THE OFFICIAL NEWSLETTER OF THE

NATIONAL COALITION OF GAY STD SERVICES

VOLUME 6 #3 January-February, 1985

[TABLE OF CONTENTS ON PAGE 2]

STATE OF THE COALITION--NCGSTDS PLANS FOR 1985

by Mark Behar, Chairperson

It's with great pleasure that I announce the NCGSTDS' anticipated plans for the new year. The NCGSTDS realized a slight increase in the number of new memberships and renewals from July 1, 1984 to December 31, 1984 (first six months of our fiscal year), when compared to similar periods in 1982 and 1983; this was also reflected in our revenues collected during this time. But because of the sizeable amount of paperwork required to maintain memberships, quality of services provided, rather than quantity of membership was the organization's focus. At the June, 1984 annual meeting, the membership authorized the purchase of a computer system that will facilitate the completion of the paperwork required for not only membership but also the Newsletter, and other functions as required, after the final profits from the August, 1984 NCGSTDS/CASTDS & AAPHR medical meetings in Chicago were deposited. The NCGSTDS shared a total of $3772.18 with AAPHR ($1886.09 each, after expenses) from the conference, which brought our savings account balance to over $7500. After thorough and exhaustive study about the type of computer hardware and software that was needed (for example, we examined IBM, Compaq, Corona, Kaypro, DEC Rainbow, AT&T, Apple, and others), the following was purchased: Compaq DeskPro Model 2 (256K, dual disk drive) with amber monochrome monitor, Toshiba P1340-P dot matrix printer, and Hayes internal Smartmodem 1200B/Smartcom II (for telecommunications with CAIN (Computerized AIDS Information Network), INAPEN (InterNational AIDS Prospective Epidemiology Network, not yet set up), and others (any suggestions?). After exploring different wordprocessing packages (we've looked at Volkswriter, WordPerfect, PeachWriter (?)), we've decided on the best (unfortunately expensive!): WordStar 2000 Plus. Our intention will be to initially load in membership information that will allow for timely renewal reminders and a more aggressive and immediate membership campaign. Your help in this membership campaign is needed--if you know anyone who might be interested in subscribing, let us know; if you have any ideas for advertising in gay targeted or medical newspapers or magazines, please share that information. Only by increasing our membership base will we be able to avoid dues increases! Second priority will be the Newsletter, which undoubtedly will take more time gaining familiarity with formating and printing. Hopefully, the Newsletter will become more regular in publication (every 2 months by the calendar) and grow more uniform in size (no more 40 or 60 page encyclopedias!); we may consider a monthly publication in the future, if need and interest develop. Third priority will be telecommunications, initially going online with CAIN and ultimately offering our own interactive network whereby Coalition membersh may dial up our computer anytime to access Newsletter information immediately, ask questions, etc. Stay tuned to the Newsletter for additional information. The NCGSTDS will advertise this computer access number after the services are developed. Until then, an

(CONTINUED on page 3)

TABLE OF CONTENTS (ALPHA): STDs

TABLE OF CONTENTS (ALPHA): AIDS [Abridged]

[Continued in Left Column]

STATE OF THE COALITION, Continued from page 1

after 11 pm (central time) "ring-back" feature will be used on the present voice phone line--414/277-7671; just to be sure, better call first and get voice confirmation that the system is operating! A survey of computer needs will be mailed to all Coalition members and friends sometime this spring. If you have a computer or are planning to acquire one in the near future, please fill it out and return. Special thanks to all Coalition members and friends who offered detailed advice about computer hard & software that helped make very difficult decisions understandable! Regretably, the U.S. Post Office announced plans to increase postage in February, 1985. I do not believe that this will necessitate an-across the board dues increase. Although it is too early to tell, one category, that of STD Services, may be affected due to their receiving 5 copies of each issue of the Newsletter, which is expensive, occasionally costing over $3 per Service per mailing. This dues increase will be discussed at our annual meeting in June, at the National Lesbian Gay Health Conference in Washington, DC (dates still unannounced by sponsoring organization). If our membership drive is successful, this can probably be postponed. Finally, unless important and significant new information about AIDS health education and risk reduction is learned, a newly revised edition of the Guidelines and Recommendations for Healthful Gay Sexual Activity brochure will not be released in 1985. The brochure will eventually be loaded into the computer for easier revisions. If you believe certain sections should be revised or updated, please let us know!

This year will again be an ambitious one--just getting the computer operational is an ambitious project! A membership drive will be of great importance, as will maintaining the overall quality of our services. We will continue to participate in important national gay/lesbian health and medical conferences affecting the gay community. As always, we need your ongoing support--not only through membership renewals, but more importantly through your constant surveillance of gay/lesbian health issues locally and nationally, and passing on information to us. We must all be committed to networking! Call or write today, with news, comment, or constructive criticism! Have a great year!

* * * * *

6th INTERNATIONAL MEETING OF INTERNATIONAL SOCIETY FOR STD RESEARCH IN ENGLAND

The 6th International Meeting of the International Society for STD Research will be held at England's Metropole Hotel in Brighton, July 31-August 2, 1985. The program will feature presentations on AIDS (clinical, therapeutic, epidemiology, laboratory), recent advances in treatment of herpes, gonorrhea, chlamydia, syphilis, other STDs; interferon therapy; hepatitis; gastrointestinal and genito-urinary tract infections; vaginitis; cervical pathology; pelvic inflammatory disease and infertility; maternal/fetal/neonatal disease; new diagnostic techniques; immunologic advances; and recent developments in epidemiology in the major STDs. Registration fees will be approximately 120 UK pounds. For additional information and for the call for papers, please contact: Sarah Storie-Pugh, Conference Organizer or Sarah Frost-Wellings, Exhibition Organizer, Concord Services Limited, 10 Wendell Road, London W12 9RT, England. The 5th International Meeting attracted over 600 people to Seattle, WA, in August, 1983.

* * *

NATIONAL LESBIAN/GAY HEALTH CONFERENCE AND NATIONAL AIDS FORUM

The 7th National Lesbian/Gay Health Conference and 4th National AIDS Forum is scheduled for June 28-July 1, 1985 at George Washington University in Washington, DC. The Conference and Forum are cosponsored by the National Lesbian and Gay Health Foundation, the STD Control Division of the Centers for Disease Control, the National Institute of Allergy & Infectious Disease, and the Addiction Recovery Corporation of Washington. A call for papers and general regiscration information will be forthcoming shortly. Peter Laqueur has been named Conference Manager, and can be reached through Baltimore HERO (Health Education Resource Organization), Medical Arts Bldg., Suite 819, Cathedral and Reed St., Baltimore, MD 21201, 301/947-2437, 685-1180. The NCGSTDS is planning to hold its annual meeting during the Conference (date and time, to be announced).

* * * * *

NATIONAL LESBIAN AND GAY HEALTH FOUNDATION SEEKS SUPPORT

by Frank Greenberg, MD, President

I am writing to enlist your support for our vital programs which benefit thousands of lesbians and gay men each year. All members of our community who have taken a personal interest in the National Gay Health Education Foundation since our formation in 1980 should be concerned that our continued growth will be impossible if we do not attract regular loyal contributors to maintain a solid financial base. Through June, 1985, we must have the funds to complete the following program commitments: 1) Continuing the first National Lesbian Health Care Survey and publishing our results [funded in part by the Ms. Foundation]; 2) Completing work on the 7th National Lesbian/Gay Health Conference to be held in Washington, DC, June, 1985; 3) Coordinating the 2nd Southeastern Lesbian/Gay Health Conference; 4) Responding to requests for regional lesbian/gay health conferences in other parts of the U.S. with field support and consultation; 5) Extension of our AIDS information network including national networking for people with AIDS by supporting the National Association of People With AIDS (NAPWA); and 6) Publication of the 1985 National Lesbian/Gay Health Directory--5th edition, the 1985 Source Book on Lesbian/Gay Health Care-2nd edition, and continued publication of our newsletter, Lesbian & Gay Health.

We have moved our offices to Washington, DC, to take a more active role in working with the major national professional organizations, with other national lesbian and gay organizations and with the federal government in shaping the response of the health care delivery system to the needs of lesbians and gay men. In order to increase awareness of the need for appropriate services to all of the members of our diverse community we have recently elected to change our name to the National Lesbian and Gay Health Foundation (NLGHF). We have many possibilities for growth, but we cannot expand our programs on your behalf without your financial support. Our work will succeed only with the security of a certain monthly budget of $25,000 to cover the costs of our health research projects, publications, and conferences. We have a plan to reach this goal. We are asking for your support as a monthly contributor to the Foundation. We are hoping to add 5000 contributors during this appeal who are willing to contribute $5-10 month in support of the above Foundation projects. With 20 million lesbians and gay men in the U.S., our job should be easy, right? I wish that it were, but we are hoping to count on your help to reach a realistic 5000 contributor level and extend our program goals after we have reached that level of member support.

First, please decide if you would like to become a monthly contributor or if you wish to give a single contribution at this time. If you would like to become a monthly contributor, write a note to this effect, and you will receive a pledge reminder in the mail. If at any time you wish to change your commitment, you are free to do so. I hope that you will condier helping us in this way. We must rely on each other now more than ever for solutions to our health concerns. We will continue to work for you within government and health institutions to insure the health and welfare of lesbians and gay men despite the worst political and budgetary environment in the country in years. I thank you for your support. Please send contributions to: NLGHF, PO Box 65472, Washington, DC 20035.

* * *

LESBIANS IN HEALTH CARE

We are lesbians working in health care with a committment to the issues facing women in general, and lesbians in particular. We represent a wide range of philosophies and approaches to health care, both mainstream and alternative. Together, we provide a supportive environment where we socialize, exchange ideas and skills, encourage personal and professional alliances and growth, and provide educational programs about our work and lives. We are exploring our dreams of providing comprehensive health care services to the lesbian community. We commit ourselves to an active struggle against the ignorance and bigotry that interfere with our delivery of and access to the best health care possible. To adequately address the issues of lesbian health and quality health care delivery, we must, as individuals and as a group, confront the problems of heterosexism, antisemitism, racism, classism, ablebodyism, ageism, and elitism which pervade our community and the world around us. We acknowledg and encourage diversity of cultural, racial, ethnic, economic, physical and philosophical backgrounds within our group, and welcome lesbians who wish to share in our struggles. Lesbian Health News is a quarterly newsletter that is published for members. For more information, contact: Jo-Ann Shain, LIHC-RCU, PO Box 1278, New York, NY 10185 (212/787-4101).

NATIONAL LESBIAN HEALTH CARE SURVEY UPDATE

by Caitlin Ryan, Project Coordinator

Dear Friends--I'm writing to follow up on our networking for the National Lesbian Health Care Survey and to ask for your support. Through your help and the help of hundreds of women and men across the country, we were able to distribute over 4800 copies of our questionnaire in every state. To my knowledge no lesbian or gay research project has ever achieved such a national response. [ED NOTE: In 1977, Karla Jay and Allen Young distributed several hundred thousand copies of their surveys to lesbians and gay men from across the U.S. and Canada; over 5000 responses were received and compiled into the landmark, The Gay Report.] By now, most of our returns are in and we're finishing up our data gathering phase. However, we still have several months of work ahead of us and need your help to complete our research. Here's how you can help us:

We are still accepting questionnaires through the middle of February, 1985. If there are women in your area who still have questionnaires and have not returned them, please ask them to do so. If you have extra copies of the questionnaires and can get them to lesbians of color, we need more returns from Black, Latina, Native American and Asian lesbians. This is very important to make our study as representative of our diversity as possible.

If you have photocopied our survey and distributed it, we need to know the number of copies you have made. This will help us figure the rate of return.

We need help in coding the questionnaires for the computer. If you live in the Washington, DC metro area and can give 10 or more hours per week for the next three months, please contact us immediately, for more information.

We need additional funds to complete the study. Thus far we have received $17,500 from the Ms. Foundation for Women and the Chicago Resource Center. In order to finish our data analysis and to prepare the results for distribution, we need to raise an additional $15,000 within the next six months. These funds are needed for computer charges, postage and communication costs between members of the research team. All donations will be tax deductible; address contributions to: National Lesbian and Gay Health Foundation, 1322 15th Street, NW, #22, Washington, DC 20005. You can help with this essential fundraising effort by contributing money, sending names & addresses of friends who would be willing to help and by passing this note on, and by working in your area for raising funds for the survey through fundraising efforts, appeals to local organizations and private mailing lists, etc.

Other researchers reviewing our project are amazed that we've been able to undertake the study for less than $100,000. This is due to our networking capacity and to the dedication of everyone involved. The response we've received from all over the country has been phenomenal. Clearly, we have identified a need and uncovered an area of vital concern to all of us. This survey, the first of its kind, represents a national community effort. Please help us to carry on this vital work for lesbians everywhere.

* * *

HUMAN SEXUALITY--NEW DIRECTIONS IN MEDICAL EDUCATION: AMSA CONFERENCE

Each year, prior to the National Convention of the American Medical Student Association (AMSA), an all day pre-convention conference is held. This year's theme of the conference is "Human Sexuality--New Directions in Medical Education," the purpose of which is to educate medical students on topics of human sexuality and health not covered in traditional medical education. The conference will be Wednesday, March 20, 1985, at Chicago's Palmer House Hotel. For more information, contact your local AMSA chapter, or the national office: AMSA, 1910 Association Dr., Reston, VA 22091, 703/620-6600.

* * * * *

BOOK: THE LAVENDAR COUCH FROM ALYSON PUBLICATIONS

Enclosed with this Newsletter is an advertising supplement from Alyson Publishers concerning the release of The Lavendar Couch, by Dr. Marny Hall, about gays & lesbians in psychotherapy.

* * *

MISINFORMATION FUELS HERPES HYSTERIA, AGAIN

At an elementary school in Sacramento, where angry parents toted picket signs protesting the enrollment of a 4 year-old boy, absenteeism was about twice the normal rate. Across the country in suburban Pasadena, Maryland, the 3 year-old boy who spawned a similar furor there spent an eighth day alone in his classroom, while in Council Bluffs, Iowa, the boycott at Longfellow Elementary School finally waned when a judge ruled the 3 year-old girl had a right to be educated. Despite the thousands of miles separating them, the catalyst for the angry words, the picketing and the classroom boycotts was the same: each preschooler has a form of herpes. None of the preschoolers have genital herpes. But tainted nonetheless by the notion of children with an STD and fueled by fears of epidemic and misinformation about the condition, the hysteria surrounding their enrollments kept emotions high and, health experts say, the truth at arm's length. What impact the slowly easing turmoil will have on the trio of children, their classmates and parents is incalculable. In any case, say health experts, the fears and suspicions left will no doubt leave a bigger imprint on those lives than the disease itself. "It's a panic situation very much reminiscent of the McCarthy days to me," said John Graves, director of the Herpes Resource Center of the American Social Health Association, of Palo Alto. What began as a news brief about a toddler's enrollment in Maryland quickly broiled into major controversy because "somebody knew just enough to be ignorant," said Shirley Fannin, Los Angeles county's associate deputy director for communicable disease control programs. "They demanded somebody so something, and it became a news story." The contagion spread when parents "put 2 and 2 together and got 1000," said James Chin, chief of California's Infectious Disease Control Section. "They don't know what the real world is." In fact, herpes is much more prevalent than commonly believed. An estimated 40% of all children come in contact with the virus by kindergarden-age, and most develop immunities. For others, the symptoms can be so mild, there is virtually no evidence of the disease. Only a small percentage suffer from the festering blisters associated with herpes simplex. Likewise, 80-90% of adults have contracted some form of herpes before reaching middle age, and few show lasting effects. The painful case of shingles that was keeping former President Nixon from attending the Reagan inauguration is the product of herpes (varicella) zoster, one type of herpes virus, while the fever that hospitalized Pope John Paul II in 1981 was the result of another. "If we go out and check any 100 kids, 33% are likely to be shedding [virus particles]," said Fannin. "If these people picketing the schools took their children and tested them, they could find they had a pariah at home. How can I prevent coming in contact with it 100%?" she asked. "The answer is there is no way. Most sources are going to be totally unknown to you." Cytomegalovirus (CMV) is another of one of the herpes viruses that is also very ubiquitous, especially among gay men, and frequently has no symptoms. Parents in Milwaukee recently confronted school board and health department officials about the safety of their children against CMV; in spite of assurances that CMV rarely caused serious consequences in children, parents kept their children out of school for a short time after fears of CMV infection in some of the children.

* * * * *

HERPES HEALTH CENTER SEEKS VOLUNTEERS

The Herpes Health Center at St. Anthony's Hospital in Milwaukee is looking for individuals interested in volunteering to answer the Herpes Helpline--a 24 hour informational service regarding sexually transmitted diseases. Preferred hours of coverage are 5-8 pm, daily (other times available). Volunteers will receive at least 3 training sessions, and at least one shift with a trainer. A minimum committment of 12 weeks is required. If interested, please contact Brenda Jo McClellan, RNCNP, 414/271-1965 x754, or write to Brenda, c/o Herpes Health Center, St. Anthony Hospital, 1004 N. Tenth St., Milwaukee, WI 53233, by February 28th.

* * *

ORAL ACYCLOVIR FINALLY APPROVED BY FDA FOR HERPES

The Food & Drug Administration finally approved oral acyclovir for the treatment of herpes. The drug will be marketed in capsule form as Zovirax, and is expected to be available for prescription sometime in March or April. Topical and intravenous solutions of acyclovir have been available for several years for treatment of various forms of herpes.

* * *

DELTA HEPATITIS TACKLED BY AMERICAN HEPATITIS ASSOCIATION

by Jerry Meltzer

The Delta Hepatitis virus was discovered by Dr. Mario Rizzetto and a team of Italian scientists in 1979. Rizzetto found a new antigen-antibody system in patients who were then infected and/or carriers of chronic active hepatitis B (HBV). The Delta virus was found to require the help of an active HBV to support its replication and expression. Persons infected with the Delta virus generally suffer a more severe and rapidly progressing illness than those with HBV. Delta has a mortality rate of 50-60% within 6 years--nearly 50 times the mortality rate of hepatitis B. One in four people infected with Delta die within two years. The major scientific breakthrough represented by the development of the HBV vaccine several years ago created greater awareness of the threat posed by all forms of hepatitis. The media has made the morbidity and mortality figures of hepatitis familiar: 200,000 new cases of HBV each year with 16,000 of these requiring hospitalization and 10% of all cases remaining ill for life and becoming chronic HBV carriers. In the United States today, there are an estimated 1,000,000 carriers. Equally startling is that nearly 7,000 Americans die each year from HBV-related illness. Although these figures have been alarming to some, most Americans are still unaware of the risks posed by hepatitis. Most people, even those within the high risk groups (homosexually active men, IV drug users, blood transfusion recipients, southeast Asian immigrants, Eskimos, health care workers at increased risk to exposure to blood & other bodily secretions, and others), have neither been tested for the hepatitis antibody nor have sought the HBV vaccination. Hepatitis is the third most commonly reported infectious disease in the country, yet fewer than 250,000 Americans have received the preventative vaccine. Delta infection occurs only at the same time as hepatitis B infection and in the presence of acute or chronic hepatitis B infection. The duration of the hepatitis B infection determines the duration of the Delta infection. Thus, the vaccination against hepatitis B prevents Delta as well. Most importantly, many populations at high risk for hepatitis B are presently free of exposure to Delta and the introduction of the Delta agent could have dramatically devastating consequences. The general public, their primary care physicians, and particularly those in high risk groups, must be educated about the risks of hepatitis infections, HBV testing, and finally, the preventative vaccination. Therefore, it is critical that a major public education campaign begin immediately. In the past year, outbreaks of Delta have been reported throughout the US at an unprecedented level. Once Delta enters a community whose members are at risk for HBV, it can spread rapidly. In September, 1983, Delta was observed in 75 IV drug abusers and their sexual partners in Worcester, Massachusetts. Twelve percent of those cases have already resulted in fulminant hepatitis and eight have died. Today, there are 125 cases reported in Worchester.

The American Hepatitis Association (AHA) was formed in November, 1983 as a non-profit education organization with membership composed of individuals whose own lives have been changed by the disease. Although based in New York City, there are regional chapters in Los Angeles, San Francisco, Detroit, and Des Moines; chapters in six other major urban areas are presently being formed. AHA has four major purposes: 1) To provide support and outreach programs for hepatitis carriers; 2) To provide and promote education and information programs to the general public on hepatitis; 3) To encourage more testing for hepatitis B and greater use of the HBV vaccine; 4) To facilitate increased research on hepatitis both for treatment and prevention. Despite hepatitis being the third most commonly reported infectious disease in the country, the extent and perils of this disease are not suffiently understood. Today there are over 1,000,000 carriers of HBV alone in the United States. In 1985, over 200,000 more Americans will become infected with HBV--20,000 of these will remain ongoing HBV carriers. Five to seven thousand people will die in 1985 from hepatitis and other related liver disorders. Ironically, the major forms of hepatitis--B and Delta--are preventable, with a widely available and safe vaccine (Heptavax). Until now there have been no ongoing private, city, state or federally funded programs available in this country to address the critical need for public information and diagnosis of this epidemic. The inauguration of the AHA marks a turning point in our national battle against the hepatitis epidemic. For more information, contact: Jerry Meltzer, American Hepatitis Association, 208 W. 13th St., New York, NY 10011, 212/340-8986.

* * *

HEPATITIS B VACCINE UNDER STUDY IN CHICAGO

Chicago's Howard Brown Memorial Clinic (HBMC) recently announced they were the recipient of a $37,235 grant from the Centers for Disease Control to continue to study of how well the hepatitis B vaccine works. The Clinic was one of the few centers in the country that pioneered the study of the vaccine's efficacy. "Sometimes it is easy to forget that hepatitis B is the single greatest disease risk gay men face," stated Gregory Shipman, MD, Medical Director and Principal Investigator of the study. The grant seeks to determine whether the vaccine gives permanent immunity to the disease or whether booster immunizations may be necessary, as they are with tetanus. Jerry Weller, chief executive officer of the Clinic, said, "The Clinic has always been and continues to be involved in research in areas which are critically important to the lives of the gay community."

* * *

HEPATITIS B RISK INCREASING

by Tam Cummings and Mark Scott with thanks to The Washington Blade, 12/21/84

Hepatitis B, which continues to be a serious disease affecting the gay community, is on the rise in the United States, jumping 68% since 1978 to 200,000 new infections each year, CDC officials told The Washington Post. Dr. James Mason, director of the CDC, joined major health groups in urging a major national push to vaccinate major risk groups--including gays and health-care workers--against the disease, which can lead to liver cancer, cirrhosis and death. Mason gave assurances that a vaccine to prevent the disease, available since 1982 but not yet in wide use, is both safe and effective. He dismissed what he called unfounded fears that the vaccine may transmit AIDS. Because it is difficult to grow the hepatitis B virus in the laboratory, the vaccine is produced from blood products taken from hepatitis barriers, including gay men, who are also at high risk of carrying the AIDS virus in their blood. But, Mason said, studies show that the AIDS virus is not present in the vaccine, and any viruses initially present would be killed during the manufacture of the vaccine. About one fifth of new hepatitis B cases occur in gay men, Mason said, noting the disease will strike 70 people per 100,000 in this country this year.

* * *

HARTFORD GAY HEALTH COLLECTIVE

by Bert Kissling

The Collective is continuing to move ahead! A new hepatitis B vaccination program has generated lots of interest. We have established a special fund to defray the costs of those who cannot otherwise afford it, and while begun with trepidation, we could see an instant run on our money and collapse of the fund, so far we are keeping it even, and with added fundraising may be able to advance the balance. Clinic attendance has also grown. We've undertaken a more advanced publicity campaign, and will predictably be spending even more, which will swell patient numbers. Our community is presently suffering a lack of internal political interest except for our own activities, and thus the parent umbrella organization is in some danger of going out of business. We are moving ahead to incorporate, and apply for federal tax-exempt status, both to be free of these problems, and to be able to provide our own umbrella for medical operations. This would enable us to move to a more widely acceptable location than the one we now occupy. The Collective plans to offer a workshop at the National Lesbian Gay Health Conference in June [if the steering committee sends out a call for papers] on people with AIDS related complex relating to an AIDS identified structure. For more information about the Collective, write or phone: Hartford Gay Health Collective, 281 Collins St., Hartford, CT 06105 (203/724-5194).

* * *

HAWORTH PRESS ANNOUNCES NEW BOOK ON CRITICAL CLINICAL ISSUES IN GAY IDENTITIES

The Haworth Press recently announced the publication of the ninth Research on Homosexuality series, Bisexual and Homosexual Identities: Critical Clinical Issues, edited by John P. DeCecco, PhD, of the Center for Research and Education in Sexuality. This 106 page volume is a discussion of sexual identity within a clinical context, i.e., within the context of depth psychology, diagnostic classification, therapy, and psycho-medical research on the hormonal basis of homosexuality. Cost of the book is $19.95 (hardbound), and is available through your bookseller, or directly from Haworth Press: 28 East 22nd St., New York, NY 10010, 212/228-2800.

* * *

CHICAGO CLINIC AWARDED CDC GRANT FOR HEPATITIS B

with thanks to Cruise Magazine, 1/18/85

Chicago's Howard Brown Memorial Clinic (HBMC) was notified by the Centers for Disease Control that it was awarded a $37,235 grant to continue to study how well the hepatitis B vaccine works. HBMC was one of the few centers which pioneered the study of the effectiveness of the hepatitis B vaccine. "Sometimes it is easy to forget that hepatitis B is the single greatest disease risk gay men face," said Greg Shipman, MD, medical director of the Clinic and principal investigator of the study. The study will help determine whether the vaccine offers permanent immunity to hepatitis B or whether booster shots may be necessary, like those needed to prevent tetanus. "The Clinic has always been and continues to be involved in research in areas which are critically important to the lives of the gay community," stated Jerry Weller, the Clinic's new chief executive officer. The grant represents a 50% increase in funding over the 1984 hepatitis B grant from the CDC.

* * * * *

CHLAMYDIA BROCHURE AVAILABLE FROM AMERICAN SOCIAL HEALTH ASSOCIATION

The American Social Health Association of Palo Alto, the parent organization of the VD National Hotline, Herpes Resource Center and the Venereal Diseases Research Fund, has announced the publication and availability of a new 4 panel brochure, "Some Questions and Answers About Chlamydia." The brochure defines chlamydia, how infections are transmitted, signs, symptoms, complications, diagnosis, treatment, and prevention, therefore qualifying as an excellent patient education tool for both men and women. The brochure was prepared in part from a grant from Lederle Laboratories. It is now available for $10 per hundred, or $80 per thousand from ASHA, 260 Sheridan Av., Suite 307, Palo Alto, CA 94306 (800/227-8922, in California, 800/982-5883).

* * *

REDUCING STRESS

reprinted from Berrien General Hospital's For Health's Sake booklet, Berrien Springs, Michigan, and The Helper, Winter, 1985 (American Social Health Association)

1) TALK ABOUT IT. When something worries you, don't bottle it up. Confide your worry to someone you can trust.
2) ESCAPE FOR A WHILE. Sometimes when things go wrong it helps to get away; escape into a movie, book, jogging, or even a brief trip. But be prepared to deal with your difficulty when you have regained your breath and balance.
3) WORK OFF YOUR ANGER. Instead of blowing up and feeling foolish and sorry later, hold off the impulse for a while. In the meantime, ptich into some physical activity like gardening, carpentry, or some other do-it-yourself project.
4) GIVE IN OCCASIONALLY. You don't always have to be right. Stand your ground on what you know is right, but do so calmly and be prepared to yield once in a while.
5) DO SOMETHING FOR OTHERS. Instead of worrying about yourself all the time, try doing something for somebody else. You'll feel better and it'll take the steam out of your worries.
6) TAKE ONE THING AT A TIME. Under tension, even a normal workload can seem unbearable. Remember this is a temporary condition. Take one important task and work it through.
7) SHUN THE "SUPERMAN"/"SUPERWOMAN" URGE. Don't expect too much of yourself. To try for perfection in everything is admirable, but it's impossible and it's an open invitation for failure. Put effort into those things you do well.
8) GO EASY WITH CRITICISM. This will save you and others unnecessary stress. You'll be better off if you search out good points and help to develop them in yourself and others.
9) GIVE THE OTHER FELLOW A BREAK. Competition is contagious. By "letting up" you help yourself; if others no longer feel you are a threat, they'll stop being threatening to you.
10) MAKE YOURSELF "AVAILABLE." Many of us have the feeling we're being "left out," slighted, rejected. The person you feel is leaving you out may feel the same way about you. Don't withdraw. It's healthier to make some of the overtures instead of always waiting to be asked.

* * *

SEXUAL ADDICTION BOOK

with thanks to SIECUS Report, January, 1985 (volume 13:3)

The Sexual Addiction is a 185 page book by Patrick Carnes written to help "sexual addicts," their family members, or other concerned persons appreciate the nature and magnitude of the problem and the possibility for recovery. Dr. Carnes describes the origins of sexual addiction, the addictive cycle with its progressive intensity, and the often desperate double life the person with this problem must lead. However, he also states that once sexual addiction is acknowledged and revealed, it will no longer have to be dealt with in isolation, and recovery via an outlined 12-step precess is possible. This 1983 book is available for $8.95 from: Comp Care Publications, 2415 Annapolis Lane, Minneapolis, MN 55441.

* * *

GAY & LESBIAN SPEAKERS BUREAU MANUAL AVAILABLE

Boston's Gay & Lesbian Speakers Bureau feels that gay men and lesbians are the best authorities on what it is like to be gay or lesbian. For the past 12 years, the Bureau has presented speaking engagements--generally free-form question and answer presentation--to college classes, religious groups, high schools, hotlines and police cadet training programs, service organizations, and in general, to anyone who is interested in learning more about the issues of gayness and lesbianism. The 74 page 8½x11, typeset Manual draws from the experiences of hundreds of Bureau members at over 1000 speaking engagements. The Manual begins with a brief history of the Bureau, along with a description of how the Bureau operates, and provides a preliminary guide for other groups wishing to set up a speaker's bureau. A second manual, describing in more detail the "nuts & bolts" of how to establish and maintain a speakers bureau is being compiled, and is expected to be available sometime in 1985. Over 30 commonly asked questions, with suggested answers are given, covering the gamut of lesbian & gay lifestyles, homophobia, discrimination, religious & health issues, among others. A chapter on group process examines the group dynamics which are often encountered in a speaking engagement. Copies are available for a donation of $10 (for individuals), $15 (organizations & institutions), plus $1.50 for postage and handling per copy. Bulk rates is $5 per copy for 10 or more (includes shipping). For more information, write or call: Gay & Lesbian Speakers Bureau, PO Box 2232, Boston, MA, 02107 (617/354-0133).

* * *

BOOK: HOMOPHOBIA--AN OVERVIEW

The largest collection of articles on homophobia published to date, this Haworth Press volume includes theoretical analyses, applied research, and a comprehensive, annotated bibliography of federal publications relating to homosexuality. Homophobia: An Overview is a 198 page hardbound book edited by John P. DeCecco, PhD, Center for Research and Education in Sexuality, San Francisco State University, published December, 1984, and was also published as a monograph in the Journal of Homosexuality, volume 10:1-2. For more information, contact your local bookseller, or The Haworth Press, 28 E. 22nd Street, New York, NY 10010 (212/228-2800). Cost is $24.95.

* * *

CHICAGO CLINIC APPOINTS NEW CHIEF EXECUTIVE OFFICER

Chicago's Howard Brown Memorial Clinic (HBMC) recently announced the appointment of Jerry Weller as the new executive director of the Clinic, succeeding Harley McMillan who resigned in mid-1984 for health reasons. Weller was most recently serving as acting director of Gay Rights National Lobby, Washington, DC, and was responsible for Congressional lobbying, fund-raising, press relations, direct mail efforts, and office administration. Weller was also executive director of Phoenix Rising Foundation of Portland, Oregon in 1979-83, where he founded and directed activities of the state's only gay and lesbian social service agency, providing counseling and public education programs. Weller was given the civil liberties award by the American Civil Liberties Union of Oregon in 1980, and was named "An Outstanding Young Man of America" in 1979.

* * *

GAY COMPUTER SERVICE OFFERS FREE TIME TO NEW USERS

The Gay News Information and Communications Network (GNIC) announced that effective immediately, new subscribers to the service would receive 2 free hours of usage as part of their membership benefits. "We believe that the only way for new members to be comfortable with a service of this type is to get 'hands-on' experience with the system," said GNIC Network spokesperson Michael Cirillo. "So we are giving new members free computer time to fully appreciate and learn all the features of GNIC at our expense." GNIC is the nation's only multi-user computer service designed specifically for use by gay men and lesbians, with local phone access from 500 points in the U.S. and Canada. GNIC provides up-to-the-minute news of importance and interest to gay men and women, as well as a multitude of on-line data bases, including an international resource directory of gay and lesbian businesses and organizations, and communications programs such as electronic mail, CHAT and TALK. There is a general public message board, on-line user profile/directory, and an arts and leisure section which carriers horoscopes, film and theatre reviews, video and TV information, book reviews, and much, much more. Users of the service can access the system 24 hours daily through one of the major nationwide public data networks. Users simply need a personal computer, word processor, or a terminal with communications capabilities, and a 300 or 1200 baud modem. There is a one-time membership sign-up fee of $40, plus a minimum of $15 per month; hourly rates are priced at $5.25/hour for connections between 8pm-8am (eastern), weekends and holidays ($7.50/hour other times). Membership includes an individual account number, account password, user's manual, and a certificate good for 2 free hours of usage. GNIC plans for the future include an on-line shopping service, home banking facilities, and traveler services. For more information, write to: GNIC Network, PO Box 115, Woodbury, NY 11797, or call 516/351-1363.

* * *

LETTER TO THE EDITOR

Dear NCGSTDS: Have I benefited from your Newsletter? You betcha! Living here in Jacksonville (Florida) had been an interesting enough challenge before the advent of AIDS. This town is fraught with homophobes being encouraged by strong Bible-belt influences. The "red-neck" ethic is still alive and well here. My "out" lifestyle has not been easy at times. It should be obvious that there are other reasons for living here aside from my homosexual nature, but my affectional preference is a very important part of who I am. This is where you come in. The Coalition's Newsletter has been most helpful in keeping me in touch with "what's going on." Nowhere else can I find subh a complete compilation of current information on the AIDS crisis. I personally subscribe to The Advocate, The New York Native, Christopher Street, The Washington Blade, The Village Voice, and have donated to and receive the newsletters of the National Gay Task Force, the Florida Task Force, the Fenway Community Center, the Gay Men's Health Crisis, and the KS/AIDS Foundation. I read most of this stuff, issue by issue, front to back. I still look forward to receiving your Newsletter. It has always been a source of new information, enabling me to "fit some of the pieces together." The information I am able to gleen from the the above, I take advantage of my position as manager of a gay bar (The Phoenix), as a member of the Board of Directors of the Bold New City Coalition for Human Awareness, and as editor of the newsletter of the Central Crisis Center (Jacksonville's crisis intervention & information/ referral hotline), to disseminate this information. The more well educated the entire community is on the subject of AIDS (and STDs in general), the healthier (both physically and psychologically) the gay community in Jacksonville will be. There's much comfort for me in knowing there are people like you and your Coalition out there. I could be very lonely (read crazed!) without the like of you guys doing what you do. I thank you sincerely. -- Ken Hunt

* * *

CHICAGO CLINIC HONORS KING'S BIRTHDAY

The Board of Directors of Chicago's Howard Brown Memorial Clinic voted to close the clinic on Tuesday, January 15, in honor of the birthday of slain civil rights leader Rev. Martin Luther King, Jr. "I'm very pleased that the clinic board chose to follow the policy of many gay organizations, civil rights groups and the federal government by regarding King's birthday as a clinic holiday," stated the clinic's executive director, Jerry Weller. "The board clearly understands that as a minority organization it is proper and important that we recognize and respect the accomplishments and dedication of Rev. King and the black civil rights movement," Weller continued. It was the decision of the board that any inconvenience posed by clinic services not being available on that day would be offset by the importance of recognizing and honoring the struggle for basic civil rights which minority groups face.

* * *

* *

NCGSTDS UNRESTRICTED/NONCONFIDENTIAL MEMBERSHIP & MAILING LIST ANNUAL UPDATE

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

AID Atlanta	1132 W. Peachtree St-NW	Suite 112/ Attn:Direct	Atlanta,	GA 30309	404/872-0600
AIDS Action Committee	Allan O'Hara	P.O. Box 4073	Key West,	FL 33040	305/294-5359
AIDS Action Council/ FARO	Gary MacDonald	1115½ Independnc Av SE	Washington,	DC 20003	202/547-3101
AIDS Committee Toronto	Kevin Orr	P.O. #55, Sta. F	Toronto, Ontario	M4Y 2L4	416/926-1626
AIDS Health Project		54 Tenth St.	San Francisco,	CA 94103	415/626-6637
AIDS Medical Foundation	Abby Tallmar	230 Park Ave. #1266	New York,	NY 10169	212/949-7410
AIDS Project- Los Angeles	Matt Redman	937½ Cole St.- #3	Los Angeles,	CA 90038	213/871-1284
AIDS-Rochester	Susan Cowell	153 Liberty Pole Way	Rochester,	NY 14604	716/232-7181
AIDS-STD Service/ St. Lukes-	Roosevelt; Marlyn Blitz	428 W 59TH St	New York,	NY 10019	212/
American Assn Phys Human Rts	Doug Carner	P.O. Box 14366	San Francisco,	CA 94114	415/558-9353
Anawim Health Care Team	c/o Dignity-Pittsburgh	P.O. Box 362	Pittsburgh,	PA 15230	412/381-6066
Awareness Jacksonville	Ken Hunt	P.O. Box 27061	Jacksonville,	FL 32205	/ -
Beach Area Community Clinic	Terry Cunningham	3705 Mission Blvd.	San Diego,	CA 92109	619/488-0644
Blue Bus Clinic	Tim Tillotson	1552 University Av.	Madison,	WI 53706	608/262-7440
Brady East STD Clinic		1240 E. Brady St.	Milwaukee,	WI 53202	414/272-2144
Calif. AIDS Project/ DOHS	Levi Kamel	P.O. Box 2230	Sacramento,	CA 95810	916/322-2087
Cascade AIDS Project	Brown McDonald	408 SW 2nd Ave.- #403	Portland,	OR 97204	503/223-8299
Clinic on 21st	Madalene Anderson	1216 NW 21st St.	Portland,	OR 97209-7503	503/226-6678
Community Health Project	Thomas Grace	208 W. 13TH ST.	New York,	NY 10014	212/691-8282
Concern	Mike Bielinski	532 S. Jackson	Green Bay,	WI 54301	414/435-4605
Counseling+Consultive Services	Bill Pellicio	161 Prospect Hill St.	Newport,	RI 02840	401/847-7229
Dallas Gay Alliance	Tom Hatfield	P.O. Box 190712	Dallas,	TX 75219	214/528-4233
Dept Public Health STD Clinic	Harborview Med Ctr ZA85	325 9th Ave.	Seattle,	WA 98104	206/223-3590
Fenway Community Health Ctr	Ken Mayer, MD	16 Haviland St.	Boston,	MA 02215	617/267-7573
Fnd. Health Educ./New Orleans	Joseph Nigliazzo, Jr/	P.O. Box 2556	New Orleans,	LA 70176	504/244-6900
GATE/AIDS Network		Box 1852	Edmonton, Alberta	T5J 2P2	403/424-8361
Gay & Lesbian Community Center	AIDS Project	1436 LAFAYETTE ST.	Denver,	CO 80218	303/831-6268
Gay Community Center Clinic		241 W. Chase St.	Baltimore,	MD 21201	301/837-2050
Gay Community News	Richard Burns	167 Tremont St. 5th Fl.	Boston,	MA 02111	617/426-4469
Gay Health Assn/ Gayline	Box 3611, Halifax South	Postal Station	Halifax, Nova Scotia	B3J 3K6	902/423-1389
Gay Men's Health Collective	Coordinator	2339 Durant Ave.	Berkeley,	CA 94704	415/644-0425
Gay Men's Health Crisis	PO Box 274	132 West 24TH Street	New York,	NY 10011	212/807-6655
Gayly Oklahoman	Ron Shaffer	P.O. Box 60930	Oklahoma City,	OK 73146	405/528-0800
Haight Ashbury Free Med Clinic	Tim Mess	558 CLAYTON	San Francisco,	CA 94117	415/431-1716
Hartford Gay Health Clinic	Bob Jolin	281 Collins St.	Hartford,	CT 06105	203/527-7099
Hassle-Free Clinic/AIDS Commit	Robert Trow	556 Church St. #2	Toronto, Ontario,	M4Y 2E3	416/922-0603
Health Issues Task Force	Ted Wilson	POB 14925 Publ Sq. Sta.	Cleveland,	OH 44114	216/XXX-XXXX
Hepatitis B Project	Ken Brock, MSW	PO Box 160486	Sacramento,	CA 95816	916/453-8995
Herpes Health Center	Brenda Jo Mc Clellan, RNP	1004 N. 10th St.	Milwaukee,	WI 53233	414/271-1965
Hollywood Health Center		1462 N. Vine Street	Hollywood,	CA 90028	213/461-9355
Howard Brown Memorial Clinic	Harley McMillen, Director	2676 N. Halsted	Chicago,	IL 60614	312/871-5777
Institute for Social Research	Jill Joseph, PhD	P.O. Box 1248	Ann Arbor,	MI 48106	313/763-0974
Iowa City Free Medical Clinic	Co-Director	P.O. Box 1170	Iowa City,	IA 52244	319/337-4459
James D'Eramo	New York Native	70 Greenwich Ave #500	New York,	NY 10011	212/925-8021
KS Clinic	A--312	UCSF HOSPITALS & Clinic	San Francisco,	CA 94143	415/666-1407
KS/AIDS Foundation	Mike Wilson	3317 Montrose, Box 1155	Houston,	TX 77006	713/524-2437
Kinsey Institute	Indiana University	416 Morrison	Bloomington,	IN 47405	
LHINC/DECC	Ellen Ives	398 Park Lane	East Lansing,	MI 48823	517/351-4000
Lesbian & Gay Community	Services Center	124 West Lake St., #E	Minneapolis,	MN 55408	612/827-5614
Lesbian & Gay People In	Medicine--AMSA	1910 Association Dr.	Reston,	VA 22091	703/620-6600
Lesbian + Gay Health Project	David Jolly	P.O. Box 11013	Durham,	NC 27703	919/286-0079
Madison Gay Center	Chaz Pope	1127 University Ave.	Madison,	WI 53706	608/251-2864
Mayor's Task Force on AIDS	Brian McNabb	City Hall #608	Boston,	MA 02201	617/424-5916
Metra Magazine	Gar Bassett	2110 Rosedale Ave	Flint,	MI 48506	313/XXX-XXXX
Monroe County Health Dept	Public Service Bldg.	Jr. College Road	Key West,	FL 33040	305/294-1021

Montreal Health Press	Donna Cherniak, MD	POB 1000 Station "G"	Montreal,Quebec,	H2W 2N1	514/272-5441
N.G.T.F.	Jeff Levi	2335 18th St., NW	Washington,	DC 20009	202/332-6483
National Gay Task Force		80 Fifth Av. #1601	New York,	NY 10011	212/741-5800
New Hampshire Feminist Health	Center	232 Court Street	Portsmouth,	NH 03801	603/436-6171
New York Dept. OF Health	Yehudi Felman, MD	93 Worth St., #306	New York,	NY 10013	212/566-7685
OUT! Newspaper	Brooks Egerton, Editor	P.O. Box 148	Madison,	WI 53701	608/256-7664
Ohio Department of Health	Div. of C.D./ Alan Ford	246 N. High St.	Columbus,	OH 43215	216/961-5806
Oklahomans For Human Rights		P.O. Box 52729	Tulsa,	OK 74152	918/592-5086
Philadelphia Community Health	Alternatives	PO Box 7259	Philadelphia,	PA 19109	215/624-2879
Pittsburgh Community Health	Services	121 S. Highland Av.	Pittsburgh,	PA 15206	412/661-6604
STD Clinic Of Anchorage	Laurel Stolpe, RN	825 "L" Street	Anchorage,	AK 99501	907/264-4611
STD Control Division	Centers for Disease Contr	Freeway Park #179	Atlanta,	GA 30333	404/329-2552
Sacramento AIDS Foundation		2115 J Street, #3	Sacramento,	CA 95816	916/448-2437
San Antonio Safe AIDS Committe		P.O. Box 15481	San Antonio,	TX 78212	512/736-5216
San Diego AIDS Project		4304 3rd Ave.,POB 81082	San Diego,	CA 92138	619/294-2437
San Francisco AIDS Foundation	James Ferels	54 Tenth Street	San Francisco,	CA 94103	415/864-4376
Seattle AIDS Action Committee		113 Summit Ave. E, #204	Seattle,	WA 98102	206/323-1229
Seattle Gay Clinic		PO Box 20066	Seattle,	WA 98102	206/329-8390
Seattle King Co. AIDS Project	14th Floor	1200 Public Saftey Bldg	Seattle,	WA 98104	206/587-4999
Siecus	Leigh Hallingby	80 Fifth Av. #801	New York,	NY 10011	212/929-2300
The Clinic--Gay & Lesbian	Community Services Ctr	1213 N. Highland Ave	Los Angeles,	CA 90038	213/464-7480
The Dryden Clinic	Frank Berrier, Jr.	1709 Dryden, Suite 1002	Houston,	TX 77030	713/795-0385
The Lambda Group, Inc.	John Taylor	P.O. Box 18302	Denver,	CO 80218	303/370-0793
The Montrose Clinic	Tom Audette	803 Hawthorne	Houston,	TX 77006	713/528-5535
Tucson Alternative Health Assn	Mike Dolores, MD	9040 N. Oracle RD. #B	Tucson,	AZ 85704	602/742-6863
VD Action Coalition	Judy Lipshutz	51 W. Warren Ave.	Detroit,	MI 48201	313/833-0622
VD Interchange/ TIS-CPS	Center For Dis Cont		Atlanta,	GA 30333	404/329-1819
VD National Hotline	Remy Lazarowicz	260 Sheridan Ave.	Palo Alto,	CA 94306	800/227-8922
Whitman-Walker Gay Men's VD	Clinic, Jim Graham	2335 18th St., NW	Washington,	DC 20009	202/332-5295
Wisconsin IN STEP	Ron Geiman	823 N. 2nd St.	Milwaukee,	WI 53203	414/289-0744

Abramson, MD	Lary	3765 16th St.	San Francisco,	CA 94114	415/565-6288
Adams	Jeff	P.O. Box 6101	Denver,	CO 80206	303/777-9530
Adams	Robert	5315 Old Middleton Rd	Madison,	WI 53705	608/231-3583
Allan, RN	Dean	Po Box 23116 Broadway Sta	Seattle,	WA 98102	206/325-3420
Babl	James	213 Fourth Av	Venice,	CA 90291	213/396-3575
Backe	Horst	506-21 Roslyn Rd.	Winnepeg, Manitoba	R3L 2S8	204/284-6618
Bales, MD	R. Craig	812 Harold	Houston,	TX 77006	512/346-4433
Barnes	Rosemary	92 Fulton Ave.	Toronto, Ontario	M4K 1X8	416/XXX-XXXX
Barrett	Donald	116 Frederick- #40	San Francisco,	CA 94117	415/864-6138
Behar, PA-C	Mark	P.O. Box 239	Milwaukee,	WI 53201	414/271-7671
Berrill	Kevin	80 Fifth Av. #1601	New York,	NY 10011	212/000-0000
Blatt, MD	David	2426 W. Foster	Chicago,	IL 60625	312/000-0000
Bolan, MD	Robert	667 Lakeview Av.	San Francisco,	CA 94112	415/587-5569
Bonnell, MD	Mark	233 Linden Court	Iowa City,	IA 52240	319/338-3419
Bowers, MD	Daniel	897 Portland Av.	St. Paul,	MN 55104	612/227-6983
Branson, MD	Bernard	101 W. Read St. Suite 815	Baltimore,	MD 21201	301/244-8484
Brauner, MD	Gary	1995 Broadway	New York,	NY 10023	212/877-2800
Brewton, MD	Gary	9353 Viscount #2066	El Paso,	TX 79925	915/593-5114
Brook, MD	David	850 Seventh Ave., #403	New York,	NY 10019	212/246-3610
Bursaw	Mike	2319 Curlew St.- #8	San Diego,	CA 92101	619/239-0104
Caceres, MD	Cesar	1759 Q Street, NW	Washington,	DC 20009	202/667-5041
Calderwood	Deryck	27 Harvey Dr.	Summit,	NJ 07901	212/273-6278
Carr, RN	Gary	222 Moultrie St.	San Francisco,	CA 94110	415/821-0951
Cohen	Bill	69 West 9th St	New York,	NY 10011	212/228-2800
Darrow, PhD	Bill	AIDS Activity-CID/CDC	Atlanta,	GA 30333	404/329-3162
Dassey, MD	David	P.O. Box 12	Riverside,	CA 92502	714/686-8187
David, MD	Harry S.	8733 Beverly Blvd. #408	Los Angeles,	CA 90048	213/657-2202
Davis, MD	Robert	566 S. San Vicente	Los Angeles,	CA 90048	213/655-6331
Davis, RN	Lisa	Box 386 171 Harrison Av	Boston,	MA 02111	617/956-5292
Dietz, RN	Susan	W292 N2038 Elmhurst Dr	Pewaukee,	WI 53072	414/691-3391

Dodge, MD	Wayne	5763 27th Av., NE	Seattle,	WA 98105	206/527-1196
Donovan	Bill	439 16th St., #3R	Brooklyn,	NY 11215	212/965-4601
Dopp	Stephen	203 Regent St.	Fredericton, N.B.	E3B 3W8	506/455-1198
Douglass,MD	Albert	5018 San Piedro	San Antonio,	TX 78212	512/826-2311
Dreisbach,MD	Dyan	584 Castro #102	San Francisco,	CA 94114	415/826-3198
Enlow, MD	Roger	125 Worth St,NY Health D.	New York,	NY 10013	212/566-1879
Epstein,PhD	David	1506 N. Kings Rd.	Los Angeles,	CA 90069	213/656-4215
Falk, PhD	Larry	448 N. County Rd	Waukegan,	IL 60085	312/244-4651
Filardo, MD	Thomas	506 S. Mathews	Urbana,	IL 61801	217/333-8366
Fisher, MD	Evelyn	2799 W. Grand Blvd.	Detroit,	MI 48202	313/876-2563
Fox, MD	Fred	Box 2575	Austin,	TX 78768-2575	512/xxx-xxxx
Gager, MD	Fred	291 Edwards St.	New Haven,	CT 06511	203/773-9004
Gaither, RN	Ron	6202 Estrella Ave.	San Diego,	CA 92120	619/265-1399
Gauthier	Thom	7981 Eastern Av.	Silver Spring,	MD 20910	301/565-0333
Gayle, MD	Terry	2443 5th Av. West	Seattle,	WA 98119	206/283-2347
Gilmore	G.M.	1003 W. Charles	Champaign,	IL 61821	217/XXX-XXXX
Goldfield	Mark	292 Park Place	Brooklyn,	NY 11238	212/789-0062
Gorman	Michael	278-D Peachtree Hills	Atlanta,	GA 30305	404/237-3891
Greenberg,MD	Frank	1616 Driscoll	Houston,	TX 77019	713/523-5204
Gremminger	Roger	929 N. Astor St. #1608	Milwaukee,	WI 53202	414/765-0849
Hadden	Stan	State Capitol #205	Sacramento,	CA 95814	916/445-8390
Harisiades	James	924 W. George St.	Chicago,	IL 60657	312/281-3874
Hauer	Laurie	707 San Bruno Ave.	San Francisco,	CA 94107	415/821-7984
Helquist	Michael	584 Castro St.- #111	San Francisco,	CA 94114	415/821-2180
Henevadl,PAC	John	1111 N. O'Connor Rd #121	Irving,	TX 75061	214/254-6523
Hickey, MD	Tom	435 E. 70th St. #9h	New York,	NY 10021	212/628-8014
Hill	William	5801 Spring Valley #1712	Dallas,	TX 75240	214/386-5388
Hodak, MD	Gregory	P.O. Box 39 A 57	Los Angeles,	CA 90039	213/660-9105
Holder	William	3441 Forbes Av.	Pittsburgh,	PA 15213	412/578-8080
Hunt	Ken	2816 College St	Jacksonville,	FL 32205	904/389-8879
Isaac, MD	Richard	190 St. George St. #605	Toronto,Ontario	M5R 2N4	416/968-2808
James, PA-C	Dennis	16 Haviland St.	Boston,	MA 02215	617/247-0212
James, PhD	Hugo	7 Franklin St.	Trumbull,	CT 06611	203/261-0869
Johnson	Doug	1313-C E. Randolph Ct.	Milwaukee,	WI 53212	414/964-0965
Kahn, PhD	Arnold	1200 17th St., NW	Washington,	DC 20036	202/833-7572
Katz, MPH	Scott	6304 F. Shanda Dr.	Raleigh,	NC 27609	919/847-2007
Keith, MD	Paul	6200 Wilshire Blvd #1510	Los Angeles,	CA 90048	213/931-1463
Killinger	Marc	932 Christian St.	Philadelphia,	PA 19147	215/627-6733
Kimmel	Doug	135 East 94th Street	New York,	NY 10128	212/348-1327
Kissling,PA	Albert	21 Redding St	Hartford,	CT 06114	203/249-2660
Klein, MD	Tom	10 E. Ontario- #2805	Chicago,	IL 60611	312/472-4677
Kooden	Hal	154 8th Av.	New York,	NY 10011	212/243-3582
Kristal	Alan	316 W. 75th St. #4c	New York,	NY 10023	212/580-2562
Krzywicki	Barry	4210 E. 11th Ave. #255	Denver,	CO 80220	303/320-8333
Laqueur	Peter	2624 St. Paul St. #2A	Baltimore,	MD 21218	301/243-0177
Lear, MD	Walter	206 N. 35th St.	Philadelphia,	PA 19104	215/386-5327
Lemley	Craig	225 Adams St. Apt 9A	Brooklyn,	NY 11201	212/522-1123
Lewis, RN	Angie	4165 Army St.	San Francisco,	CA 94131	(415/488-0381)
Lord, MD	Nancy	567 2nd Avenue #1	New York City,	NY 10016	212/685-7095
Love	Marjorie	1432 Crescent Dr.	No. Waterboro,	ME 04061	207/247-6431
Malcolm,PA-C	Zell	1616 Piedmont Ave. # B-6	Atlanta,	GA 30324	404/876-2354
Mannion	William	3640 N. Fremont	Chicago,	IL 60613	312/935-6795
Mathews, MD	Chris	4621 Vista St.	San Diego,	CA 92116	619/584-4958
Mayer, MD	Ken	369 Tappan St. Apt. 18	Brookline,	MA 02146	617/232-9861
McGraw, MD	Patrick	450 Sutter St. #1504	San Francisco,	CA 94108	415/391-0103
McMillen	Harley	2676 N. Halsted	Chicago,	IL 60614	312/871-5777
McNamara,MD	Bernard	1462 N. Vine	Hollywood,	CA 90028	213/461-9355
McShane, MD	Denny	152 Hedge Rd	Menlo Park,	CA 94025	415/327-6642
Miller	Alan	CGA--PO Box 639 Sta. A	Toronto Ontario	M5W 1G2	416/977-6320
Miller, DO	Stephen	4212 Kensington	Detroit,	MI 48224	313/886-4412
Millhofer,MD	Lawrence	326 Washington St. # 2d	Norwich,	CT 06360	203/887-3565

Moore	John	RR8, P.O.Box 174 Lot #56	Carbondale, IL	62901	618/549-1482
Moore, MD	Jim	56 Dorval Rd.	Toronto, Ontario	M6P 2B6	416/537-0657
Morris,CIS/	Tim	110 E. Warren	Detroit, MI	48201	313/833-0710
Myers, MD	Lonny	10947 S. Longwood Dr.	Chicago, IL	60643	312/445-7656
Nylund	Thomas	4422 Clinton St.	Los Angeles, CA	90004	213/665-8943
O'Brien, RN	Charleen	725 North St.	Pittsfield, MA	01201	413/499-4161
O'Hara	Allan R.	P.O. Box 4073	Key West, FL	33041	305/294-8302
Oliver, MD	Dennis	140 West 71st St. #5b	New York, NY	10023	212/724-6832
Ostrow, MD	David	155 N. Harbor Dr. #5103	Chicago, IL	60601	312/565-2109
Owen, MD	William	1580 Valencia St. #202	San Francisco, CA	94110	415/826-2400
Palmer, PA	John	301 W. 22nd St.	New York NY	10011	212/253-3620
Paroski, MD	Paul	114 Willoughby Av.	Brooklyn, NY	11205	212/622-3000
Patton	Cynthia	48 Magazine St.	Cambridge, MA	02139	617/XXX-XXXX
Payne	Kenneth	Wash.Univ-Anthro-Box1114	St. Louis, MO	63130	xxx/xxx-xxxx
Peacock	Ross	985 Madison Av.	New York, NY	10021	212/535-7200
Pickett,md	Roger	4052 N.W. 61st St.	Oklahoma City, OK	73112	405/942-3189
Pope	Chaz	11 Whispering Waters Crcl	Madison, WI	53716	608/221-2084
Read, MD	Stan	53 Rivercourt Blvd.	Toronto,Ontario	M4J 3A3	416/429-3580
Rice	Hugh O.	1426 N. Formosa Av., #2	Los Angeles, CA	90046	213/851-2134
Rice, RN	Kevin	2006 Columbia Rd. NW #42	Washington, DC	20009	202/232-6984
Richards	Jeff	41 Landers Apt. 2	San Francisco, CA	94114	415/861-1880
Rosenstein	Hanan	1436 W. Lake St.	Minneapolis, MN	55408	612/824-1772
Rutherford	Mike	GPA P.O. Box 7809	Van Nuys, CA	91409	213/873-3663
Ryan	Caitlin	1322 15th St., NW- #22	Washington, DC	20005	202/232-0188
Rybicki	Neal	359-1/2 Valley St.	San Francisco, CA	94131	415/648-2885
Sabella	William	Box 7	North Haven, CT	06473	203/239-7881
Sable, MD	Ron	3719 N. Magnolia	Chicago, IL	60613	312/929-4439
Sandberg,MD	Phil	4130 Southwest Fwy- #200	Houston, TX	77027	713/522-7009
Schram, MD	Neil	6200 Via Subida	Palos Verdes, CA	90274	213/548-0491
Schuman, PA	Eric	5817 S.W. 22nd Terr. #4	Topeka, Ks	66614	913/272-5394
Schwamb	Don	2233 N. Summit Pl #702	Milwaukee, WI	53202	414/276-2204
Selan	Bella	2400 E. Bradford Ave.	Milwaukee, WI	53211	414/963-9188
Siroty, MD	William	40 Park Ave.	New York, NY	10016	212/532-6720
Smith	Roy	1253 Walter Pl., NE	Washington, DC	20003	202/544-6292
Smith, MD	J.R.M.	601 Corydon Av.	Winnepeg, Manitoba	R3L 0P3	204/475-3540
Soares	Franklin	1503 Baker St.	Streator, IL	61364	815/672-8074
Solomon,PhD	Jerry	1722 N. Seabright Ave	Santa Cruz, CA	95062	408/425-8785
Soskolne	Colin	Univ. of Toronto	Toronto, Ontario	M5S 1A8	416/978-5479
Staebler	James	1501 Sunset Plaza Dr.	Los Angeles, CA	90069	213/854-3010
Starrett,MD	Barbara	14 E. 4th St.- #505	New York, NY	10012	212/982-2711
Steffen, PA	George	1510 W. Sunnyside Ave.	Chicago, IL	60640	312/784-1510
Steinman,PhD	Richard	U.S.ME--96 Falmouth St	Portland, ME	04103	207/780-4174
Strube, PA	Rosemary	211 Lazaretto Rd., # 4F	Prospect Park, PA	19076	215/237-9046
Taylor, MD	Robert	1755 Beacon St.	Brookline, MA	02146	617/232-1459
Thomas	John	P.O. Box 840	Elizabeth, NJ	07207	XXX/XXX-XXXX
Thompson,MD	Harvey	912-A 21st St.	Sacramento, CA	95814	916/441-2636
Tillotson	Tim	1552 University Av.	Madison, WI	53706	608/256-8476
Tranen	Beth	729 S. 6th St.	Columbus, OH	43206	614/444-9434
Truax, MD	A. Brad	3330 Third Ave. #400	San Diego, CA	92103	619/224-2921
Vachon, PA	Ron	201 E. 12th St.- #505	New York, NY	10003	(212/563-6313)
Waitkevicz	Joan	1 Haven Plaza	New York, NY	10009	212/475-6030
Washburn,MD	Peter	P.O. Box 538	Newport, RI	02840	401/846-8032
Werner	Stephen	1809 E. John	Seattle, WA	98112	206/ -
Wheeler, MD	Jim	3613 Fairmount	Dallas, TX	75219	214/559-2590
Whyte, MD	John	151 Tremont St. #21-D	Boston, MA	02111	(612/521-0625)
William, MD	Dan	69 5th Av., #10j	New York, NY	10003	212/924-5809
Wilson	Hank	55 Mason	San Francisco, CA	94102	415/441-4188
Wisniewski	Ted	2734 Orchid St.	New Orleans, LA	70119	504/488-0355
Wood, MD	Bob	3408 S. King St.	Seattle, WA	98144	206/329-3927
Zaltzberg	Ellen	230 Jay Street #17A	Brooklyn, NY	11201	212/330-0293

[Last minute additions are out of alphabetic order, at the end of the list. Next list will be published in the first issue of 1986.]

* * * * * *

AIDS EPIDEMIOLOGY/SURVEILLANCE UPDATE

abstracted from AIDS Weekly Surveillance Report, CDC AIDS Activity

As of January 21, 1985, the Centers for Disease Control AIDS Activity reports a total of 7981 adult and pediatric cases of AIDS in the U.S. (CDC strict case definition). Homosexually active men account for 73% of all cases; 17% from IV drug users; 3% from Haitians; 1% from hemophiliacs; 1% from heterosexual contacts; 1% from blood/blood product recipients; 4% 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 or Haitian or hemophilics, etc., but are only counted in the top, i.e., homosexual category. It is our contention that this confuses and misrepresents the data, which the CDC itself has admitted. --ED] 23% are from individuals aged 29 or less; 47% from ages 30-39; 21% from ages 40-49; and 9% from ages 50 and older. 59% of the individuals are white; 25% are black; 14% are hispanic; 1% are other ethnic backgrounds or unknown. Forty-eight states including the District of Columbia and the Commonwealth of Puerto Rico have reported cases to the CDC; New York and California have the most cases, with 39% and 23%, respectively; Florida, 7%; New Jersey, 6%; Texas, 5%; Illinois, Pennsylvania, and Massachusetts, 2% each; all other states have less than 2% each (comprising more than 15% of all cases). Overall mortality is 48%, which reflects an increased case-mortality since the last Newsletters. AIDS cases per million of population for the entire US is 35.1 per million, ranging from 313 per million in New York City and 287.9 per million in San Francisco, 187.6 cases per million in Miami, 110.4 cases per million in Newark, 89.5 cases per million in Los Angeles, and 14.7 cases per million in "elsewhere". These figures represent only those cases meeting the CDC's strict criteria of case definition.

As of January 8, 1985, Canada's Laboratory Centre for Disease Control in Ottawa had recorded 165 adult cases; of these, 113 (68%) are of homosexually active men. As of December 18, 1984, Quebec recorded 63 cases of AIDS, with 26 homosexually active men (HAM); Ontario had 57, with 49 HAM; British Columbia had 31, with 27 HAM; Alberta had 8, all of which were HAM; Nova Scotia had 3, with 2 HAM; Saskatchewan had 1, with 1 HAM; Manitoba and Newfoundland both had 1 each, without any HAM; no cases have been reported in New Brunswick or Prince Edward Island.

* * * * *

INTERNATIONAL AIDS CONFERENCE HAS SATELLITE MEETING

A workshop designed to explore current state-of-the-art information about AIDS etiology, epidemiology, and transmission and that is also planning to draft behavioral risk reduction guidelines for use among gay communities in the U.S., Canada, and Europe, is being scheduled for Sunday afternoon, April 14, 1985, preceding the International AIDS Conference in Atlanta, according to David Ostrow, MD, PhD, one of the organizers of the meeting. The workshop will be held with the joint sponsorship of Emory University School of Medicine, the Centers for Disease Control, and the following community organizations: American Association of Physicians for Human Rights (AAPHR), National Coalition of Gay STD Services (NCGSTDS). and National Lesbian and Gay Health Foundation (NLGHEF).

This five to six hour "piggy-backed" meeting will review the relevant data, how to convert this knowledge into updated risk reduction guidelines, drafting and polishing, discussing and critiquing the proposed guidelines. The guidelines would be published under the banner of the "Ad Hoc Working Group on AIDS Prevention" or similar title, with credit given to sponsoring organizations. If you are planning on attending the International AIDS Conference and are also interested in participating in this special Sunday workgroup, plan on arriving in Atlanta early Sunday morning or Saturday, and contact David Ostrow (312/565-2109) or Mark Behar (414/277-7671, NCGSTDS, PO Box 239, Milwaukee, WI 53201).

* * *

COMING TO ATLANTA FOR INTERNATIONAL AIDS CONFERENCE?

If you are planning to attend the International AIDS Conference in Atlanta, April 14-17, and would like to receive some southern hospitality from folks at AID Atlanta, please drop a note or call Ken South, Director, AID Atlanta, 1132 W. Peachtree St., NW, #112, Atlanta 30309 (404/872-0600).

* * *

CDC SPONSORING 48 REGIONAL MEETINGS ON MEANING OF HTLV-III BLOOD TEST

The Division of STD Control of the Centers for Disease Control is sponsoring 48 regional meetings for health personnel on dealing with the meaning of positive and negative HTLV-III antibody testing in high and low risk populations. The Division was charged with working with local and state governments and community health groups and STD clinics through 48 regions that roughly correspond to every state in the country. Only states that wanted such a meeting are being assisted by the CDC. There will be three components of the one day meetings--medical, operational & counseling, and gay community reaction. Regions are strongly encouraged by the CDC to involve local gay health workers in this third component. They are further authorized to invite those health workers that they want to participate. The major issues of discussion are: what is proper pre-HTLV-III antibody test counseling? Interpretation of seropositive, seronegative, and seroconversion in high and low risk individuals? Medical aspects of AIDS? For more information, contact your state's Division of Health, or Tim Baker, Training Coordinator, STD Control Division, CDC, 404/329-2552. All 48 meetings are scheduled to take place in February, 1985.

* * *

CAN EMPLOYMENT BE LEGALLY DENIED FOR PEOPLE TESTING HTLV-III ANTIBODY POSITIVE?

by Lou Chibbaro, Jr., with thanks to The Washington Blade, 12/14/84

The Washington, DC Office of Human Rights (OHR) is studying the question of whether private firms or local government agencies can legally deny employment to an individual based on a positive blood test for antibody to the AIDS-related virus, HTLV-III, according to Maudine Cooper, the office's director. OHR officials are acting on a formal request for an opinion on the HTLV-III question submitted by Gay Activists Alliance health coordinator, Jeff Levi. Levi, who also serves as Washington director for the National Gay Task Force, said he told Cooper in a written request that medical researchers have declared that the HTLV-III test has no clinical significance and that gay health advocates fear the test could be used as a means of discriminating against gays and others. The test is expected to be licensed by the federal government in early 1985 as a means of screening blood collected by blood banks for possible AIDS contamination. Officials with the National Institutes of Health have said that while the test is useful in screening blood, there is no evidence to indicate that a person who tests positive for the HTLV-III agent will develop AIDS. Levi said widespread discrimination could develop if employers use the test as a prerequisite for hiring or promoting employees. Cooper said researchers from her office will contact medical authorities to confirm the information submitted by Levi. If the office determines that no clinical benefits can accrue from the test and that test results can be used for discriminatory purposes, she will consider writing an opinion declaring discrimination based on a positive HTLV-III antibody test to be a violation of the District's human rights law.

* * *

ETHICAL, LEGAL, AND SOCIAL CONSIDERATIONS IN AIDS

The impact of AIDS on affected individuals, their families, friends, the medical profession, and the general public is enormous. The public health problem presented by the disease has become acute, and there is a growing awareness of the complex ethical, legal, and social problems which can accompany the spread of AIDS. Policies for dealing with patient concerns--including treatment decisions, privacy/confidentiality, guardianship, and societal discrimination and misinformation--have, to date, been isolated and inadequate. The ways in which MDs and other health workers, hospital administrators, researchers, counselors, and media representatives can address the many issues surrounding AIDS will be the focus of the Public Responsibility in Medicine and Research (PRIM&R) meeting to be held April 24-25, 1985, at Boston's Park Plaza Hotel. PRIM&R's meeting will precede a NIH/NIAID meeting on AIDS scheduled for April 26th, which will highlight the major medical and epidemiologic issues. It is hoped the two meetings will provide a comprehensive and practical overview of the tragic problems posed by AIDS and of the possible means of addressing them. For a complete program and further information, contact Joan Rachlin, PRIM&R, 132 Boylston St., Boston, MA 02116, 617/423-4112/1099.

* * *

NIAID'S AIDS WORKSHOP--THE REPORT THAT NEVER GOT PUBLISHED

The National Institute of Allergy and Infectious Disease (NIAID) called together a workshop of 10 gay health providers in April, 1984, as consultants to address the issues of educational outreach to the gay community regarding AIDS. [See NCGSTDS Newsletter, 5:4, March/April, 1984, pp. 15-16.] Unfortunately, one of the only positive results of this consultant's meeting, was a nationwide series of widely acclaimed workshops on AIDS aimed at health providers and the lay public. The consultant firm of T.J. Schmidt & Associates (1302 18th St., NW, #303, Washington, DC 20036, 202/463-8556) is chiefly responsible for these NIAID seminars; if your community is interested in co-hosting one, you are strongly encouraged to contact JoAnn Kramer of T.J. Schmidt. As excellent as these seminars are, what more can NIAID do? NIAID or T.J. Schmidt have not yet attempted to seriously work with established gay service organizations to reach out into the gay community for health education and risk reduction purposes. A summary of the consultant's report, which was promised to be distributed by NIAID, never did. What were the recommendations of the consultants? The following summary was compiled by Neil Schram, MD, Chairperson of the consultant's group, and past president of the American Association of Physicians for Human Rights (AAPHR).

These recommendations are suggested guidelines for establishing AIDS risk reduction workshops for gay males arranged through local gay and lesbian organizations. The first list of general suggestions would be useful for general discussion with local gay and lesbian organizers. We then propose five specific areas that should be dealt with, perhaps through small workshops so that a comprehensive program for a community can be developed. It is clear that different cities will have different areas that are more important than others, and it would be the community's responsibility to set priorities as well as to decide the best way to deal with the problems we have raised.

GENERAL COMMENTS:

1) Since sexuality is an important part of all of us, a risk reduction program should be developed in a positive manner with a goal of increasing self-esteem.

2) When communities develop workshops it is useful to break down the large group into smaller groups after general information is disseminated. This would allow for specific questions and an increased feeling of participation. If possible, consideration should be given to continuing the small groups after the workshop to provide ongoing peer support.

3) In developing programs, it is useful to involve mental health and other health care providers groups as well as local and state governmental officials. Social service agencies should also be involved.

4) A general program should involve many gay and lesbian organizations and indeed the networking that evolves from the development of a program is very important.

5) Up to date information on AIDS as well as risk reduction must be distributed to all physicians and other primary health care providers in the community. The city or county medical society may help in that distribution.

6) Meeting in a non-threatening way with bar, bath, and other gay business owners to enlist their assistance in risk reduction is essential.

7) Communities planning a new program are encouraged to examine existing risk reduction cards, statements and posters to avoid needless duplication. If modifications are needed permission to do so is usually easily obtained. It is suggested that NIAID provide samples of 6 such brochures, and a larger list of others available.

8) A list of local and national resource address and telephone numbers should be collected by the organizers of a workshop and be available at the workshop and later.

9) Translations of as much material as possible into minority languages appropriate for the community is strongly encouraged.

10) People with AIDS (PWAs) should be involved in the planning of the workshops and with the program itself.

11) Encourage participants in the workshop to be more involved with gay and lesbian organizations. Additionally, encourage local organizations to make a more active outreach to individuals. We consider this one of the more important recommendations because we feel the gay male who is uninvolved in the community except for brief sexual encounters is more likely to participate in high risk sexual behavior.

(CONTINUED)

NIAID'S AIDS WORKSHOP--THE REPORT, Continued

12) Increase education in activities where sexual activity is frequent, such as bathhouses. Consider films showing safer sexual behavior. If possible, show owners how it could be good for business.

13) Consider dealing with education in bookstores where sexual behavior occurs, at least with brochures and posters.

14) Try to develop emotional support programs for PWAs and those concerned about AIDS.

15) Encourage established gay and lesbian groups to develop discussions and/or programs about improving self-esteem.

16) Encourage non-gay organizations to put on programs about AIDS. This will educate some gay men who are not involved with the gay culture.

17) Recognize that sexual behavior changes, like other forms of behavior modification, cannot occur overnight. This is a long slow process and will require patience and persistence. And clearly, all the answers are not there yet.

Specific areas to be addressed, perhaps through workshops, include: compulsive sexual behaviors, gay youth, minority communities, gay men who are not members of gay groups and bisexual men, and overcoming community resistance to discussing AIDS and risk reduction.

COMPULSIVE SEXUAL BEHAVIOR (REGARDLESS OF LOCATION):

1) Prepare a list of community resources for compulsive behavior. Consider creating one such organization if one does not exist.

2) Remember again, that bars and baths must be approached in a positive, not a threatening way, and their owners need to be educated too.

3) Encourage gay organizations to make outreaches to people in bars and baths. Hopefully, joining organizations will increase self-esteem, and reduce some of the anxiety related to feeling isolated.

4) Discuss holding rap sessions in one room of bathhouses.

5) Encourage socialization in bars, possibly encouraging the lowering of the volume of music.

GAY YOUTH:

1) Brochures must be written to be easily understood by youth.

2) Efforts to reach high schools and colleges are important.

3) Encourage gay businesses and professionals to assist in efforts to reach youth (perhaps with financial help).

4) Street people need to be reached--perhaps through halfway houses, non-alcohol discos, etc.

5) Encourage gay youth support groups--perhaps through gay religious groups.

6) Create or enlist a local chapter of Parents & Friends of Lesbians and Gays.

7) Youth peer counselors are extremely important--especially for runaways, hustlers, etc.

8) Be aware of national youth resources, e.g., Institute for the Protection of Lesbian and Gay Youth (IPLGY), 112 E. 23rd St., New York, NY 10010 (212/473-1157).

9) Meetings for youth must be at times that do not require parental knowledge (e.g., late afternoons, weekends)

MINORITY COMMUNITIES:

1) Work through churches; encourage information aimed at the whole community--pass brochures to everyone.

2) Work through gay bars and organizations including gay church groups.

3) Involve, if possible, the National Council of Churches.

4) Be aware of International Association of Black & White Men Together (and their local affiliates in almost every large city), Multi-Ethnic Gay and Lesbian Exchange, National Association of Black Gays.

5) Utilize community newspapers and radio stations.

6) Utilize sympathetic health care providers.

7) Remember the hearing impaired and other physically disabled.

GAY MEN WHO ARE NOT MEMBERS OF GAY GROUPS AND BISEXUAL MEN:

1) Perhaps the best, or only way to reach this group is through non-gay organizations.

OVERCOMING COMMUNITY RESISTANCE TO DISCUSSING AIDS AND RISK REDUCTION:

1) There are no definite answers--do what's best for you. We are looking at major life-style changes.

2) Look at homophobia, sexophobia, fear of AIDS, fear of death.

(CONTINUED)

NIAID'S AIDS WORKSHOP--THE REPORT, Continued

3) Consider community workshops to raise consciousness.
4) Look at ways of enhancing community cohesiveness and maturation.
5) Try to create an increasing awareness of positive aspects of gay history.

The ten consultants were: Walter Batchelor (Washington, DC), Mark Behar (Milwaukee), Brett Cassens (Philadelphia), Don Clark (San Francisco), Harold Kooden (New York), German Maisonet (Los Angeles), Alan Malyon (Los Angeles), Stuart Nichols (New York), Larry Puchell (Washington), and Neil Schram, Chairperson (Los Angeles).

* * *

CONFIDENTIALITY HAMPERS CALIFORNIA RESEARCH

by Matthew Crews, with thanks to The New York Native, 11/19-12-2/84

A recently begun University of California research study intended to track gay men's health over a three year period has fallen victim to fears about the confidentiality of records, according to the San Francisco Chronicle. The federally financed project is supposed to follow 1200 gays, monitoring lifestyle and health status. In light of the recent controversy over safeguarding confidentiality, however, many of the 800 volunteers presently enrolled are dropping out of the study. James Wiley of the univerity's Survey REsearch Center said that if it becomes necessary to destroy information which might lead to a person's identification, records will be destroyed, even if there is a subpoena. But gay men remain skeptical, fearing that their names could end up on a government list of homosexuals or on insurance company blacklists.

* * *

HEALTH INSURANCE ABUSES

National Gay Task Force is collecting information on discrimination in health insurance coverage against any lesbian or gay man that is thought to be AIDS-related in motivation. Reports of such discrimination can be made by writing to the NGTF AIDS Program, 80 Fifth Av., New York, NY 10011 (800/221-7044).

* * *

BLOOD TESTING FOR AIDS ANTIBODY IN MARYLAND PRISONERS

by Lou Chibbaro, Jr., with thanks to The Washington Blade, 11/30/84

Maryland public health officials are considering using the soon-to-be-licensed blood test for detecting antibody to HTLV-III (the putative AIDS agent) as a means of screening prisoners entering Maryland's state correctional facilities, according to Scott Stamford, AIDS program coordinator for Maryland's Department of Health and Mental Hygiene. State and prison officials began discussing the AIDS question after one inmate in a state prison and a second inmate in a local detention facility were diagnosed as having AIDS earlier in 1984. The inmates were thought to have contracted AIDS through intravenous drug use prior to their arrival in prison. But Maryland health officials, similar to health personnel in other states, are very concerned that conditions in prisons could lead to a large number of AIDS cases among inmates in the future. "We know that despite regulations to the contrary, drug use and sexual activity are taking place in prisons," Stamford said. "Any steps we take...would be for the protection of the prison population." Stamford said he favors implementing educational programs to alert prison inmates to the dangers of AIDS and other STDs. He said such programs are hampered by prison officials who claim literature discussing subjects such as "safe sex" or STDs may be forbidden for distribution within prisons. Such prohibitions are necessary, Stamford has been told, because the literature could be interpreted as advocating sexual activity in prisons, actions prohibited under Maryland's anti-sodomy laws.

* * *

HEALTH EDUCATION, AIDS, AND THE CDC

Members of several national and community-based gay & lesbian health organizations met with officials from the federal Centers for Disease Control (CDC) in Atlanta, October 2-4, 1984, to discuss the role of the CDC in developing health education programs in AIDS risk reduction. More than 30 CDC personnel attended the 2½ days of meetings in an effort to identify major obstacles to the effective development and implementation of AIDS health education. A 17 page summary of comments from the consultants was recently made available by Marshall Kreuter, Director of the CDC's Division of Health Education/Center for Health Promotion and Education, and may be obtained by sending $2 (for reproduction, postage) to the NCGSTDS, PO Box 239, Milwaukee, WI 53201. A brief summary follows:

Consultants who participated in discussions held at the CDC in October, generated lists of AIDS-related health education barriers, needs, priorities, and options and were submitted to the Division of Health Education for action. CDC efforts to address AIDS related health education will be formulated by the end of February. The Center for Infectious Diseases and the Center for Prevention Services are currently in the process of planning their AIDS related health education responses, with the aid of the Center for Professional Development and Training nad the Center for Health Promotion. There was unanimous agreement among the consultants that health education is the only currently available means by which the risk of AIDS can be reduced; the capacity to carry out effective health education is viewed as essential to future prevention efforts including vaccination programs. With this perspective in mind, the consultants strongly urge CDC to enhance its AIDS related health education efforts. Effective networks have already been established by CDC which rapidly transfer new AIDS scientific findings to the medical community and the general public. Emphasis now needs to be placed on AIDS related health education /risk reduction efforts targeted at high risk groups. The following statements highlight the consultants' suggestions to CDC for implementing a health education/risk reduction response to AIDS:

*Leadership in the area of health education is essential. CDC should designate a point of contact (a specific individual or unit) which will demonstrate high level support and focus for those involved in AIDS related health education. CDC should also establish and identify specific policies, plans and resources for AIDS related health education.

*Staff Education is essential to assure that public health workers understand the political, social and cultural factors pertinent to reducing the risk of AIDS in gay communities and other high risk populations. A nonjudgemental attitude which enhances communications and preventive actions should be facilitated among public health workers through increased understanding of their own prejudices and fears, and by understanding the perspectives of patients' lovers and families regarding lifestyle choices.

*Research is neede for longitudinal, well controlled clinical studies to evaluate the impact of various AIDS related health education strategies. There is a need to generate data which will help determine the efficacy of health education/risk reduction efforts.

*Technical Assistance is needed to assist health care professionals to overcome attitudes which tend to inhibit gay men from discussiong their sexual oerientation and health concers. CDC needs to increase its capacity to provide professional training and to provide health education expertise in needs assessments, program development and evaluation. Practical experience for AIDS related health education programs currently resides in the gay community. CDC should identify what is known about AIDS related health education, modify approaches as appropriate, and coordinate the diffusion of educational methods to communities currently lacking expertise and resources.

These statements characterize the content of the consultants' primary messages, but they do not capture the sense of urgency nor the level of commitment that was reflected by their individual comments. Please send your comments and reactions to the NCGSTDS. The ten consultants who participated in these recommendations were: Mark Behar, PA-C (National Coalition of Gay STD Services); Robert Bolan, MD (San Francisco AIDS Foundation); Brett Cassens, MD, Alvin Novick, MD (American Association of Physicians for Human Rights); Federico Gonzalez (Gay Men's Health Crisis, New York); Harry Haverkos, MD (National Institute of Allergy & Infectious Diseases); Rebecca Ranson, Playwrite (Harrisburg Area Community College); Caitlin Ryan, MSW (National Lesbian & Gay Health Foundation & Whitman-Walker Clinic); Neil Schram, MD (Los Angeles City/ County AIDS Task Force); and Jack Whitescarver, PhD (Emory University School of Medicine).

* * *

AIDS ACTION COUNCIL OF THE FEDERATION OF AIDS-RELATED ORGANIZATIONS

by Gary B. MacDonald

AIDS Action Council of the Federation of AIDS-Related Organizations (AACFARO) has been fully operational since November, 1984, and is located within walking distance of all Congressional office buildings. The AAC's executive director and lobbyist, Gary B. MacDonald, maintains regular 9-5 pm office hours Monday-Friday, and can be reached by phone 202/547-3101/02 or after hours, 202/543-6411. Since November, 1984, AAC has been busy setting itself up as a functioning office and initiating the contacts with key Congressional staffers and Federal officials that will make the Council your effective representative in Washington. One of AAC's first formal acts is publication of a manual entitled Programs Providing Support Service for People with AIDS. The most comprehensive and up-to-date guide of its kind, the manual describes the full gamut of federal, state, local, and other resources now available to help you help people with AIDS (PWAs) deal with the financial, medial, social and psychological burdens of the disease. If you are a current member of AACFARO or a past member, you should receive a copy of the manual shortly. Request your copy of the services manual by writing to AACFARO, 1115½ Independence Av., SE, Washington, DC 20003. The cost of the manual for organizations not providing direct AIDS services is $27.50. The atmosphere on Capitol Hill is cautiously optimistic regarding AIDS research funding in fiscal year (FY) 1986. Key staffers note that, despite the presidential election, pretty much the same people who passed record AIDS research funding in the last Congress will sit on the same appropriations committees in the upcoming session. That will be helpful but not nearly enough to carry the day, however. Current FY-1985 funding for AIDS research--at $93.6 million, virtually double the Administration's request--was achieved largely through an eleventh-hour series of events that are not likely to be repeated. The AAC must be realistic in pressing the case for AIDS research funding in the context of demands for research funding from many other sources. In the coming months, major funding increases for AIDS research will depend not on quirks of fate (as they did in FY-1985) but rather on a carefully orchestrated campaign of support--call it pressure, if you will--from the widest possible array of concerned organizations and individual constituents of those Congresspersons who make the budget decisions in Washington. The passage of time is our worst enemy, yet in some ways, our most effective ally. This statement should not be construed to ignore or make light of the terrible suffering that AIDS inflicts on the lives of thousands of people as time passes. It is simply meant to underscore the grim fact that the more reported cases of frank AIDS, the more public attention is focused on the disease and, consequently, the more Congress will feel compelled to take significant action on AIDS research and AIDS-related services. If reported AIDS cases continue to double every six months, as is now happening, then state and local resources to deal with the disease and its ramifications will quickly become critically inadequate--if they are not already so. In short, it is not only PWAs who suffer from this disease. States and cities, social and medical services at all levels, and professionals in health care and other areas also feel its devastating effects, and thus have a stake in effective resolution of the crisis. National and local strategies for obtaining increased AIDS research funding must therefore depend on these "natural" constituencies throughout the US for assistance. In developing national and local networks of support for increased attention to AIDS, we must use existing resources and organizations wherever possible. This is obvious in the case of Social Security, disability, welfare, and so on, all of which are established mechanisms. But other existing resources can also be used more effectively than they have been to date. At the national level, for example, we are contacting major professional associations and other organizations with Washington offices which have a significant interest in the AIDS issue. These organizations include the American Public Health Association, National Association of Social Workers, National Assn. of Counties, American Medical Assn. and others. They are being asked to include AIDS research specifically in their own Congressional lobbying efforts. Most have been very forthcoming. Ohter more political organizations, such as the National Organization for Women, are also being tapped for grassroots support. Some of these organizations are not traditionally concerned with health issues, or would not normally appear to be targets of resource opportunity. But a little creative discussion of actual interests and the wide-ranging impact of AIDS on virtually every sphere of American life goes a long way toward convincing people of the urgency of this crisis. It is also a measure of the disease's recognized impact that almost everyone with whom we have talked has been eager to help, even though some had not fully understood AIDS or its ramifications.

(CONTINUED)

AIDS ACTION COUNCIL, Continued

Locally, most of you have already firmly established who your allies are. But it doesn't hurt to think again about potential untapped sources of support. In basic political terms, constituents are very powerful when speaking in unison. Try mobilizing local chapters of political parties, citizens action groups, health-care associations and other "special interests" who have developed their own networks and can be persuaded to take more than a casual interest in AIDS. The point of this is to coordinate an informal local group of constituents who can be galvanized on short notice to call or write letters to legislators in Congress. It's been proven time and again that this kind of pressure, and often only this kind of pressure, can change a legislator's mind. The difference between national and local lobbying strategies is this. The AAC will keep track of the latest AIDS-related developments in the research establishment and monitor the budget's process through Congress. In the meantime, we willmobilize national support among resources located in Washington. The Council will emphasize increased funding for primary AIDS research, public education, treatment therapies research, health-care costs and psychosocial services. At the local level, your job is of course to serve those with AIDS and act as public educators. But you can also mobilize your local political and other resources to stand ready--"on hold," so to speak--to apply constituent pressure when events require it. And events will probably require this pressure to be applied beginning as early as February, 1985.

Certain basic themes must define all of our efforts at both the national and local levels. Those themes are: 1)AIDS research benefits everybody, not just those who have the disease or are at risk of contracting it. 2) Lacking effective interventions to cure AIDS once it is contracted, our top priority must be to prevent people from contracting the disease--and prevention is impossible without public education. 3) Because of the unique psychosocial aspects of AIDS and its impact on federal, state, and local infrastructures, everyone has a stake in a rapid solution to this crisis.

For more information about the AIDS Action Council of the Federation of AIDS Related Organization, contact: Gary MacDonald, 1115½ Independence Av., SE, Washington, DC 20003, 202/547-3101 (urgent situations only: 202/543-6411).

* * * * *

HTLV-III VIRUS RECOVERED FROM ASYMPTOMATIC, ANTIBODY NEGATIVE PERSONS AT RISK FOR AIDS

excerpted from an abstract in Blood: Journal of the American Society of Hematology, volume 64:5, Supplement 1, November, 1984; author: J.E. Groopman, et al.

Human T-cell leukemia [lymphotropic] virus type III (HTLV-III) is a lymphotropic, cytopathic retrovirus which appears to be the primary etiologic agent in AIDS. There is nearly uniform antibody seropositivity for HTLV-III-associated antigens among patients with AIDS or AIDS-related disorders. This has lead to current efforts to screen high-risk individuals and blood donors for HTLV-III based on tests for antibody. We have studied three regular sexual partners of AIDS patients for HTLV-III and antibodies to this virus, which was measured using three methods: 1) enzyme-linked immunosorbent assay to whole disrupted virus; 2) Western blot; and 3) indirect immunofluorescence to the HTLV-III infected T-cell line H9. No antibody was detected by these three methods, but HTLV-III was readily cultured from peripheral blood lymphocytes and from saliva from the partners. All patients were asymptomatic, had normal T-cell number and subsets, normal immunoglobulin levels, demonstrated normal skin test reactivity to recall antigens, and had antibodies to other viruses such as cytomegalovirus and Epstein-Barr virus. The patients have remained asymptomatic, antibody seronegative and viremic for greater than 6 months. There appears to be an asymptomatic carrier state of HTLV-III which does not elicit an antibody response. The number of such carriers in a cohort of 50 regular partners of AIDS patients is being determined. These data suggest that development of tests for antigen as well as antibody may be important in diagnostic screening for HTLV-III infected persons.

* * * * *

COMPUTERIZED AIDS INFORMATION NETWORK (CAIN) UPDATE

The Computerized AIDS Information Network (CAIN), a database of AIDS-related information, is now available through DELPHI, a national time-share subscription service. A brochure is included with this Newsletter with subscription information. CAIN is intended to serve the informational needs of both community organizations and medical professionals. Interactive features include: a bulletin board, which subscribers can post announcements; professional conferenceing, a feature which allows on-line conferencing either on a restricted basis, or open participation by any interested subscribers. CAIN's database contains information from the following menu selections: AIDS--a section of general information including the CDC's definition of AIDS and case reporting requirements. EDUCATION/MEDIA INFORMATION--geared to the informational needs of community organizations, including risk reduction guidelines and general health tips, a listing of brochures and newsletters (with excerpts and reprints of selected examples), a reference of audio-visual resources, and a selection of current and archival news articles. SERVICE PROVIDERS--an indexed listing of organizations and individuals providing informational and referral hotlines, medical, psychological, dental, financial, and legal services, and facilities conducting AIDS-related research. ORGANIZATIONAL ASSISTANCE--a developmental assistance resource for new and existing organizations providing programatic and funding information useful in forming AIDS-related projects and service organizations. RESEARCH/CLINICAL DATA--information designed to meet the needs of health care professionals, including epidemiological statistics, information about lines of ongoing medial and behavioral research (including information about ARV/HTLV-III/LAV studies), clinical and laboratory information aobut AIDS and AIDS related conditions, and infection control guidelines for health care workers. SCIENTIFIC/MEDICAL RESOURCES--an on-line source of articles and abstracts from medical and social science journals, including abstracts from the New England Journal of Medicine and the Center for Interdisciplinary Research in Immunology and Disease (CIRID) at UCLA. CAIN is intended to ba an interactive and cooperative database on which subscribers can share information concerning AIDS. Subscribers are encouraged to become information providers for CAIN, either by submitting information to the Gay & Lesbian Community Service Center, Los Angeles or San Francisco AIDS Foundation, administrators of the system, or by entering information directly. Medical information on CAIN will be subject to review by a scientific advisory panel. To access CAIN, the only equipment needed is: a computer or computer terminal, a modem, and a telephone. Subscriptions to CAIN are available for DELPHI's standard, one-time fee of $49.95. An annual CAIN membership fee of $12 is required for subscribers outside of California. On-line time is charged at the rate of $6/hour between 6pm-8am (Pacific time) and $16/hour between 8am-6pm. CAIN has received funding from the California Department of Health Services, the Gay and Lesbian Community Service Center, and the Los Angeles and San Francisco AIDS Foundations. For additional information, contact: GLCSC, 1213 N. Highland Av., Los Angeles, CA 90038, 213/464-7400 x 277 (Russ Toth), or SF AIDS Foundation, 54 Tenth St., San Francisco, CA 94103, 415/864-4376 (Bobby Hilliard).

* * *

FEMALE PROSTITUTES MAY COMPRISE NEW RISK GROUP FOR AIDS

compiled by Sue Hyde, with thanks to Boston's Gay Community News, 12/22/84

Evidence of the HTLV-III virus in the blood of prostitutes on three continents has promoted speculations that female prostitutes may constitute another group at high risk for AIDS. According to a United Press International dispatch, 100 scientists at the International Conference on AIDS gathered to discuss the virus and the disease it is believed to cause. Newly developed blood screening tests have isolated HTLV-III antibodies in prostitutes and servicemen in Europe and the United States. And a study of prostitutes in Zaire found that about 80% had antibodies to HTLV-III, according to Dr. Phillip Markham, virologist with the National Institute of Health team that discovered the virus. A US study of military men discovered a substantial number with antibodies to the virus who belong to none of the high-risk groups. Markham said it had been concluded that they had contact with the virus through sex with female prostitutes in the US, Europe, and elsewhere. [The only way?!--ED] Markham said the antibody test, which is not available outside the research community, has revealed antibodies in more than 50% of active homosexual men in major population centers, in more than 80% of hemophiliacs who are treated repeatedly with a concentrated blood product, and in about 50% of IV drug users in major cities.

* * * * *

STATEMENT ON HTLV-III/LAV ANTIBODY TEST BY GAY HEALTH LEADERS

With the expected licensing by the U.S. Food & Drug Administration of the test for antibodies to HTLV-III/LAV, the virus considered to be associated with AIDS, it is important to state what we believe this test does and does not do, what its potential misuses are, and what risks members of the gay community face if they take this test. It is our recommendation that, except in rare circumstances, this test should be used ONLY in the context of screening blood donations and as part of research programs that guarantee strict confidentiality. Individuals should be aware that this test will NOT provide answers to such questions as: Am I healthy? Do I have AIDS? Am I a carrier of AIDS? Have I been exposed to AIDS? Can I give AIDS to someone else?

The HTLV-III antibody test does NOT diagnose AIDS. It simply meansures the development of antibodies to the HTLV-III virus. A positive test result showing the presence of antibodies could mean nothing more than exposure to the HTLV-III virus. It is not known whether individuals with positive test results will go on to develop AIDS, whether they will be harmed by additional infection by the virus, whether they are infectious, or whether they are possibly immune. Similarly, a negative test result does not necessarily mean an individual has not been exposed to the HTLV-III/LAV virus. It could mean there has been no prior exposrue or infection by the virus, that the individual is still in an incubation period before development of the antibody, that there may have been a prior infection and the antibody is no longer detectable, that the test was performed incorrectly, or that the test itself was inaccurate.

Irrespective of test results, we underscore the importance of all members of high-risk groups continuing to follow prevention guidelines that have been put forward by AIDS service organizations, including the adoption of safe sex practices. The declining rates of sexually transmitted disease among gay men in many cities show the success of these efforts. Whether one has tested positive or negative, whether one has been exposed to the HTLV-III virus or not, safe sex practices may help to prevent either new or further exposure to the virus or the transmission of the virus to another party. While the blood test will be used to screen donations at blood banks, the test will not eliminate all donations that have been exposed to the HTLV-III virus and are therefore potentially infectious. There is evidence that individuals who test negative can, in some cases, be carrying the HTLV-III virus. Therefore, this test is simply an added measure to screen donors and is NOT a substitute for the donor deferral guidelines that recommend that those persons falling into at-risk groups should refrain from donating blood at this time. This includes all males who have had sex with more than one male since 1979, and males whose male partner has had sex with more than one male since 1979.

Though we advise against individuals being tested, those who desire a test should NOT use the blood banking system as a means for getting the HTLV-III antibody test. Since the test is not 100% accurage and does not always detect infectivity, some blood that should not be transfused might pass through the system if the donor deferral guidelines are not followed in addition to the blood test. Individuals should be aware of the fact that their test results may be requested and obtained by third parties. Before requesting a blood test under any circumstances, we urge all individuals, particularly those in the gay community, to consider the following risks:

*If a positive antibody test becomes part of your medical record, it could become justification for denial of life or health insurance in the future. (We are already aware of cases where individuals considered at risk to AIDS have been denied insurance.)

*A positive antibody test could also become a reason for denying employment. While lacking in medical justification, we are deeply concerned that this test will become a mechanism for screening out individuals who are at-risk for AIDS from jobs in such fields as health care, food handling, or child care. There is no evidence that AIDS is transmitted except through exchange of vital bodily fluids. This has not stopped some from already discriminating against those somehow associated with AIDS or the groups considered to be at risk for AIDS. Given the high level of exposure to the virus--and initial studies that show a high positive test rate--among gay men, we are also concerned that potential employers may use the test as an indicator for homosexuality.

*The psychological pressures of knowing that one has tested positive to antibodies is one of deep concern to our community. While a positive test result does not necessarily mean one is going to develop AIDS, there has been sufficient inaccurate publicity suggesting that this

(CONTINUED)

STATEMENT ON HTLV-III/LAV ANTIBODY TEST, Continued

is indeed a test for AIDS. Until that link is broken, the mental health impact of receiving a positive test result could be devastating. The misconceptinos and general level of hysteria among the general public about AIDS increases the likelihood of a panicked response to a positive test result.

We continue to encourage members of our community to participate in research studies that might help find the answers to the AIDS riddle, including studies using this HTLV-III antibody test in the hope that a clearer meaning to positive and negative results might be developed. However, we continue to urge--particularly in light of the risks outlined above--that participation in research be conditioned on strong guarantees of confidentiality for all research subject participants, including the commitment that identifiers will not be shared with third parties.

The following organizations have endorsed this statement: National Gay Task Force, AID Atlanta, AIDS Education Programs (Key West), KS/AIDS Foundation of Houston, American Association of Physicians for Human Rights, Baltimore Health Education Resource Organization, Federation of AIDS Related Organization AIDS Action Council, Gay Men's Health Crisis (New York), Gay Rights National Lobby, Lambda Legal Defense & Education Fund, National Coalition of Black Gays, National Coalition of Gay Sexually Transmitted Disease Services, National Gay Rights Advocates, National Lesbian & Gay Health Foundation, San Francisco AIDS Foundation, and Whitman-Walker Clinic (Washington, DC).

* * *

CONCERNS INCREASE OVER HTLV-III ANTIBODY TEST

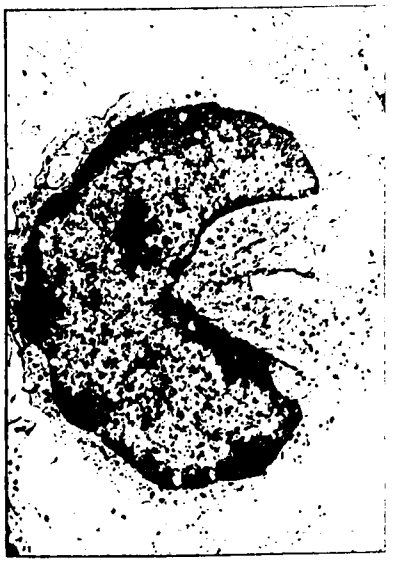
by Mark Scott, with thanks to The Washington Blade, 1/25/84

Doctors, gay leaders, AIDS activists, and blood bank representatives will soon meet to discuss what many consider troublesome issues surrounding the US Public Health Service's recently released provisional guidelines on testing blood donors for exposure to the HTLV-III virus [see MMWR article in this Newsletter]. The 2 day "Policy Conference on AIDS, Ethics, and the Blood Supply," cosponsored by the American Blood Commission and the Hastings Center, a non-partisan organization which researches scientific and medical ethics problems, will focus on ethical, legal, and public policy issues posed by the soon-to-be-available test. The PHS guidelines, released January 11, do not adequately inform individuals that the test's accuracy is in doubt, nor do they address the need for alternative testing sites, said Dr. Ronald Bayer, an associated for policy studies at the Hastings Center and chairperson of the upcoming conference. The guidelines recommend that blood banks inform an individual who tests positive for the antibody in both an initial and a follow-up test "that the positive result is a preliminary finding that may not represent true infection. To determine the significance of a positive test, the donor should be referred to a physician for an evaluation." The guidelines also recommend telling an individual who tests positive that he or she should refrain from giving blood or having intimate sexual contact with others. "That's a heavy load to lay on someone," Bayer said, especially when it is still not known whether people who have been exposed to the virus will necessarily develop AIDS. For people facing the terrifying prospect of waiting to see if they develop the syndrome, "there's very little talk [in the PHS guidelines about psychological support services," said Dr. Mathilde Krim, chairwoman of the New York based AIDS Medical Foundation. In a meeting with the PHS AIDS Executive Task Force recently, gay and AIDS activists said they are afraid that individuals preoccupied with the meaning of their positive test result may not get proper psychological counseling from AIDS service organizations, which already are operating on tight budgets. The guidelines also state that donors "should be told that they...may be placed on the collection facility's donor deferral list, as is currently practiced with other infectious diseases, and should be informed of the identities of additional deferral lists to which the positive donors will be added."

* * *

KILLER T-CELL COMPUTER VIDEO GAME

by Eric Mishara, with thanks to OMNI, 11/84



[Photo on right is an aberrant lymphocyte from the lymph node of a person with AIDS. Courtesy of Eugene M. Hoenig, with thanks to The Journal of Irreproducible Results, 30:1, 11-12/84 (a journal of scientific parody)]

A new computer video game called, "Killer T-Cell," is being played by hundreds of cancer patients in the hope it will help them conquer their disease. The game entails searching out and destroying the multiplying cancer cells, using the killer T-cell, a white blood cell, before it is itself eradicated by killer cancer cells. If the player wins, the game pronounces him cured. But if he loses, he has a relapse and must play again. "Some evidence suggests that it may be possible for people with cancer to get their immune systems back on tract by means of visualization exercises, in which you imagine you T-cells devouring cancer cells," explains Elton Stubblefield, the game's inventor. "But if this game does no more than help cancer patients feel better as they while away the hours," he says, "then I'm pleased." Stubblefield, a cancer researcher at M.D. Anderson Hospital and the University of Texas in Houston, actually invented the game to educate children about cancer. But the game also became popular with visualization therapists and cancer patients, and is now used in a number of hospitals. So far Stubblefield has sold more than 400 "Killer T-Cell" computer programs. The game can be played on any of the Apple II series computers, but will soon be available for the Commodore 64 and for IBM personal computers. "Killer T-Cell" is a maze game in which you control the motion of a white cell hunting and killing cancer cells in a maze of normal tissue. Normal cells are green, and the tumor cells are orange or purple. If you have accumulated enough points, you may kill 80% of the cancerous cells by having chemotherapy. To order the game, send $20 and your address to: "Killer T-Cell," MDAH Box 6, 6723 Bertner Av., Houston, TX 77030. All proceeds support basic cancer research. [ED NOTE: Any readers who have tried the game, please send us a note of your impressions, whether it may be useful for people with AIDS, etc.: NCGSTDS, PO Box 239, Milwaukee, WI 53201.]

* * * * *

MARATHON FOR AIDS

with thanks to Cruise, 11/16/84

Dewey Ames of the Front Runners of Detroit competed in the Maryland Marathon, December 2, 1984 in Baltimore. Dewey entered the 26.2 mile competition as a means of showing his concern for persons with AIDS in the Detroit area. Monetary pledges by the mile will be donated to the Wellness Networks AIDS Support Group, to help supply direct help for projects that will benefit all members of the Support Group. [ED NOTE: At our presstime, we did not learn how much money was raised; we felt that sharing the idea would be helpful.]

* * * * *

RUNNING FOR DOLLARS

by Danny Gossett, with thanks to The Washington Blade, 12/07/84

The Washington, DC Front Runners, a local gay and lesbian running club, sponsored its 2nd Annual AIDS Foundation Run/Walk and raised $3400 to benefit the Anthony Ferrara Memorial Fund of Whitman-Walker Clinic's AIDS Foundation. Mike Mastrobattista, organizer of this year's event, said that two participants received pledges that brought in more than $800 each. MOre than 30 runners & walkers covered nearly 220 miles, more than doubling the miles totalled in last year's walk/run.

* * *

LOVE & HEALING WORKSHOP IN SOUTHERN CALIFORNIA

The fifth Love and Healing Workshop, an intensive workshop especially designed for people with AIDS (PWAs), AIDS related complex, their loved ones and persons in the helping professions, is planned for February 4-8, 1985, at Mission San Luis Rey in Oceanside, CA. The workshop is intended to help participants discover personal resources for coping with a major crisis or loss in their lives. For more information, write: Love and Healing Workshops, PO Box 81082, San Diego, CA 92138, or call 619/294-2437.

* * *

NEW ART GALLERY OPENS AT VAUCLAIN POINT

The Peter Vomlehm Memorial Art Gallery opened December 22, 1984 at the offices of the San Diego AIDS Project in the Vauclain Point facility amid a holiday celebration party attended by over 100 persons. The opening of the gallery, which is presently showing a group exhibit of water-colors created by local AIDS patients, commemorates not only the valiant examples of living set by the late Peter Vomlehm but also the examples of loving and sharing shown by his mother, Barbara Peabody. Weekly art classes for PWAs and persons with AIDS related conditions have been taught by Ms. Peabody at the Project throughout her son's illness and subsequent death in early November. The enthusiasm of the art students has been heightened by the fact that one of their group recently had a watercolor selected for exhibition at the San Diego Art Institute. For more information, contact Tom Jefferson, San Diego AIDS Project, PO Box 81082, San Diego, CA 92138, 619/294-2437.

* * *

ACCOUNTABILITY WITH "REPORT CARD" FOR AID ATLANTA

In an effort to provide accountability to the community, AID Atlanta has published a "mini-annual report card," documenting the major accomplishments of 1984. In addition to the Board of Directors meeting 22 times during the year (!!!), AID Atlanta (AIDA) hired the Rev. Ken South as their new executive director to replace Caitlin Ryan, who moved to Washington's Whitman-Walker Clinic AIDS program; recruited, trained, and coordinated 179 volunteers who became buddies, helped in educational programs, provided office support and staffed the AIDA hotline; provided 2666 volunteer hours of service to public institutions, people with AIDS and their families and friends; published and distributed 10 brochures & pamphlets (thousands of copies); published a newsletter; established a personal care home for people with AIDS; provided numerous inservices, referrals, informational programs to community and medical groups. For a copy of AIDA's report card, and to give your community ideas, write to: AID Atlanta, 1132 W. Peachtree St., NW, Suite 112, Atlanta, GA 30309. Send a self-addressed, stamped envelope (legal sized). [ED NOTE: AIDA is to be heartily congratulated for their efforts to provide a concise summary of their activities! Every community AIDS/STD groups should consolidate their annual reports into such a format to demonstrate their interest in sharing their work with their communities.]

* * *

LISTING OF AIDS PRESENTATIONS RESUMES

In response to a need for a coordinated effort in planning and implementing AIDS public and professional educational programs, the San Francsicso AIDS Foundation will reintroduce a listing of all San Francisco Bay area and selected national AIDS related presentations of interest to both the general public and health care professionals. This new edition of the listing will be produced monthly, starting January, 1985. If you would like to receive this monthly listing, please call or write the Foundation. If you wish to report any AIDS related events you are presenting or of which you are aware, please provide the following information to our Education Department in this format: 1) Name of presentation or presenting agency; 2) Name of presentor(s); 3) Date of Presentation; 4) Times; 5) Exact place (including address & phone); 6) Registration cost (if any); 7) Target audience (lay, health care, MDs/RNs/PAs, etc.); 8) Contact person; and 9) Telephone number (and area code) of contact person. Write or call: San Francisco AIDS Foundation, 54 Tenth St., San Francisco, CA 94103-1360, 415/864-4376.

* * *

ESQUIRE MAGAZINE PROFILES GMHC'S RODGER MCFARLANE

compiled by Tam Cummings, with thanks to The Washington Blade, 12/7/84

Rodger McFarlane, executive director of New York's Gay Men's Health Crisis, was the subject of a 5 page biographical sketch in Esquire's December, 1984 article, "The Best of the New Generation," an ambitious profile of almost 300 "men and women under forty who are changing America." McFarlane, 29, who had directed the AIDS service agency since July, 1983, gets praise for running "one of the most successful ad hoc social-service agencies in recent history...McFarlane's energy is largely responsible for its success. Rodger McFarlane moves in many circles and speaks many dialects. Testifying before the city council, or being interviewed on television as one of the chief spokespersons of the New York City gay community, he can talk like a young banker who never heard of Theodore, Alabama, the place where he grew up as the second of four brothers," reads Jane Howard's profile. "As an administrator, McFarlane spends most of his time interpreting AIDS and its implications....In dealing with federal, state, and city agencies, 'by far the most demanding work I've ever done for any sustained period,' he has been obliged to learn officalese, a language that makes him cringe. "Until AIDS came along, I was about as political as a potato. I'd never felt part of the gay movement at large. GMHC for me was at first an avocational tract, a religious vocation," he stated.

* * *

HALIFAX PREPARING TO BATTLE AIDS

by David Henderson, with thanks to Toronto's The Body Politic, December, 1984

The Halifax, Nova Scotia gay community has responded to the reality of AIDS in Canada by establishing the Gay Health Association (GHA). The GHA was founded September, 1984 to help inform Nova Scotians and others in the Atlantic provinces about the facts relating to AIDS. Bill Souter, GHA media spokesperson, identifies their first priority as compiling as much information as possible on AIDS and getting that information out to the community. They have obtained over 2500 copies of two health pamphlets from San Francisco, "Can We Talk?" produced by the Harvey Milk Lesbian & Gay Democratic Club, and "Women and AIDS," from the San Francisco AIDS Foundation. Though this information comes from California, the GHA is trying to add as much local input as possible. There have been four public meetings with local doctors to talk about AIDS with the community. Rumours, Halifax's non-profit gay bar, is working with the GHA by distributing brochures on safe sex and helping to raise funds for the organization. The bar recently screened two videos by Toronto writer Michael Riordon: "AIDS--A Guide for Health Care Workers," and "AIDS--After the Fear." Attendance showed a strong concern about AIDS among gay Haligonians. Rumours patrons can support the GHA by requesting music--a 25¢ charge for requests is being given to the GHA. The organization has secured a local physician who will act as medical consultant to the media to ensure that stories are reported accurately. There is also talk of establishing a hotline for AIDS-related calls. The GHA is seeking volunteers in the Halifax area. Anyone interested in helping out or needing information should contact: Gayline, Box 3611, Halifax South Postal Station, Halifax, B3J 3K6 Nova Scotia, Canada (902/423-1389) or Rumours (gay community centre, same mailing address as Gayline), phone 902/423-6814.

* * *

"DREAM SEEKER"--A POEM

by John Lorenzini, with thanks to the Shanti Project, San Francisco, November, 1984

Do not stand at my grave and weep, I am not there, I do not sleep.
Do not stand at my grave and cry, I am not there, I did not die.
I am a thousand winds that blow. I am the diamond glint on the snow.
I am the sunlight on ripened grain. I am the gentle autumn rain.
When you awaken in the morning hush, I am the swift uplifting rush
Of quiet birds in circled flight. I am the soft stars that shine at night.
I will not find what I am seeking. I shall not know what I would know.
And yet, with laughter and with singing, In strange sweet ways, I softly go.
I have not time for tears or sorrow. Doubts are dead leaves left behind,
Because I love the endless questing, for dreams my heart will never find.

* * *

MEET #9: A PERSONAL STORY

by Keith Smith, with thanks to The Gayly Oklahoman, January, 1985

I met a new person today. One who I wish I had met a few weeks ago when he was still alive. His name was Patient #9. I couldn't find out his name due to confidentiality but it is an irrelevant fact that is unimportant now that he has gone. Patient #9 was the 9th victim of AIDS in Oklahoma and one that none of the gay community will miss because we either didn't know him or didn't care to know him. I know you must be shocked by the insensitivity of referring to a human being as a number but let's be consistent, we treated him with insensitivity when he was still alive so why fall all over ourselves now? The only thing is make sure it never happens again. #9 was born and reared in Oklahoma City and left when he was 17 years old. He fled the Bible Belt mentality of Oklahoma over 10 years ago to find a less judgmental atmosphere in which to grow, live, and experience a fuller existence. He fled to West Hollywood, where he became involved in a monogamous relationship for several years before it ended with his lover's suicide. We have no proof, but there is speculation the suicide may have been AIDS related as no one knows how many AIDS victims choose to shorten their agony in this manner. Afterwards, #9 lived with other gay friends for a year or so until he was diagnosed with AIDS himself. He was soon ostracized by his gay friends and roommates because of their fears and ignorances. So his only choice was to come home to die. In the hopes of salvaging the relationship that he had over 10 years earlier with his family, he returned to Oklahoma City to find out that his father had passed away and his mother was remarried to a man who was unable to accept his wife's long lost gay son, let alone her long lost gay son who had AIDS. #9 stayed with the family for awhile until it was too uncomfortable and too much of a hardship for them with his frequent medial needs. After a visit to Oklahoma Memorial Hospital, he was unable to go back home. For the first time, and oddly enough from strangers, #9 was able to find a sort of support group and a friend. #9 met a woman by the name of Carol Walton, an epidemiologist at the hospital, whose eyes today, sparkle when she talks about him. "He was a beautiful person," says Carol. "I liked him right away, and so did the staff. We weren't afraid of him; we knew we couldn't contract AIDS with casual contact. He was one of the few AIDS victims who didn't have some sort of support group to help him through his last days--so we in effect became that support group for him, his family." As she talked on, I wished I had known #9, this person whose memory made her glow. "He needed constant care so I went looking for a nursing home," she continued. "No one would take him. They were all afraid of the disease, afraid of a gay person, afraid of the judgements, afraid of the kids taking Dad and Mom out of the home because of #9 being there. They were all victims themselves, victims of ignorance." Finally, after about 50 nursing simes, we found one that was sensitive and caring enough. He was able to stay there for awhile until the parent company of the nursing home chain sent a quality assurance representative to check out our facilities and required the nursing home to implement all types of special facilities to deal with #9. The administrator of the nursing home where #9 was staying was shocked when she received the phone call from the home informing her that a local ambulance service, Non-Emergency Transport Service, was refusing to transport #9 to the hospital for his tests after finding out he was a person with AIDS. The attendant used the phone's handset to turn pages on his chart so as not to have even touch his chart. "This is typical," said Judy, another of the health professionals working with #9, "of the ignorance that is running rampant in both the straight and gay communities about AIDS. I was surprised because I purposely chose [that ambulance company] because they were smaller and I knew them personally. We had to reschedule the appointment for the next day because it was too late when I along with several medical experts, convinced them they were in no danger. They returned the next day, dressed like 'ghostbusters' picking up the spirit for disposal. After which they sterilized the inside of their emergency transport van. We really liked [#9] at the home," Judy continued. "We really grew close to him. My staff really surprised me; they were so good with him, and they were apologizing for the way the transport attendants were treating him, they felt so sad to see him treated this way." The ambulance transport service finally agreed that lack of information was the reason for their actions. They had no idea of how they should deal with an AIDS patient, what dangers were involved for both the patient and the attendant, etc. The company has volunteered to be the first ambulance service in Oklahoma, willing to do in-service training for their entire staff on the proper procedures for dealing with people with AIDS. "The problem is lack of education," concluded Carol. "The publicity locally is like the Reader's Digest Disease of the Day. The way it is covered, it is so spooky. People would rather have any other terminal disease than this one because of the connotations."

* * *

LIVING WITH AIDS: A SELF-CARE MANUAL

AIDS Project Los Angeles recently has published a comprehensive guide for people with AIDS (PWA) and their care-givers, Living with AIDS: A Self-Care Manual. This 95 page large-format book covers a wide range of topics, including the history and epidemiology of AIDS, symptoms and diagnosis and various treatment modalities, psychosocial aspects, practical care guidelines and taking care of personal business. Since the majority of the costs of printing the manual were provided by the State of California, Department of Health Services, and the City of Los Angeles, AIDS Project/LA is able to distribute the self-care manual free to PWAs and AIDS" organizations. AIDS organizations are required to pay the postage & handling costs of the manuals, $2; a minimal purchase price from private individuals and professional agencies ($5 + $2 postage/handling = $7) is necessary to help support the continued operations of AIDS Project/LA. Bulk ordering is available. "We believe this can be a very practical and informative guide to meet many of the needs of people with AIDS," wrote Judith Spiegel, health educator at APLA. For additional information, or if you have an opportunity to advertise the manual locally, contact: Juith Spiegel, APLA, 937 N. Cole Av., #3, Los Angeles, CA 90038, 213/871-1284.

* * *

OKLAHOMA AIDS TASK FORCE HELPS TO DIFFUSE FEAR

with thanks to The Gayly Oklahoman, January, 1985

At the December, 1984 meeting of The Oklahoma AIDS Task Force (OATF), members of the gay community and involved physicians discussed methods to provide the latest information concerni AIDS at the state and local levels. By educating the public it is hoped that more effective health care as well as community support systems can be made available to AIDS patients. Presently, the major problems facing OATF are fear and frustration. People view AIDS as a disease which can be easily transmitted through any contact with a person having it; however, this is a greatly exaggerated fear. With the fear of AIDS being great among non-high risk groups, it was recommended that physicians from the Task Force make themselves available to address local civic groups, such as the Lions & Rotary Clubs and the JayCees, to provide accurate information and to dispel myths concerning the disease. Additionally, Task Force members will draft letters for the State Medical Association's Newsletter to offer local "home town" physicians a list of symptoms associated with AIDS, as well as a referral list of infectious disease units that could better diagnose patients' symptoms.

* * * * *

MERIEUX INSTITUTE OFFERS AIDS RESOURCES

Miami's Merieux Institute, a subsidiary of Institut Merieux of Lyon, France, is now actively marketing two items, one of which may be of special interest to AIDS health workers. Focus on AIDS--A Clinical Appraisal, are the October 8, 1984 symposium proceedings of panelist Anthony Fauci, MD, Constance Wofsy, MD, Thomas Quinn, MD, Roger Enlow, MD, Evan Hersh, MD, Shlomo Maayan, MD, W. Keith Hoots, MD, and Dennis McShane, MD. This 44 page, 1984 publicatior provides a useful overview of the AIDS phenomenon, the African experience of AIDS, early testing and evaluation in the primary care setting, delayed hypersensitivity testing, and the spectrum of AIDS in clinical practice, among other topics. This book is available for free from Merieux, which is pushing its Multitest-CMI, a rapid and relatively low cost approac to evaluating cell-mediated immunity. Multitest-CMI applies seven antigens (tetanus, diptheri streptococcus, tuberculin, candida, trichophyton and proteus) plus a negative control (glyceri in an easy to apply single disposable unit for skin testing for cutaneous anergy. After the skin test, the patient must be seen in 24 and 48 hours to determine the degree of skin reactiv ty, which depends on the amount of antibodies circulating. Nonreactions suggest an impairment of cell-mediated immunity, but there is no corelation between lack of responsiveness with prognosis. For more information about the Multitest-CMI or to receive the booklet, call: 800/327-2842 (in Florida, Alaska, Hawaii, collect: 305/593-9577), or write: Merieux Institute, 1200 NW 78th Av., Suite 109, Miami, FL 33126.

* * * * *

MILWAUKEE AIDS PROJECT GRANTED CITY MONEY

Milwaukee's Brady East STD (BEST) Clinic recently announced the awarding of a $15,000 grant for establishing AIDS education & support services by the City of Milwaukee Health Department. The Milwaukee AIDS Project (MAP) was created as a standing committee of BEST Clinic and will develop a resource guide supporting healthy lifestyles and offering appropriate educational materials; establish a technical advisory council with representatives from area health departments, medical schools, blood centers, etc., to offer advice and act as credible spokespersons on behalf of MAP, when needed; to provide support services and advocacy for people with AIDS and their loved ones; and other related community educational efforts as needed. Although the City has indirectly supported BEST Clinic over the last eleven years, this marks the first time a grant was directly awarded to BEST.

* * * * *

NEW AIDS HEALTH PROJECT FOCUSES ON HEALTH PROMOTION

A prevention project directed toward persons at risk for AIDS is considered the next step in responding to the AIDS crisis. The AIDS Health Project, recently funded through the San Francisco Department of Public Health, began its prevention effort on March 19, 1984. The Project was designed in collaboration with behavioral scientists at the University of California, San Francisco, and is staffed with highly trained professionals skilled in the areas of health enhancement and AIDS prevention. The Project offers services to those at risk for AIDS and helps them confront and make changes in high risk behaviors. Utilizing an individual consultation and health assessment, life habits that may put one at risk for AIDS are targeted and an individualized plan for approaching them is developed. The Project provides ongoing educational support groups on such topics as stress management, safe sex, depression prevention and general wellness to address these issues. All of the Project's services are offered free of charge to San Francisco residents. While much is still to be learned about this disease, researchers at the University of California School of Medicine speculate that psychological and social factors may play a role in determining an individual's susceptibility to the disease. The part played by psychological factors in this susceptibility may be either direct, as suggested by recent studies on compromised immune function during emotional upheval, or indirect, as individuals may be motivated to engage in known high-risk behaviors as a consequence of emotional states. Thus, psychological and social factors such as social support, general health habits, and the management of stress are emphasized in the Project's workshops. Special attention is given to issues of both internalized and externalized homophobia and the workshops are designed to foster a gay-positive identity. In addition to work with gay men, the Project also includes outreach to at-risk youth and provides mental health services to PWAs experiencing emotional crises through San Francisco General Hospital. Other at-risk individuals are encouraged to contact the Project as well. Finally, the Project will offer educational and training seminars for mental health and health care professionals who work with at-risk populations. For more information, contact: The AIDS Health Project, 54 Tenth St., San Francisco, CA 94103, 415/626-6637. The Project shares office space with the San Francisco AIDS Foundation.

* * *

MONEY AVAILABLE FROM US CONFERENCE OF MAYORS FOR AIDS HEALTH EDUCATION

The U.S. Conference of Mayors (USCOM) recently closed its application process for grants of $5-20,000 for community-based, non-profit organizations interested in providing services for persons of high-risk who have not been adequately reached by the traditional channels of communication. Those persons may include, but are not limited to youth, Blacks, and Hispanics. "Communication with these persons is vital if the contraction and transmittal of AIDS is to be minimized," wrote J. Thomas Cochran, Deputy Executive Director of USCOM. For the purposes of this particular request for proposals, a community-based group is defined as a non-profit, non-governmental organization with established ties into the community network of gay and/or bisexual men. Organizations must demonstrate their abilities to communicate with populations at-risk and with other relevant community groups, agencies, and organizations. Awards will be announced after the USCOM AIDS Program Advisory Board has made its funding recommendations, probably early in March. The NCGSTDS will try to obtain the list of grantees, with a summary of their project plans, for the next Newsletter. $150,000 will be available during this funding cycle; additional monies may be available for the next cycle.

* * * * *

SAN DIEGO AIDS PROJECT RATED HIGHLY BY STATE

The San Diego AIDS Project (SDAP) received high ratings for meeting its objectives from the California Department of Health Services. Charged by the state to provide educational outreach programs to the high-risk for AIDS population and the community at large, the Project was commended for meeting the contract objectives "remarkably well" with its limited resources. Although manned by a small staff of three paid full-time employees and augmented by a volunteer staff of over 40, SDAP has developed, printed, and distributed close to 100,000 pieces of AIDS education literature. Press releases and public service announcements have exceeded contract objectives. Health care provider training has included six in-service trainings to hospitals, schools and health care agencies, a conference on AIDS in cooperation with the American Cancer Society, and four volunteer training seminars, just in the last few months. TV And radio talk show appearances have been well received and human interest stories such as the Peter Vom Lehm Memorial Art Gallery at the AIDS Project [see elsewhere in Newsletter for details] have been used by local media. Recognizing that "the problems related to delivering AIDS educational services in San Diego County may be complicated by a social environment hostile to gay men, even without the issue of AIDS, and a political climate sometimes unsympathetic to the crisis," the California Department of Health Services lauded SDAP for its accomplishments. For more information, contact: SDAP, POB 81082, San Diego, CA 92138 (619/294-2437).

* * *

AIDS COMMITTEE OF TORONTO REFUNDED BY CANADIAN GOVERNMENT

by Ken Popert, with thanks to Toronto's The Body Politic, January, 1985

A grant from the Canadian federal government has put the paid staff of the AIDS Committee of Toronto (ACT) back to work after a two-week lay-off occasioned by lack of funds. The award of $179,400 has allowed ACT to rehire its two existing staff and to create four more positions: counselor, media relations officer, volunteer officer and secretary. The organization will also be able to keep its office in the heart of Toronto's gay district. The terms of the program require ACT to raise a certain additional amount of money; according to ACT community education officer Kevin Orr, this could be as much as $40,000.

* * *

SANTA CLARA COUNTY, CALIFORNIA ESTABLISHES FIVE COUNTY AIDS PROJECT

reprinted with thanks to Shanti Project's Newsletter, January, 1985

The Santa Clara County Health Department has received a grant from the California State Department of Health Services for a five county regional AIDS project, to serve Santa Clara, San Mateo, San Benito, Santa Cruz, and Monterey counties. The overall goal of the project is to decrease the morbidity and mortality caused by AIDS in part by: 1) Promoting risk reduction activities among members of high risk gourps (homosexually active men, IV drug users, hemophiliacs, blood transfusion recipients, Haitians, and the sexual partners of these groups); 2) Keeping the public well informed about AIDS through community programs and media releases, to ease the fears but enlist public support for the continued work needed to defeat AIDS; 3) Encouraging coordination of resources within the five county region and establishing a network of professionals to insure knowledgeable, compassionate care of people with AIDS; 4) Developing a resource guide to be given to PWAs to assist them, their families, health care providers, etc., in planning and decision making; 5) Providing the health care agencies within the five county region with current knowledge about AIDS and encouraging them to teach prevention to their high risk patients; and 6) Maintaining surveillance of AIDS incidence. The Project will be offering a variety of programs, including: educational presentations and information to comunity groups and health care groups; confidential information and referral to private individuals with concern about AIDS; special outreach to high-risk groups on risk reducing behaviors; consultation with local press and media; literature distribution to high-risk groups, the general public, and individuals; and community forums, workshops, and seminars on AIDS information and updates. For more information, contact: Santa Clara AIDS Project, Heatlh Department, 2220 Moorpark Av., San Jose, CA 95128, 408/299-5858.

* * * * *

WHITMAN-WALKER'S AIDS EVALUATION UNIT AWARDED $15,000 BY EPISCOPALS

by Mark Scott, with thanks to The Washington Blade, 11/9/84

An Episcopal Church relief organization awarded a $15,000 grant to Washington, DC's Whitman-Walker Clinic's AIDS Evaluation Unit, ensuring the unit will be able to operate for another year, Clinic President Dusty Cunningham announced. "This is the only gay clinic in the country with a medical evaluation unit," Cunningham said. "This [grant] enables AIDS evaluation to go on--there was some doubt abot that." The Presiding Bishop's Fund for World Relief gant will help provide testing for people worried about having AIDS, according to clinic administrator Jim Graham. Since January, 1984, about 200 people have expressed such fears to clinic physicians. Two of them have been diagnosed as having AIDS, and another 50 exhibit persistent AIDS-related symptoms. "This unit is serving a very important purpose--the public clinics don't provide this," Graham stated. "One of the functions is to reassure people. There's alot of fear out there." Each test costs between $150-200, but the Clinic has been providing them at reduced cost to needy people. Over $9000 on AIDS testing has been spent in 1984 at the Clinic. The grant comes four months after Cunningham applied through the Presiding Bishop's Fund with the help of the Rev. James Holmes, curate of St. John's Church, Lafayette Square. "It's the first time the [Fund] has ever responded to a specifically gay request," Cunningham said. "It may be the first time any [gay group] ever applied." The Fund usually disburses money to overseas relief programs or disaster relief in the U.S. "The people who investigated the grant were very impressed, "Holmes said.

* * *

GAY RESORT CONVERTING TO AIDS RESIDENCE IN PALM SPRINGS

by Mark Scott with thanks to The Washington Blade, 11/23/84

A gay man's plan to convert his gay resort hotel into a residence for people with AIDS (PWA) has drawn sharp criticisms from Palm Springs (California) Mayor Frank Bogert, who called it "the worst thing that's ever happened," to the city, according to The Advocate. For the past four months, gay resort owner Fred Hardt has been planning to turn his 12-unit hotel into a full-care residence for PWAs. The hotel building would be able to accomodate 17 PWAs and 3 full time staff. The $750 to $975 a month charge PWAs would pay to live at Hardt's residence would be substantially less than most convalescent hospital fees. The facility is expected to open early in 1985, after completion of remodeling. But Mayor Bogert and city attorney William Adams plan to organize petition drives to persuade Hardt to take his idea elsewhere. Although the city has no legal way to stop the residence, Bogert said he hopes public opposition will change Hardt's mind. At a recent press conference, Bogert stated the residence would hurt Palm Springs. "When [tourists] hear Palm Springs has an AIDS place, they are not going to come here. You don't take a hospital and put it right in the middle of a resort area," he stated. "I think it's a great idea; don't get me wrong," he added. "Those people need something...I just wish [Hardt] would do it somewhere else." Further inquiries about the residence, which has been called "Hartline Residence Resort," should be sent to: Hartline, Box 2662, Palm Springs, CA 92263, 619/323-6006.

* * * * *

SAN FRANCISCO AIDS BUDGET INCREASED

by Sue Hyde, with thanks to Boston's Gay Community News, 11/24/84

San Francisco's Board of Supervisors approved an additional $2.4 million to the AIDS budget on November 5, according to the Bay Area Reporter. The extra money will double the number of beds in San Francisco General Hospital's AIDS ward, from 12-24 beds, and will double the capacity of the outpatient AIDS ward. The supplemental appropriation brings to $7.6 million the city's spending on AIDS in 1984. The only controversial item in the package was a $50,000 approriation earmarked to pay the four private investigators who conducted spying missions in the bathhouses in the fall. The investigator's reports were cited by the city's lawyers in the efforts to close the baths in October.

* * * *

CHICAGO CITY COUNCIL ALLOCATES $100,000 FOR AIDS

Chicago's City Council approved a $100,000 line item for AIDS education and research in the city's 1985 budget. "This is the first time that the Council has allocated funds directly for AIDS programs," state Jerry Weller, Chief Executive Officer for Howard Brown Memorial Clinic. "The Clinic's AIDS Project is prepared to request funding for education activities aimed at Chicago's black and hispanic gay communities as well as continuing our current support services," Weller concluded.

* * *

NUTRITIONAL STATUS AND AIDS

with thanks to San Diego AIDS Project, January, 1985

Is there a connection between nutritional status and AIDS? Some scientists from the Memorial University in Newfoundland believe there is a strong link between the two. Although there is little information on the nutritional status of PWAs, Dr. R.K. Chandra has found that the plasma and leukocyte zinc levels are diminished in PWAs. Zinc deficiency will result in a reduced antibody response, and will diminish the activity of "killer" cells that fight off disease-causing attackers. Other changes in the immune system are also involved in zinc deficiency. See: Jain, V.K., & Chandra, R.K. Does nutritional deficiency predispose to AIDS? Nutrition Research, 4:537-43, 1984.

* * *

ROLE OF VITAMIN C IN AIDS

Medical training classically has been devoid of intense instruction in nutrition and the role of vitamins (specifically megadose therapy) therapeutically. According to Robert F. Cathcart, III, MD, ascorbate (vitamin C) in very large doses (40 to greater than100 g/24 hours, IV) would have value in the treatment of AIDS. "It appears that ascorbate may assist the immune system, but that in addition, there are mechanisms whereby ascorbate acts against pathogens, especially viruses and bacteria by some mechanism which does not depend on the T-cells," Cathcart writes. Is megadose ascorbate a legitimate therapy under investigation by AIDS researchers? Are theoretical reasons for using ascorbate biochemically and physiologically sound?
To contact Robert Cathcart, III, MD, write: 58 N. ElCamino Real, #119, San Mateo, CA 94401.

* * *

DIET MAY PROMOTE IMPROVEMENT & STABILIZATION OF AIDS

with thanks to The New York Native, 1/14-27/85

Although there is no known medical cure for AIDS at the present time, there is indication that the proper use of macrobiotic interventions can help as a tool in the stabilizing or improvement of the condition. That was the theme of a forum held December 15, 1984, in New York City, with Michio Kushi, one of the world's leading authorities on macrobiotics, as a feature speaker. Kushi explained the macrobiotic way of eating as it pertains to the problem of AIDS, and how the blood purifying and balancing effects of these interventions could serve to prevent the worsening of AIDS. The use of macrobiotic interventions as a preventive measure for individuals with AIDS Related Complex was also emphasized. A research project on macrobiotics and AIDS, begun in 1984, is being conducted in collaboration with Boston University Medical School. Dr. Martha Cottrell reported that although still too early to make conclusive comments, it appears that those who have maintained themselves on the proper macrobiotic way of eating under the supervision of a "qualified macrobiotic counselor" have found their conditions have stabilized and they have not gone on to develop opportunistic infections. In some cases there have been improvements in T-cell ratios, white blood cell counts, and mitogen responses. Certainly the quality of life among these cases has improved. For more information about macrobiotics, contact Kushi or his associates (617/232-6869) or the East West Foundation in Boston (617/738-0045).

* * * * * *

DRUGS BEING TESTED IN AIDS

excerpted in part from The New York Native, 12/31-1/13/85

Following is a list of most of the important drugs being used to treat AIDS and AIDS related complex. They are all being tested in clinical trials and have varying degrees of success. Suramin, an anti-African sleeping sickness drug which seems to keep HTLV-III from replicating in test tubes but which has toxic side effects; Lentinan, an interferon-inducing substance which has been used in Japan in cancer therapy; Depsone, an antileprosy drug which has been useful in some cases of Kaposi's sarcoma; Acyclovir, a drug used against herpes which may also play a role in the treatment of "pre-AIDS;" Macrobiotic approaches, although not specific medications, may have some usefulness, especially in nutritionally deficient people; Interferon and Interleukin 2, which were heralded as potential "magic bullets" in 1983, have lost some appeal, however clinical trials are continuing; Thymosin, a thymus-derived substance which may stimulate the immune system; Ribavirin, which suppresses the replication of LAV in infected T-cells; Isoprinosine, which is thought to boost the immune system in people with AIDS Related Complex; Cimetadine, the anti-ulcer medication, seems to have immune-restorative effects, and has successfully been used for people with shingles and cancer.

* * * * *

THYMOSIN IMPROVES IMMUNE FUNCTION

by Ann Giudici Fettner, with thanks to The New York Native, 1/14-27/85

Dr. Allan Goldstein of the George Washington University

When Dr. Allan Goldstein of the George Washington University began looking into the role of the thymus gland in AIDS patients, he found what he thought were unusually high levels of thymosin alpha-1, a hormone-like fraction of thymosin, which is responsible in large part for the maturation of T-helper lymphocytes, as well as the production of interleukin-2. The question was, if thymosin triggers events that lead to the development of mature T-cells, why so those with early AIDS have so much of it and yet remain immune suppressed? At first, Goldstein thought it might be a last ditch effort by the thymus gland to counter the killing of T-helper cells by the AIDS agent. Recently, using a more sensitive assay, Goldstein's group has found that the thymosin alpha-1 is not authentic, but a cross reaction substance that may be a modified thymosin or a fragment of the molecule. This has considerable implications for defining who in the enormous number of the HTLV-III infected populations will eventually contract AIDS. Why are only 10% of those infected expected to develop the syndrome? "Is it possible that those are the ones in whom the thymus itself is infected?" asks Goldstein. He feels that by identifying those whose blood shows bogus thymosin alpha-1, persons likely to develo opportunistic infections and end-stage AIDS can be identified and treated. Before the ability to measure HTLV-III antibody, Goldstein entered patients with "high" thymosin levels in his clinical study. These were hemophiliacs and gay men with lymphadenopathy syndrome (LAS) and other early signs of AIDS. None were ill or had opportunistic infections. With the new HTLV-III assay, Goldstein now finds that 87% of the patients he identified as having early AIDS were positive for HTLV-III antibody, so his criteria of evaluating thymosin levels is as accurate as the HTLV-III antibody evaluation. Goldstein divided his patient population of 32 into 3 groups, each of which was treated with thymosin in low, middle, and high doses. Those who received the lowest dose have developed AIDS (and most of whom have died). Those receiving middle and high doses have not developed opportunistic infections nor Kaposi's sarcoma. Although still well, they still show antibody to HTLV-III & inverted T4/T8 ratios. Importantly, during the 10 weeks of thymosin therapy, the mixed lymphocyte response indicator of immune funtion was restored in the two groups treated with higher doses (T-cells live for as long as 25 years and aren't quickly regenerated). When thymosin was started in those not highly immune suppressed (T-cell ratios of 0.7 or above), patients respond better. Goldstein thinks he may have a handle on prognosis by coupling titers of HTLV-III antibody with those of thymosin alpha-1, to define who will or won't progress to AIDS. Persons with normal levels of thymosin should be followed closely for signs that their thymosin levels are changing. If you are interested in contacting Goldstein, write to: Allan Goldstein, PhD., Chairperson, Dept. of Biochemistry, George Washington, University Medical Center, WAshington, DC 20037.

* * *

RIBAVIRIN FOUND TO SUPPRESS REPLICATION OF LAV

by Charles L. Ortleb, with thanks to The New York Native, 1/14-27/85

Ribavirin (ICN Pharmaceuticals, Covina, CA) has been found by CDC scientists to suppress the replication of LAV, the virus associated with AIDS (and thought by many to be the same as HTLV-III), on infected T-lymphocytes. Ribavirin has been used for treating other human virus infections such as respiratory synctial virus and influenza A, and is known to have a suppressive effect on a number of retroviruses. The advantage of Ribavirin over Suramin, another drug which is undergoing clinical trials at the National Cancer Institute, is that it may be considerably less toxic. [The medication is now available on a "compassionate use" basis in this country, after lobbying the company's medical staff by gay health workers and others after a tip that ICN's president was against releasing the drug for "compassionate use" because he was allegedly homophobic. For more information about acquiring the drug, contact: Dr. Stafa, 818/915-7721. --EDITOR]

* * *

ISOPRINOSINE TO BE TESTED

with thanks to The Washington Blade, 1/4/85

Tests of isoprinosine, the drug believed to boost the depressed immunity of people with AIDS related complex (ARC) is beginning in several cities, including New York, San Francisco, Los Angeles, Houston, Charleston, Tampa, Milwaukee, Paris, and London, according to David Gilson, Manager of Clinical Programs at Newport Pharmaceuticals, a California company that produces the drug. Preliminary results are very encouraging, and the company is seeking other researchers interested in joining their study protocol. If interested, contact Gilson at 714/642-7511 (Pacific time). Isoprinosine is a drug which has been used for more than a decade in Europe to restore the function of T4 helper white blood cells in cancer patients. It has proven safe and effective in treating influenza, recurrent herpes genitalis, and rare sclerotic disorders, but has never been approved for use in the U.S.

* * * * *

JAPANESE DRUG DERIVED FROM MUSHROOMS USED IN AIDS-RELATED CONDITIONS

compiled by Toronto's The Body Politic, January, 1985

In Japan, a drug derived from a mushroom, lentinan, has successfully been used to improve the conditions of two people suffering from AIDS-related illnesses and who had tested postitive for HTLV viruses. The drug has been used to reduce tumor growth in Japanese patients since 1969, and is believed to stimulate the immune system.

* * *

IMMUNE SYSTEM MODULATION AFTER HTLV-III INFECTION MAY NOT IMPROVE PROGNOSIS

compiled by Toronto's The Body Politic, January, 1985

In Boston, doctors have succeeded in partially rebuilding the immune system of an AIDS patient by giving him transfusions of white blood cells (helper T-cell lymphocytes), and a bone-marrow transplant from his identical twin. Although the patient experienced a marked temporary improvement, his condition deteriorated after ten months and he died of multiple infections. "You can imagine how excited we were during those few months," said Dr. Clifford Lane of the National Institutes of Health. "Then to see the disease recurring made us think that those additional lymphocytes were being attacked in the same manner" by the AIDS virus. The doctors concluded, "Efforts directed toward restoring the immune system may be doomed to failure if strategies are not devised that can deal with the causitive factors."

* * *

POPPERS WARNING

compiled by Sue Hyde, with thanks to Boston's Gay Community News, 1/12/85

A federal study of 87 gay men with AIDS revealed that the use of poppers may be a co-factor "in the allowance or enhancing in the development of Kaposi's sarcoma (KS)." KS is a skin cancer occurring in 30% of people with AIDS (PWAs), according to the Bay Area Reporter. But physician researcher Harry Haverkos cautioned that the findings did not indicate poppers (inhalent nitrites) themselves cause AIDS. He said the use of poppers is apparently part of a "fast-lane" lifestyle which includes multiple sex partners and drug use. Use of poppers is frequent among those contracting KS, but popper use may be only one of several factors related to KS development.

* * *

NONOXYNOL-9 TO BE EVALUATED BY INSTITUT PASTEUR

In the last issue of the Newsletter, an open letter from Bruce Voeller to Dr. Edward Brandt about the effectiveness of certain agents (condoms, alcohol, ultraviolet, heat, etc.) against the HTLV-III/LAV agent was published (Volume 6:2, October/November, 1984, page 11). A copy of the Newsletter was sent to Dr. Jean-Claude Chermann, Head of Laboratory, Oncology Viral Unit at the Pasteur Institute (Institut Pasteur), Paris, with a request to evaluate the spermicidal agent nonoxynol-9, which is occasionally found in water soluble lubricants for anal intercourse. His reply: "Thank you very much for your letter of November 27, 1984. I was very interested reading your "The Official Newsletter" and confirm, as you said, that virus is very resistant to UV [ultraviolet radiation] as described in the enclosed manuscript submitted to the Lancet. ["Study of the Inactivation by Various Physical Agents of the Lymphadenopathy Associated Virus (L.A.V.)," by B. Spire, D. Dormont, F. Barre-Sinoussi, L. Montagnier, & J.C. Chermann.] Concerning the spermicidal agent nonoxynol-9, I will try to find and test it. You will be informed about the results. Looking for hearing soon from you, I remain, Sincerely yours, Dr. Jean-Claude Chermann." The NCGSTDS will of course, keep its readers advised of any further communications from Dr. Chermann.

* * *

NONOYNOL-9 TESTED BY CDC

A news release from Bruce Voeller's Trimensa Company in Los Angeles, announced that in vitro (test tube) studies performed at the CDC demonstrated the inactivation of the HTLV-III virus by nonoxynol-9, a spermicidal agent found in many vaginal contraceptives. Contrary to the claims of the hard-to-locate news release, the finding is not a significant one that will same thousands of lives, according to James Curran, MD, Coordinator of the CDC's AIDS Activity. Many gay men may have false assurances that using a lubricant with nonoxynol-9 may protect them from acquiring or transmitting the AIDS virus when as yet no clinical trials have demonstrated this contention nor have demonstrated its safety on rectal tissue. Many fear that important risk reduction and healthful sex guidelines will no longer be followed if the product is used as promoted. Nonoxynol is a nonionic surfactant and is related to the active ingredient in Oxydol laundry detergent, properties of which may be unsafe when used in anal intercourse. Repeated attempts to reach Voeller, a biochemist and former gay activist, have been unsuccessful, with phone calls and letters being unanswered.

* * * * *

SHARED NEEDLES PLACE BODYBUILDERS AT RISK

by Charles L. Ortleb, with thanks to The New York Native, 1/14-27/85

The December 27, 1984 issue of the New England Journal of Medicine contains a report of a 37-year-old bodybuilder who may have contracted AIDS while injecting anabolic steroids with a needle that was shared by other athletes. The patient denied "any history of homosexual activity and had no other risk factor for AIDS," although he did admit to having injected cocaine intravenously on one occasion approximately six months prior to his hospitalization. The researchers note that "during the four years before admission, as part of a bodybuilding program, the patient injected anabolic steroids intramuscularly approximately every week. The needles were often shared with other bodybuilders at various gyms."

* * *

HTLV-III IN SALIVA: CIRID

from CIRID AIDS Medical Update, 2:10, 1984

CIRID's editor Andrew Saxon, MD, offers comment about the recent article, "HTLV-III in Saliva of People with AIDS-Related Complex (ARC) and Healthy Homosexual Men at Risk for AIDS," by Groopman, et al. (Science, 226:447, 1984). "The finding of infectious HTLV-III virus with such high frequency in the saliva of seropositive healthy homosexuals and patients with ARC is unexpected in view of the epidemiology of AIDS. All the epidemiologic evidence suggests that AIDS is not generally transmitted by casual contact. Vast numbers of the public and health care workers have come in contact with saliva from what we now know to be likely seropositive persons with no evidence for transmission of AIDS by this route. At this time, there is no reason to adopt rigid new guidelines in regards to such things as sterilizing glasses, non-intimate kissing, etc. However, those who work in an environment where saliva is aerosolized (dentists, respiratory therapists, etc.) might take added precautions such as the use of mask and goggles or face shields. Gloves will prevent manual contact. While virus can be isolated from saliva, the amount of infectious material present may be small compared to blood or semen. Alternatively, the routes of exposure to saliva, cutaneous or oral, may be less likely to give rise to infection than rectal exposure to semen or parenteral exposure to blood products. Interestingly, none of the patients with frank AIDS had virus in their saliva. Whether this means that AIDS represents a different stage of HTLV-III infection where virus is absent from saliva or simply that there are not enough lymphoid cells present at that point to detect the HTLV-III remains to be determined. It may also be that HTLV-III has a tropism for salivary glands." ***** ***** *****

SURAMIN PROTECTION OF T-CELLS IN VITRO: CIRID

from CIRID AIDS Medical Update, 3:1, 1985

CIRID's editor Dr. Saxon offers comment about the recent article, "Suramin Protection of T-Cells in Vitro Against Infectivity and Cytopathic Effect of HTLV-III," by Mitsuya, et al. (Science, 226:172, 1984). "With the poor results of previous immunomodulator therapy trials in the treatment of AIDS, anti-viral compounds, such as inhibitors of reverse transcriptase, like suramin represent a most promising new development on the horizon in AIDS therapy. Therapeutic application of these compounds in AIDS will be the first attempt at actually combating the infectious etiology of the syndrome, HTLV-III. The successful results of these in vitro experiments provide a rational basis for a carefully monitored clinical trial of suramin in AIDS patients. A similar trial of suramin in ARC patients (AIDS related complex including lymphadenopathy) is also warranted as these patients more often than AIDS patients exhibit HTLV-III positivity in bodily fluids and probably represent an early stage of the disease. A phase I trial of suramin in these patients will have to be closely monitored for evidence of toxicity especially glomerulonephropathy, peripheral neuropathy, hypersensitivity reactions including anaphylaxis and shock as well as coma. Careful virologic, immunologic and biochemical studies must accompany this trial." ***** ***** *****

AIDS IN AFRICA: CIRID

from CIRID AIDS Medical Update, 3:1, 1985

CIRID's editor Dr. Saxon offers comment about the recent article, "AIDS in Africa," by Greenwood (Immunology Today, 5:293, 1984). "This article broadens our understanding of AIDS by presenting cases which are both similar and different from those currently seen in the US. The entirety of the cases occurring among heterosexuals, especially those frequenting female prostitutes and admitting to sexual promiscuity, defines a new AIDS high risk group. This finding substantiates the known heterosexually transmitted AIDS cases recently discussed in the medical and lay press. The dissemination of AIDS is thus not unique to homosexual sexual practices as may have once been thought early in the description of the syndrome but can be spread through any kind of sexual contact. Promiscuity does seem to be a risk factor (definition of promiscuity is not clear, however). The significance of this finding as it portends for increasing numbers of AIDS cases among US heterosexuals is clear. As to the origin of HTLV-III/LAV being central Africa only further international epidemiologic studies will answer this intriguing academic question." ***** ***** *****

AIDS MEDICAL UPDATE STATEMENT: Prepared as a public service to the medical community by the Division of Clinical Immunology/Allergy, Department of Medicine, UCLA School of Medicine. These updates represent editorial opinion and should not be construed as otherwise.

* * * * *

NY AIDS ADVISORY COUNCIL DISCUSSES TAKING STAND ON BATHHOUSE CLOSURE

by Mark Scott, with thanks to The Washington Blade, 11/30/84

The New York City AOIS Advisory Council recently discussed to take a stand on closing the city's five bathhouses. The discussion, which took place at the request of advisory council member Michael Callen but not at the urging of city or state officials, "amounts to a college-class debate to see if we want to take a position on it," said advisory vice-chairperson Peter Vogel. "We are not, repeat, not talking about closing the bathhouses," he said. "I am positive we will not reach any conclusion on it at this meeting," said the council's chair, Paul Moore, the Episcopal bishop of New York City. "There's no secret plot or anything. To have a more open discussion, we thought it would be better to have it in [closed] session." The 13 member advisory council, which advised state officials on AIDS-related developments, has no power to close the bathhouses, Moore said. So far, city and state health officials have opposed closings. "AIDS is not spread by bathhouses, and if the baths in New York are going to close, it's preferable that they close because of a lack of business," said Marvin Bogner, a spokesperson for the city's health department. "It is our belief that education is preferable to governmental intervention. The gay community in New York has undertaken an intensive educational effot focusing on the risks of intimate sexual contact, particularly with multiple partners." "We don't consider that closure will be effective," said Frances Tarlton, a spokes-person for the state's health department. The department instead will continue to fund safe-sex education efforts aimed at bathhouse patrons, she stated.

* * *

AIDS REFERENCE GUIDE FOR MEDICAL PROFESSIONALS--CIRID

The AIDS Reference Guide for Medical Professionals provides information on what AIDS is, in a nutshell. The Guide includes names, addresses, and phone numbers of appropriate agencies to contact in order to obtain detailed information on where to refer patients, where to find the latest research, how to protect oneself, and much more. Contents include chapters on: AIDS overview, case definitions, precautions, terminology associated with AIDS, psychosocial aspects of AIDS, tests currently available, newsletters, bibliographies, and resources in Los Angeles and other southern California counties. [ED NOTE: Unfortunately, if you are not a resident of these areas, you may not find these resources helpful; national resources are not listed.] The Guide is edited by the Center for Interdisciplinary Research in Immunology and Diseases (CIRID) at UCLA, which is a multidisciplinary research center focusing on immunology and diseases, and promotes laboratory and clinical research and facilitates new research information out to the medial community. The Guide costs $2.50, plus $1 for postage and handling (make checks out to the Regents of the University of California), and mail with your name, address, and zipcode to: CIRID at UCLA, Room 12-248 Factor Bldg., Dept. of Microbiology and Immunology, UCLA School of Medicine, Los Angeles, CA 90024.

* * *

AIDS MEDICAL UPDATE: CIRID NEWSLETTER

The UCLA Department of Medicine, Division of Clinical Immunology and Allergy, and the National Institute of Allergy and Infectious Diseases through UCLA's Center for Interdisciplinary Research in Immunology and Diseases (CIRID) along with the UCLA AIDS Center has published the AIDS Medical Update since July, 1983 providing the medical community and concerned groups with a synopsis of the most recent research on AIDS. The Update abstracts articles about AIDS and AIDS related matters from current medical journals. Four to six articles are summarized per issue (10-12 per year), with the original articles cited allowing the reader to refer to them for more detailed information, if desired. The principal editor, Andrew Saxon, MD, Chief of Clinical Immunology and Allergy at UCLA, adds his professional editorial comments about each article. Associate editors occasionally assist Dr. Saxon. Subscriptions are available on a one year basis only, at the rate of $6 per year. Make you check out to: Regents of the University of California in the amount of $6 and send to: CIRID at UCLA, Room 12-248 Factor Bldg., Microbiology and Immunology Dept., UCLA School of Medicine, Los Angeles, CA 90024. Include your name, address, and zip code. The NCGSTDS is happy to announce an exchange subscription with CIRID, and will reprint articles of timely interest. All such articles will be identified with "CIRID" and will include an editorial disclaimer, as requested by CIRID. We urge your support of this excellent service. If you subscribe, please mention the NCGSTDS!

* * *

BATHHOUSES CALLED 'VALUABLE TOOL' IN AIDS EDUCATION EFFORT

by Stephanie Poggi and Gerard Cabrera, with thanks to Boston's Gay Community News, 1/26/85

AIDS Task Forces in Los Angeles and San Diego have rejected San Francisco-style bathhouse regulation in favor of education about safe sex, according to the Bay Area Reporter. The LA Task Force, appointed by Mayor Tom Bradley, called the baths a valuable tool in getting out information about AIDS and the kind of sexual activities that can lead to infection. Neil Schram, MD, chair of the task force and past president of the American Association of Physicians for Human Rights, said that measures against the baths could only distract from the problem of educating gay and bisexual men about the disease. "It's the activity that is performed, not the place where it happens," he said. The San Diego taskforce, appointed by Mayor Hedgecock, agreed, stating that "informed, consenting adults have, by our national tradition, been allowed to make their own decisions about high-risk behavior--especially when the risk is not to the uninvolved bystander but rather to the individual participant.... Responsible sexual behavior rather than bathhouse closure will reduce the risk of exposure to the HTLV-III virus." Neither report recommended outlawing sexual contact or overseeing patrons' conduct in the baths. Nor were construction changes, such as removal of doors on private rooms suggested. The San Diego group added "The ultimate answer to AIDS must be medical--a vaccine and/or antiviral agent. Until then, the best interim control measure is education."

* * *

BATHHOUSE SEX PROHIBITION DISCUSSED IN DC

by Lou Chibbaro, Jr., with thanks to The Washington Blade, 1/11/85 and 1/18/85

After a short but emotional debate, members of Washington, DC's Gay Activists Alliance defeated a resolution calling for the "immediate prohibition of sexual activity" in Washington's gay bathhouses. The resolution was introduced by gay activist and former Air Force Sergeant Leonard Matlovich, and marked the first time the controversial bathhouse issue has been brought to a vote by any of Washington's gay political groups. In San Francisco and New York City, gays have become involved in bitter disputes over proposals calling for the closing of gay bathhouses or other sexually oriented establishments as a means of reducing the spread of AIDS. Matlovich's resolution also called for the "posting of warning signs concerning the danger of AIDS in every gay nightclub and bar in Washington, DC." Those opposing the resolution argued that restricting sex in bathhouses will have little or no effect on the AIDS problem because recent information from researchers indicates the disease is spread by the transferal of body fluids through what has been characterized as "high risk" sexual activity. Such sexual activity can result in the spread of AIDS just as easily in private homes as in bathhouses, said opponents. In addition, a government ban on sexual activity in bathhouses would set a dangerous precedent by allowing government officials to intrude in the private lives and private institutions of the gay community. "I didn't expect it to win," said Matlovich after the vote. "My intention is to keep the issue alive because the lives of an entire generation of gay men are at stake." Matlovich introduced and then withdrew a similar motion a week later at a meeting of the Gertrude Stein Democratic Club. He then introduced a second resolution calling for the posting of warning signs in gay bars and nightclubs. This was tabled. Several Stein members, during some 45 minutes of debate on the bathhouse question, said they believed local efforts to educate gay men about the dangers of AIDS have been inadequate. The Langston Hughes-Eleanor Roosevelt Democratic Club approved a resolution calling for the "cessation of unsafe sexual activity" in both public and private places and for the posting of signs in Washington's gay bathhouses, bars, and bookstores to warn of the dangers of AIDS. The resolution was introduced by club member Clint Hockenberry and is intended to create more awareness of the link between unsafe sexual activity and AIDS and to stress the need for gay men to voluntarily refrain from unsafe sex. Hockenberry said Hughes-Roosevelt Club members will work with officials of the Whitman-Walker Clinic to encourage owners of local gay bathhouses and bars to post signs concerning the dangers of AIDS. Medical researchers and gay health advocates have defined unsafe sex as any sexual activity that results in the exchange or transferral of body fluids.

* * *

BATHHOUSE PATRON'S NAMES SUBPOENAED IN SAN FRANCISCO

by Tam Cummings and Mark Scott with thanks to The Washington Blade, 12/21/84

In an effort to determine how many monitors will be required to enforce November's court order to reopen the baths, San Francisco subpoenaed the sign-in register of every bathhouse, according to the Bay Area Reporter. The November 28th ruling by Superior Court Judge Roy Wonder allows the bathhouses to reopen, but requires one monitor for every 20 patrons. In order to calculate the total number of monitors needed at each establishment, the city attorney's office says it needs the registers in which visiting members sign-in. Attorney Tom Steel, who represents four bathhouse owners, said he believes all will refuse to honor the subpoena.

* * *

STEAM OFF, PISSED OFF

by Sue Hyde, with thanks to Boston's Gay Community News, 11/24/84

The San Francisco central YMCA shut down its steam room and sauna for 36 hours recently in an apparent attempt to halt alleged sexual activity at the facility, according to the Bay Area Reporter. The sauna and steam room were reopened after angry members threatened to cancel their memberships and demand refunds of dues. In a closure notice, the Y management tried to spruce up its image by saying, "The Central YMCA is not a bathhouse.... We will not function as one. It has been brought to our attention through numerous member complaints that overt sexual activity continues in the adult men's center.... Until Monday, November 5, we will shut down the dry room and steam room. If this does not curb the sexual activity, we will take further action." David Kline, a Y member who said he had never seen sex in the steam room, saying, "The closure is not happening in a vacuum. Many of us are aware that the health department is conducting aggressive, covert, city-wide operations to outlaw male homosexual activity. This is a part of a policy of deliberate harassment of businesses that cater to the gay populace."

* * *

ST. LOUIS RED CROSS LIMITS BLOOD DONORS

compiled by Tam Cummings, with thanks to The Washington Blade, 12/7/84

The St. Louis Red Cross requested that health care workers who come in close contact with AIDS victims refrain from donating blood, according to The New York Native. An official with the Red Cross said that because scientists and doctors are unsure how AIDS is transmitted and because of the severity of the condition, the blood gathering organization wants to lower the risk of transmitting the syndrome through blood transfusions. The Red Cross nationally has a policy which discourages health care workers who have had close contact with hepatitis patients from giving blood.

* * *

NO SPECIAL FACILITY FOR AIDS PRISONERS IN NEWARK

compiled by Tam Cummings, with thanks to The Washington Blade, 12/7/84

Plans for a special security facility for prisoners with AIDS were rejected by a three to one margin during a city-wide referendum, according to Boston's Gay Community News. The referendum on the prosposed AIDS facility, which would have housed prisoners with AIDS from throughout New Jersey, was defeated 26.060 to 9,347. However, an official for the New Jersey correctional system said plans for the facility had already been dropped several months before the vote.

* * *

TRACK MEET HURT BY AIDS RUMOR

by Tam Cummings, with thanks to The Washington Blade, 12/14/84

Rumors that the site for a track meet to be held December 15, 1984, has been used to shelter men with AIDS have triggered a number of high school coaches to withdraw their teams from competition, according to the New York Times. The meet, being held at the 102nd Engineers Armory in New York City, is the largest high school track competition of its kind. Last year's number of competing athletes--4000--has been reduced by one-half because of the rumors. City Health Commissioner Dr. David J. Sencer said there is no AIDS threat to anyone staying at the shelter or participating in the games.

* * *

UNITED AIRLINES NOT FLYING FRIENDLY FOR WORKERS WITH AIDS

by Christine Guilfoy and Charles Michael Smith, with thanks to Boston's Gay Community News, 12/8/84 and 12/22/84

United Airlines has placed two male flight attendants on medical leave because they have AIDS and company officials refused comment on the allegation that they are considering testing their flight attendants for AIDS. The two attendants, Gar Traynor and Bruce Hall, were placed on medical leave after they informed their employer they had been diagnosed as having AIDS. Although the airline told them it took such action because they might spread the disease in their capacity as food handlers, neither was offered a transfer to other departments. John Lorenzini, the director of San Francisco's People with AIDS, told GCN he had unconfirmed reports that United had "attempted to require a lymphadenopathy test on all male flight attendants." When Joel Hopkins of United was asked if they were going to test for AIDS or if they had discussed the possibility, he replied, "No comment." United did not offer Traynor another position when he was placed on medical leave. Traynor, 37, told GCN he was a career employee for the company for ten years. When he was diagnosed with AIDS in December, 1982, he informed United because he needed to arrange his work schedule around chemotherapy. Traynor said he worked a full schedule for 6 months following his diagnosis. "Everything was fine for 6 months [but] in June, 1983 I was called in and told 'effective immediately' I was on medical leave of absence. I would retain my insurance and partial flight benefits, but no salary. There was no discussion." Traynor said the loss of salary led him to lose his apartment, his savings, and his car. Hall was diagnosed with AIDS in September, 1983 and missed work until January, 1984 when he asked for reinstatement but was refused. United claims that both Hall and Traynor are potential health risks to the public. They also said that working in the closed environment of an airline cabin would leave them vulnerable to more infections. United also doubted their ability to carry full schedules, although Traynor told GCN he had no difficulty in this regard. Traynor obtained a statement from his physician, Ronald Mitsuyasu of the UCLA Medical Center in July, 1983 which said in part, "Mr. Traynor has had no significant infections while under our care and has been fully functional in terms of his daily activities...He has no apparent medical limitations which should prevent him from performing gis work responsibilities or his usual activities of daily living." Traynor said his union, the Association of Flight Attendants, "has been 100% behind me." Traynor instituted a grievance procedure throught the union and his case was heard before an arbitrator in June. To date, no decision has been announced. Traynor said he also has filed a $20 million civil suit which he says he will drop if United will reinstate him. Marilyn Pearson, who is handling Traynor's case for the union, said, "The medical community has a consensus that people with AIDS (PWA) should be able to work unless their individual conditions warrants [otherwise]. Our position is that [United] created a blanket policy [aon PWAs]. There is no basis for that; you have to look at the individual case." At Lorenzini's request, Marcus Conant, MD, the director of the AIDS Clinical Research Center of the University of California, San Francisco, wrote to United's corporate medical director, Gary Kohn, MD, saying in part, "...the epidemiology of the disease suggests to us that this disease is transmitted in exactly the same way as hepatitis B....Individuals who are known to be hepatitis B core antigen positive are allowed to work as health care providers, day care operators and food handlers. Health care providers who have been caring for AIDS patients since the beginning of the epidemic show no signs of having contracted the disease." Traynor admitted, "I agree United should be cautious....[But] flight attendants don't really handle food. The food is already pre-containerized. We handle wrapped utensils.... I realize HTLV-III is found in saliva but my saliva isn't a threat to passengers. I'm not kissing them." Although the presence of HTLV-III is a recent research discovery, most researchers and epidemiologists agree it is an unlikely route of transmission. John Lorenzini said job discrimination has become a real threat to people with AIDS and some tell their employers they have leukemia or cancer so they can go for treatments without losing their jobs. He said fear of AIDS and homophobia are realities that PWAs are forced to deal with, and it is because of this that United has taken the actions it has, according to Lorenzini. "If we were talking about Legionnaire's disease," he said, "United would be more informed, more willing to know the information before reacting." Lorenzini has begun organizing a boycott of United and he says he has received support from several gay organizations in San Francisco. According to Hall, the decision to relieve him and Traynor of their duties was not because the airline believes AIDS is spread through casual contact, but out of their concern "about public perception should the public find out that this airline is flying people who have AIDS." The fact that the airline

(CONTINUED)

UNITED AIRLINES NOT FLYING FRIENDLY, Continued

informed its 8200 flight attendants "that there is no reason for them to fear someone with AIDS on board the airplane," he continued, means that "they have destroyed their own case." Hall, an ex-New Yorker now residing in Chicago, wants his job back, which for him is the bottom line." He has filed complaints against United through his union; a similar but completely separate case against United involves a white gay man with Kaposi's sarcoma. Hall also filed complaints with the state human rights commissions in New York and Illinois. The New York commission rejected Hall's complaint after he told them about the Illinoiw complaint; a complaint filed in one state is binding in all other states. He filed in both states because "I'm between both addresses." The complaint is expected to sit a long time at the Illinois Human Rights Commission. "The wheels of justice turn very slowly, if at all. There won't be an outcome for another year or two," Hall said. The company is dealing with the case as though "my whole accusation is inaccurate. [United] told me they don't wish to update the files and work with information available in 1984. They're still working with information made available to them [in 1983]...." A few months ago, Hall was turned down for longterm disability payments by his insurance company. His insurance company has since restored his coverage "for 200 bucks a month." Hall's lover and family are supporting him while he fights to regain his job. He also encountered anti-AIDS sentiment at Chicago's Grant Hospital. He had signed up for the hospital's Alcoholics Anonymous program to counsel people in treatment. "It's the kind of work I've done before and the kind of work I'm being degreed to do right now at Loop College in Chicago. They kicked me out because I have AIDS." Hall himself is a former alcohol abuser.

* * *

AIDS IN WEST GERMANY AND AUSTRALIA

compiled by Tam Cummings, with thanks to The Washington Blade, 12/7/84

Federal and provincial authorities in Munich, West Germany are considering a number of legislative measures and penalties to help stem the increase in AIDS cases, the newsletter, This Week in West Germany, reports. Saying that as many as 10,000 West Germans could die of AIDS by 1990, officials at a conference last month for health authorities said they are considering a penalty for persons with AIDS who engage in intimate contact with healthy persons as well as stricter controls on blood donations.

Australian health officials urged a ban on all blood donations by gays following nine confirmed AIDS deaths. Legislation has also been introduced in the small southeastern state of Victoria to prohibit gays from donating blood there following the deaths of three infants who received blood transfusions believed containing the AIDS virus and donated by a gay person. Two of Australia's seven states have suspended their artificial insemination programs and one South Australian hospital is refusing to accept sperm donations until a better testing program for AIDS is discovered, because of the possibility of transmitting AIDS through semen. State and federal health officials have agreed to coordinate a national campaign to combat the spread of AIDS, promote blood donations from women, and cooperate with the US government and the International Red Cross to devise a screening test for blood donors.

* * *

HEMOPHILIC FAMILY WITH AIDS

with thanks to the Shanti Project's December, 1984 Newsletter

A married couple near Pittsburgh and their 6-month-old all have been diagnosed as having AIDS-related complex (ARC). Doctors say this is the first instance where the child of a hemophiliac has contracted the disease. Doctors theorize that the boy's father caught the AIDS virus through blood products administered for his hemophilia, and transmitted it to his wife through sexual contact, and she, in turn, passed it to their son, either in utero, or by breast-feeding.

* * *

AUSTRALIAN AIDS

compiled by Sue Hyde, with thanks to Boston's Gay Community News, 12/15/84

Although the total number of AIDS cases lags behind that of the United States, 20 vs. over 7000, Australian gay activists are working to prevent an epidemic situation in their country. Adam Carr of the Victorian AIDS Action Committee (VAAC) estimated that there will be 300 cases by 1987. In a lengthy analysis of AIDS in Australia (OutRage, November, 1984), Carr wrote that the AIDS epidemic in Australia will be similar to that in America. "Those comforting little theories that had it that Australian men were somehow less vulnerable, because we did fewer drugs, or fucked around less, can be discarded. We are not going to be spared." It is estimated that gay men will make up 80-90% of the total number of AIDS cases, as opposed to 71% in the U.S. In New South Wales, two cases of AIDS have been attributed to blood transfusions, and in Queensland, three infants have died after receiving blood in transfusions from a gay man thought to have AIDS. Queensland lawmakers recently enacted a law setting up a $10,000 fine and a two-year jail term for anyone with AIDS who donates blood and does not state he has the disease. And one member of the Queensland parliament suggested that manslaughter charges ought to be brought against anyone who does not heed blood bank policies regarding donations and by so doing, causes a recipient to die of AIDS. Carr reported that a private group--the Bobby Goldsmith Foundation, has raised $10,000 to help coordinate and provide services to people with AIDS. Although Carr said the funds were adequate for the time being, he predicted a growing need for programs for the "worried well." Carr also speculated that the government may not be as cooperative as it has been in the past when "the heterosexual majority realizes that AIDS is not going to go away, not going to be a handful of cases followed by a miracle cure, but a major and protracted epidemic involving hundreds of deaths and the expense of millions of dollars in public funds."

* * *

RESEARCH SCAM IN AIDS

compiled by Sue Hyde, with thanks to Boston's Gay Community News, 12/22/84

Four men have been indicted on charges that they attempted to bilk the state of New York of $250,000 by inflating the cost of an AIDS research project, according to the New York Times. One of the men is former state assemblyman Stephen Greco of Buffalo, currently a $43,500-a-year intergovernmental liaison. According to the indictment, Greco was asked by one of the other three to use his political influence to insure approval of a $448,100 grant application to the state Department of Health. The application was rejected. The conspiracy involved a scheme in which the men claimed the AIDS research project would cost at least $250,000 more than its actual cost. Arraignments are underway for all four of the accused, charged with single counts of conspiracy, attempting to commit grand [grant?!] larceny, and offering a false instrument for filing. The state of New York has set aside $5.7 million to support AIDS research projects.

* * *

SYDNEY POLICE GIVEN GLOVES AND MEDICATED CREAMS

compiled by Toronto's The Body Politic, January, 1985

In Sydney, Australia, police officers are being issued plastic gloves and medicated creams after they had threatened, out of fear of AIDS, to halt alcohol breath testing of motorists. Police apparently were worried about contracting the disease through handling breathalizer equipment, in spite of assurances by government AIDS task force head David Penington that such fears constituted "unreasonable anxiety."

* * *

NAVAL PETTY OFFICER WITH AIDS GETS DISCHARGED BECAUSE OF BEING GAY

reprinted with thanks to Shanti Project's Newsletter, January, 1985

A gay naval petty officer is being discharged as a homosexual rather than receiving a medical discharge because he has AIDS. The American Civil Liberties Union is challenging the discharge on the grounds that the Navy is violating it's own regulations requiring that a person who becomes seriously ill or disabled, qualifies for a medial discharge. The medical discharge would enable the person to receive medical care at a veterans hospital with full health benefits.

* * *

AIDS AND FASCISM--QUOTE OF THE WEEK

compiled by Sue Hyde, with thanks to Boston's Gay Community News, 12/1/84 and the New York Native, issue 102

"The madness is everywhere, but greatest, of course, right here in the United States--due to many of the same factors which brought the Nazis to power in Germany during the Weimar Republic. To begin with, we have the same basic setting: a bellicose nation with delusions of grandeur, recently humiliated in was and now beset by staggering debts, challenged from within by increasingly vocal "minorities"--a nation full of bitterness, envy, frustration and shame. Enter a small group of superpatriots, convinced of their "divine" mission to defeat the "Forces of Evil" and "cleanse" the Fatherland so that "the greatest nation in the world" may finally achieve an everlasting era of Pride, Prosperity and Purity." --R. William Wedin, "AIDS and Fascism: The Devil to Pay."

* * *

BOSTON CITY HOSPITAL OUSTS MAN WITH AIDS

by Christine Guilfoy, with thanks to Boston's Gay Community News, 12/1/84

A man who was admitted to Boston City Hospital who may have AIDS was forced to leave the hospital by two physicians who feared having him near other patients. The man, whose identity has not been made public, was readmitted to the hospital after he called the Boston Globe to make the story public. Carolyn Walden, the public relations officer for the city's Department of Health and Hospitals said, "There is an ongoing investigation. This was a mistake. It is a case of miscommunication and compounded errors. The hospital is assuming responsibility for the mistake...." According to the Globe's account, the man, who was called John, was weeping as he related what had happened. John arrived at the hospital for a biopsy, and was assigned a room in a ward with other patients and went to sleep. He was awakened by Dr. James Landis, an anesthesiology resident, who asked him if he had had homosexual relations in the past three weeks. John said Landis asked loudly and without drawing the curtains. The surgical resident Dr. Richard Freeman, came to see John shortly after Landis left. "He told me to get out. He told me it was because of the nature of the problem and the suspicion I had AIDS that I could be contaminating the other patients. He didn't seem to care if I might be contaminating the public. It was snowing Tuesday night and it was cold and windy. You wouldn't put a dog out on a night like that, but they put me out." John was discharged from the hospital and then had to walk home, even though it is hospital policy to try to find transportation for patients who have no means of getting home. Walden said the physicians involved apparently misinterpreted the hospital's guidelines regarding AIDS or suspected AIDS patients. She added that the patient is back in the hospital and has been given a private room and is not in isolation. Walden said the hospital undertook a comprehensive training program last summer which covered the medical issues as well as "trying to instill in hospital workers they need not be unduly concerned with treating ADIS patients." Larry Kessler, the coordinator of the Boston AIDS Action Committee (BAAC) said the hospital administration informed them of the incident before it was published in the Globe. Kessler said the incident underscores the need for ongoing educatin programs, particularly to cover new personnel. He said Boston City Hospital has a high turnover. "We should be asking ourselves: 'Have we trained them today?'" Kessler said that Lewis Pollack, the commissioner of Health and Hospitals couldn't have been more cooperative. Several representatives of the lesbian & gay community met with Pollack, and will take part in a training program to reacquaint hospital residents with the psychosocial dimensions of AIDS. "We will [also] discuss homophobia," Kessler said. Training will be instituted on an ongoing basis for all hospital personnel with he input of the gay community, including persons with AIDS.

* * *

PASTORAL CARE FOR AIDS PATIENTS

AID Atlanta executive director Ken South, M.Div., recently announced the publication of "Pastoral Care to People With AIDS--A Ministry of Reconciliation," a seven page booklet aimed at clergy to sensitize them to the complex personal and spiritual issues that surround the disease AIDS. A 50¢ donation is requested for a copy of the brochure, and a large (6 x 9 inch) self addressed, stamped (37¢ until new postage rates become effective!) envelop would be appreciated. Send your request to: AID Atlanta, 1132 W. Peachtree St., NW, Suite 112, Atlanta, GA 30309.

* * *

AID ATLANTA TEACHES CLERGY ABOUT AIDS

with thanks from AID Atlanta Newsletter, Fall, 1984

Over the years, AID Atlanta (AIDA), through its Education Committee has provided a wide range of educational opportunities to area health care institutions. In-service training programs have been presented to physicians, nurses, social workers, and psychologists. For the first time, pastoral counselors, chaplains and community clergy have been added to the groups being sensitized to the needs of persons with AIDS (PWAs). Rev. Ken South, a pastoral counselor with three years of hospital chaplaincy experience, has developed and begun offering a three-part course on "Pastoral Care to AIDS Patients." The program is specifically designed to help hospital clergy better understand not only the disease of AIDS but the unique social and spiritual needs of the AIDS patient. Presented as a three-part program, with each segment designed to last for one and a half hours, conducted in the hospital setting, the course provides a medical overview, a session focusing on the specific needs of the AIDS patient and a final session suggesting pastoral roles for a pastoral care provider in helping not only the person with AIDS, but their lovers, friends, and family members as well. For additional information, contact Ken South, AIDA, 1132 W. Peachtree St., NE, #112, Atlanta, GA 30309, 404/872-0600.

* * *

CHURCHGOERS UPSET OVER VICAR'S AIDS

The death of a homosexual vicar from AIDS has Chelmsford, England churchgoers who shared his communion wine cup fearful they may contract the illness. "We are getting phone calls from respectable church ladies who have sipped wine from the same cup as the Rev. Gregory Richards at Holy Communion," said Tony Kirkland, medical officer for the mid-Essex area, 30 miles northeast of London. "They are worried they may have picked up the infection, but I can assure them there is absolutely nothing for them to worry about."

* * *

DISCRIMINATION ALLEGED AT NEW YORK JACK-OFF CLUB

by Jan Carl Park, with thanks to The New York Native, 12/17-30/84

David Summers and Sal Licata have enjoyed the safe-sex gatherings of an organization called the New York Jacks, a private club of men whose "preferred sexual expression" is jerking off with a group of "like-minded men." The Jacks celebrate their fifth anniversary in February. Unlike other JO clubs, the Jacks was originally founded not to counter the growing threat of AIDS but to establish an environment where men who view JO "not as a limitation of sex but as a fully satisfying expression of it" could meet and form a network of JO enthusiasts. The code for club functions, read orally to newcomers as well as given to them in print, reads as follows: 1) The doors will be open only during the first 30 minutes of an event. Latecomers will not be admitted. 2) Street clothing, including pants, must be checked on entering. 3) Activity is strictly JO. No oral or anal sex or ass play permitted. No piss scenes. 4) Guests must arrive at the door with their member hosts. 5) Each member is responsible for his guest's behavior all evening. 6) Tipping of the bartenders and coatcheck is encouraged. 7) Relax and enjoy yourself. We're all friendly and horny! We must exercise caution in our 'safe sex' behaviour. Thus it is appropriate to redefine our restriction on exchange of body fluids to include saliva (no French kissing, no spit as lube) and sweat (no oral titplay, no tonguing). Summers, who was diagnosed with AIDS in February, 1984, applied for membership in August, accompanying his lover, Licata, to the group's activities, since Licata is a member. On November 26th, Summers was denied membership due to the allegation of infraction of club rules about "exchanging body fluids"--specifically, by allowing someone to suck on his tits. The November rules published by the Jacks on "tit sucking" were not in effect at the time of Summers' "transgression," nor were they articulated to him or any other member prior to the occurence. Summers could only conclude that he was being denied admission "solely on the fact that I have AIDS." When asked if the Jacks would affirm the rights of People With AIDS (PWA) to become members of the club, a spokesperson stated, "We have no policy on that issue." When asked if there are currently members of the Jacks with AIDS, the spokesman had no comment. Legally, the Jacks can discriminate against people with AIDS if they choose to. Steven Gittelson of New York's Gay Men's Health Crisis' Legal Services noted that JO clubs in San Francisco publicly state that PWAs are welcome to join in thier safe sex activities.

* * *

PHOBIA AGAINST AIDS AFFECTS HEALTH

by Mark Scott, with thanks to The Washington Blade, 1/4/85

Preliminary findings from a study of "AIDS anxiety" by two Georgetown University researchers indicate that excessive fear of contracting the syndrome manifests itself in depression, phobias, and psycosomatic disorders. Psychologist Richard Filson and psychiatrist Charles Tartaglia, both specialists in behavioral medicine and psychosomatic illness, have nearly completed a study of two groups of gay and bisexual men begun in October [reported in last issue of Newsletter]. Using standard psychological diagnostic tests, the researchers screened about 20 men who reported being preoccupied with developing AIDS "even when they were reassured [of their good health] by their physicians." They also tested about 20 men who reported no excessive fear of AIDS. "What we found was that [the preoccupied group] was significantly more depressed and generally more anxious," said Filson. "They tend to be 'somatizers'--they tend to adapt to stress by focusing on physical concerns. They are bothered by intruding thoughts about AIDS." Filson said some study participants appeared to focus anxiety stemming from other problems--such as family or job conflicts--into AIDS phobia. "I have seen some of these people in therapy, and as you work through their real conflicts, their [phobic] concerns about getting AIDS tend to decrease." he said. Filson said he hopes to present the study results at an upcoming CDC International AIDS Conference [see elsewhere in Newsletter]. The information could help physicians and mental health workers understand and relieve their patients' AIDS anxiety, he said.

* * *

HYSTERIA ABOUT AIDS RAMPANT IN SAN FRANCISCO

by Mark Scott and Tam Cummings, with thanks to The Washington Blade, 1/4/85

The number of gay-related discrimination complaints to the San Francisco Human Rights Commission increased by nearly 50% in 1984 from the previous year--in some measure because of fear of AIDS, reports the Bay Area Reporter. "We are hearing from gay people who are fired when they take a few days of sick leave because they have the flu," said Eileen Gillis, a staff member of the HRC's lesbian/gay unit and author of a report detailing anti-gay discrimination complaints in 1984. Gillis said complaints to the HRC totaled 123 last year, up from 87 in 1983. Thirteen of the complaints in 1984 had to do with AIDS fears on the part of employers. The 123 gay-related complaints exceeded the number of complaints made on the basis of all other kinds of discrimination.

* * *

GAY BUSINESSES AFFECTED BY FEAR IN SAN FRANCISCO

by Mark Scott and Tam Cummings, with thanks to The Washington Blade, 1/4/85

Business owners along San Francisco's Castro Street shopping district say non-gays, fearful of contracting AIDS, are staying away from the district's business, The New York Times reports. "Straight people don't want to try on clothes that gays have put on, and many straights just aren't coming here any more," said Dennis Mitchell, openly gay owner of a Castro Street clothing store. "Stores are closing, and chain stores are taking over." To cope with the decrease in business, store owners say they are considering moving, opening branches in other parts of the city, or changing their product lines to attract new customers. Some gay business owners blamed recession conditions and gays' closet mentality, rather than AIDS, for the decline in sales. "Too many gay-owned businesses hide the fact that they are [gay], and big corporations tend to ignore or look down on us," said Mark Cristofer, manager of a gift store which is one of Castro Street's largest retailers. "We plan to be different from other gay companies by being an openly gay corporation serving gays, both male and female, and we will reinvest part of our revenues to help gay people."

* * * * *

BOSTON HOSPITAL WORKER GETS AIDS

by Tam Cummings, with thanks to The Washington Blade, 12/14/84

A Boston medical technician who has been diagnosed with AIDS said that he believes he contracted it after accidentally pricking himself with a needle while drawing blood samples from an AIDS patient, reports the Associated Press. Massachusetts state epidemiologist Dr. George Grady said he believes there was a 50-50 chance the man contracted AIDS in that manner. Previous studies have indicated that lab and hospital workers face little risk of contracting AIDS from their work contact patients. The patient is listed in poor condition at the New England Medical Center intensive care unit.

* * *

LESBIAN BLOOD REFUSED

by Sue Hyde, with thanks to Boston's Gay Community News, 1/26/85

A late December blood drive to collect donations form lesbians was cancelled by a Santa Ana (California) Red Cross official because he feared the consequences of publicity identifying the drive's sponsor as the Gay and Lesbian Community Services Center of Orange County. Dr. Benjamin Spindler said that publicity which announced a "gay and lesbian blood drive" would damage the reputation of the Orange County Red Cross and cause the public to question whether Spindler could adequately protect the blood supply from contamination by HTLV-III, the virus suspected of causing AIDS. Spindler is director of the Orange County Red Cross blood services. The blood drive was cancelled 3 days before its scheduled time. Dr. A. Randy Truax, a San Diego physician specializing in gay health issues, sharply criticized Spindler's move in the New York Times, calling it "blatant homophobia." He noted that the rejected blood from the lesbians was very low risk. "Not only are they turning away precious blood donations which they need," Truax stated, "but they are also turning away the very safest blood." Randy Pesqueira, the coordinator of the gay and lesbian center's AIDS Reponse Program, said he believes Spindler missed an opportunity to educate thousands of people about the safety of blood donated by lesbians. Pesqueira thinks Spindler's actions were prompted both by his own homophobia and by a communications snafu between Spindler and his staff.

* * *

PROSTITUTE HANDCUFFED & HARASSED IN AIDS SCARE

by Ron Baker, with thanks to the New York Native, 1/28-2/10/85

A prostitute suspected of having AIDS was arrested by San Francisco police, handcuffed, and forced to undergo screening for the disease at a local hospital. The woman is an IV drug user whose boyfriend has been diagnosed as having AIDS. The incident raises disturbing questions about the civil liberties of individuals whom police or other authorities might want to have tested for the so-called AIDS virus. Dr. Paul Volberding, chief of the AIDS clinic where the woman was screened, said he felt it was "inappropriate" for police to force someone to undergo screening. Local press stories quoted the prostitute as saying she would continue to solicit customers because she had no other way to earn a living. Her fellow prostitutes, however, forced her off the streets and threatened her, she said, because she "hurt business." Since then, the San Francisco AIDS Foundation has helped the woman get on welfare and has enrolled her and her boyfriend in a drug rehab program. Volberding said that far too much media attention had been given to the possible danger posed by this individual prostitute. "If you are heterosexual and you do not use prostitutes and you [meet] all your sexual contacts at singles bars, you should still consider yourself at some risk of contracting AIDS. Anyone who has been sexually active with multiple partners should be considered at increased risk for carrying the AIDS virus. That removes the burden of carrying the AIDS virus from prostitutes and puts it on everyone."

* * * * *

RECORD STORE PICKETED FOR SELLING ANTI-GAY, ANTI-PEOPLE WITH AIDS ALBUMS

reprinted with thanks from the Shanti Project Newsletter, January, 1985

San Francisco record store Butch Wax (on 18th Street) has received attention lately for continuing to sell records by entertainers Eddie Murphy and Donna Summers. Both have made derogatory remarks against gays and specifically people with AIDS. When approached by a customer, one clerk remarked "Who cares?" to his suggestion they remove the artists' records from sale. An informational picket line was conducted by some PWAs and concerned friends. They were well received by passers-by, and were able to raise the consciousness of many. No work though on whether those artist's recordings were pulled by the record store.

* * * * *

HEALTH WORKER'S AIDS PROMPTS INVESTIGATION

by Christine Guilfoy, with thanks to Boston's Gay Community News, 12/29/84-1/5/85

A commercial laboratory worker has been diagnosed as having AIDS, prompting an investigation to determine if the illness could have been contracted in the course of his work. To date, there has been no documented case of a health care worker's contracting AIDS as a result of occupational exposure. The Boston case is currently under investigation by federal, state, and local officials. The man, now in a coma, reportedly told his doctors that he was not a member of any high risk group. He did report two "needle stick" accidents which occurred in the course of his lab work last spring. Further details have been unavailable, both because the man has been unable to answer questions, and also, say investigators, because his rights to privacy may be violated if more information is released. The case is being investigated by Kenneth Castro of the CDC, George Grady of the Massachusetts Department of Public Health, and George Seage, AIDS epidemiologist for the city of Boston. Although the CDC has counted 232 health care workers among its number of AIDS cases, all but 23 of them are also members of high risk groups. In these cases, no clear link can be established between occupation and onset of AIDS. Of the 23 who are health care workers but are not in a high risk group, the CDC has been unable to establish a clear link in how the disease was contracted. In some cases, the health care worker had no direct contact with people with AIDS or their blood products. According to a summary of an article in Lancet, a nurse in Britain was stuck with a needle containing the blood of a woman with AIDS which had probably been contracted in Africa. Thirteen days after the needle stick, the nurse developed flu-like symptoms, a fever and swollen lymph nodes. The nurse showed evidence of HTLV-III antibodies 7 weeks after the accident, about 5 weeks after the onset of her illness. That the British nurse was infected with the virus after one needle stick, while US health care workers have not shown evidence of infection after a similar accident, led the British researchers to speculate that the African strain of the virus may be more virulent. However, they also speculate that the fact that in this case it was fresh blood and had been drawn from an artery may also be a factor. The nurse who was infected is now healthy. Ken Mayer, MD, research director of the Fenway Community Health Center and an AIDS researcher, said, "We don't know if all exposures are equal.... It may be that if you are exposed in a certain way, you may not get AIDS."

* * *

SMALL TOWN LIBRARIES BENEFIT FROM AIDS LITERATURE

by Tam Cummings, with thanks to The Washington Blade, 1/11/85

Interest in the AIDS epidemic may make it easier for librarians in small towns to start Gay literature collections, but such libraries still face problems more than 40 librarians concluded during a workshop sponsored by the Gay Task Force of the American Library Association. Susan Bryson, a lesbian librarian from Emmitsburg, Maryland, conducted the workshop, held during the ALA's midwinter convention at Washington, DC's Shoreham Hotel. Bryson said she held the workshop on starting gay collections in small town libraries because of difficulties she experienced with her own library. "The problem with a small town is that everyone knows everything about everyone else," Bryson, 24, said. "Many small town librarians are not professionals...and there is frequently limited space, limited funds, and no [book] selection policy." Increased interest in the AIDS epidemic may enable some small-town librarians to find space and funds for books on AIDS and other gay subjects, but the fear of being discovered as gay in a small town also means no one may check out such materials for fear of having their names discovered on the check out list. "The community will argue that there is no need for the materials since there are no requests," she said. "And the presence of the books can cause a small library to lose its biggest supporters," such as social clubs which donate time, money, and books to the libraries. Bryson said the threat of losing support and funds causes both gay and heterosexual librarians to "tread more carefully" when ordering new books.

* * *

RURAL FLORIDA TOWN RATE OF AIDS EQUAL TO SAN FRANCISCO

by Charles L. Ortleb, with thanks to The New York Native, 12/3-16/84

Belle Glade, a small town that is an hour and a half away from Miami has a rate of AIDS that could be as high as two per thousand, according to a tropical disease specialist who conducts an AIDS clinic for the community. In this small town in the heart of a rural sugar cane processing area of Florida, 25 AIDS cases have been diagnosed, and another 25 are "probable AIDS cases," according to Dr. Mark Whiteside, co-director of the Institute of Tropical Medicine in Miami. There is a high level of poverty in Belle Glade, with between 5-8000 Haitian immigrants settling there, and with several thousand Jamaicans flown in yearly as agricultural laborers. Most of the early AIDS cases occurred among either IV drug users or Haitian immigrants. Whiteside wants to look at water, food supply, and refuse, along with the rodent population, since he is especially interested in the possibilities of animal or insect vectors in the disease. He would also like to determine the role in AIDS of "immunologic enhancement," the theory that antibodies formed against one virus enhance the ability of another virus to infect an individual.

* * *

PUERTO RICAN HEALTH DEPARTMENT WORKING ON AIDS

by Lewis Medina, with thanks to The New York Native, 12/3-16/84

Several groups of homosexuals in Mayaguez in Western Puerto Rico say they are concerned by the lack of orientation they have received about AIDS and other STDs. Although authorities at the Dept. of Health of the Commonwealth of Puerto Rico are responsible for providing adequate information to the general public about health issues, it was found that they have been concentrating their efforts on certain geographical areas and are forgetting others. Health department officials have given 20 conferences in the San Juan metro area, in homes, bars, and other places frequented by area gay men; they also established a free hotline. But in Mayaguez, 60 miles away, homosexuals don't know anything about the government's work. Moraima Ramirez, Director of the Dept. of Health's Western Region maintains that area gays have shown little interest in learning about AIDS or other STDs. Only the Lions Club in San German has requested information to make an orientation campaign in their town.

* * *

SUICIDE AMONG PWAs INVESTIGATED

with thanks to The New York Native, 11/19-12/2/84

A few cases of suicide among AIDS patients have been reported from Sweden, but as far as I know, there have been no reports in the U.S. of suicide among patients with AIDS or AIDS related syndromes (in lay or medical reports). However, notice about several cases have reached me via the grapevine, and I suspect that there may be many more. I suspect that the motivation behind the underreporting may be due to a desire to avoid the fact that the overwhelming majority of people with AIDS or AIDS Related Complex are grievously depressed, and are not getting treated for that. Perry and Tross found a mood distrubance in 82.7% of cases, though only 19.2% were referred for psychiatric consultation, and only 1.9% received a psychiatric diagnosis (Public Health Reports, 1984, 99:200-05). In the interest of accurately reporting the epidemiologic features of AIDS, I am collecting information on suicide among such patients, and would appreciate it if notice of such cases could be forwarded to me. The reports should be anonymous, and should contain as much as is available of the following: age; time of diagnosis of AIDS or ARC (please specify diagnosis); previous suicide attempts or treatment for depression; time and method of suicide; and contents of suicide notes left behind (purged of identifying data). Please send to: Casper G. Schmidt, MD, PO Box 314, New York, NY 10024. They will be treated with confidentiality, and will not be used for publication unless I recieve written permission to do so.

* * *

IMPACT OF AIDS ON COMPANIONSHIP-SEEKING BEHAVIORS IN GAY MEN

excerpted from the Newsletter of the Association of Lesbian & Gay Psychologists, volume 10:4, November, 1984.

[The following abstract was presented at the 1984 annual convention of the American Psychological Association held in Toronto. It is reprinted with thanks to the authors and ALGP.] "The Impact of AIDS on Gay Men's Companionship-Seeking Behaviors and Life Patterns," by A. Chris Downs and Margaret A. Zigman. The vast majority of studies examining the impact of AIDS have focused on medical, stress, or mental health issues. In contracst, little is known about actual changes in either life patterns or interpersonal behaviors due to the onset of AOIS. We indirectly assessed changes in companionship-seeking behaviors by content analysis of the personals ads appearing in The Advocate. One issue for each of 11 years (1974-84) were analyzed for ads emphasizing physical/personal attributes, sexual intersts, hobbies and lifestyle, personality characteristics, health relationship-seeking, interest in bars, baths, etc., and drug use. A total of 45 separate categories were used. Over 4000 ads were coded and analyzed for shifts in categories as a function of public knowledge of AIDS in 1981. Briefly, the findings revealed all of the following changes when comparing pre-1981 to post-1981 ads: personal/physical descriptions have become more detailed, ads stressing S & M and group sex have declined, a larger percentage of ads now stress hobbies, lifestyle and personality characteristics, health-consciousness has increased, greater emphasis is now placed on finding and maintaining friendships and relationships, and ads discouraging drug use and "bar-hopping" have increased dramatically. While The Advocate personal ads have historically been a "sexual marketplace" for the most part, and consequently the probability of detecting change in this source seems remote, the large shifts found in this study suggest that even greater changes in both lifestyle and companionship-seeking may be occurring in the gay community.

"AIDS and Male Prostitution: Responses of Models/Massuers/Escorts to the Health Crisis in the Gay Community," by A. Chris Downs and Margaret A. Zigman. The male prostitute (also known as model, masseurs, escorts) seemingly has a unique and perilous position during the health crisis due to the onset of AIDS. Namely, prior to AIDS male prostitutes apparently ran risks comparable to those encountered by female prostitutes: violence, police arrest/harassment, non-life-threatening STDs, etc. With the onset of public awareness of AIDS (about 1981), a new and decidedly life-threatening risk emerged. Since AIDS Apparently is more threatening to gay men (or those sexually associated with them) than to women or heterosexual men, the male prostitute who serves a gay male clientele would appear to be at far greater risk. Indeed, it would seem that male prostitutes might 1) curtail or cease their activities, 2) alter their sexual activities in ways that would limit transmission of body fluids (e.g., specialize in body worship, mutual masterbation, etc.) and 3) seek clientele who are also health-conscious. In order to assess changes in the male prostitute's claimed activities (as opposed to what they actually do) we examined ads appearing in the "Pink Pages" of The Advocate. One issue for each of 11 years (1974-84) were analyzed for all of the 45 categories described in the above paper. Over 4000 ads were coded and analyzed. The findings revealed many more ad placers since 1982 stressed their health status and nondrug use than in earlier years. Further, ads were more likely to encourage no body contact, body worship, and masturbation since 1982. These findings reveal that male prostitutes who advertise are advertising in ways that are responsive to the health crisis. Actual ad to behavior consistency for these men is unknown: saying that one wants limited body contact and actually limiting the contact may be entirely different things. At the very least, the present data suggest that male prostitutes are showing some health-consciousness which hopefully is translated into actual behavior.

For more information about the Association of Lesbian & Gay Psychologists, write: ALGP, 210 Fifth Av., New York, NY 10010.

* * * * *

STD 85 PREVENTION/TRAINING CLINICS

Enclosed with this Newsletter for STD Services ONLY, are brochures describing the CDC's STD Control Division's 1985 STD Prevention/Training Clinics in nine cities. If you did not receive the brochure, send a self-addressed, business envelope with 40¢ postage, to: NCGSTDS, PO Box 239, Milwaukee, WI 53201.

* * * * * * * * *

PSYCHOLOGICAL BATTLEZONE FOR GAY MEN BECAUSE OF AIDS

by Mark Scott, with thanks to The Washington Blade, 11/23/84

Life is a "psychological battlezone" for gay men living in San Francisco where AIDS kills one person a day, said psychotherapist Stephen Morin at an American Psychological Association briefing on the psycho-social aspects of the epidemic. Morin, president of the APA's newly formed Society for the Psychological Study of Lesbian and Gay Issues, said University of California San Francisco surveys of gay men in that city show widespread grief and anxiety over the AIDS crisis, which has claimed thousands of lives nationwide. "The most common emotions are depression for the people who've died and anger at the government for being slow to act," Morin said. Surveys circulated among approximately 800 gay men May, 1984, show a dramatic reduction in the number of sex partners (from an average of 6 per month before the crisis to an average of 3.9 per month presently), and the adoption of safer sex practices. Morin suggested that gays anxious about developing AIDS try to reduce stress and channel nervous energy into healthy behaviour--"walking, meditating, versus drinking, smoking, looking for sex." Dr. Jill Joseph,a social epidemiologist with the University of Michigan, believed that more research needs to be done on the difficult mental task of altering habitual sexual behavior. "We know from smoking [studies] that change is difficult, and maintaining change is difficult," Joseph said. Joseph is currently researching behavioral changes in about 1000 gay volunteers in a Chicago AIDS study. Joseph and Morin are also studying whether anxiety and depression significantly influence the onset or progression of AIDS. According to a Columbia University School of Public Health study published in the November, 1984 issues of APA's American Psychologist, stress and depression may make individuals more vulnerable to immune system deficiencies. People who already have AIDS face something "bigger than the disease itself," said Walter Batchelor, APA Health Policy Programs Officer, and a member of the board of directors for the AIDS Action Council of the Federation of AIDS Related Organizations. Fears of rejection and discrimination, said Batchelor, often keep people with AIDS From discussion their condition with others.

* * *

OPEN LETTER TO THE NEW ENGLAND JOURNAL OF MEDICINE

by John Whyte, MD, PhD, Tufts-New England Medical Center, Boston, with thanks to The New York Native, 1/14-27/85

To the Editor: Several articles in a recent issue [311] of the NEJM present a cause for optimism in the understanding and control of AIDS. The evidence appears to be building for a causal role of HTLV-III/LAV in the AIDS epidemic. Indeed, the editorial in this same issue suggests that we have "the knowledge and the scientists needed to turn scientific medical questions into a predictable series of efforts in problem solving." This background of optimism seems based on confidence in modern biotechnology. Yet AIDS has been, from the outset, an illness with profound cultural, political, religious, and economic ramifications. This is true to some degree with all health issues, and the inadequate attention paid to these social factors is a frequent topic of discussion in medical education and practice. Nevertheless, the occurrence of AIDS in gay men and IV drug users and its connection to sexual behavior place the social/cultural aspects of this disease in bold relief. I was troubled that an editorial entitled, "What Are We Going to Do About AIDS and HTLV-III/LAV Infection?" considered only technical solutions and failed to acknowledge crucial obstacles in their way. Behavior change and public education have already begun, organized primarily from within the gay community, and may have important impact on AIDS incidence long before a vaccine is available. Some writers in the gay press have even argued that the publicity surrounding the promised vaccine is leading to an increase in transmission by allowing unfounded optimism. It is also clear that the research needed to address the scientific aspects of AIDS may be severely limited by political concerns about the use to which subjects' HTLV-III status may be put. Efforts are being made to protect confidentiality, but this still illustrates the need to consider AIDS in a broader context than immunologic science. I hope that future editorials about "What to Do..." will recognize that there are a multitude of levels on which things can be done, and multiple cultural factors that will directly affect the progress of the technological advances at hand.

* * * * *

CENTERS FOR DISEASE CONTROL

December 14, 1984 / Vol. 33 / No. 49

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Hepatitis B Vaccine: Evidence Confirming Lack of AIDS Transmission

Recent studies have provided important additional assurances concerning the safety of hepatitis B (HB) vaccine. The vaccine currently licensed in the United States is produced from pooled plasma of hepatitis B surface antigen-positive individuals, some of whom are also in high-risk groups for acquired immunodeficiency syndrome (AIDS). Concern has been expressed that the etiologic agent of AIDS might be present in the vaccine and survive the inactivation steps used in the manufacturing procedure. The concerns persisted, despite the fact that these steps were reportedly able to inactivate representative members of all known virus groups. The recent identification of a retrovirus as the etiologic agent of AIDS has allowed workers to (1) directly test the inactivation of the AIDS virus by the inactivation steps used in the vaccine manufacturing procedure; (2) look for the AIDS virus' nucleic acid sequences in the vaccine; and (3) look for serologic markers of infection from the AIDS virus in vaccine recipients. Concurrently, monitoring of AIDS patients and high-risk groups has continued in order to look for any epidemiologic evidence of an association between HB vaccine and AIDS.

The effect of the HB vaccine inactivation process on the AIDS virus and two other human retroviruses (HTLV-I and HTLV-II) was studied. Three separate inactivation steps are used in the manufacture of the U.S.-licensed HB vaccine: (1) 1 μg/ml pepsin, pH 2, 37 C (98.6 F), 18 hours; (2) 8 molar urea, 37 C (98.6 F), 4 hours; and (3) 0.01% formaldehyde, 37 C (98.6 F), 72 hours. In separate studies conducted between CDC and the vaccine manufacturer Merck, Sharp & Dohme (MSD), and between State University of New York (SUNY) Upstate Medical Center and MSD, cell culture supernatant fluid containing the AIDS virus and cultured cells containing HTLV-I, HTLV-II, and the AIDS virus were transported to MSD and individually exposed to the three inactivation steps. The materials were then returned to CDC and SUNY for detection of residual viral infectivity. Virus infectivity was assayed by adding the treated material to cultured lymphocytes and periodically monitoring these for signs of viral replication (reverse transcriptase activity and virus antigen expression) (*1*) and in the case of HTLV-I and HTLV-II, transformation (*2,3*). No residual virus was detected in material treated with formalin or urea, while material treated with pepsin at pH 2 did have residual virus present. Heat, an inactivation step used in vaccines manufactured outside the United States, has also been shown to inactivate the AIDS virus (*4*).

The second approach, which attempted to detect AIDS virus-related nucleic acid sequences using dot blot hybridization analysis of the vaccine with an AIDS virus deoxyribonucleic acid (DNA) probe, was done at MSD using as a positive control infected cellular (ribonucleic acid) RNA preparations provided by CDC. The vaccine contained no detectable AIDS virus-related sequences at a sensitivity of less than one picogram of DNA per 20-μg dose of vaccine.

The third approach attempted to detect seroconversion to AIDS virus antibodies in paired sera of HB vaccine recipients. Paired sera were examined at CDC using a highly sensitive and specific ELISA assay for the AIDS virus. No seroconversions were detected in 19 individuals who had received vaccine manufactured from plasma pools that contained plasma of homosexual men. Previous workers have reported that sera of HB vaccine recipients did not show helper-T/supressor-T ratio inversion, a finding common in AIDS patients (*5*).

Epidemiologic approaches to detect an association between HB vaccine and AIDS have included analysis of data on AIDS cases reported to CDC concerning their receipt of HB vaccine and monitoring rates of AIDS in groups of homosexually active men who did or did not receive HB vaccine in the vaccine trials conducted by CDC in Denver, Colorado, and San Francisco, California. To date, 68 AIDS cases have been reported among approximately 700,000 U.S. HB vaccine recipients; 65 have occurred among persons with known AIDS risk factors, while risk factors for the remaining three are under investigation. In addition, the rate of AIDS for HB vaccine recipients in CDC vaccine trials among homosexually active men in Denver and San Francisco does not differ from that for men screened for possible participation in the trials but who received no HB vaccine because they were found immune to HB.

Reported by B Poiesz, MD, R Tomar, MD, B Lehr, J Moore, PhD, State University of New York Upstate Medical Center, Syracuse Veterans Administration Medical Center, Syracuse, New York; Merck, Sharp & Dohme Research Laboratories, West Point, Pennsylvania; AIDS Br, Hepatitis Br, Div of Viral Diseases, Center for Infectious Diseases, CDC.

Editorial Note: The Immunization Practices Advisory Committee (ACIP) (*6*) has recommended preexposure HB vaccination for susceptible members of the following groups in the United States: health-care workers (medical, dental, laboratory, and support groups) judged to have significant exposure to blood or blood products; clients and selected staff of institutions for the mentally retarded; hemodialysis patients; homosexually active males; users of illicit, injectable drugs; recipients of certain blood products (patients with clotting factor disorders); and household and sexual contacts of HB virus (HBV) carriers. In addition, vaccine may be warranted for classroom contacts of deinstitutionalized mentally retarded HBV carriers; special high-risk populations (Alaskan Eskimos and immigrants and refugees from areas with highly endemic disease); inmates of long-term correctional facilities; and some U.S. citizens living or traveling abroad (*7*). The ACIP has also recommended screening all pregnant women belonging to high-risk groups for HB and treating their newborn infants with hepatitis B immune globulin and HB vaccine (*8*).

HB vaccine acceptance in the United States has been seriously hindered by the fear of possible AIDS transmission from the vaccine. The recent identification of AIDS' etiologic agent has made possible direct laboratory measurement of virus inactivation, nucleic acid presence, and serologic evidence of infection. These studies were unable to detect the AIDS virus' viral protein or nucleic acid in the purified vaccine product and clearly indicate that if virus were present, it would be killed by the manufacturing procedures. In addition, epidemiologic monitoring of AIDS cases and high-risk groups confirms the lack of AIDS transmission by HB vaccine. This information should remove a major impediment to vaccine use.

References

1. Feorino PM, Kalyanaraman VS, Haverkos HW, et al. Lymphadenopathy associated virus infection of a blood donor-recipient pair with acquired immunodeficiency syndrome. Science 1984;225:69-72.
2. Poiesz BJ, Ruscetti FW, Gazdar AF, Bunn PA, Minna JD, Gallo RC. Detection and isolation of type C retrovirus particles from fresh and cultured lymphocytes of a patient with cutaneous T-cell lymphoma. Medical Sci 1980;77:7415-9.
3. Kalyanaraman VS, Sarngadharan MG, Robert-Guroff RM, et al. A new subtype of human T-cell leukemia virus (HTLV-II) associated with a T-cell variant of hairy cell leukemia. Science 1982;218:571-3.
4. CDC. Update: acquired immunodeficiency syndrome (AIDS) in persons with hemophilia. MMWR 1984;33:589-91.
5. Jacobson IM, Dienstag JL, Zachoval R, Hanrahan BA, Watkins E, Rubin RH. Lack of effect of hepatitis B vaccine on T-cell phenotypes. N Engl J Med 1984;311:1030-2.
6. ACIP. Inactivated hepatitis B virus vaccine. MMWR 1982;31:317-22, 327-8.
7. CDC. Adult immunization: recommendations of the Immunization Practices Advisory Committee (ACIP). MMWR 1984;33:1S-68S.
8. ACIP. Post-exposure prophylaxis of hepatitis B. MMWR 1984;33:285-90.

CENTERS FOR DISEASE CONTROL

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

October 26, 1984 / Vol. 33 / No. 42

Current Trends

Update: Acquired Immunodeficiency Syndrome (AIDS) in Persons with Hemophilia

Reports of hemophilia-associated acquired immunodeficiency syndrome (AIDS) in the United States were first published in July 1982 (*1*). Since then, the number of U.S. patients with underlying coagulation disorders who develop AIDS has increased each year. In 1981, one U.S. case was reported; in 1982, eight; in 1983, 14; and, as of October 15, 29 cases have been reported in 1984, for a total of 52 cases (Figure 1). Two of these 52 patients had hemophilia B; one, a factor V deficiency; and one, factor VIII deficiency due to her postpartum acquisition of a factor VIII inhibitor. The remaining 48 cases occurred among hemophilia A patients. Three patients are known to have had risk factors for AIDS other than hemophilia. These 52 persons resided in 22 states. Only 10 states have reported more than one case, and no state has reported more than eight cases.

With the exception of one 31-year-old factor V-deficient individual with Kaposi's sarcoma (and without risk factors for AIDS other than his hemophilia), each patient had at least one opportunistic infection suggestive of an underlying cellular immune deficiency. *Pneumocystis carinii* pneumonia has been the most common opportunistic infection, occurring in 44 (85%) of the 52 patients. Other opportunistic infections have included toxoplasmic encephalitis (two cases), disseminated *Mycobacterium avium intracellulare* (one), disseminated cytomegalovirus infection (two), disseminated candidiasis (one), and cryptococcal meningitis (one). Thirty hemophilia patients with AIDS have died; only three of the survivors were diagnosed more than 1 year ago.

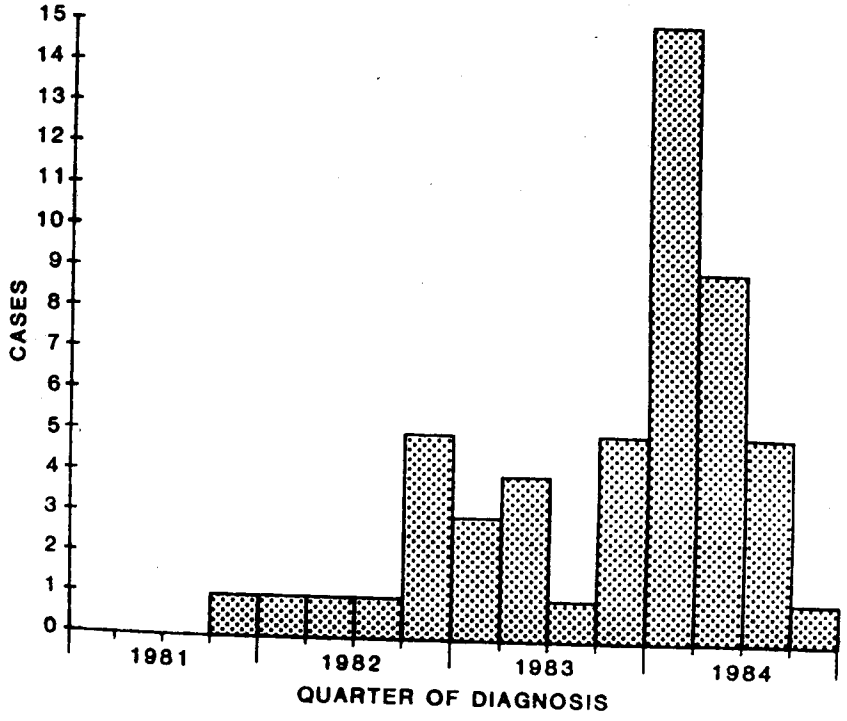
CDC has investigated the blood product usage of the majority of these cases. In nine cases, factor VIII concentrates have been the only blood product reportedly used in the 5 years before diagnosis of AIDS. These nine persons had no risk factors for AIDS other than hemophilia. The factor V-deficient patient with Kaposi's sarcoma had not used factor VIII concentrate products but had used large volumes of plasma and factor IX concentrates.

The sera of 22 (42%) of the 52 hemophilia-associated AIDS patients have been tested for antibody to antigens of the AIDS virus using Western blot analysis (*2*). Eighteen (82%) of these specimens contained antibody to one or more antigens (*2,3*). In cooperation with numerous hemophilia treatment centers and physicians, CDC has studied over 200 recipients of factor VIII and 36 recipients of factor IX concentrates containing materials from U.S. donors. Rates of AIDS virus antibody prevalence were 74% for factor VIII recipients and 39% for factor IX recipients (*3,4*). Only prospective evaluation will determine what risk of AIDS exists for seropositive individuals. A recently published study evaluated the thermostability of murine retroviruses inocculated into factor concentrates, using a cell transformation assay (*5*). After 48 hours at 68 C (154.4 F), viral titers dropped from 10^8 to two infectious particles/ml. In studies done at CDC, in cooperation with Cutter Laboratories, AIDS virus was added to factor VIII concentrate (virus titer 10^5) and the factor was lyophilized and heated to 68 C (154.4 F). The residual virus titer was determined by an infectivity assay (*6*). Virus was undetectable after 24 hours of heat treatment, the shortest time period examined.

Reported by P Levine, MD, Medical Director, National Hemophilia Foundation, New York City; Div of Host Factors, Center for Infectious Diseases, CDC.

Editorial Note: The possibility of blood or blood products being vehicles for AIDS transmission to hemophilia patients has been supported by the finding of risk of acquisition of AIDS for intravenous drug abusers (*7*) and, subsequently, by reports of transfusion-associated AIDS cases (*8*). The mainstays of therapy for the hemorrhagic phenomena of hemophilia are cryoprecipitate, fresh frozen plasma, and plasma factor preparations; these have been associated with the transmission of several known viral agents, including cytomegalovirus, hepatitis B virus, and the virus(es) of non-A, non-B hepatitis (*9*). While many U.S. hemophilia-associated AIDS patients have received blood products other than factor concentrates in the 5 years preceding their AIDS diagnosis, the occurrence of nine cases with no known risk factor or exposure other than the use of factor VIII preparations implicates these products as potential vehicles of AIDS transmission.

FIGURE 1. Hemophilia-associated acquired immunodeficiency syndrome (AIDS), by quarter — United States, 1981-October 15, 1984



The Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation (NHF) has recently issued revised recommendations for the therapy of hemophilia (*10*). To physicians treating patients with hemophilia, they recommend that (1) cryoprecipitate be used in factor VIII-deficient newborn infants and children under 4 years of age and in newly identified patients never treated with factor VIII concentrates; (2) fresh frozen plasma be used in factor IX-deficient patients in the same categories; and (3) desmopressin (DDAVP) be used whenever possible in patients with mild or moderate hemophilia A. The majority of hemophilia patients do not fit in categories (1) through (3). For these patients, MASAC recommends that, "because heat-treated products appear to have no increase in untoward effects attributable to the heat treatment, treaters using coagulation factor concentrates should strongly consider changing to heat-treated products with the understanding that protection against AIDS is yet to be proven." They also recommend that all elective surgical procedures for hemophilia patients be evaluated with respect to possible advantages and disadvantages of surgical delays.

Although the total number of hemophilia patients who have thus far developed clinical manifestations of AIDS is small relative to other AIDS risk groups, incidence rates for this group are high (3.6 cases/1,000 hemophilia A patients and 0.6/1,000 hemophilia B patients). Continued surveillance is important. Physicians diagnosing opportunistic infections or unusual neoplasms in hemophilia patients who have not received antecedent immunosuppressive therapy are requested to report these findings to local or state health departments and to CDC.

In March 1983, the U.S. Public Health Service recommended that members of groups at increased risk of acquiring AIDS should refrain from donating plasma and/or blood (*11*). A specific serologic test will soon become available for screening purposes, and thus a safer factor concentrate product should result. The preliminary evidence concerning the effects of heat-treatment on the viability of the AIDS virus is strongly supportive of the usefulness of heat-treatment in reducing the potential for transmission of the AIDS virus in factor concentrate products and suggest that the use of nonheat-treated factor concentrates should be limited. CDC and NHF will continue to study the effects of heat-treated factor on the immune status of patients with hemophilia.

References

1. CDC. *Pneumocystis carinii* pneumonia among persons with hemophilia A. MMWR 1982;31:365-7.
2. Tsang VC, Peralta JM, Simons AR. Enzyme-linked immunoelectrotransfer blot techniques (EITB) for studying the specificities of antigens and antibodies separated by gel electrophoresis. Methods Enzymol 1983;92:377-91.
3. Ramsey RB, Palmer EL, McDougal JS, et al. Antibody to lymphadenopathy-associated virus in haemophiliacs with and without AIDS. Lancet [Letter] 1984;II:397-8.
4. CDC. Unpublished data.
5. Levy JA, Mitra G, Mozen MM. Recovery and inactivation of infectious retroviruses from factor VIII concentrates. Lancet 1984;II:722-3.
6. McDougal JS, Cort SP, Kennedy MS, et al. Immunology for the detection and quantitation of infectious human retrovirus, lymphadenopathy-associated virus (LAV). J Immunol Methods (in press).
7. Spira TJ, Des Jarlais DC, Marmor M, et al. Prevalence of antibody to lymphadenopathy-associated virus among drug-detoxification patients in New York. N Engl J Med [Letter] 1984;311:467-8.
8. Curran JW, Lawrence DN, Jaffe H, et al. Acquired immunodeficiency syndrome (AIDS) associated with transfusions. N Engl J Med 1984;310:69-75.
9. Enck RE, Betts RF, Brown MR, Miller G. Viral serology (hepatitis B virus, cytomegalovirus, Epstein-Barr virus) and abnormal liver function tests in transfused patients with hereditary hemorrhagic diseases. Transfusion 1979;19:32-8.
10. National Hemophilia Foundation Medical and Scientific Advisory Council. Recommendations concerning AIDS and therapy of hemophilia (revised October 13, 1984). New York: National Hemophilia Foundation, 1984.
11. CDC. Prevention of acquired immune deficiency syndrome (AIDS): report of interagency recommendations. MMWR 1983;32:101-3.

Cryptosporidiosis among Children Attending Day-Care Centers — Georgia, Pennsylvania, Michigan, California, New Mexico

During 1984, CDC has received several reports of cryptosporidiosis among children attending day-care centers. Seven investigations conducted in five states are summarized below.

Georgia: *Investigation 1:* Two sisters, aged 2 years and 4 years, who attended an Atlanta day-care center, developed watery diarrhea in late February, and stool specimens showed *Cryptosporidium* oocysts. An investigation in April found that 27 (51%) of 53 persons had recent histories of diarrhea. Stool examinations of 50 children and 11 adult staff members revealed three other children with *Cryptosporidium*; all had recent histories of afebrile, diarrheal illness without nausea or vomiting. No asymptomatic children had cryptosporidiosis. One infected child also had *Giardia lamblia* cysts. Eight of 27 symptomatic and six of 26 asymptomatic persons had *Giardia*. Symptomatic persons had mild-to-moderate diarrhea, and most sought medical attention. No one was hospitalized.

Investigation 2: On August 27, a 2-year-old day-care center attendee in Atlanta developed severe, watery diarrhea. Stool examination on September 6 showed *Cryptosporidium*. Thus far, four (17%) of 23 children from the same room who were examined have had *Cryptosporidium*. Two of 12 children tested in other rooms at the day-care center had *Cryptosporidium*; both children were siblings of infected children in the original room. Two of the six infected children had no histories of diarrhea and were asypmtomatic at the time of the investigation; the others had mild-to-moderate diarrhea without fever. None required hospitalization, and two children were seen by physicians.

Pennsylvania: Beginning in June, the rate of diarrheal illness increased at a day-care center in Philadelphia, where 20 (34%) of 59 children were symptomatic. Stool specimens obtained from 45 children were examined for enteropathogenic bacteria, viruses, and parasites. Eleven (65%) of 17 symptomatic children and three (11%) of 28 asymptomatic children had *Cryptosporidium*. Enteropathogenic bacteria and viruses were not implicated in the outbreak (*1*).

Michigan: In September, an investigation of day-care-center-associated diarrhea in Ann Arbor found a 2-year-old with cryptosporidiosis. Review of the day-care center's records showed an increase of diarrhea among children from three rooms—two for toddler-aged children, and one for infants. Stool specimens were obtained from 38 (70%) of the 54 children in the three affected rooms and examined for parasites, *Salmonella, Shigella, Campylobacter,* and rotavirus; 21 (55%) had *Cryptosporidium*. One of these children also had *Salmonella*; another also had *Giardia*. Infected children generally had mild-to-moderate diarrhea without fever; none required hospitalization, and three children saw physicians.

California: On September 14, a 2-year-old child with a diarrheal illness who regularly attends a day-care center in San Carlos was found to have cryptosporidiosis. A survey showed that children with recent histories of diarrhea were limited to the classroom with the index child, where 10 of 11 classmates had been symptomatic. Stool specimens from all 11 children were examined for *Salmonella, Shigella, Campylobacter, Yersinia, Vibrio, Aeromonas, Edwardsiella, Plesiomonas,* and parasites. Six of 10 specimens from symptomatic children were positive for *Cryptosporidium*. *Yersinia enterocolitica* serotype 5,27 was recovered from one currently asymptomatic child who had symptoms earlier. No other bacterial pathogens were isolated. The asymptomatic child had a negative stool examination. Three parents (including both parents of the index patient), who later developed diarrhea, were positive for *Cryptosporidium*. Parents of children reported mild-to-moderate diarrhea, and most persons required medical care. No one was hospitalized.

New Mexico: During September, investigation of giardiasis in two children led to the discovery of widespread diarrheal disease in two day-care centers in Albuquerque.

Investigation 1: Eighteen (47%) of 38 children attending a day-care center had recently had diarrhea. Stool specimens from 17 symptomatic and one asymptomatic child were examined for parasites. *Cryptosporidium* alone was found in specimens from four symptomatic children. Five children had *Giardia* only; one child was infected with both parasites. Only two of six specimens with *Giardia* were examined for *Cryptosporidium*. Stool specimens were submitted by 11 household members of symptomatic children. Of seven household members reporting recent diarrheal illness, one had *Cryptosporidium*, and two had *Giardia*; one asymptomatic adult had *Giardia*. Children and adults reported mild but sometimes prolonged diarrhea, and no one was hospitalized.

Investigation 2: In this day-care center, diarrheal illness was limited to the classroom for toddler-aged children. Thirteen (81%) of 16 children and one of three adults reported recent diarrhea. Of stool specimens from 13 children examined so far, five have shown *Cryptosporidium* only, and four, *Giardia* only. Two additional children had both parasites. Two of the specimens with *Giardia* were not examined for *Cryptosporidium*.

Reported by G Bohan, MD, DeKalb County Health Dept, RK Sikes, DVM, State Epidemiologist, Georgia Dept of Human Resources; G Alpert, MD, L Bell, MD, CE Kirkpatrick, MD, JM Campos, PhD, HM Friedman, MD, SA Plotkin, MD, Children's Hospital of Philadelphia, LD Budnick, MD, RG Sharrar, MD, Philadelphia Dept of Health; ML Collinge, PhD, CL Combee, PhD, JA Gardner, MS, EM Britt, PhD, St Joseph Mercy Hospital, Ann Arbor, KR Wilcox, MD, State Epidemiologist, Michigan Dept of Health; J Bodie, MD, San Mateo County Health Dept, K Hadley, MD, San Francisco General Hospital, C Taclindo, MS, RR Roberto, MD, J Chin, MD, State Epidemiologist, California State Dept of Health Svcs; L Nims, MS, A Salas, HF Hull, MD, State Epidemiologist, New Mexico Health and Environment Dept; Protozoal Diseases Br, Div of Parasitic Diseases, Center for Infectious Diseases, Div of Field Svcs, Epidemiology Program Office, CDC.

Editorial Note: Outbreaks caused by a number of important infectious agents (including *Giardia, Shigella, Haemophilus influenza*, hepatitis A, rotavirus, and respiratory-tract viruses) have been documented in day-care centers (*2*). The investigations reported here suggest that the intestinal parasite *Cryptosporidium* should be added to this list. Although a few children had moderately severe diarrhea, none required hospitalization.

Cryptosporidium is a well-known cause of diarrhea in animals but has been recognized only recently as a cause of human disease. The first case of human cryptosporidiosis was reported in 1976; before 1982, literature exists on only seven human cases of cryptosporidiosis. Since 1982, the number of reported cases increased markedly (*3*). Initially, this increase was noted in patients with acquired immunodeficiency syndrome (AIDS), but recent reports indicate that cryptosporidiosis is common in immunologically normal persons (*4-6*). Patients with AIDS and cryptosporidiosis usually have severe, irreversible diarrhea, but persons with normal immunologic function have self-limited, although at times severe, diarrhea. The spectrum of illness caused by *Cryptosporodium* has yet to be clearly defined, and no satisfactory treatment is currently available.

Public health workers, physicians, parents, and day-care providers need to be alert to cryptospordiosis as a potential cause of outbreaks of diarrhea in day-care centers. Special concentration and staining techniques for the recovery and isolation of *Cryptosporodium* are required (*7,8*), and investigators should notify laboratory personnel that *Cryptosporodium* is considered a possible pathogen in outbreaks. Knowledge of how *Cryptosporidium* is transmitted in the day-care setting is presently lacking, and only general guildelines for the prevention and control of enteric infections are available. Cryptosporidiosis outbreaks in day-care centers should be reported to state and local health departments. CDC would also like to be notified so that the spectrum of illness of this organism in this setting can be further defined.

References

1. Alpert G, Bell LM, Kirkpatrick CE, et al. Cryptosporidiosis in a day-care center. N Engl J Med 1984;311:860-1.
2. Pickering LK, Woodward WE. Diarrhea in day care centers. Peditr Infect Dis 1982;1:47-52.
3. Navin TR, Juranek DD. Cryptosporidiosis: clinical, epidemiologic, and parasitologic review. Rev Infect Dis 1984;6:313-27.
4. Tzipori S, Smith M, Birch C, et al. Cryptosporidiosis in hospitalized patients with gastroenteritis. Am J Trop Med Hyg 1983;32:931-4.
5. Jokipii L, Pohjola S, Jokipii AM. Cryptosporidium: a frequent finding in patients with gastrointestinal symptoms. Lancet 1983;II:358-61.
6. Current WL, Reese NC, Ernst JV, Bailey WS, Heyman MB, Weinstein WM. Human cryptosporidiosis in immunocompetent and immunodeficient persons. Studies of an outbreak and experimental transmission. N Engl J Med 1983; 308:1252-7.
7. Ma P, Soave R. Three-step stool examination for cryptosporidiosis in 10 homosexual men with protracted watery diarrhea. J Infect Dis 1983;147:824-8.
8. Garcia LS, Bruckner DA, Brewer TC, Shimizu RY. Techniques for the recovery and identification of *Cryptosporodium* oocysts from stool specimens. J Clin Microbiol 1983;18:185-90.

CENTERS FOR DISEASE CONTROL

November 23, 1984 / Vol. 33 / No. 46

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Notice to Readers

Abstract Deadline for International Conference on Acquired Immunodeficiency Syndrome (AIDS)

December 10, 1984, is the deadline for receipt of abstracts to be considered for presentation at the International Conference on Acquired Immunodeficiency Syndrome (AIDS), which will be held in Atlanta, Georgia, at the Georgia World Congress Center on April 14-17, 1985. This conference will be sponsored by CDC, the Alcohol, Drug Abuse, and Mental Health Administration, the Food and Drug Administration, the Health Resources and Services Administration, the National Institutes of Health, and the World Health Organization in cooperation with Emory University School of Medicine and Morehouse School of Medicine. Inquiries related to the conference and the submission of abstracts should be directed to:

AIDS Conference Office
Centers for Disease Control
Building 1, Room 2047
Atlanta, Georgia 30333
(404) 321-2290 or FTS 236-2290

CENTERS FOR DISEASE CONTROL

November 30, 1984 / Vol. 33 / No. 47

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Current Trends

Update: Acquired Immunodeficiency Syndrome (AIDS) — United States

As of November 26, 1984, physicians and health departments in the United States had reported 6,993 patients meeting the surveillance definition for acquired immunodeficiency syndrome (*1,2*). Over 86% of the adult AIDS patients and 82% of the pediatric patients have been reported since January 1983 (Figure 1). Three thousand three hundred forty-two (48%) of all reported patients are known to have died (48% of the adults and 69% of the children), including 73% of patients diagnosed before January 1983.

Adult Patients: Among 6,921 adult AIDS patients, 59% of cases have occurred among whites; 25%, among blacks; 14%, among persons of Hispanic origin; and 2%, among persons of other or unknown race/ethnicity. Seventy-five percent of the adults were reported to be residents of New York, California, Florida, or New Jersey, with the remainder reported from 41 other states, the District of Columbia, and Puerto Rico. Identified risk groups of adult AIDS patients and trends for each group are shown in Table 1. Among the 54 AIDS patients who were heterosexual sex partners of persons with AIDS or with an increased risk for acquiring AIDS, 49 (91%) were women.

Of the adult AIDS patients, 263 (4%) have not been placed in any of the identified risk groups and are classified as noncharacteristic patients. One hundred eighty-six (71%) of the noncharacteristic patients were male; 34%, white; 43%, black; and 19%, of Hispanic origin. Investigations of 65 of the male noncharacteristic patients have identified 17 (26%) who reported a history of sexual contact with female prostitutes. Five of the 17 gave a history of over 100 heterosexual partners in the past 5 years. Seven were Hispanic; five, black; four, white; and one, Asian. Thirteen had *Pneumocystis carinii* pneumonia (PCP); three had Kaposi's sarcoma (KS); and one had another opportunistic disease. One of the nine noncharacteristic women interviewed claimed to be a former prostitute.

Pediatric Patients: Of 72 patients under 13 years of age, 81% were reported to be residents of New York, California, Florida, or New Jersey, with the remainder reported from nine other states. Forty-two (58%) of the 72 patients were male. Fifty (69%) had PCP without KS; four (6%) had KS without PCP; two (3%) had both PCP and KS; and 16 (22%) had another opportunistic disease without either PCP or KS. Twenty-five percent of the pediatric patients are white; 54%, black; and 19%, of Hispanic origin. Twenty-nine (40%) of the 72 pediatric patients came from families in which one or both parents had histories of intravenous (IV) drug abuse; 17 had one or both parents who were born in Haiti; 12 had received blood or blood components before their onsets of illness; four had hemophilia; one had a father who was bisexual; and one child's parents deny any risk factors. Risk-factor information on the parents of the eight remaining patients is incomplete.

Eighty-one adults (1% of adult patients) and 12 children (17% of pediatric patients) with transfusion-associated AIDS (TA-AIDS) have no other risk factors and were transfused with blood or blood components within 5 years of illness onset. TA-AIDS patients received blood from one to 75 donors (median 16 donors); interval from tranfusion to diagnosis was 4 months to 62 months (median 29 months for adults, 14 months for children). Median age at diagnosis of AIDS was 53 years for adults (range 19-81 years) and 14 months for children (range 4-46 months). Most adults received transfusions associated with surgery, while most infants with TA-AIDS were transfused for medical problems associated with prematurity (*3*).

FIGURE 1. AIDS cases, by half year of report — United States, 1981 through first half, 1984

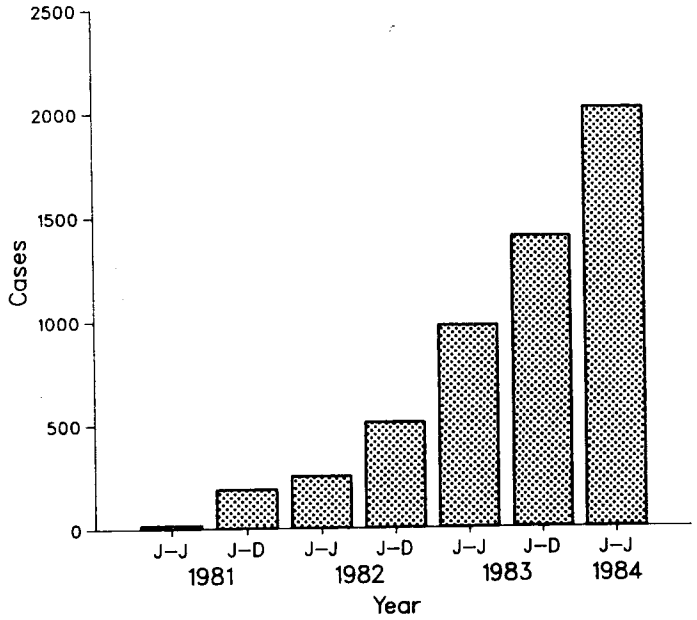


TABLE 1. Adult AIDS patients, by patient group and date of report — United States, through November 1984

	Date of report							
	Before Dec. 1982		Dec. 1982-Nov. 1983		Dec. 1983-Nov. 1984			
Patient group	No. cases	(%)	No. cases	(%)	No. cases	(%)	Total	(%)
Homosexual bisexual	636	(74.5)	1,600	(71.5)	2,802	(73.2)	5,038	(72.8)
IV drug user	121	(14.2)	401	(17.9)	668	(17.4)	1,190	(17.2)
Haitian	48	(5.6)	90	(4.0)	111	(2.9)	249	(3.6)
Hemophilia patient	7	(0.8)	11	(0.5)	28	(0.7)	46	(0.6)
Heterosexual contacts	8	(0.9)	19	(0.9)	27	(0.7)	54	(0.8)
Transfusion recipients	2	(0.2)	29	(1.3)	50	(1.3)	81	(1.2)
Noncharacteristic	32	(3.8)	87	(3.9)	144	(3.8)	263	(3.8)
Total	**854**	**(100)**	**2,237**	**(100)**	**3,830**	**(100)**	**6,921**	**(100)**

Reported by State and Territorial Epidemiologists; AIDS Br, Div of Viral Diseases, Center for Infectious Diseases, CDC.

Editorial Note: Throughout 1984, the number of AIDS cases reported increased 74% compared to the same period of 1983. Forty-two states, the District of Columbia, and Puerto Rico now require reporting of AIDS cases to health departments. Although 45 states have reported cases, the majority of adult AIDS patients continues to be reported from a small number of states. The geographic distribution of AIDS among children with parents in high-risk groups is similar to that seen for heterosexual adult AIDS patients; over 89% are from New York, California, New Jersey, and Florida. In both children and heterosexual adults, AIDS is much more likely to present with PCP and other opportunistic infections than with KS. Although the number of AIDS cases being reported continues to increase in all patient groups, the rate of increase among Haitian AIDS patients is significantly less ($p < 0.001$) than among the remaining groups.

The proportion of adult patients outside identified risk groups for AIDS has remained stable. AIDS patients classified as noncharacteristic are a heterogenous group. For example, some patients, such as 11 with KS and normal immunologic studies, may not have AIDS, even though they meet the surveillance definition. For other patients, information concerning risk factors is incomplete. Still other noncharacteristic patients may have unknowingly been the sexual partners of risk-group members (*4*).

Heterosexual transmission of AIDS has been reported in both the United States and Africa (*5-9*). In the United States, such transmission has been uncommon. When heterosexual transmission has occurred, it has primarily been from men, particularly male IV drug users, to their female partners. However, in several African countries, heterosexual transmission appears to be the predominant mode in the spread of AIDS. In Zaire, where the male-to-female ratio of AIDS cases has been reported to be 1.1 to 1, transmission from women to men may be more common than in the United States (*8*). Furthermore, among 24 adults diagnosed as having AIDS in Rwanda, 12 of the 17 men were reported to have had contact with prostitutes, and three of the seven women were prostitutes (*9*).

The importance of female-to-male transmission in the spread of AIDS in the United States and the role, if any, of female prostitutes in this transmission have not been established. Women, including female prostitutes, could be exposed to the AIDS virus through sexual contact, use of IV drugs, or transfusion. However, the number of these women presently infected is likely to be small. It is not known if such women would be as efficient as heterosexual or homosexual men in transmitting the AIDS virus. Future studies will attempt to clarify and quantify the risks of female-to-male transmission and contact with prostitutes.

References

1. CDC. Update: acquired immunodeficiency syndrome (AIDS)—United States. MMWR 1984;32: 688-91.
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.
3. Curran JW, Lawrence DN, Jaffe HW, et al. Acquired immunodeficiency syndrome (AIDS) associated with transfusions. N Engl J Med 1984;310:69-75.
4. Chamberland ME, Castro KG, Haverkos HW, et al. Acquired immunodeficiency syndrome in the United States: an analysis of cases outside high-incidence groups. Ann Intern Med 1984;100: 617-23.
5. CDC. Immunodeficiency among female sexual partners of males with acquired immune deficiency syndrome (AIDS)—New York. MMWR 1983;31:697-8.
6. Harris C, Small CB, Klein RS, et al. Immunodeficiency in female sexual partners of men with the acquired immunodeficiency syndrome. N Engl J Med 1983;308:1181-4.
7. Pitchenik AE, Fischl MA, Spira TJ. Acquired immune deficiency syndrome in low-risk patients. Evidence for possible transmission by an asymptomatic carrier. JAMA 1983;205:1310-2.
8. Piot P, Quinn TC, Taelman H, et al. Acquired immunodeficiency syndrome in a heterosexual population in Zaire. Lancet 1984;II:65-9.
9. Van de Perre P, Rouvroy D, Lepage P, et al. Acquired immunodeficiency syndrome in Rwanda. Lancet 1984;II:62-5.

CENTERS FOR DISEASE CONTROL

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

January 11, 1985 / Vol. 34 / No. 1

Provisional Public Health Service Inter-Agency Recommendations for Screening Donated Blood and Plasma for Antibody to the Virus Causing Acquired Immunodeficiency Syndrome

In March 1983, the U.S. Public Health Service issued inter-agency recommendations on the prevention of acquired immunodeficiency syndrome (AIDS) (*1*). Included was the recommendation that members of groups at increased risk for AIDS should refrain from donating plasma and/or blood. That recommendation was made to decrease the risk of AIDS associated with the administration of blood or blood products, which accounts for about 2% of all reported AIDS cases in the United States.

Evidence has shown that a newly recognized retrovirus is the cause of AIDS. Although this virus has been given several names, including human T-lymphotropic virus type III (HTLV-III) (*2*), lymphadenopathy-associated virus (LAV) (*3*), and AIDS-associated retrovirus (ARV) (*4*), it is referred to as HTLV-III in this discussion. Tests to detect antibody to HTLV-III will be licensed and commercially available in the United States in the near future to screen blood and plasma for laboratory evidence of infection with the virus. The antibody tests are modifications of the enzyme-linked immunosorbent assay (ELISA), which uses antigens derived from whole disrupted HTLV-III (*5*).

There is considerable experience with the ELISA test in research laboratories, but much additional information will be gathered following its widespread application. In the early phases of testing, a number of false-positive tests may be encountered. Adjustments in interpretation are anticipated as more is learned about the performance of the test in an individual laboratory and about the specific proportion of falsely positive or falsely negative tests in the screening setting where the test is used.

The present recommendations concern the use of these tests to screen blood and plasma collected for transfusion or manufactured into other products. They are intended to supplement, rather than replace, the U.S. Food and Drug Administration's recently revised recommendations to blood and plasma collection facilities and the earlier inter-agency recommendations (*1*). Additional public health applications of these tests in the understanding and control of AIDS will be described in a subsequent report.

BACKGROUND

Antibody Detection Studies

The ELISA test has been used in many research programs for detecting antibodies to HTLV-III in patients with AIDS and with AIDS-related conditions. In different studies, HTLV-III antibody was found to range from 68% to 100% of patients with AIDS, and in 84%-100% of persons with related conditions, such as unexplained generalized lymphadenopathy (*5-7*). Serologic surveys have yielded variable seropositivity rates in groups at increased risk for AIDS: 22%-65% of homosexual men (*8-11*), 87% of intravenous-drug abusers admitted to a detoxification program in New York City (*12*), 56%-72% of persons with hemophilia A (*13,14*), and 35% of women who were sexual partners of men with AIDS (*15*). In contrast to

THE OFFICIAL NEWSLETTER OF THE NCGSTDS - VOLUME 6, NO. 3 - JAN - FEB, 1985 - PAGE 59.

the above groups, HTLV-III antibody has been detected in fewer than 1% of persons with no known risks for AIDS (*4-10*).

The time needed to develop a positive antibody test following infection is not known. Data regarding the interval between infection with HTLV-III and seroconversion are limited. A nurse who sustained a needle-stick injury while caring for an AIDS patient developed antibody between 4 and 7 weeks following exposure (*16*). Additionally, a recent study described several asymptomatic individuals infected with HTLV-III for more than 6 months in the absence of detectable antibody (*17,18*). Nonetheless, currently available ELISA tests can be expected to identify most persons with HTLV-III infection.

Virus Isolation Studies

HTLV-III has been isolated from blood, semen, and saliva and has been recovered from many individuals in the presence of antibody (*19,20*). HTLV-III has been isolated from the blood of 85% or more of seropositive individuals with AIDS (*21*), lymphadenopathy, or other AIDS-associated conditions (*2*) and from three of four mothers of infants with AIDS (*2*). The virus has also been isolated from asymptomatic seropositive homosexual men and hemophiliacs, and has been recovered from 95% of seropositive high-risk blood donors who had been implicated in the transmission of AIDS through transfusion (*21*). The recovery of HTLV-III from these high-risk donors 2 or more years after their initial donation provides evidence that viremia may persist for years in both asymptomatic and symptomatic individuals. HTLV-III has also been isolated from some asymptomatic seronegative persons, but this is the exception (*17*).

Modes of Transmission

Epidemiologic data suggest that the virus has been transmitted through intimate sexual contact; sharing contaminated needles; transfusion of whole blood, blood cellular components, plasma, or clotting factor concentrates that have not been heat treated; or from infected mother to child before, at, or shortly after the time of birth. No other products prepared from blood (e.g., immunoglobulin, albumin, plasma protein fraction, hepatitis B vaccine) have been implicated, nor have cases been documented to occur through such common exposures as sharing meals, sneezing or coughing, or other casual contact.

Natural History of Infection

Information about the course of infection with HTLV-III is incomplete, but the majority of infected adults will not acquire clinically apparent AIDS in the first few years after infection. In some studies 5%-19% of seropositive homosexual men developed AIDS within 2-5 years after a previously collected serum sample was retrospectively tested and found to be seropositive. An additional 25% developed generalized lymphadenopathy, oral candidiasis, or other AIDS-associated conditions within the same interval (*11,22*). The long-term prognosis for most persons infected with HTLV-III is unknown.

SCREENING BLOOD AND PLASMA

Initial Testing

Persons accepted as donors should be informed that their blood or plasma will be tested for HTLV-III antibody. Persons not wishing to have their blood or plasma tested must refrain from donating. Donors should be told that they will be notified if their test is positive and that they may be placed on the collection facility's donor deferral list, as is currently practiced with other infectious diseases, and should be informed of the identities of additional deferral lists to which the positive donors may be added.

All blood or plasma should be tested for HTLV-III antibody by ELISA. Any blood or plasma that is positive on initial testing must not be transfused or manufactured into other products capable of transmitting infectious agents.

When the ELISA is used to screen populations in whom the prevalence of HTLV-III infections is low, the proportion of positive results that are falsely positive will be high. Therefore, the ELISA should be repeated on all seropositive specimens before the donor is notified. If the repeat ELISA test is negative, the specimen should be tested by another test.

Other Testing

Other tests have included immunofluorescence and radioimmunoprecipitation assays, but the most extensive experience has been with the Western blot technique (*22*), in which antibodies can be detected to HTLV-III proteins of specific molecular weights. Based on available data, the Western blot should be considered positive for antibody to HTLV-III if band p24 or gp41 is present (alone or in combination with other bands).

Notification of Donors

If the repeat ELISA test is positive or if other tests are positive, it is the responsibility of the collection facility to ensure that the donor is notified. The information should be given to the donor by an individual especially aware of the sensitivities involved. At present, the proportion of these seropositive donors who have been infected with HTLV-III is not known. It is, therefore, important to emphasize to the donor that the positive result is a preliminary finding that may not represent true infection. To determine the significance of a positive test, the donor should be referred to a physician for evaluation. The information should be given to the donor in a manner to ensure confidentiality of the results and of the donor's identify.

Maintaining Confidentiality

Physicians, laboratory and nursing personnel, and others should recognize the importance of maintaining confidentiality of positive test results. Disclosure of this information for purposes other than medical or public health could lead to serious consequences for the individual. Screening procedures should be designed with safeguards to protect against unauthorized disclosure. Donors should be given a clear explanation of how information about them will be handled. Facilities should consider developing contingency plans in the event that disclosure is sought through legal process. If donor deferral lists are kept, it is necessary to maintain confidentiality of such lists. Whenever appropriate, as an additional safeguard, donor deferral lists should be general, without indication of the reason for inclusion.

Medical Evaluation

The evaluation might include ELISA testing of a follow-up serum specimen and Western blot testing, if the specimen is positive. Persons who continue to show serologic evidence of HTLV-III infection should be questioned about possible exposure to the virus or possible risk factors for AIDS in the individual or his/her sexual contacts and examined for signs of AIDS or related conditions, such as lymphadenopathy, oral candidiasis, Kaposi's sarcoma, and unexplained weight loss. Additional laboratory studies might include tests for other sexually transmitted diseases, tests of immune function, and where available, tests for the presence of the virus, such as viral culture. Testing for antibodies to HTLV-III in the individual's sexual contacts may also be useful in establishing whether the test results truly represent infection.

RECOMMENDATIONS FOR THE INDIVIDUAL

An individual judged most likely to have an HTLV-III infection should be provided the following information and advice:

1. The prognosis for an individual infected with HTLV-III over the long term is not known. However, data available from studies conducted among homosexual men indicate that most persons will remain infected.
2. Although asymptomatic, these individuals may transmit HTLV-III to others. Regular medical evaluation and follow-up is advised, especially for individuals who develop signs or symptoms suggestive of AIDS.
3. Refrain from donating blood, plasma, body organs, other tissue, or sperm.
4. There is a risk of infecting others by sexual intercourse, sharing of needles, and possibly, exposure of others to saliva through oral-genital contact or intimate kissing. The

efficacy of condoms in preventing infection with HTLV-III is unproven, but the consistent use of them may reduce transmission.

5. Toothbrushes, razors, or other implements that could become contaminated with blood should not be shared.
6. Women with a seropositive test, or women whose sexual partner is seropositive, are themselves at increased risk of acquiring AIDS. If they become pregnant, their offspring are also at increased risk of acquiring AIDS.
7. After accidents resulting in bleeding, contaminated surfaces should be cleaned with household bleach freshly diluted 1:10 in water.
8. Devices that have punctured the skin, such as hypodermic and acupuncture needles, should be steam sterilized by autoclave before reuse or safely discarded. Whenever possible, disposable needles and equipment should be used.
9. When seeking medical or dental care for intercurrent illness, these persons should inform those responsible for their care of their positive antibody status so that appropriate evaluation can be undertaken and precautions taken to prevent transmission to others.
10. Testing for HTLV-III antibody should be offered to persons who may have been infected as a result of their contact with seropositive individuals (e.g., sexual partners, persons with whom needles have been shared, infants born to seropositive mothers).

Revised recommendations will be published as additional information becomes available and additional experience is gained with this test.

Reported by Centers for Disease Control; Food and Drug Administration; Alcohol, Drug Abuse, and Mental Health Administration; National Institutes of Health; Health Resources and Services Administration.

References

1. CDC. Prevention of acquired immune deficiency syndrome (AIDS): Report of inter-agency recommendations. MMWR 1983; 32:101-3.
2. Gallo RC, Salahuddin SZ, Popovic M, et al. Frequent detection and isolation of cytopathic retroviruses (HTLV-III) from patients with AIDS and at risk for AIDS. Science 1984;224:500-3.
3. Barré-Sinoussi F, Chermann JC, Rey F, et al. Isolation of a T-lymphotropic retrovirus from a patient at risk for acquired immune deficiency syndrome (AIDS). Science 1983;220:868-71.
4. Levy JA, Hoffman AD, Kramer SM, Landis JA, Shimabukuro JM, Oschiro LS. Isolation of lymphocytopathic retroviruses from San Francisco patients with AIDS. Science 1984;225:840-2.
5. Sarngadharan MG, Popovic M, Bruch L, Schüpbach J, Gallo RC. Antibodies reactive with human T-lymphotropic retroviruses (HTLV-III) in the serum of patients with AIDS. Science 1984;224-506-8.
6. Safai B, Sarngadharan MG. Groopman JE, et al. Seroepidemiological studies of human T-lymphotropic retrovirus type III in acquired immunodeficiency syndrome. Lancet 1984;1:1438-40.
7. Laurence J, Brun-Vezinet F, Schutzer SE, et al. Lymphadenopathy associated viral antibody in AIDS. N Engl J Med 1984;311:1269-73.
8. Melbye M, Biggar RJ, Ebbesen P, et al. Seroepidemiology of HTLV-III antibody in Danish homosexual men: prevalence, transmission, and disease outcome. Brit Med J 1984; 289:573-5.
9. CDC. Antibodies to a retrovirus etiologically associated with acquired immunodeficiency syndrome (AIDS) in populations with increased incidences of the syndrome. MMWR 1984; 33:377-9.
10. Weiss SH, Goedert JJ, Sarngadharan MB, et al. Screening test for HTLV-III (AIDS agent) antibodies: specificity, sensitivity, and applications. JAMA 1985; 253:221-5.
11. Goedert JJ, Sarngadharan MG, Biggar RJ, et al. Determinants of retrovirus (HTLV-III) antibody and immunodeficiency conditions in homosexual men. Lancet 1984;2:711-16.
12. Spira TJ, Des Jarlais DC, Marmor M, et al. Prevalence of antibody to lymphadenopathy-associated virus among drug-detoxification patients in New York. N Engl J Med 1984;311:467-8.
13. Ramsey RB, Palmer EL, McDougal JS, et al. Antibody to lymphadenopathy-associated virus in hemophiliacs with and without AIDS. Lancet 1984;2:397-8.
14. Tsoukas C, Gervais F, Shuster J, Gold P, O'Shaughnessy M, Robert-Guroff M. Association of HTLV-III antibodies and cellular immune status of hemophiliacs. N Engl J Med 1984;311:1514-15.
15. Harris CA, Cabradilla C, Klein RS, et al. Antibodies to a core protein (p25) of lymphadenopathy associated virus (LAV) and immunodeficiency in heterosexual partners of AIDS patients. Presentation at 24th Interscience Conference on Antimicrobial Agents and Chemotherapy. Washington, D.C., 1984.
16. Anonymous. Needlestick transmission of HTLV-III from a patient infected in Africa. Lancet 1984; 2:1376-7.
17. Salahuddin SZ, Groopman JE, Markham PD, et al. HTLV-III in symptom-free seronegative persons. Lancet 1984; 2:1418-20.
18. Groopman JE. Unpublished data.
19. Groopman JE, Salahuddin SZ, Sarngadharan MG, et al. HTLV-III in saliva of people with AIDS-related complex and healthy homosexual men at risk for AIDS. *Science* 1984, 226:447-9.
20. Zagury D, Bernard J, Leibowitch J, et al. HTLV-III in cells cultured from semen of two patients with AIDS. Science 1984;226:449-51.
21. Feorino PM, Jaffe HW, Palmer E, et al. Transfusion-associated acquired immunodeficiency syndrome: evidence for persistent infection in blood donors. Submitted for publication.
22. Darrow WW, Jaffe HW, Braff E, et al. Acquired immunodeficiency syndrome (AIDS) in a cohort of homosexual men. Presentation at 24th Interscience Conference on Antimicrobial Agents and Chemotherapy. Washington, D.C., 1984.
23. Tsang VCW, Peralta JM, Simons AR. Enzyme-linked immunoelectrotransfer blot techniques (EITB) for studying the specificities of antigens and antibodies separated by gel electrophoresis. Methods Enzymol 1983;92:377-91.

CENTERS FOR DISEASE CONTROL

January 18, 1985 / Vol. 34 / No. 2

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

International Notes

Update: Acquired Immunodeficiency Syndrome — Europe

As of October 15, 1984, 559 cases of acquired immunodeficiency syndrome (AIDS) had been reported to the World Health Organization (WHO) Collaborating Centre on AIDS. One hundred thirty new cases were noted in the 10 countries corresponding with the Centre at the time of the previous report (July 15, 1984), an average increase of 10 cases per week (Table 1).

TABLE 1. Reported acquired immunodeficiency syndrome cases and estimated rates per million population — 15 European countries*

Country	Oct. 1983†	July 1984	Oct. 1984	Rates§
Czechoslovakia	0	0	0	0.0
Denmark	13	28	31	6.0
Finland	¶	¶	4	0.8
France	94	180	221	4.0
Federal Republic of Germany	42	79	110	1.8
Greece	¶	2	2**	0.2
Iceland	0	0	0	0.0
Italy	3	8	10	0.2
Netherlands	12	21	26	1.8
Norway	¶	¶	4	1.0
Poland	0	0	0	0.0
Spain	6	14	18	0.5
Sweden	4	7	12	1.5
Switzerland	17	28	33	5.0
United Kingdom	24	54	88	1.6
Total	**215**	**421**	**559**	**1.5**

*Czechoslovakia, Denmark, Finland, France, Federal Republic of Germany, Greece, Iceland, Italy, Netherlands, Norway, Poland, Spain, Sweden, Switzerland, United Kingdom.

†These data were reported at the first European meeting on AIDS held in Aarhus, Denmark, October 1983.

§Based on 1983 populations, INED, Paris.

¶No data reported at this time.

**Data of July 15, 1984.

The greatest increases were observed in France, with 41 new cases (three to four per week); United Kingdom—34 new cases (two to three per week); and Federal Republic of Germany—31 new cases (two to three per week). In the other seven countries, the increase was less—two to five cases between July and October. Among the five new participating countries, three (Czechoslovakia, Iceland, and Poland) said no AIDS cases had ever been reported, and two (Finland and Norway) reported four cases each.

AIDS cases per million population were calculated from 1983 population data provided by the Institut National d'Etudes Démographiques (INED), Paris, France. The highest rate was observed in Denmark—six cases per million population; Switzerland—five per million; and France—four per million. These rates are low compared to that in the United States: 27.6 per million population as of October 1, 1984.

Of the total 559 cases, 255 (46%) deaths were reported (Table 2). The primary diseases were opportunistic infections alone for 62% (348/559) of the patients; Kaposi's sarcoma (KS) for 23% (127/559); and opportunistic infection with KS for 14% (79/559). Category "other" includes three cases of progressive multifocal leukoencephalitis (France—two; Denmark—one) and two cases of cerebral lymphoma alone (United Kingdom—one; Federal Republic of Germany—one).

The highest case-fatality rates (70%) were noted for patients with KS and opportunistic infection; the case-fatality rate for opportunistic infection alone was 49%, and for KS alone, 22%.

Ninety-four percent (525/559) of the cases were among men. The male-to-female ratio was 15.4, compared with 14.5 for the United States. Forty-nine percent of the cases occurred in the 30- to 39-year age group (Table 3).

Four groups of differing geographic origin of birth were noted (Table 4).

European: 479 cases (86% of total). Four hundred sixty-five patients lived in Europe (including European countries not yet collaborating with the Centre) before the onset of the first symptoms. Fourteen patients (3% of cases occurring among Europeans) lived outside Europe (United States—three; Zaire—two; Haiti—two; Gabon—one; Nicaragua—one; Venezuela—one; South Africa—one; Ghana—one; Congo—one; unknown—one).

Caribbean: 21 cases (4%). Nineteen patients lived in Europe (17 Haitians living in France; one Dominican and one Jamaican living in the United Kingdom). Two Haitian patients diagnosed in France lived in Haiti.

African: 45 cases (8%). These patients originated from: Zaire—19 patients; Congo—10; Gabon—three; Mali—two; Cameroon—two; Zambia—two; Madagascar—one; Cape Verde—one; Chad—one; Algeria—one; Ghana—one; Togo—one; Uganda—one. These cases were diagnosed in six reporting countries: France—33 patients; Switzerland—six; United Kingdom—two; Federal Republic of Germany—two; Greece—one; Italy—one. Seventy-three percent (33/45) of these patients resided in Europe before the onset of the first symptoms. Eleven resided in Africa, and one, in the United States.

Other origins: 14 cases (3%). Most of these originated from the American continents: United States—nine; Canada—one; Argentina—one; Nicaragua—one; Peru—one. One was from Pakistan. Of these, nine were not living in Europe before the onset of symptoms (United States—six; Argentina—one; Canada—one; Pakistan—one).

Among the Europeans, 87% (415/479) were male homosexuals or bisexuals (Table 4). Two percent (7/479) were intravenous (IV) drug abusers, and 1% (3/479) were both IV drug abusers and homosexual. These cases were diagnosed in the Federal Republic of Germany—six; Spain—three; France—one. Four percent (17/479) were hemophilia patients diagnosed in: Federal Republic of Germany—eight; Spain—four; United Kingdom—three; France—two. For 1% (3/479) of patients, all diagnosed in France, the only risk factor noted was blood transfusion. One was transfused in Haiti, and a few days later, in Martinique (French West Indies); one was transfused in Paris; and the third was a resident of Italy, who was transfused in France. For 7% (33/479), no known risk factors were noted.

Among the Caribbeans, two of 21 patients were homosexual. Nineteen did not present any known risk factors. Among the Africans, four (9%) of 45 were homosexual; 41 did not present any known risk factors. Among the 14 patients of other origins, 11 were homosexual, and two were both homosexual and IV drug abusers diagnosed in the United Kingdom and Spain. One did not present any known risk factors.

Figure 4 indicates the progression of cases and deaths by half year of diagnosis (diagnosis being the date of positive biopsy or culture confirming the disease fitting the CDC case definition) since 1981. (Before 1981, 17 cases, including nine deaths, were reported.) Fifty-two percent of the patients diagnosed 1 year ago and 72% of the patients diagnosed 2 years ago have died. Although there is no information on this point, it appears that more cases diagnosed before 1981 have been lost to follow-up.

Editorial Note: The WHO Regional Bureau for Europe consists of 32 European countries. By July 15, 1984, 10 of these countries participated in the AIDS surveillance by reporting to the

TABLE 2. Acquired immunodeficiency syndrome cases and number of deaths, by disease category — 15 European countries, through October 15, 1984

Disease category	Cases (%)	Deaths (%)
Opportunistic infection	348 (62)	169 (49)
Kaposi's sarcoma	127 (23)	28 (22)
Opportunistic infection and Kaposi's sarcoma	79 (14)	55 (70)
Others	5 (1)	3 (60)
Unknown	0 (0)	0 (0)
Total	**559 (100)**	**255 (46)**

TABLE 3. Acquired immunodeficiency syndrome cases, by age group and sex — 15 European countries, through October 15, 1984

Age group	Males	Females	Total No. (%)
0-11 months	2	0	2 (< 1)
1-4 years	0	0	0 (0)
5-19 years	5	0	5 (1)
20-29 years	86	15	101 (18)
30-39 years	263	12	275 (49)
40-49 years	130	6	136 (24)
50-59 years	28	1	29 (5)
≥ 60 years	5	0	5 (1)
Unknown	6	0	6 (1)
Total*	**525**	**34**	**559 (100)**

*Sex ratio = 15.4.

TABLE 4. Acquired immunodeficiency syndrome cases, by patient risk group and geographic origin — 15 European countries, through October 15, 1984

Patient risk groups		Nationality				Total
		European	Caribbean	African	Others	
1	Male homosexuals or bisexuals	415	2	4	11	432
2	IV drug abusers	7	0	0	0	7
3	Hemophilia patients	17	0	0	0	17
4	Transfusion recipients (without other risk factors)	3	0	0	0	3
5	1 and 2 associated	3	0	0	2	5
6	No known risk factor					
	males	21	15	26	1	63
	females	12	4	15	0	31
7	Unknown	1	0	0	0	1
Total		**479**	**21**	**45**	**14**	**559**

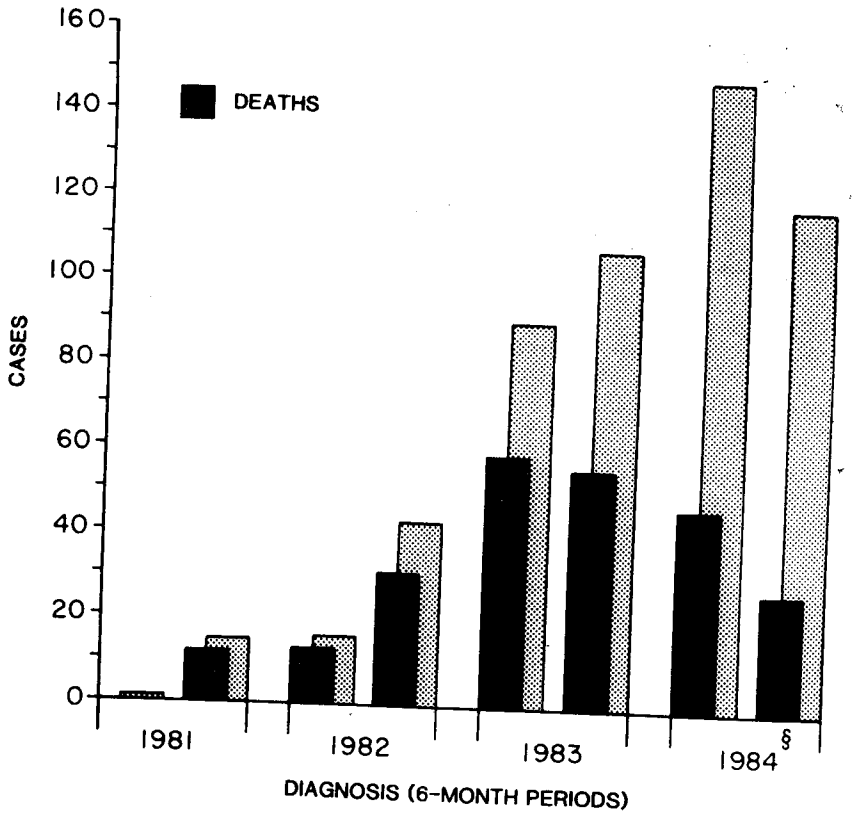
Centre. By October 15, 1984, an additional five countries had been accepted to collaborate: Czechoslovakia, Finland, Iceland, Norway, and Poland. AIDS is presently a notifiable disease in four of the 15 reporting countries: Denmark, Iceland, Norway, and Sweden.

One of the main features of the European situation is the number of cases occurring among persons originating from equatorial Africa. Because Belgium has not yet reported, the picture of the situation is incomplete. (The participation of this country is expected for the next report.)

Zaire has drawn special attention in recent publications. The occurrence among the African patients diagnosed in Europe of a number of cases originating from other African countries, and also of cases among Europeans having stayed in these countries, shows that Zaire may not be the only African focus of this disease. The lack of reported cases probably reflects lack of surveillance in other countries of this area.

Reported by JB Brunet, MD, R Ancelle, Institut de Médecine et D'Epidémiologie Tropicales, Hopital Claude Bernard (WHO Collaborating Centre on AIDS), Paris, France; Institute of Virology, Bratislava, Czechoslovakia; Statens Serum Institute, Copenhagen, Denmark; Institute of Biomedical Sciences, Tampere, Finland; Direction Général de la Santé, Paris, France; Ministerio de Sanidad y Consumo, Madrid, Spain; Robert Koch Institute, West Berlin, Federal Republic of Germany; Ministère de la Santé, Athens, Greece; General Direction of Public Health, Reykjavik, Iceland; Institute Superiore di Sanita, Rome, Italy; Staatstoezicht op de Volksgezondheid, Leidfehendam, Netherlands; National Institute of Public Health, Oslo, Norway; National Institute of Hygiene, Warsaw, Poland; National Bacteriological Laboratory, Stockholm, Sweden; Office Fédéral de la Santé Publique, Berne, Switzerland; Communicable Disease Surveillance Center, Colindale, London, United Kingdom.

FIGURE 4. Acquired immunodeficiency syndrome cases and number of deaths, by 6-month period of diagnosis — 13 European countries,* January 1, 1981-October 15, 1984†



*Denmark, Finland, France, Federal Republic of Germany, Greece, Iceland, Italy, Netherlands, Norway, Spain, Sweden, Switzerland, United Kingdom.
†Before 1981, 17 cases, including nine deaths, were reported.
§July-October 15, 1984.

****
NEXT NEWSLETTER IN APRIL: ARTICLES DUE MARCH 22!
****