THE OFFICIAL NEWSLETTER OF THE

NATIONAL COALITION OF GAY STD SERVICES

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CDC ENCOURAGES MASS TESTING, PARTNER REFERRAL, CLOSING "ESTABLISHMENTS"
with thanks to The Washington Blade, 3/21/86

The Centers for Disease Control published six new guidelines for state and local health officials to consider implementing to "facilitate identification" of persons who test positive for the HTLV-III antibody and to help prevent the transmission of AIDS. In addition to public education and "encourag[ing] voluntary" antibody testing, CDC recommends that "Infected patients should be encouraged to refer sex partners" to their doctors or have health professions "assist in notifying their partners...." The guidelines also recommend that state or local public health officials should regulate or close "establishments where there is evidence that they facilitate high-risk behaviors...." CDC also suggests that health officials should "evaluate the implications of requiring the reporting" of positive antibody test results to state health departments. [NCGSTDS ED NOTE: Please see MMWR article that details those recommendations, and a response by those attending the National Lesbian Gay Health Conference, elsewhere in this Newsletter.]

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CDC CHASTISED, CHALLENGED BY AAPHR

The American Association of Physicians for Human Rights (AAPHR) is the national organization of gay and lesbian physicians and students. We are deeply disturbed by the latest Center for Disease Control (CDC) guidelines that recommend that all high-risk individuals for AIDS take the HTLV-III antibody test, because it is clear that this is another step towards universal mandatory testing. The classic Public Health strategy in an epidemic is to identify those individuals infected and those uninfected and separate the two. HTLV-III is spread sexually or by blood or blood products. The recommendation that gay and bisexual men all be tested was made over the strong objections of the AAPHR and the National Gay & Lesbian Task Force (NGLTF). The CDC is therefore well aware that massive voluntary testing is opposed by the gay community (although supported for those individuals who think it will help them practice low-risk sexual behavior). Since gay and bisexual men can not be identified to get them to voluntarily take the test, it is clear that calls for massive voluntary testing will fail. The chances of failure are greatly increased by the efforts around the country to make HTLV-III positive tests reportable to the states. Therefore, there is only one logical explanation for such a recommendation: as had been done in the military, and proposed for immigrants, the CDC is laying the groundwork for universal mandatory testing for HTLV-III. The second part of the classic Public Health strategy--separating those infected from those uninfected can only be instituted after all those infected are identified. We challenge the CDC to tell us how they plan to separate the 1-2 million infected individuals from the remainder of society.

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SURGEON GENERAL KOOP BRIEFED BY ACTIVISTS
by Lisa M. Keen, with thanks to The Washington Blade, 4/2/86

National gay activists working on AIDS programs and lobbying briefed Surgeon General C. Everett Koop for two hours, April 2. Jeff Levi, co-director of the National Gay & Lesbian Task Force, said he and representatives of the AIDS Action Council, American Association of Physicians for Human Rights, Lambda Legal Defense and Education Fund, and the Gay Men's Health Crisis briefed Koop on education, service, and public health measures they feel are needed adequately to address the AIDS epidemic. Levi said Koop assured the activists of his commitment to fight AIDS but gave "absolutely no indication as to where he was" on any particular issues, such as the reporting of antibody tests. The meeting was arranged by Koop in preparation of his AIDS report to the public expected to be released in about three months, according to Shellie Lengel, spokeswoman for HHS Secretary Otis Bowen. Lengel said Koop is meeting with "a whole series of groups in order to gain a "personal understanding" of the epidemic. She said she did not know which other groups Koop was meeting with.

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NEW MEXICO CUTS AIDS FUNDS
with thanks to the New York Native, 5/5/86

The New Mexico House Appropriations and Finance Committee has passed HB-238, a bill which will provide $100,000 for AIDS programming. The bill was signed February 28 by Governor Tony Anaya. The bill originally called for $482,000 to be given directly to the Health and Environment Department (HED) for its AIDS programs. Lynn Tytler (R-Albuquerque), a House committee member, proposed the original amount be reduced to $241,000 and that the entire amount be used to contract services from community organizations. Senator Tom Rutherford (D-Albuquerque) agreed to cut the amount of the bill to $100,000 to ensure its passage. HED will contract the community organization New Mexico AIDS Services (NMAS) to use the money for AIDS programming. NMAS president Ron McDaniel expressed his disappointment in the cutting of funds, saying it "will result in additional human suffering and greater future expenditures of public funds," reports Russell Gray in Common Bond Ink.

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EDITORIAL REPLY TO "CONTACT TRACING DUPES GAY COMMUNITY" FROM CDC

[The following is a reply to the editorial, "Contact Tracing Dupes Gay Community," as published in the NCGSTDS Newsletter, 7:2, December/January, 1986, by Dr. Willard Cates, MD, MPH, Director of the CDC's Division of Sexually Transmitted Diseases, and Russ Havlak and Bob Kohmescher of that Division. Russ and Bob have over 36 combined years of experience in STD control directly related to the issues addressed in the editorial, and are currently responsible for training in STD intervention, HTLV-III/LAV antibody test counseling, and AIDS health education/risk reduction. In order to preserve continuity of thought, the NCGSTDS Editor's comments will follow the CDC's response, in a point-by-point refutation. You are invited to reply: NCGSTDS, POB 239, Milwaukee, WI 53201.]

"Your editorial, "Contact Tracing Dupes Gay Community," in the NCGSTDS Newsletter (1986, 7:2, 7-8) raised interesting issues about this process and concluded it had little value in preventing HTLV-III/LAV transmission. Based our 36 years of experience with "contact tracing" in STD control activities, we view the issues somewhat differently and differ in our conclusions. At the outset, we present our definition of the approach under consideration. For some years now, the STD control program's term for this process has been "sex partner referral" [hereafter referred to as SPR--Editor] rather than "contact tracing." This is not a trivial distinction. [SEE ED NOTE 1.] STD disease intervention seeks to interrupt the transmission of infection in several ways, including by educating patients about risk reduction methods and treatment compliance, and by referring sex partners for medical assessment and necessary treatment. STD control professionals approach sex partner referral from the perspective that a medical need (and indeed an ethical obligation) exists to assure people are informed about their risk of infection and provided an opportunity for medical care. Thus, we focus on the best way to assure that occurs. [SEE ED NOTE 2.]

"In most instances patients are willing and able to make referrals and they are encouraged to do so. STD professionals provide "coaching" on how to carry this out with a minimum of damage to the relationship and offer their back-up if the patient needs support or assistance. In some cases, however, patients are unable to self refer sex partners for reasons of logistics or sensitivity, or anticipate difficulty in a referral that may not be surmountable. For such sex partners, if the patient prefers, STD professionals will make the referrals and assure that the patient is not involved or identified in any way. Therefore, "tracing," or the referral of individuals by health department personnel, is just one integral part of a much larger process of disease control. [SEE ED NOTE 3.] Without question, anonymity is an impediment to sex partner referral. But in our experience, we found that nearly every gay patient has some sex partners whom they know well or can describe well enough to be located. [SEE ED NOTE 4.] Since potentially serious medical problems are involved, we disagree with the logic which suggests that the inability to refer every one of a patient's sex partners dictates not to even make an attempt to refer any. [SEE ED NOTE 5.] In fact, a patient's participation upfront in this disease intervention process usually has a residual impact. Many are motivated to continue looking even for "anonymous" sex partners long after treatment. Upon locating one of these sex partners, a patient often makes the referral him/herself, but sometimes will call the STD professional who assisted them earlier to complete the referral. The medical need for persons to know about possible exposure to HTLV-III/LAV becomes more impressive with each new scientific revelation about how this virus works. We now believe that knowledge of an HTLV-III/LAV infection may argue against the use of live viral vaccines and immunosuppressive medications, like steroids. It also may alter the medical management if the patient becomes exposed to certain communicable diseases, such as varicella [V. zoster, as in chickenpox or shingles] and tuberculosis. [SEE ED NOTE 6.] Knowledge also is vital to a patient's medical management where pregnancy or possible pregnancy is involved. Finally, studies published recently in Science and The Journal of Immunology strongly suggest that multiplication of the virus, which leads to the infection and ultimate death of T4 helper cells, is stimulated whenever the immune system becomes active. Of course, the immune system becomes active whenever an individual acquires any type of infection. Therefore, infected persons who make appropriate behavioral choices may be able to help control the course of their infection and determine whether or not AIDS is the outcome. To insist that this is equally possible for people do not know they are infected is, in our judgment, a perilous assumption.

"Turning to some of your specific concerns, you pose the question, "Why have the National VD Control Program and state health departments failed to control the incidence of infectious syphilis among homosexually active men using contact tracing as a primary intervention strategy?" Rather, we feel a more appropriate issue for critical assessment is the amount of disease that did not occur because sex partner referral efforts succeeded in preventing it. [SEE ED NOTE 7.] For example, annually this process results in the therapeutic treatment of about 16,000 sex partners for early syphilis. This treatment effectively prevented the ability of these patients to spread disease further, which experience shows would have occurred in nearly one of every two cases. In addition, each year about 45,000 sex partners to early

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EDITORIAL REPLY, Continued

syphilis are located, referred, found clinically and serologically free of disease, and given the preventive treatment. Over 15,000 of these people are exposed within the previous 30 days to an infected patient. A substantial number of these would have gone on to develop infectious disease. Annually, about 70,000 sex partners to gonorrhea patients are therapeutically treated for disease through SPR and another 79,000 receive preventive treatment. While precise data are not available, gay men are well represented in these figures for both diseases.

"Next, you build a case for why this "contact tracing" in STD control is not appropriate for controlling the spread of HTLV-III/LAV. However, we see your position as somewhat contradictory. You acknowledge that education is the only method of stopping the spread of HTLV-III/LAV; but because there is "no adequate medical intervention," you deem that efforts to reach the sex partners of infection patients to provide them that same education somehow is an unsuitable strategy. [SEE ED NOTE 8.] Frankly, we cannot imagine a more appropriate group of high risk people to directly communicate the focused message about preventive measures to limit spread of the virus. Since one partner in the relationship is infected, it is risky to assume that those individuals are uniformly following "safer sex" practices. [SEE ED NOTE 9.] Also, we make a very risky assumption by insisting that the rate of HTLV-III/LAV spread can be effectively reduced only through a shotgun dissemination of these prevention messages. This approach certainly has not worked with those infected individuals. [SEE ED NOTE 10.] You quote Felman in his chapter in Ostrow's STDs in Homosexual Men, "...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)." This fear of disclosure is real, but is not an exclusive concern of gay men. Nearly every STD patient worries about confidentiality to some degree because of the social stigma which unfortunately still attend diseases. The STD staff in health departments recognize this concern more keenly than any health care workers and realize that the ability to overcome these patient fears is essential to their public health mandate. Confidentiality, therefore is the cornerstone of the disease intervention process. When patients understand this, can see how the SPR process works, and can recognize how referrals undertaken by health department staff will protect their confidentiality, most participate in the process. For example, over 80% of all early syphilis patients discuss their sex partners and strategies for assuring they are referred. If the health departments could not deliver on their assurances of confidentiality, the disease intervention process and SPR would have come to a halt long ago. The fact that each year over 50,000 early syphilis, about 55,000 gonorrhea patients, and some 10,000 other STD patients participate in the disease intervention process without adverse incident testifies to its strength. However, that this heritage of confidentiality is commonly overlooked is not really surprising. After all, the details of STD disease intervention in general, and SPR in particular, are confidential and not for public disclosure. This job is done as quietly as is humanly possible. To those of us in STD control, no news is good news! [SEE ED NOTE 11.]

"Finally, some specific observations regarding your criticism of the CDC position on the explicitness of risk reduction materials. In developing guidelines on this matter, CDC had to consider whether basic support for the total array of AIDS-related initiatives might be placed in jeopardy by funding the purchase or development of materials used for risk reduction education that were likely to be considered offensive by society at large. CDC felt that the overall AIDS control initiative was too important to ensnare it in such controversy. More fundamentally, however, we had questioned the validity of assertions that visual and verbal explicitness was the only way to reach gay men with risk reduction messages. In our CDC careers, a number of us have worked extensively with gay men, as STD patients, as businessmen, administrators, and community group leaders in positions to support various public health programs. We are uncomfortable with the implication that gay men somehow lack the capability to comprehend such messages when they are not cast in explicit terms or that explicitness is the key factor in determining whether they will accept or reject risk reducing behaviors. Certainly in communicating with an individual, such as during a counseling session, explicit terms and references on occasion may be the only apparent way to clearly convey the risk reduction message. However, this involves a case-by-case judgment by the counselor and is a far different matter than a pamphlet, poster, or audiovisual which may be available to the general public. Recently, some have implied that an endorsement of the unrestricted use of explicit language and materials is a litmus test to gauge whether straight community agencies and officials are tolerant of the gay lifestyle in general, and therefore are worthy or unworthy of being trusted. This subliminal message, which we also found in your editorial, is unfortunate because it detracts from the important mission of controlling AIDS. Our cooperative efforts to accomplish this mission will be enhanced by avoiding the perception that validity of the message about AIDS prevention is a function of how it's presented and who is making the presentation. [SEE ED NOTE 12.]

"We hope that raising our viewpoints will promote a continued dialogue about the best ways to reduce HTLV-III/LAV transmission through constructive interaction of the STD program community, the gay community, other interested groups and organizations, as well as the general public. We feel that the invitation to respond to your editorial is a positive step in that direction."

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EDITORIAL REPLY, Continued

NCGSTDS POINT-BY-POINT EDITORIAL REPLY:

The NCGSTDS is always interested in improving communications and encouraging dialogue among our members and public health officials. We appreciate all opportunities to engage in such exchanges, and are especially appreciative of the STD Control Division's willingness to reply to our recent editorial. They are invited, as all of our readers are invited to reply to this reply or anything else published in the Newsletter. [Each numbered response corresponds to the notes listed above. The reply was written by Chairperson/Editor Mark Behar, PA-C; special thanks to Doug Johnson, RN for his suggestions.]

1) I am willing to accept the broadened concept of "sex partner referral" rather than "contact tracing" or "contact notification," although I maintain that it is mainly a semantic difference. Public health departments in different areas have all used different terms, so that if the distinction is that important from a public health perspective, than terminology should be standardized. (In 1978 I attended a CDC course named, "Venereal Disease Contact Interviewing,"--another term for the same concept of "contact tracing.")

2) Although the strategy of SPR may be valuable with certain diseases and in certain circumstances, there is no agreement that it is the "best way," especially as it is proposed for HTLV-III antibody positive sex partner referral. It is also misleading, since "best" implies that the strategy has been tested and found to be superior to other strategies. SPR for HTLV-III Ab positivity simply has not yet been tested and found effective.

3) Although willing to cooperate for other treatable STDs like syphilis & gonorrhea, there is no evidence that HTLV-III Ab positive persons will be willing or able to make SPR. That STD professionals can provide "coaching" on how to accomplish this sensitively and appropriately is laudable if it actually occurs, but whether this is likely in a sex and gay affirmative and nonjudgmental manner, especially in more conservative health departments, is doubtful. Can we expect these public health officials to be sensitive to the issues of those disenfranchized risk groups--homosexually active men, IV drug abusers, prostitutes, or others? Conspicuously absent from the details outlining the process of training and designating health officials to work in this area is any mention of sensitivity to gay issues/homophobia, for example.

4) We recognize that anonymity is an impediment to successful implementation of SPR. Gay health workers are affronted by the reluctance of public health officials to acknowledge the importance of anonymity, given the horrific examples of violations to confidentiality that abound throughout the nation. Such officials rarely preface their comments with such documentation, or condemn such infractions, or actively work to prevent such abuses in their localities (such as by testifying at legislative hearings). This demonstrates a lack of sensitivity to gay concerns and helps us understand our reluctance to trust the actions of the Public Health Service and local health departments.

5) In Wisconsin, the Division of Health conservatively estimates an average of only 5 identifiable/traceable sexual contacts per case of HTLV-III antibody positive persons. According to John Phair, MD, PhD, chief investigator for the National Institutes of Health's 5 year longitudinal M.A.C. study, each case has an average of 20 contacts. Extrapolating, these 15 untraceable contacts represent a significant obstacle to the SPR disease intervention strategy, and at an extremely expensive, and labor intensive cost. Using the money that would be used for SPR of 25% of the contacts could more efficiently be used to reach the "unreachable" other 75% through general educational campaigns! Research in the form of a demonstration project to determine the actual efficacy of this first stage of SPR (self notification by the primary HTLV-III antibody positive person)--i.e., willingness to cooperate and follow through of those contacts to actually seek counseling and to initiate behavioral change would be invaluable and convincing evidence of its effectiveness. What is now underway are 50 or more such never-before-tested programs (one in each state) without quality control or adequate supervision or safeguards to prevent abuses. What is the cost for this poorly designed, unproven experiment? According to Mervyn Silverman, MD, former Commissioner of Health in San Francisco, such widely disseminated educational messages are responsible for a greater than 80-90% reduction in morbidity with infectious syphilis and rectal gonorrhea among homosexually active men in San Francisco and New York.

6) The argument about the use of live viral vaccines and immunosuppressive medications (like steroids) with people who are HTLV-III antibody positive is provocative, although the research is speculative (if it exists at all). The contemplated use of such vaccines has not been addressed by the Immunization Practices Advisory Committee (ACIP); hopefully this group will explore this question. Certainly, as with all medical therapies, a cost-benefit analysis must ultimately determine the need for vaccinations or other therapies. The use of immunosuppressive medications must similarly be evaluated. We don't know how immunosuppressive drugs may affect the replication of HTLV-III, which requires activated T-cells. With regards to affecting the medical management of varicella (chicken pox/shingles/herpes zoster) and tuberculosis, antiviral medications such as acyclovir, or antitubercular drugs (isoniazid, ethambutol, streptomycin, rifampin, sometimes steroids & others) may also temporarily affect the immune system; does the potential benefit of such vaccines or medicines outweigh their potential risks? Women considering or seeking pregnancy should be appropriately counseled if at high risk to exposure to the AIDS virus. Knowledge of antibody status may be helpful but is not necessary, and most physicians will elect to offer a vaccine, or immunosuppressive therapy, or to make recommendations about pregnancy based on whether a person may be in a high risk category and encouraging their

EDITORIAL REPLY, Continued

participation in that cost-benefit analysis.

7) Why the contact tracing strategy hasn't reduced the incidence of infectious syphilis among homosexually active men remains central to why it is expected to be ineffective when applied to HTLV-III antibody positive sex partner referrals. This conjecture is based in fact; the CDC's position is based on wish and faulty logic, instead begging the question and offering circuitous reasoning. Contact tracing/SPR may have some benefit, especially among heterosexually active men and women. Recall that general education about STDs/AIDS risk reduction, without SPR, was responsible for a greater than 80-90% reduction in the morbidity of certain STDs among homosexually active men in San Francisco & New York. The reason why approximately 50% of new primary & secondary infectious syphilis cases are among homosexually active men (rather than 10%, the generally accepted percentage of homosexually active men in the U.S.) is that contact tracing doesn't work in situations of anonymous sexual encounters. The other important distinction in using SPR/CT for infectious STDs versus HTLV-III antibody is the therapeutic outcome resulting from immediate treatment. Educating and promoting the message of "safer sex" to all men and women who are sexually active with multiple partners (i.e., almost everyone!) is one of the best and most effective tools in prevention. SPR even if maximally effective, doesn't prevent the primary exposure to the AIDS virus, only recurrent exposures (which may be an important component in disease prevention).

8) Education is the best intervention, however the particular strategy of SPR is an inappropriate one given: its labor intensiveness & costliness, inadequate evidence of its effectiveness especially when compared to other educational approaches, and inadequate assurances against civil rights violations due to violations (intentional or not) of confidentiality, especially where strong legal protections are absent (i.e., everywhere).

9) You are unimaginative to maintain that a more appropriate group of high risk people doesn't exist! Those who are not yet infected--i.e., young men and women just entering into "stages" of sexual and drug experimentation, regardless of sexual orientation, especially among people of color who are not as likely to hear and process the risk reduction messages that may be incorrectly perceived as only directed to white, gay men. This does not suggest that partners of antibody positive persons should be given less priority for the educational message. The message must be that all persons in high risk groups and adolescents (who may not yet have entered into a high risk group), regardless of antibody status, must practice safer sex and not reuse needles if using drugs. Why is there such a reluctance to openly promote this message by health officials? Homophobia? Political or religious influences? It appears that "dirty" words and erotic concepts are more important than saving lives to our nation's public health officials.

10) Our position is to inform all members of risk groups to act as if they are antibody positive regardless of their true status. Although it seems logical, it is unproven that a person's sexual behavior is altered after knowledge of a positive antibody result. We are know that public education campaigns in cities have significantly reduced certain STD morbidity. The CDC must continue to sponsor and allocate funds for innovative and traditional health education approaches known to be effective if they continue to embark on the unproven SPR approach. This crisis mandates novel Wall Street marketing strategies. Effectively marketed television docu-dramas such as "An Early Frost" reached millions of households and significantly educated the public including high risk group members. Should we parrot most public health officials around the country who are also uncritically accepting and endorsing an untested strategy that is merely thought to be a good idea? Or should we strongly promote and support general educational approaches that have already been demonstrated effective? Perhaps these questions should be asked of legislators that control the purse strings of the PHS and state health departments. A demonstration project of SPR to demonstrate its effectiveness in low and high incidence communities, that would not jeopardize other educational approaches fiscally would be a viable compromise.

11) The assertion that the disease intervention process is "without adverse incident" with "over 50,000 early syphilis patients, about 55,000 gonorrhea patients, and some 10,000 other STD patients" is clearly unfounded. What research has the CDC done to investigate the psychological impacts of an individual and the family of a person involved in classic STD contact tracing ("You've been reported as having been exposed to herpes simplex....")? The adverse effects of HTLV-III antibody SPR will be considerably more tragic (as evidenced by abuses reported in the media) and unpredictable. Furthermore, the underlying attitudes and comments about fear of disclosure underscore the public health insensitivity to the gay/lesbian experience and the issue of homophobia related to HTLV-III antibody testing. Irrespective of AIDS itself, this test is actively being used to deprive people of their livelihoods, their insurance, their education, other opportunities, and even their children in cases of childrearing & custody. Many insurance companies are basing insurability merely on questions such as "Have you ever been advised to take or have you ever had the HTLV-III antibody test?" The same cannot be said about other STDs. At a recent public forum in Minnesota, the state epidemiologist revealed that the State Health Department has maintained a list of names of over 7000 allegedly gay men positive for gonorrhea or syphilis. As a public health worker for many years, I am aware of my own colleagues and of public health officials in local health departments who disregard confidentiality and openly speak of clients by name (usually unintentionally). Most laboratory request forms for STDs request extensive information about the patient; that these forms are filled out in multiple copies; and that non-public health staff such as secretaries, housekeeping, and laboratory staff have access to this confidential information, frequently retyping identifying patient information on

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EDITORIAL REPLY, Continued

reporting forms without regard to confidentiality. I am not challenging the integrity of these dedicated staff members--only pointing out that the potential for violations of this confidentiality is extraordinarily high and that the system doesn't have the safeguards we feel are mandated--such as federal legislation forbidding disclosure of test information for any discriminatory purposes. Many of the records that are allegedly confidential are computer entered either with codes or without. If unsophisticated adolescent computer hackers can gain entry into presumably secure Pentagon computer files, can we seriously talk about confidentiality with aggressive insurance investigators and various police & security officials seeking such information for political or other reasons? The veritable paragon of virtue within the PHS, the National Institutes of Health, has had its own computer lists of people with AIDS tampered with by reporters and sources of CBS-TV's 60 Minutes [see elsewhere for related article]. Can we disregard the fact that when person is tested by a private doctor or hospital, that information is accessible to insurance companies for reimbursement, and that it will end up in the Medical Information Bureau (MIB) which is accessible to any insurance agent in the nation? Finally, some (but not all!) states are enacting confidentiality provisions but such legislation does not protect against federal subpoena. Because public health officials have not strongly addressed these civil rights concerns in a realistic way, the PHS and local and state health departments promote an atmosphere of distrust with many high risk group members that will in no way help improve the public health.

12) There are no indications that certain explicitly written or depicted educational materials would be "considered offensive by society at large" when used for targeting high risk groups. The same may be said for published erotica ("pornography"), information about contraceptives & abortion, or other issues unrelated to sexuality, even though such materials may be viewed as offensive by a vocal minority wishing to impress their narrow views of morality on the public. The real attack is against the fostering of healthful homosexual lifestyles & homosexual relationships. Certainly the controversy generated by a vocal minority of zealots makes public health people and their financiers (legislators, bureaucrats) uncomfortable; however, to deprive the community of any input into the type of message that's best suited smacks of condescending paternalism at its worst. Imagine a committee of white men deciding the fate of an educational campaign on something targeting black or hispanic adolescents! That's what we're being told to accept by the CDC--that all educational materials must be reviewed by community panels and that all explicit material be deleted. Some gay men may find this explicit approach the only understandable and acceptable method of obtaining and processing information. Not all people are literate and well educated, and some, including homosexually active men, are "elective illiterates," actively avoiding written materials. Moreover, the best, most widely acclaimed educational materials are presented in an eye-appealing, easy to understand, unambiguous style. Gay men uniformly understand the term, "cocksucking," and clinical terms such as "fellatio," or polite terms such as "oral sex," or descriptive terms like "mouth to penis contact" just don't have the same, clear meaning. Exhibiting limitless diversity, gay men and women are part of the general public, and to imply that we are not is a homophobic attempt to segregate and isolate a vital component of society, and prevents important and creative contributions to our society's overall richness, variety, and well being.

We have always encouraged an open dialog with public health officials and continue to value that constructive interaction. We always seek out differing opinions and enjoy publishing those viewpoints and invite a response from our readers.

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KUPONA MEANS "TO GET WELL" IN SWAHILI

Kupona, which means "to get well" or "wellness" in Swahili, was formed by interested and concerned gay and non-gay individuals who found that the educational process in Chicago on AIDS did not include the black gay and non-gay community. Kupona was formed and incorporated in 1985 as an Illinois non-profit corporation to help educate the black gay and non-gay community about AIDS information. Due to the "closeted" nature of the Chicago black gay community, reaching the targeted community has been a problem. The monumental task was officially started when the South Shore Community Church Unemployment Union (SSCCUU) submitted a grant proposal to the Chicago Dept. of Public Health with the assistance of the Kupona Network, and was awarded $3600 to do educational outreach into the community. In late September, 1985, the Kupona Network and the SSCCUU along with the National Black Nurses Association--Chicago Chapter (NBNA-CC) co-sponsored an AIDS health seminar on the south side of the city. The seminar was well received with over 130 in attendance. Members of the health profession and clergy, for first time, brought credible and reliable information to a community that is still very much in the dark on the issue of AIDS. Kupona in conjunction with the NBNA-CC continues to sponsor mini-seminars at various churches, Social Security offices, and public housing projects. Our most recent seminar on AIDS was held at the Malcolm X College in conjunction with Mile Square Health Center. One of our long term goals is to become more involved in direct services to PWA and ARC patients. We are proud to announce that our first group of volunteers have just completed their support managers training, of which two of them already have patient assignments. In addition, we have temporarily secured office space at the Community Mental Health Council where we are available three nights weekly, for call-in information and referral services. One of the unique aspects of our organization is that we strongly believe that the AIDS information should be presented to blacks by blacks. This makes The Kupona Network the only black, autonomous, and mixed (gay & non-gay) organization doing AIDS outreach in the U.S. For more information, contact: Estherlyn Maymon, Secretary-Treasurer, The Kupona Network, POB 11493, Chicago, IL 60611-0493 (312/221-2939).

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MASS HTLV-3 ANTIBODY TESTING PROGRAM OPPOSED

The following statement was initially issued in a modified form by participants from the Seventh National Lesbian & Gay Health Conference and Fourth National AIDS Forum at George Washington University, Washington, DC, March 15, 1986, in response to the Public Health Service's recommendations for mass HTLV-III antibody testing of members of high risk groups (Morbidity & Mortality Weekly Report, 3/14/86; reprinted elsewhere in this Newsletter). The earlier statement represented a consensus on the part of 500 attendees representing the leadership of the nation's AIDS service providers, gay/lesbian health providers, and gay/lesbian political leadership. Since then, experts from several organizations expanded the statement to help provide our constituencies, the media, and the federal, state, and local government officials with whom we work a unified position on testing. This modified statement is supported by the following organizations: American Association of Physicians for Human Rights (AAPHR), AIDS Action Council (AAC), Gay Men's Health Crisis (GMHC), Lambda Legal Defense and Education Fund (LLDEF), National AIDS Network (NAN), National Coalition of Gay S.T.D. Services (NCGSTDS), National Gay and Lesbian Task Force (NGLTF), and National Gay Rights Advocates (NGRA). If your agency or organization would like to join the list of supporters and be listed as a signatory, contact: Terri LeMoyne, NGLTF (202/332-6483), or Miguel Gomez, AAC (202/547-3101).

CONSENSUS STATEMENT ON HTLV-III ANTIBODY TESTING AND RELATED ISSUES

We who work most closely with AIDS, and who have been and still are at the forefront of the fight against AIDS, firmly believe that every valid tool available to fight this disease should be employed. However, the existence of a test does not in and of itself justify its broad-scale use, unless valid medical or public health justifications can be made. This statement delineates what we believe to be the legitimate and dangerous uses of HTLV-III testing.

I. **Antibody Testing**--The HTLV-III antibody test measures exposure to and probable infection with the virus associated with AIDS. It does not diagnose AIDS, nor is its predictive value fully known. For the purpose of prevention, it is prudent to assume the individual is infected, although this test is not proof of ongoing infection. The presence of antibodies is correlated with HTLV-III infection. It is known that some of those infected will go on to develop AIDS or AIDS-related conditions and that some will remain asymptomatic at least for five to seven years. Current studies show that the majority of those testing HTLV-III antibody positive will remain asymptomatic.

Unfortunately, there is no medical intervention for those who test positive. At this time, the principle advice that can be given someone who tests positive is to follow safer sex and other risk reduction guidelines (i.e., not exchanging blood or semen with sex- or IV drug using-partners). However, these are recommendations that should be followed by any member of a high-risk group, whether they have tested positive or negative. (Individuals who are positive should avoid passing on the virus to others and avoid becoming infected. It should be noted that two partners in high-risk groups who have tested negative should also follow these guidelines because of the delay period between infection and development of antibodies.)

It has been suggested that knowledge of antibody status will result in greater incentive to follow risk reduction guidelines. We have no data to prove this suggested consequence of testing. We do, however, have data that show that basic education does work to reduce transmission, as judged by dramatically lower STD rates in cities like New York and San Francisco, using programs that do not use the antibody test.

We believe the decision to take this test should be an individual decision given the tremendous psychological, legal, social, and economic impact a positive test result can have on a person's life. Persons must be given the latitude to decide for themselves whether testing will help them reduce their risk. When the test is performed, it must be with the full informed consent of the individual. The informed consent process must be specific for this test; it cannot be part of a standard or general waiver associated with a battery of other tests. The consent process should outline what positive and negative test results do and do not mean, the potential psychological impact of learning one is antibody positive, and the possibilities for difficulties in insurability (insurance companies across the country are seeking to use the test as a basis for denying insurance to those who test positive) and employability (some employers are already attempting to screen their employees for antibodies even though there is no business justification for such testing) if a positive test result is known. They should also be told that in some jurisdictions, test results are reported to public health authorities (and this is a possibility in others), and the extent to which the agency offering the test will provide counseling. (Supportive psychological counseling by informed and sensitive professionals is essential to any testing program.

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MASS TESTING, Continued

Given these dangers outlined above, as well as the potential for quarantine of individuals who test positive (as has been suggested in some states), testing should be done on an anonymous basis to protect the confidentiality of those being tested. Anonymity is the only true assurance of confidentiality. Even where initially strong protections exist, there are at least four means by which they can be violated: 1) through legislation overriding the initial protections; 2) when a subject must voluntarily sign away the confidentiality protections as part of an employment or insurance application (as can be done under Colorado's reporting system, for example); 3) through a court subpoena; and 4) through informal disclosure by those who have access to the test results. Without guaranteed protections, individuals who need the test to alter their behavior are likely to be afraid to take it. The U.S. Public Health Service recently recommended mass testing on a voluntary basis of individuals in high-risk groups. We believe that this undermines the principle that taking the test must be a very individual decision. In addition, such a program will divert scarce resources from education and counseling programs that have been proven successful in reducing transmission of HTLV-III to a program of unproven value. It also fails to recognize that the nature of the decision may vary according to what purpose the test may serve. For example, high-risk women thinking of having children should be tested, but a blanket statement for homosexually active men, on the other hand, is inappropriate.

The PHS guidelines also fail to adequately address the issues of informed consent and confidentiality. Furthermore, they fail to take into account the widespread discrimination accompanying use of the test. for the government to suggest mass testing without taking measures to prevent the discrimination that may result from such a program is counterproductive.

II. **Reporting of Antibody Test Results and Contact Tracing--**The first step in any use of this test to change behavior involves convincing the individual to be tested. If individuals fear that information relating to their status might fall into the wrong hands, they will not consent to the test. We oppose reporting test results with identifiers to state authorities. Within STD clinics, or within state health department bureaucracies, assurances that these results will be kept confidential in the same manner as other STD information are simply not adequate. AIDS is not like other STDs. The stigma associated with AIDS is far greater than with other STDs and the desire of other government and nongovernment agencies to obtain AIDS-related information is also greater. The existence of sodomy laws in nearly half the states, and the failure of all but one state (Wisconsin) to provide protection against discrimination based on sexual orientation add to the fears associated with reporting. In the context of political hysteria that is often generated around AIDS, how certain can we be that health officials will resist public pressure to turn over names of those who are antibody positive to school officials, police departments, and others?

We seriously question the value of contact tracing, even on a voluntary basis. While contact tracing may be a traditional technique for managing the spread of STDs, AIDS is not a typical STD. There is no medical intervention for AIDS as there is for syphilis. We are not opposed, however, to voluntary contact notification by the person who has tested positive. Indeed, recommendations for such notification should be part of the counseling process for those who test positive. Our concern is with the government playing a direct role.

It must be noted that the potential of contact tracing could have the effects of encouraging anonymous sexual contacts. Someone fearful that in the months ahead, his or her name might be turned over to health officials as the sexual contact of an antibody positive individual, might refuse to give an accurate name to an individual--thereby eliminating the possibility for informal contacting by an infected person of his/her contacts. This is quite plausible given the number of people using false identifiers in current antibody testing programs.

We would argue, then, that the most effective use of the test is one that is voluntary, and guarantees anonymity and appropriate counseling. Anything more intrusive is likely to diminish the confidence of the very people a risk reduction program is seeking to reach.

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BLACKS, HOMOPHOBIA, AND AIDS

an opinion, by John Bush, co-chair, National Association of Black & White Men Together (BWMT), with thanks to Boston's Gay Community News, 4/12/86

There is an assumption throughout the United States promulgated by the media that Blacks are of a common mind on most issues. That idea is also prevalent when one speaks of women's concerns or gay issues. Minority groups are generally perceived as collections of individuals, who because they share similar traits, look alike, act, and think alike. We regularly hear that Blacks would be more successful in American Society if they were more committed to the Protestant Ethic, that women generally are not very dependable in stressful situations, or that gays are more likely to molest children. It seems that even though a large body of literature disputes stereotypical views, they are still widely

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AIDS BEHIND BARS: LIES AND MANIPULATION

by Tatiana Schreiber, with thanks to Boston's Gay Community News, 3/22/86

"A Florida Department of Corrections brochure that is supposed to inform prisoners about AIDS reads, "AIDS is spread by homosexual contact, and by the use of injectible drugs. You can reduce risk by avoiding homosexual activity, and by refraining from IV drug use." The brochure concludes: "REMEMBER: THE CHOICE IS YOURS. IT IS ONE OF THE FEW CHOICES YOU CAN MAKE FOR YOURSELF WHILE INCARCERATED — THE CHOICE TO BE HEALTHY OR TO TAKE YOUR CHANCES WITH DISEASE AND MAYBE DEATH."

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Misinformation about AIDS is widespread in U.S. prisons — as it is outside the correctional system. Although the gay/lesbian community outside has produced a wealth of information about safe sexual practices that can help stop the spread of AIDS, this information is not getting to prisoners. AIDS bulletins now being distributed in prisons are helping to calm unwarranted fear and panic on the part of both staff and prisoners, but these same bulletins have also contributed to confusion about who gets AIDS and how transmission can be minimized. As in the Florida brochure above, AIDS "education" in prisons typically blames a prisoner for getting AIDS and uses prisoners' fear of the disease to reinforce institutional rules forbidding all sex and drug use.

But skewed information about AIDS is only part of the problem people on the inside face as prison officials have until recently ignored the needs of prisoners with AIDS. In Massachusetts, for example, a prisoner in the state prison at Cedar Junction (Walpole) complained of weight loss (nearly thirty pounds in three months), a severe cough, a bad rash, and exhaustion. Although he has not been diagnosed with AIDS, his parents, on a visit to their son, read the word "AIDS" next to his name on a blackboard outside the corridor leading to his cell. This was the first they had heard about his condition and they were shocked, angry, and confused. So is their son, who according to Dianne McLaughlin of the Massachusetts Correctional Legal Services, has not been able to get accurate and comprehensible information about his health.

In New Jersey, according to Catherine Hanssens of the New Jersey Office of Inmate Advocacy, prisoners with AIDS have been kept in conditions nearly as restrictive as for those on death row. "They are people expecting to die, waiting to die, with few visitors and no progams." Until pressure from her office, and the intervention of the American Civil Liberties Union (ACLU), Hanssens said, prisoners with AIDS had been kept shackled to their beds over a period of four to six months.

Prisoners have always been "out of sight, out of mind," said Dr. Marta Arias-Klein, a professor of Criminal Justice at Nassau Community College in New York, so it isn't surprising that the issue of AIDS in prisons has been ignored — both by prison officials and by many AIDS activists on the outside. In addition, Klein said, prison authorities are reluctant to admit that homosexual activity and IV drug use take place in the prison system.

A recently released report from the National Institute of Justice (NIJ) found incidence rates for AIDS in U.S. prisons slightly higher than in the general population. So far there have been 455 cases of AIDS in the correctional system, with most of them occurring in four states — New York, New Jersey, Pennsylvania, and Florida.

Despite this fairly low occurrence, prisoners do have reason to be concerned. IV drug use and both consensual and coercive sexual activity make it likely that AIDS is being spread within the prisons, despite denials by corrections officials who claim that virtually all prisoners with AIDS and ARC (Aids Related Complex) had the disease before entering the correction system. In addition, severe overcrowding, lack of access to regular medical care, and unsanitary conditions create a perfect atmosphere for a whole range of illnesses to develop. People who are already in poor health are much more likely to become sick with AIDS than are people in good health.

As the number of prisoners with AIDS or ARC continues to grow, prisoners, prisoner advocates, and legal workers have begun raising serious questions not only about education, but about appropriate use of testing, medical treatment, segregation of certain prisoners, and the legal ramifications of AIDS-related policies.

Education

Corrections officials have come to agree with activists concerned with AIDS that education is essential to reduce fear and minimize transmission of the HTLV-III virus associated with AIDS. Prison authorities, however, are also concerned with maintaining "order" and "security" within the institutions, and, as a result, the educational materials being distributed inside and outside the prison system differ radically. For example, according to the Centers for Disease Control (CDC) in Atlanta, there is no evidence of AIDS being transmitted through saliva or feces. However, most of the bulletins given to inmates emphasize the danger of contact with all body fluids and of all intimate contact.

In fact, many bulletins imply that kissing can transmit AIDS. Dave Collie, public health advisor for the CDC, called this a "serious overstatement." In contrast, the most recent AIDS information available outside prisons on the sexual transmission of AIDS implicates only anal intercourse, particularly for the receptive partner, and any activity that allows semen to come in contact with blood. What the prison officials don't want prisoners to know is that it's not sex that spreads the AIDS virus, but only particular kinds of sex. "I find it really shocking," said Jeffrey Fogel of the ACLU in New Jersey. "There's something specific they could do that could save lives, but they won't do it because it would look like corrections officials were condoning sex."

Steve Lattimer, president of the New Jersey ACLU and director of the Prison Law Clinic at Rutgers University, points out that there is another reason prison officials want to make their own guidelines for handling AIDS. "It's virtually impossible for drugs to get into prisons without the complicity of guards," Lattimer said. "If the extent of that was revealed, well, it's political dynamite." According to the NIJ report, it is primarily IV drug users and not gay men who make up the population of prisoners with AIDS in New York and New Jersey.

Because of this intransigence on the part of prison authorities, members of the New Jersey Department of Health have not been allowed into the prisons in that state to provide information about AIDS to inmates and staff who have requested it. "They say sex and drugs are illegal," said Lattimer. "That's a wonderful approach. For them, it solves all problems. But, you know, the reality is otherwise."

Testing and Segregation Policies

Another issue of concern to prisoner and civil rights advocates is the use of the ELISA test for antibodies to the HTLV-III virus. Dr. Robert Cohen, director of Health Services at Rikers Island in New York, called the test of questionable accuracy. In a recent issue of the ACLU's Prison Project newsletter, Cohen cited recent studies that show only 29 percent of people who test positive for HTLV-III continue to test positive a second time, and only 23 percent of those confirm positive when tested a third time with the more expensive and accurate Western Blot test. Despite this high percentage of false positives, a Maryland prisoner told *GCN* that all inmates there are being given the test on entrance to the prison and are being segregated depending on their HTLV-III status. Several other prison systems have or are planning to begin testing and segregation of HTLV-III positive inmates.

Letters from prisoners to *GCN* indicate that in many states prisoners who test positive for HTLV-III, and, in some cases all gay prisoners, are being barred from certain jobs. According to the CDC's Dave Collie, there is absolutely no evidence of the need to restrict even people who are infected with HTLV-III from any jobs, including food handling. The CDC has issued AIDS guidelines for health and food service workers, but recently decided not to do the same for correctional facilities. "It's a political thing," said Collie. "There's nothing different about how AIDS should be treated in prisons as opposed to in the free society. We can't make their management decisions for them. We just found ourselves out of our league."

At least one lawsuit has recently been filed on behalf of prisoners who believe testing and segregation policies violate inmates' rights by jeopardizing the confidentiality of their medical records, and denying access to law libraries, exercise and visitation. In New Jersey, prisoners at the Rahweh State Penitentiary have filed a suit to protect their confidentiality while receiving adequate medical care. In order to see a doctor, inmates who were concerned about AIDS were required to submit a list of names of all prisoners who had had sex with, or shared needles with, one prisoner known to have AIDS.

Although Massachusetts prisoners are theoretically guaranteed confidentiality, Massachusetts Department of Correction (DOC) spokeswoman Gail Darnell admits that HTLV-III status is reported to the state Public Health Department and to corrections officials. The ACLU's Lattimer points out that without special precautions such as using locked boxes, any corrections officer or guard who wanted to, could easily gain access to inmates' records. Ted Hammett, author of the NIJ report, emphasized that inmates who test positive face ostracism, threats, or violent intimidation while in prison, and possible discrimination in employment, housing, and insurability once they are released.

Medical Treatment

The fact that prisoners with AIDS or ARC are receiving inadequate and even inhumane treatment is symptomatic of the general problem of health care for prisoners, according to Hanssens of the New Jersey Office of Inmate Advocacy. When the ACLU began to investigate reports of shackling of AIDS victims in a New Jersey Hospital, other prisoners with cardiac conditions or serious infections were also being kept shackled. Authorities claimed it was a necessary security precaution, but when the ACLU threatened publicity, the security risk of these primarily non-ambulatory patients abruptly disappeared.

Four prisoners with AIDS in Texas are currently hospitalized in hazardous conditions with other prisoners who have infectious diseases. They have limited visitation and exercise. In Walpole, a prisoner with ARC has not been hospitalized, despite severe symptoms, and is made to walk outside in very cold weather in order to receive visitors. Massachusetts DOC officials report no current cases of AIDS, yet a member of PUMA, the Prostitutes Union of Massachusetts, says a friend of hers was recently released from MCI-Framingham with severe symptoms of AIDS. According to her friend, "She looked as if she'd aged twenty years in the last year." The woman has since been reimprisoned and is being kept in isolation.

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Although AIDS in the U.S. prison system has been ignored until recently, Klein believes this is changing. "We must continue talking about it to develop a consciousness about this; if not out of compassion for the prisoners than at least out of concern for ourselves." Klein emphasized that people infected with HTLV-III are passing in and out of the prison system at all times.

Prisoners can get accurate information about AIDS by contacting lesbian/gay organizations, including *GCN*. It is important to try to stay healthy, to avoid reusing needles, and to avoid the specific kinds of sexual activities associated with transmission of HTLV-III. If tested for the virus, prisoners should guard against threats to confidentiality, and recognize that a positive test result does not necessarily mean a diagnosis of AIDS or ability to transmit the virus. Finally, prisoners can write to people outside and keep them informed about what kinds of medical care prisoners with AIDS or ARC are receiving. For the time being, ignorance is more contagious than AIDS.

Safe Sex

Prison officials typically try to tell prisoners that all gay sex causes AIDS. This is not true. At most, sex in which cum or blood go from one person to another, and rimming are not "safe." In fact, many AIDS researchers have recently found evidence suggesting that getting fucked in the ass without a condom is the primary mode of contracting the HTLV-III virus associated with AIDS.

We do know that mutual jerk-off, kissing, chewing, licking, etc. are okay.

One final note: it is the sharing of needles, rather than gay sex, that accounts for most of the prisoners with AIDS.

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BLACKS, HOMOPHOBIA, & AIDS, Continued from page 9

believed. Now it seems, especially since the event of AIDS, that a new stereotype has been created relative to Blacks--that being that the Black population is more homophobic (more so than whites or other racial groups), and the consequences of that homophobia have been especially hard-felt by the Black AIDS victim, the scenario being that due tot he homophobia in the Black community, the Black AIDS patient is often left abandoned by his family and friends to suffer and die alone. I have heard the Black homophobia line several times during recent conferences in New York, Boston, and other cities which I have visited as co-chair of the National Association of BWMT. My review of the literature has not permitted me to conclude that the notion of excessive Black homophobia can be substantiated. In fact, there is nothing in the literature to support that view. I contend that Blacks are no more likely to be excessively homophobic than whites. Blacks are socially stratified like all other groups in the society, and like other groups, tend to hold common values. For example, the middle class devoutly believes in the principle that hard work and honest effort yield

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BLACKS, HOMOPHOBIA, & AIDS, Continued from page 11

success. Consequently they drive themselves and their children to make every effort to realize their goals. The individuals like their counterparts in other groups, try to prevent any obstacles from standing in their way. If homosexuality (lesbian daughters or homosexual sons) poses a threat to the achievement of family goals, then it must be tactfully ignored or quietly dealt with. It might be argued that these people are not primarily homophobic because they do no like what homosexuals do, but they are essentially more concerned with what homosexuality may do to the family's life. Those who argue that the Black middle class is more homophobic than other middle class groups, may be ignoring that Blacks, like other minorities, especially other racial minorities, have to work even harder than the "so-called" majority group for acceptance in our society. The very group into which they are attempting to assimilate is the group which is predisposed to suggest that they are working too hard for acceptance. Unfortunately, most minority groups are predisposed to feel that they must be more circumspect than those whom they are attempting to emulate. (Wash me and I will be whiter than snow.) Black men who are members of organizations such as The National Coalition of Black Lesbians & Gays, Black & White Men Together, Black Men's Association of Boston, etc., tend to be middle class men, although not exclusively so. Conversations with these men have revealed that many have shared their homosexuality with their parents, and have been none the worse off for having done so. Others have not discussed the subject, primarily because they are fearful of possible negative reactions on the part of their parents. It is not possible to discuss lesbian adjustment to similar situations, because this writer has not discussed it with a sufficient number of lesbians. The small empirical study suggests that most of the men have shared their homosexuality with one or both of their parents and survived fairly well. In the Black working class, and even more so in the so-called Black "under class," it appears that homosexuality and other differing lifestyles are more readily accepted by the populace than they are in upper levels of society. There are probably many reasons for the greater amount of acceptance, but among them must be apathy in the "under class" and the preoccupation with making a living in the working class. One could also suggest that the value system is different, resulting in more of a de facto acceptance of different lifestyles. In the under class particularly, male homosexuals have been commonly referred to as sissies or by less flattering names, but in the past they have not been driven from society. It is undoubtedly correct to observe that homosexuality is not a subject that is universally discussed in the Black working class or under class communities any more than it is in other comparable communities, but by the same token, it is no more despised in those communities either. The Black church of the past has generally been quiet about homosexual members. Certainly it has been preached against, especially in fundamentalist churches. However, the Black church has traditionally depended upon homosexuals to provide various services such as choir directors, pianists, organists, as well as preachers. Those individuals also played important roles in the social life of the church. More recently, openly gay and lesbian ministers have acquired pulpits, and are actively God's love for all. Now, in the midst of the AIDS crisis, mainline churches are getting involved in AIDS education programs. Most notably the New York Council of Churches has established a Minority Task Force on AIDS, which has been charged to address the problem of AIDS in minority communities. In Boston, the AIDS Action Committee is appealing to the Black churches to get involved in AIDS education, and they are receiving favorable responses from several of the congregations. And in other cases mainline churches are holding memorial services for the dead as well as prayer services for the living. These events certainly indicate that the Black church is beginning to see the necessity of putting "God's work" above the fears of a group of sick and dying individuals. We can only speculate concerning the attitudes of other Black organizations, but it is probably fair to suggest that homophobia is certainly present, but perhaps unfair to suggest that it is getting worse. In the present AIDS crisis, to suggest that Blacks are not responding to the needs of minority individuals may be partially true. But of course that is essentially a reflection of our divided society. Once again the poor and the "outsiders" have been disproportionately affected by a ravaging disease, and it seems that whites and Blacks as well are blaming the lack of Black participation in the healing process on homophobia. Perhaps one day the full impact of the Kerner Commission report will be realized, that being that we have constructed two societies, one white and affluent, and the other Black and less so. That phenomenon guarantees that Blacks will almost always be without certain necessary information which will guarantee participation and decision-making. As long as we live in a society where a president states that he wants a color-blind society and suggests getting to that point by dismantling affirmative action programs, we must know that Blacks will not be at the forefront of major social issues or social programs. As in all other social programs, the AIDS money is in white hands and nothing will change that. It's unfortunate that the homophobia discussion has flourished because of the homosexual push for equal rights, and the disproportionate representation of AIDS among gay men, but it is unfair to imply that Blacks are not well represented in the healing process because they tend to be so homophobic. Homosexuality is certainly one of the most misunderstood social phenomena of this or any previous generation, but to say that in the face of the AIDS crisis that Blacks have demonstrated a greater homophobia, is mostly a figment of the imaginations of the purveyors of such ideas. It is difficult, it not impossible, for the thinking man to accept. The entire notion needs to be sociologically investigated, especially if it is going to be continuously reiterated as gospel. We as Blacks tend to live in separated worlds (although whites seem not to realize that) but we have been tragically defined by them as possessing common behavior patterns, as well as common thought processes, which suggests that we are all the same. These ideas have been circulated conspicuously and unconsciously. It is beyond time to set the record straight. I am sure that the Blacks love their homosexual children as much as the whites and all other groups love theirs, maybe a little more, but certainly no less. In the long run AIDS or no AIDS, the Black community will come through. I have no doubt about that.

MINNESOTA AIDS PROJECT REJECTS CONTACT TRACING, SUGGESTS ALTERNATIVES
with thanks to Minnesota AIDS Project Newsletter, March, 1986

A Minnesota Dept. of Health proposal to notify and trace sexual contacts of persons infected by the virus which causes AIDS was rejected by the Minnesota AIDS Project Board of Directors, February 19th. Alternatives such as promotion of safer sex practices, risk reduction education and counseling of AIDS-affected individuals were endorsed instead. While the Board acknowledged that contact tracing can be an effective public health measure for some diseases, members were unconvinced that it would work to stem the spread of AIDS within the gay population. A program of voluntary contact tracing received support, but such a program administered by government agencies would be rejected by the gay community, according to a statement issued by the Board. "Because of the antagonism it would generate, it could actually be counterproductive, reducing the effectiveness of other activities of the Department of Health," the statement reads. The statement stresses the Minnesota AIDS Project's dedication to finding the best means of interrupting the transmission of the AIDS virus, and emphasizes the Project's continued willingness to work cooperatively with the Health Department.

At a recent community meeting in which almost 100 men and women filled out a survey about contact notification. Nearly one-half of those responding to a survey t a recent community meeting said they have taken the HTLV-III antibody test. Ninety-five percent knew where to receive anonymous antibody testing at this time, but an overwhelming majority said they would not be tested if they had to give their names or the names of their sexual partners. The majority of respondents did not believe state health officials would be able to keep names confidential. On the issue of contact tracing, only 15% think it had any merit in slowing the spread of infection. Even less, 6% thing the Minnesota AIDS Project should support contact notification. Of the 93 people completing the survey, 92% were male, 89% acknowledged having only male sexual partners, 7% having only female sexual partners, and 4% having both male and female partners. Other questions asked: *Have you ever been tested for antibodies to the AIDS virus (HTLV-III)? yes-48%, no-52%. *If yes, what were the results? 59% negative, 23% positive, 18% not known yet. *Do you have any of the following? AIDS-3%, ARC-3%, Lymphadenopathy-3%. *Are you now practicing safer sex? Yes, all the time-78%; Sometimes-17%; No-5%. *Do you know where to receive an anonymous antibody test at this time? Yes-95%, no-95%. *If you were asked to give your name at the testing sites, would you be tested? Yes-12%, No-88%. *If you tested positive, would you give the State Health Dept. the names of your sexual partners? No-91%, Yes-9%. *Do you believe state health officials will keep your name and sexual partners' names confidential from: Insurance Companies, Yes-14%, No-86%; Homophobic extremists, Yes-19%, No-81%; Your mother, Yes-41%, No-59%. *Do you think contact notification has merit in slowing the spread of the virus which causes AIDS? No-56%, Do Not Know-20%, Yes-15%, Only With Certain Groups--Like Hemophiliacs-9%. *How do you think the Minnesota AIDS Project should address the issue of contact notification? Find Other Alternatives-58%, Not Support Contact Notification for Any Purpose-33%; Not Support Contact Notification--Except for Female Contacts of Childbearing Age-11%; Support Contact Notification-6%; Remain Neutral-4%.

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CONTACT TRACING ALTERNATIVES SUGGESTED IN MINNESOTA
by Minneapolis's Richard Osborne, with thanks to Minnesota's Equal Time, 2/19/86

[Letter to the editor, addressed to Dr. Michael Osterholm, State Epidemiologist, in reference to a recent community meeting in which Osterholm discussed the contact tracing as a viable health department disease intervention strategy.]
"At last Wednesday's meeting, unprecedented numbers of gay men and women turned out to react to the Health Department's contact tracing proposal. Those in attendance represented dozens of gay social, political, cultural and religious organizations. Individuals who were present came from a wide variety of occupational and socio-economic groups. It was obvious that the near-universal sentiment of that diverse cross-section of our community is vigorous opposition to the Department's plan. By the Department's own admission, contact tracing cannot work in the face of such opposition. Acceptance of that reality should dictate that the Department abandon consideration of contact tracing at this time, and pursue alternate strategies to end the spread o HTLV-III infection in Minnesota. Doing so would avoid needless further confrontation between the dept. and the gay community at a time when neither can afford animosity if our mutual goals are t be achieved. In response to your offer to consider suggestions from our community regarding other options, and in addition to those which the Dept. has long ago received from the Minnesota AIDS Project and other concerned individuals, I urge you and the Health Dept. to: 1) Immediately develop and implement an intensive educational campaign in the general community on the subject of safe sex practices. This campaign should result, at a minimum, in: safe-sex posters in the halls of every secondary school in the state; billboards in every city of the first, second, and third class (with emphasis on the Twin Cities); internal and external advertisements on buses in the Twin Cities and Duluth; public service ad spots on radio and television; and safe-sex leaflets in every hotel room and bar in Minnesota. 2) Continue to give adequate financial backing to the Minnesota AIDS Project and other appropriate gay-identified agencies to further safe-sex education, and other needed support services for persons with AIDS or its precursor conditions. 3) Lobby at all levels of government for expenditures to find a vaccine and cure for AIDS. 4) Lobby for increased legislative appropriations for the Minnesota Dept. of Human Rights, to be devoted to additional investigative staff for

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CONTACT TRACING ALTERNATIVES, Continued

the increasing number of AIDS-related disability discrimination claims. 5) Actively support proposals for extending civil rights protection to unmarried domestic partnerships, at the local and state levels, as a means of encouraging monogamous relationships in both the gay and non-gay communities. Although no directly related to the above proposals, I am compelled to add a further suggestion, so that the Dept. might repair its current strained relations with our community: the Dept. should adopt, announce and implement a policy of destroying all existing records of individuals who have been reported as having been exposed to syphilis and gonorrhea, once the required notification and follow-up treatment counseling has been done.

"I was absolutely stunned at your announcement that the Dept. has a list of some 7,500 gay men from that source; I can see no legitimate reason for the state to retain an individual's name after he has been notified of actual or potential exposure to a common sexually transmissible disease and has come in for treatment counseling. Finally, I must respond to your assertion that only "facts" should be considered in the debate over contact tracing and future strategies to stop the spread of AIDS. Dr. Osterholm, the fear, anger, and mistrust felt by me and many other gays reflect neither a "pro-AIDS" nor "anti-Health Department" sentiment. Rather, they reflect our profound belief that the threat to our fundamental human rights posed by the existence of AIDS is an evil of equal strength to the disease itself. As such, the existence of those feelings ARE "facts"--facts which must be included in the calculus of public policy decisions on an equal basis with your charts, graphs and morbidity statistics. To ignore our feelings will only further alienate the gay community, thereby imperiling the Dept.'s other legitimate efforts to arrest his serious health problem. Please don't attempt to impose decisions on us or formulate policies for us; rather, you should consult with us (and frequently) for our mutual benefit."

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APOLOGIES FOR CONFRONTATION WITH MINNESOTA HEALTH DEPARTMENT OFFICIAL
by Minneapolis's Morris Floyd, with thanks to Minnesota's Egual Time, 2/19/86

[Letter to the editor concerning the gay community's confrontational meeting with Dr. Michael Osterholm, State epidemiologist.]

"The community forum on AIDS held January 29 was traumatic and disappointing in several ways. It was traumatic, at least in part because it became a confrontation. The gay and bisexual male community and the public health community, however, have a similar fundamental interest in reducing future transmission of the AIDS virus and thereby limiting the magnitude of this tragedy in our state. The confrontation was in some ways understandable. We have a vivid community memory of all the ways we have experienced oppression, even from persons who called themselves our friends. Furthermore, we are only a generation away from atrocities such as the internment of Japanese-American citizens during World War II, unethical and inhumane experiments with black men and syphilis, and the use of members of the military as guinea pigs in tests of certain hallucinogenic drugs. For all of these reasons and more, we are rightfully suspicious of governmental measures which will facilitate the identification of lesbians and gays. Furthermore, we are in the midst of a peril to our health and self-understanding unparalleled by anything in our experience. Our friends and lovers are dying. We are being asked to change sexual behavior, difficult enough for anyone, especially difficult for those who have grown up "different" and who have had to fight for every scrap of perceived self-worth we collect. Our collective rage about this situation was focused and personalized in the meeting on the person of Mike Osterholm. Ironically, there may be no single person in the state who has done more to combat AIDS. In part, this is his job. But it is my perspective that he has consistently gone well beyond what might be expected of a government functionary just doing a job. As a group, we are so unaccustomed to being taken seriously by government officials that we don not always perceive their sometimes imperfect expressions of sensitivity to our concerns. Nor do we find it easy to believe it when they tell us that they have our best interests at heart. We spoke out of our rage and our pain and our frustration. Frequently we voiced legitimate fears and concerns. For that rage and for those concerns we owe no apology. There were also some personal attacks, usually sotto voce [in an undertone, not to be overheard] and heard only by those near the speaker. In my view neither Mike Osterholm nor any of his colleagues deserved that kind of attack, and apologies are due. I was disappointed that the meeting became "us" versus "them" so quickly that exploration of alternative approaches to a joint problem was foreclosed by hostility and hurt. I was especially disappointed by my own contribution to that result--an uncharacteristic silence. It could have reminded us of the significant accomplishments of the state AIDS task force to date under Osterholm's leadership. For example, it is very likely, that the hysteria about infected school children which has occurred elsewhere will have been avoided because he enabled the task force to develop guidelines in advance. In turn, this achievement will prevent at least some anti-gay backlash on the basis of AIDS hysteria. I could have acknowledged that at least some of us apparently misread Osterholm's urgency to address the virus transmission issue as an intention to "railroad" the proposal through the task force. I could have said that when he became aware of our perception in that regard he immediately pledged not to push for a too early decision. I should have said that the painstakingly prepared presentation Osterholm made was

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APOLOGIES, Continued

substantially responsive to a request by myself and other task force members for a consideration of the contact notification question within the context of a look at the overall strategy and a presentation of the pros and cons of various alternative approaches. I wish I had objected when someone characterized health department officials as "not our worst enemy." In the light of their attempts to be our friend, this was an insult. Mike Osterholm and I are not in complete agreement about the priority contact notification should play in the risk reduction effort or about a number of other issues that arose in the community meeting. But now that our disagreements and our concerns are clear, I hope we will all move to the next step, which is to rediscover our common goal and recreate whatever mutual respect and trust can be salvaged from this incident. I am excited that several persons have already made some specific suggestions and that the Minnesota AIDS Project is for the first time preparing a detailed programmatic proposal. I will be even more excited as more and more gay and bisexual men take both personal and collective responsibility to create a new climate among us. We need a climate in which "safer sex" is not only OK but de rigueur, an atmosphere in which we can be open with one another about our initial awkwardness with different forms of intimacy and support each other as we work through that awkwardness. I think it will help if we develop strategies to help each other deal with our homophobia-inspired shame so that we rediscover the ability to play with one another sexually and otherwise. I think it is essential that we come to a renewed ability to trust, first ourselves and then our sister/brother lesbians and gays. I hope we can recover enough sense of personal self worth to believe that we are worth protecting. As we get our act together in these ways, we can build our ability to work in confidence (but not naivete) with Mike Osterholm and others in the Minnesota Department of Health and our local health departments. Our failure to do so will cost us lives."

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CONFIDENTIALITY FLIMSY AT NIH

by Bruce-Michael Gelbert, with thanks to Boston's Gay Community News, 4/19/86

Lesbian and gay activists and health workers expressed anger and concern over an apparent breach in confidentiality of lists of people being treated for AIDS. The breach came to light in the course of a 60 Minutes television profile of lawyer Roy Cohn. Television reporter Mike Wallace interviewed Cohn, once Chief Counsel to Senator Joseph McCarthy, conductor of the anti-Communist and anti-homosexual "witchhunts" of the 1950s, on CBS-TV's 60 Minutes, March 30. When Cohn said he had liver cancer that is now in remission, Wallace countered that "everyone asks" if Cohn actually had AIDS. Cohn "categorically" denied having AIDS and suggested that Wallace question Cohn's doctors. The journalist then charged that "we were told by other sources [than his doctors] that Cohn's name was on the National Institutes of Health computer for AIDS." "Well, I shouldn't be," Cohn responded. "I'll get that taken care of very fast." He explained that AIDS treatment is given in the same NIH division in which he receives his treatments for cancer. Wallace then went on to discuss a rumor that Cohn is gay, to which Cohn responded, "It's a lie." In a telephone interview on April 4, Wallace told GCN he had learned of the presence of Cohn's name on an NIH computer printout from someone who had seen it there and reported it to him. He would not disclose his source, but noted that within a large agency such as the NIH, many individuals, including "doctors, nurses, technicians [and] computer people," have access to supposedly confidential computerized data. Wallace particularly emphasized the latter group and mentioned the much-publicized issue of computer break-ins. He further noted that he had forewarned Cohn that he wanted to bring up both AIDS and homosexuality during the program's segment, and said Cohn agreed that he could. Darrell Yates Rist, of the Gay and Lesbian Alliance Against Defamation (GLAAD), noted on local radio station WBAI that Wallace was "so obsessed" with baiting Cohn that "he missed the real story" he had uncovered "easy access to the AIDS list at a government facility." "How in the world did Mike Wallace gain access to a confidential file?" asked Dr. Barbara Starrett, president of New York Physicians for Human Rights (NYPHR) in an interview with GCN. "Anyone who has access to such files should insure their confidentiality," she declared. Dr. Lawrence Mass, co-founder of Gay Men's Health Crisis, author of that organization's pamphlet, "Medical Questions about AIDS," and member of GLAAD's Scientific Advisory Committee, commended that this situation "shows you how flimsy confidentiality can be...[and] why people don't want to put their names on things even where confidentiality is supposed to be guaranteed." NIH Public Information staff member Colleen Hendrickson said she was aware of Wallace's statement, but indicated "nothing has been done" to detect an information leak. She admitted after some hesitation, that the Center keeps computerized lists that mention diagnoses, but claimed that access to them is "very limited,... very restricted." Of disclosure of names by anyone with such access, she said, "release of that information is prohibited." The National Institutes of Health make up one of six agencies that comprise the federal Public Health Service, which, according to the Federal Regulatory Directory published by Congressional Quarterly, Inc., "is responsible for promoting health standards [and] assuring that the highest level of health care is available for all United States citizens."

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AID ATLANTA HARSHLY CRITICIZES CDC

by Rev. Ken South, Executive Director, AID Atlanta

[ED NOTE: The following letter was addressed to Leo Sanders, Grants Management Officer of the Centers for Disease Control, and was kindly shared by Rev. South for publication in the NCGSTDS Newsletter.]

"The Board of Directors, staff and people with AIDS whom we serve, not to mention the thousands of people who now will become infected with HTLV-III in the very near future, are extremely displeased with the events that have transpired in relation to our application to attempt to save some lives in metro-Atlanta. There have been rumors circulating through the AIDS service industry for months that it is the will of the present administration to divert all funds that were appropriated by Congress for prevention and risk-reduction to be used for massive, misguided testing programs. Now we know that this rumor is in fact reality. We were aware for a long time that prevention of the spread of AIDS in high risk groups was a low priority of the administration and of CDC, but until now we had no idea of how low a priority. It is so low apparently as to not exist. For your information and for the record, here is the litany of events that AID Atlanta participated in in good faith, meeting every requirement, and now finding out that all was a bureaucratic, political shell game aimed at keeping this community at bay while the real decisions were being made elsewhere. Decisions that will mean the lives of literally thousands of people over the next two years.

August 31, 1985. AID Atlanta submits on time (with one months' notice) a full proposal requesting $209,000 for a Metro-Atlanta risk-reduction program. This program includes innovative risk-reduction programs considered a national model by the U.S. Conference of Mayors and has a research component as well as a special outreach program for IV drug users, black men, and youth. October 10, 1985. We received a letter from Dr. Michael Lane of CDC Prevention Services, saying that all proposals will be postponed due to the issue of "sensitive" language in safe-sex programs. December 24, 1985. We received a letter from you with criteria for the establishment of a "Program Review Panel" to review sensitive language and submit a letter according to the criteria. A panel of seven professionals from the Georgia Taskforce on AIDS is assembled; they review the material and approve its use for high risk group education. We hear on the phone from Ms. Nancy Bridges that our proposal has been reviewed by your committee and is approved as is with some minor changes in evaluation techniques. January 23, 1986. Dr. James Alley, Director of Public Health for Georgia writes a letter of support of the Program Review Panel to you. February 3, 1986. The Program Review Panel signed a letter of support of the program and submitted the letter in accordance to your guidelines. Again, in phone conversations with the Grants Management Office, we are led to believe that the grant is funded, but only the paperwork has to be completed. March 17, 1986. We received a letter from R.C. Backus of the Office of Protection from Research Risk, stating that AID Atlanta must put together an Institutional Review Board before the National Institutes of Health can sign off the application. April 7, 1986. We sent in an IRB statement of purpose and a sample letter of consent to be used by research subjects. Mr. Backus assures us that a phone call to your office will complete his part of the application process. A phone call to Ms. Bridges assures me that with the call from Mr. Backus, your office is prepared to make the award. April 22,1986. A call from Ms. Bridges informs me of the following: Of the four components of the "P.S. Atlanta Risk Reduction Program," only one will be funded. COMPONENT 1: For educational seminars to reach gay men in small groups for $20,605.25 will not be funded. She informs us that CDC will recommend to the U.S. Conference of Mayors to re-fund us for that program. (They [initially] gave us $12,512.) COMPONENT 2: For Outreach to Minorities, IV Drug Users, and Youth is not funded; apparently not seen by CDC as significant risk groups.: $28,253.25 COMPONENT 3: For a mass media campaign to reach the over 200,000 people at high risk in Metro-Atlanta is not funded. "Not innovative enough.": $75,884.25. COMPONENT 4: The education of doctors to diagnose and treat for AIDS is funded for $84,957; a program that would hire Dr. B. Nahmias as health educator.

When I pointed out that the State of Georgia's Department of Human Resources has applied to the CDC for a $200,000 grant as well, and that they have as part of their program, the education of doctors, I am told that they will not be funded for that section since we are going to do that program. When I asked who will provide risk-reduction education to the people most at risk for getting this virus, the gay male community, IV drug users and others, I am told that the DHR has that program well in hand. This letter is part of a notice to you that we are applying through the Freedom of Information Act for information about personalities and policy decisions that have not only put more people at risk for this virus, but have created an atmosphere of hopelessness in this agency and in this community about the remote possibility of slowing this epidemic. We don't mind losing out proposals to others, or to the merits of the proposal being below standards, or to the lack of ability on our part to carry out the program. We do mind when our tax dollars that could save lives are politically manipulated by the buckling under to the perceived pressure of the right wing. AID Atlanta is committed to continue to save lives with or without the use of our own tax dollars. We refuse to sit by and watch more of our brothers and sisters die."

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INTERNATIONAL MEETING OF AIDS ORGANIZATIONS AT PARIS

The Association AIDES is organizing a symposium during the International Conference on AIDS entitled "An International Meeting of the AIDS Organizations (RIALS: Rencontre Internationale des Associations de Lutte contre le SIDA). This meeting will take place Wednesday, June 25, at the Palais des Congress, 2, place de la Porte Maillot, 75017 PARIS. Ten briefings of from 10 to 15 minutes each will be proposed to the participants. Registrations can be made at the welcoming desk on the day of the conference if space is still available. Organizations may exchange their technical and human experiences; specify their difficulties with which they are faced in their respective countries; define the major objectives they would like to attain; and report on the financial means at their disposal. For more info: AIDES-C.I.S., B.P. 759, 75123 PARIS CEDEX 03 (telephone: 42.77.13.23).

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VOYAGE OF HOPE DECEMBER 6 SUPPORTS AIDS AGENCIES

The Boards of Directors of the AIDS Action Council and the National AIDS Network strongly encourage your participation in the the cruise of your lifetime aboard the M/S Nieuw Amsterdam. The cruise will be a great chance to have fun, soak up some sun, and help support two non-profit organizations at the forefront of the national fight against AIDS. The cruise is a wonderful opportunity to mix pleasure with your concern for yourself and others, offering a creative alternative to informing & protecting yourself against the deadly disease. By registering for the cruise today, you assist AAC and NAN in securing comprehensive funding for AIDS research and education, and in informing the public about AIDS programs and services nationwide. Best of all, you get a tax deduction on part of your fare! Holland America Cruises to the Carribbean presents "A Voyage of Hope," December 6-13, 1986 on board the luxury liner MS Nieux Amsterdam to benefit AAC and NAN. For more information, contact: AAA Travel Agency, 1100 Spring Street, NW, Atlanta, GA 30367 (404/875-7171, Georgia WATS 800/282-0227, US WATS 800/647-3505).

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AIDS/ARC UPDATE IN SAN FRANCISCO, JULY 25-26

with thanks to Angie Lewis, RN, MS

"AIDS/ARC: Update '86" is a two day educational program designed for nurses and other health care providers who care for persons with AIDS or ARC. The conference will highlight recent advances in clinical management of people with AIDS as well as the latest research findings reported at the June, 1986 International AIDS Conference in Paris. It will be of interest to a wide range of care providers including nurses in the in-patient, out-patient, psychiatric, and community settings; nurse practitioners & physician assistants; nutritionists; health educators; respiratory care practitioners; and others who provide care in the acute and/or chronic settings. In addition to attending keynote presentations, participants will choose four concurrent sessions from many selections covering basic medical and epidemiologic AIDS/ARC information; medical implications; psychological issues; groups at risk; legal, social, political, and educational issues. In order to enhance discussion, some of these sessions will be limited in size. Conference space is limited, so early registration is encouraged. The conference has been approved by the California Board of Registered Nursing for 12 continuing education contact hours. The Conference is being sponsored by: UCSF Medical Center, SF General Hospital Medical Center, SF Dept. of Public Health, Hospice of San Francisco, AIDS Health Project of UCSF, Shanti Project, SF AIDS Foundation, Women's AIDS Network, and AIDS Project of the East Bay. Tuition ranges from $40-100. For more information: AIDS/ARC Update '86, c/o Staff Development, Langley Porter Psychiatric Hospital, Box 32 B, The Medical Center at UCSF, San Francisco, CA 94143 (415/476-7360). Enclosed with this issue of the Newsletter is an informational brochure. Anyone interested in submitting abstracts for poster sessions or interested in being community exhibitors, or displaying audiovisual materials for video showings, please contact Angie Lewis, Conference Coordinator at the above phone or address.

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CLINICAL MANAGEMENT SYMPOSIUM JULY 25-26

A two day "AIDS/ARC Update '86" program, July 25-26 sponsored by the Langley Porter Hospital and Clinics, The Medical Center at the University of California at San Francisco, and numerous AIDS-related organizations will highlight recent advances in clinical management of AIDS patients as well as the latest research findings. Participants will attend 4 of 16 concurrent sessions covering the physiological, psychological and sociological aspects of AIDS. For more information, contact Angie Lewis, RN, MSN, Box 12-D, LPPI, University of California, San Francisco, CA 94143-0984. Cost of the program is $100; 12.0 hours of CEUs are available.

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SOUTHEASTERN CONFERENCE ON AIDS

The Southeastern Conference on AIDS is being held in conjunction with the Eleventh Annual Southeastern Conference for Lesbians and Gay Men, the Sixth Annual Louisiana State Gay Conference, and a Regional Training Seminar on Lesbian and Gay Electoral Politics at Tulane University of Louisiana in New Orleans, June 5-8, 1986. The intense 4 day schedule will be cram-packed with workshops, entertainment, speeches by nationally-known speakers, a volleyball tournament, a gay-themed photographic exhibition, films, videos, a Mardi Gras cocktail party, an interfaith worship service, a picnic, a dance, a swimming party, along with important concurrent events--all designed to raise our consciousness as lesbians and gay men; all designed to increase our capacity for personal growth, for sharing, for networking in our common struggle toward a better society for all peoples. The conference planning committee emphasizes that the intention of the event is to welcome anyone who has an interest in the full acceptance of lesbians/gay people in our society. The conference does not take a position on any issue, but welcomes discussion on all issues. In providing a forum for sharing and interaction, it is hoped that together, all of the participants will make a significant contribution to the progress of equality for all peoples. The New Orleans AIDS (NO AIDS) Task Force is sponsoring the AIDS conference, and will feature participation by Paul Kawata (National AIDS Network), Gary MacDonald (AIDS Action Council), Jeff Levi (National Gay & Lesbian Task Force), Raymond Jacobs, Diego Lopez, & Luis Palacios-Jiminez (Gay Men's Health Crisis), Tom Stoddard & R. James Kellogg (Lambda Legal Defense & Education Fund), Ollie Lee Taylor & Irwin Rothenberg, (Black & White Men Together), and Rev. Ken South (AID Atlanta). For additional information, contact: NO/AIDS Task Force, POB 2616, New Orleans, LA 70176 (504/3009), or SECLGM, Inc., POB 51877, New Orleans, LA 70151-1877 (504/524-8381, 523-3922).
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NEW YORK FORUMS: ADOLESCENCE, AIDS, LESBIAN & GAY HEALTH, DRUGS, AGING, AND OTHERS
with thanks to Ron Vachon, NY Dept. of Health Office of Gay & Lesbian Health Concerns

Several exciting educational forums in a series on Lesbian and Gay Health, presented by the Office of Gay & Lesbian Health Concerns and co-sponsored by many community agencies, represents the commitment of all involved to teach and learn that health and wellness are lesbian and gay issues and concerns. Our seniors, our youth, our alcohol and drug use, our mental health and our sexual expression all are our special concerns. Learning about our wellness...and diseases...requires open discussion. These forums will both present the state of the art information and provide ample opportunity for questions and discussion. New York City's lesbian & gay communities have diligently built many agencies and institutions to take good care of our own. Lesbian and Gay Health forums are a unique opportunity to meet our experts and to discuss our health as individuals and as a community. Forums take place on the 4th Wednesday of the month, 7-9 pm at the Lesbian & Gay Community Services Center, 208 West 13th Street in the 3rd floor auditorium. February 26th: "Taking Care of Our Kids: Lesbian & Gay Adolescents" (Paul Paroski, MD, Emery Hettrick, MD, Diana Killip, MD); March 26: "Psychotherapy & Homophobia: Who? What? Where? When? (Michael Altman, CSW, Daniel Bloom, JD, CSW< Madeline Breckenridge, ACSW, Michael Shernof, CSW, ACSW); April 23: "Alcohol/Drug Addiction: What Is It? What Can We Do About It? (Dava Weinstein, CSW, Priscilla Bard, CAC, Ron Hellman, MD, Michael Picucci, CAC); May 28: "Pleasure and Health: Sexually Transmitted Diseases...Are They A Thing of the Past?" (Rona Affoumado, Saul Krugman, MD, James D'Eramo, PhD, John Thacker); and June 25: "Getting Older, Wiser & Gay: Aging Is a Gay & Lesbian Concern" (Michelle Schwartz, ACSW, and a panel of members from SAGE). For more information, contact: Office of Gay & Lesbian Health Concerns, NYCDOH, 125 Worth Street, Box 67, New York, NY 10013 (212/566-4995).

The New York State Psychological Association is cosponsoring "Adolescence and AIDS: Conference for School Pschologists and Mental Health Professionals," Saturday, April 12 at New York City's Fordham University's Law School. This conference has been designed for school psychologists, social workers, guidance counselors, administrators and other professionals working with adolescents and children to\; examine the impact of AIDS on the lives of children and adolescents in schools, evaluate the additional pressure that AIDS contributes to the adolescent's concerns about sex, sexuality and recreation; update and identify psychological, physiological and social elements associated with AIDS; and provide resource information regarding social and clinical agencies that assist AIDS and AIDS associated persons. For more information, contact Harrison, Kooden, and Associates, 123 West 44th Street, New York, NY 10036.
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NATIONAL BLACK CONFERENCE ON AIDS SET FOR JULY 18
with thanks to the Washington Blade, 3/21/86

The National Coalition of Black Lesbians and Gays (NCBLG) announced that July 18 has been set as the date for a national conference on AIDS in the black community. The conference, to be held at the Washington Convention Center, is supported in part by a $19,824 grant from the U.S. Public Health Service. For information, contact NCBLG at 202/737-5276 or 930 F Street, NW, Suite 514, Washington, DC 20004.
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ANTIBODY TESTING CONSENSUS DEVELOPMENT CONFERENCE BY NIH

The National Heart, Lung, and Blood Institute of the National Institutes of Health (NIH) and the NIH Office of Medical Applications of Research are sponsoring a Consensus Development Conference on the Impact of Routine HTLV-III Antibody Testing of Blood and Plasma Donors on Public Health. Other sponsors of the conference are the Centers for Disease Control (CDC); the Food & Drug Administration (FDA); the Clinical Center, NIH; the National Institute of Allergy & Infectious Diseases; and the National Institute of Mental Health. The Conference is planned for July 7-9 at the NIH's Masur Auditorium in Bethesda, and will bring together biomedical investigators, blood bank specialists, clinicians, consumers, and representatives of public interest groups. Following two days of presentations by medical experts and discussion by the audience, a consensus panel will consider the scientific evidence. The panel members, drawn from the medical professions, blood banking organizations, and lay persons, will formulate a draft statement responding to the following questions: What tests are currently being used? What are their performance characteristics? How should these tests by used? What impact has testing had on transfusion medicine? What constitutes a positive test? How should a positive HTLV-III antibody test be interpreted? How should positive test results be handled? What are the psychosocial ramifications for blood donors of knowledge of a positive test result? What research directions should be pursued? On the first day of the meeting, the consensus panel chairman will read the draft statement to the conference audience and invite comments and questions. The 2 1/2 day conference is open to the public, and is without charge. For more information, contact: "Impact of Routine HTLV-III Antibody Testing on Public Health," Barbara McChesney, Prospect Associates, 2115 East Jefferson St., Suite 401, Rockville, MD 20852.

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IMPACT ON PUBLIC POLICY: INTERNATIONAL FORUM ON POLICY, POLITICS, & AIDS

A four day symposium cosponsored by the New York State Department of Health and the Milbank Memorial Fund May 27-30 at the New York Hilton at Rockefeller Center features Mario Cuomo, Governor of New York, David Sencer, MD, MPH, former commissioner of the NYC Health Dept., Thomas Vernon, MD, Colorado Dept. of Health, James Wyngaarden, MD, Director, National Institutes of Health, David Axelrod, MD, Commissioner of the NY State Dept. of Health, Mervyn Silverman, MD, Former Commissioner of Health, City & County of San Francisco, Jim Curran, MD, Director, AIDS Branch, CDC, Don Abrams, MD, San Francisco General Hospital, Nathan Fain, Gay Men's Health Crisis, Robert Bazell, NBC News Science Correspondent, Virginia Apuzzo, Deputy Executive Director, New York State Consumer Protection Board, Michael Callen, People With AIDS Coalition, Tony Whitehead, Terrence Higgins Trust (in London), Rashi Fein, PhD, Professor, Economics of Medicine, Harvard Medical School, and J.B. Brunet, MD, Director, WHO Collaborating Center on AIDS in Paris, and many others. Five general topics will be covered: 1) Public Health and Private Rights: Health, Social, and Ethical Perspectives; 2) Research: International Cooperation and Competition; 3) Clinical Management: Treatment Modes and impact on the Health Care System; 4) Education and Communication: Enhancing Public Understanding and Fostering Disease Prevention; and 5) AIDS and Economics: An International Perspective. Registration fee is $250 per person ($300 after April 30). Address inquiries to: AIDS International Public Policy Conference, PO Box 2116, Albany, NY 12220.

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SOCIAL SERVICES DIRECTOR FOR SAN FRANCISCO AIDS FOUNDATION

San Francisco AIDS Foundation is seeking a social services director with an MSW degree or 2 years of graduate training in a related field, a minimum of 5 years experience in the field of human services including a minimum of 1 year experience as a program director performing administrative functions such as budget development or program quality assurance. Candidates with proof of a diagnosis of AIDS will be given preference. The director will be responsible for the administration of the Foundation's Social Services Department, and work under the general direction of the Deputy Director. Salary is $27,500 plus benefits, with a 4% increase planned for July, 1986. Interested applicants must submit a letter of application and resume by April 15 to: Personnel, SFAF, 333 Valencia St., 4th Floor, San Francisco, CA 94103.

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EXECUTIVE DIRECTOR NEEDED IN PALM SPRINGS

The Community Counseling Center/Desert AIDS Project in Palm Springs, California is soliciting resumes to fill the position of Executive Director. Managerial experience, a demonstrated sensitivity to gay individuals, a working knowledge of AIDS related issues and the ability to become involved with the diverse population of this resort area are important. An understanding of California state contracts with AIDS related organizations is helpful. Sunshine, support, and salary are available, in that order. For more information, contact: Selection Committee, P.O. Box 8925, Palm Springs, CA 92263.

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FEDERAL CHARITY DRIVE NETS CLINIC $150,000

by Rick Harding, with thanks to The Washington Blade, 4/18/86

Washington's Whitman-Walker Clinic announced that it had received over $150,000 in pledges from federal government employees through the 1985 Combined Federal Campaign charity drive. The donations are over four times the amount that the Clinic received through the program last year and represent nearly one percent of the total donations from DC based federal employees. Clinic Administrator Jim Graham said that the contributions indicate a "broad concern throughout the community over the AIDS crisis." He said the level of support indicates that donations came from the non-gay community as well as from a large number of gays and lesbians. Graham said the Clinic considers the money a "windfall" and will use the donations for projects outside of its regular $700,000 annual budget. He said the Clinic is "seriously considering" using the money to help purchase a new building in which to house its operations. A new building, he said, would allow Whitman-Walker to upgrade its laboratory and examination room facilities and to offer improved health services to the gay community. A committee of ten Clinic staff members and volunteers is being formed to decide exactly how the money will be spent and will make its recommendation to the Clinic's board of directors in the near future. Graham said he thinks the Clinic's inclusion on the printed list of eligible groups this year partially accounted for the increase in donations because it made the process easier for donors, who simply had to write in a three digit numeral to direct contributions to the Clinic. Graham also attributed part of the upswing in donations to increased advertising by the Clinic,noting that they spent a total of $1600 for advertisements in The Washington Blade and The Washington Post. In order to receive funds through the fall 1986 campaign, local groups must complete an application with the Washington CFC office by May 16. The application requires groups to prove that they provide health or welfare services to the community, that they are fiscally responsible, and are financially accountable to the public. Graham said he does not forsee any problems with the Clinic's participating in next year's campaign, since the Clinic provides direct health services, has a public board of directors, and has had audited financial statements. The CFC, which allows federal employees to make charitable donations through payroll deductions, was opened to gay groups two years ago when a federal court ruled that it was illegal for campaign organizers to pre-select charities for participation.

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AIDS PROJECT LOS ANGELES RECEIVES $440,000 GRANT

AIDS Project Los Angeles (APLA) has been awarded a $440,000 grant from the California State Department of Health Services to implement a one-year AIDS Home Health Care Demonstration Project. The purpose of this project will be to determine whether home health care for AIDS patients at certain stages is more cost effective, as well as more satisfying to the patient, than in-patient care. Carol Quinn, MD, Clinical Research Physician, has joined the staff of APLA as Project Administrator. The project was conceptualized by George Sonsel, LCSW, APLA's Director of Client Services, and based on APLA's unique method of case management. Participants for the study will be chosen through APLA as well as private sector physician referrals. To be eligible for the study, a participant must have a diagnosis of AIDS or ARC, and must require nursing care or attendant/homemaker care. A case management team will meet weekly to assess the progress of patients within the project. This management team, in cooperation with the personal physicians of the study participants, will determine the extend of need for the patient in the following areas: homemaker care, nursing care, and emotional health care. Nursing care up to 24 hours per day will be provided by the Visiting Nurses Association of Los Angeles (VNA-LA). Shanti Foundation has been subcontracted to work with the participant, significant others, and family members to see that emotional support and bereavement counseling are provided. Aid for AIDS has been subcontracted and will be responsible for financial intake and assessment and to ensure that each participant has utilized all possible financial resources. There will be no out-of-pocket expenses for the project participants. "Throughout this project we will be looking at the social and medical concerns of the participant," said Quinn. "Cost-effectiveness is a key factor to be determined, as well as what is best socially and emotionally for all concerned." Both Sonsel and Quinn believe that study results will be favorable, as the cost of home health care is believed to be well below the average cost per AIDS patient for hospitalization of $16,652.

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TOBACCO TAX FOR AIDS RESEARCH

with thanks to The Baltimore Gay Paper, April, 1986

State Senator Decatur Trotter has introduced legislation into the Maryland General Assembly which has the tobacco industry fuming. Trotter has proposed a one year, one cent addition to the state's cigarette tax to fund AIDS research and education. The proposal was introduced, according to Trotter, because Governor Harry Hughes refused to include money in the fiscal 1987 budget for AIDS education. "I just don't see how you are going to educate the public without spending money," Trotter said. Although supporting the concept of AIDS education, the opposition to the proposal is saying the money should come from general state funds rather than from a special tax. Estimates are that the tax would raise about $4.3 million. A spokesman for the Tobacco Institute and the Maryland Association of Tobacco and Candy Manufacturers said the tax was another example of people "always picking on cigarettes" and indicated that the measure might hurt tobacco farmers in southern Maryland.

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WALK FOR AIDS IN BOSTON

On Sunday, June 1, people from all walks of life will gather on the Boston Common and begin a 10 kilometer (6.2 mile) pledge walk to raise money for AIDS care and research. The "From All Walks of Life" walk hopes to bring together thousands of caring people from across six states to raise a half a million dollars for AIDS services in the northeast, and is sponsored in part by the Lotus Development Corporation and the Catherine G. Shattuck Memorial Trust. The following agencies will benefit: Elisabeth Kubler-Ross' AIDS Baby Hospice (Virginia); New England Hemophilia Foundation; National AIDS Network and the AIDS Action Council in Washington, DC; National Association of People with AIDS; Fenway Community Health Center (Boston); and the AIDS Action Committee (Boston). After leaving Boston Common, walkers will travel down Commonwealth Avenue, along the Charles River, and end at the Hatch Shell on the Esplanade where a gala jazz concert will celebrate life. Commemorative walk buttons will be given to all people who join in the walk; complimentary T-shirts will be given to everyone who collects $250 in pledges; a certificate for a brand new pair of sports shoes will be given to everyone collecting $500 or more in pledges; and a round-trip for two to Montreal, including airfare, three nights in a luxury hotel and sightseeing, will be awarded the person turning in the largest dollar amount of pledges, courtesy of Paul Gibb Travel. For more information, contact: Liz Page, 617/266-6906/437-6200, or write: FROM ALL WALKS OF LIFE, AIDS Action Committee, 661 Boylston, Street, Boston, MA 02116-9990.

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BICYCLE CROSS-COUNTRY RALLY IS NATIONAL AIDS FUNDRAISER
with thanks to Detroit's Cruise, 2/19/86

Life-Cycle '86, a cross country bicycle rally that will raise money for a national AIDS organization is scheduled to depart from New York City in mid-May, traveling westward, stopping at major cities along the way to hold fundraisers and press conferences. Educational material about AIDS and AIDS related issues will be widely distributed along the route. Life-Cycle is scheduled to terminate in San Francisco in mid-August to coincide with Gay Games II, an international sports competition. Besides fundraising, one of the primary goals of Life-Cycle '86 is to show strength and unity in response to the AIDS crisis by "linking" the country from coast-to-coast. Host cities along the route will schedule special events such as celebrity performances, and dances to coincide with the arrival of Life-Cycle. Life-Cycle hopes to get as many participants as possible by giving interested bicyclists the option of either riding the whole distance or a segment of the route, ranging anywhere from 1 to 3000 miles. As well as choosing the appropriate distance, a bicyclist can choose the terrain by picking a segment of the route that best suits their ability. Anyone interested can participate, and people with AIDS or AIDS-related conditions will be encouraged to become involved if they are able. Participating bicyclists will not be supervised with a "sag wagon" and although some of the accommodations will be in sponsors' homes and hostels, most will be camping. The route will be divided to average 65 miles per day, with six riding days a week, tentatively passing through Philadelphia, Pittsburgh, Cleveland, Toledo, Chicago, Milwaukee, Madison, Minneapolis, Des Moines, Omaha, Lincoln, Denver, Salt Lake City, Sacramento, and San Francisco. The itinerary may be changed to incorporate both cities near the route where there is interest in hosting Life-Cycle, and contingents that will meet up with the route at certain points. Scheduled also are contingents riding from Portland, Maine to New York via Boston, joining the rally at the beginning, and from San Diego to Los Angeles to San Francisco, joining the rally at the end. Life-Cycle is the most recent event organized by bicycle enthusiasts in response to the AIDS crisis. On Sept. 14, 1985, Different Spokes of New York held a one-day bike-a-thon which raised over $20,000 for local AIDS organizations, mirroring the efforts of Different Spokes of San Francisco, which held a similar rally in April, 1985 that raised over $30,000. On Sept. 21, 1985, Detroit bicyclist Mark Landsfeld rode from Alaska to Key West, Florida, raising funds for AIDS organizations in the cities he stopped in along the way, and for Detroit's Wellness Networks.

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PLAYBOY PRESIDENT CHAIRS CHICAGO AIDS BENEFIT
by Lisa M. Keen, with thanks to The Washington Blade, 4/25/86

Playboy Enterprises President Christie Hefner, daughter of Playboy founder Hugh Hefner, chaired a $100 per plate benefit April 14 that raised more than $10,000 for the Howard Brown Memorial Clinic in Chicago. The benefit, sponsored by the Merrill Chase Galleries, was supposed to feature actress Brooke Shields as honorary chairperson, but Shields was unable to attend.

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NATIONAL AIDS NETWORK GETS $25,000 GRANT FROM INSURANCE COMPANY
with thanks to Detroit's Cruise, 4/23/86

The National AIDS Network (NAN) announced a $25,000 grant from Pacific Mutual Life Insurance Company. This grant was made to assist NAN with setting up its clearinghouse. NAN is a national resource center for AIDS education and service delivery. Located in Washington, DC, NAN's objectives include: information banking, networking, technical assistance, public education, fundraising coordination and think tanking. "We are very thankful to Pacific Mutual Life Insurance Company for the grant to fund our clearinghouse," says executive director, Paul Kawata. "These set-up dollars will assist us to provide a cost-effective and highly productive approach for AIDS education and service delivery."

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MUSICTHON GRANT PROGRAM

with thanks to Los Angeles CAIN (Computerized AIDS Information Network), 3/19/86

From the time the idea for MUSICTHON 86 first began to take shape, RJO Entertainment has been committed to using a portion of the net profits (50%) from the concert to help support the work of AIDS organizations across the country. Grants will be available to any non-profit AIDS organization, including those involved in research, medical care, or support services. The grants are designed to aid the recipient in accomplishing a specific project or program that would otherwise not be feasible. RJO Entertainment also recognizes that many non-profit AIDS organizations are staffed largely by volunteers, operate on a local basis, and have low financial needs characterized by rent and telephone costs. Grants may also be made to help sustain the operations of these organizations. Grants are based on consideration of applications submitted by any organization qualified under section 501(c)(3) of the Internal Revenue code 1954 as a tax exempt organization. All qualified organizations are invited to submit an application or request additional information: RJO Entertainment, Musicthon 86 Grants, Berwin Entertainment Complex, Garden Suite 4, 6525 Sunset Blvd., Hollywood, CA 90028 (213/933-7261.

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BARBARA STREISAND TO DONATE "SOMEWHERE" PROFITS TO AIDS RESEARCH & NUCLEAR DISARMAMENT

with thanks to Detroit's Cruise, 4/2/86

Recording artist Barbara Streisand has announced that she will donate the profits of her single release "Somewhere" to AIDS research and nuclear disarmament. The profits will be shared by the American Foundation for AIDS Research (AMFAR) and PRO-Peace. "Somewhere" is the first single released from Streisand's highly successful "The Broadway Album," and was used to make her first video. The final words of the song, which is from the Broadway musical "West Side Story," are fitting for both organizations: "We truly have no choice but to find a way to live together, somehow, someday, somewhere."

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RECORD COMPANY CONCERT COLLECTS FOOD FOR NEEDY

by Lisa M. Keen, with thanks to The Washington Blade, 4/2/86

Cris Williamson, Tresa Trull, Barbara Higbie and other women music artists associated with Olivia Records, held a concert that turned out to be "one of the most successful food drives" yet for the San Francisco AIDS Foundation's Food Bank. Cary Norsworthy, director of the Food Bank, said lesbians and other women attending the concert donated more than $800 worth of food and another $200 in cash. She said that, unlike with other food drives, this one generated more organic juices and health foods. Norsworthy said Olivia Records is considering making the food drives a regular part of their concerts. The Food Bank provides a $25-30 bag worth of groceries each week to people with AIDS who need food.

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PITTSBURGH RECEIVES AIDS EDUCATION GRANT

The University of Pittsburgh has announced that it has received a grant of $181,000 from the Centers for Disease Control for an educational research project designed to help gay men avoid AIDS. The project which is affiliated with the Pitt Men's Study, will provide men with the latest scientific information about AIDS and offer a free, educational session for gay and bisexual men to inform them about methods to dramatically reduce their risk of being infected with HTLV-III, the virus which can cause AIDS. The educational sessions include general information on AIDS, very specific information about the transmission of the virus and ways to prevent infection. All men who sign up for the sessions will be required to fill out a questionnaire, and to donate about three tablespoons of blood on the day of the session and twice more in the coming year. Men who enroll have the option of deciding whether or not they want to learn their HTLV-III antibody test results. "We have a good chance to significantly reduce the expected number of AIDS cases in Pittsburgh if men educate themselves. The knowledge now exists to make AIDS 100% preventable. If that knowledge is spread throughout the community, we can profoundly lessen the impact of AIDS in Allegheny County," stated Tony Silvestre, a consultant on the project, and Director of Community Programs for the Pitt Men's Study. Research on the effectiveness of educational sessions is important for the development of risk reduction programs in other areas of the country. The researchers hope to gather important information about how best to instruct gay men about avoiding infection. Some Pitt Men's Study volunteers have already participated in similar sessions. According to one participant, "I thought that I knew all there was to know about AIDS but I left the session knowing a lot more and feeling much more able to stay healthy. I am relieved to finally feel in control." For more information, call 412/624-2008 or 624-5046, or write: Pitt Men's Study, POB 7319, Pittsburgh, PA 15213.

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SEX THERAPIST DR. RUTH FEEDS HOMOPHOBIA

by Carolyn Stack, with thanks to Boston's Gay Community News, 5/3/86

I stumbled across Dr. Ruth's radio show, "Sexually Speaking," about a year ago and since then have tuned in to a couple of her programs. Mostly I have felt amused and impressed by her graphic, witty, sex-positive responses to the questions

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SEX THERAPIST DR. RUTH, Continued

called in by listeners. Despite the cultural sex obsession, most of us find it virtually impossible to discuss the nitty gritty of what we do in bed and what we enjoy and fantasize about. But a traditional sex therapist, in a public forum, gives us permission and offers us a language in which to express our sexual pleasures and difficulties. All of the callers on the shows that I listened to were heterosexual and the kinds of questions asked were somewhat repetitious and predictable....men worried about holding erections; women worried about frequency of orgasm; people concerned about differing sexual likes and dislikes than their partners. But what was interesting was simply the phenomenon of people talking publicly about such things as blow jobs and orgasms and going down on a partner and sexual noises and different physical positions to have sex in. This was fantastic. Here was another of rare signs of hope that parts of our culture were moving away from the secrecy and taboo surrounding sex, a kind of silence that discourages sexual pleasure and intimacy and that fosters sexual violence and incest. Dr. Ruth was in Boston recently at the invitation of Tufts University and I grabbed at the chance to hear her speak. Dr. Ruth opened her hour long talk with a discussion of her felt need to teach "sexual literacy." She gave examples of the destructive effects of sexually ignorant (as distinguishable from sexually abusive) parents. We all know stories of girls who have menstruated without being prepared for it, and the vast mythology surrounding the effects of masturbation (hair on palms, insanity, loss of fertility) and the disastrous effects of lack of information about birth control and contraception. Dr. Ruth's genius came through her ability to be exceedingly positive about sexual experimentation in pursuit of pleasure and, simultaneously, very grounded in her approach to sexual safety. She was persistent in talking about the necessity of contraception and about every woman's right to safe abortion. But about 20 minutes into Dr. Ruth's talk it struck me that I was in a disappointingly familiar situation. As I turned to my lover with the question, "Where are the examples of the dykes and the faggots?" Dr. Ruth said, "And of course, whenever a homosexual couple walks into my office, I treat them with the utmost respect." With that remark she rendered one tenth of the population into the realm of the other. "I want to assure you," she continued, "that a homosexual dream or fantasy or even a homosexual experience, does not mean that you are gay." Some of us, I thought, may not feel reassured by that statement. I'm a relatively well-adjusted, 35 year old lesbian and I still felt the tug of being made invisible. I tried to imagine what it must be like for the 18 year olds in the audience who were newly out or struggling with an emerging gay identity. Here was one of the country's foremost sex educators who has become a campus cult figure because of her advocacy of sexual experimentation, delivering the message, via the assumption that everyone in the audience was straight, that gay is not the norm and that gay is an esoteric minority. The biggest blows of all came during the period of questions from the floor that followed Dr. Ruth's speech. In response to the AIDS crisis she told us she didn't believe in even discussing the question of safe sex. Gay men, she aid, should respond to the epidemic by taking the names and addresses of prospective sexual partners, ranking them in order of desirability and calling them after a cure for AIDS has been found. In short she advocates that gay men should refrain from sex. My hypothetical young faggot in the audience received the all-too-familiar message that sex for him was bad. The young lesbian in the audience got her message when Dr. Ruth presented an example of a problem that had been posed to her in the past where she advised a woman not to tell her fiance about a lesbian affair that she had prior to meeting him. Thus, she relegated lesbianism to the same pot of the morally wrong as the other deeds that she has advised people to keep secret from their primary partners...an affair with a mother-in-law or a lover's best friend. This kind of subtle homophobia that makes us invisible set the stage for a cruel queer-baiting question from the audience. Two young men stood up together and one stated that their third roommate masturbated audibly in bed and that they had found a copy of Playgirl in his belongings. Dr. Ruth addressed the first part of the question (how to approach the roommate on the privacy issue) but ignored the reference to the roommate's sexual orientation. She also choose not to comment on the cruelly of this public humiliation about both masturbation and sexual preference. Dr. Ruth's Guide to Good Sex, exemplifies the sex educator's stance on homosexuality. A separate section is assigned to "Gay Sex" and, of the five problems cited, only one relates to people with clear gay identities. Dr. Ruth isn't blatantly homophobic and she doesn't totally ignore us. We are mentioned in her talks and in her writings--but we are mentioned as tokens. In our struggle against the New Right backlash of sexual and gender oppression it is relieving to hear a vocal, respected, public advocate of sexual freedom. Dr. Ruth attributes her success, in fact, to the traditional image that she conveys of the respectable older woman. She becomes psychotherapy's "good mother" providing us with a "corrective emotional experience." Against the backdrop of the voices of our parents and culture with all their prohibitions against sex and sexual pleasure we hear Dr. Ruth's repetitive message that sex is good. We can all benefit from hearing over and over again that whatever we fantasize is okay, that acting out our fantasies is okay, that sex is fun and that it is an important part of our lives. I imagine that Dr. Ruth is great for the heterosexual couple who always do it in the missionary position and who are ashamed of all fantasy. She offers a whole new world to people with restricted sexual imaginations. I suspect and hope that she reaches many heteosexuals who lack information about birth control or who are careless about its use. She takes a courageous pro-choice stance on abortion. But I wish she would stretch herself enough to include gay men and lesbians as an integral part of the general population to whom she is speaking. And I wish she would expand her repetoire of fantasies to cross gender lines. In the Tuft's presentation, Dr. Ruth offered a fantasy to a woman asking for an idea to make a wedding night special. "Greet him at the bedroom door wearing only a fig-leaf," she said. Imagine Dr. Ruth's response if her imagination was not restricted by stereotypical gender definitions. She might have said, "Greet him at the bedroom door wearing only a harness and dildo."

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EMPLOYERS GET FACTS

by Lisa M. Keen, with thanks to The Washington Blade, 4/2/86

Representatives from Pepsi Cola, Coca Cola, AMTRAK, Gillette, Holiday Inn, the Immigration & Naturalization Service, and even the Office of the Secretary of the Department of Defense were among the more than 700 registrants for a closed circuit broadcast by 82 PBS stations March 26. The topic was AIDS in the Workplace. Among the questions discussed were: Can employers test workers? How can AIDS affect a business' health and benefits plan? Is an employee with AIDS a danger to other employees? Among the panelists were Tom Stoddard of the Lambda Legal Defense & Education Fund, and Caitlin Ryan, a private consultant to employers and health care workers on AIDS and president of the National Lesbian & Gay Health Foundation. Michael Lein-Epstein, a spokesperson for the Bureau Of National Affairs, the private publishing firm which sponsored the event, said the most frequently asked question was "Should we test our employees?" Epstein said participants in the workshop were assured that the epidemic is "not at the point where routine testing is necessary."

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HAWORTH PRESS: ANTHROPOLOGY & HOMOSEXUAL BEHAVIOR

The Haworth Press announced the publication of Anthropology and Homosexual Behavior, edited by Evelyn Blackwood of Stanford University. This truly groundbreaking volume presents the results of some of the best anthropological research on homosexuality that has been done during the past decade. The first collection of articles dealing with homosexual behavior in several different cultural areas based on data gathered by the authors in the field, it reveals for the reader the diverse and often astonishing manifestations of homosexuality in various historical periods and non-Western cultures. Discussions include the Kimam male ritualized homosexual behavior, Mexican homosexual interaction in public contexts, male homosexuality and spirit possession in Brazil, and much more. This 217 page book costs $29.95 (hard), $22.95 (soft), and is available through your bookstore (LC# 85-17758) or directly through the publisher: Haworth Press, 28 East 22nd Street, NY, NY 10010.

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INTERNS SOUGHT BY GAY TASK FORCE

with thanks to The Washington Blade, 3/21/86

The National Gay and Lesbian Task Force (NGLTF) is seeking interns to work on projects in its Washington, DC and New York City offices. Program areas include AIDS, violence, civil rights advocacy, and the media. Interns should be familiar with gay and lesbian issues, and be able to work one day a week. Intern positions are unpaid, but college credit may be obtained by students. For more information, contact Terri LeMoyne, NGLTF, 1517 U Street, NW, Washington, DC 20009 (202/332-6483).

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GOVERNMENT BROCHURE ON AIDS DISTRIBUTED TO SUPERMARKETS

with thanks to The Washington Blade, 3/7/86

A government brochure which states that the risk for contracting AIDS can be reduced by avoiding multiple sex partners and by using condoms is being distributed to some 5500 supermarkets throughout the nation, a spokeswoman for the U.S. Dept. of Health and Human Services said. Marian Segal, press officer for HHS's Public Health Service, said over 500,000 of the brochures, called, "Facts About AIDS," will be sent to the supermarkets each month. The brochures will also be distributed by the Centers for Disease Control in Atlanta to state and local public health clinics.

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POLITICAL ACTION HANDBOOK FOR AIDS

The AIDS Action Council is happy to announce the publication of "AIDS: A Political Action Handbook," scheduled for release in June. The Handbook will contain comprehensive sections on AIDS-related political issues and how to deal with them, political and legislative action on the national, state and local levels, lobbying strategies and how to carry them out and other areas of concern to those who want to mount constituent pressure for change. The new publication will be sent free to all AAC members and AIDS service-providers, and will be available to others for purchase. For more information, contact: AIDS Action Council, 729 Eighth Street, SE, Suite 200, Washington, DC 20003.

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BOSTON SEEKS COORDINATOR FOR AIDS ACTION COMMITTEE

Boston's AIDS Action Committee is a community-based support and advocacy organization seeking a master's level, licensed mental health professional as a mental health/group coordinator, responsible for mental health evaluation and referrals, and coordination of support group programs. Excellent diagnostic evaluation skills and organizational abilities are required, and experience with AIDS/ARC issues essential. A service coordinator/advocate to assist people with AIDS and ARC who will facilitate access to AIDS-specific and other social services is also needed. Also needed is an ability to work with a diverse client load, staff and volunteers. Send a cover letter and resume by April 25 to the Director of Administration--Mental Health, AIDS Action Committee, 661 Boylston St., Suite 400, Boston, MA 02116.

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FUNDRAISING POLICIES & RECOMMENDATIONS

with thanks to AID Atlanta, Inc.

The following recommendations were compiled to assist those individuals, groups, and organizations who wish to sponsor fundraising or benefit activities for AID Atlanta. Our intent is to provide a minimal amount of guidance which we hope will both make your task easier and protect our status as a tax-exempt, non-profit, service agency. Specific questions and concerns should be discussed with our Board of Directors.

1) Fundraising/benefit proposals involving the use of the name of the agency (AID Atlanta) should be presented in writing to the Board of Directors of AIDA prior to the appearance of advertising that uses our name.

2) Proposals for fundraisers/benefits should include an estimate of the amount of funds that are expected to be raised and the method that will be used. For example: raffle, movie premier, play, athletic event, etc.

3) The language used in the advertising for fundraisers/benefits should clearly specify the monetary benefit that AIDA will derive from the project. The following examples illustrate preferable advertising language: "_____ dollars from the sale of each ticket will be donated to AID Atlanta." "All cover charges (or all door charges, or ___% of cover) to be donated to AID Atlanta." "Entry fees to benefit AID Atlanta." "___ per cent of GROSS receipts will be given to AID Atlanta." "All tips collected will be donated to AID Atlanta." Language should be avoided that implies or states that an unspecified amount or percentage of the proceeds or net proceeds will be donated to AID Atlanta.

The overriding consideration in conducting fundraisers/benefits is that the potential contributor or participant can clearly determine that his/her contribution will benefit AID Atlanta and to what extent. Events which must produce a net profit in order to generate any income for AID Atlanta should be avoided. Events which provide for a percentage or a set dollar amount of admission or ticket price give the contributor the best information about where his/her money is going and protect the integrity of the event and AID Atlanta. When in doubt, please ask us!

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SCAMS AND AIDS

by Janice Irvine, with thanks to Boston's Gay Community News, 3/8/86

One of the newest products in the AIDS panic scams is Freshette--a small device that enable women to pee standing up. Freshette is marketed as providing "assurance against AIDS," in addition to being great for sports or camping. When a GCN reader wrote to the company to complain, a representative of Sani-Fem replied, "I personally believe that the anti-feminist bombers of the abortion clinics are morally wrong in their efforts to deny others their freedom of personal choice in matters affecting their personal lives. For people to deny women their right to decide for themselves whether to stand or use a public toilet seat of uncertain but definitely fatal infectiousness is equally wrong and equally anti-feminist.... Freedom and objectivity. The choice should be personal and uncoerced." There is no evidence that AIDS can be contracted from toilet seats. Directions for the device urges the user to "stand facing the toilet or with your back to the wind...." In San Diego, manufacturers of a pocket-sized "anti-viral" spray which was advertised as preventing AIDS have agreed to halt "unfair and deceptive practices" in marketing the product in Massachusetts, according to the Boston Phoenix. In a complaint filed in Suffolk Superior Court, Attorney General Francis Bellotti's office noted there is "no credible medical evidence" that AIDS or herpes can be contracted from "non-intimate contact," as the ad implies. Therefore, according to Bellotti, thee is no reason to believe the spray can prevent or cure the illnesses or improve one's resistance to them. In addition to prohibiting the deceptive advertising, the attorney general's office also required the company to refund the $8.34 purchase price to all Massachusetts customers desiring a refund. Refunds can be obtained from Virus Guard, 405 West Washington St., #192, San Diego, CA 92103.

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MONEY IN AIDS

by Marcos Bisticas-Cocoves, with thanks to Boston's Gay Community News, 3/22/86

Stock speculators are at risk because of the AIDS crisis, according to the New York Times. They report that stock in Newport Pharmaceuticals, a drug manufacturer that researches AIDS treatments, lost half its value in February. Newport's stock drop is attributed to the Food & Drug Administration's denial of the company's application to market its drug, isoprinosine. "The incident shows that investors in these stocks face some risks that are very, very hard to evaluate," said James D. McCarmant, editor of the Medical Technology Stock Letter in San Francisco. "Since many [people who own stock] can't ask the FDA for information, they must rely on the companies for all of their information. As a general rule, investors should be suspicious of any company that seems overly optimistic." Also on the business front, Abbott Laboratories of North Chicago announced on January 20 that it has won a $400,000 contract to supply HTLV-III antibody tests to the U.S. Army, according to the New York Native. All branches of the military are testing active duty personnel for the antibody. Many researchers claim HTLV-III causes AIDS. Abbott will provide the Army with 52 automated instrument systems, on which the test can be quantified, and an initial supply of 130,500 test kits. According to Miles White, manager of account sales for Abbott's diagnostic division, the final value of the contract will depend on how often the Army screens its personnel. The Army will issue another contract for additional test kits, White said. Abbott will probably receive those contracts, since only its test can be used with the instrument systems it has provided the military.

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CORPORATE SUPPORT FOR AIDS PROJECTS GROWS

with thanks to B.J. Stiles, and Foundation News, March/April, 1986

The following is an example of the growing corporate support for AIDS projects throughout the country:

Transamerica Occidental Life, Los Angeles, recently announced grants of $100,000 to the American Foundation for AIDS Research (AmFAR); $75,000 to AIDS Project/Los Angeles; and estimates that at least $100,000 in 'soft dollars'--staff time, donated services and equipment--have been contributed.

Xerox Corporation provided a loaned executive, William Misenhimer, at full salary for a year to head AIDS Project/Los Angeles, and has subsequently contributed $50,000 to AmFAR.

Levi Strauss & Co., San Francisco, gave $30,000 to the San Francisco AIDS Foundation in 1985 for an "AIDS in the Workplace" program; $6000 to the local AIDS Food Bank; and $25,000 over a two-year period for matching gifts to several local AIDS service organizations.

Bank of America, San Francisco, provided $40,000 over a two-year period to the local AIDS Foundation, in addition to rent-free space for that organization in bank-owned property.

Pacific Bell, San Francisco, contributed $4000 in 1985 to the local AIDS Foundation, and the company foundation--Pacific Telesis--gave $30,000 for the video portion of an "AIDS in the Workplace" project; $3000 to the San Francisco General Hospital for computer assistance for reading test results. Pacific Telesis is also a co-sponsor of the video-taping of the Northern California Grantmaker's recent workshop on AIDS.

The Business Leadership Task Force has been formed recently by 15 San Francisco-based corporations to serve as an educational and informational clearinghouse for various AIDS needs, and to increase corporate support for AIDS projects. In addition to the San Francisco corporations noted above, Crocker National Bank and Wells Fargo Bank are active in the formation of the BLTF, and are supporting various AIDS efforts.

In Manhattan, several leading institutions have supported research, patient services, public awareness campaigns, and AIDS in the workplace programs. Among them: Empire Blue Cross/Blue Shield, Chase Manhattan, Chemical Bank, Equitable Life Assurance Society, and Morgan Guaranty Trust Company.

In Boston, a diverse segment of the business community has begun to provide both leadership and contributions, including responses from AT&T, Saks Fifth Avenue, Hill-Holiday Public Relations, the Zayre Corporation, and Lotus Computers.

[NCGSTDS ED NOTE: Please provide us with examples of other corporate support for your community! Send info to: NCGSTDS, POB 239, Milwaukee, WI 53201.]

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AIDS IN THE WORKPLACE: RESOURCE MATERIAL & DATA REPORT

"AIDS in the Workplace: Resource Material," a 325 page comprehensive compilation of the latest information on the employment aspects of AIDS, now is available from The Bureau of National Affairs (BNA), a leading publisher of information services covering business and economics, law, taxation, labor relations, environmental protection, and other public policy issues. The resource material includes: Medical Information--statements by leading experts and Public Health Service statistics. Legislation--full text of the Vocational Rehabilitation Act of 1973, proposed federal legislation on AIDS and employment, state laws, and municipal ordinances. Litigation--full text of sex decisions on employment related AIDS cases. Guidelines--recommendations on dealing with AIDS from American Hospital Association, AFSCME, Centers for Disease Control, National Education Association, and National Safety Council. Corporate Practices--Policies on AIDS in the workplace from Bank of America, Levi Strauss & Co., and Wells Fargo Co. Policies and Positions--Statements on AIDS by American College Health Association, American Council on Education, Health Insurance Association of America, American Council of Life Insurance, Blue Cross/Blue Shield, National Restaurant Association, and DC Corporate Counsel. Publications--Articles written by Michael Cecere, JD, and Arthur Leonard, JD. The resource material, tabbed and housed in a three-ring binder, is essential for the human resource manager, personnel administrator, corporate planner, medical expert, school or university administrator, employee assistance program specialist, government policymaker, EEO or labor attorney who wants to keep up on the latest developments on AIDS in the workplace. AIDS in the Workplace: Resource Material is available for $60 from BNA Response Center, phone: 800/372-1033 (800/352-1400 in Maryland, 202/258-9401 in Washington, DC), or write: BNA Customer Service, 9435 Key West Av., Rockville, MD 20850.

The "DataReport" is a database providing the latest information on the employment aspects of AIDS, and is also available from BNA. The data report includes current information on AIDS in the workplace in four principal areas: legislation, litigation, guidelines and policies, and corporate practices. The legislative section contains summaries of proposed and enacted legislation on the federal, state, and municipal levels. The litigation section digests pertinent court and agency decisions. The guidelines nd practices section analyzes the positions of various interest groups, associations, and government agencies on AIDS employment issues. The data report is updated monthly, and may be obtained for $50. To order, write BNA PLUS, 1231 25th Street, NW, Washington, DC 20037, or call 800/452-7773 nationwide (in metro Washington, DC only: 202/452-4323).

CORPORATE U.S. LOOKS AT WORKERS WITH AIDS

by Craig Harris, with thanks to Boston's Gay Community News, 3/1/86

NEW YORK — Law & Business, Inc., a division of Harcourt Brace Jovanovich, sponsored "AIDS and Drug Abuse in the Workplace," a day-long national conference geared toward corporate managers who want to "protect" themselves from employees who use drugs or have AIDS. Fewer than 50 people — all white and predominantly male — paid $395 a head to participate in the most expensive and exclusive conference on AIDS to date, held at the Plaza Hotel's Crystal Room on February 7.

Saul G. Kramer, a labor law specialist, partner in the firm Proskauer, Rose, Goetz & Mendelson in New York City, and co-editor of the conference coursebook *AIDS & Drug Abuse in the Workplace: Resolving the Thorny Legal-Medical Issues*, presided as conference chair.

The "thorny" issues for employers whose workers use drugs or have AIDS emerged as 1) problems in testing employees for the HTLV-III virus or drug use before and/or during employment; 2) legal difficulties in minimizing an employer's responsibility toward "terminated" employees who use drugs or have AIDS; and 3) legal barriers to arguing that hiring or retaining employees who use drugs or have AIDS causes "undue hardship" to employers.

Management labor lawyers and a few business executives began the day with a lecture and slide show presentation discussing medical background on AIDS, produced by Dr. Donald Armstrong, Chief of Infectious Disease Services of New York's Memorial Sloan-Kettering Cancer Center and author of *The Acquired Immune Deficiency in Medical Microbiology* (Academic Press, 1984). After an overview of the epidemiological history of AIDS and AIDS-related diseases, and of the transmission of the HTLV-III virus associated with AIDS, panelists discussed the "importance" of screening employees for AIDS and drug use, and the limits on what drugs should be approved for workplace use.

Dr. Harold M. Ginzburg, special assistant to the acting director of the National Institute on Drug Abuse in Rockville, Maryland, presented the medical background of substance abuse. While, surprisingly, no explicit link was made between I.V. drug use and contraction of AIDS, both drug users and people with AIDS were characterized as undesirables in the workplace.

Kramer's presentation followed, covering legal barriers to management, such as federal and state anti-discrimination statutes and ordinances. Among the laws cited as particularly "thorny" were: Los Angeles ordinance No. 160289 (CCH State Labor Laws), which contains a prohibition against discrimination based on a person's suffering from the medical condition of AIDS, any medical signs or symptoms related to AIDS, or any perception that a person is suffering from the medical condition, whether that perception is real or imaginary; San Francisco's recently enacted ordinance declaring it unlawful for an employer "to fail or refuse to hire, or to discharge any individual; to discriminate against any individual with respect to compensation, terms, conditions, or privileges of employment including promotion..."; New York State Executive Law Section 296, under which AIDS is considered a handicap; California's Fair Employment and Housing Act, which prohibits discrimination on the basis of an individual's actual or perceived handicap; and sexual preference provisions in state and local discrimination laws and ordinances in Washington, D.C. and Wisconsin.

An intensive discussion ensued about the complexities of Sections 503 and 504 of the Federal Vocational Rehabilitation Act of 1973 as they relate to people with AIDS, members of risk groups, and persons perceived to be at risk of contracting the HTLV-III virus or full-blown AIDS. While people with AIDS and those perceived as having AIDS can be protected by the federal anti-discriminatory provisions for the handicapped, it was noted that court decisions are often based on whether the employer can "accommodate" the employee with AIDS "without undue hardship." Such "hardship" would include negative feelings from other employees who may work with a person with AIDS and the financial costs to the employer. For small, private employers, it was also noted, steep health insurance premiums to cover workers with AIDS may be viewed by the courts as unreasonable "accommodation" costs, thus warranting "dismissal" or failure to hire people with AIDS. Discussants also pointed out that Sections 503 and 504 are limited in jurisdiction to protect only job applicants to, and employees of, federal contractors and sub-contractors and employees paid directly by the U.S. government in federal funded programs.

Kramer continued his presentation, lamenting the difficulties employers face in defending themselves against charges of wrongful discharge when firing people with AIDS or HTLV-III positive test results. He said employers arguing that such workers were dismissed because they are contagious or at-risk to themselves cannot call upon medical data to back up their claims. He admitted, for example, that work-related stress tends to have no more of an adverse effect on people with AIDS than on employees with hypertension or many other medical conditions.

Kramer showed his ignorance of available medical data in a brief segment on personal service workers, specifically food handlers, when he opined, "It scares me a little bit. If they have not been tested, it scares me more." He jokingly added, "I mean, you're not going to want to have people with 'weeping wounds' handling your food." Even more alarming was Kramer's remark that, "The gay legal community — and believe it or not, there is a gay legal community — takes the position that the risk of airborne transmission is non-existent. The gays even have their own doctors looking after their interests. They want these people to be kept in the workplace."

Offering some final guidance to corporate lawyers who are working to limit employers' responsibilities toward people with AIDS, panelists suggested such "cost containment" measures as putting employees on leave with two-thirds pay and limited insurance coverage, and abolishing positions held by people with AIDS. Panelists did admit employers may be opening themselves up to lawsuits for invasion of privacy or intentional affliction of emotional distress for firing people with AIDS.

During a discussion of the use of the enzyme-linked immunosorbent assay (ELISA) and the Western Blot technique of detecting the presence of antibodies to the HTLV-III virus, panelists indicated their belief that these tests *can* be used to diagnose AIDS, and should be administered widely. Ginzburg asserted that approximately one third of the patients admitted to New York's Harlem Hospital are seropositive and that "all IV drug abusers, homosexuals, homosexuals' partners, Haitians, and those with blood problems" should be tested before health care is administered for any illness.

Former deputy director of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Barbara Mishkin, did express some concern about discrimination against people with AIDS, comparing mandatory HTLV-III antibody screening to sickle cell screening during the early 1970s. Mishkin did not make a link between the racism associated with sickle cell testing and the homophobia and racism associated with HTLV-III testing. She did, however, point out that discrimination against people who tested positive for sickle cell bears a marked similarity to discrimination against people testing positive for HTLV-III. She said that similar confusion over the implication of positive test results for sickle cell (indicating either the disease or the trait) resulted in violations of confidentiality, socio-economic discrimination, and increased cost of insurance coverage.

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NCGSTDS COMPUTERIZATION CONTINUES

Beginning with this issue of the Official Newsletter (volume 7:4), much of the typewritten copy will be accessible electronically, via the Computerized AIDS Information Network (CAIN). Individual articles will be downloaded to CAIN periodically, and all CAIN users will have access to the information for volumes 7:4 and 7:5. Negotiations to provide a changing "password" for the exclusive use of NCGSTDS members is planned. The printed copy of the Newsletter will consolidate all of the articles downloaded to CAIN, and will also include reproductions of Morbidity & Mortality Weekly Report, and other typeset articles. Plans are also underway to improve the indexing capabilities of articles, using principle key words. CAIN users will notice this improvement first, with the advent of index words attached to each article. Other changes in article format may be noticed, most notably less use of boldface & underlining (hidden/internal commands in the word-processing program that are unfriendly to electronic mailings). Your comments are always invited! Send electronic mail (EMail) or US mail to: NCGSTDS, POB 239, Milwaukee, WI 53201 (414/277-7671 leave message on machine).

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NCGSTDS ANNUAL MEETING REPORT

The annual meeting of the NCGSTDS was held at the Whitman-Walker Clinic in conjunction with the 7th National Lesbian & Gay Health Conference and 4th National AIDS Forum in Washington, DC, March 12, 1986. The following persons were in attendance: Zell Malcolm (Atlanta), Doug Johnson (Milwaukee), Terry Cunningham (San Diego), Larry Medley (Washington, DC), Nancy Diaz (Adelphi, MD), Paul Kawata (WDC), David Smith (Los Angeles), Russ Toth (LA), John Gigrich (WDC), Jim Ringer (WDC), Jim Graham (WDC), Bert Kissling (Hartford), Bob Jolin (Durham), and Ron Vachon (New York). After a brief welcome and history of the Coalition by NCGSTDS, chairperson Mark Behar, introductions were made and agendas were distributed. Behar gave a state of the Coalition, starting off with the extensive computerization of membership and newsletter, and future plans to interface the Newsletter's content with the Computerized AIDS Information Network

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NCGSTDS ANNUAL MEETING, Continued

(CAIN). Projected membership has been exceeded slightly, however since those projections were based on no-growth, it suggests that our membership is increasing. We must capitalize on this, especially during this Conference, and all of us must make special appeals to our friends, colleagues and acquaintances to support the NCGSTDS by joining & subscribing to the Newsletter. This was described as essential, since the time requirements for all activities of the Coalition--answering correspondence, taking care of membership renewals, etc., and all aspects of Newsletter production and distribution--approximates 2000 hours per year without significant compensation; additional financial reserves will help to pay for some of the activities. Other marketing approaches were briefly discussed, such as advertising in medical journals or gay publications. It was suggested that the Newsletter be marketed as an "AIDS tool," that could be reviewed by various professional journals & organizations. Next topic of discussion was the Guidelines & Recommendations Brochure. The brochure was described as "not flashy, just the best," in light of its position with the multitudes of community customized brochures now available; it's comprehensiveness makes it more suitable for health care providers than lay people in many circumstances. The production of the 5th edition was relegated to a lower priority and was therefore not ready for distribution as promised. It was suggested that its format be changed to a booklet, and additional sections on lesbian health, role of stress, etc., but it was pointed out that it would not be economically feasible to publish and distribute something with as limited a market appeal. Therefore, the 5th edition, which will hopefully be available by the summer, will contain updated information and sections, but be in the same, inexpensive format. The number of copies of brochure requested, and the income have been significantly reduced over the last year due to the widespread availability of more personalized & targated brochures published by local STD & AIDS service organizations. The next topic was the preliminary computer survey that was done in mid-1985. Of the 37 responses, 29 had computer systems, 8 planned to acquire systems by the end of the year. Specific hardware & software questions were asked, and copies of the results were given to CAIN. NCGSTDS hopes to work closely with CAIN for additional surveys that can facilitate electronic communications and networking. The financial statement is incomplete, since the Coalition's fiscal year is through June 30th. Total income/expenses/net for July 1, 1985 to present: $6579/$8201/($1622 loss); for 7/1/84 to 6/30/85, it was: $12,485/$12,068/$416.36. The single largest expenses are publication and mailing of Newsletters. Until November, 1985, a large number of complementary subscriptions (over 25% of all published) were distributed to agencies on our mailing list. Especially in light of the widespread community and governmental support for AIDS & STD services, this was discontinued and will result in considerable savings. Also, at the November meeting, a revised & more equitable dues structure was approved, which in part shifts some of the costs of mailing multiple copies of the Newsletter to those subscribers.

The issues of corporate & nonprofit status, and future direction of the Coalition was delegated to the Coalition's Board of Advisors, a group of Coalition members volunteering to take additional responsibilities in the management of the group. The following people have volunteered to be Board members: Ron Vachon, (NY), Hugh Rice (LA), Terry Cunningham (San Diego), Cindy Patton (Cambridge), Eric Bjorklund (Livingston, NJ), Dennis James (Boston). (At a later meeting, Ron agreed to write a draft position paper on future direction, to be initially reviewed by other Board members, then published in the Newsletter for general comment; Terry volunteered to draft articles of incorporation with the help of a local attorney, then distribute it to other board members. Again, a general appeal to the membership is being made for assistance in these areas, specifically if you would like to be listed as one of the primary incorporators. These two actions are very important since they begin to shift the burden of responsibility of the NCGSTDS to a Board, and away from a single person (the Chairperson).)

Paul Kawata from National AIDS Network addressed the group, requesting support and cooperation from NCGSTDS members. Among other things, NAN hopes to circulate a periodic newsletter focusing on issues of interest to AIDS service organizations. It was suggested that the two groups explore the possibilities of a cooperative effort for newsletter writing and information sharing. Paul indicated that because NAN was seeking funding from large agencies, he didn't think that the name of the NCGSTDS Newsletter, specifically with the term "gay," would be useful for getting such support; further, he felt that AIDS as an issue needs to be separated from the issue of gay politics & homophobia, while recognizing how intricately intertwined the issues are. [ED NOTE: I hope this paraphrasing is accurate; unfortunately there were no notes taken, and this is based on an imperfect 6 week old recall!] It was agreed to further explore those issues at a later time. Russ Toth and David Smith from CAIN then addressed the group, requesting our support. They suggested that the NCGSTDS be an information provider directly to CAIN, as a trial basis, to see how this added information can improve the quality of services offered by both groups. If all goes well, after a trial period, than a special password assessible bulletin board section can be made available to NCGSTDS members only. Jim Graham, chief executive officer of the Whitman-Walker Clinic then spoke for a short time on the malpractice insurance crisis that was affecting his clinic, and forecasted that the insurance crisis will spread throughout the nation. Whitman-Walker gained emergency city legislation for clinic malpractice insurance, and also entered into an agreement with the George Washington University Medical Center for the providing of certain services. He has elaborated his strategies in written handout, which is available by writing him (it was in preparation at the time of the meeting): Jim Graham,

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NCGSTDS ANNUAL MEETING, Continued

Whitman-Walker Clinic, 2335 18th Street, NW, Washington, DC 20009. It was reassuring nevertheless to learn that no one was aware of any successful litigation against a gay clinic.

During reports from members, several interesting features were revealed: there was almost a universal decrease in census with a corresponding decrease in STD morbidity, except for bowel infections; there was a shift in client demography, with less white gay men and more people of color; one of the possible reasons for the fewer patients and change of census may be that clients are going elsewhere for health care because of real or perceived "being called on the carpet for not practicing safer sex." Another uniform thread was the need for all STD services to beef up the services they provide, especially in the area of high quality AIDS assessment services. The same reasons for gay/lesbian STD health services being established in the early and mid-1970's--poor availability of quality health care by sensitive & knowledgeable providers, is presenting itself once again with the AIDS crisis.
There is a need in almost every community for preliminary first level AIDS assessment services to be available confidentially.
In closing, the site of the next two Coalition meetings were approved: in conjunction with the American Public Health Association's Annual Meeting in Las Vegas (Sept. 28-Oct. 2), and with the 8th National Lesbian & Gay Health Conference and 5th National AIDS Forum in Los Angeles, sometime in the spring or summer of 1987. An informal meeting may take place in conjunction with the International AIDS Conference in Washington, in 1987 also. Mark Behar was reelected chairperson/editor. Special thanks were given to Whitman-Walker Clinic for hosting our meeting and providing delicious homemade refreshments. The meeting was adjourned.
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SAFER SEX & J/O CLUBS FORMED

Increasing popularity in one of the world's oldest forms of getting off has promoted some Florida men to form a "Safer Sex and Jack-Off (J/O) Club. The club, known as "CKC," was formed over a year ago and already boasts hundreds of gay and bisexual male members. The excellent acceptance of the CKC and its approach to safer sex and J/O prompted Danny Gold, the Club's founder, to expand the club outside Florida. Major U.S. cities, such as New York, Philadelphia, Washington, DC, and Chicago now have established memberships. The response from the men in these areas has been phenomenal. As a result, expansion of the organization throughout the nation and Canada is increasing. CKC founders were cognizant of people's concerns about AIDS, herpes, and other STDs, but they decided to carry the idea of safer sex beyond the notion of a "circle jerk," as evidenced by the numerous variations of safer sex clubs around the country. Some are small groups of friends that periodically meet in each others' homes; some larger groups will take over a bar or guest house for a night of socializing and safer sex, sometimes with only visual and no personal contact, and some have evolved into strictly telephone J/O clubs. The CKC has taken ideas from all of these various groups and presents a package to all gay and bisexual men that can safely fulfill their sexual needs and fantasies. CKC is a membership club in which privacy is protected and assured. Upon acceptance of their application, a new member is provided with a complete and up-to-date membership directory of all members throughout the country. The directory provides descriptive information about each member, singles and couples, their preferred sexual activities and how and when to contact them. With this information, members can meet those in the club that they are most likely to be compatible with for active sex, new friendships and more. Through the club, members can contact other members for phone J/O, meeting 1-to-1, small parties or larger groups. Although the CKC is a safer sex club, it does not limit itself or its members to J/O only. The club recognizes and supports other sexual activities and pleasures as long as its members are health conscious in their activities. Our members are strongly encouraged to follow safer sex practices and the guidelines that we provide. The CKC sponsors and promotes groups social and sexual activities for its members. It has held dinners and safer sex parties in Ft. Lauderdale and Miami, and weekend trips to a Key West guest house for totally open activities. As the club expands to new cities and areas, a coordinator will establish and set up local social and group sexual events in each area. These activities will be published and sent to all the club's members so that local and traveling members can take advantage of the events. Most members are in the 20-40 age group, but anyone 18 or older is eligible to join, and some members are over 50. Discretion and privacy are two of the most important aspects of the CKC. Only members receive directories and updates. The directory is completely revised 3 times yearly, so that the membership list accuracy can be maintained. Privacy can be positively assured when a member chooses to use the CKC post office box for first contact with other members instead of providing his phone number or address for publication in the directory. Names and addresses of members are held in strictest of confidence, and mailing lists are never sold or otherwise compromised. In its continuing efforts to promote active and safer sex, the CKC has also been working with Florida's health spa type clubs to establish J/O and health conscious activities within the health club environment. For further information and application forms write: CKC, PO Box 330484, Coconut Grove, FL 33233. And please mention that you read about them in the NCGSTDS Newsletter.
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OLD REACTIONS TO A NEW EPIDEMIC: A PERSPECTIVE

by Anne C. Roark, with thanks to the Los Angeles Times, 3/2/86

An incurable disease. Highly contagious. Fatal to nearly all who contract it. Its victims shunned by society, even by some members of the medical community. Its cause: unknown, except to religious fundamentalists who proclaim it God's wrath against sin and perversion. The death toll: rising. A description of the AIDS epidemic? Certainly. But that description also fits virtually every major human epidemic going back as early as 4000 BC in Egypt with leprosy, continuing through the classical world with the Antonine plague, which was probably an outbreak of measles that at its height is said to have killed 5000 people a day in Rome. It moves into the Middle Ages in Europe with syphilis and bubonic plague, into the 18th and 19th centuries with cholera and tuberculosis, and finally into the 20th century with influenza, polio, and even Legionnaire's disease.

Indeed, nearly every such virulent outbreak of illness seems to carry with it not one, but two, epidemics: the physical manifestations of the disease itself and society's often predictable reactions to it--denial at first, followed by hysteria, a search for scapegoats, an onrush of commercial exploiters and, finally, though not always, improved public health standards and scientific insights that significantly prolong life expectations. "If you look at what's happening today with AIDS and you look back and see what was happening with bubonic plague, it seems to me we aren't so far ahead from previous eras, despite all of our medical technology, despite all of our sophistication," said George S. Rousseau, a University of California, Los Angeles English professor who is doing research on the connections between medicine and literature. "There really is a constant throughout history in the response to epidemics. More than anything, there is a need to mythologize disease"--to explain the seemingly unexplainable, he said. More often than not, the mythologies inspired by epidemics have made their way into the popular culture, often transforming the arts and literature, event he language we speak. Some epidemics also have dramatically changed the course of history. Scholars now believe, for instance, that the bubonic plague profoundly altered the face of Europe--collapsing its economy, rupturing its bonds of feudalism, fundamentally changing religion. Others argue that syphilis helped usher in the dramatic changes in lifestyles that characterized the Victorian Era and the Age of Puritanism. The AIDS epidemic may not have such profound effects. But "some kind of permanent changes in lifestyles will surely come about as the result of AIDS," said Brian Henderson, professor of preventive medicine at the University of Southern California and director of the university's Norris Cancer Center. "For now, we can only speculate what they will be." It remains to be seen whether a cure for the deadly syndrome or a vaccine to protect against it will be found. What is clear, however, is that only five years into the AIDS crisis, most of mankind's historical reactions to epidemics have already begun to resurface.

When AIDS was identified in the spring of 1981, it was thought not to be contagious. It did not even have a name until 1983. AIDS ravages a victim's immune system, rendering it helpless in the face of innumerable infections and cancers. Early on, it was dubbed the "Gay Epidemic." Then it was said to be a Haitian disease. Soon intravenous drug users were implicated. By February, 1986, there had been a total of 17,361 reported cases, and 9112 deaths. But many more--perhaps 2 million individuals--were thought to be carriers. Where the medical profession could offer neither hope nor protection, commercial exploiters moved quickly to fill the void. Gay sex shops sold gels and creams that promised to "protect" users. Newly created clinics offered to sell identity cards to those who "tested negative for AIDS." Newsletters promised employers the latest legal information about the epidemic. Overnight, the victims and their families had become society's new "untouchables." Even though evidence mounted by the week that quarantines would do nothing to stop the disease's spread, politicians in California, Texas, Ohio [and other states] pushed for legislation to isolate AIDS victims. Some victims were fired from their jobs. Others were denied housing. Children were barred from school. Even the dead were shunned, their bodies left unwashed in funeral homes. Man has never been particularly gracious in the face of disease. Fear of contagion--and ignorance about the source of an epidemic--have often led to quite bizarre behavior and sometimes barbaric practices. When the plague struck Europe in the mid-14th century, killing 25% to 50% of the continent's populations, it left terror in its path. Husbands fled wives. Mothers abandoned children. Bodies were dropped in the streets and no one could be found to bury them. The disease is an overwhelming infection of the blood that often turns hemorrhages black; hence its name, "the Black Death." It accompanied the Crusaders and was carried by fleas alongside the silks and spices that Western merchants brought from Asia. It recurred again and again for the next 300 years. It was "the greatest natural disaster in European history," according to Robert S. Gottfried, a professor of history at Rutgers University and author of "The Black Death: Natural and Human Disaster in Medieval Europe." In the face of this horrible pestilence, society was more concerned with discussing how deep graves should be dug than with providing care for victims--or even feeling compassion for them, Daniel Defoe said in "A Journal of the Plague Year." It was during the London plague, in fact, that the six-foot grave was established, a practice that has persisted ever since.

Throughout the ages, each epidemic has spawned strange rituals and bogus remedies to rid society of its scourge. In

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OLD REACTIONS, Continued

ancient Rome, magic was thought to be a preventive for almost everything. Bronze mirrors engraved with demons were hung in nearly every dwelling to drive off sickness. One popular cure for what was probably an early version of influenza was the cabbage bath. To prepare it, one collected the urine of people who had recently eaten cabbage. Richard Gallagher in "Diseases That Plague Modern Man," notes that the wife of the ancient Roman statesman Cato died in such a bath. Another disease that inspired bizarre remedies in the Middle Ages was syphilis. Seventeenth-century etchings show charlatans touting "sweat barrels" as a sure remedy. Inside the wooden cases, victims sat above live coals. Although only a few are live today to remember it, one of the worst pandemics--indeed, now believed to be the third most devastating worldwide epidemic of all time--was the influenza outbreak of 1918-19. The symptoms are familiar, but the death toll was not. By conservative estimates, it took 20 million lives; some believe it was closer to 50 million. Fifty percent of the dead were between 20 and 40, presumably the most vital and productive years of life. In the U.S. alone, half a million people died, and another 20 million fell sick. Little could be done to stop the flu or its pneumonic complications in 1918, although various forms of isolation were attempted. In San Francisco, for a time, all citizens were required to wear face masks. By historical standards, poliomyelitis, or infantile paralysis, was a relatively minor epidemic. Between 1915 and 1955, when Salk vaccine was introduced, fewer than half a million people, mostly children, were affected in the United States, and most of them exhibited no symptoms or experienced only minor illness. During the 40 years of the epidemic, fewer than 60,000 people died from polio--nearly the same number that now die each year because of tobacco, according to James Mason, director of the Centers for Disease Control in Atlanta. It is known that the polio virus enters the body through the mouth and is therefore transmitted almost entirely by contact with a person who is already infected. Yet, fearful that it might be caused by insects, towns across America in the 1940s sprayed substantial quantities of DDT, a toxic pesticide now outlawed because of its danger to humans as well as animals. Parents also did whatever they could to ensure that their children were not exposed to polio. Swimming pools were frequently off-limits in summer. In the summer of 1944, Milwaukee went so far as to quarantine children in their own back yards. Over the years, quarantine and isolation have certainly been the most common, if not always the most effective, way to fight epidemics.

"One of the myths about epidemics...is that there is somebody to blame--somebody is responsible," commented Rousseau, the UCLA professor. The Italians considered syphilis the French disease. The French called it the Italian disease. In the late 19th century, influenza was known as the Spanish disease; throughout the 20th century it has invariably been labeled the Hong Kong flu or the Asian flu. "In one sense, the sort of scapegoating that goes on is a way to cut down on anxiety...a way to believe that someone else is responsible--that someone else, not us, will get it," said Charles R. Rosenberg, a historian of medicine at the University of Pennsylvania. Certainly, organized religion has always stood ready to cast the blame for disease on the wicked, especially when the disease could not be otherwise explained. When cholera, marked by diarrhea and spasmodic vomiting, first reach epidemic proportions in the U.S. in the 19th century, no one suspected that it was caused by filth and unsanitary water and sewage systems. Yet someone had to be blamed. In a 19th century essay, for example, the editor of a church newspaper described the victims of cholera as "drunkards and filthy, wicked people" and the disease as "a scourge, a rod in the hand of God," according to Rosenberg in his 1962 book, "The Cholera Years."

The most obvious fallout from an epidemic is the change that occurs in science is the change that occurs in science and medicine. Some of the remedies for diseases came about quite accidentally. It was probably largely a matter of luck that a clever country doctor in England in the late 1800s noticed that dairymaids did not get smallpox. Edward Jenner's theory that the milkmaids had contracted mild cases of cowpox led him to develop an effective vaccine and lay the foundations of immunology as a science. However they were discovered, scientific insights have relegated a whole host of diseases to the history books. Antibiotics have helped doctors treat syphilis and plague. Vaccines have virtually eliminated measles and polio. Remedies for malaria and cholera also have been developed. Modern science, however, is not invincible, as the AIDS epidemic clearly illustrates. Like the flu, another disease that continues to baffle scientists, AIDS is caused by a complex virus that appears to be constantly alerting its own structure. Hence a vaccine or a drug is years away at best, researchers say. In the meantime, AIDS will continue to reverberate through society, as have epidemics through the millennium: a source of fear and consternation, a source of exploitation and discrimination, a source of grief, and for some, a source of inspiration.

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EXPERTS ASK QUESTIONS OF EXPERTS

with thanks to Mathilde Krim, PhD, and Caitlin Ryan, MSW

One of the more interesting aspects to Saturday's general session at the 7th National Lesbian & Gay Health Conference in Washington, DC, were the questions asked by the audience. The general session was keynoted by Dr. Edward N. Brandt, former Assistant Secretary of Health & Human Services, and was moderated by Mathilde Krim, PhD of the AIDS Medical

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EXPERTS ASK QUESTIONS, Continued

Foundation (AMFAR). Also participating on the panel were Drs. Michael Lange of New York's St. Lukes-Roosevelt Hospital Center and Dominique Dormont of the Pasteur Institute, and Harry Haverkos, PhD of the National Institute of Allergy & Infectious Diseases. Although the panel had exciting potential, they misread the background and failed to recognize the sophistication of the audience, and therefore provided an exceedingly unenlightening and elementary review of AIDS 101. The audience was asked to present written questions to the panel, and it is those questions which the NCGSTDS was able to obtain for publication in the Newsletter. What are the important issues and concerns of the AIDS service providers and gay/lesbian health workers? How can knowledge of these concerns help us to educate our colleagues? Following are those questions, roughly grouped by topic:

1) What numbers of people are in multiple risk group categories, i.e., gay hemophiliacs? 2) Since the formation of AMFAR, what types of research and what research centers have begun to receive grants? 3) What can we learn about possibilities for survival with AIDS from the children with the disease who are now 9-12 years old? 4) You [Brandt] indicated that the AIDS epidemic has brought gay and lesbian health issues into the public. What issues of lesbian health have emerged? 5) What is your thinking regarding other co-factor virus acting in tandem to activate the virus? Specifically, African Swine, Influenza, Epstein-Barr, CMV. 6) Could you comment on the state of research on co-factors in etiology both biological and non-biological (i.e., stress, environment)? Has research been over concentrated on HTLV-III/LAV studies? National lab and Gallo's role in that? 7) Could LAV/HTLV-III be an endogenous virus activated merely by immunosuppression? An effect rather than a cause. 8) Since opportunistic infections are characteristic of severe auto-immune and immune deficiency conditions, why is HTLV-III (a classic opportunistic visna virus) not also so considered? 9) Is there a relationship between ingestion of pork and the HTLV-III/LAV virus complex? 10) It has been theorized that the virus (LAV/HTLV-III) made the jump from monkey to mankind. What has lead scientists to believe this. 11)Could you list or explain the other viruses implicated as co-factors in development of AIDS. Also, does association always mean causality? 11) Please discuss the theories of some researchers that HTLV-III is NOT the causative agent for AIDS. No one will speak on this at this conference and I find it VERY frustrating. 12) It seems that the distinction between AIDS and ARC is a political definition rather than solely a medical one, since the issue of co-factors is unresolved. Failure to redefine the nature of the syndrome impacts on public perception of rate, seriousness, diffusion and outcomes of infection by HTLV-III, thus impacting on funding, education efforts, and efforts at disease management. What is being done to create a new definition of the meaning of HTLV-III infection? 13) Can you explain the unusual epidemiological discrepancy between African & American/European cases (heterosexuals with 50:50 male & female vs. a predominance of homosexually active cases in the US). Are ritual needle use, or ritual clitoroidectomy thought to contribute to this disparity in epidemiology? 14) Dr. Brandt said that in the USA, 200 cases per MONTH were being reported--did he not mean 200 cases per WEEK? 15) Given the influence of the conservative movement on our President, how can we best encourage Mr. Reagan to address more openly the increasing financial/social service needs of the epidemic? 16) Please speculate on the link between low level antibiotics in the food chain (especially animals), recurrent use of antibiotics in people (human animals) and mutation of organisms, including retroviruses. 17) Can you report on preliminary results of the longitudinal M.A.C. (Multicenter AIDS Collaborative) Study? Comment on reluctance of researchers to share scientific data in a timely manner. 18) A definition usually has different purposes. Health and social services in some states are given only to persons with AIDS--and not to ARC people, even though they may be in need. Please comment. 19) To what extent, if any, is competition between the Americans and the French (or among Americans in a race for the Nobel Prize) hampering our efforts to defeat AIDS? 20) Please react to the CDC's announcement on mass screening of high risk groups: implications, i.e., consequences, costs, confidentiality, will or can it (mass screening) really be undertaken? 21) Please comment on the recent CDC recommendation for mass testing in light of funding implications for research and service programs from which moneys were so recently cutback. 22) Do you feel that repeated testing of high risk people for HTLV-III antibodies will lead to desired behavioral change in the absence of adequate funds for counseling or will it only lead to further legitimization of the test as a means of social and physical isolation. 23) How accurate or inaccurate is the HTLV-III/LAV antibody test, in terms of false positives or negatives? 24) What is the correlation between antibody seropositivity for HTLV-III and positive antigenicity and/or actual viremia? 25) Is it not true that there are reported cases of persons who do not seroconvert to antibody positivity though demonstrate antigenemia? 26) What percentages of people who are HTLV-III/LAV positive will develop AIDS? Isn't it really completely unknown? I'm concerned with how "statistics" of this nature will be manipulated politically, especially by insurance companies. 27) If someone is already HTLV-III/LAV antibody positive, WHY should he avoid re-infection of the retrovirus? 28) If a CHILD is infected with HTLV-III virus, and receives routine childhood immunizations, what effect would result? Please discuss incubation period vs. time elapse for development of antibodies. 29) Since T-cell activation seems to be required for viral expression, is it safe for antibody positive people to be vaccinated. 30) Can an individual be HTLV negative, yet have AIDS virus cultured from their blood (as one could demonstrate with hepatitis B)? 31) In patients with HTLV-III infection and who are hepatitis B antibody negative, do you recommend the hepatitis B vaccine? Since this vaccine stimulates the immune system is there increased risk of "activating" replication of HTLV-III virus? 32) Could you address the question of which comes first: a) Infection with

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EXPERTS ASK QUESTIONS, Continued

HTLV-III/LAV causing immune suppression, or b) immune suppression due to some other factor allowing infection by HTLV-III/LAV, and the clinical implications of the progression. 33) What is the correlation between a positive test for antibody and actually harboring the virus? i.e., How often do people have antibody but not harbor the virus? 34) If, as you say [Dr. Lange], there may be something in the lifestyle or genetics of the individual who is antibody-positive that inhibits the development of AIDS, wouldn't this indicate a value to mass testing to establish a broad research pool? 35) Please discuss the likelihood that a person infected with HTLV-III/LAV could possibly be infected with a number of different strains--the implication this has on the development of the vaccine? 36) It has been said that a person may be most highly infectious while they are still well and that possibly that when a person develops full blown AIDS that they may no longer be infectious--comments please. 37) Has there been any findings linking early onset (age 40) if neurological diseases (i.e., Parkinson's) to AIDS? 38) Is there any evidence of an increase in lymphomas in member of the high risk groups, and is there an increase in lymphomas in antibody-negative members of high risk groups? 39) Is there research in using "passive immunity" to treat PWAs, i.e., immune factors (like gamma globulin) from people who are positive for HTLV-III antibody but are disease-free? 40) Regarding treatment of virus in PWAs, what are views on the Jaffe and Cathcart claims about massive vitamin C protocols? 41) Why is it so difficult for PWAs to get information on new experimental drugs? 42) I have heard about a new hospital in Houston to be devoted exclusively to treating AIDS patients, reminiscent of the Tuberculosis hospitals of old. What do you think of such isolation and what are its potential ramifications? 43) What is your (Dormont) treatment plan for immune reconstitution? 44) What are those in France using in the area of immunomodulation? Also, what are the results of such agents (such as cyclosporine)? 45) Do you believe genetic engineering or the new genetic splicing technique using an enzyme will be helpful in combating AIDS? And how? Is Pasteur Institute involved in this or just with drug therapeutics? 46) What are the current pharmacological treatment possibilities for HTLV-III/LAV and what is your evaluation of their efficacy and safety? 47) Do bone marrow transplants have a role in the treatment of AIDS. 48) In a panel on treatment issues why are there no holistic practitioners? When will funding be earmarked for research in this area?

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TETRACYCLINE MAY CAUSE INFLAMMATION OF PENIS

with thanks to Medical Aspects of Human Sexuality, 3/86, and Jour. of Urology, 133:1044, 1985

If a patient has an inflamed glans penis, check if he's taking tetracycline. Balanitis is a frequent form of fixed drug eruption for the antibiotic, possibly starting within an hour after taking the drug. Severe pain, swelling, and hemorrhagic ulcerations may persist for several days after drug stoppage. In some cases doxycycline may safely be substituted for the tetracycline.

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HETEROSEXUAL CONTACT NOT PREDOMINANT MODE OF HTLV-III TRANSMISSION AMONG IV DRUG ABUSERS

by Umberto Tirelli, MD, et al. (in press in JAMA)

To the Editor: The very high prevalence of antibodies to HTLV-III reported in the article by Dr. Clumeck, et al. (JAMA, 1985, 254:2599-2602) among groups of heterosexual Africans, confirms that heterosexual contact plays a major role in AIDS propagation, at least in Central Africa. To evaluate the role of heterosexual contact as opposed to the sharing of contaminated needles for HTLV-III transmission among IV drug abusers, between May, 1985 and October, 1985 we fully evaluated 30 couples of whom both were IV drug abusers and 21 couples of whom only one was IV drug abuser (19 male, 2 female) while each had a heterosexual partner not belonging to known groups at risk for AIDS, and having stable, long term (> 1 year; median duration 2.5 years) heterosexual relationships. All IV drug abusers admitted frequent sharing of syringes. Sexual behavior, evaluated through a questionnaire, was similar in both groups. In particular, the frequency of sexual contacts was low (<1 sexual contact/week). The control group consisted of 20 age matched couples evaluated in a concomitant study on sexual behavior prior to and after the diagnosis of malignancy in one of the partners (greater than or equal to 2 sexual contacts/week). Of 30 couples composed of both IV drug abusers, 7 couples were concomitantly seropositive and 18 were concomitantly seronegative. The remaining 5 couples had a discordant serology. On the other hand, of the 21 couples composed of an IV drug abuser and a non-IV drug abuser, antibodies to HTLV-III were detected in only 1 heterosexual partner of the 12 seropositive IV drug abusers and in none of the heterosexual partners of the remaining 9 seronegative IV drug abusers. Therefore, among the overall 24 couples of whom one or both partners were seropositive, concordance in HTLV-III seropositivity was present in 7/12 (58%) couples of IV drug abusers and in only 1/12 (8%) couples composed of a IV drug abuser and a non-IV drug abuser. Taking into consideration the general practice of sharing syringes among our IV drug abuser population, we can conclude that the sharing of contaminated needles plays a major role in the transmission of HTLV-III infection among IV drug abusers. The low prevalence of HTLV-III antibody among non-drug injecting heterosexual partners of seropositive IV drug abusers suggest that, at this time, sexual transmission of HTLV-III in this population occurs infrequently (8%), maybe due to the low frequency of sexual contacts. This figure may increase significantly in the future.

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WRONG AIDS PHOTOGRAPH EMBARRASSES AMERICAN SCIENTISTS

with thanks to the Computerized AIDS Information Network (CAIN), 4/12/86

U.S. scientists say they mistakenly published the wrong photographs of the virus believed to cause AIDS in an 1984 article, an error that could complicate their legal fight with French researchers over who first linked the virus to the disease. Dr. Robert C. Gallo of the National Cancer Institute acknowledged in an April 18 letter to Science, that they inadvertently published pictures of a virus found by French researchers in one of a series of key articles supporting American claims that they were the first to find the cause of AIDS. The letter said a contractor hired to take detailed electron microscopic photos of viruses suspected of causing AIDS mistakenly included pictures of a similar French virus in a composite photograph. Although the Americans say the recently discovered mistake is of little scientific consequence, the disclosure could be an embarrassment and legal complication. Last December, researchers from the Pasteur Institute in Paris filed a lawsuit against the U.S. government challenging the patent on an AIDS antibody test developed by the Gallo group. The suit seeks to have royalties from the patent turned over to the French, and contends that the American researchers used materials and information supplied by Pasteur in developing the test, a violation of an agreement that the materials were only to be used for research. U.S. researchers deny that samples of the French virus were used in the American work, contending they had many samples of their own.

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CIRID MEDICAL UPDATES

[Prepared as a public service to the medical community by the Division of Clinical of Clinical Immunology/Allergy, Dept. 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.]

HTLV-III Antibody Commercial Immunoglobulin. (D.J. Gocke, et al., Lancet, I:37, 1986) The authors analyzed 17 different lots of commercially available gammaglobulin from different manufacturers for the presence of HTLV-III antibodies. These were gammaglobulin prepared for intramuscular and intravenous gammaglobulin use, hepatitis immune globulin and anti-Rh immunoglobulin. All but the commercially available materials were positive by ELISA for anti-HTLV-III antibodies. On Western Blot analysis, 10 of the 12 commercial lots were also positive in showing binding to both the 24 and 41,000 kilodalton proteins typical of HTLV-III.

HTLV-III Antibodies in Human Immune Gammaglobulin. (D.R. Steel, JAMA, 255:609, 1986. The author reports testing two lots of commercially available immune globulin for HTLV-III antibodies and finding both to be positive by ELISA and Western Blot analysis. He also states that inquiries at the CDC, FDA, etc. have revealed to him that the current supply of commercially available gammaglobulin in the U.S. is known to be positive for HTLV-III antibody. The author then states his concern that the administration of gammaglobulin to patients may give them a false positive HTLV-III antibody test and that patients need to be forewarned about this possibility. *****CIRID ED NOTE: Both these articles emphasize the point that commercially available forms of gammaglobulin, whether it be for intravenous or intramuscular use of specific antibody preparations for hepatitis, anti-Rh or cytomegalovirus carry antibodies to HTLV-III. This occurs because these antibody preparations are made from huge pools of blood donors. Clearly a number of these donors had previously been infected with HTLV-III and had the presence of antibody in their serum. On the other hand, it has also become clear that gammaglobulin does not appear to carry any known risk of transmitting the HTLV-III. This turns out to be more fortuitous than by design in that gammaglobulin preparations are made through cold ethanol fractionation and it is now known that even 20% ethanol appears to have profound antiviral activity against HTLV-III. Thus there has been no association of administration of gammaglobulin and the occurrence of AIDS. This is particularly convincing in patients with immunodeficiency diseases such as common variable immunodeficiency who, having received relatively massive amounts of gammaglobulin on a monthly basis with no evidence of AIDS. Secondly, attempts to culture HTLV-III virus from gammaglobulin that is positive for HTLV-III antibody have been repeatedly negative. On the other hand, this material certainly contains antibody against HTLV-III. Patients receiving large quantities of intravenous gammaglobulin on a frequent basis such as patients with hypogammaglobulinemia receiving monthly IV, Ig surely have positive tests for HTLV-III. However, in that setting one should be aware of the fact that those are "false positive" antibody tests as many other antibody tests would be in such patients who are receiving passive antibody from an exogenous source. A false positive HTLV-III antibody test is highly unlikely to occur in a setting where small amounts of gammaglobulin are given such as prophylaxis for hepatitis B, as the level of the antibodies against HTLV-III would have to be astronomically high because of simple dilution factors. Unfortunately, these letters and other similar ones have engendered a greater deal of concern among individuals who have received gammaglobulin because the media has not made it clear that an individual gets antibody to HTLV-III from gammaglobulin and not AIDS itself. There have been many calls to physicians by patients concerned that they may catch AIDS from gammaglobulin because of recent media coverage which has been less than complete or accurate.

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NEW NAME FOR AIDS VIRUS?

with thanks to Science News, 4/26/86

And the winner may be...human immunodeficiency virus-I (HIV-I). Like everything else about the virus or viruses believed to cause AIDS, naming it has been thorny. The culprit is known variously as LAV-I (lymphadenopathy-associated virus), HTLV-III (human T-lymphotropic virus), and ARV (AIDS associated retrovirus). At a National Institutes of Health lecture in Bethesda, LAV discoverer Luc Montagnier of the Institut Pasteur in Paris said the international committee assigned to come up with the name had settled on HIV-I. Harold Varmus of the University of California at San Francisco, who chairs the committee, would not confirm or deny the comment, saying only that the committee has been deliberating and hopes to publish its consensus soon.

NEW THEORY ON AIDS PROPOSED

with thanks to Computerized AIDS Information Network (CAIN), 3/26/86

New research suggests that the AIDS virus may kill key immune system cells by making them commit suicide, an idea that could lead to ways to stave off the disease, said Nancy Ruddle, associated professor of epidemiology and public health at Yale University School of Medicine. The AIDS virus may escalate the production of the protein lymphotoxin, which then kills the cells. "We are now convinced that lymphotoxin can kill the cells that produce it," Ruddle said at a science writers seminar sponsored by the American Cancer Society. But the theory that virus-induced lymphotoxin leads to the crippling of the immune system in AIDS is not yet proven. T-cells normally produce some lymphotoxin to help kill germs, but the AIDS virus may make T4 cells produce abnormally high levels of the protein with no target cell around to absorb it, thereby causing death of its maker or a nearby T4 cell. If a person's response to infection with the AIDS virus is influenced by the degree that there cells produce some harmful substance, it may explain why some infected people stay relatively well while other get sicker, said Rank Rauscher, Jr., cancer society senior vice president for research. Ruddle said that if the theory is true, it might mean therapy to interfere with lymphotoxin production or activity could control AIDS in people who are infected with the AIDS virus, but whose immune systems are still strong. Although it would not be a cure since it would not get rid of the virus itself, it could hold the disease at bay while antiviral and immunomodulators do their jobs. Scientists are still looking for drugs to eliminate the AIDS virus.

HEMOPHILIACS STILL AT RISK?

by Julie Ann Miller, with thanks to Science News, 4/12/86

With the advent last year of heat treatment of vital blood factors, AIDS from such products was supposed to cease being a risk to hemophiliacs. But a report in the March 15 Lancet describes a hemophiliac whose blood showed he had been exposed to the AIDS virus after he received heat-treated factor VIII. The connection, says coauthor Gilbert C. White II of the University of South Carolina (UNC) in Chapel Hill, warrants further investigation but doesn't yet mean factor VIII is hazardous. And Peter Levine of Memorial Hospital in Worchester, Massachusetts, a medical co-director of the National Hemophilia Foundation, says the possibility that the hemophiliac was exposed to AIDS through intravenous drug use cannot be ruled out. The man, who received heat-treated factor VIII following an operation, was a mild hemophiliac who had not received blood products since 1975. Upon questioning, he admitted to having used IV drugs prior to 1978, but said he no longer used them and was in no other AIDS risk group. His blood showed no evidence of AIDS antibodies before the operation, but a blood sample taken five weeks after the operation came up positive. White and his UNC and Duke University co-workers examined several possibilities for the finding: the heat-treated factor VIII could have included live virus; inactivated virus could have caused an immune response; the factor VIII preparation could have already contained AIDS antibodies; or the patient could have used IV drugs recently. "We think it may well have been live virus," says White, "but we're not sure." While donor-blood screening--which was not available when the man received the factor VIII--combined with heat treatment is likely to handle the problem, the safety of such blood products still needs to be studied, says White. According to Levine, an international study of hemophiliacs who have received only heat-treated blood products has found no antibody-positive patients among several hundred hemophiliacs checked so far.

PREMENSTRUAL SYNDROME ALMOST DEFINED AS "PSYCHIATRIC"

by Kim Westheimer, with thanks to Boston's Gay Community News, 3/29/86

The American Psychiatric Association attempted to define premenstrual tension as a psychiatric disorder at is annual meeting in Washington, last September. According to Off Our Backs, the APA proposed that Premenstrual Dysphoric Disorder is diagnosable if a woman experiences four of the following in the week before her period: noticeable change in amount of sexual activity; persistent irritability or anger, insomnia, extreme tension, depression, marked fatigue, change in appetite, and difficulty concentrating. The Women's Committee of the APA succeeded in temporarily blocking the proposal.

CENTERS FOR DISEASE CONTROL

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Current Trends

Additional Recommendations to Reduce Sexual and Drug Abuse-Related Transmission of Human T-Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus

BACKGROUND

Human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV), the virus that causes acquired immunodeficiency syndrome (AIDS), is transmitted through sexual contact, parenteral exposure to infected blood or blood components, and perinatally from mother to fetus or neonate. In the United States, over 73% of adult AIDS patients are homosexual or bisexual men; 11% of these males also had a history of intravenous (IV) drug abuse. Seventeen percent of all adult AIDS patients were heterosexual men or women who abused IV drugs (*1,2*). The prevalence of HTLV-III/LAV antibody is high in certain risk groups in the United States (*3,4*).

Since a large proportion of seropositive asymptomatic persons have been shown to be viremic (*5*), all seropositive individuals, whether symptomatic or not, must be presumed capable of transmitting this infection. A repeatedly reactive serologic test for HTLV-III/LAV has important medical, as well as public health, implications for the individual and his/her health-care provider. The purpose of these recommendations is to suggest ways to facilitate identification of seropositive asymptomatic persons, both for medical evaluation and for counseling to prevent transmission.

Previous U.S. Public Health Service recommendations pertaining to sexual, IV drug abuse, and perinatal transmission of HTLV-III/LAV have been published (*6-8*). Reduction of sexual and IV transmission of HTLV-III/LAV should be enhanced by using available serologic tests to give asymptomatic, infected individuals in high-risk groups the opportunity to know their status so they can take appropriate steps to prevent the further transmission of this virus.

Since the objective of these additional recommendations is to help interrupt transmission by encouraging testing and counseling among persons in high-risk groups, careful attention must be paid to maintaining confidentiality and to protecting records from any unauthorized disclosure. The ability of health departments to assure confidentiality—and the public confidence in that ability—are crucial to efforts to increase the number of persons requesting such testing and counseling. Without appropriate confidentiality protection, anonymous testing should be considered. Persons tested anonymously would still be offered medical evaluation and counseling.

PERSONS AT INCREASED RISK OF HTLV-III/LAV INFECTION

Persons at increased risk of HTLV-III/LAV infection include: (1) homosexual and bisexual men; (2) present or past IV drug abusers; (3) persons with clinical or laboratory evidence of infection, such as those with signs or symptoms compatible with AIDS or AIDS-related complex (ARC); (4) persons born in countries where heterosexual transmission is thought to play a major role*; (5) male or female prostitutes and their sex partners; (6) sex partners of infected persons or persons at increased risk; (7) all persons with hemophilia who have received clotting-factor products; and (8) newborn infants of high-risk or infected mothers.

RECOMMENDATIONS

1. Community health education programs should be aimed at members of high-risk groups to: (a) increase knowledge of AIDS; (b) facilitate behavioral changes to reduce risks of HTLV-III/LAV infection; and (c) encourage voluntary testing and counseling.
2. Counseling and voluntary serologic testing for HTLV-III/LAV should be routinely offered to all persons at increased risk when they present to health-care settings. Such facilities include, but are not limited to, sexually transmitted disease clinics, clinics for treating parenteral drug abusers, and clinics for examining prostitutes.
   a. Persons with a repeatedly reactive test result (see section on Test Interpretation) should receive a thorough medical evaluation, which may include history, physical examination, and appropriate laboratory studies.
   b. High-risk persons with a negative test result should be counseled to reduce their risk of becoming infected by:
      (1) Reducing the number of sex partners. A stable, mutually monogamous relationship with an uninfected person eliminates any new risk of sexually transmitted HTLV-III/LAV infection.
      (2) Protecting themselves during sexual activity with any possibly infected person by taking appropriate precautions to prevent contact with the person's blood, semen, urine, feces, saliva, cervical secretions, or vaginal secretions. Although the efficacy of condoms in preventing infections with HTLV-III/LAV is still under study, consistent use of condoms should reduce transmission of HTLV-III/LAV by preventing exposure to semen and infected lymphocytes (*9,10*).
      (3) For IV drug abusers, enrolling or continuing in programs to eliminate abuse of IV substances. Needles, other apparatus, and drugs must never be shared.
   c. Infected persons should be counseled to prevent the further transmission of HTLV-III/LAV by:
      (1) Informing prospective sex partners of his/her infection with HTLV-III/LAV, so they can take appropriate precautions. Clearly, abstention from sexual activity with another person is one option that would eliminate any risk of sexually transmitted HTLV-III/LAV infection.
      (2) Protecting a partner during any sexual activity by taking appropriate precautions to prevent that individual from coming into contact with the infected person's blood, semen, urine, feces, saliva, cervical secretions, or vaginal secretions. Although the efficacy of using condoms to prevent infections with HTLV-III/LAV is still under study, consistent use of condoms should reduce transmission of HTLV-III/LAV by preventing exposure to semen and infected lymphocytes (*9,10*).
      (3) Informing previous sex partners and any persons with whom needles were shared of their potential exposure to HTLV-III/LAV and encouraging them to seek counseling/testing.
      (4) For IV drug abusers, enrolling or continuing in programs to eliminate abuse of IV substances. Needles, other apparatus, and drugs must never be shared.
      (5) Not sharing toothbrushes, razors, or other items that could become contaminated with blood.
      (6) Refraining from donating blood, plasma, body organs, other tissue, or semen.

*e.g., Haiti, Central African countries.

(7) Avoiding pregnancy until more is known about the risks of transmitting HTLV-III/LAV from mother to fetus or newborn (*8*).
(8) Cleaning and disinfecting surfaces on which blood or other body fluids have spilled, in accordance with previous recommendations (*2*).
(9) Informing physicians, dentists, and other appropriate health professionals of his/her antibody status when seeking medical care so that the patient can be appropriately evaluated.

3. Infected patients should be encouraged to refer sex partners or persons with whom they have shared needles to their health-care provider for evaluation and/or testing. If patients prefer, trained health department professionals should be made available to assist in notifying their partners and counseling them regarding evaluation and/or testing.
4. Persons with a negative test result should be counseled regarding their need for continued evaluation to monitor their infection status if they continue high-risk behavior (*8*).
5. State and local health officials should evaluate the implications of requiring the reporting of repeatedly reactive HTLV-III/LAV antibody test results to the state health department.
6. State or local action is appropriate on public health grounds to regulate or close establishments where there is evidence that they facilitate high-risk behaviors, such as anonymous sexual contacts and/or intercourse with multiple partners or IV drug abuse (e.g., bathhouses, houses of prostitution, "shooting galleries").

TEST INTERPRETATION

Commercially available tests to detect antibody to HTLV-III/LAV are enzyme-linked immunosorbant assays (ELISAs) using antigens derived from 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 HTLV-III/LAV antibody. However, since falsely positive tests occur, and the implications of a positive test are serious, additional more specific tests (e.g., Western blot, immunofluorescent assay, etc.) are recommended following repeatedly reactive ELISA results, especially in low-prevalence populations. If additional more specific test results are not readily available, persons in high-risk groups with strong repeatedly reactive ELISA results can be counseled before any additional test results are received regarding their probable infection status, their need for medical follow-up, and ways to reduce further transmission of HTLV-III/LAV.

OTHER CONSIDERATIONS

State or local policies governing informing and counseling sex partners and those who share needles with persons who are HTLV-III/LAV-antibody positive will vary, depending on state and local statutes that authorize such actions. Accomplishing the objective of interrupting transmission by encouraging testing and counseling among persons in high-risk groups will depend heavily on health officials paying careful attention to maintaining confidentiality and protecting records from unauthorized disclosure.

The public health effectiveness of various approaches to counseling, sex-partner referral, and laboratory testing will require careful monitoring. The feasibility and efficacy of each of these measures should be evaluated by state and local health departments to best utilize available resources.

Developed by Center for Prevention Svcs and Center for Infectious Diseases, CDC, in consultation with persons from numerous other organizations and groups.

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MORBIDITY AND MORTALITY WEEKLY REPORT

Epidemiologic Notes and Reports

Acquired Immunodeficiency Syndrome in Correctional Facilities: A Report of the National Institute of Justice and the American Correctional Association

Recently, the National Institute of Justice (NIJ) of the U.S. Department of Justice, and the American Correctional Association (ACA) jointly sponsored the development of a report on the incidence of acquired immunodeficiency syndrome (AIDS) in correctional facilities, the issues and options facing correctional administrators in formulating policy responses to the problem, and the rationales advanced for various policy choices (*1*). The report was based, in part, on a questionnaire mailed to all 50 state correctional departments, the Federal Bureau of Prisons, and 37 large city and county jail systems. Following are key findings of the report.

1. Responses were received from mid-November 1985 through early January 1986 from all 50 of the state correctional departments, the Federal Bureau of Prisons, and 33 of the 37 large city and county jail systems that had been asked to participate. A cumulative total of 766 AIDS cases meeting the CDC surveillance definition were recognized among inmates in these responding correctional systems; 24 state prison systems and the Federal Bureau of Prisons reported 455 cases, and 20 large city and county jail systems reported 311 cases.* Of the 766 AIDS patients, 322 (42%) died while in the custody of the correctional systems; 265 (35%) were released from custody; and 179 (23%) remained in custody. The remaining 26 (52%) state systems and 13 (39%) local systems responding to the questionnaire had no reported cases. Among state and federal systems, 80% of the systems accounted for only 5% of the total AIDS cases, while 4% of the systems contributed 72% of the cases. Among responding city and county systems, 69% accounted for only 5% of the total AIDS cases, while 6% accounted for 77% of the cases (Table 4).

*Because inmates may move from local to state facilities, it is possible that a small number of inmate cases have been reported more than once.

2. Respondents reported eight AIDS cases among current or former correctional staff. Seven of the eight had known risk factors for AIDS; investigation of the eighth case is not complete. None of these staff members reported involvement in an incident with an inmate in which transmission of human T-lymphotropic virus type III/lymphadenopathy associated virus (HTLV-III/LAV), the AIDS virus, might have occurred.
3. The geographic distribution of total AIDS cases among inmates is highly skewed. Over 70% of total AIDS cases in state prison systems and city and county jail systems has occurred in the mid-Atlantic region, with all of the other regions of the United States contributing much smaller percentages (Table 5).
4. In jurisdictions with large numbers of AIDS cases among inmates, the majority appears to have occurred among persons with histories of intravenous (IV) drug abuse. For example, 95% of cases in the New York state correctional system had such a history (2).
5. Responding correctional systems agreed on the importance of providing education on AIDS to staff and inmates. Ninety-three percent currently provide or are developing AIDS training or educational materials for staff; 83% currently provide or are developing such programs or materials for inmates. Responding jurisdictions in which educational programs had been in effect long enough to offer assessments of their impact reported that such programs have been effective in reducing the fears of staff (85% of jurisdictions) and inmates (79%). Timely and effective education efforts have prevented threatened job actions by correctional staff unions and generally forestalled hysteria over AIDS within the institutions of several correctional systems.
6. Six state prison systems and seven of the responding city or county jail systems are now screening or are planning to screen all inmates, all new inmates, or all inmates belonging to at least one high-risk group for antibody to HTLV-III/LAV (Table 6). Most of the other responding jurisdictions use the test on a more limited basis. This includes testing in support of diagnoses of AIDS or AIDS-related complex (ARC); testing in response to incidents in which HTLV-III/LAV might have been transmitted; testing on inmate request; and testing for epidemiologic studies of the prevalence of seropositivity and/or seroconversion within correctional facilities (Table 6).
7. The majority of responding jurisdictions (67% of state/federal systems and 70% of the city/county systems) either has in place or has in the developmental stage policies and procedures for the correctional management of inmates with AIDS, ARC, and asymptomatic HTLV-III/LAV infection. While housing policies for these inmate categories vary considerably across jurisdictions (Table 7), the four systems with almost 75% of the AIDS cases (New York state, New York City, New Jersey, and Florida) follow the same combination of policies: (1) medical segregation of all inmates with confirmed AIDS, but no segregation of inmates with ARC or asymptomatic HTLV-III/LAV infection; (2) clinical evaluation and ongoing monitoring (without testing for HTLV-III/LAV antibody) of inmates in risk groups; and (3) intensive and continuous education programs on AIDS for both staff and inmates. None of these four systems screen inmates for antibody to HTLV-III/LAV.

TABLE 4. Distribution of acquired immunodeficiency syndrome (AIDS) cases among inmates, by type of correctional system — United States

AIDS cases (range)	State/federal systems				City/county systems			
	Systems	(%)	Cases	(%)	Systems	(%)	Cases	(%)
0	26	(51)	0	(0)	13	(39)	0	(0)
1-3	15	(29)	24	(5)	10	(30)	16	(5)
4-10	5	(10)	30	(7)	7	(21)	43	(14)
11-25	2	(4)	42	(9)	1	(3)	12	(4)
26-50	1	(2)	33	(7)	1	(3)	40	(13)
51-100	1	(2)	95	(21)	0	(0)	0	(0)
> 100	1	(2)	231	(51)	1	(3)	200	(64)
Total	**51**	**(100)**	**455**	**(100)**	**33**	**(100)**	**311**	**(100)**

TABLE 5. Regional distribution of acquired immunodeficiency syndrome (AIDS) cases in correctional facilities, by type of system* — United States

Region	State systems		City/county systems	
	Cases	(%)	Cases	(%)
New England†	16	(3.7)	0	(0.0)
Mid-Atlantic§	327	(75.5)	222	(71.4)
East North Central¶	6	(1.4)	8	(2.6)
West North Central**	0	(0.0)	1	(0.3)
South Atlantic††	49	(11.3)	24	(7.7)
East South Central§§	1	(0.2)	0	(0.0)
West South Central¶¶	12	(2.8)	3	(1.0)
Mountain***	2	(0.5)	1	(0.3)
Pacific†††	20	(4.6)	52	(16.7)
Total	**433**	**(100.0)**	**311**	**(100.0)**

*Federal Bureau of Prisons excluded.
†Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut.
§New York, New Jersey, Pennsylvania.
¶Ohio, Indiana, Illinois, Michigan, Wisconsin.
**Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, Kansas.
††Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida.
§§Kentucky, Tennessee, Alabama, Mississippi.
¶¶Arkansas, Louisiana, Oklahoma, Texas.
***Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada.
†††Washington, Oregon, California, Alaska, Hawaii.

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Editorial Note: The NIJ/ACA report illustrates both the scope of the AIDS problem in correctional facilities and the diversity of the responses such facilities are taking.

TABLE 6. Policies of correctional systems for testing inmates for human T-lymphotropic virus type III/lymphadenopathy-associated virus antibody* — United States

Policy	State/federal systems		City/county systems	
	Systems	(%)	Systems	(%)
Screening†				
All or all new inmates	4	(8)	0	(0)
Members of at least one risk group	2	(4)	7	(21)
Testing *only* for diagnoses, incident response, or epidemiological studies	39	(76)	20	(61)
Testing only on inmate request	1	(2)	1	(3)
No testing	5	(10)	5	(15)
Total	**51**	**(100)**	**33**	**(100)**

*Includes actual and planned policies.
†The two screening policies are hierarchical; systems with both policies are placed in the policy category listed first.

The apparent lack of reported AIDS cases among correctional staff as a result of contact with inmates is consistent with previous findings that the risk of HTLV-III/LAV transmission in occupational settings is extremely low and does not appear to result from casual contact. Correctional staff should follow published guidelines for preventing transmission of HTLV-III/LAV infection in the workplace (*3*).

Since IV drug abuse is an important predisposing factor to both incarceration and HTLV-III/LAV infection, it is not surprising to find AIDS cases in inmate populations. It is also not surprising that a high proportion of cases among inmates has been reported from correctional facilities in New York and New Jersey, since those two states have reported 62% of all U.S. AIDS cases associated with histories of IV drug abuse. In addition, the proportion of IV drug abusers with HTLV-III/LAV antibody is reported to be higher in New York City and northern New Jersey than in other parts of the country (*4*).

Incarceration is not, in itself, associated with a risk of HTLV-III/LAV transmission. The risk of transmission in inmate populations depends on the prevalence of infection among persons who have been incarcerated and the frequency with which such persons might participate in IV drug abuse, with sharing of needles, or in sexual contact with other inmates. However, data to quantify this risk have been quite limited.

Thus far, the only study of HTLV-III/LAV transmission among inmates was conducted by the Maryland Division of Corrections (*5*). In that study, conducted from April through July 1985, serologic testing for HTLV-III/LAV antibody was offered at one facility to all 360 inmates who had been incarcerated 7 years or longer. Of the 137 inmates who participated, two (1%), both of whom had been incarcerated for 9 years, were seropositive by both enzyme immunoassay and Western blot methods. Because testing was done in a way to preserve anonymity, additional information about the seropositive inmates was not available. The possible effects of selection bias in this study are also unknown.

TABLE 7. Housing policies of correctional systems for inmates with acquired immunodeficiency syndrome (AIDS), AIDS-related complex (ARC), or asymptomatic inmates with antibody to human T-lymphotropic virus type III/lymphadenopathy-associated virus* — United States

Policy	State/federal systems Systems	(%)	City/county systems Systems	(%)
Segregate AIDS cases; maintain ARC cases and asymptomatic seropositives in general prison population†	3	(6)	3	(9)
Segregate AIDS and ARC cases; maintain asymptomatic seropositives in general prison population	10	(20)	3	(9)
Segregate all infected inmates	8	(16)	13	(39)
No segregation of infected inmates	2	(4)	0	(0)
No policy	8	(16)	1	(3)
Combinations (involving case-by-case determination)	16	(31)	10	(30)
Other policy combinations	4	(8)	3	(9)
Total	**51**	**(100)**	**33**	**(100)**

*Includes actual and planned policies.

†For the purposes of this categorization, segregation means that the basic policy is to hospitalize inmates (either within or outside the correctional system) or to administratively place inmates in separate housing units or cells.

Additional data are available from correctional facilities on the incidence of infection with hepatitis B virus (HBV), which has routes of transmission generally similar to those of HTLV-III/LAV. In two recent studies of inmates incarcerated for 1 year, annual seroconversion rates to HBV ranged from 0.8% to 1.3% (*6, 7*).

It is clear from the NIJ/ACA report that many correctional systems have given high priority to AIDS education programs and that such programs are the basis for AIDS-prevention activities in these systems. At present, most correctional systems are performing serologic tests for HTLV-III/LAV antibody on a limited basis. More extensive use of the tests, such as testing all inmates, all new inmates, or all inmates known to belong to risk groups, would undoubtedly identify additional seropositive persons, who might then be candidates for additional educational programs or other measures to decrease the risk that they might infect others. Such testing could, however, pose difficulties for a number of correctional facilities. In some jurisdictions, legal and policy provisions may currently prohibit testing. Many correctional systems assert that if testing is done, but the results cannot be kept confidential, seropositive inmates could face a range of problems, including the possibility of physical harm.

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CENTERS FOR DISEASE CONTROL

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

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Current Trends

Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus during Invasive Procedures

BACKGROUND

On November 15, 1985, "Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace," was published (*1*). That document gave particular emphasis to health-care settings and indicated that formulation of further specific recommendations for preventing human T-

lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV) transmission applicable to health-care workers (HCWs) who perform invasive procedures was in progress.

Toward that end, a 2-day meeting was held at CDC to discuss draft recommendations applicable to individuals who perform or assist in invasive procedures.* Following the meeting, revised draft recommendations for HCWs who have contact with tissues or mucous membranes while performing or assisting in operative, obstetric, or dental invasive procedures were sent to participants for comment. In addition, 10 physicians with expertise in infectious diseases and the epidemiology of HTLV-III/LAV infection were consulted to determine whether they felt additional measures or precautions beyond those recommended below were indicated. These 10 experts did not feel that additional recommendations or precautions were indicated.

DEFINITIONS

In this document, an operative procedure is defined as surgical entry into tissues, cavities, or organs or repair of major traumatic injuries in an operating or delivery room, emergency department, or outpatient setting, including both physicians' and dentists' offices. An obstetric procedure is defined as a vaginal or cesarean delivery or other invasive obstetric procedure where bleeding may occur. A dental procedure is defined as the manipulation, cutting, or removal of any oral or perioral tissues, including tooth structure, where bleeding occurs or the potential for bleeding exists.

RECOMMENDATIONS

There have been no reports of HTLV-III/LAV transmission from an HCW to a patient or from a patient to an HCW during operative, obstetric, or dental invasive procedures. Nevertheless, special emphasis should be placed on the following precautions to prevent transmission of bloodborne agents between all patients and all HCWs who perform or assist in invasive procedures.

1. All HCWs who perform or assist in operative, obstetric, or dental invasive procedures must be educated regarding the epidemiology, modes of transmission, and prevention of HTLV-III/LAV infection and the need for routine use of appropriate barrier precautions during procedures and when handling instruments contaminated with blood after procedures.
2. All HCWs who perform or assist in invasive procedures must wear gloves when touching mucous membranes or nonintact skin of all patients and use other appropriate barrier precautions when indicated (e.g., masks, eye coverings, and gowns, if aerosolization or splashes are likely to occur). In the dental setting, as in the operative and obstetric setting, gloves must be worn for touching all mucous membranes and changed between all patient contacts. If a glove is torn or a needlestick or other injury occurs, the glove must be changed as promptly as safety permits and the needle or instrument removed from the sterile field.
3. All HCWs who perform or assist in vaginal or cesarean deliveries must use appropriate barrier precautions (e.g., gloves and gowns) when handling the placenta or the infant until blood and amniotic fluid have been removed from the infant's skin. Recommendations for assisting in the prevention of perinatal transmission of HTLV-III/LAV have been published (*2*).
4. All HCWs who perform or assist in invasive procedures must use extraordinary care to prevent injuries to hands caused by needles, scalpels, and other sharp instruments or devices during procedures; when cleaning used instruments; during disposal of used needles; and when handling sharp instruments following procedures. After use, disposable syringes and needles, scalpel blades, and other sharp items must be placed in puncture-resistant containers for disposal. To prevent needlestick injuries, needles should not be recapped; purposefully bent or broken; removed from disposable syringes; or otherwise manipulated by hand. No data are currently available from controlled studies examining the effect, if any, of the use of needle-cutting devices on the incidence of needlestick injuries.
5. If an incident occurs during an invasive procedure that results in exposure of a patient to the blood of an HCW, the patient should be informed of the incident, and previous recommendations for management of such exposures (*1*) should be followed.
6. No HCW who has exudative lesions or weeping dermatitis should perform or assist in invasive procedures or other direct patient-care activities or handle equipment used for patient care.
7. All HCWs with evidence of any illness that may compromise their ability to adequately and safely perform invasive procedures should be evaluated medically to determine whether they are physically and mentally competent to perform invasive procedures.
8. Routine serologic testing for evidence of HTLV-III/LAV infection is not necessary for HCWs who perform or assist in invasive procedures or for patients undergoing invasive procedures, since the risk of transmission in this setting is so low. Results of such routine testing would not practically supplement the precautions recommended above in further reducing the negligible risk of transmission during operative, obstetric, or dental invasive procedures.

Previous recommendations (*1,3,4*) should be consulted for: (1) preventing transmission of HTLV-III/LAV infection from HCWs to patients and patients to HCWs in health-care settings other than those described in this document; (2) preventing transmission from patient to patient; (3) sterilizing, disinfecting, housekeeping, and disposing of waste; and (4) managing parenteral and mucous-membrane exposures of HCWs and patients. Previously recommended precautions (*1*) are also applicable to HCWs performing or assisting in invasive procedures.

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*The following organizations were represented at the meeting: American Academy of Family Physicians; American Academy of Periodontology; American Association of Dental Schools; American Association of Medical Colleges; American Association of Oral and Maxillofacial Surgeons; American Association of Physicians for Human Rights; American College of Emergency Physicians; American College of Nurse Midwives; American College of Obstetricians and Gynecologists; American College of Surgeons; American Dental Association; American Dental Hygienists Association; American Hospital Association; American Medical Association; American Nurses' Association; American Public Health Association; Association for Practitioners in Infection Control; Association of Operating Room Nurses; Association of State and Territorial Health Officials; Conference of State and Territorial Epidemiologists; U.S. Food and Drug Administration; Infectious Diseases Society of America; National Association of County Health Officials; National Dental Association; National Institutes of Health; National Medical Association; Nurses Association of the American College of Obstetricians and Gynecologists; Society of Hospital Epidemiologists of America; Surgical Infection Society; and United States Conference of Local Health Officers. In addition, a hospital administrator, a hospital medical director, and representatives from CDC participated in the meeting. These recommendations may not reflect the views of all individual consultants or the organizations they represented.

INDICATIONS FOR HIGH-LEVEL DISINFECTION OR STERILIZATION OF INSTRUMENTS

Surgical and other instruments that normally penetrate soft tissue and/or bone (e.g., forceps, scalpels, bone chisels, scalers, and surgical burs) should be sterilized after each use. Instruments that are not intended to penetrate oral soft tissues or bone (e.g., amalgam condensers, plastic instruments, and burs) but that may come into contact with oral tissues should also be sterilized after each use, if possible; however, if sterilization is not feasible, the latter instruments should receive high-level disinfection (*3,13,16*).

METHODS FOR HIGH-LEVEL DISINFECTION OR STERILIZATION

Before high-level disinfection or sterilization, instruments should be cleaned to remove debris. Cleaning may be accomplished by a thorough scrubbing with soap and water or a detergent, or by using a mechanical device (e.g., an ultrasonic cleaner). Persons involved in cleaning and decontaminating instruments should wear heavy-duty rubber gloves to prevent hand injuries. Metal and heat-stable dental instruments should be routinely sterilized between use by steam under pressure (autoclaving), dry heat, or chemical vapor. The adequacy of sterilization cycles should be verified by the periodic use of spore-testing devices (e.g., weekly for most dental practices) (*13*). Heat- and steam-sensitive chemical indicators may be used on the outside of each pack to assure it has been exposed to a sterilizing cycle. Heat-sensitive instruments may require up to 10 hours' exposure in a liquid chemical agent registered by the U.S. Environmental Protection Agency (EPA) as a disinfectant/sterilant; this should be followed by rinsing with sterile water. High-level disinfection may be accomplished by immersion in either boiling water for at least 10 minutes or an EPA-registered disinfectant/sterilant chemical for the exposure time recommended by the chemical's manufacturer.

DECONTAMINATION OF ENVIRONMENTAL SURFACES

At the completion of work activities, countertops and surfaces that may have become contaminated with blood or saliva should be wiped with absorbent toweling to remove extraneous organic material, then disinfected with a suitable chemical germicide. A solution of sodium hypochlorite (household bleach) prepared fresh daily is an inexpensive and very effective germicide. 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. Caution should be exercised, since sodium hypochlorite is corrosive to metals, especially aluminum.

DECONTAMINATION OF LABORATORY SUPPLIES AND MATERIALS

Blood and saliva should be thoroughly and carefully cleaned from laboratory supplies and materials that have been used in the mouth (e.g., impression materials, bite registration), especially before polishing and grinding intra-oral devices. Materials, impressions, and intra-oral appliances should be cleaned and disinfected before being handled, adjusted, or sent to a dental laboratory (*17*). These items should also be cleaned and disinfected when returned from the dental laboratory and before placement in the patient's mouth. *Because of the ever-increasing variety of dental materials used intra-orally, DHCWs are advised to consult with manufacturers as to the stability of specific materials relative to disinfection procedures.* A chemical germicide that is registered with the EPA as a "hospital disinfectant" and that has a label claim for mycobactericidal (e.g., tuberculocidal) activity is 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 (*15*). Communication between a dental office and a dental laboratory with regard to handling and decontamination of supplies and materials is of the utmost importance.

USE AND CARE OF ULTRASONIC SCALERS, HANDPIECES, AND DENTAL UNITS

1. Routine sterilization of handpieces between patients is desirable; however, not all handpieces can be sterilized. The present physical configurations of most handpieces do not readily lend them to high-level disinfection of both external and internal surfaces (see 2 below); therefore, when using handpieces that cannot be sterilized, the following cleaning and disinfection procedures should be completed between each patient: After use, the handpiece should be flushed (see 2 below), then thoroughly scrubbed with a detergent and water to remove adherent material. It should then be thoroughly wiped with absorbent material saturated with a chemical germicide that is registered with the EPA as a "hospital disinfectant" and is mycobactericidal at use-dilution (*15*). The disinfecting solution should remain in contact with the handpiece for a time specified by the disinfectant's manufacturer. Ultrasonic scalers and air/water syringes should be treated in a similar manner between patients. Following disinfection, any chemical residue should be removed by rinsing with sterile water.

2. Because water retraction valves within the dental units may aspirate infective materials back into the handpiece and water line, check valves should be installed to reduce the risk of transfer of infective material (*18*). While the magnitude of this risk is not known, it is prudent for water-cooled handpieces to be run and to discharge water into a sink or container for 20-30 seconds after completing care on each patient. This is intended to physically flush out patient material that may have been aspirated into the handpiece or water line. Additionally, there is some evidence that overnight bacterial accumulation can be significantly reduced by allowing water-cooled handpieces to run and to discharge water into a sink or container for several minutes at the beginning of the clinic day (*19*). Sterile saline or sterile water should be used as a coolant/irrigator when performing surgical procedures involving the cutting of soft tissue or bone.

HANDLING OF BIOPSY SPECIMENS

In general, each specimen should be put in a sturdy container with a secure lid to prevent leaking during transport. Care should be taken when collecting specimens to avoid contamination of the outside of the container. If the outside of the container is visibly contaminated, it should be cleaned and disinfected, or placed in an impervious bag (*20*).

DISPOSAL OF WASTE MATERIALS

All sharp items (especially needles), tissues, or blood should be considered potentially infective and should be handled and disposed of with special precautions. Disposable needles, scalpels, or other sharp items should be placed intact into puncture-resistant containers before disposal. Blood, suctioned fluids, or other liquid waste may be carefully poured into a drain connected to a sanitary sewer system. Other solid waste contaminated with blood or other body fluids should be placed in sealed, sturdy impervious bags to prevent leakage of the contained items. Such contained solid wastes can then be disposed of according to requirements established by local or state environmental regulatory agencies and published recommendations (*13,20*).

Developed by Dental Disease Prevention Activity, Center for Prevention Svcs, Hospital Infections Program, Center for Infectious Diseases, CDC.

Editorial Note: All DHCWs must be made aware of sources and methods of transmission of infectious diseases. The above recommendations for infection control in dental practices incorporate procedures that should be effective in preventing the transmission of infectious agents from dental patients to DHCWs and vice versa. Assessment of quantifiable risks to dental personnel and patients for specific diseases requires further research. There is no current documentation of patient-to-patient blood- or saliva-borne disease transmission from

procedures performed in dental practice. While few in number, reported outbreaks of dentist-to-patient transmission of hepatitis B have resulted in serious and even fatal consequences (*9*). Herpes simplex virus has been transmitted to over 20 patients from the fingers of a DHCW (*10*). Serologic markers for hepatitis B in dentists have increased dramatically in the United States over the past several years, which suggests current infection-control practices have been insufficient to prevent the transmission of this infectious agent in the dental operatory. While vaccination for hepatitis B is strongly recommended for dental personnel (*21*), vaccination alone is not cause for relaxation of strict adherence to accepted methods of asepsis, disinfection, and sterilization.

Various infection-control guidelines exist for hospitals and other clinical settings. Dental facilities located in hospitals and other institutional settings have generally utilized existing guidelines for institutional practice. These recommendations are offered as guidance to DHCWs in noninstitutional settings for enhancing infection-control practices in dentistry; they may be useful in institutional settings also.

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VIRGINIA & MARYLAND HOLD OPPOSITE VIEWS ON TESTING

by Peg Byron, with thanks to The Washington Blade, 5/2/86

The Commonwealth of Virginia began a $500,000 program of vigorously promoting the HTLV-III Antibody test at over 100 local VD clinics around the state. Gay and AIDS activists are objecting to the plan, charging it could lead to discrimination against people who test positive, and drive some people who need VD treatment away from the clinics. State budget analyst Nancy Roberts said a total of $543,569 was appropriated for the testing at Governor Gerald Baliles' request. The funds provide about $100,ooo to five "alternate testing sites" which began offering the test on an anonymous basis last summer, as well as to the STD clinic-based program. $82,000 will be for contracts to community based AIDS service groups. Then $40,000 to $50,000 will be added to the balance, approximately $360,000 to cover the testing program until the fiscal year begins in July. In contrast to Virginia's and the CDC's strategy to reduce HTLV-III transmission, the state of Maryland emphatically rejected those recommendations. The Governor's Task Force on AIDS, which is headed by Dr. Edward Brandt, former Assistant Secretary of Health, issued a statement endorsed by Maryland's Health Department that describes claims that antibody screening helps educate people as unsubstantiated, while education programs without the test have been proven to work. State AIDS Program Coordinator Scott Stamford said that Brandt in particular, "quite vocally" opposed recent CDC pronouncements on testing. The Task Force recommends waiting for the NIH's consensus conference in July (see elsewhere in Newsletter).

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NUTRITION AND AIDS

by Peter McKnight, RD, with thanks

Malnutrition is known to suppress the immune system. It therefore appears likely that any therapy for people with AIDS (PWAs) would require nutritional support. Key nutrients involved with immune function include calories, protein, vitamins A, C, B-6, pantothenic acid, folic acid (Kraus & Mahan; Food Nutri. & Diet Therapy, 6th edition, Philadelphia: W.B. Saunders, 1979), and zinc (Chandra, "Does Nutrition Definitely Predispose to AIDS?" Nutri. Research, vol. 4, 537-43, 1984). Vitamins A and C are necessary to maintain the body's physical barriers to infection. Vitamins B-6 and pantothenic acid are involved with immunity and antibody formation. Folic acid (a B vitamin) participates in white blood cell formation (Kraus & Mahan). Zinc deficiency causes a decrease in immunity to disease (Chandra). Calories, despite their bad reputation among dieters, are absolutely essential in adequate amounts for the body to function properly. Weight loss is frequently a problem for PWAs (O'Sullivan, et al.; "Evaluation of body weight and nutritional status among AIDS patients," Jour. of the Amer. Diet. Assoc., vol. 85, 1483-84, Nov., 1985) and weight gain back to one's usual weight should be a goal. Some suggestions for weight gain are given below. If someone has severe problems taking food by mouth, he should discuss with his doctor the possibility of a tube feeding or, if the intestines are not functioning, a parenteral (intravenous) feeding. A registered dietitian can assist the PWA and his physician in determining which type of feeding best meets his needs. Vitamin and mineral needs are best met by eating properly, however if it has been determined that you are missing certain food groups from your diet, a basic supplement such as Centrum or Unicap M meets the recommended dietary allowances for key nutrients, except for calories and protein which must come from food, or a product such as Carnation instant breakfast, or Ensure, which are supplemented with vitamins and minerals. Taking megadoses of vitamins (Alhadeff, "Toxic effects of water soluble vitamins," Nutr. Reviews, vol. 42, February, 1984) and minerals, however, is dangerous and taking excess zinc can ironically, impair immune function (Tufts University Diet & Nutr. Letter, 2:11, January, 1985). We have all been warned to watch for promoters of miracle cures who are out to make a fast buck. Some PWAs, however, may decide to try untested methods of treatment. One way to screen for rip-offs is to ask yourself "Is this an outrageous fee for treatment?" Remember, no one has the right to charge you money to experiment on your body. Also beware of the macrobiotic diet or other diets low in calories and protein. The macrobiotic diet made headlines a few years ago for causing death by malnutrition ("The Macrobiotic Diet--No way to treat cancer." Tufts Univ. Diet & Nutr. Letter, January, 1985.) It is low in calories, protein, vitamins D, B-6, B-12, riboflavin, niacin, folic acid, calcium and iron, many of the key nutrients needed for proper immune function. By following dietary guidelines such as those listed below for adequate calorie and protein intake and avoiding dietary advise which deprives a person of the nutrition they need, the PWA can improve his nutritional state and hopefully benefit his total well-being.

EATING HINTS: *Try eating small portions at meals and have inbetween meal smacks. *Keep smacks handy for nibbling. *Try eating a smack before going to bed. *Rely on foods you really like during your not-hungry periods. *Take advantage of the times when you're felling well. Breakfast is often the best meal of the day for may people, and breakfast-type meals may be preferred at other times, not just in the morning. *Try not to miss meals. *If the smell of food cooking makes you nauseated, let someone else cook (Meals-on-wheels may be helpful) or try a cold meal (sandwiches, cold meat platters, etc.). *Don't allow others to pressure you into the "eat-a-little-more" syndrome. Eat what you can, when you can. *If beef or port taste bitter, try fish or poultry. If you develop a dislike for these foods, you can still get enough protein from milk and dairy products, cheese, eggs, and vegetable proteins such as dried beans and peas, peanut butter and tofu (these must be combined with grains to be "complete"). *Supplemental feedings such as milkshakes, custards, Carnation instant breakfast, Ensure, or Sustacal increase both calorie and protein intake (and some contain a full complement of vitamins and minerals). Eggnog should be made with a soft poached egg in a blender or with egg custard since raw egg can be the source of salmonella infection. (Adapted from USDHHR Publication "Eating Hints." NIH Publication No. 82-2079, Reprinted April, 1982.)

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AEROSOL SPREAD OF DIARRHEAL DISEASES

by Julie Ann Miller, with thanks to Science News, 4/12/86

A virologist is making what he calls a "radical" proposal for the mechanism of dispersal of rotaviruses, the agents most commonly responsible for hospitalized cases of diarrheal disease in children. Previous research had demonstrated transmission of the viruses by contaminated water, but Carl D. Brand of Children's Hospital in Washington, DC, argues that they must also employ other routes. In temperate climates, rotaviruses show a striking seasonality; there are several hundred times as many cases in the winter as in the summer. Brand proposes that the low indoor humidity in winter increases the survival of the virus, which is released into the environment in large numbers--1 billion viruses per gram of feces of an infected infant. A "rotovirus aerosol" might be created when an infant's diapers are changed, bedding is aired or a toilet is flushed.

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BROAD BASED PUBLIC INFO CAMPAIGN IS BENEFICIAL

with thanks to The Baltimore Gay Paper, 3/86

Southern California Cooperative AIDS Risk Reduction Education Service (CARES) announced the findings of its 400 person survey of AIDS related public policy issues, which indicated that Southern Californians are better informed about AIDS than others polled nationally. Southern California CARES is a unique regional effort, fostered by the State of California Dept. of Health Services and administered by AIDS Project/Los Angeles. It joins together 10 local community support, education and referral organizations providing direct AIDS related services to the general public and sexually active adults. The CARES survey results which differed in certain significant respects from an earlier, national poll commissioned by the Los Angeles Times. The CARES survey showed that a sample of residents from Southern California were better informed about the risks of AIDS to themselves and others. Pollster James Kleckner of Universal Communications pointed out the differences between the two polls' methodologies and results. "The Times surveyed individuals across the country. Since Southern California CARES is an educational program geared to reach Californians, we were interested specifically in how area residents were thinking about AIDS-related issues," said Kleckner. "The results of this survey reflect the differences in attitudes and understanding of AIDS issues by Southern Californians." One-third of all respondents expressed interest in learning more about how AIDS is transmitted. They considered the AIDS epidemic as a primary problem facing their community, and strongly agreed with the statement that "AIDS will eventually become an epidemic for all the public." But despite a high-level of interest in and knowledge about the subject, respondents reported misunderstandings about the ways in which AIDS can be transmitted, including fears that AIDS may be contracted by donating blood to a blood bank and sharing a drinking glass with someone with AIDS. Additionally, close to 10% of all respondents considered AIDS "very contagious," despite medical evidence to the contrary. Residents of Southern Orange and San Diego Counties followed by Los Angeles County residents particularly were concerned about getting AIDS. On a scale of 1-10, all respondents expressed moderate concern (5.5) about contracting AIDS from "having sexual relations with a heterosexual." When asked about the risks of "having sex with many different partners," all respondents expressed a significant degree of concern about "having sex with many different partners" with no exchange of fluids (6.4). Respondents were optimistic about finding a solution to the AIDS problem (a score of 7.9 out of 10), but pessimistic about the near-term consequences of the disease. Respondents rated the statement, "AIDS will eventually become an epidemic for all the public," 6.1. A strong response of 7.5 was elicited from the statement, "fear of AIDS is spreading faster than the disease." Survey results are estimated accurate within plus/minus 4.5% John Mortimer, Director California CARES, pointed to the results of this survey to confirm the need for a broad-based public information campaign about AIDS. "Southern California CARES will reach the general public and sexually active adults through a media-intensive campaign which will `fight the fear with the facts'," said Mortimer. "This survey shows that even though Southern Californians are better educated about AIDS and its risks, there is a clear need to broaden this understanding. It is the goal of Southern California CARES to alleviate unnecessary fears and curb the spread of AIDS in Southern California."

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BOSTON PUBLIC TRANSIT ADS TARGETS IV DRUG USERS

by Christine Guilfoy, with thanks to the New York Native, 4/28/86

A public information campaign about AIDS is scheduled to appear on Massachusetts Bay Transit Authority (MBTA) buses, trains, and trolleys, marking the first time information about AIDS will appear on public transit in the city. Conceived by Boston's Dept. of Health and Hospitals and provided as a public service by Transit America, the campaign will pay particular attention to trying to reach intravenous drug users who are at high risk for AIDS. The campaign is modeled after one in New York City and uses the same advertisements developed there. Boston strap-hangers will soon see two of those advertisements, one of which is addressed to the population at large, the other specifically to intravenous drug users, with 1400 posters being produced. Drug users will be warned not to shoot drugs and not to share needles or "Works." The general advertisement contains the message that AIDS cannot be spread through certain types of contact, such as shaking hands, or from doorknobs or toilet seats. Boston AIDS coordinator Linette Liebling was especially pleased about the low cost involved in the high visibility campaign, saying the city has had to spend only $650. Liebling praised Transit America and the MBTA for producing the ads and producing the space free of charge, as a public service. Transit America is under contract to the MBTA to provide the advertisements that appear on the transportation system. Senior vice president and general manager of Transit America Robert Meara called the campaign "long overdue," and said "everybody in the country hopes to put a stop to this dread disease [and] if we can play any part, we're glad to do it." Meara said his firm donates "hundreds of thousands of dollars" worth of space each year for public service advertising. City officials have recently begun to grapple with the issue of how intravenous drug users can be reached and educated about the risk of contracting AIDS. It is believed that AIDS is spread in this group through shared use of contaminated needles and "works," such as cookers and cotton used to prepare heroin for injection. Experiences in other cities such as New York and Newark, have indicated that when HTLV-III infects this population, it is capable of rapidly spreading. In New York City, some studies indicate up to 80% of IV drug users have been exposed to the virus. About half of that city's new caseload are now drug users. But it is believed that public education in Boston, where the epidemic started later, could help prevent the same pattern from developing in that city. The ads are significant because they tell addicts something they might not be aware of--that is, not only should they not share needles if they use drugs, but they should not share other types of paraphernalia which also could transmit the virus.

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PSAs ON AIDS

with thanks to The Washington Blade, 3/7/86

A number of entertainers and celebrities--including comedienne Carol Burnett and actress Brooke Shields--will appear in television public service announcements (PSAs) on AIDS sponsored by the American Foundation for AIDS Research (AmFAR), according to the foundation's press spokeswoman Susan Martin. Martin, in a press release, said the PSAs are designed to educate the public about AIDS and to urge support for research into the cause, treatment, and prevention of the disease. Martin noted that in addition to Burnett and Shields, celebrities appearing in the soon-to-be-aired PSAs are Elizabeth Taylor, AmFAR's national chairperson; Judd Hirsch, Morgan Fairchild, Tony Danza, Robert Guillaume, Matthew Broderick, Ed Flanders, and William Daniels. Martin said all celebrities participating in the PSAs donated their services.

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FASHION AD CAMPAIGN BENEFITS AMFAR

by Barry Adkins, with thanks to the New York Native, 4/28/86

New York's social event of the season may have taken place on April 29, when violet-eyed Elizabeth Taylor, and Calvin Klein, the man who has given us the most incredible fashion ad campaign ever, co-hosted a benefit for the American Foundation for AIDS Research (AmFAR). The star-studded, fashion photography happening and cocktail party took place at the New York Convention Center's Crystal Palace, and featured what the promoters called "the world's largest photo session" of various stars, including Taylor and Klein. The group photos will be used in a print advertising campaign in national fashion, fragrance, and cosmetic industry trade publications. Peter Rogers Associates created the theme, "AIDS Strikes Without Prejudice." Guests also had the opportunity to bid on art which had been donated for the event. The new fashion industry effort complements a previously launched series of ads featuring top fashion models, including Christie Brinkley, which were developed under the theme, "For the Future of Our Children." AmFAR is a national organization which provides funding for AIDS research, and is headed by Drs. Michael Gottlieb and Mathilde Krim.

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SHOE DESIGNER RAISES AIDS CONSCIOUSNESS WITH AD CAMPAIGN

with thanks to Miami's TWN, and The Baltimore Gay Paper, 3/86

Kenneth Cole, president of Kenneth Cole Productions is applying his $250,000 spring ad budget to a public awareness campaign for AIDS, according to Advertising Age. Cole will bring together top models from the Elite, Ford and Wilhelmina agencies (including Christie Brinkley) for ads which will be placed in March and April fashion magazines. Annie Liebowitz will do the photography. Tag line of the campaign will be "For the future of our children," and all ads will include an appeal for contributions to the American Foundation for AIDS Research (AmFAR). "AIDS is affecting our industry and a lot of others," Cole said. "So this season, rather than advertise, we thought we could do something much more worthwhile."

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INSURANCE GROUPS CONTRIBUTE TO RESEARCH

with thanks to The Washington Blade, 3/21/86

Officials from two insurance associations representing nearly 1000 life and health insurance companies across the country recently contributed $1.16 million to the American Red Cross and three other institutions for AIDS education and research. Richard Schweiker, president of the American Council of Life Insurance, said his group, along with the Health Insurance Association of America, have historically been active in efforts to combat "threats to the health and longevity of policy holders," and that it was "clear" that the insurance industry had to do something to combat AIDS. Schweiker said that the insurance companies he represents are "interested in giving risk evaluations"--which would include the HTLV-III antibody test--before extending policies to individuals, and that his group opposes legislation such as Councilman John Ray's insurance bill before the Washington DC City Council which prohibits companies from discriminating in providing insurance coverage on the basis of any AIDS screening tests. The contribution includes $900,000 to the American Red Cross for education programs, $160,000 to the American Foundation for AIDS Research for general research, and $160,000 to the Sloan-Kettering Institute in New York and the University of Alabama for a joint research study.

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TEENAGERS ENGAGE IN ORAL SEX

with thanks to Medical Aspects of Human Sexuality, 3/86, and Arch. of Sex. Behav., 14:41, 1985

Remind even your younger teenaged patients that sexually transmitted infections can be spread via mouth-to-genital contact. A University of North Carolina study of high school students (average age 16) shows that no fewer than 53% of boys and 42% of girls have had oral sex, giving or receiving cunnilingus more often than fellatio. Oral-genital stimulation is engaged in by 69% of either sex who've had coitus, and also by 25% or virgin boys and 15% of virgin girls.

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GAY GAMES OFFER POSITIVE SELF-EXPRESSION

by Dr. Tom Waddell, President, San Francisco Arts & Athletics, Inc., with thanks to Triumph in '86, Jan., 1986

[ED NOTE by Mike Hippler, with thanks to the New York Native, 4/14/86: Tom Waddell was a practicing physician with the Army in 1967 when he decided to train for the United States Olympic Team, eventually placing 6th in the decathalon in Mexico City. It was then that he first began to think about establishing another kind of Olympic Games--an Olympics just for other gay people like himself. He came out in People Magazine in 1976, and in 1980, quit his job as the medical director of a large corporation, organized a board of directors, and began raising money for what was then termed the first Gay Olympics. Working with an entirely volunteer group, Waddell and company struggled financially through the first year, until help came from an unlikely and unwilling source. When the U.S. Olympic Committee (USOC), seeking to disassociate itself from the Games, obtained a court injunction forbidding the gay group the use of the word "Olymics," contributions began pouring in for the first time. "It was David versus Goliath, and people love an underdog." says Waddell. At the heart of the matter was homophobia, although USOC tried to deny it. As a result of USOC's intervention, people began to see the Games as Waddell had envisioned them--as a way for gay people to express pride in themselves and to counter this kind of thoughtless, arrogant prejudice. At the cost of $397,000 (with no more than $1000 coming from any single donor), in August 1982, the Gay Games began. Over 1300 athletes (700 men nd 600 women) from 12 countries and 179 cities converged in San Francisco to compete in 17 different sports. The most popular of these, says Waddell, were the "skin sports"--swimming, wrestling, and physique, for instance. But the most exciting events, he adds, were the Opening and Closing Ceremonies in Kezar Stadium. To see the athletes marching under the banners of their respective cities, in a line that stretched the length of the stadium and more, was a sight that filled Waddell. "Participation was the key," he explains, "not competition. There were no minimal standards. You didn't have to be great, just serious about your sport. We knew there were going to be better teams, better times, elsewhere, but we didn't care. Instead, we wanted to redefine winning. For us, it wasn't beating anyone else but doing your best." Although it took some of the athletes a while to grasp this concept, in the end, most of them were enthusiastic about it. Some even filled in for athletes on other teams when needed. "These athletes saw that the Games weren't about high-level competition but about being together with their brothers and sisters and having a good time," concludes Waddell. As a result of the first Games, there was a resurgence of interest in sports in the gay community nationally and a growth in the number of gay sports organizations, such as the International Gay Volleyball League and the International Gay Bowling Organization. The major difference between this year's Games, however, and those four years ago, is that this year the specter of AIDS looms heavily over the community, which is making fundraising especially difficult for the Games' organizers. Last time, explains Waddell, 55 non-profit gay organizatios were all chasing the same dollars. This time AIDS organizations are receiving most of the available money. "I'm all for that," contends Waddell, "but people ought to realize that there is more than one approach. We are starting to see ourselves as diseased, depressed, negative individuals, and we've got to stop that. We need a different perspective, and the Games can help us to gain that perspective." Assuming that the money will come in and the Games will receive the large donations needed between now and August, the board of directors must soon begin thinking about the future. Questions they must consider include: Should the Games continue? Where will they be located? Who will have control? How can responsibility for the Games be transferred, and how can the present organizers ensure that the philosophy of the Games will remain intact? This last question is the most important to Waddell, who, above all else, is interested in heightening people's awareness. "We, as gay people, have a great opportunity to become teachers," he says. "We have opened up that first door. Let's continue to open up those doors." The projected cost of this year's Games is $800,000, and over 5400 athletes are expected to participate.]

There is probably universal agreement within the gay community that a serious dilemma has descended upon us in the form of AIDS. The disease has created not only a health crisis, it has also presented us with profound social and political problems. We are a community under fire. The most important fight on our hands is, of course, to find a way to prevent and cure AIDS, but there are other activities that serve us well as a community. We do need to remind ourselves that we are a unique gathering of people with many unique qualities. It may appear from the way the media handles the problem that we are a depressed community, floundering about, waiting for the other shoe to drop; but in reality we continue to be a productive, creative, active and extremely health conscious community. The Gay Games began prior to the harsh statistics of the AIDS epidemic. The Games do not exist in response to AIDS; they exist on their own merit as a manifestation of the high level of athletic participation in the gay community. They provide a counterbalance tot he negativity and the paranoia and the damaged self-image that many of our members are experiencing. In this, the AIDS era, we must acknowledge our problems and deal with them forthright. We have squared off in the fight against AIDS and we can be proud of our efforts. But we must also acknowledge our self-worth and examine our other capabilities. The Games are our showcase. It is important that we pursue them proudly and unabashed, so we can see ourselves as we really are, fully vested citizens of the world, living up to our potential. We cannot ignore AIDS. We do not ignore AIDS. Nor can we ignore the need to continue to grow in stature as a community. The Gay Games provide us with a needed

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GAY GAMES, Continued

perspective of ourselves. Please be a part of them.

Scheduled for August 9-17, 1986 in San Francisco, Gay Games II will feature 18 individual and team sports. Everyone is eligible to enter, and no particular level of athletic ability is required. Although medals will be awarded, participation is valued more than winning. Sports for the Games are: basketball, bowling, boxing, cycling, golf, marathon, physique, billiards, powerlifting, racquetball, soccer, softball, swimming & diving, tennis, track & field, triathalon, volleyball, and wrestling. Competition will be held for both men and women in all activities except wrestling, which will be for men only. Most sports have various age groups, and some have many different events. The number of entrants is limited in certain sports due to the size of facilities. Entry fees are $20 per person per sport, and must be received by June 1. For more information, contact: Sara Lewinstein/Hal Herkenhoff, Sports Directors, SFAA, 526 Castro St., San Francisco, CA 94114 (415/861-8282). Already over 200 men and women athletes from the U.S., Australia, Canada, and England have already registered to compete.

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CITIES SHARING AIDS DATA

with thanks to the Computerized AIDS Information Network (CAIN), 4/11/86

Thirteen U.S. cities that account for 70% of the nation's AIDS cases are combining forces and sharing strategies to fight the deadly disease, Chicago's health commissioner Lonnie Edwards said. "We at the local level are especially tuned in to the fact that control of this epidemic must be guided by the very best of our wisdom," said Edwards. The cities' public health officials agreed in their first all-day session to hold regular meetings and share tactics and problems in the AIDS fight, said Edwards, who arranged the session. AIDS patients who cannot afford expert treatment should be provided such care at public expense, they said. While the group of public health administrators and epidemiologists did not act on Edwards' proposal for a computerized AIDS information network, he said that plan would be discussed at future sessions. Health officials from New York, San FRANCISCO, Philadelphia, Miami, Los Angeles, Baltimore, Denver, Chicago, Minneapolis, Dallas, Newark, Santa Ana, and Washington, DC attended. Other issues took precedence over his proposal for computerized, inter-city exchange of AIDS information, he said. Paul Kawata of the National AIDS Network (NAN), a Washington-based alliance of AIDS service and education groups, said that the proposal would duplicate a state-funded computer network operating out of California for more than a year. The California Health Services Department's funded Computerized AIDS Information Network (CAIN) provides subscribers nationwide with access to newspaper and magazine articles, scientific and medical research reports, and other information, Kawata said.

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PHILADELPHIA MAYOR ISSUES NONDISCRIMINATION ORDER

by Lisa M. Keen, with thanks to The Washington Blade, 4/25/86

Philadelphia Mayor Wilson Goode announced that he had signed an executive order barring discrimination against people with AIDS in city services and employment. Goode indicated he issued the order at the urging of the city's public health department and Commission of Sexual Minorities, according to the Philadelphia Gay News. The City Solicitor, in a March 4 memo to Goode, advised that the Philadelphia Fair Practices Act included protections for people with AIDS under its "handicaps" provision.

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HOLISTIC HEALTH CARE DIRECTORY FOR AIDS IN NEW YORK

by Michael Hirsch

New york AIDS Action announces the publication of "Holistic Health Care for AIDS," a directory of resources available to people with AIDS and ARC in New York City. The directory is a simple and "easy to read" listing of adjunctive health care practitioners grouped in the following categories: acupuncture, chiropractic, counseling, healing, herbology/homeopathy, massage/bodywork, meditation/yoga, nutrition and reiki. Each section begins with a short and helpful description to further guide readers. The Directory begins with two strong and important pieces that help to offer this resource as a tool for personal self-empowerment for people with AIDS and ARC: "THE DENVER PRINCIPLES," a self-proclaimed Bill of Rights for People with AIDS/ARC written in 1983; and "HOW TO USE THIS DIRECTORY," a sown to earth and common sense way to approach these therapies. The Directory also offers a listing of holistic and traditional organizations that offer support, and a listing of interesting books and audio tapes under the section of "self-help." The Directory was the creation of New York AIDS Action Founder/Director Michael Hirsch who led a team of dedicated volunteers, and lists only practitioners who have expressed a willingness to work with PWAs and AIDS issues. The Directory is available for free to PWAs/PWARCs from the Intake Dept. of Gay Men's Health Crisis (254 W. 18th Street, New York), or by mail for $3.50 from New York AIDS Action, 263A West 19th Street, New York, NY 10011 (212/807-0699).

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HALF OF SAN FRANCISCO GAYS INFECTED, RANDOM SURVEY SHOWS

by Michael Helquist, with thanks to The Washington Blade, 2/21/86

Half of the gay men participating in a random survey in San Francisco have been infected with the HTLV-III virus, according to preliminary data from a long-term study conducted by the University of California--Berkeley. In addition to the high infection rate, the study also found that as many as three-quarters of those infected may also be carrying the AIDS virus. The study is one of several in the nation that have followed the natural history of AIDS viral infection among gay men. In San Francisco, more than 800 gay men were randomly selected from among 3000 households in 19 different census tracts known for their high numbers of gay residents. The random selection is important because previous studies of prevalence of AIDS viral infection have relied on the skewed sampling of clients of STD clinics. Other studies have reviewed blood samples from participants in research that led to the development of the hepatitis B vaccine. According to Dr. Warren Winkelstein, director of the University of California--Berkeley AIDS study, these latest results provide a more accurate picture of the spread of the epidemic in San Francisco. Two previous studies in San Francisco had revealed AIDS viral infection among 37% and 50% of gay men. Of the 800 gay men who agreed to be tested for presence of the HTLV-III antibody, about 50% of them tested positive. Researchers have generally suggested that individuals exposed to the virus should presume that they are infected with the virus itself. The Berkeley study found that as many as 75% of the men with the HTLV-III antibody also carry the virus itself. Recent studies conducted by the CDC and the National Cancer Institute have indicated that from 60-80% of gay men with positive antibody test results also have an active infection, meaning that they are carrying the virus. This Berkeley study confirms this high rate, using a much larger and more representative sample of gay men. Winkelstein and his associates also studied the relationship between AIDS viral infection and sexual practices. During a recent conference on population studies at Stanford University, Winkelstein reported that the frequency of sexual contacts is strongly related to infection with the AIDS virus. Twenty-five percent of the gay men who reported up to 10 male sexual partners in the previous two years revealed positive antibody test results. The rate of positive test results increased to 52% among those who reported from 11 to 50 sexual partners. Among the 200 heterosexual men in the study there were no positive antibody test results. The Winkelstein study has also measured the relative risk related to certain sex acts, but no preliminary results have been released yet on these measures. The number of sexual contacts leading to viral infection assumes that most activities involved an exchange of bodily fluids, described as "unsafe sex" in AIDS prevention and educational materials. The study is expected to shed some light on those studies that suggest some sexual activities, such as oral sex, may be less risky than previously suspected. Researchers advise that strict adherence to the "safe sex" guidelines is necessary until there is clear evidence to warrant any changes. The Berkeley research is supported by a $3.4 million grant from the National Institute of Allergy and Infectious Diseases.

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DOOR-TO-DOOR BLOOD TESTS IN DALLAS HALTED

by Craig C. McDaniel, and edited by John A. Fall, with thanks to the New York Native, 3/3/86

County health officials in Dallas have put on hold a federally financed survey to determine the prevalence of the so-called "AIDS virus" through door-to-door blood tests. An inadequate number of survey takers and the lack of confidentiality were cited as reasons for the project being placed on hold. Dallas County Court members criticized the program, which they approved last fall, and which included a $243,000 grant from the Centers for Disease Control. The survey included "innocent" question, but also asked for a blood sample, said Dr. Charles Haley, a county epidemiologist. "If someone came to my door asking me for an AIDS test, I'd run them off the porch," said Commissioner Jim Jackson. "Who are you going to get to consent? I'd think it's just a waste of money." Bill Nelson, president of the Dallas Gay Alliance, said he feared test information might become public and doubted the effectiveness of the program. "People want to stop the spread of AIDS, but using the test won't stop it," he said. Haley said more survey takers would be hired to question between 2-3000 residents. Lawyers are seeking ways to ensure confidentiality of the respondents.

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POLICE FROM DETROIT ISSUE AIDS GUIDELINES

with thanks to Detroit's Cruise, 4/9/86

The Detroit police department has issued a "training bulletin" on AIDS for its officers. The two page memo gives basic guidelines on the potential risk of occupational exposure to the virus causing the disease. The guidelines were prepared by Dr. John B. Waller, Detroit Public Health Director, who stressed that AIDS is transmitted "primarily through intimate sexual contact, blood, or perinatal transmission." The bulletin warns of potential dangers that officers might face in the course of their day to day activities. The guidelines emphasized the need to handle with extreme care needles, syringes, and other sharp instruments that are or may be contaminated with blood or other body fluids. The guidelines also warn that when the possibility of exposure to blood or other bodily fluids exists, precautions should be followed and advised that hands should be washed "immediately and thoroughly" if they accidentally become contaminated with blood. As for mouth to mouth resuscitation, mouth-pieces, resuscitation bags or other ventilation devices should be used. The bulletin was read for five consecutive days at roll calls in the precincts and stated equipment and further guidelines would be forthcoming.

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PBS' FRONTLINE CRITICIZED

by Peg Byron, with thanks to The Washington Blade, 3/28/86

PBS-TV's Frontline aired its controversial documentary about an indigent man with AIDS, March 25th, and drew vehement criticism from gay and AIDS activists around the country. The two-hour program, "AIDS--A National Inquiry," focused on the last months in the life of Fabian Bridges, who claimed he was continuing to have sex, for money and "other times for affection," after he was diagnosed with AIDS. Frontline is being criticized for its use of an extreme case in presenting AIDS issues and is accused of actually encouraging Bridges' alleged activity. The program acknowledged that the film crew paid Bridges small amounts of money, occasionally bought him food, and once bought him a radio. Frontline Executive Editor Louis Wiley defended the transactions as involving insignificant amounts of money and as not unusual in the course of covering an individual over a long period of time. "It would have been wrong to give him larger sums of money that would have changed what he was doing," Wiley said. But it was the stinginess of Frontline's help that some people criticized. For example, the program's narrator at one point said the crew gave Bridges $15 a day for "a cheap motel room" on the condition that he not prostitute himself. Ron Najman, spokesman for the National Gay & Lesbian Task Force (NGLTF), noted that in spite of that caveat, Frontline's film was "about [Bridges] having sex with people." "Is it wrong to suggest [Frontline] was paying him to have sex with people?" Laurie Behrman, spokeswoman for New York's Gay Men's Health Crisis (GMHC), pointed out that Frontline paid Bridges, who was penniless, money to get by on, "but not enough to get out of the situation he was in." Frontline sandwiched the film between discussions by a panel of AIDS experts, such as Dr. Mathilde Krim of the American Foundation for AIDS Research, and anti-gay representatives, such as Congressman William Dannemeyer (R-CA). Several gay activists refused Frontline's invitations to participate on the panel. In protest of the film, NGLTF Co-Director Jeff Levi dropped out at the last minute, Najman said, because of "groundswell feeling within the community nationwide that he should not participate." Richard Dunne, executive director of GMHC, and Larry Bush, an aide to California State Rep. Art Agnos also refused to appear. Krim said that she and some other panel members "had given some thought to staying out completely," but they decided, "better us being there than some idiots." Krim noted that Bridges was earning $19,000/year before being diagnosed with AIDS and "wasn't a prostitute." She suggested that he was using PBS--which at one point reportedly allowed him to live out of its camera van. "as dull as he was," Krim said, "he knew what the reporters wanted to hear." In San Francisco, nearly 300 people picketed the local PBS station, KQED, and after the show held a press conference calling for an economic boycott of the station, according to reports. Holly Smith, spokeswoman for the San Francisco AIDS Foundation, called the show "a missed opportunity" for educating the general public and "extremely negative, racist, and homophobic." Diego Lopez, GMHC's clinical director who was diagnosed with AIDS last month, said on the panel that the film was "a real victimization of this person by all the institutions that failed him...." Mervyn Silverman, former San Francisco health commissioner, said the film was "an exploitation by the media" because Bridges was the star of the program and that the people in the media who were filming knew the acts he was engaging in and gave him $15 and a radio, rather than either providing enough money so that kind of activity didn't take place or make sure that he was placed with gay associations...that would protect him and society." "Instead," said Silverman, "it was a hot story." Bridges, who reportedly went to a clinic in Indianapolis for a gonorrhea infection, described for Frontline unsafe sex acts he was still having with unwitting strangers. Frontline's narrator then announced, "We decided to tell health officials what we knew...." The crew contacted the Cleveland City Council and filmed their subsequent discussions. Buck Harris, a Cleveland gay activist and a state health department employee, said the Cleveland gay community had "a lynch mob mentality" towards Bridges. But it was the gay community in Houston that eventually cared for Bridges after he returned there, shielding him from ongoing media coverage; Houston's health department, which notified him he would be arrested if he had sex; and the vice squad, which had him under surveillance. Gay and prison reform activist Ray Hill counseled Bridges and brought him to the home of a KS Foundation board member. Bridges stayed there until he was hospitalized; he died on November 17 and was buried in a public grave. Frontline commentator Judy Woodruff advised listeners at the start of the program to turn to the gay community as the authorities on AIDS information, and many people phoned local hotline numbers flashed on the screen during the program.

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PBS BOYCOTT LAUNCHED IN SAN FRANCISCO

with thanks to Kim Westheimer, with thanks to Boston's Gay Community News, 4/19/86

Lesbian and gay activists have launched a boycott against the Public Broadcasting System affiliate in San Francisco which aired a March 25 television documentary depicting a black man with AIDS as a prostitute. The documentary has been criticized for taking advantage of Fabian Bridges, the now deceased person with AIDS, who had no access to health care or support and was paid $15 a day for his cooperation with film crews as his health was deteriorating. Coming Up! reported that a broad-based coalition of political and professional organizations in the lesbian and gay community announced the boycott of TV station KQED after the station, citing "freedom of the press," ignored demands that the show be canceled. Boycott organizers have asked people not to pledge money to the station until KQED produces a show that is positive in its depiction of persons with AIDS and until airing of the Bridges' documentary (Frontline) is investigated.

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EROTICA INDUSTRY ENCOURAGED TO INCLUDE SAFER SEX PRACTICES

The following statement was issued by many individuals representing AIDS service organizations from around the nation (A list of supporters was not available by press time; it is in compilation.), from the Seventh National Lesbian/Gay Health Conference and Fourth National AIDS Forum, March 13-16, 1986, in Washington, DC.

Sensitive and fully aware of the multiplicity of issues surrounding erotica, and acknowledging its continued use by consumers from a wide and varied audience, the undersigned AIDS prevention representatives from their respective organizations wish to work with the erotica industry to encourage safer sex practices. We recognize that the erotic media (photographs, magazines, stories, film, video, etc.) are an important means by which many people learn and reinforce the patterns of their sexual expression. We urge the erotica industry to join with us because we believe that together we can be more effective in the AIDS prevention effort. We are aware that the erotica industry is currently under attack from right-wing elements in this society. We do not want to join in that attack; indeed, we wish to be able to work with the erotica industry to affirm positive and healthful sexuality. We encourage the industry to use its imagination, resources, and our AIDS prevention Guidelines to include safer sex practices, especially the use of condoms in their productions. We are strongly concerned about the risks facing actors, actresses, models, etc. working in the production of erotica, but we are confident that by joining efforts, the erotica industry will help to save countless lives.

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MEDICAL ANSWERS ABOUT AIDS--2ND EDITION RELEASED BY GAY MEN'S HEALTH CRISIS

The second edition of Gay Men's Health Crisis's "Medical Answers About AIDS--Basic Questions and answers about AIDS" is available in bulk quantity at 58 cents per copy, by writing to GMHC, Box 274, 132 West 24th Street, New York, NY 10011 (212/807-7035). The 43 page booklet answers over 30 commonly asked questions about the syndrome, including transmissibility, signs & symptoms, diagnosis, treatment, and prevention. The booklet concludes with a statement supporting an overall philosophy that incorporates civil rights into public health: "Historically, homosexuals have been stereotyped as incapable of establishing enduring monogamous relationships. Illogically, this prejudice has been used as a justification for denying homosexuals the theological, social and legal opportunities to establish such relationships. Logically, a number of leading medical and scientific authorities have expressed their belief that the cultural sanctioning of same-sex relationships would help to encourage the establishment of more stable monogamous relationships among gay men (STD rates among lesbians have always been and remain the lowest of any group identified by sexual orientation). The protection of the basic civil liberties of all lesbian and gay persons, which would include the recognition of same-sex relationships, should thus be an essential consideration in the long-range preventive medicine of AIDS and other sexually transmitted diseases."

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MEDICAL CONSULTATION REQUESTED

An Australian man is seeking a medical consultation for atypical signs and symptoms suggestive of AIDS related conditions. In spite of repeatedly normal white blood cell counts (and T-cell subsets), and negative HTLV-III antibody tests, the person and his doctors are unable to explain or treat his symptom complex. Any clinician willing to consult with this person's physician, is asked to contact the NCGSTDS, PO Box 239, Milwaukee, WI 53201 (414/277-7671) for a copy of the address and 4 page letter.

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NATIONAL STRATEGIES FOR AIDS STUDIED

The National Academy of Sciences (NAS) and the Institute of Medicine (IOM) have launched an intensive, six-month study to assess national strategies for scientific research, health care delivery, and public health measures in response to the growing national and international problem of AIDS. The study was initiated by the governing councils of the NAS and the IOM to provide an independent setting for identifying public and private sector policies most likely to accelerate development of effective research, prevention, and treatment of the disease. The joint NAS/IOM study will be conducted by two panels and a coordinating steering committee. Research on AIDS has proceeded rapidly, including early isolation of the responsible virus and development of a blood test that uses detection of AIDS antibodies to identify infected individuals. Nevertheless, there are many remaining research needs such as development of an AIDS vaccine and of effective treatment programs. The new NAS/IOM committee will examine whether additional targeting and coordination of such efforts might speed progress progress in coping with the disease. Support for the study has been provided by a consortium of foundations including the Carnegie Corporation of New York, the Charles E. Culpeper Foundation, the William and Flora Hewlett Foundation, the John D. and Catherine T. MacArthur Foundation, and the Rockefeller Foundation.

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GAY/LESBIAN ISSUES DISCUSSED BY CONFERENCE OF MAYORS

with thanks to Detroit's Cruise, 2/19/86

The U.S. Conference of Mayors considered several issues of concern to the gay/lesbian community at their January meeting in Washington, DC. The Mayors AIDS Task Force and the affiliated U.S. Conference of Local Health Officers met to discuss the local response to AIDS, and the U.S. Conference of Mayors' National Institute of Policing sponsored a panel discussion that included police/gay community relations. Jeff Levi, NGLTF Director of Governmental and Political Affairs, and Kevin Berrill, NGLTF Violence Project Coordinator, presented briefing papers and policy statements to each of the groups. On January 21, health officers representing 32 localities participated in a Conference of Local Health Officers discussion of AIDS. Recommendations from that meeting to the Mayors AIDS Task Force included: opposition to the reporting of HTLV-III antibody test results "except in the context of epidemiological study;" support for federal guidelines for addressing AIDS issues in the community; increased federal funds to assist localities in "dealing with this national epidemic;" support for education efforts "at every opportunity" including where appropriate, "preparation of explicit materials targeted to high risk populations." While unanimous in their support for "adherence to the strictest confidentiality protocols" as an "absolute minimum condition for any AIDS-related health activities," the health officers were split in their views on whether HTLV-III testing sites should be anonymous or collect identifiers in a confidential manner. Slightly more than half of the groups favored total anonymity. Perhaps the most unambiguous statement was on the subject of quarantine. The health officers declared that "quarantine has no known effective application in reducing the transmission of HTLV-III/LAV infection at this time. Under no circumstances is a quarantine warranted for a class or group of individuals who are HTLV-III/LAV seropositive." NGLTF, in its position paper prepared for the health officers, made clear its opposition to mass screening for HTLV-III and mandatory reporting of test results, its support for anonymous testing, and its fear that contact tracing programs would drive people away from testing sites and encourage anonymous sexual encounters. "The health officers were very aware of the concerns of the gay community, particularly in the areas of testing and the use of coercive measures," Levi said. "It was gratifying to see the high level of interest from health officers from cities large and small. It was also interesting to note that those most sensitive to the concerns of those at high-risk were those health officers from communities with the most experience with AIDS. That shows the success of community efforts to work with health officers." The Mayors AIDS Task Force received a presentation from the health officers on January 22nd. Mayor Diane Feinstein of San Francisco, who chairs the Task Force, also made a strong appeal for closure of bathhouses as an effective way of halting transmission of AIDS. NGLTF, in a position paper prepared for the meeting, reiterated its opposition to "government regulations that attempt to police the sexual behavior of individuals....We are concerned that [such] regulatory actions...establish a dangerous precedent in favor of the reinstitution of sodomy statutes and other violations of the right to privacy." Lambda Legal Defense and Education Fund contributed a discussion of the constitutional issues related to bathhouse closure for the paper. With the assistance of NGLTF's Berrill, the Conference of Mayors' National Institute of Policing sponsored a panel discussion entitled "Police Relations with the Minority Community." The panel included Seattle Police Chief Patrick Fitzsimons who spoke on police/gay community relations in that city. Fitzsimons described measures his department has taken to "bring the police closer to the gay community," including the establishment of the Police/Gay Task Force, publication of a safety brochure to deter anti-gay violence, initiation of gay awareness training programs, and enforcement of strict policies prohibiting disrespectful language and behavior towards lesbians and gays. According to Berrill, "the Conference of Mayors panel afforded a unique opportunity to examine the problems and the progress that has been made in the area of police/gay community relations. I hope Seattle's example will encourage other police departments to reach out and work with local gay people." A paper prepared by Berrill for the meeting addressed the need for dialogue, training, hiring of openly gay and lesbian law enforcement personnel, strategies to deal with anti-gay violence, and vigorous response to complaints of police abuse. The paper described progress in these areas in various police departments around the country. Copies are available from NGLTF (80 Fifth Av., #1601, New York, NY 10011).

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INFORMATION WANTED BY U.S. CONFERENCE OF MAYORS AIDS PROGRAM

by Deborah E. Lamm, Assistant Executive Director

The AIDS Program of the U.S. Conference of Mayors (USCM) was created two years ago in order to educate local public officials about AIDS and to offer direct support to community-based organizations so that they, in turn, can educate members of high-risk groups. The "AIDS Information Exchange" which you receive is an example of USCOM's work in this field. In the interest of keeping abreast of community-based AIDS activities, USCM requests your assistance in compiling AIDS-related materials (e.g., brochures, pamphlets, factsheets, posters) produced by your group to the USCM, 1620 Eye Street, NW, Washington, DC 20006, Attn: Alan Gambrell. If possible, provide ten copies of each item. Thanks!

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COUPLE TAKES IN BOY WITH AIDS

with thanks to the Computerized AIDS Information Network (CAIN), 3/28/86

The first time the woman saw the little boy with AIDS, he was in a hospital crib and had tubes in his nose. "I want him," said the 50 year old woman who has raised 11 children of her own, and then became Massachusett's first and only foster mother of a child with AIDS. "We explained to her that the child was very ill, and we urged her not to make a decision until she had seen him in the hospital," an unidentified social worker told The Boston Globe. The state Dept. of Social Services had searched for a foster home for the 2 year old boy for months, and has been looking since last summer for a home for a 2 year old girl suffering from AIDS. The boy contracted AIDS from his mother, a heroin addict and prostitute who died last fall. His father was killed in a brawl, and family members could not take care of the baby. The foster mother was given one week of intensive training at the hospital, where she learned how to change the child's diapers safely, bathe him, prepare foods and insert and remove the nose tube he sometimes needs because of congestion. She is required to wear gloves for many tasks, and she sterilizes the boy's dishes and utensils and keeps them in a separate cupboard. One of the woman's grown daughters also took the training and helps with the boy's care. State guidelines discourage kissing on the mouth. "But I hug him lot," the woman said. "Why should I be afraid? God takes care of us." A visiting nurse and a play therapist come in once a week, and the woman exercises the boy's legs every day to help him stand straight. The child sleeps in a crib next to the woman's bed, and she and her husband often are up at night when the boy has trouble breathing. Since moving into the foster home, the boy has returned to the hospital four times for a total of 30 days. His foster mother goes with him and sleeps in a bed next to his. She said she understands how sick the boy is, but she plans to take in another AIDS child when he is gone. "You need a lot of patience and a lot of love," she told the Globe. "The hardest thing is when he's very sick, and I take him in the hospital with the fear that he may not return home."

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ANIMATED AIDS VIDEOTAPE FOR SCHOOL CHILDREN

with thanks to The Washington Blade, 3/7/86

Cartoonist Charles Thompson from Charlottesville, Virginia released a half-hour animated videotape on AIDS recently, aimed primarily at school children. Thompson, who has made other health-related films, said he felt a cartoon would provide information on AIDS in an "anxiety-reducing" and "non-threatening" way. Because AIDS is spread primarily through sexual contact and intravenous drug use, Thompson said he believes it is important to educate teenagers "who face decisions on drugs and sex at 13-14 years old." Besides school systems, the film is being used in colleges, prisons, and hospitals. The film's language and content were approved for student audiences by the superintendent of Charlottesville city schools, and the script was reviewed by lesbian author Rita Mae Brown.

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SUICIDE & AIDS RISK LINK CITED

with thanks to Computerized AIDS Information Network (CAIN), 3/24/86

The death of Rodney Self, a 32 year old Dallas man with AIDS who apparently jumped from his 6th floor hospital room window, dramatizes the need for new approaches to help victims of the disease. Counselors said they have stepped up training on helping suicidal people with AIDS because of a growing awareness that the double blow of terminal illness and social stigma puts such people at a high risk. Suicide prevention workers said there is an increased awareness about AIDS sufferers looking at suicide as a way out. "The grim reality of AIDS is that each one thinks they're going to be the one to beat it and I think when the realization comes that they're not going to. I think that's pretty overwhelming," said Williams Waybourn, a member of the board of directors of the Dallas Gay Alliance. In a similar incident last October, two men believed to be suffering from AIDS tied themselves together at the waist and jumped 35 floors from their New York apartment building. Waybourn said workers believe there have been other AIDS-related suicides, but they have not been publicized. Counselors dealing with suicidal PWAs can do little more than listen, he said. "Its nothing you can argue against rationally. AIDS is fatal." Judie Smith, director of education for the Dallas Suicide and Crisis Center said there are few statistics on suicide among PWAs, but it is receiving more attention. She said the problem probably would be a major topic of a suicide prevention workers' conference in Atlanta. A spokeswoman for the Parkland Hospital where the suicide occurred, said no additional counseling is planned for other AIDS patients. She said administrators are checking windows to see if they are secure, but fire codes prohibit barring them. "We will make sure that our nursing staff is just very sensitive," said Catherine Ellis. She said nurses strive to make AIDS patients aware of the counseling available. Rex Patton, a volunteer with the Buddy Project for PWAs at the Oak Lawn Counseling Center, said, "We listen and that's probably the biggest thing a buddy does." He said that although most people diagnosed with AIDS think about committing suicide, many really want someone to give them reasons to keep on living.

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JEWISH AIDS PROJECT MOBILIZED

A National Jewish AIDS Project was established to generate, mobilize, and coordinate efforts in the community to respond to the needs of victims of the fatal disease and their families. The project was launched at a meeting of the Reconstructionist Foundation which brought together key figures from Jewish religious organizations and welfare agencies with gay activists. The impetus for the meeting and the project came from Foundation executive director Rabbi David Teutsch. Describing AIDS as "the most rapidly developing health crisis in American society since World War II," Teutsch pointed out that the number of people affected by it goes beyond the gay Jewish population and their families, and "is much vaster than people realize." People who have had blood transfusions in the past may also be at risk. The project will provide education and information to the Jewish community about AIDS and how to help its victims, galvanize the "pooling of resources" on their behalf, and function as a clearinghouse for the victims themselves as to whom to turn to in the community for pastoral counseling, family and home care services and legal assistance. A top priority will be to educate rabbis, rabbinical students, chaplains, and Jewish communal service professionals on AIDS and how to work with the victims and their families. "Members of synagogues are afraid to tell their own rabbis their children are dying in another city," he said. Educating rabbis, Teutsch believes, is crucial, not only because they do pastoral counseling but also because through their sermons and influence "they can open up the issue in the community." It is not only rabbis who need sensitization on the issue, Teutsch continued. It is also funeral directors, who need to treat AIDS victims in the same manner as other deceased persons; doctors and dentists; and synagogue groups doing "bikur cholim" (visiting the sick). All of these need information to be able to "overcome their fears" of contact with AIDS victims and their families, he said. A second major goal--mobilizing, developing, and coordinating home care resources for people with AIDS--derives from the fact that they are "best cared for at home," he said. Provisions need to be made for their meals, including kosher food for those who need it, and occasional transportation. Various Jewish agencies and bikur cholim groups could provide them with such services. A third aim is to involve various Jewish civil rights organizations in "advocacy" on behalf of people with AIDS. This includes legal work for AIDS victims who are fired or evicted, and legislative lobbying for government funding of hospice programs and other non-hospital services. The director of the project will be Daniel Najjar, a board member of Bet Mishpacha, the 20 year old gay and lesbian synagogue in Washington, DC. Najjar said that Jewish people with AIDS feel "they can't turn to the community for help even when they are dying. They have a desperate need to link up" with the Jewish community, he said. Najjar estimated that at least 300 to 500 Jews have been diagnosed with AIDS since 1979. This estimate is based on taking 2.2% (the percentage of Jews in America) of the CDC figure of reported diagnosed cases. Synagogues in Los Angeles, San Francisco, and New York "have lost members to AIDS, and most major cities' Jewish communities currently have members who are sick and dying," Najjar said. "Those areas of the country which have been hardest hit by the disease are also the largest areas of Jewish population--New York, California and Florida." Rabbi Yoel Kahn, spiritual leader of Shaar Zahav, the gay congregation in San Francisco, said he is being referred one person with AIDS per week. Everyone in his congregation, he said, "has lost a close friend. Most lost several. Older members...have stopped counting after 20." The Jewish organizations whose key figures are involved with the project include the (Reform) Union of American Hebrew Congregations, the (Conservative) Rabbinical Assembly, the Association of Jewish Family and Children's Agencies, the Council of Jewish Federations, the Federation of Reconstructionist Congregations and Havurat, and the World Congress of Gay and Lesbian Jewish Organizations. Najjar said the project has already had some initial pledges of funds and that it will be seeking additional seed money to get it underway. The National Jewish AIDS Project will initially operate out of offices at 2025 Eye Street, NW, #721, Washington, DC 20006 (202/387-3097). "AIDS victims feel a sense of abandonment, which augments and intensifies their tragedy," Teutsch said. The community can and must deal with this sense of abandonment by "reaching out" to them, and showing them that "the vast majority of Jews are deeply concerned."

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FLINT, MICHIGAN ORGANIZES AIDS PROJECT
with thanks to Detroit's Cruise, 4/2/86

Detroit's Wellness Network, Inc. has begun a satellite operation in the Flint/Ann Arbor area of Michigan. In operation for almost 3 years, Wellness began the expansion into Flint/Ann Arbor through the efforts of concerned individuals from various parts of the state. Wellness-Flint offers a variety of services dealing with positive health practices, with a special emphasis on AIDS. A referral line, staffed weekdays from noon until 6 pm has been installed at the Hurley Medical Center's out-patient laboratory. Volunteers are available to answer questions and concerns about AIDS, other STDs, the HTLV-III antibody test, as well as giving information about safe sex practices. Among other services, Wellness-Flint offers support to persons with AIDS, their families, lovers and friends, and support to those persons exposed to the AIDS virus. In order to effectively meet their goals, Wellness-Flint needs persons who are willing to devote their time and energies to helping this cause. For additional information: Wellness Networks, Inc., PO Box 3605, Flint, MI 48502 (313/257-9447).

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GAY/LESBIAN NATIONAL ORGANIZATIONS NEED YOUR SUPPORT!

Following are a list of the national gay & lesbian organizations that need your support. Their victories will benefit all of us!

NATIONAL GAY/LESBIAN TASK FORCE (NGLTF) is the premiere political & civil rights organization, now with offices in New York City and Washington, DC. Address: NGLTF, 80 Fifth Av., #1601, New York, NY 10011 (212/741-5800).

AIDS ACTION COUNCIL (AAC) is the major lobbying force for AIDS service organizations in the nation's capitol. Address: AAC, 729 Eighth Av., SE, #200, Washington, DC 20003 (202/547-3101, Contact: Gary MacDonald, executive director.)

FUND FOR HUMAN DIGNITY (FHD) operates the national gay/lesbian clearinghouse, the National Gay/Lesbian Crisisline and AIDS 800 (1/800/221-7044, in AK, HI, NY: 212/807-6016). Address inquiries: FHD, 80 Fifth Av., New York, NY 10011 (212/741-5800).

NATIONAL AIDS NETWORK (NAN) is the newest of the national organizations, designed to meet the growing needs of AIDS education and service providers. Address inquiries: NAN, 729 8th Street, SE, Washington, DC 20003 (202/546-2424 contact: Paul Kawata, Executive Director).

AMERICAN ASSOCIATION OF PHYSICIANS FOR HUMAN RIGHTS (AAPHR) is the nation's gay/lesbian physician & medical student social support, educational, and political organization, offering much input and expert testimony to the NIH, CDC, and other public health organizations, and helping to educate fellow medical professionals about gay/lesbian issues. Address: AAPHR, PO Box 14366, San Francisco, CA 94114 (415/558-9353, contact: Doug Carner, Administrative Assistant).

NATIONAL LESBIAN AND GAY HEALTH FOUNDATION (NLGHF) cosponsors national lesbian & gay health conferences and national AIDS forums, and is involved with other major projects, e.g., a landmark national lesbian health survey is being compiled. Address: NLGHF, PO Box 65472, Washington, DC 20035 (202/797-3708, contact: Caitlin Ryan).

NATIONAL COALITION OF GAY SEXUALLY TRANSMITTED DISEASE SERVICES (NCGSTDS) circulates the widely read & acclaimed Newsletter, which is a "must read" for gay health workers, politicos, and AIDS service providers. Address: NCGSTDS, POB 239, Milwaukee, WI 53201 (414/277-7671, contact: Mark Behar).

NATIONAL GAY RIGHTS ADVOCATES (NGRA) is a public interest law firm, interested in test cases involving civil & constitutional rights of sexual minorities. Address: NGRA, 540 Castro St., San Francisco, CA 94114 (415/863-9156).

LAMBDA LEGAL DEFENSE & EDUCATION (LLDEF) provides legal assistance to the gay/lesbian community in major areas of civil rights infractions/discrimination. Address: LLDEF, 132 W. 43rd Street, New York, NY 10036 (212/944-9488).

INSTITUTE FOR THE PROTECTION OF LESBIAN & GAY YOUTH (IPLGY) recently opened the first certified high school for openly gay/lesbian youth (Harvey Milk High School), and offers many supportive services for youth dealing with their sexuality. Address: IPLGY, 112 East 23rd Street, 4th Floor, New York, NY 10010 (212/473-1113, contact: A. Damien Martin, Executive director.)

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STANFORD UNIVERSITY CARES

Stanford University is hosting a garden party and reception in support of San Francisco area AIDS organizations. As an educational and research institution, Stanford can play a vital role in bringing together medical researchers, concerned lay people, educators and health care providers who are working to understand and combat AIDS. This reception is part of our community's response, and acknowledges that AIDS threatens all of us--if only by claiming the lives of people we respect and care for. It is also an opportunity to recognize the efforts of Stanford's medical community in research and treatment of AIDS. The reception will occur on May 10, and will be followed by a performance of "Unfinished Business" by Theatre Rhinoceros of San Francisco. For more information, contact: Stanford Cares, POB 8265, Stanford University, Stanford, CA 94305.

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LAMBDA FILES PROTEST OVER INSURERS USE OF TEST

with thanks to The Washington Blade, 3/21/86

Charging that insurers are using AIDS to discriminate against gay men, Lambda Legal Defense and Education Fund filed a complaint March 10 with New York State's Insurance Department. The gay legal rights advocates called for an investigation of insurance company use of the HTLV-III antibody test as a requirement for insurance coverage "for single men in general, and gay men in particular." The complaint was filed on behalf of a New York City man, Kenneth Cornet, who was told by Bankers Security Life Insurance Society to take the blood test. Cornet's application for $100,000 in life insurance was rejected by Bankers Security when he refused to take the test. New York Governor Mario Cuomo has proposed legislation that would ban use of the antibody test by insurance companies in New York State. In a recent meeting with gay activists, he promised to pursue Lambda's complaint and push hard for his bill.

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SENATE HEARS PLEAS TO MAKE NEW DRUGS MORE AVAILABLE

by Lou Chibbaro Jr., with thanks to The Washington Blade, 4/18/86

A man with AIDS and a woman whose child died of AIDS told a Senate committee that both gay and non-gay people with AIDS face frustration and despair over their inability to obtain experimental drugs that are widely reported in the news media. Nathan Smith, a hemophilia patient who said he contracted AIDS through use of co-taminated blood products, and Helen Kushnick, whose three-year old son died of AIDS he had contracted from a blood transfusion, gave emotional accounts of how the disease changed their lives and the lives of their families. Smith and Kushnick joined NGLTF official Jeff Levi and seven federal health officials in testifying before the Senate Committee on Labor and Human Services, in the Senate's first hearing on the AIDS epidemic. Senator Orrin Hatch (R-Utah), chairman of the committee, said he called the hearing to "take stock of where we are, both in government and the private sector, in terms of learning about AIDS, in fighting its spread, and eventually, in curing it." Smith and Kushnick, who serves as a member of the board of the American Foundation for AIDS Research (AmFAR), said people with AIDS are also becoming increasingly frustrated when they see reports in the news media about potential drugs thought to be able to check the AIDS virus within the body. The two said that while the National Institutes of Health has touted these drugs in press conferences, NIH officials have dashed the hopes of "thousands" of people with AIDS by refusing to make such experimental drugs available to more than a few patients in selected cities. Dr. Anthony Fauci, an official with NIH, told the committee all drugs must be tested for safety before being disseminated widely. Fauci also noted that while NIH is hopeful that some drugs may soon prove effective in treating AIDS, there is no known drug that has been shown to halt or reverse the destruction of the body's immune system brought on by AIDS. However, Smith and Kushnick, along with Levi, called on the committee to prod government officials into making experimental drugs available to more people with AIDS even if the drugs' effectiveness is not proven. "The federal government must step in to assure that the person with AIDS in Phoenix or Des Moines has the same chance for receiving the best available treatment and care as the person with AIDS in San Francisco or New York," Levi said. Levi and Gary MacDonald, executive director of the AIDS Action Council, praised Hatch for organizing the hearing and for supporting increased funding for the fiscal year 1986 AIDS budget. Hatch said that he will study written testimony submitted by all witnesses at the hearing to determine if additional funding is needed for government AIDS programs.

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TREATMENT PROGRAMS WOULD BENEFIT FROM KENNEDY AIDS PACKAGE

by Kim Westheimer, with thanks to Boston's Gay Community News, 5/3/86

A $25 million AIDS funding bill was filed by U.S. Senator Edward Kennedy (D-MA), and has received mixed reactions from AIDS activists. The bill would establish grants for public education programs and for in-patient and out-patient treatment for people with AIDS. In addition, it calls for Congressional authorization of an already existing AIDS research coordinating committee which oversees the National Institutes of Health's (NIH) AIDS activities. The legislation provides for $10 million annually for fiscal years 1987-89 in grant money to private and public non-profit organizations for AIDS education, and $15 million in grants for both in- and out-patient care and treatment for people with AIDS. The bill must be approved by the Senate Labor and Human Resources Committee before reaching the full Senate. One of the most important segments of the legislation, according to AIDS activists, is the grant money for out-patient treatment. This money could be used to fund hospice care, an alternative to hospital treatment, for PWAs. "We need a legislative vehicle to raise issues of providing care [outside of hospitals.]" said the NGLTF's Jeff Levi. "I would hope as the bill evolves, the focus will be on the care and treatment section." "Our sense is that it's a timid step in the right direction," said Paul Boneburg, director of Mobilization Against AIDS. "Right now 20,000 people have AIDS and 200,000 have ARC. Hundreds of thousands of Americans are sick and are going to get sick, and we're talking about $15 million for hospice care?"

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SIGNIFICANT OTHERS BENEFIT PWAS

with thanks to The Washington Blade, 3/14/86

A study released by the St. Luke's Roosevelt teaching hospital in Manhattan revealed that "AIDS patients who have a strong supportive relationship with a `significant other' can often be discharged fromt he hospital even at the end stages of the disease." Mary Belmont, RN, helped head up the 16 month study of 152 AIDS patients at the hospital, said that she came across several AIDS patients "who, judging by their nursing notes, should have been in comas, and yet they were going home, because they had important people in their lives who were able to provide them with a profound level of support."

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PHYSICIANS NEEDED FOR NATIONAL ASHA REFERRAL NETWORK

Since 1979, the toll-free VD National Hotline of the American Social Health Association has answered approximately 300 calls a day regarding sexually transmissible diseases from people throughout the United States. Specially trained volunteer operators can refer callers to pubic clinics or private physicians for diagnosis and/or treatment through the use of computerized referrals. A survey done by the Hotline in 1982 revealed that many callers prefer diagnosis and treatment by private physicians rather than public clinics. That same year, an editorial by selected ASHA board members requesting physicians to join the Hotline's referral network was placed in various medial journals. We currently have approximately 1500 physicians from varied specialties, but still need many more to meet the needs of our callers. We need the clinicians associated with your membership to join the VD National Hotline referral network. All interested practitioners are asked to contact the Hotline, who will then send a questionnaire. Family practitioners, gynecologists, obstetricians, dermatologists, urologists, internists, and those working in gay community practices are especially needed. For additional information, contact: Michael Edell, Director, VD National Hotline, 260 Sheridan Av., Suite 307, Palo Alto, CA 94306, or call 415/327-6465 (Pacific time, Monday-Friday, 8am-4:30pm).

SPANISH EDUCATIONAL MATERIALS AVAILABLE

The Funcacion AIDS de Puerto Rico, Inc. (FAPRI) has published three booklets in Spanish which may be of interest to groups working with Spanish-speaking communities: "Sexo Mas Sano/Cuerpo Mas Sano" (a safer sex guide for gay men), "Preguntas y Respuestas Sobre AIDS" (answers to some 30 questions about AIDS, for general use), and "Cuando un amigo tiene AIDS..." (a Spanish-language version of a booklet prepared by Chelsea Psychotherapy Associates, "When a friend has AIDS..."). Copies may be obtained by writing to: FAPRI, Call Box 8347, Fernandez Juncos Station, Santurce, Puerto Rico 00910. The Foundation is interested in receiving copies of any Spanish-language publications, posters, etc. related to AIDS.

PHOENIX AIDS HOSPICE SOUGHT

with thanks to the Computerized AIDS Information Network (CAIN), 4/12/86

Fearing that people with AIDS will become "modern day lepers," a Roman Catholic nun and the chaplain at Adobe Mountain School in Phoenix have joined efforts to raise funds for a group home for people dying from the disease. "Many of these people have no place to go and no one to care for them...they die alone and lonely," said Sister Teresa McIntier, who has been active in the hospice movement in the Phoenix area. She and the Rev. Ken Van De Ven are working with the newly formed Housing, Hospice and Medical Care (HHMC) for AIDS in an effort to provide group care for victims of the fatal disease. Marion Lazarous and John Rowell, two nurses who helped found HHMC, said they were convinced by their experiences in local hospitals that there is a need for such a facility. They said they asked for help from Sister McIntier and the Rev. Ken Van De Ven because the clergy has a reputation for understanding and helping dying patients. "There is a stigma against persons with AIDS," said Sister McIntier. "Society sometimes treats people as if their disease is a punishment from God. When they condemn [patients] that way, they are acting as judges, when God is the only real judge." Nearly all of the more than 100 Phoenix-area PWAs are homosexual men, Roswell said. Van De Ven said many AIDS patients suffer additional emotional pain from condemnation, rejection, and abandonment. "The [Catholic] Diocese supports a very compassionate, charitable approach to AIDS," he said. "Many are judgmental of people who get AIDS, but the church isn't that way. We support compassion, not condemnation, and we accept people as we find them." County-supported nursing homes will not accept a patient who is too ill to return home but not sick enough to be hospitalized, Rowell said, often leaving AIDS patients with nowhere to turn. Mary Kelly, director of Maricopa County's long term care program, said none of the county's contracted nursing homes are willing to take AIDS patients. "There is the fear of the unknown...." Edgy Fine, a social worker for the county, said she has met with groups in other cities about the feasibility of group homes. She also has approached Phoenix-area hospitals about the possibility of opening a home, but found that most did not believe there was a strong need for such a facility.

HOUSTON MAY OPEN AIDS HOSPITAL

with thanks to the New York Native, 4/28/86

The first hospital in the nation devoted to AIDS research and diagnosis may be opened in Houston, if a plan to convert a for-profit hospital is worked out. The University of Texas (UT) Board of Reagents recently approved the plans for Citizens Hospital, a 150 bed facility operated by AMI Corporation with the University providing clinical direction and research. The hospital would be called the Southwest Institute of Immunological and Infectious Disorders, and would be available to local AIDS patients. "I hope the public in general realizes the objective is a good one. There is no element of quarantining or ostracizing AIDS patients, and there is no risk to the population around [the hospital]," said Dr. Peter Mansell, who heads UT's AIDS program at M.D. Anderson Hospital and Tumor Institute.

HOMOPHOBIA CONTINUES AMONG PHYSICIANS

with thanks to Detroit's Cruise, 3/26/86

A recent study published in the January, 1986 issue of The Western Medicine Journal shows significant negative attitudes among physicians toward homosexuality. A research team consisting of faculty from three San Diego colleges and universities conducted the study using questionnaires distributed to the entire membership of the San Diego County Medical Society. The questionnaire, separating respondents by the area of medical specialty, asked how physicians felt toward homosexual applicants to medial school, homosexual physicians, and treatment of homosexual patients. When asked if a "highly qualified homosexual applicant" should be admitted to medical school, 29.7% of the physicians responded negatively. Differences among areas of specialty on this item were significant, with 49% of the orthopedic surgeons being opposed, while only 9.2% of the psychiatrists opposed. In answer to another survey question, homosexual physicians would find the most opposition if they sought residency training in pediatrics (45%) or psychiatry (39%). It is interesting to note, however, that pediatricians and psychiatrists themselves did not share this negative view of homosexuals entering their own fields of specialty. Only 1.6% of psychiatrists would discourage residency in their own field. Referrals to known homosexual physicians would be discontinued by substantial numbers of responding physicians. According to the study, more than 40% would discontinue referrals to homosexual pediatricians and psychiatrists, 25% to homosexual general surgeons, and nearly 20% to homosexual radiation therapists. The smallest loss of referrals would be from psychiatrists, pediatricians, and internists. When asked how physicians feel toward treating homosexual patients, the majority (60.6%) reported "no negative feelings;" whereas, 39.4% felt "sometimes" or "often uncomfortable." However, of those who reported being "often uncomfortable," fewer pediatricians and internists were represented; no psychiatrists reported feeling "often uncomfortable." The head of the research team, Dr. Christopher Mathews, noted that the study was conducted before widespread media attention to AIDS. According to Mathews, "If the study were conducted today, it would be very difficult to distinguish between homophobia and the stigma which has been associated with AIDS." Mathews went on to say that various studies have suggested that negatively stereotyped patients receive less adequate health care. Furthermore, the study shows that sexual orientation is a barrier to professional entry and pursuit of specialty practice no matter how highly qualified the individual.

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DOCTORS REQUIRED TO MAKE HOUSE CALLS IN NEW YORK

with thanks to Philadelphia Gay News, and The Baltimore Gay Paper, April, 1986

Doctors undergoing residency at New York City's Bellevue Hospital are providing unique care to many AIDS patients--they are making house calls on people who are sick or dying from the disease. While the program has been criticized for taking the young physicians away from the hospital, many of them say it provides them with important skills in dealing with patients who are near death. Residents have helped dying patients achieve their last wish of dying at home with family, friends or pets close at hand, even though loved ones were eager to have the patients admitted to a hospital for fruitless and expensive emergency care. One doctor told the family of a young gay Puerto Rican man dying from the disease. "Sending Jamie to the hospital is a temptation because it might buy him a little more time. But once there you wouldn't be able to stop what they'd do, and it is not what he wanted." The untraditional role for doctors is defended by Dr. Mack Lipkin, Jr., the head of an internal medicine residency program at Bellevue, where AIDS has become the single most common diagnosis and where more AIDS patients are treated than any other hospital in the nation. "Doctors must be taught how to attend the dying," Lipkin said. "Helping people to die with dignity and comfort is a basic part of a skilled physician's function. This is something a good doctor does well."

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PARENTS RAISE LEGAL FEES TO KEEP PWA OUT OF SCHOOL

with thanks to Los Angeles CAIN,3 2/27/86

Parents who don't want teen age AIDS victim Ryan White going to school with their children began passing the hat after a judge ruled they must raise a $12,000 bond to pursue their legal fight. "We started going door-to-door...and now we're thinking about car washes and rummage sales," Mitzie Johnson, head of Concerned Citizens and Parents of Western Middle School in Kokomo, Indiana. Howard County Circuit Judge Alan Brubaker, whose temporary restraining order bars Ryan from school, granted a request by Ryan's attorney, Charles R. Vaughn, for the bond. It would cover damages suffered by the 14-year-old boy and legal expenses should the case be dissolved. David Rosselot, the attorney representing the parents, has five days to submit a written guarantee for the money. He said he did not expect any problem meeting the bond. Ryan, who contracted AIDS from treatments for hemophilia, was first banned from classes by school officials in July. The parents went to court after the county health officer said Ryan could attend school without threat to anyone else, provided he followed state guidelines for children with AIDS. About half of the school's 360 students were kept home, and many parents said they were doing so because of the AIDS controversy. Ryan monitored classes through a home telephone hookup with the school.

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EVICTION FOUGHT OF PWA's SURVIVOR

by Bruce-Michael Gelbert, with thanks to Boston's Gay Community News, 4/12/86

More than 200 lesbian, gay and housing activists rallied in New York City's Chelsea section of Manhattan on March 29, in protest of eviction proceedings against a gay man whose lover recently died of AIDS. The afternoon action was organized by the Chelsea AIDS Committee on behalf of Michael Brown, lover of the late Robert Hayes, and took place where Hayes and Brown had shared a rent-stabilized apartment for eight years. Brown's name was not on the lease. In December of last year, Acting State Supreme Court Justice Helen Freedman ruled against Brown, in favor of landlord Bruce Kafenbaum. However, according to rally organizer and openly gay Chelsea District leader Tom Duane, eviction of Brown is currently stayed pending reconsideration of that decision. Brown's legal aide, Russell Pearce, has asked Freedman to declare Brown his surviving spouse, so that he could be protected under an emergency order forbidding evictions of spouses and family members of deceased tenants. The emergency order was issued by the State Division of Housing and Community Renewal, and blocks a November, 1985 ruling by the state court of appeals that relatives of a deceased tenant do not have the right to renew a lease. Should Freedman uphold her ruling for landlord Kafenbaum, the contingent "will stand outside the building and not let the marshall go in to evict Michael Brown." Most speakers at a rally addressed both discrimination against lesbians and gay men and the lack of rights for tenants in general. State Assemblyman Richard N. Gottfried told protesters that "apartments have to provide housing, not profits," but that "we're up against anti-AIDS propaganda...anti-gay propaganda [and] the political power of the real estate lobby." He asserted that the Legislature not only has to protect the rights of families, but to broaden its definition of family. State Senator Franz S. Leichter called landlords "heartless individuals" and Coalition for Lesbian and Gay Rights (CLGR) spokesperson Eleanor Cooper declared, "When greed is a dominant motive in the city...people lose their homes." Openly gay State Committee Member David Rothenberg, former candidate for a New York City Council position, called landlords "profiteers [who] create a condition where people are expendable." CLGR spokesperson Andy Humm stated, "There is no housing policy in this city, other than...survival of the greediest." Demonstrators chanted, "Stop AIDS evictions, save our homes," and carried signs that read, "Leases for life partners," "Save survivors' homes," and "Humanize landlords." The Chelsea AIDS Committee is prepared to organize other such actions if necessary, according to Duane.

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FLORIDA REPRESENTATIVE THROWS PWA OUT OF OFFICE

with thanks to Miami's TWN, and The Baltimore Gay Paper, April, 1986

Twenty-nine year old Jim Adams has had AIDS since October, 1984, and he's accustomed to dealing with people who are afraid to get near him. But Adams has never been treated worse than when he went into the private law offices of Florida State Representative Tom Woodruff (R-Pinellas) seeking legal help. Woodruff greeted Adams in the lobby, inviting him into his office. The attorney was filling out a standard form, but stopped when he asked Adams about his occupation. "I told him I was disable and he said, `why?' I said that I had cancer and he said, `what kind?' When I told him it was Kaposi's sarcoma, he said that he had never heard of that. I told him it was fairly rare, that it was AIDS-related." Woodruff turned stiff and stood up, telling Adams, "I can't represent you. You're endangering my life and you're endangering my staff. I'll have to ask you to leave." "My first reaction was to get upset, but I told myself there was no need getting radical in his office; there are other ways of handling this," Adams said. He left Woodruff's office calmly, walking to a pay phone to call his media contacts.

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SEATTLE VOLUNTEER ATTORNEYS FOR PWAS

with thanks to Staff Notes--A Newsletter for the Staff of Seattle Gay Clinic, March, 1986

Wills will be provided free of charge for people with AIDS who cannot otherwise afford to have their legal needs met, by a group of Seattle attorneys who have recently formed an organization to provide this service, Volunteer Attorneys for People With AIDS (VAPWA). VAPWA will assist people with AIDS or ARC in drafting wills, powers of attorney, directives to physicians and other related documents. A power of attorney permits another person to manage the legal affairs of the PWAs, including the power to write checks and sign documents. A directive to physician, or "living will," while not legally binding, can express a person's preference for a dignified death over a mechanically prolonged life. These documents would be beneficial even to those with little property. Those seeking information or wishing to make an appointment with an attorney, may leave a message for the VAPWA coordinator at 206/322-2777.

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TEACHER PLACED ON LEAVE FOR POSITIVE ANTIBODY TEST IN FLORIDA

with thanks to Miami's TWN, and The Baltimore Gay Paper, April, 1986

When a surgical nursing assistant learned that a patient scheduled for minor surgery had been exposed to the AIDS virus, she took a double-take. Realizing that the patient was her 10 year old son's elementary school teacher, she had no option but to inform the school principal. Now Betty Peters is without a job and the 28-year old teacher has been placed on paid medical leave.

ANTI-AIDS TEST INSURANCE BILL PASSES IN DC

by Lou Chibbaro Jr., with thanks to The Washington Blade, 4/25/86

The Washington, DC City Council's Committee on Consumer and Regulatory Affairs unanimously approved a bill establishing a 5-year moratorium on the use by insurance companies of tests for exposure to the AIDS virus as a means of denying or restricting applicants from receiving life, health, or disability insurance. The bill would prohibit insurance firms from denying, canceling, or refusing to renew insurance coverage because an individual tested positively on "any test to screen for the presence of any probably causative agent of AIDS...." After a five-year period, the bill allows insurance firms to apply to the city's superintendent of insurance for permission to use a test for the purposes of establishing rate differentials for persons testing positively, but the legislation does not allow firms to deny coverage. Bill Bogan, a spokesman for the Metropolitan Washington Committee on AIDS Issues, a coalition of gay groups, called the bill a "very acceptable compromise" and urged gays to ask their councilmembers to support the legislation. Representatives of the insurance industry, however, said the bill unfairly penalizes insurance firms by preventing them from determining whether an applicant is at risk for AIDS. "This will allow someone to go to [a clinic], find out he tests positive [for HTLV-III antibody], and then apply for $400,000 in life insurance," said Russell Iuclano, legislative director of the American Council of Life Insurance Companies. Iuculano said insurance firms will be forced to raise rates for all customers to recoup potential losses, requiring healthy persons to pay an "AIDS tax." He said the insurance industry will step up its lobbying campaign against the bill in the full Council. The bill would empower the city's superintendent of insurance, five years after the legislation passes, to give insurance companies "permission to increase rates, premiums, dues, or assessments, or impose a surcharge, for individuals who test positive for exposure to the probably causative agent of AIDS." The bill also prohibits insurance companies from engaging in "redlining" or refusing to issue coverage to persons in certain neighborhoods or to persons within certain categories, such as single men over the age of 30. The bill goes before the full 13 member Council for a first reading on May 13.

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POLITICIAN SAYS INSURANCE COMPANIES WON'T GET RESULTS IN CALIFORNIA

edited by John A. Fall, with thanks to the New York Native, 3/3/86

California State Assembly Speaker Willie Brown said January 31 that protected confidentiality of HTLV-III antibody test results will remain the law in the state. Insurance lobbies have been seeking the repeal of Assembly Bill 403, legislation passed last year which protects people with positive test results from discrimination. "One power the Speaker always has is the power to kill a piece of legislation," Brown told the gay political action committee, the Alliance. Brown represents the northern half of San Francisco in the state legislature, and is considered the second most powerful politician in California after Governor George Deukmejian, reports Brian Jones of the Bay Area Reporter.

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NGRA SUCCESSFUL AGAINST INSURANCE COMPANY

Munich American Reassurance Company in Atlanta tried to deny gay people life insurance, by establishing new underwriting guidelines to identify people they considered to be in an AIDS high risk category. Those new guidelines singled out unmarried men; residents of certain cities such as San Francisco, New York, and Miami; those who chose beneficiaries other than a spouse or a child; or those who led an "illicit or promiscuous lifestyle." National Gay Rights Advocates threatened Munich American with a lawsuit and also informed the California Department of Insurance of this new AIDS risk profile underwriting guideline. The California Dept. of Insurance said that such guidelines would be illegal in California and the Dept. supported NGRA's viewpoint. Munich American agreed to revoke these new guidelines as criteria for insurance in all 50 states. This is an important victory because it its the first time an insurance company has been forced to revise its entire underwriting approach to AIDS. It was only with your help and encouragement that NGRA was successful in challenging this type of unreasonable, discriminatory behavior. With your continued support and contributions, NGRA will be able to continue to fight challenges to our civil liberties. For more information, write: NGRA, 540 Castro Street, San Francisco, CA 94114 (415/863-3624).

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INDIANAPOLIS WANTS TEST REPORTS

by Lisa M. Keen, with thanks to The Washington Blade, 4/2/86

The public health board for the Indianapolis area passed an ordinance in February which calls for positive antibody test results to be reported to health officials. Although the ordinance says the reports should be made without identifying the names of the persons testing positive, a health board spokeswoman said that gays are concerned the ordinance is an "initial step" toward eventually collecting names of high risk group members. Dr. Virginia Caine, a member of the Marion county Health and Hospital Corporation, the autonomous health board for the Indianapolis area, said that while she "doesn't foresee" the need for collecting names, "you never know." The board, some of whose members are appointed by the mayor, can pass regulations independently of the City Council. Current Health and Human Services Secretary Otis Bowen was a member of the board before accepting his appointment from President Reagan.

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BILL WOULD BAN ANTIBODY-POSITIVE PERSONS FROM MARRYING

edited by John A. Fall, with thanks to the New York Native, 3/3/86

Legislation in the Pennsylvania House of Representatives would prohibit anyone who tests positive for antibodies to HTLV-III from ever marrying in that state. The legislation, which is currently in the House Committee on Health and Welfare, was authored by Democratic Representative Russell T. Letterman. If passed, the bill would amend the 1953 Marriage Law by requiring a couple to take antibody tests within 30 days of applying for a marriage license. Regulations guaranteeing the confidentiality of test results are not included in the bill. Letterman told James Roberts of Au Courant that he proposed the measure primarily to prevent the birth of children with AIDS. The representative revealed that his bill is also aimed at gay people. "If they want to be so bold about what they want to do and what they are, they should be willing to come out and admit they want to get married," he said, defining "they" as "the gay world." Fellow Representatives Babette Josephs said she thought the bill would be killed in committee. "There is going to be a flood of these types of bills," she said. "They don't acknowledge that exposure to HTLV-III doesn't mean anything, and they are the result of panic."

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POSTAL SERVICE APOLOGIZES FOR OPENING AIDS PACKAGES

edited by John A. Fall, with thanks to the New York Native, 3/31/86

San Francisco's Harvey Milk Lesbian and Gay Democratic Club has received an apology from a U.S. Postal Service official for the recent interception, opening, and return of AIDS education pamphlets mailed by the club to Caribou, Maine. Titled, "Can We Talk?", the pamphlets were sent to Communique newspaper. Before the package could reach the paper, however, Caribou postmaster Paul Michaud opened it and decided the materials consisted of "sexually oriented advertising." The educational materials were returned to the club, with instructions to mail the pamphlets as pornography in the future. The club responded with letter demanding an apology from the U.S. Postal Service, "Only through the elimination of high risk behaviors can the spread of AIDS be curtailed," the letter stated. "The fact that some of these high risk behaviors are sexual activities does not make health crisis in formation discussing these behaviors `pornographic' nor `sexual advertising.'" San Francisco Postmaster Mary Brown responded to the club's letter with an apology. She stated that she felt the pamphlets were not pornography, and that Michaud violated postal regulations by intercepting and returning the pamphlets without receiving a complaint from the addressee, Communique.

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FEDERAL CONTRACTORS CHARGED WITH AIDS DISCRIMINATION

with thanks to the New York Native, 5/5/86

Two federal contractors, GTE Southwest and ENSERCH Corporation, face charges of AIDS-related employment discrimination. The complaints, filed with the Office of Federal Contract Compliance Programs (OFFCP) in Dallas, charge the companies violated section 503 of the federal Violations Act, which bans companies doing business with the federal government from discriminating against handicapped people. The former maitre d' of the executive dining room and the director of food services filed complaints against ENSERCH. The two charges against GTE Southwest were made by a general warehouse worker and a draftsman. Only one of the employees actually has AIDS. The other three tested positive for antibodies to HTLV-III, the putative cause of AIDS. Although still receiving pay and benefits, the four employees have not been allowed to return to work. James Koerber, assistant regional administrator of OFCCP, said if it is a case of handicap discrimination, "then we indeed have a reason to investigate to assure that the regulations have been complied with," reports Philadelphia's Au Courant. OFCCP sent a letter dated March 19 to each of the companies, informing them that they have 60 days to resolve the matter before legal action is taken.

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RADIO STATION INTERVIEWS CANCELED DUE TO FEAR

with thanks to The Washington Blade, 3/21/86

Two men with AIDS canceled a scheduled interview on a Norfolk, Virginia, all-news radio station after a station announcer angrily denounced their upcoming appearance, according to a Norfolk gay newspaper, Our Own. The day before the scheduled interview, WNIS announcer Chuck Sherman complained about the show and asked, "What if one of the men with AIDS slobbers on my microphone and I should get a paper cut on my hand?" Sherman said he would not return to the station the next day unless the management sterilized the studio where the interview was to take place. A spokeswoman for the Tidewater AIDS Crisis Taskforce who had coordinated the interview with another station announcer said the men canceled because they did not want "to force their cause" upon a group that had not educated itself about AIDS. Joe Postove, the announcer who was to interview the men, said on his show the next day that the "station did more yesterday to promote fear and bigotry than any other broadcasting outlet that I am familiar with." WNIS General Manager Bob Sinclair told Sherman on the air, "I applaud your courage in speaking out on something you believe in." Sinclair told the Blade that the station had received numerous calls over the incident, and that 80% of the responses had been in support of Sherman.

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INTERNATIONAL AIDS CLINIC TO OPEN IN NEW YORK & PARIS

by Barry Adkins, with thanks to the New York Native, 3/10/86

A new international AIDS clinic will soon open in New York and Paris. The clinic will be administered by Genevieve M. Clavreul, MPA, of Paris. Clavreul heads a corporation called Total Health Enhancement and Revitalization Resort (THER&R) will will also open La Rencontre de l'Espoir, a resort located close to Paris which will combine the "ultimate medical and nursing care with the best research program available in the world" for people with AIDS. A team of "top" international doctors and researchers will work together between the two cities. Clavreul is negotiating with Dr. Joseph A. Sonnabend, who is expected to head the New York Clinic. Clavreul said the clinic will offer multi-disciplinary treatments designed for the individual patient. She said patients will have the benefit of seeking treatments from around the world. For more information, call: 516/333-8378.

CANADIAN SERVICEMAN DIES OF AIDS

edited by John A. Fall, with thanks to the New York Native, 3/24/86

A member of the Canadian Armed Forces recently became the first serviceman in that country to die of AIDS, according to National Defense Public Relations Officer Major Ray Windsor. Although no details about the patient were released, an unidentified source told Ken Popert of Toronto's The Body Politic that the man died at the National Defense Medical Center, where doctors "did a good job of taking care of him." The major stated that the recent death had not led the military to consider using an antibody test for screening recruits, as is done in the U.S. According to Windsor, "The policy is still that, while the Surgeon General is concerned and is carefully monitoring the situation, he is not taking any extraordinary or special steps to screen people coming into the military." There is one other publicly acknowledged case of AIDS in the Canadian Armed Forces.

CONDOMS PUSHED IN AUSTRALIAN CINEMAS

Cartoon advertisements urging young people to use condoms will be screened in cinemas and drive-ins from now on as part of a New South Wales Health Department campaign to combat AIDS. The State's cheif medical officer, Dr. Tony Adams, said the ads were targeted at men and women aged 18 to 25 but the Government wanted to persuade everyone that condoms should be used as a protection against all sexually transmitted diseases. "The use of condoms is our major weapon in combatting the spread of AIDS now that we have sealed off the risk of transmitting it through the blood transfusion service," said Adams. "Condoms are an indispensable accessory for the safer sexual practices which should be adopted if sexually transmitted diseases are to be curbed." Adams said the $50,000 six-month cinema promotion complemented changes to regulations which had previously forbidden the advertising of condoms and was a forerunner to a major, State-wide "condom awareness" radio campaign to soon start. Ads would be screened at major metropolitan cinemas in Sydny, Newcastle and Wollongong as well as suburban drive-ins.

CONDOMS WON'T BE SHOWN IN AUSTRALIAN THEATRE

by Janice Irvine, with thanks to Boston's Gay Community News, 3/1/86

The Greater Union Theatre here offered to run cinema advertisements for a local AIDS hotline but refused to use the work "condom," according to the Sydney Morning Herald. The anti-AIDS campaign here features cartoons, some of which depict or mention condoms. The theater will air censored cartoons with "M" and "PG" rated films, in which the cartoon will be blacked out with the words: "We can't show condoms but we can tell you how they help prevent AIDS." Below these words will appear the number of the AIDS hotline. One theater director justified the censorship by saying, "The public don't [sic] want to be confronted with that sort of advertising." But a local health department official countered, "It is hard to understand when one considers that the same chain shows films which include incest, fellatio and nudity."

RADIO JINGLES GET CANCELLED IN NEW SOUTH WALES

by Kendall Lovett, with thanks to Marcos Bisticas-Cocoves and Boston's Gay Community News, 3/22/86

The new Minister for Health in New South Wales, Australia, Barry Unsworth, has cancelled a series of radio jingles which were to be part of the Health Department's safer sex condoms campaign. The Minister said the jingles were tasteless and that he did not believe they would be cost-effective in reaching groups at high risk for AIDS. The jingles were set to the tune of a hit song, "Who's Sorry Now," popular in the fifties. The National Sexually Transmitted Disease Counselors Association has called for Minister Unsworth to reconsider his decision. Government officers involved in the condom promotion campaign also expressed disappointment with the decision. However, few have been willing to criticize the Minister, particularly after his warning that Health Department leakers of information would find themselves scrubbing floors in Tibooburra if caught. Tibooburra is a small town in northwest New South Wales, known for its high temperatures during the summer.

MEXICAN FUND FOR AIDS SET UP IN TIJUANA

edited by John A. Fall, with thanks to the New York Native , 3/3/86

A private organization, the International Front for the Defense of Human Rights in Tijuana, announced plans to establish a trust fund for financing AIDS-related projects, such as sponsoring preventive education efforts and provision of financial support to people with AIDS or ARC. The trust fund is desperately needed in Tijuana, where employed people earn only about $23.50 to $28.20 weekly, and 40% of the population is either unemployed or underemployed. "It would be very much like what was done when people were donating money to help the people in the earthquake in Mexico City," said Emilio Velasquez, the Front's president and founder of the fund. The Front has been involved in AIDS education projects for four years. Although Mexican government health providers have received training from the organization, the government has not supported the group's efforts in any manner. Help has come primarily from health care organizations in San Diego.

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MEXICAN GROUP FORMS, NEEDS SUPPORT

by John Kyper, with thanks to Boston's Gay Community News, 4/12/86

Last September's devastating earthquake resulted in the destruction of a number of the Mexico City's gay bars and establishments, many of which had been located in the heavily-damaged downtown area. In addition, sensationalistic coverage of AIDS related issues in the mass media continues to subject gays to scapegoating. Calamo, a new group formed shortly before the earthquake, is now attempting to address these and other issues in the gay and lesbian community here, after a lengthy period of movement disorganization marked by the collapse of Grupo Lambda de Liberacion Homosexual nearly two years ago. Calamo, named for Walt Whitman's poem "Calamus" from Leaves of Grass, was formed in July, 1985, and held its first conference at the end of February. Unlike some previous gay organizations that were primarily political in nature, Calamo has been structured as an asociacion civil, similar to a non-profit corporation in the U.S. According to founder Arturo Vazquez, the group will work to build the gay and lesbian community by providing legal, medical and counseling services, as well as by providing a cultural and educational forum. "The general aim, " state Vazquez, "is oriented towards the opening of alternative spaces, to fill an emptiness that denies our identity and makes us an object of social intolerance." Calamo desperately seeks financial and other support from the international gay and lesbian community. Letters can be sent to: Calama, Espacios y Alternativas Comunitarias, A.C., Culiacan #118, 3er Piso, Col. Hipodromo Condesa, Mexico, D.F., Mexico.

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BRITISH INSURERS MAY REFUSE COVERAGE

edited by John A. Fall, with thanks to the New York Native, 4/7/86

British insurance companies have begun considering the restriction of insurance availability for people with AIDS or ARC, people who test positive for antibodies to HTLV-III, and people suspected of belonging to "high risk" groups. A document presented at a February 19th meeting of the companies outlining their positions on AIDS was reported on by John Marshall of Gay Times. "Because of the exceedingly unfavorable prognosis, all applicants in whom AIDS or ARC is established should be turned down until further notice," the document states. "This also applies in view of the currently incalculable risk for applicants infected with the AIDS virus." The document also discusses "non-medical" circumstances which could indicate that an insurance applicant belongs to a group at "high risk" for contracting AIDS. Unmarried male applicants and couples of the same sex seeking a joint policy would be suspected of homosexuality. The insurance companies want people suspected of belonging to "high risk" groups to take the HTLV-III antibody test. According to the document, anyone who refuses to take the test should not be given insurance.

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BRITISH BILL COULD CENSOR AIDS-PREVENTION EDUCATIONAL MATERIALS

edited by John A. Fall, with thanks to the New York Native, 3/3/86

Legislation currently being considered in the House of Commons could lead to the censorship of AIDS-prevention educational materials and mandate the ban of sexually explicit publications if passed. The Obscene Publications Bill, proposed by Member of Parliament (MP) Winston Churchill, would prohibit the sale of materials depicting masturbation, sodomy, oral/genital contact, oral/anal contact, or the "lewd exhibition" of genital organs. During debate on the bill, Churchill said explicit sex magazines are "sold all too often by local news agents where children go to buy their sweets." He claimed the bill was needed to curb the amount of pornography available to young people in Britain, report John Marshall and David Browne of Gay Times. MP Chris Smith interrupted the debate to emphasize the difficulty of determining what constitutes a "lewd exhibition." One clause of the bill is "obsessively concerned with the anus," according to MP Jo Richardson, who found the proposal biased against lesbians and gay men. "I think that in many respects this could be seen as a thinly veiled attack on any visual depiction of homosexual relationships, because that's what the bill could lead to," she said during the debate. "It could be an example of gay bashing that I don't think this House would want to involve itself in." The House of Commons is expected to vote on the bill this summer.

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SISTER SADIE SPEAKS: AN OPINION
with thanks to San Jose's Our Paper Your Paper, 3/19/86

[Sister Sadie, Sadie the Rabbi Lady is one of the most out spoken members of San Francisco's Sisters of Perpetual Indulgence, a health consciousness-raising theatrical drag group of nuns. Sadie has performed around the country, receiving rave reviews everywhere. I'm also proud to admit that Sadie is my cousin the sister! --NCGSTDS ED] The national gay community has mortal enemies who appear on television daily. While the name Falwell comes to mind immediately, Jerry is far from alone and we need to be reminded of who these people are and what they are saying and doing. You could argue back and forth that the arch-conservative fundamentalists will always be there and that their ranks reain about the same and that's life and there's no reason to run around screaming about it `cause that'll just make it worse. I don't buy that argument. As the goddesses say: "Know Thine Enemies And Smack 'Em Down Whenever You Can." While I was busy sending out letters across the country asking people to keep calling the Old Time Gospel Hour on Sundays during Jerry's pitches for money, he was busy getting rid of that phone number an even dropping the Moral Majority. At first, I was delighted to see that development. I even figured that maybe, just maybe, I might have helped push that out. But that was wishful thinking, and the news of all isn't so great at all. I think Falwell's advisors came down hard on him and cinvinced him to become less inflamatory--for the moment. His stand on South Africa didn't earn him too many points, and as for the gay issue, I suggest that sexual matters will always be a favorite little item to be used at will. After all, it's not popular to dump on blacks and Jews these days, but gays continue to be an easy scapegoat. To them, we'll always be the mentally ill commie perverts who are the child-molesting direct threat to the traditional family and everything that their Christian America stands for. More importantly, there is a regrouping and consolidating going on within the television evangelical movement which is much more dangerous than you may suspect. As you may have heard on the news or read in many papers, Falwell's operation, under the shell of the Liverty Broadcasting Foundation, has recently purchased the floundering Christian Broadcasting Network and is beaming his diatibes across the cable waves 24 hours a day. And he's announced clearly that he intends to get much more political. But it's not just good ole Jerry at the pulpit and that's where the insidious problem lays. The new rising stars are more gentle-natured and attractive just-home-folks- in appearance and have been rising for some time, actually. Heading the list is Pat Robertson, a really friendly-looking paternal image of loving and caring old tyme God-fearing optimism (however you define that mess of adjectives). His style belies his lack of sympathy and understanding for those who haven't seen the divine wisdom of born-again tithe-paying right-wing fundamentalism. Appearing nightly, and daily, sometimes as a pair or often on her own and with regular visitors, is a very seet-looking middle-aged blonde lady who reminds me of my next-door neighbor or the yuppie personnel supervisor, I used to report to at Ma Bell. She has an unusual first name which is easy to remember: Danuta. Danuta Sodderman. And her style is equally charming. She oozes warmth and an aura of complete authority in all matters at teh same time. How does she do it? With `expert' visitors who answer all her earnest questions to which all those folks out there just have to have the definitive answer. And boy, do they get it. Then, when they're done, they heal you by remote control. I urge you to tune this stuff in and watch for as long as you can stand it. What emerges is a series of take shows and fast-track Jerry Lewis-type telethons with frequent pulpit stops inbetween. But it's those little chit-chat sessions that Pat and Danuta specialize in. They are clever and subtle--great media manipulators, I must unfortunately admit, [much like our Chief Executive?]. Paddy Chayevsky might have had them in mind when he wrote Network. So unless you do listen carefully, you tend to miss the major flaw in the logic from which all the rest flows. Statements are tossed out so rapidly and with complete `of course' acceptance, that it's easy to see how the listening audience falls into the trap. It's the same story of `the bigger the lie, the easier it is to make people believe.' And that's completely and utterly Hitlerian. And that's why I'm running scared. `Running scared' isn't the best way of expressing my concern. Rather it's a state of constant awareness and rage which keeps me on my toes. But there is a greater depth to my life, of course. After all, living well is still the best revenge! Nuntheless, let's not underestimate what's going on. Good ole Pat has expressed great interests in running for president, fer chrissakes! And in the meantime, good old George Bush has heaped praise on top of praise on Jerry's head as he moves further to the right in the hopes of making proper bedmates of the millions of born-again followers he's wooing for votes. Is George thinking of offering the number 2 spot to Robertson? You know, even if Bush gets the nomination and loses the race, just think of the enhanced status of the religious bigots if Robertson gets the second spot. Far fetched? Don't be too sure. Sure to go down to defeat? Don't bet on it, kids. Look for a close race no matter who runs with Bush and no matter who runs on the Demo slate. In close races, everybody wins, including the losers (and the losers' supporters). `Cause next time, they've got a good start bassed on their last close call. Of course, you can rest easy that at least Falwell won't be a candidate. He reminds us of that all the time. Makes it so much easier to trust in his religious commitments, right? Get real, Lucille. Good ole Pat is the partner in this good guy/bad guy scenario. They've got all the bases covered for their planned grand slam. If you think all this is one great over-reaction, I ask you to consider history. If you know more of the history of the fundamentalist movement in the U.S., the more disgusted you may become. Compare with the history of the rise of Adolph Hitler--gaining power through not only the big lies but through the laying out of his entire

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SISTER SADIE, Continued

grand, demented scheme in Mein Kampf. He was right upfront about his plans from the beginning, and Germans still bought it. And people like me who wrote warnings about it were carted off to the concentration camps and ovens. Gosh, this is such a heavy subject that it's even getting me down! And since I'm known in many circles as a fun and upbeat kind of guy/girl/nun, I might add that sometimes the underbelly of reality needs to be exposed--if for no other reason than to compare the crap with the good stuff.

There's still lots of good stuff out there, but we've gotten bogged down these past few years, haven't we? The scourge of AIDS has affected everyone in one way or antoher and this continued bigotry feeds very nicely on it, too. I really hate to read articles which outline a seriuos problem, bring everyone down, and then leave them hanging. The only reason to delve into a problem is to find solutions. Anyone can define the problem, but everyone needs to be a part of the solution in a matter such as this. And there are as many perspectives in attacking the bigots as there are caring and involved people. Through the Sisters of Perpetual Indulgence, I have been involved, and continue to be so in a more individual manner, by calling attendtion tot he nonsense with nunsense. Poking fun helps. Outrage helps. But mine is only one perspective. You're creative, aren't you, darlings? Surely you could figure a little something to do that fits within your time constraints and lifestyles, no? If you'd like to sit home and help, you can do that, too. Now that Jerry and his pals are on the tube constantly, why not take a moment or two to call their other toll free numbers and educate them or give 'em a taste of your attitude? You can call Danuta and Pat with the 700 /club (members are asked to send in $700/year) at: 1/800/446-0700 or 1/804/420-0700. And if you'd like to cal' Jerry's Liberty Baptist College student volunteer phone line has already been disconnected. The more calls these people get which put them back in their place, the more impact it will have, I assure you. Don't assume the folks who answer those lines aren't aware of the controversies and don't question their own involvement. They're human too! Just show them the errors of their ways. Remember, their strength is in numbers and big bucks. Our strength is in numbers too. We don't have big bucks, so why not call on their dime--over and over and over until you're sick of it. `Cause when you're sick of it, you'll know its working--'cause they'll be sick of it too! Remember, it's free to you and costly to them. Did you read about Edward Johnson of Atlanta who hooked up his computer to Falwell's number and cost him half a million bucks by automatic redial? I consider him a national hero. Now don't get into illegal activity, but do call often. Now Falwell is having his people sask for the name and number of every caller and then call them back. Don't let that stop you. Every single time they pick up the phone, it costs them. Every time they have to call back it costs again--whether the number they call back is legit or not. Numbers. That really is the key. It has been estimated that upwards of 5 1/2 million people tune in, turn on and drop bucks regularly; if each only gave an average of $50/year, that's $275 million right thee. As a matter of fact, the 700 Club alone takes in ove $230 million annually and boasts 29 million viewers. They buy huge chunks of TV. Falwell opens Save-A-Baby Foundations and Baptist college media-manipulation classrooms that support the rationale for fag-bashings and abortion clinic bombings, not to mention the political meddling in foreign countries. But also remember this: even the absolutely most conservative estimate of the gay population of this country is about 10 million (4%). Now if you consider a more reasonable number, like 10%, and add to that those who fall into all the other categories of bisexuality and add to that the number of people who might be sexually straight but politically supportive, and you just might wind up with a number like 40 or 50 million! With numbers likd this, we should be winning, but we ain't. The other end of the coin is the coins!! But no, darlings, I'm not asking for any coins. Save them and enjoy them on whatever turns you on. Support our existing gay and lesbian political organizations [see next article]. Consider membership in organizations dedicated to combating the plague of born-again bigotry. It's only one idea, friends. Got a better one? So go for it already, and share it with us. And in the meantime, I'll keep writing but promise to find some more fun stuff to bubble up with. Oy vey, what a life! And until then, it's now. Love and knishes, --Sister Sadie, Sadie, the Rabbi Lady.

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FALWELL BLAMES `MILITANT GAYS' FOR FINANCIAL PROBLEMS

by Rick Harding, with thanks to The Washington Blade, 4/4/86

Fundamentalist minister and right-wing political activist Jerry Falwell in a recent fundraising letter blamed the "militant gay community" for contributing to serious financial problems with his organization. In his appeal for donations, Falwell said "We are near defeat at this moment," and "we do not have enough regular monthly support to continue much longer." He said that "homosexual newspapers" have encouraged readers to jam toll-free counseling lines and that gays have ordered thousands of free bibles, books, and materials from Falwell and "have burned them." Falwell estimates that the movement by the "militant gay community" has cost his organization between $1-2 million. His letter refers to a story which appeared first in The Washington Post which detailed how an Atlanta man programmed his computer to call Falwell's toll-free line every 30 seconds. Falwell said that each call costs his organization up to one dollar.

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BLUE CROSS PROBLEMS FOR ATTORNEY OF PWA

with thanks to the New York Native, 4/28/86

Alice Philipson, an attorney with Bay Area Lawyers for Individual Freedom (BALIF), expressed her frustration when, for the second time, an AIDS patient who had trouble with Blue Cross insurance died before she could take the case to court. Although families of the deceased continue to take their cases to court, "Without a live plantiff it's harder to get to court in a timely manner. We don't have the same leverage," Philipson told Gregory Douthwaite of the Bay Area Reporter. She went on to say that Blue Cross acted in "bad faith" by failing to pay claims until the suit was filed.

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GEORGIA GOVERNOR RENEGES ON AGREEMENT WITH AID ATLANTA

The Governor's office of the State of Georgia has unilaterally decided to block the intentions of the State Legislature by reneging on an agreement with AID Atlanta to help stop the spread of AIDS. Apparently after months of negotiating and well documented meeting in which the State's only AIDS service and prevention was promised $100,000 for education and prevention of the deadly disease, the Governor's office has denied the Department of Human Resources the possibility of carrying out their agreement with the agency. The State Legislature voted to permit DHR to use the $100,000 for "per diem costs and contracts" in the Budget summary but the executive branch for some unstated reason is not willing to associate the Governor's office with the AIDS agency. AID Atlanta started the proper procedure to secure funds from the state by testifying to the Board of Directors of DHR in April, 1985, and has worked with the Department through the priorities process over the course of the year until the proposal made its way through the Governor's budget and then to the capitol for an affirmative vote. During the process, the Department's own AIDS task force supported the request for education and added an additional request that was not part of the DHR appropriations package for $300,000 for a general public education program for the state. Behind closed doors and through frantic telephone calls, AID Atlanta was told they might have a possibility of receiving life-saving funds for the agency which serves 130 people with AIDS, their families and friends, if they could find a "more acceptable" agency to pass through the funds so the State would not have to print AID Atlanta on a contract. Even after such a wiling agency was found, officials at AID Atlanta were told that the "executive branch" would not approve of the arrangement. The AIDS epidemic continues to rage in Georgia and especially in Fulton County [metro Atlanta]. Last year, AID Atlanta provided services to 190 people with AIDS in Fulton County and in each of 7 cities and towns in the State. Its AIDS Info-line program operates four phone lines, including a TTY for the hearing impaired, receives hundreds of calls about AIDS and is staffed 12 hours daily by trained volunteers. The State's AIDS information program has a statewide number with a tape-recorded message at the other end. This program will now be in serious jeopardy due to this "slight of hand" by the State. Over the last 12 months, information on AIDS has been mailed all over the state at mailing costs of $7074 including over 30,000 individual pieces of mail. Printing of educational information has cast over $14,000 for the year. Over 300 volunteers have been trained by the agency at a cost of over $4000. Over 100 agencies, hospitals, groups and churches have been given educational seminars on AIDS over the past year as well. All these programs have been supported to date by private contributions and a contract with the Fulton County Health Dept. at 15% of our total budget. With the prospect of over 400 cases of AIDS by the end of 1986 and the growing daily demands on the agency from speaking and educational materials, AID Atlanta can no longer survive on tag sales and $5 contributions. AID Atlanta regrets very much the fact that while the State of Georgia is 10th in the nation in cases OF AIDS, it is turning its back on the problem, hiding its head in the sand with the hope it will go away. IT WON'T. With the fear of AIDS so powerful that even the Governor's office refuses to be associated with the response to the epidemic directly, more people, not less, will be infected in this state and die. The fear associated with AIDS is very real, so real in fact, that it has placed the shield of petty politics between it and what is perceived as an issue "too hot to handle." The AIDS virus will continue to spread, people will continue to react out of fear rather than facts, and people will continue to die without support from their own state. AID Atlanta will continue to serve the general public, to work towards the reduction of the fear of AIDS by providing the facts about the disease, will continue to provide the only prevention program in the state to slow the spread of the epidemic, and will continue to serve the needs of the people dying with the disease as well as give hope to those who are living with AIDS, in spite of the lack of courage and care from this state and its Governor for its own citizens.

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PRANK LETTERS IN HOUSTON

by Lou Chibbaro Jr., with thanks to The Washington Blade, 2/28/86

Someone posing as a doctor affiliated with an "AIDS testing center" apparently is sending bogus letters to residents of Houston's Montrose neighborhood stating that the letters' recipients have been "exposed" to a person carrying the AIDS virus, reports the Montrose Voice. The letters, which are stamped "Second Notice," and which are signed by a "Dr. Ronnie Embrachney," urge recipients to refrain from any intimate contact with anyone and ask recipients to "contact this office immediately" for testing. The letter's heading provides no phone number and lists the center--"The Acquired Immune Deficiency Syndrome Testing Center"--as being reachable through a post office box in Houston's Medical Center district. A. U.S. Postal Service official in Houston, however, said that the post office box number printed on the letter does not exist. Kenneth Vance, director of Houston's gay-oriented Montrose Counseling Center, told the Montrose Voice he thinks the letters are either a scare tactic or a "bad joke" orchestrated by a prankster. Vance theorized that the names of persons who received the letters were obtained from the phone directory and selected for their location in Montrose, Houston's largest gay & lesbian neighborhood.

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LEGISLATION MOUNTS IN STATES

by Richard Merritt and Gail Toff, with thanks to The Nation's Health, March 1986

The number of AIDS-related bills continues to mount. More than 30 measures in 12 states have been added to the list of pending legislation. Before the 1986 sessions began, 17 states had considered AIDS legislation; 8 adopted one bill each. Although research, public education, protecting the blood supply, and patient confidentiality are still major issues, this year's batch of bills also focus on specific population groups: applicants for marriage licenses, school children, prisoners, and the proprietors and customers of sexually-oriented establishments. A number of states are considering bills that would require prospective newlyweds to undergo a test for the AIDS virus. In NEW YORK, for example, SB 7006 and AB 8436 amend the state's domestic relations law, requiring people applying for a marriage license to take the AIDS antibody test. A measure in FLORIDA (HB 137) separates students with AIDS from the rest of the school population and also directs school districts to dismiss, with pay, any teacher infected with the disease. The bill also allows the Dept. of Education to require both students or teachers to submit to the test if there is probable cause to suspect they have AIDS. A NEW JERSEY bill (AB 4217) would allow the health department to license adult book stores and get the name, address and social security or driver's license number of people who frequent such establishments. [NCGSTDS ED NOTE: Don't federal social security/Internal Revenue Service laws prohibit use of the social security number for identification or any other purposes other than IRS/tax uses?] MICHIGAN HB 5279 requires anyone arrested for violating state and local ordinances prohibiting prostitution to submit to the AIDS antibody test. Information on those whose test results are positive would be forwarded to the judge or magistrate responsible for setting the conditions of release pending trial. MICHIGAN 5281 would require the Public Health Dept. to interview residents diagnosed as having the disease to ascertain their sexual contacts and inform those contacts and inform those contacts of their potential exposure to the virus within 30 days of the initial interview; HB 5272 allows insurers to ask potential customers AIDS-related questions and require them to take an examination to detect the virus. MICHIGAN HB 5247 directs the Corrections Dept. to test prisoners for AIDS before they are placed in state correctional facilities and isolate those who are diagnosed as having the disease. In ALABAMA, HB 25 provides for the quarantining of any county jail or state penitentiary inmate diagnosed as having the virus. A WEST VIRGINIA measure (HB 1393) redefines first and second degree murder to include the "intentional transmission" of AIDS by someone who has the disease. [Thanks to Lambda Legal Defense Fund for the following addendum: COLORADO HB 1290 comprehensively abridges civil rights in the name of "public health" with 5 primary components--reportability to the health department of all people with AIDS or viral infection as determined by antibody testing; release of those names, addresses, & other identifying information to district court judges upon "showing of necessity" (like child custody cases?!); implementing contact tracing to "prevent the spread of disease;" mandatory examination and testing of any suspected cases; and isolation restrictions/quarantine of suspected cases until the results of such examinations & tests are known, and longer if persons violate cease & desist orders.]

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COLORADO QUARANTINE LEGISLATION DYING

by Lisa M. Keen, with thanks to The Washington Blade, 4/2/86

A bill to empower health authorities to detain and test persons "reasonably suspected" of being infected with AIDS appears to be dead in a Colorado State Senate committee. The bill, which also requires clinical laboratories conducting antibody tests to report the names and addresses of persons testing positive to state or local health officials, passed the State House March 5 on a 46 to 17 vote. It also passed the Senate's Health, Environment, Welfare and Institutions Committee, but in what one Senate aide described as a killing tactic, the bill was referred to a Senate Appropriations Committee. Appropriations Committee Chairman Senator Cliff Dodge said last week that he will not consider any of the 20 bills pending before the committee until the state's budget is finished. That makes the AIDS bill "as good as dead," said Bob Schaffer, majority administrative assistant to the committee. The legislature will recess April 15. Ironically, said Schaffer, it is the rural legislators who are against the AIDS bill. He said the bill "would cost some money" to implement, "and the rural legislators don't want to put up the money. It's not a problem for them."

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SUPREME COURT TO DECIDE WHAT DISEASES CONSTITUTE `HANDICAP'

by Lisa M. Keen, with thanks to The Washington Blade, 4/25/86

The U.S. Supreme Court agreed to review a case which may ultimately decide whether AIDS can be considered a "handicap" in bringing suits. The case, Nassau County v Arline, involves a teacher who was dismissed from her position instructing elementary school children because she had tuberculosis. Attorneys for the Nassau County School Board in northeast Florida, contend that policy questions involving contagious diseases "differ markedly" from those involving most handicaps because of an employer's reluctance to expose other employees or clients to infection. They further urge that because this case has already been "widely interpreted as precedent for AIDS cases," the "time is now" for the high court to "determine directly and clearly that infectious diseases are not `handicaps'." The school board is appealing a decision from the 11th Circuit U.S. Court of Appeals last September in which the court held that communicable diseases fall "neatly within" the definition of a handicap under the Rehabilitation Act of 1973. That Act says a handicap includes "any physiological disorder or condition...affecting one or more" of several body systems, including respiratory, neurological, and skin. Oral arguments are expected next fall.

DRUG IN SEMEN MAY TRIGGER ALLERGY

with thanks to Medical Aspects of Human Sexuality, 3/86, and JAMA, 254:531, 1985

When a person reports an allergic reaction, consider whether its due to exposure to a drug transmitted via seminal fluid. A 33-year-old woman told Pittsburgh allergists Richard Green and Mayer Green that on three occasions she'd experienced hives, nausea, eyelid heaviness, eye burning, vaginal itching, and "fullness" in the throat. The symptoms had occured each time within 30 minutes after sexual intercourse. She'd had hives only once before, as a child when she took penicillin. Just before her new outbreak began, her boyfriend had started taking dicloxacillin for a skin infection. After he followed the allergists' advice and used a condom, she no longer suffered symptoms.

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FEMALE TO MALE TRANSMISSION MORE LIKELY

with thanks to The Washington Blade, 4/11/86

A new AIDS warning was made to heterosexuals by two doctors who said they have "well documented" evidence that women can infect men with the HTLV-III virus through vaginal intercourse. A woman who got AIDS from her bisexual husband infected a 26 year old man with whom she had frequent sex after her husband died, according to two Cleveland physicians in a letter to the New England Journal of Medicine. According to their reports, the couple engaged in conservative sex practices--no oral or anal sex, sex during menstruation, or with other people. With only 45 of the 19,181 AIDS cases reported to the CDC attributed to men infected by women, researchers have questioned if the virus can really be transmitted that way. This new report follows a recent finding that the virus can be present in vaginal secretions.

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MILITARY RECRUITS REGISTER ANTIBODY POSITIVE

with thanks to The Washington Blade, 4/11/86

Of the 138,000 military recruits tested for the HTLV-III antibody so far, 198 men and 12 women have tested positive, reports the magazine, Army Times. Incidences of positivity were highest among recruits from the east and west coasts, and among older recruits. The recruit region for New York, New Jersey, and Pennsylvania reported the highest positivity rate, at 23 cases per 10,000 recruits tested. The lowest incidence of positivity was recorded for the midwest region (Illinois, Michigan, Ohio, Indiana, and Wisconsin) with 7 cases per 10,000; those 26 and older tested positive at a rate of 46 per 10,000.

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MILITARY AIDS ANTIBODY LISTS MADE PUBLIC

with thanks to Indianapolis' The Works, and The Baltimore Gay Paper, April, 1986

Military health officials have confirmed the fears of many when it was revealed the armed forces were offering names of those who had tested positive for the AIDS antibody to local health authorities. The revelation came from a New York City health official who had refused the list. The military caused considerable dismay when it announced its policy of universal testing in late summer. Initially, it had said that the reason for the testing was merely to prevent risk in the field where blood transfusions might have to occur during combat. Those testing positive positive were merely to be transferred to noncombat duty. However, it was then announced that anyone testing positive would, in fact, be discharged. After it was publicly revealed that the lists were being offered, Pentagon officials developed a slightly more restrictive policy that the lists will only be made available to certified health officials upon request.

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COURT BARS AIDS CHILDREN FROM SCHOOLS

with thanks to the New York Native, 4/28/86

As a result of the Plainfield and Washington Boroughs' fight against New Jersey Education Commissioner Saul Cooperman's policy requiring schools to admit children with AIDS, a state appeals court struck down the policy March 27. The court ruled that officials of the Education Dept. did not follow administrative procedures in adopting the policy. Judge Herman Michels was quoted as saying, "The commissioner's actions in promulgating the policy guidelines without notice or time for public comment, did not evince a concern for the rights and concerns of both local boards or education and by the children affected by them," reports Au Courant.

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FATHER FIGHTS ORDER TO TAKE TEST FOR VISITATION

with thanks to The Washington Blade, 3/21/86

A gay father in Chicago is defying a circuit court judge's order that he take an HTLV-III antibody test in order to gain visitation rights to his children. National Gay Rights Advocates (NGRA), a gay legal organization, is representing the man whose case is now under reconsideration in the Domestic Relations Division of the Cook County Circuit Court. According to NGRA legal director Leonard Graff, the judge ordered the man to take the antibody test after the man's former wife said she feared the children would "catch AIDS" from their father. Both sides are now filing briefs in preparation for the rehearing.

YEAST BASED HEPATITIS VACCINE SCHEDULED FOR 1987 RELEASE

by Rick Harding, with thanks to The Washington Blade, 4/18/86

A spokesperson for Merck, Sharp, & Dohme, the pharmaceutical company which manufacturers the Hepatitis B Vaccine (Heptavax), said that a new form of the vaccine produced from yeast rather than from blood plasma may be available for high-risk groups in 1987. Russ Durbin, the Merck spokesperson, said the company began developing genetically-engineered hepatitis B vaccine in 1984 when concerns first emerged that AIDS might be transmitted through blood or blood products, such as Heptavax. Subsequent studies verified that each of the three purification steps in preparing the vaccine killed the HTLV-III virus, but use of the vaccine among some high-risk groups, particularly among gay men, still dropped off. The genetically-engineered vaccine, called Recombivax, said Durbin, is not intended to replace Heptavax, but to be available as an alternative to those people who still fear contracting AIDS through the blood-based vaccine. The new vaccine has passed safety trials and is now being tested in humans.

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NEW HEPATITIS VACCINE?

by Rick Harding, with thanks to The Washington Blade, 4/11/86

Medical researchers in San Antonio, Texas have discovered a new vaccine for hepatitis B that may be effective for the 5-10% of people for whom the current vaccine is ineffective. Dr. Ronald Kennedy, principal author of an article in Science magazine, told the Blade that the vaccine discovery also led to the development of a new method of vaccine synthesis. That new synthesis, he said, may be useful in developing vaccines against other viruses, including the HTLV-III virus, which is commonly believed to cause AIDS. Kennedy said the new hepatitis B vaccine was developed by stimulating a special strain of the hepatitis B antibody in rabbits and then injecting the rabbit antibodies into chimpanzees. He said the vaccine stimulates different cells than does the Heptavax-B vaccine (currently used to immunize against hepatitis B) and could benefit the small number of people who find Heptavax-B ineffective. Kennedy said he and the other scientists who worked on the project at San Antonio's Southwest Foundation for Biomedical Research, have no plans at present to develop and have the new hepatitis vaccine approved for humans. But Kennedy added that a scientist from the People's Republic of China had expressed interest in continuing the vaccine project. Kennedy said his group has now secured funding to begin a project that will enable them to apply the new vaccine synthesis to AIDS research.

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ASYMPTOMATIC CARRIERS SPREAD MOST HERPES

with thanks to Medical Aspects of Human Sexuality, 3/86, and STD, 12:33, 1985

Herpes simplex virus (HSV) is commonly transmitted by people who not only show no symptoms but also have no idea they carry the infection. Investigators at the University of Washington Genital Herpes Research Clinic tracked down 66 individuals who transmitted the disease to clinic patients. Of these sex partners, fully 57% had no lesions at the time of transmission. Indeed, 35% had evidently never shown symptoms of any kind. Of those who reported having had lesions indicative of herpes, most (60%) were undiagnosed. They thought the ulcers were due to such causes as "yeast infection," "infected hair follicles," and "friction from intercourse." Only two of the contacts knew they had herpes and were showing symptoms at the time of transmission.

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OPPORTUNISTIC INFECTIONS & SYSTEMIC LUPUS ERYTHEMATOSUS

with thanks to Rheumatology News, February, 1986

Patients afflicted with systemic lupus erythematosus (SLE) may be highly vulnerable to opportunistic infections, which may prove to be fatal and remain unsuspected until after death. According to Drs. D. Hellman, M. Petri and Quinn Whiting-O'Keefe of he University of California, San Francisco (UCSF), "opportunistic infections are a major cause of mortality in SLE and are frequently undetected until autopsy." The opportunistic infections which SLE patients appear to be most vulnerable to are Candida sepsis and Pneumocystis carinii pneumonia, and treatment of the patients appeared to be ineffective against the infections, the researchers indicated. "All patients with opportunistic infection had been taking greater than 15 mg per day of prednisone for at least one month," and additionally, several were also taking an immunosuppressive agent. The information was presented in a poster session at the recent Western Region meeting of the American Rheumatism Association.

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PROSTITUTES TAKING THE HEAT FOR HETEROSEXUAL AIDS

by Anne Phibbs, with thanks to Boston's Gay Community News, 3/29/86

Prostitutes, in particular female prostitutes, are quickly becoming the group most blamed for the spread of AIDS into the heterosexual population of the U.S. More and more often prostitutes are mentioned, by the press and by researchers, as a possible risk group for the AIDS virus and as possible transmitters of the virus to straight men, and, through these men, to straight women. Media accounts about individual prostitutes with AIDS have only added fuel to this fire of fear and blame.

In 1983 in Connecticut, for example, the State Legislature responded to publicity about a female prostitute who allegedly had AIDS by passing a bill to give local boards of health the authority to confine a person with AIDS who poses "a substantial threat to public health." In Delray Beach, Fla., Lydia Munoz, having been diagnosed with AIDS and charged with prostitution, was put under house arrest and has been forced to wear an electronic beeper which goes off if she moves more than two hundred feet from her home. (See *GCN*, Vol. 13, No. 24).

And in Houston, Texas, the Commissioner of the Texas Department of Health proposed the addition of AIDS to the list of diseases subject to quarantine by the state. His plan, which would have made possible the quarantining of an "incorrigible" person with AIDS, was apparently spurred by health authorities' knowledge of Fabian Bridges. Bridges had come to Houston from Ohio, where he had been diagnosed with AIDS, and was suspected of being a prostitute. Because the physician who diagnosed Bridges informed the Houston City Health Department that he thought Bridges would continue to be sexually active, Bridges was kept under police surveillance until he was picked up on a misdemeanor charge. He died of AIDS in a state mental hospital approximately one month later. The proposal for adding AIDS to the list of diseases subject to quarantine was later withdrawn from consideration by the Commissioner of the Texas Department of Health. (See *GCN*, Vol. 13, No. 26 and Vol. 13, No. 28).

The "public," as reported in the media and told to us by researchers, is concerned not with prostitutes getting AIDS but with prostitutes giving AIDS to their male, heterosexual often middle-class customers — a "concern" not without historical parallels. According to Allan M. Brandt in his book *No Magic Bullet: A Social History of Venereal Disease in the United States Since 1880*, (Oxford U. Press, 1985), prostitutes were rounded up between 1918 and 1920, supposedly in order to keep U.S. troops safe from syphilis and gonorrhea. Congress authorized a "civilian quarantine and isolation fund" for this purpose, eventually committing to prison hospitals over 18,000 women either infected with venereal diseases or thought likely to become infected.

As one might suspect, no johns were rounded up and imprisoned in 1918, just as no one today is suggesting that prostitutes' customers are actually spreading AIDS as much as prostitutes. Blaming prostitutes for transmitting AIDS into the "general population" has even surfaced in the gay press. An article in the Dec.18, 1985 issue of *the weekly news, a gay publication from Miami, Fla., by Joseph McQuay, was titled "Prostitutes Aren't Changing, But Johns* Are Starting To Think Twice." In it, McQuay quotes Daniel Little, R.N., who counsels prostitutes through a Dade County program. Little, describing some prostitutes as slaves whose pimps hook them first on drugs and then on the sex necessary to get the drugs, states, "But those slaves are passing the [AIDS] virus on to your husbands, your brothers and your boyfriends who bring it home to you. And that's not fair." Although Little goes on to say that he believes the best defense is education that will help prostitutes protect themselves and the general population, the implication of his earlier statement is clear: prostitutes, no matter where they may have contracted AIDS, are responsible for its transmission.

Studies, Testing, and the Threat of Quarantine

The Centers for Disease Control's (CDC) *Morbidity and Mortality Weekly Report* (MMWR) of December 6, 1985, lists the categories of women considered most at risk for AIDS. 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; women who have engaged in prostitution; and women who are or have been sex partners of men who... are bisexual, have hemophilia," belong to high risk groups and/or show signs of HTLV-III infection. This definition of women most at risk for AIDS is misleading. First, very few studies have been undertaken on prostitutes and AIDS. In fact, William Darrow, research sociologist for the CDC, told *GCN* that the CDC has not yet published any data on prostitutes and AIDS. Priscilla Alexander, Education Coordinator for Call Off Your Old Tired Ethics (COYOTE), the San Francisco-based prostitutes' rights organization, knows of just eight studies on prostitutes and AIDS in the U.S. and said there are three to four more in Central Africa.

Apart from the lack of information about prostitutes and AIDS transmission, Alexander's examination of these eight U.S. studies uncovers further holes in the CDC's assertion that prostitutes are among those most at risk for contracting AIDS. Finding a significant difference in seropositivity rates between prostitutes on the east coast and those on the west coast, Alexander states that, "The difference between the east and west coasts appears to be directly related to the different antibody prevalence in the IV user population." Alexander further explains that since in New York City an estimated 40 to 50 percent of IV drug users are seropositive, while in San Fransico only about 10 percent are, and since in the U.S. some prostitutes, particularly street prostitutes, are IV drug users, the high percentage of seropositivity among prostitutes in eastern cities like New York and Miami is explained more by their IV drug use than by their prostitution.

Alexander is not the only prostitutes' rights advocate to feel wary of the trend toward viewing prostitutes as a high risk group. Arlene Carmen, Program Associate at the Judson Memorial Church (United Church of Christ and American Baptist) in New York City and co-author, along with Howard Moody, of *Working Women, The Subterranean World of Street Prostitution* (Harper and Row, 1985), has been working in the church's ministry to street prostitutes for over eight years. She told *GCN*, "The same thing will happen to prostitutes that has happened to gay men, in that prostitutes with AIDS who are also IV drug users will be put into the "sexual" category [as opposed to the IV drug user category] and will be stigmatized as deviant." Carmen also noted that, "It's [categorizing prostitutes as a risk group] got the potential to create the same stigma that homosexuals faced when they were realized as a risk group."

But even more important to most prostitutes than being labeled a risk group for AIDS is the steadily growing perception that prostitutes are transmitting AIDS to the general population via heterosexual male customers. Carolyn Kessler (not her real name), a working prostitute and member of the Prostitutes Union of Massachusetts, PUMA, an organization of feminist prostitutes and ex-prostitutes which provides support groups and housing for battered prostitutes, told *GCN* "The public/media fear is really outrageous. They're [the public] afraid the streetwalkers will give it [AIDS] to white, middle-America men who will spread it to the mothers of their children, and then it will get into middle-America." Priscilla Alexander asserts there is no known evidence that prostitutes have transmitted AIDS to their male customers. She states, "If infected female prostitutes were transmitting the virus to their male customers, by this time we would already have seen a sharp increase in the number of heterosexual men with AIDS."

There are a number of reasons why many prostitutes and prostitute advocacy groups feel transmission of the AIDS virus from female prostitutes to male customers is unlikely to occur. First and foremost is many prostitutes' practice of "safer" sex and their widespread use of condoms. Secondly, recent theories about AIDS transmission suggest that the number of sexual partners a person has is not necessarily more important in transmission of AIDS than the type of sexual activity engaged in. A third reason is that transmission of the virus appears to occur far more frequently from male to female than from female to male. To date, it remains unclear how a woman could pass the HTLV-III virus in her body fluids into a man's blood stream.

Up until approximately one week ago this was almost a moot point because the HTLV-III virus had not been found in women's genital secretions and because saliva is not considered a source of transmission. But on March 7, doctors in California and Massachusetts announced the isolation of the virus in genital secretions. The researchers from the University of California at San Francisco were particularly cautious about their findings, stating that only small amounts of the virus were present in vaginal fluid and that it is still not easily passed from women to men.

Despite the lack of concrete evidence of prostitutes transmitting AIDS, or perhaps because of this lack, the CDC is currently undertaking a major study of prostitutes and AIDS. When asked why the CDC was undertaking such a study, William Darrow replied, "We are studying prostitutes because the general public is concerned about transmission from prostitutes to heterosexual men." Known officially as "Epidemiologic Studies of HTLV-III Infections in Selected Women in the U.S.," this study is made up of six institutions conducting studies in nine cities.

While Darrow told *GCN* the CDC's study had the support of both COYOTE and another prostitutes' organization, Hooking Is Real Employment, HIRE, in Atlanta, the study is controversial and troublesome to some prostitutes in two ways. First, Priscilla Alexander told *GCN* she would rather see a study done on women and AIDS rather than prostitutes and AIDS because "I don't want prostitutes scapegoated." She said a study of women could well prove that the rate of prostitutes with AIDS is not higher than that of all women with AIDS. Alexander added that when researchers study women they are concerned with how women get AIDS, but when they study prostitutes researchers are concerned with how prostitutes can give AIDS to heterosexual men. Arlene Carmen of Judson Memorial Church reiterated this point, saying that her program decided against cooperating with the CDC study because they felt the lack of scheduled follow-up of the women in the study demonstrated the researchers' over-riding concern with transmission and not with the women themselves.

The second problem with the CDC's prostitute study concerns that part of the study in Miami and Los Angeles, where, according to Darrow, prostitutes in jail will be studied. Darrow claims the use of these incarcerated women is completely voluntary and that complete anonymity is assured. But Priscilla Alexander of COYOTE refused to work with the Los Angeles study because, as Alexander said, women in prison can have very little free choice about participation in the study.

The threat that perhaps looms largest in the minds of many prostitutes today, much as it must have almost 70 years ago, is that of quarantine. Carolyn Kessler told *GCN*, "Whenever prostitutes get it [an illness, like AIDS], that's when they start talking about quarantine." Dolores French, president of HIRE and a working prostitute, said that possible quarantine and force-testing of prostitutes for the HTLV-III virus were major concerns, adding, "People talk more about force-testing prostitutes than any other group of people."

In addition, for French, the AIDS scare and threat of quarantine bring the government one step closer toward control of prostitution, as is already the case in parts of rural Nevada. Under the guise of "protecting the public," French said the government could begin controlling prostitutes with AIDS through quarantine and forced testing, and then move to controlling the lives of prostitutes without AIDS. Priscilla Alexander notes that for months now prostitutes in Seattle, Washington, have been forcibly tested for HTLV-III anti-bodies upon their arrest. Prostitute groups like HIRE, PUMA, and COYOTE all support the decriminalization as opposed to the legalization of prostitution. For them the "protection" and "legitimacy" of the government only means less control over their lives.

Safe Sex, Condoms, and the Police

One way that prostitutes *are* taking control of their lives in the face of AIDS is by engaging in safer sex practices and using condoms as much as possible. Carolyn Kessler told *GCN* that while currently "a lot of prostitutes are afraid of AIDS" they "almost always used condoms anyway." Certainly some, if not much, of the current "public concern" about prostitutes spreading AIDS stems from ancient untruths that prostitutes are unclean, the carriers of numerous sexually transmitted diseases, and are people who do not care about themselves or their customers. William Darrow told *GCN* "If the disease [AIDS] is sexually transmitted, then prostitutes will get it, won't they?" Not according to Dolores French, who says that even "women who have never used condoms before are learning how...," or Arlene Carmen, who told *GCN* "It's the business of a prostitute to protect herself." Priscilla Alexander also mentions that not only are women buying 40 percent of condoms now, but much of the more common sexual activities for which a prostitute is paid, namely hand-jobs and blow-jobs, are considered relatively "safe."

This is not to say all prostitutes practice safe sex or use condoms. Many women literally cannot afford to demand safe sex from unwilling customers and some women are unaware of the use of condoms. Still, prostitute groups argue that the answer is not forced testing, stigmatization or quarantine, but education — and not only *for* prostitutes but *via* prostitutes. COYOTE's Policy on AIDS, as developed at their 1985 convention, reads in part, "We believe that prostitutes, because of their varied sexual experience, would make excellent educators in programs to help people reorient their sexual practices to conform to the safe sex guidelines."

The issue of condoms has become more than a merely personal one for many prostitutes, as police in New York, Atlanta, and other cities routinely use the condoms found on women as evidence against them in prostitution trials. Dolores French told *GCN* she knows of a series of cases where call girls were arrested and charged with prostitution. Some condoms were found in the women's purses and the police used those condoms as evidence that they were soliciting sex for money. Michael Hauptman, an attorney in Atlanta specializing in criminal defense, is currently making motions in the cases of women arrested on prostitution charges that possession of condoms should not be allowed as evidence. He told *GCN* that "there will be an increase in venereal disease because people will not want to carry around damaging evidence on them" and that "we are arguing that people [police] will prefer to stop the spread of disease rather than gain minimal evidence."

The use of condoms as evidence of prostitution is also illegal, as police may not present evidence for a crime they could never have confiscated until an arrest was made. In a key setback for those who want to blame prostitutes for the spread of AIDS while simultaneously using against them one of the things that protects them from the illness, Judge Kristen Glen in New York City ruled on January 23, 1986, according to the New York Law Journal, that "the officers swearing to such complaints [against prostitutes] are, therefore, either relying on evidence seized after the arrest, which is entirely impermissible...or they are lying. Neither is acceptable."

DOES EVERYONE IN LOS ANGELES HAVE AIDS? OPINION

by Charles L. Ortleb, publisher, with thanks to the New York Native, 4/14/86

Ben Stein is a columist for the Los Angeles Herald Examiner, and he is about to make the same mistake that the Native has made for the last three years. He's pursuing the truth about an epidemic. On March 25, Stein wrote a column that contained some of the most disturbing anecdotal information we've read in years. Here are the opening paragraphs:

"Everyone in Los Angeles is sick all of the time. It started about 5 years ago, when a strange flu hit this city. At first, the flue seemed to primarily affect people in the entertainment industry: agents, writers, and producers would come down with a severe cough, a sore throat, a bad headache, aches and pains, and a fever. That flu would remain powerful for about two weeks, and then the patient would feel better and go bck to work. The joker was that after a few weeks--or maybe a few days--of work, the patient would begin to feel sick again and would experience a severe relapse. The relapse would last another two weeks, and then the patient would recover and go back to making phone calls, taking pitches, drawing up deal memos, scrutinizing budgets, casting and figuring out what kind of car to buy with the car allowance. Then, after another few weeks, the patient would get sick again. The point is that once you got this particular kind of flu, you never got better permanently. You never felt perfect again for more than a few weeks, and a state of just getting over the flu or just coming down with the flu became permanent. A vague, spaced-out feeling, chronic fatigue just over your shoulder, always breathing down on you, a susceptibility to wild upsets of the bowels all became part of daily life. What is causing this "non-stop" flu? Stein has asked a couple of doctors and they've only been able to come up with feeble answers about all the immigrants who have flooded Los Angeles. Stein is flabbergasted, and can't understand why the press is ignoring what's going on. Yet while everyone knows that some kind of incurable flu that defeats the body's efforts to destroy it is now pandemic in Los Angeles, I have seen no articles about it, had no public health instruction about it. It is as if half the people in the city were wearing pineapples on their heads, and yet no one has paid any attention."

We have warned the Centers for Disease Control, New York State Commissioner of Health David Axelrod, the City of New York, gay leaders, Congressmen Ted Weiss and Henry Waxman, and selected members of the scientific press about the implications of finding African Swine Fever in AIDS patients. any sober expert on Swine Fever would immediately worry out loud that AIDS is just the tip of the Swine Fever iceberg, and that the virus doesn't select hosts by means of their sexual proclivities, and that the disease would be much more widespread in the general population in a matter of time. AIDS patients could be seen as the only ones who can't handle basic Swine Fever infection, the ones whose immune systems collapse first. Swine Fever doesn't only cause "AIDS" in pigs. It also can cause chronic respiratory problems for life. And Swine Fever is not spread only through the kinds of sex that give the geniuses at the CDC hard-ons and hate-ons. On many occasions, when I've talked to Swine Fever expert Dr. William Hess of the U.S Dept. of Agriculture about the connection between AIDS and Swine Fever, he says he "hopes" there is no connection. An admirable sentiment, but the reason for it is that he knows only too well that Swine Fever is the most problematic, misunderstood, under-researched, devastating disease of swine, and if it is now able to do its problematic, misunderstood, under-researched, devastating work on human beings, the results could be a national medical disaster reminiscent of the flu epidemic in the early part of this century. Or worse. (Such a disaster would convince the Mormun-run CDC that Jesus Christ would soon be making a comeback in Salt Lake City.) A Sept. 17, 1985 memorandum from the New York State Dept. of Health reported on a study of the blood from 110 donors from New York City: "In this population the African Swine Fever virus antibody is present in 4.5% (5/110_ of the populaiton." Moreover, 26 blood samples had what is called "atypical fluorescence" reaction, which the state did not consider positive. We've said before that they may be playing with fire, because these results suggest to us that African Swine Fever has begun to infect the general population of New York City. Out in LA, the very alert Ben Stein is fishing around for an explaination for the growing numbers of people who are sick with something they feel they will never shake.

"We can never be certain that whatever diseases we have here will, like vanity license plates, spred through society and the nation at large. Already my friends in the East tell me the non-stop flue has hit Washington and New York in a big way. This nation can be genuinely disabled by these incurable diseases. The individuals who have them are severely pained, physically and psychically. Having the flu half your life hurts, take it from me. Can anyone help? Isn't this worthy of national attention? Are we just going to have the stock market go up forever while everyone gets incurable viruses? I'm scared!"

I certainly wouldn't like to be the one to have to tell the people of Los Angeles that the results of the cover-up of the connection between AIDS and Swine Fever are that the entire city is running around with a chronic pig disease. Those people who laugh about our expose of the Swine Fever cover-up may soon have to look elsewhere for a chuckle.

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VACCINE PROSPECTS EXPLORED

with thanks to James F. Cawley, MPH, PA-C, with thanks to PA Update, 3/86

The only certain barrier to the transmission of AIDS is a vaccine. Although a number of measures intended to limit the spread of AIDS have been instituted (e.g., screening blood donors for antibody to HTLV-III), the incidence of the syndrome continues to rise rapidly. At present, the prospects for the development of an AIDS vaccine seem distant; experts from the CDC say that such a vaccine is at least 5 to 8 years away. Of all that had been written lately about AIDS, there is very little specific information on the prospects for an AIDS vaccine. Recently, in the New England Journal of Medicine (Francis, D., Petricciani, J., 1985, 313:1586-90), researchers from the FDA and the CDC addressed the biologic and immunologic issues related to AIDS vaccine development. It is clear from the article that no breakthroughs are imminent. Vaccines directed against retroviruses do exist. Feline leukemia virus is a retrovirus that causes a common disease in cats, the manifestations of which are quite similar to those of AIDS in human beings. This virus has been well studied, and a vaccine for feline leukemia has recently been licensed by the FDA. The feline leukemia virus vaccine model is important for the development of other retroviral vaccines, and suggests that a vaccine can be produced to effectively neutralize HTLV-III, which is a biologic relative of feline leukemia virus. However, there are major differences between the two viruses. Feline leukemia virus infects cells differently than does HTLV-III. Moreover, antibody to feline leukemia virus is highly protective; it is not known whether neutralizing HTLV-III antibodies are protective against AIDS. Antibodies found in the sera of infected patients can neutralize HTLV-III in vitro (Ho, D., et al.,NEJM, 1985, 312:649-50.), but the prevalence of these antibodies is low (as opposed to other types of antibodies used to detect exposure to the virus). Because retroviruses have a predilection for genetic recombination and have been associated with malignant disease, it is unlikely that an AIDS vaccine will emerge from a live or live-attenuated virus model. This leaves the possibility of a killed-virus vaccine, but the development of such a vaccine can be complicated. Such a virus must be cultivated in an appropriate cell line, viral antigen must be purified, and viral nucleic acid must be removed. This extensive processing could easily cause the loss of key structural antigens essential to the induction of neutralizing antibodies. Another approach would be to use recombinant DNA technology to incorporate the HTLV-III genome into bacteria or yeast cells that elaborate virus-specific proteins. Using this system, the infective virus is not produced, and large quantities of antigen can be made. However, antigen produced in this fashion may not be immunogenic, i.e., it may not induce neutralizing antibodies, since it is theoretically different from naturally occurring viral antigen. Assuming that an immunogenic AIDS vaccine could be developed, further problems surround the testing and evaluation of such a vaccine. One of the early steps would be to administer the vaccine to animals. The chimpanzee is a good model since it is readily infected with HTLV-III and has predictable responses to infection. However, this model is expensive and can be used to establish only the most basic safety and efficacy data. Testing of a prototype vaccine in humans, particularly given the nature of the disease, would require that many questions of safety be answered first. Apart from all of the methodologic problems related to the development of an AIDS vaccine, there is a further reason why a vaccine is unlikely to appear soon--the long incubation period of naturally occurring disease. Most experts estimate the AIDS incubation period to be between two and five years. Even if a vaccine were available now, it would take at least that long (and probably much longer) to definitely answer questions about its efficacy and safety. AIDS poses the most difficult challenge of this decade to biomedicine. An AIDS vaccine is a possible but distant goal. In the meantime, we must rely on other methods of controlling the spread of this serious disease. [NCGSTDS ED NOTE: I believe the author to be unrealistic about evaluating the efficacy of the not-yet-developed vaccine. The hepatitis B vaccine offers immunity for an unknown period of time, yet antibody levels can be measured over time; booster vaccinations can be administered when antibody levels fall below a protective level. Vaccination against HTLV-III presumably would operate in a similar fashion.]

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VACCINE TESTED IN ANIMALS

by Lou Chibbaro Jr., with thanks to The Washington Blade, 2/28/86

A government health official disclosed that scientists with the National Cancer Institute have developed a technique for inducing mice and rhesus monkeys to produce antibodies that kill the AIDS virus in the test tube. Dr. Walter R. Dowdle, temporary AIDS coordinator for the Dept. of Health & Human Services, said that development of the technique represents another important "step" toward production of an AIDS vaccine. Dowdle and Dr. Peter J. Fischinger, deputy director of NCI, said the technique was developed by identifying the precise molecular structure of the protective envelope surrounding the AIDS virus and by isolating "sub-unit" proteins of the envelope through a process of genetic engineering. Fischinger said the sub-unit proteins, or antigens, were then injected into mice and rhesus monkeys in different amounts and combinations. Eventually NCI scientists discovered that a certain genetically-engineered antigen induced the animals to produce an HTLV-III antibody that attacked and killed the HTLV-III virus in a test tube experiment. HTLV-III antibodies produced in humans as a result of exposure to the AIDS virus have been unable to check the virus and thus unable to prevent the disease from spreading in many people who become infected. Dowdle said scientists have already begun testing the genetically-engineered antigen procedure on chimpanzees. He said the chimps will be injected with live HTLV-III virus to determine whether the antigen technique induces the chimps into producing the "neutralizing" antibodies. If the experiment succeeds in checking the AIDS virus in the chimps, Dowdle said, the findings will represent a "major breakthrough" and could lead to production of an AIDS vaccine for humans within "a few years."

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VACCINE RESEARCH: PROMISING PROTEIN

by L. Davis, with thanks to Science News, 3/8/86

A viral antigen that "does the right stuff" has brightened hopes for the development of an AIDS vaccine, government scientists said at a recent press briefing. The antigen, a protein from the outer coat or envelope of the AIDS retrovirus, triggered an immune response when injected into animals, according to researchers at Duke University in Durham, North Carolina and the National Cancer Institute in Bethesda. Antibodies made by the animals neutralized the AIDS virus in the test tube (in vitro). Thus far, researchers have induced antibody formation in goats, rabbits, mice and guinea pigs. They have begun tests on rhesus monkeys to see if the protein, called gp120, will similarly prod a primate immune system into making the neutralizing antibodies. But since none of these animals is susceptible to human AIDS, the real test of the antigen's potential as a vaccine will come with chimpanzees, who are vulnerable tot he virus. The researchers hope that exposure to the antigen alone will have the chimpanzee's immune system revved up and ready with antibodies, able to neutralize the virus before it can invade the animals' cells. Antibodies with at least a slight ability to neutralize the AIDS virus in vitro have been found in the blood of some AIDS and "pre-AIDS" patients, yet have been ineffective against the virus. According to Don Francis of the Centers for Disease Control in Berkeley, the situation in people with AIDS is "very different from pre-exposure presentation [of the antigen] to an individual who has not seen the virus, and whose system has not been deranged by the virus." Antibodies formed in the body are a response to the living, whole virus. But researchers can't use the whole virus as a vaccine, even if it is killed, because of a double risk: the virus might revitalize itself, and the incorporation of viral genes into cellular DNA might at some point trigger cancer. Instead, researchers have looked for nongenetic bits of the virus, like gp120, that the immune system recognizes as foreign. Even if gp120 protects chimpanzees against AIDS, there are still potential roadblocks. Most worrisome is the variability of the virus: will an antigen that comes form one viral strain, and confers immunity against it, give any protection against another? Research has focused on the envelope protein in part because something on the outer coat of the virus must remain constant if the virus is to continue to recognize and bind with its host cells. While gp120 is one of the most variable of the viral proteins, there are stretches within it that remain unchanged throughout the different viral strains. "The question is," says Francis, " are those conserved regions important in producing neutralizing antibodies?" If they are, gp120 from any strain might elicit antibodies that recognize the protein of any other strain. Hepatitis B, for example, is a virus with multiple subtypes, but with enough stability among the strains that one vaccine protects against all of them. Even if the antibodies turn out to be strain-specific, gp120 may still be useful, says Peter Fischiger of NCI's Frederick Cancer Research Center. "With some retroviruses," he says, "we have seen that as you continue immunizing, the neutralizing response becomes broader." The earliest possible testing of an AIDS vaccine in humans would be in 1988, according to Anthony S. Fauci, of the National Institute of Allergy and Infectious Diseases in Bethesda. "You're going to have to tack on at least a few years more," he adds, because the disease's long latency period will increase the time necessary to determine the vaccine's efficacy.

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VACCINE & SECOND GENERATION ELISA TEST HOPES CONTINUE

with thanks to the New York Native, 4/14/86

Genetic engineers at DuPont have grown three proteins from HTLV-III genes which they believe could be the basis for a vaccine against HTLV-III infection. The three proteins--P24, GP120, and GP41--are transplanted to the common E. coli intestinal bacteria. The result is the production of proteins which, if purified, the engineers believe, could result in the destruction of the HTLV-III infected cells by the body's own natural defenses. DuPont has also done research with a "second generation" HTLV-III antibody ELISA test, which it plans to market in the near future. It was developed with Centocor, a company that produces diagnostic tests. The "second generation ELISA" is made from genetically engineered material. According to DuPont, it should be less expensive and more accurate that the ELISA test currently in use.

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VIRUS CARRIERS DIAGNOSTIC TEST BEING DEVELOPED

with thanks to the Computerized AIDS Information Network (CAIN), 4/11/86

Although it falls short of a full diagnostic test for AIDS, Abbott Laboratories is developing a test that can determine if a person carries the AIDS virus, Robert A. Schoellhorn, Abbott's chairman and chief executive officer said. The test is still in clinical trials with the FDA, but represents a significant advance in research into the diagnosis and management of AIDS. Unlike earlier tests, which indicate the presence of the antibody produced by the body in response to the AIDS virus, Schoellhorn said the new procedure can detect the presence of an antigen associated with the virus itself in blood, saliva, and other body fluids. Schoellhorn and other Abbott spokesmen acknowledged that the new test falls short of the company's announced goal of developing a simple clinical procedure to provide early diagnosis of whether a person actually has AIDS or ARC. Nonetheless, an unidentified company spokesperson said a person who tests positive with the new procedure is highly likely to develop the disease and be in need of medical treatment.

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FOOL-PROOF AIDS TEST CLAIMED

by Julie Ogletree, with thanks to Boston's Gay Community News, 5/3/86

A California biotechnology firm claims it has developed a diagnostic test that can detect the AIDS virus, according to the Washington Post. Cetus Corp. says its test could be on the market within a year. Before it could be released it would have to be approved by the Food and Drug Administration. The test uses "gene-probe" technology to detect the genetic material that comprises the AIDS virus, and is genetically designed to bind only with the DNA that is unique to the AIDS virus. AIDS testing has become a $75 million a year business in the U.S. alone, and more than $150 million worldwide. Cetus research vice-president Jeffrey Price said that the test will give it an edge in the $4 million diagnostics marketplace.

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AIDS VIRUS SURVIVES TESTS

with thanks to the Computerized AIDS Information Network (CAIN), 4/8/86

The AIDS virus remains active outside the body much longer than previously believed, but common disinfectants re sufficient to neutralize it, according to a new study. Tests conducted during a three month study suggest the need for more careful guidelines for laboratory personnel working in AIDS research, scientists reported in an article to be published in the Journal of the American Medical Association. The tests showed that the virus can live up to 15 days in a water-based solution of human blood cells at room temperature outside the body. As the temperature is increased, the virus can survive for increasingly shorter periods. Dried, the complete inactivation of the virus required 3 to 7 days. Although it was previously believed the the virus died quickly outside the body, the new findings do not mean that it can be spread by casual contact such as touching a toilet seat. Also, the preparations used in the tests contained viral concentrations thousands of times higher than those in the blood of people with AIDS, according to virologist Phillip D. Markham of Bionetics Research Inc., of Rockville. Intact, unbroken skin still is an effective barrier to the virus, said Dr. Lionel Resnick of Miami Beach's Mt. Sinai Medical Center. However, lab workers were once again cautioned about their contact with the virus, since it may persist in a viable state even at elevated temperatures, when wet or dry.

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LESBIAN STEREOTYPING

with thanks to Medical Aspects of Human Sexuality, 3/86, and Sex Roles, 12:143, 1985

People are more likely to think a woman is a lesbian if they find her physically unattractive, according to psychologist Mary Armanda Dew. At Johns Hopkins University in Baltimore, Dew displayed photos of 22 women, none of whom were identified as to sexual orientation. Fifty respondents gave opinions about the women and then guessed which ones were lesbians. The women the respondents suspected of being gay tended to be the ones they'd judged to be less "pretty," that dressed least well, had the least attractive hairstyle, and were perceived the least desirable to meet.

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GENE TRIGGERS VIRUS REPLICATION

by Lisa M. Keen, with thanks to The Washington Blade, 4/2/86

Scientists at the National Cancer Institute reported that a specific gene within the HTLV-III virus is "an absolutely requirement" in order for the virus to replicate. In a report published in the March 27th Nature magazine, the scientists identified the gene as "tat-III" [tat = transactivator] and said that derivatives of HTLV-III without the "tat-III" gene "failed to produce or expressed unusually low levels of virus....the observation that "tat-III" is critical for HTLV-III replication has important clinical implications," said the report, "and suggests that specific inhibition of the activity of "tat-III" could be a novel and effective therapeutic approach to the treatment of AIDS."

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GENE-SPLICING STOPS AIDS VIRUS

with thanks to the Computerized AIDS Information Network (CAIN), 3/28/86

Research teams from Harvard and the National Cancer Institute say scientists have found a way to inactivate the AIDS virus, a breakthrough toward developing drugs or a vaccine to combat the fatal disease. Gene-splicing techniques were used to render the virus harmless by inactivating one of its genes in laboratory experiments, The New York Times and The Los Angeles Times reported. Findings were reported by scientists at the National Cancer Institute in the British medical journal Nature, and by a team at Harvard University's Dana Farber Cancer Institute in the biomedical journal Cell. The two groups worked independently of each other. Dr. William A. Haseltine, leader of the Harvard team, said the virus was crippled by removing a key gene called the transactivator which accelerates production of the virus by an infected cell. Although scientists believe the crippled virus may be a prototype for a possible vaccine, they cautioned against undue optimism. "This is not a cure for AIDS or a vaccine for AIDS," Dr. Flossie Wong-Staal of the NCI cautioned. "We don't have a drug yet, but we are pretty certain that we will be able to find drugs," Haseltine concluded.

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SMALLPOX VACCINE MODIFICATION MAY HELP AIDS EFFORT
with thanks to the Computerized AIDS Information Network (CAIN), 4/9/86

A smallpox vaccine modified to include part of the AIDS virus produced some immunity to AIDS in mice, suggesting that it might also protect against the deadly disease in humans, according to a new report. The vaccine was genetically engineered to include the gene responsible for making the outer coat of the virus, a protein called the envelope. It is believed that this gene can be used to produce immunity against AIDS, said one of the vaccine's developers, Bernard Moss of the National Institute of Allergy & Infectious Disease (NIAID) in Bethesda. Moss said the next step was to attempt immunizing monkeys to see if they develop antibodies. Considerable research remains before such a vaccine can be tried on humans. Myron Essex, an AIDS authority at Harvard's School of public Health said of Moss' work that "it's been well proven that it works in principle." Essex said he has an interest in the research because the AIDS envelope protein was discovered in his laboratory. "I think there's general consensus that that's the right molecule" to use in the development of an AID Vaccine,he said. Moss was one of the pioneers in showing that smallpox virus can be modified to protect against other diseases. Enzo Paoletti of the New York State Dept. of Health has independently developed modified smallpox vaccines. Paoletti said that he has also inserted genes from the AIDS virus into smallpox vaccine, but he said he couldn't discuss his research until it was published in a scientific journal. Paoletti and Moss are working separately to develop smallpox vaccines modified to protect against herpes hepatitis, rabies and certain veterinary diseases. Moss recently announced successful animal tests of a modified smallpox vaccine to protect against respiratory syncytial virus, one of the most important and serious causes of respiratory infection in young children. Smallpox vaccine consists of the virus that causes cowpox, vaccinia, which is similar enough to the virus causing smallpox that when it is injected into people it causes them to build immunity that protects against the disease smallpox. That discovery was made by the English physician Edward Jenner in 1796, and has been used for almost 200 years, amply testifying to its safety and efficacy. The AIDS envelope gene would operate normally when it was spliced into the genes of vaccinia virus.

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NEXT NEWSLETTER

Article submissions for the next issue of the NCGSTDS Official Newsletter, volume 7:5, June/July, are due by June 20, 1986. Anticipated publication and mailing will be in July. Address articles to: NCGSTDS, PO Box 239, Milwaukee, WI 53201. Thanks!!

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VIRUS FOUND IN RED BLOOD CELLS, VAGINAL & CERVICAL SECRETIONS
by J. Silberner, with thanks to Science News, 3/15/86

Scientists tracking AIDS have identified the suspect virus in vaginal and cervical secretions of some antibody-positive women and have found possible signs of it in red blood cells. Though the discovery of the virus in genital secretions does not prove that women can infect men through heterosexual contact, the virus's presence does provide a possible route for transmission, according to members of two research groups that made the findings independently of one another. Suspected female-to-male transmission is uncommon, as of March 10, only 41 of the 18,070 reported U.S. AIDS cases were in men with heterosexual activity as the only possible exposure, according to the CDC in Atlanta. Although heterosexual transmission in both men and women "has been going up," according to CDC epidemiologist Harold Jaffe, it has remained at about 1% of the total US cases, and it's not thought likely to increase in the next year or two, but he says, "beyond that who knows?" Both studies were described in the March 8 Lancet. In one, Harvard and Boston University researchers collected cervical secretions from 14 women who were HTLV-III antibody positive. Only three were free of signs of immune dysfnction, and all were in high-risk groups--because of either intravenous drug abuse or sexual relations with intravenous drug users or bisexual men. Four of the women were prostitutes. To make sure they were not looking at viruses from the blood, cervical secretions were collected during the middle part of the menstrual cycle. Virus was found in 4 of the 14 women. In the second study, University of California-Berkeley researchers grew low but measurable levels of virus from the vaginal and cervical secretions of 4 out of 8 antibody-positive women. One woman from whom the virus was cultured was menstruating at the time of collection; another initially cultured negative, but tested positive after self-induced orgasm. Researchers from both groups note that despite the low virus levels and the relative infrequency of female-to-male transmissions, the studies indicate such transmission is plausible and emphasize the importance of safer sex practices. Constance Wofsy of UC-San Francisco says, "It confirms there is some virus there and therefore the vagina in a nonmenstruating woman could be a potential source of virus exposure [to her sexual partner]. But the factors that will allow a man to be susceptible to this small number of viral particles need to be determined. This just gives a little more emphasis to why people should use condoms." Neither study identified the cellular residence of the virus, which is now known to infect not only white blood cells but also central nervous system cells. In the February Proceedings of the National Academy of Sciences, Morton Cowan of UCSF and his colleagues describe finding abnormally high levels of an enzyme in the red blood cells of people with AIDS. The abnormality may prove useful as a confirmatory AIDS test, he says, and also suggests that the virus may be infecting the precursor cells that differentiate into red blood cells. "It warrants further investigation," he concludes.

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AIDS EPIDEMIOLOGY/SURVEILLANCE UPDATE

abstracted from AIDS Weekly Surveillance Report, CDC AIDS Activity

As of April 28, 1986, the Centers for Disease Control AIDS Activity reports a total of 20,088 adult and pediatric cases of AIDS in the U.S. (CDC strict case definition). PATIENT RISK GROUP: 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 a "high risk" group, yet they had accounted for 3% of all cases. The CDC continues to receive criticism for their atypical "hierarchical" listing, whereby if homosexually active men are also IV drug users or hemophiliacs, they are only counted in the top, i.e., homosexual, category, therefore confusing and misrepresenting the data. CDC officials admit this situation. --ED] AGE: 22% of the cases are aged 29 or less; 47% from ages 30-39; 21% from ages 40-49; and 10% from ages over 49. RACIAL/ETHNIC BACKGROUND: 59% of the cases are white; 25% are black; 14% are hispanic/latino; 2% are other or unknown. GEOGRAPHICAL DISTRIBUTION: 55 states and territories, including the District of Columbia & Puerto Rico have reported cases to the CDC; New York & California have the most cases, with 33% & 23%, respectively; Florida, New Jersey, & Texas report 7%, 6% & 6%, respectively; Illinois, Pennsylvania, Massachusetts, the District of Columbia, and Georgia, each report 2% of the cases; all other areas each report 1% or less. OVERALL MORTALITY: 54%. CASES PER MILLION OF POPULATION: 88.2 overall for the entire U.S.; it ranges from 682.9 pM in New York, 653.1 pM in San Francisco, 229.9 pM in Los Angeles, 371.5 pM in Miami, 256.4 pM in Newark, and 43.6 pM elsewhere in the U.S., irrespective of standard metropolitan statistical area.

NEW AIDS VIRUS MAY OFFER HOPE

by L. Davis, with thanks to Science News, 4/5/86

Two new members were proposed for the AIDS group of viruses. One apparently causes AIDS, while the other appears harmless to humans and may even protect against AIDS. According to the researchers, the findings bring possibilities for prevention as well as for understanding the origin of the disease. One of the newly identified variants, named human T-lymphotropic virus type IV (HTLV-IV, hereafter abbreviated H-4), was first isolated in healthy prostitutes in Senegal. Max Essex of the Harvard School of Public Health in Boston, who headed the team that discovered the virus as well as a similar strain in African green monkeys, says the virus may be a "missing link" between the monkey and human viruses. The devastating effect of the AIDS virus may be due in part to its youth: human bodies have yet to evolve defenses against it. But the origin of the disease has been a mystery. Serum samples drawn from Africans in the mid-1970s and tested in the last few years show signs of the virus, or of a closely related one, and retrospective diagnoses of AIDS have been made for a few Africans who came to Europe for treatment at about that time. Essex postulated last year that the AIDS virus made its way into Africans who ate or were bitten by primates infected with a closely related virus, but the idea has met with hostility from Africans who feel unjustly burdened with responsibility for the epidemic. H-4 is closely related to the AIDS virus: some antibodies made in response to one virus recognize and cross-react with particles from the other, and the viruses home in on the same target in the body, a T-cell subgroup of the immune system. But while the AIDS virus is lethal, people infected with H-4 remain healthy. The team has followed more than 50 infected Senegalese for up to three years, and has found no signs of virus-causing illness, including AIDS. In fact, there has been only one reported case of AIDS in the entire country. "You have to wonder why [AIDS] is in neighboring countries and not there [in Senegal]," says Phyllis Kanki of Harvard. And there is no evidence of asymptomatic infection with the AIDS virus in Senegal, Essex says, thought "to our knowledge, HTLV-III/LAV [the AIDS virus] is present in Dakar, Senegal, where we did our study." All this could mean, Essex suggests, that H-4 affords natural protection against AIDS. At the least, the variant could serve as a natural laboratory for scientists studying the disease process in AIDS. "We feel that what we might have is a naturally attenuated variant in this general family [of human T-lymphotropic viruses]," Essex says. "It doesn't seem to be killing the same cells, although it infects them....So we should be able to learn a lot about how people can be protected against disease development after infection with a virus of this general type." The new findings have rekindled long-simmering competition among scientists in this area. Essex's decision to announce his findings two weeks before their scheduled publication in the April 11 Science appeared to be prompted by the release the day before of new, unpublished AIDS findings by a European team. According to Luc Montagnier of the Institut Pasteur in Paris, his team has isolated a previously unidentified AIDS-causing virus in two patients in European hospitals. Montagnier's group was the first to isolate a virus associated with AIDS, which he called LAV, for lymphadenopathy associated virus. He has named his new variant LAV-II [L-2]. While L-2 is no cause for optimism, H-4 might bring researchers closer to an AIDS vaccine. It is "totally impossible," Essex says, to use H-4 itself as a vaccine, since it sets up a persistent infection of unknown outcome. But it may be helpful because it shares many antigens with the AIDS virus--most significantly, perhaps, some surface antigens that are likely candidates as the viral part that recognizes the T cell target. "I think that taking parts of this virus, to see whether or not they would be effective as a vaccine, is certainly appropriate," says Essex. These are not likely to be the only variants found. "We predict that there will be other viruses in the spectrum that range from the African green monkey prototype...through to the HTLV-III/LAV-type virus as we know it," says Essex. "It's quite generally understood that this family of viruses has a very sloppy means of replication and therefore a very high rate of mutation."