of other things.

Heckler: "We can now identify **AIDS** victims with essentially 100 percent certainty."

Fact: 79 percent of individuals with unexplained symptoms WHO DID NOT HAVE **AIDS** showed up positive on this test.

Heckler: "We will have a vaccine available in two years."

Fact: It took 14 years to develop an available vaccine for Hepatitis B AFTER its accurate screening test was discovered in 1968. Hepatitis B is a lot easier to work with than HTLV-3.

The saddest truth is that an **AIDS** vaccine is likely to take even longer to develop . . . once we establish its cause.

So why the Big Deal?

Good question. There is not one shred of evidence to prove this agent causes **AIDS** — quite simply, many people with **AIDS** or "**AIDS**-related conditions" demonstrate the presence of this agent. (They also show the same evidence of CMV virus, Herpes, Hepatitis and mumps.)

(But remember, it is an Election Year, folks.)

This announcement is a significant first step, but the **AIDS** crises is NOT OVER.

What can you do?

— Protect yourself. **HERO** has free literature available that aims to keep you healthy. Call 947-AIDS or stop by our booth.

— Do your part: We here in Baltimore can help fit this (and other pieces) into the **AIDS** puzzle through **SHARE**, the Study to Help the **AIDS** Research Effort at Johns Hopkins. Volunteer for **SHARE**. It is free, it will monitor your health very carefully, and it just might lead to the development of the **AIDS** vaccine more quickly. Call 955-7090.

REMEMBER: BE CAREFUL AND STAY HEALTHY

This message is brought to you by **HERO**, Baltimore's **AIDS** information and service organization.

LOOK FOR OUR SAFE SEX POSTERS AND BROCHURES, AND VISIT OUR BOOTH.

FARO MEETING MINUTES

by Walter Batchelor

The following recommendations on the future of the Federation of AIDS Related Organizations (FARO) was approved by FARO member organizations in New York City, June 18, 1984.
1) We acknowledge the value of the resource clearinghouse project and hope that some other organization will take it on. However, financial reality dictates that we must recommend discontinuance of funding for this project by FARO.
2) We identify a need and strongly support the creation of an independent National Association of People With AIDS [see related article in this issue--ED]. We encourage funding by foundatior grants, local organizations and individuals, and active support by FARO member organizations.
3) We recommend: a) That the "lobby project" (FARO/AIDS Action Council) be continued, headed by an executive director, who will also be a lobbyist, who will also work with the Executive Branch, who will communicate and meet with local AIDS organizations and indivuals whenever possible, and who will be hired for a one-year term for the present; b) That there be a board of directors composed of approximately 5-6 persons chosen by the 12 organizations that have contributed to the "lobby project" during 1983-84 (Gay Men's Health Crisis, New York; National Gay Task Force; AID Atlanta; AIDS Action Committee, Boston; AIDS Project/Los Angeles; AIDS/KS Committee, Houston; Persad Center, Pittsburgh; Association of Lesbian & Gay Psychologists; New Mexico Physicians for Human Rights; East End Gay Organization for Human Rights, Southampton, NY; Dallas Gay Alliance; San Francisco Fund for an AIDS lobby.) c) That there be at least one person with AIDS on the Board of Directors, that the Board be representative of AIDS organizations nationwide insofar as possible, and that it be composed of those individuals who will give it the best direction and strongest support. d) That there be a duty on the parts of the Board of Directors and Executive Director to communicate with member organizations, to act as resource persons and to devote significant time to their duties; e) That the Board establish and supervise a search procedure for the Executive Director; f) That the Board act as supervisor to the Executive Director, and as liaison between the Executive Director and FARO member organizations; g) That the Board of Directors not be bound by the decisions of the previous FARO Steering Committee; h) That basic FARO membership be set at $50 per year to encourage the largest possible membership and the broadest representation of AIDS-related organizations; i) That additional funds be raised by local groups and member organizations for the "lobby project," and that the members of the Board of Directors actively solicit contributions from national organizations; and j) That the renewed FARO/AIDS Action Council be based in Washington, DC, and that the search for an Executive Director, office space, etc., begin as soon as possible.

It was later agreed that Walter Batchelor and Jeff Levi would head a search committee for an Executive Director, that the salary would be in the mid 20s, that the Executive Director would work closely and cooperatively with NGTF and all other organizations involved in AIDS activity, and that the search process should begin as soon as possible. For those organizations not yet a member of the FARO/AIDS Action Council, send a check for $50 (or more) to: FARO/AIDS Action Council, c/o Walter Batchelor, 310 Elm Av., Takoma Park, Maryland 20912. [ED NOTE--The NCGSTDS is a member and encourages your organization to join!!]

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STATE FUNDING FOR AIDS INCLUDES FLORIDA, CALIFORNIA & NEW YORK

with thanks to Equal Time (Minneapolis) and This Week News

The Florida legislature recently became the third in the country to approve state funding of AIDS research. The new state budget includes a modest $250,000 for AIDS research at the University of Miami. New York and California have also approved state AIDS funds for research. Florida ranks just below those states in the number of documented AIDS cases--299 as of May 21, 1984.

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FARO (CLEARINGHOUSE) REORGANIZED INTO AIDS ACTION COUNCIL (LOBBYING PROJECT)
reprinted with thanks from The Washington Blade, 6/29/84

Impatient with what were viewed as plodding efforts in AIDS lobbying, the Federation of AIDS Related Organizations (FARO), was dissolved during the National Lesbian/Gay Health Conference & Third AIDS Forum in New York, after a meeting of some of the 60 member organizations. In its place, the FARO AIDS Action Council will have a $50,000 budget to hire a lobbyist to work under the direction of a 6 member board. Co-chair of that board and president of New York's Gay Men's Health Crisis Paul Popham said that FARO's other component, a clearinghouse of information for AIDS projects around the country, was scrapped for "lack of funding" [and lack of interest! --ED]. "The clearinghouse project was a couple of thousand dollars in debt," Popham said in a telephone interview with the Blade. "We hope to collect back dues from some (FARO) members to make it up." [ED NOTE: One of the main reasons for the debt was that FARO had clearly prioritized its lobbying project ahead of its resource clearinghouse. Many FARO members believed that the resource clearinghouse had a more important function, especially in light of the apparent redundancy of lobbying efforts by other gay organizations such as Gay Rights National Lobby, National Gay Task Force, and others, and with no other groups picking up the clearinghouse function. Thus, many groups refused to pay FARO monthly dues, arbitrarily decided to be $50/month by the now defunct steering committee--it was initially $50/year--since there was so little progress with the clearinghouse.] Popham said that the new lobby project will focus on both the legislative and executive branches, which until now have been divided between the Gay Rights National Lobby and the National Gay Task Force, respectively. Popham said the FARO project will target appropriations lobbying and the National Institutes of Health. Jeff Levi, head of NGTF's Washington office, is chair of the new FARO project and said he is charged with hiring the new lobbyist as soon as possible. The new incarnation of FARO is funded by a dozen AIDS organizations and other groups in cities around the country.

The six members of the new FARO/AIDS Action Council (lobbying project) are: Paul Popham (New York Gay Men's Health Crisis), 40 East 10th St., New York, NY 10003, 212/512-3673 w, 477-4613 h; Jeff Levi (National Gay Task Force), 2335 18th St., NW, Washington, DC 20009, 202/332-6483 w, 387-3152; Walter Batchelor (American Psychological Association), 1200 17th Street, NW, Washington, DC 20036, 202/955-7745 w, 270-0716 h; Matt Redman (Los Angeles AIDS Project), 8401 Fountain Av., Los Angeles, CA 90069, 213/657-1234 w, 650-4124 h, 871-1284 (AIDS Project/LA); Mike Richards (Dallas Gay Alliance), 5207 Maple Springs, Dallas, TX 75225, 214/559-2606 h; and Dan Turner (AIDS/KS Foundation of San Francisco) 3851 18th St., San FRancisco, CA 94114, 415/821-1756. Three additional individuals are resources for the Council: Caitlin Ryan (AID Atlanta), 550 Cresthill Av., Atlanta, GA 30306, 404/892-2459 h, 872-0600 (AIDA); Jason Schneider (AIDS Action Committee--Boston), c/o Fenway Community Health Center, 16 Havilund St., Boston, MA 02115, (no phone listed); and Jeanmarie Theine, 2030 Vermont, Houston, TX 77019 (no phone listed).

Financial support and membership in the new FARO/AIDS Action Council is needed to help finance lobbying functions; please send checks for $50 (or more) to the FARO/AIDS Action Council, c/o Walter Batchelor, 310 Elm Av., Takoma Park, MD 20912.

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SAN FRANCISCO AIDS FOUNDATION SEEKS STAFF

The San Francisco AIDS Foundation is recruiting for several positions, according to executive director James M. Ferels. The following positions are available: Financial Manager ($25,000); Education Director ($25,000); Information & Referral Coordinator ($20,000); Social Worker ($19,950); Administrative Assistant/Secretary ($18,000); and Clerical Assistant ($16,500). All positions include fringe benefits. Women and people of color are especially encouraged to apply. Eligible people with AIDS diagnosis will receive preference. For more information, contact: James Ferels, Executive Director, San Francisco AIDS Foundation, 54 Tenth St., San Francisco, CA 94103-1360 or call 415/864-4376. Deadline for receiving applications is August 9. [ED NOTE: This deadline has obviously past, however if you are still interested, you are encouraged to apply; never know when another vacancy will develop!]

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CONFIDENTIALITY AND AIDS TESTING

by Christine Guilfoy with thanks to Boston's Gay Community News, August 11, 1984

Several gay activists have begun meeting with officials of the National Institutes of Health (NIH) and the Centers for Disease Control (CDC) to develop policy regarding confidentiality issues of LAV/HTLV-3 antibody screening. The screening tests are presently used only for research but are expected to be widely available by the end of the year. The NIH plays a major role in funding research on AIDS and the CDC maintains a large amount of information about people with AIDS (PWA) as part of their function of tracking the disease. CDC, however, does not reference AIDS cases by names, but rather uses a code. Representatives from the Lambda Legal Defense and Education Fund in New York indicated that they have have been negotiating with the CDC and NIH for nine months to insure confidentiality is built into research contracts. The latest meeting took place on July 30, with Edward Brandt, Assistant Secretary of Health and Human Services present. Gay activists at the meeting were Chris Collins of Lambda, Jeff Levi of the Washington office of the National Gay Task Force, Neil Schram of the American Associatior of Physicians for Human Rights, and Bruce Voeller of the Mariposa Foundation. The discussions will be watched closely because of the important medical, psychological, and political implications the screen is likely to raise. Some worry that large numbers of persons with inadequate information and inadequate medical and psychological support will want to be tested. Shirley Barth, a spokesperson for the Public Health Service (PHS) acknowledged there is a draft of confidentiality policies in the works but she would not comment on it. Some of the points of discussion were enumerated by Levi:

*That persons participating in LAV/HTLV-3 screening studies do so with informed consent. All participants in such research be informed that the medical implications for either a positiv or negative test are unclear for any given individual and that it is not known what kind of relationship exists, if any, between the presence of antibody and the development of clinical illness.

*That procedures be built in so that all participants are told of possible adverse consequences to them should they test positive for the antibody. For example, it should be pointed out that insurance companies may start asking if a person has ever been tested positive for LAV/HTLV-3 antibodies and attempt to exclude those who answer positively from certain types of coverage because of a "pre-existing condition" clause. Rodger McFarlane of New York's Gay Men's Health Crisis revealed such incidents of insurance company denial of coverage to men with abnormal T-cell subset tests. Levi said the negotiating group expressed concern over the possibility of establishing a LAV/HTLV-3 positive result as a "surrogate marker for homosexuality." There was also particular concern that government agencies might begin sharing information with each other. The negotiating group wants guarantees that NIH or CDC would not be able to give information to the Justice Department or to the Department of Defense. Gay men who participate in research studies which ask questions about sexual activity and recreational drug use may open themselves up to prosecution by another government agency. Persons participating need assurances that such information will not be voluntarily revealed to third parties. Levi said they wanted safeguards so that if a third party requests the information, the participants will be notified so they may take legal action, if necessary, to prevent dissemination of the information. In addition to research safeguards, Levi says the group has also discussed confidentialiy regarding blood banks and rejected donors. "It is irrelevant to a blood center why people shouldn't be donating," said Levi. Schram, like Levi, is concerned that agencies involved in researching the LAV/HTLV-3 screen will not provide participants with detailed information and adequate followup. Until adequate confidentiality safeguards are worked out, he feels, gay men should not be screened. In a recent issue of Gay Community News, Bob Andrews, the media coordinator of the Boston AIDS Action Committee and a person who has been screened as HTLV-3 antibody positive in a research study wrote, "My reaction to the results of my screening is that I have not been given any information that helps me personally. The direct impact is, in fact, the opposite. Because I now know that I have been exposed (even though having antibodies may prove to be the best possible result) i have a sense of doom....No one else should be subjected to this increased anxiety until more substantial information is known about HTLV-3...." That federal officials are not attuned to the needs and concerns of gay people was recently underscored at a meeting at the city health department in New York City. When the development of a uniform confidentiality statement and a uniform consent form was brought up in discussions about a research project at the City's Blood Center, PHS representative Dr. Robert Gordon shocked the whole room by saying he didn't like arbitrary regulations because they impair

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CONFIDENTIALITY AND AIDS TESTING, Continued

creative research. McFarlane said Gordon suggested they lobby the review boards at the institutions where research on the screen occurs. When participants asked why the onus to protect research participants should be on the community, Gordon daid he simply didn't believe PHS could regulate researchers in the manner being requested. McFarlane said Gordon demonstrated his ignorance when he likened informing an individual he was LAV/HTLV-3 antibody positive to telling somebody they have high blood pressure.

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BOSTON'S FENWAY DEVELOPING PROTOCOL FOR LAV/HTLV-3 ANTIBODY SCREENING

compiled from an article by Christine Guilfoy, Boston Gay Community News, 7/21/84

Boston's Fenway Community Health Center is establishing a protocol in preparation for testing for antibody of the putative AIDS agent, LAV/HTLV-3. A person wishing to receive screening will be required to attend three educational sessions. At the first session, a medical staff person will provide information as to what the test is and is not and the client will receive a packet of information about AIDS, testing pitfalls, and other related areas. The client will be required to review this information at home and return several days later if he decides to go ahead with screening. This final decision will rest jointly with the client and provider. Larry Kessler, coordinator of the Boston AIDS Action Committee said, "It will be available if it is within context, if they think they've been exposed. If it looks like a positive reading will send them off the wall, we won't do it. It's a bit of red tape. We're not making it easy, but we're not blocking it either." If the decision is made to do the screen, a complete physical exam will be done and blood drawn. The results will be given by the medical provider in the third session, who will interpret it as well as possible in light of the individual's medical profile. From individuals who have gone through the process, it has become clear that support will be needed for persons testing positive.

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LAV/HTLV-3 SCREENING TEST PERMITS ISSUED TO FIVE COMPANIES

from an article by Christine Guilfoy, Gay Community News, 7/21/84

Secretary of Health and Human Services Margaret Heckler announced that five permits were issued to develop a screening kit for antibody to LAV/HTLV-3 to be distributed commercially. The kits will have to be licensed by the Food & Drug Administration before distribution. The five companies are: Travenol-Genentech of Chicago; Abbott Laboratories, Chicago; Electronucleonics, Inc., Columbia, MD; Litton-Bionetics, Kensington, MD; and Duponst of Wilmington and Biotech Research Laboratories of Rockville, who hold a joint permit. Shirley Barth, a spokesperson for Heckler, said that the kits initially will be made available to blood banks.

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DUTCH DOCTORS DISPUTE GALLO'S HTLV-3 FINDINGS

by James E. D'Eramo, PhD, with thanks to the New York Native, June 18-July 1, 1984

Dutch AIDS Researchers are doubtful about the assertion of Dr. Robert C. Gallo, of the National Cancer Institute, that he has discovered the putative AIDS virus and that within a few years an AIDS vaccine will be developed and produced on a large scale. The retrovirus "discovered" by Gallo, Human T-cell Lymphotropic (Leukemia) [retro] Virus (HTLV-3), is indeed the same as the retrovirus Lymphadenopathy Associated Virus (LAV) discovered over a year ago by French scientists at the Pasteur Institute in Paris. Dr. Jan van Wijngaarden, Dutch AIDS Coordinator, believes that Gallo has insufficient proof for his assertions. The Dutch intimated that the announcement of Gallo's findings by Secretary of Health Margaret Heckler could be viewed as a publicity maneuver for the Reagan re-election campaign. Van Wijgaarden emphasized that the proposed HTLV-3 blood test can't be taken seriously because scientists do not know the true significance of a positive test result; the test can neither predict nor confirm the presence of AIDS. Further, van Wijngaarden feels the news will be detrimental in the campaign to prevent AIDS through safe and healthy sexual techniques. Some gay men may unwisely regard the identification of the putative agent as a panacea instead of a promising hypothesis.

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SOME SPECIAL ASPECTS OF FORTHCOMING BLOOD "MARKERS" FOR AIDS

by Al Novick, MD, AIDS Project of New Haven

In the last weeks, we have heard convincing evidence that LAV/HTLV-3 is causally associated with AIDS and with the lymphadenopathy syndrome. An antibody to LAV/HTLC-3 has also been identified in the blood of a number of patients. We may safely predict that this antibody test will become available soon for studying AIDS in its various manifestations. Other tests, based on antibodies to the same or other viral componenets are likely to follow. Following is an examination of some of the scientific and/or social and ethical concerns that may be aroused by this important advance in medical science.

First, there will be concerns about whether the two viruses are indeed, the same. While that answer is crucial (since neither can really qualify as causal on the basis of current evidence if they are not the same), we must anticipate that the answer to this question is surely known or knowable currently, and will have to be revealed shortly. If they are not the same, both will have to be considered to be opportunistic infections, pending further evidence. [It should be noted here that LAV=Lymphadenopathy Associated Virus, first reported in Science, May, 1983, and HTLV-3=Human T-cell Lymphotropic/leukemia (retro-)Virus, reported by Gallo, et al. of the National Cancer Institute, April, 1984.] If the two viruses are the same, causality must still be proved. Again, we may realistically anticipate that public and scientific interest is so intense that further data will follow quickly from the same and additional laboratories. But we must also anticipate a tendency (based on wishful thinking) to behave as if causality is already clearly established and, perhaps, to make decisions, on this basis, which may not be fully justified. The cause of AIDS will almost surely be shown to involve co-factors and host factors, none of which are currently identified. The current test is apparently based on an antibody (Ab) to one component or to a complex of components not yet characterized from the virus. We will need to know many details of this Ab, in whom it occurs, when it appears, whether it persists, whether it's appearance correlates with particular manifestations of AIDS or with particular prognoses, whether it occurs in the absence of clinical manifestations of AIDS, and whether it is an indicator of infectiousness or immunity, or neither Briefly, we need to know the following:

1) How widespread the Ab is in the "general" population, especially in high incidence cities for AIDS.
2) Whether the same Ab occurs in patients and/or in the general population in other AIDS communities--Haiti, Zaire, Uganda, and Western Europe, for example.
3) Whether the Ab occurs in persons highly exposed to persons with AIDS (PWA) such as health care workers (especially those who have experienced needle-stick or mucous membrane exposures), household contacts of PWAs, sex partners of PWAs (especially low-risk sex partners--male or female partners of women with AIDS, female partners of bisexual men with AIDS, and partners of blood transfusion recipients with AIDS). The purpose here would be to delineate seroconversion vs. clinical disease.
4) Does seroconversion without clinical illness represent a stage in the disease process or immunity?
5) What proportion of persons with AIDS Related Complex (ARC), AIDS, Kaposi's sarcoma (KS), particular opportunistic infections (OI), other possibly related AIDS related malignancies, etc., exhibit the Ab?
6) Does seroconversion occur relative to exposure to virus and relative to clinical illness?
7) Does timing of seroconversion, Ab titre, or other features have prognostic meaning?
8) Does seroconversion correlate with T4:T8 ratios, lymphopenia, anergy, lymphadenopathy, or other indices?
9) Does presence or titre of Ab correlate with culturable virus in blood, semen, feces, or other body fluids? Can this give a clue to transmissability?
10) How likely is someone who is negative today become positive tomorrow or next month?
11) How likely is someone who currently tests positive ever become negative in the future (when clinically well or ill, etc.)?

Taken together, we would hope to know whether Ab presence reveals only effective exposure to virus and predicts nothing about outcome and whether this Ab reveals transmissibility precisely or only in the sense that the person may or may not be transmitting. What do negative or positive results really mean?

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SOME SPECIAL ASPECTS, Continued

Important clinical questions may be phrased in alternative ways.
1) Does the test tell us something about current health?
2) Does a positive or negative test have prognostic meaning?
3) Does a particular sequence of tests have prognostic meaning (i.e., positive followed by negative)?
4) Would a positive test mean that the person's blood was unsuitable for human transfusion? Even if the answer to that question is unknown, would a positive result be an indicator of risk?
5) Would a positive result imply current active transmission potential? Or, would it simply rasie that question for future research to clarify?
6) Does it identify persons who are immune or likely to be?

Who should be tested in order to establish the meaning of the test? Studies should follow formal research protocols. Tests should be performed and evaluated entirely in a research fashion until the meaning is clear. Individual patients should neither be evaluated or informed of their status since the psychological burdens of a positive test can not currently be alleviated and the danger of incorrectly evaluating a negative test is also substancial. In whatever studies are proposed, reviewed, and approved, the subjects should be asked to consent to being studied knowing that they will not have current access to the results. Their physicians should also be excluded from current knowledge of the results since neither the patient nor his physician would be able to use that information productively and might use it destructively. It would seem reasonable and proper to promise to review the results with the subject and/or his physician when the significance of the test had become established. Who might these subjects be?
1) The participants in the currently on-going prospective studies of healthy gay men in 5 communities.
2) The already stored serum samples from the above.
3) PWAs or persons with ARC who are currently being studied in other protocols.
4) Stored serum at CDC or NIH of earlier patients with AIDS or ARC.
5) The hepatitis B cohorts still being followed in San Francisco and New York.
6) Health care workers being followed under CDC or NIH studies following accidental needle-sticks or mucous membrane exposures to AIDS patient's body fluids.

One could certainly plan other kinds of studies--of the sex partners of PWAs, friends of IV drug users with AIDS who have shared injection equipment with the patient, the mothers and fathers of infants with AIDS, persons who have recieved transfusions now known to be from persons who have AIDS, etc. Such studies seem mroe intrusive into the subject's status without the likelihood of being able to provide them individually with useful information in the near future. They should be planned and carried out only with great compassion for the additional anxiety and uncertainty that will arise from enlisting the person's cooperation but then appropriately not reporting the results to them or advising them on the meaning of the results for a substantial period of time. No person would benefit from knowing his Ab status presently. That information should be closely held until there are scientifically defendable (peer reviewed) views on the meaning of the test(s). Then, everyone who has been tested should have access to the results if the results can benefit him and everyone who is then informed should have a full explanation of the meaning of the test for him. Pending establishing the meaning of the test(s), clinical labs should not perform the test on a fee-for-service basis or as part of clinical care. Some labs may soon offer and advertise such tests. They should be actively discouraged from doing so until the tests are fully evaluated. A clear demand for evaluation will arise from the blood bank community. While I can think of no reason not to test donated blood, the donor should not be informed, currently, of his status. Retrospective information, when the meaning fo the test comes to be known, should be planned compassionately. After identifcation of the meaning of the test, I see no problem with taking positive blood out of the blood supply. This seems indicated. There may well be a rising demand for access to gamma globulin from persons who have developed "immunity" to the AIDS virus. Clearly, we are a long way from identifying or understanding immunity in this syndrome. Clinical trials of therapy based on immune serum must not proceed until justified by clear evidence.

(CONTINUED)

SOME SPECIAL ASPECTS, Continued

In summary, the tests, which are in the process of being developed and are based on Ab to LAV/HTLV-3, must be evaluated in a large number of ways before their theoretical or clinical meaning becomes clear. We will all look forward to the identification of transmissability, immunity, "resistance" to clinical manifestations (perhaps indicating something about co-factors or host factors), and prognostic indicators. We may even hope that success with animal models may even be facilitated by improved knowledge of when active LAV/HTLV-3 infection is actually occurring. These studies, however, should be done without communicating results to the human subjects until we can reasonably explain the significance of positive or negative results to each subject. The subjects should know that the results will be withheld from them for the meantime, since test results without known meaning cannot be useful to clinical care. Patients should be informed about the results of their tests when the meaning is clearly established by publication and peer review.

[DO YOU HAVE COMMENTS OR FEELINGS ABOUT THESE ISSUES? SHARE THEM WITH THE NCGSTDS, POB 239, MILWAUKEE, WI 53201.]

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SALVATION ARMY NIXES CLOTHES FROM AIDS VICTIMS

by David France, with thanks to the New York Native, June 18-July 1, 1984

When an estate attorney called the Salvation Army to donate the clothing of a man who had died of AIDS complication, she was told that, no matter how clean, the articles would not be accepted, according to a volunteer at New York's Gay Men's Health Crisis. Salvation Army officials deny that this reflects agency policy per se, but Bob Brennan, director of operations for thier Adult Rehabilitation Center, said that he would not under any circumstances, direct his employees to pick up clothing donations from people who, to his knowledge, died of AIDS. "Why is anybody telling us about the AIDS when they call for a pickup?" Brennan wondered. "Are they really trying to donate the clothing or are they trying to find out our opinion on AIDS?" "This is consistent with the homophobia of the Salvation Army," said Michael Callen, founding member of the support group People With AIDS. The Salvation Army forfeitted $4.5 million when their contracts expired with New York City last June 30, because they refused to sign a statement saying they would not discriminate against lesbian or gay employees, as required by New York Mayor Ed Koch's Executive Order 50. The Army also refused a cash donation of $500 raised by a gay and lesbian organization, because they did not agree with the nature of the group. Major Borror, general secretary for the men's social services department of the Army said, "I'm not a doctor [but] I understand that AIDS is highly contagious."

* * *

FAMILY GUIDE FOR PEOPLE WITH AIDS

"If someone in your family has contracted AIDS, you may feel that your life suddenly resembles a roller-coaster ride." This statement is the beginning of The AIDS Family Guide: A Series of Handbooks for People With AIDS, a pamphlet developed for relatives of people who have been diagnosed with AIDS. Included are suggestions about how to take care of both the person with AIDS and the loved ones during the difficult periods. Some of the topics covered: ways of coping; patient advocacy; taking care of personal affairs, emotional stress, medical issues, insurance forms; living with someone who has AIDS; and several sections on basic information about AIDS. The booklet was written by Michael Helquist, an accomplished writer for several gay newspapers, and published by the San Francisco AIDS Foundation, an agency that has contributed immeasurably in community education and patient services. For more information write: SF AIDS Foundation, 54 Tenth St., San Francisco, CA 94103-1360 or call 415/863-AIDS.

* * *

MINORITIES AND AIDS

with thanks to AID Atlanta Newsletter

In a recent article picked up by the Gay Press Association, Dion Sanders put in print what many of us working in AIDS activities have known all along, that instances of AIDS among minorities have been overlooked by the press. When asked why the data had not been previously reported, Dr. Richard Selik, director of the CDC's AIDS information suggested, "Perhaps they, for some reason, thought it wasn't newsworthy." Curious statements aside, 40% of people with AIDS (PWA) are minorities, people of color, and Sanders maintains that the proportion of blacks and Hispanics among PWAs is nearly double the proportion of blacks and Hispanics in the US population as a whole. Minorities combined comprise a total of 40.4% of AIDS cases (as of January, 1984), with 21.3% of the cases, black, and another 4.4%, Haitian; Hispanics comprize 14.4%. A reason for these omissions of data according to Sanders is, "The belief that AIDS is a "white gay man's disease" [which] stems from a long-held perception of the gay community by the general public--especially by minority communities--[that the community] is exclusively white, despite the emergence of gay and lesbian people of color into the public eye in recent months." Like the general public, many gay people consider AIDS a white disease: many whites fail to include people of color in educational programs, in graphic designs on AIDS materials, in memberships in organizations, on Boards of Directors; many people of color avoid risk reduction guidelines, appear to be in higher attendance at the baths, are sparsely represented in AIDS & gay health organizations and at national gay health conferences and meetings. Billy Jones, International Co-Chair of Black & White Men Together (BWMT) and Chair of the National Coalition of Black Gays, speaking at a fall, 1983 meeting of the steering committee meeting of the now-defunct Federation of AIDS Related Organizations, called for an increased involvement of people of color on all levels of AIDS work, and suggested interaction with local and national BWMT. Grace Laurencin, MD, representing Women's AIDS Network at that FARO meeting, acknowledged that while outreach to black communities is attempted, the cultural issues within the black community are different, so that these attempts are not generally successful. Jeff Levi, from the Washington office of National Gay Task Force, observed that in Washington, DC, where most AIDS programs have been coordinated by whites with a population almost 70% black, money has been provided by the city specifically to address this problem. The first Black Community Forum sponsored by the AIDS Education Fund at the Whitman-Walker Clinic in Washington, however was disappointingly underattended, although there were many ideas for outreach and dialogue. Washington, Philadelphia, and Atlanta all have large black populations. Philadelphia is one of the first cities to develop a specific educational program for the black community, working closely with BWMT. In developing outreach programs for minority communities, Jones and Lauencin both suggest that an accepted member of that community must be included in planning, development, and presentation stages of any attempt, if it is to be successful. Coalition building has long been a problem in the gay community. In responding to the AIDS crisis, it becomes essential.

* * *

GUIDE FOR PEOPLE WITH AIDS DISTRIBUTED BY KEY WEST MEMORIAL HOSPITAL

The third edition of the booklet, "A Guide for People with AIDS" is now available from Key West Memorial Hospital. The booklet was written by Allan O'Hara, coordinator of the hospital's AIDS Educational Programs, has proven useful to those with AIDS an their significant others, family, and friends. The booklet has been widely distributed around the country, and is available for $2 (free for PWAs). Write: P.O. Box 4073, Key West, FL 33041.

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WARNING TO USERS OF INHALANTS

The following printed warning is prominently posted in establishments selling inhalant nitrites ("poppers") in San Francisco:

WARNING

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 inhalation 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. [Copyright, 1984, Pacific Western Distributing Corp. (RUSH Liquid Incense), San Francisco, CA 94105.]

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GURU WARNS: AIDS WILL KILL TWO-THIRDS OF WORLD'S POPULATION
reprinted with thanks from Sexuality Today Newsletter, May 28, 1984

[ED NOTE--The following "alternate viewpoint" is presented for your information only. We encourage you to address your comments to the Rajneesh Medical Corporation, PO Box 14, Rajneeshpuram, Oregon 97741 (503/489-3268); send a copy to the NCGSTDS!]

In response to the alarming spread of AIDS, the guru Bhagwan Shree Rajneesh, who came from India to central Oregon in 1981 with disciples, has recently issued a warning about AIDS and has set forth guidelines toward curbing the disease--guidelines which in effect signify that AIDS can no longer be treated as an issue affecting the homosexual community alone. Rajneesh, who is noted for his talks on the Tantric utilization of sex and sex-energy for meditation and higher consciousness, has stated that AIDS is the disease which Nostradamus predicted would kill 2/3 of the world's population; it will do so, the guru seems to warn, unless the sexual laxity and carelessness of the modern world comes to an end. According to Swami Shyan John, MD, of the Rajneesh Medical Associates, the guru has issued the following guidelines to be followed by all women and men for the sake of avoiding AIDS: "If you are ready and can drop sex altogether through understanding and without repression, this is the safest protection from the disease. Or remain with the same partner, merge into the same partner, move more and more into intimacy and less into sexual activity. Even if you are with one partner or vary your partners and you choose to have sex, at least make use of the scientific knowledge available: use condoms during the sex act and latex or rubber gloves during foreplay. [!!!] Oral sex and anal sex should be completely avoided, since there is no way to protect yourself from exposure to AIDS....The final thing is to remember that you must scrupulously wash yourself after any sexual exposure." According to the Rajneesh Medical Associates staff, anal sex and oral sex are the mahor forces for the spread of the disease. At Bhagwan Shree Rajneesh's community in Oregon, free condoms and surgical-quality gloves are being distributed to commune members. Individuals in the community have stated that they have moved more and more into the dimension of love, awareness, and intimacy since these measures were taken.

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AID ATLANTA SPONSORS AIDS-AWARENESS GROUPS

AID Atlanta, a nonprofit volunteer organization, is sponsoring a series of weekly discussion groups coordinated by professional experts in each field of discussion, providing a forum for general questions and public discussion as well as opportunity for private discussion of personal concerns. Eight weekly groups were planned: 1) Medical Aspects of AIDS--Discussion of clinical and scientific aspects of AIDS and the significance of this epidemic to the community. Factual information about AIDS, its origins, its transmission, and its consequences will be outlined in accurate nontechnical terms understandable by nonprofessional audiences. Current statistics on the proportions of the epidemic will be reviewed, with projection of anticipated trends. Current research on AIDS will be briefly evaluated. 2) Living with Death and Dying (Terminal Illness Workshop)--Elizabeth Kubler-Ross' description of stages of acceptance of death for oneself or others will be outlined and illustrated. Discussion will center on coping mechanisms for both the patient and family in dealing with terminal illness, including both psychological-emotional aspects as well as practical-logistic issues. An experiential workshop will include exercises in confronting one's one conception of death and dying. 3) Social Alternatives to the Gay Lifestyle (Non-Sexual Social Interaction)--Representatives of organizations and activities of special interest and reward to gay people will outline a variety of alternative media for social encounter within the gay community, including athletics, arts, games, intellectual interests, religious interests, and political interests, and other common denominators shared among gay people. 4) The Personal Side of AIDS: Psychosocial Implications --In contrast to medical-technical aspects of AIDS, this discussion will explore the personal, psychologic, and social implications of AIDS for individuals & communities, gay and straight. As the "modern day leper," the AIDS-person is met with hysteria and rejection founded irrationally in misinformation, fear, & narrow-mindedness, even within the gay community. Effects of

(CONTINUED ON PAGE 40)

NEW YORK ARCHBISHOP JEOPARDIZES HEALTH OF CHILDREN

The following statement was issued by the First International/Sixth National Lesbian and Gay Health Conference, and represents the consensus of over 1000 health care professionals and people with AIDS from around the world.

"Archbishop O'Connor has threatened to sacrifice the welfare and safety of the needy children of New York City rather than comply with Mayor Ed Koch's Executive Order 50, prohibiting employment discrimination against lesbians and gay men. In threatening the city with the closure of the archdiocesan day-care facilities, the Archbishop makes his priorities clear: the needs of children are less important than political gains. The Archbishop cites Churcs teachings which oblige him to withdraw care from children rather than sign a document forbidding discrimination against lesbians & gay men. He states, 'I cannot change Church teachings. I cannot be ambiguous.' There is no ambiguity in Church teachings on one point: we have a moral mission to care for the poor, the needy, the children among us. It is those innocents whom the Archbishop holds ransom with this threat, and those who will suffer if he carries through on it. The Archbishop has stated that he 'is not sure he understood the subject' of homosexuality. We agree, and urge that he give the subject further study. We urge, further, that he study the wisdom of jeopardizing the health and safety of our children, in direct opposition to the teachings of the Church, which tell us that it is our duty to care for those who cannot care for themselves."

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GOVERNMENT CONDEMNED FOR LACK OF INITIATIVE IN AIDS

with thanks to Boston's Gay Community News, August 4, 1984

A national magazine of "technology and its implications" will publish in its August issue an article condemning the government's lack of initiative in provinding funds for AIDS research. Technology Review jumps into AIDS reporting with "Too Little Aids for AIDS" by Judith Randal. Randal calls onto the carpet Health and Human Services Secretary Margaret Heckler for her department's negligence in responding to the AIDS crisis. Worse than its reluctance to spend money for AIDS research, says Randal, is the Reagan administration's misleading and dangerous implication that "AIDS has now been converted from a health emergency to a manageable problem." She says that HTLV-3 is an unsubstantiated causal agent; that the AIDS blood test is an unknown quantity; that development of a vaccine is problematic and estimates it to be a 6-8 year project; and that treatment is no better now than it was three years ago. Randal posits that the federal machinery is not equipped to cope with epidemics and health emergencies, and although Congress has passed legislation establishing a mechanism to automatically allocate funds for health emergencies, no money has yet been appropriated to it. As one scientist observed, "AIDS is a tragic problem, but what if it was a much larger problem? We'd really be in trouble then."

* * *

NATIONAL ASSOCIATION OF PEOPLE WITH AIDS FORMED AT NEW YORK CONFERENCE

Twenty-eight people who have Acquired Immune Deficiency Syndrome (AIDS and AIDS-related conditions organized the National Association of People With AIDS (NAPWA) during the First International/Sixth National Lesbian & Gay Health Conference and Third AIDS Forum in New York City, June 19th, according to founding member Bobbi Campbell. NAPWA will provide peer support, educational materials, referrals, risk reduction materials, health advocacy, and social opportunities for people with AIDS by people with AIDS. NAPWA is open to all people with AIDS and AIDS-related conditions. NAPWA projects include a newsletter, an 800 (toll-free) number hotline, and a speaker's bureau. Noting that the organization was the first of its kind in the country, Campbell said that NAPWA would also work cooperatively with AIDS organizations and government agencies to fundraise and to improve service provision to people with AIDS and AIDS-related conditions. The 28 founding members of NAPWA who attended the four day health conference at New York University, are from New York, San Francisco, Los Angeles, Houston, Dallas, Chicago, Atlanta, Philadelphia, and Washington, DC. Bernice Goodman, past-president of the National Gay Health Education Foundation, which sponsored the health conference, said the Foundation was "fully committed to people with AIDS" and AIDS-related conditions and would help NAPWA develop specific funding and project proposals. For further information, please contact: Arthur Felson, 444 Hudson St., Box G27, New York, NY 10014 (212/929-5741) or Bobbi Campbell, 519 Castro Box M46, San Francisco, CA 94114 (415/553-2509 or 665-3787).

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DC GAY MEN SURVEY SHOWS CHANGES DUE TO AIDS

by Dave Walter, with thanks to The Washington Blade, June 15, 1984

A summer, 1983 survey of Washington, DC area gay men by Drs. Paul Van Ness and Larry Puchall, two gay psychologists, indicates that most of the respondents are well informed about AIDS and that many of them have changed their sexual activities to reduce the risk of contracting disease. Approximately 1,033 questionnaires were completed and returned last summer, when mainstream media reports about AIDS were at their peak. Sixty-eight percent scored well enough on an "AIDS information quiz" to be considered well informed about the subject. The survey results indicate that many gay men reported altering their sexual behavior because of the AIDS crisis. For example, 57% said they had, after hearing about AIDS, reduced the number of sexual partners they had per month. There was also a drop-off of bathhouse attendance and a decrease in what are thought to be high risk sexual activities, such as oral-genital and receptive anal intercourse. More than half of the sample reported greater concern about contracting AIDS at the time of the survey than they had been when they first learned about AIDS. Additionally, 89% said they are more cautious about a potential sexual partner's state of health, 40% try to find out how sexually active the partner is, 29% inspect the partner's body for "signs of illness," and 14% try to find out the partner's history of STDs. Respondents were also asked their opinions about AIDS. About 66% believed that gay men should reduce their number of sexual partners; nearly 24% felt that gay men should refrain from giving blood, while another 38% said only "highly sexually active" gay men should refrain from donating. Also, nearly 65% said the AIDS crisis is the problem demanding "the greatest time, energy, and money" by the gay community. In their conclusions, Van Ness and Puchall refer to "good news and bad news"--the good news being that a significant number of gay men said they were being more cautious in their sexual activities because of AIDS; the bad news "is that another group of gay men had not reduced their numbers of sexual partners and probably continue to be at higher risk." They noted 11% said they had increased their numbers of partners, although most of that increase occurred among gay men who had lower numbers of partners per month to begin with. [ED NOTE: Sorry, no mention of whether "safe sex" practices, e.g., wearing of condoms, non-sharing of body secretions, were predominant activities in the groups that increased the numbers of partners; this would not elevate risk.] Van Ness and Puchall plan to publish their findings with a more complete analysis in the fall, and said they hope their research will serve a "consciousness-raising and educational function in our community to help more gay men become sensitized to hard but responsible decisions about their sexual behaviors."

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WASHINGTON, DC AIDS EVALUATION UNIT AT WHITMAN-WALKER

by Jim Marks, with thanks to The Washington Blade, June 15, 1984

In January, 1983, Washington, DC's Whitman-Walker Clinic the AIDS Evaluation Unit, the only gay supported medical unit in the country that can detect the basic symptoms of AIDS and determine if these symptoms are caused by such diseases as hepatitis and mononucleosis or if there are indications of an underlying immune system dysfunction. The evaluation system, which is essentially a thorough screening process, begins at Whitman-Walker's Gay Men's VD Clinic. Individuals are first tested for the most common sexually transmitted diseases. If any of these basic screening tests are positive, the person is treated, counselled, and reassured. Those who warrant more complete examination fill out a personal history form. Twelve blood samples are drawn for a battery of tests developed by the Clinic and Maryland Medical Laboratories. This is now the standard "panel" of tests offered by physicians and private clinics throughout the Washington area. The patient is then given a thorough physical exam and skin testing, which is read three days later when the person returns. One final session is required to discuss the results of the tests, provide counseling and health care advice, and if necessary, referred to a specialist for further evaluation and treatment. So far, about 100 people have requested evaluation. Of these, according to medical director Dr. Peter Hawley, 30 have had symptoms serious enough to warrant the full battery of tests. Of these 30, approximately 25% had nothing wrong, and 50% had the so-called AIDS-related complex, an underlying problem with the body's immune system that has not yet developed into diagnosable opportunistic infections or into recognizable AIDS. When the AIDS Evaluation Unit was planned, funding for the testing was to come equally from a $15,000 grant from the Eugene & Agnes Myer Foundation and from the patients themselves. To date, however, only one person has been able to afford the $250 suggested donation (the tests cost $500-1000 privately) and the Unit is searching for additional funding.

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CENTERS FOR DISEASE CONTROL

June 22, 1984 / Vol. 33 / No. 24

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Update: Acquired Immunodeficiency Syndrome (AIDS) — United States

As of June 18, 1984, physicians and health departments in the United States had reported 4,918 patients meeting the surveillance definition for acquired immunodeficiency syndrome (*1,2*). Over 70% of the adult AIDS patients and nearly 80% of the pediatric patients have been reported since January 1983 (Figure 1). Although 2,221 (45%) of all reported patients are known to have died (45% of the adults and 68% of the children), more than 76% of patients diagnosed before July 1982 are dead.

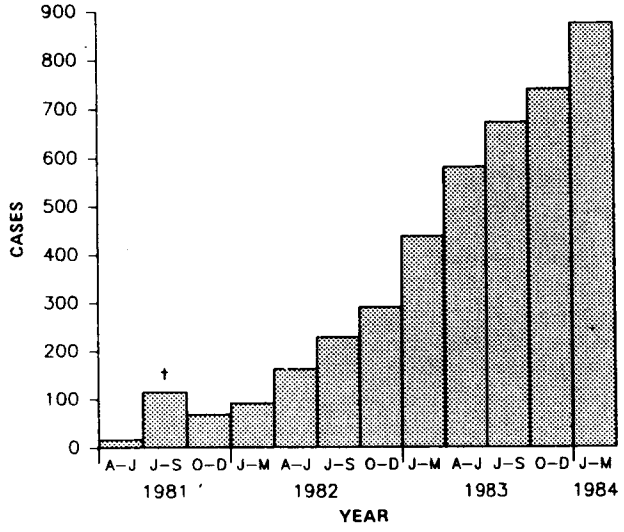
Adult patients: Among 4,861 adult AIDS patients, *Pneumocystis carinii* pneumonia (PCP) continues to be the most common opportunistic disease. Fifty-three percent of patients had PCP without Kaposi's sarcoma (KS); 24% had KS without PCP; 6% had both PCP and KS; and 17% had other opportunistic diseases without either PCP or KS. Of the 1,502 patients with KS, 1,396 (93%) have been homosexual or bisexual men. Ninety percent of adult AIDS patients are 20-49 years old, and 333 (7%) are women. Fifty-eight percent of the cases have occurred among whites; 25%, among blacks; and 14%, among persons of Hispanic origin.

Groups at highest risk of acquiring AIDS continue to be homosexual or bisexual men (72% of patients) and intravenous drug abusers (17%); 11% of patients have other or unknown risk factors. These include persons born in Haiti (4% of total cases), patients with hemophilia (1%), heterosexual partners of persons with AIDS or at increased risk for acquiring AIDS (1%), and recipients of blood transfusions (1%). The 52 adults with "transfusion-associated" AIDS have no other known risk factor for AIDS and were transfused with blood or blood components within 5 years of illness onset. Twenty-seven (52%) are known to have died. To examine possible trends in all patient groups, adult patients were divided into four equal categories based on date of report (Table 1). Except for a statistically significant decrease in the proportion of Haitian-born patients ($p < 0.001$), the distribution of cases by patient groups has remained relatively constant over time.

Seventy-eight percent of the adults were reported to be residents of New York, California, Florida, or New Jersey at the time of their onsets of illness. The remaining patients were reported from 41 other states, the District of Columbia, and Puerto Rico. Over time, the proportion of patients from New York has significantly decreased ($p < 0.001$), while the proportion for other states has significantly increased ($p < 0.001$) (Table 2).

Pediatric patients: Of the 57 patients under 5 years of age, 45 (79%) were reported to be residents of New York, Florida, California, or New Jersey at the time of their onsets of illness. Thirty-one (54%) of the 57 patients were male. Forty-four (77%) of the patients had PCP without KS; one (2%) had KS without PCP; two (4%) had both PCP and KS; and 10 (18%) had opportunistic infections without either PCP or KS. Twenty-nine percent of the pediatric patients are white; 50%, black; and 21%, of Hispanic origin. Of the 57 pediatric patients, 23 came from families in which one or both parents had a history of intravenous drug abuse; 13 had one or both parents who were born in Haiti; and 12 had transfusions with blood or blood components before their onsets of illness. Risk factor information on the parents of eight of the nine remaining patients is incomplete.

FIGURE 1. AIDS cases, by quarter of report — United States,* second quarter 1981 through first quarter 1984



*Because of incomplete data, cases reported during the second quarter of 1984 are not shown.

†Includes backlog of cases identified at beginning of CDC surveillance.

TABLE 1. Percent distribution of adult AIDS patients, by patient group, divided into quartiles based on date of report — United States

	Patient group							
Quartile*	Homosexual/ bisexual	IV drug user	Haitian-born	Hemophiliac	Transfusion recipient	Heterosexual sex partners	Other/ unknown	Total
1	72.3	16.4	5.0	0.9	0.4	1.1	3.9	100% (N = 1,216)
2	70.9	17.2	4.7	0.6	1.4	0.9	4.3	100% (N = 1,215)
3	72.4	18.0	3.2	0.4	1.2	0.6	4.2	100% (N = 1,215)
4	71.9	18.4	2.5	1.2	1.3	0.5	4.2	100% (N = 1,215)
Total	71.9	17.5	3.8	0.8	1.1	0.8	4.1	100% (N = 4,861)

*Quartile 1 contains cases reported during or before February 1983; quartile 2, between February 1983 and September 1983; quartile 3, between September 1983 and February 1984; and quartile 4, during or after February 1984.

TABLE 2. Percent distribution of adult AIDS patients, by residence at onset of illness, divided into quartiles based on date of report — United States

	Residence at onset of illness					
Quartile*	California	Florida	New Jersey	New York	Other	Total
1	20.1	6.7	6.7	49.5	17.0	100% (N = 1,216)
2	22.7	7.9	5.9	41.2	20.3	100% (N = 1,215)
3	25.4	6.8	6.7	37.0	24.1	100% (N = 1,215)
4	21.7	6.3	6.5	39.5	26.0	100% (N = 1,215)
Total	22.5	6.9	6.4	41.8	22.4	100% (N = 4,861)

*Quartile 1 contains cases reported during or before February 1983; quartile 2, between February 1983 and September 1983; quartile 3, between September 1983 and February 1984; and quartile 4, during or after February 1984.

AIDS — Continued

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

Editorial Note: Nationally, the reported incidence of AIDS among adults continues to increase but at an apparently slower rate than in early 1983. Despite this increase, the proportion of adult patients outside of population groups previously identified as being at increased risk for AIDS has remained constant.

Most adult AIDS patients continue to be reported from among residents of a small number of states. It is unknown whether the decrease in the proportion of patients reported from New York and the increase in reporting from other states represents a true change in geographic distribution of patients or increased recognition and reporting of this syndrome in other states. Forty-one states, the District of Columbia, and Puerto Rico have either made AIDS reportable or have legislation pending to do so.

The geographic distribution of AIDS in children under 5 years old is similar to that seen for adult AIDS patients and is compatible with transmission from affected mothers before or at birth or transmission through blood transfusion. In both children and heterosexual adults, AIDS is much more likely to present with opportunistic infections than with KS.

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2. Selik RM, Haverkos HW, Curran JW. Acquired immune deficiency syndrome (AIDS) trends in the United States, 1978-1982. Am J Med 1984;76:493-500.

CENTERS FOR DISEASE CONTROL

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

June 29, 1984 / Vol. 33 / No. 25

Current Trends

Gonorrhea — United States, 1983

In 1983, the number of gonorrhea cases reported to CDC fell to 900,435, a 6.3% decrease from the 960,633 cases reported in 1982. Gonorrhea rates also declined to 387.6 per 100,000 population, down 7.3% from 1982. This continues a trend that began in 1975 (Figure 1). Between 1975 and 1983, reported gonorrhea rates remained highest in the south-

Gonorrhea — Continued

eastern United States but followed the national trend of decline. Rates in the mid-Atlantic region generally declined more slowly than those in other reporting regions. While the greater proportion of reported cases came from the public sector, both the public and private sectors shared in the decline.

From 1982 to 1983, rates decreased by 9.5% for males and 4.0% for females (Table 3). Even with declining morbidity, persons 20-24 years old continued to account for 35%-40%, and persons 15-19 years old, for nearly 25%, of all reported cases of gonorrhea each year. Rates for 20- to 24-year-old males and females were highest up to 1982. By 1982, rates for 15- to 19-year-old females exceeded those for 20- to 24-year-old females.

Between 1976 and 1982, the annual number of reported cases of penicillinase-producing *Neisseria gonorrhoeae* (PPNG) increased from 98 cases to 4,457 cases, then decreased to 3,720 cases in 1983. Of all PPNG cases reported since 1976, 59.0% have been from three geographic areas: California (21.5%), Florida (20.4%), and New York City (17.1%).

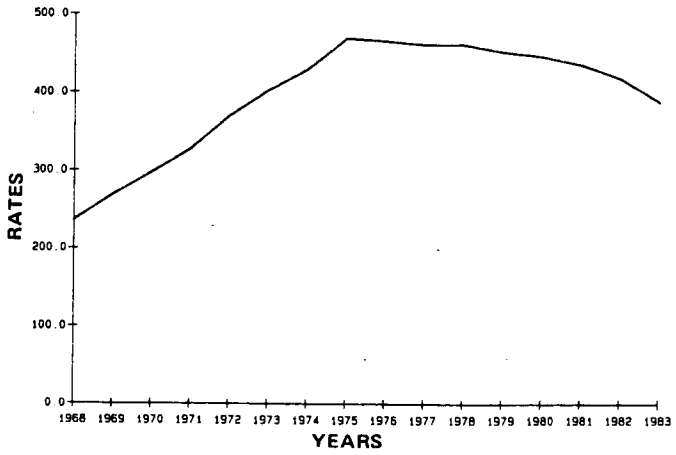
In early 1983, an outbreak of nonpenicillinase-producing (chromosomally mediated) resistant *N. gonorrhoeae* occurred in North Carolina (*1*). Since that outbreak, this strain has been reported with increasing frequency from 16 other states (*2*).

Reported by Sexually Transmitted Diseases Laboratory Program, Center for Infectious Diseases, Div of Sexually Transmitted Diseases, Center for Prevention Svcs, CDC.

Editorial Note: Between 1960 and 1975, the number of gonorrhea cases reported in the United States increased substantially. The largest increases occurred among persons 15-24 years of age, partly because of the post-World War II "baby boom," which created a larger population in this age group. Since 1975, both the public and private sectors have reported a decline in gonorrhea cases. This decline may have been influenced by one or more of the following: more focused control activities; changes in surveillance and reporting resulting in better case identification and earlier treatment; or changes in biologic properties of the organism or in biologic and behavioral host factors.

Morbidity declined among both males and females but more slowly for females. This trend is disturbing, especially for younger females, because of the potential for more severe immediate and chronic sequelae, such as pelvic inflammatory disease and infertility (*3*).

FIGURE 2. Gonorrhea incidence rates, per 100,000 population — United States, 1968-1983



Gonorrhea – Continued

The slower decline in morbidity among females may be due to less effective control measures to decrease transmission to females than to males, variations in surveillance and reporting between males and females, or differences between males and females in care-seeking behavior. Because more than half of all gonorrhea cases are reported from public clinics, and because males account for more than half of public clinic attendance (*2,4*), decreases in male morbidity may be more accurately represented, while cases among females may be underreported or undetected by the existing surveillance system. Additionally, if females seek care from sources other than public clinics, cases may not enter the reporting system.

Gonococcal antibiotic resistance has assumed increasing importance for national and local control programs. Although PPNG declined in 1983, nonpenicillinase-producing resistant *N. gonorrhoeae* (chromosomally mediated) has been observed with increasing frequency. While a larger proportion of PPNG has been linked to domestic transmission, foreign importation continues to contribute significantly to PPNG morbidity in the United States (*5*). In contrast, other resistant *N. gonorrhoeae* has been largely associated with endemic transmission (*2*), with importation infrequently documented for these cases.

Reporting of all gonorrhea cases from both public and private sectors is encouraged. Additional emphasis should be placed on examining trends and reporting patterns, especially for teenagers and females. These activities should be supported by testing all gonococcal isolates for β-lactamase (penicillinase) production. Screening of all β-lactamase-negative treatment failure isolates for penicillin susceptibility is recommended to identify other resistant organisms (*1*). CDC guidelines provide treatment recommendations for both penicillin-susceptible and -resistant cases of *N. gonorrhoeae* (*6*).

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TABLE 3. Selected gonorrhea incidence rates per 100,000 population, by age group, sex, and year — United States, 1982 and 1983

Year and age group	Males	Females
1982		
15-19	980	1,425
20-24	2,107	1,356
25-29	1,365	567
All ages	518	324
1983		
15-19	888	1,344
20-24	1,908	1,303
25-29	1,236	555
All ages	469	311

CENTERS FOR DISEASE CONTROL

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

July 13, 1984 / Vol. 33 / No. 27

Epidemiologic Notes and Reports

Antibodies to a Retrovirus Etiologically Associated with Acquired Immunodeficiency Syndrome (AIDS) in Populations with Increased Incidences of the Syndrome

Evidence implicates a retrovirus as the etiologic agent of acquired immunodeficiency syndrome (AIDS). Two prototype isolates have been described. One was isolated from the lymph node cells of a homosexual man with unexplained generalized lymphadenopathy, a syndrome associated with AIDS, and was termed lymphadenopathy-associated virus (LAV) (*1*). A morphologically similar T-lymphotropic retrovirus (HTLV-III) was isolated from lymphocytes of 26 (36%) of 72 patients with AIDS and from 18 (86%) of 21 patients with conditions thought to be related to AIDS (*2*). The isolation of retroviruses antigenically identical to LAV from a blood donor-recipient pair, each of whom developed AIDS, provides further evidence that this virus is the etiologic agent of AIDS and may be transmitted through blood transfusion (*3*).

Although direct comparative results have not been published, HTLV-III and LAV are likely to be the same virus because: they have the same appearance by electron microscopy; they are both lymphotropic and cytopathic for OKT-4 cells; isolates from American AIDS patients, when compared, were immunologically indistinguishable from LAV (*3*); serologic tests of a large number of specimens from patients with AIDS or related conditions show similar results when either of the prototype viruses is used as antigen (*4*); and preliminary results suggest that LAV and HTLV-III are at least highly related based on competitive radioimmunoassay of their core proteins (*5*).

Three basic serologic procedures are currently described for detection of antibody to HTLV-III/LAV: an enzyme-linked immunosorbent assay (ELISA) to whole disrupted virus (*6-8*); a radioimmunoprecipitation assay (RIPA) to the presumed major core protein (called p25) of LAV (*9*); and assay of antibody to major viral antigens by the Western blot technique (*10, 11*). Sera from several high-risk populations are being tested by these techniques by the National Cancer Institute, the Institut Pasteur, and CDC, with the support of numerous collaborators. The objectives of these investigations are to determine the frequency of exposure to HTLV-III/LAV and to correlate seropositivity with current infection, clinical signs and symptoms, and prognosis.

Preliminary data suggest that serologic evidence of exposure to HTLV-III/LAV may be common in certain populations at increased risk for AIDS. Antibody to HTLV-III was detected by ELISA in sera from six (35%) of 17 American homosexual men without symptoms of AIDS (*6*). Sera from eight (18%) of 44 homosexual men without lymphadenopathy attending a venereal disease clinic in Paris had antibody detected by ELISA to LAV (*7*). Antibody prevalence to LAV (RIPA) has increased from 1% (1/100) in 1978 to 25% (12/48) in 1980 and 65% (140/215) in 1984 among samples of sera from homosexual men attending a sexually

AIDS – Continued

transmitted diseases clinic in San Francisco (*12*). Antibody prevalence among the above men tested in 1984 who had no symptoms or clinical signs of AIDS or related conditions was 55% (69/126) (*12*). In New York City, where the AIDS cases among intravenous (IV) drug users are concentrated, 87% (75/86) of recent heavy IV drug users without AIDS had antibody to LAV by ELISA, while over 58% (50/86) of the same group had antibody to LAV detected by RIPA (*13*). In contrast, fewer than 10% of 35 methadone patients from New York City had antibody to LAV detected by RIPA. All of these latter patients had been in treatment at least 3 years with greatly reduced IV drug usage (*14*). Seventy-two percent (18/25) of asymptomatic persons with hemophilia A in a home-care treatment program demonstrated antibody to LAV antigens utilizing the Western blot technique (*11*). All had used factor VIII concentrates from 1980 to 1982.

Reported by DC Des Jarlais, PhD, New York State Div of Substance Abuse Svcs, M Marmor, PhD, H Cohen, MPH, New York University Medical Center, S Yancovitz, MD, J Garber, Beth Israel Medical Center, S Friedman, PhD, Narcotic and Drug Research, MJ Kreek, MD, A Miescher, MD, E Khuri, MD, Rockefeller University, New York City, SM Friedman, MD, New York City Dept of Health, R Rothenberg, MD, State Epidemiologist, New York State Dept of Health; D Echenberg, MD, P O'Malley, E Braff, MD, San Francisco City/County Health Dept, J Chin, MD, State Epidemiologist, California Dept of Health Svcs; P Burtenol, MD, Hemophilia of Georgia, Atlanta, RK Sikes, DVM, State Epidemiologist, Georgia Dept of Human Resources; Div of Viral Diseases, Div of Host Factors, AIDS Activity, Center for Infectious Diseases, CDC.

Editorial Note: The high prevalence of antibody to HTLV-III/LAV among these groups and the increasing prevalence among homosexual men in San Francisco add further support to HTLV-III/LAV being the etiologic agent of AIDS. They further demonstrate that exposure to the virus is much more common than AIDS itself among populations with increased incidences of the disease. If AIDS follows the pattern of many other infectious diseases, host response to infection would be expected to range from subclinical to severe. Milder disease states for AIDS have been suspected, since the reported frequency of lymphadenopathy and immunologic abnormalities, conditions associated with AIDS, has also been high in these groups. These data, based on limited samples of high-risk groups, suggest the spectrum of response to infection with HTLV-III/LAV may be wide.

These serologic tests are sufficiently sensitive and specific to be of value in estimating the frequency of infection with HTLV-III/LAV in certain populations and for providing important information about the natural history of the disease in such groups. Less clear are the implications of a positive test result for an individual. For some, the result may be a false positive caused by infection with an antigenically related virus or nonspecific test factors. The determination of the frequency and cause of falsely positive tests is essential for proper interpretation of test results, but remains to be established, particularly in populations, such as blood donors who belong to no known AIDS risk groups, where the prevalence of true infection with HTLV-III/LAV is expected to be very low.

A positive test for most individuals in populations at greater risk of acquiring AIDS will probably mean that the individual has been infected at some time with HTLV-III/LAV. Whether the person is currently infected or immune is not known, based on the serologic test alone—HTLV-III/LAV has been isolated in both the presence and absence of antibody—but the frequency of virus in antibody-positive persons is yet to be determined. For seropositive individuals with mild or no signs of disease, including those in whom the virus can be demonstrated, the prognosis remains uncertain. The incubation period for the life-threatening manifestations of AIDS may range from 1 year to more than 4 years (*15*).

Carefully planned and executed studies will be required to resolve these issues, and to clarify remaining questions about the natural history of AIDS and risk factors for transmission of the virus.

AIDS – Continued

Until the usefulness of positive and negative serologic tests is fully established, all individuals in populations with increased incidences of AIDS, as well as those outside such groups with positive tests, should comply with the March 1983 Public Health Service recommendations for the prevention of AIDS to minimize the transmission of the syndrome (*16*). Abstention from IV drug usage and reduction of needle-sharing and other use of contaminated needles by IV drug users should also be effective in preventing transmission of the virus and of AIDS. There remains no evidence of transmission of AIDS through casual contact. Prevention measures should stress that transmission has been only through intimate sexual contact, sharing of contaminated needles, or, less frequently, through transfusion of blood or blood products.

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CENTERS FOR DISEASE CONTROL

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Epidemiologic Notes and Reports

Chromosomally Mediated Resistant *Neisseria gonorrhoeae* — United States

During 1983-1984, an increasing number of cases of β-lactamase negative, penicillin-resistant *Neisseria gonorrhoeae* were reported to CDC. Unlike penicillinase-producing *N. gonorrhoeae* (PPNG), which have plasmid-mediated resistance to penicillin, these β-lactamase negative, resistant gonococci have chromosomally mediated resistance based on available data.

The first reported outbreak of chromosomally mediated (β-lactamase negative) resistant *N. gonorrhoeae* (CMRNG) in the United States occurred in Durham County, North Carolina (*1*). Since this outbreak, in which more than 200 cases were eventually detected, 16 other states have reported cases with resistant gonococci. Of these, Tennessee, New Mexico, and Oregon have reported more sustained outbreaks.

Cases in these outbreaks were detected either by routine screening of all gonococcal isolates (New Mexico) or screening of primary treatment failure isolates (Tennessee, Oregon) for susceptibility to penicillin at the local or state levels. Screening was performed by disk agar diffusion or by growth on penicillin-containing media. Gonococcal isolates that grew on media containing 1.6 μg/ml of penicillin or produced a zone of inhibition less than 26 mm, with a 10 UNIT penicillin disk, were submitted to CDC for confirmation of resistance. Minimum inhibitory concentrations by the agar dilution susceptibility test were determined for antimicrobials that included penicillin, ampicillin, tetracycline, cefotaxime, cefuroxime, cefoxitin, spectinomycin, and trimethoprim/sulfamethoxazole. Isolates resistant to penicillin and ampicillin were equally resistant to tetracycline by agar dilution susceptibility testing.

Of all CMRNG isolates submitted to CDC for agar dilution susceptibility testing during 1983-1984, 11.0% were susceptible to less than 2 μg/ml of penicillin; none were susceptible to less than 2 μg/ml of tetracycline; and only 47.0% were susceptible to less than 0.5 μg/ml trimethoprim and 9.5 μg/ml sulfamethoxazole (trimethoprim/sulfamethoxazole). All isolates were susceptible to spectinomycin, cefoxitin, cefuroxime, and cefotaxime. Immunologic characterization demonstrated that all CMRNG isolates were serogroup IIb (the majority of the same serovariant) based on serotyping by experimental monoclonal antibodies to major outer membrane protein (*2*). Of the 18 New Mexico cases, two distinctly different serovariants were detected within serogroup IIb.

*ERRATUM CORRECTED (VOL. 33:31, August 10, 1984, page 456)

Neisseria gonorrhoeae — *Continued*

Clinical and epidemiologic information were obtained for patients whose isolates were tested. Excluding North Carolina, of the 16 other reporting states, over half of the CMRNG cases were from Tennessee, New Mexico, and Oregon.

Tennessee: All the 14 Tennessee patients were heterosexuals, and two patients could be linked to interstate travel to Virginia or North Carolina. Strains from the Tennessee cases were immunologically similar and had similar antimicrobial susceptibility patterns consistent with continued endemic transmission within the state.

New Mexico: Of the 18 CMRNG patients from New Mexico, seven were heterosexual (three males, four females), and 11 were homosexual males. All heterosexual patients and seven homosexual patients were infected with gonococcal strains immunologically identical, with similar antimicrobial susceptibility patterns. Strains from these cases were more resistant to penicillin than strains from the other four homosexual patients. Heterosexual CMRNG patients could not be linked to homosexual CMRNG patients by sexual history or naming of sexual contacts. All homosexual patients were clustered within Albuquerque; heterosexual patients were more widely distributed throughout the state. Based on immunologic studies of the gonoccoci recovered from these individuals and examination of temporal and geographic variables for heterosexuals versus homosexuals, at least two separate outbreaks with no demonstrable common source occurred in New Mexico. No evidence for interstate or foreign transmission into New Mexico could be identified for any of the cases.

Oregon: Of the eight cases reported from Oregon, all occurred among homosexual males. Gonococcal strains from these individuals shared identical immunologic and antimicrobial susceptibility patterns. No epidemiologic evidence for interstate or foreign transmission could be documented for any of these cases, suggesting only endemic transmission within the homosexual community in Oregon. No additional cases have been reported from Oregon since March 1984.

Reported by M Kimberly, DrPh, State Laboratory Director, W DeVault, CE Chapman, MD, G Conrad, Venereal Disease Control, RH Hutcheson, Jr, MD, State Epidemiologist, Tennessee State Dept of Health; JM Mann, MD, L Nims, Scientific Laboratory, A Chowning, E Montes, Venereal Disease Control, HF Hull, MD, State Epidemiologist, Health Svcs Div, New Mexico Dept of Health and Environment, L Foster, MD, D Harger, H Horton, Venereal Disease Control, C Schade, MD, JA Googins, MD, State Epidemiologist, State Health Div, Oregon Dept of Human Resources; Sexually Transmitted Diseases Laboratory Program, Center for Infectious Diseases, Div of Sexually Transmitted Diseases, Center for Prevention Svcs, Div of Field Svcs, Epidemiology Program Office, CDC.

Editorial Note: Seventeen states, including North Carolina, have reported cases of CMRNG to CDC since 1983. The majority of these cases were detected as primary therapeutic failures to the penicillins or tetracyclines. Gonococcal strains from the majority of U.S. outbreaks and cases have generally been immunologically similar (serogroup IIb) with similar antimicrobial susceptibilities.

Based on epidemiologic data, foreign importation has been infrequently documented for these CMRNG strains in the United States (*3*). In contrast, foreign importation contributes to the largest proportion of PPNG in the United States, although domestic transmission became more important after 1976 (*4*).

Cases of CMRNG may be detected by screening for penicillin resistance at the local or state levels to guide appropriate therapy and permit rapid follow-up of cases. Screening by disk agar diffusion or with penicillin-containing media will identify chromosomally mediated resistance to penicillin. Disk susceptibility testing to tetracycline and trimethoprim/sulfamethoxazole should be performed only by standardized procedures using appropriate controls (*5,6*). Inconsistent results to these two antimicrobials may be seen with disk susceptibility testing (*5,6*).

Based on agar dilution susceptibility testing, infections caused by CMRNG should clinically respond to therapy with recommended dosages of spectinomycin, cefoxitin, cefotaxime, or ce-

Neisseria gonorrhoeae – *Continued*

furoxime. CDC treatment guidelines for PPNG infections provide the recommended schedules for these antimicrobials and emphasize the importance of the immediate use of spectinomycin as primary therapy for gonorrhea cases when treatment failures are suspected (*7*).

Since 1975, gonorrhea has generally declined in the United States (*8*). PPNG increased dramatically between 1976 and 1982 but decreased in 1983 (*8*). Unfortunately, cases of CMRNG have been reported with increasing frequency since the North Carolina outbreak. Because the extent and prevalence of CMRNG infections are not yet fully understood, screening of all β-lactamase negative (nonpenicillinase-producing) primary treatment failure gonococcal isolates for penicillin susceptibility (*1*) is encouraged at the local and state levels to improve surveillance and guide appropriate therapy. Screening at the community level should be most cost-effective, since the majority of these CMRNG strains are equally resistant to tetracycline, thereby preventing unnecessary and usually ineffective retreatment with a tetracycline. Because of high secondary treatment failure rates with tetracycline, tetracycline should not be used as the drug of choice for either PPNG or CMRNG infections that have failed primary therapy with penicillin or ampicillin. Spectinomycin, cefoxitin, or cefotaxime should be used to treat CMRNG infections at dosages recommended for PPNG (*7*).

More active surveillance for these CMRNG infections will be required to determine their accurate prevalence, and support control activities.

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CENTERS FOR DISEASE CONTROL

August 3, 1984 / Vol. 33 / No. 30

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

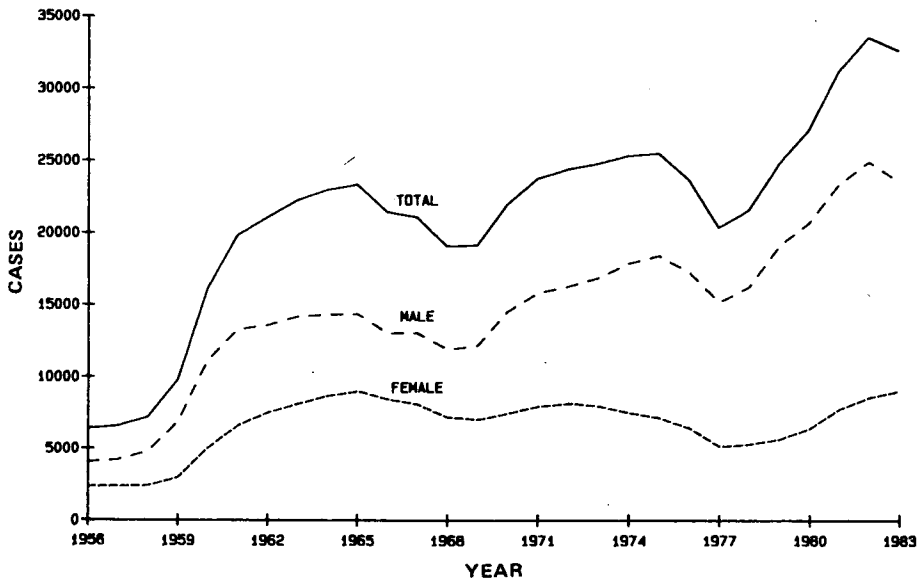
Syphilis — United States, 1983

Although the incidence of primary and secondary syphilis in the United States steadily increased from a low of 9.4 cases per 100,000 population in 1977 to 14.6/100,000 in 1982, the reported national incidence decreased to 14.1/100,000 in 1983 (Figure 1). Reported primary and secondary syphilis cases totaled 32,698 in 1983, a 3% decrease from the 33,613 cases reported in 1982.

The changes in the number and rate of primary and secondary syphilis cases varied with sex and sexual preference. Among women, the number and rate of reported cases increased in 1983; however, among men, reported cases and the rate decreased (Table 1). Thus, the decrease in the 1983 national incidence was attributable to the decrease in the rate of reported cases occurring among men. During 1981-1983, the rate of cases per 100,000 population reported in men decreased 0.9% but increased 15% among women. The sex ratio (males: females) among primary and secondary syphilis cases increased from 1.5:1 in 1967 to 3.2:1 in 1980 but declined during 1981-1983 from 3.0:1 in 1981 to 2.6:1 in 1983.

The proportion of men with primary and secondary syphilis who named other men as sex partners increased from 23% in 1969 to 42% in 1982 but decreased to 40% in 1983. The

FIGURE 1. Reported primary and secondary syphilis cases, by sex — United States, 1956-1983



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES / PUBLIC HEALTH SERVICE

Syphilis – Continued

Early congenital syphilis (CS) among children under 1 year of age still contributes to neonatal morbidity. The number of cases of early CS decreased from 422 in 1971 to 104 in 1978. In 1981, reported cases increased to 160; in 1982 and 1983, 159 and 158 cases of CS were reported, respectively. Fifteen states reported no early CS in 1982 or 1983. Four states accounted for most (62%) of the cases of early CS reported in 1983: Texas (26%), Florida (15%), California (11%), and New York (9%). Though the rate of primary and secondary syphilis cases occurring among women increased 15% between 1981 and 1983, the number of cases detected through prenatal testing increased to a lesser degree.

Reported by Operational Research Br, Evaluation and Statistical Svcs Br, Div of Sexually Transmitted Diseases, Center for Prevention Svcs, CDC.

Editorial Note: The distribution of syphilis cases underwent several key changes between 1967 and 1979. The most important of these included (1) a twofold increase in the ratio of reported cases among men to reported cases among women; (2) an increase in cases among men reported by public clinics—from 32% to 56% of the total cases; and (3) an increase in the percentage of white men with early syphilis who reported at least one male sex partner from 38% in 1969 to 70% in 1979 (*1*). Most of these trends have continued since 1980. In addition, the percentage of total cases reported from public clinics (about 74% since 1980) and the percentage of cases among men reported from public clinics (about 55% since 1979) have been fairly constant. The ratio of cases reported among men to cases among women has declined between 1980 and 1983. The percentage of late and late latent syphilis cases reported has also declined from 59% in 1969 to 24% in 1983.

The decrease in the national incidence of reported syphilis cases may represent, in part, a response to public health recommendations to decrease risks of sexually transmitted diseases (*2*). With the media attention given acquired immunodeficiency syndrome (AIDS) and herpes, syphilis rates may be affected indirectly, as gonorrhea rates have been in certain localities (*3,4*).

The continued occurrence of a fairly constant number of cases of CS between 1981 and 1983 may reflect the increase in the incidence of early infectious syphilis among women, a lack of availability of prenatal care, or a failure of the prenatal-care system to provide timely screening, serologic testing, and prompt follow-up (*5,6*). Eighty percent of women with primary and secondary syphilis are in their reproductive years (15-34 years of age).

TABLE 3. Rates of primary and secondary syphilis* in selected cities per 100,000 population — United States, 1981-1983

Cities	Rates per year 1981	1982	1983
San Francisco, Cal.	178.7	180.5	158.5
New Orleans, La.	123.2	134.3	106.4
Atlanta, Ga.†	129.0	132.4	106.4
Newark, N.J.	62.0	68.1	96.9
Charlotte, N.C.	33.6	52.2	90.0
Dallas, Tex.†	84.9	89.6	87.0
Miami, Fla.†	39.4	70.6	80.8
Houston, Tex.†	80.7	95.8	80.5
Washington, D.C.	103.2	74.0	64.3
Tampa, Fla.†	63.1	88.0	55.4
New York, N.Y.	36.7	37.1	35.6
Los Angeles, Cal.†	24.9	25.1	24.6
Denver, Colo.	34.0	34.5	21.7

*Source: CDC 73.688 (Division of Sexually Transmitted Diseases).

†Reported data includes information from surrounding counties: Atlanta (Fulton County); Dallas (Dallas County); Miami (Dade County); Houston (Harris County); Tampa (Hillsborough County); Los Angeles (Los Angeles County).

Syphilis – Continued

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International Conference on Acquired Immunodeficiency Syndrome

An International Conference on Acquired Immunodeficiency Syndrome (AIDS) will be held April 15-17, 1985, at the World Congress Center, Atlanta, Georgia, sponsored by CDC; the National Institutes of Health; the Food and Drug Administration; the Alcohol, Drug Abuse, and Mental Health Administration; the Health Resources and Services Administration; and the World Health Organization. The purpose of the meeting is to review strategies for the prevention and control of AIDS and to exchange information on screening and diagnostic tests for AIDS and on the epidemiology, virology, immunology, clinical manifestations, and treatment of AIDS. Seating will be available for 1,800 participants. An announcement of keynote speakers and a call for abstracts will be published later. To obtain further information and future announcements, contact:

AIDS Conference
Building 1, Room 2047
Centers for Disease Control
Atlanta, Georgia 30333.

Experimental Infection of Chimpanzees with Lymphadenopathy-Associated Virus

Evidence from two investigations indicates that the retrovirus etiologically linked to acquired immunodeficiency syndrome (AIDS) may infect chimpanzees (*Pan troglodytes*). In the first study, investigators from CDC and Emory University's Yerkes Regional Primate Research Center, Atlanta, Georgia, inoculated two chimpanzees with lymphadenopathy-associated virus (LAV) (*1*), one of two prototype retrovirus isolates etiologically associated with AIDS (*2*). Both animals were virologically and serologically negative before inoculation; both were injected simultaneously with concentrated virus and autologous lymphocytes that had been infected in vitro with LAV. Both animals were immunostimulated concomitantly by inoculation of diphtheria-tetanus toxoid and pneumococcal vaccine. One animal received human lymphocytes as an additional immunostimulant.

Six days after inoculation, a retrovirus identified as LAV by reverse transcriptase assay, direct immunofluorescence, p25 competitive radioimmunoprecipitation, and electron micros-

AID ATLANTA SPONSORS AIDS AWARENESS GROUPS, Continued from Page 30

AIDS on individuals, families, and communities will be discussed with persons having AIDS, those with preliminary symptoms, and lovers, mothers, and survivors. 5) Stress & the Immune System (Stress Management Workshop)--Outline of basic fact concerning relationships between mechanisms for resisting infection and the experience of psychological stress, with special attention to AIDS and the sources of emotional stress typical in the lives of gay people. Effective stress management and stress reduction techniques that can be practiced without specia materials or equipment will be demonstrated and practiced under guidance. 6) Diet, Nutrition, Exercise & Immunity (Health Maintenance Workshop)--Discussion of basic principles of health maintenance through sound diet and reasonable exercise, with special attention to the body's immune system. Guidance away from poor diet habits toward more healthful eating patterns will be provided. The role of regular exercise in maintaining healthy immunity to infection will be evaluated and demonstrated. 7) Reduction of AIDS-Transmission Risk (Alternatives in Sexual Expression--Discussion of current theories of transmission of the putative AIDS agent. Special attention will be directed to evaluation of transmission risks inherent in various forms of sexual expression. Suggestions will be offered for alternative lower-risk forms of sex without sacrifice of significant quality of sexual excitation or gratification. 8) Legal Issues for Gay People and People with AIDS--Powers of attorney, wills, joint ownership, resources. For more information, contact: AID Atlanta, 1801 Piedmont Rd., #208, Atlanta, GA 30324.

* * *

LAV — Continued

copy was identified from peripheral lymphocytes of both animals. The virus was isolated from both animals from six consecutive lymphocyte specimens obtained every 2-4 weeks. The most recent specimens were obtained more than 4 months after inoculation. Antibody to the major core protein (p25) of LAV was first detected 3 months after inoculation and was again present at 4 months. In both animals, five consecutive postinoculation T_4/T_8 ratio determinations have shown an apparent downward trend, although values are significantly below normal in only one. No clinical illness has been detected in the animals, and physical examinations have remained normal.

In the second study, investigators at the National Institutes of Health (NIH) and Southwest Foundation for Biomedical Research have found evidence of transmission of HTLV-III to two chimpanzees receiving human plasma from an individual with the lymphadenopathy syndrome. Evidence for infection includes anti-HTLV-III seroconversion, depression of T_4/T_8 ratios, and, in one animal, the development of severe, prolonged lymphadenopathy coincident with seroconversion.

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Editorial Note: Primate transmission experiments have been under way at CDC and NIH for some time. LAV and HTLV-III, as well as human AIDS tissue, have been inoculated into several species of primates, including marmosets, rhesus monkeys, and chimpanzees. Except for some lymphocyte changes (3), no disease or infection has been previously reported. The studies reported here indicate that LAV/HTLV-III can be transmitted to chimpanzees both by inoculating virus isolates and human plasma. In some instances, immunologic abnormalities and prolonged lymphadenopathy have followed inoculation, but opportunistic infections or tumors characteristic of AIDS have not developed. Transmission of HTLV-III from lymphocyte-poor human plasma is consistent with reports of AIDS among recipients of plasma or anti-hemophilic concentrates made from pooled plasma (*4,5*).

The virus isolated from the LAV-inoculated chimpanzees was morphologically and immunologically identical to LAV. Virus particles were morphologically distinct from the Type D retrovirus etiologically implicated in "simian AIDS," a transmissible syndrome of macaques (6,7).

Long-term follow-up of the LAV and HTLV-III-infected chimpanzees, as well as other primates, is continuing. Careful examination of the interaction between infection and host response in primates could clarify the pathogenesis of AIDS in humans.

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