THE OFFICIAL NEWSLETTER OF THE

NATIONAL COALITION OF GAY STD SERVICES

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 Articles for the Newsletter, or inquiries about membership or subscriptions may be addressed to Mark P. Behar, PA-C, Chairperson, NCGSTDS, PO Box 239, Milwaukee, WI 53201-0239 (414/277-7671). Please credit the NCGSTDS when reprinting items from the Newsletter. We're eager to hear from you, and will try to answer all correspondence! The NCGSTDS is the proud recipient of the National Lesbian/Gay Health Education Foundation's JANE ADDAMS-HOWARD BROWN AWARD, for outstanding effort and achievement in creating a healthier environment for lesbians and gay men, June 12, 1983.

TABLE OF CONTENTS-Abridged

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NCGSTDS ANNUAL MEETING RESCHEDULED

Due to the unfortunate cancellation of the 7th National Lesbian/Gay Health Conference and the 4th National AIDS Forum by the National Lesbian & Gay Health Foundation, the NCGSTDS Annual Meeting, which was originally scheduled to take place during that time, has been rescheduled for the 113th Annual Meeting of the American Public Health Association, November 17-21, 1985 in Washington, DC. Any agenda items should be submitted (or called in) at least one month before that date for consideration. A future issue of the Newsletter will provide details about that meeting, and special activities, functions, and programs associated with the Gay & Lesbian Public Health Workers Caucus.

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NCGSTDS COMPUTER SURVEY

Almost 10% of all NCGSTDS members have returned their salmon-colored computer survey, distributed with the last issue of the Newsletter. If you presently have, or soon plan to acquire a personal computer, and haven't yet filled out and returned the survey, please call or write and we'll send you a blank form. NCGSTDS, PO Box 239, Milwaukee, WI 53201 (414/277-7671). Thanks!

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COMPUTERIZATION OF NCGSTDS

Slowly but surely, the NCGSTDS is being computerized! Already, the entire membership list is "online," and membership renewal notices are being called up regularly. Hopefully, by the end of the summer or fall, we will be able to incorporate the mail-merge function, so that a more personal appeal for membership renewal will be forthcoming. The next issue of the Newsletter (volume 7:1) will hopefully be entirely computer written, and will be out in September. Look for our new look (perhaps, like a haircut, it would be best if it is not so noticeable!) soon! Any suggestions and constructive criticisms on how to use our computer (a Compaq 256K) and word processing program (Wordstar 2000 Plus) are always invited.

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AAPHR ANNUAL MEDICAL CONFERENCE IN VANCOUVER, AUGUST 7-10

The Annual General Meeting and the Annual Medical Conference of the American Association of Physicians for Human Rights (AAPHR) is scheduled for AUgust 7-10, 1985 at Vancouver's (British Columbia) Denman Hotel. The planning committee has tried to arrange a program of diverse interest to practitioners interested in lesbian & gay health care, as well as to recognize interactions within the broader communities in which we live. As well, a special social program including a welcome cocktail party and a boat cruise of Vancouver's spectacular harbor, is planned. A distinguished faculty will be presenting such topics as: chemical dependency, aging, self-defense for lesbians, sexual abuse, PMS, sexual assault intervention, osteoporosis, intestinal syndromes in gay men, lesbian health needs survey, and promoting alternative socializing. Some of the numerous topics on AIDS include: ethics, politics, counseling aspects, epidemiology, immunology, viral interactions, viral esophageal ulcers & candida, KS, lymphadenopathy, respiratory infections, hematology, gastro-intestinal infections, and reactions of medical personnel and intimates to persons with AIDS. Other topics will cover hepatitis, herpes, and a review of the MACS study and INAPEN. Registration fees range from $225-300 (AAPHR member & nonmember), to $13-25 for students. For additional information, contact: AAPHR, PO Box 14366, San Francisco, CA 94114, or call 415/673-3189 and speak with Doug Carner. AAPHR designates this CME activity for 20 credit hours in Category 1.

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GAY/LESBIAN HEALTH CONFERENCE & AIDS FORUM CANCELLED-*BULLETIN!*

After several attempts to reschedule the 7th National Lesbian/Gay Health Conference and 4th National AIDS Forum, Caitlin Ryan of the National Lesbian & Gay Health Foundation has announced that the conferences will be cancelled. It is hoped that both conferences will be rescheduled for the Spring, 1986, for Washington, DC. The NCGSTDS meeting that was originally scheduled at that time will be rescheduled to coincide with the annual meeting of the American Public Health Association in the autumn [see related article].

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NALGAP FIRST NATIONAL CONFERENCE, SEPTEMBER 26-29 IN CHICAGO

The First National Conference of the National Association of Lesbian & Gay Alcoholism Professionals is scheduled for Chicago's Holiday Inn Mart Plaza, September 26-29, 1985. Do you treat minorities? Most minorities are visually identifiable. Fortunately, we are increasing our knowledge of the elderly, Blacks, Hispanics, Jews, American Indians, but very little is known about the gay man or lesbian, because the largest majority of them remain hidden. Knowledge and clinical strategies are needed to reach the chemically dependent members of this minority group. This First National Conference is built on the theme of our organization inviting all lesbians, gay men and our non-gay colleagues along the roads of chemical freedom and lesbian and gay pride. These are too often the roads less traveled; the difference will be made by taking them. This Conference offers knowledge and treatment strategies for the lesbian & gay alcoholic and their codependenats in the following areas: adult children of alcoholics; assessment and treatment; sexuality issues; specialized treatment programs & private practice. The Indiana Counselors Association on Alcohol and Drug Abuse (ICAADA) grants 18 hours of credit for Counselor Certification (CAC, CBC). For more information contact: Vivian Larsen, 312/524-0236, or Bob Kajdan, 815/338-2500 x500, or write to: Trove of Treasurers, Inc., PO Box 381, 353 W. Lincolnway, Valparaiso, IN 46383.

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ALCOHOLICS ANONYMOUS INTERNATIONAL CONVENTION

with thanks to The Body Politic (Toronto), July, 1985

Some 50,000 members of Alcoholics Anonymous from around the world are expected to descend on Montreal July 4-7 to celebrate the 50th anniversary of their organization. The officially recognized gay & lesbian contingent is expected to include some 5000 participants. Most of the Conference activities will center on the Palais de Congres, and there will be a big lesbian & gay dance (sans alcohol, of course) on July 13th at the CEGEP de Vieux Montreal. *****

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NONOXYNOL-9 CORRECTIONS!

Apologies are due for several errors appearing in the last two issues of the Newsletter: Volume 6:3, p. 38, "Nonoynol-9 [sic] Tested by CDC" [typo! Nonoxynol-9], and volume 6:4, p. 18, "AIDS Prevention Drug Discovered???--Editorial." Nonoxynol-9 is a nonionic surfactant primarily used as a spermicidal agent in many contraceptive products including diaphragm creams & jellies, contraceptive sponges, sexual lubricants, and some latex condoms. Dr. Bruce Voeller, PhD, president of the Mariposa Education & Research Foundation [not Trimensa--a totally separate company, as was incorrectly indicated] has been one of the chief proponents of using Nonoxynol-9 as an adjunctive with condoms as an effective way of preventing the acquisition/spread of HTLV-III/LAV/ARV, the putative AIDS agent(s). Voeller has maintained that the FDA has tested Nonoxynol-9 exhaustively and found it safe in foods, medications, and cosmetics, and preliminary in vitro tests by CDC scientists have shown it to be virucidal against HTLV-III. Some clinicians/scientists maintain however, that Nonoxynol-9 was never or inadequately tested on rectal mucosa and was never intended to be used in the anorectum during the earlier FDA testing. Voeller states that Nonoxynol-9 is safe when used as an anorectal lubricant; it is virucidal against HTLV-III; and that we should promote the use of both Nonoxynol-9 as a chemical barrier with condoms as a physical barrier to further reduce the risk of HTLV-III transmission during anal intercourse. One fianl clarification/correction: Mariposa Foundation and Trimensa are totally separate entities according to Voeller, and are not related; and that the brand ForPlay Sexual Lubricant is manufactured by Trimensa, not Mariposa. Thanks to Dr. Voeller for helping to clarify these issues and for his dedication, interest, and work to help promote the continuing health and welfare of our gay community.

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SEXUAL ORIENTATION AND THE LAW: BOOK REVIEW

reviewed by Stephen M. Byers, Esq., Attorney-at-Law, Milwaukee, with great thanks

Sexual Orientation and the Law, by National Lawyers Guild, Anti-Sexism Committee of the San Francisco Bay Area Chapter, Roberta Achtenberg, JJD, Editor, Published by Clark Boardman Company, Ltd., New York, 1985. [Enclosed with Newsletter is advertising brochure--ED]

The promotional materials accompanying this publication claim that it presents clear, expert treatment of the wide-ranging legal issues affecting millions of citizens. After reading this publication, this claim is well-founded! Editor Pamela Achtenberg has successfully collected practical and informative discussions of the individual rights and liberties of every gay and lesbian citizen, as well as an interesting article on those who wish to become citizens. The greatest asset of this publication is the fact that it is practical. It doesn't get lost in theories or historical ramblings. It does, in fact, discuss practical legal issues facing gays and lesbians, analyzes these issues and suggests practical solutions.

The publication is divided into three main areas. The first, and undoubtedly the most useful for the general practioner, deals with family and property. The articles dealing with child custody and visitation and children in a gay or lesbian family are particularly interesting and useful. Although these areas are governed predominantly by the individual state's laws, the strategies and considerations discussed in each of these chapters is insightful and once again, practical. Undoubtedly the most timely discussions in this book are those relating to estate planning, and cohabitation or property agreements. This is especially true in light of the current health crisis facing the gay community and the resulting focus on long-term relationships. SOL is well worth the price for these chapters alone! The contributing authors in these chapters have drawn together in one place the legal, ethical, and tax considerations of estate planning for gays & lesbians and their partners/significant others, as well as the drafting of cohabitation or property agreements. Immediately following the discussion, there are numerous sample forms. Nothing is more welcome to a busy practitioner than sample forms one can use as guides in drafting an individual agreement, will, etc. Most importantly, these forms are very well written. The discussions of guardianships, powers of attorney and living wills are especially insightful and must be read by any legal practitioner dealing with PWAs.

The second major section of this work deals with civil rights and discrimination. The discussions of the the rights of gays and lesbians in the areas of employment, public accomodations, immigration and the military are well done and contain excellent strategic ideas. Unlike the State of Wisconsin, no other state has legislation protecting gays and lesbians in the areas of employment, services, accomodations and consumer goods. SOL addresses these areas as well.

The final major section of the book deals with criminal law. This section if probably the least helpful, as the area of criminal defense does not lend itself to a discussion of specifics in defending gay or lesbian clientele. With the exception of a few good sections on how to best handle the defense of a gay/lesbian client, to be sure their sexual orientation does not affect their constitutionally protected rights, the work mainly recants general principles of criminal procedure and strategy.

Sexual Orientation and the Law is indispensible to any legal practitioner who deals with the gay and lesbian communities. Although it is not the definitive legal source for all questions regarding issues specific to gays & lesbians, it does present, in one volume, a concise, accurate and practical discussion designed to assist legal practitioners in effectively addressing the legal needs of gay & lesbian clientele. The book will pay for itself (its cost--$75) the very first time you use it. And it may very well be one of the best investments for a gay health clinic (or AIDS service organization) to add to their reference libraries!

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CAIN MESSAGES FOR NCGSTDS

Although slow in getting started, the NCGSTDS is now begining to regularly exchange messages over the Computerized AIDS Information Network accessible via Delphi (for information contact: 800/544-4005 for Delphi, 213/464-7400 for CAIN--Russ Toth). Want to exchange important information or ask a question and can't call or write a letter to NCGSTDS? Leave an electronic mail letter! We try to read our messages & letters every weekend & try to reply promptly! Want to list announcements quickly for everyone? It's easy to do on CAIN. [Just because it took Mark Behar of the NCGSTDS several months to figure it out doesn't mean that you can't do it faster. I'm just computer illiterate!]

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AIDS EPIDEMIOLOGY/SURVEILLANCE UPDATE

abstracted from AIDS Weekly Surveillance Report, CDC AIDS Activity & The Body Politic, 7/85

As of June 24, 1985, the Centers for Disease Control AIDS Activity reports a total of 11,271 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; 1% from hemophiliacs; 1% from heterosexual contacts with PWAs or at risk for AIDS; 1% from blood/blood product recipients; and 7% from those in no apparent risk/unknown risk group. [Note, that Haitians are no longer considered "high risk; they had accounted for 3% of all cases. Medical politics!

The CDC continues to be criticized for this atypical "hierarchical" listing--some of the homosexually active men may also be IV drug users or hemophiliaces, etc., but are only counted in the top, i.e., "homosexual" category. It is our contention that this confuses and misrepresents the data, which CDC officials themselves have admitted.--Editor.] 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; and 1% are other/unknown. 48 states including the District of Columbia and Puerto Rico ahve reported cases to the CDC; New York and California have the most cases, with 36% and 23% respectively; Florida, 7%; New Jersey, 6%; Texas, 5%; Pennsylvania, Illinois, Massachusetts, the District, and Georgia all have 2% respectively. (As of March 4th, only Idaho, North & South Dakota, and Montana have not reported any cases.) Overall mortality has increased to 50%. AIDS cases per million of population for the entire U.S. is 49.5 per million, ranging from 412.0 per million in New York City, 395.3 pm in San Francisco, 248.5 pm in Miami, 142.9 pm in Newwark, and 126.1 pm in Los Angeles, to 22.5 pm for 'elsewhere,' irrespective of standard metropolitan statistical area.

As of June 4, the Laboratory Centre for Disease Control (LCDC) in Ottawa had recorded a total of 230 adult cases of AIDS in Canada; of these, 173 (75%) were homosexually active men. Asterisks (*) indicate that AIDS is reportable in the following breakdown by provinces: Ontario*, 97; Quebec, 72; British Columbia*, 43; Alberta*, 10; Nova Scotia, 5; Saskatchewan*, 1; Manitoba, 1; New Foundland, 1; No cases are yet reported in New Brunswick*, Prince Edward Island, or the Territories. [Note that the Province of Quebec, with the cities of Montreal and Quebec, do not require reporting of AIDS to public health officials!--EDITOR]

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BLASTOCYSTIS HOMINIS INFORMATION SAUGHT

Practitioners having information about the fungus Blastocystis hominis, and its significance in stool specimens of patients with minimal symptomatology, are asked to contact Dr. Roger Gremminger, 929 N. Astor St., #1608, Milwaukee, WI 53202 (414/765-0849).

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CONDOM CAPER FOILED

with thanks to the San Diego AIDS Project

The Deputy Director of Public Health Service in San Diego County, Donald G. Ramras, MD, told the San Diego AIDS Project, "that the County did not look upon distribution of condoms at the Lambda Pride Festival as meeting the County's definition of a health education or prevention function that met their need." Therefore, the Department did not provide condoms to the AIDS Project as it did in 1984, nor assist them in outreach to the gay and bisexual community at its largest gathering of the year. SDAP had based an educational and prevention program for the Festival around the theme "Get Into Rubber" and along with printed information (funded in part by the California Dept. of Public Health), condoms and a lubricant containing nonoxynol-9 were to be passed out to gay and bisexual men. Dr. Hal Frank, SDAP Director, immediately turned to other resources after the rebuff from the County, which in part resulted in the donation of several hundred condoms. The County had decided that the Lambda Pride Festival was more a social gathering than an opportunity to take advantage of the site, the purpose, the need, and the large numbers of gay and bisexual men gathered. Rarely does such an educational and preventional program literally offer itself to a public health agency. Recommendations from the U.S. Department of Health and Human Services state that "condoms have been suggested as a means of preventing the spread of AIDS."

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MILITARY RETHINKING ANTIBODY POSITIVE LISTS

by Lou Chibbaro, Jr., with thanks to The Washington Blade, 5/3/85

Dr. Joseph O'Malley, the medical-technical services officer for the American Red Cross' national headquarters, said he was informed the the Dept. of Defense is considering backing down from its recent directive calling on civilian blood banks to turn over to military doctors the names of service members who test positive for the HTLV-III antibody. Military officials told O'Malley they agreed to grant private blood banks a waiver from complying with their reporting directive after Red Cross blood banking officials (and others) expressed strong opposition to the directive. A spokesperson for the DOD however, said he was not aware of plans to issue a waiver for civilian blood banks and maintained that the DOD's plans to carry out the reporting requirements of the directive remain in place. "There is some speculation going on based on rumor," said Major Pete Wyro, a Pentagon public affairs officer.

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MILITARY SEEKS ANTIBODY TEST RESULTS

by Marcos Bisticas-Cocoves, with thanks to Boston's Gay Community News, 5/4/85

The U.S. Department of Defense (DOD) has ordered military and civilian blood banks to hand over the names of military donors who test positive for the HTLV-III antibody. In a March 13 memo to the Surgeons General of the Army, Navy, and Air Force, Lt. Col. Anthony Polk of the DOD Military Blood Program Office wrote, "Military and civilian agencies collecting blood at military installations will provide positive test results for antibody to HTLV-III to the respective service military health agency responsible for the medical evaluation and counseling of reactive donors (BLOOD PROGRAM PERSONNEL WILL NOT RELEASE TEST RESULTS TO NON-MEDICAL PERSONNEL)." However, Peter Page, Director of the American Red Cross Blood Services for the Northeast Region, said at an AIDS onference on April 25 that it is not the policy of the Red Cross to reveal test results except to donors. Brian McDonough, Executive Director of San Francisco's Irwin Memorial Blood Bank told GCN, "We aren't going to comply [with this policy]. State law prohibits that we comply. I cannot think of a single blood banking colleague who would comply." McDonough said that DOD has taken action to grant California an exemption from the policy because of state law. According to Kathy Gilberd of the National Lawyers Guild, because there is no confidentiality in military doctor/patient relations, this policy has grave implications for gay soldiers. When asked how blood banks would respond to this policy, McDonough said, "Either the policy will eventually change, or civilian agencies will stop taking blood at military installations."

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SOME AIDS MONEY REDIRECTED TO HTLV-III ANTIBODY ALTERNATE SITE TESTING

compiled by Stephanie Poggi, with thanks to Boston's Gay Community News, 5/4/85

An April 3rd letter from a Health and Human Services (HHS) official to a Congressional Appropriations Subcommittee outlines a plan to use some funds earmarked for AIDS and other health programs to pay for alternative testing sites for the HTLV-III antibody, according to the Washington Blade. The plan to redirect $10.4 million was immediately criticized by gay/lesbian and health organizations who insist that additional funding for AIDS programs should be requested from Congress, not diverted from existing programs or from victims of other diseases. The letter from John O'Shaughnessy, HHS assistant secretary for management and budget, provides that $3.9 million will come from research funds for AIDS, hepatitis B, alcoholism and environmentally-related diseases. The remaining $6.5 million will come from what HHS describes as reserve or idle funds in the CDC's Division of STD Control program and the National Health Service Corps, a program designed to provide MDs to the medically underserved and needy, especially in rural and low-income areas.

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ANTIBODY TEST CONTROVERSY CONTINUES--A COLLECTION OF ARTICLES & OPINIONS

YES--HAVE YOUR BLOOD TESTED

by Robert Jeddeloh, MD, Minneapolis, with thanks to Equal Time, 5/1/85

[Many have written] of the HTLV-III antibody test and [have given] the view held by many gay/lesbian organizations that the test, though a good screening tool to protect the blood supply, is of no benefit and may actually prove detrimental to gay men. I recently attended the First International Conference on AIDS held in Atlanta [in April] and sensed a changing view towards the HTLV-III antibody test. As more data accumulates with the test and different levels of technical proficiency demonstrate the idiosyncracies of each manufactured kit, the reliability of the test in identifying antibody people is increasing. The question remains--what to tell a positive, asymptomatic person. Evidence mounts that though asymptomatic, a person who is antibody positive has been [infected with] the HTLV-III virus. With exposure comes the possibility of virus infectivity and transmission. To screen blood donors the test is as effective as any blood test can be. To screen a general population such as gay men, the utility of the test is open to question. But putting aside the question of confidentiality, itself a serious issue, what are the rights of an individual to know his own antibody state? If the test is positive what does that man do? Despite the statements of G/L organizations, a well informed gay man who finds himself antibody positive can use the information to maximize his lifestyle potential and take precautions to protect his partners. Sharing toothbrushes, razors, semen take on more intense consequences. A negative antibody test may give license to avoid precautions. A positive or negative test does not mean that person will not go on to develop AIDS but with a positive test the possibility exists of transmitting the HTLV-III virus. [ED NOTE: So too with a falsely negative antibody test, ehh?] The tasks of educating the gay population will likely remain in the gay community despite the continued demands for more funds. The precautions each individual takes remains a function of that person's sense of personal health and community responsibility. The HTLV-III antibody test can be another tool by which a gay man assesses his own health needs. The potential for abuse of the antibody test is clear and a healthy dose of paranoia has proven an important part of gay survival but as the AIDS scene and scientific research advance, the beneficial effects of the test should not be overlooked and an adamant stand against the HTLV-III antibody test is premature.

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YES--GET TESTED!

by Stephen P. Brasch, MD, Chicago, with thanks to GayLife, 4/4/85

I am surprised at the response organized gay political groups have had towards the development of testing for AIDS virus (HTLV-III) antibodies. Certainly there are many objections which are both emotional and ill-founded. The arguments against using [the test] have been two-fold: 1) political and social--people are afraid of being reported and classified as carriers (I call this the Auschwitz effect); and 2) technical reasons--the medical community does not know how to interpret results, or how to confirm positives or negatives. As Dr. Robert Gallo, discoverer of the HTLV-III virus stated recently, gay groups are "slashing their throats" because of concerns over confidentiality. No conclusions may be scientifically drawn about a person's sexual preferences because of a positive antibody test (Would blood transfusion recipients, hemophiliacs and Haitians also be gassed?). This is a matter our politically active gay groups (such as NGTF) should be addressing in a scientific, emotionally-rational manner. Regarding technical problems with the current test, it should be noted that no test is 100% accurate. There are always some false-positives and/or false-negatives associated with all testing. A physician is trained to interpret test results knowing test limitations. All tests have limitations and must be interpreted on an individual basis. We currently have no sure-proof tests for many conditions we diagnose today, e.g., non A-non B hepatitis, herpes, pre-AIDS, common colds and flus. To say that a particular test is not useful is not appropriate. Gay men must be tested. We must collect data so further research can be conducted. We must gain experience with present testing so needed improvements may be developed. TEsting will allow us to identify ourselves as carriers and to protect our partners and ourselves. We must identify those infected so suitable treatment may be rendered when available. The only way improved tests, treatment and vaccine development will be accomplished is with the support of the gay community. It is a responsibility we have towards each other, towards society and to ourselves to know if we are possibly transmitting a potentially fatal disease. In all likelihood we will not succumb to gas chambers, but to a virus which we have the ability to control.

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NO!! FLIP A COIN INSTEAD!

by David G. Ostrow, MD, PhD

Thinking about getting the new HTLV-III antibody test? Flip a coin instead. Why? For the following reasons:

1) A positive test will not tell you whether or not you have or are going to develop AIDS, whether or not you are capable of transmitting the virus or AIDS to your intimate contacts or whether or not a non-specific symptom, like weight-loss, fever or fatigue, is a sign of AIDS or ARC. Flip a coin, the results will tell you just as much, but without the problems of confidentiality or potential loss of employment.

2) A negative test does not mean you have not been exposed to the virus nor can transmit the disease to your sexual contacts. As many as 20% of gay men who tested negative for HTLV-III antibody actually had the HTLV-III virus present in their bodies. Flip a coin instead, only you will know the result.

3) A positive or negative test does not tell you whether or not it is safe to have sex with someone else. Whatever your HTLV-III antibody status, sex involving the exchange of bodily fluids including saliva, semen, stool, or blood, is not safe for you or your partner. Remember, a high proportion of antibody negative persons actually carry the virus and may transmit it to partners. And if you are HTLV-III antibody positive, that doesn't mean that your immune system is protecting you from the effects of further exposures. As 30-70% of gay men tested for HTLV-III antibody have been positive, your chances of a "positive" test result is about the same whether you actually get the test or flip a coin. But HTLV-III antibody testing exposes you to potential problems with co-workers, with insurance, even in terms of employment and access to health care services. So flip a coin. It's fast, it's free, and it's confidential.

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PROPOSED BAN ON HTLV-III ANTIBODY TEST REJECTED BY HHS

by Marcos Bisticas-Cocoves, with thanks to Boston's Gay Community News, 5/25/85

The Department of Health & Human Services (HHS) has decided to go ahead with plans to help establish alternative sites for the HTLV-III antibody test, despite opposition from the Philadelphia and Chicago health departments (see related article). However, the Illinois Department of Public Health has refused to use federal funds to establish alternative test sites. Arguing that high-risk donors would choose the relative anonymity of blood donor centers over the visibility of alternative test sites and thus infect the blood supply, the health commissioners of those two cities urged HHS Secretary Margaret Heckler to reconsider establishing alternative test sites. Heckler was also asked to forbid blood banks from revealing test results to donors, and to restrict the distribution of the test kits to research and blood screening, in order to discourage high-risk individuals from donating blood. On April 23, former CDC director and Acting Assistant Secretary of Health James O. Mason responded to these proposals: "After considering all sides of the question we did decide that provisions for alternative test locations should be made, in order to protect blood collection agencies from being used by high-risk individuals seeking to learn if they carry antibodies to the virus." The letter went on to say that regulations neither require nor prevent blood banks from reporting test results. Mason also stated that the availability of the test need not be restricted since "the package inserts clearly state that the primary use of the test is to screen blood and plasma." Despite the intentions of HHS, the Illinois Dept. of Public Health has decided to block the establishment of alternative test sites within the state and to develop its own guidelines for blood screening. Under their plan, "...blood banks would not report the... HTLV-III test results to any donor. This action is based on sound public health and medical practice...and is supported by the existing blood banking and clinical laboratory licensing laws in Illinois," wrote former Illinois Director of Public Health Thomas Kirkpatrick. He went on to write that the relevant statutes require the results of medical tests be given to the physician who ordered the test, and not to the person who was tested.

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FEW TEST ANTIBODY POSITIVE

by Mark Scott, with thanks to The Washington Blade, 4/5/85

Fewer than 200 of the 50,000 donor blood units screened thus far with the new HTLV-III antibody test have tested positive for exposure to the HTLV-III virus, the probable cause of AIDS. Figures collected by the American Red Cross from its regional blood centers show that less than one percent of the total blood units tested are positive--a percentage consistent with the results obtained by the test's manufacturer, Abbott Laboratories. Abbott tested 17,400 blood units before gaining federal licensing for the antibody test in March.

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ANTIBODY PREVALENCE AMONG GAY MEN

by Mark Scott, with thanks to The Washington Blade, 5/17/85

Thirty percent of the 1153 gay men enrolled in a federally funded study at Baltimore's Johns Hopkins University Medical Center have been exposed to HTLV-III, the probable cause of AIDS. Dr. Frank Polk, principal investigator of the Study to Help AIDS Research Effort (SHARE) project, indicated that this was an indication of how widespread exposure [and infection and antibody positivity, all presumably synonymous--ED] to the virus may be among Baltimore and Washington metropolitan gay men. Studies in San Francisco, Los Angeles, and New York--where AIDS is most prevalent--have shown that between half and two-thirds of gay men tested have been exposed to HTLV-III. A Seattle study released in March indicates that about 35% of gay men there are antibody positive. The 30% figure for the Baltimore-Washington study "was higher than I would have thought at the beginning of the study," said Polk, but said that the percentage may be lower for the entire area gay male population. Men entering the study--to determine what symptoms may precede the development of AIDS--may have had reason to worry that they had already been exposed to HTLV-III, said Polk. About 20% of the SHARE participants entering the study reported chronic swollen lymph nodes, which can be a symptom of HTLV-III infection, he said. The study population is also 90% white and mostly affluent and well-educated, Polk admitted. "It's not a representative population," he said. "I would reckon [the HTLV-III antibody positivity rate] is lower in the general [gay] community." SHARE began April, 1984, with a grant from the National Institutes of Health and will continue for three more years. Participants will continue to be checked periodically for immune system dysfunctions--such as unbalanced T-cell counts--and for exposure to HTLV-III, said Polk.

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NEW BLOOD TEST INVESTIGATED

from Science, May 31, 1985, Volume 228, pp. 1094-96

A new blood test known as RIP/SDS-PAGE (radioimmunoprecipitation and sodium dodecyl sulfate-polyacrylamide gel electrophoresis) recognizes two glycoproteins (gp160 and gp120) as the antigens most consistently recognized by antibodies found in people with AIDS, ARC, and healthy homosexual males. Although most antibody positive samples from people with ARC and healthy gay men also reacted with the virus core protein p24, less thatn half of the AIDS patients revealed a positive band with p24 under the same conditions. This suggests that the RIP/SDS-PAGE may be a valuable confirmatory assay for establishing the presence or absence of antibodies to HTLV-III in human sera, especially in selected sera that give otherwise uninterpretable results by established ELISA and Western Blotting, and especially "false positives." The new test is thought to virtually eliminate the possibility of false positives.

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ABBOTT LABS REPORTS INCREASED PROFITS THIS YEAR

with thanks to Chicago's GayLife, 4/18/85

Abbott Laboratories of North Chicago, IL, manufacturer of the leading blood screening test kit for antibodies to HTLV-III, reported a 17% increase in net income during the first quarter of 1985. Abbott received massive publicity earlier this year when it was the first company to receive a license for the highly controversial test. In the quarter, net income rose from $87.7 to $102.2 million; sales increased 5% to a record $756.2 million. The federal Food and Drug Administration has estimated that HTLV-III antibody test sales will be as high as $90 million annually.

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CHICAGO & PHILADELPHIA HEALTH DEPARTMENTS FIGHT HTLV ANTIBODY TEST PLAN

by Marcos Bisticas-Cocoves, with thanks to Boston's Gay Community News, 4/27/85

The Chicago Health Department has joined the Philadelphia Dept. of Health in opposing alternative HTLV-III antibody testing sites and disclosure of testing results. In a letter to DHHS Secretary Margaret Heckler dated March 25, Chicago Health Commissioner Lonnie Edwards stated, "We believe that DHHS should focus primarily on the protection of the blood supply, and the best wa to achieve that is by restricting its use to blood centers without disclosure of test results." He wnt on to write that since the HTLV-III antibody test is of little use in diagnosis, it should be used only for blood screening and research. A similar letter had been sent by the Philadelphia Department of Health on March 6. The Philadelphia letter stated that the test "should be approved for the purposes of screening blood and for research," but should not be made "available to the general public." Both health departments argue that, in addition to restricting the test to screening and research, blood that tests antibody positive should be discarded, that no record should be kept on a donor deferral list, and that no alternative test sites should be established. It was argued that test results should not be disclosed because such results are not diagnostic of AIDS, because the media attention surrounding the case has given the public the false impression that it is an "AIDS test," and because individuals who want the test may inadvertantly introduce HTLV-III into the blood supply. The departments disagree on the rationale for opposing the development of alternative test sites. According to Shirley Haas of the Chicago Health Department, establishment of these sites would be prohibitively expensive, costing an estimated $3 million; only about one-tenth of the cost would be covered by DHHS. Philadephia objects on the grounds that individuals at high risk for AIDS would prefer to be tested at blood donor centers and thus retain relative anonymity. The Detroit Dept. of Health has reportedly also issued a letter of opposition to Heckler, according to Debbie Lamm of the US Conference of Mayors, however Commissioner of Health Dr. John Waller couldn't be reached by press time.

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NEUTRALIZING HTLV-III ANTIBODIES & FELINE LEUKEMIA VACCINE

with thanks to Oncology Times, and Jean McCann, March & April, 1985 issues

The discovery of neutralizing antibodies against HTLV-III by three researchers working independently, was disclosed by Dr. Robert Gallo of the National Cancer Institute. Gallo indicated that these new findings help explain why not all those infected with the causative agent of AIDS come down with the overt disease. They may also lead to passive immunization of those with "early" AIDS, and later on, to a vaccine. Speaking to the Congress on Recombinant DNA Research, Gallo said that independently, "Marjorie Guroff of our group [at NCI], Martin Hirsch at Mass General, and Robin White in London now have evidence for the first time that people do have neutralizing antibodies to the virus." In Lincoln, Nebraska, the first vaccine against the Feline Leukemia Virus (FeLV) has stirred renewed hope for a vaccine against another retrovirus, the putative agent of AIDS. The new vaccine reliably prevented cancer in cats exposed to extreme challenge with the virus sufficient to cause disease in 60% of control cats. How this breakthough vaccine will relate to the development of a vaccine against a virus such as HTLV-III is not yet clear, although the prospects have caused excitement in the research community. It has been speculated that this can serve as a model, although there is not enough similarity between the two viruses to warrant alot of discussion, according to Richard Sharpee, senior research scientist at Norden Laboratories, which is marketing the vaccine. One of the major differences between the viruses is that FeLV doesn't show an antigenic shift, which seems to be present with HTLV-III/LAV/ARV. Sharpee said the new feline vaccine , marketed as "Leukocell," is now being stocked in veterinarians' offices across the country, pending public announcement of its availability. It is not only the first vaccine to prevent leukemia, but the first anticancer one developed since a vaccine was developed against Marek's disease in chickens. It is also the first vaccine against a retrovirus. It is estimated that there are 50 million cats in the United States; maybe one third of them will come into contact with the virus in their lifetime and maybe 10-15% of them will succumb to feline leukemia.

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PROTECTING THE BLOOD SUPPLY

San Deigo AIDS Project, 4/23/85

Generally, we tend to look to the north for positive political and social action on the AIDS front. And again, San Francisco has led California, if not the entire country, in releasing the figures resulting from the HTLV-III antibody tests at the Irwin Memorial Blood Bank. The good news--only 12 units of blood have been identified as antibody positive, out of an inventory of more than 5300 units. Those in the blood-banking field expressed surprise and delight at these findings. [ED NOTE: What about the false negatives?] What no one has yet said is that the gay community is chiefly responsible for taking measures that have protected the blood supply from the spread of AIDS. Nearly two years ago, gay communities across the nation joined with blood banks to take steps to prevent the contamination of blood. There was great pressure from within the gay communities to refrain from donating blood. The evidence now shows that strategy was successful. And the obvious result that the spread of AIDS has been sharply limited (though the numbers continue to climb) has been ignored by the media. Unfortunately, the San Diego Blood Bank has not seen the importance of this positive approach to the education of the general community. The Blood Bank is withholding the release of any information until after checking and re-checking with the manufacturer of the antibody test kits (Abbott Labs) for possible error. In the meantime, such fundamentalist [ED NOTE: hatemongering] groups as the California Coalition for Traditional Values, spearheaded by San Diegan Tim LaHaye, send millions of copies of a direct-mail appeal opposing California legislation (AB-1) stating that "homosexuals have been allowed to compromise the nation's blood supply system by a medical elite that was too tolerant to offend sodomites." That literature features the photo of the 66-year-old San Francisco nun who died from an AIDS-contaminated blood transfusion. LaHaye's message is quite clear: filthy faggots kill the innocent. It is important to get support from those agencies in San Diego which have accurate information to counter the emotionalistic fervor of fundamentalists churning up hate campaigns. We should be proud of our efforts to protect the country's blood supply. We should share in the credit because long before the HTLV-III antibody testing, local gays took it upon themselves to make a far more effective move to protect the general populace. Another lie has been put to rest! How long it will take to completely bury that lie is up to the gay community. Now that the fundamentalists have latched onto AIDS, whatever happended to child molestation, women's rights, abortion and just plain homosexuals? It is time to let the general populace know what the gay community has been doing and what it is doing each day--with the agonizing deaths fo friends and lovers or with each pint of blood that has been kept from the nation's precious blood supply and with each breath any of us take of God's given air. It's called acknowledging a job well done.

--Tom Jefferson, SDAP Special Projects/Media Coordinator, with acknowledgement from the Bay Area Reporter.

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NEW YORK CITY TESTS 100 FOR ANTIBODY IN FIRST MONTH

with thanks to The Washington Blade, 6/21/85

About 100 people in New York City have had their blood tested for antibody to HTLV-III during the first month of testing by the city's health department. The department does not operate alternative test sites itself, but does process tests on behalf of private physicians in the city, according to spokesman Marvin Bogner. Gay groups in the city, most notably the Gay Men's Health Crisis, have urged people not to take the test because of its possible threat to an individual's privacy and mental health.

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ANTIBODY TESTING CAN BE MISPROMOTED

with thanks to AIDS Education Programs, Key West, FL, April, 1985

If you see anyone advertising the HTLV-III Antibody test as "AIDS Screening" or "AIDS testing," notify the Food & Drug Administration (Frank Young, MD, Commissioner, FDA, 5600 Fishers Lane, Rockville, MD 20857). They are violating FDA regulations and steps can be taken regarding this false advertising. The test is labeled stating that it does not diagnose AIDS and should not be used as an AIDS screening tool or to identify people in a risk group. If you learn of an insurance company or employer using this test as a screening procedure, notify John Boring, National Gay Task Force, 80 Fifth Av., #1601, New York, NY 10011 (212/741-5800).

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AIDS AND STD PRIORITIES: DEAR COLLEAGUE FROM THE AMERICAN VD ASSOCIATION

by Franklyn N. Judson, MD, President, American VD Association

[ED NOTE: The following article was taken from AVDA's Dear Colleague letter, dated March 25, 1985. We encourage you to comment directly to Dr. Judson, Metro Denver Health, Disease Control Service, 605 Bannock St., Denver, CO 80204-4507.]

"The HTLV-III/LAV epidemic appropriately has come to overshadow other STD and while a high level of funding for HTLV-III research is justified, we must work to assure that it does not come at the expense of existing STD control programs. I am most concerned about the lack of movement towards an organized HTLV-III control program. At this point, it seems that control measures, such as the new ELISA HTLV-III antibody test, are being directed exclusively at preventing transfusion acquired infections, which represent less than 1% of all infections. Are we guilty of taking an ostrich approach to the most deadly STD threat in recent history? The realities of imperfect diagnostic tests and fears about confidentiality should not drive us to the sidelines to observe the natural history of this epidemic. In my mind, the consequences to gay men and other high risk groups of doing nothing are far worse than the sonsequences of an active program that at least considers the use of traditional public health disease control measures. These might include serologic screening of high risk individuals for HTLV-III, compulsory reporting of test results for entry into resptricted access registers, contact tracing and cluster interviews, and legal restrictions on the sexual activities of seropositive individuals. For years, each of these measures has been practiced to control infectious syphilis, 60-70% of which occurs in gay men. The goal for the near term is to better understand the epidemiology of sexually transmitted HTLV-III infections and to contain further spread of the virus. The longer term goal is to use registers to quickly and efficiently recall seropositive individuals for effective antivirals, and seronegative individuals for retesting and administration of protective vaccines. No matter what form control programs may take, their success will depend upon the active participation and support of gay organizations and the gay community at large. This support will understandably be weak until we are able to convince the general public that there is virtually no risk of contracting AIDS through nonsexual contact with HTLV-III positive men, and until we are able to assure gay men that their confidentiality will be protected."

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AMERICAN RUN FOR THE END OF AIDS

The American Run for the End of AIDS (AREA) is a cross-country marathon run around the continental United States by gay American athlete, Brent Nicholson Earle, of New York City. The purpose of the run is to raise money for AIDS, to raise the consciousness and morale of gay people around the country and to promote better understanding and communication between gay and straight Americans. AREA will begin and end in New York City, commencing in the spring of 1986 and ending in the fall of 1987, the run will encompass as many cities and as much area as humanly possible. AREA is not a race, but a run which symbolizes the tremendous effort made by so many people to fight and overcome the terrible disease AIDS. A committee is being formed to organize and promote the run and to establish the AREA Fund. The donations will be evenly divided between AIDS research, support for PWAs, and educational programs for the public. For more information, contact: AREA, c/o Brent Nicholson Earle, 2350 Broadway, New York, NY 10024.

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SF AIDS FOUNDATION SUPPORTS "YOU DECIDE" POLICY ABOUT ANTIBODY TESTING

by Ron Baker, with thanks to the New York Native, June 17-30, 1985

The San Francisco AIDS Foundation, which four months ago advised everyone against having their blood tested for antibody to HTLV-III, has shifted its position to a "you decide" policy. The change comes about as rigid assurances of anonymity are built into the alternative test site program. They also see the program as an opportunity to educate people about AIDS. The Foundation is preparing to publish a lengthy brochure entitled, "AIDS Antibody Testing At Alternative Test Sites: Information to Help You Make An Informed Decision About Whether or Not to Take the Test." The local gay press, the gay political establishment, the gay physicians association, as well as a large segment of city health department personnel in San Francisco have likewise publicly recommended against having bloods tested for HTLV-III antibody.

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BIKE TOUR OF CONTINENT TO RAISE FUNDS FOR DETROIT AIDS GROUP

Bicyclist Mark Landsfeld began an estimated 6800 mile bike tour of North America in Anchorage, June 7th in an effort to raise consciousness and funds for the fight against AIDS. The tour is scheduled to conclude in Key West by about September 21. Flat sum contributions, or per mile pledges are encouraged, with donations being tax deductable. For more information, contact: Mark For Wellness, Wellness Networks, Inc., PO Box 1046, Royal Oak, MI 48068. Wellness Networks have been regularly publishing "healthful sexual activity" information and advice in Detroit area gay publications.

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BIKE-A-THON RAISES $33,000 FOR AIDS

compiled by Stephanie Poggi, with thanks to Boston's Gay Community News, 4/27/85

On Saturday, April 6, approximately 75 lesbians and gay men bicycled 100 miles from San Francisco to Guerneville, CA to raise money for the San Francisco AIDS Foundation. A joint effort of the lesbian and gay bicycling club of San Francisco and the AIDS Foundation, over $33,000 was pledged to support AIDS programs and services.

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ARTS AGAINST AIDS IN CHICAGO RAISES $5000

by Sid Smith, with thanks to the Chicago Tribune, 5/14/85

The Chicago performance community pulled together for an ambitious, entertaining, and emotionally rousing "Arts Against AIDS" benefit that raised an estimated $5000. Described as the first in a series of efforts, the program played to a standing-room-only crowd at Second City, offered an impressive lineup of top local talent, including actors, singers, comics, and musicians. Money for the project goes to the newly created Biscotto/Miller Fund, which will provide financial assistance to Chicago theatre community members stricken with AIDS. The fund was named for Tom Biscotto, a Goodman Theatre employee, and actor J. Pat Miller, who both died from AIDS within the last year.

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DC GRANTS FUNDS TO AIDS EDUCATION FUND

by Lou Chibbaro, Jr., with thanks to The Washington Blade, 5/3/85

The District of Columbia Commission on Public Health announced it is providing the Whitman-Walker Clinic's AIDS Education Fund with a grant of $40,000 to supplement the Fund's fiscal year 1985 budget. The Clinic originally asked for $65,000 in supplemental funding during a February meeting with Clinic Administrator Jim Graham and DC Public Health Commissioner Dr. Andrew McBride. The Clinic has already received $23,000 from the city for the current fiscal year. Graham and Caitlin Ryan, the Clinic's AIDS Education Fund director, said the additional monies will greatly increase the Clinic's ability to assist persons with AIDS and to step up its public education programs to prevent the spread of AIDS. Ryan said that a budget request will soon be submitted to the city for 1986 which will enable them to retain two new employees. On March 5th, the City Council's Committee on Human Services approved $175,000 in funding for the District's AIDS effort for fiscal year 1986. It was unknown how much of these funds would be earmarked for the Whitman-Walker Clinic.

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WALKATHON FOR AIDS IN LOS ANGELES

with thanks to CAIN, Los Angeles, 6/6/85

Los Angeles Mayor Tom Bradley is serving as chairperson of a ten kilometer walkathon that will benefit the AIDS Project/Los Angeles, Sunday, July 28, starting on the "sky set" of Paramount Studios in Hollywood. The fundraiser is being cosponsored by the Los Angeles Times, Frontiers Magazine, Colin Higgins and the Frontrunners Club. For additional information, contact 213/879-8951.

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NEBRASKA RAISES MONEY FOR LOCAL AIDS RESEARCH AND GRNL

by Doug Hinckle, with thanks to The Washington Blade, 5/10/85

Representatives of the Imperial Court of Nebraska (ICON), an organization which stages drag shows to raise money for gay groups, visited Washington, DC to lobby hometown legislators and to present the Gay Rights National Lobby (GRNL) with a $10,000 contribution. ICON Emperor Gary West of Omaha and President Don Randolph of Council Bluffs, Iowa said their organization raised $21,000 in four days "doing drag shows, raffles, auctions, and a picnic." $11,000 of that money was donated to the University of Nebraska Medical Center for AIDS research.

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TORONTO MEN NEEDED

by Colin Soskolne, PhD

Did you know that the male sexual contacts of men already ill with any of the AIDS-related conditions or AIDS itself are being recruited into a prospective study in Toronto? The sexual contacts should be logistically accessible to the Toronto area and the sexual contact should have taken place within one year of the onset of signs and symptoms in the person now ill with either AIDS or ARC and the last sexual encounter should have occurred within the last three years. Such men are encouraged to communicate the fact of their illness to any traceable Toronto-based amle sexual contacts and to encourage those contacts to participate in a study which offers total confidentiality, three-monthly monitoring of the contact's health, and access to professionals to assist with any concerns that these individuals may have. It is only through such communication that a cohort of sexual contacts can be successfully recruited for followup-up purposes. The sexual contacts, in turn, may volunteer their participation to the Toronto-based study office by calling 416/595-4940.

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EPIDEMIOLOGISTS & BIOSTATISTICIANS INVOLVED IN AIDS NEEDED

All epidemiologists and biostatisticians involved in AIDS research are needed for collaboration by the university of Toronto's Department of Preventive Medicine & Biostatistics to help develop an explanatory and predictive epidemic model for AIDS. The purpose of this information gathering is to: 1) iteratively, with collaborating groups, develop epidemic models of the spread of AIDS, and then 2) convene an international consensus workshop of collaborators, experts, professionals and lay participants leading to the publication of a joint proceedings. Your data would always remain your property and any publication of your data would be under your own name(s) in the workshop proceedings. Where data from collaborating centers are pooled for analysis, resulting summary papers forming part of the workshop proceedings will acknowledge any collaboration. The purpose of this series of events is to understand the AIDS epidemic in terms primarily of macro-behavioral variables. Understandings derived are expected to assist in designing public health control strategies. If you are interested in collaborating in this international effort, please send a letter expressing both strong support for the research and the likely data availability. Your letter is necessary as supporting documentation for a grant application intended for submission to the Canadian government as a potential funding agency. The materialization of our objectives is contingent upon the success of our grant application. Please send all correspondence or inquiries to: Dr. Colin Soskolne, Dept. of Preventive Medicine & Biostatistics, University of Toronto, Toronto, Ontario M5S 1A8 CANADA or call 416/978-5479.

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INTERNATIONAL SYMPOSIUM ON AFRICAN AIDS

In many respects, African AIDS presents remarkable features and recent studies indicate that the situation now prevailing in Equatorial Africa is a crucial public health problem. The purpose of this first international symposium is to summarize and discuss the most recent data on the clinical, epidemiologic, and virologic aspects of African AIDS. The Symposium is scheduled for November 22-23, 1985 in Brussels. Abstracts of poster sessions must be received no later than July 15th. Registration fees will be $50 for students, $70 everyone else before October 10. For more information write: D. Shanni, Administrative Assistant, International Symposium on African AIDS, SDR Associated, Rue Vilain XIIII, 17 A, B-1050 Brussels.

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NEW ZEALAND FIGHTS AIDS WITH INFORMED CONSENT

by Galvin Young, with thanks to Toronto's The Body Politic, June, 1985

A bill to legalize homosexual acts between consenting males 16 years of age or older and to include sexual orientation as a ground for complaint of discrimination under the Human Rights Commission Act was introduced into the New Zealand Parliament March 8th, and passed first reading by a free "conscience vote" of 51 to 24, and was referred to committee for study and the hearing of public submissions. The lesbian and gay communities are broadly supportive, although there are divergent views on some details. While it is possible that amendments may be moved on the age of consent question, an argument finding favor with Members of Parliament (MP) is that age of consent must be 16 in order to allow a public health campaign against AIDS, and to encourage gays to seek help and advice. At present health authorities are faced with advising people about safe sex for sexual acts which are illegal, while gays seeking help must, by implication, admit they have broken the law. These are factors considered to act against an effective AIDS campaign, in a country which aas not yet had any "home grown" cases of AIDS. In a sensitive and logical speech on the bill's introduction, Fran Wilde refruted each of the major myths about gays, from religious arguments to those about child molestation. Wilde represents perhaps the most liberal electorate in the country, and is unlikely to be harmed by her sponsorship of the bill. Conservative MP Norman Jones says "legalizing homosexuality would help spread the disease through the schools, the streets and the community." Tory MP Graeme Lee says the acceptance of the bill into Parliament was a dark day in the history of the country. Lee and Jones are to join government MP Geoff Braybrooke in a speaking tour to oppose the bill, whild Lee is also threatening to introduce a bill to outlaw lesbian sexual activity.

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EURO GAY HEALTH CONFERENCE

The European Gay Health Conference '85 was held in London, May 31-June 2, to discuss gay health care issues in Europe and strategies for tackling the growing problem of AIDS. The Conference was held under the auspices of the European Gay Health Care Organization with the Terrence Higgins Trust as the United Kingdom host organization. The main aim of the conference was to bring together gay health care professionals and voluntary workers from all over Europe to review international medical research, and provide a forum for health advisors and educational groups who are dealing with the wider consequences of the AIDS epidemic in order to learn from each other. For additional information, contact: John Fitzpatrick, Conference Coordinator, The Terrence Higgins Trust (a registered charity to inform, advise and help on AIDS), BM AIDS, London WC1N 3XX (telephone: 01.278 8745).

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TRADE UNIONISTS IN AUSTRALIA JOIN FIGHT AGAINST AIDS

compiled by Stephanie Poggi, with thanks to Boston's Gay Community News, 6/15/85

Unwarranted concern over contracting AIDS in the workplace has led to the formation of a Trade Unions Working Party within the AIDS Council in New South Wales, Australia. A similar group was previously formed within the Victorian AIDS Council by the Plumbers and Gasfitters Union. Both groups involve straight and gay trade unionists who consier it important for the labor movement to play a positive role in the fight against AIDS in Australia. According to member Ken Davis of the Gay Solidarity Group and secretary to the NSW Working Party, the unionists are concentrating on making articles available to key union journals to dispel misinformation about AIDS. The Working Party is also intent on eliminating ignorance about the illness in workplaces. Reluctance of social security staff, for instance, to interview people with AIDS and related conditions is being met with information sessions coordinated by union activists. The Working Party is also urging gay men and lesbians to join their unions and become active as a first line of defense for employment rights. [--Filed from Sydney by Kendall Lovett.]

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CONTROL OF AIDS: BIOBEHAVIORAL APPROACHES

Chicago's David Ostrow, MD, PhD, announced plans for publication of a book of proceedings of a workshop on AIDS Risk Reduction that was presented in conjunction with the International Conference on AIDS in Atlanta, April 14, 1985. The Control of AIDS: Biobehavioral Approaches will contain over 15 chapters and is expected to be published late this year in paperback format to help reduce cost. A future issue of the Newsletter will provide additional details.

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CANADIAN AIDS GROUPS MEET

by Christine Bearchell, with thanks to the New York Native, 6/17-30/85

AIDS service organizations from several major Canadian cities convened in Montreal for their first country-wide meeting early in May. In spite of the preponderance of experts on the conference program, participants from the gay community tended to find the information sharing and mutual support among grassroots organizations the most important aspect of the event, which was primarily financed by the federal Ministry of Health. The seven gay or gay-oriented groups and one Haitian community organization formed Canadian AIDS Society/Societe Canadienne du SIDA (CAS), outlined a mandate, structure, and strategy, and elected a steering committee. Kevin Orr, community relations officer for the AIDS Committee of Toronto (ACT) and a member of the CAS steering committee, is optimistic about the new coalition's potential to fulfill its extensive mandate--from securing funds for all AIDS-related activities to identifying medical and psychosocial trends and advising on AIDS testing and treatment. According to Ottawa's Laboratory Centre for Disease Control (LCDC), there were 212 cases of reported AIDS in Canada as of May 1. But as in the U.S., cases seem to be diagnosed faster than public health officials can do the paperwork to report them. The pattern of spread is similar to the U.S., only it's about two years behind. Increased awareness outside the gay community is also proving important. In the early stages of the crisis, the gay community feared that the Canadian Red Cross might succumb to homophobic public or politial pressure. Now communications channels seem well-established between the two groups, a development that is particularly significant in light of the controversy over testing. The Red Cross is the only blood bank system in Canada, where private banks do not exist. AIDS service organizations have been kept abreast of the decision-making. Antibody testing will begin in midsummer; it remains to be decided whether or not results will be given out before the meaning of a positive test is conclusively known. In addition to their willingness to fund grassroots groups, Canadian governments' funding of research compares favorably, on a per capita basis, with that of the U.S. Whether or not and to what extent research is funded here, there is an underlying awareness among most AIDS activists that the really crucial work is being done in France and the U.S. and that those countries' funding and research policies have implications for the health of the whole world's population. So far, Canadian gays and lesbians have been spared the media-inspired "public backlashes" that have been unleashed on gay people in Australia and Britain, where AIDS has progressed to a similar stage as in Canada. The LCDC has been quick to correct misinformation or distortion in press coverage of AIDS, and, with a few obnoxious exceptions, the media have behaved accordingly. Two years lead time is not enough to prevent the hundreds, and probably thousands of Canadians who are or will be exposed to AIDS from becoming afflicted with the syndrome. Yet there are lives to be saved by spreading awareness about how to have relatively safer sex, reducing panic and homophobia, and keeping the pressure on to finance public education and research. It is, as usual, a race against the clock to maximize the advantage of learning from the experience of others. For more information, contact: Richard Burzynski, Association Homophile de Montreal/Gay Montreal Association, CP 1164, Succursale H, Montreal, Quebec H3G 2N1 (514/937-7596).

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CHRISTIAN RESPONSE TO AIDS: NEW BROCHURE

The Universal Fellowship of the Metropolitan Community Churches (UFMCC) has published a brochure on AIDS: A Christian Response, providing a loving, religiously-oriented discussion about the syndrome, risk reduction, the role of God in this crisis, what the local church can do, and what it's like for people who have AIDS, among other topics. The brochure also offers the name & chapter references of helpful scriptures. The pamphlet was written by The Reverend Stephen A. Pieters, and reflects his own experience as a person with AIDS. For a copy of the brochure, or to learn bulk ordering rates, please send a self-addressed stamped legal-sized envelope with $1 (to help in publication expenses) to: UFMCC, 5300 Santa Monica Blvd., #304, Los Angeles, CA 90029-9990, 213/464-5100.

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CANADIAN AIDS SOCIETY FORMS IN MONTREAL

by Ed Jackson, with thanks to The Body Politic, July, 1985

The first crucial steps towards the creation of a national Canadian AIDS organization were taken in Montreal recently, when the mandate and structure of the new coordinating body, called the Canadian AIDS Society (CAS), were hammered out by representatives of AIDS support groups from across the country at the first national conference on AIDS [see related article, "Canadian AIDS Groups Meet."] Much of the groundwork for organizing the conference was done by Richard Burzynski, hired as the sole staff member for the three months preceding the conference. Burzynski claimed the absence of adequate funds for advertising and a lack of interest in Montreal's gay community, particularly it's French-speaking segment, hampered his organizing. The major AIDS organization in Montreal, the Montreal AIDS Resource Committee/Association des Ressources Montrealaises sur le SIDA (MARC-ARMS), is a division of Gay Montreal Association. Founded in January, 1984, it is primarily an English-speaking organization and is perceived as such by gay Francophones. Observers of the Montreal gay scene say Francophone gays do not yet believe AIDS is a seriuos threat. The saturation coverage on the topic in the English-language Canadian and American media has not penetrated tp the French-speaking population of Quebec. In addition, Francophone gays are said to believe AIDS is a risk mainly to the English -speaking gay men who travel frequently to New York and San Francisco. [ED NOTE: Shades of medieval Europe, where syphilis was called, "the French disease," by the Napalese, "le mal de Naples," by the French, "the Spanish disease," by the English, etc.!] The conference was more successful in securing the participation of nurses involved in an AIDS support group in the Haitian community. Montreal has a large Haitian population, but despite a relatively high number of AIDS cases of Haitian origin reported in Quebec, there had been almost no contact between gay and Haitian groups until the conference. "I think the conference was a very good thing," said Marie-Luce Ambroise, a Haitian nurse at Montreal General Hospital. "I never knew there was a group like MARC-ARMS doing the same thing as we are." Ambroise is a member of la Groupe de soutien pir le SIDA (AIDS support group) and was chosen as one of the six members of the steering committee of the new CAS. Ambroise said there were both language and cultural impediments to gays and Haitians cooperating with each other. Haitians are primarily French-speaking, and it is also necessary to communicate in Creole dialect to the segment of the community that is not educated. A community forum on AIDS planned for June, for example, will provide information in both languages. Many people in the Haitian community do not want to work with gay people, Ambroise said. "It's a taboo," she explained. "We don't accept it (homosexuality) and it's not talked about." However, she added that this was no problem for the Haitian nurses' group. "We want to know how to work with homosexuals. We have to get help. I'm sure we [the Haitian support group and MARC-ARMS] are going to work together." Keynote speaker Dennis Altman, an Australian writer and political commentator who has just completed a book on the politics of AIDS, tole the assembly that the disease was changing the very nature of the gay movement. He said he worried about "the new stress on professional credentials rather than movement experience" which is creating a cadre of full-time gay experts, particularly in the U.S. Altman also expressed surprise at the typically Canadian tone of politeness he observed at the conference. "It strikes me as an outsider that you could do with a lot more anger," he said. "We have a right to be angry." The Canadian Air Line Flight Attendants' Association (CALFAA) sent two official delegates to the AIDS conference, the only union to do so. CALFAA represents 6000 flight attendanets from eight major air carriers in the country. According to Paul Gauthier, one of the CALFAA representatives, officials in his union have been very interested in learning more about AIDS. He said CALFAA is setting an example for other labor unions by carrying information about AIDS in its newsletter and by briefing union health and safety committees on how to deal with AIDS patients. At least three of CALFAA's members have contracted AIDS, and it is also believed that the first AIDS patient identified in North America (sometimes known as Patient Zero) was a Canadian flight attendant.

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NEW ZEALAND GAY COMMUNITY NEEDS YOUR HELP!

The AIDS Support Network of Auckland, New Zealand needs supporting comments about the positive role that law reform will play in control of AIDS, according to Tony Hughes, Coordinator of the Auckland AIDS Project in a letter to the NCGSTDS. The Homosexual Law Reform Bill before Parliament would make it an offense to discriminate against anyone on the grounds of their sexual orientation. The Salvation Army supported a petition opposing the proposed law which has resulted in their international headquarters in London requesting a full report on the issue. Although the international headquarters has the power to intervene, Commissioner William Cairns, the international secretary for the army's South Pacific and East Asia region, said that he did not see anything like that happening. Meanwhile, a television drama series based on the work of the Salvation Army (also known as Sallie Ann) has been canned because of the army's political stand on the Bill. Television New Zealand decided to drop the series, tentatively titled, "Blood and Fire" even though the format of the 44 part series had been approved and the first episode written. "Nobody would argue about the good work the Salvation Army does, but I cannot make a program about a group that has alienated a large percentage of its potential audience," said producer John Whitwell. Nurses at Auckland Hospital were told to stop asking patients to sign the petition against homosexual law reform. New Zealand's Scout Association also opposes the Bill, saying that it would prevent the rejection of scout leaders on the basis of homosexuality. Various religious groups took up both sides of the issue as well. Passage of the Bill will greatly improve the chances of an effective prevention campaign in respect to AIDS. Please send supporting documentation to: Tony Hughes, Coordinator, Auckland AIDS Project, PO Box 6663, Wellesley St., Auckland 1, New Zealand.

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TORONTO MAYOR PROCLAIMS AIDS AWARENESS WEEK

by Ric Taylor, with thanks to Toronto's The Body Politic, June, 1985

In marked contrast to 1984, Toronto's Mayor Art Eggleton and the Metropolitan Toronto Chairman Dennis Flynn have both backed the city's second AIDS Awareness Week, planned by the AIDS Committee of Toronto (ACT) for June 10-16, 1985. Each day of the week will have a different focus. On Monday, June 10, a press conference will deal with "AIDS and the Heterosexual Connection," with an evening performance entitled, "Caught in the Act: A Safe Sex Cabaret." Tuesday will focus on "AIDS and the Health of the Gay Movement," with a panel discussion of sexuality and AIDS. On Wednesday, a forum will address the question, "Should the women's community join the fight against AIDS?" Thursday's program will feature an up-to-date medical information forum focusing on viruses, psychological ramifications (including those for the worried well) and legal issues, "AIDS in '85: A Forum for Gay Men." Friday will see a condom blitz bar crawl. A preview of "No Sad Songs," a film coproduced by ACT will be offered on Saturday, and Sunday will feature a forum on "AIDS and the Matter of Blood," dealing with blood donations, transfusions and testing. Several fundraising events, the presence of AIDS support booths at hospitals, and a photo exhibit documenting the lives of two people with AIDS will also take place during the week.

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VANCOUVER AIDS GROUP GETS FEDERAL GRANT

by Neil Powers, with thanks to Toronto's The Body Politic, June, 1985

Health and Welfare Canada has for the first time committed itself to financial support for a community-based AIDS organization from its regular programs. Last year's commitment of $1.4 million to AIDS research was a special allocation made outside the federal health department budget. The grant to AIDS Vancouver was announced in a letter from energy minister Pat Carney, the Member of Parliament from Vancouver Center, to the Vancouver gay community. The letter, in part told of a personal tragedy "...with the recent death from AIDS of the brother of one of my dearest friends." The grant is being made by the regional office of the health dept.'s Health Promotion Directorate, which has not yet committed itself to a specific sum. AIDS Vancouver Chairperson Gordon Price hopes for at least $250,000, but cautions that the allocation has been approved in principle only, saying that the federal money is contingent upon funding from the City of Vancouver. The money will be used to provide information and heighten public awareness of AIDS, to run support services, and to help build a network of concerned organizations.

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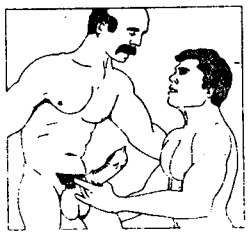
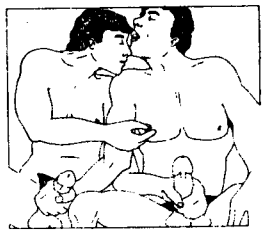
PRINTER CENSORS SAFE SEX DRAWINGS

by Matthew Stadler, with thanks to the New York Native, 5/6-19/85 and
by Lou Chibbaro, Jr., & Mark Scott, with thanks to the Washington Blade, 4/26/85

St. Louis' gay newspaper, No Bad News (NBN) recently announced that it will no longer use the Granite City Press-Record Journal as its printer after they refused to print their April edition unless the paper agreed to censor drawings promoting safe sex that depicted naked men touching each other. The drawings in question were taken from posters funded by the Australian government to help fight the AIDS epidemic, and were developed by the Sydney Gay Counseling Service and the Health Department of New South Wales, in a "Rubba Me" safe sex campaign, which encourages the use of rubbers and various erotic rubbings. Chris Edwards, managing editor of NBN, said he "realized that this joint effort by the gay community and a large state government was an important story." The posters have been displayed in Australian gay bars and bathhouses. The printer was charged with harming efforts to curtail the spread of AIDS by preventing the distribution of safer sex information.





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SUBWAY FARECARD'S AIDS MESSAGE STIRS CONTROVERSY

compiled by Marcos Bisticas-Cocoves, with thanks to Boston's Gay Community News, 4/20/85

On March 25, Washington, DC's Whitman-Walker Clinic asked public transportation officials to remove a subway farecard stating in part that "50% of the cases of AIDS are black and hispanic" after receiving complaints from local latino leaders, according to the Washington Blade. Caitlin Ryan, program manager of the Clinic's AIDS Education Fund, said the ad was intended to inform the black and latino communities that AIDS is not solely a white male disease. Fifty percent of Washington's AIDS cases are black, and only 5% are latino. Rita Loler, Deputy Director of Latino Affairs for the District of Columbia, said "Our concerns were definitely not anti-gay....[AIDS] cuts across ethnic boundaries. We were concerned that their [ad] was misleading...[that] it would create an additional stigma for a group that is already stigmatized." Ryan said that the ad will be rewritten and will be resubmitted at a later date.

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EDUCATIONAL MATERIAL REQUESTED BY GMHC

The Department of Education of New York's Gay Men's Health Crisis is currently seeking copies of any healthy sex, risk reduction, and educational materials, including audio-visuals to design, implement, and evaluate AIDS risk reduction programs which are intended to significantly advance the course of presention of AIDS among gay and bisexual men in the community at large. A review of the existing materials will enhance GMHC's endeavors as they continue to serve the community in our struggle against AIDS. The materials that we develop will be available upon request. Please send materials to: Raymond Jacobs, GMHC Department of Education, Box 274, 132 West 24th St., New York, NY 10011 (212/807/7035).

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CONDOMS: LAND 'O LATEX ON SAN FRANCISCO'S CASTRO STREET

with thanks to the San Francisco AIDS Foundation and the Bay Area Reporter, 5/2/85

It's Condom Mania on Castro Street in San Francisco, as area businesses launch an "at cost" condom campaign with designer condoms, tickler condoms, and lubed & unlubed condoms to name a few. The condom promotional plan was implemented by Les Pappas, community business outreach coordinator for the San Francisco AIDS Foundation. The aim is to make condoms readily available so that AIDS prevention is not just talked about, but acted upon. Business owners are taking the lead in bringing condoms out from "behind the counter" and creating ways for customers to easily and cheaply get condoms. One business will be selling condoms at cost--for between 7¢ and 13¢ each. "What's important about condoms," Pappas said, "is that people do need to experiment with different varieties so that they can find the brand which works best for them. Condoms come in different shapes, sizes, colors, ... and textures, so it's important to know which condom type adds the most pleasure to your personal sexual expression." Another barrier to condom use, besides sex appeal and availability, is a "fear" that they will break or not work properly. Pappas explained that there are three common reasons for condom breakage which can easily be avoided. Latex condoms are not effective if they are more than two years old, because the latex breaks down; have air bubbles trapped in them, because they can more easily burst; and if oil or petroleum-based lubricants (crisco, lube, performance) are used, because these will cause the latex to break down. It is commonly believed by medical researchers that condoms will prevent the passage of many common sexually transmitted pathogens, including herpes, yeasts, CMV, EBV, gonorrhea, syphilis and chlamydia. Although not yet conclusively studied, condoms are also thought to be effective barriers against HTLV-III, the virus associated with AIDS.

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BARTENDERS COUNSEL PATRONS ABOUT AIDS

by John Wetzl, with thanks to the Sentinel USA, 4/11/85

San Francisco's AIDS Foundation struck out on a new front in the anti-AIDS effort, teaching bartenders how to inform patrons directly in the bar setting about AIDS risks. In a meeting in March, some 14 area bartenders discussed how best to convince colleagues and patrons to give up risky sex practices to prevent AIDS and other STDs, and brings the educational effort right to the transit point, where many contacts for sex are made. Rick O'Brian, bartender at a popular club in the Castro, is concerned that young people first entering the bar scene need to have infomration at their disposal that bartenders could obviously provide. The group also discussed the possibility of bartenders distributing 15,000 condoms the AIDS Foundation will provide to Tavern Guild bars in the near future. For more information, contact Les Pappas of the AIDS Foundation: 415/864-4376.

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DOCUMENTARY ON AIDS WINS GOLDEN EAGLE AWARD

"For Our Lives," a video documentary on AIDS, has been awarded a Golden Eagle by the Council on International Nontheatrical Events (CINE) as evidence of its suitability to represent the United States and American cinematography in international festivals abroad. Michelle Paymar, director/writer/producer, and Garland Kyle, writer/producer will travel to Washington, DC in December to CINE Annual Awards Ceremonies to accept this prestigious award. "For Our Lives" combats the fear and misinformation surrounding the AIDS crisis, provides current and unsensationalized information about the disease and promotes risk-reduction through safe[r] sex practices. Nearly 50 people, all of whom volunteered their labor and expertise, were involved in the making of the documentary. The media professionals who comprised the production crew, the editor and producer/director, are women who donated their media skills to help fight a disease whose victims are generally young, gay men. Kyle is also director of health education at The Gay & Lesbian Community Services Center in Los Angeles. Through screenings for television, community centers, clinics, schools, professional associations, hospitals, and political groups, the documentary is reaching gay men, health professionals, educators, students, public officials, and general audiences interested in gaining greater awareness of this complex and controversial disease. For more information, contact: Garland Kyle, GLCSC, 1213 N. Highland, Los Angeles, CA 90038, 213/464-7400 x274.

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MOTHER'S HANDY SEX GUIDE

The Los Angeles Gay & Lesbian Community Services Center and the AIDS Project/Los Angeles are jointly sponsoring the L.A. CARES project to spread important information about AIDS and safer sexual activities. L.A. CARES stands for the Los Angeles Cooperative AIDS Risk Reduction Education Service. The major thrust of the L.A. CARES promotion has been mother's love and concern for her children, gently reminding the gay community of our responsibility to each other, to be well informed about gay health issues, and to practice safer sex. An elderly actress personifies "mother" in billboards, posters, videotapes, and brochures. Mother's Handy Sex Guide is an illustrated storypamphlet with three safer sex "porno" stories eroticizing healthful sexual activities. The back page of the pamphlet offers the essential facts about not sharing body secretions, and lists "safe," "possibly safe," and "unsafe" activities, offers "mother's advice" and lists several local social service/AIDS organizations and their phone numbers. For more information, contact L.A. CARES, c/o AIDS Project/LA, 937 N. Cole, #3, Los Angeles, CA 90038, (213/871-AIDS), or c/o GLCSC, 1213 N. Highland, Los Angeles, CA 90038 (213/464-7400).

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HOT LIVING: EROTIC STORIES ABOUT SAFER SEX

The first book to consciously eroticize safer sex practices has just been published by Alyson Publications. Hot Living, whose contributors include many of the country's top gay writers (John Preston, Phil Andros, Toby Johnson, George Whitmore, Tripp Vanderford, T.R. Witomski, Robin Metcalfe, Max Exander, Mach, Marty Rubin, Frank Mosca, Darrell Yates Rist, Eric Rofes, and David Barton-Jay), proves that safer sex is satisfying in the most convincing way possible. Another reason that Hot Living is exceptionally important is that most publishers of gay porn unfortunately, have shown little interest in publishing safer-sex pornography. If Hot Living is successful, it will encourage other publishers to follow suit. The book has 16 stories in almost 200 pages, and costs $7.95. Royalties from this book are being given to New York's Gay Men's Health Crisis. Contact Alyson Publications, Inc., PO Box 2783, Boston, MA 02208 (in Europe: GMP Publishers, PO Box 247, London, N15 6RW), ISBN 0 932870 85 6.

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CAMPAIGN '85 MEANS SAFER SEX IN ATLANTA

The "P.S., I Love You," (or, "Play Safe[r], I Love You") campaign is well-organized and about to take off, according to AID Atlanta (AIDA) Campaign '85 co-chairs Jesse Peel, MD, and Ken Kimsey. A $12,000 grant from the US Conference of Mayors will help the campaign committee reach thousands of sexually active gay men in metro-Atlanta with positive information and images about AIDS risk reduction through safer sexual activities. Randy Godwin and Alan Perreault are heading up a media group to promote high visibility. A calendar featuring "A Man a Month" from area organizations and gay businesses is a centerpiece of the media efforts. Similar to a calendar project from Houston's AIDS/KS Foundation, each man's photo in the 15 month calendar will be accompanied by a light-hearted but useful comment about safer sexual practices. Bar napkins, coasters, matchbooks and condoms will flood area bars and businesses in the summer and fall, featuring the "P.S., I Love You" theme and the AID Atlanta phone number. T-shirts and a special "Bag of Tricks," or "Safe[r] Sex Survival Kit" will be distributed and sold as a useful novelty item to reinforce the message. Dozens of small group parties will begin in homes around Atlanta in June, focusing on the theme of safe sex. Trainers, or "party consultants" will be instructed on how to conduct the planned small group sessions. The format for the parties will include a safer sex trivia game, a smorgasbord of condoms and information about them, a role-play on how to tell your partner you're into safer sex, and a feature about the fringe benefits of playing safer. A "Play Safe[r] Survey" in a self-addressed card format is also being distributed. The survey is designed to help in planning and education to stop the spread of AIDS, and asks some basic demographic questions (sex, age, city of residence, race, income, and sexual orientation) in addition to questions about source of AIDS information, use of "safer" sex activities, and the HTLV-III antibody test. For more information, contact AID Atlanta, 1132 W. Peachtree St., NW, Suite 112, Atlanta, GA 30309.

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JERK-OFF ENTHUSIASTS CLUBS

by Jeffrey Meiser, JOE Club of New York City, with thanks to the NY Native, 5/6-19/85

The reason for the existence of the Jerk-Off Enthusiasts clubs is to provide gay men with a healthy means of expressing their sexuality. Through our one-to-one contact, our phonesex clubs as well as our weekly groups on Thursdays and Sundays, and hopefully our weekend excursion to the Poconos, our purpose is to promote safe, healthy sexual expression. Recently, a writer from the Native attended one of our weekly groups. One of our uniformed fluid patrol officers, as well as several of the staff in the bar, saw this individual possibly engaging in an unhealthy exchange of blody fluids. The fluid patrol officer warned this individual that our Safe[r] Sex Rules are posted at the door and he would have to leave if he proceeded to in any way break them. The writer became infuriated and said that this guy on our fluid patrol should be fired for his accusations. Your writer then retrieved his clothes and left. If this constitutes a creation of a humiliating situation for anyone ("Night on the Town," Native 114, 4/22-5/6/85), then we wish those individuals would frequent one of the other clubs, backrooms, movie houses, or bathhouses, where what we believe are unsafe sexual acts can take place. There are few places in [New York City] where gay men can get together to have safe[r] sex, and we will do everything in our power to insure that our group is one of them. We refuse to change our standards merely because a writer...threatens to publish something negative about our club. If enforcement of our safe sex standards is something to be condemned, then we will risk the wrath of your newspaper. If your writer is not aware of them, perhaps he should read the statistics published in your paper. We stand behind our action; but if you believe that your writer was correct in using his power ...to publish something negative about our groups, then we believe it is time you reevaluate the articles you print on the AIDS epidemic.

Jan Carl Park responds: I am a major supporter of J.O. clubs and the safe[r]-sex activities they represent. I am not a supporter of gay businesses that are rude to customers because they are the only game in town (fortunately, in this case there are others doing the same thing better). As the compiler of the Night on the Town page [in the Native], I have received much criticism for listing J.O. clubs in the entertainment section of the paper, from individuals at the Native and people on the street, but I persist because I believe that J.O. clubs are a sane alternative to anonymous backroom sex.... The person reporting on the behavior of your club's employee is one of my most trusted sources--and, for your information, as well-informed as most on the topics of safe[r] sex and AIDS. His comments were not unlike those I have received from other people who have attended...J.O.E. sessions. To hire an individual who is rude and coarse to enforce rules in a situation that requires a bit of diplomacy (to say the least) seems to me equivalent to hiring a gorilla to bake a cake.

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NATIONAL GAY HEALTH CLUB OWNERS CONVENE

with thanks to Cruise (Detroit), 5/29/85

Gay health club owners from around the country in Indianapolis May 13-15 to discuss issues of mutual concern. Present were owners & representatives from 53 clubs from around the country except New York. Attending were delegates from the Independent Gay Health Clubs of America, the Club Bath Chain, and many non-affiliated clubs. Guest speakers included Dr. Brett Cassens, president of the American Association of Physicians for Human Rights, a gay/lesbian physician group, and Dr. Bruce Voeller, president of the Mariposa Foundation and co-founder of the National Gay Task Force, among others. The conference included frank and candid discussions on the necessary role of the gay health club as a center for dissemination of information on AIDS, the status of IGHC's legal defense fund, and the role of gay health clubs in the protection of sexual civil liberties. Unanimous agreement was reached in the following areas: Working with local health departments to the fullest possible extent. Promoting sexual responsibility within gay health clubs through the distribution of AIDS literature and promoting the widespread use of condoms. Encouraging an exchange of information concerning AIDS with all gay health clubs in North America. Initiating a broad dialogue with the entire gay business community to enlist their support in our efforts to make our community healthy. Remaining committed to the protection of sexual civil liberties. Continuing the ongoing efforts to raise and maintain a national legal defense fund for the future of the gay health club industry and the rights of its members.

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INDEPENDENT BATHHOUSES AGREE ON SAFER SEX

by Mark Scott, with thanks to The Washington Blade, 5/24/85

Representatives of 52 bathhouses around the country agreed at an Indianapolis meeting to provide safer-sex education for their patrons, according to Stan Berg, managing director of the Independent Gay Health Clubs, a chain of about 40 bathhouses. The 3-day meeting, hosted by IGHC was the first of its kind. "For 52 clubs to come to an agreement on this is pretty amazing," said Berg. According to Club Baths Chain founder Jack Campbell, bathhouse representatives agreed "there were certain steps they should be taking: handing out safer-sex condoms, removal of slings and glory-hole booths." Most representatives indicated their bathhouses had already adopted some of those measures, Campbell said. Berg said he was disappointed that more bathhouses did not send representatives. Two hundred invitations had been mailed to bathhouses from across the country. Conspicuously absent from the meeting were representatives of bathhouses headed by CBC President Charles Fleck, who is currently at odds with Campbell over the safer-sex issue. Early in May, Campbell persuaded majority stockholders from 11 CBC bathhouses to withhold their dues from CBC, charging that Fleck had acted irresponsibly by refusing to promote safer sex. Fleck told the Blade he did not attend the Indianapolis meeting because of a death in his family. He also said that CBC bathhouses have adopted some safe-sex measures, but "we have to give the customers credit for being adults--I'm not going to tell them what to do." [ED NOTE: See related article!]

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ATLANTA BATTLES GAY BATHHOUSES

by Gerald A. Cabrera, with thanks to Boston's Gay Community News, 4/13/85

A February 28th preliminary hearing in Superior Court in Atlanta has quieted little of the furor surrounding the February 10 police raid of the Locker Room Health Club and Club Atlanta, two gay bathhouses. The Locker Room has since voluntarily closed after first signing a compliance order to prohibit "sodomy" in thier bathhouse. "Sodomy" in Georgia includes both oral and anal sex. Fulton County Solicitor Jim Webb filed a civil suit under a state public nuisance law, demanding that the bathhouses be closed to prevent the further spread of AIDS. In addition, ten people were arrested in the raid on the two baths. Club Atlanta, which remains open, has begun posting safer sex guidelines and distributing condoms to their patrons. Ken South of AID Atlanta (AIDA) said he was pleased with the Club's new efforts at safer sex education. South said that AIDA had refused to support the Club unless they made changes, especially in the encouragement of safer sex practices. The establishement of a monitoring group was suggested, in addition to the promotion of the safer sex guidelines. The monitoring group would be made up of members of the Atlanta Business and Professional Guild. Nick Dana, head of the Lesbian/Gay Rights Chapter of the American Civil Liberties Union indicated that other avenues besides a legal one are being pursued. Morris Redding, Atlanta's Chief of Police, has planned a meeting between himself, two gay representatives, Gene Guerrero, Executive Director of Georgia's ACLU, and a representative from the metro vice squad. The group will try to reach an understanding about past actions of the vice squad and current enforcement policy. Dana described Redding as "ccoperative and supportive" and said he hoped the vice squad would see they were using "selective enforcement" by exclusively targeting the bathhouses. Mayor Andrew Young has also communicated his support for the meeting. In the meantime however, Brian Spears, attorney for the Club Atlanta, and Dana expect to see continued vice squad harassment of gay men.

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UNDERCOVER ACTIVISTS AT NY BATHS

with thanks to The Washington Blade, 5/24/85

A group of volunteer gays has begun monitoring bathhouses to determine whether the facilities are complying with safer sex guidelines, reports The Advocate. The group, known as the Coalition for Sexual Responsibility, is sending volunteers into each of the city's 10 baths to sign in undercover as a patron. While inside the facility, these volunteers will check to see that the bathhouse has eliminated glory holes, slings, and other accoutrements of "unhealthful" sex; they will also check to see if safer sex literature is posted and available, whether condoms are available, and whether bathhouses are adequately lighted. Those bathhouses which fail or refuse to comply with the recommendations will be picketed, but one bath owner said, there "wasn't any disagreement or animosity" between bath owners and the Coalition. The bath owners said most of the facilities had already established some of the safer sex recommendations before the Coalition formed.

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US CONFERENCE OF MAYORS AWARD EDUCATION GRANTS

from AIDS Information Exchange, Volume 2:3, April, 1985

Grants totaling $186,664 have been awarded by the U.S. Conference of Mayors (USCM) to 11 community-based organizations for projects to initiate or expand upon existing AIDS information/education services. The eleven community projects were selected from 60 proposals from 55 locally based organizations submitted to the Conference of Mayors in response to a Request for Proposals (RFP) issued in December, 1984. Under the RFP guidelines, eligible community-based groups were defined as non-profit, non-governmental, locally-based organizations with established ties into the community network of gay and/or bisexual males. Funding will be for a period of up to 12 months, dependent upon the project's workplan and objectives.

In March of 1985, an independent advisory board created by the U.S. Conference of Mayors was convened to review proposals and to make recommendations for awarding contracts. Of the 60 proposals reviewed, the advisory board recommended nine to receive grant awards with funding beginning this month, while two projects were approved contingent upon USCM receiving additional funding from the U.S. Department of Health and Human Services.

Program Descriptions

In dealing with the AIDS crisis, community-based organizations are in a position to effectively communicate to at-risk groups the preventive measures that may minimize the possibilities of contracting and transmitting the disease. Proposals from twenty-seven states and the District of Columbia were reviewed by the advisory board. Funded organizations will be conveying risk reduction methods and general AIDS information and counseling through a variety of methods, both traditional and innovative, including the use of telephone tapes, fact sheets, buttons, audio-visual presentations, individual sessions, and group seminars.

Several of the groups developed themes for their programs. In addition to informing high risk populations, five of the funded projects include the presentation of health education messages to health professionals. Following are brief descriptions of the eleven funded projects, amounts funded, and contacts for further information.

AID Atlanta has developed "Campaign 85" as the banner for its risk reduction program. Components of the campaign include a safe sex survey of gay males; focus groups established to discuss the AIDS issue with members of the gay community; trainers who will conduct safe sex seminars for various gay organizations; sub-group task forces, which will contact and meet with specific at-risk groups (gay Black men, gay youth, and IV drug abusers); and an extensive media campaign to distribute the safe sex message through posters, napkins, matchbooks, decals/stickers, flyers, pamphlets, direct mailings, and newspaper advertisements.

Contact: Ken South; AID Atlanta; 1132 W. Peachtree Street, NW, Suite 112, Atlanta, GA 30309; (404) 872-0600; $12,513.37.

Brady East STD Clinic of Milwaukee will develop its educational outreach by building upon its established network of contacts with gay/lesbian groups, businesses catering to gays and lesbians, health professionals, and religious leaders. Activities include publishing articles in gay publications; revising and updating AIDS educational materials; development and distribution of health education materials directed at specific segments of the gay population; presentations to gay/lesbian groups; and contact with gay/lesbian establishments about the existence and availability of AIDS educational materials.

Contact: Nova Clite; Brady East STD Clinic; 1240 East Brady Street, Milwaukee, WI 53202; (414) 449-1700; $18,730.00

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US CONFERENCE OF MAYORS, Continued

Foundation for Health Education, New Orleans, Inc. will be conducting a series of AIDS educational forums targeted for a gay audience; preparing and publishing AIDS awareness newsletters and updating an AIDS prevention brochure; training volunteers who will assist in AIDS-related activities; presenting monthly educational meetings -- led by a health professional -- directed at gay and health community audiences; and expanding its speakers bureau.

Contact: Joseph Nigliazzo, Jr.; Foundation for Health Education, New Orleans, Inc.; P.O. Box 51537, New Orleans, LA 71051-1537; (504) 587-7406; $19,860.00.

Health Issues Task Force of Cleveland has four components to its program. A safe sex campaign will utilize posters, buttons, advertisements in gay and traditional newspapers, and brochures. The campaign will include bartender education in the promotion of safe sex, safe sex pledge month, and sports tournaments publicizing AIDS education. Health Issues Task Force will also conduct in-service training for health professionals; outreach to gay and bi-sexual Blacks and closeted gays through Black and traditional media channels; and increased support and counseling to AIDS and AIDS Related Complex (ARC) patients.

Contact: Theodore R. Wilson; Health Issues Task Force; P.O. Box 14925, Public Square Station, Cleveland, OH 44114; (216) 752-5876; $19,064.00.

KS/AIDS Foundation of Houston, Inc. will be conducting its program of AIDS education efforts in collaboration with two other Houston area gay community service organizations. KS/AIDS will conduct workshops on avoiding the transmission of AIDS; produce a videotape on health promotion and disease prevention; develop an AIDS telephone tape for youth; develop a health education training package for educators at the high school and college levels; and prepare individualized fact sheets for distribution to at-risk populations who have been traditionally difficult to reach ,i.e., Hispanics, closeted gays and those new to the gay life-style.

Contact: Michael B. Wilson; KS/AIDS Foundation of Houston, Inc.; 3317 Montrose, Box 1155, Houston, TX 77006; (713) 524-2437; $19,959.60

Minnesota AIDS Project will convey a safe sex message through the "Captain Condom" character, a humorous superman-like character who promotes safe sex by intervening "in various situations to assist gay men in reducing risk for AIDS while remaining sexually active." The primary forum for the Captain Condom message will be safe sex seminars, which will include a slide tape presentation followed by open discussions on safe sex. Personal appearances of the cartoon character will be made at bars, organization meetings, and other sites in order to promote the safe sex seminars. Posters will be distributed, and condoms will be given away at bars, bath houses, and other establishments frequented by gay and bisexual men.

Contact: John Weiser; Minnesota AIDS Project; P.O. Box 300122, Minneapolis, MN 55403; (612) 824-1772; $19,096.00.

One in Long Beach, The Center, a gay/lesbian community and health center, will conduct AIDS awareness and education programs under its existing Project AHEAD (AIDS Health Education and Assistance Delivery). An extensive volunteer training program has been developed to carry out The Center's AIDS educational efforts. AIDS literature will be prepared and AIDS services will be documented for dissemination to the community. Volunteers will distribute AIDS information in locations frequented by gay men and to appropriate organizations, e.g., gay and traditional community agencies.

Contact: Michael Noll; One in Long Beach, Inc., The Center; 2025 East 10th Street, Long Beach, CA 90804; (213) 498-8801; $13,728.00.

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US CONFERENCE OF MAYORS, Continued

Philadelphia AIDS Task Force expresses the concern that a misconception exists in the Black community that AIDS is not a problem among Blacks. In targeting young, urban Black men -- gay and heterosexual -- Philadelphia AIDS will be conveying its message through music in the form of a "rap" record -- a narrative song explaining the AIDS issue. An ad campaign incorporating the theme of the record will be developed utilizing posters and brochures on safe sex.

Contact: Nicholas Ifft; Philadelphia AIDS Task Force; P.O. Box 7259, Philadelphia, PA 19101; (215) 574-9666; $13,710.00.

Western New York AIDS Program will be producing an educational cabaret-style show designed for gay and bisexual audiences. This safe sex presentation will be performed live twice and videotaped for future use in bars, counseling groups, home parties, and other settings. In addition, safe sex pamphlets and condom use pamphlets will be produced for distribution at the cabarets and subsequent video presentations.

Contact: Ross G. Hewitt; Western New York AIDS Program; Buffalo AIDS Task Force, Inc.; P.O. Box 38, Bidwell Station, Buffalo, NY 14222; (716) 881-2437; $10,185.00.

Two projects were awarded grants totaling $39,819 contingent upon USCM receiving additional funding on May 1, 1985:

Fenway Community Health Center will establish a program of special services for the Metro-Boston Haitian community. A clinical coordinator will act as a liaison with the Haitian community in providing AIDS outreach, referral, counseling and education. In addition, AIDS educational materials specifically targeted to Haitian immigrants will be prepared.

Contact: Gail Sharfman; Fenway Community Health Center; 16 Haviland Street, Boston, MA 02115; (617) 267-7573; $19,819.20.

Personal Liberty Fund will provide AIDS educational services to northern New Jersey through the distribution of safe sex leaflets, factsheets on AIDS, and Spanish language versions of AIDS literature. In addition, a medical referral list wil be established, quarterly meetings will be held with health professionals, and an ongoing speakers bureau will be established by the project.

Contact: Personal Liberty Fund; P.O. Box 1431, New Brunswick, NJ 08903. $20,000.

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CARE BEYOND THE HOSPITAL: VIDEOTAPE ABOUT AIDS

AIDS: Care Beyond the Hospital is a videotape version of a slide presentation specifically designed as a teaching tool for health care providers who are or will be working with people with AIDS in the home. There are two versions of the videotape. The 45 minute Case Management version includes a section on case management of the PWA, and is directed to visiting, public health and hospice nurses, social workers, discharge planners, hospital nurses, and other practitioners. The 30-minute Attendant Care version omits the case management section and outlines basic home hygiene techniques, and is intended for home health aides, attendants, & volunteers caring for PWAs. The video presentations, in whole or in part, specifically are not to be shown to general audiences, or to lay people, or to groups of gay men who are not providing services to PWAs or on any mass media. Videotapes are available on VHS only, for $75 each. Contact: San Francisco AIDS Foundation, AIDS Care Video, 333 Valencia Street, 4th Floor, San Francisco, CA 94103 (415/864-4376).

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BOSTON AIDS CONFERENCE EXAMINES THE PERSONAL SIDE

by Christine Guilfoy, with thanks to Boston's Gay Community News, 4/6/85

BOSTON — On a sunny Saturday, March 23, the AIDS Action Committee (AAC) attracted over 200 people — mostly men — to its one-day conference: Living With AIDS: Our Community in Action.

Focussing on the political organizing and personal concerns raised by the AIDS epidemic, the conference had workshops on everything from AIDS 101 to Gay Rage: Mourning and Bereavement.

Cindy Patton, the chairperson of the steering committee of AAC and one of the conference organizers, told *GCN* the idea of the conference was to give people a sense they can do things. "We tried to structure the workshops around action; workshop presenters were asked to give concrete suggestions about what people can do." She pointed to workshops such as Staying Well: Exercise, Nutrition and Stress Reduction; Safe Sex; and the Gay Movement and AIDS Organizing as examples of the practical approach.

Patton noted that many — she estimated up to half — of those attending the conference are people who have previously been largely uninvolved in political organizing.

The conference also was notable for its above-average outreach to the deaf men's community, a number of whom attended sessions throughout the day.

In the opening remarks of the day, Diego Lopez, clinical director of Gay Men's Health Crisis (GMHC) in New York, told the audience that "gay rage" is a positive motivating factor in political organizing. Lopez noted a phenomenon in New York City which he terms "AIDS envy." He said a number of gay men with ARC have expressed a wish to get AIDS, and several have maintained their lives were better for getting AIDS. Ascribing such a reaction to internalized homophobia, Lopez maintained that mistreatment from without must be focussed back outward in order for an individual to remain emotionally healthy. "We cannot accept anything less than equal rights as a citizen who pays taxes in this country. That's what we have to do with gay rage," he added. Lopez said that gay people have to shed the notion they have been brought up to believe that "American society will take care of us if we behave." Of the AIDS crisis, Lopez said gay people are viewed as "expendable." He added, "The rest of society is not going to look out for us the way we will look out for one another....We must become ambassadors of [quality] health care and ambassadors of dignified dying." Lopez concluded "Rage is a response to teach with....It is the only response we can win with."

A workshop on discrimination and stigmatization was presented by Kevin Cathcart, director of the Gay and Lesbian Advocates and Defenders (GLAD), and Geno Lipsky, a man who lost his job when his employer discovered he had AIDS.

Cathcart began by describing some past and on-going cases which GLAD has worked on involving medical institutions and health care providers who have refused treatment to people with AIDS. Cathcart said in some instances health care providers took actions "completely unrelated to what the risks [in treating people with AIDS] are."

Because of handicap laws, Cathcart said, people with AIDS have greater legal protections than gay men generally but are "also in the worst position [for health reasons] for carrying on long-term lawsuits. But neither housing nor job discrimination cases have come to GLAD, in part, he said, because people with AIDS often don't have the energy to fight such cases in court.

There have been, however, other cases which involve discrimination against lesbians and gay men fuelled by AIDS hysteria. Cathcart said GLAD recently took a case of a gay man whose child custody and visitation rights are being challenged because his wife believes he will pass AIDS on to his daughter. The man does not have AIDS.

However, Cathcart believes the greatest increase in discrimination cases will come about as a result of the HTLV-III antibody test. "In occupations, such as the military, the test may be viewed as a marker for homosexuality." Emphasizing that gay men not donate blood, he also said that gay men who need to have their blood tested in the course of their medical care be specific about what their blood may or may not be tested for.

Many of the audience questions centered around the antibody test, but Cathcart said unless a person is part of a research study or is under a trusted medical care provider's orders to do so, gay men should not take the test. "Insurance companies can ask you if you have tested positive for HTLV-III and refuse coverage if you test positive for a pre-existing condition. Once you have the test, there is no way back from that." Of the government's touting of the antibody test, Cathcart said, "The headlines say the AIDS test will make the blood supply safer; well, Margaret Heckler is lying." He said the Heckler press conference announcing the licensing of the test occurred on a Saturday to minimize public response from groups which opposed the test.

Cathcart told the assemblage that a major obstacle to gay civil rights are the sodomy laws which still exist in 25 states and advocated working on the repeal of those laws. In addition, he suggested that people donate money to gay organizations, support people who are bringing cases to court, make use of the human rights ordinances in existence, and work to pass a statewide lesbian and gay civil rights bill.

Geno Lipsky, who also helped organize the conference and is a member of the steering committee of AAC, was diagnosed with AIDS in late 1983. He has had two life-threatening bouts with pneumonia in that time. When Lipsky returned to his job at an insurance company after his first illness, he told the company medical department that he was being treated for skin cancer. However, the medical director told him that he knew Lipsky had AIDS and that he had better " 'fess up to it." When Lipsky returned to his office after refusing to answer, he was shunned by coworkers who would not share the water fountain, the phones or a computer terminal with him. He was required to provide letters from his health care providers saying he would not infect his coworkers.

Lipsky's company eventually tried to get him to work at home. When he refused, he was offered his own office, which he also refused. Eventually, Lipsky's supervisor increased his work load and threatened to give him a poor work evaluation when he couldn't keep up. When the company offered him full medical benefits if he would leave, Lipsky said he accepted, for two reasons. First, he was afraid he might no longer have the stamina to keep up with the increased workload. He was afraid of being fired and losing everything, including much needed medical benefits. Secondly, Lipsky described his work environment as "unsupportive" and added "I didn't need this, it's enough to have the illness without this....They were pigs."

In a workshop entitled AIDS: The challenge to friends, families, and lovers, workshop leaders Joe Interrante, Gail Scharfman and Mike Ward talked about their experiences in their relationships with people with AIDS. Interrante said he would subtitle the workshop "creative coping." Interrante, whose lover Paul died of AIDS seven months after he was diagnosed, said, "It's an intense experience, issues got compressed into a seven-month period. He aged 20 to 30 years in those seven months."

Saying that the illness "rearranges the rhythms of daily life and structures daily activities," he nonetheless urged that time be set aside to talk about relational and emotional issues. He also emphasized, as did Scharfman and Ward, that the workload be shared with friends. "You will get frustrated and tired," said Interrante. "Don't feel guilty. Get rest and help from other people. Give yourself a rest."

Ward, whose lover was diagnosed eleven months before he died, said, "It was a hard way to lose somebody. But we had a chance to go through a lot of passages together." Ward told the audience he and Mark relied on their "gay family." "Mark's friends, said Ward, "made a list of things they could do. They said we'll do it

BOSTON AIDS CONFERENCE, Continued

when you need it, and we'll butt out when you don't."

Gail Scharfman, whose longtime friendship with Bob led her to manage his affairs when he became ill, said they "worked hard to keep life as normal as possible. We used old ways of coping and new ways." Scharfman drew laughter from the audience when she described how they would make cocktails every night and then not drink them.

Both Scharfman and Ward said they wished they had worked harder to "bring [blood] families in." Both felt they had reached closure in their own relationship, something Mark and Bob had not accomplished with their families. Said Ward, "I have regrets I didn't bring the family in more. If you're in a position to help with that kind of closing, do."

Ward said a hard thing for him to learn, was when to take over. And Interrante said, "Just because a person has AIDS doesn't mean they're always right." He added "You have to work things out, you may advocate a position, but ultimately it was up to Paul." Ward said, "He and I learned to say 'no' when people were overly solicitous, overly helpful. But the more you let other people help you, the more healthy you'll come through the process yourself."

In his advice on bringing the relationship to closure, Ward said, "Ask them if there's anything they need to say. Ask yourself that, too, so you're not left holding the bag."

Members of the audience talked about their experiences. One man expressed regret that he hadn't confronted sooner the emotional and relational issues with a friend who died of AIDS. "Do it now," advised the man. "You don't have a lot of time. I should have written him a letter when I found out about his diagnosis. I waited because I was afraid to say the wrong thing. Well, say it, even if it's wrong. I wish I hadn't waited until the night before his death."

* * *

Statement From the International Community of Gay Men and Lesbians at the International Conference on AIDS, April 14-17

On April 15, Secretary Margaret Heckler of the U.S. Department of Health and Human Services, made a distinction between those classified as being at risk for AIDS and the "general public." We point out that gay men, hemophiliacs, intravenous drug users, Haitians, and people with AIDS are *also* among the general public, and failure to acknowledge this is a denial of our basic humanity.

Secretary Heckler has stated on many occasions, as she did again on April 15, that AIDS is the nation's number one health priority; yet her department has requested fewer financial resources to deal with a growing and indeed overwhelming problem. In fact, the Reagan Administration is proposing to spend $11.9 million *less* on AIDS in fiscal year 1986 in the face of an expected doubling of AIDS cases.

Mrs. Heckler's description of the war against AIDS omitted the tremendous burden that the gay and lesbian taxpaying community has borne to make up for an inadequate federal response to education, social services, patient care, general health, and prevention programs.

We are particularly concerned that there is no recognition of the extensive efforts of the gay and lesbian community to prevent further spread of the disease. Nor is there recognition of the importance and dignity of human sexual relationships and the responsible expression of those relationships.

If we are to win the war Secretary Heckler has declared, her department must make available resources to community organizations that have, for nearly four years, borne the greatest weight of informing, educating, and caring for at-risk populations.

We commend the efforts of researchers and clinicians who have responded to this epidemic without adequate assistance from the Administration.

We urge Secretary Heckler to act immediately to halt the further spread of AIDS by committing additional resources to education and prevention. We further urge the Administration to commit resources to patient services to those individuals already ill with AIDS and AIDS-related conditions.

[Signed,]

Federation of AIDS-Related Organizations, Washington, D.C.; Gay and Lesbian Physicians of New England; AIDS Response Program of Orange County, Garden Grove, Ca.; AIDS Service Group of Long Beach, Ca.; Lesbians in Health Care, N.Y.C.; Long Beach Gay and Lesbian Center; Lesbian and Gay Health Advocacy, N.Y.C.; National Coalition of Gay STD Services; Health Education AIDS Liaison, N.Y.C.; Milwaukee AIDS Project/Brady East STD Clinic; Institute for Advanced Study of Human Sexuality; Wisconsin Governor's Council on Lesbian and Gay Issues; AIDS Council of Northeastern N.Y.; Colorado AIDS Project, Denver; East End Gay Organization (EEGO) for Human Rights, Long Island, N.Y.; American Association of Physicians for Human Rights; AIDS Rochester, Inc., Rochester, N.Y.; Georgia Association of Physicians for Human Rights; Rochester N.Y. Area Task Force on AIDS; Baltimore Health Education Resource Organization; Mid-Hudson Valley N.Y. AIDS Task Force; Atlanta Gay Center; Gay Men's Alliance of Hudson Valley, N.Y.; Gay Rights National Lobby; Southern Tier AIDS Program, Binghamton, N.Y.; Gay Men's Health Crisis (GMHC), N.Y.C.; National Association of Business Councils; AIDS Action Committee of Boston; San Diego AIDS Project; National Lesbian and Gay Health Foundation; Mariposa Education and Research Foundation; Life Foundation, Honolulu; Lesbian and Gay Health Project of North Carolina; Minnesota AIDS Project; Pittsburgh AIDS Task Force; Bold New City Coalition (BNCC) AIDS Task Force, Jacksonville, Fl.; Fenway Community Health Center, Boston; National Gay Task Foce; Lesbian/Gay Caucus, American Public Health Association; Whitman-Walker Clinic, Washington, D.C.; Gay and Lesbian Public Health Workers Caucus; Outrage, Melbourne, Australia; Bay Area Physicians for Human Rights; AIDS Atlanta; AIDS Project, New Haven; National Association of People with AIDS; Buffalo AIDS Task Force, Buffalo, N.Y.; Lesbian and Gay People in Medicine; Chicago Area AIDS Task Force; Howard Brown Memorial Clinic; Los Angeles Gay and Lesbian Community Services Center; Lesbian and Gay Physician Assistant Caucus; Desert AIDS Project, Palm Springs, Ca.; Swedish Physicians Against AIDS; Holland AIDS Information; Gary B. Macdonald, Washington, D.C., Werner P. Kuhn, Albany, N.Y.; Steve Peskind, Garden Grove, Ca.; James D'Eramo, Ph.D., N.Y.C.; Ron Sabir, M.D., Chicago; Michael Helquist, San Francisco; Donna F. Putterman, N.Y.C.; Glenn D. McGahee, Atlanta; Michael Arconad, N.Y.C.; Gregory F. Shipman, M.D., Chicago; Clark Taylor, Ph.D., San Francisco; Hal Frank, Ph.D., San Diego; Seth Prosterman, San Francisco; Bruce Voeller, Ph.D., Los Angeles; Laurie Novick, Albany, N.Y.; Peter Patrick, Washington, D.C.; Jane C. Holmes, Long Island, N.Y.; Cheo Torano, M.P.H., Chapel Hill, N.C.; Jackie Nudd, Rochester, N.Y.; David Jolly, M.S.P.H., Durham, N.C.; John J. Altieri, Rochester, N.Y.; Anthony Siestre, Pittsburgh, Pa.; John E. Egan, Westchester, N.Y.; Joseph Sonnabend, M.D., N.Y.C., Charlene Ketchum, Binghamton, N.Y.; Ben Paniagua, Long Beach, Ca.; Brian Saltzman, M.D.; Neil Schram, M.D., Los Angeles; Mark Behar, P.A-C., Milwaukee, Wi.; Patricia E. Rickmann, R.N., Denver; Bill Wade, D.D.; Dennis J. McShane, M.D., Menlo Park, Ca.; Stosh Ostrow, M.D., Atlanta; Peter Laqueur, Baltimore; David E. Blatt, M.D., Chicago; David M. Moore, D.O.; George Brenning, Atlanta; Nancy L. Roth, Washington, D.C.; Paul A. Moore, Albany, N.Y.; Mel Rosen, N.Y.C., Richard D. Dunne, N.Y.C.; Terry Fonville, M.D., N.Y.C.; Cindy Patton, Boston; Larry Kessler, Boston; Paul A. Paroski, Jr., M.D., N.Y.C.; Bruce J. Thompson, C.S.W.; Marc Rubenstein, M.D., N.Y.C.; David McEwan, M.D., Honolulu; Ford Campbell, Minneapolis; Ken Hunt, Jacksonville, Fl.; Julian Rush, Denver; Jeffrey Levi, Washington, D.C.; Caitlin Ryan, M.S.W., Washington, D.C.; Robert Judden, M.D.; Alvin Novick, M.D., New Haven; J. Monroe, N.Y.C.; Pete Hawley, M.D., Washington, D.C.; Phil Nash, Denver; Peter Ralin, Denver; Rena Davis, Denver; Pan Rickmann, Denver; Dennis Altman, Melbourne, Australia; Beth Brown, Atlanta; Federico Gonzalez, N.Y.C.; Katie Sprutta, Chicago; Bill Manniun, Chicago, Yke Algra, Amsterdam; Alan Kristal, Dr.P.H., N.Y.C.; John Beldekas, Ph.D., Boston; Domnic Julvio, White Plains, N.Y.; Larry Muss, M.D., N.Y.C.; Patricia Maher, Brooklyn, N.Y.; Keith Lawrence, N.Y.C.; Jane Quimby, N.Y.C.; Herbert Rusche (West German Parliament), Die Gruenun im Bundestag, Germany; Jerome Freeman, Buffalo, N.Y.; Richard Waddell, Washington, D.C.; Frank Lilly, Ph.D., N.Y.C.; John Richardson, N.Y.C.; World Health Organization

SHOULD GAY MEN BE TESTED FOR HTLV-III ANTIBODY?

by Mark Scott, with thanks to The Washington Blade, 4/26/85

With few exceptions, health professionals and Gay activists interviewed by the Blade this week said there is no good reason for healthy Gay men to take the test for HTLV-III antibody.

"I think there's m ore harm than good in it," said Dr. Frank Polk, head of Baltimore's SHARE Project. "It won't tell you if you're going to get AIDS. If a person tests positive, the only thing we can recommend is a change in [sexual] behavior—and that should be done [whether or not] you know you're positive."

A positive result could "freak people out," Polk said, leaving them to worry constantly whether—or when—they will develop AIDS. (Centers for Disease Control studies indicate that about one-tenth of those infected with the HTLV-III virus will go on to develop AIDS within five years.)

Conversely, Polk said, a negative result could give an individual an incentive to relax his concern about safety in sex.

Since the enzyme immunosorbent assay (ELISA) test for the HTLV-III antibody has an unproven accuracy rate, said Polk, expensive confirmatory tests are needed to make sure a result is accurate.

Risks "go beyond" accuracy?

Gay activists, who have warned for months that test results could be used to identify high-risk individuals, this week pointed to the Defense Department's plan to collect the names of military blood donors who test positive for the HTLV-III antibody (see story, page 1).

"This is what we predicted might happen all along," said Jeff Levi, director of governmental and political affairs for the National Gay Task Force. In January, NGTF and 15 other Gay and AIDS service organizations issued a statement, which has since been widely printed in the Gay press, urging Gay men not to take the test.

"The risks of this test go beyond whether it is accurate or not," said Dr. Brett Cassens, president of the American Association of Physicians for Human Rights, a Gay group. Cassens said that insurance companies and employers could also seek the names of people who have tested positive for the HTLV-III antibody.

So far, California is the only state which has passed legislation making it illegal for health professionals or blood banks to share HTLV-III test results with others.

Test only if symptomatic

Dr. Peter Hawley, the Whitman-Walker Clinic's medical director, and Dr. Richard DiGioia, co-chairman of the D.C. AIDS Task Force and a private-practice physician with a large Gay clientele, said the HTLV-III test should be performed—in conjunction with other diagnostic tests—on individuals who have persistent AIDS-related symptoms, such as fever, swollen lymph nodes, and weight loss.

The test might also be recommended, said DiGioia, for people who have been exposed to significant risk, such as the lovers of people who have developed AIDS.

"But in terms of Gay men who are feeling well and have no history of significant exposure, I do not recommend it," said DiGioia.

D.C., Maryland, and Virginia health officials take a similarly dim view of mass screening for the HTLV-III antibody. Virginia originally did not plan to arrange for alternative sites, where high-risk people could get tested without giving blood, because "it would be unfair to offer it when we didn't know what a positive result means," said Dr. Martin Cader, director of the state Bureau of Communicable Disease Control.

But earlier this month, Cader said, health officials decided to set up "four or five" regional sites to keep high-risk people from being tested at blood banks.

Maryland and D.C. will also offer alternative testing sites to protect the blood supply, but will warn individuals beforehand that the test cannot tell if AIDS is going to develop.

Some say 'take the test'

A few doctors and Gay activists recommended that all Gay men—healthy or not—be screened for the HTLV-III antibody as a way of stopping further transmission of the virus.

"People who [test] positive should change their behavior to avoid exposure to other infectious agents" which could serve as co-factors in developing AIDS, said Dr. Donald Francis, assistant director of the CDC's division of viral diseases. "People who are negative should be very selective of who they have sex with" and avoid intercourse with people testing positive.

Francis—who emphasized he was expressing his own opinion and not CDC policy—said it is not realistic to expect that Gay men testing positive would change their behavior in order not to infect others.

"I don't think there's going to be a large number of people going out and trying to infect other people," he said.

CDC has not released an official position on Gay men taking the test.

Dr. Bruce Voeller, president of the Mariposa Foundation, a sexual research organization, said a positive test result could provide a powerful motivation for behavioral change.

"If I have a piece of information that I have a 20 percent chance of getting a fatal disease and that some change in my behavior may put me in the [other] 80 percent," said Voeller, "I'm going to want to know."

* * * * *

NY PERFORMERS PRESENT BENEFIT FOR AIDS

by Matthew Stadler, with thanks to the New York Native, 5/6-19/85

Mike Nichols, Elaine May, Joan Rivers, and other special guests appeared May 19 at the Shuber Theater in New York for Comic Relief, a night of comedy entertainment to benefit the AIDS Medical Foundation. Tickets ranged from $100-500. Meanwhile, Bette Middler has agreed to participate in a benefit for the Gay Men's Health Crisis sponsored by Actor's Equity, for a November performance, which will also raise money for the AIDS Medical Foundation and the AIDS Resource Center.

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News Commentary

VOCAL GAY PRESENCE AT ATLANTA CONFERENCE

by John Beldekas, with thanks to Boston's Gay Community News, 5/18/85

ATLANTA — This city was the recent host of the International Conference on AIDS, April 14-17, attended by over 2300 clinicians, health care workers and scientists from over 30 countries. Unlike other AIDS meetings, the lesbian and gay scientific community was very visible and vocal. During the opening session on Monday April 15, Andrew Young, mayor of Atlanta, stressed the need for greater understanding about the disease. Young drew an analogy to the 1950s when Black men were dying from drug addiction, and said that no one cared then because the victims were Black. He urged that bigotry not be an obstacle to compassion for people with AIDS today.

Secretary of Health and Human Services Margaret M. Heckler delivered the keynote address, focusing on preventing AIDS from spreading to the "general public." Many of those present interpreted her remarks as blaming the at-risk populations for the disease. In response, several members of the audience organized a caucus of the international lesbian and gay community to draft a reply statement to Heckler's speech. The statement was signed by every gay organization attending the conference and was signed and endorsed by the World Health Organization. (See sidebar for text of statement.)

A workshop entitled "AIDS Risk Reduction Guidelines" was held on April 14. Not part of the main conference, the session was organized by Dr. David Ostrow, and its purpose was to establish a new set of guidelines for healthy sex. 'Healthy" rather than "safe" were terms stressed as more sex-positive and gay-affirmative.

David Francis of the Centers for Disease Control (CDC) opened the workshop with a disturbing account of the epidemic, stating that further transmission of the virus and disease was unacceptable to him and must be halted immediately. Implying further transmission might be acceptable to gay men, Francis recommended that individuals transmitting the HTLV-III virus be identified and their activity controlled.

Francis also expressed concern that gay men were being fed a false line in terms of the actual safety of "safe sex," because the prevalence of the virus is so high within the community that chances of coming in contact with a person who is positive for HTLV-III is about 40 percent. Francis said that with the availability of the blood test, gay men should "know [their] own sero-status" and advocated testing all gay men. Francis was unclear about how such testing would be implemented, but did say at one point that "you will all be tested," suggesting that gay men should or would be tested even against their will.

However, in an interview after the session, Francis said testing should be done on a voluntary basis. He argued that knowledge of one's own sero-status would be the chief deterrent to further spread of the virus.

Many gay activists and scientists believe that healthy gay men should not be tested, arguing that knowledge of sero-status is not necessary to halt the spread of the virus or the disease. Activists have also pointed out that while many men will feel the need to know their sero-status, and while this knowledge will give some men relief from anxiety, for most it will lead to more anxiety and denial. Further, the test could serve to segregate gay men into sero-positive and sero-negative camps without any solid medical basis.

Knowing one has a negative sero-status can lead to further risk reduction, but can also lead to a false sense of security. Some men may believe that as long as they have sex with other sero-negative persons, they will be safe without taking other precautions. Sero-positive men, conversely, may be led to believe they will not spread the virus as long as they have sex with other men who test positive. However, repeated exposure to many antigens may be the deciding factor in getting the disease, so sero-positive persons must be as cautious as anyone else. In other words, antibody-positive or antibody-negative, all gay men must follow the same "healthy sex guidelines."

* * * * *

NEW JERSEY BACKS OFF REPORTING PLAN

with thanks to The Washington Blade, 5/17/85

The New Jersey Department of Health shelved a plan to seek legislation requiring the collection of names of all people who test positive for the HTLV-III antibody. The plan would have required of all doctors, blood banks, and even alternative testing sites to report to the state heatlh department the names of people testing positive. "Given the stigmatization and serious legal and civil rights concerns associated with this test and with AIDS, we could very well see a decline in [blood] donations by those [general public] fearing their names would be turned over to state health officials," testified Jeff Levi, director of governmental and political affairs of the National Gay Task Force. Another aspect of the proposed reporting plan would threaten the blood supply, testified Levi. "The identity of individuals getting the antibody test at alternative testing sites would no longer be kept confidential," he said. "The purpose of creating the alternative testing sites was to discourage individuals from donating blood.... The attraction of teh alternative site was the guarantee of confidentiality, if not anonymity," he said. "This would be lost if [names of people testing positive] were shared with the state."

* * *

IS CANCER A SOCIAL DISEASE?

with thanks to The Tarrytown Letter [and special thanks to Larry F. who sent it to us!]

Fritz Zorn's personal account of cancer has been hailed as an "intellectual event" in Europe and a work of devastating power. Appropriately titled Mars, *this book exposes a society at war with individuality, and whose most respected citizens behave as though emotionally dead. Through cancer, Zorn finally was able to recognize the false role he had played, move out of this shadow-world, and for the first time, come* alive.

Now in a new edition published by Alfred A. Knopf, Mars *is creating a similar sensation here in the United States. Its author was a brilliant student, a successful professor and an aspiring playwright—here are the details of his life:*

I'm young and rich and educated, and I'm unhappy, neurotic, and alone. I come from one of the very best families on the east shore of Lake Zurich, the shore that people call the Gold Coast. My upbringing has been middle-class, and I have been a model of good behavior all my life. My family is somewhat degenerate, and I assume that I am suffering not only from the influences of my environment but also from some genetic damage. And of course I have cancer. That follows logically enough from what I have just said about myself. There are two points I would like to make about my cancer. On the one hand, it is a physical disease from which I will most likely die in the near future, but then again I may win out against it and survive after all. On the other hand, it is a psychic disorder, and I can only regard its onset in an acute physical form as a great stroke of luck. By this I mean that in view of my unfortunate family legacy, getting cancer was by far the cleverest thing I have ever done in my life. No one, of course, is happy to get cancer; but since my life has never been very happy, I feel, after thinking things over carefully, that I'm better off now than I was before.

In recollecting my childhood, I have to begin by saying that I grew up in the best of all possible worlds. The attuned reader will realize instantly from this remark that my life was bound to go wrong. I gather from what other people have told me that I was a lovable, lively, cheerful—indeed, even a sunny—child. This would seem to suggest that I had a happy childhood. But apropos of happy childhoods, I recall a Dr. Lonelyhearts column I once saw in a magazine. A young man had written in to say that he was at his wits' end and felt totally unable to cope with life. This struck him as all the more astonishing because he had had such a happy childhood. Dr. Lonelyhearts's response was very simple. If the young man felt unable to cope with life now, then his childhood clearly had not been happy. And when I consider how I have managed my life up to this point—or mismanaged it—I can only assume that my childhood wasn't happy, either.

Sexuality was obviously a discordant element. It was classed among all those other unmentionable things that found no place within the narrow scope of our familial harmony. I thus came to see anything that had to do with sex as hostile; it was bad, and I was afraid of it. I always blushed whenever sex came up in a conversation; and I was afraid of such conversations because my blushing embarrassed me.

I attended several dancing classes to learn how to get along with girls, but I couldn't learn how to dance at all, and I learned how to get along with girls even less. I was intelligent, but I didn't know how to do anything. Outwardly, I seemed to be almost repulsively normal, but I was anything but a normal, healthy young man. To the rest of the world, I was known as someone who busied himself with the "higher things," but inwardly I realized that I had fallen way behind and really belonged among the very youngest boys in our school. In short, I had all the prerequisites for becoming a very unhappy person.

No sooner said than done. I got sick. I didn't know at the time that I had a disease, nor did I even know the name of the disease. It's one of the most widespread diseases of our time. It's called depression. I would guess now that it began when I was about seventeen or eighteen. It hasn't left me since.

All life strives constantly to merge with other life, to penetrate it, unite with it; and any dividing, holding apart, splitting off, or separating always means death. Those who unite with others live; those who keep themselves apart die. But that was the very motto we lived by in my parents' house: Isolate Yourself and Die! The logic of this motto, of this commandment, is flawless because the dead are the least likely people of all to draw attention to themselves by a *faux pas*.

We could put it this way: I was too correct to be capable of love. I wasn't even really myself. All I was was correct, for if my real self had shown its face anywhere in that world of politeness and empty formalities, it would immediately have been felt as a disturbing element. I was not a self, an individual who was separate and distinct from his environment. I was a conforming particle within that environment.

I feel my behavior conformed very well to the rules of society and the rules of cancer. I have been unhappy all my life, but since my good breeding told me it was "not nice" to complain about unhappiness, I never said a word about it. In the world I lived in, tradition demanded that I not create a disturbance or call attention to myself, no matter what the cost to me. I knew that I had to be correct and to conform; above all, I had to be normal. But normality as I understood it meant that I shouldn't tell the truth but should be polite instead. I was a good boy all my life, and that's why I got cancer.

The threat of death made me realize that if I did ultimately manage to escape this real death, I might finally have a chance at true resurrection, resurrection to a new life that would perhaps not be as painful as the previous one had been.

If it makes any sense at all to speak of cancer as an idea, then I would have to say that getting cancer was the best idea I have ever had. ●

THEATER OF AIDS

by Micheal Bronski, with thanks to Boston's Gay Community News, 6/29/85

The response of art to life is sometimes very slow. Plays and movies about the Viet Nam war took more than ten years to surface. There has yet to be good media representation dealing with abortion and women's struggles to control reproduction. Part of this is just the time it takes for any idea to reach fruition in production. A more important aspect is probably that some material is just not perceived as being marketable. Until Terms of Endearment became a hit, it was a truism in the movie business that a "cancer movie" would never be a hit. Not only must someone be willing to create this art, but there must also be an audience willing to attend and embrace it. It is a great surprise, then, that New York now has two plays about AIDS--As Is and The Normal Heart. (This is even more surprising when you realize that The Normal Heart is an outright political polemic.) But before these plays became media events touted by Time and Newsweek, a small revue--The A.I.D.S. Show--was being written and presented in San FRancisco by Theater Rhinoceros. After a sell-out stint in their home city, they toured the West Coast and have just spent a week in Boston playing to packed houses as a benefit for the AIDS Action Committee. The A.I.D.S. Show is a collection of 27 skits, written by the cast as well as others, and performed by a troupe of nine men and three women. They range from the manic Bette Midleresque production number, "Rimmin' at the Baths" to a strong, moving monologue by Ellen B. Davis--"The Nurse," in which a woman working with AIDS patients grapples with her irrational fear for her children. "It's My Party," in which a group of queens sits around playing Trivial Pursuit and talks about sex, safer sex, and no sex, is as quick-witted and insightful as any great comedy. The only two bits which are below standards are "Reverend What's Her Name," by novelist Dan Curzon, a shallow, obvious jab at fundamentalist Christians using AIDS for their own purposes, and a monologue, "Land's End," in which a gay man talks to his dead lover, but which is filled with too much of the sentiment the show has generally managed to avoid. In fact it there is any salient feature about the Show--its basic professionalism and talent taken for granted--it is the ability to approach this material and face it forthrightly and honestly. The bulk of people who attend theater (and movies) do so to be entertained. They may want to laugh or cry, but for the most part they do not want to be made to feel uncomfortable. (That's why a topic like the Viet Nam war took so long to get to the popular media; everyone was so worn out after watching the real war on the news, they didn't have the patience or the courage to deal with it again.) Any show about AIDS is clearly not going to make many people comfortable. Theater Rhinoceros has managed to overcome this problem by packaging their message, information, and content in easily understood and familiar packages. They ahve taken common forms--the TV sit-com, game show parody, the monologue, even the one-liner--and have re-forged them to build a coherent, tight show. Knowing that you cannot preach to the terrified, they have made the wise decision to play much of the material for humor, and what is not played for laughs (both open and nervous) is played for honest and plain feeling. "I like cruising, getting drunk, stoned on grass, doing poppers, and having sex with strangers. Call me old fashioned," says a man during the "It's My Party" skit; we laugh not only at the juxtaposition, but at the honesty and the truth beneath the joke. It is interesting that two of the most effective pieces--"The Nurse" and "Moma's Boy"--are both monologues by women. The material here is more open, less defensive, and more emotionally searing. I suspect that for both the writers and the performers--as well as the audience--this may be easier to hear coming from women rather than men: not only because women's feelings have been given more cultural weight, but also because gay men, who are more clearly affected by the disease, may have a harder time articulating such powerful feelings without some guard or self-defense mechanism. The fact that there are two AIDS shows in New York, as well as The A.I.D.S. Show and who knows how many other small theater peices in the works, attests to the concern and importance being attached to the topic. It's not what most people would want, or expect, from theater, and yet they are going and enjoying the shows. What is even more amazing is that the critical community (the straight critics) is endorsing the plays. There is a tradition in U.S. theater (actually all entertainment) to devalue or dismiss political material. (This ignores the fact that all art is political, ehtat even, or perhaps especially something like Mickey Rooney and Ann Miller telling bigit jokes in Sugar Babies is political.) The Show (as well as the others) has managed to make audiences, and critics accept this material, deal with it, and respect both the material and its creators. They have done this through energy, talent, political commitment, and most of all through courage. Courage to face the material themselves and transform it into art, to brin their idea to the stage and share them with the audiences, and courage. in an imdustry and world which tends to shun what it cannot deal with, to take a chance, to speak from the heart, and to be out, open, and honest.

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WISCONSIN GOVERNOR WOULD REFUSE TO ORDER INTERNMENT

by Sue Burke, with thanks to GayLife, 4/18/85

Wisconsin Governor Anthony Earl believes it is his job to carry out an "upfront" campaign to enforce the nation's only state-wide law guaranteeing basic civil rights for gay people. And he plans to fight the state legislature if necessary to get the money to hire a liaison to the gay & lesbian community. Earl made his remarks at a dinner at Milwaukee's gay/lesbian Cream City Business Association, honoring him with the group's 1984 Torch Bearer Award for "that non-gay person who has best advanced understanding and acceptance of the gay community." Discrimination against gays/lesbians in employment, housing, and public accomodations was outlawed in Wisconsin in 1982. Earl's press secretary is an openly gay man, and he has appointed a state-wide council on lesbian & gay issues to help enforce the gay rights law. Earl said the law and the willingness to enforce it has made it easier for Wisconsin to deal with AIDS. "We can approach this problem as a matter of medicine and not as morality, and that's an important difference between this state and others," he said. Earl pledged that if the federal government ever ordered the internment of gays to prevent the spread of AIDS, he would "file" that order with the order he received to plan to evacuate urban areas in the event of nuclear war, which hs has refused to carry out. The gay civil rights law benefits everyone, not just gays he said, because everyone has a friend or family member who is gay. "There is no greater waste that the waste of human talent and human potential due to discrimination," he said. Basic civil rights was a non-partisan issue in Wisconsin, he stressed. But he doubted that gay rights laws could be expanded soon to include alternative families legislation due to the "drift to the right" in state politics.

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POPPERS MANUFACTURER DIES OF AIDS

by Lou Chibbaro, Jr., and Mark Scott, with thanks to The Washington Blade, 4/26/85

W. Jay Freezer, head of a company which manufacturers nitrite inhalants or "poppers," died of AIDS last month, according to the New York Native. Freezer, who was 45, was chairman of the board of Pharmex, Ltd., which makes popper brands popular with gay men, such as "Rush" and "Bolt."

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NITRITES CONTROL REQUESTED BY COMMITTEE TO MONITOR POPPERS

Hank Wilson of San Francisco's Committee to Monitor Poppers (55 Mason St., San Francisco, CA 94102, 415/441-4188) has recently requested California's AIDS Advisory Commission to review the role of inhalant nitrites in the AIDS crisis, due to epidemiologic and immunologic research that indicates that nitrite inhalants may be an important cofactor in the development of AIDS and specifically Kaposi's sarcoma. Six specific actions are being requested: 1) Funding for research on nitrite inhalants, especially investigating alleged immunosuppression and judgement impairment. 2) Labeling reform, recommending to the Federal Consumer Products Safety Commission that some warning be imprinted about nitrites potential for intoxication, judgement impairment, and immunosuppression. 3) Warning notice at point of sale. San Francisco has an ordinance mandating that merchants selling poppers post a warning sign. Legislation could mandate such a warning throughout the state. 4) Research tax. A special tax could be levied on nitrite manufacturers and as a sales tax, which could finance research. 5) Prohibition of using nitrite inhalants in public places. This measure would protect the non-user much like anti-tobacco smoking measures. Use in private would be permitted but use in public areas such as bars, discos, bookstores, theaters, etc. would not be allowed. Passive inhalation may give non-users headaches and possibly some immunosuppression. This too requires further research and investigation. 6) Review of AIDS education efforts. The potential dangers of inhalant nitrites need to be publicized. Current education efforts often lump "poopers" into the general "drugs and alcohol" category. Many consumers do not think of poppers as drugs because of the way they are advertised & promoted (ads in gay papers and sex magazines; sold openly in bookstores, bars, etc.) and merchandized. Education materials need to state "alcohol and drugs, including poppers (nitrite inhalants)" to insure that the at-risk community understands the potential serious health risks of using poppers. For more information, contact Hank at the above address/phone.

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ALTERNATIVE THERAPIES FOR AIDS

from People With AIDS Update, February, 1985 (a publication of the San Francisco AIDS Foundation and the Shanti Project)

A resource manual on alternative therapies for AIDS is being developed by Washington, DC's Whitman-Walker Clinic. Anyone with information should send it to Catlin Ryan, c/o Whitman Walker Clinic, 2335 18th Street, NW, Washington, DC 20009 (202/332-5295).

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VOLUNTEERS NEEDED FOR ISOPRINOSINE STUDY

by Sue Burke, with thanks to Madison (Wisconsin) OUT!, April, 1985

Dr. Robert Keller, an immunologist at the Medical College of Wisconsin and the Veterans Administration Medical Center in Milwaukee, wants to study gay men who have been exposed to HTLV-III. The study involves administration of isoprinosine to those who are HTLV-III antibody positive and who are mildly symptomatic and those who develop AIDS or ARC. Keller emphasized that isoprinosine is not a cure, and compared it to administering insulin to a diabetic. He received permission from the FDA to use isoprinosine on people with early symptoms of AIDS. For more information, contact Keller at the VA: 414/384-2000 x 2851.

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ISOPRINOSINE APPROVED BY FDA

with thanks to The Washington Blade, 5/17/85

The Food and Drug Administration agreed to let Newport Pharmaceuticals of newport Beach, California distribute isoprinosine, a drug which has been shown to restore immune system function, to doctors of people with AIDS who request it. The company will begin supplying the drug immediately, according to company spokesperson Luana Kruse. FDA decided to allow the distribution after news reports revealed that many people with AIDS have been going to Mexico to get the drug because it wasn't licensed for sale in the US. Isoprinosine has been un use for more than a decade in Europe to restore the function of T-4 white cells in cancer patients. The drug has given ambiguous results in people with AIDS and AIDS-related complex. Studies are underway in nine cities.

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ISOPRINOSINE SHIPMENTS HALTED BY COMPANY

by Mark Scott, with thanks to The Washington Blade, 6/21/85

The Newport Pharmaceutical Company stopped shipping isoprinosine to the doctors of people with AIDS who request it, said company spokeswoman Luana Kruse. The Food & Drug Administration agreed to let the company distribute the drug, which has been shown in some studies to restore immune system function in cancer patients, even though it has never been licensed for sale in the United States. But under the FDA's regulations, Newport Pharmaceuticals had to agree to distribute the drug free and monitor the results in patients. "We couldn't do that for every AIDS patient in the country," Kruse said. "We have responsibilities to our stockholders." As of last week, Newport was supplying the drug to about 15 doctors on behalf of 50 people with AIDS. The company will continue providing isoprinosine to them but has turned down the requests of about 20 other physicians in the last weeks, she said. To supply the drug and monitor a patient's progress can cost as much as $2000 in lab, personnel, and paperwork costs, Kruse said. She described Newport as a small company, with 50 employees and a net income of $500,000 in the nine months ending January 31. FDA spokeswoman Faye Peterson said the FDA does not allow unproven drugs to be sold because of the potential for abuse. "It would be easy [for companies] to say 'We're going to study this drug,' never prove its effectiveness, and still make a lot of money in the meantime," she said. Isoprinosine has given ambiguous results in PWAs and PWARC. The FDA allowed Newport, the sole manufacturer of isoprinosine in the U.S., to offer the drug after it was widely reported that people with AIDS and ARC were going to Mexico to buy it.Newport-sponsored studies of the drug on ARC patients are ongoing and will probably be finished by the year's end, Kruse said.

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NEW SHINGLES TREATMENT

with thanks to Los Angeles CAIN, 3/18/85

A report in the Journal of the American Medical Association (JAMA) by Sklar, et al, reports of a new treatment for shingles, a painful remanifestation of the chickenpox virus (herpes zoster). Using a chemical called adenosine monophosphate (AMP), the group treated 32 people with shingles within 3 days of the onset of their rash. After 4 weeks, 88% of the treated group and 43% of the placebo group were pain free, and all those from either group treated for an additional three weeks with AMP had total resolution of the rash. Researchers noted at followup periods of 3-18 months, no recurrances, faster healing, and less virus shedding. These preliminary findings offer great hope, however, much additional testing must take place before any drug can be considered safe and effective for FDA licensure.

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VACCINE CAUSES INFECTION IN PWA

Center for Interdisciplinary Research in Immunology & Disease (CIRID), prepared as a public service by the Division of Clinical Immunology/Allergy, Dept. of Medicine, UCLA School of Medicine. This Update represents editorial opinion and should not be construed as otherwise. Andrew Saxon, MD, Editor in Chief. For Info call: 213/825-1510.

Elsewhere in this Newsletter is the reprint of the MMWR (34:16, pp 227-28) on "Disseminated Mycobacterium bovis infection from BCG Vaccination of a Patient with AIDS. The authors report a 31 year old man with AIDS/KS. 13 months after his KS failed to respond to vincristine, he went to Tijuana and received a BCG vaccination. The lesion healed in a few weeks but 4 months later he developed systemic symtoms and then the BCG site ulcerated. Cultures of the lesion and blood grew M. bovis, BCG strain. *****Editorial comment: This article raises two important points. First, patients with known or suspected immunodeficiency states should not be given live (attenuated) vaccines. This includes BCG, oral polio, and rubella vaccines. There is extensive evidence that attenuated vaccines may give rise to serious clinical infections in the immunocompromised host. AIDS and ARC patients should not receive any live/attenuated vaccines. This does not include vaccinations such as tetanus toxoid or influenza. The second point is that practitioners need to be vigilant to the fact that many patients with AIDS or ARC are seeking unorthodox and potentially dangerou therapies in countries such as Mexico. Often, so-called "immune stimulation" therapy is given and BCG vaccination is an example of this. Patients seek these therapies usually out of a sense of hopelessness. It is therefore important that practitioners 1) try to encourage patients, their family and friends to discuss their feelings about the illness and deal appropriately with these feelings rather than fleeing from them; 2) explain to patients that such unorthodox therapies are of no value and potentially may shorten their lives; and 3) keep an open uncritical relationship with the patient so that should he obtain some form of unorthodox treatment, the patient will inform the practitioner rather than hide that fact.

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REAGAN ADMINISTRATION CONSIDERS QUARANTINE

by Charles Ortleb, with thanks to The New York Native, June 17-30, 1985

At a May 20 meeting in Washington between a group representing people with AIDS in America and Dr. James Mason, director of the Centers for Disease Control revealed that the Reagan Administration is considering a quarantine of people with AIDS. Paul Boneberg, who heads the Mobilization Against AIDS, told the Native that Mason told the stunned group of 12 people he had been at an administration meeting that morning at which quarantine for AIDS patients had been discussed. According to Boneberg, Mason says he is personally against quarantine. The group pleaded with Mason to provide more money for public education on AIDS, to which Mason responded, "do you really believe gay men can be changed through education?" The head of the CDC is from a Mormon college in Utah which allegedly has used electroshock "aversion therapy" to "change" homosexuals. Boneberg told the Native that his impression was that Mason is totally unapologetic for the administration's approach to the AIDS crisis. He said he was shocked at how insensitive Mason was to the PWAs in his presence, and that it appeared Mason had no intention of monitoring recent treatment developments in Paris. [EDITORIAL COMMENT from the Native: Isn't it time someone convened a commission to ascertain how extensively religion in general and Mormonism in particular is shaping a genocidal approach to AIDS in America?]

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HEARING IMPAIRED CAN NOW ACCESS AIDS INFORMATION

compiled by Stephanie Poggi, with thanks to Boston's Gay Community News, 5/4/85

Boston's AIDS Action Committee (AAC), a community-based educational and service group, has installed a Teletype Device for the Deaf (TDD) to better allow the hearing impaired access important information about AIDS. A deaf person with a TDD can call the AAC Hotline and ask questions and receive information over a screen hookup. In Boston, the AAC Hotline can be reached weekdays, noon to 8 pm, and Saturdays, 10 am to 4 pm at 617/536-7733; in Massachusetts, the toll-free number is 800/235-2331.

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NATIONAL VIGIL AGAINST AIDS

compiled by Stephanie Poggi, with thanks to Boston's Gay Community News, 5/4/85

Mobilization Against AIDS, a west coast-based organizing group, is planning a Memorial Day vigil across the US and Canada "to remember and honor the thousands who have died from AIDS." The candlelight vigil will take place in Boston, Dallas, Houston, Denver, Columbus, Minneapolis, Los Angeles, Oklahoma City, Detroit, Chicago, Seattle, Milwaukee, Long Beach (CA), Jackson (MS), Portland, San Diego, San Francisco, and Toronto on May 27, 1985. Mobilization Against AIDS is also working to gather 100,000 signatures urging Congress and the President to "act more effectively" against AIDS. The petitions will be presented in Washington, DC by a delegation of people with AIDS. For additional information, please contact: Mobilization Against AIDS, 335 Noe Street, San Francisco, CA 94114, 415/431-4660.

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VOLUNTEERS NEEDED FOR HERPES HELPLINE IN MILWAUKEE

Volunteers are wanted to answer the Herpes Helpline (414/271-1212), a 24 hour informational phone service dealing with sexually transmitted diseases in the greater Milwaukee area. Three hours per week for a minimum 12 week committment is required. Hours are flexible. Training begins soon. If interested, contact Brenda McClellan, RNCNP, Herpes Health Center, 414/271-1965 ext. 754, or write c/o St. Anthony's Hospital, 1004 N. 10th Street, Milwaukee, WI 53233.

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HPA-23, FOSCARNET, AND OTHER TREATMENTS

excerpted (with apologies) from Darrell Yates Rist, with thanks to NY Native, 6/17-30/85

[Ed Note: If any of our readers are still seeking one single source of up-to-date and provocative information about AIDS, than turn to the Native! This particular article touches on several issues; we freely sample but acknowledge this format is far from satisfactory.] New York's Dr. Joseph Sonnabend comments: "I'm not a great believer that this retrovirus [HTLV-III] is the sole causative agent of [AIDS]. There are co-factors, and there may be treatment modalities that aren't aimed at the retrovirus. But you have to pursue what's available, and right now we ought to be looking at these anti-virals." He assesses what is available. Ribavirin: "Shit." Suramin: "Unconsciounable. The doctors using that are criminals. To them the patients are just guinea pigs. Last week there was a report from NIH on four patients on that drug, three of which had toxicity severe enough to put them in the hospital." Foscarnet: "Seems to be the drug most active in its anti-viral activity. It's shown to be effective against herpes viruses and especially CMV. Toxicity is minimal. In Sweden there are trials on CMV, but not yet on AIDS. The reality at the moment is, it's not available." HPA-23: "I'm not convinced it works. If it's any good, I think we'd know about it. I'm talking about curing the disease. But if it's not a cure, maybe at least it can slow the illness down. Right now, the question's got to be, 'Is there any harm?' I don't think there is...." When asked what he would do if he had AIDS, Sonnabend replied, "I'd go to Paris." The Pasteur Institute in Paris is where HPA-23 is available, however patients must have the virus isolated before Paris researchers will accept them for treatment. The viral isolation labs in the U.S. are few: University of Nebraska; New York Hospital (Jeffrey Lawrence); Massachusetts General (Boston); USCF (Jay Levy); the Centers for Disease Control (Atlanta); "Then there's [Dr.] Michael Lange. He doesn't have a lab. He wishes he did. (Lange is at New York's St. Luke's -Roosevelt Hospital and is also with the AIDS Medical Foundation's Scientific Committee.)

(Continued)

HPA-23, FOSCARNET, Continued

Dr. Michael Lange comments: "HPA-23 is not a cure. Theoretically, there is not a drug that can cure this disease. We don't even have the scientific basis for conceptualizing that at present. You can suppress the virus, but once it's in the system, it's there to stay. We do know that if the immune system is chronically stimulated, the infected T-cells swell to five times their size and burst, releasing myriad viruses that go on to infect more T-cells. That's if there's nothing to interfere with the replication of the virus, like an anti-viral drug. But you've got to inhibit the virus before it destroys the whole immune system." Which factors stimulate the T-cells, abetting the virus's spread? "LAV/HTLV-III affects the T-cells at different rates. Certain co-factors--they're probably different in different groups--influence that. Any foreign antigenic material can stimulate the immune system--other viruses, like CMV, may be specific for the development of KS. Or Epstein-Barr virus....A common cold, poisons in the air. Parasites produce a lot of foreign antigens.... Semen, healthy semen stimulates the system. And anything that activates the T-helper cells activates the virus. A major factor is that, after nearly every viral infection--herpes, for example--the immune system doesn't work well for even as much as a year. It's this kind of thing that produces what may be a critical load of the AIDS virus.

Dr. Jean-Claud Chermann (Pasteur Institut) comments: "LAV/HTLV-III is a retrovirus which attacks the body's T-cells. Those cells are essential to the immune system. Retroviruses replicate--or reproduce--by means of an enzyme called reverse transcriptase. If you want to fight against the replication of such a virus, you have to inhibit the reverse transcriptase, and you have to inhibit it without killing healthy T-cells. HPA-23 does that.... We decided to liik at [HPA-23] 10 or 15 years ago [finding it] effective against murine leukemia in mice.... We described this work in the Journal of the National Cancer Institute (Volume 53) back in 1974. We also knew that HPA-23 was active against some neurotropic viruses, like the rabies virus, as well as encephalomyocarditis and scrapie infection in mice. But more important, we knew that the drug was active against Creutzfeldt-Jacob [a rare neurologic disorder] in humans.... So, to use an inhibitor of reverse transcriptase was our goal as soon as we discovered LAV. And we knew that HPA-23 was an inhibitor of reverse transcriptase, and that it was tolerated in humans. We started using it in patients with AIDS in May 1983, right after we isolated LAV [reported in Lancet, 2/23/85].... When we decided to use HPA-23 in AIDS, we had to ask ourselves 'What will be the marker of a possible action of this drug?'" The protocol needed people who tested not only antibody positive for HTLV-III/LAV but also had to have the actual virus isolated from the T-lymphocytes. " A patient may seem very well, feel well, but still be affected by the virus. We have to test the blood to know whether the virus is still there, and we can't be sure of any progress with the drug except after one, two, or three years...." Only two compounds are known to inhibit the virus in vivo--HPA-23, and suramin; and suramin has been shown to have rather severe and toxic side effects in many patients. Then there is Foscarnet. "It's a very good inhibitor of reverse transcriptase in vitro.... It's practically on the same level as HPA-23." What is the chance of HPA-23 being tested in the US? Chermann admitted that his staff were preparing a big report for the FDA, including toxicity data, so that a common protocol with the drug can include American physicians.

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CHANCROID OUTBREAK IN THE BRONX

City Health Information (CHI), New York City, 3/27/85

In December, 1984, the New York City Health Dept.'s Bureau of VD Control reported an increase in the number of patients with genital ulcers in the Bronx. Patients with darkfield-negative genital ulcers and those diagnosed clinically as primary syphilis but who continued to have genital ulcers after adequate treatment with benzathine penicillin were seen. Prostitutes appeared to have been involved in the transmission of chancroid in this cluster of patients with genital ulcers. New York City apprears to account for over 30% of all cases of chancroid in the U.S. Chanroid is caused by the bacterium Hemophilus ducreyi, which is sensitive to sulfanamides (e.g., Gantisin) as well as other antibiotics. Less than 100 cases are reported annually in this country.

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CINCINNATI REBUTS THREAT TO GAY AIDS COUNSELORS

by John Zeh, with thanks to Boston's Gay Community News, 4/13/85

Cincinnati city health workers received assurances at a hearing ot the City Council Human Resource Committee that sexual orientation or advocacy of gay and lesbian rights will not be grounds for firing. Councilman J. Kenneth Blackwell had sought a change in city policy to prohibit "active homosexuals and gay rights advocates" from working in the Health Department's AIDS screening and counseling program. Blackwell had said that gay men lack objectivity in counselling peers for "behavior modification" of sexual activity. He said if "quarantine or other restrictions" were deemed necessary to "shield potential victims," a gay activist might not recommend them. Speakers against Blackwell's proposal included Dr. Michael Mavroidis, president of AIDS volunteers of Cincinati (AVOC), who warned that Blackwell's actions carried a "greatly destructive potential." "The struggle to contain AIDS would be seriously weakened if the City's STD program is disrupted by a politically inspired witchhunt that would fire certain people or forbid their being hired," he said. Diane Coil, a representative of the National Organization of Women (NOW), urged that the "ongoing mutual cooperation and respect" between the STD clinic and gay men and lesbians be preserved so the battle against AIDS is not "subverted to [Blackwell's] uninformed, irresponsible, and politically-motivated demands." Blackwell is up for re-election this November. Arriving halfway throught he hearing, Blackwell repeated that anyone who believes homosexuality "is normal or desirable cannot counsel people at risk to infection." A written statement from Health Commisssioner Stanley Broadnax, solicited by Blackwell, was presented by STD Clinic Director Michael Ritchey. In part, that statement said, "Mating habits of heterosexuals, bisexuals, and homosexuals are all significant factors [in AIDS]" and that there has been no call by federal or scientific researchers for quarantine as a method of containment. Broadnax' statement also noted: "The use of quarantine to remove promiscuous individuals could result in quarantine of over half the US population. There are no scientific data available which indicate that an individual's sexual preference impacts upon his/her ability to perform professionally or objectively. The concept of using peers as counselors is not new." Ritchey, who also spoke against Blackwell, added that he "refuses to allow dying patients to be used as pawns" and that "There is a difference between disease control and prevention, and the isolation of certain people who are unacceptable to others." Chair Marian Spencer pledged at the hearing's conclusion that "Civil servants are removed only for cause. It is this committee's position that we are an open employment group. People who are doing their job shall not be subject to the constraint of removal."

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SOUTH CAROLINA'S HEALTH COMMISSIONER SUGGESTS SANITARIUMS

by Bruce Smith (AP Writer) with thanks to The Charlotte Observer, 4/29/85

According to South Carolina's top health official, Dr. Robert Jackson, commissioner of the state's Dept. of Health and Environmental Control (DHEC), doctors may have to resort to isolating AIDS patients in sanitariums in order to control the spread of the syndrome. "With AIDS we are largely back in the 1800s in terms of the absence of any known control measure other than preventing contact," he told doctors attending the annual meeting of the S.C. Medical Association. "I'm not sure that if we aren't prepared to think seriously about control measures that too many people are going to feel uncomfortable at best and fascist at worst, that we're going to be able to deal effectively and urgently with this illness." In the past, "certain of our public health efforts to deal with diseases have required a rather constrained attitude toward the behavior of individuals," he said. "We disregarded to some extent people's economic rights as well as their human rights having reached the decision that protection of the community is of greater urgency," Jackson said. "We incarcerated individuals, we institutionalized individuals and we took whatever steps were physically necessary to prevent them from spreading whatever the illness was they had. If this disease continues to spread and if it continues to be a disease we are powerless to treat, then I think clearly questions will begin to arise about the need to institute the same kind of somewhat Draconian historical measures." And Jackson said he questions whether society is prepared to accept such steps because of the "enormous concern in giving sometimes undue emphasis to people's human rights."

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MEDICAL DIRECTOR FOR AIDS PROJECT IN SEATTLE NEEDED

The Seattle-King County Department of Public Health is recruiting for the position of Medical Director, AIDS Project. This is a new position which is immediately available. The ideal candidate will be a gay-senstivie physician who is board certified or board eligible in infectious diseases, preventive medicine or other relevant specialty, and who has proven clinical, epidemiologic, and administrative skills. An appointment to the regular faculty of the University of Washington School of Medicine or School of Public Health is negotiable, depending on qualifications. Salary is negotiable. Interested persons should send a resume and list of references to: Patricia Canova, Manager, Regional Health Services, Seattle-King County Department of Public Health, 400 Yesler Way, Seattle, WA 98104, 206/587-2752.

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GOVERNMENTS CONTEMPLATE RESTRICTIVE MEASURES

by Nathan Fain, with thanks to the Voice, 5/14/85

With all the talk about AIDS as the epidemic of the century, several governments are contemplating measures that restrict those presumed to be infected. In Sweden, the health ministry has begun discussing whether AIDS should be classified as a quarantinable disease. In the United Kingdom, physicians have been authorized to detain AIDS patients in hospitals, perhaps for life. In West Germany, a proposal to force members of risk groups to take blood tests, and to criminalize sexual activity by people diagnosed with AIDS failed to pass the Bundestag. Meanwhile, reports from Havana indicate that some refugees returning from US prisons are being placed in quarantine because the government fears they may be infected with AIDS. The World Health Organization has quietly begun to examine whether travel restrictions might be placed on citizens of nations where AIDS is prevalent, such as the US. No measures have been taken, in part because of the difficulty of certifying good health. (Vaccination certificates are the standard control; there is no vaccine against AIDS yet.) Requiring an antibody-negative test result for anyone crossing an international border would be complicated and costly. But if the epidemic continues to spread, a system of passport controls may well come into use. On the home front, the ranks of those demanding quarantine of infected homosexuals have been joined for the first time by a state's chief medical officer. Dr. Robert Jackson of South Carolina suggests that "somewhat Draconian historical measures," such as imprisonment or detention, may be necessary to stop AIDS. They could prove unpopular, Jacson warns, because of "enormous concern in giving sometimes undue emphasis to people's human rights."

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GAY DOCTOR DENIED MEDICAL ACADEMIC APPOINTMENT

Alleging discrimination on the basis of his sexual orientation, pediatrician Dr. Paul Paroski Jr. filed civil suit against Brooklyn's Downstate Medical Center and New York City Health & Hospitals Corporation for denial of a promised medical academic appointment. This landmark suit is the first case of discrimination of a physician in an academic setting on he sole issue of sexual orientation. In addition, charges have also been filed under New York City's much debated Executive Order 50, banning discrimination on the basis of sexual orientation. This marks the first time that the Order has been evoked in the professional setting. In these suits, Paroski is seeking a retroactive academic appointment at Downstate Medical Center. Paroski is a well-known gay health care activist, working as a trail-blazing volunteer for the National Lesbian & Gay Health Foundation, Lesbian, Gay, & Bisexual People In Medicine, and the American Association of Physicians for Human Rights, among others. He has also extensively worked as a consultant to the Centers for Disease Control on the issue of gay/lesbian health, and has been intimately involved with AIDS, both locally and nationally. Paroski was assured an academic appointment at Downstate while employed by an affiliate hospital. According to sources at Downstate, the sole reason for appointment denial was Paroski's sexual orientation. The chairman of Downstate's Department of Pediatrics, Lawrence Finberg, MD, felt that Paroski's "political activism" was inappropriate for his pediatricians and therefore refused to process the appointment. He is presently in charge of over 50 physicians and responsible for over 1000 patients a day at Woodhull Medical and Mental Health Center in New York City.

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HHS' MASON MEETS WITH MOBILIZATION AGAINST AIDS

by Mark Scott, with thanks to The Washington Blade, 5/24/85

The HTLV-III antibody test should not be used "for taking away anyone's civil rights," said former CDC director Dr. James Mason, now acting asisstant secretary for health, in a meeting with members of Mobilization Against AIDS, a newly formed national AIDS lobby based in San Francisco. "To use [the test] for that would be a breach of moral and ethical precepts," Mason said. But Mason stopped short of agreeing to ask the Department of Defense, as Mobilization members urged, to abandom its plan to collect the names of military personnel who test positive. Dean Sandmire, a Mobilization member and person with AIDS from San FRancisco, presented Mason with petitions bearing 10,000 signatures and calling for "all our elected representatives at all levels of government to move this nation into a "moon launch" mentality to end this epidemic." The petitions included signatures from 30 states and were gathered in five weeks, said Mobilization coordinator Paul Boneberg. The intent is to collect one million signatures by late September, when another lobbying delegation will return to Washington. For more information about Mobilization Against AIDS or to help collect signatures on a petition:

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FARO/AIDS ACTION COUNCIL HIRES ANOTHER LOBBYIST

by Mark Scott, with thanks to The Washington Blade, 5/24/85

The AIDS Action Council of the Federation of AIDS Related Organizations (FARO) retained Daniel Maldonado, a former aide to Representative Edward Roybal (D-CA), as a part-time consultant to the Council for next year. "We've retained him to build coalitions of health-related organizations on AIDS for the purpose of increasing funding for AIDS-related activities," said Council Executive Director Gary MacDonald. "There's no question but that Dan is one of the saviest heads in Washington on legislative matters. He has all kinds of contacts." From 1981 to February, 1985, Maldonado served as Roybal's assistant on matters relating to the Appropriations Committee. Prior to that time, he was associate director of the President's Regulatory Council, which develops legislative recommendations for the President. Maldonado, who is not gay, said "one of the things that has to get done is to build a strong public-health [funding] base for emergencies like AIDS."

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EPISCOPAL BISHOP MAKES AIDS APPEAL

with thanks to Chicago's GayLife, 4/18/85

Bishop William Swing, one of the highest ranking officials in the Episcopal Church, said it is "time to stop washing our hands like Pontius Pilate and start getting our hands deeper in the pursuit of a cure" for AIDS, according to San Francisco's Bay Area Reporter. Swing made the remark at the first monthly "AIDS Healing Service," cosponsored by the Episcopal Diocese of California, Grace Cathedral and the AIDS Interfaith Network. "For too long politicians have dragged their feet because they fear that they would be subsidizing a gay lifestyle or promiscuity. It is too late to posture. All kinds of people are dying," said Swing. "The first reaction of the Moral Majority was to push for blame, judgement, and condemnation. Many have said that AIDS is God's judgement on the homosexual community [but] there is more going on in the AIDS crisis than finding an answer to the question: 'Who sinned?' The AIDS crisis cries out for healing, not condemnation...cries out for mercy, not throwing stones...cries out for deeper understanding, not knee-jerk homophobia. The same biblical literalists who love to tell about everyone's restraining in the story of the woman taken in adultery are the first people to declare that the stones should be flung at homosexuals."

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MASSACHUSETTS PROPOSES $1.8 MILLION FOR AIDS

by Christine Guilfoy, with thanks to Boston's Gay Community News, 5/11/85

Massachusetts state officials announced a proposed AIDS funding package of $1.83 million, which includes $1.63M for general funding and $200,000 for HTLV-III antibody testing, and represents a shift in philosophy from funding research to provision of services to people with AIDS. Larry Kessler, coordinator of Boston's AIDS Action Project (AAC), characterized the proposed funding level as acceptable but said $2.5M is the figure actually needed. Kessler said it would be important to supplement state funding with a comprehensive search for other money. For example, it would be important to make a soncerted effort to get as much as possible out of the federal Medicaid program such as home care attendants for PWAs. He also said there may be additional funds in the state mental health budget which could be tapped. Massachusetts Secretary of Human Services, Philip Johnson, said the proposed $1.63M is a lump sum and has not been broken down. He did, however list his priorities as follows: Developing a comprehensive plan for home and hospice care; Ensuring that persons eligible for Medicaid receive all entitled benefits; Hiring a statewide AIDS coordinator; Identifying and training mental health professionals to work with patients and families; Developing education programs for risk groups, health care providers and the public; Continuing research; Funding the state AIDS information line; Studying the possibility of establishing an AIDS ward at one of the state's public health hospitals. Johnson told the audience he expects a new statewide AIDS coordinator will be hired soon. The coordinator will "manage the state AIDS programs, facilitate the Governor's Commission [on AIDS], act as a liaison between groups and develop new programs."

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DC POLICE MISHANDLE PRISONER WITH AIDS

edited by Matthew Stadler, with thanks to the New York Native, 5/20-6/2/85

A 21-year-old man who was stopped for a traffic violation and then arrested on an outstanding warrant for jumping bail, was mistreated for two days by District of Columbia police, who were uncertain how to handle him because he has AIDS. The man's ordeal began when following his arrest, he informed the police that he had AIDS. The police then tried to have him admitted into DC's main cellblock, at DC General Hospital's prison ward, and the main unit at the DC jail's infirmary, but officials at all three places said they would not take a prisoner with AIDS. He was finally placed inthe isolation section of the jail infirmary. Major Ivan Anderson ordered the man's clothes burned to prevent contamination, and apparently, destroyed the man's wallet in the process. Once in isolation, the man was denied access to a telephone and the prescription medicine he needed to treat an infection he ahd as a result of the disease. Attorney Jim Graham, administrator of the Whitman-Walker Clinic, was not allowed to meet with the man, although Graham was working to secure his release. Graham told Lou Chibbaro of the Washington lade that he was met at the cellblock by a US marshal, who told him, "This is what all these faggots deserve." A second marshal, wearing plastic gloves, turned the man over to Graham. DC Jail Administrator William Long and Ronald Hein, chief deputy marshal of the US Marshal Service, told Chibbaro that they were willing to initiate educational efforts to better inform their employees how to handle AIDS patients. No specific plans are yet under way.

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PACIFIC NORTHWEST STD COMMUNITY RESOURCES DIRECTORY

Health care workers in the states of Oregon, Idaho, Washington, and Alaska have a new resource to help in referring client's inquiries about sexually transmitted diseases & AIDS to sympathetic & knowledgeable local providers. Compiled and published by the Health Information Network of Seattle, the Pacific Northwest STD Community Resources Directory --3rd edition will be an invaluable guide for health care providers, health educators, mental health therapists and counselors, providing information on area hotlines, medical and social service and research facilities. The directory may be purchased for $5, but membership in the HIN for $10/year is encouraged! Contact HIN, PO Box 30762, Seattle, WA 98103 or call 206/784-5655.

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ADMINISTRATIVE/CLINICAL ASPECTS OF MENTAL HEALTH TREATMENT OF AIDS

with thanks to Los Angeles CAIN, 6/11/85

A conference on the Administrative and Clinical Aspects of Mental Health Treatment of AIDS at the University of California--San Francisco, September 13-14, 1985, is being cosponsored by the University of California--San Francisco AIDS Clinical Research Center, UCLA AIDS Center, and the Center for Interdisciplinary Research in Immunologic Diseases (CIRID). The conference intends to educate therapists and administrative and clinical directors of community agencies assigned the task of treating AIDS patients about mental health and social sequellae of the epidemic. Faculty from the University of California and San Francisco community agencies who are familiar and experienced with AIDS treatment issues will share their experiences about effective policy implementation and clinical treatment. Specific emphasis on the first day's session will be on the interaction of health and mental health services, public policy responses to the epidemic, introduction to specific elements of a comprehensive service delivery system, and discharge planning from inpatient units. The second day will feature neurological and medical issues in AIDS progression and mental health treatment issues. For more information, contact: AIDS Clinical Research Center, 400 Parnassus, A523, University of California, San Francisco, CA 94143. Leon McKusick will be chair of the Conference committee.

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LOVE & HEALING WORKSHOP IN SOUTHERN CALIFORNIA

by San Diego AIDS Project, with thanks to CAIN, 6/13/85

San Diego AIDS Project (SDAP) is hosting an intensive workshop designed for PWAs, PWARC, their loved ones, and persons in the helping professions, August 26-30, 1985, at the Mission San Luis Rey near Oceanside. Registration deadline for the 6th Love & Healing Workshop is August 19, and tuition for the five day session is $395. Those who cannot afford the fee can apply for scholarships provided by the Imperial Court of Southern California. For professionals, the workshop is worth 30 hours of CEU. For more information, contact: Love & Healing Workshop, PO Box 81082, San Diego, CA 92138 or call 619/294-2437.

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ATLANTA "SELLS" SHARES TO HELP SUPPORT HOME FRONT PROJECT

After 8 months of continuous effort, struggle, and planning, the Home Front Committee of AID Atlanta (AIDA) is proud to announce the opening of its first residence for people with AIDS. As of June 1, AIDA is serving at least nine PWAs who have expressed a desire to live at the facility. The rent to be charged to tenants will probably only cover 1/3 to ½ the monthly costs to operate the residence, therefore continuous fundraising must take place. In order to help support the operations, AIDA will be "selling" Care Share Certificates, at $10 per share. These certificates will be suitable for framing.

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WASHINGTON, DC CLINIC PROJECTS 400 MORE AIDS CASES IN NEXT 18 MONTHS

by Lou Chibbaro, Jr., with thanks to The Washington Blade, 4/5/85

The number of AIDS cases in the metropolitan Washington, DC area could increase by as much as 68% over the next year and a half, and leaders from the gay and non-gay communities must begin planning on ways to cope with these additional cases, officials from the Whitman-Walker Clinic told a community meeting, recently. It is estimated that there will be 200 more persons living with AIDS than there are today, with each person potentially in need of services such as housing, legal aid, and financial assistance. The Clinic's total AIDS program budget for fiscal year 1986 could be as much as $410,300, with $165,300 needed to address basic AIDS services alone, according to a draft report speculating on how the community must respond to the crisis next year. Additional services include public education, housing, direct assistance to AIDS patients, the AIDS evaluation unit, and possible medical testing for factors such as the HTLV-III antibody. The report's projections are thought to be conservative estimates by community members who attended a meeting where the report was released. A final report will be forthcoming, based on additional views and comments from community members.

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MOTHER WITH AIDS IN CAMBRIDGE PROMPTS SCHOOL POLICY

by Michael Schwartz, with thanks to Boston's Gay Community News, June 8, 1985

Spurred by the possibility of a public panic over the AIDS-related death of a mother of a school child, Cambridge, Massachusetts school and health officials recently adopted guidelines concerning children with AIDS. The officials also took measures toward educating parents and school staff about AIDS, but have conspicuously avoided directing education efforts to high school students. The guidelines and public education program have been credited with preventing panic but have also drawn criticism. The guidelines, based on guidelines already adopted in Florida and Connecticut and being considered in Boston, permit children with AIDS, ARC, or HTLV-III antibody positive tests to remain in school, except in extreme circumstances. Criticism centers on a letter sent by Cambridge School Superintendent Robert Peterkin to all parents of school children, which reassures the public but also spreads what gay and lesbian activists see as misinformation about AIDS. They also point to severe shortcomings in the guidelines' plans for public education. All staff members in area schools received a letter from the Superintendent, a letter from the city's health Commissioner, and the proposed guidelines concerning children with AIDS. When asked about the guideline specifying educational programs for parent groups, Health Commissioner Dr. Melvin Chalfen said the school system planned wither to use school committee meetings or to refer questions to the Cambridge City Hospital. Since only one person had actually called the school with questions about AIDS, however, Giroux indicated they were leaning toward the latter option

public information officer

Albert Giroux indicated they were leaning toward the latter option. Officials were considering adding AIDS education to the "health program" already provided to high school students, although medical experts in the schools were already getting and answering questions about AIDS. A letter from school officials was sent to all parents of Cambridge school children and was distributed in 6 non-English languages, in accord with the state bilingual education law. It stated that a parent of an area school child had died of AIDS, and contained the following:

"Medical authorities have assured us that the children DO NOT HAVE AIDS. In addition, information from federal, state, and city medical officials report that in studies of households where a member died of AIDS, no other member of the household contracted the disease. Medical authorities also stated that the disease is not commonly contagious. Individuals are infected with AIDS through unusual sexual contact or intravenously. Please be assred that to the knowledge of School and Health officials, No Cambridge School student or parent has AIDS."

Some community members commented that the schools handled the situation exceptionally well, acting promptly and with foresight. Others disagreed sharply, pointing first to the statement in the letter to parents that "...unusual sexual contact...." was misleading and "an extremely strong value judgement," according to Kevin Cathcart of Gay and Lesbian Advocates and Defenders (GLAD). There were also objections to the statement that "...the children DO NOT HAVE AIDS." since it implies that if they did, they would be treated differently. Also, there is no way to know which children did in fact have the disease; or conversely, which children most assuredly did not have the disease. Jonathan Handel, founder of the Cambridge Lesbian and Gay Alliance (CLAGA) pointed out the guideline's emphasis on education for staff and parents glaringly omitted targeting of students, who are "...fucking around with the same sex and the other sex, and they're shooting up intravenously. It's cowardly of the school system not to present them with the kind of information whty need to protect themselves. [Kids] need to hear about safe[r] sex information, about sharing needles, and the teachers and parents are not going to be able to tell them what they need to know."

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AIDS COUNSELING WAITING LIST IN SAN FRANCISCO

with thanks to The Washington Blade, 5/17/85

The three-year-old AIDS Foundation in San Francisco says that a recent upsurge in the number of diagnosed AIDS cases and a delay in getting city funding for additional staff power has forced the organization to create a waiting list for people with AIDS wanting to learn about availability of area services. Three social workers are presently counseling 300 PWAs.

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TV CREW REFUSES TO TAPE MEN WITH AIDS

compiled by Stephanie Poggi, with thanks to Boston's Gay Community News, 4/13/85

A WNBC-TV television crew refused to tape an interview at a Manhatten studio with two men who have AIDS, according to the New York Times. The taping was completed by another camera operator when the two men being interviewed agreed to pin microphones on themselves and to dispose of them after the taping. Medical authorities reaffirmed that members of the television crew are in no danger, but Bud Carey, vice president and general manager of the station said, "Even members of the medical community are not sure themselves when it comes to AIDS."

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WOMAN WITH AIDS BARRED FROM TV STUDIO

with thanks to The Washington Blade, 5/10/85

Technicians for a local television talk show asked a woman with AIDS not to enter their control booth during the airing of a program on AIDS and the black community. Sunneye Sherman, the woman with AIDS, was preparing to watch her mother Ina Sherman, a nurse, on Washington, DC's WHMM-TV's Evening Exchange program when technicians objected to her watching from the control booth where they were working. During the Evening Exchange program, sponsored by Howard University, gay activist and advisory neighborhood commission chairperson Phil Pannel charged that black gay social organizations in Washington are unwilling to take responsibility for AIDS education and fund-raising. "It comes from a certain amount of 'collective denial,'" Pannell said. "It's as if, 'It hasn't affected me personally, so I won't do anything about it.'"

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RELIGIOUS LEADERS WANT COMPASSION FOR PEOPLE WITH AIDS

compiled by Stephanie Poggi, with thanks to Boston's Gay Community News, 4/6/85

Meeting in March at an interfaith forum on religion and AIDS, a group of Jewish, Roman Catholic, and Protestant leaders issued a joint statement calling for "compassion" for people with AIDS, according to the New York Times. The group challenged assertions from other religious leaders that the disease was a punishment from God. Rabbi Balfour Brickner of the Stephen Wise Free Synagogue compared gay men today to Jews in the Middle Ages who were accused of causing the plague by contaminating the wells of Europe. "Jews were falsely accused and put to death," he said. Similarly, homosexuals are charged with causing a medical epidemic of which they are the victims rather than the cause, he said. "The effects of ignorance and bigotry are terrifying and lethal." Reverand Carl Flemister, executive minister of the American Baptist Churches of Metropolitan New York, criticized fundamentalist preachers such as Jerry Falwell for pushing the notion that AIDS is divine retribution. The fact that this idea is popular, Flemister said, "shows that we haven't gotten our act together on sexuality in the religious community." In the question and answer period, several audience members charged Archbishop John J. O'Connor of New York with fueling hostility to gay people by refusing to comply with Mayor Koch's anti-discrimination order. Monsignor Basler of the Roman Catholic Diocese of Brooklyn, which has complied with Koch's order, conceded there is "ambiguity" toward homosexuality in the Catholic Church, but claimed there is plenty of compassion for those who have AIDS.

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VA WILL HELP VETS WITH AIDS

with thanks to the Washington Blade

Former servicemen with AIDS are "welcome to seek treatment" at the nation's 172 Veteran's Administration hospitals, officials told the Gay Veterans Association (GVA) at a recent meeting Ralph Crossen, special assistant to VA administrator Harry Walters, said VA hospitals are required by law to admit any veteran who received an honorable discharge from the military and who cannot afford private hospitalization. He said AIDS patients have been admitted to 54 VA hospitals, mostly in New York and San Francisco. John Paine, GVA president asked the military to allow the group to place its brochures at all military outprocessing centers so that gay veterans may learn about GVA.

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BLACK WOMEN'S HEALTH

compiled by Stephanie Poggi, with thanks to Boston's Gay Community News, 5/25/85

The editors of SAGE: A Scholarly Journal on Black Women are soliciting manuscripts for the fall, 1985 issue on Black women's health. The editors encourage articles on the status of Black women's health--mental and physical, on the impact of new health technologies on Black women's health, on Black women as health care providers, on Black women and alternative healing systems; analyses on Black women's experiences with health care delivery systems; personal analyses of Black women's experiences with illness; and interviews with Black women health activists. The submission deadline is August 15. For more information, write to: SAGE, PO Box 42741, Atlanta, GA 30311-9741.

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SPIDERMAN UPDATE

quote from Mark Zanger, from his "Don't Quote Me" column in the Boston Phoenix, 2/26/85
compiled by Stephanie Poggi, with thanks to Boston's Gay Community News, 4/6/85

"The best available estimates are that 80 to 90% of sexual harassment of children is committed by male family members. In the [Spiderman comic, run in the Boston Globe, February 17], the figure is 33%. It is thought that one in five girls experiences sexual harassment, compared with one in 10 boys. In the comic, twice as many boys are harassed as girls; the opposite of the real world--a girl harassed by her father or stepfather--is the last one presented in the comic....What we have, at least for adult readers, is an unnecessary strong dose of misogyny and homophobia mixed into the sound medicine."

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FUNERAL HOMES CAPITALIZE ON AIDS IN DALLAS

by Mark Scott, with thanks to The Washington Blade, 4/5/85

After several funeral homes in Dallas reportedly refused to handle the bodies of persons who died of AIDS without using elaborate and expensive precautions, the Dallas Gay Alliance asked the Texas health department to establish guidelines for embalming and burying people who have died from AIDS. The DGA's request stems from several incidents reported in the Dallas area by families of people with AIDS. In one case, a funeral home allegedly charged a family an extra $200 for gloves and gowns used to handle the AIDS patient's body, while another funeral home allegedly tried to sell a family a $900 "germ-free" coffin. A third family reported that a funeral home refused to permit open-casket viewing unless a plastic shield were placed over the body.

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MOTHER TERESA VISITS DC AREA AIDS PATIENTS

by Lisa M. Keen, with thanks to The Washington Blade, 6/21/85

Nobel Peace Prize winner Mother Teresa visited AIDS patients at George Washington University Hospital, escorted by gay physician Dr. Richard DiGioia who cares for a number of the area's AIDS patients. According to DiGioia, who is also cochair of the DC AIDS Task Force, Mother Teresa greeted each patient personally, asked questions about their families, and asked them to pray. Mother Teresa's visit to PWAs came as a result of a letter from a patient of DiGioia's who does not have AIDS, but wanted to write her to tell of the suffering of AIDS patients and ask her to visit them during her trip to Washington this month. Mother Teresa arrived with little fanfare or notice, having just met with President Reagan who had presented the 1979 Nobel Peace Prize Winner with the Medal of Freedom. One AIDS patient with whom Mother Teresa visited felt honored by her visit. DiGioia said he did not know if the letter to Mother Teresa concerning AIDS mentioned that the disease has primarily stricken gay men. But, he added after the visit was over, "I think more Christians should take a lesson from her example and quit being so judgemental and start acting like Christians should act."

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HTLV-III DISEASE, NOT AIDS

excerpted (with apologies) from Ann Giudici Fettner, with thanks to NY Native, 6/17-30/85

[ED NOTE: The following excerpts are from an interview with Dr. Major Robert Redfield, head of the US Army's infectious disease wing [sic]. We have freely sampled several topics, and acknowledge this format is far from satisfactory. We urge our readers to subscribe to the Native to get the best overall coverage of AIDS related news.]

Major Redfield acknowledges that the disease AIDS is just another infectious disease, one difficult to transmit casually and one that everyone isn't going to contract. He dislikes using the term, "AIDS." "The worst thing we can do naming this virus [referring to the disputed multiple names] is putting 'AIDS' in it. Remember what 'AIDS' is? It's an epidemiological surveillance definition, and clinically it's harmful, not helpful. We don't talk about AIDS here; we talk about HTLV-III disease. It's a virus that causes destruction of T-cells, and because all the stigmata created by AIDS is still out there, and because 'AIDS' is inaccurate we prefer using the name human T-cell lymphotropic virus disease." What about treatment? "The antivirals may play a role in stopping the virus from replicating and causing more damage so that the five-to-eight year survival is stretched to 10-20 years. There are two approaches, antiviral and immunoaugmentation. We're using suramin, and we're encouraged. We're going to have to evaluate the results objectively before we're really sure of what we're getting.... The drug clearly inhibits the virus from replicating, and that's very important.... If we can show objectively that the drug really stops the virus--and the evidence is that it does--and that the toxicity is tolerable, we'll move back and start treating earlier. We know that, while on suramin, the virus is shut off, but that doesn't stop disease from progressing. ... We may find out that, even though we can't isolate virus from people whild they're on suramin therapy, it may actually hurt T-cells." How is Kaposi's sarcoma different from other opportunistic diseases? From the beginning, KS in AIDS has been like a subliminal message inserted into a film about the disease. But nobody has yet been able to translate the disease engendered by this clue. Redfield thinks KS is "etiologically linked," but not caused by HTLV-III. "We've had epidemiological evidence of that for a long time. KS occurs disproportionately in people developing AIDS, mainly in those whose homosexual promiscuity is the risk factor. KS may be a separate agent expressed on the basis of defective cellular immunity, but I doubt that because it's expressed at an earlier stage of cell-mediated immunity. I think it may be a complication of the polyclonal B-cell response that is stimulated by virus; the same way Epstein-Barr virus can drive towards translocation of Burkitt's lymphoma, HTLV-III-stimulated polyclonal B-cell activation may drive towards KS, or non-Hodgkins lymphoma. With Burkitt's, EBV may drive towards a non-infectious malignancy. It may be that KS is caused by a unique organism in which cell-mediated immunity plays an important role. It's that B-cell activation that messes up regulation in the endothelial cells and causes KS, the same way EBV causes screw-ups in the way these cells divide, so you start getting translocations and Burkitt's." It also may be that the use of inhalent nitrites (poppers) still has to be correlated with the development of KS. Is the military really interested in 'witchhunting' those service-people who test antibody positive? The background on this controversy (which revolves around HTLV-III antibody screening being considered for all recruits) is that for "classified" reasons, the Army still inoculates recruits against smallpox, which is generally thought to have been eliminated worldwide. Even when smallpox was endemic, several categories of persons could not be vaccinated because of the potential danger of becoming infected by the vaccine itself. Those who are immunocompromised head the list. The outcome of vaccination in such people is vaccinia--smallpox--and often is fatal. Also contraindicated for vaccination are those with skin eruptions. "When the Army talks about screening people for HTLV-III, people immediately say we're trying to discriminate. We aren't. Here's the point: I'm going to give a [smallpox] vaccine that may kill if the person is HTLV-III antibody positive...." Redfield has already had one case, in an apparently healthy young heterosexual man, who then developed vaccinia; he was found to be HTLV-III positive. Though he recovered from the vaccinia, the recruit's T-cell ratio is still changing and he has crypto infection. He said the Washington Blade, in their recent interview with him, didn't bother to make clear the danger of vaccinating those who may be unknowingly immunosuppressed. And one other thing: "As long as it's in the best interest of the patient [with AIDS], they stay on active duty. When they can no longer do so, they receive separation with full benefits,"Redfield concluded.

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CENTERS FOR DISEASE CONTROL

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Epidemiologic Notes and Reports

Disseminated *Mycobacterium bovis* Infection from BCG Vaccination of a Patient with Acquired Immunodeficiency Syndrome

In December 1982, Kaposi's sarcoma and acquired immunodeficiency syndrome (AIDS) were diagnosed in a 29-year-old white homosexual man. A trial of vinblastine sulfate failed to decrease the progression of his skin lesions. In February 1984, when seen in a clinic in Tijuana, Mexico, he was given a BCG vaccination. The expected local lesion from the BCG vaccination healed normally within the next few weeks. In June, he developed chills and fever to 39.4 C (103 F), weakness, fatigue, anorexia, and a mild headache. In July, the site of BCG vaccination on his left arm ulcerated, draining a small amount of pus and blood. A previously enlarged lymph node in the left axilla increased substantially in size and became very tender. Because of the possibility of disseminated BCG infection, treatment was begun with INH 300 mg/day, ethambutol 25 mg/kg/day, and pyridoxine. He rapidly became afebrile and regained his feeling of well-being. The ulcer healed slowly, and the enlarged lymph node decreased in size and tenderness. Two blood cultures taken June 28 and a culture of the ulcerating lesion taken July 16 grew *Mycobacterium bovis*, BCG strain. A blood culture taken July 23, just before therapy, grew *M. fortuitum*.

Reported by RE Winters, MD, School of Medicine, University of California, Los Angeles, LQ Hanh, MD, Tuberculosis Control Unit, Los Angeles County Dept of Health Svcs, J Chin, MD, State Epidemiologist, California State Dept of Health Svcs; Div of Tuberculosis Control, Center for Prevention Svcs, AIDS Br, Div of Viral Diseases, Center for Infectious Diseases, CDC.

Editorial Note: BCG vaccine contains live mycobacteria derived from a strain of *M. bovis* attenuated through years of serial passage in culture by Calmette and Guerin at the Pasteur Institute, Lille, France. Although BCG has been widely used throughout the world, its use in the United States is limited to those uncommon situations in which uninfected persons are repeatedly exposed to infectious tuberculosis, and other means of preventing infection cannot be applied (*1*). BCG has also been used to stimulate the immune system of patients with various cancers, especially malignant melanoma, with the objective of causing regression of the tumors (*2*). As with any vaccine containing live organisms, however, it is contraindicated in persons with severely impaired immune responses, including those with AIDS, because disseminated infection with the organism contained in the vaccine may result.

M. bovis and *M. tuberculosis* (the *M. tuberculosis* complex) are pathogenic for man and are distinct from the "atypical" mycobacteria that tend to be opportunistic. Infection with *M. bovis* or *M. tuberculosis*, even if disseminated, is generally not considered opportunistic and is, therefore, not used as a marker for AIDS in CDC's surveillance definition of AIDS (*3*). The BCG strain of *M. bovis*, however, being attenuated and not usually a cause of disease, may be considered an opportunist.

Of the 9,760 AIDS patients in the United States reported to CDC as of April 24, 1985, 2.7% were reported to have tuberculosis. Disseminated atypical mycobacterial infection, used as a marker for AIDS, was reported in 3.7%. Another 0.9% were reported to have disseminated infection with an undetermined species of mycobacteria. The true cumulative incidence of mycobacterial infections in AIDS patients is undoubtedly higher. The opportunistic infections reported to CDC's AIDS surveillance program are largely limited to those present at the time AIDS is diagnosed. Disseminated mycobacterial infections are not common among the initial opportunistic infections in AIDS patients, but in one series of 71 AIDS patients, 24 (34%) reportedly developed infection with *M. avium* complex organisms at some time during their illness (*4*). The great majority (94%) of the atypical mycobacterial infections reported to the AIDS surveillance program have been due to *M. avium* complex; 4% were due to *M. kansasii*; and 2%, to other species. Besides the patient reported here, only one other AIDS patient had disseminated *M. fortuitum* reported; the *M. fortuitum* cannot be explained by the BCG vaccine and may represent a contaminated culture rather than a true infection.

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CENTERS FOR DISEASE CONTROL

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Current Trends

Changing Patterns of Acquired Immunodeficiency Syndrome in Hemophilia Patients — United States

The pattern of hemophilia-associated AIDS appears to be changing in that the number of cases may be stabilizing or declining, and the characteristics of new cases appear to be changing. As of April 1, 1985, CDC has received reports of 73 cases of hemophilia-associated acquired immunodeficiency syndrome (AIDS) among U.S. patients. The first case was diagnosed in 1981; eight cases were diagnosed in 1982; 13, in 1983; 45, in 1984; and six, thus far in 1985 (Figure 2). Four of these 73 had known risk factors for AIDS other than a coagulation disorder requiring treatment with commercial factor concentrates or cryoprecipitate. Patients with severe hemophilia A (hereditary factor VIII deficiency) continue to account for the majority (52 [71%]) of hemophilia-associated AIDS cases. Patients with mild or moderate hemophilia A account for an additional 13 (18%) cases. The remaining cases consist of

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MMWR

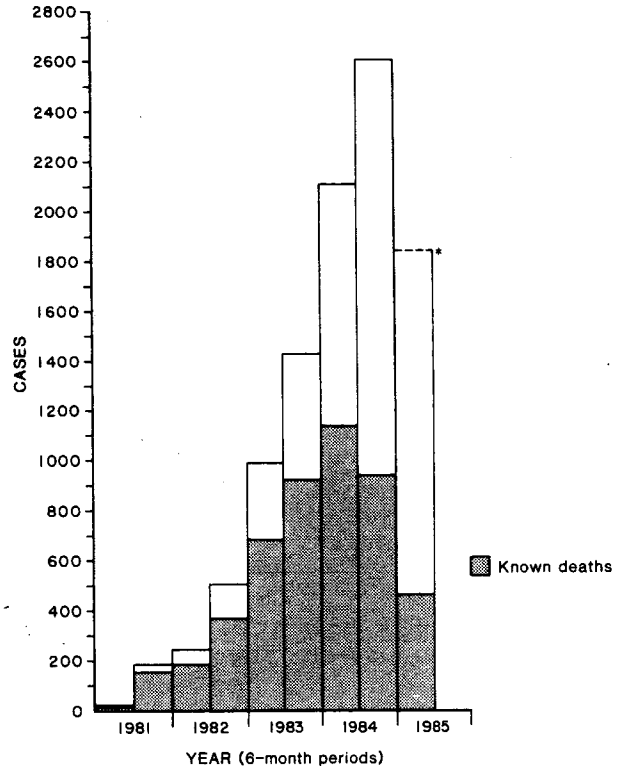
MORBIDITY AND MORTALITY WEEKLY REPORT

Current Trends

Update: Acquired Immunodeficiency Syndrome — United States

As of April 30, 1985, physicians and health departments in the United States had reported 10,000 patients (9,887 adults and 113 children) meeting the surveillance definition for acquired immunodeficiency syndrome (AIDS) (*1,2*). Since the initial reports of AIDS in the spring of 1981 (*3,4*), the number of cases reported each half-year has increased (Figure 1). Over half of the 10,000 cases have been reported within the last 12 months. Four thousand nine hundred forty-two of all reported patients are known to have died (49% of the adults and 69% of the children); 75% of patients diagnosed before January 1983 are known dead.

FIGURE 1. Acquired immunodeficiency syndrome cases and known deaths, by 6-month period of report — United States, 1981-April 1985



*Data incomplete

Adult patients. Among adult AIDS patients, there has been no significant change over time in distribution by age, race, and sex. Ninety percent of adult patients are 20-49 years old. Sixty percent are white; 25%, black; and 14%, Hispanic. Ninety-four percent are men.

Reported cases have increased substantially in all patient groups. However, some changes in the relative proportion of cases have been noted. Since 1981, the proportion of AIDS cases in transfusion recipients has increased significantly ($p < 0.01$), while the proportion of cases in "other/unknown" patients has decreased significantly ($p < 0.001$) (Table 1). The latter reflects a smaller rate of increase of AIDS among Haitian-born patients who are placed in the "other/unknown" category. Although there has been a slight increase in the proportion of patients who are homosexual/bisexual men, it is not statistically significant.

The proportion of adult patients with Kaposi's sarcoma (KS) alone and with both KS and *Pneumocystis carinii* pneumonia (PCP) has decreased significantly ($p < 0.001$) (Table 2). This is associated with a significant increase in the proportion of cases with PCP and no KS. The distribution of cases with other opportunistic diseases has remained relatively constant.

Adult AIDS patients have been reported from 46 states, the District of Columbia, and three U.S. territories. Among cases reported before May 1983, 47% of the adults were residents of New York. Between May 1984 and April 1985, the proportion of adults reported with AIDS from this state decreased significantly ($p < 0.001$) to 34% of the total.

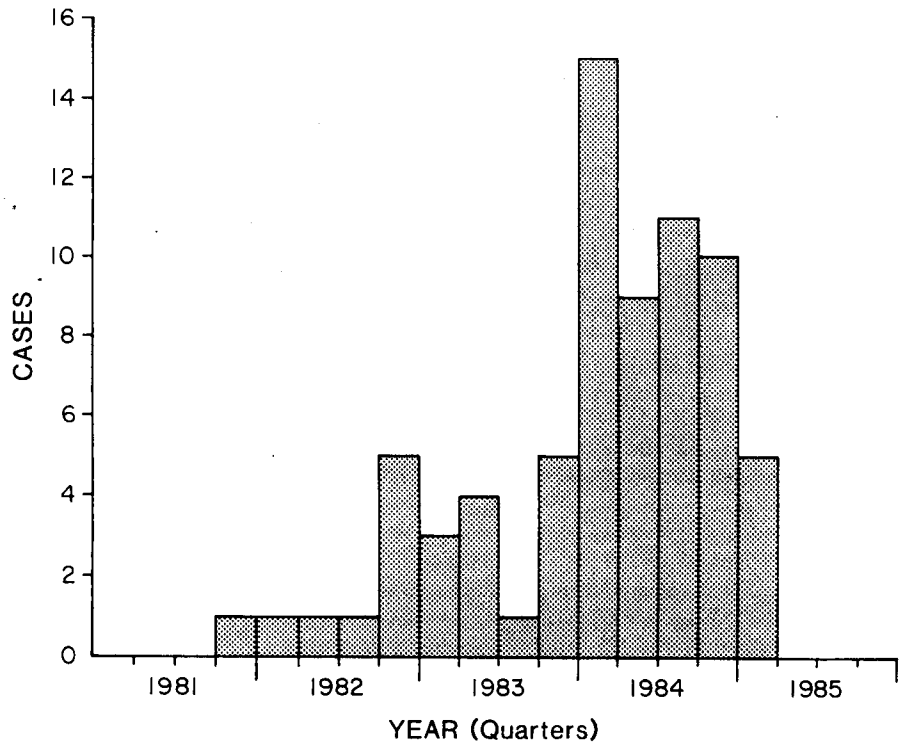
Pediatric patients. Among AIDS patients under 13 years old, there has been no statistically significant change in distribution by age, race, sex, and disease presentation over time. Fifty-

TABLE 1. Acquired immunodeficiency syndrome (AIDS) patients, by patient group and date of report — United States, through April 1985

	Cases reported							
	Before May 1983		May 1983-April 1984		May 1984-April 1985			
Patient group	No.	(%)	No.	(%)	No.	(%)	Total	(%)
Adult								
Homosexual/bisexual	992	(71.5)	2,070	(72.5)	4,199	(74.4)	**7,261**	**(73.4)**
IV drug user	233	(16.8)	510	(17.9)	942	(16.7)	**1,685**	**(17.0)**
Hemophilia patient	11	(0.8)	17	(0.6)	37	(0.7)	**65**	**(0.7)**
Heterosexual contact	13	(0.9)	23	(0.8)	45	(0.8)	**81**	**(0.8)**
Transfusion recipient	12	(0.9)	34	(1.2)	88	(1.6)	**134**	**(1.4)**
Other/unknown	126	(9.1)	202	(7.1)	333	(5.9)	**661**	**(6.7)**
Total	**1,387**	**(100.0)**	**2,856**	**(100.0)**	**5,644**	**(100.0)**	**9,887**	**(100.0)**
Pediatric								
Parent with AIDS or at increased risk for AIDS	11	(57.9)	27	(67.5)	43	(79.6)	**81**	**(71.7)**
Hemophilia patient	2	(10.5)	1	(2.5)	3	(5.6)	**6**	**(5.3)**
Transfusion recipient	2	(10.5)	8	(20.0)	5	(9.3)	**15**	**(13.3)**
Other/unknown	4	(21.1)	4	(10.0)	3	(5.6)	**11**	**(9.7)**
Total	**19**	**(100.0)**	**40**	**(100.0)**	**54**	**(100.0)**	**113**	**(100.0)**
TOTAL	**1,406**	**(100.0)**	**2,896**	**(100.0)**	**5,698**	**(100.0)**	**10,000**	**(100.0)**

three patients with hemophilia B (hereditary factor IX deficiency), three with von Willebrand's disease, one with an acquired inhibitor to factor VIII, and one with factor V deficiency. These patients resided in 27 different states. Cases reported per state ranged from one to nine (median two).

FIGURE 2. Hemophilia-associated acquired immunodeficiency syndrome, by year — United States, 1981-1985



Ten patients had no documented use of blood products other than factor concentrates in the 5 years preceding their diagnoses. One patient with von Willebrand's disease, diagnosed in January 1985, had no documented use of blood products other than cryoprecipitate in the 3 years preceding diagnosis.

Sera from 29 (40%) of the 73 cases were obtained and tested by the Western blot method (*1*) for antibody to human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV); 22 (76%) of the 29 were antibody-positive.

Of the opportunistic infections considered by CDC to be indicative of underlying cellular immune deficiency, *Pneumocystis carinii* pneumonia (PCP) remains the most common infection diagnosed in hemophilia-associated AIDS. Sixty-one (84%) of 73 patients had PCP alone or in combination with one or more other opportunistic infections.

Thirty-eight (52%) of the 73 hemophilia patients with AIDS have died. Seven (20%) of those still alive have survived 1 year or more since diagnosis; one (3%) has survived longer than 2 years.

Surveillance indicates the characteristics of recently diagnosed hemophilia-associated AIDS cases may be changing, and the number of new cases diagnosed by quarter may be stabilizing in this population. Ten of the 23 patients diagnosed since August 1, 1984, have disorders other than severe hemophilia A. This represents a change in proportion from earlier diagnosed cases (10 of 50 [p = 0.05]). During 1984, more cases of hemophilia-associated AIDS were diagnosed than in all previous years of surveillance. However, unlike the epidemic pattern for all AIDS, the number of hemophilia-associated AIDS cases in 1984 has not increased in each quarter (Figure 2). It is possible that a significant number of hemophilia-associated AIDS cases not yet reported to CDC have already been diagnosed at some time in 1984, and the temporal distribution of cases is subject to change with receipt of reports of such cases. However, preliminary results from a simulation of 1985 hemophilia/AIDS reporting indicate that the expected number and distribution of cases would not sufficiently change the 1984 hemophilia-AIDS epidemic pattern.

Reported by Div of Host Factors, AIDS Br, Div of Viral Diseases, Center for Infectious Diseases, CDC.

Editorial Note: HTLV-III/LAV has been implicated as the causal agent of AIDS (*2-5*), and in the hemophilia population, commercial factor concentrates are suspected as the vehicle for transmission of the virus (*6-8*). Recently, exposure to HTLV-III/LAV through use of cryoprecipitate has been documented in studies of the seroprevalence (two of six tested) (*9*) and seroconversion (two of 11 seroconverting during a 1-year period) (*10*) in hemophilia patients using this product exclusively. The development of AIDS in three patients with von Willebrand's disease, one of whom had no documented blood product exposure other than cryoprecipitate and no other risk factor for AIDS, is further strong evidence to consider chronic use of cryoprecipitate a definite risk factor for AIDS. This may be especially true for those who are exposed to multiple donors (more than 80 per year). The magnitude of this risk may depend on geographic locality.

Trends in both the number and characteristics of recently reported hemophilia-associated AIDS appear to be changing. Patients with mild or moderate hemophilia and those with von Willebrand's disease tend to use significantly less clotting factor products in their disease therapy than do those with severe hemophilia and are more likely to be treated with products other than commercial factor concentrates. The recent increase in AIDS cases reported among persons with milder hemophilia may reflect earlier exposure of persons with severe hemophilia A to HTLV-III/LAV than of those with mild or moderate hemophilia or von Willebrand's disease. Continuous surveillance will be needed to monitor these trends. Physicians and other health-care personnel are encouraged to report suspected AIDS cases to CDC through their local or state health departments.

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eight percent of the pediatric patients were under 1 year old at diagnosis. Fifty-five percent are black; 22%, white; and 21%, Hispanic. Sixty-three percent are male. Sixty-eight percent had PCP without KS; 2% had KS and PCP; 4% had KS without PCP; and 26% had other opportunistic diseases. Eighty-one (72%) of the 113 pediatric patients came from families in which one or both parents had AIDS or were at increased risk for developing AIDS; 15 (13%) had received transfusions of blood or blood components before their onsets of illness, and six (5%) had hemophilia. Risk factor information on the parents of the 11 (10%) remaining patients is incomplete. Pediatric cases have been reported from 17 states; cases reported per state ranged from one to 53 (median one). Eighty-two percent of the pediatric cases have been reported from New York, New Jersey, Florida, and California. Of the 81 pediatric patients with a parent with AIDS or at increased risk for AIDS, 69 (85%) were residents of New York, New Jersey, or Florida—states in which over 84% of the heterosexual adult cases were reported.

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

Editorial Note: The number of AIDS cases reported nationally continues to increase. The first 5,000 diagnosed cases were reported to CDC between June 1981 and June 1984 (37 months); the last 5,000 cases have been reported since June 1984 (10 months).

Haitian-born AIDS patients have now been placed into the "other/unknown" group. The previous separate listing for Haitian-born patients has been discontinued in light of current epidemiologic information that suggests both heterosexual contact and exposure to contaminated needles (not associated with intravenous [IV] drug abuse) play a role in disease transmission (*5-7*). Similar risk factors have been described for AIDS patients in some central African countries (*8-10*). Evidence from surveillance case report forms is insufficient to establish the specific modes of transmission in particular cases reported among Haitian immigrants.

Among Haitian-American control patients who were age- and sex-matched to patients with AIDS, the prevalence of antibody to human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV) was 5% (*7*). While this seroprevalence is lower than that found in other patient groups, it is several times higher than that seen in random blood donors. The following U.S. Public Health Service guidelines continue to apply: blood and/or plasma should not be donated by persons with symptoms and signs of AIDS, sexual partners of AIDS patients, sexually active homosexual/bisexual men with multiple partners, Haitian entrants to the United States, present or past abusers of IV drugs, patients with hemophilia, and sexual partners of individuals at increased risk for AIDS (*11*).

The proportion of AIDS patients with a history of blood transfusion as their only risk factor has increased significantly during the last 2 years, although these cases still contribute less than 2% of the total. Because the time from infection with HTLV-III/LAV to onset of AIDS may be several years, persons exposed to the virus through transfusion before institution of the self-deferral guidelines for blood donors in 1983 and screening of blood for HTLV-III/LAV antibody in 1985 may remain at risk of AIDS.

Over 93% of all AIDS patients who have KS are homosexual/bisexual men (*12*). Although the proportion of homosexual/bisexual men reported with AIDS has been increasing, the proportion with KS has decreased significantly and has led to an overall decrease in the proportion of adult cases with KS. The reasons for the change in proportion of KS cases among homosexual/bisexual men are unclear.

Forty-five states, the District of Columbia, and Puerto Rico now require reporting of AIDS to health departments. Although the majority of cases have been reported from a few states, proportionately greater increases have recently been noted from other states. The geographic distribution of AIDS among children with parents in high-risk groups is similar to that seen for heterosexual adult AIDS patients. Since several years usually separate acquisition of infection with HTLV-III/LAV and onset of AIDS, current reports of AIDS cases may not reflect the present geographic distribution of infected persons.

TABLE 2. Percent distribution of adult acquired immunodeficiency syndrome patients, by disease and date of report — United States, through April 1985

Disease*	Before May 1983	May 1983-April 1984	May 1984-April 1985	Total
KS, no PCP	24.7	24.1	18.9	**21.2**
KS and PCP	10.3	6.7	4.3	**5.8**
PCP, no KS	51.3	51.7	59.5	**56.1**
Other opportunistic diseases	13.7	17.5	17.2	**16.8**
Total	**100.0**	**100.0**	**100.0**	**100.0**

*KS = Kaposi's sarcoma; PCP = *Pneumocystis carinii* pneumonia

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CENTERS FOR DISEASE CONTROL

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

World Health Organization Workshop: Conclusions and Recommendations on Acquired Immunodeficiency Syndrome

An international conference on acquired immunodeficiency syndrome (AIDS), sponsored by the U.S. Department of Health and Human Services and the World Health Organization (WHO), was held in Atlanta, Georgia, April 15-17, 1985. It was attended by over 3,000 participants from 50 countries and was followed on April 18-19 by a WHO consultation to review the information presented at the conference and to assess its international implications.

The group of WHO consultants concluded that information is now sufficient to permit health authorities to take actions that may decrease the incidence of AIDS among certain risk groups. The group submitted the following conclusions and recommendations:

1. WHO should:
   a. Establish a network of collaborating centers with special expertise in the field. The centers should assist in training staff members and providing reference panels of sera, evaluation of diagnostic tests, and provision of advice on the production of working reagents. They should also assist in preparing educational material and organizing studies to determine the natural history of the disease and the extent of infection in different parts of the world.
   b. Coordinate global surveillance of AIDS using a compatible reporting format and the currently accepted case definition. WHO should disseminate these data and other important developments on the disease as widely and as rapidly as possible.
   c. Assist in developing an effective vaccine, and when appropriate, developing international requirements for the vaccines. WHO should take an active role in facilitating the evaluation of candidate vaccines.
   d. Encourage and assist in periodic serologic studies in countries where AIDS has yet to be recognized and should ensure the collection of comparable data and representative selections of sera, since lymphadenopathy-associated virus/human T-lymphotropic virus type III (LAV/HTLV-III) infection precedes AIDS in an individual or a community, early recognition will require serologic studies in groups with potential risk of infections.
2. Member countries should:
   a. Inform the public that LAV/HTLV-III infection is acquired through heterosexual and homosexual intercourse, needle-sharing by intravenous drug abusers, transfusion of contaminated blood and blood products, transmission by infected mothers to their babies, and probably repeated use of needles and other unsterile instruments used for piercing skin/mucous membranes. Information should be provided about the risk of LAV/HTLV-III infection and AIDS, especially to those men and women who may be at increased risk because of multiple sexual partners. There is currently no evidence of spread of LAV/HTLV-III by casual social contact even within households. Provision of timely and accurate information on these points is recommended to allay inappropriate public concern.
   b. Ensure that health-care workers are informed about AIDS and LAV/HTLV-III infection, modes of transmission, clinical spectrum, available programs of management (including psychosocial support), and methods for prevention and control.
   c. Assess the risk that AIDS poses to each country's population and establish methods of diagnosis, surveillance, and laboratory testing, including specific tests for LAV/HTLV-III.
   d. Screen, where feasible, potential donors of blood and plasma for antibody to LAV/HTLV-III, and not use positive units for transfusion or for the manufacture of products where there is a risk of transmitting infectious agents. Potential donors should be informed about the testing in advance of the donation.
   e. Reduce the risk of transmission of LAV/HTLV-III by factor VIII and IX concentrates by treating them by heat or other proven methods of inactivation. The use of such products is recommended.
   f. Inform potential donors of organs, sperm, or other human material about AIDS, and encourage groups at increased risk of infection to exclude themselves from donating. Whenever possible, serologic testing should be performed before these materials are used. This is particularly important when donor material is collected from an unconscious or deceased patient on whom relevant information may be absent.
   g. Refer individuals with positive tests for antibody to LAV/HTLV-III for medical evaluation and counseling. Such people should be encouraged to inform their health-care attendants of their status.
   h. Develop guidelines for the total care of patients and for handling their specimens in hospital and other settings. These guidelines should be similar to those that have been effective for care of patients with hepatitis B.
   i. Develop codes of good laboratory practice to protect staff against risk of infection. Such recommendations may be based on those found in the Laboratory Biosafety Manual published by WHO (*1*). The level of care required for work with specimens from patients infected with LAV/HTLV-III is similar to that required with hepatitis B. The use of class II biologic safety cabinets is recommended. These cabinets are adequate for containment of other agents, such as herpes and hepatitis viruses, mycobacteria, and protozoa, that may be present in the specimens. For work involving production and purification of LAV/HTLV-III, P3 biosafety containment levels must be employed.
   j. Collect and store serum samples from representative laboratory workers at the time of employment and at regular intervals thereafter, to be able to assess the risk of laboratory acquired infection and effectiveness of biosafety guidelines. Countries should provide this information to WHO for collation and dissemination. Provision of samples and testing should be carried out with the informed consent of the subjects.
   k. Be aware of the importance of keeping confidential information about the results of serologic testing and the identity of AIDS patients. Serologic testing should be undertaken with the informed consent of the subject.

Abstracted from WHO Weekly Epidemiological Record *1985;60:129-39.*

Reference

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MORBIDITY AND MORTALITY WEEKLY REPORT

Epidemiologic Notes and Reports

Testing Donors of Organs, Tissues, and Semen for Antibody to Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus

The U.S. Public Health Service has recommended that all donated blood and plasma be tested for antibody to human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV), the virus that causes acquired immunodeficiency syndrome (AIDS) (*1*). It is additionally recommended that blood or serum from donors of organs, tissues, or semen intended for human use be similarly tested and that the test result be used to evaluate the appropriate use of such materials from these donors. Although AIDS has not been reported to have been associated with such use, semen and other body fluids, including blood, may harbor the virus. Thus, organs, tissues, and semen obtained from HTLV-III/LAV antibody-positive persons must be considered as potentially infectious. Persons in groups having an increased risk for AIDS should not donate organs, tissues, or semen, regardless of the result of the antibody test; this is the same policy currently followed for blood donations. It is recognized that the circumstances of organ procurement and the logistics of transplantation may in some instances not permit the use of an HTLV-III/LAV test. However, when feasible such testing is prudent.

Reported by U.S. Food and Drug Administration; Alcohol, Drug Abuse, and Mental Health Administration; National Institutes of Health; Health Resources and Svcs Administration; CDC.

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Recommendation of the Immunization Practices Advisory Committee (ACIP)

Recommendations for Protection Against Viral Hepatitis

*The following statement updates all previous recommendations on use of immune globulins for protection against viral hepatitis (*MMWR *1981;30:423-35) and use of hepatitis B vaccine and hepatitis B immune globulin for prophylaxis of hepatitis B (*MMWR *1982;31:317-28 and* MMWR *1984;33:285-90).*

INTRODUCTION

The term "viral hepatitis" is commonly used for several clinically similar diseases that are etiologically and epidemiologically distinct (*1*). Two of these, hepatitis A (formerly called infectious hepatitis) and hepatitis B (formerly called serum hepatitis) have been recognized as separate entities since the early 1940s and can be diagnosed with specific serologic tests. The third, currently known as non-A, non-B hepatitis, is probably caused by at least two different agents, and lacking specific diagnostic tests, remains a disease diagnosed by exclusion. It is an important form of acute viral hepatitis in adults and currently accounts for most post-transfusion hepatitis in the United States. An epidemic type of non-A, non-B hepatitis, which is probably spread by the fecal-oral route and is different from the types seen in the United States, has been described in parts of Asia and North Africa (*2*).

A fourth type of hepatitis, delta hepatitis, has recently been characterized as an infection dependent on hepatitis B virus. It may occur as a coinfection with acute hepatitis B infection or as superinfection of a hepatitis B carrier (*3*).

HEPATITIS SURVEILLANCE

Approximately 21,500 cases of hepatitis A, 24,300 cases of hepatitis B, 3,500 cases of non-A, non-B hepatitis, and 7,100 cases of hepatitis type unspecified were reported in the United States in 1983. Most cases of each type occur among young adults. Since reporting from many localities is incomplete, the actual number of hepatitis cases occurring annually is thought to be several times the reported number.

IMMUNE GLOBULINS

Immune globulins used in medical practice are sterile solutions of antibodies (immunoglobulins) from human plasma. They are prepared by cold ethanol fractionation of large plasma pools and contain 10%-18% protein. In the United States, plasma is primarily obtained from professional donors. Only plasma shown to be free of hepatitis B surface antigen (HBsAg) is used to prepare immune globulins.

Immune globulin (IG) (formerly called "immune serum globulin," ISG, or "gamma globulin") produced in the United States contains antibodies against the hepatitis A virus (anti-HAV) and the hepatitis B surface antigen (anti-HBs). Tests of IG lots prepared since 1977 indicate that both types of antibody have uniformly been present. Hepatitis B immune globulin (HBIG) is an IG prepared from plasma containing high titers of anti-HBs.

Neither IG nor HBIG commercially available in the United States transmits hepatitis or other viral infections. There is no evidence that the causative agent of AIDS (human T-lymphotropic virus type III/lymphadenopathy-associated virus [HTLV-III/LAV]) has been transmitted by IG or HBIG (*4*).

Serious adverse effects from immune globulins administered as recommended have been exceedingly rare. Standard immune globulins are prepared for intramuscular use and should not be given intravenously. Two preparations for intravenous use in immunodeficient and other selected patients have recently become available in the United States but are not recommended for hepatitis prophylaxis. Immune globulins are not contraindicated for pregnant women.

HEPATITIS A

Hepatitis A is caused by the hepatitis A virus (HAV), a 27-nm ribonucleic acid (RNA) agent that is a member of the picornavirus family. The illness caused by HAV characteristically has an abrupt onset with fever, malaise, anorexia, nausea, abdominal discomfort, and jaundice. Severity is related to age. In children, most infections are asymptomatic, and illness is usually not accompanied by jaundice. Most infected adults become symptomatically ill with jaundice. Fatality among reported cases is infrequent (about 0.6%).

Hepatitis A is primarily transmitted by person-to-person contact, generally through fecal contamination. Transmission is facilitated by poor personal hygiene, poor sanitation, and intimate (intrahousehold or sexual) contact. Common-source epidemics from contaminated food and water also occur. Sharing utensils or cigarettes or kissing are not believed to transmit the infection.

The incubation period of hepatitis A is 15-50 days (average 28-30). High concentrations of HAV (10^8 particles/g) are found in stools of infected persons. Fecal virus excretion reaches its highest concentration late in the incubation period and early in the prodromal phase of illness, and diminishes rapidly once jaundice appears. Greatest infectivity is during the 2-week period immediately before the onset of jaundice. Viremia is of short duration; virus has not been found in urine or other body fluids. A chronic carrier state with HAV in blood or feces has not been demonstrated. Transmission of HAV by blood transfusion has occurred but is rare.

The diagnosis of acute hepatitis A is confirmed by finding IgM-class anti-HAV in serum collected during the acute or early convalescent phase of disease. IgG-class anti-HAV, which appears in the convalescent phase of disease and remains detectable in serum thereafter, apparently confers enduring protection against disease. Commercial tests are available to detect IgM anti-HAV and total anti-HAV in serum.

Although the incidence of hepatitis A in the United States has decreased over the last 15 years, it is still a common infection in older children and young adults. About 38% of reported hepatitis cases in this country are attributable to hepatitis A.

Recommendations for IG prophylaxis of hepatitis A. Numerous field studies conducted in the past 4 decades confirm that IG given before exposure or during the incubation period of hepatitis A is protective against clinical illness (*5-7*). Its prophylactic value is greatest (80%-90%) when given early in the incubation period and declines thereafter (*7*).

Preexposure prophylaxis. The major group for whom preexposure prophylaxis is recommended is international travelers. The risk of hepatitis A for U.S. citizens traveling abroad varies with living conditions, incidence of hepatitis A infection in areas visited, and length of stay (*8,9*). In general, travelers to developed areas of western Europe, Japan, and Australia are at no greater risk of infection than in the United States. In contrast, travelers to developing countries may be at significant risk of infection. In such areas, the best way to prevent hepatitis A and other enteric diseases is to avoid potentially contaminated water or food. Drinking water (or beverages with ice) of unknown purity and eating uncooked shellfish or uncooked fruits or vegetables that are not peeled (or prepared) by the traveler should be avoided.

IG is recommended for travelers to developing countries if they will be eating in settings of poor or uncertain sanitation (some restaurants or homes) or will be visiting extensively with local persons, especially young children, in settings with poor sanitary conditions. Persons who plan to reside in developing areas for long periods should receive IG regularly if they anticipate exposure as described above or will be living in rural areas with poor sanitation.

For such travelers, a single dose of IG of 0.02 ml/kg is recommended if travel is for less than 2 months. For prolonged travel, 0.06 ml/kg should be given every 5 months. For persons who require repeated IG prophylaxis, screening for total anti-HAV antibodies before travel may be useful to define susceptibility and eliminate unnecessary doses of IG in those who are immune.

Postexposure prophylaxis. A serologic test for the diagnosis of acute hepatitis A is now widely available. Since only 38% of acute hepatitis cases in the United States result from hepatitis A, serologic confirmation of hepatitis A in the index case is recommended before treatment of contacts. Serologic screening of contacts for anti-HAV before giving IG is not recommended because screening is more costly than IG and would delay its administration.

IG should be given as soon as possible after exposure; giving IG more than 2 weeks after exposure is not indicated.

Specific recommendations for IG prophylaxis of hepatitis A depend on the nature of the HAV exposure:

1. *Close personal contact.* IG is recommended for all household and sexual contacts of persons with hepatitis A.
2. *Day-care centers.* Day-care facilities with children in diapers can be important settings for HAV transmission (*10-12*). IG should be administered to all staff and attendees of day-care centers or homes if: (a) one or more hepatitis A cases are recognized among children or employees; or (b) cases are recognized in two or more households of center attendees. When an outbreak (hepatitis cases in three or more families) occurs, IG should also be considered for members of households whose diapered children attend. In centers not enrolling children in diapers, IG need only be given to classroom contacts of an index case.
3. *Schools.* Contact at elementary and secondary schools is usually not an important means of transmitting hepatitis A. Routine administration of IG is not indicated for pupils and teachers in contact with a patient. However, when epidemiologic study clearly shows the existence of a school- or classroom-centered outbreak, IG may be given to those who have close personal contact with patients.
4. *Institutions for custodial care.* Living conditions in some institutions, such as prisons and facilities for the developmentally disabled, favor transmission of hepatitis A. When outbreaks occur, giving IG to residents and staff who have close contact with patients with hepatitis A may reduce the spread of disease. Depending on the epidemiologic circumstances, prophylaxis can be limited in extent or can involve the entire institution.
5. *Hospitals.* Routine IG prophylaxis for hospital personnel is not indicated. Rather, sound hygienic practices should be emphasized. Staff education should point out the risk of exposure to hepatitis A and emphasize precautions regarding direct contact with potentially infective materials (*13*).

Outbreaks of hepatitis A among hospital staff occur occasionally, usually in association with an unsuspected index patient who is fecally incontinent. Large outbreaks have occurred among staff and family contacts of infected infants in neonatal intensive-care units. In outbreaks, prophylaxis of persons exposed to feces of infected patients may be indicated.

6. *Offices and factories.* Routine IG administration is not indicated under the usual office or factory conditions for persons exposed to a fellow worker with hepatitis A. Experience shows that casual contact in the work setting does not result in virus transmission.
7. *Common-source exposure.* IG might be effective in preventing foodborne or waterborne hepatitis A if exposure is recognized in time. However, IG is not recommended for persons exposed to a common source of hepatitis infection after cases have begun to occur in those exposed, since the 2-week period during which IG is effective will have been exceeded.

If a foodhandler is diagnosed as having hepatitis A, common-source transmission is possible but uncommon. IG should be administered to other foodhandlers but is usually not recommended for patrons. However, IG administration to patrons may be considered if (a) the infected person is directly involved in handling, without gloves, foods that will not be cooked before they are eaten; (b) the hygienic practices of the foodhandler are deficient; and (c) patrons can be identified and treated within 2 weeks of exposure. Situations where repeated exposures may have occurred, such as in institutional cafeterias, may warrant stronger consideration of IG use.

For postexposure IG prophylaxis, a single intramuscular dose of 0.02 ml/kg is recommended.

HEPATITIS B

Hepatitis B virus (HBV) infection is a major cause of acute and chronic hepatitis, cirrhosis, and primary hepatocellular carcinoma worldwide. The frequency of HBV infection and patterns of transmission vary markedly in different parts of the world. In the United States, western Europe, and Australia, it is a disease of low endemicity, with only 0.1%-0.5% of the population being virus carriers and infection occurring primarily during adulthood. In contrast, HBV infection is highly endemic in China and Southeast Asia, sub-Saharan Africa, most Pacific islands, and the Amazon Basin; in these areas, 5%-15% of the population carry the virus, and most persons acquire infection at birth or during childhood. In other parts of the world, HBV is moderately endemic, and 1%-4% of persons are HBV carriers. Recommendations for prophylaxis of hepatitis B will vary in accordance with local patterns of HBV transmission. The recommendations that follow are intended for use in the United States.

Hepatitis B infection is caused by the HBV, a 42-nm, double-shelled deoxyribonucleic acid (DNA) virus. Several well-defined antigen-antibody systems have been associated with HBV infection (Table 1). HBsAg, formerly called "Australia antigen" or "hepatitis-associated antigen," is found on the surface of the virus and on accompanying 22-nm spherical and tubular forms. HBsAg can be identified in serum 30-60 days after exposure to HBV and persists for variable periods. The various subtypes (adr, adw, ayw, ayr) of HBsAg provide useful epidemiologic markers. Antibody against HBsAg (anti-HBs) develops after a resolved infection and is responsible for long-term immunity. Anti-HBc, the antibody to the core antigen (an internal component of the virus), develops in all HBV infections and persists indefinitely. IgM anti-HBc appears early in infection and persists for 6 or more months; it is a reliable marker of acute or recent HBV infection. The hepatitis B e antigen (HBeAg) is a third antigen, presence of which correlates with HBV replication and high infectivity. Antibody to HBeAg (anti-HBe) develops in most HBV infections and correlates with lower infectivity.

The onset of acute hepatitis B is generally insidious. Clinical symptoms and signs include various combinations of anorexia, malaise, nausea, vomiting, abdominal pain, and jaundice. Skin rashes, arthralgias, and arthritis can also occur. Overall fatality rates for reported cases generally do not exceed 2%. The incubation period of hepatitis B is long—45-160 days (average 60-120).

TABLE 1. Hepatitis nomenclature

Abbreviation	Term	Comments
	Hepatitis A	
HAV	Hepatitis A virus	Etiologic agent of "infectious" hepatitis; a picornavirus; single serotype.
Anti-HAV	Antibody to HAV	Detectable at onset of symptoms; lifetime persistence.
IgM anti-HAV	IgM class antibody to HAV	Indicates recent infection with hepatitis A; positive up to 4-6 months after infection.
	Hepatitis B	
HBV	Hepatitis B virus	Etiologic agent of "serum" or "long-incubation" hepatitis; also known as Dane particle.
HBsAg	Hepatitis B surface antigen	Surface antigen(s) of HBV detectable in large quantity in serum; several subtypes identified.
HBeAg	Hepatitis B e antigen	Soluble antigen; correlates with HBV replication, high titer HBV in serum, and infectivity of serum.
HBcAg	Hepatitis B core antigen	No commercial test available.
Anti-HBs	Antibody to HBsAg	Indicates past infection with and immunity to HBV, passive antibody from HBIG, or immune response from HBV vaccine.
Anti-HBe	Antibody to HBeAg	Presence in serum of HBsAg carrier suggests lower titer of HBV.
Anti-HBc	Antibody to HBcAg	Indicates past infection with HBV at some undefined time.
IgM anti-HBc	IgM class antibody to HBcAg	Indicates recent infection with HBV; positive for 4-6 months after infection.
	Delta hepatitis	
δ virus	Delta virus	Etiologic agent of delta hepatitis; may only cause infection in presence of HBV.
δ-Ag	Delta antigen	Detectable in early acute delta infection.
Anti-δ	Antibody to delta antigen	Indicates past or present infection with delta virus.
	Non-A, non-B hepatitis	
NANB	Non-A, non-B hepatitis	Diagnosis of exclusion. At least two candidate viruses; epidemiology parallels that of hepatitis B.
	Epidemic non-A, non-B hepatitis	
Epidemic NANB	Epidemic non-A, non-B hepatitis	Causes large epidemics in Asia, North Africa; fecal-oral or waterborne.
	Immune globulins	
IG	Immune globulin (previously ISG, immune serum globulin, or gamma globulin)	Contains antibodies to HAV, low titer antibodies to HBV.
HBIG	Hepatitis B immune globulin	Contains high titer antibodies to HBV.

HBV infection in the United States. The estimated lifetime risk of HBV infection in the United States varies from almost 100% for the highest-risk groups to approximately 5% for the population as a whole. An estimated 200,000 persons, primarily young adults, are infected each year. One-quarter become ill with jaundice; more than 10,000 patients require hospitalization; and an average of 250 die of fulminant disease each year. Between 6% and 10% of young adults with HBV infection become carriers. The United States currently contains an estimated pool of 500,000-1,000,000 infectious carriers. Chronic active hepatitis develops in over 25% of carriers and often progresses to cirrhosis. Furthermore, HBV carriers have a risk of developing primary liver cancer that is 12-300 times higher than that of other persons. It is estimated that 4,000 persons die from hepatitis B-related cirrhosis each year in this country and that more than 800 die from hepatitis B-related liver cancer.

The role of the HBV carrier is central in the epidemiology of HBV transmission. A carrier is defined as a person who is HBsAg-positive on at least two occasions at least 6 months apart. Although the degree of infectivity is best correlated with HBeAg-positivity, any person positive for HBsAg is potentially infectious. The likelihood of developing the carrier state varies inversely with the age at which infection occurs. During the perinatal period, HBV transmitted from HBeAg-positive mothers results in HBV carriage in up to 90% of infected infants, whereas 6%-10% of acutely infected adults become carriers.

Carriers and persons with acute infection have highest concentrations of HBV in the blood and serous fluids; less is present in other body fluids, such as saliva and semen. Transmission occurs via percutaneous or permucosal routes. Infective blood or body fluids can be introduced by contaminated needles or through sexual contact. Infection can occur in settings of continuous close personal contact, such as in households or among children in institutions for the mentally retarded, presumably via inapparent or unnoticed contact of infectious secretions with skin lesions or mucosal surfaces. Transmission of infection by transfusion of contaminated blood or blood products has been greatly reduced since the advent of routine screening with highly sensitive tests for HBsAg. HBV is not transmitted via the fecal-oral route or by contamination of food or water.

Serologic surveys demonstrate that, although HBV infection is uncommon among adults in the general population, it is highly prevalent in certain groups. Those at risk, based on the prevalence of serologic markers of infection, are described in Table 2. Immigrants/refugees and their descendants from areas of high HBV endemicity are at high risk of acquiring HBV infection. Homosexually active men and users of illicit injectable drugs are among the highest-risk groups, acquiring infection soon after adopting these lifestyles (10%-20%/year). Inmates of prisons have high prevalence of HBV markers usually because of prior parenteral drug abuse; actual risk of transmission in prisons is also associated with parenteral drug abuse in prisons. Patients and staff in custodial institutions for the mentally retarded are also at increased risk of having HBV infection. Classroom contacts, particularly teachers or instructors, of some deinstitutionalized carriers may also be at higher risk than the general population. Household contacts and sexual partners of HBV carriers are at increased risk, as are hemodialysis patients and recipients of certain pooled plasma products.

There is increased risk for medical and dental workers and related laboratory and support personnel who have contact with blood. Employment in a hospital without exposure to blood carries no greater risk than that for the general population.

Hepatitis B prophylaxis. Two types of products are available for prophylaxis against hepatitis B. Hepatitis B vaccine, licensed in 1981, provides active immunization against HBV infection, and its use is recommended for both pre- and postexposure prophylaxis. IG products provide temporary, passive protection and are indicated only in certain postexposure settings.

IG and HBIG. IG and HBIG contain different amounts of anti-HBs. IG is prepared from plasma that is not preselected for anti-HBs content. Since 1977, all lots tested have contained anti-HBs at a titer of at least 1:100 by radioimmunoassay (RIA). HBIG is prepared from plasma preselected for high-titer anti-HBs. In the United States, HBIG has an anti-HBs titer of higher than 1:100,000 by RIA. There is no evidence that the causative agent of AIDS (HTLV-III/LAV) has been transmitted by IG or HBIG (*4*).

Hepatitis B vaccine. Hepatitis B vaccine licensed in the United States is a suspension of inactivated, alum-adsorbed 22-nm surface antigen particles that have been purified from human plasma by a combination of biophysical (ultracentrifugation) and biochemical procedures. Inactivation is a threefold process using 8M urea, pepsin at pH 2, and 1:4000 formalin. These treatment steps have been shown to inactivate representatives of all classes of viruses found in human blood, including the causative agent of AIDS (HTLV-III/LAV) (*14*). HB vaccine contains 20 μg/ml of HBsAg protein.

After a series of three intramuscular doses of hepatitis B vaccine, over 90% of healthy adults develop protective antibody (*15,16*). A course of three 10-μg doses induces antibody in virtually all infants and children from birth through 9 years of age. The deltoid (arm) is the recommended site for hepatitis B vaccination in adults; immunogenicity of vaccine in adults is significantly lower when injections are given in the buttock (81%) (*17*). The immunogenicity of the intradermal route has not yet been clearly established.

Field trials of the U.S.-manufactured vaccine have shown 80%-95% efficacy in preventing infection or hepatitis among susceptible persons (*16,18*). Protection against illness is virtually complete for persons who develop adequate antibody levels* after vaccination. The duration of protection and need for booster doses are not yet defined. However, only 10%-15% of per-

*Adequate antibody is 10 or more sample ratio units (SRU) by RIA or positive by enzyme immunoassay.

TABLE 2. Prevalence of hepatitis B serologic markers in various population groups

Population group	Prevalence of serologic markers of HBV infection	
	HBsAg (%)	All markers (%)
High risk		
Immigrants/refugees from areas of high HBV endemicity	13	70-85
Clients in institutions for the mentally retarded	10-20	35-80
Users of illicit parenteral drugs	7	60-80
Homosexually active men	6	35-80
Household contacts of HBV carriers	3-6	30-60
Patients of hemodialysis units	3-10	20-80
Intermediate risk		
Health-care workers—frequent blood contact	1-2	15-30
Prisoners (male)	1-8	10-80
Staff of institutions for the mentally retarded	1	10-25
Low risk		
Health-care workers—no or infrequent blood contact	0.3	3-10
Healthy adults (first-time volunteer blood donors)	0.3	3-5

sons who develop adequate antibody after three vaccine doses will lose antibody within 4 years, and among those who lose antibody, protection against viremic infection and liver inflammation appears to persist. Immunogenicity and efficacy of the licensed vaccine in hemodialysis patients is much lower than in normal adults; protection may last only as long as adequate antibody levels persist (*19*).

Vaccine usage. Primary vaccination consists of three intramuscular doses of vaccine, with the second and third doses given 1 and 6 months, respectively, after the first. Adults and older children should be given 20 μg (1.0 ml) per dose, while children under 10 years should receive 10 μg (0.5 ml) per dose. For patients undergoing hemodialysis and for other immunosuppressed patients, a 40-μg (2.0-ml) dose should be used. Vaccine doses administered at longer intervals provide equally satisfactory protection, but optimal protection is not conferred until after the third dose. Hepatitis B vaccine should only be given in the deltoid muscle in adults and children or in the anterolateral thigh muscle in infants and neonates. Since hepatitis B vaccine is an inactivated (noninfective) product, it is presumed that there will be no interference with other simultaneously administered vaccines.

Data are not available on the safety of the vaccine for the developing fetus. Because the vaccine contains only noninfectious HBsAg particles, there should be no risk to the fetus. In contrast, HBV infection in a pregnant woman may result in severe disease for the mother and chronic infection for the newborn. Pregnancy should not be considered a contraindication to the use of this vaccine for persons who are otherwise eligible.

Vaccine storage. Vaccine should be stored at 2 C-8 C (36 F-46 F) but not frozen *Freezing destroys the potency of the vaccine.*

Side effects and adverse reactions. The most common side effect observed in prevaccination trials was soreness at the injection site. Among an estimated 750,000 vaccinees, approximately 100 episodes of severe illness have been reported after receipt of vaccine. These have included arthralgias, neurologic reactions (such as Guillain-Barré syndrome), and other illnesses. The rate of Guillain-Barré syndrome following HB vaccine does not appear to be significantly increased above that observed in normal adults. Such temporally associated illnesses are not considered to be etiologically related to hepatitis B vaccine.

Effect of vaccination on carriers and immune persons. The vaccine produces neither therapeutic nor adverse effects in HBV carriers (*20*). Vaccination of individuals who possess antibodies against HBV from a previous infection is not necessary but will not cause adverse effects. Such individuals will have a postvaccination increase in their anti-HBs levels. Passively acquired antibody, whether from HBIG or IG administration or from the transplacental route, will not interfere with active immunization (*21*).

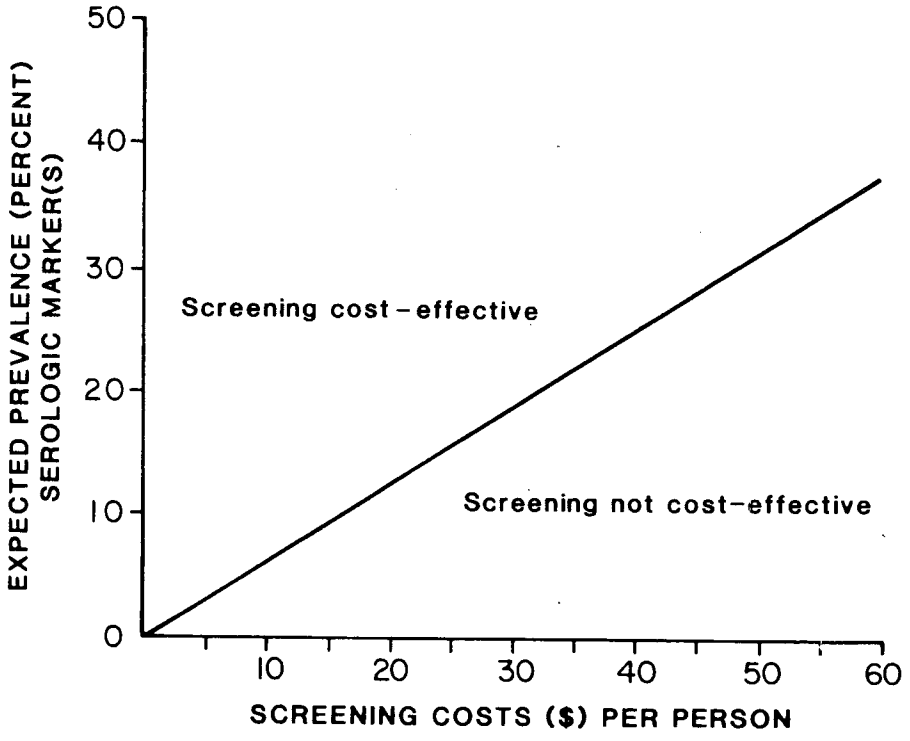
Prevaccination serologic screening for susceptibility. The decision to screen potential vaccine recipients for prior infection depends on three variables: (1) the cost of vaccination; (2) the cost of testing for susceptibility; and (3) the expected prevalence of immune individuals in the group. Figure 1 shows the relative cost-effectiveness of screening, given different costs of screening tests and the expected prevalence of immunity. In constructing the figure, the assumption was made that the cost of three doses of vaccine is $100 and that there are additional costs for administration. For any combination of screening costs and immunity to hepatitis, the cost-effectiveness can be estimated. For example, if the expected prevalence of serologic markers for HBV is over 20%, screening is cost-effective if costs of screening are no greater than $30 per person. If the expected prevalence of markers is less than 8%, and if the costs of screening are greater than $10 per person, vaccination without screening is cost-effective.

Screening in groups with the highest risk of HBV infection (Table 2) will be cost-effective unless testing costs are extremely high. For groups at intermediate risk, cost-effectiveness of screening may be marginal, and vaccination programs may or may not utilize screening. For groups with a low expected prevalence of HBV serologic markers, such as health professionals in their training years, screening will not be cost-effective.

For routine screening, only one antibody test, either anti-HBc or anti-HBs, need be used. Anti-HBc will identify all previously infected persons, both carriers and noncarriers, but will not discriminate between members of the two groups. Anti-HBs will identify those previously infected, except carriers. For groups expected to have carrier rates of under 2%, such as healthcare workers, neither test has a particular advantage. For groups with higher carrier rates, anti-HBc may be preferred to avoid unnecessary vaccination of carriers. If the RIA anti-HBs test is used for screening, a minimum of 10 RIA sample ratio units should be used to designate immunity (2.1 is the usual designation of a positive test). If enzyme immunoassay (EIA) is used, the manufacturers' recommended positive is appropriate.

Serologic confirmation of postvaccination immunity and revaccination of nonresponders. When given in the deltoid, hepatitis B vaccine produces protective antibody (anti-HBs) in more than 90% of healthy persons. Testing for immunity following vaccination is not recommended routinely but is advised for persons whose subsequent management depends on

FIGURE 1. Cost-effectiveness of prevaccination screening of hepatitis B virus vaccine candidates*



*See text for assumptions.

knowing their immune status, such as dialysis patients and staff, and for persons in whom a suboptimal response may be anticipated, such as those who have received vaccine in the buttock.

Revaccination of persons who do not respond to primary series (nonresponders) produces adequate antibody in only one-third when the primary vaccination has been given in the deltoid. Therefore, revaccination of nonresponders to deltoid injection is not recommended routinely. For persons who did not respond to a primary vaccine series given in the buttock, preliminary data from two small studies suggest that revaccination in the arm induces adequate antibody in over 75%. Revaccination should be strongly considered for such persons.

Preexposure vaccination. Persons at substantial risk of acquiring HBV infection who are demonstrated or judged likely to be susceptible should be vaccinated. They include:

1. *Health-care workers.* The risk of health-care workers acquiring HBV infection depends on the frequency of exposure to blood or blood products and on the frequency of needlesticks. These risks vary during the training and working career of each individual but are often highest during the professional training period. For this reason, it is recommended that vaccination be completed during training in schools of medicine, dentistry, nursing, laboratory technology, and other allied health professions.

   The risk of HBV infection for hospital personnel can vary both among hospitals and within hospitals. In developing specific immunization strategies, hospitals should use available published data about the risk of infection (*22-24*) and may wish to evaluate their own clinical and institutional experience with hepatitis B. Studies in urban centers have indicated that occupational groups with frequent exposure to blood and/or needles have the highest risk of acquiring HBV infection, including (but not limited to) the following groups: medical technologists, operating room staff, phlebotomists and intravenous therapy nurses, surgeons and pathologists, and oncology and dialysis unit staff. Groups shown to be at increased risk in some hospitals include: emergency room staff, nursing personnel, and staff physicians.

   Other health-care workers based outside hospitals who have frequent contact with blood or blood products are also at increased risk of acquiring HBV infection. These include (but are not limited to): dental professionals (dentists, oral surgeons, dental hygienists), laboratory and blood bank technicians, dialysis center staff, emergency medical technicians, and morticians.
2. *Clients and staff of institutions for the mentally retarded.* Susceptible clients and staff who work closely with clients of institutions for the mentally retarded should be vaccinated. Risks for staff are comparable to those for health-care personnel in other high-risk environments. However, the risk in institutional environments is associated, not only with blood exposure, but also with bites and contact with skin lesions and other infective secretions. Susceptible clients and staff who live or work in smaller (group) residential settings with known HBV carriers should also receive hepatitis B vaccine.
3. *Hemodialysis patients.* Numerous studies have established the high risk of HBV transmission in hemodialysis units. Although recent data have shown not only a decrease in the rate of HBV infection in hemodialysis units but also a lower vaccine efficacy in these patients, vaccination is recommended for susceptible patients. Environmental control measures and regular serologic screening (based on immune status) of patients should be maintained.
4. *Homosexually active men.* Susceptible homosexually active men should be vaccinated regardless of their ages or duration of their homosexual practices. It is important to vaccinate persons as soon as possible after their homosexual activity begins. Homosexually active women are not at increased risk of sexually transmitted HBV infection.
5. *Users of illicit injectable drugs.* All users of illicit injectable drugs who are susceptible to HBV should be vaccinated as early as possible after their drug use begins.
6. *Recipients of certain blood products.* Patients with clotting disorders who receive clotting factor concentrates have an elevated risk of acquiring HBV infection. Vaccination is recommended for these persons and should be initiated at the time their specific clotting disorder is identified. Screening is recommended for patients who have already received multiple infusions of these products.
7. *Household and sexual contacts of HBV carriers.* Household contacts of HBV carriers are at high risk of acquiring HBV infection. Sexual contacts appear to be at greatest risk. When HBV carriers are identified through routine screening of donated blood, diagnostic testing in hospitals, prenatal screening, screening of refugees, or other screening programs, they should be notified of their status and their susceptible household contacts vaccinated.

   Families accepting orphans or unaccompanied minors from countries of high HBV endemicity should have the child screened for HBsAg, and if positive, family members should be vaccinated.
8. *Other contacts of HBV carriers.* Persons in casual contact with carriers at schools, offices, etc., are at minimal risk of acquiring HBV infection, and vaccine is not routinely recommended for them. However, classroom contacts of deinstitutionalized mentally retarded HBV carriers who behave aggressively or have special medical problems that increase the risk of exposure to their blood or serous secretions may be at risk. In such situations, vaccine may be offered to classroom contacts.
9. *Special high-risk populations.* Some American populations, such as Alaskan Eskimos, native Pacific islanders, and immigrants and refugees from areas with highly endemic disease (particularly eastern Asia and sub-Saharan Africa) have high HBV infection rates. Depending on specific epidemiologic and public health considerations, more extensive vaccination programs should be considered.
10. *Inmates of long-term correctional facilities.* The prison environment may provide a favorable setting for the transmission of HBV because of the frequent use of illicit injectable drugs and homosexual practices. Moreover, it provides an access point for vaccination of parenteral drug abusers. Prison officials should consider undertaking screening and vaccination programs directed at those who abuse drugs before or while in prison.
11. *Heterosexually active persons.* Heterosexually active persons with multiple sexual partners are at increased risk of acquiring HBV infection; risk increases with increasing sexual activity. Vaccination should be considered for persons who present for treatment of sexually transmitted diseases and who have histories of sexual activity with multiple partners.
12. *International travelers.* Vaccination should be considered for persons who plan to reside more than 6 months in areas with high levels of endemic HBV and who will have close contact with the local population. Vaccination should also be considered for short-term travelers who are likely to have contact with blood from or sexual contact with residents of areas with high levels of endemic disease. Hepatitis B vaccination of travelers ideally should begin 6 months before travel in order to complete the full vaccine series; however, a partial series will offer some protection against HBV infection.

Postexposure prophylaxis for hepatitis B. Prophylactic treatment to prevent hepatitis B infection after exposure to HBV should be considered in the following situations: perinatal exposure of an infant born to an HBsAg-positive mother; accidental percutaneous or permucosal exposure to HBsAg-positive blood; or sexual exposure to an HBsAg-positive person.

Recent studies have established the relative efficacies of immune globulins and/or hepatitis B vaccine in various exposure situations. For perinatal exposure to an HBsAg-positive, HBeAg-positive mother, a regimen combining one dose of HBIG at birth with the hepatitis B vaccine series started soon after birth is 85%-90% effective in preventing development of the HBV carrier state (*25,27*). Regimens involving either multiple doses of HBIG alone, or the vaccine series alone, have 70%-75% efficacy, while a single dose of HBIG alone has only 50% efficacy (*28*).

For accidental percutaneous exposure or sexual exposure, only regimens including HBIG and/or IG have been studied. A regimen of two HBIG doses, one given after exposure and one a month later, is about 75% effective in preventing hepatitis B following percutaneous exposure; a single dose of HBIG has similar efficacy when used following sexual exposure (*29-31*). IG may have some effect in preventing clinical hepatitis B following percutaneous exposures and can be considered as an alternative to HBIG when it is not possible to obtain HBIG.

Recommendations on postexposure prophylaxis are based on the efficacy data discussed above and on the likelihood of future HBV exposure of the person requiring treatment. In perinatal exposure and percutaneous exposure of high-risk health-care personnel, a regimen combining HBIG with hepatitis B vaccine will provide both short- and long-term protection, will be less costly than the two-dose HBIG treatment alone, and is the treatment of choice.

Perinatal exposure. One of the most efficient modes of HBV transmission is from mother to infant during birth. If the mother is positive for both HBsAg and HBeAg, about 70%-90% of infants will become infected, and up to 90% of these infected infants will become HBV carriers. If the HBsAg-positive carrier mother is HBeAg-negative, or if anti-HBe is present, transmission occurs less frequently and rarely leads to the HBV carrier state. However, severe acute disease, including fatal fulminant hepatitis in the neonate, has been reported (*32,33*). Prophylaxis of infants from all HBsAg-positive mothers is recommended, regardless of the mother's HBeAg or anti-HBe status.

The efficacy of a combination of HBIG plus the hepatitis B vaccine series has been confirmed in recent studies. Although the following regimen is recommended (Table 3), other schedules have also been effective (*25-27,34*). The major consideration for all these regimens is the need to give HBIG as soon as possible after delivery.

HBIG (0.5 ml [10 μg]) should be administered intramuscularly after physiologic stabilization of the infant and preferably within 12 hours of birth. Hepatitis B vaccine should be administered intramuscularly in three doses of 0.5 ml (10 μg) each. The first dose should be given concurrently with HBIG but at a different site. If vaccine is not available at birth, the first vaccine dose may be given within 7 days of birth. The second and third doses should be given 1 month and 6 months, respectively, after the first. Testing for HBsAg and anti-HBs is recommended at 12-15 months to monitor the final success or failure of therapy. If HBsAg is not detectable, and anti-HBs is present, the child has been protected. Testing for anti-HBc is not useful, since maternal anti-HBc may persist for more than 1 year; the utility of testing for IgM anti-HBc is currently being evaluated. HBIG administered at birth should not interfere with oral polio and diphtheria-tetanus-pertussis vaccines administered at 2 months of age.

Maternal screening. Since efficacy of the treatment regimen depends on administering HBIG on the day of birth, it is vital that HBsAg-positive mothers be identified before delivery. Mothers belonging to groups known to be at high risk of acquiring HBV infection (Table 4)

TABLE 3. Hepatitis B virus postexposure recommendations

	HBIG		Vaccine	
Exposure	Dose	Recommended timing	Dose	Recommended timing
Perinatal	0.5 ml IM	Within 12 hours	0.5 ml (10 μg) IM of birth	Within 12 hours of birth*; repeat at 1 and 6 months
Sexual	0.06 ml/kg IM	Single dose within 14 days of sexual contact	†	—

*The first dose can be given the same time as the HBIG dose but at a different site.
†Vaccine is recommended for homosexual men and for regular sexual contacts of HBV carriers and is optional in initial treatment of heterosexual contacts of persons with acute HBV.

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SURVEY OF RESEARCH ON STDS

The Division of Sexually Transmitted Diseases of the Center for Prevention Services/Centers for Disease Control has recently released a 129 page book of abstracts and bibliographies covering the literature in the field of STDs (including AIDS), from May, 1983 to May, 1984. Over 3000 foreign and domestic biomedical periodicals were searched using MEDLINE (the National Library of Medicine's remote access retrieval service) and SDILINE (selective dissemination of information) which lists by month, the newest citations from journals indexed in NLM's Index Medicus. To acquire a copy of Survey of Research on STDs, contact the CDC's Technical Information Services or the Division of STDs, ATlanta, GA 30333.

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"MORAL MAJORITY" PICKETS FOR QUARANTINE

with thanks to The Washington Blade, 6/21/85

About 12 people picketed Chicago City Hall early this June, calling for quarantining people with AIDS, according to GayLife. AIDS "is attacking and ruining innocent families," said Rev. Hiram Crawford, a member of the city's Moral Majority chapter. "It is a gay disease, and it could strike your little boy." Crawford also alleged that AIDS is spread through sneezing or handling food. "They had brains enough to quarantine [tuberculosis], they should have brains wnough to quarantine AIDS," he said.

should be tested routinely for HBsAg during a prenatal visit. If a mother belonging to a high-risk group has not been screened prenatally, HBsAg screening should be done at the time of delivery, or as soon as possible thereafter, and the infant treated as above if the mother is HBsAg-positive. If the mother is identified as HBsAg-positive more than 1 month after giving birth, the infant should be screened for HBsAg, and if negative, treated with hepatitis B vaccine and HBIG.

The appropriate obstetric and pediatric staff should be notified directly of HBsAg-positive mothers, so the staff may take appropriate precautions to protect themselves and other patients from infectious material, blood, and secretions, and so the neonate may receive therapy without delay after birth.

Acute exposure to blood that contains (or might contain) HBsAg. For accidental percutaneous or permucosal exposure to blood that is known to contain or might contain HBsAg, the decision to provide prophylaxis must take into account several factors: (1) the hepatitis B vaccination status of the exposed person; (2) whether the source of blood is known or unknown; and (3) whether the HBsAg status of the source is known or unknown. Such exposures usually occur in persons who are candidates for hepatitis B vaccine; for any exposure in a person not previously vaccinated, hepatitis B vaccination is recommended.

The following outline and table summarize prophylaxis for percutaneous (needlestick or bite), ocular, or mucous-membrane exposure to blood according to the source of exposure and vaccination status of the exposed person (Table 5). For greatest effectiveness, passive prophylaxis with HBIG (or IG) should be given as soon as possible after exposure (its value beyond 7 days of exposure is unclear).

1. *Exposed person not previously vaccinated.* Hepatitis B vaccination should be considered the treatment of choice. Depending on the source of the exposure, HBsAg testing of the source and additional prophylaxis of the exposed person may be warranted (see below). Screening the exposed person for immunity should be considered if such screening is cost-effective (as discussed in preexposure prophylaxis) and if this will not delay treatment beyond 7 days.
   a. *Source known HBsAg-positive.* A single dose of HBIG (0.06 ml/kg) should be given as soon as possible after exposure and within 24 hours, if possible. The first dose of hepatitis B vaccine (20 μg) should be given intramuscularly at a separate site within 7 days of exposure, and the second and third doses given 1 month and 6 months later (Table 5).† If HBIG cannot be obtained, IG in an equivalent dosage (0.06 ml/kg) may provide some benefit.

†For persons who are not given hepatitis B vaccine, a second dose of HBIG should be given 1 month after the first dose.

TABLE 4. Women for whom prenatal HBsAg screening is recommended

1. Women of Asian, Pacific island, or Alaskan Eskimo descent, whether immigrant or U.S.-born.
2. Women born in Haiti or sub-Saharan Africa.
3. Women with histories of:
   a. Acute or chronic liver disease.
   b. Work or treatment in a hemodialysis unit.
   c. Work or residence in an institution for the mentally retarded.
   d. Rejection as a blood donor.
   e. Blood transfusion on repeated occasions.
   f. Frequent occupational exposure to blood in medico-dental settings.
   g. Household contact with an HBV carrier or hemodialysis patient.
   h. Multiple episodes of venereal diseases.
   i. Percutaneous use of illicit drugs.

   b. *Source known, HBsAg status unknown.* The following guidelines are suggested based on the relative probability that the source is HBsAg-positive and on the consequent risk of HBV transmission:
      (1) *High risk that the source is HBsAg-positive, such as patients with a high risk of HBV carriage (Table 2) or patients with acute or chronic liver disease (serologically undiagnosed).* The exposed person should be given the first dose of hepatitis B vaccine (20 μg) within 1 week of exposure and vaccination completed as recommended. The source person should be tested for HBsAg. If positive, the exposed person should be given HBIG (0.06 ml/kg) if within 7 days of exposure.
      (2) *Low risk that the source is positive for HBsAg.* The exposed person should be given the first dose of hepatitis B vaccine (20 μg) within 1 week of exposure and vaccination completed as recommended. Testing of the source person is not necessary.
   c. *Source unknown.* The exposed person should be given the first dose of hepatitis B vaccine (20 μg) within 7 days of exposure and vaccination completed as recommended.

2. *Exposed person previously vaccinated against hepatitis B.* For percutaneous exposures to blood in persons who have previously received one or more doses of hepatitis B vaccine, the decision to provide additional prophylaxis will depend on the source of exposure and on whether the vaccinated person has developed anti-HBs following vaccination.
   a. *Source known HBsAg-positive.* The exposed person should be tested for anti-HBs unless he/she has been tested within the last 12 months. If the exposed person has adequate§ antibody, no additional treatment is indicated.

§Adequate antibody is 10 SRU or more by RIA or positive by EIA.

TABLE 5. Recommendations for hepatitis B prophylaxis following percutaneous exposure

Source	Exposed person	
	Unvaccinated	Vaccinated
HBsAg-positive	1. HBIG x 1 immediately* 2. Initiate HB vaccine† series.	1. Test exposed person for anti-HBs.§ 2. If inadequate antibody,¶ HBIG (x1) immediately plus HB vaccine booster dose.
Known source		
High-risk HBsAg-positive	1. Initiate HB vaccine series 2. Test source for HBsAg. If positive, HBIG x 1.	1. Test source for HBsAg only if exposed is vaccine nonresponder; if source is HBsAg-positive, give HBIG x 1 immediately plus HB vaccine booster dose
Low-risk HBsAg-positive	Initiate HB vaccine series.	Nothing required.
Unknown source	Initiate HB vaccine series.	Nothing required.

*HBIG dose 0.06 ml/kg IM.

†HB vaccine dose 20 μg IM for adults; 10 μg IM for infants or children under 10 years of age. First dose within 1 week; second and third doses, 1 and 6 months later.

§ See text for details.

¶Less than 10 SRU by RIA, negative by EIA.

(1) If the exposed person has not completed vaccination and has inadequate levels of antibody, one dose of HBIG (0.06 ml/kg) should be given immediately and vaccination completed as scheduled.

(2) If the exposed person has inadequate antibody on testing or has previously not responded to vaccine, one dose of HBIG should be given immediately and a booster dose of vaccine (1 ml or 20 μg) given at a different site.

(3) If the exposed person shows inadequate antibody on testing but is known to have had adequate antibody in the past, a booster dose of hepatitis B vaccine (1 ml or 20 μg) should be given.

b. *Source known, HBsAg status unknown.*

(1) *High risk that the source is HBsAg-positive.* Additional prophylaxis is necessary only if the exposed person is a known vaccine nonresponder. In this circumstance, the source should be tested for HBsAg and, if positive, the exposed person treated with one dose of HBIG (0.06 ml/kg) immediately and a booster dose of vaccine (1 ml or 20 μg) at a different site. In other circumstances, screening of the source for HBsAg and the exposed person for anti-HBs is not routinely recommended, because the actual risk of HBV infection is very low (less than 1 per 1,000).¶

(2) *Low risk that the source is HBsAg-positive.* The risk of HBV infection is minimal. Neither testing of the source for HBsAg, nor testing of the exposed person for anti-HBs, is recommended.

c. *Source unknown.* The risk of HBV infection is minimal. No treatment is indicated.

Sexual contacts of persons with acute HBV infection. Sexual contacts of HBsAg-positive persons are at increased risk of acquiring HBV infection, and HBIG has been shown to be 75% effective in preventing such infections (*31*). Because data are limited, the period after sexual exposure during which HBIG is effective is unknown, but extrapolation from other settings makes it unlikely that this period would exceed 14 days. Prescreening sexual partners for susceptibility before treatment is recommended if it does not delay treatment beyond 14 days after last exposure. Testing for anti-HBc is the most efficient prescreening test to use in this population group.

A single dose of HBIG (0.06 ml/kg) is recommended for susceptible individuals who have had sexual contact with an HBsAg-positive person, if HBIG can be given within 14 days of the last sexual contact, and for persons who will continue to have sexual contact with an individual with acute hepatitis B before loss of HBsAg in that individual. In exposures between heterosexuals, hepatitis B vaccination may be initiated at the same time as HBIG prophylaxis; such treatment may improve efficacy of postexposure treatment. However, since 90% of persons with acute HBV infection become HBsAg-negative within 15 weeks of diagnosis, the potential for repeated exposure to HBV is limited. Hepatitis B vaccine is, therefore, optional in initial treatment for such exposures. If vaccine is not given, a second dose of HBIG should be given if the index patient remains HBsAg-positive for 3 months after detection. If the index patient is a known carrier or remains positive for 6 months, hepatitis B vaccine should be offered to regular sexual contacts. For exposures among homosexual men, the hepatitis B vaccine series should be initiated at the time HBIG is given, since hepatitis B vaccine is recommended for all susceptible homosexual men. Additional doses of HBIG are unnecessary if vaccine is given. IG is an alternative to HBIG when it is not possible to obtain HBIG.

Household contacts of persons with acute HBV infection. Prophylaxis for other household contacts of persons with acute HBV infection is not indicated unless they have had identifiable blood exposure to the index case, such as by sharing toothbrushes or razors. Such exposures should be treated similarly to sexual exposures. If the index patient becomes a hepatitis B carrier, all household contacts should be given hepatitis B vaccine.

DELTA HEPATITIS

The delta virus (also known as hepatitis D virus [HDV] by some investigators) is a defective virus that may only cause infection in the presence of active HBV infection. The delta virus has been characterized as a particle of 35-37 nm in size, consisting of RNA (mw 500,000) as genetic material and an internal protein antigen (delta-antigen), coated with HBsAg as the surface protein (*3*). Infection may occur as either coinfection with hepatitis B or superinfection of a hepatitis B carrier, each of which usually cause an episode of acute hepatitis. Coinfection usually resolves, while superinfection frequently causes chronic delta infection and chronic active hepatitis. Both types of infection may cause fulminant hepatitis.

Delta infection may be diagnosed by detection of delta-antigen in serum during early infection and by the appearance of delta antibody during or after infection. Routes of delta transmission appear to be similar to those of hepatitis B. In the United States, delta infection occurs most commonly among persons at high risk of acquiring HBV infection, such as drug addicts and hemophilia patients.

A test for detection of delta antibody is expected to be commercially available soon. Other tests (delta antigen, IgM anti-delta) are available only in research laboratories.

Since the delta virus is dependent on hepatitis B for replication, prevention of hepatitis B infection, either preexposure or postexposure, will suffice to prevent delta infection in a person susceptible to hepatitis B. Known episodes of perinatal, sexual, or percutaneous exposure to sera or persons positive for both HBV and delta virus should be treated exactly as such exposures to hepatitis B alone.

Persons who are HBsAg carriers are at risk of delta infection, especially if they participate in activities that put them at high risk of repeated exposure to hepatitis B (parenteral drug abuse, homosexuality). However, at present there are no products available that might prevent delta infection in HBsAg carriers either before or after exposure.

NON-A, NON-B HEPATITIS

United States. Non-A, non-B hepatitis that presently occurs in the United States has epidemiologic characteristics similar to those of hepatitis B, occurring most commonly following blood transfusion and parenteral drug abuse. Multiple episodes of non-A, non-B hepatitis have been observed in the same individuals and may be due to different agents. Chronic hepatitis following acute non-A, non-B hepatitis infection varies in frequency from 20% to 70%. Experimental studies in chimpanzees have confirmed the existence of a carrier state, which may be present in up to 8% of the population.

Although several studies have attempted to assess the value of prophylaxis with IG against non-A, non-B hepatitis, the results have been equivocal, and no specific recommendations can be made (*35,36*). However, for persons with percutaneous exposure to blood from a patient with non-A, non-B hepatitis, it may be reasonable to administer IG (0.06 ml/kg) as soon as possible after exposure.

Epidemic (fecal-oral) non-A, non-B hepatitis. In recent years, epidemics of non-A, non-B hepatitis spread by water or close personal contact have been reported from several areas of Southeast Asia (Indian subcontinent, Burma) and north Africa (*2*). Such epidemics generally

¶ Estimated by multiplying the risk of vaccine nonresponse in the exposed person (.10) by the risk of the needle source being HBsAg-positive (.05) by the risk of HBV infection in a susceptible person having an HBsAg-positive needle-stick injury (.20).

affect adults and cause unusually high mortality in pregnant women. The disease has been transmitted to experimental animals, and candidate viruses have been identified; however, no serologic tests have yet been developed (*37*).

Epidemic non-A, non-B hepatitis has not been recognized in the United States or western Europe, and it is unknown whether the causative agent is present in these areas.

Travelers to areas having epidemic non-A, non-B hepatitis may be at some risk of acquiring this disease by close contact or by contaminated food or water. The value of IG in preventing this infection is unknown. The best prevention of infection is to avoid potentially contaminated food or water, as with hepatitis A and other enteric infections.

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QUESTIONS AND ANSWERS ABOUT THE HTLV-III ANTIBODY TEST

Reprinted with permission (and thanks!) of Baltimore Health Education Resource Organization (HERO). This is one example of an excellently written brochure designed to help a person decide whether or not to be tested for antibody to HTLV-III. For bulk ordering information (customized printing of local resource numbers, if desired) contact: HERO, Suite 819, 101 W. Read Street, Maltimore, MD 21201, or call 301/945-AIDS.

SHOULD I TAKE THE TEST?

You are probably considering taking the HTLV-III antibody test because you have questions like these:

Question 1 - Have I been infected with HTLV-III (the "AIDS" virus)?
Question 2 - Am I now infected with HTLV-III?
Question 3 - Do I have AIDS (Acquired Immunodeficiency Syndrome)?
Question 4 - Will I develop AIDS in the future?

In the past, you may have asked similar questions about another disease and gotten a simple "Yes" or "No" answer. You are hoping for the same type of answers from the HTLV-III antibody test.

But this test won't give you all the answers. It may give you the answer to question #1 ("Have I been infected with HTLV-III?"). This test will NOT answer questions #2, #3, and #4. The reasons why the test does NOT answer these three questions are as follows:

Am I now infected with HTLV-III?
This test tells whether or not you HAVE BEEN infected with HTLV-III. It does not specify whether or not the virus is still present in your body, although present evidence suggests that a person infected with HTLV-III remains infected.

Do I have AIDS now?
Being infected with HTLV-III, the condition which may be indicated by a positive test, is not the same thing as having AIDS. It is possible to have an HTLV-III infection and yet not have AIDS.

Will I develop AIDS in the future?
If you have a positive HTLV-III antibody test, no one can say for sure what the outcome of such an infection will be, but doctors have noted at least 3 possibilities. AIDS, a life threatening illness, is only one of these. Two other possible outcomes are no illness and mild non life-threatening illness.

Realizing that the HTLV-III antibody test will not answer all the questions you have about your risk of getting AIDS, you may be in a better position to decide whether or not you want to take the test.

WHAT WILL I GAIN OR LOSE FROM TAKING THE TEST?

You will learn your "probable antibody status" to HTLV-III: "probable"--- AIDS, may give occasional mistaken results; "antibody"--because this is a test for an antibody (a substance produced by your body's immune system) to HTLV-III; "status"--because you'll know where you stand with regard to previous infection with HTLV-III, the cause of AIDS. It is possible that knowing this information may help you to protect your own health and the health of others. (See guidelines below.) In this case, everyone would gain.
But possible problems could occur under this circumstance: if you take the test and have a positive result which becomes a part of your medical record, you could have trouble if this record were ever shared with employers or insurance companies. If, on the other hand, you take the test at a site where no names are asked, no one but you (and those people you may decide to tell) will know your result. After reading the information below, you should consider how knowing your test result might affect YOU, even if you have no fear of others' reactions. Only you can know if such knowledge would be a loss or a gain.

WHAT DOES A "NEGATIVE" TEST RESULT MEAN?

A "negative" test result is a probable "No" answer to the question "Have I been infected with HTLV-III?" It means that no antibody to HTLV-III was detected in your blood. However, if you belong to one of the groups considered to be at high risk for developing AIDS (homosexual and bisexual men, I.V. drug users, hemophiliacs, and male or female sexual partners of persons in these groups) your negative test result could have a different meaning. Here are two other possible meanings:

Although you may have been infected with HTLV-III, it is possible that your body has not yet made an antibody to the virus.

Although an antibody to HTLV-III may actually be present in your blood, for some reason the test failed to detect it. (This is known as a "false negative" result.)

If you are in a high-risk group and have a negative test, you should carefully read the information below and consider having a second test in 3-6 months.

IF MY TEST IS NEGATIVE, HOW CAN I AVOID FUTURE INFECTION WITH HTLV-III?

If your test result is negative, there is a good chance that you are not infected with HTLV-III (the "AIDS virus"). You can use this piece of good news as the starting point of a serious effort to avoid future infection, by following these guidelines:

*If your risk factor for developing AIDS is that you are a man who has sex with other men, you should realize that HTLV-III (the "AIDS virus") is present in body fluids of infected people. Because HTLV-III may be widespread among Gay men, sex acts with other Gay men that expose you to their body fluids (including blood, semen, and saliva) ARE NOT SAFE. It is best also to avoid exposure to urine and feces. Unsafe acts include rectal intercourse, oral-genital contact, intimate kissing, and any other sex act you know of in which you contact body wastes or fluids of another. You cannot safely engage in these acts unless you are sure that your partner is not infected with HTLV-III. Because it is difficult to know this information about most other people, you should take some time to reconsider and modify your ways of getting sexual pleasure. For more guidance on this topic, refer to additional information on safe sex practices.

If your risk factor is I.V. drug use, you can probably guess what the first guideline for avoiding HTLV-III infection is: Get the help you need to stop shooting drugs. If you won't stop shooting, then you must stop sharing needles. Needle sharing causes you to inject a small amount of another person's blood into your body along with whatever disease-causers they may carry in their blood, including HTLV-III, the cause of AIDS. Because HTLV-III may be widespread among I.V. drug users, needle sharing IS NOT SAFE. Try to get a new needle in a sealed package, and never let anyone else use it.

If you are a heterosexual partner of a person in a high risk group, follow the guidelines for Gay men listed above and also avoid vaginal intercourse.

Never snare needles with other people for any reason, including tatooing and injecting hormones for body-building.

WHAT DOES A "POSITIVE" TEST RESULT MEAN?

A positive test result is a probable "Yes" answer to the question "Have I been infected with HTLV-III?" It means that you are very likely to have been infected with HTLV-III and to have developed an antibody (a substance made by your body's immune system.) It does not tell when the infection took place or if HTLV-III, the virus that caused your immune system to make the antibody, is still present. Most important, a positive test does not mean that you now have AIDS or that you will necessarily develop it in the future.

WHAT SHOULD I DO IF MY HTLV-III ANTIBODY TEST IS POSITIVE?

First of all, don't panic. Your positive test is only one part of your total health picture. You should see a doctor who can help you to evaluate your health as a whole.

Current information shows that most people with a positive antibody test do NOT have AIDS at the time of testing. At present, scientists believe that AIDS will occur in a fraction of the group of people with a positive antibody test. More will develop a non life-threatening illness, and still others may not be sick at all.

HOWEVER.....

Because HTLV-III MAY BE present in your body and body fluids, you may be able to pass this virus to other people, even if you are not now ill, even if you never develop AIDS. For this reason, you should make every attempt to follow these quidelines:

Do not donate blood or plasma for transfusion, organs for transplant, or sperm for artificial insemination. If you have designated on your driver's license for your organs to be donated, you should have this designation removed.

Avoid possible transmission to others through sexual acts that expose them to your body fluids or body wastes. These acts include sexual intercourse, oral-genital contact, and intimate kissing.

Avoid sharing personal items, such as toothbrushes and razors, which can transmit the virus to other people.

If you cut yourself and spill blood on clothes or furniture, or if you need to clean surfaces soiled with saliva, urine. feces, semen, etc, wash with water mixed with household bleach (one half cup of bleach to four and a half cups of water.)

IF MY TEST IS POSITIVE, SHOULD I TELL ANYONE?

After reading this brochure, you should realize that many people don't understand as much as you do about the meaning of a positive HTLV-III antibody test. Also, once you have given this information to someone else, you no longer have control over who will hear it. For these reasons, you may want to limit the people you tell to those who stand to gain from knowing:

Inform your sex partner or partners, and share with them the information about HTLV-III that you have received.

Tell your doctor and dentist. These people may be exposed to your body fluids and should know about your positive test. Your doctor may be able to help you to evaluate your test result in the context of your health as a whole. Discuss with your doctor or dentist whether this test result should be placed in your medical record to avoid unwanted disclosure of your result in the future.

IF MY TEST IS POSITIVE, WHAT CHANGES SHOULD I MAKE IN MY DAILY ACTIVITIES?

Even though your test for HTLV-III antibody is positive, you do not need to change your life beyond the suggestions listed above. The following additional points may be helpful:

Contact with family and friends can be normal; hugging and kissing on the cheek does not spread the virus.

Contact with other people at work or in the community should be as usual. Special precautions and restrictions are not usually necessary. It is recommended that health care workers contact their local health department or employee health center for specific recommendations.

WHAT IF MY TEST RESULT IS POSITIVE AND I AM OR WANT TO BECOME PREGNANT?

If you are now pregnant, discuss your positive result with your doctor **IMMEDIATELY.** If you intend to become pregnant, and you or your partner are a member of a high risk group, you should be tested for the HTLV-III antibody before becoming pregnant.

It is possible for a mother who has HTLV-III infection to transmit the virus to her newborn infant. Some of these infants have died. A woman who has a positive HTLV-III antibody test or who has a sexual partner with a positive test, should postpone pregnancy until the question of whether she is currently infected with the virus can be answered. Answering this question may require a test for HTLV-III itself (instead of HTLV-III ANTIBODY.) It is likely that such a test will be widely available at some future date.

WHAT IF MY TEST RESULT IS POSITIVE AND I BECOME ILL?

You don't need to worry about every minor change in your health. But you should be aware of some of the "danger signals" of AIDS. These are important changes in your health which you should bring to a doctor's attention. The danger signals include:

-Unexplained fever, chills, or night sweats, lasting 2 weeks or more;
-Unexplained weight loss of 10 pounds or more;
-White patches in your mouth;
-Dry cough, unrelated to smoking, lasting 2 weeks or more;
-Unexplained diarrhea, lasting 2 weeks or more;
-Severe shortness of breath;
-Swollen or tender lymph glands in the neck, jaw, armpit, or groin;
-Any unusual bruise, bump, swelling, or skin discoloration, including skin rashes, lasting two weeks or more;
-severe confusion or change in mental status.

The sooner you bring such symptoms to a doctor's attention the better off you will be. You should have a doctor who knows about any part of your life that puts you at risk of getting AIDS. You should tell this doctor about your positive HTLV-III antibody test. If you do not already have a doctor with whom you feel you can be honest, you may be given a referral number to call when you are at the HTLV-III antibody testing site.

WHAT IF BOTH MY SEX PARTNER AND I HAVE POSITIVE TESTS? IS IT SAFE FOR US TO HAVE SEX?

No one can say for sure what the risk to each of you may be in this situation. However, some scientists believe that there may be "co-factors" involved in a person's getting AIDS. (The gist of the "cofactor" idea is that there may be conditions that must be present before a person infected with HTLV-III will develop AIDS.) If such "co-factors" do exist, it might be possible for you and your partner to pass them to each other, increasing the risk of AIDS for one or both of you. It is possible that repeated exposure to HTLV-III, or exposure to slightly differing types of the virus might also increase your risk. For these reasons, no one can advise you about the safety or danger of sex between two people with positive tests; however, you are encouraged to practice safe sex until more is known.

WHAT SHOULD I DO IF I DECIDE NOT TO TAKE THE TEST?

You should follow the precautions below if you are in a high risk group for AIDS, or a sexual partner or a person at high risk:

To lower your changes of getting the infection if you are not infected, or of giving it to someone else if you are infected you should use "Safe Sex" practices. These are practices which lower or stop the sharing of "body fluids" from partner to partner. "Body fluids" include blood, semen, saliva, urine, and feces. For more guidance on this topic, refer to additional information on safe sex practices.

Limit the number of sexual partners you have. The best way is to have sex with only one person--who only has sex with you.

Do not donate blood, plasma, body organs, sperm or other tissues. If you have designated on your driver's license for your organs to be donated, you should have this designation removed.

Do not share your toothbrush, razor, or other tools that could come into contact with your blood or secretions.

Do not share needles if you inject drugs.

Women should **use effective birth control** to postpone pregnancy until more is known about HTLV-III infection.

CENTERS FOR DISEASE CONTROL

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

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Current Trends

Revision of the Case Definition of Acquired Immunodeficiency Syndrome for National Reporting—United States

Patients with illnesses that, in retrospect, were manifestations of acquired immunodeficiency syndrome (AIDS) were first described in the summer of 1981 (*1,2*). A case definition of AIDS for national reporting was first published in the *MMWR* in September 1982 (*3,4*). Since then, the definition has undergone minor revisions in the list of diseases used as indicators of underlying cellular immunodeficiency (*5-8*).

Since the 1982 definition was published, human T-cell lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV) has been recognized as the cause of AIDS. The clinical manifestations of HTLV-III/LAV infection may be directly attributable to infection with this virus or the result of secondary conditions occurring as a consequence of immune dysfunction caused by the underlying infection with HTLV-III/LAV. The range of manifestations may include none, nonspecific signs and symptoms of illness, autoimmune and neurologic disorders, a variety of opportunistic infections, and several types of malignancy. AIDS was defined for national reporting before its etiology was known and has encompassed only certain secondary conditions that reliably reflected the presence of a severe immune dysfunction. Current laboratory tests to detect HTLV-III/LAV antibody make it possible to include additional serious conditions in the syndrome, as well as to further improve the specificity of the definition used for reporting cases.

The current case definition of AIDS has provided useful data on disease trends, because it is precise, consistently interpreted, and highly specific. Other manifestations of HTLV-III/LAV infections than those currently proposed to be reported are less specific and less likely to be consistently reported nationally. Milder disease associated with HTLV-III/LAV infections and asymptomatic infections may be reportable in some states and cities but will not be nationally reportable. Because persons with less specific or milder manifestations of HTLV-III/LAV infection may be important in transmitting the virus, estimates of the number of such persons are of value. These estimates can be obtained through epidemiologic studies or special surveys in specific populations.

Issues related to the case definition of AIDS were discussed by the Conference of State and Territorial Epidemiologists (CSTE) at its annual meeting in Madison, Wisconsin, June 2-5, 1985. The CSTE approved the following resolutions:

1. that the case definition of AIDS used for national reporting continue to include only the more severe manifestations of HTLV-III/LAV infection; and
2. that CDC develop more inclusive definitions and classifications of HTLV-III/LAV infection for diagnosis, treatment, and prevention, as well as for epidemiologic studies and special surveys; and
3. that the following refinements be adopted in the case definition of AIDS used for national reporting:
   a. In the absence of the opportunistic diseases required by the current case definition, any of the following diseases will be considered indicative of AIDS if the patient has a positive serologic or virologic test for HTLV-III/LAV:
      (1) disseminated histoplasmosis (not confined to lungs or lymph nodes), diagnosed by culture, histology, or antigen detection;
      (2) isosporiasis, causing chronic diarrhea (over 1 month), diagnosed by histology or stool microscopy;
      (3) bronchial or pulmonary candidiasis, diagnosed by microscopy or by presence of characteristic white plaques grossly on the bronchial mucosa (not by culture alone);
      (4) non-Hodgkin's lymphoma of high-grade pathologic type (diffuse, undifferentiated) and of B-cell or unknown immunologic phenotype, diagnosed by biopsy;
      (5) histologically confirmed Kaposi's sarcoma in patients who are 60 years old or older when diagnosed.
   b. In the absence of the opportunistic diseases required by the current case definition, a histologically confirmed diagnosis of chronic lymphoid interstitial pneumonitis in a child (under 13 years of age) will be considered indicative of AIDS unless test(s) for HTLV-III/LAV are negative.
   c. Patients who have a lymphoreticular malignancy diagnosed more than 3 months after the diagnosis of an opportunistic disease used as a marker for AIDS will no longer be excluded as AIDS cases.
   d. To increase the specificity of the case definition, patients will be excluded as AIDS cases if they have a negative result on testing for serum antibody to HTLV-III/LAV, have no other type of HTLV-III/LAV test with a positive result, and do not have a low number of T-helper lymphocytes or a low ratio of T-helper to T-suppressor lymphocytes. In the absence of test results, patients satisfying all other criteria in the definition will continue to be included.

CDC will immediately adopt the above amendments to the case definition of AIDS for national reporting. This revision in the case definition will result in the reclassification of less than 1% of cases previously reported to CDC. The number of additional new cases reportable as a result of the revision is expected to be small. Cases included under the revised definition will be distinguishable from cases included under the old definition so as to provide a consistent basis for interpretation of trends. CDC will also develop draft classifications for disease manifestations of HTLV-III/LAV infections other than AIDS, distribute these widely for comment, and publish the results.

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

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Results of Human T-Lymphotropic Virus Type III Test Kits Reported from Blood Collection Centers — United States, April 22,-May 19, 1985

In March 1983, the U.S. Public Health Service (PHS) recommended that members of groups at increased risk for acquired immunodeficiency syndrome (AIDS) refrain from donating plasma and/or blood (*1*). The 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 (*2*).

Since that recommendation, evidence has shown that a newly recognized retrovirus, human T-lymphotropic virus type III (HTLV-III), is the cause of AIDS (*3-5*). An ELISA test designed to detect antibody to HTLV-III was developed. A previous report described serologic surveys with use of this test (*6*). In January 1985, the PHS issued provisional recommendations for screening donated blood and plasma for antibody to HTLV-III (*6*). In early March, ELISA test kits developed for detecting antibody to HTLV-III in donated blood and plasma were licensed and made commercially available.

The American Red Cross, the Council of Community Blood Centers, and the American Association of Blood Banks have provided data on test kit results for the 4-week period April 22, to May 19, 1985. During this period, 131 blood centers and banks reported results from screening 593,831 units of blood. An initially reactive test was found for 5,313 units (0.89%); 1,484 units (0.25%) were repeatedly reactive.* Repeatedly reactive rates varied by region of the country, ranging from 0.08% to 0.32% (Table 1).

*A sample that is reactive on two independent ELISA assays (done in duplicate at the same time or singly at different times) is defined as repeatedly reactive. If tested three times, and found reactive twice, it is also defined as repeatedly reactive.

TABLE 1. Number of blood units screened for HTLV-III and percentage repeatedly reactive, by geographic region—United States, April 22,-May 19, 1985

	North-west	North-east	South-west	South-east	Total
Total units tested	27,174	269,032	116,812	180,813	**593,831**
Repeatedly reactive (%)	0.08	0.32	0.24	0.18	**0.25**

Reported by the American Red Cross; Council of Community Blood Centers; American Association of Blood Banks; Office of Epidemiology and Biostatistics, Center for Drugs and Biologics, U.S. Food and Drug Administration.

Editorial Note: The data shown represent about 70% of all blood collected in the United States during the 1-month period. They demonstrate rapid implementation of HTLV-III antibody screening nationally. Since these data represent initial results of testing by many centers, future results may vary. It is not possible from these data to determine how many of the repeatedly reactive samples represent true HTLV-III infection or are false positives. Additional data correlating screening results and other test methods, such as Western blot, will be presented at a conference sponsored by CDC, the U.S. Food and Drug Administration, and the National Institutes of Health (NIH) to be held at NIH on July 31, 1985. Organizations wishing to send representatives to this conference or persons wishing to attend should contact one of the three agencies for additional information.

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COMMENTARY: DROPPING THE OTHER SHOE

by Ann Giudici Fettner, with thanks to The New York Native, 7/1-14/85

Throughout the AIDS epidemic, I've been hag-ridden by a couple of entities that aren't easily put to rest. One is the baffling occurrence of HTLV-III antibody in some disease-free African populations. The other is the elusive delta hepatitis virus. Therefore, the June 6 issue of the *New England Journal of Medicine*, with articles on both subjects, is a treasure trove. When read in the same sitting, the articles reinforce the visceral feeling that if the facts about these disparate entities are mingled, a third construct can be made without too much stretching.

The reason the delta model is so compelling is its apparent ability to arrive in the body disguised as, or to exert its effects only in the presence of, its first cousin, hepatitis B. Delta is a hybrid structure with a delta core wrapped in an envelope whose surface antigen reads "hepatitis B." The delta virus is a defective RNA virus (which puts it in the same league as HTLV-III), which cannot survive on its own and which "requires the helper function of a DNA virus, hepatitis B, to support its replication and expression," according to authors Norman Nishoka and Jules Dienstag of Massachusetts General Hospital. They go on to state that "Delta superinfection can transform asymptomatic or mild chronic hepatitis B to severe, progressive chronic active hepatitis and cirrhosis and can accelerate the course of chronic active hepatitis B." The viral fragment is transmitted primarily through blood, affecting recipients of transfusions and IV-drug abusers. Since the latter group's intimate sexual contacts are also affected, that very few gay men have this hepatitis is strange, says the editorial.

Now, let's jump to the next page in the *Journal* and look at the results of the Belgian/National Cancer Institute study of healthy people in eastern Zaire who are positive for HTLV-III antibody by both the ELISA and Western blot tests. Twenty-two percent of those studied were positive, but none had AIDS and *none were immunosuppressed*. The reasons proposed by the article for this dichotomy are three: "the virus may have been different from HTLV-III; subjects in this region may be less sensitive to the immunologic complications of infection with HTLV-III; or the subjects may have survived infection and complications that had occurred before the investigation."

Come on, fellas! There's another possibility that screams for mention, and you know it: HTLV-III may not alone be capable of causing AIDS, any more than the RNA delta hepatitis virus alone can cause hepatitis. That's the other shoe that simply has to drop at the National Cancer Institute before long.

If being positive for HTLV-III doesn't necessarily result in a depression or inverted ratio of T-4/T-8 cells, what's it doing? Alone, apparently, nothing much. It certainly isn't that people in Zaire don't get AIDS; there probably is more of the disease in that country than anywhere in the world. As reported earlier in the *Native* (issues 113 and 114), AIDS cases are streaming into the two Kinshasa hospitals at a truly alarming rate. And there are many AIDS cases fanning eastward from the area of the present study, across the border in Rwanda and Burundi. Again, look to the 51% of the remote, nomadic Turkana tribe in the deserts of northern Kenya, which is HTLV-III positive but not ill. And the 1972 frozen blood samples of healthy Ugandan children, over two-thirds positive for HTLV-III.

There are a lot of scientists who early on believed that AIDS is an illness the genesis of which requires more than a single virus. For the past year, since U.S. Secretary of Health and Human Services Margaret Heckler's announcement of "the cause" in April 1984, these men and women have been relegated to the ranks of amateurs, cranks. Their names, once prominent in AIDSlore, are rarely seen on papers in major journals, which now largely accept only those that connect themselves with HTLV-III or LAV. Most researchers in the U.S. opt for "HTLV-III," while Europeans, busy accusing NCI's Dr. Robert C. Gallo of, at the least, stealing the virus from France's Dr. Luc Montagnier of the Pasteur Institute, revolve around "LAV." (I can scarcely believe I'm writing these words. Talk about theater of the absurd!)

A molecular biologist from the National Institutes of Health with whom I was dining recently said, referring to HTLV-III, "It was too pat. It was just too simple. I don't believe it's that simple." That same unease is affecting more and more people. We're years into this disease and papers are beginning to appear that raise the same questions that were raised two years ago. Other papers, such as the one above on Zaire, do not ask questions that are so obvious they seem to be highlighted on the page. New/old words such as *macrophage* and *co-factor* float to the top again.

But we wait for a scientist who can't be ignored to say, "Wait a minute, we've got to rephrase the question. Either a retrovirus known as HTLV-III/LAV destroys the T-4 cells or it does not. If it does not—and that apparently is the case—we must immediately turn our attention to the identification of that/those co-factor(s) responsible for causing suppression of the immune system." It might seem so now, but it really wouldn't be such a big deal to get that out in the open. Remember how you felt when you finally screwed up your courage and spoke aloud a dark "secret" you'd labored under forever? And had the listener say, "Oh sure, me too; that's a bitch, isn't it," and turn at once to a more interesting topic? No big deal.

Let's ask them to start looking in earnest at things like the ubiquitous yet mysterious Epstein Barr virus; at the much maligned, but still viable African Swine Fever virus over which Dr. Jane Teas has been pilloried and scientists turned to liars. The whole range of parvo viruses are suspect. Members of that family have recently been shown to kick off sickle-cell crises and flare-ups of rheumatoid arthritis, though they cause no human disease—yet.

We've very recently begun dealing with something here that we used to assign to malign spirits or to the gods, a mythical entity with the amazing ability to float undead/unalive until it reaches a host. There, it *becomes* the host by integrating its genetic material into that of the host cells where it grows. It comes in disguises, in match-ups between the whole and the fragment. It comes different, it jumps from one species to another, encoding its genome into ours. It's a virus and we still are just at the starting gate. That's great, but we should be standing here with more dignity. If nothing else, the deaths caused by the disease are so truly dreadful and somehow unnecessary, as all death in the young seems, that we should approach with care. More plainness, perhaps.

One of the most pleasant aspects of living in Africa is that the children can come play with yours for hours on end and never is there a whine of "mine!" or a fight. From living in abject horror of kiddy birthday party melees, I learned to enjoy the soothing voices of children accommodating each other and reality. Their reality is that there isn't any room for hassles. No one's got anything, there's no time, no room for kids to yammer at each other. So they don't.

If we hadn't the time for it, our scientists wouldn't hassle and yammer and clutch to "mine." It's a tenure mentality, at work where there should be free-wheeling creativity and exchange to encourage new ways to approach difficult problems. I don't need my scientists to look like Brooks Brothers people. Albert Einstein and Linus Pauling suit me just fine. I'd like a little eccentricity thrown in, for what it brings to those who otherwise might merely be technicians. But, whatever the final result, if it isn't based on a true scientific, human spririt, if there isn't dignity and integrity, it's no good.

Isn't there another shoe to drop? Won't someone end the suspense? ■

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JOHNSON & JOHNSON DISLIKES "BAN-AIDS" CAMPAIGN

The Johnson & Johnson Company, manufacturers of Band-Aids adhesive bandages, has ordered the San Diego AIDS Project to "cease and desist" its now popular "Ban-AIDS" campaign. In a letter received from the Fortune 500 company's legal representatives, the manufacturer complained of a trademark infringement by SDAP in its use of the image of a stick-on bandage with the words "BAN AIDS." Emblazoned on t-shirts, bumper stickers, and education/prevention materials, the San Diego campaign received widespread attention recently at the International AIDS Conference in Atlanta in April. Dr. Hal Frank, director of SDAP, said that the colorful t-shirts were one of the most popular items displayed at the conference, selling out on the first day. Pitted against the giant international conglomerate which produces the bulk of health care items used world-wide, SDAP with its miniscule budget of under $40,000 per year, has turned the demand over to its legal counsel. "In our opinion," said Frank, "the success of the BAN AIDS campaign is based on the public's response to the need to eradicate AIDS as the nation's number one health danger. We wonder what would have happened if we had used the term 'CURE AIDS?'" The San Diego AIDS Project can be reached at P.O. Box 81082, San Diego, CA 92138 (619/294-2437). T-shirt supplies have been depleted, and there are no plans to reorder them at this time.

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TWA HOSTAGES HIDE HOMOSEXUALITY

Two hostages on hijacked TWA Flight 647 pretended to be brothers in order to hide their homosexuality, fearing their Shiite Moslem captors would punish homosexuals with death, according to Jack McCarty, 40, in a copyrighted interview in the San Francisco Examiner. Had the captors known about his relationship with Victor Amburgy, 31, "they could have justified killing us," he stated. McCarty said that in addition to telling the captors that he and Amburgy were brothers, he tried to act tough and was helped by his military styled fatigue clothing. The captors did not know that it is common garb in San Francisco's predominantly gay Castro district. McCarty arm-wrestled with one of his captors, suffering a bruise when his hand smashed back against a table top. "Good man," one of the terrorists said, giving him a thumbs up sign, McCarty said. McCarty said he and Amburgy were locked in a basement room for three days, where their meals were shoved through a metal grate door and rats crawled on the floor. "It is impossible to describe--realizing from the time the [Navy diver] serviceman was dead that you were very possibly going to die," he said. The terrorists comstantly threatened them with death by psychological intimidation, including a version of Russian roulette--aiming a gun at a hostage, spinning the barrel and pulling the trigger. McCarty said his work counseling people dying of AIDS at San Francisco's Shanti Project had taught him to confront death, and he had drawn on that experience many times in Lebanon. McCarty urged fellow hostages to meditate and was asked to counsel people, his captors thinking that meditation was yoga.

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* END OF VOLUME 6:5!! Next issue of the News- *
* letter will be Volume 7:1,August-September, *
* 1985, tentatively scheduled for publication *
* early in September. Deadline for articles, *
* August 16th. Due to a scheduled move of *
* NCGSTDS offices at the end of August, cor- *
* respondence (and publication of Vol. 7:1) *
* may be delayed. Thanks for your understanding!*
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