THE OFFICIAL NEWSLETTER OF THE

NATIONAL COALITION OF GAY STD SERVICES

VOLUME 7:2 DECEMBER/JANUARY, 1986

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NCGSTDS MEETING MARCH 12!

Although thrown slightly off kilter by the rescheduling of the 7th National Lesbian Gay Health Foundation's 7th National Lesbian/Gay Health Conference and the 4th National AIDS Forum for March 13-16, 1986, the NCGSTDS will host its annual meeting on Wednesday, March 12, 1-4 pm at the Whitman Walker Clinic, 2335 18th Street, NW, Washington, DC 20009 (202/332-5295). In order to avoid conflict with other meetings and conference activities, the meeting was scheduled the day before the general conference is scheduled to begin at the facility of one of the Coalition's founding members. PLEASE CALL THE NCGSTDS TO RSVP ANYTIME (414/277-7671--leave message on recorder with your name & agency (if applicable), how many will attend, and if known, when you are arriving and where you will be staying). Send agenda items as soon as possible to the NCGSTDS: PO Box 239, Milwaukee, WI 53201. The next Newsletter (7:3) will be out prior to the meeting and will outline the agenda.

NCGSTDS RAISES DUES, PUBLISHES MEMBERSHIP BROCHURE

After several years of maintaining membership dues at a constant level, the NCGSTDS membership attending the recent annual meeting of the NCGSTDS at the American Public Health Association in Washington, DC, approved a proposal to raise membership dues, effective January 1, 1986. In spite of the slight increase in several of the membership categories, membership is still a great bargain, according to chairperson Mark Behar. Dues not only entitle members to a subscription to the informative Official Newsletter, but also to a copy of the latest Guidelines & Recommendations for Healthful Gay Sexual Activity brochure (the 5th edition will be mailed to members around March, 1986), and other benefits to be announced in the Newsletter. Along with the dues revision, a new brochure for new and renewal members will be available to replace the one page "Fact Sheet" and "Membership Renewal" forms. A copy of the new brightly designed brochure is enclosed with this newsletter; please pass it along to a friend who may be a potential member! The new dues are as follows (old dues in parentheses): Category 1) Associate/Corporate Membership--$250/year (no change); 2) Group Medical Practice--$50/year ($55 was old rate); 3) Individual Practicing Physician/Health Provider--$35/year (no change); 4) STD/AIDS Service Organization or Agency--$50/year (was $35); 5) Individual--$25/year (was $20); 6) Subscription to Official Newsletter Only--$25/year (was $20); 7) Newsletter exchange/Complementary (nonvoting)--Limited numbers available (previously unlimited, accounting for over 20% of all mailings); 8) Overseas Subscription (nonvoting)--$55/year (no change--expensive international overseas postage!).

7th NATIONAL LESBIAN GAY HEALTH CONFERENCE & 4th NATIONAL AIDS FORUM

The long awaited for gay & lesbian health provider event of the year is soon to take place. The 7th National Lesbian/Gay Health Conference and 4th National AIDS Forum, cosponsored by the National Lesbian/Gay Health Foundation, the CDC, the NIH, Whitman-Walker Clinic, and several other groups, is scheduled for March 13-16, 1986 at The George Washington University Marvin Center. (The NCGSTDS will host its annual meeting on the afternoon of March 12--see related article.) The call for papers has long been out, and there is a need for non-AIDS related submissions. For additional information, or for registration, contact NLGHF Conference, POB 65472, Washington, DC 20035 (202/797-3708). [A brochure describing the Conference will be included with the Newsletter if it is received before our mailing.]

APHA 114TH ANNUAL MEETING IN LAS VEGAS SEPTEMBER 28-OCTOBER 2, 1986--CALL FOR PAPERS

The 114th Annual Meeting of the American Public Health Association is scheduled for 6 weeks earlier than usual in 1986, September 28-October 2, in Las Vegas. The Lesbian & Gay Caucus of the APHA is presently soliciting abstract submissions for papers, workshops, and panel discussions. The theme for the conference is: "Local Health Services: Crises on the Front Line." Due to the lack of scientifically credible health policy on many aspects of AIDS, and that among the main impacts of this problem are: 1) additional prejudice and hysteria directed toward persons in high risk groups; and 2) legislation and health policy which do not address the difficult problems of the AIDS epidemic. It is believed that formulation and dissemination of a well reasoned and scientifically substantiated public health policy will be far more beneficial than imposed policy and legislation after the fact. The LGC/APHA hopes to promote both the protection of civil rights and control of the AIDS epidemic by presenting coherent public health policy to legislative and public health officials, scientists, and the press. For now, Alan Kristal (NYC Dept. of Health, 125 Worth St., #326, New York, NY 10013) will draft a policy statements on contact tracing and bathhouse closure. Michael Gorman (278 Peachtree Hills Av., Atlanta, GA 30305) will draft a policy statement on prevention/health education. Ron Stall (17 Clement St., San Francisco, CA 94118) will draft a policy statement on prevention of IV drug related transmission. Experts in pharmacology and/or the FDA and its operation are needed to address expanding and organizing anti-viral drug trials. Outreach to other professional and political organizations and individuals is needed. If you are interested in helping in this effort, contact Alan Kristal (see above address). Future issues of the Newsletter will have updates about the 1986 APHA meetings, and the AIDS policy task force of the LGC/APHA. The NCGSTDS will host its semi-annual meeting during these meetings.

INTER-NATIONAL AIDS PROSPECTIVE EPIDEMIOLOGY NETWORK UPDATES

by David Ostrow, MD, PhD, with thanks to the INAPEN Newsletter, 12/85

The last few months have been very busy and productive for the Inter-National AIDS Prospective Epidemiology Network (INAPEN), an organization formed in August, 1983 to help accelerate the pace of AIDS epidemiology research through methods standardization and data pooling, to assist investigators in smaller communities or without funding for developing prospective natural history studies, to facilitate the exchange of information and methodological advances among AIDS research investigators, and to help protect the confidentiality of participants in prospective AIDS epidemiological studies. 1. American Social Health Association to Jointly Develop Funding for INAPEN Development. At the November meeting of the board of directors of the American Social Health Association (ASHA), tentative approval was given to joint ASHA-INAPEN development of a comprehensive plan for implementation and funding of the next stage(s) of INAPEN, which includes implementing the electronic networking component. 2. Plans for Joint INAPEN-WHO Meeting in June, 1986. Many of you are already aware of the 2nd International AIDS Conference scheduled for June 22-24, 1986, in Paris (see last issue of NCGSTDS Newsletter for details). Plans are underway to hold a joint INAPEN-WHO AIDS Group meeting to discuss our mutual goals in AIDS research and data pooling. This meeting will provide INAPEN members with the opportunity to meet with European colleagues and discuss research strategies, methods development and priorities for collaborative efforts. Similarly, the WHO AIDS Collaborative Group, which has recently announced the formation of a collaborative multi-national approach to AIDS research in Europe, will be able to observe our approach and experience in these areas. 3. Proceedings of Workshop on AIDS Control to be Published Soon. The final edited manuscripts from last April's Workshop on AIDS Education and Control (in conjunction with the First International AIDS Conference in Atlanta) were sent to the publisher, Irvington Press in New York City. An April, 1986 publication date is expected. Many INAPEN, NCGSTDS, and AAPHR members contributed to the success of the workshop and its proceedings. The book, which is titled, The Biobehavioral Control of AIDS, is composed of four major sections and appendices. A special discount price for INAPEN, NCGSTDS, and AAPHR members will be offered. Details will be forthcoming in the next NCGSTDS Newsletter. The book will have sections on biological issues in AIDS control, ethical issues, practical issues, and examples of effective AIDS control programs. Appendices will include samples of safer sex guidelines, some of which have been banned in their local communities, a listing of AIDS service organizations, a bibliography, commentaries on such matters as the control of AIDS among heterosexuals, gay youth, specific AIDS control, issues for health professionals, and the role of the bureaucratic policies and attitudes in hindering community-based education and prevention efforts. 4. Two INAPEN Membership/Board Meetings Planned for 1986. There will be two membership & board meetings for INAPEN in 1986; the U.S. meeting will be planned in cooperation with the National Lesbian/Gay Health Foundation Cosponsored 4th National AIDS Forum and 7th National Lesbian Gay Health Conference, scheduled for March 12-16, in Washington, DC. (The NCGSTDS meeting is planned for Wednesday afternoon, March 12, 1-4pm at the Whitman-Walker Clinic). The second INAPEN meeting will be held in conjunction with the AAPHR-GMA International Conference on Homosexuality and Medicine, August 14-16, in London. (See related article in Newsletter, and enclosure). If you are interested in presenting a workshop contact David Ostrow (312/565-2109) immediately!! Submissions could report on any aspect of cooperative AIDS research that may be of interest to others. Suggested uses of the INAPEN database to examine specific AIDS research questions (i.e., are nitrites specific risk factors in AIDS?) or descriptions of your attempts to initiate the use of the INAPEN database and suggested improvements in it would be welcome submissions. 5. Changes in INAPEN Personnel. Laura Coats, who expertly managed most of the secretarial, administrative, and communication functions of INAPEN during its formative stages has moved to another job. We wish her much success in her new position and will miss her dearly! Among the volunteers who is functioning as volunteer administrator for INAPEN, is William Hocker, a psychology graduate student. We warmly welcome Bill and appreciate his help in furthering our efforts. For more information about INAPEN, write to: David Ostrow, MD, PhD, INAPEN, 259 E. Erie, #108, Chicago, IL 60611 (312/908-4694).

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NCGSTDS COMPUTERIZATION PROGRESSES!

The NCGSTDS' last issue of the Newsletter. although almost fully computerized, had two major technical flaws which hopefully have been corrected in the present issue: numerous typographical errors (many of which were intentional, to keep our more critical readers on their toes!), and uneven contrast of pages that used both printer and typeset copy (2 pages are shot for the offset plate together, and it is difficult to predetermine which pages will be together--the first & last are pasted up on the same board, the second & second from the last, etc.). We have used our spelling checker program for all computer generated copy (although it is very time consuming--about 1 hour for every 5-6 pages of copy--we may have to live with the typos if we are pressed for time!), and have used fresh printer ribbons for the actual printing. Hopefully, these solutions will produce a higher quality, easier to read product. If you have any other suggestions as how we can improve the Newsletter, drop us a line! One suggestion was to use a larger type, but we are trying to determine the quantity of material we could squeeze into each issue. We presently use a non-proportional space 20 pitch font--a standard typewriter uses a 10 or 12 pitch font; our pre-computerized Newsletter used a 12 pitch Tempo Smith Corona font. In 1986 we hope to be capable of electronically transmitting the entire contents of each issue to another member's computer. For those readers who are computer buffs, the typewriter copy of this issue of the Newsletter constitutes over 300K of information! Thanks for your patience during our difficult periods!

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HOMOSEXUALITY AND MEDICINE: FIRST INTERNATIONAL CONFERENCE, CO-SPONSORED BY AAPHR

Included with this Newsletter is a copy of the preliminary program for the AAPHR's 1986 Conference, **Homosexuality and Medicine: First International Conference**, planned for London, August 14-16, 1986. The Conference is being organized by the Gay Medical Association, and is being co-sponsored by the American Association of Physicians for Human Rights (AAPHR), who will also be holding their annual general meeting as part of the Conference, and the European Gay Health Care Foundation. The aim of the Conference is to enable health professionals from countries with differing medical and social systems to discuss the wider issues involved in the provision of professional services by and for gay men and women. The Conference will be held at The Royal Society of Medicine, 1 Wimpole Street, London W1M 8AE, England. Morning sessions will comprise two plenary lectures by invited speakers and specialist presentations on hepatitis b (carriers and vaccines); homosexuality and the international classification of diseases; counseling; trends in S.T.D.s; homosexuality in countries where it is illegal; safer sex; aging; AIDS phobia; homosexuality and the undergraduate curriculum; the gay bowel syndrome; and the use and abuse of alcohol and other drugs. Afternoon sessions will be devoted to free communications o 20 minute papers, posters, and videos/films (for which abstracts are invited), as well as workshops with the following topics: educating the profession; victimization/coming out professionally; the seven ages of homosexuality; the gay doctor and the law; women's health issue; confidentiality; using professional journals; and international cooperative AIDS research. **Abstracts which should contain no more than 300 words must be submitted on the enclosed forms, and received by no later than February 28, 1986.** The social program includes a reception at The Royal Society of Medicine, and a performance at the Barbican Theatre, the London home of the Royal Shakespeare Company, and the AAPHR banquet. (It is rumored that a certain group of sisters may make a guest appearance!) For more information, contact: In the United States: Dr. David Ostrow, MD, PhD, 259 E. Erie, #101C, Chicago, IL 60611, (312/908-4694 w, 565-2109h), Dr. Margie Sved, MD, 1001 Monmouth Av., Durham, NC (704/724-5116 w, 733-3418 h), or the offices of AAPHR, P.O. Box 14366, San Francisco, CA 94114 (415/558-9353); in Canada: Dr. Richard Isaac, MD, 190 St. George St., #605, Toronto, Ontario M5R 2N4 (416/530-2111) or Dr. Brian Willoughby, MD, 404-1160 Burrand Street, Vancouver, British Columbia, Canada V6Z 2E8 (604/879-9854); or in Europe: the GMA Secretariat, Caroline Roney Medical Conference Organizers, 100 Park Road, London NW1 4RN, England.

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STATE OF THE ART FOR THE PRACTITIONER: UCLA CONFERENCE

The Department of Continuing Education in Health Sciences of the University of California--Los Angeles (UCLA), the UCLA AIDS Center, the Center for Interdisciplinary Research in Immunology and Diseases at UCLA (CIRID); the National Institute of Allergy and Infectious Disease (NIAID); and the UCLA School of Medicine are cosponsors of the conference, "AIDS: State of the Art for the Practitioner," Saturday, January 11, 1986 at the Neuropsychiatric Institute Auditorium in Los Angeles. The course chairman is Michael S. Gottlieb, MD. Topics covered include clinical aspects, HTLV-III testing, experimental therapy as well as the psychological, social, and medicolegal implications of the epidemic, and will include a panel discussion and a question & answer session. Registration fee is $90 for physicians (6 hours of CME for doctors & dentists). Also scheduled for January 11, is a public forum on AIDS, to address facts, perceptions, and myths. Planned for the spring, 1986, is a conference on AIDS and the alcoholic/drug dependent client. For more information, contact UCLA Extension, P.O. Box 24901, Dept. K, Los Angeles, CA 90024.

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PUBLIC POLICY DIMENSIONS ON AIDS IN NEW YORK

with thanks to Los Angeles CAIN (Computerized AIDS Information Network), 12/17/85

The AIDS United Hospital Fund of New York and the Institute for Health Policy Studies of the University of California--San Francisco are sponsoring an important two day conference on AIDS Public Policy Dimensions, January 16-17, 1986, at the Omni Park Central Park Hotel, 870 Seventh Av. at 57th Street. For more information or registration, call 212/645-2500 x 575 or 578.

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REAGAN BRIEFED ON AIDS

with thanks to The Washington Blade, 1/3/86

President Reagan received his first major briefing on the government's efforts to address AIDS, December 19, according to the New York Times. At the meeting, Dr. Donald Macdonald, acting assistant secretary of Health and Human Services, reportedly told Reagan that the government's AIDS research program might reveal so much information on viruses and disease that one day it might be viewed as "the health equivalent of the Manhattan Project," which produced the first atomic bomb. Reagan's only question, reported the Times, was about where the largest numbers of AIDS cases are in the nation. He was told New York State, which included New York City, had nearly one-third of all reported cases. Although the President had attended other briefings on AIDS, the 30 minute meeting was his most extensive so far.

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TELECONFERENCE ON AIDS IN WORKPLACE PLANNED FOR MARCH
with thanks to Detroit's Cruise, 12/18/85

The first national teleconference on AIDS in the Workplace, cosponsored by the Bureau of National Affairs (BNA) and the Public Broadcasting System (PBS) will be transmitted March 26, 1986, to more than 100 sites nationwide, from 1-4 pm (EST) from the studios of WETACOM, a subsidiary of WETA-TV in Washington, DC. The teleconference will provide a forum for a comprehensive investigation and discussion of the legal and medical issues, public policy implications, and employer/employee concerns of AIDS in the workplace. The seminar will bring together top public health officials, attorneys, policymakers, insurance representatives, corporate and union officials, and gay rights advocates. More than 2000 people are expected to attend. BNA is a leading publisher of information services covering employee relations, business and economics, law and taxation, environmental protection, and other public policy issues. AIDS in the Workplace is one of five seminars included in the launch of PBS' National Narrowcast service (NNS), designed to meet the education, information, and training needs of the American workforce in business, industry, and public service. Seminar participants include Dr. James Allen, Center for Infectious Diseases, AIDS Activity, U.S. Public Health Service/Centers for Disease Control; Gerald W. McEntee, president, American Federation of state, County and Municipal Employees (AFSCME); Mark Rothstein, JD, MD, visiting professor of law at the University of Houston; Michael Cecere, JD, partner, Jackson, Lewis, Schnitzler & Krupman; Thomas Stoddard, legislative director of the New York Civil Liberties Union; Karen Clifford, legal counsel for the Health Insurance Association of America; Arthur Leonard, associate professor of labor law, New York Law School, and a member of the Board of Directors of Lambda Legal Defense and education Fund; and Caitlin Ryan, MSW, president, National Lesbian & Gay Health Foundation, and health educator and consultant, Spencer/Rich & Associates, Inc. Some of the issues to be explored: Can employers test and screen workers and applicants for AIDS (HTLV-III antibody)? What privacy rights do employees have? What are the legal rights of PWAs under EEO and handicap statutes? How and why are they being successful in legal challenges? What are the legal rights of co-workers of PWAs? What is the effect of AIDS on the insurance industry? Will federal, state, and local governments follow San Francisco's example and ban AIDS discrimination? How will the new CDC guidelines impact health care institutions,school districts, and employee personnel practices? What position will unions take on AIDS in the workplace? The teleconference will be offered at or near the local public television station in over 20 cities. Contributing organizations to the seminar are: The American Civil Liberties Union, The National Education Association, the National Gay/Lesbian Task Force, the American Foundation for AIDS Research, and Spencer/Rich & Associates, Inc. Registration for the seminar is $125 through March 7, and $160 thereafter. [NCGSTDS EDITORIAL COMMENT: !!!!!] For more information, contact Abby Strongin, 202/452-4200.

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FIRST WEST COAST REGIONAL CONFERENCE ON AIDS AND ETHNIC ISSUES PLANNED

The devastating effects of the AIDS epidemic are increasing in ethnic minority communities. People of color make up 41% of all AIDS cases in the country. A close look at AIDS cases reveals a disproportionate number of blacks struck by the deadly disease. Although blacks account for about 12% of the entire population of the country, they account for 25% of all AIDS cases; hispanics account for 14% of AIDS cases in the country. It is of obviously great importance that people of color, regardless of sexual orientation, understand how AIDS is and is not transmitted to overcome fears, uncertainties, and misinformation about the disease. The Third World AIDS Advisory Task Force serves as an advisory group to service providers addressing AIDS prevention, education, and delivery of direct services to third world communities in the San Francisco Bay area. The Task Force is presently planning the **First West Coast Regional Conference on AIDS and Ethnic Issues**, April 24-26, 1986, which will primarily address the disease and its impact on third world communities. An important aspect of the conference will be the opportunity to network with AIDS service providers and AIDS agencies in the Bay area, and to provide a forum in which to exchange knowledge and information. The Task Force is seeking financial support of $25,000 to host this conference, which hopes to attract 300 people. The Task Force is also seeking co-sponsorship by sympathetic organizations. Please contact us immediately: Ernesto Hinojos, Education Department, San Francisco AIDS Foundation, 333 Valencia St., 4th Floor, San Francisco, CA 94103 (415/864-4376).

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BLAMING THE VICTIM IN SAN ANTONIO
by Regina Gillis, with thanks to Boston's Gay Community News, 11/9/85

San Antonio's Metropolitan Health District has announced it will criminally charge people with AIDS who remain sexually active in an attempt to "control the disease." The city's health department sent letters to 17 PWAs, notifying them of the possibility of facing third degree felony charges if they engage in sexual relations. The letters also warned their recipients against needle sharing and donating blood, and urged them to notify their doctors and dentists of their diagnosis, according to the New York Times. Beverly Smith, president of the San Antonio AIDS Foundation, criticized the move, saying that PWAs are not "thinking about having sex--they're thinking about how much time they have left." Forty persons in San Antonio have been diagnosed with AIDS since 1981, with 23 deaths.

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MARDI GRAS AIDS SEMINAR: FEBRUARY 9-11, 1986 IN NEW ORLEANS FEATURES HOMOPHOBE PAUL CAMERON

"AIDS: A Medical Crisis--Legal Aspects," is being hosted at The Sheraton New Orleans Hotel, February 9-11, 1986 and is being targeted to employers, attorneys, hospital administrators, insurers, medical personnel, business executives, restauranteurs, other professionals, and other interested parties. This Mardi Gras seminar is being sponsored by Legal-Medical Seminars, Inc., an agency devoted to presenting practical information on medical and legal topics through a multi-disciplinary seminar format geared to professionals, and Martin B. Flamm, MD, JD, and Judy A. Gic, CRNA, JD, co-founders of Legal-Medical Seminars. At this intensive seminar, the following topics will be covered: *What types of screening procedures employers may follow in hiring new employees; *whether certain employees may be screened differently, particularly those in the hospital and food service and restaurant industries; *what hospital liability is before and after the new blood screening test; *whether hospitals and their agents can refuse to admit or treat AIDS victims; *what causes of action can be brought against someone who infects another with AIDS; *whether insurance companies can refuse to issue insurance to single men or those with roommates; *whether government can regulate sexuality by health policy due to the AIDS crisis; *varying perspectives on the rights of the victim versus the rights of society. Some of the program topics include: basic medical aspects; transmissibility and public health aspects; AIDS impact on homosexual crime [!!!!]; hospital liability; civil litigation & communicable disease; housing & insurance problems of the AIDS victim; AIDS in the work place--victim's & employers's perspectives; employer's duty to warn others; government attempts to regulate morality. The most notable faculty members are: **Paul Cameron, PhD**, who is listed as a theoretician, clinician, and researcher whose controversial perspectives on the AIDS crisis has received widespread national media attention has published and lectured extensively on economic and sexual factors influencing cultural viability" and **Neil Schram, MD**, who is chairman of the Los Angeles City & County Task Force on AIDS, and past president of the American Association of Physicians for Human Rights. Cameron was recently censured by several professional groups for his outspoken, bigoted, homophobic rhetoric, and Draconian measures directed to the gay community. Cameron resigned from the American Psychological Association in 1983 shortly before the association was ready to charge him with unethical conduct for misrepresenting other people's research in order to claim homosexuals are child molesters. [According to Madison's OUT!, when Cameron testified as an "expert witness" in a U.S. District Court in Northern Texas, the judge complained he had distorted data to claim that gay men were 43% more likely to be criminals than straight men. Cameron calls for a quarantine of anyone with a positive HTLV-III antibody test, claiming it is "presumptive evidence" that the person has AIDS, and is holding open the idea of quarantining all gay men. Speaking this August on a Philadelphia radio talk show, Cameron said gay waiters sometimes ejaculate into food before serving it, and some gay men enjoy removing the claws and teeth of gerbils and hamsters and then having the dying animal crawl up their rectums.] Cameron and Schram will be providing individual perspectives and offer rebuttal and counter rebuttal. The registration fee will be $350. For more information, or to receive a registration form or to comment/complain, call Sandy, 504/865-8364, or write to: LMS, Inc., 4324 Veterans Blvd., Suite 1-D, Metairie, LA 70006.

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MASKS ISSUED TO FRESNO POLICE & SHERIFFS

edited by John Fall, with thanks to the New York Native, 11/18-24/85

Plastic masks for administering mouth-to-mouth resuscitation have been placed in all police and sheriffs' patrol vehicles, in an attempt to avoid the transmission of AIDS. "Let's face it," said police spokesperson Sgt. Mike Gutherie, "with all the publicity about AIDS, officers have to have at least some hesitancy in the backs of their minds when they give mouth-to-mouth to someone." Fear of AIDS prompted law officials to use the devices, but the masks can also impede the transmission of other diseases. "There have been horror stories about (rescue) people contracting everything from the common cold to tuberculosis and hepatitis," Gutherie said. The "Res-Q-Flow" masks fit over the victim's nose and mouth. A rescuer can then blow air through a tube and into the victim's lungs, reports United Press International.

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HOAX ABOUT AIDS EMPTIES PUBLIC LIBRARY

with thanks to The Milwaukee Journal, 12/22/85

A prankster's telephone call about an "AIDS inspection" led to the closing of the Madison (Wisconsin) Public Library for about 20 minutes. Officials said the city's main library was cleared after a caller advised a library employee that a team of health inspectors was on its way to check parts of the building because someone who recently died of AIDS had frequented the building. The male caller suggested that people be removed from the library so they would not be disturbed by the sight of inspectors wearing protective outfits. Natalie Tinkham, head of the library's adult services section, said that she thought the request was unusual but eventually asked 100 employees and patrons to leave. The speaker sounded sober and rational, she said. The speaker also mentioned he had called five restaurants and that one had agreed to shut down for a similar "inspection," she said. Patricia Natzke, director of the city's health department, said the calls underscored a need for the public to get accurate information about AIDS, which she reaffirmed was not transmitted by ordinary, casual contact.

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STATE LEGISLATURES URGED TO INITIATE CONTACT TRACING

by Lou Chibbaro Jr., with thanks to The Washington Blade, 12/13/85

[Please see commentary article on contact tracing by NCGSTDS Editor which follows.]

The head of an organization representing the nation's state health departments urged states to pass laws that require local health departments to keep confidential records of persons who test positive for the HTLV-III antibody and to identify and locate the sexual partners of people who test positive. George Degnon, executive director of the Association of State and Territorial Health Officers (ASTHO), called for AIDS record keeping and "contact tracing" requirements at a panel discussion on AIDS sponsored by the National Conference of State Legislatures, held at the J.W. Marriott Hotel in Washington. The panel was attended by more than 100 members of state legislatures from states throughout the country. Degnon said local health departments and state health agencies have developed an "excellent record" of confidentiality for their venereal disease testing and treatment programs. He said the same confidentiality would be adhered to for AIDS antibody testing and record keeping. To further ensure AIDS-related confidentiality, Degnon said his organization is also asking states to pass strict confidentiality laws which would safeguard AIDS records from law enforcement subpoenas. Gay rights organizations monitoring the AIDS epidemic have strongly opposed record-keeping requirements for persons testing positive for the HTLV-III antibody. They have expressed even greater opposition to proposals for mandatory "tracking," or identifying sexual partners of those who test positive. Such requirements will "guarantee that those in high risk groups will shy away from taking the test," said Jeff Levi, director of governmental and political affairs for the National Gay/Lesbian Task Force (NGLTF). Levi criticized Degnon for comparing AIDS testing programs with VD testing, saying the consequences posed by AIDS will be sufficient to drive most people away from taking the AIDS antibody test if they know their names will be kept on a state list. Levi noted that gay groups monitoring the AIDS situation in Colorado report that persons seeking the antibody test have begun to give false names, including the name "Ronald Reagan." Caitlin Ryan, former program manager for the Whitman-Walker Clinic's AIDS Education Fund and another speaker at the AIDS panel, urged legislators to implement counseling programs along with antibody testing. Noting that news of a positive test result has led some people to commit suicide, Ryan said it is crucial that states provide adequate funding for training of health workers who conduct testing programs. Ryan and others involved in AIDS patient care have called for voluntary contact tracing programs which involve asking people who test positive for the AIDS antibody to discreetly notify their sexual partners of their positive test results and to urge the partners to take the test. Others speaking on the panel were Dr. J. Michael Lane, director of the Centers for Disease Control's Center for Prevention Services, and Karen Williams, director of Research for the Health Insurance Association of America. Lane told the panel that more than five years of studies have confirmed that AIDS cannot be transmitted through casual contact. He said the CDC has recommended that local and state governments not pass laws making HTLV-III antibody testing mandatory for employment and attending schools. Williams urged the legislators in the audience not to pass laws banning health or life insurance companies from requiring insurance applicants to take the antibody test. She said such bans prevent insurance companies from conducting standard underwriting practices and will result in higher insurance premiums for all groups.

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CONTACT TRACING DUPES GAY COMMUNITY: EDITORIAL

by Mark Behar, PA-C, Chairperson, NCGSTDS

Suggestions for implementing contact tracing of people who test HTLV-III antibody positive are based on a similar model for syphilis and has several false premises that have not been clearly brought up or discussed. A few sections from Yehudi Felman's chapter on syphilis in Ostrow's STDs in Homosexual Men (NY: Plenum, 1983) will help illustrate certain features about contact tracing for syphilis. My comments will follow. "...It is [homosexually active] men who presently are responsible for about half of all reported infectious syphilis in the United States. When the natural reluctance of homosexual men to name their sexual contacts is taken into account, especially if their contacts are still 'in the closet,' the ratio of homosexual to heterosexual patients with syphilis is probably even higher....Indeed, the success of the National Venereal Disease Control Program in controlling syphilis in the heterosexual community poses the question of why the program has failed to control syphilis in the homosexual male community (p. 39)...The program has been in existence for the last thirty years and is based upon several principles. The most important of these is that the incubation of infectious syphilis is 21 days. Thus the sexual partners of a patient with syphilis will not become infectious for 3 weeks, and the investigator has that period during which to find the sexual contacts of an infected patient before they become infected and transmit the infection to others....The purposes of the interview are: to educate the patient concerning the signs and symptoms of syphilis and how to recognize the disease in himself and in his sexual partner, and to locate sexual contacts who may have been infected by the patient, as well as sexual partners of the contacts, before further individuals become infected....The average homosexual male may be expected to name 3 or 4 contacts, and sometimes more than 10. The mobility of the population underscores the necessity that local health departments in various geographical areas of the country be prepared to exchange contact tracing information immediately to insure prompt examination and treatment of infected contacts. This information exchange is made possible through the

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CONTACT TRACING EDITORIAL, Continued

auspices of the Interstate Communications Control Service, which is available throughout the United States....Patients with primary syphilis are questioned about sexual contacts during the preceding 3 months; those with secondary syphilis are asked about the preceding 6 months; those with early latent syphilis about the preceding 18 months. However, the chances of successful contact tracing become less likely the longer the time that has elapsed since sexual encounter occurred (p. 51)." Unfortunately, the anonymity of many of the sexual contacts of homosexual men tends to impede contact tracing to a great degree. How can the health department trace the contacts of an individual with infectious syphilis if the patient himself does not know who they are? To a large extent, this is the reason why traditional approaches toward syphilis control (i.e., contact tracing), .though relatively successful in the past decade in the heterosexual community, are not as successful in the homosexual community. Furthermore, many individuals are understandably afraid to name their sexual contacts for fear that their homosexuality as well as their VD will be disclosed (p. 52)."

1) Why have the National VD Control Program (now the Division of STD Control in the CDC) and state health departments failed to control the incidence of infectious syphilis among homosexually active men by using contact tracing as a primary disease intervention strategy? The answer to this question will help us understand why a similar program attempting to be implemented to control infection with HTLV-III will also be unsuccessful in homosexually active men.

2) The differing incubation times between infectious syphilis and HTLV-III constitutes another important difference. Exposure to HTLV-III is thought to induce antibody production in most people within 4-8 weeks, however unlike syphilis, it is not known whether a person is infectious (or exactly how infectious?) during this "incubation" stage; strictly speaking, "incubation" refers to the time between contact with the infectious agent and the induction of any host reaction ("infection") along with the first appearance of clinical signs & symptoms. It has been estimated that this may range for up to 5-15 years or more for HTLV-III infection. How extensive a contact tracing will take place? How many months or years of sexual contacts will an interviewer investigate?

3) Although the purposes of the interview--to educate a person about the disease, to locate sexual contacts and the contacts of those contacts, and to initiate treatment, are useful in syphilis, even if they would be successful among homosexually active men (and as was noted above, is not successful), there is still no adequate medical intervention (treatment or vaccine), and according to Public Health Service estimates, such interventions will not be available for anywhere from 5-15 years. All we can do is teach "safer" sex practices and prevention (something non-gay public health workers are hesitant to initiate and advocate for, in part due to misinformed legislative influences and moralistic, Victorian efforts that define such efforts as pornographic, obscene, deviant, offensive and therefore inappropriate for public funding; it certainly demonstrates where their priorities are, and they're not for saving gay men's lives--"dirty" words are perceived as more threatening and dangerous than risky sex). CDC Director Dr. James O. Mason feels that tax dollars can't be used to "eroticize homosexuality," according to AAPHR (American Association of Physicians for Human Rights) President Dr. Alvin Novick. Would educational material on another subject targeting hispanic or black youth be better written in Anglicized, academic writing styles, or in conversational Spanish or black dialect? Some "enlightened" physicians may recommend regular antibody testing (counseling and psychological health is seen as irrelevant) and maybe other lab work to determine the extent of infection. Exactly what is the psychological impact of people viewing themselves as "walking time bombs?"

4) We all can imagine the potential confidentiality and civil rights infractions that could result when people who really wanted to could gain access to confidential medical information. If teenage computer hackers can break into the Department of Defense's computers, think of the challenge of breaking into the "confidential" medical files of health departments to find out who's homosexual/antibody positive! Only Wisconsin and California have legislation designed to protect confidentiality, with stiff penalties for violations--for the time being. Insurance company lobbyists (with considerable financial resources and incentive) are diligently trying to overturn such legislation, in spite of the well intentioned and presently benevolent health department officials.

5) Need we speculate about the "unsafe" sexual activities (i.e., sharing of body secretions) engaged by sexual partners of HTLV-III antibody positive individuals? Will contact tracing be attempted for everyone who was named by an antibody positive person? Or just those that practiced "unsafe" sex with them?

6) Anonymity of sexual encounters, although discouraged by gay health providers and in safer sex guidelines, may be justifiable to one who fears being contacted by a public health officer and distrusts the health department's concept of confidentiality. And what about the guy who is known only by a first name "who lives somewhere on the east side and is a teacher or doctor but I can't remember the details except his car was red with a torn vinyl seat?"--this is the type of information that challenges and complicates the investigation of field workers.

7) Based on this information, I think it's clear that national proposals for contact tracing are designed to contact primarily white, middle class heterosexuals rather than to target educational programs to homosexually active men, adolescents, and minorities. The federal government's "public education" effort through Congressional appropriations to the CDC (earmarked for contact tracing by grants to state health departments) is an attempt to deceive the public into believing that the government is "doing something." Yet the primary strategy suggested will do little to help the largest percentages of people who are at risk for AIDS because attention and funds are being diverted away from

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CONTACT TRACING EDITORIAL, Continued

effective public education measures (albeit with explicit language) to a strategy supporting a more socially acceptable but ineffective and labor intensive methodology. The gay community once again is finding itself responsible for the education of its own community, with insignificant financial resources and expertise to adequately address the issue, especially in smaller states and communities.

8) What positive and constructive suggestions can replace contact tracing as a strategy for disease intervention? Contact tracing directed to heterosexuals within a small community may be an interesting demonstration project, however it is too labor intensive to be of much value in the long run. If the federal government is reluctant to fund educational materials or projects with explicit language, than redirect those funds to other agencies, such as the U.S. Conference of Mayors AIDS Program Advisory Board (who have already dispersed a meager few hundred thousand dollars, which have done incredibly creative, and exciting projects as previously reported in this Newsletter), or the Counsel of Governors (who have done nothing as a group yet). The federal government in the name of the President himself, should not be intimidated by misinformed groups and individuals, and be willing to support educational efforts directed to the gay community, even if the language used is not socially acceptable--they must remember that words do not kill, only diseases and hatred kill. What novel and innovative community education projects can be creatively financed by private enterprise to educate the gay community and the rest of the public about AIDS and as well as risk reduction/prevention, and just as importantly, to evaluate the effectiveness of these programs, and to tailor them to individual communities, including people of color and youth? (Abbott Laboratories has advertised the availability of a newly written brochure to combat AIDS hysteria.) What other ideas can you think of? Your comments about contact tracing as an intervention strategy are invited. Send to: NCGSTDS, PO Box 239, Milwaukee, WI 53201.

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MISSISSIPPI AIDS BENEFIT PERFORMERS ARRESTED FOR CROSS-DRESSING

edited by John Fall, with thanks to the New York Native, 12/16-22/85

Meridien, Mississippi police raided a local nightclub during an AIDS benefit and arrested four of the benefit's performers, who were charged with violating an ordinance which prohibits a person from dressing in clothes judged to be inappropriate to one's sex. Although Mayor Jimmy Kemp denied that "selective enforcement" of the clothing law had occurred, the head of Mississippi's American Civil Liberties Union disagreed, reports San Francisco's Bay Area Reporter. Police officers disrupted the event, held at Talk of the Town shortly after midnight. "It seems to me that this bar has been operating without disturbance for some time," said Hillary Chiz, "and why the Meridien police would choose to go in at a time when they were having a legitimate benefit, I don't know."

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PHILADELPHIA AIDS BENEFIT RAIDED

with thanks to Detroit's Cruise, 11/27/85

The Philadelphia Liquor Control Board raided an AIDS benefit 15 minutes after it started. The Philadelphia AIDS Task Force, which put the event on, thought they could give away free wine to anyone paying the ten dollar donation at the door. But the PLCB said they were selling liquor without a license.

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INDIANA MAY CLOSE GAY BUSINESSES

by Marcos Bisticas-Cocoves, with thanks to Boston's Gay Community News, 12/21/85

Indiana's state health director may close all of the state's gay bars, baths, bookstores, and movie houses in an attempt to halt the spread of AIDS, according to the Works. According to Mike Androvett of television station WISH in Indianapolis, Indiana Commissioner of Public Health Woodrow Myers met with Marion County Prosecutor Stephen Goldsmith and members of the Marion County Board of Health to discuss legal methods of closing all places in the county where gay men might congregate. It was later revealed that Myers' plan encompassed the entire state. Reports indicate that the commissioner reasons that if gay businesses close, gay men cannot meet, that if gay men cannot meet, they cannot have sex, and that if gay men cannot have sex, the AIDS epidemic will cease. Local gay and lesbian groups are mobilizing to fight the threat posed by the state. Justice, a statewide gay and lesbian organization, issued a statement November 16 opposing the closure of any gay and lesbian business, calling the intended action "a severely homophobic response to the AIDS issue" and not a means of preventing the disease. Sources in the state health department say that Myers will take some action on closure in mid-January.

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NGTF ISSUES NEW STATEMENT ON HTLV-III ANTIBODY TESTING

with thanks to NGTF's Task Force Report, 11/85

When the first test for HTLV-III antibodies was licensed by the FDA in March, 1985, there were many questions about its reliability and meaning. New data from experts at blood centers and alternative testing sites, where the tests have been utilized for the past several months, was presented at a recent meeting sponsored by the Public Health Service. Studies indicate that test procedures have been developed that make it possible to be more confident about the ability to detect antibodies in those who actually have them. However, test results are still of only limited value to individuals who wish to learn something definitive about their risk of developing AIDS. The antibody tests--ELISA and Western Blot--can at best test for the presence of antibody. These tests do not diagnose or predict AIDS; and, in their current state of development, it is not clear that these tests can reliably distinguish those who are harboring the live virus--and are therefore potentially infectious--from those who merely have antibody (which itself cannot cause disease). Some of the significant new information about HTLV-III antibody testing:

1) When a blood sample tests positive on repeated ELISA tests and when the result is confirmed by a Western Blot test (a more expensive and less readily available form of testing), one can be virtually certain that the results are accurate, that the individual tested has been exposed to [and infected with] the virus, and that the results do not represent "false positives." [NCGSTDS ED NOTE: Yet false positives exist and are explainable by several factors, such as pregnancy. What are the false positives rates, and some common explanations for them?]

2) One cannot yet be quite as confident that all the false negatives have been eliminated by this multiple test procedure. While one study indicated that it is not possible to detect actual live virus in any of the samples testing negative for antibody, suggesting that there had been no prior exposure to--or infection with HTLV-III in those persons, the possibility still exists that a negative test result might occasionally occur in individuals who had only recently been exposed and who had not yet developed significant levels of antibody.

3) While in one small-scale study the virus could be cultured in fully 60% of those who tested positive on the ELISA and Western Blot tests, the remaining 40% did not appear to be harboring live virus [ED NOTE: Not culturable is not equivalent to absence of virus.] This suggests that a positive test result from the antibody test(s) may not be equivalent to a positive test result for the live virus that is the primary cause of AIDS.

Regardless of test results, we underscore the importance of members of high risk groups continuing to follow prevention guidelines that have been put forward by AIDS service organizations, including the adoption of safer sex practices for those not in long-term monogamous relationships. The declining rates of certain sexually transmitted diseases among gay men in many cities demonstrate the success of these efforts. While these antibody tests are being used successfully to screen donations at blood banks, it is important to remember that for the time being, antibody screening is only an added measure to ensure the safety of the blood supply and is NOT a substitute for the donor deferral guidelines which recommend that those persons falling into high risk groups should refrain from donating blood at this time. This includes all males who have had sex with more than one male since 1977, and males whose male sex partners have had sex with more than one male since 1977. Though we do not feel that there is compelling reason to recommend that members of high risk groups be tested en masse, those who desire to learn their antibody status would be best advised to seek out testing under conditions that are totally confidential (and preferably anonymous), such as the alternative testing sites that nearly all the states have established for this purpose. These sites are prepared to provide counseling before and after the test. Individuals considering antibody testing should be aware of the fact that their test results may be requested or obtained by third parties. Before requesting a blood test under any circumstances, we urge individuals, particularly those in the gay community, to consider the following risks:

1) If a positive antibody test becomes part of your medical record, it could provide justification for denial of health, life, or disability insurance in the future. There are now clear indications that at least some insurance companies are indeed viewing a positive antibody test as grounds for refusing insurance to new applicants and limiting their liability for AIDS-related claims filed by those recently insured.

2) A positive antibody test could be used to deny employment. While lacking in medical justification, this test could provide a mechanism for screening out individuals who are at-risk to AIDS from jobs in such fields as health care, food handling, or child care. Given the proportionately higher level of exposure to the virus among gay men, we are concerned that potential employers may also use the test as a surrogate indicator for homosexuality.

3) Positive test results might in the future be reported to your state health department. Though mandatory reporting (such as is the case for syphilis) has not yet gone into effect in any state, and though New Jersey rejected such a proposal this past summer, more recently the Colorado Board of Health gave tentative approval to a measure that would require the reporting of the names and addresses of those who are antibody positive.

We continue to encourage members of the community to participate in research studies that might help find the answer to the AIDS riddle. However, we continue to urge--particularly in light of the risks outlined above--that participation in research be conditioned on strong guarantees of confidentiality for all research participants, including the commitment that identifiers not be shared with third parties. A test for HTLV-III antigen, that would be equivalent to testing for

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NGTF ISSUES NEW STATEMENT, Continued

the presence of live virus, is not being developed and may become available in 6 to 12 months. Though such a test will eliminate some of the ambiguity that still surrounds a positive test result for antibody, even a positive test for virus will not in itself be a diagnostic test for AIDS, which only develops in a small percentage of those infected with the virus.

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RED CROSS LAUNCHES NATIONAL EDUCATION EFFORT
by Rick Harding, with thanks to The Washington Blade, 11/15/85

The American National Red Cross confirmed that plans to begin television public service announcements this winter to educate viewers on how AIDS is transmitted and to dispel misinformation on the disease. The announcements, which are being produced in conjunction with the US Public Health Service, are the first step in a new major effort by the Red Cross to educate the general public on AIDS. The organization's national Board of Governors voted last month to expand its set of 12 corporate objectives to include the major AIDS education effort. Other established objectives already include providing disaster relief and maintaining the national blood supply. Carol Sussman, director of the organization's newly established AIDS Public Education Program, said the primary objective of the program is to provide factual, reliable information on AIDS and to "de-myth" the public's perception of the disease. Sussman said the Red Cross does not want to duplicate the work of other organizations, but feels it can play a major part in providing resources and referrals to the general public and in "cooling down" AIDS hysteria. The Red Cross generally will not target high risk groups, especially current efforts by other groups, especially gay organizations, are already adequate. But the general public's hysteria over AIDS, said Red Cross public relations manager Gene Jeffers, is not being adequately addressed, and Red Cross officials think their agency's widespread recognition and respect in "home town America" make it a natural choice for spearheading a major AIDS education effort. Jeffers said a project prerequisite will be to educate Red Cross workers and volunteers about AIDS and "get them up to speed" on current information about the disease. The group has consulted extensively with the CDC and PHS and will begin forwarding information to its nearly 3000 chapters nationwide soon. At the same time, said Jeffers, local Red Cross chapters will assess what AIDS resources are available in their communities and what assistance is needed from the Red Cross. Program workers at the national Red Cross offices will use information from the assessments to develop specific programs which they will then make available to local chapters. In addition to the public service announcements, programs under consideration include informational videotapes which could be used for community forums and local television programming, an hour-long documentary on AIDS to be aired over PBS and local television stations, and a variety of printed information. Jeffers said that if Red Cross chapters find that such a need exists, future services could include direct assistance for people with AIDS, such as help for homebound AIDS patients. Although the national office will develop standardized project materials, Sussman said, most of the work will be performed by individual chapters. So far, said Jeffers, response from the local chapters to the AIDS project has been "extremely positive." The Red Cross has not yet determined how much its new AIDS education project will cost, said Jeffers, but he said the organization has applied for grants from private corporations that have an interest in AIDS education, such as health, pharmaceutical, and insurance companies. Jeffers said the Red Cross' decision to make AIDS a major organizational focus stems from its commitment to address major health problems rather than any reaction to AIDS-related problems in maintaining the safety of the nation's blood supply. Jeffers said published reports of people's fear of contracting AIDS has led to a reduction in numbers of people wiling to donate blood are false. The blood supply is actually up by 3% over this time last year. Caitlin Ryan, former head of Whitman-Walker Clinic's AIDS programs, said she feels a national AIDS education effort by the Red Cross is "especially appropriate" because the group is "well integrated into the mainstream and can help in communities where there are no established AIDS services." For more information, contact: Susan Blake, Carol Sussman, or Dennis Zaenger (202/639-3112/3106).

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SLIM DISEASE IN UGANDA ASSOCIATED WITH HTLV-III INFECTION
abstracted from Serwadda, D., et al, The Lancet, 10/19/85, 849-52.

A new disease has recently been recognized in rural Uganda, and because the major symptoms are weight loss an diarrhea, it is known locally as "slim disease." It is strongly associated with HTLV-III infection (63 out of 71 people have antibody), and affects women nearly as frequently as men. The clinical features are similar to those of enteropathic AIDS as seen in neighboring Zaire, however the syndrome is rarely associated with Kaposi's sarcoma, although KS is endemic in this area of Uganda. Slim disease occurs predominantly in the heterosexually promiscuous population and there is no clear evidence to implicate other possible means of transmission, such as by insect vectors or re-used injection needles. Ritual scarification and blood letting practices are not a feature of the peoples of this region of Uganda.

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CALIFORNIA PLANNERS ADVOCATE CELIBACY TO PREVENT AIDS

by Ron Baker, with thanks to San Francisco's Bay Area Reporter, and the New York Native, 11/18-24/85

Recommendations of celibacy and a plan to divide Californians into HTLV-III antibody positive or negative categories are being seriously considered by the California State Department of Health Services, at the urging of a panel of physicians and state officials. At a meeting held October 5 in Los Angeles, a panel of ten physicians and state officials, most of whom are gay, outlined a series of recommendations in an eight-page memo that included calling for celibacy and strong advocacy of HTLV-III antibody testing to end "denial" by gay men about AIDS infection. Other education messages advocated by the group included, "We are losing the battle against AIDS," as well as a recommendation to drop the category of "possibly safe" sex acts. The proposals, part of a package of recommendations, will be publicly discussed at the first formal meeting of the California AIDS Strategy Commission, on November 7. The Commission's decisions will be forwarded to Governor George Duekmejian and the State Legislature in January, and are intended to serve as a model for other states and the federal government. Among the San Francisco Bay area members of the panel were San Francisco AIDS researcher Dr. Marcus Conant, San Francisco opinion researcher Larry Bye, California AIDS Advisory Committee Chairman Bruce Decker, and California State Assemblyman William Filente. Also attending the meeting were Dr. Neil Schram, past president of the American Association of Physicians for Human Rights, Stan Hadden, gay liaison in the office of California State Senate President David Roberti, and Dr. Robert Anderson, AIDS Section Chief of the State Department of Health Services. Reactions to the proposals were swift and sharply negative. As responses mounted, some members of the group insisted on terming their proposals a "starting point" rather than a final document. "These messages were really meant to serve as an outline for discussion," Hadden told the Bay Area Reporter. One factor participants said entered into their recommendations was the fear that unless gay men and other high risk individuals voluntarily submit to antibody testing, they may eventually be required to take the test. Bye said there was a clear sentiment among the group to "strongly push antibody testing among high-risk groups as a means of slowing disease transmission and forcing people to overcome denial."

"If you want to avoid AIDS or other sexually transmitted diseases, avoid sex," is one of the messages formulated by the group. Their proposal also calls for advising California residents to "be celibate" or to have safe sex with partners who are "antibody/virus negative." The plan offers no advice to California citizens on how they can be sure of their sexual partners' HTLV-III or viral status. Reaction to these and other messages in the plan by San Francisco AIDS experts and AIDS organizations has ranged from disbelief to anger. Dr. Donald Abrams, Assistant Director of the AIDS Clinic at San Francisco General Hospital told the Bay Area Reporter (BAR), "Such policies would create what the New York Times called `the new apartheid,' pitting antibody-negative individuals against those who are antibody-positive. Dr. James Dilley, project director of the University of California at San Francisco AIDS Health Project, called the celibacy message "awful." As a general community message, he said, "Celibacy won't fly. It will be viewed as anti-sex and anti-gay." Antibody negative individuals who won't practice safe sex should "find an uninfected partner," according to one of the recommendations. But trying to find an uninfected partner might turn into a "risky search," says Dr. Peter Goldblum of the UCSF AIDS Health Project. "Health d=educators cannot endorse this type of message as a strategy for effective AIDS prevention," Goldblum said. Tim Wolfred, director of the SF AIDS Foundation, said, "We're absolutely opposed to any policy that uses the antibody test to isolate gays, bisexuals, and members of other high-risk groups from the general population." The group's recommendations include telling individuals, "HTLV-III infection will have a profound, terrible impact on your life." According to Abrams, researchers don't really know what HTLV-III infection means. "Certainly it doesn't necessarily imply something `terrible' for every infected individual," said Abrams. "The Department of Health Services should beware of [putting out] doomsday predictions which may lead to resignation and futility," added Dilley.

Sam Puckett, a consultant to the San Francisco AIDS Foundation, told BAR the group's recommendations "reflect a lack of understanding on the part of the AIDS medical profession about what will or won't motivate people." In a letter to the AIDS Activity Office of the SF Dept. of Public Health, Puckett called the recommendations "amateurish, childish, and ineffective." Puckett said the recommended messages "prove the case that there must be `civilian control' of any medical information included in educational programs." The group's plan also proposes that the state develop a strategy for state and county surveillance of AIDS cases, AIDS-Related Complex cases, and antibody-positive individuals. Data on seropositive rates would not require personal identifiers, according to the memo. The group discussed the need for encouraging antibody testing among high-risk groups, especially gay and bisexual men. Questions arose of how such a test program could be implemented and how the information gained from the testing would be used. "Anonymous testing must continue," the memo urges, "with counseling for seropositives." The goal of an expanded HTLV-III antibody testing program is to "keep uninfected people uninfected." Moving ahead with the antibody test program "may divide the population into `positive' and `negative' camps," but such a program "could stimulate the push for vaccine development and anti-viral drug trials."

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COLORADO BECOMES FIRST STATE TO REGISTER ANTIBODY POSITIVE PERSONS

by Phil Nash, with thanks to The Washington Blade, 11/1/85

Colorado became the first state in the nation to keep a registry of names of persons who test positive for the HTLV-III antibody, October 30. By law, laboratories must report the sources of blood samples tested for antibodies to the AIDS virus. The registry will include names of all persons with positive results who have been tested at the state's 10 alternated test sites, at blood bank facilities, or through private health care providers. The list will include names, addresses, telephone numbers, and sexual orientation of persons who test positive as determined by the ELISA test and confirmed by the more specific Western blot. Dr. Thomas Vernon, executive director of the Colorado Dept. of Health, strongly advocated the reportability regulation over the objections of the American Civil Liberties Union, the Colorado AIDS Project, the director of Denver's largest blood bank, and Denver's top public health official. Vernon pleaded with the state health board to allow health officials "to tell an anxious public that we are doing what we know how to do" to stop AIDS. Vernon said that it is "most unfortunate" that AIDS thrives in a climate of social discrimination. But he pointed out that Colorado health officials have an untainted record in protecting confidentiality for gonorrhea, syphilis, and hepatitis B, infections also associated with gay men. But gay health advocates stress that making positive HTLV-III serology reportable would seriously impair the effectiveness of alternate site testing. They argued many gay men would decline to be tested if they knew their test results would be kept in a registry. Other health officials stated that in the absence of a treatment for the infection, keeping records of virus carriers is meaningless. The ACLU suggested that positive serology be reported by number, not by name. The Colorado AIDS Project, a gay community-based organization, now counsels persons who are concerned about confidentiality to seek the test using a false name. While health officials say they cannot condone such a practice, they will not ask for identification before administering the test. They warn that persons using false names should leave information on how they can be contacted later. Despite concerns among gay men about the health dept.'s stance, about 200 persons per week are being tested at the alternate test sites. These numbers remain constant in spite of heavy media coverage of the reportability regulation. Vernon is mounting a highly visible campaign to assure the gay community the the health department is taking exceptional measures to maintain its unblemished record of protecting the confidentiality of medical records. In addition to speaking before gay organizations and being interviewed by a local gay newspaper, he has also vigorously spoken out about two widely-reported incidents of discrimination against persons who have had positive HTLV-III test results. Both cases have involved sexually active male teenagers who were not publicly identified. The first reported incident involved the quarantine of a boy living in a Denver residential treatment center. He was isolated from the other residents, fed on disposable dishes, and his laundry was handled separately. Vernon and other health officials criticized the director of the facility for imposing inappropriate quarantine measures. The youth was allowed to resume normal activities when it was discovered that the ELISA test had been a false positive. The second incident involved a 17 year old male who was suspended from Denver Public Schools after confiding in a school counselor that his HTLV-III antibody test was positive. The news traveled quickly to Denver Public Schools Superintendent James Scamman, who removed the student from the classroom and offered to provide the youth home instruction. Scamman angered public health officials by requesting that the names of any additional students or employees who test positive for the HTLV-III antibody be reported to the school district. Vernon and both Denver daily newspapers rebuked Scamman's action. The school board has since stated that in the future such cases will be considered individually. Vernon reiterated that personal information will not be released to insurers, employers, family members, law enforcement agencies, or any federal agency requesting the information. "Given that we have 30 other tests including tests for measles, Colorado tick fever, syphilis, Rocky Mountain spotted fever--you name it--we decided there is no justification for doing less for AIDS as long as we guarantee the same level of confidentiality with HTLV-III reports," Vernon said. He had four reasons why he pushed for making antibody positive serologies reportable:

1) To assure that persons who are positive for antibody are adequately counseled by their health care providers, many of whom are not aware of the latest information about HTLV-III infection and AIDS;

2) To give seropositive persons immediate access to anti-viral therapies, should they become available;

3) To trace the progress of HTLV-III infection through groups at risk for AIDS and to determine whether any new demographic groups are at increased risk for exposure; and

4) To assure a wary public that everything that can be done to control the disease is being done.

Chances of right-wing political forces obtaining the HTLV-III records for the purpose of quarantining gay men or persons with a positive serology are "a flat out zero," Vernon stated emphatically. Vernon said he has talked with leaders of the Republican-dominated Colorado legislature, asking them to give no consideration to "ridiculous, stupid legislation that would drive underground the very people we need to work with."

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AFL-CIO PASSES AIDS RESOLUTION

by Rick Harding and Peg Byron, with thanks to The Washington Blade, 11/22/85

At its biennial convention in October, the AFL-CIO, a federation of 97 trade unions representing over 13 million workers, passed a resolution which opposes screening workers for AIDS, recommends educating union members about the epidemic, and urges pressure on the government to increase AIDS funding. The federation's executive council also passed a policy statement which decries discrimination by employers based on sexual orientation and urges the government to enact civil rights laws to protect gays and lesbians. The nearly 1000 delegates to the convention passed the AIDS resolution by acclamation. The resolution states that the AFL-CIO "oppose[s] screening workers for AIDS unless and until the Centers for Disease Control recommends such action." Included in the AFL-CIO's membership are about 4 million food service workers, some of whom recently have faced the threat of massive screenings. According to gay activist Bill Olwell, convention delegate and vice president of the United Food and Commercial Workers International Union, the AFL-CIO will, as prescribed by the resolution, work to educate workers through the use of union publications, films, and speeches about AIDS. AFL-CIO Information Director Murray Seeger said the group's 50 full time lobbyist would add to its list of lobbying objectives pressuring the government to increase AIDS funding and programs. In its policy statement, the AFL-CIO's 35 member executive council stated: "It is the responsibility of trade unions to guarantee that workers be judged on their work and not by irrelevant criteria of what they do in their private lives." It further stated that "the AFL-CIO protests any personnel actions taken against any worker merely on the basis of sexual orientation." The union is distributing a manual that contains the resolution and policy statement to all member unions, political parties, and other political organizations, Olwell said. [An excellent brochure was written by the AIDS Education Committee of Service Employees International Union (SEIU) Local 250, Hospital and Institutional Workers Union, 240 Golden Gate Av., San Francisco, CA 94102 (415/441-2500): "AIDS and the Health Care Worker--A Guide to the Problems and Needs of People With AIDS." Write them for a copy.]

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SAFER SEX PARTIES

A new, privately financed community education brochure on "How To Have A Hot J[ack] O[ff] Party In Your Own Home" was recently published by JO Buddies of San Francisco. The fully illustrated, explicit pamphlet describes in detail how to host a jack off party which "...can provide a secure, clean sex positive, loving environment...." The pamphlet suggests that a party be sponsored for raising money for your favorite community service group. It covers who to invite and who not to invite, and how to invite guests, specifying limits of sexual activities, what type of music, decor, and refreshments are suggested and what type of additional supplies may be needed. It also offers suggestion as to how to deal with inappropriate sexual behavior. For a copy of the publication, send $2.50 for a single copy, $15 for 10 copies (bulk discount rates for orders of 100 or more) to: JO Buddies, 1150 Bryand St., San Francisco, CA 94103. Also listed are similar organizations in Los Angeles, Chicago, Kansas City, New York, Cincinnati, metro Washington, and Salem (NH).

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BATH CHAIN DEMANDS SAFER SEX

with thanks to The Washington Blade, 12/6/85

The Independent Gay Health Clubs distributed directives to gay bath and health clubs across the country asking them to sign a pledge that they will "prohibit promiscuous, anonymous, unsafe sexual activity" in common areas. The directive was distributed to all of the approximately 150 gay baths and health clubs in the country with a warning that any of IGHC's 30 member clubs not signing the pledge will face automatic expulsion from the organization. John Lewis, co-owner of the Club Bath Chain which operates Washington, DC's only remaining gay bathhouse, said his club no longer has common areas and has been working with the city's Whitman-Walker Clinic to create a safer atmosphere within the club. Increased lighting, changed common areas, condoms provided at low cost, and safer sex literature are a few of the recommended changes. IGHC President Stan Berg said he is "disgusted" by unsafe conditions in a majority of the country's gay bathhouses and clubs and by a lack of willingness by the clubs to disseminate AIDS information.

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SAFER SEX VIDEO ENDORSED BY SF AIDS FOUNDATION

with thanks to Detroit's Cruise, 11/27/85

HIS Video, a division of VCA pictures, is releasing the very first major safer sex video in December, titled Life Guard. Officially endorsed by the San Francisco AIDS Foundation, Life Guard draws the line between risky behavior and truly safer sex. The video contains graphic scenes that demonstrate exactly what sexual acts are safe. Prominent male stars like Leo Ford and Rick Donovan (who came out of retirement to do this) lend their talents to these erotic and informative sequences. HIS Video has provided regional AIDS groups across the country with copies of the video at a reduced rate for fundraising. The tape is also available to the general consumer for $39.95, so the message of "playing it safe for fun" reaches a large number of people. As a bonus, a special safer sex brochure is included in every copy of the video.

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MR. SAFE SEX'S BOOK TO BE PUBLISHED
with thanks to Detroit's Cruise, 12/18/85

Jack Campbell, president of the Association of Club Body Centers, a chain of health clubs catering to gay men, has announced that former marine sergeant Glenn Swann's book, which eroticizes safer sex, will be published this winter by New American Library. Swann and noted gay author John Preston have collaborated on this seven vignette novel about Swann's sexual activities. Swann and Campbell will tour North America in the spring of '86 promoting not only safer sex and the book, but also a new film starring Swann. Fundraising will also be done for gay athletes planning to participate in the Gay Games, which will be held in San Francisco in August. The Club Body Centers are cosponsors of the games and are sending athletes to the events. Swann will enter several swim events. Swann will be attending the University of Miami's winter '86 semester, and will also be giving safer sex instruction at the Club Body Center Miami during that period. Men interested in learning about safer sex should contact him in Miami: Glenn Swann, 3025 Coral Way, Miami, FL 33145 (305/444-2576). Swann's latest film, "Discharged," will soon be filmed in San Diego.

COMMENTARY: THE MESSAGE TO GAY MEN ABOUT "SAFER SEX" AND ANTIBODY TESTING
by Bob Bolan, MD, with thanks to AAPHR NEWSLETTER, November, 1985

You've asked for my opinions on the need to strengthen the message to gay/bisexual men about safer sex and antibody testing. What follows are views from the bias of a clinician who sees the disease every day and can think of little else than stopping the transmission of this virus. From a public health standpoint I believe that any gay/bisexual man sexually active outside a monogamous relationship who is not consistently and rigidly following safe practices (preferably excluding saliva exchange as well) must be encouraged to be tested. Ideally this encouragement should be made in an atmosphere where short and long term counseling can be made available to persons with positive test results. Counseling is helpful both for emotional adjustment and for behavioral change assistance. We must abandon our reluctance to encourage testing in persons for whom a positive test may result in a significant adverse psychological effect. With antibody prevalence now being estimated at close to 50% of our community in San Francisco, we are fast reaching saturation kinetics and will lose our community if we do not abandon our timid approach to this antibody test. Legitimate issues like civil rights can create smokescreens and excuses for not being as fully informed about one's risks as possible. When acting as a personal physician our role is different from a public health advisor and our primary concern is for our patient. We may be inclined to counsel against testing because of the adverse effects we might fear or predict for that individual. I find it difficult to wear the two hats successfully and suspect that most of my colleagues also find it difficult. I believe a source of confusion in AIDS risk reduction messages may arise from failure to distinguish between these dual roles. Surely we have tried to balance the good of the individual with the good of the community and have tried to do the best job possible of telling what time it was in the community. In other words, we've always tried to divine what information would be most likely to be positively received and sensibly acted upon at any given time. I've always been uncomfortable with that and felt it was extremely paternalistic and very, very physician-typical behavior. But the time is late, long past that for tolerance of philosophical whimsy. This is not a virus with which we can bargain. It does not care for fine discussions on ethics, civil rights, or psychological distress. We have helped move the community but I think we're still a little slow in learning how to read the disease and tell the time. Every time we learn something new about the virus or the natural history of the disease it adds another dimension to our worst possible fears. There really is no excuse for optimism in the framing of our messages. The responsibility we have assumed is too great. It's time to stop having sex, any sex that can transmit this virus, period. No more denial, no more clouding the issues. Just no more "any risk sex." Our backs are to the wall. Three other points. People are listening to us. 90% of gay men surveyed can quote the risk reduction guidelines with 95% accuracy--complete with typographical errors. It takes time for information and messages to diffuse through the community and it probably takes even longer to correct misinformation, recommendations based on incomplete information or to change existing messages. The antibody testing vagarities are the best case in point. There are still thoughtful, intelligent people who believe that the currently used tests have a 20-40% false positive and false negative rate. These rumors circulated wildly in February (1985) before the tests were released and were finally laid to rest in April at the Atlanta meetings [the International AIDS Meeting]. I think the position "don't take the test" was erroneous, especially after the alternate test sites were secured. To hide from any information about this disease whether positive or negative, whether we think that the information will tell us anything or not is not going to serve us well. We must at all times know as much as we can about it and be willing to risk psychological distress for the safe of knowing our real enemy better. We have been able to deal effectively if not immediately with panic, repression, abrogation of personal rights in the public sector and are not going to allow an AIDS Dachau. We have not dealt effectively enough with our real enemies: personal denial and the AIDS virus. [AAPHR EDITORIAL NOTE: IF THE PREVALENCE OF "VIRUS-POSITIVE, ANTIBODY-NEGATIVE" INDIVIDUALS PROVES TO BE SIGNIFICANT, THE ABILITY OF SEROLOGIC SCREENING TO SEPARATE INFECTED FROM UNINFECTED PERSONS WILL BE COMPROMISED. IN THAT CASE, THE MESSAGE TO HIGH RISK GROUP MEMBERS, WHETHER SERO-POSITIVE OR NOT, WILL BE THE SAME--PRACTICE SAFE SEX ALL THE TIME. DR. BOLAN CONCURS WITH THIS INTERPRETATION.]

AIDS ACTION COUNCIL ANNOUNCES STAFF ADDITIONS

by Lou Chibbaro Jr., with thanks to The Washington Blade, 12/20/85

The AIDS Action Council, a national organization representing local AIDS service groups, has hired Washington health lobbyist Judy S. Wortman as its chief lobbyist for increased federal funding for AIDS research, the Council's Executive Director Gary MacDonald reported. From March, 1984 to her present appointment, Wortman, 45, worked as a lobbyist and manager for the American Institute of Biological Sciences, where she served as liaison to Congress and federal agencies for 35 scientific societies representing over 70,000 scientists. "We're absolutely delighted to have her on board," said MacDonald, who called Wortman a "highly experienced" lobbyist familiar with the Washington political scene. The AIDS Action Council (AAC), formerly called the Federation of AIDS Related Organizations (FARO), was created in 1983 by individuals associated with gay-oriented health clinics and AIDS service organizations. In addition to MacDonald and Wortman, the organization recently hired Miguel Gomez, former director of constituent services for the now defunct Gay Rights National Lobby, to serve as its coordinator of AIDS service groups. Congress approved and President Reagan signed an appropriations package for the Department of Health and Human Services that includes $234 million for AIDS programs for fiscal year 1986. The amount represents a major increase over the approximately $100 million allocated FY 1985. Congress is expected to approve between $6-10 million more for AIDS programs for the Food & Drug Administration in the Department of Agriculture. MacDonald noted that a combination of stepped up lobbying among national and local gay organizations, including AAC and the National Gay/Lesbian Task Force (NGLTF), and intense media coverage of the AIDS epidemic were probably most responsible for the increased funding.

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SAN FRANCISCO GETS AIDS DISCRIMINATION LAW

with thanks to The Washington Blade, 11/29/85

San Francisco Mayor Dianne Feinstein signed into law November 20 an ordinance prohibiting discrimination against people in San Francisco with AIDS or AIDS-related complex. The comprehensive law covers employment, housing, businesses, providers of goods and services, and private schools. It does not cover public schools, which are not under the city's jurisdiction. According to Dana Van Gorder, legislative assistant for Supervisor Harry Britt, who introduced the ordinance, it provides that a person who feels he or she is being discriminated against may either go before the city's Human Rights Commission or directly to court, and allows for the complainant to sue for attorney's fees and punitive damages. The city of Los Angeles passed the nation's first AIDS anti-discrimination ordinance in August. According to the Bay Area Reporter, the cities of Berkeley, Haywood, and Oakland are also considering such ordinances.

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FEDERAL LAW PROHIBITS AIDS DISCRIMINATION

edited by John Fall, with thanks to the New York Native, 11/18-24/85

Persons who have been denied employment, subjected to discrimination at work, or denied admission or services by any federally funded agency because they have (or are thought to have) AIDS may be protected by federal legislation prohibiting discrimination against the disabled. Section 504 of the Rehabilitation Act of 1973 (29 USC 794) provides wide-ranging protection of the rights of persons who are disabled or perceived as being disabled. The law applies to employees, applicants for employment, and service beneficiaries of federally funded agencies. Examples of agencies which are covered by Section 504 include hospitals, nursing homes and other health care facilities, state and county welfare facilities, state and county welfare departments, colleges and universities, public school districts, public housing authorities, etc. Complaints of discrimination on the basis of disability may be sent to the US Dept. of Health and Human Services, Office for Civil Rights (contact nearest federal government office to determine region address).

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FUNDING FREEZE FOR AIDS EDUCATION

with thanks to the Los Angeles Times Service, 12/4/85

Federal health officials, fearing a "backlash" from both the public and the White House, have instituted a freeze on AIDS educational grants nationwide until they can decide "what level of explicitness...is acceptable for US Public Health Service funded projects." Officials at the Centers for Disease Control confirmed that they have placed "on hold" eight AIDS "innovative risk reduction" proposals whose funding requests totaled more than $1.6 million. The proposals were sought by the agency as part of a campaign to halt the spread of AIDS, which is transmitted primarily through sexual contact. The materials, both written and audio-visual, presumably would instruct homosexually active men who are the majority at risk for AIDS in the U.S., on "safer" sex practices. "There was some concerns that there would be a backlash against the federal government funding "pornography," said Donald Berreth, a CDC spokesperson.

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ANTIBODY TEST POPULAR AMONG EUROPEAN GAYS
by Michael Helquist, with thanks to The Washington Blade, 12/6/85

During the recent international AIDS conference in Brussels, physicians and researchers from several European nations noted the widespread use of the HTLV-III/LAV antibody test among gay men in their countries. In contrast to the neutral or hostile positions taken by most U.S. gay organizations and AIDS service agencies, several European groups encourage the test, according to the physicians. In addition, individual men have apparently decided that it is best to know one's health status vis-a-vis exposure to the AIDS virus. As one man attending an AIDS forum in Paris remarked, "We simply want to know where we stand."

ONTARIO AIDS GROUP FINDS BETTER ATTITUDE IN NEW GOVERNMENT
by Ric Taylor, with thanks to The Body Politic, November, 1985

Ontario health minister Murray Elston announced Sept. 25 that his ministry would establish an Ontario AIDS Public Education Advisory Panel, which will spend $200,000 on getting information to the public and to groups at risk for AIDS. "Public education activities will include the production of information materials for physicians and other health care practitioners; speakers knowledgeable about the disease will be made available to concerned groups such as school boards and parent teacher associations; there will be a concerted effort to get factual, nonbiased information before the general public," said Elston in a prepared statement. Elston also announced a grant of $100,000 to the AIDS Committee of Toronto--less than half the amount ACT requested for the next year. ACT chairman Tom Alloway expressed "cautious optimism" over the announcement. "They've invented a new hoop for us to jump through by deciding to seek matching funds for ACT from the federal department has shown little interest to date in making such allocations. He added: "Funding ACT's operational budget is still not secure. Our projects will have to continue to depend for financing upon our vigorous fundraising campaign with the community, corporations and foundations." Alloway takes encouragement from an apparent change in attitude towards ACT by the Ontario government. "There seems now a complete willingness on their part to count on ACT's experience and on going work in public education and counseling. ACT can look forward to membership on the Ontario Provincial Advisory Committee on ACTS--something we've been seeking since its inception--and on the new public education advisory panel."

TELEPHONE SURVEY CONDUCTED BY HARRIS ON AIDS
by Bill Baumer, with thanks to the New York Native, 10/28-11/3/85

Some 42% of the adult population (who have telephones and do not object to answering telephone surveys, etc.) in this country are worried that someone close to them might have been exposed to AIDS, according to a recent Harris Poll survey. While only 40% of the respondents said they personally knew someone with AIDS, 12% expressed concern that a close family member might have been exposed to the disease. A substantial majority of those polled (81%) are convinced that it is "entirely possible" that AIDS "can spread widely through the non-homosexual part of the population," and it is not "by and large limited to the homosexual community." The growing level of concern among the population has not prompted calls for quarantine of AIDS patients or those in the high-risk groups; a majority of those surveyed believe that the federal government should increase funding for treatment, prevention, and finding a cure for AIDS. A majority (86%) are convinced that a cure for AIDS will be found "within the next few years," and a 74% majority believes that the federal government should "put up $5 billion for a crash research program to find ways of treating, curing, and preventing AIDS from spreading." When asked if AIDS patients "should be treated the way lepers were treated for a long time," a resounding 80% said no. An even larger percentage (87%) said hospitals in every community should accept AIDS patients and make sure they will obtain full medical care. Another large majority (80%) favors raising significant sums of money to educate the public on how to avoid "the risks of getting AIDS." When asked about the controversial HTLV-III/LAV blood antibody test, 71% of those responding said those who opt to take the test should be "guaranteed" that positive test results will not be passed on to others without their permission. The poll results show some confusion on how AIDS can be transmitted. Large majorities acknowledge that AIDS can be spread through "homosexual acts" (96%); "contaminated blood transfusions" (95.5%); "use of contaminated needles" (94%); and being "born a child of a parent with AIDS" (88%). Many respondents (53%) think AIDS can be transmitted by more casual forms of contact, and a slight majority (53%), think people can get AIDS "by living in the same house with an AIDS victim." Other findings about casual contact include: *45% agree that AIDS can be transmitted by "inhaling sneezes or coughs" of AIDS patients; *37% think "working side by side with someone with AIDS" can put them at risk; 35% said "being in the same hospital room with an AIDS patient can lead to transmittal; *33% agree that "going to a party where someone with AIDS is" can be a means of getting the disease; *31% think that AIDS can be contracted by "sitting in a classroom with an AIDS victim;" *31% are convinced that AIDS can be transmitted by "eating in the same restaurant where an AIDS victim is eating;" *30% say "breathing too close to an AIDS victim" will lead to the disease. The telephone poll was conducted between September 5-8, 1985, with a cross section of 1255 adults responding, with a margin of error ±3%. [Percentages rounded to nearest point.]

AT&T HELPS CRISISLINE

with thanks to The Washington Blade, 12/6/85

The AT & T Foundation, the philanthropic arm of American Telephone and Telegraph, awarded a grant of $10,000 to the Fund for Human Dignity's national toll-free gay/lesbian Crisisline. AT&T Foundation Vice President Charles Evans said the Foundation values both "the vital role the Fund plays in fostering public understanding of gay people, and the important service Crisisline provides in connection with the AIDS epidemic." According to Lance Ringel, executive director of the Fund, the Crisisline receives over 2000 calls per month from people across the country seeking information and referral on gay-related issues. The line costs about $53,000 per year to operate, Ringel said, adding that additional grants and private donations to fund the line are being sought. The Fund recently acquired the Crisisline from the National Gay Task Force, Ringel said, because NGTF was considering abolishing the service due to its own financial difficulties and because NGTF plans to soon shift its office to Washington, DC, from New York. The Fund was founded in 1974 as a nonprofit arm of NGTF with the purpose of educating the public about gays and lesbians.

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JEWISH UNION SUPPORTS INCREASED AIDS FUNDING

with thanks to The Washington Blade, 12/13/85

The Union of American Hebrew Congregations passed a resolution calling for increased governemnt AIDS funding and for an end to discrimination against people with AIDS, reports the Bay Area Reporter of San Francisco. The group, which is composed of over 750 Jewish congregations across the country, passed the resolution at its 58th general assembly and called on its congregations to educate their members about AIDS and to support community education efforts. In his opening remarks, Union President Rabbi Alexander Schindler said that AIDS has spawned a "secondary scourge" as deadly as the disease itself, a "wave of hysteria" with symptoms including "ostracism, prejudice, and violence."

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CHICAGO ARCHDIOCESE STUDIES ACTION AGAINST AIDS

edited by John Fall, with thanks to the New York Native, 12/23-29/85

Joseph Cardinal Bernardin will establish an Archidocesan Task Force to decide how the archdiocese should respond to the AIDS epidemic in Chicago. The committee will work on improving pastoral care of people with AIDS and their families. Obtaining housing and medical facilities for AIDS patients, as well as promoting public education about the syndrome, will also be concerns of the task force, reports Windy City Times.

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COMMUNION RITUAL TRANSFORMED IN RESPONSE TO AIDS IGNORANCE

edited by John Fall, with thanks to the New York Native, 12/2-8/85

National Cathedral, the mother church of the episcopal denomination in the U.S., offers its congregation members fearful of contracting AIDS a choice of ways of RECEIVING HOLY Communion. People may now drink communion wine from a common chalice, the traditional method, or may have the communion wafer dipped into a container of wine from which no one drinks. The newly introduced method is known as intinction. The intinction procedure was offered by the clergy when it noticed that fewer people than usual were accepting full sacrament because of fears of contracting AIDS. Despite reports from the CDC that no one has contracted AIDS from a common drinking vessel, two out of five communicants request intinction, Provost Charles Perry told William Hines of the Chicago Sun-Times.

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EVANGELIST BILLY GRAHAM NOT JUDGING THE "INTENTIONS OF THE LORD"

by Rick Harding, with thanks to The Washington Blade 12/20/85

The Reverend Billy Graham does not concur with the highly publicized opinions of some other religious leaders that AIDS is the wrath of God on gays. In response to a reporter's question, Graham said he believes no one is "in a position to judge the intentions of the Lord." The well-known television evangelist added that "AIDS is a dread disease that we all should be working together to eradicate." Graham met with DC Mayor Marion Barry to discuss preparations for a religious crusade to be held in Washington April 27 through May 4. According to a Graham media coordinator, Larry Ross, Graham will hold the crusade at the invitation of a coalition of over 400 area churches. Although no church with a predominantly gay congregation is participating with the crusade organizers, the Rev. Larry Uhrig, pastor of one of DC's two Metropolitan Community Churches, said he has "a great deal of respect for Graham" and "encourage[s] religious gay people to attend the crusade....I don't think gay people would feel at all uncomfortable" at the crusade, Uhrig said, adding that he has "never heard Graham attack homosexuality or gays." Graham made his most recent statement on the issue of homosexuality in November during a question and answer period following a lecture at Wheaton College in Illinois, Ross said. According to Ross, Graham told his audience at the college that we should "love people whoever they may be" and that we should not "pick out homosexuality" for criticism, but should instead concentrate on sins such as greed, jealousy, and lust. Crusade organizers say Graham will be in town on a number of occasions over the next several months to plan for the crusade, which is expected to draw over 20,000 people on each of its eight nights.

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ISRAEL MOVES ON AIDS

with thanks to the Wisconsin Jewish Chronicle, 12/27/85

Guidelines to help stop the spread of AIDS in Israel have been drawn up by the director general of the Health Ministry in conjunction with experts from around the country and representatives of the Finance Ministry. From now on, all blood donations will be routinely checked for antibodies to the AIDS virus, either at the central blood bank or at individual hospitals. Any suspicious blood will be destroyed, except for a small sample which will be tested twice more. One final verification of the presence of the AIDS virus in the blood sample, the donor will be called into the district office and given medical guidance. The Health Ministry also plans to give the police and the school medical services guidance on how to handle suspected people with AIDS, most of whom are homosexuals.

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CHINA TO SCREEN FOREIGNERS FOR AIDS

edited by John Fall, with thanks to the New York Native, 11/25-12/1/85

China will monitor tourists, foreign students, and Chinese tour guides, and also test blood samples in an attempt keep out of the nation. Rapid AIDS diagnostic units will be used to identify suspicious illnesses and to quickly trace the contacts of any person found to have the syndrome, the official Chinese News Service said, according to Rueter The news article said no Chinese citizens have yet been diagnosed with AIDS.

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NEW JERSEY FOUNDATION RECEIVES AIDS GRANT

edited by John A. Fall, with thanks to the New York Native, 11/4-10/85

The Hyacinth Foundation, Inc., has received the first grant in the state of New Jersey to develop support services for people with AIDS, AIDS-related complex, and their lovers, friends, and families. Hyacinth Foundation is the non-profit branch of the Institute for Personal Growth, Inc., the largest gay, lesbian, and bisexual counseling center in the state. The grant will be administered by Dr. Margaret Nichols, executive director of both Hyacinth and PGI, and Dr. Lee Katoff, an AIDS expert with experience with both the Atlanta AIDS Project and the New York Gay Men's Health Crisis. Nichols and Katoff are currently developing four major projects through this grant:

1) Together with the Middlesex County AIDS Support Network, Hyacinth will offer a comprehensive system of support services, and individuals and family counseling in the Central New Jersey area.

2) Also with the Middlesex County AIDS Support Network, a training program will be offered to interested volunteers in Central New Jersey.

3) Hyacinth will sponsor a Gay Men's Health Crisis "AIDS Forum" in Northern New Jersey, a major educational seminar aimed at health care workers.

4) Hyacinth will network with other grassroots efforts throughout the state, such as those in Jersey City and Atlantic City.

For further information, contact Drs. Nichols or Katoff, 201/246-8439.

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BOSTON'S AIDS ACTION COMMITTEE OFFERS P-R KIT FROM RECENT $100,000 FUNDRAISER

In response to numerous calls and inquiries about a recent fundraiser that netted $100,000 for Boston's AIDS Action Committee, a public relations kit has been developed that describes what the event was and how it was perceived in the community. In brief: AAC interested two top area radio stations in doing something about AIDS, and they agreed to cooperate with one another, putting aside all competitive rivalry for the event, which was a noteworthy accomplishment all by itself! Each station went after a star entertainer, and some of the rock groups, local people and businesses vendors, and advertisers were asked to be co-sponsors and offered their assistance. The event was pulled together in an amazing 6 weeks, thanks to an enthusiastic committee of 8 people, who devoted about 20 hours a week apiece, for this time. Cyndi Lauper and Dionne Warwick, two of the featured entertainers, capitalized on the energy of the audience which was estimated to be comprised of about 40% gay/lesbian, and 60% straight, and made appropriate references about AIDS research and services. Less than $5000 was spent to stage the event, and no complementary tickets were offered which eliminated those in the entertainment industry seeking freebies. Entertainers were neither paid for their services, nor for their room, board, or travel. The record industry picked up those expenses, and local hotels donated much of the lodging. This was the second large event that netted over $100,000 this autumn. The first fundraiser was the Artcetera '85 art auction, and also demonstrated a good mix of gay and straight sponsors and participants, which included the entire Congressional delegation sign on as sponsors, and the governor and mayor serving as guest auctioneers. AAC is interested in hearing about your projects, resources, victories, and successes. Please write: Larry Kessler Executive Director, AAC, 661 Boylston Street, Boston, MA 02116, 617/437-6200/536-7733.

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BALTIMORE MINORITY TASK FORCE CONFERENCE

by Thomas Frasier, with thanks to The Baltimore Gay Paper, 12/85

The conference held Friday, October 18, at the Baltimore Convention Center on AIDS in the black community should have finally made one thing very clear, that AIDS is not just a homosexual problem, it is a sexually transmitted disease that respects no social, sexual, or racial distinction.

While the conference was well attended, it appeared to attract mainly social and health care professionals. Approximately one-quarter those attending were white and in spite of prominent black leaders scheduled to speak—Maryland's Congressman Parren Mitchell, Congressman Louis Stokes of Ohio, the Superintendant of the Baltimore Public Schools Alice Pinderhughs, and the very dynamic Hilda Ford, Personnel Director of the Baltimore City Civil Service Commission to address the *issues of AIDS*—representatives from the NAACP, the Urban League, the leaders of the black religious community were conspicuously absent. As Eddie King from HERO pointed out during lunch, "There are a lot of people not here who should be."

It would seem that local black leaders still see AIDS as a Gay disease primarily affecting white Gays and not as a threat to the black community. The presentations made at this conference made it quite clear that both assumptions are false. It seems also that there is a reluctance on the part of established black organizations to admit to a Gay/Lesbian presence in their midst, or if they do, then a reluctance to attend for fear that their presence would be seen as giving their approval to Gay/Lesbian lifestyles.

The medical statistics show that blacks, which comprise 22% of the population of Maryland, constitute 64% of the AIDS cases reported in the state. While males account for 91% of the cases and females 9% in the state, most women with AIDS in Maryland are black, and the 2 pediatric cases here are children of black women. While among whites the majority (63%) of AIDS cases in the state, are among Gay males, it is not true in the black community where the majority of the cases are almost equally divided between male homosexuals (31%), bisexual males (25%), and heterosexual I.V. drug users (22%) which includes both men and women.

It was pointed out by Dr. John Maupin, deputy commissioner of the Baltimore City Health Department and a member of the Minority Task Force of HERO, that Baltimore City teenagers *are* sexually active. The proof is in the statistics for gonorrhea in Baltimore for this age group, which is 384% above the national average! There are 300,000 I.V. drug abusers in the city, and city teenagers come in contact with them *and* use drugs themselves.

Since AIDS is spread primarily through sexual contact and I.V. drug use, AIDS introduced into this teenage population will spread just as it has under similar circumstances in the Gay/Lesbian community. Since 60% of Baltimore's teenage population is black, AIDS *is* a problem in the black community.

The black community could benefit from the Gay community's example in its fight against AIDS by keeping informed about the disease and its transmission and the dissemination of "safe sex" standards to control its spread.

Hilda Ford, Mayor Schaefer's liaison to the Gay and Lesbian community, pointed out the fear about AIDS which pervades the whole issue. She asserted that "We must change what we can change, or we will be defeated by this fear. We must convert irrational fear into a catalyst for responsible action. There are actions we can take *now*." She pointed out the need for providing the black community with programs to disseminate information on AIDS. She related an anecdote in which she saw a look of shock come over a person's face when she told them that she was speaking at this conference, she replied to that look by saying, "I didn't say I *had* AIDS, I'm only going to speak about it!"

Ms. Ford pointed out that people who speak out against homophobia and against AIDS are often labeled Gay. Every non-Gay or Lesbian at the conference was certainly aware of this problem, and this was undoubtedly a factor for some in determining whether to come to this conference. To establish programs and spread information requires leadership, Ms. Ford said, and those leaders need to be supported and protected. Ms. Ford recalled her own experiences in the days of the Civil Rights Movement when people who spoke out for racial equality were labeled communists and how so many people were more afraid of being called that than they were of racism. "We must talk about AIDS," she said. "It is not popular. You will get in arguments because of the stupid things (you will) hear."

She said in her closing remarks that the black community is late in recognizing the problem of AIDS and its effects. Dr. Bernard Branson made it clear that the disease has gone unrecognized and unchecked. Evidence of this is the fact that 80% of the recent cases in Maryland have been black.

Dr. Branson went on to say that while only 1 in 10 who are exposed to the disease actually contract it, it is not only the identified AIDS patient who is infectious, but also those who have been exposed who also carry and transmit it.

AIDS did not exist before 1974. "It first appeared in Uganda and came to the USA in 1978. Since then it has spread rapidly," Branson said. "No one knows why it showed up." Three-quarters of the cases in the black community have spread through heterosexual contact. Most Blacks consider themselves safe if they avoid "effeminate" men, which is a serious mistake. According to Dr. Branson, "Not many men in the black community (who have occasional homosexual contact) consider themselves Gay; their heterosexual partners are at risk, and may not know it."

Perhaps the most moving part of the conference was a young black man with AIDS who spoke in the morning session of the conference. As a businessman, he is not a derelict, but a viable member of Maryland's upwardly mobile middle-class black community. He accused the black clergy of moralizing when they should be out there doing something about the problems facing the black community.

The black clergy that *were* at the conference are evidently *not* typical of the attitudes of many of their colleagues; which is unfortunate, for as Congressman Stokes of Ohio pointed out in his luncheon speech, "The black church has a special (leadership) role in the black community." He went on to say that the black clergy have had a crucial role in the fight against disease in the black community, like hypertension and cancer and their leadership is needed to fight the war against AIDS.

This conference was organized by HERO's Minority Task Force. It takes great courage for members of the black community to face the problem of AIDS in their community. It is a divisive issue and not very different from the problems Gays/Lesbians have in accepting our own great diversity as we too go about our quest for social acceptance.

It is not easy for the black community to claim issues as their issues which do not add luster to their self-image. It is not easy for them to deal with the destructive influence of drug abuse and sexual irresponsibility, but before you can come to terms with a problem you must identify it—regardless how uncomfortable that may be, or whose feathers get ruffled in the process.

There is a killer in our midst and its victims do not even know they are being killed until it is too late. Sex is not something most people like to talk about. You only hear what they feel comfortable telling you, which is not necessarily the same as telling what they really do. There is "safe sex" and there is "bad sex," the difference between the two is not in the fact that people are "good" or "bad," but in the difference between ignorance and education, between being sexually frustrated by that ignorance and acknowledging the sexual dimension of the human condition and guiding it into responsible activity, activity where one is able to care for the well-being of one's partner and to respect one's self and what one is.

As was pointed out several times at this conference, most black Gays and Lesbians do not leave the black community to become part of the Gay/Lesbian community the way a great many Whites do. What we must realize is that the Gay/Lesbian community is a relatively new phenomenon for everyone.

A new-comer to Baltimore, like myself, has little to lose by identifying with the Gay/Lesbian community, but to many native Baltimoreans the potential loss of respect from their families and employers is a major consideration. Black *or* white. The problem is not only to accept themselves, but then to be accepted for what they are by those with whom they are close. The black community in Baltimore is only one such community facing this problem, a problem exacerbated by the intrusion of the AIDS crisis.

The black and Gay/Lesbian community have a great deal in common. And for the black Gay or Lesbian the pain and anger is even further compounded and not just because of AIDS. It goes much deeper than that. When one is a member of one minority as I was, sitting in a conference of another minority, I was aware that while I was a member of a racial majority which made that a minority, my own status as a Gay man made me just as much a minority in that majority as their race did to them. Our differences from that majority seemed to make us more alike, our goals and dreams remarkably similar. It would seem that we could learn a great deal from each other's solutions. And, if this conference is any indication, it seems that we might even consider working together for our own, our mutual and each other's benefit.

BOSTON QUARANTINE PROPOSAL WITHDRAWN, BUT "ISOLATION" BILLS STILL ALIVE

by Kim Westheimer, with thanks to Boston's Gay Community News, 12/28-1/4/86

BOSTON — A proposal to isolate people with AIDS and require mandatory HTLV-III testing for public service employees was withdrawn from the Boston City Council floor on December 18, by its sponsor, City Councillor Albert "Dapper" O'Neil, before the vote took place. Boston's lesbian and gay community, concerned that the bill may be re-introduced, is joining communities in other states that are fighting quarantine measures.

O'Neil's bill called for mandatory testing of food handlers, people in "service occupations (barbers, eye doctors)," and elementary and secondary school teachers. It would require the firing of all such employees who test positive for the HTLV-III virus antibodies, as well as for the establishment of "AIDS research institutes," places where "patients can be treated in isolation." Public health officials would be given the power to determine whether compulsory quarantine measures could be used to place people in these "institutes."

The entire proposal is identical to "A Memorial Bill to Stop AIDS," published by Lyndon LaRouche's National Democratic Policy Committee. It includes vintage LaRouche rhetoric such as, "The usurious interest rate policies of Federal Reserve Chairman Paul Volcker, coupled with the 'Big MAC'-style austerity programs have ravaged the sanitation and medical infrastructure of urban America, making the nation vulnerable to these kinds of epidemics [such as AIDS]." Despite such jargon, and despite the Massachusetts Department of Public Health's consistent assertion that people with AIDS in this state will not be quarantined, activists took the bill seriously, viewing it as part if a nation-wide trend to isolate people with AIDS and to foster homophobia and irrational fears of contracting the disease.

News of the bill reached the office of Boston's gay city councillor, David Scondras, around 4:00 p.m. on the day before a vote on the measure was to take place. Members of the lesbian and gay community were alerted, and within the hour, at least five organization's phone trees were in motion to fill the council chambers for the following day's session.

"People were outraged and horrified," said Sarah Holmes of the Gay and Lesbian Defense Committee, who worked to activate the committee's phone tree. "Response was quick and good."

"Councillors' phones were off the hook with people protesting the measure," said French Wall, an aide to Scondras. "It was very clear very early on that he [O'Neil] was completely alone on this."

Wall surmised that obvious lack of support for the measure influenced O'Neil's decision to withdraw the proposal. Referring to a controversial vote on a condominium conversion bill that was also to take place that session, Wall pointed to another reason why O'Neil may have changed his mind. "He [O'Neil] knew that the condo bill would grab a lot of publicity. His timing was off. He'll do it [introduce the bill] when he can yell and scream more." O'Neil could not be reached for comment on his bill.

Four lesbians and gay men who attempted to make an appointment to talk to O'Neil can attest to O'Neil's ability to yell and scream. Upon entering "Dapper's" office with a sign saying, "Cut the Crap Dap — Quarantine AIDS ignorance, not people with AIDS," they were met by O'Neil "throwing a temper tantrum," said Holmes. He ordered them out of his office and threatened to call security, while a secretary who works for O'Neil expressed surprise that so many lesbians and gay men appeared at City Hall on such short notice.

Proposals to quarantine people with AIDS have also surfaced in other parts of the country. In Connecticut, the House and Senate passed a bill in May of 1983 (See *GCN*, Vol. 11, No. 45) revising the state's quarantine law. The revised law, signed by the state's governor, William O'Neill, gave local boards of health the authority to confine a person with AIDS who poses "a substantial threat to public health." This bill was introduced after wide publicity about an alleged woman prostitute with AIDS. According to William Olds of the Connecticut American Civil Liberties Union (ACLU), the bill has not yet been utilized.

In Delray, Beach, Fla., a 20-year-old Black woman, Lydia Munoz, was put under "house arrest" after having been diagnosed with AIDS and charged with prostitution. She must wear an electronic beeper which goes off if she goes more than two hundred feet away from her home.

Elsewhere in Florida, according to Michael Billhymer, administrative assistant to the Health Crisis Network, judges in Dade and Broward Counties are deciding, on a case-by-case basis, whether or not to quarantine people with AIDS who are in prison. Some people with AIDS are being put in isolation within the prison system. Billhymer told *GCN* that, on December 18, a Florida judge offered a number of women who were arrested for prostitution reduced sentences if they agreed to be tested for gonorrhea, syphilis, herpes, and the HTLV-III virus. The judge did not say what would happen if they tested positive.

The commissioner of the Texas Department of Public Health is proposing that the commissioner of health, or the designee of the commissioner of health, be able to institute quarantine measures for people with AIDS. In his proposal, local health authorities would also be given a good deal of power to decide who could be quarantined. "We don't know under the proposed rule, if they would go and pick up someone and say they are a public threat just because they have AIDS," said Glen Maxey of the Lesbian/Gay Rights Advocates in Austin, Texas.

Most states do not need to develop new quarantine laws in order to put people with AIDS under quarantine, according to Jeff Levi of the National Gay Task Force. "Almost every health commissioner has the ability to quarantine anyone who is considered a threat to the public health," Levi said. "Quarantine is not a practical solution to the problem," he continued. "It would force people underground. Why would you want to get diagnosed? It would undermine all the other public health measures that are appropriate when dealing with this disease."

ATLANTA'S HEART STRINGS UNITES COMMUNITY FOR FUNDRAISER

"Heart Strings--An Evening of Hope for the Healing of AIDS," will be the most important fundraising event of the year in Atlanta, as it addresses the most pressing health problem we face on February 23, 1986. The event promises to rally the spirit and unity of Atlanta--to literally pull at its heartstrings, and at the same time will raise both awareness of this fatal and misunderstood disease, and the critical funds needed to seek solutions to its end. Heart Strings plans to involve every faction of the city in a premiere event at the city's Fox Theatre, and will be a major musical production involving more than 500 singers, dancers, and musicians. Initiated by DIFFA (Design and Interior Furnishings Foundation for AIDS), Heart Strings will involve the efforts of may established organizations in the city, making it the first AIDS benefit in the nation to pool the resources of all of its citizens. For more information, contact: DIFFA/Heart Strings, 1012 Crescent Av., Atlanta, GA 30309, 404/873-5677.

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WHITMAN-WALKER RECEIVES MONEY FROM ALUMNI, CHANGES NAME OF AIDS PROJECT

with thanks to The Washington Blade, 11/15/85

Washington, DC's Whitman-Walker Clinic has announced it has changed the name of the AIDS Education Fund to the Whitman-Walker Clinic AIDS Program. This was done in order to consolidate all four of the major AIDS projects of the Clinic into one program so that they could be more easily coordinated by the steering committee. The four major projects consolidated under the new name include: AIDS Services (providing buddies, support groups, etc.); AIDS Foundation (giving financial assistance to people with AIDS); AIDS Evaluation Unit/HTLV-III Antibody Testing Project; and the Schwartz/Engebretsen Housing Services. Whitman-Walker Clinic also has specialized programs addressing men's STDs, alcoholism & substance abuse, a women's rap group, counseling, and a hotline. The new AIDS program was recently presented with almost $8000 by Yale University Gay and Lesbian Alumni (GALA) after the group held a gay alumni cocktail party attended by 200 people at a private home. Yale GALA announced that it would be holding a question and answer session at a later get-together on How to Form Your Own Gay and Lesbian Alumni Group. Representatives of schools planning to attend include Berkeley, George Washington, Stanford, University of Virginia, Julliard, Duke, and Brown. For additional information, call 202/354-2596.

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ART AUCTION FOR NEW YORK'S GAY MEN'S HEALTH CRISIS

edited by John A. Fall with thanks to the New York Native, 11/11-17/85

Leading U.S. artists and art dealers have joined together in the fight against AIDS, donating works of art to the Gay Men's Health Crisis Art Auction, November 20. Three hundred works of art have been donated including pieces by Pablo Picasso, Willem de Kooning, Louise Nevelson, Robert Rauschenberg, up-and-coming artists Keith Haring and Jean-Michel Basquiat, Piero Dorazio, Anthony Caro, and David Hockney. All mediums will be represented (painting, lithographs, drawings, prints, sculpture, etc.). "The cooperation from artists and dealers has been extraordinary," said Nathan K. Kolodner, benefit auction chairman. "The response has been one of caring and support, and the quality of the pieces they have donated demonstrates their concern in helping GMHC continue their important work." Dealers from Chicago, San Francisco, Houston, and London, as well as from New York, have contributed works from their best artists. "Weare very gratified by the overwhelming response from the art community with the works they have donated, " says Richard Dunne, executive director of GMHC. "This important event will raise much needed funds to benefit our work in providing services to AIDS patients and education to the community."

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FUNDRAISING/INFORMATIONAL OPPORTUNITY OFFERED BY AIDS PROJECT LOS ANGELES WITH "976-FUND" LINE

AIDS Project/Los Angeles kicks off the holiday season with the establishment of "976-FUND, a fundraising phone line that will also give callers one-minute of current information about pertinent AIDS issues. At the end of the informational message, callers will be referred to 800/922-AIDS in case they require additional information. The 976-FUND line was provided by Intercambio, Inc., a provider of 976 phone services in California. The line can take up to 24 calls a minute, 24 hours a day, seven days a week. The caller is automatically charged $2 per phone call on their phone bill. Out of this $2, $0.50 will go directly to Pacific Bell for the service. Out of the $1.50 gross revenue it receives per phone call, Intercambio will retain $0.50 to cover operational expenses only, donating $1.00 per call directly to AIDS Project/Los Angeles (APLA). APLA was founded in 1982 and is one of the leading organizations dealing with AIDS education and services in the country. Monies donated to APLA help finance the following programs: professional psychological counseling, advocacy for public assistance, food services, necessities of life program, shelter, in-home assistance (Buddy Program), day-care, dental care, transportation, insurance information and advocacy, financial information, legal assistance, religious and spiritual counseling, recreational and socialization activities, personal grooming care, workplace availability, and educational services (including printed materials, hotlines, and speakers bureaus). For additional information, contact: Hope Boonshaft-Lewis or Jane Summer (213/553-1438), or APLA, 7362 Santa Monica Blvd., West Hollywood, CA 90046 (213/876-8951).

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BOSTON ROCKS AGAINST AIDS

with thanks to Boston's Gay Community News, 12/21/85

Dionne Warwick and Cyndi Lauper demonstrate a touch of sisterhood and a determination to raise support for their brothers and sisters affected by AIDS, by joining Boston's AIDS Action Committee Executive Director Larry Kessler and WBCN-FM disc jockey and Boston Against AIDS organizer Charles Laquidara at a press conference before the Boston Against AIDS concert held December 4th. Two thousand people paid $50 each to squeeze into the Metro Dance Club, raising $100,000 for the AIDS Action Committee and the AIDS Research Unit of Massachusetts General Hospital. In reference to the organizers' lack of experience with AIDS work, and apparently with the gay and lesbian community as well, AAC fundraising committee chairperson Harry Collings told the Boston Globe, "What struck me was how much they wanted to learn about the [AIDS] issue. That was great. Because of who they were, we knew they would be reaching out to the general population in incredible numbers, people we couldn't reach." The event drew a crowd mixed in terms of sexuality, gender, and race, and was perhaps the first AIDS fundraising event to include a number of sports celebrities among its sponsors.

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"WHITE PARTY" DRAWS 2700, RAISES $43,000 FOR AIDS RESEARCH

by Gerald Lebonati, with thanks to the New York Native, 12/23-39/85

Miami's event of the season was the "White Party," held December 1 at the Vizcaya Palace and museum, and sponsored by the Health Crisis Network (HCN) to benefit AIDS research, the gala was attended by over 2700 people and grossed more than $43,000. Men and women in white paid $15 apiece to dance beneath the full moon or socialize among the lighted walkways, bridges, theater gardens, grottoes, long vistas, French parterres, 17th century sculptures, fountains, and carved stone peacocks of the 30-acre estate. Some arrived by yacht, most by land. More than a few people said they felt transported back to the fantasy land of the Gatsby era and a time when life seemed frivolous and simple. "The whole point of the party," said Sally Dodds, executive director for Health Crisis Network, "was to promote community awareness. The theme was one of exploring more satisfactory interpersonal relationships and encouraging people toward safer lifestyles. As a community, Dade County is recognizing that, indeed, we do have a problem. We are where New York and San Francisco were two years ago." Broadway and television star Nell Carter made a surprise appearance and receiving an overwhelming response from the audience, who would not let her go without a song. She relented and sang an a cappella version of a ballad by Bob Dylan. The mansion, now county owned, receives 300,000 visitors a year. It was built by the late James Deering with his artist-partner Paul Chalfin, who eventually masterminded the development of Vizcaya. Together, Deering and Chalfin traveled in Europe, buying objects d'art, antique furniture, rugs, and entire rooms from ceiling to floor to be reassembled and fitted into Vizcaya. Although the music stopped at 11 pm at the waterfront mansion, dancing continued at a nearby disco, with the profits and all liquor revenues from the party going to HCN.

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CUT-A-THON FOR CLINIC

by Doug Hinckle with thanks to The Washington Blade, 11/1/85

Need a hair cut? The Action to Stop AIDS Project (ASAP) will be sponsoring a hair cut-a-thon to raise money for the proposed Ray Engebretsen House for people with AIDS in Washington, DC, November 10. Twenty-five of DC's top hair designers will be on hand to cut hair for a donation of $10 or more to the Whitman-Walker Clinic. ASAP Co-chairs Dennis Loftis and Gabriel Clark say that at least one stylist from most of the major salons in the area will be on hand.

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AID FOR AIDS CONCERT PLANNED

with thanks to GNIC and Wisconsin InStep, 12/19/85

A concert to benefit AIDS, patterned after the Live Aid Concert for African famine victims, has been tentatively scheduled for March 22 at the Tampa (Florida) Stadium, said its California promoter and a city official. "Musicon '86: The Aid for AIDS Concert" is expected to raise between $15-50 million for the International AIDS Foundation, said Steven Ostrow, president of RJO Entertainment, who also said he hopes for a worldwide television audience. "Through the performers, celebrities, and dignitaries involved, we hope to increase the public awareness of the disease on a worldwide level," Ostrow said. He hopes to sign 30 top performers for the concert, with a contract signed by January 6, according to Rick Nafe, executive director of the Tampa Sports Authority, and added that RJO is negotiating for cable and network television coverage. Although originally scheduled for Los Angeles, it was moved to Florida because of better weather and because the Tampa Stadium is wired for broadcasting such events as the Super Bowl, Nafe said. Only two concerts have been held at the stadium since a riot in 1977. The announcement for the AIDS show came days after Rod Stewart performed there before 32,000 people, the first concert at the stadium in about five years.

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BENEFITS FOR AIDS IN PENNSYLVANIA, NEW YORK, NEW JERSEY, MAINE

edited by John A. Fall, with thanks to the New York Native, 10/28-11/3/85

Local gay business owners are planning a concert to raise money for Philadelphia Community Health Alternatives, the parent agency of the Philadelphia AIDS Task Force (PATF). The event, titled Friends for Life, will take place in December, and organizers hope to raise at least $200,000. Friends for Life organizers plan to ask music performers from Philadelphia to volunteer for the concert. The Hooters, a rock group from the area, has already agreed to perform, according to concert production supervisor Giovani Vitacolonna. Hall and Oates, Arethra Franklin, and Teddy Pendergrass will be among the other performers asked to appear, reports Frank Broderick in Au Courant. PATF president Nick Ifft, MD, requested the money raised by the concert be allocated first to preventive educational efforts. Ifft asked for the remaining money to be used for support services for PWAs and for establishing housing for AIDS patients.

John Calvi will perform at a benefit concert for the AIDS Council of Northwestern New York, November 1. A gay singer and songwriter, Calvi is also a massage therapist, who has developed "Soft Touch," a therapeutic massage program for people with AIDS. For more information, contact ACNENY (518/434-4686).

The rock group Turning Point will donate the proceeds of their forthcoming album to AIDS research. The four-member band became interested in the AIDS epidemic when one of them read the cover story on the syndrome in Life magazine earlier this year, reports Kurt Praschak of Wayne Today. "Hey, that article amazed me," said lead vocalist Bob Opperman. "You can feed the hungry, you can shelter the people--but AIDS, man, it's the biggest problem to which there's no solution." The band initially had trouble finding a record company to produce their album. Support for the project eventually came from Broccoli Rabe Entertainment, the company now producing the album. "The younger generation is really influence by rock 'n' roll," said drummer John Pellegrino. "Maybe our efforts can make them more aware of this terrible problem."

Our Paper, Portland's (Maine) gay monthly, is sponsoring an AIDS benefit tea dance and lip-sync show November 10. Over 50 prizes, including cash, gift certificates to local stores, and dinners around town will be awarded. The projected goal of the benefit is a minimum of $5000, which will go to the Maine Health Foundation, a not-for-profit organization that has been doing research into AIDS cases in Maine. They also support a hotline that has been open for several months. Although there are only 11 diagnosed cases as yet in Maine, Our Paper organizer Alice Dunn said, "the official count is inaccurate. In the past week alone, I've seen four cases here in Portland. Two have died and two are near death." According to reports, gay men are the only currently affected group to have AIDS in the state. Dunn added that the response by the local Portland community has been strong in supporting the benefit. Outside of Our Paper and the hotline, there are no other groups doing education about the crisis. **[Thanks to Anne-chrisine d'Adesky for this news item.]**

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MOTHERS OF PWAs ORGANIZE IN SAN DIEGO

with thanks to People With AIDS Update (from San Francisco's Shanti Project & SF AIDS Foundation), 12/85

San Diego has recently seen the start of an incredible new group. Following is the founding statement of the Mothers of PWA/PWARC's Organization, as written by Barbara Peabody, Lee DeWitt and Miriam Thompson. Please lend your support. Parents' support networks are being considered in other communities. Contact our office to let us know how you're doing!! Write: PWAU, c/o Shanti Project, 890 Hayes Street, San Francisco, CA 94117 (415/558-9644).

Our purposes are as follows: 1) **Mutual Support:** You are NOT alone; other mothers are having, or have had, the same experience. We can share knowledge, exchange useful hints on physical and emotional care of our children, and offer comfort. 2) **Organize a Telephone Network:** At times, we cannot leave our patients alone and yet need supportive contact. 3) **Dissemination of Information About AIDS:** Ignorance breeds prejudice, as we all know of unnecessary and cruel discrimination against AIDS patients and their families, banning them to "leper status." 4) A **"Substitute Mother" Program** for patients rejected and abandoned by their families. 5) **Encouragement of Other Mothers,** who, for varying reasons, are hesitant or fearful of giving their AIDS-stricken children as much love and care as possible; they need it now more than ever in their lives. If the patient is homosexual, this includes helping the mother to accept his homosexuality--he is still her child, no matter what. It also includes helping mothers bear the despair and frustrations of AIDS, and to face and cope with bereavement.

United, we can work for insured home care; patients not requiring immediate treatment but too ill to take care of themselves are often left in the hospital; that is expensive, unnecessary, and emotionally undesirable for the patient. United, we can also apply political pressure for increased funding for research, patient treatment, and the many support programs needed for both patient and family. AIDS affects not only our children, but also us, their mothers. The loss of a child--a part of oneself--is unbearable enough: the unique pain of seeing a child suffer and die from this mysterious and horrifying disease, AIDS, is excruciating. By uniting, we can help each other bear our losses, and out of our own understanding help other patients and their families, and together, work to bring an end to this devastating illness. Will you please join us? Please call the San Diego AIDS Project (619/294-AIDS), or write to MAP, SDAP, POB 81081, San Diego, CA 92038, for more information.

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SUICIDES RELATED TO AIDS CONTINUE IN NEW YORK

by Peg Byron, with thanks to The Washington Blade, 11/1/85

New York City recorded its third AIDS-related suicide in one week, bringing the total of such suicides known in the area this year to seven. Scott Sack, 35, leaped from the window of his 17th floor hospital room, according to police reports. He had been admitted to the New York University Medical Center, believed to be suffering from AIDS. A friend who came to visit that evening found Sack's bed empty and the window in the room broken. Earlier in the week, two men tied themselves together at their waists and jumped from the 35th floor of their East Side apartment building. One of the men, Charles Villalonga, 43, had been suffering from AIDS for some months and had left his Washington, DC-based government job earlier in the year. In August, a 34-year old man died when he leaped from the 7th floor of New York's St. Luke's-Roosevelt hospital, after being told he had AIDS. The ombudsman for the Gay Men's Health Crisis, Robert Cecchi, said his organization receives suicide threats from people with AIDS every day. "Suicide usually happens in the beginning of the diagnosis rather than at the end," said Cecchi. "Earlier [in the AIDS crisis] many people would say after the diagnosis, `I'll be the one to make it.'" Cecchi said statistics since then have made that optimism less common. "I am convinced there would be fewer suicides if people got more support from their physicians" to face AIDS with more hope, said Cecchi. Earlier suicides this year included two Westchester men who committed suicide together after one of them was tested positive for the AIDS antibody. Another New York man, who had worked as a volunteer for an AIDS service organization for several years, jumped from his Manhattan penthouse in the spring, reportedly leaving medical bills and insurance forms strewn about a table in his apartment.

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BENEFITS AWARDED TO MAN CARING FOR DYING LOVER

by Regina Gillis, with thanks to Boston's Gay Community News, 11/9/85

The state of California recently awarded unemployment benefits to a 34 year old gay man when he quit his job to care for his dying lover. The case is significant as it broadens the category of "good cause(s)" for leaving employment. Under the California Unemployment Insurance statute, one such "good cause" recognized by the state is provision of care to a seriously ill or dying spouse, child, or blood relative residing in the same household. In the Sept. 13 ruling by Administrative Law Judge Robert P. Mason, the relationship between the gay man and his lover with AIDS was deemed as significant as that between blood relations or a married couple. Mason stated that unemployment benefits were appropriate because "even though a blood or marital relationship did not exist, it is recognized that non-blood, non-legal relationships may be established which are as meaningful, if not more meaningful, than the relationships created by blood or the bonds of marriage." Although heartened by the decision, Roberta Achtenberg, director of the Lesbian RIGHTS Project and attorney for the man who won the benefits, told GCN she could not call the decision a true precedent, "...but it carries significant persuasive value on other similar cases." She added that the Unemployment Insurance Appeals Board, which declined to appeal the case, does not recognize the decision as binding. Achtenberg's client, who wishes to remain anonymous, had been a computer instructor for a San Francisco firm for 2 years when his 39 year old lover was diagnosed with AIDS in January, 1984. They had been living together for over 4 years. In April, 1985, the man was given a 2-month leave from work in order to allow him to care for his lover at home. According to Achtenberg, it was understood among the physicians and the employer that his lover would most likely die within the 2 months' time. When his lover did not die within that time, the man applied for an extension of the leave, but was denied. It was at this time that he handed in his resignation and applied for unemployment benefits. The man's lover died June 7, and the man was denied benefits by the Employment Development Department of the state in July. The EDD decision was appealed shortly thereafter, and was legally represented by the Lesbian Rights Project, a nonprofit, public interest law firm dealing primarily with lesbian/gay-family related issues.

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BALTIMORE "HEROS" HANDLE 400 CALLS ON USA HOTLINE

by Doug Hinckle, with thanks to The Washington Blade, 12/13/85

Members of the Baltimore Health Education Resource Organization (HERO) handled 400 calls a day at a toll-free AIDS hotline set up by the USA Today newspaper to operate in conjunction with a series of articles on AIDS that ran earlier see related article). Shifts of three operators each, answering calls from across the country, worked from offices in the 11th floor suite in the USA Office Tower in Arlington, Virginia in metropolitan Washington, DC. "The phones keep ringing, right off the hook," said Billy Hansen Sparks, HERO's evening shift manager for the hotline. Sparks, answering the AIDS Hotline one of the mornings, said calls have been coming in from an equal number of heterosexuals and gays. "A lot from southern areas--gay callers," added Sparks, "who haven't received [AIDS] education yet." Although real specific information isn't given out, knowledgeable local clinic & AIDS service organization names & addresses were given out. Wendy Tate, case surveillance investigator for HERO, was also answering questions from a lot of southern callers. "A lot from the rural South," she said. "They have questions about safe sex. I even had one ask if he could get AIDS through getting a tatoo. The funny one was the plumber," she began, but was interrupted by another caller.

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TRANSMISSION OF VIRUS BY SCHOOL CHILDREN DOES NOT OCCUR

Although worried parents have voice fears that their children might be infected with AIDS by classmates with the disease, researchers now have convincing evidence that such transmission does not occur. A three-year study at a special boarding school for sick and handicapped children has shown that AIDS-infected children who live, eat and study with other students will not pass along the virus causing AIDS. The study was done at a boarding school in western France where about 50 hemophiliac students--about half of whom were infected with the AIDS virus--shared living quarters and classrooms with 70 uninfected students, said Luc Montagnier, a virologist at the Pasteur Institute in Paris. Details of the research would soon be published in a medical journal. The children were between 3 and 16 years old and had lived together for one to three years. "None of the other children have been infected with the AIDS virus," said Montagnier, one of the discoverers of the virus. The conclusion that AIDS cannot be spread among schoolchildren was reinforced by an additional finding. The hemophiliac students did pass hepatitis B to some healthy classmates, suggesting that an exchange of blood or other body secretions occurred between the students, probably through scratches on their hands, Montagnier said. The study was not undertaken to determine whether children could transmit AIDS, but was part of a long-term project to monitor the health of the children at the special school. Parents in several American cities have threatened to boycott schools when they learned that their children could be attending school with AIDS-infected children. Public health officials have said repeatedly that the disease cannot be spread through casual contact.

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AIDS SURVIVAL STUDY IN BOSTON

Statistics on AIDS show that more than 80% of the people diagnosed with AIDS two years ago have died. Yet little attention is paid tot he 20% of the cases who survive longer. In particular, there has been no systematic study of people who continue to live in a stable state of health for much longer periods. The Boston AIDS Action Committee is planning a study of long term survivors of AIDS to try to identify factors which may have contributed to their long survival. We hope that this information will be useful to other people with AIDS and to our scientific understanding of AIDS. The study is divided into two phases. In phase I, we hope to establish informal contacts with large numbers of long term survivors of AIDS to gather impressions regarding the aspects of medical care, nutrition, lifestyle, medication, and coping styles which may have contributed to their success in battling the disease. In phase II, we will use the information gathered in phase I to prepare a more systematic questionnaire for distribution. If you have AIDS which was diagnosed more than 2 years ago we would appreciate hearing from you. All information will be kept strictly confidential. For more information, contact: Survival Study, c/o John Whyte, MD, PhD, Boston AIDS Action Committee, 661 Boylston St., Boston, MA 02116, or you may contact Larry Kessler at 617/437-6200.

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TRANSIENT ANTIBODY TO LAV/HTLV-III AND T-LYMPHOCYTE ABNORMALITIES IN WIFE OF MAN WHO DEVELOPED AIDS

abstracted from Burger, H., et al, Annals of Internal Medicine, 103:4, 545-47, October, 1985

This article reports the apparent spread of the AIDS virus (LAV/HTLV-III) in a white American family from husband to wife through heterosexual contact. Although the wife remained clinically well, she developed antibody to LAV and a decreased number of T-helper cells. She was followed for 10 months; after exposure to her husband's semen was discontinued by his using condoms, the LAV antibody was no longer detectable and the T-helper cell number returned to normal. The man had hemophilia A and developed the `lymphadenopathy syndrome,' antibody to LAV, and a low number of T-helper cells. He later developed AIDS, and lost the antibody to LAV. Because the incubation period of AIDS may be long, it will be important to follow this woman's clinical status, serologic findings, and T-lymphocyte profile to determine whether the current trend continues or disease appears in the future. [ED NOTE: The authors, who include Montagnier & Chermann from Pasteur Institute in Paris, interpret the absolute number of T-helper cells for the woman--624/mm^3, which was considered within normal limits; earlier, this value was 531/mm^3, which was considered mildly decreased. The woman's husband had a severely decreased absolute number of T-helper cells of between 145-133/mm^3.]

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NUTRITIONAL ADVICE AGAINST AIDS

by Doug Hinckle with thanks to The Washington Blade, 10/25/85

Nutritionist Dr. Gwendolyn Pla spoke to a group of black men on "Nutrition and AIDS" at a forum sponsored by the DC Coalition of Black Gay Men and Women and Black & White Men Together as a part of a series to educate blacks about the risk of AIDS. Pla urged everyone to begin the fight against AIDS on a personal level by eating. "Just do that!" said Pla. "We don't know if improved nutrition will affect AIDS, but in some cases better nutrition has lessened the severity of other disorders." Moderation was stressed throughout Pla's presentation. Plan your day, eat a variety of foods and stay within your weight limit was some of the advice Pla gave to the group. Pla also warned against using alcohol, cigarettes, and recreational drugs, because they interfere with how food is used in the body. Too much sex can also be bad for your nutrition, said Pla, citing deficiencies in zinc. Pla recommended lean meats, eggs, and wheat cereal for zinc deficiency.

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LOUISVILLE HOSPICE & AIDS

with thanks to Computerized AIDS Information Network (CAIN) and AIDS Project/Los Angeles, 12/26/85

Hospice of Louisville (Kentucky), Inc. has begun a program for people with AIDS and is working with the gay community there. If you have any questions about the hospice movement, client referral or other questions, concerns, or needs, please contact: Dee Markley, Hospice of Louisville, 982 Eastern Parkway, Louisville, KY 40217 (502/636-5214).

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WASHINGTON LOBBYIST NEEDED BY NGLTF

The National Gay/Lesbian Task Force is seeking an experienced lobbyist with political experience with community-based organizations to represent it on issues of concern to the lesbian and gay community including AIDS and other health and civil rights issues. The lobbyist is based in Washington, DC, and reports to the Director of Governmental & Political Affairs (Jeff Levi). Qualifications required: lobbying experience at federal or local government level; political experience with community-based organizations; familiarity with civil rights/civil liberties issues; strong writing skills; willingness to travel; flexible working hours; willingness to perform majority of own clerical support work. If interested, send resume and a writing sample to: NGLTF--DGPA, 2335 18th Street, NW, Washington, DC, 20009.

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PHYSICIAN ASSISTANT AND PHYSICIAN/MEDICAL DIRECTOR NEEDED AT BOSTON'S FENWAY

Boston's Fenway Community Health Center is seeking energetic self-starters with experience in ambulatory primary care. The Fenway is a free-standing non-profit ambulatory health facility in Boston's Back Bay. The Center is nationally recognized for its services to the gay community, its leadership in advocating and providing quality health services for people with AIDS, and for its educational efforts with local and state agencies. The Center is the recipient of federal and state funds for AIDS education and research, and is participating with the Centers for Disease Control in a 3 year research project. The Fenway has an interesting patient population comprised of elderly and student/young adult neighborhood residents and the lesbian/gay community in the greater Boston area. The Fenway Community Health Center offers affordable, sensitive, quality health care to all people, regardless of income, in a nonjudgemental way. The Center, which handled over 17,000 patient visits in 1984, maintains backup relationships with Beth Israel and New England Deaconess Hospitals for patients requiring hospitalization. Interested candidates should send their resume to Jerry Feuer, PA-C, Medical Administrator, Fenway Community Health Center, 16 Haviland Street, Boston, MA 02115 (617/267-7573).

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BOSTON'S AIDS ACTION COMMITTEE SEEKS HOUSING COORDINATOR

AIDS Action Committee of Boston is seeking a full-time coordinator of housing services for clients with AIDS or AIDS related conditions. Experience in developing housing resources and managing group homes is preferred, as is a working knowledge of people with AIDS and AIDS-Related Conditions. Salary ranges from $18-22,500, plus benefits. Send resumes to the Personnel Committee, AAC, 661 Bolyston St., Boston, MA 02116. AAC is an equal opportunity employer.

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MEDICAL DIRECTOR FOR WOMEN'S CLINIC IN SAN FRANCISCO NEEDED

San Francisco's Lyon-Martin Clinic is a community clinic providing a full range of primary health care services to non-lesbians and lesbians. The Clinic is organized as a private, non-profit corporation, funded by client fees, the Mayor's Office of Community Development, the United Way and fundraising activities. There are 6 staff members who provide services to approximately 300 women per month. The medical director functions as the person with legal responsibility for medical care provided by the clinic. The director ensures compliance with state regulations for Dept. of Health Services for Community Clinics, ensures that all activities and procedures of the Clinic are in compliance with state and federal rules and regulations as well as in organizational protocols. She will also function as a staff physician, and will be instrumental in the development of the Clinic's service programs, policies and its general growth. The Lyon-Martin Clinic is looking for a medical director who meets the following job qualifications, can fulfill the identified job responsibilities and who can make a commitment of up to 12 months to this job. Areas of responsibility include staff supervision (monitors staffing patterns, staff evaluation, staff training & development, case conferences with practitioners, & in-service training for clinical staff); and administration of clinical practice (compliance with state, federal rules & regs, establishment of MQA committee & standards, writing protocols, chart review & approval, program development, feasibility analysis & research, prepares written oral presentations on medical issues, oversees staff recruitment). Applicants should be in general family practice or Ob/Gyn, board certified, at least 2 years post-graduate residency, primary health care/community clinic experience with emphasis especially in women's health care issues and knowledge & sensitivity to lesbian health issues. The applicant should also have staff supervisory skills, and an administration/management background with bilingual skills are preferred. Interested applicants should send vita and letter of interest and experience in women's & family health care to: Medical Director Search, Lyon-Martin Clinic, 2480 Mission Street, Suite 214, San Francisco, CA 94110 (415/641-0220).

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HIGH RISK GROUPS & DRUGS

by Lisa McCullough, with thanks to The Washington Blade, 12/20/85

As reports of a possible AIDS epidemic among heterosexuals in central Africa gather strength, the question arises as to what is the real high-risk group for AIDS. Up until now, health officials in the United States have been working on the assumption that sexually active Gay men make up the group at highest risk for AIDS, with intravenous drug users ranking second. But with reports of HTLV-III antibody tests turning up positive among the heterosexual population in Africa, that assumption is being challenged. Add to this the suspicions of several investigators that abuse of recreational drugs is a major factor not only in the prevalence of AIDS but in vulnerability to the AIDS-related diseases, and the picture becomes even murkier.

Dr. Caesar Caceres, who worked at the U.S. Public Health Service until 1969 and who is now an internist in private practice in Washington, D.C., recently published an article in The Wall Street Journal describing his interpretation of data concerning people with AIDS compiled by the Centers for Disease Control. In that article, Caceres cited CDC statistics together with results from a study of 87 people with AIDS conducted by Dr. Harry Haverkos, a researcher at the National Institute of Allergies and Infectious Diseases (NIAID), and results from his own study of 20 patients he has treated for AIDS.

On the basis of those results, Caceres asserts that abuse of recreational drugs, including nitrite inhalants (poppers), marijuana, and cocaine, is a major contributing factor to susceptibility to HTLV-III infection and that use of such drugs is "the unnoticed link in AIDS cases." Caceres believes that the CDC's assumption that homosexuality is "the key shared trait" among people with AIDS may not be adequate in determining who is really at the greatest risk for the disease.

Chuck Fallis, a spokesman in the CDC's public relations office, says that "it was pretty apparent from the beginning" that Gay and bisexual men comprised the group most often reported with AIDS; therefore, when the CDC began compiling data on AIDS in 1981, this group was classified as the highest risk group.

Fallis explains the manner in which the CDC gathers data on AIDS cases: reports from attending physicians are voluntarily submitted to state health departments, which then, using a standard form provided by the CDC, code the information and forward it to the CDC for statistical analysis.

Debbie Deppi, a statistician in the CDC's Center for Infectious Diseases, described the form that the CDC provides: There are demographic questions about the person's area of residence, income level, family history, and so forth, and questions about his or her sexual orientation and practices. The form also asks whether the person has used chemotherapeutic and/or intravenous drugs. But there is *no* request for information regarding whether he or she has used drugs such as cocaine or marijuana on a regular basis.

Fallis declined to comment on why CDC does not request information about recreational drug use among people with AIDS. A spokesperson for Dr. James Curran; director of CDC's AIDS program, said Curran could not be reached for comment before January.

Meade Morgan, a statistician in CDC's Statistics Branch of the AIDS program, says that the CDC is "interested in possible routes of exposure" to HTLV-III, so information about recreational drug use "is not considered significant" in that context.

Caceres contends that, without data on recreational drug use, the CDC cannot accurately assess the relative importance of shared traits among people with AIDS.

"Back in 1982, when I first reported a case," Caceres said, "I was interested in getting [questions about recreational drug use] on the form. I suggested *then* that there should be a way of reporting it." Caceres questioned his own AIDS patients about their use of drugs and says he found that the great majority of them "had habitually used oral street drugs for at least several years...before contracting AIDS-related diseases."

NIAID's Haverkos, whose findings were recently published in the journal Sexually Transmitted Diseases, estimates from his study of 87 Gay men with AIDS that at least 75 percent of them used "street drugs," including poppers, methaqualone (Quaaludes), cocaine, and marijuana, at least once a week for at least several years.

Haverkos' study also shows that there is a correlation between drug use and the kind of AIDS-related disease a person is likely to contract. The patients in his study were grouped by whether they had Kaposi's sarcoma (KS) or *Pneumocystis carinii* pneumonia or both. Haverkos found that those with KS showed "more recreational drug use" than those with *P. carinii* pneumonia and that the factor "most strongly associated with [KS] was the use of large quantities of nitrite inhalants," or poppers...

"Nitrites enhance the probability of getting KS," Haverkos says. He points out that nitrites cause swelling of the blood vessels and that KS is a blood vessel tumor, which may explain the high incidence of KS among those who frequently used poppers. CDC's Morgan agrees with Haverkos' findings that recreational drug use "might be associated with disease outcome."

In his study, Haverkos also found that Gays with KS had higher incomes, more sexual encounters involving anal intercourse (more than 100 different partners per year), and more sexual encounters with partners from bathhouses than those with *P. carinii* pneumonia.

"AIDS is clearly a sexually-transmitted disease," says Haverkos, "and Gay men...put themselves at risk through sexual intercourse." But on the basis of his findings, Haverkos concludes that "drugs may determine which [people] get a certain [AIDS-related] disease and which don't."

The connection between AIDS itself and drug use is less clear, however. Caceres says he is convinced, in spite of the paucity of hard clinical proof, that use of cocaine, marijuana, and other "street drugs" suppresses the immune system, leaving the body vulnerable to attack by invading agents such as HTLV-III. Since drugs are prevalent among the Gay population, Caceres says, Gays who use drugs are hurting themselves by damaging their immune systems and increasing their chances of getting AIDS.

Haverkos presents his results with the caveat that they are based on a relatively small group of individuals. Caceres has not published his findings in any of the refereed medical journals, and he admits that his evidence for a correlation between AIDS and drug use is both "circumstantial" and based on "a small subsample" of infected individuals. But he says, "We don't have time to wait" for these findings to be reviewed, published, and finally read by the medical community at large. Such a route of dissemination "is not what's needed in an emergency situation" such as the AIDS epidemic, he says. "I'm only interested at the moment in helping people."

But both Caceres and Haverkos acknowledge the importance of gathering data on recreational drug use among people with AIDS. Haverkos states, "Researchers who seek to clarify the etiology of AIDS would do well to design their studies and analyze their data in such a way" that separate cofactors such as drug use may be considered. Caceres says he "cannot imagine" why the CDC still does not request that information on its standard form. "In effect, the CDC knew about [the need for the data] two years ago," he says. "We should have this question asked nationally so we can get verification."

Caceres' belief that drugs augment the risk of HTLV-III infection among Americans sheds no light on the situation in Africa, however. Experts agree that recreational drugs are not likely to be available in central African countries to the degree that they are in the United States.

The factors influencing the transmission and disease manifestations of AIDS in Africa, together with the increase in cases of aggressive KS there, remain a mystery. First of all, tests for HTLV-III antibody have turned up positives, predominantly among African *heterosexuals*. African officials are highly reluctant to disclose any information they may have about homosexual practices in their countries, but it is generally held that anal intercourse among men is at least as prevalent in Africa as it is in Western countries. There are anecdotal reports that anal intercourse forms part of tribal rituals, so that the term "homosexual" may be misunderstood by native Africans and the term "heterosexual" misapplied by Western investigators.

Second, a preliminary study conducted at a hospital in Zaire by researchers at the Institute of Tropical Medicine and a group, headed by Robert Gallo, at the National Cancer Institute indicated that "[KS] in Zaire is not associated with HTLV-III infection." This finding, published last year in The New England Journal of Medicine, was based on ELISA tests of serum samples from 14 KS patients from a rural area of Zaire. None of the samples was positive for HTLV-III antibody, and none of the patients showed abnormal numbers of T-helper cells; both those features are considered hallmarks of AIDS.

Finally, doctors and researchers are dumbfounded by the highly aggressive form of KS that has begun to strike people throughout central Africa. Even though the link between HTLV-III infection and KS in Africa is weak, this new form of the disease is adding to the confusion and hysteria over the AIDS epidemic there.

Efforts to elucidate the cause of this aggressive KS, its possible connection to AIDS, and perhaps the status of the disease worldwide are likely to suffer from the controversy over the African origin of AIDS. Health officials in African countries deny the existence of any real proof that HTLV-III is a virus endemic to Africa, while the bulk of the evidence gathered by American and European investigators indicates that the virus is not newly introduced to the population there.

Fallis says the CDC will "probably not" revise its classifications of high-risk groups in view of the reports from Africa.

"Only one percent of AIDS cases in the U.S. are heterosexuals," said Fallis, "and we still don't know how [the disease is] spreading to heterosexuals in central Africa."

NGTF AIDS Update

NATIONAL GAY TASK FORCE
80 FIFTH AVENUE
NEW YORK, NEW YORK 10011

Mandatory Reportability, Contact Tracing, and HTLV-III Antibody Testing

The National Gay Task Force and other civil-liberties and AIDS-service organizations have grown increasingly concerned over the possibility that state governments might move precipitously towards (1) mandatory reportability of positive HTLV-III antibody test results and (2) institution of contact tracing to notify sexual (or needle-using) partners who may have been exposed to the virus. There is the danger that these measures will be resorted to as a concession to a public asking "that something be done" but without determining how effective overall the use of these public health powers would be in terms of AIDS prevention, and, if they are determined in any way desirable, how best they might be implemented. In so far as institution of either measure will tend to discourage individuals from having the test performed, they would ironically have the opposite effect of that desired by many of those in health departments who now propose these actions.

I. A. NGTF continues to regard mandatory reportability that extends to retention of identifying (as opposed to statistical) information, as neither justifiable nor desirable. Our position was stated originally in an update, dated 8/28/85, entitled "Reportability and HTLV-III Antibody Testing". The principle reasons for our opposition, in brief:

o the traditional rationale for keeping names, therapeutic intervention, is absent.

o epidemiolgical data about antibody testing can be collected without collecting names and addresses.

o reportability will undermine the anonymity/confidentiality at the already successful HTLV-III testing sites (a.k.a. "alternative testing sites"), and thereby undermine the confidence of the communities at increased risk who make use of those sites.

o the potential damage to individuals -- in terms of discrimination and stigmatization -- in the event of the unauthorized release of this information is far greater than for an ordinary STD. In Colorado, the one state that has thus far implemented reportability, a 17 year old boy was removed from regular school classes when his positive antibody status was discovered by school authorities.

o it is not yet definitively known if the presence of antibody always indicates infectivity or risk to developing ARC/AIDS.

B. As a public health strategy contact tracing for AIDS -- asking those who test positive for HTLV-III antibody to name sexual and needle-sharing partners so that the health department may contact and counsel them -- does not offer the same clear benefit as it does in the case of diseases -- like syphylis -- for which treatments are available. Its prevention value is less compelling since by this time in the epidemic, it is unlikely many sexually active or IV drug-using members of the groups at increased risk are unaware that they may have been exposed to the virus. The prevention value is clearer for those individuals who are not aware that they belong to a group at increased risk-- i.e., that they were the sexual or needle-sharing partners of possible carriers -- especially if they are women who might consider pregnancy at a later date.

Contact tracing suffers from some of the same potential pitfalls of reportability. It may have the effect of discouraging members of the affected communities from visiting HTLV-III testing sites (a.k.a. alternative testing sites) or health department-run STD clinics, where education and voluntary testing is available, if they imagine that they may find themselves in the situation of being pressured to give names and addresses of contacts. If public health representatives are knocking on doors (or otherwise searching people out) then the possibility of this provocative information, far more stigmatizing than is the case for any ordinary STD, falling into hands of unsympathetic parties, is increased. Aggressive pursuit of the contact tracing model is inimical to building a bond of trust that promotes cooperative interaction between attendees of testing sites or STD clinics and public health representatives.

Potentially, a policy of contact tracing might have the unfortunate effect of encouraging anonymous sexual contacts over those that involve a process of discussion and familiarization between prospective sexual parters, if the individuals in question fear that divulging names and identifying information would ultimately place them at risk to being contacted by public health authorities. Those conducting AIDS prevention education regard the familiarization process as conducive to responsible decisions about adherance to safe sex guidelines.

Both reportability and contact tracing are explored further in a Question and Answer section beginning on page 5.

II. New CDC Letter Addresses Reportability, Contact Tracing, and Other Issues. On December 6, 1985, the Director of the Centers for Disease Control, Dr. Jim Mason, sent a memorandum to state and territorial health officials that explores what additional options might be taken to encourage prevention through use of the HTLV-III antibody test(s) and includes a discussion of contact tracing and reportability.

A. Fortunately, the recommendations adopt an appropriately cautious stance on reportability, stating merely that "we need to begin evaluating the implications of requiring some kind of reporting of positive HTLV-III/LAV antibody results to the health department...Requiring reporting of positive results, especially with personal identifiers, needs to be weighed against the possibility that such requirements might discourage high-risk persons from agreeing to non-anonymous testing." This will hopefully have a restraining effect upon state health departments -- there have been signs in recent months that other states such as Arizona might follow Colorado's example -- overly eagre to embrace mandatory reportability that extends to the listing of names and addresses. The CDC tacitly concedes that reportability need not extend to collection of names and addresses:

"If testing and notification does not include personal identifiers, notification could still provide valuable statistical data to indicate the prevalence of infection and to assist in planning and evaluation, such as for coordinated programs of community-based health education and risk reduction."

B. The CDC in its memorandum discusses the relevance of the classic contact tracing model to curbing HTLV-III infection but ultimately they "recommend a departure from this approach with HTLV-III/LAV patients at this time." They suggest, after noting the absence of therapeutic intervention for infection, "that identifying information not be sought for partners [who may have been exposed]." Under their suggested scenario "the patients themselves would be encouraged to make as many referrals [for testing and counseling] as possible." Only if "the patient registers a preference for the counselor to contact and refer known partners...[then] sharing identifying information would be necessary."

C. Another recommendation made by the CDC is that health departments should now consider steps to "openly offer and encourage people to have voluntary HTLV-III/LAV testing in STD clinics and in clinical settings where IV drug abusers or prostitutes are seen." It is in this context that a modified contact tracing model is suggested.

D. Fortunately, the CDC guidelines do give some emphasis to the confidentiality issues raised by their recommendations: they wisely recommend that health departments should be considering the advisability of "Assuring that your regulations and statutes protecting the confidentiality of all health department records relating to infection and other STDs include protection from disclosure through litigation, or any other disclosure not agreed to by the patient." Further, as regards contact tracing in particular, they advised that "in states where such information is not protected from disclosure through litigation, e.g., subpoena, we would recommend against maintaining formal name-identified records concerning such referrals."

III. Recommendations for Responding to the CDC Guidelines: These guidelines are reasonable in so far as they make some concession to the need for sensitivity in the use of contact tracing and caution in advancing towards reportability of names and addresses.

A. The recommendation in favor of making the test available in STD clinics is of concern in that HTLV-III testing requires a sensitivity that is readily provided at most of the special testing sites, but which is in many cases different from that cultivated in your typical STD clinic, where the atmosphere can verge on the coercive. These special sites, established originally as "Alternative Testing Sites," in most states already provide a confidential and in many cases totally anonymous testing procedure -- the ideal from the point of view of protecting against abuses -- and in most cases careful pre- and post-test counseling. STD clinics, on the other hand, are used to providing all sorts of tests, but none as potentially alarming or provocative as this, and usually in a bland factory-like manner, without careful counseling to guard against misinterpretation of results or special precautions to guard against disclosure to unauthorized parties. Consequently, the special HTLV-III testing sites (where distinct from STD clinics) are better-suited to continue as the primary outlets for testing. This would not preclude STD clinics from providing information about the test and AIDS prevention.

B. Contact tracing may be justifiable when there is reason to believe that the sexual or needle-sharing contact may not be aware that s/he may have been exposed. Clearly it is more likely to be successful if the integrity of the confidential (and preferably anonymous) testing procedures at HTLV-III testing sites are preserved, i.e., if mandatory reportability of names and addresses is avoided, since the bond of trust between the antibody positive individual who is interviewed and the testing center personnel is enhanced. Ultimately contact tracing, however it is conducted, depends on voluntary cooperation; intimidation will never substitute for trust and sensitivity in eliciting that cooperation.

C. The CDC is correct that the notification of contacts is best left to the antibody positive individuals themselves. Thorough counseling should be made available to those who are contacted, advising them of the possibility that they are infected and infectious, telling them of the availability of testing for antibody and the limitations of these tests.

D. Besides counseling, in those selected cases where notification may be justified and where the antibody positive individual asks the health department to notify the contact, confidentiality protections must be carefully constructed to reduce the possibility that the identity of the antibody positive individual is revealed to unauthorized third parties, including the contacts. The CDC's cautionary words to state and territorial epidemiologists on the need for confidentiality of AIDS-related records are welcome as are their recommendations for protecting records from release through litigation. It should be noted that to the best of our knowledge no state has yet made its STD records subpoena-proof. This should be a condition attached to any consideration of HTLV-III/LAV testing using personal identifiers.

E. As already noted, mandatory reportability can be implemented without the hazard of confidentiality abuses if the data required is limited to statistical information needed by epidemiologists to chart the development of the epidemic and excludes name, address, and social security number. If ability to notify antibody positive persons for the purposes of treatment (when it becomes available) is viewed as the pivotal issue in any jurisdiction considering mandatory reportability, case reports of antibody positive individuals could be coded by random alphanumeric sequence (or possibly using the not entirely random Soundex system), with the key to the identifying information remaining in the hands of the treating physician, so as to allow for eventual notification should there be a compelling reason to do so at a future date.

F. We recommend that organizations concerned with civil rights aspects of AIDS in the various states involve themselves in advising health departments that will receive and consider the 12/6/85 CDC recommendations on reportability, contact tracing, and on making the test available in the standard STD clinic format.

Keep in mind, the recommendations contained within the CDC letter are non-binding and are not being imposed upon any local or state health department. Therefore, at the discretion of these health departments and the public health policy boards and political representatives to whom they report, these suggestions can be both improved upon, or at the other extreme, disregarded in favor of more insensitive techniques that in the final analysis may not serve the goal of AIDS prevention.

VI. Mandatory Reportability and Contact Tracing: Question and Answer Section:

Q: Since mandatory reportability and contact tracing are strategies that have traditionally been at the disposal of epidemiologists and public health officials, why shouldn't they be employed to their fullest extent?

A: While it may be reassuring from a public relations perspective for public health officials to "pull out all the stops" and employ all options at their disposal, the appropriateness of specific public health measures must be judged calmly and intelligently, taking into account their impact on HTLV-III testing sites -- which are working well -- their potential for preventing future infection, and also their potential for causing harm through misuse, and for shaking the bond of trust that is necessary between the affected communities and public health departments. Also, it is not yet clear that the test itself is specific for infectivity or the danger of developing ARC or AIDS. In justifying his action in Colorado, Dr. Vernon, the director of that state's Department of Health, referred to a need to "say to an anxious public that we are doing what we know how to do." However, officials should realize that clumsy public health policy that has the effect of driving the disease underground is bad public health policy and cold comfort indeed to an understandably concerned public.

* * *

Q: If the health department gives its assurance that mandatory reportability and contact tracing will not lead to unauthorized release of names for the purposes of single case discrimination or quarantine, why oppose this effort?

A: It is important to keep in mind that however trustworthy and conscientious such a civil servant or appointee may be, s/he may not be in office next year or the year after, or may be forced to take action by a politically-motivated superior or a state/local legislature. Furthermore, maintenance of confidentiality ultimately depends on a network of individual health department employees; the possiblities for breaches are real and the potential damage for individuals or stigmatized groups is enormous.

* * *

Q: But epidemiologists argue that they need the data that reportability would yield to track the extent of the epidemic.

A: The statistical needs of epidemiologists could still be satisfied by allowing access to cumulative test results that do not contain identifying information linked to any particular individuals.

* * *

Q: Will it not be desirable to have a list of antibody positive persons so that when treatment for HTLV-III infection becomes available, it will be possible to let them know immediately?

A: The possible eventual notification value is undermined by the fact that the test is not known definitively to correlate with presence of significant quantities of the live virus capable of attacking and depleting the T-Cells. Also, it is not very plausible to imagine that someone who is antibody positive for HTLV-III would not learn of and act to gain access to such treatment.

* * *

Q: What has been the effect of mandatory reportability in Colorado, the one state that has implemented it?

A: It is reported that gay men are now shunning the test or are giving false names to prevent their going onto the registry. These reprucussions had been predicted by the Colorado AIDS Project and ACLU in that state when they testifed against mandatory reportability. It is reported that the health department is now tacitly condoning the the use of false names -- de facto anonymity -- by no longer requiring ID when individuals are tested.

* * *

Q: How reliable are the blood tests that would provide the data on which reportability and contact tracing would rest?

A: The usefulness of the various tests (ELIZA, Western Blot, or Immunofluorescence assay [IFA]) for determining who is infectious and who is definitely at risk for becoming ill at some point later in life is not definitively known. As long as the diagnosis and prognosis for antibody positive persons is imperfectly understood, or until a test(s) is available that clearly indicates carrier status, then the arguments for reportability and contact tracing are not utterly compelling. Though the CDC is inclined towards making blanket statements endorsing the test as a screen for identifying those who are carrying the virus, spokespersons for the FDA (which licenses and regulates use of the tests) have been more cautious in their assessments.

* * *

Q: Which states have formally considered making reporting of positive HTLV-III/LAV antibody test results mandatory?

A: New Jersey held hearings in May on mandatory reportability and, after hearing the evidence in favor and the disadvantages, rejected this proposal. In August, Colorado went against objections from local organizations and made reportability mandatory effective in October. In November, New Mexico considered but ultimately tabled a proposal for reportability. South Carolina recently decided to make the test reportable effective in January. Arizona is now said to be considering mandatory reportability.

* * *

Q: Could insurance companies, employers, or the military, gain access to lists through legitimate means?

A: As things stand now, even if mandatory reportability became widespread, it is highly unlikely that they could gain access. Only a major reversal of past precedent could bring about this draconian vision. However, indavertent disclosure cannot be ruled out; all security systems are vulnerable to failure; to say otherwise is pure hubris.

* * *

Q: Could mandatory reportability create a list that might be used to initiate quarantine procedures or threaten specific individuals with such measures?

A: In theory, yes. However, mass quarantine of all antibody positive individuals would be highly impractical; if only 25% sought testing, the government would have to intern or otherwise monitor/confine upwards of quarter of a million of people. It would unfortunately be more feasible for local health departments to use their list to harass individuals. In San Antonio the health commissioner decided, based on a report that one or two individuals were placing others at risk, to write a threatening letter to all the persons with AIDS in his jurisdiction. Theoretically, the same high-handed action could be taken against those who are antibody positive, (particularly in low incidence areas, where their number are fewer), and with the same attendant risks that the letter would fall into the hands of unsympathetic third parties.

* * *

Q: Isn't it true that health departments have a good record in protecting the confidentiality of those who visit STD (Sexually-Transmitted Disease) clinics and doesn't this indicate that we can have equal confidence in these protections as regards AIDS?

A: Yes, they do have a good record as regards ordinary STDs. But AIDS carries a stigma that far exceeds that of virtually any other illness. Public fear of casual contagion, though without medical justification, would likely result in unprecedented pressure being placed on the system of confidentiality such as that typically used in public STD clinics. Driven by such unwarranted fears, and perhaps abetted by prejuduce against gay men, local health department functionaries with access to a registry of test results might conceivably feel justified in leaking the name of an antibody positive individual holding a position as a teacher, food-service, or health care worker. Mandatory reportability would make breaches of test result confidentiality more likely and would require the "alternative testing sites" that provide antibody testing to abandon the best form of protection: anonymous testing procedures.

* * *

Q: What might be the effect of mandatory reportability and contact tracing on the blood banks on which we all depend?

A: Mandatory reportability and contact tracing might have a deleterious effect on the ability of blood banks to attract and maintain eligible donors. Though the rate of positivity among blood donors has been less than one half of one percent, some members of the non-high-risk group public might be deterred from giving blood if they felt there was even a slight chance that their names would be reported to state health authorities and connected with AIDS or that they would be interviewed regarding their sexual contacts. Recall the that in some cities a segment of the blood donating public for a time shunned donation out of a totally unfounded fear that they might get AIDS from a dirty needle, resulting in a 10% drop in blood supplies.

Prepared 12/19/85.

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CENTERS FOR DISEASE CONTROL

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

***** PAGE 30 * THE OFFICIAL NEWSLETTER OF THE NCGSTDS * VOLUME 7:2 * DECEMBER/JANUARY, 1986 *****

Current Trends

Recommendations for Assisting in the Prevention of Perinatal Transmission of Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus and Acquired Immunodeficiency Syndrome

The information and recommendations in this document are intended to assist health-care providers and state and local health departments in developing procedures to prevent perinatal transmission of human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV), the virus that causes acquired immunodeficiency syndrome (AIDS).

This document contains recommendations for providing counselling and, when indicated, testing for antibody to HTLV-III/LAV for women who are at increased risk of acquiring the virus and who are either pregnant or may become pregnant. It is important that these women know they are at risk, as well as know and understand their HTLV-III/LAV-antibody status, so they can make informed decisions to help prevent perinatally acquired HTLV-III/LAV.

Through counselling, uninfected women can learn how to avoid becoming infected, and infected women can choose to delay pregnancy until more is known about perinatal transmission of the virus. If already pregnant, infected women can be provided information for managing the pregnancy and caring for the child.

Currently available data indicate that most pediatric HTLV-III/LAV infections and AIDS are acquired perinatally from infected women, but additional studies are needed to better quantify the risk of transmission from an infected pregnant woman to the fetus or newborn.

The recommendations below pertain to women. However, men who are HTLV-III/LAV-antibody positive should also be counselled regarding the risks of sexual and perinatal transmission, so they can refer for counselling and testing their sex partners who may be pregnant or considering pregnancy.

BACKGROUND

Pediatric AIDS Cases due to Perinatal Transmission. As of December 1, 1985, 217 (1%) of the 15,172 AIDS cases reported to CDC occurred among children under 13 years of age. Sixty percent of these children are known to have died. These 217 cases represent only the more severe manifestations of HTLV-III/LAV infection. Less severe manifestations, often described as AIDS-related complex (ARC), are not reported to CDC, so the number of children with clinically significant illness attributable to HTLV-III/LAV infection is greater than the reported cases of pediatric AIDS. In addition, a number of infected children are probably asymptomatic.

HTLV-III/LAV – Continued

Of the 217 reported pediatric AIDS patients, 165 (76%) have as their only known risk factor a mother belonging to a group with increased prevalence of HTLV-III/LAV infection. An additional 18% of the pediatric cases are attributable to transfusions of blood or blood products, while risk factor information is missing or incomplete on the remaining 6%. Of the 217 children with AIDS, 48% had mothers who were intravenous (IV) drug abusers; 17% had mothers who were born in Haiti; and 10% had mothers who were sex partners of either IV drug abusers or bisexual men.

Of the patients with perinatally acquired AIDS, 45% resided in New York City, while Florida and New Jersey accounted for an additional 32%.

Mechanisms of Perinatal Transmission. It is believed that HTLV-III/LAV is transmitted from infected women to their fetuses or offspring during pregnancy, during labor and delivery, or perhaps shortly after birth. Transmission of the virus during pregnancy or labor and delivery is demonstrated by two reported AIDS cases occurring in children who had no contact with their infected mothers after birth. One was delivered by Cesarean section (*1,2*).

Transmission of the virus after birth has been implicated in one case of HTLV-III/LAV infection in a child born to a mother reported to have acquired the infection from a postpartum blood transfusion. Since she breastfed the child for 6 weeks, the authors suggested breastfeeding as the possible mode of transmission (*3*). Recently, HTLV-III/LAV has been isolated from the breast milk of infected women (*4*).

Risk of Perinatal Transmission from Infected Mothers. The rate of perinatal transmission of HTLV-III/LAV from infected pregnant women is unknown; however, available data suggest a high rate. In one study of 20 infants born to infected mothers who had already delivered one infant with AIDS, 13 (65%) had serologic and/or clinical evidence of infection with HTLV-III/LAV several months after birth (*5,6*). Since these women were selected on the basis of having previously transmitted HTLV-III/LAV perinatally, this study may overestimate the average risk of transmission for all infected pregnant women.

Perinatal transmission from an infected mother to her newborn is not inevitable. Of three children born to women who became infected with HTLV-III/LAV by artificial insemination from an infected donor, all were in good health and negative for antibody to the virus more than 1 year after birth (*7*). Another child, born to a woman who was already pregnant at the time of AIDS diagnosis and was demonstrated to be viremic, was seronegative, culture negative, and healthy at birth and at 4 months of age (*8*). In a retrospective study evaluating nine children under 5 years of age whose mothers were later diagnosed with AIDS, two (22%) had antibody to HTLV-III/LAV (*9*). The infection status of these women during pregnancy was unknown.

In these studies, the rate of transmission ranged from 0% (0/3) to 65% (13/20). Additional studies are needed to better define the rate of transmission and variables associated with it.

Risk of Illness among Infected Pregnant Women. Pregnancy is associated with suppression of cell-mediated immunity and increased susceptibility to some infections (*10*). The T-helper to T-suppressor ratio is decreased during normal pregnancy, being lowest in the third trimester, and returns to normal approximately 3 months postpartum (*10*). It is not known whether pregnancy increases an infected woman's risk of developing AIDS or ARC, but one study suggests it does (*6*). Fifteen infected women who were well at time of delivery were followed an average of 30 months after the births of their children. Five (33%) subsequently developed AIDS; seven (47%) developed AIDS-related conditions; and only three (20%) remained asymptomatic. These results may not apply to all infected pregnant women, but they do suggest an increased likelihood of developing disease when an HTLV-III/LAV infection occurs in association with pregnancy.

HTLV-III/LAV – Continued

Prevalence of HTLV-III/LAV Infection. Counselling and testing for antibody to HTLV-III/LAV, when indicated, to reduce perinatal transmission of AIDS will be most beneficial in populations of women with increased prevalence of the virus (Table 1). These include: women who have used drugs intravenously for nonmedical purposes; women who were born in countries where heterosexual transmission is thought to play a major role (*11,12*); women who have engaged in prostitution; and women who are or have been sex partners of men who abuse IV drugs, are bisexual, have hemophilia, were born in countries where heterosexual transmission is thought to play a major role (*11,12*), or have evidence of HTLV-III/LAV infection.

The prevalence of antibody to HTLV-III/LAV in U.S. populations of men and women ranges from less than 0.01% in female blood donors to as high as 74% in men with hemophilia (*13-15*). Among heterosexual IV drug abusers, the prevalence of HTLV-III/LAV infection ranges from 2% to 59% in various geographic areas (*16,17*). Seroprevalence among the heterosexual partners of persons at increased risk for AIDS varies from 10% in female partners of asymptomatic, seropositive hemophilia patients to 71% in the female partners of men with AIDS or ARC (*18-20*). Among prostitutes, the HTLV-III/LAV antibody prevalence varies from 5% to 40%, depending on geographic area, with most of the women with positive tests relating histories of IV drug abuse (*21*). Among female blood donors in Atlanta, Georgia, who

TABLE 1. Prevalence of HTLV-III/LAV antibody in heterosexual populations — United States

Populations	Location	No. tested	Prevalence (%)
Intravenous drug abusers (*16,17*)	New York City	274	59
	NJ* < 5 miles from NYC†	204	56
	NJ 5-10 miles from NYC	124	43
	NJ > 100 miles from NYC	55	2
	San Francisco	53	9
Persons with hemophilia (*13,14*)		234	74
Factor VIII concentrate recipients		36	39
Factor IX concentrate recipients		15	40
Cryoprecipitate only recipients			
Female prostitutes (*21*)	Seattle, Washington	92	5
	Miami, Florida	25	40
Female sex partners of men with AIDS or ARC (two separate studies) (*19,20*)		7	71
		42	47
Female sex partners of men with asymptomatic HTLV-III/LAV infection (*18*)		21	10
Haitians (*12*)	New York City	97	4
	Miami, Florida	129	8
Female blood donors (*15*)	Atlanta, Georgia	28,354	0.01

*New Jersey.
†New York City.

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HTLV-III/LAV – Continued

denied belonging to high-risk groups, 0.01% had repeatedly reactive enzyme-linked immunosorbent assays (ELISAs) followed by reactive Western blot tests (*15*).

Commercially available tests to detect antibody to HTLV-III/LAV are ELISAs using antigens derived from whole disrupted HTLV-III/LAV. When the ELISA is reactive on initial testing, it is standard procedure to repeat the test on the same specimen. Repeatedly reactive tests are highly sensitive and specific for antibody to HTLV-III/LAV. However, when the ELISA is used to screen populations in which the prevalence of infection is very low (such as blood donors or women not in high-risk groups), the proportion of repeatedly reactive results that are falsely positive will be higher. For that reason, an additional test, such as a Western blot, is recommended following repeatedly reactive ELISA results, especially in low-prevalence populations. In populations with high prevalence of infection (e.g. homosexual men or IV drug abusers), most repeatedly reactive ELISAs are reactive by Western blot or another test. For example, among 109 IV drug abusers whose sera were repeatedly reactive by ELISA, over 85% were reactive by Western blot (*22*). In contrast, in a low-prevalence population of 69 female blood donors whose sera were repeatedly reactive by ELISA, only 5% were reactive by Western blot (*15*).

Due to the seriousness of the implications of HTLV-III/LAV-antibody reactivity, it is recommended that repeatedly reactive ELISAs be followed by an additional test, such as the Western blot. Women with sera repeatedly reactive by ELISA and reactive by Western blot should have a thorough medical evaluation. HTLV-III/LAV has been isolated from a single specimen in 67%-95% of persons with specific antibody (*23,24*). Because infection has been demonstrated in asymptomatic persons, the presence of specific antibody should be considered presumptive evidence of current infection and infectiousness.

RECOMMENDATIONS

Women Who Should be Offered Counselling and Testing. *Counselling services and testing for antibody to HTLV-III/LAV should be offered to pregnant women and women who may become pregnant in the following groups*: (1) those who have evidence of HTLV-III/LAV infection; (2) those who have used drugs intravenously for nonmedical purposes; (3) those who were born in countries where heterosexual transmission is thought to play a major role (*11,12*); (4) those who have engaged in prostitution; (5) those who are or have been sex partners of: IV drug abusers, bisexual men, men with hemophilia, men who were born in countries where heterosexual transmission is thought to play a major role (*11,12*), or men who otherwise have evidence of HTLV-III/LAV infection. If data become available to show that HTLV-III/LAV-antibody prevalence is increased in other groups or settings, counselling and testing programs should be extended to include them. Routine counselling and testing of women who are not included in the above-mentioned groups is not recommended due to low prevalence of infection and concern about interpretation of test results in a low-prevalence population. However if a woman requests it, the service should be provided in accordance with these recommendations.

Settings for Offering Counselling and Testing. Counselling and testing for antibody to HTLV-III/LAV to prevent perinatal transmission is recommended in the setting of any medical service in which women at increased risk are commonly encountered. These include services for treating IV drug abuse (i.e., detoxification and methadone maintenance), comprehensive hemophilia treatment centers, sexually transmitted disease clinics, and clinics that serve female prostitutes. In addition, services related to reproduction, such as family planning and infertility services, gynecologic, premarital, or preconceptual examinations, and prenatal and

HTLV-III/LAV – Continued

obstetric services should also consider offering counselling and testing if high-risk women are seen at these facilities. Testing for antibody to HTLV-III/LAV should be performed with the woman's consent after counselling is provided regarding risk factors for infection, the interpretation of test results, the risks of transmission, and the possible increased likelihood of disease among women infected with HTLV-III/LAV in association with pregnancy. The counselling and testing must be conducted in an environment in which confidentiality can be assured. In settings where confidential counselling and testing cannot be assured, information should be provided and referrals made to appropriate facilities.

Frequency of Testing. Detectable antibodies to HTLV-III/LAV may not develop until 2-4 months after exposure. This, and whether the woman is continuously exposed, should be taken into account when considering the need for, and frequency of, repeat testing. High-risk women should be offered counselling and testing before they become pregnant. During pregnancy, counselling and testing should be offered as soon as the woman is known to be pregnant. If the initial test is negative, repeat testing may be indicated near delivery to aid in the clinical management of the pregnant woman and newborn. If this final test is negative and the mother's risk of exposure no longer exists, she may safely consider breastfeeding the child, and management of the child need not include the same concerns that would be appropriate if the woman had had a positive test or if she were at high risk and had not been tested at all.

Counselling Women with Positive Results. Women with virologic or serologic evidence of HTLV-III/LAV infection should be counselled regarding their own risk of AIDS and the risk of perinatal and sexual transmission of HTLV-III/LAV. Infected women should be counselled to refer their sex partners for counselling and testing. If the partners of these women are not infected, both members of the couple should be counselled on how they may modify their sexual practices to reduce the risk of HTLV-III/LAV transmission to the uninfected partner. In addition, the couple should be told not to donate blood, organs, or sperm and should be discouraged from using IV drugs and advised against sharing needles and syringes. When seeking medical or dental care for intercurrent illness, they should inform those responsible for their care of their positive antibody status so appropriate evaluation can be undertaken. Recommendations for providing information and advice to individuals infected with HTLV-III/LAV have been published (*25*).

Infected women should be advised to consider delaying pregnancy until more is known about perinatal transmission of the virus. Pregnant infected women may require additional medical and social support services due to an enhanced risk of opportunistic infections and psychosocial difficulties during and after pregnancy. Obstetric-care providers should be alert to signs and symptoms of HTLV-III/LAV and related opportunistic infections in these pregnant women and to the need for specialized medical care.

HTLV-III/LAV-infected women should be advised against breastfeeding to avoid postnatal transmission to a child who may not yet be infected. The child should receive follow-up pediatric evaluations to determine whether he/she has HTLV-III/LAV infection, and to diagnose and treat promptly any diseases that may be secondary to HTLV-III/LAV infection. Recommendations for educating and providing foster care for infected children have been published (*26*).

Counselling Women with Negative Test Results. A negative ELISA for HTLV-III/LAV antibody in women who have no clinical or laboratory evidence of HTLV-III/LAV infection is evidence that they have probably not been infected. However, uninfected women who have sex

HTLV-III/LAV – Continued

partners with evidence of HTLV-III/LAV infection or with an increased risk of becoming infected should be informed that sexual intercourse increases their risk of infection. These women should be informed of the risks associated with pregnancy if they become infected and advised to consider delaying pregnancy until more is known about perinatal transmission of the virus or until they are no longer considered to be at risk for acquiring the virus. In addition to preventing pregnancy, the consistent and proper use of condoms can offer some protection against HTLV-III/LAV infection.

High-risk women, even if seronegative, should be told not to donate blood or organs. To decrease their risk of becoming infected, IV drug abusers should be encouraged to seek treatment for their drug abuse. Persons counselling IV drug abusers should know that IV drug abuse is often strongly ingrained and compulsive. Despite educational efforts and encouragement for treatment, some addicts will continue to abuse drugs or relapse after treatment. If drug abuse continues, they should be advised not to share needles or syringes and to use only sterile equipment.

Additional Considerations. These recommendations will be revised as additional information becomes available. It is recognized that provision of the recommended professional counselling, HTLV-III/LAV-antibody testing and associated specialized medical services will take time to implement and may stress available resources, particularly in public facilities, which are most greatly affected. Health-care providers, social-service personnel, and others involved in educating and caring for HTLV-III/LAV-infected persons should be aware of the potential for social isolation and should be sensitive to the need for confidentiality. They should be familiar with federal and state laws, regulations, and policies that protect the confidentiality of clinical data and test results. Each institution should assure that specific mechanisms are in place to protect the confidentiality of all records and to prevent the misuse of information. Anonymous testing would not be appropriate if it prevents adequate counselling and medical follow-up evaluation.

Hospital precautions for managing infected women and infants should be patterned after those for caring for patients with HTLV-III/LAV infection (*27,28*). Additional recommendations will follow.

DEVELOPMENT OF THESE RECOMMENDATIONS

The information and recommendations contained in this document were developed and compiled by CDC and the U.S. Public Health Service in consultation with individuals representing: the Conference of State and Territorial Epidemiologists, the Association of State and Territorial Health Officials, the American Public Health Association, the United States Conference of Local Health Officers, the American Medical Association, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the Planned Parenthood Federation of America, the American Venereal Disease Association, the Division of Maternal and Child Health of the Health Resources and Services Administration, the National Institute on Drug Abuse of the Alcohol, Drug Abuse, and Mental Health Administration, the National Hemophilia Foundation, the Haitian Medical Association, the American Bar Foundation, and the Kennedy Institute of Ethics at Georgetown University. The consultants also included representatives of the departments of health of the areas with the largest number of perinatally transmitted pediatric AIDS cases: New York City, Florida, and New Jersey. These recommendations may not reflect the views of all individual consultants or the organizations they represented.

1. Lapointe N, Michaud J, Pekovic D, Chausseau JP, Dupuy JM. Transplacental transmission of HTLV-III virus. [Letter] N Engl J Med 1985;312:1325-6.
2. Cowan MJ, Hellmann D, Chudwin D, Wara DW, Chang RS, Ammann AJ. Maternal transmission of acquired immune deficiency syndrome. Pediatrics 1984;73:382-6.
3. Ziegler JB, Cooper DA, Johnson RO, Gold J. Postnatal transmission of AIDS-associated retrovirus from mother to infant. Lancet 1985;i:896-7.
4. Thiry L, Sprecher-Goldberger S, Jonckheer T, et al. Isolation of AIDS virus from cell-free breast milk of three healthy virus carriers. [Letter] Lancet 1985;ii:891-2.
5. Scott GB, Fischl MA, Klimas N, et al. Mothers of infants with the acquired immunodeficiency syndrome: outcome of subsequent pregnancies. Atlanta, Georgia: International conference on acquired immunodeficiency syndrome, April 14-17, 1985.
6. Scott GB, Fischl MA, Klimas N, et al. Mothers of infants with the acquired immunodeficiency syndrome: evidence for both symptomatic and asymptomatic carriers. JAMA 1985;253:363-6.
7. Stewart GJ, Tyler JPP, Cunningham AL, et al. Transmission of human T-lymphotropic virus type III (HTLV-III) virus by artificial insemination by donor. Lancet 1985;ii:581-4.
8. CDC. Unpublished data.
9. Thomas PA, Lubin K, Enlow RW, Getchell J. Comparison of HTLV-III serology, T-cell levels, and general health status of children whose mothers have AIDS with children of healthy inner city mothers in New York. Atlanta, Georgia: International conference on acquired immunodeficiency syndrome, April 14-17, 1985.
10. Weinberg ED. Pregnancy-associated depression of cell-mediated immunity. Rev Inf Dis 1984;6: 814-31.
11. WHO. Acquired immune deficiency syndrome (AIDS). Report on the situation in Europe as of 31 December 1984. Weekly Epidemiological Record 1985;60:85-92.
12. Castro KG, Fischl MA, Landesman SH, et al. Risk factors for AIDS among Haitians in the United States. Atlanta, Georgia: International conference on acquired immunodeficiency syndrome, April 14-17, 1985.
13. Jason J, McDougal JS, Holman RC, et al. Human T-lymphotropic retrovirus type III/lymphadenopathy-associated virus antibody: association with hemophiliacs' immune status and blood component usage. JAMA 1985; 253:3409-15.
14. Gjerset GF, McGrady G, Counts RB, et al. Lymphadenopathy-associated virus antibodies and T cells in hemophiliacs treated with cryoprecipitate or concentrate. Blood 1985;66:718-20.
15. CDC. Unpublished data.
16. Spira TJ, Des Jarlais DC, Bokos D, et al. HTLV-III/LAV antibodies in intravenous drug abusers: comparison of low and high risk areas for AIDS. Atlanta, Georgia: International conference on acquired immunodeficiency syndrome, April 14-17, 1985.
17. Weiss SH, Ginzburg HM, Goedert JJ, et al. Risk for HTLV-III exposure and AIDS among parenteral drug abusers in New Jersey. Atlanta, Georgia: International conference on acquired immunodeficiency syndrome, April 14-17, 1985.
18. Kreiss JK, Kitchen LW, Prince HE, Kasper CK, Essex M. Antibody to human T-lymphotropic virus type III in wives of hemophiliacs: evidence for heterosexual transmission. Ann Intern Med 1985; 102:623-6.
19. Redfield RR, Markham PD, Salahuddin SZ, et al. Frequent transmission of HTLV-III among spouses of patients with AIDS-related complex and AIDS. JAMA 1985;253:1571-3.
20. Harris CA, Cabradilla CD, Robert-Guroff M, et al. HTLV-III/LAV infection and AIDS in heterosexual partners of AIDS patients. Minneapolis, Minnesota: Twenty-fifth interscience conference on antimicrobial agents and chemotherapy, September 29-October 2, 1985.
21. CDC. Heterosexual transmission of human T-lymphotropic virus type III/lymphadenopathy-associated virus. MMWR 1985;34:561-3.
22. CDC. Unpublished data.
23. Feorino PM, Jaffe HW, Palmer E, et al. Transfusion-associated acquired immunodeficiency syndrome: evidence for persistent infection in blood donors. N Engl J Med 1985;312:1293-6.
24. Jaffe HW, Feorino PM, Darrow WW, et al. Persistent infection with human T-lymphotropic virus type III/lymphadenopathy-associated virus in apparently healthy homosexual men. Ann Intern Med 1985;102:627-30.
25. CDC. Provisional Public Health Service inter-agency recommendations for screening donated blood and plasma for antibody to the virus causing acquired immunodeficiency syndrome. MMWR 1985;34:1-5.
26. CDC. Education and foster care of children infected with human T-lymphotropic virus type III/lymphadenopathy-associated virus. MMWR 1985;34:517-21.
27. CDC. Acquired immune deficiency syndrome (AIDS): precautions for clinical and laboratory staffs. MMWR 1982;31:577-80.
28. CDC. Recommendations for preventing transmission of infection with human T-lymphotropic virus type III/lymphadenopathy-associated virus in the workplace. MMWR 1985;34:681-6, 691-5.

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CENTERS FOR DISEASE CONTROL

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

CDC Surveillance Summaries 1985

Hepatitis Surveillance, 1982-1983

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Introduction

The various types of viral hepatitis have a major impact on the public health of this nation. The objective of national surveillance of viral hepatitis is to provide serologic, demographic, and epidemiologic information that will aid in formulating policies for the prevention and control of these diseases. The purpose of the hepatitis surveillance report is to interpret and disseminate this information, as well as to present new developments and clarify issues related to viral hepatitis.

Information on hepatitis is obtained by two surveillance systems. The CDC National Morbidity Reporting System collects incidence data on cases reported by each state and territory. These data, which include numbers of cases of each type of hepatitis classified by age of patient and date reported, appear in the Morbidity and Mortality Weekly Report (MMWR) and the MMWR Annual Summary, and are summarized in this report as well. Serologic and epidemiologic data pertaining to risk factors of disease acquisition are obtained from the Viral Hepatitis Surveillance Program (VHSP), a separate, voluntary reporting system operated by the Hepatitis Branch (formerly Division of Hepatitis and Viral Enteritis, Phoenix, AZ), Division of Viral Diseases, Center for Infectious Diseases, Centers for Disease Control, Atlanta, GA. The VHSP obtains its information from the viral hepatitis case records (CDC form 53.1). These forms can be obtained from the Hepatitis Branch.

Since 1980, the VHSP has received reports on approximately half the cases reported in the MMWR. CDC's ability to accurately analyze and interpret nationwide trends and patterns, identify high-risk groups, and determine mechanisms of transmission for each type of hepatitis depends on two factors: 1) local medical communities' utilization of appropriate serologic tests to distinguish between the different types of hepatitis and 2) the voluntary cooperation of the state and local health departments in completing and submitting the VHSP forms. Non-A, non-B hepatitis is now a separate reportable disease category, and since this type of viral hepatitis remains a diagnosis of exclusion, serotesting is even more important. Differentiation of any of the types of viral hepatitis based on clinical or epidemiologic characteristics alone is no longer acceptable since there is considerable overlap of the different types of hepatitis with respect to these characteristics.

Underreporting and inaccurate diagnosis impede CDC's ability to develop guidelines for preventing and controlling hepatitis and to assess the impact of prevention strategies.

Morbidity Trends Based on MMWR-Reported Cases

Incidence Reported in the United States. Table 1 shows the changes in incidence of reported cases of hepatitis, by type, since 1966. In 1983, the reported incidence of hepatitis B surpassed that of hepatitis A for the first time. Of the 56,469 cases of viral hepatitis reported in 1983, 38% were reported as hepatitis A, 43% as hepatitis B, only 6% as hepatitis non-A, non-B, and 13% as unspecified hepatitis. Although the rates of hepatitis A and unspecified hepatitis have declined, the increase in the rate of hepatitis B and the institution of reporting of hepatitis non-A, non-B have resulted in a nearly constant overall rate of viral hepatitis. In part, these trends may be artifacts due to increased utilization of specific tests for both hepatitis A and hepatitis B and increased awareness of hepatitis non-A, non-B.

Incidence Reported by State and Region. The reported rates for hepatitis A and hepatitis B by state for both 1982 and 1983 are shown in Figures 1-4. In 1983, states in the west and southwest regions continued to report high rates of hepatitis A. However, several states from other regions reported the highest disease rates; these states had either foodborne or community-wide outbreaks. The states with the highest rates of hepatitis B were clustered primarily on the east and west coasts, as in previous years. Hepatitis non-A, non-B has been a separate reportable disease in the MMWR only since 1982. The low reported rates for this disease are believed to be due to incomplete serologic testing and underreporting. At this time, these rates are not thought accurate enough to be presented by state or region.

By 1983 the rate of hepatitis B had equalled or surpassed that of hepatitis A in six of the nine regions in the United States (Figure 5). Since 1980, the total rate of hepatitis reported has remained fairly constant in most of the regions. However, in the East-South Central, West-South Central, Mountain, and Pacific regions, the total rate of hepatitis continues to fluctuate as a result of fluctuations in the rate of hepatitis A.

Incidence Reported by Age. Persons in the 20- to 29-year age group continue to have the highest rates of both hepatitis A and hepatitis B (Figure 6). The risk of acquiring hepatitis A appears to have declined in persons of all age groups except those less than 15 years of age. Day care centers are well recognized as high-risk areas for the transmission of hepatitis A (*1-3*), not only for day care attendees and workers but also for their household contacts. In addition, more complete testing, including serologic markers for acute hepatitis A and hepatitis B, may have resulted in reclassification of the type of hepatitis in older persons. Although

TABLE 1. Reported cases of viral hepatitis by type and year, United States, 1966-1983

	Types of hepatitis									
	Hepatitis A		Hepatitis B		Non-A, non-B†		Unspecified§		Total	
Year	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*
1966	32,859	16.77	1,497	0.79	—	—	—	—	34,356	17.56
1967	38,909	19.67	2,458	1.28	—	—	—	—	41,367	20.95
1968	45,893	22.96	4,829	2.49	—	—	—	—	50,722	25.45
1969	48,416	23.98	5,909	3.02	—	—	—	—	54,325	27.00
1970	56,797	27.87	8,310	4.08	—	—	—	—	65,107	31.95
1971	59,606	28.90	9,556	4.74	—	—	—	—	69,162	33.64
1972	54,074	25.97	9,402	4.52	—	—	—	—	63,476	30.49
1973	50,749	24.18	8,451	4.03	—	—	—	—	59,200	28.21
1974	40,358	19.54	10,631	5.15	—	—	8,351	3.95	59,340	28.07
1975	35,855	16.82	13,121	6.30	—	—	7,158	3.44	56,134	26.34
1976	33,288	15.51	14,973	7.14	—	—	7,488	3.57	55,749	25.97
1977	31,153	14.40	16,831	7.78	—	—	8,639	3.99	56,623	26.17
1978	29,500	13.53	15,016	6.89	—	—	8,776	4.02	53,292	24.44
1979	30,407	13.82	15,452	7.02	—	—	10,524	4.79	56,393	25.62
1980	29,087	12.84	19,015	8.39	—	—	11,894	5.25	59,996	26.49
1981	25,802	11.25	21,152	9.22	—	—	10,975	4.79	57,929	25.26
1982	23,403	10.11	22,177	9.58	2,629	1.14	8,564	3.40	56,773	24.52
1983	21,532	9.20	24,318	10.39	3,470	1.48	7,149	3.05	56,469	24.12

*Rate/100,000 population.
†Not reported until 1982.
§Not reported until 1974.

Source: MMWR

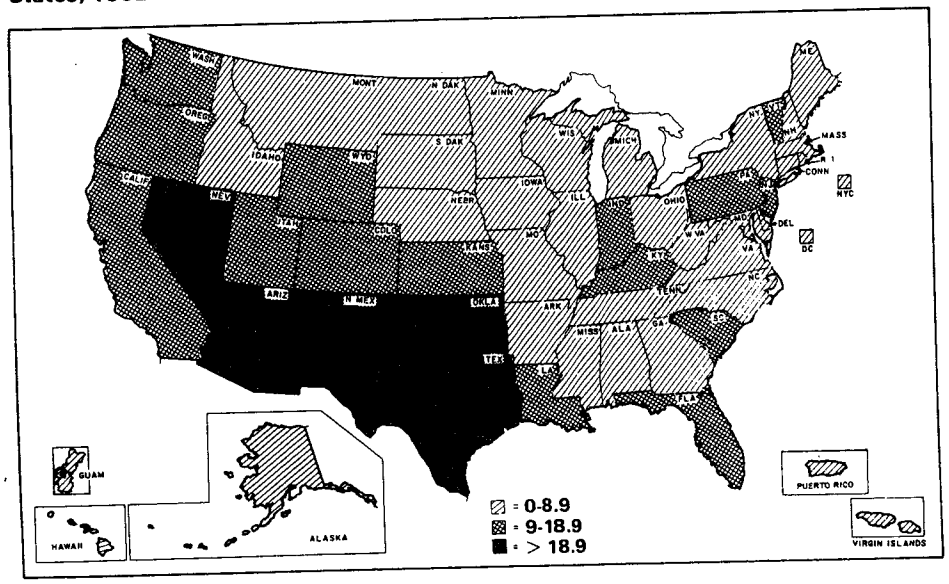
persons under 15 years of age still experience low rates of hepatitis B infection, the risk of acquiring this disease has increased for all other age groups. Persons in the 15- to 39-year age groups, particularly, tend to be in the high-risk categories associated with hepatitis B, such as health care workers, parenteral drug abusers, and homosexual men.

Epidemiologic and Clinical Characteristics—Cases Reported to VHSP

Case Definition. The purpose of collecting epidemiologic data on reported cases of viral hepatitis is to define the different groups at risk of acquiring acute hepatitis infection and to assess trends in the frequencies with which these groups acquire disease. Reporting of asymptomatic carriers and/or persons with chronic hepatitis (B or non-A, non-B) may obscure the trends associated with new disease acquisition. Therefore, the VHSP requires that reported cases meet certain criteria as outlined below, and encourages persons reporting to use these criteria before cases are reported.

The case definition for acute viral hepatitis in the VHSP includes 1) an illness with discrete date of onset and 2) jaundice and/or elevated serum aminotransferase levels greater than 2½ times upper limit of normal. Serologic criteria used to distinguish the different types of hepatitis are as follows: hepatitis A is defined as IgM anti-HAV-positive (regardless of HBsAg status), hepatitis B as HBsAg-positive with IgM anti-HAV negative or not done, and hepatitis non-A, non-B as HBsAg-negative and IgM anti-HAV-negative. In 1982, although 82% of all the cases reported to VHSP were tested for at least one serologic marker, only 71% had sufficient serologic testing to designate a specific type. In 1983, 85% were tested for at least one serologic marker, but only 79% had sufficient serologic testing to designate a specific type of hepatitis. Only those cases with a specific serologic diagnosis are included in the following analyses.

FIGURE 1. Reported cases of hepatitis A per 100,000 population, by state, United States, 1982



States, 1983

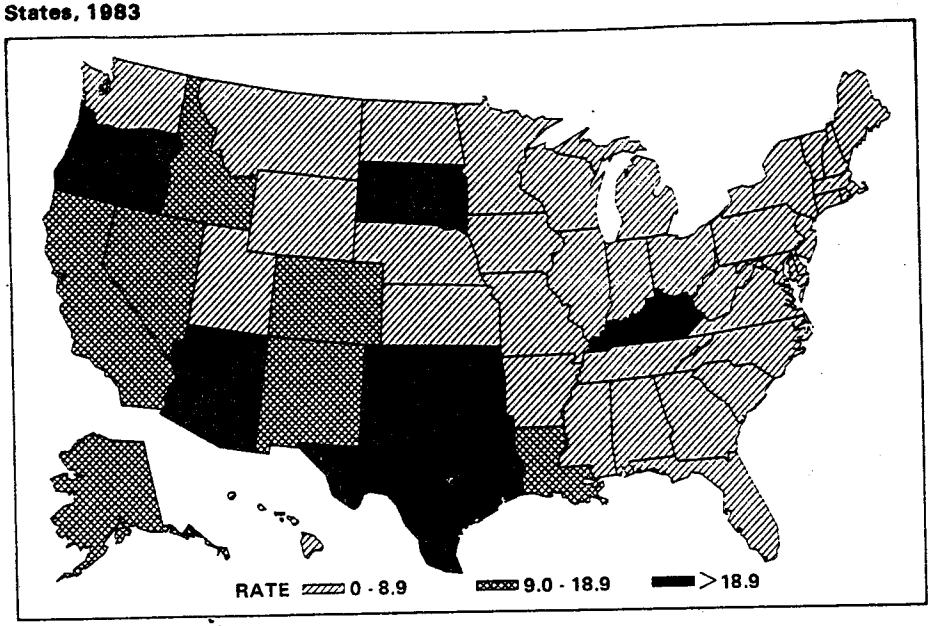


FIGURE 3. Reported cases of hepatitis B per 100,000 population, by state, United States, 1982

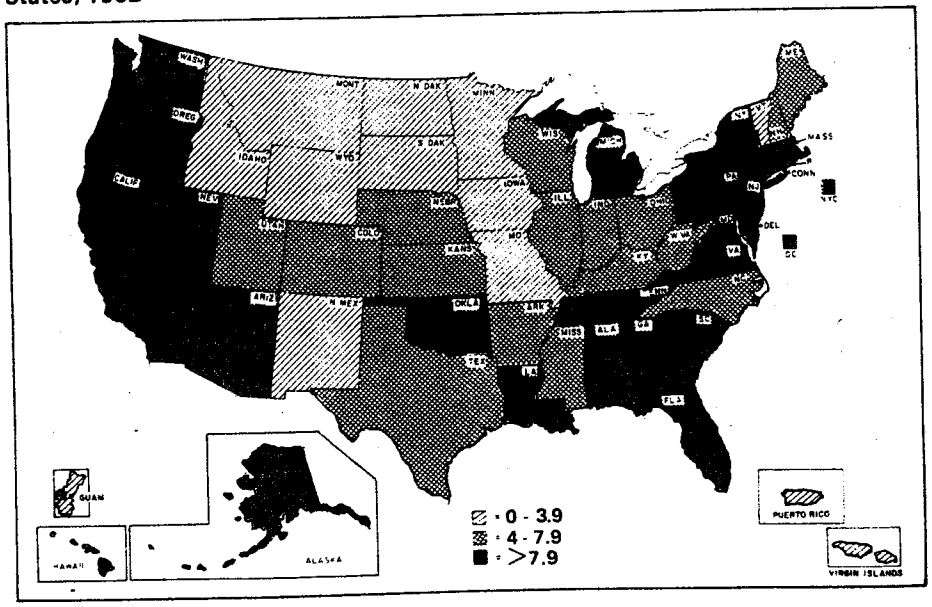


FIGURE 4. Reported cases of hepatitis B per 100,000 population, by state, United States, 1983

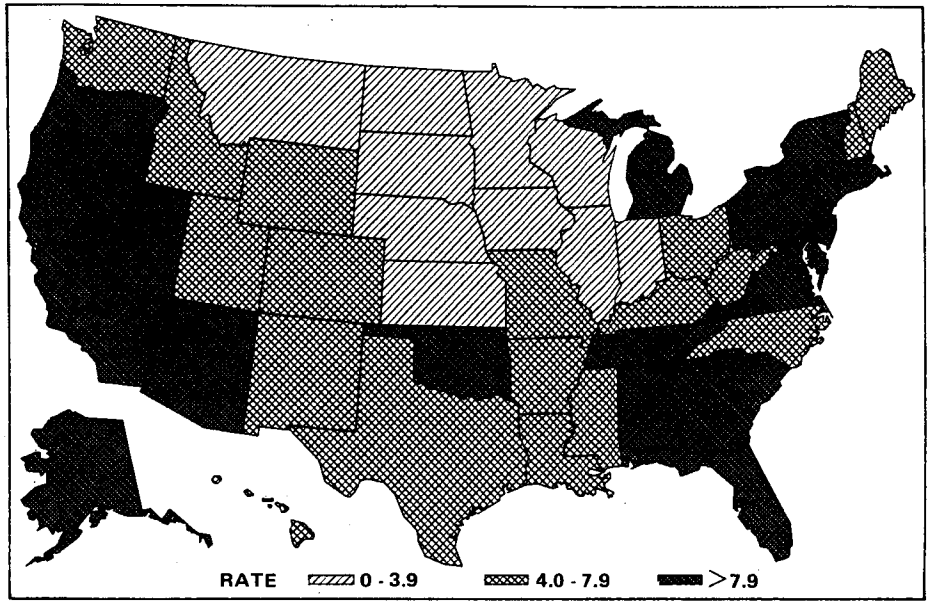
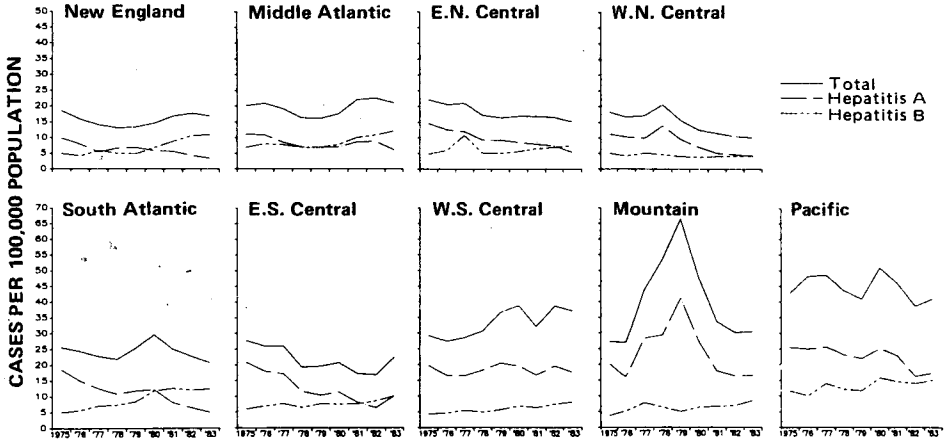


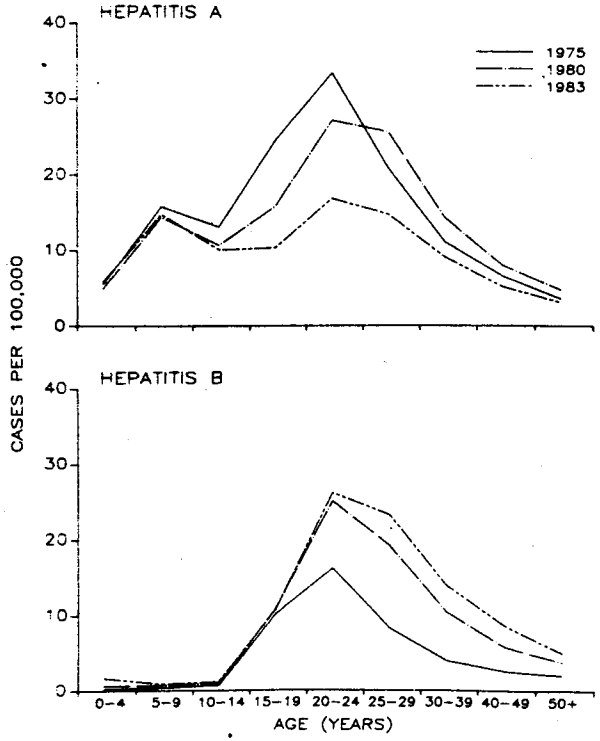
FIGURE 5. Reported cases of viral hepatitis, by region, United States, 1975-1983



In addition to incomplete serologic testing, some of the cases reported did not satisfy the criteria for acute hepatitis, in that no date of onset was reported or the patient was listed as asymptomatic. Among reported cases of hepatitis A and hepatitis non-A, non-B, 3% and 5%, respectively, showed no date of onset. However, 13% of the reported hepatitis B cases either showed no date of onset or were indicated as asymptomatic. These cases were compared with hepatitis B cases that did fulfill the criteria for acute hepatitis; there were no significant differences with respect to age, sex, ethnic group, or most of the epidemiologic risk factors frequently reported for persons with hepatitis B. However, persons with hepatitis B who were asymptomatic or had no date of onset were more likely to be dialysis patients or have histories of blood transfusion, hospitalization prior to their onset of hepatitis, surgery, or dental work. These persons may have been routinely screened for HBsAg and found to be positive without any evidence of acute illness. Since these persons did not fulfill the case definition and might simply be carriers of hepatitis B virus, they were excluded from any further analysis.

Epidemiologic Characteristics. Tables 2 and 3 show the distribution of viral hepatitis types A, B, and non-A, non-B by age, sex, and ethnic group for 1982 and 1983. Hepatitis A was the predominant type of hepatitis occurring among persons < 15 years of age. All three types of hepatitis were seen most frequently among persons 20-29 years of age. However, the age distribution of persons with non-A, non-B hepatitis is bimodal, with peaks occurring in the 20- to 29-year age group and the over-50-year age group. The second peak observed in

FIGURE 6. Reported cases of viral hepatitis, by type and age, United States, 1975, 1980, 1983



the over-50-year age group is largely the result of the greater frequency with which post-transfusion hepatitis occurs in this group. The male-to-female ratio is about 1:1 for both hepatitis A and hepatitis non-A, non-B, and 2:1 for hepatitis B. Each type of hepatitis occurred predominantly among the white ethnic group. Blacks represented a higher proportion of hepatitis B cases than they did of the other two types; and hepatitis B was the predominant type of hepatitis among blacks.

Tables 4 and 5 give the frequencies with which epidemiologic and clinical characteristics were reported for cases with hepatitis types A, B, and non-A, non-B for the years 1982 and 1983. For hepatitis A, contact with a person infected with hepatitis A, association with a day-care center, and international travel were factors reported with the highest frequency. Homosexual men have also been identified as being at high risk of acquiring hepatitis A (*4*). Although only 2% of all the cases reported this behavior, in some states the frequency ranged as high as 20%.

For hepatitis B, contact with a person infected with hepatitis B, parenteral drug abuse, and a variety of other potential percutaneous exposures were among the factors most frequently reported. Health care workers and homosexual men are well recognized high-risk groups for hepatitis B (*5-9*). Although only 7% to 8% of all patients with hepatitis B reported that they were employed in a medical or dental field, this occupational factor accounted for as many as 15% of all hepatitis B cases in some states. In addition, only 8% to 9% of all patients with hepatitis B reported homosexual activity, but in some states the frequency with which this behavior was reported in cases was as high as 20%. The risk factor reported with the greatest frequency among patients with hepatitis B was contact with another case. In some instances, the simultaneous presence of other factors such as drug abuse, working in a health-related occupation, or homosexual activity may be responsible for transmission. In other instances, however, transmission of hepatitis B due to personal contact is probably the result of heterosexual activity involving multiple sex partners (*10*). Whether other percutaneous exposures, including those related to prior hospitalization and dental work, are true risk factors is unknown. Without a control population, the significance of these factors cannot be assessed.

For non-A, non-B hepatitis, a history of receiving blood transfusions, parenteral drug abuse, and other percutaneous exposures were the factors most frequently reported. The frequency with which these factors were reported, particularly drug abuse, varied widely from state to state. In addition, although only 5% of the patients with non-A, non-B hepatitis reported having worked in a medical or dental field, a previously recognized risk for acquiring non-A, non-B hepatitis (*11*), this occupational factor accounted for up to 20% of the cases in some states. The high frequency with which potential percutaneous exposures such as prior hospitalization and surgery is reported is related to receiving blood transfusions.

Clinical Characteristics. The frequencies with which jaundice and hospitalization for hepatitis were reported were similar for all three types of hepatitis. Cases reported to VHSP have a higher rate of hospitalization than cases identified in other epidemiologic studies (*11,12*), suggesting that reported cases may be more severe. However, this rate has declined from 63% in 1976 to 56% in 1980 to between 33% and 46% in 1983, perhaps as a result of improved reporting. The case-fatality rate is lower for reported cases of hepatitis A and highest for reported cases of hepatitis B and non-A, non-B, even when examined by specific age groups. In addition, patients hospitalized with hepatitis, regardless of the type, have a case-fatality rate four to six times higher than patients not hospitalized for their hepatitis.

TABLE 2. Distribution of viral hepatitis types A, B, and non-A, non-B, by age, sex and ethnic group, United States, 1982, VHSP

	Hepatitis A N=7,698		Hepatitis B N=8,414		Non-A, non-B hepatitis N=2,543	
Age	No.	%	No.	%	No.	%
< 5	342	4.4	39	0.5	35	1.4
5-9	684	8.9	39	0.5	48	1.9
10-14	605	7.9	70	0.8	78	3.1
15-19	789	10.2	858	10.2	223	8.8
20-29	2,574	33.4	3,924	46.6	847	33.3
30-39	1,251	16.3	1,612	19.2	472	18.6
40-49	512	6.7	683	8.1	202	7.9
50-59	395	5.1	497	5.9	234	9.2
60+	430	5.6	557	6.6	373	14.7
Unknown	116	1.5	135	1.6	31	1.2
Sex						
Male	4,294	55.8	5,222	62.1	1,321	51.9
Female	3,318	43.1	3,114	37.0	1,208	47.5
Unknown	86	1.1	78	0.9	14	0.6
Ethnic group						
White	6,028	78.3	5,432	64.6	1,987	78.1
Black	442	5.7	1,655	19.7	232	9.1
Hispanic	459	6.0	355	4.2	83	3.3
Other	769	10.0	972	11.6	241	9.5

TABLE 3. Distribution of viral hepatitis types A, B, and non-A, non-B, by age, sex and ethnic group, United States, 1983, VHSP

	Hepatitis A N=7,854		Hepatitis B N=8,925		Non-A, non-B hepatitis N=2,960	
Age	No.	%	No.	%	No.	%
< 5	353	4.5	46	0.5	31	1.0
5-9	801	10.2	42	0.5	58	2.0
10-14	648	8.3	54	0.6	84	2.8
15-19	712	9.1	775	8.7	217	7.3
20-29	2,486	31.7	4,045	45.3	955	32.3
30-39	1,240	15.8	1,800	20.2	580	19.6
40-49	453	5.8	720	8.1	245	8.3
50-59	351	4.5	498	5.6	243	8.2
60+	473	6.0	582	6.5	425	14.4
Unknown	337	4.3	363	4.1	122	4.1
Sex						
Male	4,210	53.6	5,454	61.1	1,437	48.5
Female	3,494	44.5	3,266	36.6	1,446	48.9
Unknown	150	1.9	205	2.3	77	2.6
Ethnic Group						
White	6,106	77.7	5,840	65.4	2,244	75.8
Black	418	5.3	1,693	19.0	328	11.1
Hispanic	459	5.8	390	4.4	99	3.3
Other	871	11.1	1,002	11.2	289	9.8

***** THE OFFICIAL NEWSLETTER OF THE NCGSTDS * VOLUME 7:2 * DECEMBER/JANUARY, 1986 * PAGE 37 *****

References

1. CDC. Hepatitis outbreak in a day-care center—Texas. MMWR 1980;29:565-75.
2. Hadler SC, Erben JJ, Francis DP, Webster HM, Maynard JE. Risk factors for hepatitis A in day-care centers. J Infect Dis 1982;145(2):255-61.
3. Hadler SC, Webster HM, Erben JJ, Swanson JE, Maynard JE. Hepatitis A in day-care centers: a community-wide assessment. N Engl J Med 1980;302(22):1222-7.
4. Corey L and Holmes KK. Sexual transmission of hepatitis A in homosexual men—incidence and mechanism. N Engl J Med 1980;302(8):435-8.
5. Maynard JE. Viral hepatitis as an occupational hazard in the health care profession. Hepatitis Viruses 1978 (proceedings of the 1976 Intl. Symp. on Hepatitis Viruses, Tokyo, 18-20 November 1976. University of Tokyo Press), 293-305.
6. Hadler SC, Doto IL, Maynard JE, et al. Occupational risk of hepatitis B infection in hospital workers. J Infect Control, 1985;6:24-31.
7. Dienstag JL and Ryan DM. Occupational exposure to hepatitis B virus in hospital personnel: infection or immunization? Am J Epidemiol 1982;115(1):26-39.
8. Szmuness W, Much MI, Prince AM, et al. On the role of sexual behavior in the spread of hepatitis B infection. Ann Intern Med 1975;83(4):489-95.
9. Schreeder MT, Thompson SE, Hadler SC, et al. Hepatitis B in homosexual men: prevalence of infection and factors related to transmission. J Infect Dis 1982;146(1):7-15.
10. Alter MJ, Ahtone J, Wisefuse I, Starko K, Vacalis TD, Maynard JE. Risk of hepatitis B virus transmission between heterosexuals. In: Vyas GN, Dienstag JL, Hoofnagle JH, eds. Viral Hepatitis and Liver Disease. New York: Grune and Stratton, Inc. 1984:636.
11. Alter MJ, Gerety RJ, Smallwood LA, et al. Sporadic non-A, non-B hepatitis: frequency and epidemiology in an urban U.S. population. J Infect Dis 1982;145(6):886-93.
12. Francis DP, Hadler SC, Prendergast TJ, et al. Occurrence of hepatitis A, B, and non-A, non-B in the United States - CDC Sentinel County Hepatitis Study I. Am J Med 1984;76:69-74.

TABLE 4. Epidemiologic and clinical characteristics of reported cases of viral hepatitis, by serologic type, 1982, VHSP

	Percentages of cases		
	Hepatitis A N=7,698	Hepatitis B N=8,414	Non-A, non-B hepatitis N=2,543
Epidemiologic characteristics			
Child/employee in daycare center	6.7	0.7	2.2
Contact of daycare child/employee	10.3	1.8	3.6
Personal contact with hepatitis A	29.5	1.6	4.6
Employed as a foodhandler	6.2	4.0	5.1
Foodborne or waterborne outbreak	6.0	0.3	1.1
International travel	5.2	1.4	2.2
Personal contact with hepatitis B	1.8	14.6	5.0
Employed in medical/dental field	1.9	8.1	5.5
Assoc. with dialysis/transplant	0.3	1.8	1.5
Blood transfusion	0.8	3.9	9.8
Hospitalized prior to illness	4.3	14.4	20.4
Surgery	2.0	7.0	11.2
Dental work	5.5	14.5	13.8
Drug abuse	2.4	13.5	9.1
Homosexual activity	1.9	7.8	2.1
Other percutaneous exposures	3.7	16.6	15.3
Clinical characteristics			
Jaundice	78.3	74.8	63.8
Hospitalized for hepatitis	39.6	47.7	48.0
Death as a result of hepatitis	0.6	1.3	2.5

Note: Percentages are based on the number of persons who answered the question. For hepatitis A, the last 10 epidemiologic characteristics were answered by relatively few cases; therefore, the percentages are underestimated and cannot be accurately compared with the hepatitis B and non-A, non-B groups.

TABLE 5. Epidemiologic and clinical characteristics of reported cases of viral hepatitis, by serologic type, 1983, VHSP

	Percentages of cases		
	Hepatitis A N=7,854	Hepatitis B N=8,925	Non-A, non-B hepatitis N=2,960
Epidemiologic characteristics			
Child/employee in daycare center	6.3	0.5	1.9
Contact of daycare child/employee	9.8	1.5	3.7
Personal contact with hepatitis A	27.7	1.1	3.3
Employed as a foodhandler	6.1	3.4	4.5
Foodborne or waterborne outbreak	4.0	0.2	0.6
International travel	6.3	0.7	1.7
Personal contact with hepatitis B	1.7	14.8	4.9
Employed in medical/dental field	1.1	6.9	4.9
Assoc. with dialysis/transplant	0.3	1.7	1.7
Blood transfusion	0.7	3.5	10.6
Hospitalized prior to illness	3.6	14.4	21.5
Surgery	1.6	6.7	11.6
Dental work	4.5	13.7	13.6
Drug abuse	2.7	12.7	10.9
Homosexual activity	1.6	8.7	2.1
Other percutaneous exposures	3.8	15.3	14.9
Clinical characteristics			
Jaundice	78.2	74.5	61.4
Hospitalized for hepatitis	33.2	44.4	45.6
Death as a result of hepatitis	0.6	1.6	2.0

Note: Percentages are based on the number of persons who answered the question. For hepatitis A, the last 10 epidemiologic characteristics were answered by relatively few cases; therefore, the percentages are underestimated and cannot be accurately compared with the hepatitis B and non-A, non-B groups.

TABLE 6. Hepatitis types A, B, and non-A, non-B case fatality rates by hospitalization status, 1983, VHSP

	Case fatality rates		
	Hepatitis A N=7,854	Hepatitis B N=8,925	Non-A, non-B hepatitis N=2,960
Hospitalized	1.4	3.0	3.9
Not hospitalized	0.3	0.6	0.6
Total	**0.7**	**1.7**	**2.1**

CENTERS FOR DISEASE CONTROL

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Acquired Immunodeficiency Syndrome: Meeting of the WHO Collaborating Centres on AIDS

Following a consultation on acquired immunodeficiency syndrome (AIDS) in April 1985, the World Health Organization (WHO) established a network of Collaborating Centres on AIDS to provide a framework for international cooperation, including training, provision of reference reagents, evaluation of methods, and epidemiologic surveillance (*1*). The directors of the WHO Collaborating Centres, together with other experts in virology and public health, met in Geneva, Switzerland, September 25-26, 1985, to make recommendations for WHO's 1986-1987 international activities on AIDS.

Participants at the meeting reviewed the epidemiologic status of AIDS and affirmed the disease was now a major public health problem in several countries of the developed and developing world. Over 13,000 AIDS cases were reported from 1981 to September 1985 in the United States, and the number of reported cases will probably double in 1986. More than 2,000 cases have been reported from 40 other countries. The Director-General of WHO expressed the great degree of concern felt in almost all 166 Member States of WHO regarding AIDS.

In the United States and western Europe, approximately 90% of cases among adults continued to occur in homosexual and bisexual men, intravenous drug users, and sexual partners of persons in these groups. Although it is expected that additional AIDS cases may develop in recipients of blood and blood products who are already infected with the causative virus of AIDS, lymphadenopathy-associated virus/human T-lymphotropic virus type III (LAV/HTLV-III), future infections from blood and blood products can now virtually be considered preventable by screening blood donations for evidence of antibodies to the virus. Most pediatric cases of AIDS have occurred among children of persons in known risk groups. In several developing countries, however, most adult AIDS patients have been sexually active heterosexual men and women.

There is no evidence that LAV/HTLV-III is spread through casual contact with an infected individual, such as contact in family settings, schools, or other groups living or working together. The risk of infection of health-care workers seems very remote. At present, there is no evidence that blood-sucking insects transmit the disease.

The group concluded that an internationally accepted case definition of AIDS, relevant to its most severe clinical manifestations, was needed for surveillance purposes. For therapeutic trials or other research purposes, broader definitions may be required.

In countries where appropriate technologies are available, the surveillance definition for AIDS given by CDC and published by WHO (*2*) was endorsed by the group. Surveillance definitions are now being developed for use in countries where access to diagnostic techniques is limited.

The group concurred on the following issues:

1. For routine, large-scale testing for AIDS, the only practical methods currently available involve tests for antibodies to LAV/HTLV-III.
2. All sera reactive for anti-LAV/HTLV-III antibody in a radioimmunoassay (RIA) or enzyme-linked immunoabsorbent assay (ELISA) test should be confirmed by an independent test system, e.g., by immunoprecipitation or immunoblot tests. Assays for this antibody of higher specificity but lower sensitivity than that of conventional commercial ELISAs may be more appropriate for seroepidemiologic studies where confirmatory tests are not available.
3. Posttransfusion AIDS can be eliminated by excluding donors from groups at increased risk of infection and by screening all units of blood for antibodies to LAV/HTLV-III. Because infection can be transmitted from women to babies during the perinatal period, women who are antibody-positive should be advised to avoid pregnancy.
4. Reusing unsterile needles carries with it the risk of transmitting AIDS and other blood-borne infections. This procedure should be strongly discouraged.
5. The possible transmission of infectious diseases through the use of jet injection devices was discussed. After considering the available information, the group concluded that there was no evidence of a risk of transmission of blood-borne infection from using such devices.
6. Studies to identify effective therapeutic regimens for AIDS patients and work on developing vaccines are in progress in several countries. Successful therapy may require a combination of antiviral agents and substances that enhance immune responsiveness. Passive protection against infection is being pursued experimentally, including the use of monoclonal antibodies and hyperimmune gammaglobulin. Further work towards understanding the role of antibody in preventing and treating AIDS is required before these substances can be utilized in patients.
7. New antiviral drugs require careful study using the procedures of classical drug-evaluation protocols, under the guidelines of national control authorities. Studies to define the pharmacology, toxicity, and tolerated dosages must precede studies to determine the benefit.
8. Placebo-controlled studies in patients with mild forms of disease due to LAV/HTLV-III infection should be encouraged. Such studies will yield an answer on the efficacy of a drug more quickly and with fewer patients than the use of historic controls.
9. The prevalence of AIDS will depend heavily on the success of risk-reduction programs based on public information and education.
10. Because patients infected with LAV/HTLV-III often have immune-function abnormalities, administration of the commonly used live-virus vaccines (e.g., polio, measles) to such individuals could pose a theoretical risk. However, to date, no unexpected adverse reactions have been noted in individuals with antibody to LAV/HTLV-III, and such patients are free of overt signs of clinical AIDS when given the vaccines recommended by WHO for childhood or adult immunization programs.
11. T-lymphotropic retroviruses of simians provide potentially valuable models for studying the control and treatment of AIDS (*3*).
12. An important aspect of WHO activities on AIDS will be the collection of data on the incidence of the disease or its causative virus by Member States and the WHO Collaborating Centres and the regular transmission of this information to WHO headquarters. Wherever possible, information on the gender, age, recognized risk factor (if any), and major clinical features should also be provided

A full report of the meeting is available from the Director, Division of Communicable Diseases, WHO, Geneva.

Adapted from WHO Weekly Epidemiological Record *1985;60:333-5.*

References

1. WHO. Acquired immune deficiency syndrome (AIDS). WHO consultation. Weekly Epidemiological Record 1985;60:129-30.
2. WHO. Acquired immune deficiency syndrome (AIDS). Revision of the case definition of AIDS. Weekly Epidemiological Record 1985;60:270-1.
3. WHO. T-lymphotropic retroviruses of non-human primates. WHO informal meeting. Weekly Epidemiological Record 1985;60:269-70.

CENTERS FOR DISEASE CONTROL

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Current Trends

Summary: Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus in the Workplace

The information and recommendations contained in this document have been developed with particular emphasis on health-care workers and others in related occupations in which exposure might occur to blood from persons infected with HTLV-III/LAV, the "AIDS virus." Because of public concern about the purported risk of transmission of HTLV-III/LAV by persons providing personal services and those preparing and serving food and beverages, this document also addresses personal-service and food-service workers. Finally, it addresses "other workers"—persons in settings, such as offices, schools, factories, and construction sites, where there is no known risk of AIDS virus transmission.

Because AIDS is a bloodborne, sexually transmitted disease that is not spread by casual contact, this document does *not* recommend routine HTLV-III/LAV antibody screening for the groups addressed. Because AIDS is not transmitted through preparation or serving of food and beverages, these recommendations state that food-service workers known to be infected with AIDS should not be restricted from work unless they have another infection or illness for which such restriction would be warranted.

This document contains detailed recommendations for precautions appropriate to prevent transmission of all bloodborne infectious diseases to people exposed—in the course of their duties—to blood from persons who may be infected with HTLV-III/LAV. They emphasize that health-care workers should take all possible precautions to prevent needlestick injury. The recommendations are based on the well-documented modes of HTLV-III/LAV transmission and incorporate a "worst case" scenario, the hepatitis B model of transmission. Because the hepatitis B virus is also bloodborne and is both hardier and more infectious than HTLV-III/LAV, recommendations that would prevent transmission of hepatitis B will also prevent transmission of AIDS.

Formulation of specific recommendations for health-care workers who perform invasive procedures is in progress.

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

Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus in the Workplace

Persons at increased risk of acquiring infection with human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV), the virus that causes acquired immunodeficiency syndrome (AIDS), include homosexual and bisexual men, intravenous (IV) drug abusers, persons transfused with contaminated blood or blood products, heterosexual contacts of persons with HTLV-III/LAV infection, and children born to infected mothers. HTLV-III/LAV is transmitted through sexual contact, parenteral exposure to infected blood or blood components, and perinatal transmission from mother to neonate. HTLV-III/LAV has been isolated from blood, semen, saliva, tears, breast milk, and urine and is likely to be isolated from some other body fluids, secretions, and excretions, but epidemiologic evidence has implicated only blood and semen in transmission. Studies of nonsexual household contacts of AIDS patients indicate that casual contact with saliva and tears does not result in transmission of infection. Spread of infection to household contacts of infected persons has not been detected when the household contacts have not been sex partners or have not been infants of infected mothers. The kind of nonsexual person-to-person contact that generally occurs among workers and clients or consumers in the workplace does not pose a risk for transmission of HTLV-III/LAV.

As in the development of any such recommendations, the paramount consideration is the protection of the public's health. The following recommendations have been developed for all workers, particularly workers in occupations in which exposure might occur to blood from individuals infected with HTLV-III/LAV. These recommendations reinforce and supplement the specific recommendations that were published earlier for clinical and laboratory staffs (*1*) and for dental-care personnel and persons performing necropsies and morticians' services (*2*). Because of public concern about the purported risk of transmission of HTLV-III/LAV by persons providing personal services and by food and beverages, these recommendations contain information and recommendations for personal-service and food-service workers. Finally, these recommendations address workplaces in general where there is no known risk of transmission of HTLV-III/LAV (e.g., offices, schools, factories, construction sites). Formulation of specific recommendations for health-care workers (HCWs) who perform invasive procedures (e.g., surgeons, dentists) is in progress. Separate recommendations are also being developed to prevent HTLV-III/LAV transmission in prisons, other correctional facilities, and institutions housing individuals who may exhibit uncontrollable behavior (e.g., custodial institutions) and in the perinatal setting. In addition, separate recommendations have already been developed for children in schools and day-care centers (*3*).

HTLV-III/LAV-infected individuals include those with AIDS (*4*); those diagnosed by their physician(s) as having other illnesses due to infection with HTLV-III/LAV; and those who have virologic or serologic evidence of infection with HTLV-III/LAV but who are not ill.

These recommendations are based on the well-documented modes of HTLV-III/LAV transmission identified in epidemiologic studies and on comparison with the hepatitis B experience. Other recommendations are based on the hepatitis B model of transmission.

COMPARISON WITH THE HEPATITIS B VIRUS EXPERIENCE

The epidemiology of HTLV-III/LAV infection is similar to that of hepatitis B virus (HBV) infection, and much that has been learned over the last 15 years related to the risk of acquiring hepatitis B in the workplace can be applied to understanding the risk of HTLV-III/LAV transmission in the health-care and other occupational settings. Both viruses are transmitted through

HTLV-III/LAV – Continued

sexual contact, parenteral exposure to contaminated blood or blood products, and perinatal transmission from infected mothers to their offspring. Thus, some of the same major groups at high risk for HBV infection (e.g., homosexual men, IV drug abusers, persons with hemophilia, infants born to infected mothers) are also the groups at highest risk for HTLV-III/LAV infection. Neither HBV nor HTLV-III/LAV has been shown to be transmitted by casual contact in the workplace, contaminated food or water, or airborne or fecal-oral routes (*5*).

HBV infection is an occupational risk for HCWs, but this risk is related to degree of contact with blood or contaminated needles. HCWs who do not have contact with blood or needles contaminated with blood are not at risk for acquiring HBV infection in the workplace (*6-8*).

In the health-care setting, HBV transmission has not been documented between hospitalized patients, except in hemodialysis units, where blood contamination of the environment has been extensive or where HBV-positive blood from one patient has been transferred to another patient through contamination of instruments. Evidence of HBV transmission from HCWs to patients has been rare and limited to situations in which the HCWs exhibited high concentrations of virus in their blood (at least 100,000,000 infectious virus particles per ml of serum), and the HCWs sustained a puncture wound while performing traumatic procedures on patients or had exudative or weeping lesions that allowed virus to contaminate instruments or open wounds of patients (*9-11*).

Current evidence indicates that, despite epidemiologic similarities of HBV and HTLV-III/LAV infection, the risk for HBV transmission in health-care settings far exceeds that for HTLV-III/LAV transmission. The risk of acquiring HBV infection following a needlestick from an HBV carrier ranges from 6% to 30% (*12,13*), far in excess of the risk of HTLV-III/LAV infection following a needlestick involving a source patient infected with HTLV-III/LAV, which is less than 1%. In addition, all HCWs who have been shown to transmit HBV infection in health-care settings have belonged to the subset of chronic HBV carriers who, when tested, have exhibited evidence of exceptionally high concentrations of virus (at least 100,000,000 infectious virus particles per ml) in their blood. Chronic carriers who have substantially lower concentrations of virus in their blood have not been implicated in transmission in the health-care setting (*9-11,14*). The HBV model thus represents a "worst case" condition in regard to transmission in health-care and other related settings. Therefore, recommendations for the control of HBV infection should, if followed, also effectively prevent spread of HTLV-III/LAV. Whether additional measures are indicated for those HCWs who perform invasive procedures will be addressed in the recommendations currently being developed.

Routine screening of all patients or HCWs for evidence of HBV infection has never been recommended. Control of HBV transmission in the health-care setting has emphasized the implementation of recommendations for the appropriate handling of blood, other body fluids, and items soiled with blood or other body fluids.

TRANSMISSION FROM PATIENTS TO HEALTH-CARE WORKERS

HCWs include, but are not limited to, nurses, physicians, dentists and other dental workers, optometrists, podiatrists, chiropractors, laboratory and blood bank technologists and technicians, phlebotomists, dialysis personnel, paramedics, emergency medical technicians, medical examiners, morticians, housekeepers, laundry workers, and others whose work involves contact with patients, their blood or other body fluids, or corpses.

Recommendations for HCWs emphasize precautions appropriate for preventing transmission of bloodborne infectious diseases, including HTLV-III/LAV and HBV infections. Thus, these precautions should be enforced routinely, as should other standard infection-control precautions, regardless of whether HCWs or patients are known to be infected with HTLV-III/LAV or HBV. In addition to being informed of these precautions, all HCWs, including students

HTLV-III/LAV – Continued

and housestaff, should be educated regarding the epidemiology, modes of transmission, and prevention of HTLV-III/LAV infection.

Risk of HCWs acquiring HTLV-III/LAV in the workplace. Using the HBV model, the highest risk for transmission of HTLV-III/LAV in the workplace would involve parenteral exposure to a needle or other sharp instrument contaminated with blood of an infected patient. The risk to HCWs of acquiring HTLV-III/LAV infection in the workplace has been evaluated in several studies. In five separate studies, a total of 1,498 HCWs have been tested for antibody to HTLV-III/LAV. In these studies, 666 (44.5%) of the HCWs had direct parenteral (needlestick or cut) or mucous membrane exposure to patients with AIDS or HTLV-III/LAV infection. Most of these exposures were to blood rather than to other body fluids. None of the HCWs whose initial serologic tests were negative developed subsequent evidence of HTLV-III/LAV infection following their exposures. Twenty-six HCWs in these five studies were seropositive when first tested; all but three of these persons belonged to groups recognized to be at increased risk for AIDS (*15*). Since one was tested anonymously, epidemiologic information was available on only two of these three seropositive HCWs. Although these two HCWs were reported as probable occupationally related HTLV-III/LAV infection (*15,16*), neither had a preexposure nor an early postexposure serum sample available to help determine the onset of infection. One case reported from England describes a nurse who seroconverted following an accidental parenteral exposure to a needle contaminated with blood from an AIDS patient (*17*).

In spite of the extremely low risk of transmission of HTLV-III/LAV infection, even when needlestick injuries occur, more emphasis must be given to precautions targeted to prevent needlestick injuries in HCWs caring for any patient, since such injuries continue to occur even during the care of patients who are known to be infected with HTLV-III/LAV.

Precautions to prevent acquisition of HTLV-III/LAV infection by HCWs in the workplace. These precautions represent prudent practices that apply to preventing transmission of HTLV-III/LAV and other bloodborne infections and should be used routinely (*18*).

1. Sharp items (needles, scalpel blades, and other sharp instruments) should be considered as potentially infective and be handled with extraordinary care to prevent accidental injuries.
2. Disposable syringes and needles, scalpel blades, and other sharp items should be placed into puncture-resistant containers located as close as practical to the area in which they were used. To prevent needlestick injuries, needles should not be recapped, purposefully bent, broken, removed from disposable syringes, or otherwise manipulated by hand.
3. When the possibility of exposure to blood or other body fluids exists, routinely recommended precautions should be followed. The anticipated exposure may require gloves alone, as in handling items soiled with blood or equipment contaminated with blood or other body fluids, or may also require gowns, masks, and eye-coverings when performing procedures involving more extensive contact with blood or potentially infective body fluids, as in some dental or endoscopic procedures or postmortem examinations. Hands should be washed thoroughly and immediately if they accidentally become contaminated with blood.
4. To minimize the need for emergency mouth-to-mouth resuscitation, mouth pieces, resuscitation bags, or other ventilation devices should be strategically located and available for use in areas where the need for resuscitation is predictable.
5. Pregnant HCWs are not known to be at greater risk of contracting HTLV-III/LAV infections than HCWs who are not pregnant; however, if a HCW develops HTLV-III/LAV infection during pregnancy, the infant is at increased risk of infection resulting from

HTLV-III/LAV – Continued

perinatal transmission. Because of this risk, pregnant HCWs should be especially familiar with precautions for the preventing HTLV-III/LAV transmission (*19*).

Precautions for HCWs during home care of persons infected with HTLV-III/LAV. Persons infected with HTLV-III/LAV can be safely cared for in home environments. Studies of family members of patients infected with HTLV-III/LAV have found no evidence of HTLV-III/LAV transmission to adults who were not sexual contacts of the infected patients or to children who were not at risk for perinatal transmission (*3*). HCWs providing home care face the same risk of transmission of infection as HCWs in hospitals and other health-care settings, especially if there are needlesticks or other parenteral or mucous membrane exposures to blood or other body fluids.

When providing health-care service in the home to persons infected with HTLV-III/LAV, measures similar to those used in hospitals are appropriate. As in the hospital, needles should not be recapped, purposefully bent, broken, removed from disposable syringes, or otherwise manipulated by hand. Needles and other sharp items should be placed into puncture-resistant containers and disposed of in accordance with local regulations for solid waste. Blood and other body fluids can be flushed down the toilet. Other items for disposal that are contaminated with blood or other body fluids that cannot be flushed down the toilet should be wrapped securely in a plastic bag that is impervious and sturdy (not easily penetrated). It should be placed in a second bag before being discarded in a manner consistent with local regulations for solid waste disposal. Spills of blood or other body fluids should be cleaned with soap and water or a household detergent. As in the hospital, individuals cleaning up such spills should wear disposable gloves. A disinfectant solution or a freshly prepared solution of sodium hypochlorite (household bleach, see below) should be used to wipe the area after cleaning.

Precautions for providers of prehospital emergency health care. Providers of prehospital emergency health care include the following: paramedics, emergency medical technicians, law enforcement personnel, firefighters, lifeguards, and others whose job might require them to provide first-response medical care. The risk of transmission of infection, including HTLV-III/LAV infection, from infected persons to providers of prehospital emergency health care should be no higher than that for HCWs providing emergency care in the hospital if appropriate precautions are taken to prevent exposure to blood or other body fluids.

Providers of prehospital emergency health care should follow the precautions outlined above for other HCWs. No transmission of HBV infection during mouth-to-mouth resuscitation has been documented. However, because of the theoretical risk of salivary transmission of HTLV-III/LAV during mouth-to-mouth resuscitation, special attention should be given to the use of disposable airway equipment or resuscitation bags and the wearing of gloves when in contact with blood or other body fluids. Resuscitation equipment and devices known or suspected to be contaminated with blood or other body fluids should be used once and disposed of or be thoroughly cleaned and disinfected after each use.

Management of parenteral and mucous membrane exposures of HCWs. If a HCW has a parenteral (e.g., needlestick or cut) or mucous membrane (e.g., splash to the eye or mouth) exposure to blood or other body fluids, the source patient should be assessed clinically and epidemiologically to determine the likelihood of HTLV-III/LAV infection. If the assessment suggests that infection may exist, the patient should be informed of the incident and requested to consent to serologic testing for evidence of HTLV-III/LAV infection. If the source patient has AIDS or other evidence of HTLV-III/LAV infection, declines testing, or has a positive test, the HCW should be evaluated clinically and serologically for evidence of HTLV-III/LAV infection as soon as possible after the exposure, and, if seronegative, retested after 6 weeks and on a periodic basis thereafter (e.g., 3, 6, and 12 months following exposure) to determine if transmission has occurred. During this follow-up period, especially the first 6-12 weeks, when most infected persons are expected to seroconvert, exposed HCWs should receive counseling about the risk of infection and follow U.S. Public Health Service (PHS) recommendations for preventing transmission of AIDS (*20,21*). If the source patient is seronegative and has no other evidence of HTLV-III/LAV infection, no further follow-up of the HCW is necessary. If the source patient cannot be identified, decisions regarding appropriate follow-up should be individualized based on the type of exposure and the likelihood that the source patient was infected.

Serologic testing of patients. Routine serologic testing of all patients for antibody to HTLV-III/LAV is not recommended to prevent transmission of HTLV-III/LAV infection in the workplace. Results of such testing are unlikely to further reduce the risk of transmission, which, even with documented needlesticks, is already extremely low. Furthermore, the risk of needlestick and other parenteral exposures could be reduced by emphasizing and more consistently implementing routinely recommended infection-control precautions (e.g., not recapping needles). Moreover, results of routine serologic testing would not be available for emergency cases and patients with short lengths of stay, and additional tests to determine whether a positive test was a true or false positive would be required in populations with a low prevalence of infection. However, this recommendation is based only on considerations of occupational risks and should not be construed as a recommendation against other uses of the serologic test, such as for diagnosis or to facilitate medical management of patients. Since the experience with infected patients varies substantially among hospitals (75% of all AIDS cases have been reported by only 280 of the more than 6,000 acute-care hospitals in the United States), some hospitals in certain geographic areas may deem it appropriate to initiate serologic testing of patients.

TRANSMISSION FROM HEALTH-CARE WORKERS TO PATIENTS

Risk of transmission of HTLV-III/LAV infection from HCWs to patients. Although there is no evidence that HCWs infected with HTLV-III/LAV have transmitted infection to patients, a risk of transmission of HTLV-III/LAV infection from HCWs to patients would exist in situations where there is both (1) a high degree of trauma to the patient that would provide a portal of entry for the virus (e.g., during invasive procedures) and (2) access of blood or serous fluid from the infected HCW to the open tissue of a patient, as could occur if the HCW sustains a needlestick or scalpel injury during an invasive procedure. HCWs known to be infected with HTLV-III/LAV who do not perform invasive procedures need not be restricted from work unless they have evidence of other infection or illness for which any HCW should be restricted. Whether additional restrictions are indicated for HCWs who perform invasive procedures is currently being considered.

Precautions to prevent transmission of HTLV-III/LAV infection from HCWs to patients. These precautions apply to all HCWs, regardless of whether they perform invasive procedures: (1) All HCWs should wear gloves for direct contact with mucous membranes or nonintact skin of all patients and (2) HCWs who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient-care equipment until the condition resolves.

Management of parenteral and mucous membrane exposures of patients. If a patient has a parenteral or mucous membrane exposure to blood or other body fluids of a HCW, the patient should be informed of the incident and the same procedure outlined above for exposures of HCWs to patients should be followed for both the source HCW and the potentially exposed patient. Management of this type of exposure will be addressed in more detail in the recommendations for HCWs who perform invasive procedures.

Serologic testing of HCWs. Routine serologic testing of HCWs who do not perform invasive procedures (including providers of home and prehospital emergency care) is not recommended to prevent transmission of HTLV-III/LAV infection. The risk of transmission is extremely low and can be further minimized when routinely recommended infection-control precautions are followed. However, serologic testing should be available to HCWs who may wish

to know their HTLV-III/LAV infection status. Whether indications exist for serologic testing of HCWs who perform invasive procedures is currently being considered.

Risk of occupational acquisition of other infectious diseases by HCWs infected with HTLV-III/LAV. HCWs who are known to be infected with HTLV-III/LAV and who have defective immune systems are at increased risk of acquiring or experiencing serious complications of other infectious diseases. Of particular concern is the risk of severe infection following exposure to patients with infectious diseases that are easily transmitted if appropriate precautions are not taken (e.g., tuberculosis). HCWs infected with HTLV-III/LAV should be counseled about the potential risk associated with taking care of patients with transmissible infections and should continue to follow existing recommendations for infection control to minimize their risk of exposure to other infectious agents (*18,19*). The HCWs' personal physician(s), in conjunction with their institutions' personnel health services or medical directors, should determine on an individual basis whether the infected HCWs can adequately and safely perform patient-care duties and suggest changes in work assignments, if indicated. In making this determination, recommendations of the Immunization Practices Advisory Committee and institutional policies concerning requirements for vaccinating HCWs with live-virus vaccines should also be considered.

STERILIZATION, DISINFECTION, HOUSEKEEPING, AND WASTE DISPOSAL TO PREVENT TRANSMISSION OF HTLV-III/LAV

Sterilization and disinfection procedures currently recommended for use (*22,23*) in health-care and dental facilities are adequate to sterilize or disinfect instruments, devices, or other items contaminated with the blood or other body fluids from individuals infected with HTLV-III/LAV. Instruments or other nondisposable items that enter normally sterile tissue or the vascular system or through which blood flows should be sterilized before reuse. Surgical instruments used on all patients should be decontaminated after use rather than just rinsed with water. Decontamination can be accomplished by machine or by hand cleaning by trained personnel wearing appropriate protective attire (*24*) and using appropriate chemical germicides. Instruments or other nondisposable items that touch intact mucous membranes should receive high-level disinfection.

Several liquid chemical germicides commonly used in laboratories and health-care facilities have been shown to kill HTLV-III/LAV at concentrations much lower than are used in practice (*25*). When decontaminating instruments or medical devices, chemical germicides that are registered with and approved by the U.S. Environmental Protection Agency (EPA) as "sterilants" can be used either for sterilization or for high-level disinfection depending on contact time; germicides that are approved for use as "hospital disinfectants" and are mycobactericidal when used at appropriate dilutions can also be used for high-level disinfection of devices and instruments. Germicides that are mycobactericidal are preferred because mycobacteria represent one of the most resistant groups of microorganisms; therefore, germicides that are effective against mycobacteria are also effective against other bacterial and viral pathogens. When chemical germicides are used, instruments or devices to be sterilized or disinfected should be thoroughly cleaned before exposure to the germicide, and the manufacturer's instructions for use of the germicide should be followed.

Laundry and dishwashing cycles commonly used in hospitals are adequate to decontaminate linens, dishes, glassware, and utensils. When cleaning environmental surfaces, housekeeping procedures commonly used in hospitals are adequate; surfaces exposed to blood and body fluids should be cleaned with a detergent followed by decontamination using an EPA-approved hospital disinfectant that is mycobactericidal. Individuals cleaning up such spills should wear disposable gloves. Information on specific label claims of commercial germicides can be obtained by writing to the Disinfectants Branch, Office of Pesticides, Environmental Protection Agency, 401 M Street, S.W., Washington, D.C., 20460.

In addition to hospital disinfectants, a freshly prepared solution of sodium hypochlorite (household bleach) is an inexpensive and very effective germicide (*25*). Concentrations ranging from 5,000 ppm (a 1:10 dilution of household bleach) to 500 ppm (a 1:100 dilution) sodium hypochlorite are effective, depending on the amount of organic material (e.g., blood, mucus, etc.) present on the surface to be cleaned and disinfected.

Sharp items should be considered as potentially infective and should be handled and disposed of with extraordinary care to prevent accidental injuries. Other potentially infective waste should be contained and transported in clearly identified impervious plastic bags. If the outside of the bag is contaminated with blood or other body fluids, a second outer bag should be used. Recommended practices for disposal of infective waste (*23*) are adequate for disposal of waste contaminated by HTLV-III/LAV. Blood and other body fluids may be carefully poured down a drain connected to a sanitary sewer.

CONSIDERATIONS RELEVANT TO OTHER WORKERS

Personal-service workers (PSWs). PSWs are defined as individuals whose occupations involve close personal contact with clients (e.g., hairdressers, barbers, estheticians, cosmetologists, manicurists, pedicurists, massage therapists). PSWs whose services (tattooing, ear piercing, acupuncture, etc.) require needles or other instruments that penetrate the skin should follow precautions indicated for HCWs. Although there is no evidence of transmission of HTLV-III/LAV from clients to PSWs, from PSWs to clients, or between clients of PSWs, a risk of transmission would exist from PSWs to clients and vice versa in situations where there is both (1) trauma to one of the individuals that would provide a portal of entry for the virus and (2) access of blood or serous fluid from one infected person to the open tissue of the other, as could occur if either sustained a cut. A risk of transmission from client to client exists when instruments contaminated with blood are not sterilized or disinfected between clients. However, HBV transmission has been documented only rarely in acupuncture, ear piercing, and tattoo establishments and never in other personal-service settings, indicating that any risk for HTLV-III/LAV transmission in personal-service settings must be extremely low.

All PSWs should be educated about transmission of bloodborne infections, including HTLV-III/LAV and HBV. Such education should emphasize principles of good hygiene, antisepsis, and disinfection. This education can be accomplished by national or state professional organizations, with assistance from state and local health departments, using lectures at meetings or self-instructional materials. Licensure requirements should include evidence of such education. Instruments that are intended to penetrate the skin (e.g., tattooing and acupuncture needles, ear piercing devices) should be used once and disposed of or be thoroughly cleaned and sterilized after each use using procedures recommended for use in health-care institutions. Instruments not intended to penetrate the skin but which may become contaminated with blood (e.g., razors), should be used for only one client and be disposed of or thoroughly cleaned and disinfected after use using procedures recommended for use in health-care institutions. Any PSW with exudative lesions or weeping dermatitis, regardless of HTLV-III/LAV infection status, should refrain from direct contact with clients until the condition resolves. PSWs known to be infected with HTLV-III/LAV need not be restricted from work unless they have evidence of other infections or illnesses for which any PSW should also be restricted.

Routine serologic testing of PSWs for antibody to HTLV-III/LAV is not recommended to prevent transmission from PSWs to clients.

Food-service workers (FSWs). FSWs are defined as individuals whose occupations involve the preparation or serving of food or beverages (e.g., cooks, caterers, servers, waiters, bartenders, airline attendants). All epidemiologic and laboratory evidence indicates that bloodborne and sexually transmitted infections are not transmitted during the preparation or serving of food or beverages, and no instances of HBV or HTLV-III/LAV transmission have been documented in this setting.

All FSWs should follow recommended standards and practices of good personal hygiene and food sanitation (*26*). All FSWs should exercise care to avoid injury to hands when preparing food. Should such an injury occur, both aesthetic and sanitary considerations would dictate that food contaminated with blood be discarded. FSWs known to be infected with HTLV-III/LAV need not be restricted from work unless they have evidence of other infection or illness for which any FSW should also be restricted.

HTLV-III/LAV — Continued

Routine serologic testing of FSWs for antibody to HTLV-III/LAV is not recommended to prevent disease transmission from FSWs to consumers.

Other workers sharing the same work environment. No known risk of transmission to co-workers, clients, or consumers exists from HTLV-III/LAV-infected workers in other settings (e.g., offices, schools, factories, construction sites). This infection is spread by sexual contact with infected persons, injection of contaminated blood or blood products, and by perinatal transmission. Workers known to be infected with HTLV-III/LAV should not be restricted from work solely based on this finding. Moreover, they should not be restricted from using telephones, office equipment, toilets, showers, eating facilities, and water fountains. Equipment contaminated with blood or other body fluids of any worker, regardless of HTLV-III/LAV infection status, should be cleaned with soap and water or a detergent. A disinfectant solution or a fresh solution of sodium hypochlorite (household bleach, see above) should be used to wipe the area after cleaning.

OTHER ISSUES IN THE WORKPLACE

The information and recommendations contained in this document do not address all the potential issues that may have to be considered when making specific employment decisions for persons with HTLV-III/LAV infection. The diagnosis of HTLV-III/LAV infection may evoke unwarranted fear and suspicion in some co-workers. Other issues that may be considered include the need for confidentiality, applicable federal, state, or local laws governing occupational safety and health, civil rights of employees, workers' compensation laws, provisions of collective bargaining agreements, confidentiality of medical records, informed consent, employee and patient privacy rights, and employee right-to-know statutes.

DEVELOPMENT OF THESE RECOMMENDATIONS

The information and recommendations contained in these recommendations were developed and compiled by CDC and other PHS agencies in consultation with individuals representing various organizations. The following organizations were represented: Association of State and Territorial Health Officials, Conference of State and Territorial Epidemiologists, Association of State and Territorial Public Health Laboratory Directors, National Association of County Health Officials, American Hospital Association, United States Conference of Local Health Officers, Association for Practitioners in Infection Control, Society of Hospital Epidemiologists of America, American Dental Association, American Medical Association, American Nurses' Association, American Association of Medical Colleges, American Association of Dental Schools, National Institutes of Health, Food and Drug Administration, Food Research Institute, National Restaurant Association, National Hairdressers and Cosmetologists Association, National Gay Task Force, National Funeral Directors and Morticians Association, American Association of Physicians for Human Rights, and National Association of Emergency Medical Technicians. The consultants also included a labor union representative, an attorney, a corporate medical director, and a pathologist. However, these recommendations may not reflect the views of individual consultants or the organizations they represented.

References

1. CDC. Acquired immune deficiency syndrome (AIDS): precautions for clinical and laboratory staffs. MMWR 1982;31:577-80.
2. CDC. Acquired immunodeficiency syndrome (AIDS): precautions for health-care workers and allied professionals. MMWR 1983;32:450-1.
3. CDC. Education and foster care of children infected with human T-lymphotropic virus type III/lymphadenopathy-associated virus. MMWR 1985;34:517-21.
4. CDC. Revision of the case definition of acquired immunodeficiency syndrome for national reporting—United States. MMWR 1985;34:373-5.

HTLV-III/LAV — Continued

5. CDC. ACIP recommendations for protection against viral hepatitis. MMWR 1985;34:313-24, 329-335.
6. Hadler SC, Doto IL, Maynard JE, et al. Occupational risk of hepatitis B infection in hospital workers. Infect Control 1985;6:24-31.
7. Dienstag JL, Ryan DM. Occupational exposure to hepatitis B virus in hospital personnel: infection or immunization? Am J Epidemiol 1982;115:26-39.
8. Pattison CP, Maynard JE, Berquist KR, et al. Epidemiology of hepatitis B in hospital personnel. Am J Epidemiol 1975;101:59-64.
9. Kane MA, Lettau LA. Transmission of HBV from dental personnel to patients. JADA 1985;110: 634-6.
10. Hadler SC, Sorley DL, Acree KH, et al. An outbreak of hepatitis B in a dental practice. Ann Intern Med 1981;95:133-8.
11. Carl M, Blakey DL, Francis DP, Maynard JE. Interruption of hepatitis B transmission by modification of a gynaecologist's surgical technique. Lancet 1982;i:731-3.
12. Seeff LB, Wright EC, Zimmerman HJ, et al. Type B hepatitis after needlestick exposure: prevention with hepatitis B immune globulin. Ann Intern Med 1978;88:285-93.
13. Grady GF, Lee VA, Prince AM, et al. Hepatitis B immune globulin for accidental exposures among medical personnel: Final report of a multicenter controlled trial. J Infect Dis 1978;138:625-38.
14. Shikata T, Karasawa T, Abe K, et al. Hepatitis B e antigen and infectivity of hepatitis B virus. J Infect Dis 1977;136:571-6.
15. CDC. Update: evaluation of human T-lymphotropic virus type III/lymphadenopathy-associated virus infection in health-care personnel—United States. MMWR 1985;34:575-8.
16. Weiss SH, Saxinger WC, Rechtman D, et al. HTLV-III infection among health care workers: association with needle-stick injuries. JAMA 1985;254:2089-93.
17. Anonymous. Needlestick transmission of HTLV-III from a patient infected in Africa. Lancet 1984;ii:1376-7.
18. Garner JS, Simmons BP. Guideline for isolation precautions in hospitals. Infect Control 1983;4: 245-325.
19. Williams WW. Guideline for infection control in hospital personnel. Infect Control 1983;4:326-49.
20. CDC. Prevention of acquired immune deficiency syndrome (AIDS): report of inter-agency recommendations. MMWR 1983;32:101-3.
21. CDC. Provisional Public Health Service inter-agency recommendations for screening donated blood and plasma for antibody to the virus causing acquired immunodeficiency syndrome. MMWR 1985;34:1-5.
22. Favero MS. Sterilization, disinfection, and antisepsis in the hospital. In: Manual of Clinical Microbiology. 4th ed. Washington, D.C.: American Society for Microbiology, 1985;129-37.
23. Garner JS, Favero MS. Guideline for handwashing and hospital environmental control, 1985. Atlanta Georgia: Centers for Disease Control, 1985. Publication no. 99-1117.
24. Kneedler JA, Dodge GH. Perioperative patient care. Boston: Blackwell Scientific Publications, 1983: 210-1.
25. Martin LS, McDougal JS, Loskoski SL. Disinfection and inactivation of the human T-lymphotropic virus type III/lymphadenopathy-associated virus. J Infect Dis 1985;152:400-3.
26. Food Service Sanitation Manual 1976. DHEW publication no. (FDA) 78-2081. First printing June 1978.

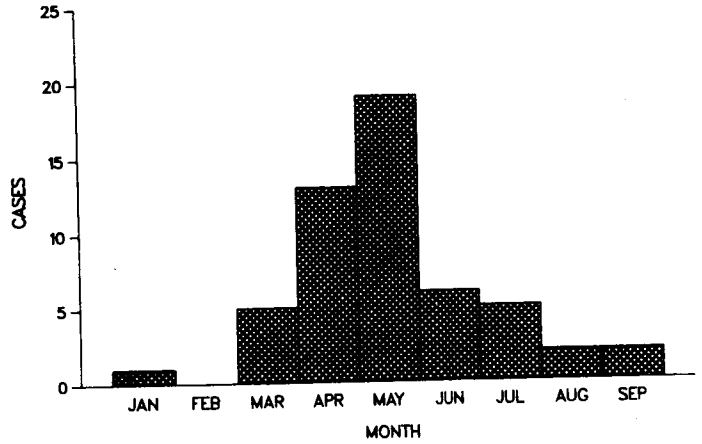
MMWR
MORBIDITY AND MORTALITY WEEKLY REPORT

Chancroid — Massachusetts

From January 8, to September 30, 1985, 53 patients with culture-confirmed or clinically suspected chancroid were treated in Boston-area sexually transmitted diseases (STD) clinics (Figure 2). In the previous 2 years, only two chancroid cases had been diagnosed in Massachusetts. The outbreak was terminated by intensive surveillance efforts, contact tracing, and antimicrobial treatment of both symptomatic and asymptomatic sex partners.

The first presumed case of chancroid occurred in a man who had recently arrived from Florida and who denied having had sexual intercourse while in Massachusetts. He presented to the Boston City Hospital STD Clinic on January 8 with a tender penile ulcer on the foreskin that had been present for 2 weeks, accompanied by swollen, tender, right-sided inguinal lymph nodes. He was treated for presumed syphilis with 2.4 million units of benzathine penicillin, administered intramuscularly. On follow-up examination 1 week later, the ulcer was unchanged, but he had developed swollen, tender, left-sided inguinal lymph nodes. Chancroid was suspected, but the patient failed to respond to oral tetracycline, 500 mg four times a day. On January 24, therapy was changed to oral erythromycin, 500 mg four times a day, with subsequent improvement.

FIGURE 2. Chancroid cases, by date of diagnosis — Massachusetts, January-September 1985



In March, five additional males with soft, penile ulcers and tender inguinal adenopathy were seen at the Boston City Hospital and New England Medical Center STD clinics. In these cases, serologic tests for syphilis were negative, as were cultures, direct fluorescent-antibody tests, and/or Tzanck smears for herpes simplex virus. The cases were presumptively diagnosed as chancroid and responded positively to erythromycin. In early April, the Division of Communicable and Venereal Diseases, Massachusetts Department of Public Health began enhanced surveillance and case investigation after four additional similar patients were seen. By September 30, 53 patients with presumed or culture-confirmed chancroid were identified. The epidemic peaked in April/May, when 32 (60%) of the 53 chancroid patients were seen. Only four cases have been diagnosed since August 1, and three of these appear to have been contracted outside Massachusetts.

Thirty-nine (74%) of the 53 cases were in males. All the males had one or more tender penile ulcers, often with ragged edges. Tender unilateral or bilateral inguinal adenopathy occurred in 33 (85%) men, and five men developed fluctuant buboes. All 14 women had ulcers; two (14%) had asymptomatic cervical ulcers that were found only on examination; six (43%) had only perianal ulcers; and the remaining six (43%) had symptomatic vulvar ulcers. Six of the women had tender inguinal adenopathy. Before chancroid was suspected, several patients underwent surgical procedures because of inguinal adenopathy (herniorrhaphy) and erosive anal lesions (hemorrhoidectomy).

The etiology was confirmed by isolation of *Haemophilus ducreyi*, serology, and exclusion by laboratory evidence of other recognized causes of genital ulcers. Of 28 patients whose ulcers were cultured for *H. ducreyi*, four (14%) were positive. However, indirect immunofluorescence of ulcer smears using a monoclonal antibody directed against *H. ducreyi*, identified rod-shaped organisms typical of *H. ducreyi* in 15 (54%) of 28 specimens, including three of four culture-positive cases. A dot-immunobinding serologic test for *H. ducreyi* antibody, using an *H. ducreyi* outer membrane preparation as antigen, yielded positive results in nine (32%) of 28 cases. All patients were serologically negative for syphilis. No patient tested for herpes simplex virus (by culture, direct fluorescent-antibody test, or Tzanck smear) or lymphogranuloma venereum (by serology) was positive.

Prostitution appeared important in transmitting the disease. Two-thirds of the male patients had recent sexual exposure to prostitutes. Of the 14 females, eight were prostitutes, and all frequented a distinct geographic area of the city. An additional three women had sexual exposure to men known to be sexually active with prostitutes in the same geographic area.

Control measures began in mid-April, immediately after the initial recognition of cases. The sexual partners of the chancroid patients and their sexual contacts were identified, interviewed, examined, and treated (whether lesions were present or not) with oral erythromycin, 500 mg four times a day, or trimethoprim/sulfamethoxazole, two tablets twice a day, each for 10 days. Intensive efforts were made to locate, examine, and treat all prostitutes from the identified Boston area. All were treated with prophylactic antimicrobial therapy. All Massachusetts STD clinics were notified of the outbreak, and all implemented clinical protocols. A medical advisory memorandum outlining the clinical and laboratory characteristics of chancroid were distributed to neighborhood health centers, infection-control nurses, hospital emergency rooms, and private physicians in the Boston area.

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Chancroid – Continued

Editorial Note: Chancroid is an uncommon disease in the United States. In 1983, 847 cases were reported, an incidence of 0.4/100,000 (*1*). Ninety percent of cases were reported by four states—Florida, New York, Georgia, and California—and CDC has investigated outbreaks in three of these states (Florida, New York, and California) during the last 3 years. Nevertheless, this episode demonstrates that outbreaks may occur elsewhere. Although the origin of this outbreak is unclear, it seems likely that an individual infected outside Massachusetts was the source. The fact that three of the four patients whose chancroid occurred after August 1 became infected outside Massachusetts reinforces this suspicion.

Chancroid must be differentiated from other sexually transmitted infectious diseases with genital ulceration (syphilis, genital herpes, lymphogranuloma venereum, granuloma inguinale), but differentiation on clinical grounds can be difficult. The culture of *H. ducreyi* is also difficult and requires special media and personnel experienced with growing *H. ducreyi*. Although laboratories experienced with growing *H. ducreyi* have reported isolation rates as high as 80% from clinically suspected cases (*2*), isolation rates far less than this are generally reported. Both the recent description of a dot-immunobinding serologic test and a means to detect *H. ducreyi* in ulcer material by immunofluorescence offer promising aids to diagnose chancroid where culture has been unsuccessful or impossible to perform (*3*).

Tetracycline was formerly a preferred treatment for chancroid. However, many strains of *H. ducreyi* are now tetracycline resistant (*4*). Similarly, in some areas of the world, including the United States, increased resistance to trimethoprim has recently been described (*5,6*), making treatment with the synergistic combination of trimethoprim/sulfamethoxazole less reliable than before (*5-7*). Yet, trimethoprim/sulfamethoxazole remains reliable in areas where such resistance has not been documented. As a consequence, oral erythromycin, 500 mg four times a day, or intramuscular ceftriaxone, 250 mg, once, have recently been recommended as the preferred drugs for the treatment of chancroid (*8*).

The apparent successful termination of this outbreak demonstrates how promptly implemented surveillance and intervention measures can be effective in controlling outbreaks of sexually transmitted diseases. With chancroid, because asymptomatic carriage of *H. ducreyi* in males and females has been described (*5,9,10*), aggressive tracing and treatment of sex partners, whether symptomatic or not, was an integral part of this strategy.

References

1. U.S. Public Health Service. Sexually transmitted disease statistics, 1983. U.S. Department of Health and Human Services, February, 1985; issue no. 133.
2. Ronald AR, Plummer FA. Chancroid and *Haemophilus ducreyi*. Ann Intern Med 1985;102:705-7.
3. Schalla WO, Sanders LL, Schmid GP, Tam MR, Morse SA. Investigation of clinically suspected cases of chancroid using a dot-immunobinding assay and immunofluorescence. J Infect Dis (in press).
4. Kraus SJ, Kaufman HW, Albritton WL, Thornsberry C, Biddle JW. Chancroid therapy: a review of cases confirmed by culture. Rev Infect Dis 1982;4(S):S848-56.
5. Taylor DN, Pitarangsi C, Echeverria P, Panikabutra K, Suvongse C. Comparative study of ceftriaxone and trimethoprim-sulfamethoxazole for the treatment of chancroid in Thailand. J Infect Dis 1985;152:1002-6.
6. Schmid GP. The treatment of chancroid. JAMA (in press).
7. Naamara W, Kunimoto D, Plummer F, et al. Treatment of chancroid with enoxacin. Brighton, England: The 6th international meeting of the international society for STD research, July 31-August 2, 1985.
8. CDC. 1985 STD treatment guidelines. MMWR 1985;34(suppl 4):76S-7S.
9. Kinghorn GR, Hafiz S, McEntegart MG. Oropharyngeal *Haemophilus ducreyi* infection. Br Med J 1983;287:650.
10. Kinghorn GR, Hafiz S, McEntegart MG. Genital colonisation with *Haemophilus ducreyi* in the absence of ulceration. European Journal of Sexually Transmitted Diseases 1983;1:89-90.

CENTERS FOR DISEASE CONTROL

December 13, 1985 / Vol. 34 / No. 49

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Notice to Readers

Seventh National Lesbian/Gay Health Conference; Fourth National AIDS Forum

The Seventh National Lesbian/Gay Health Conference and Fourth National AIDS Forum will be held March 13-16, 1986, at George Washington University, Washington, D.C., sponsored by the National Lesbian and Gay Health Foundation, Inc.; CDC; the National Institute of Allergy and Infectious Diseases, the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, the National Institute of Mental Health, National Institutes of Health; Alcohol, Drug Abuse, and Mental Health Administration; George Washington University Medical School; the Center for Interdisciplinary Studies of Immunology at Georgetown University; Addiction Recovery Corporation; the Washington, D.C., AIDS Task Force; and the Whitman-Walker Clinic, Washington, D.C.

The purpose of the meeting is to discuss developments in health-care delivery to lesbians and homosexual men; discussions will include acquired immunodeficiency syndrome (AIDS), addiction, and general lesbian and homosexual health concerns. Scientific papers and workshop proposals are now being solicited. For further information and future announcements, contact: NLGHF Conference, P.O. Box 65472, Washington, D.C., 20035; telephone (202) 797-3708.

CENTERS FOR DISEASE CONTROL

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

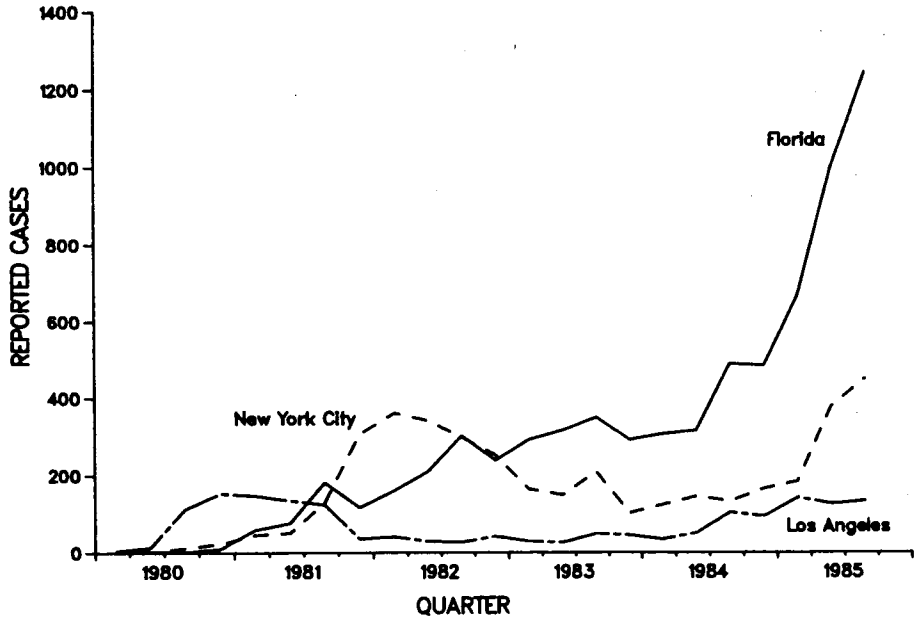
January 10, 1986 / Vol. 35 / No. 1

Current Trends

Penicillinase-Producing *Neisseria gonorrhoeae* — United States, Florida

During the first 9 months of 1985, CDC received reports of 6,020 cases of penicillinase-producing *Neisseria gonorrhoeae* (PPNG) among civilians, over twice the 2,973 cases reported for the same period in 1984. For the first time, PPNG has been reported from all 50 states within a given calendar year. Three areas, New York City, Los Angeles, and Florida, accounted for 71% of all cases, and all three experienced large increases in 1985 (Figure 2).

FIGURE 2. Penicillinase-producing *Neisseria gonorrhoeae*, by quarter — Florida, New York City, Los Angeles, calendar years 1980-1984 and January-September 1985



PPNG — Continued

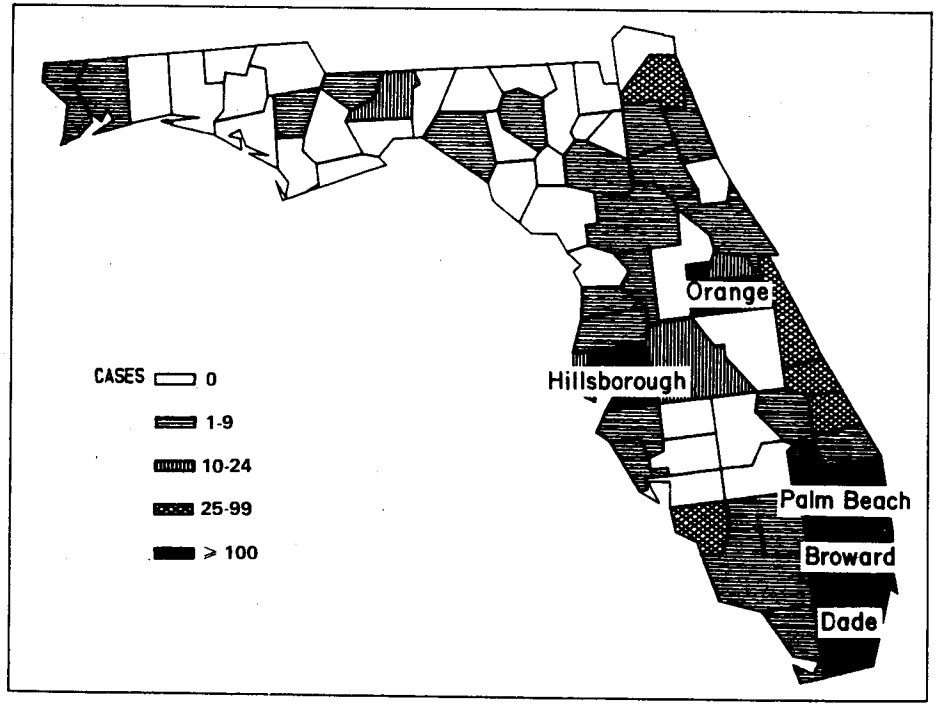
In New York City, reported PPNG has increased from 311 cases during the first 9 months of 1984 to 1,015 cases during the same period in 1985 (226%). In Los Angeles, PPNG increased from 179 cases in 1984 to 389 cases in 1985 (117%).

In Florida, PPNG increased from 1,109 cases in 1984 to 2,898 cases in 1985 (161%). PPNG accounted for 7% of all reported gonorrhea morbidity in Florida and is concentrated in the southernmost portion of the state. The number of cases has progressively increased since 1981, despite a temporary plateau during 1983-1984. The five counties reporting the most cases were: Dade (1,740), Palm Beach (266), Broward (220), Orange (143), and Hillsborough (124) (Figure 3). PPNG has spread slowly northernward during 1985, with 36 of 67 Florida counties reporting PPNG cases.

PPNG, as a percentage of all reported gonorrhea, was highest in Dade County, a metropolitan area of 1.8 million people that includes the city of Miami. During the first 9 months of 1985, 35% of all reported gonorrhea in Dade County was attributable to PPNG. This proportion increased from 25% of cases in January to over 51% in September.

PPNG patients were predominantly male (67%) and black (86%). However, these proportions are not appreciably different from patients with penicillin-sensitive *N. gonorrhoeae* and may represent the patient population seen in public health clinics. Less than 10% of total gonorrhea morbidity (including PPNG) in Dade County is reported by private physicians and hospital emergency rooms. Interviews with infected patients have suggested that nonprescription use

FIGURE 3. Penicillinase-producing *Neisseria gonorrhoeae* cases, by county — Florida, January-September 1985



RESOURCE FOR ALTERNATE HEALTH, Continued from Page 74

project grew out of a conversation between Caitlin Ryan, former project manager of the Clinic's AIDS Education Fund (now called the Whitman Walker Clinic AIDS Program), and Dr. Paul Van Ness, a clinical psychologist with a special interest in holistic health care. Although geographically limited in its listing of practitioners, the descriptions and annotated bibliographies on the various approaches will provide valuable information to any reader. Van Ness attempted to write a document that was not biased toward any particular approach and that was open to including all approaches that would not ordinarily be referred to by mainstream medicine. The Sourcebook includes chapters on vitamin C therapy, macrobiotics, guided imagery, acupuncture, massage, homeopathy, nutrition, and a special self-help section on the use of audiotapes for meditation, relaxation, guided imagery and visualization. The Sourcebook has an interactive format. Three tear-out evaluation forms ask the reader to critique the Sourcebook itself and practitioners listed whom they have used, as well as to recommend additional practitioners for listing in an updated supplement to be published in several months. The tone of the Sourcebook is set in its introduction which acknowledges that these approaches may not be everyone's cup of tea and that any claims of cure should be approached with cautious openness. At the same time, Van Ness felt a balanced presentation of the alternative treatments, about which there is much uninformed gossip in connection with AIDS, would be an important educational service. A significant value of all these approaches is their ability to improve anyone's quality of life--whether he has AIDS or ARC, or is "worried-but-well," needing to constructively channel AIDS anxiety, or anyone for whom the AIDS epidemic has increased interest in preventive health. The emphasis here is on learning how to take control of one's own health care and support the insight that it makes sense for anyone to simply turn over all medical decisions to any practitioners--mainstream medical or otherwise. All ways of improving one's condition--even when the condition is a life-threatening illness--require the person to make decisions about treatment. The introductory guidelines make some suggestions for this effort. Van Ness also hopes that his format might be a model for other geographic areas to provide practitioner information specific to that locale. He emphasizes that such an effort should be inclusive rather than exclusive. It would be presumptive for the authors of similar sourcebooks to decide which approaches are worthy of inclusion and which are not. Rather, inclusion should be based on prior experience using the approach with AIDS-related problems or prevention, or a specifically acknowledged willingness to do so. Then, one trusts the consumer to provide evaluative feedback that adds to the educational process. The Sourcebook can be purchased for a $3, tax-deductable contribution to: Whitman Walker Clinic AIDS Program, 2335 18th Street, NW, Washington, DC 20009 (202/332-5939).

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PPNG — Continued

of antibiotics and drug-related, part-time prostitution have contributed to this epidemic. Case-control studies to determine the influence of these factors are being implemented.

Reported by R Morgan, MD, Dade County Dept of Public Health, Preventive Health Svcs, JJ Witte, MD, State Epidemiologist, Florida Dept of Health and Rehabilitative Svcs; Epidemiology Research Br, Program Svcs Br, Div of Sexually Transmitted Diseases, Center for Prevention Svcs, CDC.

Editorial Note: Since the introduction of PPNG into the United States in 1976, outbreaks have been reported from several areas, including New York City (1), Los Angeles (2), Shreveport, Louisiana (3), and Washington state (4). The epidemic situation in south Florida, however, is without precedent in the United States. Although PPNG rates comparable to those reported here have been observed in Southeast Asia (5), this is the first time that absolute and proportional rates of this magnitude have been seen in the United States.

The number of PPNG cases reported in Florida may substantially underestimate the disease. The low number of reported gonorrhea cases from the private health sector is probably due to underreporting. Moreover, transmission of disease by prostitutes and the inappropriate use of antibiotics have been cited as contributing factors to the south Florida epidemic, as well as in some nations of Southeast Asia (6).

In response to this outbreak, the Florida Sexually Transmitted Diseases Control Program plans to revise certain aspects of clinical and laboratory services and disease intervention (contact-tracing) procedures. Educational programs for both health professionals and the general public will be initiated. On a national level, CDC reemphasizes the necessity of testing all gonococcal isolates for β-lactamase production (7) and suggests that all patients with a presumptive diagnosis of gonorrhea, who have recently traveled to Florida, Los Angeles, New York City, or Southeast Asia, be treated for PPNG according to treatment schedules published in the 1985 STD Treatment Guidelines (8). Copies of these guidelines can be obtained by writing to Technical Information Services, Center for Prevention Services, CDC, Atlanta, Georgia 30333.

References

1. CDC. Penicillinase-producing *Neisseria gonorrhoeae* (PPNG) number of reported cases United States: calendar years 1976-1983. Sexually Transmitted Disease Statistics, 1983. Atlanta, Georgia: U.S. Department of Health and Human Services, Public Health Service, 1985;133:5.
2. CDC. Penicillinase-producing *Neisseria gonorrhoeae*—Los Angeles. MMWR 1983;32:181-3.
3. CDC. An outbreak of penicillinase-producing *Neisseria gonorrhoeae*—Shreveport, Louisiana. MMWR 1980;29:241-3.
4. Handsfield HH, Sandström EG, Knapp JS, et al. Epidemiology of penicillinase-producing *Neisseria gonorrhoeae* infections: analysis by auxotyping and serogrouping. N Engl J Med 1982;306:950-4.
5. Brown S, Warnissorn T, Biddle J, Panikabutra K, Traisupa A. Antimicrobial resistance of *Neisseria gonorrhoeae* in Bangkok: is single-drug therapy passé? Lancet 1982;ii:1366-8.
6. CDC. Penicillinase-producing *Neisseria gonorrhoeae*—United States, worldwide. MMWR 1979;28:85-7.
7. CDC. Infections due to penicillinase-producing *Neisseria gonorrhoeae*—Florida. MMWR 1981;30:245-7.
8. CDC. STD treatment guidelines. MMWR 1985;34(suppl 4):75S-109S.

PEOPLE OF COLOR & AIDS: WHO'S TAKING ACTION

by Marcos Bisticas-Cocoves, with thanks to Boston's Gay Community News, 12/28-1/4/86

Gay and lesbian communities have generally responded to the AIDS crisis with courage, insight and compassion. Lacking any significant federal response until recently, AIDS action groups have sprung up around the United States in an effort to combat the syndrome and the attacks on the communities affected by it. Yet, either because of the passive racism of ignorance, or the active racism of intent, some AIDS organizations appear to operate on a myth current in the straight media: AIDS only affects gay white men.

The fact is, however, that AIDS disproportionately affects Black and Latino communities. Nationally, 40 percent of AIDS cases are Black and Latino. The New York City Department of Health reports that over half of the people affected by the syndrome there are Black and Latino (see chart). In Miami, 28 of the 33 pediatric AIDS cases, or nearly 85 percent, are Black.

While it is easy to find figures on Black and Latino people with AIDS, similar figures for Asian and Native American peoples are difficult, if not impossible, to find. The Atlanta-based Centers for Disease Control (CDC) refuses to release statistics on either Asians or Native Americans with AIDS. The CDC argues that it will not release statistics on either group because the number of cases is so small that someone might be able to figure out who the cases are. Some Asian AIDS activists question whether the statistics that do exist are accurate, suggesting that cultural biases against homosexuality and the Asian community's lack of access to information about the disease may cause AIDS cases to be under-reported.

The make-up of GMHC's staff, volunteers, and clientele is not reflective either of the population of people with AIDS or of the population of the city as a whole. Lori Behrman, media spokesperson for the organization, estimated that there are two people of color on the center's staff. Sandi Feinblum, assistant director of clinical services, conjectures that between five and ten percent of her department's volunteers are people of color. According to intake department coordinator Patrick Hacker, between July and December of 1985, GMHC had 434 white referrals, 99 Black referrals, and 85 Latino referrals.

No one *GCN* spoke to knew how many people of color GMHC serves.

Although GMHC claims it does not do any outreach, the group does, in fact, do effective outreach to gay, white men through its educational material, through its speakers' bureau, and most importantly, through street tables it places across the city. According to Jerry Johnson, who is the organization's hotline coordinator and is responsible for community education, GMHC has translated some of its literature from English into Spanish. According to Welsh, the speakers' bureau has given "several hundred talks" since August, of which "no more than ten to 15 have been to groups of exclusively Black and minority members." Welsh stressed that the bureau only speaks at the invitation of groups. Johnson said that of the approximately 50 tables that GMHC has sent to neighborhoods since September, only about 20 percent have gone to neighborhoods that are primarily of color, and that approximately ten percent of the tabling staff was of color. Welsh related that, in his experience staffing tables in "minority" communities, the GMHC tables were avoided. He attributed this to the "perception" by the community that the staffers are "white middle-class gay men" and outsiders.

GMHC has similar problems in providing social services to communities of color. Referring to the agency's famed buddy system, Feinblum said, "Part of our difficulty is finding volunteers in different geographic locations. We don't get volunteers from the South Bronx. We've made attempts — but there isn't a large gay community in the South Bronx."

GMHC staff gave a variety of reasons for the disparity between the numbers of people of color with AIDS in the city and the possible number that the social service organization sees. Behrman said that although GMHC has a responsibility to respond to all people with AIDS, "we are the only organization in New York City" serving people with AIDS, and that the city and federal governments must take responsibility as well. Johnson cited the homophobia of the Black and Latino communities, but declined to note similar difficulties in reaching out to white communities. Welsh argued, echoing Behrman, that the GMHC staff is already overworked with the caseload it sees, and that it has budget constraints.

Although all seemed to agree that GMHC efforts in addressing issues of race were lacking, some expressed vague hopes for the future. Welsh said that the organization "may become more aggressive" in reaching out to communities of color. Less vaguely, Johnson said that the organization would be developing special literature targeted to communities of color.

Another Response: The Pacific Center AIDS Project

"White AIDS-related organizations must demand funding for Third World outreach," said Jon Peterson, of Oakland, California's Pacific Center AIDS Project. "In its absence, they must find a way to fund it anyway. If you have *x* amount of dollars, a part of that money must include Third World outreach. Cut back elsewhere if you must."

Peterson, a Black gay man and the project's director of education, is responsible for, among other projects, outreach to the Black community. As muticultural specialist for the project, Danny Zielinski is in part responsible for outreach to Latino communities.

Peterson stressed that outreach to communities of color is most effective when it comes from the community itself: "Third World people need outreach done by Third World people. They need information that is sensitive to their culture, and a person who can explain things in culturally appropriate ways. Because of educational discrimination, they need literature that is sensitive to their educational background: something brief, not an excessively long narrative."

According to Peterson, "a radically different approach is necessary to reach people of color" than that used to provide information to the white gay community. Peterson said an effective approach includes home educational campaigns, where a person of color invites people into his or her home to hear an AIDS presentation by a health care provider from the community; culturally appropriate and relevant educational materials; and in cases of intravenous drug users, teaching assistance from former intravenous drug users. Peterson stressed, "It is insufficient to have an all-white staff who are concerned about AIDS among Blacks and Latinos. The most well-intentioned white AIDS staff will not be able to reach the Third World community."

Jon Peterson also discussed ways in which existing services must be revamped if they are to respond to the needs of Black communities: "The Department of Health and Human Services has reported that Blacks are the one group whose general health status is not improving. This epidemic adds to a long list of problems that the Black community faces at this time. Black people need to confront yet another life-threatening illness. The community needs to be sensitized, and we need to prepare the community for more death and dying. And we need to help people with AIDS who are dealing not only with the stress of racism but also a life-threatening illness."

So, whom do AIDS organizations represent and whose needs do they respond to? Are predominantly white-run and white-focused organizations capable of responding to the crisis of people of color with AIDS? What are multi-racial AIDS organizations doing? How are organizations of people of color responding to AIDS?

One Response: The Gay Men's Health Crisis (GMHC)

"GMHC has done pathetically little to include minorities," said Howard Welsh, coordinator of GMHC's speakers' bureau. Welsh's explanation: "We don't go where we're not invited."

The Gay Men's Health Crisis, based in Manhattan, is the United States' oldest and largest AIDS service organization. Founded in 1982, it has a staff of 35 and over 1,000 volunteers. In November, GMHC was actively serving 1,082 clients. This amounts to nearly half of all people with AIDS in the city.

The project is much smaller and very different from GMHC. Founded in May 1983 as an adjunct to the Pacific Center for Human Growth, a gay and lesbian mental health agency, the project employs 11 people and has approximately 70 volunteer counselors. The project currently has about 100 clients, of whom 40 are people with AIDS and 60 are friends, family, and lovers of people with AIDS (PWA). There have been approximately 200 cases of AIDS in Alameda and Contra Costa Counties, the area served by the center.

The 11-member staff includes a Black man, a Black woman, and a Latino man. The volunteer counselors include seven Black people, six Latinos, and three Asians. Thirty-five percent of the project's clients are people of color. Approximately 40 percent of the AIDS cases in the two counties come from communities of color. The project publishes information in English, Spanish, and Chinese.

Jim Sanchez, a gay Latino and one of the project's support volunteers, talked to *GCN* about ways to provide Latino communities with services around AIDS: "It must go through the family. Many gay Latinos don't identify with the gay community, and won't have access to information in gay papers, and won't bring that information into the home. Information must be provided in Spanish, especially medical terminology. Some people do fine in English around every-day conversation but will get lost around medical terminology." Sanchez said sensitivity about cultural differences is essential, noting in particular his experience with a Mexican family with a son with AIDS: "I remember he [the PWA] had a 17-year-old sister, and when I was talking to his parents and she walked in, we had to change the subject. She probably knew more than they did about it, but you have to realize these things and not be pushy. When I would deal with the parents, the wife would be listening, and ask her husband to ask me questions, even though she knew I spoke Spanish. They were religious, Catholic, and needed to feel comfortable with their son [as part of] the church. They were different from a modern-day [white] family, and it was easier for me [than for a white person] to be aware of their culture, and easier for them to get information from me."

Peterson continued, "Because of the realities of social class, we may not be able to assume the costs of private health care providers." He said that the costs for poor and working-class Blacks, "many of whom are dependent on public subsidy like SSI and Medi-Cal [state Medicaid in California], are severe." Peterson stressed, as did Sanchez, that it is especially important for support people interacting with families of PWA to share a similar background, so they can explain the syndrome and its ramifications in culturally appropriate ways.

Arguments for Autonomy

Gil Gerald, executive director of the National Coalition of Black Lesbians and Gays, is not interested in white AIDS organizations doing outreach to Black people per se: "Outreach is a continuation of setting an agenda from the white perspective. Black people need to be involved before the agenda is set. And when the agenda is more inclusive, it is different. We have come as an afterthought. Well, no thank you."

"I'm convinced we have to work for ourselves," Gerald continued. "We've waited long enough for white AIDS organizations to get their act together. We need autonomous Black gay and lesbian organizations, and part of the solution is for us to go for the dollars ourselves, and do the work ourselves."

Gerald sees such autonomous organizations as complements to, not competitors with, existing white AIDS organizations: "There needs to be a recognition that organizations that serve the Black community be in the Black community. It's not always appropriate for white-based organizations to assume responsibility for working in the Black community."

Some of Gerald's sentiments were echoed by Suki Ports of the New York City Council of Churches' Minority AIDS Task Force. Ports, a third-generation Japanese-American, said that the task force is "interfacing with GMHC on how to go about providing comprehensive services" to people of color with AIDS. Ports stressed that institutions, such as hospices, must be set up by people of color to specifically serve the needs of people with AIDS in their communities.

Ports is also concerned that information be culturally sensitive: "You can't just give [a white person] with high school Spanish a brochure to translate. You have to develop special materials for the community." Ports mentioned considerations in providing information to Asian communities, saying, "There is often a great reluctance to talk about sexuality or homosexuality in Asian cultures. It is not polite conversation in public, or for that matter, in private." She concluded that AIDS information must be provided to Asians from their own communities.

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Predominantly white AIDS action groups must begin to prioritize programs for people of color with AIDS. And they must do so with direction from members of the communities they by-and-large do not serve. Hopefully organizations of people of color will be able to respond where white organizations have failed. But given their limited financial resources and other pressing needs, it is sure to be an uphill battle.

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THE CDC'S MAGIC OF NUMBERS-- The Centers for Disease Control (CDC) AIDS Activity compiles all the epidemiology and surveillance data as reported by state and local health departments. They report, among other data, the percentage of people with AIDS within a specific race (white, black, Latino, other, or unknown). However, such information is always compared to total census, which is taken from the 1980 US Census Summary: General Social and Economic Characteristics, PC 80-1-C, and represent the percentage of total population within a specific race. These figures have severe limitations. First, the racial categories used by the CDC and local health authorities are not consistent with categories used by the Census Bureau. While the CDC, et al. consider Latinos as a separate racial group, the Census Bureau considers Latino people to be a separate ethnic group, the members of which can be of any race. Most Latinos are considered to be "white" or "other" by the Bureau. Second, the CDC refuses to release AIDS figures for Asians, Pacific Islanders, Native Americans, Aleuts, or Eskimos, claiming that to release such figures would compromise the confidentiality of those people with AIDS. "Other" also includes a large portion of the Census Bureau's statistics for Latinos. Third, people of "unknown" race are people with AIDS whose race was not reported to the loacl health department. Finally, Census figures notoriously undercount people of color, and the exact degree of error is unclear.

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ATTITUDE AND STRESS

by Ann Giudici Fettner, with thanks to the New York Native, 11/25-12/1/85

I stumbled across the way gay men use the word "attitude" while researching my book on AIDS, in an article by Carl Maves in the Advocate: "Look, over there, that guy's giving me ATTITUDE! Okay for you, asshole, guess what you're getting back? More attitude, of course." The Random House Dictionary defines attitude as a "manner, feeling, etc. toward a person or a thing." That's the tack I'm taking here, an attitude toward a thing. The thing is AIDS; more important, however, is attitude toward the self. Experienced charge nurses will all tell you, "It's the attitude, you know. If two people come in with identical illnesses, the one who gets well and goes home is the one none of us can stand." I'm sure this is true. (That's what angered and saddened me when I went with the PWAs to see Dr. James Mason of the Centers for Disease Control Native 134. I wanted a combative atmosphere, to see righteousness, out-front anger, an energy that indicated a fight was joined--not acceptance.) Nick Wade, a friend who is a psychologist/immunologist speculates that people are either reflections of their immune systems or vice versa. People who raise horses call this state of being "collected," an animal who is pulled together, ready to do whatever is required, to run, to fight. We need to collect our immune systems as if we were readying horses for a race. You know this has got to be done to combat AIDS. Having been a woman in a WASP male society, having lived as a white in a black country, often being perceived as "abrasive," I've got a faint notion of what it's like to be a gay men in America. But only faint. The feelings directed against me have been relatively casual; I don't scare them as much as you do. But, unless one can handle the "attitude," the result is constant stress. Stress is hard to define, because it means different things to different people. Some really get off on it. The stress of being under siege is another situation. Now even gay men are being told that they're poisonous, that sex is out. A lot of people, gay and straight, are saying that. Certainly, those who've been out every night fucking their heads off have to stop messing around like that; it was dangerous before there was AIDS and it could be a death sentence now. But sex is a great releaser of stress, and by being careful (you know, you've seen all the health education/safer sex brochures) the risks are enormously diminished. Becoming celibate isn't an option for most people; the stress involved may well negate what health gains are accrued. Take a lesson from women who decide they absolutely don't want to get pregnant: they don't. If you absolutely don't want to contract an infection, you don't have to. But sex doesn't handle the other stress, particularly now that AIDS is making crazy people crazier. If you're antibody positive or have some degree of AIDS, or are just worried about it, it's important to deal with stress. There are lots of ways to do it. Some work for one, but not for others.

STRESS AND IMMUNITY. Without question, stress interferes with the immune system. Numerous examples of this are leaking into the medical literature. It's hard to quantify the effects of stress, so there's been a lot of resistance among scientists about the psychological effects; but some reports can't be ignored. There is a compelling relationship between the emotions and chemical changes in the body. The central nervous system releases a protein molecule called substance P, for which T-helper cells have a receptor. The corticotropin releasing factor stimulates the pituitary gland (the master control), causing it to release other substances in the adrenal gland, which regulate the body's ability to respond to stress. Dr. Neal Miller of Rockefeller University in New YORK, whose research led to the development of biofeedback, has said that there is "evidence showing the dangerous effects of certain conditions that might loosely be described as stressful--social disorganization, membership in groups with conflicting mores, or sudden changes of life produced by migration or the loss of a spouse." (Sound familiar?) For instance, among men whose wives have died of breast cancer, the rate of cancer skyrockets. The same holds true for women who have recently been widowed. Dental students' immune system were evaluated at Harvard during their first year of study. Measuring the amount of immunoglobulin-A (which fends off viruses such as those that cause colds) in saliva, and divided between those who want power and those who want close relationships, the power group was found to be the most profoundly stressed--and immune-depressed. Psychologist John Jemmott, who conducted the research, commented, "Now we'd like to see if we can raise immune levels by making people more relaxed." It's becoming more relaxed that we're after--letting go of "attitude" about the self, about the AIDS epidemic, about the sneers and slights laid on by people who are themselves so unsure that they look for scapegoats. That's there problem; it need not be ours. The social and legal fallout has to be dealt with aggressively; but on a private level, homophobia isn't worth a moment of anyone's time. The more sure one is about one's personal value, the less impact fools will have. One way to gain surety is through the use of meditation tapes to help reduce stress, to get yourself more "centered." Washington psychologist Paul Van Ness has recently written a resource book that describes many available tapes, as well as names and addresses of area and national practitioners of other holistic approaches to AIDS ($3, tax deductible, to Whitman Walker Clinic AIDS Program, 2335 18th Street, NW, Washington, DC 20009; see related article elsewhere in Newsletter). One set of tapes Van Ness has audited is called Tapping Deeper Resources: Visualization and AIDS, designed for "worried well." The booklet that accompanies the tapes has some valuable insights. "Applied Meditation is an approach that can allow you to find your own answers. Problem solving on a deeper level attunes you to become intuitively aware of what is going on in your body, and of what you need to do to better maintain your well-being. Deep within us lies the wisdom and the courage to confront the presence of AIDS and take charge of our lives...." Several other relaxation, meditation, and guided

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ATTITUDE AND STRESS, Continued

imagery tapes are also listed in Van Ness' Sourcebook. Being ill or worried about becoming ill is a humbling experience. Like all experiences, it can be used in a negative or positive way. One can rail against the "fates" or start appreciating the value of what there is that is fine. (But don't get so humble you start turning over to others the control of your life and health.) Learn from all this; begin to take control. Don't believe the prognosis of AIDS is a death sentence. It has and will kill a lot of people, but it won't get everyone who is infected. Decide you're an exception and work at that. If your doctor wears a long face and seems pessimistic, find another. It's your life. If he hasn't any hope, what can he or she do for you? Believe in yourself and in life. Sometimes when I'm very happy, I think back to several people I know who've committed suicide. Sure, things were hard for them, but look what they're missing! Giving up the will to live is giving up life. Find a social structure that supports you. There are plenty of us who share the same human values, who want for ourselves and each other the same good things. Now's the time to get together, to hang tough, to "collect," to ready ourselves to fight, if necessary (I think it is), to love and enjoy what is good. And set some goals. For instance, I can't die until I get my last child through college (I've managed to string this out over six of them!); and I can't die until I've spent more time with the guy I love. Do the same: find a goal. As defined by Maves, "attitude " is a nasty, self-preoccupied little word. As the way you choose to view your own worth and the importance (or lack thereof) of what goes on in your life, attitude is quite another. Let's all take stock and turn this thing around. I really think it's possible. Let me put it another way. As Colin Norman of Science magazine says, when the New York Times starts using phrases like "anal intercourse," you can bet the American fascination with the "novelty" of gays is quickly coming to an end. Gerry Studds is a hell of a legislator and a brave man. He ran for office on his merits, and he won on them. No one should do less.

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ALUMINUM FOR AIDS DRIVE SPONSORED BY BLACK & WHITE MEN TOGETHER/SAN DIEGO

Black and White Men Together of San Diego (BWMT/SD), a multi-racial organization for all people, whose goal is to live in a society free of all racism, is organizing a drive to collect aluminum cans in order to raise funds for AIDS education in San Diego. The need for education to reduce the incidence of AIDS has been overlooked in the black and hispanic communities. The general perception of AIDS nationally has been that the epidemic has been "a white man's disease." Statistics prove that perception incorrect. In San Diego, the rise of AIDS cases has no racial boundaries. Minority groups are being touched by the los of young people because of AIDS. The Aluminum for AIDS Drive will raise funds to provide a continuing education and prevention information to the minorities in San Diego. Arrangements have been made with aluminum recycling centers throughout the county to credit donation to the Aluminum for AIDS Drive. Posters will be distributed and displayed at each center. BWMT/SD will schedule pickup of donated aluminum within the San Diego city limits. One specific project is the distribution of a rap record entitled, "Respect Yourself," which was developed by BWMT/Philadelphia under a grant from the U.S. Conference of Mayors AIDS Program Advisory Board. "Respect Yourself" was written to appeal to black youth with the focus of making them aware that AIDS can threaten their health and lives also. For more information, contact: Art Scarson, BWMT/SD, P.O. Box 964, San Diego, CA 92112 (619/297-6452).

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PARIS AIDS BENEFITS HONORS LIZ TAYLOR

by Micheal Helquist, with thanks to The Advocate, 1/7/86

The most popular entertainers in France joined guest of honor Elizabeth Taylor for a spectacular AIDS benefit in Paris, November 25. Billed as an "international gala" to benefit anti-AIDS efforts, dozens of film, television, theater and recording stars--including Audrey Hepburn, Shirley Verrett, Eartha Kitt, Simone Veil and female impersonators who doubled for the stars in attendance--participated in the four hour evening of entertainment before an audience of 600 benefactors. Approximately $800,000 was netted from the benefit, the first major AIDS fundraiser in Paris, will support AIDS research at the Pasteur Institute and the AIDS education and support programs of Aides, the primary group in France dealing with the epidemic. Daniel Defert, president of Aides, told The Advocate how important it was that the Association of Artists Against AIDS (AAAA), sponsors of the event, "have recognized that funding is needed for education and support programs as well as for research." Defert noted that approximately 60,000 individuals in Paris have probably been exposed to the AIDS virus already, and that Aides has grown quickly in an attempt to meet the increasing need for information and counseling. Jacques Chirac, mayor of Paris, presented Taylor with an honorary plaque, which she accepted "in the name of people with AIDS. We must work together to ensure the dignity and self-respect of people with AIDS as well as to ensure funds for research." Taylor is the chief spokesperson for the American Foundation for AIDS Research (AFAR), established just a week before the recent death of her friend, Rock Hudson. Popular French entertainer Line Renaud, founder of AAAA and organizer of the Paris gala, publicly credited Taylor's success with the September Commitment to Life banquet for AIDS Project Los Angeles as the inspiration for her own efforts. Renaud and AAAA have also planned a special nationwide television broadcast, entitled "In the Name of Love," to inform the public about AIDS and to solicit further funding.

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NEWS FROM NASHVILLE
with thanks to The Advocate, 1/7/85

Nashville CARES was recently established to provide education about AIDS and support services for people with AIDS in the metro Nashville area. In addition to training volunteers and working with other local groups to assure adequate response to the AIDS crisis, Nashville CARES is planning an AIDS information hotline. For more information, contact: Janet Pierce, Metropolitan Community Church, 131 15th Av. N., Nashville, TN 37203 (615/320-0288).

CHAMPAIGN/URBANA AIDS SUPPORT NETWORK FORMS
edited by John A. Fall, with thanks to the New York Native, 11/4-10/85

At least one person with AIDS has died within the past year in the Champaign/Urbana (Illinois) area there are perhaps as many as three other cases in the community at this time. In order to provide a support network for PWAs during this critical period of their life, the local gay community has developed two parallel support systems to provide assistance when and if such persons desire and request these services. Several individuals will be participating in the training and services provided by the Mercy Hospital Hospice Service. In order to develop the skills and competence necessary to be of assistance during the terminal stages of the illness. A second group has volunteered to act as "buddies" to PWAs, providing such services as housecleaning, visitation, and other activities as needs develop. For additional information, contact the Gay & Lesbian Switchboard, 217/382-8040 (weekdays, 7-10 pm).

GROUP ORGANIZED TO STOP AIDS DISCRIMINATION
edited by John A. Fall, with thanks to the New York Native, 11/4-10/85

National Gay Rights Advocates (NGRA), a public interest law firm, has formed the AIDS Civil Rights Project (ACRP), which will initiate legal actions to deal with AIDS-related cases in the areas of employment, housing, insurance, education, and health care. The group will also publish material summarizing the legal issues faced by people with AIDS. NGRA has named Benjamin Schatz, JD, as director of the project. "At present, we have a unique opportunity to create positive legal precedents," the Harvard Law School graduate stated. "It is crucial for gay men and women to realize that AIDS-related discrimination threatens not only those with AIDS, but indeed the entire gay and lesbian community." Schatz's salary will be paid by grants, and private donations will be sought to pay for legal expenses.

BALTIMORE'S JOHNS HOPKINS HOSPITAL OPENS AIDS UNIT

Baltimore's Johns Hopkins Hospital plans to open a 10-bed, formal, comprehensive AIDS service to provide state-of-the-art care and treatment for people with AIDS, previously dispersed throughout the hospital. "The new unit will allow us to improve our existing inpatient and outpatient services for AIDS patients," said John D. Stobo, MD, William Osler Professor of Medicine and Chief of Medicine at The Johns Hopkins Medical Institutions. "We can care for AIDS patients more efficiently, effectively and comprehensively in a nursing unit with specially trained health professionals," said B. Frank Polk, MD, professor of epidemiology at Hopkins' School of Public Health and principal investigator of the Study to Help AIDS Research Efforts (SHARE). The hospital has admitted approximately 120 people with AIDS since 1983, with almost 60% of these admissions during 1985, and an average daily census between 8 and 9. Preliminary plans call for a social worker and religious and legal counselors to assist patients during their course of medical treatment. The unit is only one of a handful in the United States and is modeled after similar units in San Francisco and elsewhere. For more information, contact: Marion Glick or Joann Rodgers, 301/955-6680, TJHMI, 600 North Wolfe Street, Baltimore, MD 21205.

GAY COUPLE ONCE DENIED CHILDREN ASKED TO TAKE BABY WITH AIDS IN BOSTON
edited by John A. Fall, with thanks to the New York Native, 11/11-17/85

Boston's Department of Social Services (DSS), which took two foster children away from Don Babets and David Jean five months ago, recently offered the gay couple a 20-month-old Haitian girl with AIDS. A television reporter revealed the offer and said the couple had refused the baby, "not because of any fear of the disease but because, clinically, their household was not the best facility for the child." The baby needs intravenous feedings every two hours and has a life expectancy of six years. The DSS denied the allegations, but Babets told Brian Eric Quinby of Philadelphia Gay News that the agency had contacted the couple. Babets also suggested that the DSS may sue gay men and lesbians as last alternatives for children no one else will accept. DSS caused much controversy last spring when it took two foster children from Babets and Jean, and subsequently formulated a policy which practically excludes gay men and lesbians from being foster parents.

DRUGS & AIDS BROCHURE PLANNED BY AIDS PROJECT IN SPRINGFIELD, MISSOURI

The Education Committee of the AIDS Project of Springfield (MO) is planning to publish a brochure on the relationship between drug and alcohol abuse and the development of AIDS. In order to make the brochure as accurate and informative as possible, we are interested in collecting as much pertinent material as possible. For more information, contact: Jon Scroggins, Director of Education, AIDS Project/Springfield, 718 N. Kansas Expressway, Springfield, MO 65802, or call 417/864-8373.

MEXICAN PHARMACISTS CRITICIZE U.S. DRUG BUYERS

by Kim Westheimer, with thanks to Boston's Gay Community News, 12/14/85

U.S. citizens who go to Mexico to purchase large quantities of drugs believed by some to be helpful in AIDS treatment have been criticized by pharmacists in Tiajuana, according to the New York Native. The drugs, isoprinosine, ribavirin, and pranosine (imitation isoprinosine), are scarce due to the recent earthquakes in central Mexico. U.S. visitors have bought out supplies of these drugs in some pharmacies. "We have always been willing to share what we have," said Jorge Guiterrex, who works at a pharmacy, "but we resent the selfishness of these North Americans who don't give a damn about our people. They only think of themselves, and think that because they have lots of dollars that we will sell them anything they want. Most of them are from San Diego and L.A. I can tell the people from San Francisco and other parts of the state. They have a better attitude. Except the people from New York. They are bigger jerks than those from San Diego or L.A." [NCGSTDS ED NOTE: Why not limit sales? Or charge more and donate extra profits to local community efforts? Or refuse to sell to those who are rude? Etc., etc.!]

RESEARCHERS SAY 70% OF AIDS PATIENTS HAVE BEEN DRUG ABUSERS

with thanks to the New York Native, 11/4-10/85

Two Washington, DC researchers say at least 70% of AIDS patients have been drug abusers, and that rather than doubling or tripling every year, the number of new AIDS cases is nearing a stable level. According to writer Terry Krieger and internist Dr. Cesar A. Caceres, who discussed their research for the first time on a special David Brudnoy Show about AIDS on Boston's WRKO the day before the report was released, the federal government's Center for Disease Control reports 17% of AIDS patients have been intravenous drug users. Krieger and Caceres point out,, however, that the CDC classifies AIDS patients by "risk groups" and, if an AIDS patient belongs to two or more "risk groups," he or she is assigned only to the one listed first. "Since the CDC lists intravenous drug users below homosexuals and bisexual men," Krieger and Caceres explain, "it classifies AIDS patients as IV-drug users only if they are exclusively heterosexual IV-drug users." If homosexual and bisexual IV-drug users are counted, Krieger and Caceres say, at least 25% of AIDS patients have been intravenous drug users. The Washington researchers observe, "While the CDC collects data on intravenous drug use among all AIDS patients, it collects data on non-intravenous (or oral) drug use only among some AIDS patients in special studies." Krieger and Caceres say such CDC studies indicate at least 75% of homosexually active AIDS patients (or at least 54% of all AIDS patients) have been oral drug abusers--people who do not use intravenous drugs but have used oral "street drugs" such as marijuana, cocaine, "poppers," and so on, at least once a week for at least several years. "If we add 54% to the 25% of AIDS patients classified as IVDU," Krieger and Caceres say, "we find at least 79% of AIDS patients have been drug abusers." According to Krieger and Caceres, "It appears that HTLV-III will produce AIDS only if the immune system is already damaged." They suggest that at least 79% of AIDS patients may have had pre-existing immune damage from drug abuse, and at least 6% more may have had it from poor environment, serious illness, repeated transfusion of blood products, or congenital deficiency. "It appears that AIDS patients have not been healthy people who got AIDS simply because they had sex with the wrong person," say Krieger and Caceres. "Rather, they seem to have been people who already were sick in the sense of having a damaged immune system. Some evidently were sick because they were unlucky--they did not ask to be born in Haiti or with hemophilia--but apparently most were sick because they abused drugs. And, we fear, some of today's drug abusers probably will be most of tomorrow's AIDS patients." The researchers also point out, "Like other health-related conditions, AIDS has been reported annually, that is, by the number of cases each year. But AIDS also has been reported cumulatively, that is, by the total number of cases since the condition was identified. They say, "The cumulative reporting of AIDS has fostered the belief that the number of new AIDS cases has grown each year (which is true), as well as the belief that the year-to-year rate of increase of new AIDS cases has risen (which is not true). In fact, the rate of increase has declined." According to Krieger and Caceres, the rate of increase has dropped from 449% between 1980 and 1981, to 94% between '83 and '84, to only 50% between the first six months of last year and the same period this year. "Instead of doubling or tripling (which means increasing by 100% or 200%) every year," Krieger and Caceres say, "AIDS appears to be heading toward a stable level. Indeed, an analysis of AIDS trends conducted at the CDC last year found `the composite trend for all U.S. AIDS cases' was in `a transition period' that may plateau in 1985." The writer/physician team concludes, "AIDS has been a physical calamity for individuals struck by it, a social calamity for groups identified with it, and a psychological calamity for people frightened by it. But the nation's overall health probably has been endangered less by AIDS than by the pervasive drug abuse that may be a cause of it."

INSURANCE COMPANIES ASKING QUESTIONS

edited by John Fall, with thanks to the New York Native, 12/16-22/85

A guide for detecting signs of AIDS in life insurance applicants has been written for publication in an insurance underwriters' journal. "AIDS: An Underwriting Concern," by Minnesota Mutual Life underwriter Christine Bellefeuille, summarizes medical aspects of AIDS and certain lifestyles as "clues" for insurers to investigate. The article was obtained prior to its publication by Minneapolis & St. Paul's Equal Time, reports J.C. Ritter. "Unfortunately," Bellefeuille writes, "the majority of AIDS risk applicants we will see will not have been diagnosed as yet or will deny the diagnosis. This is where the underwriting dilemma lies. The article advises underwriters to look for physical symptoms related to AIDS, records of previous HTLV-III antibody tests, a history of venereal disease, and "evidence of promiscuity." The writer contends that such details are "of concern especially in combination of high-risk groups, areas or associated symptoms." After discussing high-risk groups and the cities with the highest numbers of AIDS cases, Bellefeuille writes, "Underwriting individuals from one of these risk populations or areas is especially challenging since we cannot underwrite based on sexual preference, gender, or marital status." Minnesota Mutual's director of public relations, Mark Hier, called the paper "background" for underwriters, but denied that it reflected the company's official policy for avoiding coverage of people with AIDS.

The Insurance Departments of Pennsylvania and Delaware have allowed insurance companies to supplement their coverage applications with questions about AIDS, ARC, and the HTLV-III Antibody test. At least three companies, including Lincoln National Corporation and Northwestern Mutual Life Insurance Corporation, have received permission to place questions related to AIDS on their applications. Lincoln's Director of Media Relations, Jerry Davis, told John Ward of Philadelphia Gay News that the company asked its applicants the three following questions in relation to AIDS: "During the past ten years, have you been told that you have AIDS or ARC? During the past ten years have you sought treatment in connection with AIDS or ARC? During the past ten years have you tested positive for the antibody for the AIDS virus? In delaware, where insurance companies only have to file changes in applications, the state approved Lincoln's use of those questions in October. Northwestern applications ask if an applicant has been advised against donating blood and whether the applicant has a condition indicating AIDS. Spokesperson Mark Lucious said Northwestern has received approval from 17 states for asking potential clients these questions.

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VITAMIN C: A WORD OF CAUTION

by Ann Giudici Fettner, with thanks to the New York Native, 12/30/85-1/5/86

When drugs and other active substances work, they obviously do so on a multitude of levels by interacting with various chemicals in the body, which is why I've suggested that whatever self-medication one with AIDS tries should be taken with the full knowledge of a physician. Now comes a letter copied to Linus Pauling, Robert Cathcart, and the Native, from Bernard Bihari of Downstate Medical Center, questioning the use of vitamin C. Bihari, who you may recall, has a treatment protocol using a drug to block the opiate receptors, investigated the effects of vitamin C before agreeing to use it in patients. He writes the following: "Relating to articles cited in Dr. Cathcart's papers, Bihari states that, "Vitamin C enhances interferon synthesis, a response that probably explains its usefulness in treating ordinary viral infections. This effect, however, raises serious questions about the safety of supplemental vitamin C, especially in high doses, in the treatment of AIDS and AIDS-related illnesses. A number of studies have indicated that alpha-interferon is continuously elevated to very high levels in many patients with AIDS, ARC, and HTLV-III related immune suppression. Some researchers have suggested that high interferon levels may be central to the pathophysiology of the disease and that high interferon levels may have a negative prognostic significance in patients with these disorders. In view of this, any treatment that stimulates an increase in interferon levels in PWAs and PWARCs may be dangerous and is, I feel, strongly contraindicated." The papers by Bihari draw a picture of the similarities in high alpha interferon levels in patients with AIDS, lupis, and rheumatoid arthritis, all diseases that, while poorly understood, have a multitude of similar characteristics: abnormal T-cell subsets, suppression of cellular immunity, polyclonal hyperglobulinemia (B-cell dysregulation), and circulating immune complexes. Some pre-AIDS patients were found to have this elevated interferon long before any physical symptoms appeared, and Bihari evidently feels that the substance may herald severe AIDS. The alpha interferon seen in patients is described as "unusual;" Bihari cites a study with Kaposi's sarcoma patients which indicates that those with high levels of interferon fail to respond to treatment. Interestingly, two-thirds of the KS patients had the DR-5 genetic marker (the first cases of KS were very heavily weighted with this marker), and both lupus and rheumatoid arthritis tend to strike those with family tendencies for these autoimmune diseases. This is an area not yet explored as well as it should be in AIDS. There may be susceptibles who develop severe diseases, as well as those who, through infected, won't progress to AIDS per se. This information about alpha interferon is suggestive, and many thanks to Dr. Bihari for following up on it. We're sure to have further discussion of vitamin C, let's reserve judgment and wait on taking more than an ordinary amount as a dietary supplement. The alpha interferon titers well correlate with much of what Luc Montagnier [French discoverer of LAV] said vis-a-vis autoimmune diseases.

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CONCERNED INSURANCE PROFESSIONALS FOR HUMAN RIGHTS DISCUSS POSITION

by Edmund Sutton, with thanks to the New York Native, 12/2-8/85

Concerned Insurance Professional for Human Rights (CIPHR) held their second organizational meeting in Los Angeles November 9, during which insurance executives from New York, Los Angeles, San Francisco, and a variety of administration sections discussed forming a unified position on the use of HTLV-III antibody testing for insurability, and to ask and answer questions surrounding undeveloped policy and procedure for dealing with these claims. Brent O. Nance, CLU, was elected chairman and spokesperson for the group. Several interim officers were also elected th helm the newly created informational organization, until such time as permanent officers can be elected. Nance founded CIPHR in October, in response to memorandums circulated to insurance underwriting firms by two major carriers, Lincoln National Life and Nationwide Life, stating unofficially that, because of the epidemic proportions of AIDS and the burgeoning number of claims being filed, two carriers were considering utilizing "lifestyle screening" to determine whether "high-risk" individuals (gays) would be eligible for new health/life/disability policies. Included in the screening process would be the use of the controversial ELISA test for HTLV-III antibodies, which has been determined not accurate enough for medical purposes. Another method likely to be used is the "redlining procedure," whereby entire areas would be designed "highrisk" by zip code. Areas most likely subject to be "redlined" would include Los Angeles, San Francisco, Houston, and New York City, which have the highest incidence of AIDS cases in the US. In an effort to stem the tide of these hostile actions, it was unanimously agreed by the insurance executives attending the CIPHR meeting that the most effective tool available to the industry would be to provide educational literature or seminars to inform insurance agents "from the inside," given the fact that input from underwriters and agents could be used to decide how future procedures and policy would be formed. However, many executives felt that unless the educational campaign were highly coordinated, it could put their jobs on the line. Many insisted on remaining anonymous. As one agent described it, "There are some real fire-breathers on those advisory councils." But all agreed that sexual preference had no place in determining insurability and that the "AIDS antibody test" should not be permitted, except to screen donated blood for contamination. As the agents exchanged claims horror stories, one field representative described the atmosphere at Transamerica, based in San Francisco, which has a history as a liberal employer. Transamerica's normal requirements include a blood test and standard hepatitis test for 26 to 30 year-olds who apply for $500,000 or larger policy coverage. They will now tack on the antibody test. If the test is positive, then another will be done; then Western Blot; then a T-cell leukocyte test. If an abnormal T-cell count results, combined with a complete medical history and further medical examination, they may overlook the test results and insure anyway. So far, Transamerica is alleged to have dropped areas in five states from coverage. All the executives at the meeting felt certain that the situation surrounding AIDS policy would grow far worse before it improved, and advised that al individuals become better acquainted with their coverage, adding that the opportunity to purchase adequate coverage could be coming to an end. The New York chapter of CIPHR will hold an organizational meeting early in 1986. (Living With AIDS: A Self-Care Manual answers questions asked about insurance and health care, and is available by writing to AIDS Project/Los Angeles, 7362 Santa Monica Blvd., Los Angeles, CA 90046 (213/876-8951).

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GAY AND LESBIAN INSURANCE PROFESSIONALS ORGANIZE

edited by John A. Fall, with thanks to the New York Native, 11/4-10/85

Concerned Insurance Professionals for Human Rights (CIPHR) has been formed to address discrimination relating to gay and lesbian concerns. CIPHR will work to overcome discrimination in all areas of the insurance industry: property and casualty, life, health, disability, and group plans. The issues addressed will include education, AIDS discrimination, underwriting, claim denials, legislation, hiring practices, and privacy rights in all facets within the industry. Membership will be open to friends of the lesbian and gay community within the insurance industry. Because of current insurance industry practices, the complete anonymity of all members will be assured. Interested persons can contact CIPHR at PO Box 691006, Los Angeles, CA 90069-9006, or by phoning Brent O. Nance, CLU, 213/854-3322.

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HOSPITALS THREATENED BY COST OF AIDS TREATMENT

edited by John Fall, with thanks to the New York Native, 11/18-24/85

Hospital administrators recently told a Congressional subcommittee that the increasing number of AIDS patients unable to pay for treatment jeopardizes the financial stability of the U.S. health care system. New York hospitals may experience the greatest burden, since they treat a relatively high percentage of drug addicts suffering from AIDS, according to Dr. Jo Ivey Boufford, the president of the New York City Health and Hospitals Corporation. "We are treating a disproportionate share of cases from the drug-abusing community, who usually are sicker and have more complications." Boufford testified before the House Energy and Commerce Committee's subcommittee on health and the environment, November 1.

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'EARLY FROST' DRAWS BIG MONDAY NIGHT AUDIENCE; COMMUNITY REACTION POSITIVE

by Doug Hinckle, with thanks to The Washington Blade, 11/15/85

An Early Frost, the first prime time made-for-television movie dealing with AIDS, aired November 11 on NBC, and according to the Nielson Ratings, the show led its time slot with a 25.1 rating. The drama, about a gay lawyer diagnosed with AIDS, beat out ABC's Monday Night Football game (which took a 19.3 rating)and CBS's regular series Cagney and Lacey, which aired a controversial episode about the bombing of abortion clinics. Here's what some local Washington, DC gay community members thought about the drama: **Craig Howell, age 39, economist:** An Early Frost was exceptionally well done for a TV movie. The contrast with conventional TV offerings--such as North and South, whose final episode I had to force myself to watch the night before and which came across like ante-bellum Dallas--was quite striking. It was about as heavy as most TV audiences could endure. The characters were well-drawn, and the situations depicted seemed only too realistic. **Kerry Shapiro, 27, person with AIDS:** I was pleased with it. I thought they seemed to touch on most aspects of the disease. I like the way they handled the issue of being gay. I think as far as bringing information and the human side of this disease to the general public, it succeeded. **Chi Hughes, 27, program director, Whitman-Walker Clinic:** It was good for people who need to know about AIDS in lay terms. Of course, it did not delve into the importance of AIDS in the gay community, but maybe another movie will do that. **Bill Wilson, 35, microphotographer:** I thought parts of it were excellent. I thought they should have shown another peer group session because it was left like he [the son] didn't get support from the group, which might discourage other persons with AIDS from going to sessions. **Paulette Goodman, 52, president of Parents FLAG:** I was very moved. They did a sensitive job. They brought out the issues. The mother was beautiful, strong and vulnerable. **Robert Reid-Pharr, 20 student:** I thought the film did a good job of speaking to the issues that some people with AIDS face. However, I was distressed to see that the image of people with AIDS as given out by the media is once again white, upper middle class, male and gay. **Richard DiGioia, MD, 40, medical doctor:** Generally speaking, it presented a good combination of up-to-date medical information and compelling drama. It accurately reflected the range of emotions people with AIDS and their loved ones experience. **Caitlin Ryan, MSW, 38, health consultant and former AIDS program manager, Whitman-Walker Clinic:** It was good. They picked a white, middle-class family, someone the "heartland" could identify with. As a first effort, it was useful. I hope TV doesn't leave it at that, because people of color, IV drug users, the poor, women, and children are affected also. **Lawrence Washington, 35, social worker:** I thought it showed a lot of research on the part of the actors and writers. It showed a range of reactions on the part of family members, in particular to the first time knowledge of homosexuality was brought up. It showed despair on the part of persons with AIDS, and dealing with suicide--an area we need to focus out attention on. But it tended to wrap things up too neatly. The issues continue to go on. I'd like to see something dealing with AIDS also deal with more complex problems.

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DOCUMENTARY WITH HUMOR & HEART UNDER PRODUCTION FOR PBS

with thanks to Los Angeles CAIN (Computerized AIDS Information Network), 12/12/85

"The AIDS Show Documentary" is the working title of a PBS television special by award winning film makers Robert Epstein (**The Times of Harvey Milk**) and Peter Adair (**Word Is Out**). Now in production, the documentary combines the on-state stories of the plays characters with a backstage look at the actors, writers, and directors who bring them to life. Approaching the subject of AIDS with heart, humor, and soul, the documentary presents the human side of the AIDS story. In helping a general audience accept the realities of the epidemic, it presents a model for individuals and community response. Although the project is scheduled for completion in February, 1986, your tax-deductible contributions are needed to help the production come to fruition. Please send your contributions to: Film Arts Foundation/AIDS Show, c/o Epstein/Adair Co-Productions, 2051 Third Street, San Francisco, CA 94107 (415/864-6714 or 621-6735).

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USA TODAY HAS AIDS SERIES

with thanks to Detroit's Cruise, 12/11/85

USA Today, the national newspaper, is doing a special five day report on AIDS designed to take the readers inside the controversy and the sorrow surrounding the dreadful disease. On Monday, December 9, the series will focus on the impact of AIDS with a look at 24 hours in the life of the disease across the USA. "To panic or not to panic" was the topic for Tuesday, December 10th; Also on that date the paper's hotline will begin taking readers questions about the disease. On Wednesday, the series will explore the support that people with AIDS are finding across the country. The Thursday, December 12 installment will discuss the use of the HTLV-III antibody test and how the use of this so-called "AIDS Test" has landed some people in the unemployment line. The series concluded Friday with a look at AIDS and women, and the current state of AIDS research.

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TRAVEL RESTRICTIONS ANTICIPATED BY MONTAGNIER

edited by John Fall, with thanks to the New York Native, 11/18-24/85

Dr. Luc Montagnier, the French scientist credited with first discovering the LAV/HTLV-III virus, warned recently that a cure or vaccine for the virus must be found soon to prevent international restrictions on personal freedom. Speaking before the French/American Chamber of Commerce, Montagnier predicted that some nations might begin HTLV-III antibody testing in airports. "If we don't solve this, then we will get into trouble, because there will be more and more infected people in our countries. The countries which have not been already infected will take measures to [limit] importation of the virus." Montagnier made his comments during a discussion of the virus in general, reports John Werzl of Sentinel USA.

MOBILIZATION AGAINST AIDS ISSUES 9 POINT STATEMENT

by Sib Connor, with thanks to Boston's Gay Community News, 11/9/85

Approximately 400 people gathered for a candlelight vigil and rally sponsored by Mobilization Against AIDS (MAA) October 26-27 in San Francisco. According to MAA co-chair Paul Boneberg, the event focused on two primary objectives: to obtain increased government funding in the fight against AIDS, and to secure national legislation prohibiting discrimination against PWAs. MAA is also demanding a change in the terms used to gauge government spending. Although the government is spending a couple of hundred million dollars a year on AIDS, Boneberg maintains that this isn't enough. The MAA has called for one hour of government spending to be put towards AIDS, the equivalent of a half a billion dollars. MAA outlined 9 essential points directed to Congress:

1) Provide $60 million for community-based national AIDS education/prevention programs.

2) Provide $500 million for AIDS research programs.

3) Provide $55 million for community-based programs for food, housing, home health care, social work, counseling, and hospice services for PWAs and PWARCs.

4) Provide treatment programs with proven effectiveness that employ both traditional and alternative approaches in areas of high incidence of AIDS.

5) Pass federal laws guaranteeing anonymity in HTLV-III antibody testing and confidentiality of participants in research programs and AIDS treatment.

6) Provide an independent, national AIDS research coordinating council, including PWAs and PWARCs, to ensure that AIDS research efforts are well planned, and to avoid unnecessary duplication, with results made available to researchers and interested members of the public.

7) Call upon the CDC to reexamine and expand the current definition of AIDS.

8) Outlaw discrimination against PWAs and PWARC in employment, housing, insurance, medical care, and funeral services.

9) Investigate the FDA, the NIH, and the NCI, and draft legislation based on results of the investigation that expedites effective AIDS treatment and access to experimental drugs used in other countries, as well as international AIDS research cooperation.

According to Boneberg, the MAA's 9 point plan is the first comprehensive strategy put forth thus far.

VIGIL IN SAN FRANCISCO CONTINUES

with thanks to The Washington Blade, 12/20/85

Seven people with AIDS or AIDS related conditions who chained themselves to a San Francisco public building in October say they will continue their vigil--in spite of some of the coldest and wettest weather in the city's history--until government officials respond to their demands. According to San Francisco's Bay Area Reporter, the vigil began October 28 after an all night protest organized by the Mobilization Against AIDS. The seven men--along with two others who have since left the group--chained themselves to the doors of the old Federal Building in the city's United Nations Plaza to protest government inaction in helping PWAs or PWARCs. Their demands are that the Federal Food and Drug Administration approve the prescription of AIDS-related drugs currently available only in Mexico and France, for the government to reclassify PWARCs to enable them to receive government benefits, and for the government to target $500 million for AIDS research for the next year. The men's efforts appear to have rallied the city's gay community and over $1000 has been raised to help their vigil so far. Local residents have provided the men with meals and have erected and decorated a 15 foot Christmas tree at the vigil location. In a letter delivered to the protesters, Rep. Sala Burton (D-California) said she agreed that ARC has "not received sufficient attention" and that she was working in Congress to ensure that people with ARC who are disabled receive Social Security benefits "without delay." Aides from Burton's office say that she will visit the vigil site on her next trip to San Francisco. The protesters say they will continue their vigil until they receive an "adequate" response to their demands or "until they die."

GAY RIGHTS NATIONAL LOBBY VOTES TO DISSOLVE, BECOME ARM OF HUMAN RIGHTS CAMPAIGN FUND

by Lou Chibbaro Jr., with thanks to The Washington Blade, 12/6/85

The board of directors of the Gay Rights National Lobby (GRNL) , citing continuing financial problems, voted November 4 to dissolve and to turn over its membership rolls and a debt of about $40,000 to the Human Rights Campaign Fund (HRCF), the national gay political action committee based in Washington, officials of both organizations announced. Board members from both GRNL and HRCF hailed the decision as a constructive solution to GRNL's lingering financial problems and as a means of strengthening HRCF's membership base and pool of potential contributors. Vic Basile, HRCF's executive director, said that HRCF will retain GRNL's lobbying functions as a division within HRCF called the "Gay Rights National Political Education Project." He called their merging a "remarriage," referring to GRNL's creation of HRCF in 1981 and HRCF's subsequent departure from GRNL's headquarters and separation as an organization two years later. HRCF, a bipartisan political action committee (PAC) raises money to contribute to candidates for Congress who support gay and lesbian rights. Earlier this year, HRCF established a new, separate fund within the PAC from which campaign contributions would be made to candidates who support more federal funding for AIDS programs. National Gay Task Force (NGTF) recently rejected a proposed merger with GRNL because of fears about the combined debts from both groups would be too great. GRNL has a loyal group of contributors capable of contributing as much as $100,000 a year or more. Sources from GRNL's board said the merger plans with HRCF calls for dismissing GRNL's three member staff, including executive director Nancy Roth. Roth reportedly has a contract that calls for her retention beyond the date the board established to retire GRNL as a corporate entity. Basile and other HRCF Board members plan to hire a lobbyist and hope to expand GRNL's original objectives of pushing for a national gay rights bill and other gay rights causes. Jean O'Leary, a GRNL board member from Los Angeles and executive director of the National Gay Rights Advocates, a gay litigation group, and Gil Gerald, GRNL's newly-elected treasurer and executive director of the National Coalition of Black Lesbians and Gays both supported the decision. GRNL board members Adam DeBaugh, an official with the national office of the Metropolitan Community Churches, and Frank Kameny both differed, expressing concern about perceptions of past attempts of other organizations to undermine GRNL, and that if support were forthcoming the group's financial problems could have been overcome. GRNL was formed in 1976 at a gay rights conference in Chicago called by the late David Goodstein of the Advocate. GRNL was originally established as a Washington-based lobby for gay & lesbian concerns. In 1981, former GRNL Executive Director Steve Endean created HRCF as the nation's first gay political action committee. At the time, he sought to keep GRNL's and HRCF's functions separate in order to avoid a direct link between lobbying efforts and political contributions to candidates. In 1983, when Endean resigned as GRNL's and HRCF's executive director, Basile was named Endean's successor at HRCF.

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NATIONAL GAY TASK FORCE ANNOUNCES CHANGES

The National Gay Task Force recently announced a name change to National Gay/Lesbian Task Force (NGLTF), to help provide more visible recognition to the equal role of lesbians in the work and mandate of the organization. (The NCGSTDS will incorporate this change, beginning with the next issue of the Newsletter.) The NGLTF Crisisline has changed its name to "The National Gay/Lesbian Crisisline-AIDS-800," and is now a division of NGLTF's educational affiliate, the NGLTF Fund for Human Dignity. Aubrey Wertheim remains the coordinator, and the numbers to call are unchanged: 800/221-7044, in NY State: 212/807/6016. NGLTF is shifting its AIDS Program and Violence Program staff to Washington, DC, to join Director of Governmental & Political Affairs, Jeff Levi. The Membership and Development Programs will remain in New York, as will Ron Najman, Media Director. John Boring, the author of many of the AIDS Updates that NGLTF has issued over the last 3 years, will be leaving the agency to pursue personal and professional goals in San Francisco.

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SEX AND GERMS: THE POLITICS OF AIDS

A new book by popular Boston writer Cindy Patton looks beyond the homophobic, one dimensional analyses that are legion in the popular media. Sex and Germs: The Politics of AIDS, rather than being a "how-to-avoid" book, offers instead serious analysis of the AIDS epidemic and the ways in which AIDS is rewriting the history of sexuality, medicine, and contemporary attitudes about each. Sex and Germs looks at the erotophobic and germophobic mentalities that fuel popular responses to AIDS, ranging from the fear of catching the virus to anti-gay attacks of diverse kinds; Sex and Germs analyzes the ethical crisis triggered by AIDS research as well as the legal problems encountered by people with AIDS; Sex and Germs describes the biology of the disease, explaining its character and evaluating prospects for relief; Sex and Germs looks at the New Right response to AIDS and discusses the culture of the gay and lesbian communities most directly threatened, and the character of their response. Sex and Germs is available from local bookstores or prepaid from South End Press, 116 St. Botolph St., Boston, MA 02115 for $9 plus $1.50 postage & handling (specify bookrate or UPS). The book is 195 pages and has a bibliography and index.

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HOTELS ARE NEXT?

by Sib Connor, with thanks to Boston's Gay Community News, 11/30/85

The New York State Health Commissioner announced November 16th that the state's drive to regulate "unsafe" sexual activity in baths and bars will be extended to any hotel in which such activity is found to be taking place, according to the New York Times. Appearing on WNBC-TV, Commissioner Dr. David Axelrod, said that new state regulations forbidding "high risk" sex, which went into effect on October 25, have helped force a decline in patronage at gay bathhouses, clubs, and bars. However, Axelrod said, there were "indications" that there was an increase in anal and oral sex in other establishments, especially hotels. State and city inspectors, Axelrod said, are authorized to order action against any public establishment that "promotes" sexual activities judged by the State Public Health Council to spread AIDS. "We won't inspect hotel rooms" routinely, stated Axelrod. But, he added, "if we find that the hotel, by virtue of information we obtain, is catering to that kind of activity, then I think we will have reason to take action and, if necessary, a warrant to go into the rooms if it becomes essential." Maintaining that the regulations are not specifically aimed at homosexuals, Axelrod said, "Our concern is not who you are, but what you do and how you place yourself at risk in public establishments."

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CONTROVERSY & DIALOG ABOUT SAFER SEX IN SAN FRANCISCO

with thanks to Bay Area Reporter, 11/14/85, and Brian Jones and Drs. Marcus Conant & Robert Bolan (with apologies to all for editorial comments by NCGSTDS editor)

"The report to the Bay Area Reporter on the [San Francisco] AIDS Advisory Committee meeting analyzes only half of the story. Your reporter sought the opinion of experts to examine the best way to present the message that '"we are losing the battle against AIDS;" however, he did not examine the message itself. For how long will we continue to debate how the messenger will be cloaked, and fail to discuss the message that he bears? I challenge the BAR to the task of responsible investigative reporting. Examine for your readers the accuracy of the messages that were discussed by the AIDS Advisory Committee. Is it false that we are "losing the war against AIDS?" Is it false that HTLV-III-3 infection will have a profound, terrible impact on your life? Is it false that the best way to avoid contracting a sexually transmitted disease is to avoid having sex? Is it false that individuals must have safe[r] sex exclusively? Is it false that if you cannot have safe[r] sex 100 percent of the time, you should find a sero-negative sexual partner? Reasonable people may disagree on when one should whisper or shout "Fire" in a crowded theater, but there would be no doubt in the gay community that the fire is real." --Marcus A. Conant, MD

"BAR ED NOTE: Reasonable people do not shout fire in a crowded theater because the ensuing stampede would only add to the death toll from the catastrophe the messenger was warning against. Moreover, given recent statistics on the dramatic drop in venereal disease rates among gay men and the apparent stabilization in new AIDS cases, it may be false that we are "losing the war against AIDS," at least on one level. The fire surely is real. All the more reason not to throw dynamite around." --Ray O'Loughlin, Bay Area Reporter (BAR), San Francisco

"Dr. Strangelove is back. The moment I saw "celibacy" in the headline, I knew that Marcus Conant, MD was at it again. Marcus Conant, MD, is an AIDS doctor who says no sex is safe sex. He would whack peepees wherever they arise. He has pushed his celibacy trip for years now and earned himself the reputation of a crank. His peers who are seriously into AIDS prevention have dismissed Conant's celibacy crusade as a joke. But nobody's laughing at Conant's new playmates--the right-wingers who control [California's] health bureaucracy. In a matter of weeks, Conant's **"NO SEX IS SAFE SEX"** may become official policy. Marcus Conant, MD first pushed celibacy when he was head of the now defunct National AIDS Foundation. Other prevention professionals declared celibacy an unworkable and ineffective strategy. Unable to get his own way, Conant drifted away. He tried to change the rules of the game. In May, 1984, he called a nationwide conference of AIDS experts to redefine sex risks. He shuffled the deck himself and believe me there were no gay libbers in this group. There were Good Family men from the CDC in Atlanta, wearing polyester pants and little white plastic pocket-liners in their shirts. Even these conservative AIDS experts did not agree with Conant. They rejected celibacy as impractical. They endorsed a concept of AIDS risks which put various sex practices on a spectrum. It was a definition nearly identical to the "safe, possibly safe, unsafe" concept in standard use today. Marcus Conant, MD couldn't repudiate those findings right away, back in 1984. To hand pick your own experts, then repudiate their findings because they don't agree with you, might seem a tad unscientific. So Conant laid low. [NCGSTDS ED NOTE: Are non-San Francisco readers getting a feeling of a rather biased opinion of this writer?!] Dr. Strangelove isn't laying low now. He's on a high-profile state AIDS panel. He has teamed up with the right-wingers who wanted to keep filthy fags from touching

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CONTROVERSY & DIALOG, Continued

each other long before a thing called AIDS. The AIDS panel would toss aside the current prevention campaign, declaring, "We Are Losing the Battle Against AIDS." They would have the state declare: "To Avoid AIDS, Avoid Sex...Be Celibate." The panel urged all gay men to take the HTLV-3 antibody test. Then, you negatives who think celibacy is a drag, "find an uninfected partner" and go whole hog. You positives are doomed. HTLV-3 infection "will have a profound, terrible impact on your life." Don't even think about sex. This plan is a horror. Its "all or nothing" approach would encourage many to abandon safe sex. If no sex is safe sex, why bother? And count on one thing--people will have sex. This should seem obvious. The celibacy crusade, in effect, blames gay men for causing AIDS. This will play well in the [California Governor] Deukmejian administration, which has resisted any state role in effective AIDS prevention. Why spend money on education? Just tell the filthy buggers to cut it out. In this scenario, Marcus Conant, MD will play the Carrie Nation, wielding his axe of temperance to cut off the sex of his fellow gay men. At its most fundamental level, Conant's crusade tells us much more about the doctor, than it tells about ourselves. Marcus Conant, MD seems mired in sexual shame and in self-loathing. He is striking out against demons which dwell in his own psyche. This is one AIDS doctor who has gone over the edge. Problem is, he may take the rest of us with him." --Brian Jones [NCGSTDS ED NOTE: Jones's commentary seems to personally attack the person, Dr. Conant, rather than challenge his ideas and strategies. The following reply will help clarify some of the issues.]

"I, too, disagree with Dr. Marcus Conant's views on AIDS risk reduction. However, I think the November 14 BAR editorial [by Jones] widely missed the mark by trying to discredit and personally malign the man. There is ample evidence in the literature on behavior change with which to intelligently refute an education campaign based upon denial of a biological drive. Argue with him on the data, don't call him names--that does not discredit him or his viewpoint, it's just silly posturing. The prevalence of AIDS virus in our community is now estimated by two of the ongoing AIDS studies to be about 50%--one out of two gay/bisexual men is infected. Anyone who is not having only safe sex with secondary partners is probably already infected and able to transmit virus even though he feels perfectly fine. I believe this is the basis for Conant's advice to learn your antibody status; if you are negative and are unable (unwilling) to consistently stick to the safe activities then you should find a similarly antibody negative partner. From a public health perspective this is hardly a foolish viewpoint--it is coldly rational. What is wrong with it is that the antibody test is not positive in 100% of infected individuals. Dr. Jay Levy, at University of California-San Francisco, has found living virus in 2% of a sample of persons who repeatedly tested negative for the antibody. Other researchers at Pacific Presbyterian Medical Center have found virus in 10% of 60 or so individuals whose antibody tests remained negative. These investigators claim to have a more sensitive culture technique than that currently in use by others. If higher estimates of falsely negative tests are confirmed, then for truly negative individuals, Conant's method would be like letting a fox loose in the chicken coop. Further, it [is thought it] can take up to six months after infection with the virus to develop the antibody. So, before making any assumptions about the safety of engaging in AIDS-unsafe behaviors with another negative person one would need two negative results, the second one being at least six months following the last potential virus exposure. [NCGSTDS ED NOTE: This assumes that people will honestly reveal their true antibody status to potential sex partners; would you truly trust someone you had just met to level with you that they had two antibody tests 6 months apart, both of which were negative, without any intervening unsafe sex? Come on doctors! Look at the experience of women "wishing" birth control and neither using a method nor insisting that partners use condoms. They are minimizing or denying the risk of pregnancy, just as homosexually active men deal with the risk of AIDS. Your expectations of people sharing their feelings and emotions with potential partners they don't know very well is incredibly naive and unrealistic! That's why a two tiered society based on AIDS antibody status (negatives vs positives) just won't work.] What about the efficacy of safe[r] sex guidelines? For those who are antibody negative consistent and absolute adherence to the guidelines is required to remain uninfected. To remove all risk one must even eliminate behaviors from the "possibly safe" category, including "wet" kissing. The "possibly safe" has been the most difficult category for people because data linking these behaviors to AIDS transmission is the least certain. For those who are antibody positive, the risk reduction messages are the same because we hope that by avoiding exposure to additional infections (parasites, CMV, etc.) one can remain healthy and [it is believed] survive with the AIDS virus. The other great hope is that infected people will feel a sense of responsibility to not transmit the virus to another individual. In fact, the survey conducted by Research & Decisions Corp. for the [San Francisco] AIDS Foundation showed that in the May 1985 sampling of the participants that 92% agree that it is an individual's responsibility to avoid transmitting the virus to others. However, 20% of the sample continued to place themselves (and their partners) at some risk by practicing unsafe sex with secondary partners some of the time. Another very interesting finding from the survey revealed that 3% of the sample reported using IV drugs in the previous six months. This 3% accounts for 38% of all the anal intercourse reported by all the study participants. Obviously these people are motivated by something other than care for themselves and their partners. In fact, it is likely that the group of individuals who consistently practice unsafe sex probably do not share values with most of the rest of the community and are not going to respond to nicy-nice messages about caring. In fact, they may not respond to anything. I believe that as a community we can no longer project the attitude that sexual gratification holds primacy over health, that it's understandable and OK to "slip" and transmit the

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CONTROVERSY & DIALOG, Continued

virus as long as we are "trying" to be safe. Coming around to this attitude, however, is not to be confused with having an effective education/behavior change program in place to help those individuals having trouble. We have two behavior change programs in San Francisco that are based upon attitudinal surveys: the AIDS Health Project and the Stop AIDS Project. They have not been specifically evaluated because of insufficient research funds. This is unfortunate because unless we can document that educational models are effective then we have no direct proof with which to counter naive education attempts which exhort people to change by, in effect, shouting louder t them with more drastic demands. The last time either behavioral survey questioned their participants was spring, 1985. They should be funded to go out again. Other attitude/behavior studies should be funded. For example, a lot of men are having the antibody test done. How [is knowledge of] its results affecting sexual behavior? Specifically, are all those who are antibody negative consistently practicing safe[r] sex? If not, then what beliefs do they have about susceptibility to the disease? What attitudes do they have about health, about sexual expression? Are they risk takers in other areas of their lives? And so forth. Similarly, what about those who are antibody positive? What about their sexual behaviors now that they know? What are their values pertaining to community, tot he safety of others? Is there any evidence of despairing behavior--"I'm already infected, what the hell." Is there any [internalized] homophobia--"I'm infected and I'm going to take others out with me." These questions and many others should be asked [NCGSTDS ED NOTE: one additional question that frequently goes unasked is about the generalizeability of these findings to gay communities outside of San Francisco--in the rest of the country!] so that more specifically targeted programs can be designed and introduced. Sexual behavior is very complex and our understanding of its motivators is incomplete but this is all the more reason to try and advance that understanding. We may be making headway, and maybe we aren't losing the war but let's cut the metaphors and talk English--people are still transmitting virus. Let's stop the magical thinking and accept the reality that people don't die of sexual frustration, they die of [complications brought on by] AIDS. The nonrational mind, where sexual fantasies and behavior urges reside, must not be allowed to prevail when it pulls one towards dangerous behavior. We must take control and we must adopt the principle as a community that sexual transmission of this virus is not acceptable--ever." --Robert K. Bolan, MD [NCGSTDS ED NOTE: And adopt as a community that safer sex is achievable, attainable, enjoyable, and socially acceptable and desirable!!]

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AIDS ACTIVISTS FILE SUIT AGAINST DISCRIMINATORY "SAFE SEX" REGULATIONS
by Sib Connor, with thanks to Boston's Gay Community News, 12/14/85

In an attempt to stop the closure of gay bars and bathhouses, activists here are challenging New York's Public Health Council's (PHC) newly implemented "safe sex" regulations. The Coalition for Lesbian and Gay Rights (CLGR) has filed suit against the state of New York, charging that the language in the PHC's regulations is anti-gay and too broad. The regulations were instituted October 25, ostensibly as a means of curbing the spread of AIDS, and have already forced the closure of one gay club in New York City, the Mineshaft. Filed December 2 in State Supreme Court of Manhattan, the CLGR suit questions the definitions in the PHC's regulations of "high risk" sex and of "public establishment," and names of defendants the PHC, Governor Mario Cuomo, State Health Commissioner Dr. David Axelrod, and Attorney General Robert Abrams. According to the PHC regulations, "high risk" sex is defined as fellatio and anal intercourse. The CLGR is charging that the definition is anti-gay, since no mention is made of vaginal intercourse. Darrell Yates Rist, a member of the newly formed Lesbian and Gay Anti-Defamation League (LGADL), which supports the CLGR suit, says the regulation discriminates against gay men: "[the regulation] names [gay] sex acts to the exclusion of the main heterosexual sex act as dangerous when there are verifiable cases of heterosexual transmission of AIDS." The PHC definition of "high risk" sex also contradicts guidelines generally accepted by most AIDS activists, which stress avoidance of receptive anal intercourse, particularly without a condom, and rimming (oral-anal contact). Contrary to PHC regulations, which do not even mention rimming, most guidelines include any acts which involve the exchange of bodily fluids. According to Andy Humm, a member of CLGR, opponents of the regulations are also wary of the PHC's definition of an "establishment." The regulation defines the term as "any place in which entry, membership, goods, or services are purchased," a definition which CLGR contends is so broad it could be used against hotels and even apartments. CLGR is asking for a declaratory statement from the court overturning the regulations.

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NEXT NEWSLETTER

The next issue of the Official NCGSTDS Newsletter will be out prior to the March meeting and National Lesbian/Gay Health Conference. Deadline for articles is February 21, 1986!

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OF SAFER SEX AND REJECTION: SPEAKING OUT

by Bruce-Michael Gelbert, with thanks to Boston's Gay Community News, 12/7/85

There are two aspects of the issue of safer sex in this AIDS crisis time that have occupied my thoughts and entered my conversations but that I have not seen discussed in print. I want to share several experiences, give encouragement and hopefully, get encouragement. The matters I want to raise overlap and concern the reactions of our peers to current sexual practices. I want to mention first that I was a participant in the "800 Men," New York's Gay Men's Health Crisis' research and education project. For 19 intense hours one October weekend, gay and bisexual men participated in seminars and discussion groups, heard speakers, did role-playing exercises, viewed videos, and completed an extensive questionnaire concerning safer sex guidelines, sexual practices now deemed unhealthy, and the AIDS crisis. Some of my experiences during these sessions influenced what I write here. Early this past summer, I vacationed in an American city popular with gay male tourists. At one of the bars, I spoke with a man staying at the same guesthouse as I, and there was a mutual attraction. He asked the question, once considered quite crass, and now seeming not at all unreasonable, "What do you do [sexually]?" and I launched into my safer sex rap He was striving for a carefree vacation and I was clearly being a problem, so he fled. He made me think of the theme Death in Venice shares with Jaws: let's not trouble the tourists about the cholera plague/shark problem or they'll leave. I was dejected and disillusioned, but mostly angered. I was rejected for doing what I felt was right. I had a similar experience in a largely gay resort later in the summer. A candidate for a vacation affairette spoke of his lack of strict adherence to safe sex guidelines. I urged caution. I cited past connections to people who'd developed AIDS as an incentive to him to play safely, pointing out that opting for healthy sex practices would preclude exposure were I a carrier. He avoided me as a poor risk for the rest of our stay there. I quickly found a fellow New Yorker I knew would respect the limits I observe. When my small-discussion group from the "800 Men" weekend held a reunion at the beginning of November, one of the men told a similar story. He'd met someone in a bar and they seemed in agreement about having safe sex only. When they went home, however, the man my friend picked up wanted to fuck, without a condom, and when David refused, the man lost interest in continuing. David was disappointed but stood his ground. I've held to my principles despite the consequences and championed the erotic possibilities of safer sex practices in many conversations. The "800Men" experience perhaps provided encouragement to others finding themselves in similar situations. I'd like to know if other readers have had to face the problem of rejection for insisting on safer sex by those remaining unconvinced. One observes healthy sex guidelines to avoid contracting or transmitting HTLV-III virus. One's partner or oneself may have it in his system without knowing it, indeed without feeling ill. If one adheres strictly to safer sex practices, there should be no [or much reduced] danger to the other if one partner is infected. A large number of the participants in the "800 Men" project heard a presentation by a panel that included people with AIDS, one of whom spoke on a subject new and shocking to many in attendance: People with AIDS are not necessarily celibate. He wasn't speaking of the kind of vindictive menace who seeks to infect the unsuspecting. He is open about being a PWA and scrupulous about following safer sex guidelines. He is a member of a jerk-off club, the currently popular looking-and-touching-only, safer sex alternative to the back-rooms. No one he has contact with should expect to be more at risk from him than from any other gay man. Prejudice and fear resulting from rumor and uncertainty make many people react with extreme, irrational hostility to the thought of a PWA having any sort of sex. With dismay, I heard this kind of hysteria expressed during the "800 Men" weekend. I've heard it within my own circle of friends and was in fact goaded into questioning my doctor, a knowledgeable lesbian respected by the community for her work with PWAs, who confirmed the irrationality of the fears and the absence of risk when safer sex precautions are observed. I raise this issue because the idea of a PWA's sexuality is one that clearly takes many people time to adjust to. People react emotionally to it, not intellectually, unless forced to confront their prejudice. Society is, after all, just awakening to the fact that the aged and the disabled are not asexual, and this is a new hurdle. When people in my "800 Men" group were sounding off on this subject, the GMHC group coordinator pointed out that there were PWAs participating in the project. He said that there could be someone with AIDS in the room and asked how we thought they would feel hearing such sharp remarks. This forced people to examine their reactions and they softened considerably. When a role-playing session later that day had pairs of people work out a scenario in which a potential sex partner reveals he has an AIDS-related condition, sanity, sensitivity, and safety prevailed. There are parallels to be drawn here. A presumably healthy person who insists exclusively on safer sex; a PWA or PWARC who is sexual and scrupulous; and, for that matter, someone who admits to having had safer sex with a PWA or PWARC--all can present a problem, all can be subject to rejection by peers from whom we expect greater understanding. I'd like to hear your reactions. [Address correspondence to Glebert c/o Speaking Out, Gay Community News, 167 Tremont St., 5th Floor, Boston, MA 02111, or c/o NCGSTDS, PO Box 239, Milwaukee, WI 53201-0239.]

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"THE MAKING OF A REPUBLICAN"

with thanks to Madison, Wisconsin's OUT!, 12/85

Alex Thien, who writes a humorous column for the Milwaukee Sentinal, recently told the story of a public relations dynamo from Stevens Point (Wisconsin) who wanted to surprise his audience. He unveiled a giant photo of two elephants making love. The photo's caption read "The Making of a Republican." The audience laughed, but then he got a surprise when one of the viewers pointed out that both elephants were males.

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LESBIANS IN SAN FRANCISCO PART OF AIDS, INSEMINATION STUDY

by Peg Byron, with thanks to The Washington Blade, 11/15/85

The possibility of AIDS infection through artificial insemination will be assessed in a California study of 400 lesbians who were artificially inseminated since 1980. The Lesbian Insemination Project (LIP) is being conducted by lesbians, according to the study's director Cheri Pies and is a joint project of the Association for Women's AIDS Research and Education (AWARE) and the University of California at Berkeley. Four women in Australia have been reported as being infected with the AIDS virus due to insemination with infected sperm. An Australian study, reported by the British medical journal Lancet in September, found 8 women who had been inseminated with semen donated by a symptomless AIDS antibody carrier. Of those eight, four tested positive for the antibody. One of the four also had generalized, persistent lymphadenopathy, but was otherwise in good health except for occasional minor mouth ulcerations, the study said. Three years after these women had been inseminated, none of their sexual partners showed any signs of infection themselves, in spite of regular sexual contact without condoms, "highlighting the low risk of female-to-male transmission in contact to a reported rate of 70% antibody positivity among the wives of HTLV-III positive hemophiliacs," the study said. None of the women became pregnant as a result of receiving the infected semen. "We don't think we will find many women who test positive [for the HTLV-III antibody] because insemination is not an efficient mode of transmission," said Pies. "There is little or no blood exchanged," said Pies, "and it is not as invasive as intercourse--there's no friction." Lesbians are considered good subjects for such a study because some may have had deliberately chosen gay men as their sperm donors, and they are likely to have had fewer or no sexual contacts with men which would provide other potential sources of infection. Concern about AIDS among women has been high in the San Francisco Bay area, where a recent forum on lesbians and AIDS drew over 200 women. Pies, who authored Considering Parenthood: A Workbook for Lesbians, said the study's participants will be tested for the HTLV-III antibody, which has been associated with AIDS; asked about the sexual orientation of their semen donor, if known; and queried on how many times they were inseminated, and when. Pies noted that on the average, a woman will use seven donations in the process of getting pregnant, since pregnancy does not usually occur with the first insemination. "If there is a high risk in having a large number of [male] sex partners, then women should not use a large number of donors" with insemination, she said. LIP researchers are making extensive efforts to guarantee anonymity for the study participants and will offer further testing and counseling for anyone who tests positive.

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LESBIAN HEALTH CARE IS LACKING, PRELIMINARY RESULTS OF SURVEY SHOW

by Rick Harding with thanks to The Washington Blade, 11/22/85

Preliminary results of a national survey indicate that, due to discrimination, many lesbians are receiving substandard health services, said lesbian health study coordinator Caitlin Ryan at the recent American Public Health Association conference. Ryan, outlining trends noted in the survey rather than citing actual statistics, said that a number of respondents indicated they had faced discrimination when they revealed their sexual orientation to their health provider--discrimination which ranged from lack of sensitivity or a patronizing attitude to attempted seduction and rape. Ryan, president of the National Lesbian and Gay Health Foundation which sponsored the survey, said it is important for a health provider to know that his or her patient is a lesbian, particularly in the areas of gynecological health, mental health, and counseling. The purpose of the National Lesbian Health Care Survey, which is thought to be the first of its kind, is to provide a baseline of information on lesbian health care rather than to provide any specific hypotheses. It has been widely assumed that lesbians are more healthy than most people, but the results of the survey do not support that assumption. Ryan based her remarks on a review of 600 of the nearly 2000 surveys that have been returned. Almost 5000 questionnaires were distributed in 1984 to lesbians in all 50 states and the District of Columbia. Ryan said the data will be released after the survey results are coded and analyzed by computer. It is estimated that an additional $25,000 in grants and donations will be needed to complete the project. The Lesbian and gay Caucus of the American Public Health Association sponsored Ryan's and a number of other sessions of particular interest to the gay community. Over 10,000 public health workers attended more than 2000 health presentations over the 5 day event.

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COMING OUT TO YOUR GYNECOLOGIST

by Kim Westheimer, with thanks to Boston's Gay Community News, 12/14/85

Have you come out to your gynecologist? According to a survey of over 1800 homosexually active women, reported in the American Journal of Public Health and Sojourner, if you haven't, you're in the majority. Fifty-five percent of those surveyed have never discussed their sexual orientation with their gynecologist. Apparently assuming heterosexuality for all women, 91% of the surveyed women's gynecologists had never asked clients about their sexuality. Women would be more likely to disclose their sexuality if this information were not written on their medical records, according to 60% of those surveyed. However, of the women who had come out to their gynecologists, 30% were met with a negative response (e.g., the doctor left the room and had the nurse finish questioning or the doctor made a referral to a mental health professional). Twenty-two percent of the women thought that their health care would improve if their gynecologist was aware of their sexual preference.

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ALCOHOLISM CENTER FOR WOMEN SEEKS DONATIONS

The Alcoholism Center for Women in Los Angeles continues as a leader in the field of alcoholism by providing much needed services to alcoholic women and their loved ones. Your support, commitment, donation, and your help is needed to make up the difference between our funding contracts and the needs of the ACW clients. Every year, more and more women have found hope and sobriety at the Center, which is a non-profit, tax-exempt organization helping 3000 women at high risk for alcohol related problems every year. ACW provides both residential and out-participant services, as well s a primary prevention program and family services. Your donations are needed today! Please write for more information: ACW, 1147 S. Alvarado, Los Angeles, CA 90006 (213/381-7805).

VIDEOTAPE LIBRARY AT SAN DIEGO AIDS PROJECT

Chris Hart, Education Outreach Coordinator at the San Diego AIDS Project, announced the establishment of a library of videotapes featuring the many different aspects of AIDS which includes training sessions, medical news broadcasts and dramatic presentations. The library is open to the public and each videotape may be borrowed for 2 days at a time. A refundable deposit of $60 will be required at the time of check-out. Some of the topics now available at the library are "The Medical Aspects of AIDS," "Psychosocial Aspects of AIDS," "HTLV-III Testing," "Grief and Bereavement," and many more. Most of the tapes were filmed with training purposes in mind for counselors, health care professionals. At this time, the AIDS Project Library is seeking additional commercial or cable TV programs about AIDS. For more information about the Library, call or write: Chris Hart, SDAP, PO Box 89049, San Diego, CA 92138 (619/543-0300).

LUBRICANT COMPANIES CEASE CLAIMING THEIR PRODUCTS PREVENT AIDS

edited by John Fall, with thanks to the New York Native, 12/9-15/85

Two companies stopped claiming their sexual lubricants could prevent the transmission of AIDS after receiving threats of prosecution from the U.S. Postal Service and the federal Food & Drug Administration. Rub, distributed by T.O.G. Distributors in West Hollywood, and Conceptrol, distributed by Male Marketing in North Hollywood, both contain nonoxynol-9, a spermicidal agent which has killed the HTLV-III virus in laboratory tests. No proof exists, however, that it kills the virus during anal intercourse. Both products had been advertised as "AIDS preventives," reports Update. "It was never my intention to mislead anyone," said Jerry Bellenger of Male Marketing. "We don't know whether it works in humans...I was hopeful it would work, and I think it does."

CONDOMS USED FOR WATERPROOFING WEAPONS

with thanks to Madison, Wisconsin's OUT!, 12/85

The Australian army has purchased 54,000 condoms for waterproofing guns. Senator Gareth Evans, minister of Resources and Energy, speaking for Defense Minister Kim Beazley, explained the purchase to the Senate: "I am assured that the contract for the purchase of these condoms was placed after independent leak-and-burst tests in which the condoms were inflated to a volume of more than 12 liters. My advice is that, while the practice of placing condoms over rifle barrels is not formally recommended in any army documents, it is understood to be an effective means of waterproofing."

CONDOMS SHOWN TO BLOCK AIDS VIRUS IN TESTS AT THE UNIVERSITY OF CALIFORNIA

with thanks to Computerized AIDS Information Network (CAIN), AIDS Team, and the San Francisco Chronicle, 12/18/85

Tests show definitely that the AIDS virus cannot penetrate the fine membranes of condoms, University of California researchers recently reported. As a result, they said, using condoms during sexual activity can be a major factor in preventing the spread of AIDS. Dr. Jay A. Levy, a virologist at the University's San Francisco medical school, tested five different types of commercially available condoms by filling them with a fluid containing a high concentration of the AIDS virus. Then, he waited to see if the infectious organisms could pass through the membranes. No virus particles were able to move out of the condoms when they were inserted for as long as 30 minutes into a solution of tissue cells in which viruses are normally cultured. There was no leakage even when the condoms were subjected to pressure, as long as they did not rupture. Even after analyzing the culture medium for three weeks, there was no sign that any organisms had passed through the membranes, according to the researchers. Levy's tests, which were commissioned by the San Francisco AIDS Foundation, used three types of latex condoms, one type made of natural lamb skin, and one made of a synthetic skin. All proved to have the same protective ability. This demonstrates that what AIDS service agencies and gay health organizations have been promoting for several years is sound advice, and that condoms are an effective barrier against the virus. [NCGSTDS ED NOTE: What next needs to be demonstrated is the durability of condoms during anal intercourse, the role of different lubricants, and whether the spermicidal agent nonoxynol-9 when used with condoms are effective against HTLV-III/LAV.]

CONSERVATIVES BLAME SPREAD OF AIDS ON PORNOGRAPHY

by Christine Guilfoy, with thanks to the New York Native, 12/9-15/85

A conference on AIDS sponsored by conservative and right-wing groups has resulted in a call for the quarantine of individuals who "spread the AIDS virus." The November 21 conference, which was cosponsored by Morality in the Media, focused heavily on pornography and drug use as critical factors in the spread of AIDS. Participants called for tougher enforcement of obscenity laws, a return to monogamy within marriage, and the curbing of drug use, to contain the spread of the disease. Speaking to the audience of 75 were such notable figures as Roman Catholic Bishop Lawrence J. Riley and Massachusetts Senate President William M. Bluger. Vernon H. Mark, MD, director of neurosurgery at Boston City Hospital, created the greatest stir, when he said that individuals spreading the HTLV-III virus should be exiled to an uninhabited island off Cape Cod. Mark said he favored testing of four groups: people with recurrent sexually transmitted diseases, people attending drug treatment clinics, prostitutes, and people who have received blood transfusions "over the last four years." Mark told the Native that he would use the Western Blot antibody test as the screening device. He did not explain to the audience, however, the limitations of that test as a screening or diagnostic device. Senator Bluger was asked by a reporter if he would introduce quarantine legislation, but he ridiculed the question and then refused to answer, saying he was at the conference "to learn." (The Massachusetts Commissioner of Public Health, Bailus Walker, has publicly stated that he opposes quarantine, calling it an outdated method of control and also saying that not enough is currently known about the transmission of AIDS for it to be an effective tool.) Other speakers focused on the proliferation of pornography and tied that to the spread of AIDS. Victor Cline, a University of Utah psychologist, asserted that exposure to pornography "leads to a number of social ills and negative effects." He said "inhibitions" are lowered by reading pornography. "Pornography exposure lessens taboos and leads to sexual aggression, multiple partners, and deviance," he said, adding, "Pornography leads to multiple partners, which if conditions are right, may lead to AIDS." Although he said his talk would support Cline's, Gabriel Nahas, MD, a professor of anesthesiology at Columbia University, suggested that prior immune suppression is necessary to the development of AIDS. Citing studies done on marijuana and the immune system, Nahas said that smoking marijuana depresses the immune system, leaving the individual more vulnerable to a disease such as AIDS. "AIDS might develop in people only if the immune system is already damaged. [PWAs] are not people who had sex with the wrong person but people who were already sick." Nahas also said marijuana acts as an "aphrodisiac," leading individuals to have indiscriminate sexual encounters. "Under the influence of drugs, people more easily start behaving like animals." Former public health official Nicholas J. Fiumara, MD, gave generally accurate information about the transmission of AIDS to the general public. At one point, he told the audience that even if a food worker with an active case of A IDS spit in their food, they could not come down with the disease. The audience moaned and gasped in horror.

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WOMAN WITH AIDS KEPT UNDER ELECTRONIC SURVEILLANCE

edited by John A. Fall, with thanks to the New York Native, 11/4-10/85

A prostitute with AIDS has been placed under electronically monitored house arrest, in an effort by law officials to keep her confined after jail employees expressed fear of contracting the illness. "I wanted her off the streets, for the protection of the public, but on the other hand, I knew the jail employees were concerned," said Judge Edward Garrison, who placed the prostitute under house arrest. The woman, 20-year-old Lydia Munoz, must wear a three ounce plastic transmitter, reports the Associated Press. Munoz's home phone picks up the transmitter's signal every 35 seconds and sends it to computers in the sheriff's office, in Delray Beach, Florida. The signal stops going to the computer when Munoz is more than 200 feet from the phone.

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BLACK LESBIAN RELATIONSHIPS SURVEYED IN LOS ANGELES

with thanks to Detroit's Cruise, 11/27/85

A survey exploring the many aspects of black lesbian relationships is currently being conducted by University of California-Los Angeles researchers, headed by Dr. Vickie Mays. In particular, the researchers are interested in documenting those things which make it easier or more difficult for black lesbians to find and keep friendships and lover relationships. The study hopes to discover ways to decrease the stresses black lesbians face in their intimate relationships by uncovering what black women look for and want in these relationships. In order for the results of the study to be useful, it is important that as many black lesbians as possible provide input to the study by completing the questionnaire. All answers are confidential. If you are interested in participating, call 213/396-4906 to have a questionnaire mailed to you or send a postcard to Dr. Vickie M. Mays, Black Women's Relationship Project, UCLA, 405 Hilgard Av., Los Angeles, CA 90024. Participation in the study will help enrich black lesbian relationships.

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NAVY RESTRAINED FROM DISCHARGING ANTIBODY POSITIVE RECRUITS
by Lou Chibbaro Jr., with thanks to The Washington Blade, 1/3/86

A federal judge in Washington issued a temporary restraining order barring the Navy from discharging five recruits who had tested positive for the HTLV-III antibody. U.S. District Court Judge Stanley Harris issued the restraining order at an emergency hearing requested by gay rights attorney Susan Silber, who said she filed a motion for the order shortly after the recruits were informed by naval officials that they would be discharged New Year's Eve. The five recruits were among what military spokesman have said may be as many s several dozen enlistees who were pulled from basic training programs after their blood tested positive for the HTLV-III antibody. The antibody tests were given as part of a blanket testing policy initiated by all branches of the service as a means of curtailing the possible spread of AIDS within the military. Silber said she filed the lawsuit on behalf of the five recruits at the same time that she filed the request for the restraining order. The suit seeks to permanently bar the Navy from discharging the men solely on the ground that their blood has HTLV-III antibody. It maintains that unless they show specific signs or symptoms of illness, the men should not be forced out of the military. Navy representatives argued at the emergency hearing that the Navy maintains complete discretion to discharge recruits for health reasons. Under court rules, the restraining order will remain in effect for 10 days, and Silber said another hearing will be scheduled prior to its expiration. Silber said that she will introduce a motion at the second hearing for an injunction to bar the Navy from discharging the recruits until the completion of the lawsuit. Silber said she also represents another nine recruits in the Navy who expect to be discharged shortly due to positive HTLV-III tests.

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PENTAGON TESTS ALL MILITARY FOR HTLV-III ANTIBODY
by Lou Chibbaro Jr., with thanks to The Washington Blade, 10/25/85

Pentagon officials announced plans to test the blood of 2.1 million active duty members of the military for the HTLV-III antibody. Members of the military who are diagnosed as having AIDS, as defined by the CDC, will be given a medical discharge under honorable conditions; servicepeople found to have a positive blood test for antibody will be retained in the service but will most likely be prohibited from overseas assignments or from sensitive duties such as those located at nuclear weapons sites. The decision to require across-the-board HTLV-III antibody testing was made a short time after the Armed Forces Epidemiological Board, a civilian advisory group, submitted a report to the Pentagon opposing blanket testing, according to the Associated Press. The report stated, "Such screening [for all active military personnel] is unnecessary based on information currently available relative to the threat of the illness to others or the limitation of personnel to perform their duties." The Epidemiological Board, which consists of physicians and scientists, noted in the report that it favors HTLV-III antibody screening for military recruits and for active duty members who are slated for overseas assignments that could involve combat. Military officials said the screening policy was needed because soldiers involved in combat would be required to give or receive blood on the battlefield and that it would be impossible to test the blood for the HTLV-III antibody under such circumstances. The officials also said members of the military routinely receive live virus vaccines and that such vaccines could result in illness and possible death to soldiers whose immune systems are weakened from the AIDS virus. Pentagon officials said that blanket screening would most likely be implemented in phases, with military personnel already stationed overseas receiving the testing first. Next, would probably be servicepeople awaiting overseas assignments, and persons slated for domestic assignments receiving the test in a third stage.

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NAVY RECRUITS STILL ON HOLD AT BETHESDA NAVAL HOSPITAL
by Lou Chibbaro Jr., with thanks to The Washington Blade, 12/6/85

Five naval recruits who were abruptly removed from their basic training centers in October after they tested positive for the HTLV-III antibody remained in a medical holding unit at Bethesda Naval Hospital. One of the five, who asked that he not be identified, said he and the other men are seeking legal assistance form the local chapter of the American Civil LIBERTIES Union in an effort to prevent the Navy from discharging them. But he admitted that they have little hope of staying in the service. The five created a stir within the military when they contacted The Washington Post about what they claim was insensitive treatment from the Navy following the discovery of HTLV-III antibody, which was obtained through the military's recently implemented program of screening recruits for the antibody in all branches of the service. The men told the Post they were traumatized when naval officials tersely informed they they had the "AIDS antibody" and were being removed from their units and transferred to Bethesda Naval Hospital for extensive medical tests. The Navy appeared to have violated its own policy concerning antibody testing by failing to provide the five men with sufficient counseling, written information about AIDS, or advice on whether they can seek legal counsel to help them remain in the service. All branches of the military have the authority to discharge recruits who are found to have medical conditions that make them unsuitable for the military. Persons found to carry the antibody who were beyond the recruitment stage--or who had completed their basic training period--would be allowed to remain in the military as long as they showed no signs of clinical illness, according to military officials.

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HEALTH EDUCATION ASSOCIATION OF DETROIT HELPS PWAs
with thanks to Detroit's Cruise, 11/27/85

Health Education Association of Detroit (HEAD) is a new organization that hopes to provide direct financial assistance to PWAs when there is need and other resources are not available, according to founder Chet Simpson. The direct support of persons with AIDS will rely on the kindness of those who contribute time, money, or effort. For more information: HEAD, 124 W. State Fair, Detroit, MI 48203, or call Judy, at 313/892-6335.

ATLANTA'S EMORY DENTISTRY SCHOOL REFUSES PEOPLE WITH AIDS
with thanks to The Journal of AID Atlanta, 12/85

Deborah Krix, RN wrote a letter in response to a situation that she, as a health-care professional, found intolerable. One of her patients had a severe toothache. That patient also had AIDS. After many hours of attempting to secure an appointment for emergency dental care at a number of clinics, Atlanta's Emory School of Dentistry agreed by phone to give treatment. The patient arrived at Emory, was taken to an office, and informed that no treatment would be given. The reasons for this denial are in Debbie's letter:

"To Dr. Joseph L. Konzelman, DDS, Chairman, Department of Oral Medicine, Emory University School of Dentistry, 1462 Clifton Rd., NE, Atlanta, GA 30322: I was deeply distressed to hear from one of my patients that your dental program refused to render him dental care. Last Friday, October 18th, one of my patients was referred to the dental school for services. Your establishment was informed in advance that he had AIDS. Upon arriving at Emory, the dental care he so urgently needed was refused. The reasons given at that time were that they are not equipped to handle patients with this diagnosis, the inability to sterilize the equipment used for him and fear that the dentist would give him an infection. It is attitudes and policies like these that continue to propagate the false ideas that the public has regarding the disease AIDS. I am enclosing a copy of the infection control guidelines from the CDC for your information. The Georgia Dental Association also has guidelines for the care of these patients. I am sure they would share their findings with you. Emory University has a reputation as a leader in health care in the United States. It is unfortunate that the dental school's actions and attitudes do not reflect this reputation for high quality care and, therefore cannot share the esteem earned by the hospital. The ideas that patients who suffer from AIDS be classified as "lepers" and called that to their face, as my patient was, appalls me. To give him a pill and send him home without offering him any treatment is barbaric. In refusing to care for these unfortunate people your school only contributes to alienating them further from society. It is imperative that the Emory Dental School address this issue and be willing to accept the responsibilities associated with giving dental care to the community."

Tragically, Debbie Krix fell from a horse Saturday, November 9, suffering massive cerebral hemorrhage, where she died the next day after being transferred from two other Atlanta hospitals to Emory's brain trauma intensive care unit, a ward that she once worked on. As an in-home nurse, Debbie cared for a number of people with AIDS, being a constant source of support and quality care for all her patients. Her death was very difficult for them, losing a fine nurse and a good friend. Debbie will be remembered as caring, compassionate, and courageous. Her willingness to object in writing to the policy at Emory that denies all PWAs dental care indicates something of the spirit of Ms. Krix.

Denial of dental care to PWAs is not limited to Emory. This is a national problem that requires the attention of the American Dental Association and regional associations of the dental profession. Most PWAs in need of dental care receive emergency treatment in secret at night or on weekends. Dentists willing to treat AIDS patients are few, and they fear their staffs and other patients would not be willing to work in or receive treatment at a clinic that treated AIDS patients. Many persons with AIDS have been living for months without general dental maintenance and specialized services that they or their insurance would pay for. AID Atlanta (AIDA) joins with Deborah Krix, RN, in stating that it is imperative that all dental professionals address this issue and be willing to accept the responsibilities associated with giving dental care to the community. Joseph Konzelman, DDS, chairman of the Department of Oral Medicine, had the responsibility of informing the patient that no treatment was available for PWAs at Emory. He told the patient, "I'm sorry. I'm sure this makes you feel like a leper." He further stated, "If I were in private practice, I would take you back there right now and pull that tooth." Konzelman's position was an ultimate professional dilemma. Before him was a human being in pain and his skills as a dentist and the resources of the clinic could eliminate that pain. However, policy at Emory's School of Dentistry prevented him from rendering the needed treatment. As an employee of the School, he had little choice but to follow policy. Upon receipt of Debbie's letter, he responded in a letter dated October 28, which follows. Konzelman circulated Debbie's letter to the Director of Clinical Affairs, who has yet to respond.

"Dear Ms. Krix: Thank you for your letter of October 22. I commend you for your professional zeal and sound ethical stand which you clearly expressed. I completely and unequivocally agree with you. Last week I moved my private patient care practice to the Northside Hospital Doctors Building and Northside Hospital. In that setting I am able to see any patient I choose without the boundaries of institutional policies. I am not in a position to either change or explain Emory policies. I will give a copy of your letter to our director of clinical affairs. If I can help you or any of your patients at any time, please call on me."

DEPUTIES "STRUCK" BY BLOOD OF HOMOSEXUAL, HTLV-III ANTIBODY POSITIVE PRISONER FEAR AIDS
with thanks to the Milwaukee Sentinal and The Associated Press, 11/14/85

Two Outagamie County (Wisconsin) sheriff's deputies are scared they might get AIDS because a homosexual prisoner slashed his wrists and squirted blood on them. The deputies came into contact with the blood October 24 at the county jail, Sheriff Thomas Drootsan said. One of the deputies said, "I may have ruined my whole life, my family's life, and everything I've ever stood for is gone." He continued, "I'm kind of apprehensive. I haven't even kissed my wife since it happened." He said that when he first learned the prisoner had AIDS, he was "sick to my stomach. I really feel like I had been violated." The two deputies must wait four weeks from the day of the incident before they can be tested to determine if they were exposed to the virus, Drootsan said. The 25 year old prisoner had slashed his wrists in a faked suicide attempt that he hoped would lead to his escape. A female friend of the prisoner was arrested outside the jail and a gun was found in her car. She has been charged with aiding and abetting an attempted escape, resisting arrest and disorderly conduct, Assistant District Attorney John Des Jardins said. According to authorities, the woman told detectives she was to shoot any officers who left the jail with the prisoner when he went to the hospital. At St. Elizabeth Hospital, the prisoner received 46 stitches for his injuries, inflicted with a smashed "security" razor, Drootsan said. Drootsan admitted he was livid at the red tape he had encountered in an attempt to confirm the AIDS diagnosis. "When it happened, we immediately asked the doctor at the hospital if the prisoner had AIDS, because the prisoner is a known homosexual," Drootsan said. "The doctor told me he couldn't answer that question (because of patient confidentiality.) That upset me because two of my deputies came in contact with the prisoner while trying to subdue him," he said. "They came in personal contact with his wounds and had blood squirted at them, including towards their mouths. Drootsan said one of the deputies suffered an abrasion in the scuffle with the prisoner and that blood from the prisoner was on the abrasion. The second deputy had a scab from a previous injury and there was blood from the prisoner on it. "I'm telling you right now that we are not going to accept that prisoner or any other prisoner who has a communicable disease," Drootsan said. "We're protected by the state law. But, by god, trying to find out if a prisoner has AIDS right now is next to impossible and I am not happy about that. The prisoner was recently transferred to the Winnebago Mental Health Institute in Oshkosh and it's my understanding that he had himself tested for AIDS (there). We just got the results back and they showed the results tested positive. How I found this out was by pure luck," he said. "I called (the Wisconsin Division of Health in) Madison to find out the results of the test and was told flat out, `It's none of your business.' Can you believe that?" The sheriff said that, when he told his deputies that the prisoner had AIDS, one turned white and "began bawling." Drootsan said that the first item of discussion at a meeting of the State Sheriff's Association in Appleton will be how to handle prisoners who may have AIDS. He said association members may vote on a resolution to get the state to establish a hot line that could identify individuals who have AIDS or have been shown to have been exposed to the AIDS virus. He also expressed concern that state law did not allow a blood test on prisoners without their consent.

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BROCHURE ON ALTERNATIVE HEALTH CARE APPROACHES TO AIDS & ARC

The AIDS Action Committee's Alternative Therapies Subcommittee has recently published a brochure on "Alternative Health Care Approaches to AIDS & ARC." "Alternative therapies" refers to a wide variety of modern treatment modalities which are based on traditions of healing from around the world. The Alternative Therapies Subcommittee of Boston's AIDS Action Committee is committed to a holistic approach which believes that regular medical care can be supplemented by such alternative therapies as nutrition & macrobiotics, acupuncture, hands-on therapies (massage, SOMA neuromuscular integration, chiropractic), Rubenfeld synergy method, insight meditation, stress reduction, and attitudinal healing. For a sample brochure, send a SASE, with a $1 donation to: AAC/ATS, 661 Boylston St., Boston, MA 02116, or call 617/536-7733 or 437-6200.

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CAIN NEEDS INFORMATION FROM YOUR AREA!
by Los Angeles Computerized AIDS Information Network (CAIN)

The Computerized AIDS Information Network (CAIN) is interested in expanding its network of information from around the country, and whether you have computer access and belong to CAIN, or if you don't, but are just a dedicated, interested health worker wanting to help disseminate local news of national interest, your assistance is needed. CAIN is a database of AIDS-related information available through DELPHI, a national computer time-sharing subscription service. CAIN is intended to serve the informational needs of both community organizations and medical professionals, with interactive features including a bulletin board where subscribers can post announcements, conferencing, and several other features. For membership information, or to submit your information: Russ Toth, CAIN, 1213 N. Highland Av., Los Angeles, CA 90038 (213/464-7400 x277), or if you have a computer and are a member of CAIN, address electronic mail to "LACAIN."

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QUARANTINE PROPOSED AS CALIFORNIA BALLOT INITIATIVE
edited by John Fall, with thanks to the New York Native, 11/25-12/1/85

A proposed 1986 ballot initiative that would make the quarantine of AIDS patients legal has been filed with the California Attorney General's office, by Brian Lantz, a candidate for U.S. Senate, and Khushro Ghandhi, the West Coast coordinator for the National Democratic Policy Committee, an independent group associated with arch-conservative Lyndon LaRouche. "We are placing before the voters of California a ballot initiative whose purpose is to ensure that AIDS is dealt with by the state as a deadly communicable disease threatening the public health and welfare," Lantz and Ghandhi said in a joint statement. If the measure is put on the ballot and passes next November, the state would have the power to isolate identified carriers of "the virus" and prevent these carriers from working in any jobs involving food preparation and physical contact with the public, according to Ghandhi. A petition drive to qualify the initiative for the 1986 ballot will probably begin soon, reports Gracie Bonds of the Sacramento Bee. The director of the California Department of Health Services, Kenneth Kizer, said that a law similar to the proposed ballot initiative was adopted by the state over two years ago. Kizer called supporters of the measure "ill informed."

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OHIO BILL CALLS FOR QUARANTINE
with thanks to The Washington Blade, 11/1/85

Ohio State Representative Don Gilmore introduced legislation calling for a quarantine of PWAs and requiring that children with AIDS be educated at home. The bill states that any health care worker who knows of a person with AIDS must report the person to a regional board of health which will "order the isolation" of the patient. The isolation will continued, the bill says, until the attending physician certifies that the "patient has recovered and is no longer liable to communicate the disease to others." The proposed bill further states that no child of school age with AIDS shall be permitted to attend school until released from isolation by the board of health. Hearings are expected on the bill early in January. Scott Walton, executive director of the Columbus gay organization Stonewall Union, said that his group would actively oppose the bill and that they plan to form a statewide coalition for that purpose by December. Dr. Thomas Halpin, chief of the Ohio Health Dept.'s Bureau of Preventive Medicine, said that the health department "doesn't think it would be reasonable to quarantine" PWAs. "It would not be an effective way to handle the problem," Halpin said, since people with infectiuos diseases are most contagious before they even start showing symptoms of the disease. Also, it would effectively "condemn them to isolation for the rest of their lives." Gilmore said he thinks quarantining PWAs is in the best interest of public health since "health officials are still ambiguous about how the disease is transmitted." Gilmore introduced the bill as an emergency measure, which means it would take effect immediately upon passage and require a two-thirds majority of both houses--rather than a simple majority as is usually required--to pass.

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TEXAS PLANS TO INITIATE QUARANTINE OF PEOPLE WITH AIDS?
with thanks to Mike Richards, Director, Dallas Gay Alliance Gay Community Center

On December 14th, the Texas State Board of Health voted to tentatively approve placing AIDS under the list of quarantinable diseases, an action that was vigorously opposed by all AIDS and gay political organizations in the state. Before the quarantine proposal becomes effective, there will be a public hearing January 13, 1986, in Austin. If the commission still considers the quarantine proposal appropriate, it will go into effect February 1, 1986. According to a fact sheet prepared by the Texas Department of Health, the proposed rule is intended to protect public health by allowing for the immediate medical isolation of AIDS patients who refuse to alter their behavior to limit the spread of the disease. It applies only to those few PWAs who might willfully continue sexual activity or other disease-spreading practices, such as sharing needles. The proposed rule is intended to be used only in specific circumstances and only as a last resort, and would redefine quarantine so its use would apply only to those few PWAs whose irresponsible actions threaten public health. The Dallas Gay Alliance and other gay political and AIDS organizations believe that if this proposal becomes law, it will only further hinder all our efforts to combat the spread of AIDS. Texas needs your help and input! Please write a letter urging Texas Board of Health members to reconsider quarantine and to support our position to appoint a broad based task force to make recommendations other than quarantine. Please send a copy to Lesbian/Gay Rights Advocates, P.O. Box 822, Austin, TX 78767 (Pat Cramer, 512/444-4117). Written comments may be addressed to: *Dr. Charles E. Alexander, Chief, Bureau of Epidemiology, Texas Dept. of Health, 1100 W. 49th Street, Austin, TX 78756. *Ron J. Anderson, MD, Chairman, Texas Board of Health, c/o Parkland Memorial Hospital, 5201 Harry Hines Blvd., Dallas, TX 75235 (214/637-8076). *Arthur L. Raines, MD, Vice-Chair, Texas Board of Health, P.O. Box 686, Cleburne, TX 76031 (817/645-3967).

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NEW YORK TOUGHENS GAY BATHHOUSE REGULATIONS

by Peg Byron, with thanks to The Washington Blade, 11/1/85

In a move opponents term as a step toward the recriminalization of sodomy, New York's Governor Mario Cuomo issued regulations designed to restrict sexual activity in gay bathhouses and ultimately close such establishments. With language a Lambda Legal Defense spokeswoman described as "maybe the worst possible," the regulations end several weeks of well publicized deliberation by Cuomo and his staff. Specifically, the regulations empower local authorities to close down establishments where sex "that would introduce semen into the anal or oral cavity" is allowed, according to Francis Tarleton, a spokeswoman for the state health department. Asked whether such restrictions might be used, for example, by a hotel in refusing to rent rooms to gay men, Tarleton said she did not know what in the regs would restrict their application to baths or backroom bars. The new rules also make no mention of vaginal intercourse, which has allegedly spread the AIDS virus within New York's large intravenous drug-using population. The state has issued no guidelines addressing IV drug abusers. The state's AIDS Institute director Mel Rosen said that drug IV abusers would soon replace gays as the most vulnerable risk group in New York. National Gay Task Force spokesman Ron Najman said the language of the regs "does seem to prohibit private behavior between adults" and, he added, "they are on a slippery slope to sodomy's criminalization." Thomas Stoddard, staff counsel for New York Civil Liberties Union, agreed, saying that the new rules "provide justification for the criminalization of consensual sodomy by analogy--and sodomy laws have traditionally been the keystone for gay oppression." By indiscriminately defining all anal and oral sex as "high risk," such regulations could negatively influence next year's anticipated Supreme Court consideration of sodomy laws, Stoddard said. The New York regulations focus on the owners of establishments where so-called high risk sex takes place, authorizing local offices to inspect them and close "establishments, including certain bars, clubs and bathhouses which are used as places for engaging in high risk sexual activities which contribute to the propagation and spread of AIDS-associated retroviruses," said Tarleton, quoting from the regulations. Local gay activists, including those in the Coalition for Sexual Responsibility and the governor's own AIDS Advisory Panel, have urged a different approach for regulating the baths, according to Michael Callen, a member of both groups. They had devised educational, structural, and hygenic guidelines, but few bathhouse owners complied voluntarily with them, Callen said. The state Advisory Panel recently recommended mandatory compliance for licensing, although some gay activists and physicians have called for closure. Callen, who has AIDS himself, argued that saving lives was not sufficient reason to infringe on civil liberties. The strategy for the gay rights movement has been based on the concept the consenting adults in private have the right to do what they want," said Callen, "and we can't abandon that strategy now." "They talk about anal sex and fellatio without any mention of condoms or ejaculation," said Stoddard. State officials have not y et figured out how to enforce the regulations, although Cuomo said of the baths in an October 28th network television broadcast, "We'll start closing them today." At press time, none had been closed in New York City, whose 10 bathhouses account for most of those in the state. New York City Mayor Ed Koch said the city would begin enforcing the new state regulations immediately, but refused to give details on how that would be done.

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YELLOW JOURNALISM CHARGES TRIGGER PROTEST AGAINST NEW YORK PAPER

by Peg Byron, with thanks to The Washington Blade, 12/6/85

The New York Post was accused of homophobic AIDS coverage by over 600 angry gay demonstrators who rallied outside the tabloid's lower Manhattan office. Protesters carried signs fashioned after the Post's front page style reading "Post Goes Down--Gays Delighted" and "Gays Erupt! Post Buried Alive!" Many threw rags into a pile as an expression of their opinion of the paper. The rally was called by the Gay and Lesbian Anti-Defamation League (GLAD), a new organization addressing "scurrilous representations of lesbians and gay men throughout the city and the nation," its chairman, Gregory Koilvakos, told the Blade. GLAD is calling on major Post advertisers to pull their holiday ads until the /Rupert Murdoch-owned tabloid apologizes to the gay community and moderates its editorial slant. Recent Post coverage has included headlines calling gay bars "AIDS Dens," and anti-gay articles, such as one report calling gays "desperate men...without families...without lovers...without real friends." A GLAD flier accuses the Post of "depict[ing] gays as despicable people who deserve to get AIDS and die." The Post refused to comment on the protest other than repeating its claim that the paper's editorial stance is not anti-gay. Its coverage of the rally gave emphasis to protest placards that read "S&M Is Safe Sex."

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AIDS AWARENESS WEEK DECLARED IN HAWAII AND HONOLULU

with thanks to Lifelines, December, 1985, The Newsletter of The Life Foundation

Hawaiian Governor George Ariyoshi and Honolulu Mayor Frank Fasi issued proclamations declaring the week November 2-9 to be AIDS Awareness Week. Life Foundation, Hawaii's volunteer AIDS service organization, was prominently mentioned in the Mayor's Proclamation. Both documents were issued to coincide with a series of educational programs and lectures throughout the state by the Foundation. For more information, contact: The Life Foundation, 320 Ward Av., Suite 104, Honolulu, Hawaii 96814 (808/528-1919).

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CONSTANT CALLER TIES UP FALWELL'S LINE FOR MONTH
with thanks to the Milwaukee Journal, 12/21/85

An Atlanta man angered by television evangelist Jimmy Swaggart took it out on the Reverend Jerry Falwell, by having his home computer call Falwell's toll-free phone line every 30 seconds for eight months. "I realized the best way to tie him (Falwell) up was to call his 800 number," said Edward Johnson, who stopped the calls after Southern Bell threatened to cut off his phone service. Johnson, 46, a self-employed computer systems analyst, said the constant calls were intended to hurt Falwell's fundraising organization. He said he launched the campaign after seeing an April 7th broadcast in which TV preacher Jimmy Swaggart talked about AIDS and homosexuals. He said he earlier had been angered when his mother contributed to television evangelists. "She almost gave the family farm away," he said. He connected a modem to his home computer to have the machine make the calls. When Falwell's operators answered, they heard only silence until hanging up. Thirty seconds later, the computer would call again. Mark DeMoss, an administrative assistant to Falwell, said the preacher, based in Lynchburg, Virginia, planned to sue Johnson. DeMoss said the calls to the "Old Time Gospel Hour" line might have cost Falwell as much as a dollar each.

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SISTERS OF PERPETUAL INDULGENCE WRITE OPEN LETTER [AN OPINION!]

"An open letter to radicals, activists, moderates, and couch potatoes, from Sister Sadie, Sadie, The Rabbi Lady of The Sisters of Perpetual Indulgence: Out of my rage against hypocrisy and bigotry, I've come up with an idea that's not so much new as it is more and more important and now refined and legal: LET'S KNOCK FALWELL OUT OF THE BOX! Every single one of us, while sitting comfortably at home, can be of true value in winning the war against the religious bigots. I urge you to consider this: 1) Jerry Falwell and the Old Time Gospel Hour hit our cable airwaves on Sunday nights while most folks are at home. Their market tunes in, buys the guilt trips and calls the toll-free number to atone with dollars: 1-800-446-5000. 2) How many phone lines could they have? 25? 50? 200? 3) What would happen if even a portion of us called that number while Falwell is on the air soliciting? He asks for callers to either donate or seek counseling. 4) Since we all know it's they who need counseling, why don't we tell 'em so. And if they hang up, why not call 'em back--again and again and again and again. 5) Nothing fights scam artists like a major slap in the pocketbook. So how's about it? Can you think of a better or easier or more satisfying way to stomp out Falwell disease? And it's even easier if you've got an automatic redial on your phone. I know that not everybody will go for the gusto, but if you really want to show your solidarity to the fight for our freedom, this can turn into a major number: 1-800-446-5000. Remember: it costs you nothing except a little finger and mouth action. Now don't be profane or make pledges in phony names or anything like that. You wouldn't do that, would you? But do join the battle. Thanks a million." [Ed Note: See related article!]

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SADIE, SADIE, THE RABBI LADY HELPS KICK OFF NEW ORLEANS AIDS AWARENESS PROGRAM

The Foundation for Health and Education of New Orleans (FHENO) has invited Sister Sadie, Sadie, the Rabbi Lady, of San Francisco's famed Sisters of Perpetual Indulgence, to help kick off their upcoming AIDS awareness program in Louisiana. Recently funded by a grant from the U.S. Conference of Mayors, FHENO director Dr., Nick Bellos, has asked Sadie to host(ess) informational seminars and panels on the psychological effects of AIDS within the gay community of New Orleans during the first of a series of programs beginning in the autumn. While certainly not an expert or representative of any medical or helping institutions, Sadie's presence is part of Bellos' desire to bring the Foundation's message of health awareness to many who might otherwise become too depressed or apathetic to the struggle for more public information and care. To that end, organizations in wishing to provide publications or other information or support to FHENO's new program are asked to to contact Sister Sadie by calling 415/MANY-MEN (626-9636). Said Sadie following the invitation, "Although rumors of our demise have been greatly exaggerated in some small minds and circles in San Francisco, the spirit of the Sisters continues throughout the world through our individual nunsense and numerous "daughter" convents in such cities as Toronto, Sidney, London, and even Dallas and Milwaukee!" Sadie is known for comedy shtick and songs which inform and uplift while remaining entertainingly raunchy. The Sisters of Perpetual Indulgence (PO Box 69, 4646 18th St., San Francisco, CA 94114) is an order of gay male nuns dedicated to the promulgation of universal joy and the expiation of stigmatic guilt. SPI's ministry is one of public manifestation and habitual perpetration.

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FEMALE IMPERSONATORS AMONG SNAKES
with thanks to Madison, Wisconsin's OUT!, 12/85

Scientists studying red-sided garter snakes in Manitoba (Canada), have found that approximately one in seven snakes is a "female impersonator," according to the New York Times. The snakes exude female-like scents "enticing the courtship of other males," according to researchers. They found no females in 33 out of 200 "mating balls" consisting of as many as 100 entwining snakes.

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MEDICAL DEFINITION OF AIDS RELATED CONDITIONS (ARC) PROPOSED BY BAY AREA PHYSICIANS FOR HUMAN RIGHTS

San Francisco's Bay Area Physicians for Human Rights (BAPHR), through their scientific affairs committee, has developed a working definition of AIDS Related Conditions (ARC) to facilitate communications among physicians and health service agencies. BAPHR points out that the lack of a universal definition of this complex of medical findings has complicated delivery of health care, insurance coverage, and disability classification for these patients who may be as disabled or more disabled than some patients with full-blown AIDS. The "working definition" assumes that other established causes of the abnormal findings have previously been ruled out. After this initial workup, the patient can be said to have ARC if certain clinical, immunologic, and laboratory criteria are met. The clinical criteria are weighted as to importance; e.g., lymph node enlargement for six months or more carries more weight than some inflammatory skin diseases. The definition does not require having the result of the HTLV-III antibody test. Some people with ARC eventually develop AIDS. The guidelines will be proposed to the Centers for Disease Control for consideration, since it is the official governmental body which usually promulgates such definitions for federal and local health agencies, as they have done for AIDS. Until such time as CDC decides on their own definition, the BAPHR is suggested as a working substitute.

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SPERM AS A VECTOR FOR INFECTION

with thanks to Medical Aspects of Human Sexuality, November, 1985

Question: Can sperm serve as a vector for pathogenic organisms and thus be the causative factor in Pelvic Inflammatory Disease? Answer: Both in vitro and in vivo studies of sperm have indicated attachment of bacteria to spermatozoa. This occurs as a result of an apparently selective mechanism. Bacteria considered nonpathogenic for the urinary tract, such as Staphylococcus epidermidis and diphtheroids, do not show attachment. In vitro studies indicate that organisms such as Proteus, Serratia, Escherichia coli, Ureaplasma, and Chlamydia bind to a high degree to spermatozoa. From a pathophysiological point of view, this attachment of bacteria, particularly E. coli and Serratia, may result in agglutination of the spermatozoa as well as in marked inhibition of sperm motility and long-term survival. Attachment of bacteria to Trichomonas vaginalis has also been noted, and probably serves as a vector in bacterial transport. Both sperm and organisms can move throughout the pelvis in females. Scientific literature lacks proof that bacteria attached to spermatozoa may be the direct cause of PID. In vitro studies support not only bacterial attachment, but resultant migration of the bacteria attached to sperm through the cervical mucus. A smear obtained from the peritoneal fluid of a patient with acute salpingitis also showed sperm with bacteria attached. We have on two occasions (unpublished)--with the use of monoclonal antibodies against C. trachomatis--noticed Chlamydia attached to sperm recovered from the abdominal cavity. From the same patient, only C. trachomatis was isolated from peritoneal fluid and tubal washings. (This answer was written by Jan Friberg, MD, PhD (Director of Reproductive Endocrinology and Infertility, Mt. Sinai Hospital & Rush Medical Center, Chicago), and Miguel Suarez, MD (Director of the Microbiology Laboratory, Department of Ob/Gyn at those same hospitals.) [ED NOTE: Several questions come to mind as to how this applies to AIDS. 1) Can viruses, especially retroviruses like HTLV-III also attach to spermatozoa? 2) What specific components of semen are thought to carry & transmit the putative AIDS agent? 3) Must infected white blood cells be present in semen to transmit the putative AIDS virus? 4) Does this suggest that vasectomized men would be unable to transmit the virus? Can virus be isolated from the semen of vasectomized people with AIDS/AIDS-Related Complex/positive HTLV-III/LAV antibody? If you can authoritatively address these issues, let us know (NCGSTDS, PO Box 239, Milwaukee, WI 53201).]

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GARDNERELLA SUSPECTED AS SYMPTOMATIC MALE STD

Gardnerella vaginalis (formerly known as Hemophilus vaginalis and Corynebacterium vaginalis) has long been identified as a cause of a nuisance vaginal condition ("bacterial vaginosis" is thought to be caused by gardnerella, mobiluncus, and other anaerobic bacteria) causing foul-smelling discharge and other irritation in women. Although known to be sexually transmitted, however it is rarely associated with urethral signs or symptoms in men, even though it has been isolated from the male's genitourinary system. According to a recent report in Urology (Watson, RA, Gardnerella vaginalis: Genitourinary pathogen in men, 25:3, 217, 1985), if a man presents with balanoposthitis (inflammation of head and foreskin of penis), suspect gardnerella. The anaerobe is usually thought of as a pathogen in women that lurks in the male urethra asymptomatically. However, it's evidently second only to candida as the cause of purulent inflammation of the foreskin and glans. Gardnerella balanoposthitis is characterized by an excessive, foul-smelling ("fishy") discharge from beneath the foreskin, and nonerosive maculopapules on the mucosal surfaces of the foreskin and glans. The bacterium is especially sensitive to cephalosporin and ampicillin, and metronidazole, although the Food & Drug Administration has not approved metronidazole for this purpose, however the CDC recommends this drug as the first choice for treatment of gardnerella.

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ARMY OFFERS CLASSIFICATION SCHEME FOR INFECTION WITH HTLV-III/LAV
abstracted from New England Journal of Medicine, 314:2, pp. 131-32, 1/9/86

Before the identification of HTLV-III/LAV as the cause of AIDS, the clinical recognition of disease depended upon the occurrence of secondary opportunistic infections and certain neoplastic processes. However, focusing on the late complications of HTLV-III infections severely limits the clinical appreciated of the spectrum of disease as related to its causative agent. Although the natural history of infection is only partially defined and is still under investigation, it is clear that people with AIDS represent only a minority of the spectrum of patients who have been infected. Clinically, a person with HTLV-III infection may present with anything from asymptomatic (with viremia, or antibody or both), through chronic generalized lymphadenopathy, to subclinical and clinical T-cell deficiency. Recently, Drs. Robert Redfield, D. Craig Wright, and Edmund Tramont of the Walter Reed Medical Center & Army Institute of Research have adopted a staging classification for HTLV-III/LAV infection in adults to provide uniformity within its health care system for routine clinical evaluation of patients with AIDS, to facilitate an understanding of the natural history of these infections, and to help evaluate the clinical response to antiviral treatment regimens directed against HTLV-III/LAV. Stage WR0 (WR=Walter Reed) designates high-risk contacts of persons with documented HTLV-III/LAV infection (positive antibody and/or virus isolation). Stages WR1 through WR6 require documentation of infection (positive antibody and/or virus isolation) along with varying degrees of presence of chronic lymphadenopathy, T-cell lymphopenia (<400), delayed hypersensitivity (with intact, partial or complete cutaneous anergy to 4 test antigens), and presence/absence of thrush and opportunistic infections. The authors stress that the use of the word "stage" does not imply that all patients will have progressive disease. Many questions about clinical progression are currently unanswered; this staging classification is designed to facilitate their resolution the authors conclude. [NCGSTDS ED NOTE: This is the first formal presentation of a staging classification, and for the reasons stated, it will probably evolve into a useful tool. Notably absent is mention of some of the AIDS related cancers (e.g., Kaposi's sarcoma), oral "hairy leukoplakia," central nervous system manifestations (e.g., retinitis, memory/personality changes), and some of the constitutional symptoms (e.g., weight loss, fevers, diarrhea).]

CIRID MEDICAL UPDATES

[Prepared as public service to the medical community by the Division of Clinical Immunology/Allergy, Department of Medicine, UCLA School of Medicine. This update represents editorial opinion and should not be construed as otherwise. Published by the Center for Interdisciplinary Research in Immunology and Disease (CIRID) at UCLA and by the UCLA AIDS Center. Andrew Saxon, MD, Editor in Chief; Peter Wolfe, MD, Associate Editor. For more information call 213/825-1510.]

Resistance of AIDS Virus at Room Temperature. (Barre-Sinoussi, F., et al., Lancet, ii:721, 1985). To define the potential for persistence of infectivity of the AIDS virus outside the body, the authors performed experiments designed to assess the infectivity of the AIDS virus (HTLV-III/LAV) maintained at room temperature and after drying. In the first experiments, live virus was placed in sealed glass tubes at room temperature containing liquid medium. Material was removed from the sealed tubes at days 2, 4, and 7 and then used to infect a line of stimulated T-helper cells. A reverse transcriptase (RT) assay was performed on the cell free supernatant to assess viral activity. There was no difference in RT activity between control virus suspensions and those incubated for 2 and 4 days; a slight reduction was observed at 7 days. In the second set of experiments, virus was allowed to dry on petri dishes at room temperature. At 4 and 7 days, the material in the petri dishes was resuspended in water and used to try to infect stimulated T-helper cell lines. While there was a significant reduction in the infectivity of the dried virus material at day 4 and 7, infectious virus could still be recovered from the dried materials at both times as determined by its ability to infect stimulated T cells. The authors conclude that the persistence of infectiuos LAV at room temperature may explain the appearance of some AIDS cases in non-risk groups. They advise that laboratory and other health care workers increase safety precautions when working with the virus or body fluids from persons with AIDS virus infection. CIRID EDITOR NOTE: These authors performed an elegantly simple series of experiments designed to define the potential for retention of infectivity of LAV at room temperature under conditions of moisture and dryness. Their results show that infectivity persists in liquid medium almost completely for days, but infectivity is much reduced by drying. Since the assay for virus is not quantitative, it is impossible to tell whether drying for 4 or 7 days inactivated any specific percent of the virus. In any case, some viable virus remained. Their claim that their results could explain some cases of AIDS in non-risk groups seems appropriate scientifically, though evidence for casual transmission is still lacking. At present, the minimum amount of virus necessary for successful infection is not known; therefore, any extrapolation from this type of in vitro study must be made with some caution. There is no evidence that AIDS virus infection occurs via any other means than sexual contact, blood contamination, or the maternal-fetal routes. Their admonition to increase vigilance against contamination in the laboratory is well taken; fortunately, the virus is inactivated by a variety of common chemicals, including sodium hypochlorite (1:10 dilution of household bleach with water), ethyl alcohol (35% or more), etc.

MORE NEW DRUGS AGAINST AIDS

by Ronald Kotulak, with thanks to the Chicago Tribune, 11/24/85

A new class of compounds designed to fool the AIDS virus has produced promising new results in preliminary tests with patients, according to the National Cancer Institute. According to Dr. Robert Gallo, chief of NCI's Laboratory of Tumor Cell Biology, there is complete restoration of immunological function and a great deal of clinical improvement in people with AIDS (PWAs). Gallo discussed the new findings at the First International Conference on African AIDS held recently in Brussels. Researchers are focusing on Central Africa because it is thought that the immunity destroying disease originated there and is epidemic in much of the region. The new class of compounds, called dideoxynucleosides is being tested by Dr. Samuel Broder, NCI's clinical director, and Dr. Dani Bolognesi, associate director of Duke University's Cancer Center. The new class of compounds is not considered a cure-all, Gallo said, and further studies are being planned to determine the long term effects. Newer and better drugs probably will be devised fairly rapidly as more information about the virus becomes available, he added. "We view this with a certain amount of cautious optimism and with a felling of excitement that 1986 or 1987 will bring some interesting results in therapy," he said. Researchers got the idea for the latest therapy when they were baffled at the way the virus was quickly able to change part of its genetic instructions for its protein coat. A key enzyme, polymerase, was found to be prone to making mistakes, often incorporating the wrong nucleosides, the building blocks for genetic material, to produce the genetic variations. "We decided that if the virus can fool us, we can fool it," Gallo said. The new compounds do that by providing the enzyme with false nucleosides that go into the DNA copy of the virus. But because the copies are useless, the DNA chain doesn't work and the infected cell does not make copies of the AIDS virus. By inhibiting the replication of the virus, the disease process is halted, and patients have a chance to recover. The AIDS virus is a retrovirus that has an RNA genetic core. Most viruses, such as the one that cause the common cold, are made up of DNA. When a DNA virus infects a cell, it takes over the cell's machinery to make copies of itself. But a retrovirus works differently, using the polymerase enzyme to make DNA copies of itself. These copies are incorporated into the cell's DNA genetic code from where they order the construction of new viruses. Gallo said researchers are beginning to realize that AIDS actually involves a spectrum of diseases from cancers to infections and that a new name probably is needed for AIDS. The AIDS virus, also known as HTLV-3/LAV, can destroy brain cells without causing other symptoms characteristic of an acquired immune deficiency. The virus seems to grow in a certain type of white blood cells, macrophage monocytes that migrate to the brain where it can cause the infection and destruction of the nerve cells there. This is thought to be one of the most problematic and serious of the ramifications of the disease.

In a surprise development at the Conference, Belgian organizers of the two-day symposium were stung by the decision of three research groups to withdraw their presentations. The pullout appeared to have been triggered by orders from Zaire's Ministry of Health forbidding at least one of its AIDS researchers from attending the meeting. Following suit, scientists from the Centers for Disease Control, led by Dr. Jonathan Mann, stationed in Zaire's capital, Kinshasa, supported the boycott. Subsequently, Dr. Peter Piot of Antwerp, another AIDS researcher in Zaire, and Dr. Francoise Brun-Vezinet of the Hospital Claude Bernard in Paris also withdrew. Piot said the government of Zaire opposed the Conference because of its location in the country of its former colonial masters, and because "some people are using this [assertions that AIDS originated in Africa] as an excuse for racism." Zaire was the Belgian Congo before it won its independence.

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NEW DRUG REMOVES CHOLESTEROL FROM OUTER ENVELOPE OF VIRUS

Scientists searching for the achilles' heel of the AIDS virus believe they have found a promising new strategy--a drug that wrecks the crucial outer coat of the lethal microbe. The drug, AL 721 seems to carry no dangerous side effects, a major advantage over many other experimental anti-AIDS drugs, and appears to remove cholesterol from the outer membrane or envelope of the virus, changing its structure, in vitro (in test tubes). Without an intact envelope, the virus is thought to be powerless to infect. In a cautiously worded letter in a recent New England Journal of Medicine, Dr. Prem S. Sarin of the National Cancer Institute and other researchers said the drug could protect vulnerable white blood cells from infection by the virus. Dr. Fulton Crews of the University of Florida, said experts have long known that solvents can kill viruses. But until now, no one has considered assaulting them inside the human body by drawing out the cholesterol that is part of their outer membranes. "Cholesterol makes membranes rigid and hard," Crews said. "So when you pull the cholesterol out, the membrane does, in essence, melt." Several other experimental AIDS medicines work by attacking reverse transcriptase, an enzyme the virus uses to take command of infected cells. However, many of these drugs also have damaging side effects that could limit their long-term use.

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RESOURCE FOR ALTERNATIVE HEALTH CARE FOR AIDS

by Paul N. Van Ness, PhD, January 6, 1986

The Whitman Walker Clinic of Washington, DC, a longstanding lesbian and gay health clinic, has sponsored the publication of a large-format, 25 page booklet, "Alternative and Holistic Health Care for AIDS and Its Prevention: A Sourcebook of Descriptions, Bibliography, and Practitioners in the Washington, DC--Baltimore, Maryland Area." The idea for the

<CONTINUED ON PAGE 48>

GAY MEN TO CONDUCT RESEARCH OF DRUGS EFFECTIVE AGAINST AIDS

edited by John Fall, with thanks to the New York Native, 11/18-24/85

A group of gay men announced that they would begin research into the effectiveness of combining the use of the drugs ribavirin and isoprinosine against AIDS. The group cited the slowness of the federal bureaucracy and the rising number of AIDS deaths as the reasons they will undertake the research. "We hope to find a safer and more monitored way for people to use them," said Martin Delany, one study organizer, in reference to the two drugs. "Traditional research methods make it difficult to test combinations. Any testing of these drugs in combination may be far away." Ribavirin is an anti-viral drug and isoprinosine boosts the immune system. The group will be monitoring their simultaneous use by people with AIDS, but it will not distribute the drugs to anyone. The study will be sponsored by the Documentation of AIDS issues and Research Foundation, Inc. (DAIR). Delany stated that at present no physicians are involved in either DAIR or the research project.

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SEARCH FOR VACCINE SECONDARY TO NEED FOR PUBLIC EDUCATION, ACCORDING TO AMA REPORT

by Rick Harding, with thanks to The Washington Blade, 12/13/85

An American Medical Association council report called the search for an AIDS vaccine "secondary" to the need for public education to curb the spread of AIDS. Although the development of a vaccine is "highly desirable," the group's Scientific Affairs Council reported, it is not likely to occur in the immediate future. "Our only weapons are education about the disease and the preventive measures that should be taken." The AMA House of Delegates, following the council's lead, voted to launch an AIDS Action Plan to get current information about AIDS development to doctors. The delegates approved a preliminary AIDS Action Plan which calls for providing physicians with current AIDS information and establishing physicians as credible sources of AIDS information for the general public. A more comprehensive action plan and a breakdown of funding needs will be presented to the delegates at their next meeting in June, according to AMA spokesperson William Small. Besides the action plan, the 371 delegates considered several other resolutions concerning AIDS. One resolution, which was withdrawn from consideration after drawing a great deal of criticism during committee debate, recommended that the AMA lobby states to require HTLV-III antibody testing of people applying for marriage licenses. The delegates deferred voting on two other AIDS-related resolutions pending further study. Once called for conducting a study of the public health implications of allowing children with AIDS to attend school. The other called for the AMA to oppose discrimination against people who have AIDS or positive HTLV-III antibody test results, or people who are at high risk of contracting the virus. The resolution also called on the AMA to oppose legislation that would lead to such discrimination. Small said the deferred resolutions probably would be acted upon at the June meeting. The AMA is the county's largest professional society of physicians, with 258,000 members representing over half of all physicians in the U.S. AMA's political action committee (AMPAC) has an annual operating budget of over $125 million.

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HEPATITIS B VACCINE CHANGES ON HORIZON?

with thanks to Detroit's Cruise, 12/26/85

A study conducted recently at the Walter Reed Army Institute revealed that the cost and uncomfortable side effects of immunization with the hepatitis B vaccine can be substantially reduced by using one-tenth of the currently recommended dose administered subcutaneously rather than into the muscle. Cutting the quantity of vaccine in this manner provides the same amount of protection, and significantly reduces costs. [ED NOTE: Whether these savings would be passed on to the consumer is not known; in fact, some speculate that the cost won't be significantly altered due to the pharmaceutical company's need to recover research & development investments. What this may suggest is that clinicians may elect to give the vaccine in altered dose and administration without FDA approval, if additional research evidence supports the Walter Reed findings.]

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COMBINATION THERAPY FOR CHRONIC HEPATITIS B

abstracted from Lancet 2:358, 1985, with thanks to Medical Tribune, 11/6/85

"Encouraging results" from a trial of combined interferon-acyclovir therapy in hepatitis B have been reported by Dr. S.W. Schalm and colleagues at the University Hospital Dijkzigt in Rotterdam. Twelve patients with chronic hepatitis B and active viral replication received 15 mg/kg of acyclovir intravenously twice daily for two weeks following a four-week course of intramuscular alpha-interferon. The combination was well-tolerated provided acyclovir was given after the effects of interferon therapy had worn off. When given in combination, the two agents had a significantly greater antiviral effect on hepatitis B, expressed as a fall in the level of DNA polymerase activity and hepatitis B e antigen (HBeAg), than either interferon or acyclovir alone. "Combination therapy appears the most promising for conversion of a state of active viral replication into virus latency," the Dutch team concluded.

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AIDS EPIDEMIOLOGY/SURVEILLANCE UPDATE

abstracted from AIDS Weekly Surveillance Report, CDC AIDS Activity

As of December 30, 1985, the Centers for Disease Control AIDS Activity reports a total of 15,948 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; 2% from blood/blood product recipients; and 6% from those in no apparent risk or 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 "heirarchical" listing--some of the homosexually active men may also be IV drug users or hemophiliacs, but are only counted in the top, i.e., "homosexual" category, therefore confusing and misrepresenting the data, which CDC officials themselves have admitted.--ED] 22% are from individuals aged 29 or less; 47% from ages 30-39; 21% from ages 40-49; and 9% from ages over 49. 59% of the individuals are white; 25% are black; 14% are hispanic; and 2% are other/unknown. 55 states and territories, including the District of Columbia & Puerto Rico have reported cases to the CDC; New York and California have the most cases, with 34% and 23%, respectively; Florida, New Jersey, and Texas each have 7%, 6%, and 5% of the cases, respectively; Illinois, Pennsylvania, Massachusetts, Georgia, and the District of Columbia each have 2% of the cases. Overall mortality is 51%.AIDS cases per million of population for the entire U.S. is 70.1 per million, ranging from 555.1 per million in NYC, 536.5 pM in San Francisco, 306.3 pM in Miami, 202.4 pM in Newark, 177.6 pM in Los Angeles, and 33.9 pM for elsewhere, irrespective of standard metropolitan statistical area.

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CURE IN 5-10 YEARS?

with thanks to The Washington Blade, 11/1/85

Dr. Anthony Fauci, director of the National Institute of Allergy & Infectiuos Diseases, said at a recent press conference that although no date could be pinpointed for finding a cure for AIDS, he considers the 5-10 year estimate of the Public Health Service to be "reasonable." Fauci said the current sexual behavior modification by gay men should, "within a couple of years," result in a slowing down of the curve of new AIDS cases. If high-risk group[s continue to practice safe sex, the curve will eventually level off and then decrease, Fauci said, noting that the process is a slow one since AIDS has an unusually long incubation period.

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THREAT OF AIDS CONTAGION BY TEARS DISCOUNTED BY EYE EXPERTS

Because of the possible public fear of contracting the AIDS virus during routine eye-care, a blue ribbon panel of eye specialists appointed by the National Society to Prevent Blindness (NSPB) reported that neglecting such treatment greatly outweighs the slim possibility of contracting the AIDS virus during an eye examination. The general public is putting itself at risk by neglecting routine eye treatment and avoiding screening tests for such potentially blinding eye diseases as glaucoma, diabetic retinopathy, and macular degeneration, or other conditions such as amblyopia and strabismus, for fear of contracting AIDS as a result of contact with medical equipment that may have been exposed to the tears of people with AIDS. After considering all available evidence, the Task Force on AIDS and Eye Health Care concluded that no known case of AIDS has been traced to transmission of the virus through tears. Task Force members included Denis O'Day, MD, Vanderbilt University School of Medicine professor of ophthalmology, Nashville, and Frank Newell, MD, editor of the American Journal of Ophthalmology. O'Day pointed out that evidence indicates that eye health care workers and volunteers are not at any significant risk of contracting the disease as a result of contact with only the tears of AIDS patients. He advised that to eliminate any risk of transmitting the AIDS virus to eye patients, all health care workers and volunteers adopt the simple standard sterilization procedures recommended by the Centers for Disease Control [see previous issue of Newsletter for reprint of MMWR, 34:34, 8/30/85). The Task Force also concluded that the risk for contracting the AIDS virus in screening programs is remote under current hygenic procedures. Those engaged in glaucoma screening using the Schiotz applanation tonometers (contact tonometers) are encouraged to adhere to the sterilization procedures recommended by the CDC. Optionally, disposable single-use tonometer tips (tonotips) can be used. The non-contact (air puff) tonometer does not touch a patient's eye and therefore could not be a mechanism for transmission of the virus. In preschool vision screening programs, the use of disposable, single-use occluders (a shield used to cover first one eye and then the other during the screening) is recommended. The NSPB was established in 1908, and is the oldest voluntary health agency nationally engaged in preventing blindness through a comprehensive program of community services, public and professional education and research. NSPB provides screening programs for adults and preschoolers through its 26 affiliates in the U.S. and Puerto Rico. In 1984, 177,982 persons were screened for glaucoma, and 281,700 preschoolers were screened for vision problems in Society sponsored projects. In addition, the Society sets standards for screening procedures and trains health care workers and volunteers from community service organizations to conduct their own screening programs.

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