THE OFFICIAL NEWSLETTER OF THE

NATIONAL COALITION OF GAY STD SERVICES

VOLUME 8:3 SPRING, 1987

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NATIONAL AIDS NETWORK PREVIEWS 87

by Paul Akio Kawata, Executive Director

"Together in '87 We Can Fight This Epidemic!" is an exclamation that describes the National AIDS Network (NAN) 1987 mission. NAN's vision is to be a national information resource center for AIDS education and service delivery and is here to make your lives easier. NAN evaluates our success by our ability to give you quality services. Your input to this work plan is always greatly appreciated.

1>**Counterpart Conferences** highlighted 1986. These conferences brought together the counterparts from different agencies to share resources towards an end of duplication of efforts. In some cases, as in the New York State conference, participants have continued to meet independently of NAN. In 1987, NAN hopes to host two regional and five national Counterpart meetings. Announced so far: March 27, Counterpart luncheon in conjunction with the National Lesbian/Gay Health Conference in Los Angeles; April 21-22 in conjunction with the American Medical Association's conference, "AIDS and Public Policy: A Community Response," in Chicago; May 11, a regional conference to discuss direct mail fundraising for AIDS-related groups in San Francisco; and June 1-5, assorted Counterpart roundtable discussions for the Third International Conference on AIDS in Washington, DC.

2>**The Monitor** was our professionally bimonthly published newsletter, which began NAN's information sharing process. Most people enjoyed the Monitor, but requested more technical information on a more timely basis. Beginning in March, a new bimonthly publication—The Network News—will focus on technical assistance and highlight some of the different successful programs from across the country. The Monitor will become quarterly.

3>**Other Publications.** Our AIDS Service Profiles directory was a well-received look at a cross section of the organizations that make up NAN. We intend to update this publication in August. If you want your agency featured in the next issue, please complete the survey that will be circulated later this summer. We will continue to work with the AIDS Action Council to update the directory of AIDS Service Providers. Look for a new format now that we have d-base III. When we first published this directory, we had 135 names; currently we have over 250 organizations. You will receive an updated directory with your membership renewal.

4>**National Fund Raising** involved 3 projects in 1986. Using SHOWTIME's movie, As Is, we had some success raising money for local community groups. Our use of the movie, The AIDS Show, and Casey Donovan's cocktail parties were not as well received. One major national fund-raising project is slated for this year. Actress Joan Rivers has agreed to be one of the National Celebrity Chairs for NAN's national Hair Cut-A-Thon. We will be contracting the services of a professional event production team to assist your agencies in coordinating this event at the local level.

5>**National Education** began with the release of 60 celebrity public service announcements designed for local broadcast media. There is a possibility that additional PSAs will be produced in 1987. NAN will also offer 2 videotapes to member agencies. Sex, Drugs, and AIDS will be offered for a reduced price to certain agencies, and Hour Magazine has produced a video with Dr. Isadore Rosenfield interviewing Dr. Anthony Fauci. Announcements about these tapes are forthcoming.

6>**The NAN Fund** will start disbursing up to $1000 grants to local community based agencies. The money was collected from the Stamp Out AIDS project. NAN has agreed to serve as grant administrator for this project. Contact our office for details about applying for a grant.

7>**Membership Dues** in 1987 will be based on a percentage of your agency's annual budget, rather than a flat fee. That amount is calculated as one tenth of one percent of your annual budget. Minimum dues for smaller agencies will be $100, and maximum dues for large agencies will be $10,000.

8>**Technical Assistance** has been difficult due to our limited staff size. However, NAN provided two day intensive workshops, phone consultations, and technical assistance packets. Our new policy of Management by Wandering Around (MBWA) will allow each of our staff members to spend at least one week each quarter in the field at different agencies. Listening to your problems and learning about your programs will enable us to better serve your needs. We want to know you, we want to know what works and what doesn't work.

9>**Minority Project.** Important challenges face people of color in 1987. In February we will release our report on the status of minorities in AIDS service organizations. Included in this report will be an action plan for NAN to address the issue of racism, education, and services to minorities.

10>**National Association of People With AIDS (NAPWA)** offices were moved to NAN headquarters. NAPWA will publish a general brochure, a guide for the newly diagnosed PWAs called Hints (in cooperation with NAN), be ready to distribute the second issue of its quarterly NAPWA News, and begin to expand its own network of local PWA groups.

11>**Brochure Clearinghouse.** In December, we mailed out a packet containing the latest brochures from several agencies. We intend to continue this program by creating a different thematic mailing every other month. If you would like to share your brochures, please contact Jay Coburn in our office.

This is our game plan for 1987. It's only effective if it meets your needs. Call us (202/347-0390)! We like hearing from you. As I wrote you last December, if someone did not write to complain, we would not know to fix the process. Invite us to your city! We want to meet you! For further information or membership, write: National AIDS Network, 1012 14th Street, N.W., #601, Washington, DC 20005 (202/347-0390).

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SHR: NEXT NEWSLETTER!

Articles for the Fall, 1987 issue of the newly renamed NCGSTDS Official Newsletter—SEXUAL HEALTH REPORTS (SHR) volume 9:1, will be due by October 16, 1987. Planned publication and mailing will be in early November. Address articles to: NCGSTDS, P.O. Box 239, Milwaukee, WI 53201. Thanks for your understanding!

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SYPHILIS ON RISE AMONG HETEROS

with thanks to Detroit's Cruise, 5/27/87

In an unexpected reversal of a downward trend, the number of a downward trend, the number of reported syphilis cases in the U.S. is increasing dramatically. The increase appears to be caused by a rise in heterosexual cases, often involving black and Latino female prostitutes and intravenous drug users, according to public health officials across the country. They cautioned, however, that the outbreaks are still under investigation and that different factors may be important in various regions of the country. Nationally, cases of infectious syphilis increased about 25% through April 1987, compared to 1986, according to the Centers for Disease Control. Reported cases of primary and secondary syphilis cases occur in regions of the country with high numbers of AIDS cases. That suggests that many heterosexuals are failing to protect themselves against exposure to the AIDS virus despite the blitz of publicity about contracting the virus through sexual contact. At the same time, syphilis cases in homosexually active males are declining. "...The heterosexuals do not have the same AIDS fear [as the homosexuals]," declared Dr. Surekha Mishal, acting director of Los Angeles County's sexually transmitted diseases program.

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SYPHILIS ASSOCIATED WITH PCP?

by Tom Steele, with thanks to New York Native, 3/2/87

A research team consisting of two veterinarians and two physicians reported in the March 1976 issue of Archives of Pathological Laboratory Medicine that they had detected pulmonary infection with pneumocystis carinii pneumonia (PCP) in two owl monkeys and two chimpanzees. PCP is one of the major forms of mortality in people with AIDS. The authors mention almost in passing that four years before the four monkeys died, one of them was inoculated "intratesticularly" with Treponema pallidum, the spirochete bacteria that causes syphilis. The possible connection between the inoculation and the later onset of pneumocystis is only perfunctorily addressed. "....The clinical histories of the owl monkeys were similar and included progressive weight loss, anorexia, failure to thrive, and death.... In both chimpanzees, an underlying myeloproliferative malignant neoplasm was associated with Pneumocystis infection." At no point in the lengthy paper is the possibility raised that syphilis had spread among the monkeys; the only VDRL results reported are those for the monkey infected by inoculation, who tested positive three weeks before death.

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COST & TREATMENT OF VD

with thanks to Science News, May 2, 1987

Although other sexually transmitted diseases are more feared and attract more attention from scientists and the public, Chlamydia trachomatis is the most common such STD in the U.S., infecting more than 4 million people annually. According to a new study by the Centers for Disease Control in Atlanta and the University of California at San Francisco. C. trachomatis infections cost the U.S. more than $1.4 billion per year in direct and indirect costs. However, new approaches to treating gonorrhea might significantly reduce the price tag for Chlamydia, say the researchers in the April 17 Journal of the American Medical Association. They recommend that women being treated for gonorrhea be treated for chlamydia at the same time, using a combination therapy of ampicillin and tetracycline. Currently, treatment for gonorrhea is oral doses of either ampicillin or tetracycline, but ampicillin is ineffective against chlamydia and tetracycline is not quite as effective as ampicillin against gonorrhea. A combination dose is warranted, say the authors, because of the frequency with which the two infections coexist in a patient. Between 25 and 50% of women with gonorrhea also have a chlamydia infection, often asymptomatic. [NCGSTDS ED NOTE: Clinicians should also consider alternate drugs, such as amoxicillin for ampicillin, and doxycycline or erythromycin for tetracycline, in the proper regimens!! Also, due to the high rate of asymptomatic nature of the infection, men patients should always be examined by stripping the urethra ("milking" the penis) and looking for white blood cells on oil immersion examination of a gram stained smear. It is truly surprising how many men have this condition but yet deny any signs or symptoms!]

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HETERO CASES GO UNREPORTED?

with thanks to Detroit's Cruise, 1/28/87

Dr. Mark Kaplan, a leading AIDS researcher and former member of the AIDS team at the National Cancer Institute, says that 75% of AIDS cases go unreported, most of them among heterosexuals. Kaplan said nearly two thirds of all persons with AIDS have severe neurological problems. Kaplan, who is an associate professor of medicine at Cornell University and Chief of Infectious Diseases and Immunological studies at North Shore University Hospital in New York, based his observations on his own research and experience. "The Centers for Disease Control doesn't seem to recognize anything but late-stage cases of AIDS. We are seeing more and more cases of early AIDS and primarily in non-gay persons," Kaplan said, saying the CDC should significantly expand its definition of AIDS.

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ONTARIO FUNDS AIDS HOSPICE

with thanks to Toronto's Epicene, May, 1987

The Ontario Ministry of Health is contributing $1 million toward the cost of a hospice in downtown Toronto for people in the advanced stages of AIDS. Casey House is expected to open in the fall, once the steering committee (which chose the site and raised the first $500,000) chooses a hospital to administer the facility and sets guidelines for it. Word that the grant was approved came just in time—as the committee's option on the property they'd chosen was due to expire.

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HEPATITIS THREAT FROM SPERM DONORS

with thanks to the Washington Post News Service, 3/09/87

The first documented case of hepatitis B transmitted through artificial insemination has prompted health officials to urge that all sperm donors be screened for the liver ailment. A 37-year old Colorado woman developed acute viral hepatitis B in 1982, several months after being donor-inseminated with sperm from an anonymous donor. Later it was discovered that the donor semen contained the hepatitis B virus. The woman recovered fully after three weeks in the hospital. Potential transmission of hepatitis B through semen is known, but infection through donor insemination was theoretical until the Colorado case, according to the Journal of the American Medical Association. Though the incidence of hepatitis B in semen donors probably is less than 1%, the JAMA report said, routine screening of donors could eliminate even that small risk without adding significantly to the cost of the procedure. More than 60,000 donor inseminations were performed in the United States last year. Blood donations in the U.S. are now screened for evidence of hepatitis B, syphilis and HIV (the putative AIDS virus).

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HEPATITIS B IMPLICATED AGAIN

with thanks to Detroit's Cruise, 3/18/87

Tainted hepatitis B serum may have caused the AIDS crisis in the gay community, and the CDC may be covering up large percentages of heterosexuals at risk for AIDS, according to leading AIDS scientist Dr. Mathilde Krim of the American Foundation for AIDS Research (AmFAR). Krim's theory of why the disease took hold: "In the early 1970s the majority of blood products were brought from foreign countries," she said. The blood from these countries, she continued, "was pooled donor blood, unscreened and untested for disease other than hepatitis. Many different blood products were adapted from this blood, among them factor VIII, which is used to treat hemophiliacs, and gamma globulin, which is used generally in the treatment of hepatitis." Krim went on to explain that many gay men, because of a variety of sexual practices and promiscuity, had frequent occurrences of hepatitis and were given treatments from this infected blood. "This was particularly true in the large gay centers like New York and San Francisco, where the percentage of that population with the (hepatitis) antibodies now is close to 90%. We have tested blood (in the laboratory) with the virus, cleaned the blood and still found the virus gamma globulin." According to Krim, 98-100% of all hemophiliacs requiring periodic factor VIII replacement in the U.S. and Britain carry antibodies to HIV. Most of these hemophiliacs, she believes, will contract AIDS. When the first cases of AIDS among hemophiliacs were discovered, already 25% of them had antibodies. This tainted blood theory, Krim said, was yet another reason for not accusing gay men of causing their own disease as some ill-informed, religious, and right-wing fanatics have stated.

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COMMUNICABLE DISEASES PROTECTED

by Lisa M. Keen, with thanks to The Washington Blade, 3/6/87

Gay/Lesbian legal activists hailed the U.S. Supreme Court decision that persons with communicable diseases are protected by the federal Rehabilitation Act, saying that both the language of the decision and the margin of vote were "spectacular victories" for people with AIDS. The high court, in a quickly rendered 7 to 2 decision, ruled that Nassau County School Board in Florida violated Section 504 of the Rehabilitation Act of 1973 when it dismissed Ms. Gene Arline, a third grade schoolteacher for having tuberculosis. According tot he decision, the Act protects disabled persons "against discrimination stemming not only from simple prejudice, but from `archaic attitudes and laws'..." concerning people with contagious diseases. In addition to protecting persons whose contagious disease results in a physical or mental impairment, said the court, the Act also protects those whose contagious disease "might not diminish" their capabilities "but could nevertheless substantially limit" their ability to work "as a result of the negative reactions of others...." In constructing the Act, said the Court, Congress acknowledged "that society's accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from the actual impairment." In one of 19 prolonged footnotes to the decision, the Court quoted from a book on cancer, saying, "Any disease that is treated as a mystery and acutely enough feared will be felt to be morally, if not literally, contagious. Thus, a surprisingly large number of people with cancer find themselves being shunned by relatives and friends...."

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PAUL POPHAM SUCCUMBS TO AIDS

with thanks to the New York Native, 5/18/87 and to Peg Byron of the The Washington Blade, 5/8/87

Paul Popham, the first president of New York's Gay Men's Health Crisis died May 7 at Memorial Sloan-Kettering Cancer Center in Manhattan, of complications from AIDS at the age of 45. Popham was known for bringing a professional, large-scale approach to gay organizing and was dedicated to the needs of people with AIDS. Firm but soft spoken, Popham helped turn GMHC into a multi-million dollar organization, an unheard of scale for a gay effort at that time. GMHC announced that its newly purchased building at 12933 West 20th St. "will be dedicated to Paul Popham and the spirit and caring he exemplified." Popham was diagnosed with AIDS in 1985. Later that year, he retired as president of GMHC but became the first chairman of the AIDS Action Council, which he helped organize because of frustration with a lack of government research efforts. Born in Idaho, Popham graduated with a degree in political science and was awarded a Bronze Star for his service in Vietnam. At the time of his death, he was employed at McGraw Hill, Inc. Popham was unable to speak at the National Lesbian & Gay Health Conference in Los Angeles, but he sent a note of apology when he was unable to attend because of his illness. "To my brothers and sisters, proud and besieged Gay Men and Lesbians," he wrote to conference attendees, "it has been a long journey and hard fight for me personally. I am proud of our accomplishments, but I know I am leaving you with enormous tasks unfinished. I plead with you: Please fight harder than ever. We must make the world healthy for ourselves and especially for the next generation."

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NAMES PROJECT TO HONOR DEAD

with thanks to the Baltimore Gay Paper, March, 1987

A group of Northern California community activists have launched an ambitious effort to memorialize the thousands of Americans who have been killed by the epidemic of AIDS. Calling themselves The NAMES Project, the group is creating a memorial composed entirely of thousands of individual fabric panels, each bearing a name of a single person lost to AIDS. Designed and constructed in homes across America by the friends, lovers and families of people who died of AIDS, the panels will be assembled into one massive expanse of names and displayed across the Capitol Mall in Washington, DC on Sunday, October 11, 1987, the day of the National March on Washington for Lesbian and Gay Rights. Inspired by the American folk art traditions of quilting and sewing bees, The NAMES Project is a collaborative expression of profound individual struggles against a devastating epidemic. "We hope that the creation of this memorial will provide a positive means of expressing our community's loss as well as a dramatic illustration of the impact of the AIDS epidemic on American society," said Project Director Cleve Jones. Those wishing to participate in the project are encouraged to design and create fabric panels three feet by six feet in size. All people who have experienced the loss of a loved one to the AIDS epidemic are welcomed to participate and organizers suggest that businesses, churches and other community groups sponsor construction of panels commemorating their members or employees who have died of AIDS. Tax-deductible contributions may be sent to: The NAMES Project, P.O. Box 14573, San Francisco, CA 94114.

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BOBBY REYNOLDS DIES

by Rick Harding, with thanks to The Washington Blade, 5/1/87

San Francisco AIDS activist Bobby Reynolds died at his home of complications related to AIDS April 27 at the age of 40. According to the San Francisco Chronicle, during the five years following his diagnosis with AIDS, Reynolds counseled numerous others with AIDS. He also appeared repeatedly on local and national television to talk about the disease, and he helped organize AIDS fundraisers. San Francisco Mayor Dianne Feinstein said that the city was "indebted" to Bobby Reynolds for his work "to help other[s]...and to increase this community's awareness of a new and dread disease." California Assemblyman Art Agnos called Reynolds "one of the heroic figures in this struggle to defeat the disease."

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U.S. AIDS EDUCATION PLANS

by Rick Harding, with thanks to The Washington Blade, 3/20/87

At a Congressional hearing on AIDS education, US Dept. of Health and Human Services Assistant Secretary for Health Robert Windom acknowledged that the federal government currently has very few programs in place to educate the public about AIDS. During the hearing, Windom announced that he was releasing a controversial and long-awaited federal AIDS education plan from the Public Health Service. In response to questions from members of the House Human Resources and Intergovernmental Relations Subcommittee, Windom said that some AIDS education projects proposed as far back as 1985 are still in the "planning stage." Among the AIDS education programs still in the planning stage are: >A "clearinghouse" of information run by federal, state, local, and private organizations; >Education projects for college campuses produced in conjunction with the American College Health Association; >A mass-mailing, to every home in the country, of condensed copies of Surgeon General C. Everett Koop's report on AIDS. Subcommittee chairman Rep. Ted Weiss (D-NY) vehemently criticized Windom and PHS for showing a "lack of urgency" in educating the public on AIDS. "The federal response [to AIDS education]," Weiss said, "has been slow, limited, and ultimately impotent." Dr. Walter Dowdle, director for the Centers for Disease Control Center for Infectious Diseases, defended the "hours of hard work" on the part of many people in developing federal AIDS education strategies. He noted that PHS does have several effective educational programs in place, including the AIDS antibody testing program which includes counseling for those testing positive, and the national AIDS hotline. The PHS AIDS education plan outlines education projects already in place and others to be implemented in 1987. The document echoes a February White House memo encouraging AIDS education in the context of marriage, asserting that the only way to be sure of preventing AIDS infection is by "practicing abstinence" or by "having a mutually monogamous marriage." The PHS plan advocates the use of condoms to prevent transmission of the AIDS virus but warns to "be aware that condoms sometimes fail." Members of Congress and AIDS activists criticized the PHS plan for being an "overly moralistic" approach to AIDS education and for being devoid of significant new programs. Weiss said "Most of the components in the plan are matters that have been talked about for years, and few are ready to be implemented." Rep. Gerry Studds (D-Mass.), an openly gay member of Congress, said he was especially concerned that a section of the document discussing programs for targeting gay and bisexual men indicates such programs were already instituted by the middle of 1986. "I don't find it very reassuring to find that [PHS] seems to think that the battle to educate gay men about AIDS has already been fought and won," said Studds. Jeff Levi said one recommendation in the plan—to spend $1 million on a mass media education project—is "especially ridiculous." Levi referred to the National Academy of Sciences AIDS report released last year which called for a much higher amount to be spent on a mass media effort. The NAS report asserted that to influence behavior affecting AIDS transmission, "policymakers must begin to contemplate expenditures similar to those made by private sector companies to influence behaviors." It notes that private companies spend "$30 million to introduce a new camera, or $50-$60 million to advertise a new detergent." Besides the mass media effort, which includes hiring a professional advertising agency, the plan also calls for new programs to:

>Target and educate women who may be sex partners of person in high risk groups;

>Target and educate prostitutes who use IV drugs or who are sexually involved with IV drug abusers, and encourage the prostitutes to be tested for the AIDS antibody;

>Develop AIDS training programs for physicians, nurses, drug abuse counselors, and other health care professionals.

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CONGRESSIONAL AIDS ADVISORY PANEL

by Lisa M. Keen, with thanks to The Washington Blade, 3/20/87

Republican Senator Pete Wilson introduced a bill February 26 to establish a Congressional advisory panel on AIDS. The bill was co-sponsored by four Republicans and four Democrats: Senators Daniel Patrick Moynihan and Alfonse D'Amato (New York); Bill Bradley & Frank Lautenberg (New Jersey), Alan Cranston (California), Lowell Weicker (Connecticut), David Durenberger (Minnesota), and Lloyd Bentsen (Texas). The bill is similar to two bills introduced in January to create a National Commission on AIDS that would monitor and make recommendations on how to manage the government's response to the AIDS epidemic. Whereas the first two bills would create a commission composed of the Secretaries of several administration departments plus other federal health officials and appointees, Wilson's bill calls for an independent panel headed by the National Academy of Sciences. The Academy is the blue ribbon research group which recommended dramatic increases in the federal government's funding to address the AIDS epidemic. Wilson's bill has been referred to Senator Kennedy's Committee on Labor and Human Resources. Its referral to a subcommittee is still pending.

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MELVIN BOOZER DIES OF AIDS

with thanks to New York Native, 3/30/87

Melvin Boozer, a prominent gay rights activist, died of complications from AIDS March 6 at the age of 41 in Washington, DC. One of the founders and past co-chair of the Langston Hughes-Eleanor Roosevelt Democratic Club, Boozer was a longtime activist for gays and blacks, addressing the issue upon his nomination for vice president of the United States at the 1980 Democratic Convention: "I know what it means to be called a nigger," he said from the podium at Madison Square Garden, "and I know what it means to be called a faggot, and I can sum up the difference in one word: none." From 1979 to 1981, Boozer served as president of the DC Gay Activists Alliance; for the next 2 years, he was the Washington Director of the National Gay Task Force. Immediately thereafter, he became involved in the Langston Hughes-Eleanor Roosevelt Club, a group founded to give greater voice to lesbian and gay blacks.

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CDC AIDS CATEGORY MAY CHANGE

by Chris Bull, with thanks to Boston's Gay Community News, 5/10-16/87

The Centers for Disease Control (CDC) will propose a new definition of people with ARC that would include "severe" cases in the same category as people with AIDS. If accepted, the new counting system could swell the official number of people with AIDS by as much as 30%. AIDS activists have called for an expanded definition of the illness for some time. They argue that the CDC's current statistics grossly underrepresent the spread of the illness and serve to deny disability insurance and medical care to people with ARC. "At the very least, the new statistics may help shock people into putting more pressure on the government," commented Pat Christen, of the San Francisco AIDS Foundation. Ben Schatz, director of the AIDS Civil Rights Project at National Gay Rights Advocates (NGRA) noted, "The desire of the administration to minimize the epidemic will be exposed and their inaction highlighted." Schatz added that a new definition would also "take away some of the hoops people must jump through to get medical care." Unlike people with AIDS, people with ARC must currently prove they are disabled in order to get Medicaid coverage for health care. The CDC's proposal will be presented to the Council of State and Territorial epidemiologists at a May 16-20 conference in Santa Fe, New Mexico. The council must discuss, modify and vote on the final draft of the proposal before it can be adopted, according to Chuck Fallis of the CDC. The CDC proposal would include only "severe" manifestations of ARC, which for about 20% of total ARC cases. The CDC declined to make public the proposal, but Dr. Rick Vought of the Vermont State Health Department said that it would include: people with wasting disease, who lost up to 25% of their body weight; viral infections of the brain which cause memory loss; and people with tuberculosis who test HIV antibody positive. Vought, who is also president of the Council of State Epidemiologists, said that "tinkering with case definitions of the wide spectrum of illness associated with the [HIV] virus. He said he hoped the new definition would "Get across the idea that the problem is not isolated to people with AIDS." He added that to include more than the most severe cases would "raise havoc" in reporting procedures. The CDC's 1985 revised case definition, much less radical than the latest proposal, caused confusion in health departments across the country. He said frequent changes in the case definitions may ruin the ability of health experts to trace the disease over time. "We will lose our ability to tell how we are doing if we are not careful to come up with new accounting procedures that allow for new case definitions." Vought added that the scientific information available on ARC is so minimal that determining exactly what effect the new case definitions will have on final statistics is impossible. "There is so much nondescript symptomatology and such a wide spectrum of illness from fever and diarrhea to pneumonia that many cases simply are not reportable." He estimated that at least 50% of people with ARC will eventually develop full-blown cases of AIDS. Dr. Reddi, the epidemiologist for the Chicago Dept. of Public Health, believes that the new case definitions will place a burden on doctors and health officials. However, he said that the present reporting requirements may actually discourage some doctors from reporting. For example, he said that in some cases biopsies are required to prove that a person has AIDS, a requirement that causes many doctors not to report. Reddi said that many health officials fear that overly stringent requirements for reporting will cause doctors to simply ignore the guidelines as they often do with chicken pox. "We must draw a fine line here between including everyone who tests positive as a person with AIDS and including only those with full-blown AIDS while respecting the increasing demands on doctors and health departments." Officials in the federal government may also balk at the new definition because it is expected to add more people to disability benefit rolls. PWAs automatically receive Medicaid while people with ARC must prove their disability, a process that entails extensive paperwork and can take months to complete. Christen of the San Francisco AIDS Foundation said that denying people with ARC insurance is "inhuman." She stressed that the federal government should begin preparing immediately for the increased case load. So far, she added, the Reagan administration has done very little planning for the millions of people in this country who may develop ARC or AIDS.

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FDA REGULATIONS RAISE QUESTIONS

by Peg Byron, with thanks to The Washington Blade, 4/10/87

The Food & Drug Administration's (FDA) proposal to change the rules governing experimental drugs for life-threatening and serious illnesses has stirred both criticism and confusion as the 30-day comment period draws to a close. The rule change, whose comment period is scheduled to end April 20, would allow pharmaceutical companies to offer experimental drugs to patients with life-threatening illnesses such as AIDS soon after studies with small groups of volunteers have been made. The drug companies are only required to notify the FDA of their action, not wait for approval, which can only be revoked if data shows the drug "clearly does not provide therapeutic benefit or would be dangerous," an FDA spokeswoman said. In the case of serious illnesses, like Alzheimer's Disease, for example, treatment with experimental drugs requires sufficient evidence of both safety and effectiveness, said the spokeswoman, Faye Peterson. The regulation change would also allow companies to charge for the use of experimental drugs, which are now provided for free until full approval for marketing is granted by the FDA. The proposals, issued March 10, are intended to "bring promising new drugs to desperately ill patients as early in the drugs' development as possible and well before general marketing [approval] would normally provide," Peterson said. "The Commissioner alluded to the problem of AIDS as bringing this need to light," she added. But some critics, including Rep. Ted Weiss (D-NY), see the FDA's agenda differently and fear the rules could prove counterproductive and even dangerous. The FDA "may be using AIDS to further its agenda for deregulation" in accordance with Reagan ideology, Weiss said shortly after the proposal was announced. Weiss, who said he may hold hearings on the FDA's action, said the agency was side-stepping its obligation to determine a drug's effectiveness before allowing widespread use. "That's not the way the law is written," Weiss said. "This is a very dangerous path for the FDA to be going down." Jeff Levi, executive director of the National Gay & Lesbian Task Force, agreed, saying, "I have a real problem with letting a drug out that you don't have to prove is safe. It only has to be proven harmful." Ensuring drug safety "is the reason the FDA was created," Levi said. He also warned that the complex rule changes could lead to prohibitive costs for patients using experimental AIDS drugs and cause a shortage of volunteers willing to participate in controlled clinical trials that use placebos or drugs viewed as less desirable. The pharmaceutical companies have not rallied to the FDA's suggestion either, even though the proposal allows charging for experimental drugs. A spokesperson for the Pharmaceutical Manufacturing Association (PMA), said the industry trade group had not yet decided its position on the proposal and found the issues so complex that it recently asked the FDA to grant a 45-day extension for the comment period. "We haven't really finalized a comment," said PMA spokeswoman Page Blankingship. "The proposal seems to raise a whole lot of issues," including liability problems for the drug companies and questions about whether the companies or the FDA would be responsible for treatment protocols of the experimental drugs. The proposed rule changes are so complex that even Weiss' office, while looking upon them with great suspicion, has not finalized its comments yet either. Levi, however, points to serious issues beneath the surface of the proposals—the ongoing shortage of AIDS drug trials. "We're reacting to what the FDA is proposing rather than saying, `Here is the problem and what would be the best solution'," he said. "The problem is there are not enough trials being conducted right now. Congress has given NIH plenty of money for them, but there are no more than about 400 [patients]in clinical trials right now." The numbers of people with AIDS in controlled trials using the newly-approved AZT (Retrovir) and other drugs only reached about 400 in the past few weeks, and totaled about 100 in January. One NIH spokeswoman, trying to explain the difficulties in getting a response to a reporter's questions about the much-touted AIDS Treatment Evaluation Unit program, said recently, "They're so swamped over there; they don't even have a secretary." The program, using major medical centers around the country, was announced with great fanfare last July and was to have enrolled 1000 patients in clinical trials by this past December. Levi said funding is available for 8-10,000 patients to be in clinical trials, "which would come close to taking care of the demand" for drugs among the country's approximately 12,000 surviving people with AIDS. Levi blamed a shortage of AZT for use in comparison studies of newer drugs and NIH bureaucracy for the small number of clinical trials.

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KOOP ADDRESSES TEXAS LEGISLATURE

by Craig McDaniel, with thanks to the New York Native, 4/20/87

U.S. Surgeon General C. Everett Koop warned a joint session of the Texas legislature that patient care costs related to AIDS "will be astronomical," and called on the lawmakers to joint in a "national dialogue" to solve the crisis. AIDS, said Koop in his March 27 address, is a "...grave threat to our national health and well-being." Koop continued, "You have only begun what appears to be a long and fearful journey. All signs point to this disease being a burden to us for the rest of the century." Rep. Brad Wright (R-Houston), chairman of the House Committee on Public Health, drew a sharp response from Koop when Wright suggested that AIDS is spread by illegal activities in Texas, and that AIDS "victims" should therefore bear their own burden. "We may have to take a position with respect to certain high-risk categories," Wright said after a public hearing on AIDS funding. "I don't think you can ignore the problem because the behavior which may be largely the source of the transmission is prohibited, but I do think it's a consideration." Texas has a law prohibiting homosexual sodomy and intravenous drug use. "As a public health officer, as a physician, as someone who has practiced the Hippocratic oath for 50 years, I believe that when people are sick you have to take care of them," Koop said. The Texas Dept. of Health has estimated that the number of cases of AIDS will be more than 16,000 by 1991, and some legislators have asked the state to commit $4 million to education programs over the next two years. Koop maintained that money by itself won't be enough to solve the problem. "You have to have ideas. But most of all, you have to have coalitions that are willing to work together and get something accomplished."

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CIVIL DISOBEDIENCE PRESSURES GOV'T

by Kim Westheimer, with thanks to Boston's Gay Community News, 4/26-5/9/87

A newly formed organization called "Act Up" is spurring on civil disobedience in an effort to pressure the government to take action on AIDS-related issues. After coordinating a protest on Wall Street earlier this year in which 17 people were arrested, Act Up turned out nearly 300 people for a demonstration April 15, stopping traffic on a major artery outside a federal building to protest the National Institutes of Health for failing to spend tax money on AIDS education and research. It was held to coincide with the evening rush to the post office to beat the deadline for filing federal tax returns. The protest had been planned as a legal demonstration, but "People felt powerful enough to do an unplanned action," said Michael Petrelis, a person with AIDS who was at the rally. "[They] sat in the street and stopped traffic." At the Wall Street demonstration which demanded the release of experimental anti-AIDS drugs, many people wanted to join the 17 who were committing civil disobedience, however the demonstration's marshals prevented them from doing so because of prior arrangements with police. "The police were completely unprepared," said Larry Kramer, one of the initiators of Act Up and noted playwright. "We screwed up traffic for over an hour.... [Police eventually] formed a phalanx with billy clubs.... Twenty to 30 of them moved forward and pulled and pushed people out." Demonstrators were generally ignored by the mainstream press which had flocked to the post office for the their traditional stories about people waiting till the last minute before filing their tax returns. The day following the post office demonstration, approximately a dozen members of Act Up who were students at New York University, disrupted a speech being given at the school by Mayor Ed Koch. Protesters claimed that Koch has failed to advocate for adequate medical care for people with AIDS, citywide AIDS education and state and federal funds to combat AIDS. They also asserted that he has not adequately enforced the city human rights law in AIDS-related cases. Four of the students were evicted for the disruption. Tom Hickey, one of the NYU protesters, said Act Up's activities have stirred up activism on campus and has helped educate the community. In addition to initiating more local demonstrations, Act Up is considering networking with other cities for coordinated demonstrations, especially at the upcoming International AIDS Conference in Washington, DC. For additional information, contact: Act Up, c/o Lavender Hill Mob, 496A Hudson St., Suite G-19, New York, NY 10014.

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LAVENDER HILL MOB CONFRONTATION

by Mike Salinas, with thanks to the New York Native, 5/18/87

Members of the Lavender Hill Mob (LHM), New York's confrontational grassroots gay rights group, testified before the Governmental Operations Subcommittee on Human Resources in Washington, April 29. The subcommittee, chaired by Rep. Ted Weiss (D-NY), convened the hearings to discuss the Food and Drug Administration (FDA), especially with respect to its proposed new rules to regulate the availability of experimental drugs for AIDS. Dr. Frank Young, commissioner of the FDA, was scheduled to testify on its behalf. His administration has been the source of heated controversy, accused of withholding potentially lifesaving treatments from the public. Persons with AIDS and AIDS-related conditions have been clamoring for ribavirin, AL 721, DTC, and a number of other promising treatments, but the FDA has been slow to give approval to any AIDS treatment. The enormously expensive and highly toxic Retrovir (formerly called AZT) is the only medication the agency has approved to date, and that six years into the epidemic. Testimony submitted to the subcommittee by "Mobster" Marty Robinson accused the FDA "tokenism" in its drug trials, of "immoral" behavior in its placebo studies of drugs for life-threatening disorders, of having "hidden behind a guise of cautious scientific detachment, [and] failing to use its clout to prevent excessive profiteering and delay by drug companies." "Rather than take a passive role in these matters," Robinson testified, "the FDA should be on the front line, utilizing its expertise to assure progress and call public attention to any indications of stalling or road blocking on the part of drug companies." Decrying the inability of independent researchers to "obtain, suggest, and utilize treatments suspected of value" without effective FDA procedures, Robinson maintained the FDA has "no methodology for evaluating and utilizing data from experience in independent physicians now treating AIDS patients." The matter of the DFS's apparent lack of interest in treatments originating from foreign countries was also addressed by Robinson. "Experience indicates there has been ongoing resistance to making these potentially effective drugs available," he said. Robinson concluded his testimony, which was entered into the Congressional Record, with the remarks, "In the context of AIDS, the `passive posture' which Frank Young assigns to the FDA is inexcusable. For the Reagan administration's policy of `benign neglect' to be followed by the United States Congress would be worse than criminal. The lessons of Nuremburg are that `following orders' is no excuse. Neither is institutional stagnation, ignorance, or prejudice." After the testimony, Young conferred briefly with the Mob and agreed to meet with them "before the end of May" to discuss their concerns. The next day, on April 30, the Mob moved to Georgetown University, where U.S. Secretary of Education William Bennett has been invited to speak at one of the school's forums. Upon completion of Bennett's remarks, the floor was opened to questions, at which point Mob members Robinson and Michael Petrelis unfurled the Mob's bright lavender banner and shouted, "If you want an education educate yourselves as to how the federal government has used AIDS as a political weapon, instead of working to find a cure," among other statements. Security forces were called to oust the protesters, who exited chanting "Test drugs, not people," one of their favorite slogans. Once outside the auditorium, security officers attempted to pressure the demonstrators to sign a statement that they had entered the building illegally. They refused on the grounds that the forum was open to the public. Eventually they were released.

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KOOP'S NUMBER TO EXPRESS PRAISE

with thanks to Lifelines, the Newsletter of Honolulu's Life Foundation, March, 1987

To many people's surprise and satisfaction, Surgeon General C. Everett Koop has firmly yet compassionately addressed many of the issues surrounding the AIDS health crisis. We strongly urge the membership to call his office and compliment him on his innovative, assertive, and effective education efforts. Callers may speak with his secretary at 202/245-6467. We have been told that most of the callers to date have called to disapprove of his strategies. And while you're on the phone, give The White House a call to let the President know how good a job you think the Surgeon General is doing. The White House's Commentary Line number is 202/456-7639.

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POLITICS OF AIDS

by Eileen Raphael, Frontline

The Politics of AIDS by Nancy Krieger and Rose Appleman is the first in a new series of pamphlets published by Frontline newspaper. The pamphlet is a thoroughly researched and popularly written examination of the tough political questions that the AIDS epidemic poses: What's wrong with the way the U.S. government allocates resources in the fight against AIDS? Why does AIDS disproportionately impact minority communities? What will be the impact of the AIDS epidemic on the already crisis-ridden health care system in the U.S.? How has AIDS been used to inflame homophobia and slow progress toward lesbian/gay rights? The authors have extensive experience with the AIDS issue. Krieger is a public health epidemiologist whose work focuses on the health status of working class and minority people. Appleman writes on lesbian /gay rights issue for Frontline newspaper.

Frontline Pamphlets will provide an in-depth look t current issue which, like the AIDS crisis, have emerged as vital questions for the U.S. progressive movement. To order a copy of The Politics of AIDS, send $4.80 (California residents add 6.5%) to: Frontline Pamphlets, P.O. Box 2729, Oakland, CA 94602 (bulk discounts available).

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POSITION STATEMENTS ON AIDS: AAPHR

by the American Association of Physicians for Human Rights (AAPHR)

1) We endorse the position of the National Academy of Sciences and the Surgeon General that currently, risk reduction education must be the primary tool for controlling the spread of HIV and other immunosuppressive infectious agents.

2) We call for the passage of legislation at the local, state and national level which will guarantee the rights of persons with AIDS, ARC, HIV infection and persons perceived as being at risk. That legislation must include prohibition on discrimination in education, housing, the workplace, service delivery and insurance.

3) We oppose mandatory HIV testing programs of any kind, including those used to screen for employment or insurance purposes. We endorse the availability of anonymous HIV screening. All HIV testing must include education, supportive counseling and linkage to appropriate medical and psychosocial support services.

4) We support the development of AIDS education programs for all members of health delivery system. Such programs should cover the full range of HIV-related diseases, appropriate infectious control procedures, and the psychosocial needs of persons with AIDS, ARC, HIV infection, and persons perceived as being at risk.

5) When effective non-discriminatory legislation is in place, then AAPHR urges that AIDS surveillance be expanded to include all group IV cases in the spectrum of HIV disease. In order to achieve this goal, an intensive education effort of all health care personnel will be necessary.

6) We call for intensified local, regional and national planning for the provision of comprehensive health care services to persons with HIV-related conditions. Local AIDS task forces must be established in all communities. These task forces must be authorized to prepare comprehensive AIDS health care plans. Adequate funding must be provided for implementation of these plans.

7) We call for the full scale release, in the U.S. and Canada, of AZT and Ribavirin for the treatment of people with appropriate group IV HIV disease. To insure appropriate use of these new agents, education of both doctors and patients is mandatory. AAPHR recommends, for humanitarian reasons, that persons with HIV disease desiring admission to the U.S. or Canada, for the purpose of treatment, should not be excluded.

8) In view of the central position of the Centers for Disease Control and the National Institutes of Health, in the setting of national AIDS policy, we encourage those public health agencies responsible for AIDS policies to tolerate employment of openly gay personnel.

[Note: Group IV HIV disease includes persons with clinical symptoms and signs of HIV infection other than or in addition to lymphadenopathy. Patients in this group are assigned to one or more subgroups based on clinical findings. These subgroups include constitutional disease, neurologic disease, secondary infectious diseases or cancers, and other conditions resulting from HIV infection. Groups I refers to acute HIV infection with an mono-like syndrome; group II refers to asymptomatic HIV infection; and group III refers to persistent generalized lymphadenopathy. Refer to MMWR, 35:20, reprinted in the NCGSTDS Newsletter, 7:5, page 27, for details of the HIV/AIDS classification system.]

FEDERAL AIDS ED PLAN "MEANINGLESS"

by Stephanie Poggi, with thanks to Boston's Gay Community News, 3/22-28/87

A March 16 Congressional hearing on the federal government's AIDS education efforts only confirmed the view of many gay activists that the Reagan Administration intends to do virtually nothing to stop the spread of the disease. Gil Gerald, director of minority affairs for the National AIDS Network (NAN), who testified at the hearing, commented that the proceedings "clearly showed the government was not up to the task." Following the hearing, called by Rep. Ted Weiss (D-NY), the government released a long-awaited AIDS education plan. It stresses sexual abstinence and monogamy as preventative measures. Jim Gottlieb, an aide to Weiss, called the plan "a meaningless document." Jeff Levi, executive director of the National Gay & Lesbian Task Force (NGLTF), echoed Gottlieb's sentiments, saying, "They still haven't come to terms with the magnitude of AIDS." Among the eye-openers at the hearing was the revelation that the Centers for Disease Control (CDC) has spent almost nothing of its fiscal year '87 allotment for education. According to Weiss aide Gottlieb, CDC officials claimed they expected to spend $20 million of the $75 million allotted by the time the fiscal year runs out in October. But questioning by Weiss made it clear that spending on any of the proposed education projects was not likely until the beginning of next year. The education plan, which includes a school campaign, public media campaign, and the establishment of a national clearinghouse on AIDS, represents little in the way of new initiatives. Activists were critical of both its "moralizing" tone and of the fact that it does not target any programs at IV drug users, people of color or at gay and bisexual men. In his testimony at the hearing, NAN's Gerald stressed the disproportionate incidence of AIDS among people of color and the need for targeted programs. He called for culturally-sensitive education programs, for funding for AIDS organizations working within communities of color—which continue to be the poorest of the AIDS organizations—and for on-going evaluation of the government's AIDS education programs. Gerald told GCN he also attempted to dispel the notion that programs aimed at IV drug users are "one and the same" as programs aimed at people of color. "There is no one risk factor for minorities," said Gerald. "It has to go beyond that." Gerald also emphasized the fact that AIDS adds a heavy burden to people of color who are already at a disadvantage under the current discriminatory health system. NGLTF's Levi said he was disturbed that language about "safer sex" had disappeared form the final draft of the education plan, which was circulated in earlier drafts. Apparently, the US Dept. of Education or other top administration officials scrapped the "safer sex" language in favor of the plea for abstinence and monogamy. Earlier drafts seen by Congressional sources also included a statement condemning discrimination against people with AIDS. According to Levi, the Justice Dept. was instrumental in removing the clause.

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CONTROVERSIAL SEX-ED PLAN

by Lou Chibbaro Jr., with thanks to The Washington Blade, 1/30/87

The White House apparently has decided to back U.S. Surgeon General Dr. C. Everett Koop's controversial call for sex education in public schools as a means of curtailing the AIDS epidemic, despite heated protests from conservative members of President Reagan's cabinet. Spokesmen for both Koop and the U.S. Health and Human Services Secretary Otis Bowen said that the Reagan Administration has decided that Koop should continue to promote publicly his proposals calling for frank discussion in the nation's public schools about safer sex techniques. Early in January, news reports surfaced claiming that at least five cabinet members— including Attorney General Edwin Meese III, Secretary of Education William Bennett, Secretary of Labor William Brock, Secretary of Interior Donald Hodel, and Secretary of Housing and Urban Development Samuel Pierce— raised sharp objections to Koop's proposals during a White House Domestic Policy Council meeting. The Washington Times and syndicated columnists Rowland Evans and Robert Novak reported that the cabinet members objecting to the proposals accused Koop of failing to take a "moral" position by calling for sexual abstinence. Evans and Novak said other opponents, including Education Undersecretary Gary Bauer, attacked Koop for not stressing that heterosexual relations are "clearly" preferable to homosexual relations. Most of the controversy centered around a 36-page report Koop released last October, called the Surgeon General's Report on AIDS, which has been printed and distributed by the U.S. Public Health Service. The report advocates that schools and local communities initiate aggressive public education campaigns on the dangers of AIDS and steps people can take to avoid contracting the disease. "There is now no doubt that we need sex education in schools and that it includes information on heterosexual and homosexual relations," Koop wrote in the report. Koop states in the report that condoms have been shown to prevent the AIDS virus from being transmitted and that persons at risk for AIDS should use condoms during vaginal or anal intercourse. The reports by Evans and Novak and The Washington Times stated that Bauer and several cabinet members urged President Reagan to order Koop to advocate "family values" and "fidelity" rather than the use of condoms in the context of safer sex education in public schools. Other sources familiar with the controversy said Koop's opponents had urged the President to stress the "family values" theme in his State of the Union message. Although Reagan didn't mention the Koop report in his televised address, he did raise the subject in a written State of the Union "message" submitted to Congress. "Last year the Surgeon General issued a report that was a landmark in public education about AIDS," Reagan wrote. "I guess there's no way he can call it a `landmark' report and not endorse it," said Loye Miller, Bennett's press secretary. Miller added that he believes the "differences between Bennett and Koop on this have been exaggerated in the press." Jim Brown, Koop's press spokesman, said Koop "totally agrees" with Reagan's call for stressing of moral and cultural values in sex education programs. Brown also said the press may have exaggerated the opposition to Koop's report by some of the cabinet members, adding: "Much of this was over whether Dr. Koop wanted to set curricula for the school boards. Dr. Koop never said he wanted to tell school officials what to do." Assistant Secretary for Health Dr. Robert E. Windom has been assigned the job of directing top HHS officials to help develop a plan for disseminating the principles of Koop's report to local communities and local school boards, Brown said. Brown said Reagan Administration officials, whom he declined to name, have directed HHS to leave it to local school boards and communities to decide if and how they want to use the information. Gay rights leaders and the heads of AIDS patient advocacy groups have praised Koop for releasing his AIDS report. "The opposition from within the Administration was predictable," said Gary MacDonald, former executive director of the AIDS Action council, a national group that lobbies for increased AIDS research funding. "We commend Dr. Koop for taking such a strong stand."

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PROTESTS DIRECTED AT CDC, TIMID

by Bob Lederer, with thanks to Boston's Gay Community News, 3/22-38/87

Angry gay voices disrupted the otherwise orderly proceedings of the Conference on HIV Antibody Testing, sponsored by the Centers for Disease Control (CDC) in Atlanta on February 24-25. Members of the Lavender Hill Mob (LHM), a small New York City lesbian and gay direct-action group, maintained a vocal role throughout the event, condemning the CDC and sharply criticizing the more established lesbian/gay and AIDS groups present for timidity and racism. The established organizations, including the National Gay and Lesbian Task Force (NGLTF) and Gay Men's Health Crisis (GMHC), denied the charges and called LHM's tactics unduly confrontational. LHM attracted substantial national TV and press coverage through costumes, leaflets, testimony, and disruptions. Calling the conference "a hoax and cover-up for government inaction," the LHM said in a statement, "Instead of mandatory testing, the conference should have been devoted to exchanging information on experimental drugs and safe sex education that can save people's lives." LHM leaflets bore the slogan "Test drugs, not people" and relabeled the CDC "the Center for Detention Camps." The federal agency, the LHM charged, "is "under the control of Mormons and bigoted right-wing conservatives."" On the opening day, LHM members Michael Petrelis and Eric Perez dressed as gay inmates in Nazi concentration camps with pink triangles on their gray uniforms. Although the conference was not explicitly debating quarantine, an LHM statement explained that "mandatory testing and contact tracing are the first steps necessary towards that end." During a workshop on confidentiality, Petrelis, a 28-year old Person with AIDS, shouted "Don't tell me it's not possible to be rounded up. You did it with the Japanese in World War II and you will do it again if you want to." Arguing that "there is no such thing as confidentiality," Petrelis gave the example that his Social Security and disability files clearly indicated that he is a PWA. The next day, as CDC Deputy Director Walter Dowdle was closing the conference, LHM members unfurled their banner in front of him and shouted, "What about saving people's lives?" and "Where's the ribavirin?" Ribavirin is an experimental drug which has shown some promise in treating AIDS. The federal government has yet to approve its use, and some PWAs have traveled to Mexico or resorted to the black market to obtain it. Earlier, LHM interrupted a press conference at which a coalition of mainstream lesbian/gay and AIDS groups read a consensus statement on fighting AIDS. LHM member Petrelis shouted, "You're completely out of touch with our anger, with what the gay community really wants. What you're doing today is just perpetuating this farce." Bill Bahlman, another LHM member, added, "You should be screaming, instead of pretending this is rational." Urvashi Vaid, publicity director of the NGLTF, responded, "I share your anger. I thing you do us a disservice attacking us this way.... It's hard for me to be on the receiving end. We just express things differently." Petrelis also accused the lesbian/gay groups present at the conference of not representing Blacks and Latinos. Black LHM member Eric Perez explained, "The mainstream groups are white, middle-class, male-dominated. They don't deal with the fact that the primary injustice nonwhite lesbians and gays face is not being white. There's a refusal to struggle against that as well as homophobia." NGLTF Executive Director Jeff Levi disagreed. "These people are totally unfamiliar with what we do. The minority issue has been consistently raised by us in testimony, press statements and proposals," Levi said. He also claimed that the LHM was all-white. Other gay spokespeople had different reactions. Tim Sweeney, Associate Executive Director of Gay Men's Health Crisis (GMHC) of New York, said, "People of color are not properly represented and don't get the services they need from most lesbian/gay groups and services. But in addressing mandatory testing, we were directly addressing a major concern of women of color—after all, who are the major clients of STD and prenatal clinics?" Ben Schatz, Director of the AIDS Civil Rights Project of National Gay Rights Advocates (NGRA), said, "The lack of Black and Latino representation is a systematic problem, not only in lesbian/gay organizations, but in the lesbian/gay community and in the [straight] country as a whole." According to LHM, only one Third World health official, a black man who supported mandatory testing, was on a discussion panel in Atlanta. Although a majority of PWAs in most major US cities are non-white, no representatives of Third World AIDS or gay groups were present at the conference. Craig Harris, interim chair of the National Minority AIDS Council and an AIDS Project coordinator for the National Coalition of Black Lesbians and Gays, said he was not notified in advance about the conference, by either the CDC or other gay groups. He observed, "It is unfortunate that not only have Black, Latino and Asian AIDS professionals not been recognized by the CDC, but other gay/lesbian and AIDS advocates have not assisted in efforts to include them." Several other representatives of Third World AIDS groups contacted by this reporter also said they were not contacted in advance by either the CDC or other gay or AIDS groups. Since they were not at the proceedings, these spokespeople declined to comment on the LHM charges. LHM's charges of timidity by gay and AIDS groups in fighting for gay demands also evoked differing responses. VAID and GMHC's Sweeney asserted at the conference that 6 years of systematic work by gay and AIDS groups had been instrumental in defeating mandatory testing. However, LHM's Perez argued that massive costs and inevitable resistance by "target populations" made the proposal unfeasible and thus, a false issue. Further, he contended that these groups avoided public advocacy in conference workshops, while privately conferring with health officials. "They went there to shake hands, not to shake up, to be good boys and girls," Perez charged. GMHC's Sweeney defended the coalition. "We worked 18 hours a day there. We raised issues successfully and did a lot of lobbying with public health officials. We attempted to control the tenor of debate and turn the issue to the need for education." LHM also charged that he other gay groups present excluded them from strategy sessions, statement-drafting, and press conferences. Levi confirmed this, saying, "They [LHM] clearly were there to disrupt both the [CDC] conference and what we were trying to do. That was not consistent with our strategy." However, Sweeney of GMHC, a group currently under fire by various New York gay activists for alleged political timidity, said, "There's plenty of room for different strategies. They need to respect us and we them. But we need to be sure we channel most of our anger outside, not turn on each other. Sometimes to get people's attention you have to step on their foot, which is the Lavender Hill Mob's tactic. But then there needs to be a group that can engage in a meaningful dialogue, sometimes quietly, to work through people's fears." NGRA's Schatz said, "I think there's an anger in the gay community that needs to be expressed. They played a different role, but it's an important role. That doesn't mean I agree with everything they did." The LHM has been active since the fall of 1986, and was formed primarily by present of former members of other organizations who wanted to escalate the level of lesbian/gay protest. Among their past activities have been disruptions of a dinner for political and church officials, a service by anti-gay Archbishop John J. O'Connor, a forum at which New York Times representatives spoke about balanced reporting, and sit-ins at the offices of New York Senators Alfonse D'Amato and Daniel Patrick Moynihan.

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NASHVILLE: FIGHTING CLOSETS

by Elizabeth Pincus, with thanks to Boston's Gay Community News, 2/1-7/87

The effort to combat AIDS/ARC proceeds with varying degrees of sophistication in the large metropolitan areas of the country. Smaller cities have also rallied forces, though less visibly lesbian/gay communities and more conservative attitudes may hinder some attempts to secure funds, offer preventative education and provide direct services for people with AIDS/ARC. But 6 years into the epidemic, increasing public recognition of the scope of the crisis and its impact on all communities brings increasing mobilization. Nashville (population 450,000) is a boom town, if civic boosters, industrial magnates and the Wall Street Journal can be believed. The fastest growing southern mecca since Atlanta, it's renowned as a hub of the music industry and now boasts a rise in TV and film production as well; it gains increasing importance as the "third coast" of the entertainment industry. Anti-labor laws favorable to business expansion are encouraging rapid development— a strange mix of thriving yuppiedom and old-time "genteel" conservatism smack in the middle of the bible belt. Still a city of segregated neighborhoods, Nashville was a hotbed of civil rights activism in the '50s and '60s and Black colleges and churches flourish. Generally speaking, lesbians and gay men maintain a very low profile. To date, about 80 people have been diagnosed with AIDS in the city, three quarters of whom have died. Until recently, most people with AIDS in Nashville were New York or California residents who returned home to be among family and friends following their diagnosis. State epidemiologist Gary Swinger, who has been tracking al cases of AIDS in Tennessee, now fears that an increasing number of persons will contract AIDS from other state residents. He reports that in Tennessee, progress of the disease is 3 to 4 years behind that of large urban areas. Similarly, public awareness and concern about the disease is less advanced. "People don't think AIDS will happen here," says Nashvillian Jaan Sturgis, "but it is happening. This is not a profound statement— people are dying here like they are everywhere. We fear that middle-sized towns like Nashville will be the next wave of the AIDS epidemic." Sturgis works as an administrative assistant for Nashville CARES (Council on AIDS Resources, Education and Services), a non-profit AIDS community service organization of about 100 volunteers. He and CARES Executive Director Janet Pierce are the only two paid staff in all of Tennessee working with AIDS direct service groups. Organized in 1985, they operated out of a heater closet equipped with a phone at the local Metropolitan Community Church. Now with their own office and an annual budget of about $90,000, they feel relatively well-endowed; fledgling AIDS organizations in Knoxville, Memphis, Chatanooga and Johnson City, Tennessee have made less progress in their respective communities. But all of these groups share the hope that immediate, multi-cultural efforts at preventative education will hold off the rapid spread of AIDS that is now threatening smaller towns. Says Pierce, a former pastor of the MCC, "A year and a half ago, mainly through the prodding of one individual, we realized that AIDS was going to be a problem in Nashville. We thought that if we were trained and ready to deal with it, we might be able to make an impact through education, through encouraging safer sex. Since Nashville doesn't have a highly structured gay community, for an organization to survive it needed to be identified solely as an AIDS group. We didn't want homosexuality to get used as a red herring to distract people from the issue of AIDS." So since its inception, Nashville CARES has aggressively sought diversity among its board members and volunteers. Many of the original organizers were lesbians and gay men connected with the MCC and/or health care and social service agencies. When the first official board of directors was convened in January 1986, they extended outreach to successfully include a balanced mix of women and men, people of color, and representatives from legal, medical ethics, religious and financial communities. They tried to maintain the original purpose of education high risk communities first while presenting a gay-positive— if somewhat cautious— approach to the general public. Pierce notes that early efforts to combat AIDS/ARC in California and New York had a white gay male public profile, and assumed a degree of acceptance that she feels would not hold true for much of the rest of the country. "In Nashville," she explained, "we clearly identify as an autonomous social service agency offering general compassion in a time of crisis. I believe we're doing exciting things that will be used as models for other cities our size. This is not to discount the help from the gay community— many of our volunteers are gay and our most successful fundraising has occurred in gay bars. But politically, it's more effective here to identify as a human services group with diverse members." Pierce added that in the South, many gay men are closeted and themselves prefer this careful approach to fighting the epidemic. She does, however, also acknowledge accompanying problems. For example, whereas the nationwide mortality rate for PWAs is about 50%, nearly 75% of PWAs in Nashville have died. Pierce suspects that being closeted, fearing discrimination, and/or denying the possibility of having AIDS may lead to late diagnosis and, consequently, faster death. Also, places to go for diagnosis and treatment are not as easily identifiable. That is changing now through the effort of Nashville CARES, but the town's conservative tenor does not always embrace those who part from convention. Sturgis expressed frustration nonetheless with the cautiousness of Nashville's lesbian/gay community. "There's a lot of apathy, if not divisiveness here," he says. "Just an overall conservatism. People are afraid of losing their jobs if they come out...." He explained that a very active and political group called the Tennessee Gay Coalition (TGC), comprised equally of women and men, had flourished in Nashville through the late '70s, uniting particularly during the heyday of Anita Bryant. But the group has floundered since 1981. Because of the recent backlash against gay people, probably due in part to hostility around AIDS, former TGC members are now instigating moves to rekindle their organization. Particularly, consternation has arisen over numerous arrests in city parks, primarily of gay men, for allegedly "soliciting crimes against nature." The local newspaper prints the names of those arrested and, according to Sturgis, in these instances job loss and community censure are indeed very serious problems. In such a reactionary climate, discrimination against PWAs remains an overwhelming concern. Since most Nashvillian PWAs have, in essence, come home to die, securing housing and employment has thus far presented a less urgent need. But emotional support is often sorely missed, especially when PWAs feel the isolation of hiding their condition. Nashville CARES offers a number of support programs staffed by trained volunteers; early on, CARES sought help from existing AIDS organizations to facilitate the development of sensitive, professional services. Programs include support groups, a buddy system, hospital and home visits, referral services and varied efforts at community education. Though progress has undoubtedly been made, Sturgis and Pierce both expressed worry that safer sex has not yet become a must in the minds of Nashvillians, both gay or straight. On February 14, a precedent-setting event occurred in Nashville— a Black restaurant/bar called the Park Avenue Lounge sponsored a fundraiser to benefit Nashville CARES. A club known for throwing benefits for many varied civic groups, as well as for offering diverse

(Continued)

NASHVILLE, continued

music from jazz to rhythm & blues to contemporary rock, Park Avenue was approached by Nashville CARES in an effort to further include the Black community in the fight against the disease. The club responded enthusiastically with the Valentine's Day event billed "From Our Hears to Our Community" and, according to many local residents, this effort to unite concerns about racism and to unite concerns about racism and homophobia was a Nashville first. "On the subject of AIDS" says Park Avenue owner Dweyne Tucker, "I think Blacks and other minorities need more awareness about how the disease is communicated. As with other communicable diseases, people have false ideas about how you contract them, from the toilet seats to kitchen utensils, whatever. We thought it would be a good reason to use the Park Avenue as a vehicle for education, for communicating facts." Prior to the event, Tucker had no idea what to expect in terms of crowd turnout or reaction from residents in the club's predominantly Black north Nashville neighborhood. "We're waiting to see what happens more than anyone," he explained. As it turned out, a reasonably-sized crowd of over 100 showed up for the afternoon benefit. Tucker and Pierce were very pleased with the diversity of people and the inroads made to increase awareness that AIDS/ARC is a public health issue of concern to everyone. "From Our Hearts to Our Community" was both festive and serious,with varied, multi-ethnic presentations and a tone of political urgency. Pierce expressed particular pleasure that the music and dance offerings reflected Afrikan cultural influence, and that discussions of AIDS stressed world-wide cooperation. A key focus of the event was AIDS/ARC preventative education. Patrons were offered literature, information charts and condoms, and a short video about AIDS slated for New York Public Schools was screened. A doctor from the Nashville CARES board of directors hosted a lengthy question and answer session. Care was taken to both applaud the gay male community for their fast response to the crisis, and to stress that gay men are not to blame. Analogously, board member Reverend Edwin Sanders emphasized the importance of dispelling the racist idea that AIDS can be blamed on Africa. Repeatedly, the message from the benefit was the need for compassion and increased understanding among all sectors. Says Tucker, "It still seems that there's not an awareness of the right kind of scale for a city the size of Nashville. We hope the event will make it easier for other businesses that do not generally have a [recognizable] gay clientele to take a public interest in the disease." Pierce feels that the Park Avenue event is a successful example of Nashville CARES' approach to fighting AIDS/ARC— an approach that includes coalition-building with communities of color and all segments of society. It's an approach, she believes, that will work with increasing success for AIDS organizations everywhere.

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RED CROSS, ROTC VIOLATE HIV LAW

with thanks to Madison, Wisconsin's OUT!, June, 1987

The Badger chapter of the American Red Cross in Madison and the University of Wisconsin-Madison Reserve Officer Training Program (ROTC) violated Wisconsin law governing the confidentiality of AIDS exposure tests, according to State Representative David Clarenbach (D-Madison). The Red Cross released HIV antibody test results of 27 Navy ROTC cadets to their unit's medical coordinator, Lt. Gerald Matthews, upon request. Clarenbach said the law, which he authored, provided that results be released only to certain health-care providers with specific permission, and that military officials and employers were not among them. "This incident is an obvious violation of the law," said Clarenbach, "and demonstrates in graphic terms the need for more stringent regulations." Clarenbach said the incident has prompted him to propose legislation to stiffen penalties against those who violate the confidentiality law. Information about the cadets was released after they had participated in a blood drive on the University campus. The Red Cross screens all blood donations for the AIDS antibody. The incident surfaced after a ROTC cadet, upon quitting the military program this year for other reasons, received his medical records. The cadet, who did not wish to be identified, showed Clarenbach the file, which contained a photocopied list of 27 cadets and their HIV antibody status. Lt. Matthews said a similar master list was in the medical files of all the students who took the test. Matthews insisted that no harm was done because none of the tests were positive. If any had tested positive, he claimed that those results would have been expunged from the list. But Clarenbach pointed out that even a negative test result can be harmful to one's reputation. Given the current AIDS hysteria, he said, the fact that a person had even taken the test could be interpreted that he or she was in a high-risk group. In a letter to the legislator on February 25, Dr. Gary Becker, director of the Badger Red Cross's blood services, wrote: "I want to apologize for this error, and will do so personally to your constituent if desired." Becker also called his action a "stupid and totally inadvertent" mistake. Red Cross Associate Attorney General Karen Shoos Lipton said in a letter to Becker that "the disclosures...do constitute a violation of the statute." According to Wisconsin Statute 146.025 (8) and (9), violations of the confidentiality provision may be liable to the subject of the test for actual damages and costs, plus exemplary damages of up to $1000 for a negligent violation, up to $5000 for an intentional violation, and for criminal penalties of up to $10,000 and/or up to 9 months imprisonment.

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MILITARY POLICY CHANGES

with thanks to Detroit's Cruise, 5/13/87

Military personnel who test positive for the AIDS virus will get a chance to remain on active duty under a new Pentagon policy— but if they break the rules, they could be kicked out of the service. Among other restrictions, any of the 2.1 million uniformed personnel who test positive for the virus known as HIV will have to agree in counseling to engage in "maximum safe sex" by using condoms, officials say. Defense Secretary Caspar Weinberger signed the new policy and sent his assistant secretary for health, Dr. William Mayer, to brief reporters on the 9-page guidelines. Mayer made it clear the rules will be strict. "If [a person] violates the counsel, he will be punished," Mayer said. This punishment could conceivably mean a discharge. Authorities will be allowed to revoke security clearances and deny access to classified information to infected personnel. The policy addresses the reserve forces for the first time, restricting the service of those who test positive and denying them treatment for the disease at military hospitals. The policy exempts from tests the nearly 1 million civilians working for the Defense Department, largely because the legality of the matter "is still in the courts," Mayer said, but civilians might be tested in places where they would be working closely with uniformed personnel.

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CONDOM ADVERTISING OK'D BY FDA

with thanks to The Washington Blade, 4/24/87

In an April 7, 1987 letter to condom manufacturers, the Food & Drug Administration gave condom manufacturers the go-ahead to advertise that latex condoms help prevent the spread of AIDS. Condom manufacturers had been prohibited from making such claims before, according to the New York Times. The letter notes, however, that while latex condoms have shown themselves to be effective against spreading AIDS, natural membrane condoms have not.

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ANTIBIOTIC DISCOVERED IN MUD

with thanks to the Star, 2/24/87

Researchers have literally unearthed a new antibiotic— by digging in the mud. The antibiotic Azactam (aztreonam), was developed from a soil sample dug up from a New Jersey forest by a microbiologist from Squibb Pharmaceuticals. Dr. Gerald Bodey, a cancer specialist at Houston's M.D. Anderson Hospital, says Azactam is effective against infections in patients whose natural immune systems have bee weakened by chemotherapy. Azactam is classified as a monobactam, and was originally isolated from Chromobacterium violaceum, with a wide spectrum against a wide spectrum of gram-negative aerobic pathogens. Azactam, unlike the majority of beta-lactam antibiotics, does not induce beta-lactamase activity and its molecular structure confers a high degree of resistance to hydrolysis of beta-lactamases.

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HUNGARY BEGINS MANDATORY TESTING

with thanks to New York Native, 4/13/87

The Hungarian news service MTI announced March 30 that Hungary has introduced mandatory screening for its citizens to determine seropositivity for HIV antibodies. According to MTI, 114 Hungarians so far have tested positive, with the total expected to be 6,000. To date, only 4 Hungarians have been diagnosed with AIDS, one of whom has died. "Those people belonging to the highest risk groups (homosexuals and hemophiliacs) are being compulsorily tested," MTI told Reuters News Service, giving no details. Foreign blood preparations have been withdrawn from circulation, according to Reuters, after some were found to be positive for antibodies to the virus. All donated blood had been tested since July, 1986. Hungarian officials have set up a telephone answering service for citizens seeking information about AIDS. [At least for those citizens who have access to telephones!—NCGSTDS Ed]

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EUROPE GETS SEXY ON SAFER SEX

by Martin Heggestad, with thanks to Boston's Gay Community News, 3/15-21/87

Some European governments have shown considerable sexual openness in their AIDS educational campaigns, as shown by some examples reported in the West German news magazine Der Spiegel. In Switzerland, a TV news anchorman demonstrated on the air how to put on a condom, although he used his middle finger rather than the proper organ. In Denmark, a public health agency put full-page ads in newspapers showing a picture of Copenhagen's red-light district with the caption, "You can get more than a quick fuck here." In Norway, almost every newspaper has carried an ad showing an erect penis with arms stretched out as if to dive into a pool. The caption: "Think before you leap into pleasure." In Finland, public health officials have proposed subsidizing condoms so that teenagers can better afford them. However, in Italy, a safer sex campaign has met opposition from the Catholic Church. Radio Vatican stated, "It is not the condom, but rather chastity which is the true weapon against AIDS."

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QUARANTINE ATTEMPTED IN GHANA

with thanks to the New York Native, 4/27/87

Immigration officers at the Lagos airport in Accra, Ghana, mistakenly detained a man they incorrectly believed had AIDS, the Indian Express has reported. The detention, which took place in March, stemmed from officials misunderstanding the man's "legal aid" certificate. "This man has A certificate!" one officer shouted, resulting in a fracas the Express described as "hell breaking loose." Immigration officers called the riot police, who arrested the man. The victim of the misunderstanding, described only as a "student expelled from the United States," was then taken to the University of Lagos teaching hospital for examination. Hospital authorities refused to examine him and contacted Health Minister Professor Olikoye Ransome-Kurti, who ordered that the student be quarantined in an infectious disease hospital. "The student, who was disturbed by the panic, bolted," reports the Express.

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LAWYER DETAINED FOR HAVING CONDOMS

with thanks to Detroit's Cruise, 4/22/87

A female lawyer in Britain who followed the advice of a British government sponsored anti-AIDS campaign said she was briefly arrested, strip-searched and given a urine test for carrying a packet of condoms. The British government has mounted a multimillion-dollar publicity drive warning of the dangers of AIDS and suggesting people use condoms. Its campaign slogan is "Don't die of ignorance." The 30-year-old woman said she was returning form a vacation in India when she was stopped by customs officers at London's Heathrow Airport. She said that when they found the condoms in her luggage they arrested her, strip-searched her and gave her a urine test. The woman said a customs officer told her that carrying condoms was a "reasonable grounds" for arrest since drug smugglers sometimes fill them with drugs and then swallow them to avoid detection. The woman said that after the results of her urine test was negative, she was released.

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SOVIETS PLAN AIDS HOTLINE

with thanks to Chicago's Windy City Times, 3/12/87

The Soviet Union is undertaking a program to combat AIDS that will include a telephone hotline and medical examinations, reports the March 8 Chicago Sun-Times. According to Dr. Georgy Khlyabich, a Health Ministry official, there are 13 known cases of AIDS in the Soviet Union, one involving a Soviet citizen. A Foreign Ministry spokesman said that there are 20 known cases of AIDS in the Soviet Union, but that none involve Soviets. The discrepancy between the two figures is unresolved. Khlyabich said the hotline is being established "so people can call and clarify their symptoms with less worry."

DEATH PENALTY IN TAIWAN

with thanks to New York Native, 5/11/87

Taiwan's most prestigious hospital has recommended the death penalty for anyone knowingly infecting others with HIV, the alleged AIDS virus, United Press International reports. Dr. Wang Cheng-yi of the Taiwan University Hospital said willful HIV infection is "tantamount to murdering and thus should be punished accordingly." Cheng-yi called for fines of at least $290 for doctors who fail to report cases of AIDS, in addition to other penalties, which were not described. There was no immediate indication from the government of Taiwan as to how it intends to respond to Cheng-yi's suggestions. According to UPI, Taiwan has only one confirmed case of AIDS, reportedly a homosexually active businessman who often traveled abroad. He died in Taipei, about 6 months ago.

MEXICAN DRUGS REQUIRE PRESCRIPTIONS

by Robert Blizard, with thanks to The Washington Blade, 1/23/87

South-of-the-border excursions into Mexico by people with AIDS and HIV infection to purchase the experimental AIDS drugs ribavirin and isoprinosine could be curtailed by U.S. Attorney Peter Nunez's decision announced December 15 to start prosecuting smalltime drug smugglers to the fullest extent possible, reports Update, a weekly Southern California gay/lesbian newspaper. Nunez reportedly said he will require a prescription from a U.S. doctor in order to bring these drugs across the U.S. border. Many people have already traveled to Tiajuana to buy prescription medications where they are sold over the counter without a written doctor's order. In the past, Customs officials have permitted people to bring enough of the drugs back from Mexico for personal use only. Nunez refused to be available for comment.

ISRAELI ARMY ACCEPTS PWAs

with thanks to the New York Native, 4/27/87

The Israeli Defense Force (IDF, Israel's Armed forces) will "consider" accepting AIDS "victims" [sic] who volunteer to serve in its ranks, according to Bamahaneh, the Israeli Army weekly. The article quotes outgoing IDF chief medical officer Tataluf (Res.) Moshe Raveh as saying that, although persons with AIDS will be exempt from conscription, in "special cases it will be possible to consider volunteering." According to the Jerusalem Post, the IDF will continue to draft homosexuals, even though the first case of AIDS in the Army has been detected. "It was just a question of time before the first sick soldier was identified," said Raveh, who also reported that the soldier is being treated "like someone suffering from any other disease defined as endangering health."

INDIAN GOVERNMENT MANDATES TESTING

by Mike Salinas, with thanks to the New York Native, 3/9/87

The Indian government has begun deporting foreign students who test positive to antibodies to HIV. So far, one Kenyan, one Ethiopian, and three Tanzanians have been expelled. A confidential circular was sent to Indian universities last year, requesting authorities to screen all foreign students for the presence of HIV antibodies within a month of admission. Also, according to sources in new Delhi, everyone in the tiny Yadava community in Bihar was tested for antibodies, "because many of them practice sodomy." Those tests, according to the government, came up negative. Meanwhile, Dr. K.K. Ghosh, the executive director of India's Foundation for Education Against AIDS, has publicly called for a health system for the purpose of "certifying the Western Blot test had been taken, just as it used to be compulsory for Indian citizens to take certificates for measles and cholera for entry to some European countries." According to reports in The Independent and The Hindustan Times, 65 people out of 25,000 screened have tested positive for HIV antibodies. The testing policy will be extended to include all foreigners in India. Efforts to obtain an official statement and additional information from the Indian Embassy proved fruitless, as they did not return the Native's numerous calls.

RUSSIAN AIDS TESTING SITE

by Matthew Daniels, with thanks to The Advocate, and People With AIDS Update, May, 1987

Authorities have opened a testing site for people who fear they might have AIDS, though the disease (known as SPID in Russian) is not officially recognized as having affected Soviet citizens. Communist officials reported that 20 foreigners in the Soviet Union have AIDS, and expressed fear that the disease might be spread to the Soviet population through sexual contact. Of the 60 people tested so far, none have had results showing exposure to the HIV virus. The testing, which is guaranteed to be anonymous, includes questions asking, "Have you had sex with foreigners?" and "Have you had sex with a member of your own sex?" Homosexual activity is a criminal offense in the Soviet Union.

AFRICAN "TERRORISTS" BLAMED

by Martin Heggestad, with thanks to Boston's Gay Community News, 5/10-16/87

South African Foreign Minister Roelof F. Botha claims that rebels entering the country from neighboring Back African states are to blame for spreading AIDS in South Africa according to the Associated Press via the New York Post and the Chicago Sun-Times. "AIDS gets into this country in ways you wouldn't even think of," said Botha, speaking during a campaign appearance. "Terrorists cross our borders carrying a more dangerous bomb in their bodies than in their hands. They come from camps where AIDS is rife." Health officials report that 64 people in South Africa, most of them gay or bisexual men, have AIDS or have died of the disease.

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RACISM & AIDS IN ITALY

by Steve Miller, with thanks to the New York Native, 3/16/87

Thousands of anonymous fliers warning people to defend themselves against AIDS were distributed in Perugia, Italy, late in January. The leaflets describe AIDS "symptoms" and list the "high risk" groups. They then launch into an attack against gays, IV-drug users, hemophiliacs, and "the African and South American populations," having an extremely alarmist tone. Among other things, they warn people to avoid pools, public baths, and even barbers. The police confiscated many of the fliers and they began an investigation to determine the identify of the authors.

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JAPAN PROPOSES TESTING FOREIGNERS

by Martin Heggestad, with thanks to Boston's Gay Community News, 4/12-18/87

The Japanese government has proposed an anti-AIDS program which includes compulsory HIV-antibody testing of all foreigners entering the country, according to the New York Times. The guidelines, which do not yet have legal force, also suggest requiring doctors to report AIDS cases to public health authorities, screening blood donors for HIV antibody, and possibly requiring tests for gay men and IV-drug users. Apparently wishing to avoid accusations of xenophobia, officials said they would study the policies of other countries before implementing these guidelines. Although there have been few AIDS cases in Japan so far, public anxiety has been high since a Japanese prostitute died of the disease in January.

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SWEDES & DUTCH SPLIT ON AIDS PLAN

by Martin Heggestad, with thanks to Boston's Gay Community News, 3/15-21/87

Sweden and the Netherlands have developed sharply contrasting approaches to the problem of AIDS. The Swedish tack, which emphasizes compulsory testing and allows for surveillance, appears to have had less success at stopping the spread of the illness than the education-oriented program of the Dutch. According to a report in the West German newspaper Der Spiegel, Sweden has become the only Western European country besides Iceland to require health workers to report the names of all people who test positive for the HIV antibody. As of September 1985, Swedish doctors are legally compelled to test patients upon mere "suspicion" of an HIV infection. To date, 1323 antibody-positive residents of Sweden have been identified. These people are legally forbidden to donate blood, organs, or sperm. Prostitutes who test positive must give up their profession. In addition, doctors are permitted to "forbid" certain sexual practices to health-care clients with positive antibody tests. If the client does not appear to comply, the doctor can turn his or her personal data over to public health authorities, who may at their discretion use such means as official warnings, police surveillance, and confinement to a hospital. This last measure has been used only once, in the case of an IV-drug user. According to some observers, Der Spiegel reports, these measures have been counterproductive, leading to an atmosphere of fear and distrust of public health officials. The Dutch, on the other hand, are conducting one of Europe's most comprehensive AIDS education campaigns, working to promote safer sex and drug use practices. They have avoided scare tactics, claiming that while sensational advertising may attract attention, it has poor results in changing behavior. Jan van Wijngaarden, coordinator of AIDS policy in the Netherlands, told Der Spiegel "We are afraid of fear." The Dutch program focuses on intensive counseling, preferably in small groups. According to psychologist David Stein, "To change sexual behavior is a very difficult process. We can only proceed one step at a time." Although it is too early to tell for sure, it seems that the Dutch may be having greater success than their more heavy-handed neighbors. Der Spiegel reports that the use of condoms is long since widespread in the gay mecca of Amsterdam. In addition, educational efforts and the dispensing of disposable syringes have led to a low rate of HIV infection among IV-drug users.

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MANDATORY TESTING FOR TRAVELERS?

with thanks to New York Native, 4/13/87

Twenty-five experts gathered in Geneva recently, under the auspices of the World Health Organization (WHO), to discuss a proposal to require screening of international travelers for the presence of antibodies to HIV. The experts, representing a dozen Western and developing countries, determined that screening would create "serious logistic, epidemiologic, economic, legal, political, and ethical problems," according to Houston's Montrose Voice. "The diversion of resources to HIV screening and away from educational programs and measures to protect the blood supply is not justified," the panel concluded, after meeting for 3 days. It was the consensus that, "at best, and at great cost," screening measures would "retard only briefly the spread of HIV, both globally and with respect to any particular country." The experts recommended educational programs, for national and international passengers, about the transmission of the virus and the syndrome itself. They emphasized that travelers who test positive for antibodies to HIV present no danger to the passengers. WHO officials indicated that final recommendations for travelers on prevention of AIDS will be sent to governments worldwide within the next few months.

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ITALIAN CONTROVERSY ABOUT CONDOMS

by Steve Miller, with thanks to the New York Native, 3/9/87

Giovanni Spandolini, the Italian Defense Minister, announced February 2 that the military will dispense condoms, free of charge, to all soldiers, including new draftees. In Italy, all men are required to serve in the army for one year. The decision to supply the condoms followed a similar policy implemented during the previous week by the director of the prison of Bologna, where a large number of inmates were known to have tested positive for antibodies to HIV. In Bologna, free condoms were given to all prisoners. The decision in Bologna met with approval from prison officials throughout the country, and it is expected to be implemented in prisons throughout Italy. The prison policy in Bologna and the military's new approach seem to acknowledge that prisoners and soldiers engage in sex in cells and barracks. Rather than ignoring the fact or moralizing about it, the Italian officials appear to have accepted it. In the military, this approach will coincide with an education program. In addition to the prophylactics, the recruits and soldiers will receive pamphlets and illustrated charts explaining AIDS. The Minister of Defense is also planning periodic visits by doctors, who will conduct information sessions. Posters have been put up on bulletin boards and in other prominent places. Some of the information seems a bit bizarre. For example, the posted notices advise the soldiers to change their underwear often and to use new razors every day. They also describe symptoms and advise against casual sex. At the same time that he made the announcement about the condoms, Spandolini unveiled a program to give the antibody test to all new recruits. During a 3-day medical exam of recruits, which takes place before they are actually inducted, the test will be optional, since at that time, the recruits are still considered civilians whose consent is needed for such testing. All accepted soldiers, however, will undergo the test once they arrive at the barracks, before they begin training. The officials claim to guarantee anonymity, but admit that besides going to the recruit himself, the information about positive tests will go to the Ministry of Health and the Ministry of Defense. At the time of the announcement, Spandolini said that the screening program is just being conducted to determine the extent of infection by the virus. As more details of the military plans have been revealed, it became clear that more than just information gathering was behind the tests. Recruits who test positive for HIV antibodies will undergo further tests, and if they show any other clinical symptoms of AIDS-related diseases, they will be declared "temporarily unfit." If found to be antibody positive but has no other symptoms, the recruit will be placed on "convalescent leave." In both cases, the authorities claim to guarantee strict confidentiality, and they promise not to reveal the medical reason for the discharge from the military. They do not suggest how the rejected recruit will explain his status to prospective employers, or to his family and friends. During the same week as Spandolini's announcement, the Italian Minister of Health, Carlo Donat Cattin, a Christian Democrat, found himself embroiled in a political scandal as a result of one of his recent statements about AIDS. While testifying before a Committee on Health Issues in the Italian Chamber of Deputies, he said, "AIDS is an illness that only strikes those who go looking for it." That remark made him the center of a political crisis on the issue of AIDS. Some of the parties of the left in the Italian government have called for Cattin's resignation, others have asked for a no confidence vote. One group of deputies has asked Bettino Craxi, the Italian Prime Minister, for a clarification of the government's position on AIDS. They want to know whether "the absurd statements made by the Minister of Health in Parliament represent the views of the government." The leaders of the Radical party asked the Prime Minister to stop Cattin from issuing "his daily edicts which are permeated with the inertia and ineffectiveness of the office which he directs. We find ourselves presented with a cultural and clerical offensive worthy of the Holy Office tied to a policy of irresponsible and counterproductive `tranquilization.'" Cattin was also attacked in an article in Unita, the official newspaper of the Italian Communist Party. Rocco Buttiglione, the author of the article, accused the government's statements of containing "a hint of the Middle Ages, supporting the indissolubility of matrimony and the prohibition of all types of sexuality outside of it." This charge that Cattin desires a return to a medieval sense of morality is a common one among opponents on the left and in the gay rights groups. They contend that Cattin has a n agenda, as a Christian Democrat, to reinforce and impose his own and the Catholic Church's concept of proper morality. In response to these charges, Cattin has said in the Parliament, "One can't ask a government minister to be amoral or to refuse to express his morality." By the end of the week, Panorama, a weekly Italian news magazine, published a featured article called "At Risk Minister" concerning the controversy involving the official. In that article, it was reported that leaders of the Italian gay rights movement had been trying to meet with the Minister, but never received any response from his office. Finally, after a month of silence, Cattin said, "These people, besides being homosexuals, are maniacs. My assistants can listen to them. I have better things to do." During the same time, the country's Chamber of Deputies, fearing that they are not getting enough accurate information, had arranged for a lesson on AIDS, behind closed doors, given by a prominent immunologist, Professor Fernando Aiuti (whose name, ironically, could be translated as "aids"), and an expert from the World Health Organization. According to statistics recently published by an AIDS Commission created by the European Economic Community, the pattern of AIDS cases in Italy is the reverse of that found in the rest of Western Europe and the United States. Homosexually active men account for just under 30% of all reported cases in the country, while IV drug users make up over 60%. Lombardy, whose capital is Milan, is the Italian province with the largest number of reported cases in the country, 206, as of February 19, compared to 558 for the entire nation.

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CONDOMS & POLITICAL ASYLUM

with thanks to Detroit's Cruise, 5/13/87

An odd game of political intrigue was played out at the Shannon, Ireland airport, when two young Russians were mistaken for defectors. The two, traveling from Havana to Moscow, went to the duty-free shop at Shannon Airport during a brief layover and asked for "protection." Officials whisked away the male for questioning, assuming the couple was interested in political asylum from their country. It took 20 minutes for the officials to discover that the man's request, in broken English, was not for political protection; the couple were attempting to buy condoms, but had not known the word.

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DANISH REPORT ON AIDS

by Leora Nelson, with thanks to Toronto's Epicene, May, 1987

The growing openness of society about sexual matters and alternative forms of cohabitation have developed ... in more possibilities for the individual homosexual to live openly in accordance with his identity. The difference between North American and Scandinavian social attitudes toward people with AIDS (and toward homosexuality) is brought to light in the May, 1985 "Danish National Health Board Report to the Ministry for the Interior on the Disease AIDS and Proposals for Anti-Infection Measures." Danish rational conservatism is progressive compared to the vague moral terror with which AIDS is viewed in the U.S. The report identifies risk groups as homo- and bisexuals, intravenous drug users, and hemophiliacs, but does not implicate gay people and users of intravenous drugs as selfish, irresponsible individuals endangering society by indulging themselves. Homosexuality is treated as part of the status quo, rather than as a social or sexual disorder. This attitude fosters a pragmatic approach to the problems of people with AIDS and their care, and to controlling the spread of the virus that causes AIDS (HIV). The report's authors note that "all this talk about AIDS may be an impediment" to the development of popular acceptance of gay people "in view of the fact that information and understanding of the life and conditions of homosexuals in society are still lacking." They emphasize the need for serious study and for a cooperative effort to prevent the spread of HIV. They also praise government grants to the national lesbian and gay association, Forbundet af 1948 (F-48), and credit the association with greatly assisting in public information campaigns. Last year, the Municipality of Copenhagen gave F-48 $50,000 (Canadian), which was used to hire a volunteer coordinator for AIDS research funding and publicity. The allocation of government funds to a gay group is an encouraging indication of public faith in the competence of the gay and lesbian community. Such faith is sadly lacking in North America. This side of the Atlantic, fundamentalist propaganda has clouded the issue, portraying AIDS as divine retribution on a society that allows perverts and junkies to breathe its air. Such propaganda misdirects the energies of concerned heterosexuals toward homophobia, rather than encouraging efforts to control the spread of HIV and deal with the individual and longterm (social) consequences of AIDS. The December 1986 Vatican letter to Roman Catholic bishops on "The Pastoral Care of Homosexual Persons" did nothing to improve the prognosis for the general acceptance of gay men and lesbians: "Even when the practice of homosexuality may seriously threaten the lives and well-being of a large number of people, its advocates remain undeterred and refuse to consider the magnitude of the risks involved." The blaming of homosexuals for the spread of HIV presumes our irresponsibility and takes from us the right to seek the comfort of sexual fulfillment. The social implications of AIDS have the potential to scar more people more seriously than the deaths it has caused and will cause. Gay and lesbian sex is not decadent, nor is it a luxury. The rise of the right wing in the US has conveniently magnified the voice of the Roman Catholic Church, whose tune had been taken up by fundamentalists raving publicly about our "sickness" and "selfishness." A federal government politically and economically aligned with Falwell's infamous "Moral Majority" and several state governments indebted to fundamentalist factions for financial contributions create an unfavorable climate for constructive cooperation between government and gay and lesbian groups concerned with AIDS. The US does fund medical research on AIDS. And there is an abundance of gay and lesbian community groups providing support for PWAs, or trying to protect them from discrimination. But these organizations rarely receive financial assistance from governmental bodies. Partly as a result of this situation, information campaigns in the US (as in Canada) have been less intensive than those undertaken in Western European countries, including the UK. In Denmark—as in Norway, Sweden and England—public information campaigns have been thorough. Television ads and door-to-door leafleting have succeeded in reaching most households. In Denmark the need for safer-sex education in the schools is a priority: "It is imperative that young people of school age be informed, as they are about to have their first sexual experience. [Young gay people] living through the often difficult acknowledgment of their own identiy must be given a realistic attitude to AIDS." In the US, measures to update sex education programs in schools to include information about AIDS are often tentative, and are subject to censorship by moralist lobby groups, who claim that safer-sex education promotes "sexual deviance." Problems of geography, jurisdiction and cultural diversity have also contributed to the inability of North American governments to devise a public policy as reasonable and coherent as that set forth in the Danish report. Brief, comprehensive and straightforward, the report presents facts and proposes practical means for dealing with them, many of which have been set in motion. Mainly, it advocates public education at various levels. Government objectives are defined as: stopping the spread of HIV; minimizing the fear and suffering caused by AIDS; and limiting the economic consequences of the epidemic. Unless many US government releases, the Danish report is not an exercise in rhetoric: "Official efforts against the epidemic and its consequences aim at changing behavior patterns without invading the individual's justified right to privacy and personal integrity, even though this may result in restrictions in the the authorities' scope of action. ....The public authorities must show their acceptance of, and care for, these [risk] groups by involving them in close cooperation concerning the combat of the epidemic and its consequences." Perhaps Denmark is not in all respects a gay paradise, but its government's policy is certainly clearer, more liberal and better considered than that prevalent in the US.

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EUTHANASIA IN NETHERLANDS

with thanks to the New York Native, 4/27/87

Doctors in the Netherlands, where studies have previously shown an estimated 5000 terminally ill cancer patients annually choose euthanasia, are now hastening death for persons with AIDS. United Press International reports as many as one in eight PWAs may be availing themselves of lethal injections by consenting physicians. Such injections are considered "active euthanasia," as distinguished from "passive euthanasia," which occurs when a doctor causes death by withholding life-sustaining equipment or treatment. Although ending the life of a person with a terminal illness is a crime int he Netherlands, courts have charted a course allowing doctors who follow a specific set of guidelines to avoid prosecution. Dr. Sven Danner, head of the AIDS unit at Amsterdam's Academic Medical Center, said he and his staff will administer euthanasia to patients only if there is confirmed AIDS diagnosis, the patient decision is in writing, there is unbearable and incurable suffering, and there is a second medical opinion.

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A CONDOM NATION: DEATH CONSPIRACY

by Judith Woodburn, with thanks to Milwaukee Magazine, April, 1987

Condom, thy name is legion. Ever since mild-mannered Surgeon General C. Everett Koop recommended them as a means of controlling the spread of AIDS, condoms suddenly are appearing not only on television talk shows and in the headlines of respectable newspapers but also at social gatherings, where certain party-goers have seemed more than usually predisposed to recycling their favorite old tales of condomiana.

For example, there's the popular "showering with your raincoat on" gag. (Now that condoms are enjoying such popularity, this one's hardly funny anymore, except perhaps to youngsters who haven't showered yet at all.)

For those who blossomed in the pre-Pill era, there is the inevitable "rubber in the wallet" nostalgia and the pastoral Herman Raucherian memoir in which the teller semi-modestly paints himself as a priapic but bashful young stud whose only barrier to erotic fulfillment is . . . the censorious pharmacist. (It is not likely that "first diaphragm" experiences will ever evoke such misty declamations, but I do not consider this a great injustice.)

One also might invoke the stock market; it seems that disease has been nearly as good for the rubbers industry as World War II was for the rubber industry. Local investment broker Larry Gellman tells me that one of his clients made $61,000 (better than a 60 percent return on his investment) in just a few short months by investing in a condom manufacturer.

Finally, there are the fashion trendsetters, like one 30-ish man I know who recently was moved to proclaim as his motto that, "I used condoms when condoms weren't cool."

On a personal level, those women who have tried fruitlessly to drum up enthusiasm for the topic in the past may find this sudden energetic embrace of it somewhat surprising. More broadly speaking, this newly observed zeal makes the Puritan reserve of many television stations — including channels 4, 6 and 12 here — who have declined the advertising of condoms seem all the more puzzling.

A number of groups already have noted the aura of Dionysian glee suffusing most prime-time television programs and simply consider it a matter of social responsibility to allow the purchase of air time for a moderating message. If any given character on "Dynasty" can hop in and out of bed with a mean frequency of three times per installment, they ask, mayn't condom manufacturers be allowed to suggest — delicately, of course — what safety precautions she might take along?

It would seem at first blush that the condom is a product tailor-made for television. TV advertising always has thrived on setting up perilous hygiene threats — halitosis, houseitosis, ring around the collar — and then promising us relief in the form of some deodorant or cleansing agent.

Now comes a bona fide disease that truly is threatening, and Carter Wallace, the manufacturer of Trojans, again has the answer. Nice people have litter box odor. Nice people get "adult breath." Nice people worry about "feminine freshness." Nice people also worry about AIDS.

As ridiculous as this juxtaposition may seem, it does serve to remind us that no matter how virtuous the rhetoric of the debate over condom ads may grow, the fact remains that they're still just ads.

There's a product to be sold here. Given that, condom ads are as likely to trade in euphemization and the selective use of facts as any others on the airwaves.

So those who are tender of psyche and faint of heart won't have to worry that condom makers will spend costly network time reminding us that AIDS is only about six years old in this country and there are no definitive studies yet on the long-term effectiveness of condoms in preventing AIDS transmission. They surely won't waste precious advertising seconds telling viewers about the one Miami study of heterosexual AIDS patients in which men with AIDS used rubbers and two out of 12 of their spouses became infected anyway. They won't tell us about the low-end 72 percent effectiveness rate of their product in preventing pregnancy or that at least one AIDS expert has said, "It is probably just as easy to catch AIDS [from a carrier] as to get pregnant." And it is not likely that we ever will get any distressing information from a TV commercial about the *other* indelicate ways in which AIDS might possibly be transmitted. Things a condom can't do anything about.

Like all other television advertising, the condom ads will remain purposefully vague and totally tasteful (not to mention free of much useful information). After all, the manufacturers of Lysol toilet disinfectant are still calling it the "bathroom bowl."

IT MAY BE DIFFICULT, THEN, for condom advertisers and their proponents to understand exactly how contrary their message nevertheless may run to the ethos of American TV advertising. And it is not a matter of mere sexual prudery.

For nearly 50 years, television advertisers have been using the bright promise of sex to sell everything from toothpaste and antiperspirant to Toyotas and Chevrolets. Now, condom ads want to use the threat of death to sell rubbers.

The drama of this turnabout cannot be underestimated. For if it is true what Edna St. Vincent Millay said about childhood being "the kingdom where nobody dies," it has been even more true of television advertising. Until now, doctors in the cleanly world of TV ads have never had to contend with anything more severe than a case of caffeine-induced jitters or sinus headache, pressure and pain. Suddenly, for the first time in the history of television — and, for that matter, most of our lifetimes — sex can be deadly.

And therein lies the enormity of the distortion in today's hubbub over condomology: Throughout known history, of course, sex virtually always has been a pestilent undertaking. There were the unnamed "copulation sicknesses" of Roman and Egyptian civilizations, and since at least 1494, when it is thought that Christopher Columbus brought it back from a business trip to the New World, there has been syphilis to contend with.

And this has been truly curable only within the past 50 years. It is nothing more than coincidence, but it is interesting to note that penicillin — the first specific cure for syphilis — came into popular usage almost simultaneously with television. The antibiotic was discovered in 1928, the very year that the first drama was presented on television by General Electric, and it came into widespread use in 1943, just two years after the Federal Communications Commission authorized commercial television broadcasts.

So, since its birth, television has existed in an erotically hygienic bubble, and as its viewers we have grown up blissfully safe from any audiovisual confrontation about the microbial dangers of sex. We learned from Lysol what tiny, evil civilizations can lurk on bathroom surfaces, and we learned from Listerine about the bacteriological threat to fresh breath. But TV sex has remained pristine, its hygienic luster dimmed by nothing that a good spritz of FDS couldn't cure.

No wonder a condom ad is shocking. As for condoms themselves, television's short-sheeting of history also may allow us to forget that they probably have been around since Caesar Augustus's times — and not for reasons of birth control.

Today, in the post-Pill era, we are likely to think of the condom as a contraceptive device that recently has been pressed into service as a barrier to disease. But history tells us otherwise. The great 16th-century Italian anatomist, Fallopius, claims to have invented a linen sheath as a protection against syphilis, not conception. And it wasn't until the 18th century — Casanova's era, by the way — that the contraceptive qualities of devices were even given much thought.

In the 19th century, when syphilis ran rampant in Western Europe, the condoms were still valued more for their prophylactic properties than anything else, and proper Victorian husbands who may have committed the indiscretion of having visited prostitutes at one time or other felt compelled to use them to protect their wives from infection.

(Continued)

CONDOM NATION, continued

Such was their penance: The condoms in use at that time were not particularly pleasant or convenient to use; most had to be tied like a package at the top with a length of ribbon. But they did have a certain air of respectability, as evidenced by one brand that featured a likeness of Queen Victoria on its package. (As an interesting historical exercise, you might try picturing Ronald Reagan being similarly honored . . .)

Thanks to the discovery of vulcanization, the U.S. War Department could, in the early 1900s, issue cheap armor in the form of rubber condoms to all sailors going on shore leave, as well as to all soldiers serving overseas in World War I. This measure was quite controversial at the time to those who were morally opposed to birth control. But we can be quite certain that the War Department's main concern was not in protecting the women with whom the soldiers "fraternized."

ALL OF THIS, OF COURSE, continues to have certain parallels in the present debate over television advertising. In France, for example, a predominantly Catholic country where the birthrate has been unusually low for quite some time, the advertising of condoms on television had been proscribed by governmental decree. In response to the AIDS problem, the government finally has relaxed the ban and condom advertisements are *de mode* — but only the disease-control function of condoms may be mentioned, not the birth control one.

Obviously, though, the key consideration in this situation is not one of morals per se, nor even of offending the delicate sensibilities of certain viewers. The issue is one of pure national self-interest: keeping the death rate down and the birthrate up.

In the world of American television — and Milwaukee is certainly a prime example — the condom issue remains far more muddied. Television executives claim to be concerned about offending the moral sensitivities of their viewers with the ads, but that is difficult to believe when the same stations will allow the ad I recently saw for Marcy exercise equipment. In this commercial, a young (and devastatingly well-built) man is pumping iron in the early morning light when a beautiful young woman swaddled in an oversized white robe appears and admiringly asks, "Do you do this *every* morning?" (Lest the naifs among us misunderstand, we seem to be witnessing the first such morning these two have spent together. And they obviously aren't even well-enough acquainted yet to know one another's exercise habits.)

Given the ubiquity of this kind of advertising, I find it far more plausible that television executives are worried about upsetting the *advertisers*. Once the notion of deadly sex fully penetrates the pristine world of television advertising, it can make for some particularly glaring contradictions.

Imagine, for example, the exercise ad followed by 30 seconds with the makers of Trojans: A rational and attractive young man or woman appears on the screen to remind us that the sex act implied in the previous 30 seconds was virtually crawling with malevolent microbes. We may find ourselves musing not over the aphrodisiacal charm of sophisticated exercise equipment, but rather over whether that muscular young man used a condom. ■

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SEXUAL HEALTH REPORTS (copyright)

SEXUAL HEALTH REPORTS (SHR; SeHeR/phonetically, See Here!)—how does that sound as the new name for the Official Newsletter of the National Coalition of Gay Sexually Transmitted Diseases (NCGSTDS)? It's certainly easier to say and remember than "N.C.G. et cetera Newsletter!" In spite of our 8 years of hard work, our paying subscribers/members reflect only a small percentage of our estimated readership. Since 1979 when the NCGSTDS was created by health care workers from around the country, our readers have continually expressed satisfaction with our attempts to capsulize information in the Newsletter. We are very appreciative of the kind letters of praise as well as the occasional admonishments for oversights. The NCGSTDS is one of the oldest and most comprehensive sources of information of its kind available, and many readers have beseeched us to expand the publication. As a volunteer run, not-for-profit endeavor, we just can't even consider such requests without a substantially expanded base of subscribers, increased income, and enhanced staff support. We have almost become paralyzed just in the production of this issue of the Newsletter (that's why it's so late), due to the vast amount of work required in compiling all the information. In 1986, during meetings held during the 7th National Lesbian & Gay Health Conference and 4th National AIDS Forum at Whitman-Walker Clinic in Washington, DC, Paul Kawata of the National AIDS Network and others suggested that our very name may very well be the primary barrier to membership—a kind of very subtle "homophobia" just by virtue of the word "gay" in our name. Also during that meeting, our friends in San Diego—especially Terri Cunningham of the Beach Area Community Clinic, kindly wrote up a draft of bylaws, which was subsequently distributed to the entire membership for comment several months ago. In addition to the suggestion to formally incorporate as a nonprofit organization, their were three additional options: to incorporate as a private, for-profit business, with the same goals targeting the gay/lesbian community, but with a framework more conducive to business development; change the name of the publication as was described above, either with or without the corporate status changing; and last, cease all operations before burnout or other serious damage occurs.

So what are we to do?! The dilemma was thoroughly discussed with NCGSTDS members attending the 8th National Lesbian & Gay Health Conference & 5th National AIDS Forum in Los Angeles this March. The following changes will be implemented beginning with Volume 9:1 of the Newsletter (Fall, 1987), unless there are other suggestions or significant opposition to the proposed change. The Newsletter will be renamed, SEXUAL HEALTH REPORTS, but the name of the organization will continue to be known as the National Coalition of Gay Sexually Transmitted Disease Services (NCGSTDS). The organization will focus its primary energies into the Newsletter; and membership will revert to subscriptions only. Cost of subscriptions will go up gradually for continuing subscribers, more steeply for new subscribers, and a new "Fact Sheet" will be printed to reflect these changes. If our subscriptions increase substantially over the next year, and if we get enough additional income to help salary part time staff, than bigger and better changes will be considered. As always, we invite your comments! This is your chance to speak your mind!! NCGSTDS, P.O. Box 239, Milwaukee, WI 53201.

FLOATING CONDOMS IN BOSTON

by Kim Westheimer, with thanks to Boston's Gay Community News, 4/26-5/9/87

Floating helium-filled condoms, safe sex kits and free condoms were prevalent on two college campuses on April 8. Safe sex kit distribution at the University of Massachusetts was fairly noncontroversial while condom distribution at Boston University is part of an ongoing debate. The AIDS Awareness Committee of the University of Massachusetts distributed 300 safe sex kits, including condoms, water-based lubricant and educational pamphlets. "People were supportive," said David Jones of the Committee. "Even people who laughed at first asked questions and picked up information." The AIDS Awareness Committee, co-sponsored by a Student Nurse Association and the lesbian and gay center on campus, has worked closely with Boston's AIDS Action Committee and the Fenway Community Health Center in developing an educational plan. According to Jones, the group is particularly indebted to the Fenway, which saved the day when condoms ordered by the group were not delivered in time for the April 8 event. The health center filled in with an "emergency loan" of condoms. According to the Boston Herald, Boston University (BU) President John Silber has banned distribution of safe sex kits on campus, calling such activities "immoral." But the student Civil Liberties Union distributed 200 condoms following an April 8 forum addressing AIDS. Reproductive rights advocate Bill Baird has joined the fray at BU. Baird was arrested at BU 20 years ago for distributing condoms on campus. His arrest led to the US Supreme Court ruling that overturned a Massachusetts law barring distribution of birth-control information to unmarried people. According to the Boston Phoenix, Baird was invited by the student government association of BU's College of Liberal Arts to address "God, Government, and Sex." When Baird heard about Silber's reluctance to have safe sex kits on campus he decided to pass out condoms and mobilize students to confront Silber. While Baird personally confronted Silber. While Baird personally confronted Silber on ABC television's Good Morning America on April 8, his attempt to get students involved was less successful. Student government vice president Jorgette Theophillis, in a letter to the Phoenix, said Baird cannot mobilize students because "in his position as an outside speaker, he cannot challenge the university's ruling through [his actions].... In all of his excitement for confrontation, the purpose of his lecture has been lost: namely, the discussion of reproductive rights."

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NETWORKS GAVE 60 MINUTES EACH IN 86

with thanks to the New York Native, 2/9/87

According to an article in the January 26 Daily News, AIDS was the eighth most frequent news story on the ABC, CBS, NBC, and PBS evening newscasts. Out of the approximately 5720 minutes of news time each network broadcast each year, roughly 60 minutes was devoted to the AIDS crisis. The biggest story of the year was the Iran-Contra affair, which received 386 minutes of air time on ABC, 308 on CBS, and 292 on NBC. News about South Africa was second, followed by the Challenger spacecraft disaster, the Chernobyl nuclear power plant disaster, international terrorism, the Philippines story, tax reform, and the AIDS crisis. The data was compiled by DWJ Associates.

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CONDOMS SOLD: SEATTLE'S RUBBER TREE

by Michael Zielenziger, with thanks to the Knight-Ridder News Service

On a gloomy Friday night, customers crowd into a small store in a quiet neighborhood. The place is called the Rubber Tree, but it is not peddling plants. The Rubber Tree is the only store in America that specializes in selling condoms, its owners say. In recent months, the boutique has drawn lots of new customers who fear the spread of AIDS and are attracted by the low-key atmosphere, competitive prices and an astounding array of prophylactics. "We sell about 55 different varieties of condoms," said Julia Forbes, a manager of the nonprofit boutique. "And we only sell brands that we really believe to be safe and reliable, so that excludes some of the real exotic ones." Lambskin and latex, ribbed and plain, colored or clear, water-based or silicone, an astounding array of condoms lines the shelves of the small store. A half-dozen varieties of Japanese condoms are available, and the store offers variety packs, in-store specials and other promotions. Customers also find charts and pamphlets describing the differences in condoms and how they should be used. About a dozen unpackaged condoms line one shelf, giving customers a chance to see the different designs. Forbes estimated that business at the Rubber Tree has increased by 30% since a blizzard of publicity concerning AIDS and other sexually transmitted diseases refocused attention on condoms, an old but reliable method of preventing the spread of diseases, according to their proponents. "It used to be busy just on Friday and Saturday nights," said one of the workers at the store. Now, it's busy all the time, she said. "We want people to ask questions, to be knowledgeable, to be responsible for what they do sexually," Tess said, "but we also want them to be adventurous in their choices and have fun." She said a primary mission of the store is to ensure that people aren't intimidated by contraceptive choices. Do they have any favorites to recommend? "I like the Japanese ones," Tess said, "because the boxes are so pretty. When you're done with the condoms you can use [the boxes] for candy." Customers say they come back to the store because the Rubber Tree offers a wide selection, discount prices and a nonconfrontational atmosphere that makes it easy to ask delicate questions. "You go into a pharmacy and there's a man in a white coat towering over you," said a male customer who asked not to be identified. "Here you don't feel like people are looking over your shoulder." In a sense, the new-found popularity of the store marks something of a milestone in the history of America's sexual revolution. The store was founded in 1975 by members of the Seattle chapter of Zero Population Growth who sought to reduce unwanted pregnancies by making contraceptives more easily available. At the time, other methods of contraception like IUDs and the birth control pill were far more popular. With AIDS an increasing concern, however, condoms have gained new popularity. Men and women interviewed at the Rubber Tree say AIDS has forced them to think more seriously about condoms. Forbes estimated that about 45% of the store's clients are women. She said the store is designed to be a complete and confidential center where customers can have questions answered frankly without intimidation, receive discount prices and get medical referrals if needed. A spot check of neighboring pharmacies indicated that the Rubber Tree's prices are about 25% below retail. The store also offers a mail-order service for condoms, spermicides, lubricants, books and greeting cards containing condoms.

CONDOM MANUFACTURERS HOMOPHOBIC?

The Gay and Lesbian Press Association (GLPA), the nation's only gay and lesbian trade association, endorsed a consumer action against two condom manufacturers--Carter-Wallace and Ansell Americas--to protest the condom industry's refusal to advertise in gay/lesbian publications. "While it would be irresponsible for us to call for an industry-wide boycott because of the AIDS crisis, we are asking gay men not to buy Trojan or Lifestyles condoms and send wrappers from these companies' competitors to their marketing departments," said Don L. Volk, GLPA president. Joe DiSabato, president of Rivendell Marketing in New York instituted the action after refusals by the industry to place ads in gay publications. Approximately 50 gay newspapers in the country ran an editorial by DiSabato "Can Anything Stop Homophobia in the condom Industry?" in March. "It is unconscionable that Ansell President John Silverman said, `AIDS is a condom marketers' dream' when gay men are dying," said Volk. GLPA earlier this year sent letters to the three television networks encouraging them to run condom ads to help stem the spread of the disease, according to Volk. "Gay and lesbian publications throughout the country have been at the vanguard in AIDS education," said Volk. "Without the efforts of the gay press, I believe there would have been considerably more AIDS deaths. For condom manufacturers to ignore the gay market by featuring women or non-gay couples in their advertising is a gross insult [and grossly insensitive] to our community. We call for this consumer action to show that we are not the `captive' audience condom manufacturers might believe us to be," he said. GLPA is a trade organization of publications and individuals devoted to the gay/lesbian community. The group represents approximately 400 publications from weeklies to monthlies. For more information write: GLPA, POB 8185, Universal City, California 91608-0185 (818/761-6772).

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PROPHYLACTICS ON PRIME TIME?

by John Grey, with thanks to the New York Native, 3/9/87

Increased public awareness of AIDS as a threat to the heterosexual community has led in recent weeks to a near-complete reevaluation of policies prohibiting condom advertisements on television. Capped by announcements February 19 that CBS and NBC would allow their owned and operated stations to accept condom advertisements, there are now anywhere from 30 to 60 TV stations across the country that have pronounced condom ads suitable for broadcast. KRON-TV, an NBC affiliate owned by Chronicle Broadcasting in San Francisco, focused national attention on the issue January 15 when it announced it would not only accept condom advertising but would donate all revenue earned from commercials to AIDS research organizations. It also stipulated that any condom manufacturers who advertised on the station match the funds, in essence doubling the cost of the airtime for the advertiser. KRON, like most stations that have agreed to air condom ads, retains the right to reject commercials it deems inappropriate, and to schedule the ads in select time periods, typically from around 10 am to 3 pm, and after 11:30 at night. KRON's current policy allows only commercials stressing condoms' health benefits; contraceptive-oriented advertising is still not accepted. Carter-Wallace, maker of Trojan condoms, is so far the only manufacturer willing to meet KRON's demands. The company began a six-month test run on the station in February. The station's public affairs coordinator, Javier Valencia, says Carter-Wallace and the station will jointly donate $25,000 to both the San Francisco AIDS Foundation and the American Foundation for AIDS Research. Few stations are as demanding-- or as generous-- as KRON, WXYZ-TV in Detroit made the decision to accept condom ads over a year ago, when it was sold by ABC to the Scripps Howard Broadcasting Company, but only recently was able to sign a condom account. WXYZ's assistant general manager, Tom Griersdorn, says ABC's "stringent restrictions" would never have allowed the ads; but he says Scripps Howard, which owns eight other TV stations in Cleveland, Cincinnati, Phoenix, and West Palm Beach, has promised to support the local station's decision. Ansell-Americas, makers of Lifestyles condoms, began running ads on the Detroit station January 26. The narrative commercials feature a woman, clearly concerned, discussing AIDS and how condoms can help prevent the disease. "I'll do a lot for love," she says, "but I'm not ready to die for it." Unlike KRON, WXYZ is adding the condom revenue into its coffers, as it would with any other account. "We saw no reason to mask it," Griersdorn says. "We took it for what it was-- an advertiser promoting a product." He notes the station has been and continues to air public service announcements regarding AIDS "and other sexually transmitted diseases." KRON's Valencia responds, "Each station has to run its operations the way it feels is most appropriate." Valencia responds, "Each station has to run its operations the way it feels is most appropriate." Valencia says KRON's decision to donate its profits to AIDS organizations was based on a desire to focus public attention on the disease. "We really wanted to stress the health/AIDS issue, and encourage people to realize that the only way we'll solve this problem is through research. We wanted to keep the focus on AIDS." Other stations across the country have been spurred toward accepting condom ads by increased pressure from community groups and the government. At a House subcommittee meeting in Washington February 10, Surgeon General C. Everett Koop urged television stations to accept ads for condoms, and said the ads should instruct consumers on "proper use of condoms from start to finish." The ABC network, which has not approved condom ads for its owned television stations, has said it will run a public service announcement supplied by the American Foundation for AIDS Research in which Koop appears saying, "The best protection against the infection right now, barring abstinence, is the use of a condom." So far none of the three major broadcast networks has approved national condom advertising, usually citing viewer aversion to the moral implications of the ads. This, however, is not substantiated by the stations currently airing condom spots. KRON reports viewer response has been two to one in favor of the ads, while WXYZ's initial response was two to one against the commercials, by the end of the first week viewer phone calls were two to one for the ads. "Naturally, you hear from the people who adamantly oppose quickly, then those who support you come later, but just as loud," WXYZ's Griesdorn says. Although gay men have been most heavily hit by AIDS in this country, no ads running or submitted for approval to the above stations mention homosexuality or appear to be geared toward the gay market. KRON's Valencia notes that television advertising, because of its expense and wide reach, is "generally only used to reach a mass audience." He says condom manufacturers would likely use the gay print media to target gay consumers. Plus, he notes, "The gay community has done an excellent job on its own of getting the information out."

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INDIANA PUB. SERVICE ANNOUNCEMENTS

with thanks to Detroit's Cruise, 2/25/87

TV stations are still debating whether to accept condom ads as a deterrent against the spread of AIDS. State health officials in Indianapolis, frustrated by the refusal of some stations to air explicit advertisements about how AIDS is spread, have taken matters into their hands. Health officials there have come up with their own ad campaign to get the message out, using a lighter approach in the new public service spots. One commercial shows a medieval scene with a knight talking to a maiden who suddenly pushes him away. An announcer interjects: "No more one-(k)night stands" for her. Another ad shows a knight clanking down a hallway in his heavy armor. The voice-over says there are better ways to protect yourself against AIDS and adds: "These aren't the Dark Ages." State officials hope the commercials will lure people's attention and get them to look into the facts about AIDS. The commercials were paid for by the Centers for Disease Control, which is supporting the state's off-beat approach.

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YET ANOTHER CONDOM AD

with thanks to Detroit's Cruise, 2/25/87

In the wake of the decision by several television stations to carry condom ads, several ad agencies are rushing into production television ads for their clients. The emphasis of the ads is on the protection from disease condoms provide and steers clear of their birth control properties. Ramses Extra condoms has chosen to promote parental involvement in its spots. The 30-second spot opens on what is presumed to be a college student reading a letter from his father. a voice-over, of the father reading the letter, says that his son "lives in a world I never imagined... with herpes and AIDS and a whole list of scary diseases I can't even pronounce." The son then opens a wrapped gift of Ramses. The voice-over explains the condoms are a gift of love and understanding, and the letter is signed: "Take care of yourself... PA." It closes with the theme "Ramses Extra-- the take-care condom." The commercial is the latest in a series of TV spots by condom marketers now that many independent stations and network affiliates have agreed to accept them to fight sexually transmitted diseases.

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PROTECT YOURSELF MESSAGES AIRED

In a move to address the rising AIDS risk among young heterosexuals, The Johns Hopkins School of Public Health, WJZ-TV 13 and an award-winning Baltimore advertising firm, Trahan, Burden and Charles, are planning a rock video public service announcement urging the use of condoms. The planned 30-second video, to be created and filmed by the ad firm, focuses exclusively on the use of condoms for disease prevention. Frequent airing of the message--the first in Baltimore—is scheduled to begin in the spring and will be offered by WJZ, via satellite, to all other local and national stations. WBAL-TV 11 has agreed to broadcast the spot, and WMAR-TV 2 has also expressed interest in it. Hopkins officials praised WJZ General Manager Jonathan Klein for suggesting the joint public service project. His station also plans coverage of the entire issue through news programming and an hour-long prime-time "People are Talking" special March 27th. "To say that this message is an attempt to save lives is simply to state the truth," says Steven Muller, president of The Johns Hopkins University. "Hopkins is committed to AIDS treatment and research, as well as to AIDS prevention. That's what this is all about." "We initially went to Jonathan Klein on behalf of the School of Public Health to ask that the station accept condom advertising," according to Elaine Freeman, director of public affairs for The Johns Hopkins Medical Institutions. "He explained that Westinghouse policy prohibits use of these ads, but quickly proposed the PSA project as a viable alternative. We couldn't be more pleased or more grateful. This is a courageous public stance. "Because Jonathan asked for a spot that would appeal to young people, we turned to Alan Charles, at Trahan, Burden and charles, who has a flair for creating powerful ads with just the right rock video flavor. Alan immediately recognized the importance of this project and offered to do the PSA on a pro bono basis." In recent weeks, federal, state and local health officials have intensified plans for campaigns to teach prevention of AIDS. The U.S. Surgeon General, C. Everett Koop, has called for explicit instructions in the schools on how to use condoms to reduce the risk of transmitting AIDS during sexual activity.

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ADVERTISING HETERO HORROR: AIDS PSAs

with thanks to Toronto's Epicene, May, 1987

The Canadian Public Health Association (CPHA) has produced four television public service announcements (PSAs) on AIDS, in each official language, which manage to offend both the gay community and religious moralists. The ads, which cost $200,000, were funded by the government. All of them assume a heterosexual audience and none conveys guidelines for safer sex. Three of the ads advise viewers to avoid sexual contact with more than one partner--or to use condoms. The fourth PSA, which does not mention condoms, shows a middle class family scene. "Our commitment to each other means we're not at risk," says the husband; the wife responds that "our example and some factual information are the best protection we can offer [the kids]." A private broadcasting industry advisory committee on commercials, the Telecaster Committee of Canada (TCC)--which includes CTV—decided to approve this ad. The other three PSAs are unacceptable, TCC says because they condone casual sex. The CBC has decided to run all of them. Bob Tivey, executive director of AIDS Vancouver, says the CPHA's ads give "a lot of people a false sense of security." The week before the PSAs were screened for the press, Bishop Bernard Hubert, president of the Canadian Conference of Catholic Bishops, lobbied the heads of major media outlets in opposition to ads advocating the use of condoms.

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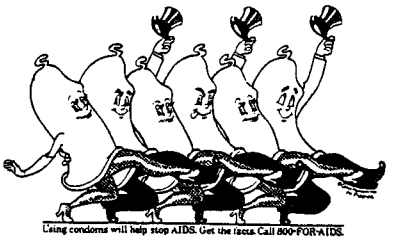

DANCING CONDOM T-SHIRTS

with thanks to Los Angeles Computerized AIDS Information Network (CAIN), 5/9/87

The Safer Sex Is Great Sex t-shirts with their chorus line of dancing condoms are now available. In an effort to promote safer sex through humor, designer Valerie Randall created dancing condoms to benefit the San Francisco AIDS Foundation (SFAF). The shirts are sold only by mail order, with $3 of the purchase price from each one donated to the AIDS Foundation. Presence, Randall's company, developed the logo and silkscreened it in six colors on white 100% cotton t-shirts. "Our approach is education through humor and is easier to confront than the frightening news we read everyday in the papers," says Randall. "The reaction from everyone who sees the dancing condom t-shirt is great! The logo suggest direct action to take against AIDS and other sexually transmitted diseases. It's a serious subject, but presenting the facts with a little humor gets people's attention. Ron DeLuca, Development Director of the SFAF, has officially authorized Presence to use the SFAF's name in promoting the shirts. "Even the U.S. Surgeon General promotes the use of condoms in stopping AIDS," says Randall. "It's a nationwide concern and we hope to educate people to stop the spread of disease, not to panic." For more information about the t-shirts, or to order call the Presence 24-hour line at 415/928-8676, or mail your name, address and telephone number with $12 plus $1.75 per shirt for shipping (and local sales tax for California residents) to: Presence, 1850 Union Street #114, San Francisco, CA 94123. Please specify size as S, M, L, or XL.

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AGENCY QUITS OVER OFF-COLOR COMMENT

by Peg Byron, with thanks to The Washington Blade, 3/6/87

An off-color AIDS comment by a condom manufacturer prompted its advertising agency to resign from the account in February. Della Femina, Travisano & Partners, Inc., denounced a remark by the head of the makers of Lifestyle Condoms, published in a Time magazine article at that time. "AIDS is a condom marketer's dream," the magazine quoted John Silverman, president of Ansell-Americas, as saying. Silverman has since tried to indicate the quote was out of context but has not denied it. Another executive for the firm told the Wall Street Journal the company was considering firing the ad agency anyway. Jerry Della Femina, chairman of the Madison Avenue ad firm, called Silverman's remark "contrary to everything we believe in." In a statement issued by his office, Della Femina also said AIDS "isn't a marketer's dream; it's a human nightmare and we choose not to work with anyone who believes otherwise."

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MEAL CARDS & CONDOMS

with thanks to Detroit's Cruise, 5/13/87

Students at the University of Washington can now purchase condoms with their dormitory meal cards. The campus convenience store, run by the University's Housing and Food Service Department, received its first case of condoms last month and has sold 42 of the 50 boxes. "They'll stay there until we're asked to have them removed," campus food service Director Joe Xavier said recently. "Right now, no one has said anything." The store doesn't take case. Purchases must be made through the "A La Carde" program, in which students put money into a fund that is accessed through the form meal card. This is the first time condoms have been sold at the convenience store. "It's a health issue," he said. "I think throughout the country there's AIDS awareness. I'm sure that's the reason," he said.

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NEBRASKA STUDENTS GIVE OUT CONDOMS

by Lisa M. Keen, with thanks to The Washington Blade, 4/10/87

The Gay/Lesbian Student Association at the University of Nebraska in Lincoln distributed free condoms during "National Condom Week" in February--but not without some controversy. According to the Coalition for Gay and Lesbian Civil Rights' newsletter, university officials attempted to bar the distribution of the condoms by citing a 1943 statute that made it unlawful to "sell, give away, or otherwise dispose of any prophylactics except by license." The gay student group pointed out that the statute had been declared unconstitutional in 1983, so the university officials sought a temporary restraining order from the Lancaster County District Court. Judge Donald Endacott, who had declared the 1943 statute unconstitutional, denied the university's request.

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FLAVORED GELS FOR CONDOMS

with thanks to Detroit's Cruise, 3/4/87

A Tasty Kind of Love, a flavor gel designed to eliminate the harsh rubber taste of condoms for those that enjoy oral sex has been introduced. "The question that kept on coming up at safe sex forums I attended was why can't condoms be flavored. The condom manufacturers don't care, so I decided to develop this product," said its creator Jeff Satkin. The water based gel comes in a plastic tube and is designed solely for oral use and is not designed to be a lubricant. The gel flavor is a FDA approved natural flavor blend. A tube costs $5.95 plus $1.50 shipping and is available from A Tasty Kind of Love, Inc. [ED NOTE: No word as to whether the gel also has nonoxynol-9]

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CONDOM HISTORY REVEALED

by Lisa M. Keen, with thanks to The Washington Blade, 3/6/87

The March Discover magazine reports that 2000 years ago the Chinese constructed condoms out of oiled silk paper. Roman soldiers, it says, reportedly made their condoms using the muscles of their slain enemies. Referring to a new book on the history of the condom, the magazine notes that the oldest condoms made from animal tissue were discovered just a few years ago in the ruins of a castle in Warwickshire, England, apparently discarded in the 1600s. Condoms apparently got their name from a "Dr. Condom or Condon," says the magazine, who reportedly crafted one for Charles II, who ruled England in the late 1600s. While the early animal-tissue ones were "not unlike tobacco leaves," the 19th Century versions were "made of animal intestine that was soaked in water, then turned inside out, soaked in a weak alkaline solution, scraped, disinfected with vapor from burning brimstone, washed, blown up, dried, cut to a length of six or seven inches, and ribboned at the open end." "Clearly," states Discover, these 19th Century versions "weren't playthings of the poor."

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FORCE "UNMARRIED" MEN: WEAR CONDOMS

by Kim Westheimer, with thanks to Boston's Gay Community News, 3/15-21/87

Legislation should be introduced to make it mandatory for unmarried men to wear condoms during intercourse until an effective and safe AIDS vaccine is found and approved, claims a local group in Los Angeles. "There are some people who have caused more deaths than a terrorist. We call them the AIDS TERRORISTS," states the AIDS Prevention Project, in a February 24 press release. "These people know they have AIDS but still practice unsafe sex. This law would give people the legal right to demand safer sex." "It would be very difficult to enforce," acknowledged Alex Franco, spokesperson for the AAP. But, contends the organization, "For those refusing to wear condoms, the penalty would most likely be AIDS." The AAP is primarily a group of "concerned parents," said Franco.

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CUTE CONDOM COMMERCIALS

with thanks to Detroit's Cruise, 3/25/87

Ah the clever condom marketers. When the networks refused to clear the way for contraceptive advertising, at least one condom company said (paraphrased): "Contraceptives? Gracious no! These prophylactics prevent AIDS, not babies." The campaign for Ansell-Americas' LifeStyles condoms shows a woman saying she's afraid of AIDS, then notes that the Surgeon General has determined "proper use of condoms can reduce your risk." While this spot was still rejected by the networks, it's "we are not selling contraceptives" technique has already influenced a new generation of condom commercials. Here's a peek:

SCENE: A sunny beach, a young man and woman walk along the edge of the water.
MAN: Look, honey. There's a jellyfish!
WOMAN: Yikes, I've heard they sting. But wait— that's not a fish at all. It's a Modern Romance rubber.
MAN: Why so it is. It looks so lifelike. I'll bet those condoms would make a great addition to the aquarium.
WOMAN: You genius! With all the Modern Romance varieties, we could have rippled sea anemones, squiggly jellyfish and brightly colored glowworms— without the fuss!
MAN: Let's hurry home to our aquarium, hon.
WOMAN: You're so spontaneous. Hooray!

SCENE: A suburban driveway, a young woman is trying to start her car. The handsome neighbor offers to help.
MAN: What seems to be the problem, Gloria?
WOMAN: It's my nephew's birthday and a dozen 2nd-graders will be here any minute. I wanted to decorate the place, but I haven't got any balloons.
MAN: Try one of these.
WOMAN: A Heartbeat condom? Great idea! (She blows it up). Why-- it's perfect. Got any more?
MAN: I always keep some around for emergencies.
WOMAN: Smart thinking. Hey— could you tie this into one of those little poodles?
MAN: Ouch!

SCENE: The high school prom, a girl is dancing with her date.
WOMAN: What a dreamy evening!
MAN: Sure is. Only one thing left to do...
WOMAN: I know. I can hardly wait. I've got the Hold-Tite condoms.
MAN: I've got the M&Ms. We should probably start filling them now.
WOMAN: I sure am glad we volunteered to be on the door prize committee. These candy-filled condoms will delight everyone.
MAN: And Hold-Tites hold just the right amount.
WOMAN: More economical than Baggies!
MAN: Let's go hand them out.
WOMAN: Right on-- but don't forget to save one for yourself!

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TREATMENT NEWS FROM PROJECT INFORM

by John S. James, with thanks to AIDS Treatment News, 3/13/87

Project Inform, one of very few organizations willing to collect and disseminate information about medical treatments for AIDS and ARC not yet approved by the U.S. Food and drug Administration, has become a unique resource center. In phone and mail contact with thousands of patients and hundreds of physicians and scientists, this organization may be the first anywhere to spot certain themes of trend concerning what treatments people are using, and which ones seems to be most successful. We interviewed some of the founders and staff of Project Inform, asking them for information which might be useful to our readers. Project Inform, a community organization based in San Francisco, is sponsored by the non-profit Documentation of AIDS Issues and Research Foundation, Inc. (DAIR). Although officially a project of DAIR, Project Inform is in fact autonomous. Existing independently before its affiliation with DAIR, Project Inform sets its own policy, raises its own money, and is the larger and more widely known of the two organizations. Project Inform first came to public notice by organizing an "underground" medical research study, of the effects of a combined AIDS/ARC treatment consisting of an antiviral and an immune modulator (ribavirin and isoprinosine). Official researchers strongly prefer to study a single drug at a time, and they had not researched the combination therapy despite a growing expert consensus that it was appropriate. Later, some of the members started BARIG, the Bay Area Ribavirin Interest Group, which organized monthly trips to Mexico to purchase ribavirin at a special group price. BARIG no longer operates because the manufacturer of ribavirin, ICN Pharmaceuticals, no longer makes the group price available. Last June, Project Inform received a grant from ICN to hire a research professional to analyze the results of its study of ribavirin and other alternative treatments. The first group of questionnaires has been compiled, and the tabulations are being analyzed. Project Inform currently provides information on six different treatments: antivirals ribavirin and d-penicillamine; immune modulators naltrexone, isoprinosine and DNCB; and aerosol pentamidine for prevention of pneumocystis. Two other treatments now being considered but not included in the official list at this time are AL 721 (antiviral) and immuthiol (immune modulator). The organization has an office in San Francisco which answers about 75 phone calls and mails 40 to 50 information packets per day. In other cities--including New York, Chicago, Tulsa, and Long Beach--it is helping local groups develop similar treatment-information. Project Inform can only supply information about the six treatments above. You may reach Project Inform (800/822-7422; in California, 800/334-7422; 415/928-0293) to obtain a packet of treatment information. Physicians can request a much more detailed packet-- including a bibliography of over 500 medical papers on ribavirin going back to 1972. Some of the important themes from Project Inform staff include:

>There is a growing consensus that treatment should begin at the earliest reasonable time. By monitoring changes in T-cell subsets and other blood parameters, physicians can spot early signs of trouble. Patients can then make decisions about beginning treatments.
>Patients need a physician who will support and help them pursue a future. The attitude could be something like "let's try to find out how to keep you alive." If a doctor seems to write a patient off as dead, the patient may set out to find another doctor.
>Patients often want to participate with their physicians in evaluating treatment options, and to choose among them. They have a right to know, to follow the research, have an opinion, and get physicians to discuss their choices.
>Many scientific and medial experts believe that multiple treatments for HIV infection will be necessary. Unfortunately, official AIDS research has only recently begun to test a combination antiviral and immune restorative treatment, a strategy long urged by Project Inform and others.
>There is also a growing belief among physician researchers in the need to combine more than one antiviral tactic, not necessarily at the same time. In addition, Project Inform is increasingly hearing from people who are using more than one immune modulator. Fortunately, the ones being combined are usually mild, such as naltrexone, isoprinosine, and DNCB, and project Inform has not heard of any problems due to drug interactions.
>Many patients at risk for pneumocystis will want to consider preventive treatment with pentamidine aerosol. Many patients define being at risk as including those who have serious ARC, and others with very low T-helper cell counts, as well as those who have already had pneumocystis, or who are beginning chemotherapy for KS.

Physicians and patients should be aware of this new aerosol pentamidine preventive treatment, which appears to be close to 100% effective in preventing pneumocystis with practically no side effects, and apparently no interactions with other drugs. Project Inform can refer physicians to experts who can answer their questions about how to use this treatment. A number of persons taking AIDS are also using aerosol pentamidine, as the rules of the AZT clinical trial permit its use.

>Project Inform is seeing a growing belief in the use of acyclovir, either in combination with AZT or ribavirin, or alone to prevent or treat certain opportunistic viruses.
>A Congressional committee or other investigative body should devote full attention to what is going on with AL 721. This promising, inexpensive, and completely safe antiviral has suffered from severe and unjustified delays in research and in availability to patients. Baffling delays in approval of ribavirin by the U.S. Food and Drug Administration also need investigation.
>Certain attitudes are helpful or harmful. Avoid the "Treatment of the month club;" instead, choose knowledgeably and give a treatment a chance to work (not ignoring side effects, of course). Long-term, consistent use is important. Many treatments take six weeks to three months before they have an effect. Preventive treatments, of course, may never show proof that they have worked.

A central theme of Project Inform is that patients have a right to take an active role. Nobody has the answer on AIDS treatment. Patients and physicians urgently need better access to information and expert advice-- especially for persons who are antibody positive and are considering treatment options now. Project Inform exists because we cannot wait for certainly, but must use the best information available.

For more information about subscriptions to AIDS Treatment News, send $25 per quarter to: John S. James, P.O. Box 411256, San Francisco, CA 94141, or call 415/282-0110.

TREATMENT: ETHICS & ACCESS

by Don Gorman, with thanks to DAIR Update, April, 1987

Persons with life-threatening illnesses are denied the use of potentially life saving medications owing to restrictive Food and Drug Administration (FDA) guidelines for investigational drugs (INDS). Drugs proven reasonably safe, though not yet proven effective, are subjected to lengthy test trials. Even safe and effective treatments are subjected to inordinate delays (2-5 years) before receiving approval by the FDA. Mike Shaffer, FDA spokesperson, has stated that the FDA cannot process all the applications it receives and the wait for drug approval continues to increase (Hirschman, 1986). Physicians are unable to obtain medications felt to be useful for certain patients. Persons with life-threatening illnesses such as Acquired Immune Deficiency Syndrome (AIDS), where no treatment has yet been certified as effective, are not afforded the option to try a medication that may offer some benefit. Experimental treatment studies are limited and half of participants are given placebos in order to fulfill control group requirements. Patients may be restricted from participation in research studies due to inconvenience, expense or failure to meet study criteria. Gieringer (1986) states that regulation imposes costs and delays on the development of new drugs. Certain drugs with "orphan drug" status (of unique value to special patients) are not placed on the market for economic reasons as their potential sales are too small to cover costs of FDA testing requirements.

This problem is an issue for physicians and researchers. Some doctors would like to make experimental treatments available to their patients while others fear an increase in quackery. Many researchers fear that increased availability of experimental treatments would threaten drug testing procedures. Increased availability of experimental treatments requires decentralization of FDA regulation, which threatens its power and control. Drug companies stand to profit by decreased FDA regulation as this would improve free market capabilities. Most importantly, this problem is an issue for people with AIDS, AIDS related conditions (PWAs/ARCs) and other life threatening diseases in situations where effective treatments are unknown. Persons in these situations need the freedom to take greater responsibility for their care, take greater risks and make informed decisions in conjunction with health care providers--choices that are potentially life sustaining.

A Question of Ethics

My position is that it is unethical to deny patients with life threatening illnesses the use of potentially life saving medication. INDs in stage III clinical trials (see Appendix A for definition) should be available for compassionate use, especially when the alternative without treatment is death. I agree with the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1983) that, "as and ethical matter, the principle of self determination implies as a corollary, the responsibility of individuals for their choices." With increased risks and wider freedom of choice, the idea of "informed consent" is imperative. The responsibility for this must be shared between individuals and their health care providers.

Support for this Position

It could be argued that pursuit of life sustaining therapies is a constitutionally guaranteed right. This is the position by Brandt in his book Ethical Theory (1959), that human beings have a 'prima facie right' to that which offers positive assistance for maintenance of life. In 1962, when new legislation required that drugs be proven not only "safe", but "effective", this was opposed by the American Medical Association (AMA) as a violation of patients freedom of choice (Gieringer, 1986).

The law permits obtaining unlicensed drugs from foreign countries and transportation of these drugs into this country in quantities for personal use. It is also legal for physicians to monitor patients using these medications. Several prominent physicians and AIDS researchers are on record as stating they feel this is ethically correct (Novick, 1985 and Levine & Bermel 1985). Given this situation, we must recognize the different standards being applied to those with the resources to travel and obtains drugs vs. those who might be able to afford the drugs but are not well enough or lack funds to travel. Sellars and Hospers (1952) discuss the questionable ethics involved with the application of double standards. It is my position that when life is compromised owing to the application of a double standard, there is little to question that unethical restrictions exist.

There is a great deal of support to allow for the use of untested drugs by dying persons who request them. Dr. Matilde Krim, chairperson of the AIDS Medical Foundation believes that certain experimental treatments should be supplied for compassionate use by individuals who do not qualify for clinical trials. She asks, "What is to lose?" (Grady, 1986, Aug.). Again, she is on record as saying it is immoral to give people

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TREATMENT: ETHICS, continued

nothing when there is potential benefit from treatment under investigation (Chase, 1986, June 18). Dr. Clyde Crumpacker (Boston AIDS researcher) agrees with the necessity for placebo controlled studies but believes in compassionate use of experimental treatments by dying patients when requested. He states, "the care of the patient has to come first" (Guilfoy, 1985). The FDA has been accused of lacking compassion in disregarding personal values and attitudes concerning risk (Gieringer, 1986). Even H. Meyer, Md, (1986) Director of the Center for Drugs and Biologics of the United States Public Health Service in Washington D.C. has stated that "patients cannot be asked to tolerate unnecessary delays in the release of drugs that offer hope of curing or improving the illness".

The Opposing View

The opposition argues that making experimental treatments available on a compassionate use basis will lower testing standards and that individuals would not participate in double blind studies if they could obtain the treatments without restriction. Current establishment control would be weakened and there is resistance to this within the government. Other arguments which exist are that liberalized uses of INDs will create possible harm to persons using them and that persons in life threatened conditions will be at increased risk of quackery. Hirschman (1986) points out that presently there is no punishment incurred for delaying drug release by that if FDA approval is granted and something goes wrong, the are responsible.

An Answer to the Opposition

Certainly it is reasonable that medications be made available by licensed personnel in order to protect against quackery. It is also important that individuals utilizing IND treatments be monitored by licensed personnel. There is no need that increased availability of INDs for compassionate use be exclusive of double blind studies. However, there would need to be offers of compensation for volunteers and allowance for drug companies to charge for IND use, which is not presently allowed (Gieringer, 1986). This would also be consistent with the free market and consumer choice approach. INDs being used on a compassionate use basis could provide additional data to double blind studies. Miotke (1986) suggests that decentralization of FDA authority to non-governmental bodies, i.e. committees of experts at medical centers, hospitals and/or universities, would allow post market surveillance of drugs which has reached Phase III testing. Of course, if adverse effects were discovered at any time to outweigh benefits, the FDA could recall a medication from use. Additional methods for testing a drug's effectiveness advocated by Dr. Krim are: Using a patient's own medical history to measure drug effectiveness and a chart audit of persons not doing the treatment, also known as historical controls (Chase, June 18, 1986).

The fear that an experimental treatment may cause harm is greatly diminished by the time it reaches stage III trial, in that persons needing such treatments are already in life threatened conditions, the benefit outweighs the risk. And yet the current FDA approval system can actually contribute to the harm to individuals by denying them the potential benefit of such drugs (Gieringer, 1986).

The liability issue would have to be assumed in greater part by the patient for use of INDs. Responsibility could be acknowledged with a true informed consent. Presently, informed consent is a generally acknowledged requirement for treatment, by patients often have unrealistic expectation of treatments and new technologies (Hutzler, 1986, June). Current and up to date information re. INDs in use could be made continuously available to consumers who, in conjunction with their physicians, could decide whether or not to continue treatment. In such a situation the FDA no longer bears sole responsibility and liability for drug effectiveness. Drug companies would no longer be required to sustain the inordinate financial burdens created by current testing requirements. Finally, patients in life threatened conditions would no longer be victimized by excessive restrictions and delays.

Conclusion

In terms of ethical theory, the FDA'S's monopoly on drug regulation resembles the situation described by egoistic ethical theory. There is a sense of "blatant egoism" in that there is a monopoly, and the FDA being a government institution, is in a position to make the rules. These restrictions fostered by the FDA under the guise of consumer protectionism guarantees complete FDA control and resembles the "unpleasant form of enlightened egoism". The methods I have proposed for drug testing and availability for persons

(Continued)

TREATMENT: ETHICS, continued

in life threatened situations are characterized by the "utilitarian" theory, i.e. they create the greatest good for the greatest number. The President's Commission for the Study of Ethical Problems (1983) has stated that it is the moral obligation of society to ensure that adequate health care be accessible to individuals without subjecting them to excessive burdens. Presently, the system's refusal to allow consumer choice re the use of INDs when the alternative is death constitutes 'excessive burden'. I believe I have also demonstrated the benefits to society and the individual of FDA reform in testing INDs. It is clear that compassion and responsibility are not mutually exclusive (Grady, 1986).

The FDA's monopoly on drug testing and regulation is inconsistent with free market enterprise. Private consumer groups actually have the best incentives to oversee availability without delays. And, as Gieringer (1986) plainly states, informed consumer choice regarding drug efficacy would eliminate the economic and ethical dilemmas of the present regulatory system. The subject of FDA reform has been advocated for may years. The experience of so many PWAs/ARCs has demonstrated that current FDA restrictions on the use of INDs are not defensible from any position, whether scientific, economic or ethical.

References:

Brandt, R.B. (1959). Ethical Theory. Englewood Cliffs, N.J.: Prentiss-Hall, Inc.

Chase, M. (1986, June 18). Aids Research stirs bitter fight over use of experimental drugs. The Wall Street Journal p. 25.

Gieringer, D.H. (1986, May 20). Compassion vs. control: FDA investigational drug regulation. Policy Analysis (no. 72) Washington D.C.: Cato Institute.

Grady, D. (1986, Aug.) Look Doctor, I'm Dying. Give Me the Drug. Discover. pp. 78-86.

Guilfoy, C. (1985, May 11). Aids conference ponders the ethics of research. Gay Community News. p.1, 12.

Hirschman, D. (1986, July 23). US Doctors Decry 'Absurd' FDA Delays in Approving Drugs. San Francisco Examiner.

Hutzler, J.C. (1986, June). When is a Research Procedure Ready for Clinical Application? Transplantation Proceedings, Vol XVIII, No. 3, Suppl. 2 pp 78-79.

Levine, C. & Bermel, J. (Eds.). (1985, Aug.). Aids: The Emerging Ethical Dilemmas. (A Hastings Center Report Special Supplement) New York: Institute of Society, Ethics and the Life Sciences.

Meyer, H.M. (1986, Aug. 26). Seeking AIDS Cure. San Francisco Examiner, Editorial.

Miotke, J. (1986). Widening the Distribution of Experimental AIDS Treatments. Unpublished master's thesis, University of California, Berkeley.

The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. (1978). Ethical Guidelines for the Delivery of Health Services by DHEW. (DHEW Publication No. 08 78- 0010). Washington DC: US Government Printing Office.

Novick, A. (1986, Jan 19). Ethical Considerations in the Administration of Unlicensed Drugs for Persons with HTLV III Infection. Presented at the meeting of the New York Physicians for Human Rights.

Presidents Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavorial Research (1983). Securing Access to Health Care. Vol. 1. Washington DC: US Government Printing Office.

Sellars, W. & Hospers J. (1952). Readings in Ethical Theory. New York: Appleton-Century-Crafts, Inc.

Appendix A:

Phase I, to study the drug's toxic effects on on healthy people.

Phase II, to determine its efficacy on a small, carefully selected target population.

Phase III, to measure efficacy in a larger (up to 3000 subjects) target population.

[DAIR is the Documentation of AIDS Issues and Research Foundation, Inc. of San Francisco. To subscribe to DAIR Update, write to: 2336 Market St. Suite 33, San Francisco, CA 94114.]

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NCGSTDS IN CONGRESSIONAL RECORD

Thanks to Congressman Gerry E. Studds of Massachusetts, the Surgeon General's Report on AIDS was recorded in its entirety into the Congressional Record of March 26, 1987 (pp. E1152-1157). Under "additional information" in the report are the names, addresses, phone numbers of some of the AIDS resource organizations, including the NCGSTDS and its chairperson, Mark Behar. Due to the NCGSTDS' listing, scores of requests for more information, primarily from students doing reports, have been received. Until recently, all such requests have been forwarded to the National Gay/Lesbian Clearinghouse & Crisisline/AIDS 800—projects of the Fund for Human Dignity. The NCGSTDS now sends a form letter with the names of several national and local resources so a person can expend his/her own time in getting information.

AAPHR ANNUAL MEETING

The Annual Meeting of the American Association of Physicians for Human Rights (AAPHR) and AIDS Update is taking place at the Hyatt Regency Hotel in Minneapolis, August 4-7. In addition to multiple presentations of general interest on AIDS, and other gay and lesbian health issues, an award to Mathilde Krim, paper/poster sessions, a Mississippi River dinner cruise, and additional events. Included with this Newsletter are pamphlets describing the conference. For additional information, contact: Diane Campbell, MD, Conference Coordinator, 4600 Park Av., South, Minneapolis, MN 55407, or call Hanan Rosenstein, MD, 612/824-1772.

BIOLOG. WARFARE AIDS CONNECTIONS?

by Bob Lederer, with thanks to Boston's Gay Community News, 4/26-5/9/87

The Pentagon has issued contradictory statements as controversy grows over allegations of a biological warfare connection to AIDS. On March 30, the Soviet news agency TASS repeated earlier reports of a study by two East German microbiologists, Jakob and Lilli Segal, concluding that AIDS was caused by a genetically-engineered virus. The Segals argue that the virus may have been created and spread accidentally by the U.S. Army's Biological Warfare Laboratory at Fort Detrick, near Frederick, Maryland. According to this theory, the virus was experimentally injected around 1977 into "volunteer" prisoners, who after several months without symptoms, were released and unknowingly spread the disease. The Soviets have also cited two other doctors, one British and one North American, who maintain that HIV, the putative virus considered by many to trigger AIDS, could only have been created by laboratory splicing of two infectious animal viruses. However, the doctors, citing several medical journal articles, believe the virus may have been created in civilian rather than military labs engaging in cancer research. US military and diplomatic spokespeople have repeatedly issued heated denials of the Soviet charges, labeling them "an insidious disinformation campaign." But in elaborating their denials most recently, Pentagon officials have admitted a Ft. Detrick role in AIDS research, and have also contradicted each other. The Philadelphia Daily News reported on February 18, 1987, that Col. David L. Huxsoll, chief of the u.S. Army Research Institute of Infectious Diseases at Ft. Detrick, stated at a press conference that his facility had begun assisting the National Institutes of Health with AIDS research. "We are now looking at the anti-AIDS possibility of materials at our laboratory," Huxsoll reportedly said. In denying the Soviet charges, the official added, "Studies at the Army laboratories have shown that the AIDS virus would be an extremely poor biological warfare agent." No further details of these studies were provided. However, according to the New York Times of April 8, a Pentagon report on AIDS only acknowledges Ft. Detrick's role in testing the drug ribavirin against AIDS, claiming that the lab "had no other involvement in AIDS research." The government document reportedly added that "the Ft. Detrick facility never conducted any experiments with the AIDS virus in the course of its earlier biological warfare research." What neither statement mentioned was that Ft. Detrick's involvement in AIDS research is not a recent development. Since 1983, the "Frederick Cancer Research Facility"—the allegedly "civilian" part of Ft. Detrick— has done such work as part of the AIDS Task Force of the National Cancer Institute (NCI), directed by Dr. Robert Gallo. For years, this fact has been openly discussed, though not publicized, in Congressional budget hearings. It resurfaced during the recently settled lawsuit against the NCI and Gallo by the Pasteur Institute in Paris. Gallo was accused of using Pasteur's specimens of HTLV-III (now called HIV) to falsely claim credit for "discovering" the virus and to claim the royalties from the HIV antibody blood test. On Feb. 8, 1987, lawyers for the Pasteur Institute were to present in court two different copies of a letter sent from scientists at Ft. Detrick to Gallo's lab concerning HIV virus research. In one version, certain key information had been blacked out. As the British magazine New Scientist of Feb. 12 reports, "the copies of the letter provide powerful evidence that someone has tampered with scientific data." Pasteur lawyers were preparing to demand original documents from Ft. Detrick. However, at that point Gallo and the NCI agreed to settle the suit by sharing credit for "discovering" HIV with the Pasteur Institute. On March 31, US President Ronald Reagan and French Prime Minister Jacques Chirac announced the settlement, which splits the profits from HIV antibody tests between the two countries. It was the first time Reagan had ever publicly uttered the word "AIDS" since the epidemic was named in 1981. The question of the altered letter was never pursued. The Ft. Detrick installation has a 40 year history of biological warfare research. In 1969, President Nixon claimed that the US was ending the biological warfare program and Ft. Detrick would be converted into a National Cancer Institute lab. But a recently settled lawsuit by the Foundation on Economic Trends, a Washington-based environmental group, forced the Dept. of Defense to admit that secret biological warfare research continues at Ft. Detrick and 127 other government and university sites around the country. On Feb. 17, 1987, the Federal court for the District of Columbia approved the settlement requiring all such labs to prepare environmental impact statements within 21 months. One of the activities acknowledged to be occurring at Ft. Detrick was the creation of new viruses by genetic engineering. America's historic use of biological and chemical warfare against so-called "enemy" countries has been well documented. Among the poisonous agents unleased by the US military were anthrax, plague and yellow fever in North Korea in the 1950s, Agent Orange (a highly toxic herbicide thought to cause cancer) in Vietnam in the 1960s, African Swine Fever in Cuba in 1970 and 1980, and dengue fever in Cuba in 1981. Often these toxins were sprayed from the air; the African Swine Fever Virus was brought in on foot by CIA-employed Cuban exiles who infected pig feed with it (Covert Action Information Bulletin, Summer, 1982). In each case, many people became seriously ill and some died. More recently, Nicaragua has been investigating the possibility that the 1985 outbreak of dengue fever along its Honduran border may have resulted from the release of infected mosquitoes by US reconnaissance overflights. The East German study alleging a biological warfare origin to AIDS has been covered periodically since 1985 by the international press, but rarely byt he US mainstream media. However, after the renewed TASS publicity on March 30, the Associated Press put the story, accenting the US denial, on its North American and international wires, and it was reported by CBS televison's evening news broadcast. Over the years, gay newspapers have periodically speculated about biological warfare theories. So have some right-wing journals. In fact, the two doctors cited by the Soviets, John Seale of London and Robert Strecker of Los Angeles, ironically hold extreme right-wing views. They believe that the AIDS virus, rather than being a product of US biological warfare research, was engineered in Soviet-instigated cancer research experiments and then spread with Soviet complicity to attack the US population. Seale's theories have been publicized by Lyndon LaRouche's organization, known for its racist, Anti-Semitic and anti-gay views. [NCGSTDS ED NOTE: Isn't it interesting how we interpret this last bit of information as severely challenging the credibility of the entire thesis?!]

ORAL SEX LOW RISK ACC'D TO STUDY

by Lou Chibbaro Jr. with thanks The Washington Blade, 3/27/87

An article published in a February, 1987 British medical journal The Lancet once again confirms earlier medical reports that anal intercourse appears to represent the most serious risk of contracting the virus that causes a while oral sex appears to represent a low risk for acquiring the AIDS virus. The Lancet article, based on a study conducted by researchers affiliated with four universities and Chicago's gay-oriented Howard Brown memorial Clinic, states that "receptive anal intercourse" accounted for nearly all new infections of AIDS among a group of 2507 gay and bisexual men. The article reports that all of the 2507 men tested HIV antibody negative at the beginning of the study. At the end of a six month period, 95 men, or 3.8%, tested positive. Among the men who reported that they did not engage in receptive anal intercourse six months before they were first tested and six months after they were tested, only 0.5% tested positive. Among those 0.5% who tested positive, all said they engaged in either receptive or insertive anal intercourse prior to the six-month period calculated in the test results, the article said. In contrast, the article states that among those who said they engaged in receptive anal intercourse with two or more partners during each of these six month periods, 10.6% tested positive. Those who reported having receptive anal intercourse with 5 or more partners had an 18-fold greater risk factor in contracting the AIDS antibody, the report states. No one tested positive among the men engaging in "receptive oral intercourse" with a t least one partner but who had not engaged in either receptive or insertive anal intercourse. "The absence of detectable risk for seroconversion due to receptive oral-genital intercourse is striking," the article states. As in previous studies, the researchers who prepared The Lancet article cautioned that the sample size of those who seroconverted—95—is relatively small and that it is possible that a larger sample would detect oral sex as a potential risk factor. The article noted that oral sex and other sexual practices in which little or no correlation could be made for HIV seroconversion—among them enema or douche use before sex, fisting, and dildo use—"are all potentially unsafe." "HIV infection apart, many of these practices have already been associated with other sexually transmitted diseases that present a public health threat to [homosexually active males]," the article states. The article's principal author is Dr. Lawrence A. Kingsley of the Graduate School of Public Health, University of Pittsburgh; other researchers were from the following institutions: Johns Hopkins University in Baltimore, University of California—Los Angeles, and Northwestern University in Chicago.

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ANAL SEX [WITHOUT CONDOMS] RISKY

[NCGSTDS ED NOTE: In this press release from the Johns Hopkins Medical Institutions, the distinction between unprotected and protected (with condoms) is never made. It appears, that the prestigious MAC Study neglected to make this distinction; therefore, any mention of anal intercourse does not refer to condom use. Therefore, nothing can be said about the role of condoms! Que loco!]

Results of a new multicenter study offer the strongest evidence yet that avoiding anal intercourse is the best way for sexually active gay men to reduce their risk of infection with HIV, the virus that causes AIDS. Moreover, the study further confirms that the risk of new HIV infection rises dramatically with an increase in the number of sexually active partners who engage in anal intercourse. In the study, reported in the February 14 issue of Lancet by scientists from The Johns Hopkins School of Public Health, three other universities and the National Institutes of Health, anal intercourse accounted for nearly all new HIV infections among a group of 2507 gay and bisexual men. The investigators found that "receptive anal intercourse" was the only significant risk for HIV infection, with the risk increasing from threefold for one partner to 18-fold for five or more partners. No new HIV infections were observed in 218 men who did not engage in "receptive or insertive anal intercourse" with the year prior to confirmed infection, they said. "This study should focus the public health community on strategies to limit further spread of HIV infection by reducing anal intercourse," says the articles lead author, Lawrence A. Kingsley, DrPH, of the Graduate School of Public Health, University of Pittsburgh. "This must remain the cornerstone message of `safer sex' guidelines and large-scale community educational projects focused on reducing HIV transmission among homosexual men." Of the almost 5000 men in the Multicenter AIDS Cohort Study (MACS), scientists analyzed the reported sexual activities of 2507 who were free of HIV infection when the study began. Within the first six months of the study 95 (3.8%) became infected. In Baltimore, 3.5% (26 of 749) became infected. In the 621 men who reported that they reduced or stopped receptive anal intercourse, the risk of new HIV infection was 3.2 (reduced) or 1.9% (stopped). This contrasts with men who continued the practice with two or more partners (10.5% risk). Other than anal intercourse, no other sexual exposure appeared to increase significantly the risk of HIV infection among the men studied, including oral-genital intercourse with and without ejaculation. A small, but not significant risk was found in using enemas or douches prior to receptive anal sex because they increased trauma to the rectal area. MACS is following 4995 gay and bisexual men to examine the natural history of AIDS. When the federally funded study began in April 1984, 1835 men had been infected with HIV. B. Frank Polk, MD, MSc, professor of epidemiology, directs the Hopkins component of MACS, known as the Study to Help AIDS Research Efforts (SHARE). In addition to Hopkins and Pittsburgh, the collaborating universities are Northwestern, Chicago, and University of California, Los Angeles. The National Institute of Allergy and Infectious Diseases funds the study, which will continue at least through 1991.

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NEXT NEWSLETTER

As this Newsletter is being prepared, articles for the Summer, 1987 issue of the NCGSTDS Official Newsletter, volume 8:4, have already been collected. (You should see the pile on my desk!). Hopeful (!) publication and mailing will be in September. However, due to unforeseeable circumstances, publication may be delayed. Address inquiries and articles to: NCGSTDS, P.O. Box 239, Milwaukee, WI 53201. Thanks for your understanding!

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CENTERS FOR DISEASE CONTROL

January 30, 1987 / Vol. 36 / No. 3

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Surveillance Summary

Viral Hepatitis — 1984

Information on viral hepatitis is obtained through two surveillance systems. Incidence data are collected from cases reported to the CDC National Morbidity Reporting System by each state and territory. The number of cases, age of patient, and date reported of each type of hepatitis as classified by physician's diagnosis appear in the Morbidity and Mortality Weekly Report (*MMWR*) and the *MMWR* Annual Summary. Serologic and epidemiologic data pertaining to risk factors of disease acquisition are obtained from the Viral Hepatitis Surveillance Program (VHSP), a totally separate voluntary reporting system operated by the Hepatitis Branch, Division of Viral Diseases, Center for Infectious Diseases, Centers for Disease Control.

Morbidity Trends Based on Cases Reported to the *MMWR*

Figure 1 shows the changes in incidence of reported cases of all hepatitis since 1955 and by type since 1966. In 1984, the reported incidence of hepatitis B surpassed that of hepatitis A for the second consecutive year. Of 57,557 cases of viral hepatitis reported to the *MMWR* in 1984, 38% were reported as hepatitis A; 45%, as hepatitis B; 7%, as hepatitis non-A, non-B; and 10%, as unspecified hepatitis. Virtually no change occurred in the reported incidence of hepatitis A, while there were slight increases in the reported incidence of hepatitis B and hepatitis non-A, non-B. Combined with a decline in the rate of unspecified hepatitis, these changes have resulted in a nearly constant overall rate of viral hepatitis.

In 1984, states in the west and southwest regions continued to report high rates of hepatitis A. Historically, the major contributing factors to these high rates have been transmission of hepatitis A in day care and sustained community-wide outbreaks due to person-to-person spread. Foodborne-associated outbreaks of hepatitis A often account for large year-to-year fluctuations in hepatitis A rates. The states with the highest rates of hepatitis B are clustered primarily on the east and west coasts as in previous years. Non-A, non-B hepatitis has been a separate reportable disease category in the *MMWR* since 1982. The low reported rates for this disease are believed to be due to incomplete serologic testing and underreporting.

Persons in the 20- to 29-year age group continue to have the highest rates of both hepatitis A and hepatitis B. The risk of acquiring hepatitis A appears to have declined in persons of all age groups except those less than 15 years of age. Some of this decline may be due to increased use of available serologic tests which may have resulted in reclassification of the type of hepatitis occurring in older persons.

Although persons under 15 years of age still experience low rates of hepatitis B infection, the risk of acquiring this disease continues to increase for all other age groups. Persons in the 15- to 39-year age groups tend to be in the high-risk categories (i.e., health care workers, parenteral drug abusers, and homosexual men) for acquiring hepatitis B.

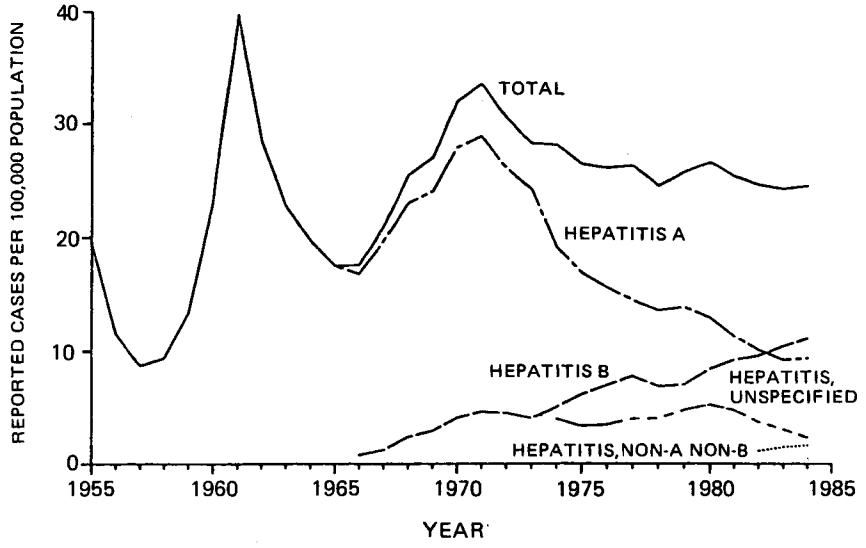
Viral Hepatitis Surveillance Program

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

The number of cases reported to the VHSP was 24,613 in 1984, representing 43% of the cases reported to the *MMWR* in the same year and down from 47% in 1983. Reporting of cases to the VHSP is not consistent among states because, while many states reporting to the *MMWR* also report to the VHSP, many of the states do not. The percentage of agreement in reporting between the *MMWR* and the VHSP, however, is not necessarily a measure of the actual completeness of reporting from a particular state. Despite the difference in numbers, the cases reported to the VHSP are similar to those reported to the *MMWR* with respect to the relative frequencies of the different types of hepatitis as well as the age distribution of the cases.

While serologic tests for diagnosing hepatitis B, including hepatitis B surface antigen (HBsAg), have been available since the early 1970's, a laboratory test for IgM antibody to hepatitis A virus (IgM anti-HAV) has only been available since 1981. The use of these two serologic tests to distinguish between the different types of viral hepatitis has increased over the past 4 years. The tendency for physicians to use both tests has increased from 27% in 1981 to 64% in 1984, while the frequency with which HBsAg is used as the only serologic test has decreased from 43% to 19%.

FIGURE 2. Hepatitis rates, by year, United States, 1955-1984



Copies of the entire Hepatitis Surveillance Report Number 50 (issued March 1986) are available from the Hepatitis Branch, Division of Viral Diseases, Center for Infectious Diseases, Centers for Disease Control, Atlanta, Georgia 30333, telephone number (404) 321-2342.

CENTERS FOR DISEASE CONTROL

February 6, 1987 / Vol. 36 / No. 4

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

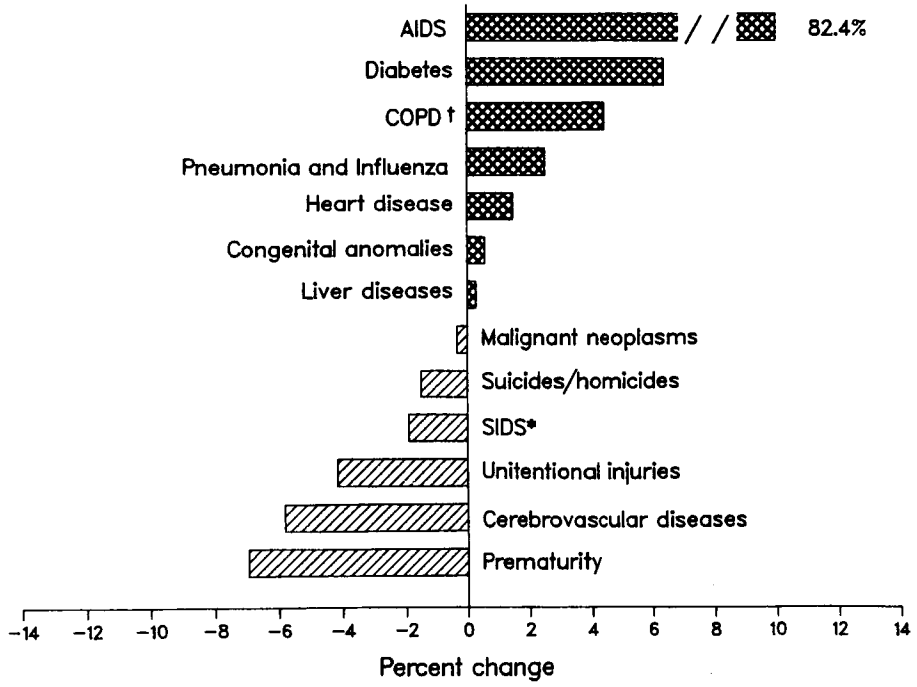
Perspectives in Disease Prevention and Health Promotion

Changes in Premature Mortality — United States, 1984-1985

Premature mortality in the United States, as measured in total years of potential life lost (YPLL) before age 65, increased from 11,788,125 in 1984 to 11,844,475 in 1985, an increase of 0.5%. This is the second straight year with an increase in total YPLL; prior to this increase, there had been 3 years of gradual decline. However, the rate of YPLL/1,000 persons has decreased every year since 1980. In 1985, the rate decreased 0.3% from the 1984 level; this is explained by an increase of 1.7 million in the number of persons under age 65 in the U.S. population from 1984 to 1985.

The rate of YPLL/1,000 persons increased for seven of the 13 leading causes. As with total YPLL, the most notable rate increase was for AIDS. Other increases in the rate of YPLL occurred for diabetes (6.4%), chronic obstructive pulmonary disease (4.5%), pneumonia and influenza (2.5%), heart disease (1.5%), congenital anomalies (0.6%), and diseases of the liver and cirrhosis (0.3%). Declines in the rate of YPLL were noted for prematurity (7.0%), cerebrovascular diseases (5.8%), unintentional injuries (4.2%), sudden infant death syndrome (1.9%), suicide and homicide (1.5%), and malignancies (0.3%) (Figure 2).

FIGURE 2. Percentage of change in rates of years of potential life lost before age 65 — United States, 1984-1985



* Sudden infant death syndrome.
† Chronic obstructive pulmonary diseases.

A major reason for the increase in total YPLL is the greater number of deaths from the acquired immunodeficiency syndrome (AIDS). The YPLL due to AIDS increased from 82,885 in 1984 to 152,595 in 1985; this represented a rate increase of 82.4%.

Death due to AIDS became the 11th leading cause of YPLL in 1985; in 1984, it was the 13th leading cause. The relative rankings of the remaining 12 leading causes of YPLL did not change. Unintentional injuries, malignancies, and heart disease continue to be the three leading causes of YPLL in the United States.

TABLE V. Estimated years of potential life lost before age 65, 1984 and 1985, and cause-specific mortality, 1985, by cause of death — United States

Cause of mortality (Ninth Revision ICD)	YPLL for persons dying in 1984*	YPLL for persons dying in 1985*	Cause-specific mortality, 1985 † (rate/100,000)
ALL CAUSES (Total)	11,788,125	11,844,475	874.8
Unintentional Injuries § (E800-E949)	2,313,048	2,235,064	38.6
Malignant neoplasms (140-208)	1,804,809	1,813,245	191.7
Diseases of the heart (390-398,402,404-429)	1,564,522	1,600,265	325.0
Suicide, homicide (E950-E978)	1,250,642	1,241,688	20.1
Congenital anomalies (740-759)	685,315	694,715	5.5
Prematurity ¶ (765, 769)	474,290	444,931	2.9
Sudden infant death syndrome (798)	316,909	313,386	2.0
Cerebrovascular disease (430-438)	266,486	253,044	64.0
Chronic liver diseases and cirrhosis (571)	233,099	235,629	11.2
Pneumonia and influenza (480-487)	163,474	168,949	27.9
Acquired immunodeficiency syndrome (AIDS)**	82,885	152,595	2.3
Chronic obstructive pulmonary diseases (490-496)	123,275	129,815	31.2
Diabetes mellitus (250)	119,555	128,229	16.2

* For details of calculation, see MMWR Supplement, Premature Mortality in the United States, December 19, 1986, Vol. 35, No. 2S. Cause-specific mortality rates were obtained from the National Center for Health Statistics, Monthly Vital Statistics Report (MVSR), Vol. 34, No. 13, September 19, 1986. Age-specific population estimates for 1984 and 1985 were obtained from the Bureau of the Census, Estimates of the Population of the United States by Age, Sex, and Race: 1980 to 1985, Series P-25, No. 985.

† Cause-specific mortality rates as reported in the MVSR are compiled from a 10% sample of all deaths.

§ Equivalent to accidents and adverse effects.

¶ Category derived from disorders relating to short gestation and respiratory distress syndrome.

** Reflects CDC AIDS surveillance data.

CENTERS FOR DISEASE CONTROL

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Epidemiologic Notes and Reports

Penicillinase-Producing *Neisseria gonorrhoeae* — United States, 1986

In 1986, 16,608 cases of infection caused by penicillinase-producing *Neisseria gonorrhoeae* (PPNG) were reported to CDC. This represented 1.8% of all reported gonorrhea and was a 90% increase over the 8,724 cases reported in 1985. PPNG incidence has risen fourfold since 1984. Sixty-four percent of cases in 1986 occurred in the three areas previously identified as hyperendemic—Florida, New York City, and Los Angeles (*1*).

New York City experienced the greatest proportional increase of PPNG incidence despite its policy of treating all patients diagnosed with gonorrhea in the public clinics with antimicrobials effective against PPNG. In 1986, 3,986 cases were reported, compared with the 1,567 cases reported in 1985—a 154% increase. The proportion of total gonorrhea attributable to PPNG was 4.3%. Outbreaks have been identified in suburban areas of New York City located on Long Island and in New Jersey and Westchester County.

In Florida, 5,629 PPNG cases were reported—34% of the national total. In Dade County (Miami), Florida, the most severely affected county in the country, reported cases of PPNG increased from 2,455 in 1985 to 2,648 in 1986—an 8% increase. In 1986, the proportion of total gonorrhea attributable to PPNG in Dade County was 22%. Excluding Dade County, reported cases in Florida increased from 1,710 in 1985 to 2,981 in 1986—a 74% increase. The number of counties in Florida reporting hyperendemic PPNG (a proportion of PPNG > 3%) rose from 16 counties in 1985 to 31 counties in 1986. These counties contain 69% of the state's population.

In Los Angeles, the number of cases increased from 488 in 1985 to 942 in 1986—a 93% increase. Another center of PPNG activity, probably representing secondary spread, has also been identified in suburban Orange County.

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Editorial Note: The incidence of antibiotic-resistant gonorrhea, and PPNG in particular, continues to increase and is spreading to previously unaffected areas. In earlier PPNG outbreaks, travel to PPNG endemic areas and prostitute contact were cited as risk factors for infection (*2*). While these factors may play an important role in the spread of PPNG disease to areas previously free of disease, once PPNG becomes endemic, it has the same epidemiologic characteristics as endemic, antibiotic-sensitive gonorrhea. PPNG patients have been predominantly inner-city residents, members of ethnic minority groups, and heterosexuals. Although high-risk groups for gonorrhea have included homosexual men, PPNG outbreaks among homosexual men are rare. The reasons for this are not entirely clear. Recent evidence from a CDC study in Miami has associated PPNG infection with inappropriate use of antibiotics (*3*).

Patients with inadequately treated PPNG infection are at high risk for complications. Women are especially at high risk for pelvic inflammatory disease. PPNG is effectively treated with ceftriaxone or spectinomycin, in doses recommended in the "1985 STD Treatment Guidelines" (*4*).

Once antibiotic-resistant gonorrhea becomes endemic, eradication is extremely difficult; it is also expensive. In these areas, all patients with a presumptive diagnosis of gonorrhea should be treated with either ceftriaxone or spectinomycin. Comprehensive recommendations for prevention, surveillance, diagnosis, and control of antibiotic-resistant gonorrhea have been recently developed by CDC in consultation with an expert advisory panel and are currently being reviewed by state and local health officials. These will be published later this spring as an MMWR supplement.

References

1. CDC. Penicillinase-producing *Neisseria gonorrhoeae* —United States, Florida. MMWR 1986;35: 12-4.
2. Jaffe HW, Biddle JW, Johnson SR, Wiesner PJ. Infections due to penicillinase-producing *Neisseria gonorrhoeae* in the United States: 1976-1980. J Infect Dis 1981;144:191-7.
3. Zenilman JM, Bonner M, Sharp K, Alexander ER. Penicillinase-producing *Neisseria gonorrhoeae* (PPNG) in Miami: etiologic roles of core group transmitters and of the illicit use of antibiotics [Abstract]. New Orleans: 26th Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC), 1986.
4. CDC. 1985 STD treatment guidelines. MMWR 1985;34(4S).

CENTERS FOR DISEASE CONTROL

March 13, 1987 / Vol. 36 / No. 9

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

International Notes

Survey of Non-U.S. Hemophilia Treatment Centers for HIV Seroconversions Following Therapy With Heat-Treated Factor Concentrates

Until 3 years ago, non-heat-treated factor concentrates were used in treating congenital and acquired clotting factor deficiencies. At that time, heat-treated factor concentrates were introduced because the unheated concentrates had been epidemiologically linked with the exposure of large numbers of U.S. hemophilia patients to the human immunodeficiency virus (HIV) (*1*). There have now been a few reports of HIV seroconversion associated with heat-treated factor concentrates (*2,3*). Because several hemophilia treatment centers (HTCs) outside the United States began using heat-treated factor concentrates somewhat earlier, a sample of major non-U.S. HTCs identified by the U.S. National Hemophilia Foundation were

contacted during November and December 1986 and asked to help estimate the continued risk of seroconversion among their patients deficient in factor VIII and factor IX. Patients with von Willebrand's disease and other clotting factor deficiencies were not included.

The directors of 13 HTCs located in western Europe, Canada, and Australia were asked to provide information concerning: 1) HIV antibody seroprevalence rates within their patient populations; 2) whether they were using, and when they had begun to use, heat-treated factor concentrate products (*4-6*); and 3) details regarding any HIV seroconversions occurring among their patients while receiving heat-treated factor concentrates. Most HTCs monitor the serologic status of their seronegative hemophilia A and B patients at approximately 3-month intervals and were confident of all these patients' serologic status as of late July 1986. Of the combined total of 2,370 hemophilia A patients and 434 hemophilia B patients served by the HTCs in this survey, over 1,300 were still seronegative when heat-treated factor concentrates became available. Approximately 50% of the seronegative patients were classified as severely deficient in factor VIII or factor IX; the remainder had either moderate or mild hemophilia*.

*Severity is defined on the basis of percent of normal factor activity: severe, < 1% of normal; moderate, 2-5% of normal; mild, > 5% of normal.

Of the 23 patients who had their first documented positive HIV antibody test after receiving heat-treated factor concentrate, 16 seroconverted within 6 months of last receiving untreated factor concentrates. The remaining seven individuals fell into three groups (Table 1). Group 1: Two patients were first found to be seropositive more than 6 months after starting to use heat-treated factor concentrate products (at 7 and 10 months, respectively). However, for both of these patients, the last seronegative test had taken place several months before their last treatment with unheated factor concentrates. Group 2: Two patients who were seronegative within the initial 6 months of heat-treated factor concentrate therapy (at 3 and 5 months, respectively) were not tested again until after the initial 6 months (at 8 and 10 months, respectively), at which time they were seropositive. Group 3: Three pediatric patients were seronegative at 8, 12, and 16 months after first receiving heat-treated factor VIII concentrate but had their first of many consistently seropositive tests at 10, 13, and 22 months after treatment, respectively.

The patients in Group 3 had no reported risk factors for HIV infection other than hemophilia and reportedly had received no other blood components during this time period. All three pediatric patients were severely deficient in factor VIII. One child, a 6-year-old, had received vials from four lots in the 10-month interim before seroconversion. He is presently asymptomatic and his reported T-cell values are normal; no HIV cultures have been attempted. The other two children, aged 4 and 13, had received large amounts of heat-treated factor VIII concentrates for extended periods either as therapy for an inhibitor or as routine care. The 4-year-old was found to be HIV culture positive in 1986 and now has AIDS. The 13-year-old had severe T-cell abnormalities by mid-1986 and now has lymphadenopathy and encephalopathy.

The many lots of concentrate received by each of the three patients in Group 3 had come from three different U.S. manufacturers. The plasma used by each of the U.S. manufacturers was collected before serologic screening of donors for HIV antibody became available. In addition, during the first 5 months of the 13-month interval before seroconversion, one of the three patients had also received extremely large amounts of heat-treated factor VIII concentrate prepared by a European manufacturer using a wet-heat process. The manufacturer had used unscreened plasma from U.S. donors.

The three patients who seroconverted (Group 3) represent 0.7% of the total 450 initially seronegative hemophilia A patients and 0.2% of the total 1,300 patients who were serologically monitored for > 1 year after beginning to use unscreened, heat-treated factor. Since November 1985, no seroconversions have been observed among the patients included in the survey.

Although information on the transition to using unscreened, heat-treated factor in each HTC is readily available, the dates of subsequent transition to using donor-screened, heat-treated factor concentrate products by each HTC are not. One HTC reported beginning to use donor-screened, heat-treated factor therapy in August 1985; however, for most HTCs, this transition occurred between February and July 1986. No cases of seroconversion following the use of donor-screened, heat-treated products were identified through this survey.

Four percent (50) of the 1,300 seronegative patients in this survey were followed for > 1 year while receiving donor-screened, heat-treated factor concentrates. Follow-up on the remainder is approaching 1 year. In early March 1987, supplemental information was obtained from eight of the 13 HTCs. These eight HTCs collectively have 60% of the seronegative patients; no further seroconversions have been found. Although over 600 patient-years of therapy with donor-screened product have elapsed without a recognized HIV seroconversion, the risk associated with unscreened, heat-treated product is so low that several more months of surveillance will be required before a statistically significantly further reduction of risk can be substantiated.

TABLE 1. Distribution of patients in surveyed non-U.S. hemophilia treatment centers, by interval between therapy with heat-treated factor concentrates and HIV seroconversion

Last seronegative test	First seropositive test after initial 6 months
Preceding heat-treated factor usage	2
During initial 6 months of heat-treated factor usage	2
After initial 6 months of heat-treated factor usage	3

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Editorial Note: Earlier published reports disclosed no seroconversions among selected hemophilia patients followed for up to 1 year after beginning therapy with heat-treated factor concentrates (*7-10*). However, during the past 12 months, published (*2,3*) and unpublished reports (personal communication, I Walker, MD, Hamilton, Ontario, Canada; FG Hill, MD, MRC Path, Birmingham, United Kingdom; G Mariani, MD, Rome, Italy) have described several hemophilia patients who had seroconverted after receipt of unscreened, heat-treated factor concentrates. In June 1986, one U.S. manufacturer (Armour Pharmaceutical Company) offered to exchange any remaining heat-treated factor VIII concentrates produced from plasma collected before the availability of a test for HIV antibody with the equivalent amount of antibody-screened product. Similar exchanges are now available through four other U.S. producers (Alpha Therapeutics, American Red Cross, Cutter Laboratories, Hyland Therapeutics).

The influence of previous exposure to allogeneic proteins and other infectious agents as well as the HIV inoculum size and differences in inoculum strain may alter the seroconversion

intervals among hemophilia patients. For this reason, it is currently uncertain whether anecdotal reports that seroconversion in other risk groups occurs within 8 to 12 weeks after exposure can be generalized to hemophilia patients (*11*). One study suggests that the vast majority of hemophilia seroconversions would be detectable ≤26 weeks (*12*). The distribution of seroconversion latency periods for hemophilia patients is not yet known. Therefore, it is uncertain whether any of the three seroconversions in persons with a documented seronegative test ≥6 months after beginning to use only heat-treated factor concentrates could be associated with the former source of exposure.

No cases of seroconversion among patients using only donor-screened, heat-treated products have been reported to date. With the exception of the HTC surveyed in Australia, less than a year has elapsed since most of the HTCs surveyed began administering donor-screened, heat-treated factor concentrates. Further longitudinal studies by several of the HTCs in this survey may substantiate the additional margin of safety provided by screening donated plasma for HIV antibody. Donor-screened, heat-treated factor concentrates remain the recommended therapy for patients requiring factor replacement.

References

1. CDC. Update: acquired immunodeficiency syndrome (AIDS) in persons with hemophilia. MMWR 1984;33:589-91.
2. White GC, Matthews TJ, Weinhold KJ, et al. HTLV-III seroconversion associated with heat-treated factor VIII concentrate [Letter]. Lancet 1986;1:611-2.
3. Van den Berg W, ten Cate JW, Breederveld C, Goudsmit J. Seroconversion to HTLV-III in haemophiliac given heat-treated factor VIII concentrate [Letter]. Lancet 1986;1:803-4.
4. Levy JA, Mitra G, Mozen MM. Recovery and inactivation of infectious retroviruses from factor VIII concentrates. Lancet 1984;2:722-3.
5. Spire B, Dormont D, Barre-Sinoussi F, Montagnier L, Chermann JC. Inactivation of lymphadenopathy-associated virus by heat, gamma rays, and ultraviolet light. Lancet 1985;1:188-9.
6. McDougal JS, Martin LS, Cort SP, Mozen M, Heldebrant CM, Evatt BL. Thermal inactivation of the acquired immunodeficiency syndrome virus, human T lymphotropic virus-III/lymphadenopathy-associated virus, with special reference to antihemophilic factor. J Clin Invest 1985;76:875-7.
7. Rouzioux C, Chamaret S, Montagnier L, Carnelli V, Rolland G, Mannucci PM. Absence of antibodies to AIDS virus in haemophiliacs treated with heat-treated factor VIII concentrate [Letter]. Lancet 1985;1:271-2.
8. Felding P, Nilsson IM, Hansson BG, Biberfeld G. Absence of antibodies to LAV/HTLV-III in haemophiliacs treated with heat-treated factor VIII concentrate of American origin [Letter]. Lancet 1985;2:832-3.
9. Gazengel C, Larrieu MJ. Lack of seroconversion for LAV/HTLV-III in patients exclusively given unheated activated prothrombin complex prepared with ethanol step [Letter]. Lancet 1985;2:1189.
10. Mannucci PM, Gringeri A, Ammassari M. Antibodies to AIDS and heated factor-VIII [Letter]. Lancet 1985;1:1505-6.
11. Ho DD, Sarngadharan MG, Resnick L, Dimarzo-Veronese F, Rota TR, Hirsch MS. Primary human T-lymphotropic virus type III infection. Ann Intern Med 1985;103:880-3.
12. Ludlam CA, Tucker J, Steel CM, et al. Human T-lymphotropic virus type III (HTLV-III) infection in seronegative haemophiliacs after transfusion of factor VIII. Lancet 1985;2:233-6.

Outbreak of Hepatitis B Associated with an Oral Surgeon — New Hampshire

During the first 6 months of 1986, four clinical cases of hepatitis B were reported in a city in New Hampshire. Each case was serologically confirmed, and the patients had all been seen by the same oral surgeon. All patients had undergone tooth extractions 3 to 5 months before becoming ill; three had had multiple extractions during single office visits. All four patients denied other risk factors for hepatitis B virus infection. One patient developed periarteritis nodosa with severe complications, including mesenteric arteritis with colonic perforation, mononeuritis multiplex with paraplegia, and ulceration into the joint space of one ankle.

Of the four patients, one remained seropositive for hepatitis B surface antigen (HBsAg) for more than 6 months and became a chronic hepatitis B carrier. He was tested and found to have HBsAg subtype ad, the same subtype as the oral surgeon. Ten other cases of hepatitis B were reported in the city during the first 6 months of 1986. Two of the patients were intravenous drug users; two were contacts of patients with unreported cases of hepatitis; and six had no identified risk factors. None of these ten patients had been treated by a dental professional or had undergone surgery.

The oral surgeon had been practicing in the city (population 75,000) for 25 years. His practice was limited to dental extractions, usually performed with a combination of intravenous sedation and local anesthesia. He had never had any symptoms suggestive of hepatitis B and had never received hepatitis B vaccine. He had never been tested for hepatitis B serologic markers prior to the outbreak. In July 1986, he was seropositive for HBsAg and hepatitis e antigen (HBeAg) and negative for IgM antibody to hepatitis B core antigen, indicating that he was probably a hepatitis B carrier. He was not aware of having had any skin lesions on his hands in the past year. Although he was careful to scrub his hands between surgical procedures, he did not wear gloves.

The oral surgeon discontinued his practice when the outbreak was discovered on June 30, 1986, and has not reopened his office. Letters were sent to all patients whom he had treated after January 1, 1985, informing them of their possible exposure to hepatitis B virus and offering free testing for hepatitis B serologic markers.

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Editorial Note: Eight other outbreaks of hepatitis B traceable to dentists or oral surgeons have been reported since 1974 (*1,2*). The number of clinically infected patients in each outbreak has ranged from three to 55. Two of the nine clinically ill patients in one outbreak died of fulminant hepatitis B (*2*); no other deaths have been reported. In each outbreak, the implicated dentist or oral surgeon was seropositive for HBsAg and (if tested) HBeAg and did not use gloves during dental or surgical procedures. None of the dentists who were hepatitis B carriers were aware of their chronic infections. Traumatic procedures (surgery, extractions) have been associated with a higher infection risk than non-traumatic procedures (fillings, denture fittings, etc.). Transmission has been thought to occur through apparent or inapparent lesions on the dentist's hands.

The repeated occurrence of outbreaks associated with dentists or oral surgeons is especially disturbing because there are easily available and widely recommended measures to prevent them. A safe, effective vaccine against hepatitis B became available in 1982, and, since the late 1970s, national dental authorities have urged dental practitioners to wear gloves during all procedures involving hand contact with patients' mouths (*3-5*). In March 1986, a national random telephone survey revealed that 44% of non-federal, practicing dentists and oral surgeons in the United States had been vaccinated against hepatitis B (CDC, unpublished data). Only 15% of respondents used gloves routinely for all procedures.

Recurrent, avoidable outbreaks such as this one should prompt dentists and oral surgeons to seek hepatitis B vaccination and to use gloves routinely when treating patients.

References

1. Kane MA, Lettau LA. Transmission of HBV from dental personnel to patients. J Am Dent Assoc 1985;110:634-6.
2. Shaw FE, Barrett CL, Hamm R, et al. Lethal outbreak of hepatitis B in a dental practice. JAMA 1986;255:3260-4.
3. Council on Dental Material and Devices, Council on Dental Therapeutics, American Dental Association. Infection control in the dental office. J Am Dent Assoc 1978;97(4):673-7.
4. Council on Dental Therapeutics, American Dental Association. Guidelines for infection control in the dental office and the commercial dental laboratory. J Am Dent Assoc 1985;110:969-72.
5. CDC. Recommended infection-control practices for dentistry. MMWR 1986;35:237-42.

Tuberculosis and AIDS — Connecticut

Until 1983, the incidence of tuberculosis in Connecticut had steadily declined for several decades. In 1982, it reached its lowest point, 5.0 cases per 100,000 population. Since then, tuberculosis incidence in Connecticut has fluctuated above that level, with a rate of 6.2 in 1983, 5.6 in 1984, and 5.1 in 1985. A rate of 6.0 is projected for 1986. This would be an 18% increase over 1985. Concern about a possible association between human immunodeficiency virus (HIV) infection and the rise in tuberculosis morbidity led to an evaluation of data on acquired immuno-deficiency syndrome (AIDS) and tuberculosis in Connecticut.

The entire AIDS register was confidentially linked to the tuberculosis case register dating back to 1970 to determine the proportion of tuberculosis patients with a diagnosis of AIDS, the proportion of AIDS patients with tuberculosis, and the interval between the diagnosis of tuberculosis and AIDS. The following selected characteristics of those with both diagnoses were also studied: age, sex, race and ethnicity, geographic location by city size, and risk factors for a diagnosis of AIDS. Patients were placed in subgroups by each of these characteristics, and the incidence rate of tuberculosis in individuals with and without AIDS in each subgroup was calculated and compared. A 3-year incidence rate of tuberculosis was used for these comparisons because most diagnoses of tuberculosis in AIDS patients occurred in the 3-year period beginning 30 months before and ending 6 months after the diagnosis of AIDS.

As of September 1, 1986, 18 cases of tuberculosis had been diagnosed among the 299 cumulatively reported AIDS cases in Connecticut. The 18 tuberculosis patients with AIDS (TB/AIDS) ranged from 24 to 53 years of age, with a median of 33 years. Fourteen (78%) were male; 11 (61%) were black; 13 (72%) came from the six cities in Connecticut with a population of 100,000 or greater; and seven (39%) were intravenous drug abusers. One of the 18 cases of tuberculosis was diagnosed in 1973 and another in 1980. The remaining 16 cases were diagnosed after January 1, 1982, and represent 5.4% of all AIDS cases reported to date and 2.0% of all 816 tuberculosis cases diagnosed and reported from 1982 through 1986. When these 16 cases are analyzed by year of diagnosis, there appears to be no significant rise or fall in the frequency of tuberculosis patients with AIDS (TB/AIDS) for the years 1982 through 1986.

Compared with tuberculosis patients without AIDS in Connecticut, TB/AIDS patients were younger and more likely to be male, black, and from a large city. Compared with AIDS patients without tuberculosis, TB/AIDS patients were more likely to be black and from a large city and to have intravenous drug abuse as an AIDS risk factor. Age and sex distribution were similar in both groups.

Among the 18 TB/AIDS patients, the diagnosis of tuberculosis occurred from 10 years before to 19 months after the diagnosis of AIDS, with a median of 4 months before the diagnosis of AIDS. Fourteen (78%) of TB/AIDS patients were diagnosed as having tuberculosis within 3 years of their diagnosis of AIDS (2.5 years before to 0.5 years after).

Table 4 shows the crude 3-year incidence rate of tuberculosis in AIDS patients and in the general population without AIDS according to sex, race, and city size as well as the incidence rate adjusted for these three factors and age. In all groups, the rate of tuberculosis (risk ratio) in AIDS patients was more than 100 times the incidence in the general population.

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Editorial Note: The demographic characteristics of TB/AIDS patients in Connecticut are similar to those found elsewhere; individuals are most likely to come from groups that have a higher incidence of tuberculosis and are at risk for AIDS (*1-3*).

TABLE 4. Three-year incidence of tuberculosis in 20- to 49-year-olds with and without AIDS, by selected demographic characteristics — Connecticut, 1986

Characteristics	AIDS patients* TB rate	(cases)	General population† TB rate	(cases)	Risk ratio§
Sex					
Male	6,250	(10)	18.8	(119)	333
Female	7,692	(2)	12.7	(84)	605
Race					
Black	12,121	(8)	102.8	(95)	118
White	3,670	(4)	5.4	(63)	677
Other	—	(0)	112.4	(45)	—
City Size					
≥100,000	9,677	(9)	44.7	(111)	216
<100,000	3,226	(3)	8.8	(92)	367
Adjusted¶	2,671	(12)	15.7	(203)	170.3

*Incidence of tuberculosis 2.5 years before to 0.5 years after diagnosis of AIDS per 100,000 AIDS patients as of 4/1/86.

†3-year incidence of tuberculosis per 100,000 individuals without AIDS, 1982-1984.

§Ratio of 3-year incidence of TB/AIDS to TB/non-AIDS.

¶Adjusted for age (5-year intervals), race, sex, and city size according to 1980 census.

The following factors suggest an association between tuberculosis and AIDS in Connecticut: the 5.4% incidence of tuberculosis in AIDS cases, the clustering of the development of tuberculosis and AIDS within a distinct time period (within 3 years of diagnosis of AIDS), and the 100-fold or greater risk of tuberculosis among AIDS patients than among the general population. The risk that persons with latent tuberculous infection who develop AIDS will develop clinically active tuberculosis cannot be determined from these data. However, to the extent that individuals with AIDS are representative of the general population in prevalence and incidence of tuberculous infection, this risk could be as much as 100- to 200-fold greater than that of their non-HIV-infected counterparts.

The total number of AIDS patients in the United States meeting the CDC surveillance case definition represents only a fraction of the number of persons with HIV infection. It has been estimated that, in 1985, for every diagnosed case of AIDS, there were 50 to 100 persons with HIV infection (*4*). The number of tuberculosis patients with HIV infection but without AIDS in Connecticut may also exceed the number who have overt AIDS.

These data further support recently published guidelines that risk factors for HIV should be identified as part of the evaluation of persons with tuberculous infection (*5*). HIV antibody testing should be offered, and, where there is both tuberculous infection and HIV infection, isoniazid preventive therapy should be offered. Conversely, persons who are positive for HIV antibody should be offered tuberculin skin testing, and isoniazid preventive therapy should be offered to reactors (*5*).

References

1. CDC. Tuberculosis and acquired immunodeficiency syndrome—Florida. MMWR 1986;35:587-90.
2. Sunderam G, McDonald RJ, Maniatis T, Oleske J, Kapila R, Reichman LB. Tuberculosis as a manifestation of the acquired immunodeficiency syndrome (AIDS). JAMA 1986;256:362-6.
3. Stoneburner RL, Kristal A. Increasing tuberculosis incidence and its relationship to acquired immunodeficiency syndrome in New York City. Atlanta, Georgia: International Conference on Acquired Immunodeficiency Syndrome (AIDS). April 14-17, 1985.
4. Curran JW, Morgan WM, Hardy AM, Jaffe HW, Darrow WW, Dowdle WR. The epidemiology of AIDS: current status and future prospects. Science 1985;229:1352-7.
5. CDC. Diagnosis and management of mycobacterial infection and disease in persons with human T-lymphotropic virus type III/lymphadenopathy-associated virus infection. MMWR 1986;35:448-52.

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MORBIDITY AND MORTALITY WEEKLY REPORT

Epidemiologic Notes and Reports

Human Immunodeficiency Virus Infection in Transfusion Recipients and Their Family Members

CDC has received a report of human immunodeficiency virus (HIV) infection among multiply-transfused leukemia patients in New York City. In addition, there have been several reports that persons with transfusion-associated HIV infection have transmitted the virus to their sexual partners and newborn children. All infected transfusion recipients described in these reports had received blood or blood components before routine screening of donated blood for HIV antibody was begun in the spring of 1985.

Multiply-Transfused Leukemia Patients

During the past year, four long-term leukemia survivors at Memorial Sloan-Kettering Cancer Center in New York City developed unexplained fever, weight loss, diarrhea, or lymphadenopathy. They subsequently had positive serological tests for HIV antibody. A retrospective study of other multiply-transfused leukemia patients was conducted to determine how many had been infected with HIV. Informed consent was obtained from all living patients. Positive enzyme immunoassay (EIA) tests were confirmed by Western blot assay. Patients known to have other risk factors for HIV infection were excluded from the study.

Sera were located for 182 deceased and obtained from 22 surviving leukemia patients treated during the years 1978-1986. Sixteen of these transfusion recipients were seropositive for HIV antibody (Table 1). They had received a mean of 27 units of packed red blood cells (range 2-56) and 137 units of platelets (range 10-483). Forty-five percent of these 204 patients had acute myelogenous leukemia; 20% had acute lymphocytic leukemia; 13%, chronic myelogenous leukemia; 4%, chronic lymphocytic leukemia; 6%, myelodysplastic syndromes; and 12%, other or unclassified leukemias. There was no correlation between type of leukemia and the presence of HIV antibody. An additional 23 newly diagnosed, untreated, and untransfused leukemia patients were tested and all were seronegative.

TABLE 1. HIV serology results in leukemia patients, by year of specimen collection — Memorial Sloan-Kettering Cancer Center, New York City

Years	Total number of patients tested	Number with positive test	Estimated* risk per component
1978-80	86 (55M,31F)†	0 (0%)	0.00%
1981-83§	77 (39M,38F)	9 (12%) (6M,3F)	0.07%
1984-86§	41 (21M,20F)	7 (17%) (2M,5F)	0.10%
Total	**204 (115M,89F)**	**16 (8%) (8M,8F)**	**0.05%**

*Estimated risk based on an average of 164 components per recipient.

†M=males; F=females.

§These patients were treated before screening of blood products began in March 1985; 22 long-term survivors, four of whom were seropositive, are included.

Additional Case Reports From Other Areas

Case 1: An elderly man with no known risk for AIDS received multiple units of blood in early 1982, including one from a donor who subsequently tested positive for HIV antibody. The recipient developed *Pneumocystis carinii* pneumonia (PCP) in 1983 and died in 1984. His wife, who did not have any other risk factors for AIDS, had had vaginal intercourse with him until he became ill in late 1982. In late 1984, her HIV antibody test was positive and she was diagnosed as having a type of lymphoma indicative of AIDS (*1*).

Case 2: A pregnant woman with no other risk factors for AIDS received four units of blood in 1978, including one from a donor who later tested positive for HIV antibody. A son, born in 1980, had failure to thrive beginning at 13 months of age and died with PCP in 1986. The woman, her son, her husband, and the child born shortly after the transfusion all tested positive for HIV antibody.

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Editorial Note: At present, prevention of HIV infection and AIDS is dependent upon deferral of blood or plasma donation by persons at increased risk for AIDS, testing of donated blood and plasma for HIV antibody, heat treatment of clotting factor concentrates, avoidance of unprotected sexual contact and needle sharing by persons infected with HIV, and prevention of perinatal transmission by infected women. Counseling and HIV antibody testing have been recommended for persons at risk for infection (including homosexual/bisexual men, intravenous drug abusers, hemophilia patients, prostitutes, and persons who have had sexual contact with members of these groups) (*2*). Routine counseling and antibody testing have not been recommended for blood transfusion recipients because, in general, their risk for infection is extremely low. However, as illustrated by this report and others (*3*), some multiply-transfused persons may be at a higher risk for HIV infection. In addition, some persons with transfusion-associated HIV infection have transmitted the virus to their sexual partners and, perinatally, to their infant children.

Although the number of infected transfusion recipients in the United States is unknown, it can be approximated using estimates of the prevalence of infection in donors, the efficiency of transmission, and the number of units transfused per year. In 1985, 0.04% of donations were positive for HIV antibody by Western blot assay (*4*). If 0.04% had been the seroprevalence among donors in the year prior to screening, if all seropositive units had transmitted infection (*5*), and if each seropositive unit had gone to a different recipient, then 7,200 of the approximately 18 million components transfused in 1984 (American Blood Commission, unpublished data) might have transmitted infection. If 60% of these recipients have died from

their underlying disease (*6*), then approximately 2,900 living recipients who acquired a transfusion-associated HIV infection in 1984 would remain. Most of these would be asymptomatic. The number of infected donors was probably lower in earlier years. Mathematical projections from reported transfusion-associated AIDS cases estimate that approximately 12,000 people now living in the United States acquired a transfusion-associated HIV infection between 1978 and 1984 (*7*).

Blood banking organizations in the United States have begun "look-back" programs to identify previous recipients of blood from donors who tested positive for HIV antibody after screening began. In one region, 70% of recipients identified through such a program had HIV antibody (*8*). However, look-back programs cannot identify all infected transfusion recipients because many infected donors may have refrained from donating or become too ill to continue to donate after HIV serologic testing of donors began.

The risk of HIV transmission by transfusion was low, even before screening, and has been virtually eliminated by the routine screening of donated blood and plasma. However, since HIV-infected persons are at risk for developing AIDS or related conditions themselves and may transmit infection to others, physicians should consider offering HIV antibody testing to some patients who received transfusions between 1978 and late spring of 1985. This consideration should be based on the likelihood of infection in a recipient and the likelihood of transmission from that recipient. The risk of infection is greatest if the recipient received large numbers of transfusions and if the blood was collected during the few years before screening in an area with a high incidence of AIDS. (The leukemia patients in this report received many units of blood and blood components in an area with a higher prevalence of HIV than most parts of the United States, so their seropositivity rate is higher than would be expected in other patients. Conversely, persons who received a small number of units in a low prevalence area would have an extremely low risk of HIV infection.) Testing is particularly important if the patient is sexually active. Since the overall prevalence of infection in transfusion recipients is expected to be low, the positive predictive value of EIA screening tests for HIV antibody will be much lower than that seen when testing high-risk populations (*9*). Therefore, all transfusion recipients with a positive EIA should also have their serum tested by a second method (Western blot assay, immunofluorescence assay) before they are informed of their test result. Seropositive persons should be evaluated for signs and symptoms of AIDS or related conditions and counseled regarding the avoidance of HIV transmission to others.

References

1. Duncan ED, Miller HJ, McKeever WP. Non-Hodgkin's lymphoma, HTLV-III/LAV, and HTLV-III/LAV antibody in the wife of a man with transfusion-acquired AIDS. Am J Med 1986;81:898-900.
2. CDC. Additional recommendations to reduce sexual and drug abuse-related transmission of human T-lymphotropic virus type III/lymphadenopathy-associated virus. MMWR 1986;35:152-5.
3. Troy K, Cuttner J, Zaroulis C. Incidence of anti-HIV antibodies in patients with acute leukemia treated between 1978 and 1986 [Abstract]. Blood 1986;68:135a.
4. Schorr JB, Berkowitz A, Cumming PD, Katz AJ, Sandler SG. Prevalence of HTLV-III antibody in American blood donors [Letter]. N Engl J Med 1985;313:384-5.
5. Ward JW, Deppe DA, Samson S, et al. Risk of human immunodeficiency virus infection from blood donors who later developed the acquired immunodeficiency syndrome. Ann Intern Med 1987; 106:61-2.
6. Perkins HA, Samson S, Rosenschein S, et al. Risk of AIDS from blood donors who subsequently develop AIDS. Presented at the International Conference on Acquired Immunodeficiency Syndrome (AIDS), Atlanta, Georgia, April 16, 1985.
7. Peterman TA, Lui K, Lawrence DN, Allen JR. Estimating the risks of transfusion-associated AIDS and HIV infection. Transfusion (in press).
8. Menitove JE. Status of recipients of blood from donors subsequently found to have antibody to HIV [Letter]. N Engl J Med 1986;315:1095-6.
9. Ward JW, Grindon AJ, Feorino PM, Schable C, Parvin M, Allen JR. Laboratory and epidemiologic evaluation of an enzyme immunoassay for antibodies to HTLV-III. JAMA 1986;256:357-61.

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MORBIDITY AND MORTALITY WEEKLY REPORT

Epidemiologic Notes and Reports

Antibody to Human Immunodeficiency Virus in Female Prostitutes

Seroprevalence surveys for antibody to human immunodeficiency virus (HIV) in women with histories of prostitution have shown varying results since testing began in 1984. In sub-Saharan Africa, where HIV is thought to be transmitted primarily through heterosexual exposure (*1-3*), one (1%) of 98 prostitutes tested in Accra, Ghana (*4*), to 29 (88%) of 33 prostitutes in Ngoma, Rwanda (*5*), had HIV antibody (*3-7*). In Europe, where homosexual exposure and abuse of intravenous (IV) drugs are major risk factors for HIV infection (*8*), none of 50 prostitutes tested in London (*9*), none of 56 in Paris (*10*), and none of 399 in Nuremberg, West Germany (*11*), had antibody to HIV. However, 10 (71%) of 14 prostitutes who abused IV drugs in Pordenone, Italy (*12*), and 14 (78%) of 18 who abused IV drugs in Zurich, Switzerland (*13*), were infected. Seventeen (1%) of nearly 2,000 registered prostitutes in six West German cities were HIV-antibody positive; half of these infected women abused IV drugs (*14*). In Athens, Greece, 12 (6%) of 200 registered prostitutes were HIV-antibody positive; none abused IV drugs (*15*).

As of March 10, 1987, 2,159 women in the United States were reported to have met the CDC surveillance case definition for AIDS. The cumulative incidence of AIDS in black and Hispanic women was more than 10 times that for white women (*16*). Over 70% of these women reported with AIDS resided in New York, New Jersey, or Florida (*17*). Over half (51%) had abused IV drugs; 27% were sexual partners of men with AIDS or at risk for AIDS; and 10% had received transfusions of blood or blood products. No risk factors have as yet been reported for the remaining 12% (*18*).

To assess HIV-antibody prevalence and determine risk factors in U.S. prostitutes, CDC is collaborating with others in an ongoing, cross-sectional study of women who have engaged in prostitution in seven geographic areas: Atlanta, Colorado Springs, Las Vegas, Los Angeles, Miami, Newark-Jersey City-Paterson, and San Francisco. Some collaborators are recruiting primarily incarcerated women (Los Angeles and Miami). Others are recruiting primarily through sexually transmitted disease (STD) clinics (Colorado Springs and Las Vegas); methadone maintenance clinics (the three northern New Jersey cities); or outreach efforts, such as newspaper advertising, circulation of pamphlets, and direct contacts on the street (Atlanta and San Francisco). Study participants are not necessarily representative of all female prostitutes in these areas.

For this study, prostitution is defined as the exchange of physical-sexual services for money or drugs. Any woman ≥18 years of age who has engaged in prostitution at least once since January 1, 1978, is eligible. Participation entails voluntary, informed consent; names and other personal identifiers are not recorded. Participants are interviewed for their medical histories and sexual and other exposures. They are also examined for signs of HIV infection and IV-drug abuse and are asked to provide 10 ml of blood for serologic testing. Serum is tested for HIV antibody by enzyme immunoassay and Western blot methods.

The analysis reported here has been restricted to the 835 study participants who were tested for HIV antibody and the 568 study participants for whom an interview form was submitted to CDC before March 10, 1987. The prevalence of HIV antibody in prostitutes so far tends to parallel the cumulative incidence of AIDS in women in the seven research sites (Table 1), suggesting that risk factors for AIDS in female prostitutes may be similar to those in other women living in these geographic areas. The prevalence of HIV antibody in prostitutes and the cumulative incidence of AIDS in women are highest in northern New Jersey and Miami. In southern Nevada, where only one woman has been reported with AIDS, none of 34 prostitutes have had HIV antibody.

In the seven areas, reported rates of AIDS were higher for black women (359.6/1,000,000) and Hispanic women (40.2/1,000,000) than for white (25.3/1,000,000) and other (Asian and Native American) women (16.2/1,000,000). Similarly, black and Hispanic prostitutes in these areas had a higher prevalence of HIV antibody (15%) than white and other prostitutes (7%) (odds ratio [OR] = 2.5; 95% confidence interval [CI] = 1.4-4.4).

Half the prostitutes interviewed in this multicenter collaborative study gave histories of IV-drug abuse; 47 (76%) of 62 with antibody to HIV have injected drugs (OR = 3.6; 95% CI = 2.0-6.7). IV-drug abuse is associated with HIV infection in prostitutes and with AIDS in women regardless of racial and ethnic background (Table 2).

Over 80% of prostitutes interviewed through January 1987 reported that at least one of their partners had used a condom. Husbands or boyfriends of the respondents were much less likely to use condoms during vaginal exposure than clients (16% as compared with 78%, p = 0.005). Twenty-two (4%) prostitutes reported condom use with each vaginal exposure during the past 5 years. Eleven percent of 546 prostitutes with unprotected vaginal exposure were HIV-antibody positive; none of 22 prostitutes whose partners always used condoms were seropositive (p = 0.10 after controlling for IV-drug abuse).

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Editorial Note: The collaborative study reported here was designed to determine the prevalence of HIV infection in female prostitutes in selected U.S. cities and the risk factors for infection in these women. Seroprevalence in study participants so far has varied widely from city to city and tends to parallel the cumulative incidence of AIDS in women in these areas. The major risk factor for HIV infection in prostitutes appears to be IV-drug abuse. Women with unprotected vaginal exposures also appear to be at greater risk than those whose male partners always used condoms. When used properly and consistently with each sexual exposure, latex condoms should greatly reduce the sexual transmission of HIV (*7,11,19*).

Efforts to stop the spread of HIV infection in prostitutes and to their sexual partners require multiple approaches. These might include counseling and HIV-testing programs for individuals at risk for infection, additional control measures by local public health and law enforcement agencies, and the involvement of voluntary and other social service organizations.

Persons who continue to engage in prostitution remain at risk for acquiring and transmitting HIV. Prostitutes and their consorts should be provided counseling services and voluntary testing for HIV antibody (*20-22*). Seronegative persons who continue to engage in prostitution should insist on the use of condoms to reduce their own chances of infection. Seropositive prostitutes should know that the only certain way of preventing sexual transmission of the virus is to abstain and not engage in prostitution. Seropositive persons who continue to engage in prostitution should insist on the use of condoms to prevent transmission of the

TABLE 1. HIV antibody in female prostitutes and reported AIDS cases in women — selected cities, United States, March 10, 1987

	Female prostitutes		Women with AIDS*	
	HIV-antibody positive/tested	Percent positive	No.	Cases/ 1,000,000†
Eastern United States				
Atlanta	1/92	(1.1)	8	12.5
Miami	47/252	(18.7)	100	145.3
Newark-Jersey City-Paterson	32/56	(57.1)	143	526.2
Western United States				
Colorado Springs	1/71	(1.4)	1	9.6
Las Vegas	0/34	(0.0)	1	16.0
Los Angeles	8/184	(4.3)	26	21.7
San Francisco	9/146	(6.2)	21	71.9

*Includes 45 women (≥16 years of age) from Miami and one from Newark who were born in countries where heterosexual transmission is believed to play a major role.

†Rate based on the number of females (≥16 years of age) reported as residing in the urban area or place of study (*26*).

TABLE 2. Risk factors for HIV antibody in female prostitutes and for AIDS in women, by race or ethnic group — selected cities, United States, March 10, 1987

	Female prostitutes*		Women with AIDS†	
	HIV-antibody positive/tested	Percent positive	No.	Percent of total
Black or Hispanic				
IV-drug abuser	31/124	(25.0)	108	(43.0)
Other, unknown	12/156§	(7.7)	143	(57.0)
Total	43/280	(15.4)	251	(100.0)
White or other				
IV-drug abuser	16/157	(10.2)	26	(53.1)
Other, unknown	3/127¶	(2.4)	23	(46.9)
Total	19/284	(6.7)	49	(100.0)

*Analysis restricted to the 564 study participants (of 835 tested) who answered the question regarding IV-drug abuse.

†Includes 46 women who were born in countries where heterosexual transmission is believed to play a major role, who were reported to CDC as meeting the surveillance case definition for AIDS, and who were residents of one of the seven research sites.

§Odds ratio = 4.0; 95% confidence interval = 2.0-8.2.

¶Odds ratio = 4.7; 95% confidence interval = 1.3-16.5.

virus to others. IV-drug abusers should be offered treatment for their addictions and warned not to share needles or syringes.

State and local governments are approaching the problem of HIV infection in prostitutes in a variety of ways. Since March 1986, the Nevada Board of Health has required prostitutes in county-licensed brothels to be tested for HIV antibody as a condition for employment and monthly thereafter. If a woman is seropositive, she is denied employment as a prostitute. Since October 1986, Florida has required convicted prostitutes to be tested for STDs, including HIV. It is a misdemeanor in Florida for anyone who has tested positive for HIV and has been informed of the result to engage in prostitution. In Atlanta, the Mayor's Task Force on Prostitution has recommended educational materials for prostitutes, clients, and law-enforcement officers as well as voluntary testing for STDs (including assays for HIV antibody) for everyone arrested for sexual offenses and their steady partners.

Traditionally, medical care, therapy for drug addiction, welfare benefits, and vocational rehabilitation have not been routinely offered to women apprehended for prostitution (*23-25*). Now some organizations are introducing innovative approaches to male, as well as female, prostitutes. The California Prostitutes Education Project attempts to warn prostitutes about the dangers of unprotected exposures and provides educational sessions on how to prevent infection. Children of the Night (Los Angeles), Covenant House (New York City), Orion House (Seattle), and other social-service organizations offer counseling and sanctuary to homeless adolescents, including those involved in prostitution. State and local health departments often work closely with these organizations to provide voluntary testing and treatment for STDs.

References

1. Brun-Vezinet F, Rouzioux C, Montagnier L, et al. Prevalence of antibodies to lymphadenopathy-associated retrovirus in African patients with AIDS. Science 1984;226:453-6.
2. Piot P, Quinn TC, Taelman H, et al. Acquired immunodeficiency syndrome in a heterosexual population in Zaire. Lancet 1984;2:65-9.
3. Quinn TC, Mann JM, Curran JW, Piot P. AIDS in Africa: an epidemiologic paradigm. Science 1986;234:955-63.
4. Neequaye AR, Neequaye J, Mingle JA, Adjei DO. Preponderance of females with AIDS in Ghana [Letter]. Lancet 1986;2:978.
5. Van de Perre P, Clumeck N, Carael M, et al. Female prostitutes: a risk group for infection with human T-cell lymphotropic virus type III. Lancet 1985;2:524-7.
6. Kreiss JK, Koech D, Plummer FA, et al. AIDS virus infection in Nairobi prostitutes. N Engl J Med 1986;314:414-8.
7. Mann J, Quinn TC, Piot P, et al. Condom use and HIV infection among prostitutes in Zaire [Letter]. N Engl J Med 1987;316:345.
8. CDC. Update: acquired immunodeficiency syndrome—Europe. MMWR 1986;35:35-8,43-6.
9. Barton SE, Underhill GS, Gilchrist C, Jeffries DJ, Harris JRW. HTLV-III antibody in prostitutes [Letter]. Lancet 1985;2:1424.
10. Brenky-Faudeux D, Fribourg-Blanc A. HTLV-III antibody in prostitutes [Letter]. Lancet 1985;2:1424.
11. Smith GL, Smith KF. Lack of HIV infection and condom use in licensed prostitutes [Letter]. Lancet 1986;2:1392.
12. Tirelli U, Vaccher E, Carbone A, DePaoli P, Santini G, Monfardini S. HTLV-III antibody in prostitutes [Letter]. Lancet 1985;2:1424.
13. Luthy R, Ledergerber B, Tauber M, Siegenthaler W. Prevalence of HIV antibodies among prostitutes in Zurich, Switzerland. Klinische Wochenschrift (in press).
14. Schultz S, Milberg JA, Kristal AR, Stoneburner RL. Female-to-male transmission of HTLV-III [Letter]. JAMA 1986;255:1703-4.
15. Papaevangelou G, Roumeliotou-Karayannis A, Kallinkos G, Papoutsakis G. LAV/HTLV-III infection in female prostitutes [Letter]. Lancet 1985;2:1018.
16. CDC. Acquired immunodeficiency syndrome (AIDS) among blacks and Hispanics—United States. MMWR 1986;35:655-8,663-6.
17. CDC. Update: acquired immunodeficiency syndrome—United States. MMWR 1986;35:757-60,765-6.
18. Lifson AR, Castro KG, Narkunas JP, Lekatsas A, Ksell TE, Fox RS. "No identified risk" cases of acquired immunodeficiency syndrome. Paris: Second International Conference on AIDS, 1986.
19. Conant M, Hardy D, Sernatinger J, Spicer D, Levy JA. Condoms prevent transmission of AIDS-associated retrovirus [Letter]. JAMA 1986;255:1706.
20. CDC. Update: acquired immunodeficiency syndrome (AIDS)—United States. MMWR 1984;33:661-4.
21. CDC. Recommendations for assisting in the prevention of perinatal transmission of human T-lymphotropic virus type III/lymphadenopathy-associated virus and acquired immunodeficiency syndrome. MMWR 1985;34:721-6,731-2.
22. CDC. Additional recommendations to reduce sexual and drug abuse-related transmission of human T-lymphotropic virus type III/lymphadenopathy-associated virus. MMWR 1986;35:152-5.
23. Benjamin H, Masters REL. Prostitution and morality. New York: Julian, 1964.
24. Darrow WW. Prostitution and sexually transmitted diseases. In: Holmes KK, Mardh P, Sparling PF, Wiesner PF, eds. Sexually transmitted diseases. New York: McGraw-Hill, 1984:109-16.
25. Yondorf B. Prostitution as a legal activity: the West German experience. Policy Analysis 1979;5:417-33.
26. Bureau of the Census. 1980 census of population. Washington, DC: US Department of Commerce, 1982; (volume 1, characteristics of the population· chapter B, general population characteristics, table 31; series PC 80-1).

Disseminated Gonorrhea Caused by Penicillinase-Producing *Neisseria gonorrhoeae* — Wisconsin, Pennsylvania

During the period August-September 1986, CDC received four reports of disseminated gonococcal infection (DGI) caused by penicillinase-producing *Neisseria gonorrhoeae* (PPNG).

Cases 1 and 2: A 28-year-old woman (Patient 1) was admitted to a Racine hospital on August 4, 1986, with a 1-week history of arthritis of the left knee with effusion. Synovial and cervical cultures were both positive for PPNG. She was treated for 2 days with intravenous penicillin. When the culture results became known, her therapy was changed to ceftriaxone, 500 mg once daily. Despite the change in therapy, the knee remained swollen. Even though the dosage of ceftriaxone was increased to 1 g every 12 hours, the knee had to be surgically drained on August 14. The woman recovered rapidly and was discharged 1 week later.

The index patient's only recent sexual partner (Patient 2) was examined on August 8. He had had urethritis for 1 week and a swollen, painful left wrist for 2 weeks. Nine days earlier, he had been treated for the wrist symptoms with a non-steroidal, anti-inflammatory agent. Upon examination, the patient had purulent urethritis and a tender, slightly swollen wrist. Urethral culture was positive for PPNG. The wrist was not cultured. He was treated intramuscularly with 2 g of spectinomycin and recovered completely.

Case 3: A 20-year-old woman seen in an emergency room in Philadelphia had had wrist pain for 1 week and pain in the right knee, left ankle, and the dorsum of the left hand for 3 days. On physical examination, she was febrile, had tenosynovitis of the extensor tendons of the left hand, and had effusion of the right knee and ankle. Arthrocentesis of the knee yielded purulent fluid which grew PPNG. A cervical culture was also positive for PPNG. Initially, she was treated intravenously with penicillin; therapy was changed to cefotaxime when culture results became available. She recovered completely.

Case 4: A 52-year-old woman seen in a Philadelphia emergency room had had pain in the right wrist and third finger of the left hand for 2 days. She was febrile, and the right wrist and proximal interphalangeal joint of the left third finger were swollen and tender. Arthrocentesis of the wrist yielded purulent fluid that grew PPNG. She was treated intravenously with penicillin. Therapy was changed to intravenous ceftriaxone when culture results became available. She recovered completely.

Antibiotic-susceptibility testing, auxotype, protein I serovar determination, and plasmid analysis of isolates from all patients were performed at CDC. All isolates were resistant to penicillin (minimum inhibitory concentration [MIC] 1-8 μg/ml), and all demonstrated moderate chromosomally mediated resistance to tetracycline (MIC range: 0.5-4.0 μg/ml) and to cefoxitin (MIC range: 0.5-2.0 μg/ml). All were sensitive to spectinomycin and ceftriaxone. All isolates were auxotype/serovar class Pro^-/IA-6, and all contained the 2.6 megaDalton (mDal) cryptic plasmid, the 3.2 mDal β-lactamase plasmid, and the 24.5 mDal conjugative plasmid. Despite the similarity of the isolates, suggestive of a clonal origin, no linkage could be demonstrated between the two Philadelphia patients or between either Philadelphia patient and the Wisconsin patients.

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Editorial Note: DGI, a serious complication of gonorrhea, is estimated to occur in 0.5%-1.0% of all gonococcal infections. Tenosynovitis and septic arthritis are the two most common clinical syndromes (*1*).

Published reviews have reported that DGI is predominantly caused by organisms which are extremely susceptible to antibiotics and are more likely to be nutritionally fastidious, requiring arginine, hypoxanthine, and uracil for growth ($A^-H^-U^-$ auxotype) (*2-4*). This may have led to the mistaken impression that antibiotic-resistant strains of *N. gonorrhoeae* do not cause DGI.

Cases of DGI caused by PPNG are being reported more frequently (*5-7*). There have also been reports of DGI caused by gonococci with chromosomally mediated resistance to penicillin (*8*). Furthermore, in a recent, large prospective study, DGI isolates were no more susceptible to antibiotics than isolates from localized anogenital gonorrhea (*9*).

Patients with DGI caused by resistant gonococcal strains should be hospitalized and treated with ceftriaxone (1-2 g/day intravenously) until signs and symptoms resolve. Daily outpatient therapy with either ceftriaxone (250 mg intramuscularly) or an oral regimen defined either by in-vitro susceptibility tests should follow, for at least 1 week of antimicrobial therapy. When an infection does not respond to appropriate antimicrobial therapy, surgical drainage should be considered.

Less than 50% of synovial-fluid cultures in gonococcal arthritis are positive. Therefore, antibiotic-resistant *N. gonorrhoeae* should be considered in culture-negative, clinically diagnosed cases of gonococcal arthritis that do not respond to standard antimicrobial therapy.

In 1986, 16,608 PPNG infections were reported to CDC (*10*), a 90% increase from 1985. As the incidence of PPNG and other resistant strains increases, there is likely to be an increase in the incidence of DGI caused by antibiotic-resistant *N. gonorrhoeae*.

References

1. Masi AT, Eisenstein BI. Disseminated gonococcal infection and gonococcal arthritis—II: clinical manifestations, diagnosis, complications, treatment, and prevention. Semin Arthritis Rheum 1981;10:173-97.
2. Wiesner PJ, Handsfield HH, Holmes KK. Low antibiotic resistance of gonococci causing disseminated infection. New Engl J Med 1973;288:1221-2.
3. Thompson SE, Reynolds G, Short HB, et al. Auxotypes and antibiotic susceptibility patterns of *Neisseria gonorrhoeae* from disseminated and local infections. Sex Transm Dis 1978;5:127-31.
4. O'Brien JP, Goldenberg DL, Rice PA. Disseminated gonococcal infection: a prospective analysis of 49 patients and a review of pathophysiology and immune mechanisms. Medicine 1983; 62:395-406.
5. Rinaldi RZ, Harrison WO, Fan PT. Penicillin-resistant gonococcal arthritis: a report of four cases. Ann Intern Med 1982;97:43-5.
6. Thompson J, Dunbar JM, VanGent A, VanFurth R. Disseminated gonococcal infection due to a β-lactamase-producing strain of *Neisseria gonorrhoeae*: a case report. Br J Vener Dis 1981; 57:325-6.
7. Saraux J, Vigneron A, Berthelot G, Dombret M, Smejian J, Kahn M. Disseminated gonococcal infection caused by penicillinase-producing organisms in patients with unusual joint involvement. J Infect Dis 1987;155:154-5.
8. Strader KW, Wise CM, Wasilauskas BL, Salzer WL. Disseminated gonococcal infection caused by chromosomally mediated penicillin-resistant organisms. Ann Intern Med 1986;104:365-6.
9. Bohnoff M, Morello JA, Lerner SA. Auxotypes, penicillin susceptibility, and serogroups of *Neisseria gonorrhoeae* from disseminated and uncomplicated infections. J Infect Dis 1986;154:225-30.
10. CDC. Penicillinase-producing *Neisseria gonorrhoeae*—United States, 1986. MMWR 1987;36: 107-8.

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MORBIDITY AND MORTALITY WEEKLY REPORT

Perspectives in Disease Prevention and Health Promotion

Progress Toward Achieving the National 1990 Objectives for Sexually Transmitted Diseases

The health objectives for the nation, established in 1979 (*1*), included 11 goals relating to the control of sexually transmitted diseases (STDs). Five are considered appropriate areas for federal involvement: gonorrhea, gonococcal pelvic inflammatory disease, syphilis, provider awareness, and student awareness. A statement of each of these objectives and the progress toward their achievement follows:

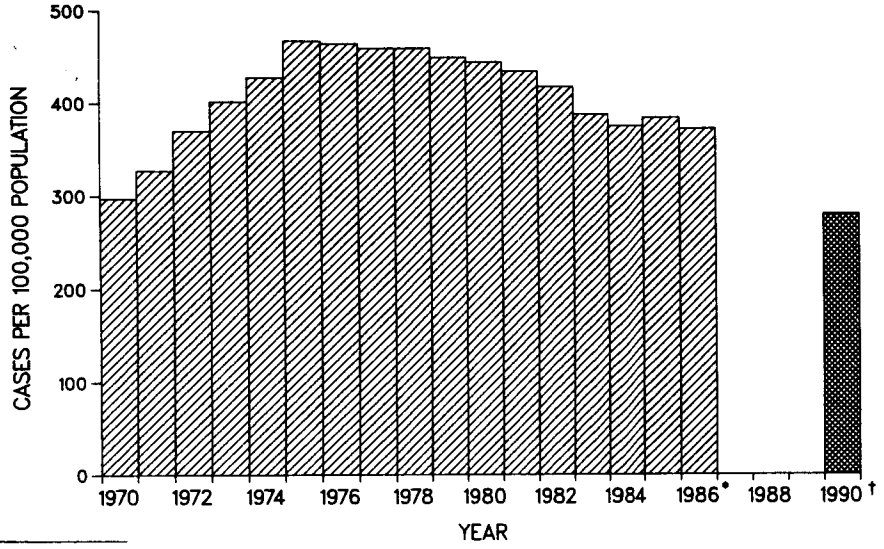
By 1990, reported gonorrhea incidence should be reduced to a rate of 280 cases per 100,000 population.

During the 1960s, reported gonorrhea rates increased approximately 15% per year. In 1972, a national gonorrhea control program was initiated, and, by 1975, the rapid increase had halted. The rate of decline was slow through 1979, but it accelerated from 1979 to 1984 (Figure 1). Then, in 1985, overall gonorrhea rates increased slightly, reversing the downward trend that had lasted for a decade (*2*). In 1986, total gonorrhea rates decreased to 372 cases per 100,00 population, returning to the 1984 level. However, all of the 1986 decline occurred among males; gonorrhea rates among females continued to increase. It now appears that the 1990 target of 280 cases per 100,000 population may not be met. One of the primary factors limiting the effective control of gonorrhea within the United States is the epidemic of organisms that are resistant to standard therapies (Figure 2). Since 1984, the number of resistant strains has been increasing rapidly. Reported numbers increased 98% in 1985 and an additional 90% in 1986 (*3*).

By 1990, reported incidence of gonococcal pelvic inflammatory disease should be reduced to a rate of 60 cases per 100,000 females.

Based on 1984 rates, the 1990 objective addressing gonococcal pelvic inflammatory disease (GPID) is likely to be achieved. However, GPID accounts for less than half of all pelvic inflammatory disease (PID). For example, *Chlamydia trachomatis* infection is estimated to account for one-quarter to one-half of all PID cases occurring each year (*4*). Therefore, in 1985, the Public Health Service (PHS) broadened the original emphasis of this objective to include all PID. CDC has established a target of 560 PID cases per 100,000 population by 1990. Currently, data from the Hospital Discharge Survey conducted by the National Center for Health Statistics and the National Drug and Therapeutic Index indicate a trend toward a decline in the overall PID rate.

FIGURE 1. Incidence of gonorrhea by year — United States, 1970-1990



*1986 projected.
†1990 objective.

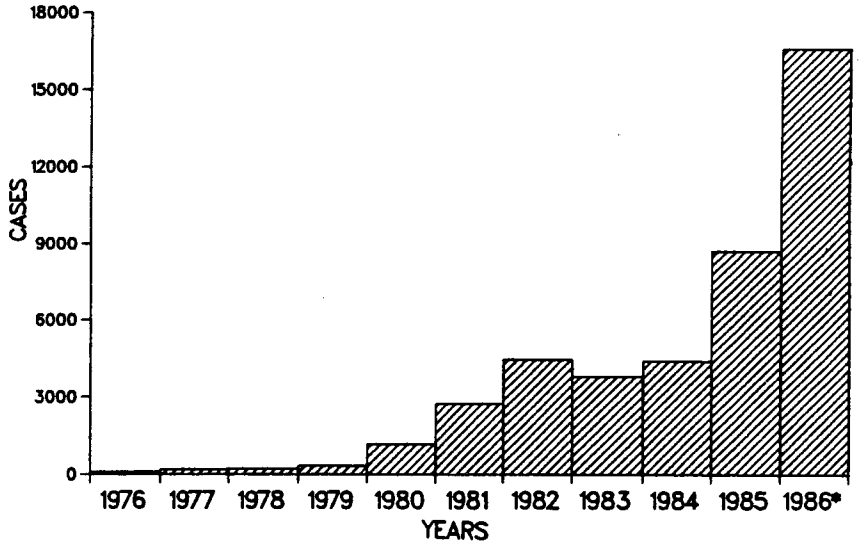
By 1990, the reported incidence of primary and secondary syphilis should be reduced to 7 cases per 100,000 population per year, with a reduction in congenital syphilis to 1.5 cases per 100,000 children under 1 year of age.

Rates of primary and secondary syphilis decreased markedly between 1982 and 1986 (Figure 3). The majority of the decrease has occurred in males and probably reflects behavioral changes among homosexual males in response to acquired immunodeficiency syndrome (AIDS) prevention recommendations (*5*). Behavioral changes among populations at high risk for AIDS are likely to result in lower incidence rates for other STDs in these same groups (*6, 7*).

Reported rates of congenital syphilis among infants reached an all-time low of 3.0 cases per 100,000 live births in 1980, but, with the exception of FY 1982, have increased steadily since then. The 1986 rate was almost 13% higher than the 1985 rate, with three-fourths of the cases occurring in California, Florida, New York, and Texas. Several factors have contributed to the apparent increase. They include improved national surveillance, increased emphasis on reporting of stillbirths attributable to syphilis, and actual increases in the rate of infectious syphilis among females of childbearing age (*8*).

By 1990, at least 95% of health care providers seeing patients with suspected cases of sexually transmitted diseases should be capable of diagnosing and treating all currently recognized sexually transmitted diseases....

FIGURE 2. Cases of gonorrhea involving resistant strains — United States, 1976—1986



*1986 projected.

Although training for health care professionals in the treatment of STDs has improved in recent years, it is still short of the necessary quality and scope. Since 1979, PHS has emphasized four approaches to improving the training of clinicians treating STD patients. First, 10 STD Prevention/Training Centers were established to improve the diagnostic, therapeutic, and patient management skills of mid-career clinicians directly involved with STD patients (*9*). Second, PHS has funded the development and pilot testing of STD curricula in six medical schools. A survey in 1986 found that, in these medical schools, STD training had increased to an average of 10 hours per student (CDC, unpublished data). The same survey showed that 44% of medical schools had no clinical curriculum on STDs. Third, PHS has funded an increasing number of STD Research Training centers to encourage young scientists to pursue an academic career in STD research (*10*). Fourth, PHS has funded the development of an instructional package for clinicians who do not frequently see STD patients in their practices. This package should be available by late fall 1987. Despite these efforts, it is unlikely that this objective will be met by 1990. Making a meaningful impact on medical school training will require more intensive marketing of the value of the STD curriculum and followup on these efforts.

By 1990, every junior and senior high school student in the United States should be receiving accurate, timely education about sexually transmitted diseases.

No systematic measures of this objective are available. In 1983, the Gallup Institute Youth Survey found that only one-third of high school respondents considered themselves "very informed", and almost one-half considered themselves "somewhat informed" about STDs (Gallup Institute, unpublished data). CDC has since placed more emphasis on behavioral knowledge and attitudes related to biological facts. Principally through state STD units, CDC actively promotes adoption of STD education for junior and senior high school students. Increased attention to school-based education as a way to prevent AIDS should improve knowledge, attitudes, and behaviors affecting other STDs as well.

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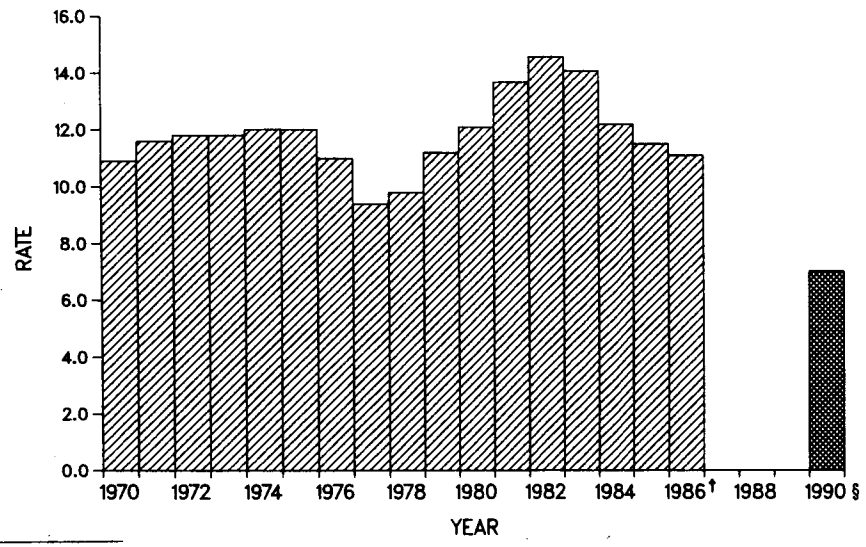
FIGURE 3. Primary and secondary syphilis incidence rates* — United States, 1970—1990



*per 100,000.
†1986 projected.
§1990 objective.

Editorial Note: Between the time of establishing the health objectives for the nation in 1979 and the third review of progress toward their achievement in November 1986, the national STD status has followed an irregular course. During this interval, a major new sexually transmissible agent, human immunodeficiency virus (HIV), has come to dominate the field. Moreover, the variety and burden of STDs have increased markedly. More than 50 diseases and syndromes account for over 13 million cases and 7,000 deaths annually from STDs, excluding AIDS. The costs of treating PID and its sequelae alone are estimated to exceed $2.6 billion annually.

The population at risk for STDs increased markedly between 1970 and 1980, with the coming of age of the "baby boom" cohort and the increased sexual activity among this segment of the population (*11*). This factor greatly influenced trends in both bacterial and viral STDs from 1979 to 1986. However, in the 1980s, as this group has become older and their sexual behaviors have stabilized, the chances for progress toward achieving the 1990 objectives have improved.

STD control for the balance of the 1980s and into the next decade will focus on the primary prevention of all sexually transmitted infections, especially the persistent viral infections for which no therapies or vaccines exist. This new emphasis will require a shifting of priorities, which have historically been focused on secondary prevention efforts. However, if current primary prevention efforts are successful, an overall reduction in all STDs will result.

References

1. Public Health Service. Promoting health/preventing disease: objectives for the nation. Washington, DC: US Department of Health and Human Services, 1980.
2. CDC. Sexually transmitted disease statistics. Atlanta, Georgia: US Department of Health and Human Services, Public Health Service (in press).
3. Zenilman JM, Cates W Jr, Morse SA. *Neisseria gonorrhoeae*: an old enemy rearms. Infect Dis and Med Lett Obstet Gynecol 1986;8(suppl):2s-9s.
4. CDC. *Chlamydia trachomatis* infections: policy guidelines for prevention and control. MMWR 1985;34(suppl 3):53S-74S.
5. CDC. Syphilis—United States, 1983. MMWR 1984;33:433-6,441.
6. Judson FN. Fear of AIDS and gonorrhea rates in homosexual men [Letter]. Lancet 1983;2:159-60.
7. CDC. Declining rates of rectal and pharyngeal gonorrhea among males—New York City. MMWR 1984;33:295-7.
8. CDC. Congenital syphilis—United States, 1983-1985. MMWR 1986;35:625-8.
9. Margolis S. Initiation of the sexually transmitted diseases prevention/training clinic program. Sex Transm Dis 1981;8:87-93.
10. Cates W Jr. Priorities for sexually transmitted diseases in the late 1980s and beyond. Sex Transm Dis 1986;13:114-7.
11. Zelnik M, Kantner JF. Sexual activity, contraceptive use, and pregnancy among metropolitan area teenagers: 1971-1979. Fam Plan Perspect 1980;12:230-7.

Current Trends

Self-Reported Changes in Sexual Behaviors Among Homosexual and Bisexual Men from the San Francisco City Clinic Cohort

From January 1978 through April 1980, approximately 6,700 homosexual and bisexual men attending a clinic for sexually transmitted diseases in San Francisco were enrolled in studies of the prevalence and incidence of hepatitis B virus infection (*1*). Approximately 1,300 participants answered standardized questions regarding their sexual practices. From December 1983 through December 1985, a random sample from this study group was asked to participate in studies of the acquired immunodeficiency syndrome (AIDS) by providing further information about their sexual behaviors (*2,3*). Study results show that homosexual and bisexual men in San Francisco have considerably reduced both their number of nonsteady sexual partners and their participation in specific sexual practices associated with increased risk of human immunodeficiency virus (HIV) infection, especially receptive anal intercourse.

Questionnaires administered to a subset of 126 members of this random sample in 1978, 1984, and 1985 provided data on their number of steady and nonsteady male partners in the 4 months preceding each interview. The numbers of steady partners (individuals with whom the participant had had sexual contact on three or more occasions during the 4-month period) rose from a mean of 1.6 per person in 1978 to 2.5 per person in 1984, then decreased to 1.5 in 1985. Numbers of nonsteady partners (defined as individuals with whom the participant had had sexual contact only once or twice) decreased from a median of 16 per person (mean = 29.3) during the 4-month period in 1978 to 3 (mean = 14.5) in 1984. By 1985 the median was 1 (mean = 5.5).

Participants also reported the percentage of time in the preceding 4 months that their sexual contacts with male partners included penetration or exchange of body fluids. To estimate a risk index of sexual activities that may have resulted in exposure to HIV in the previous 4 months, the percentage of time the participant engaged in each of several types of sexual behaviors was multiplied by the number of steady and nonsteady male partners during the same period.

The risk index for receptive anal intercourse with nonsteady partners decreased 90% between the two interview periods in 1978 and 1985. The risk index for receptive anal intercourse with a steady partner remained close to zero for each of the three 4-month periods in 1978, 1984, and 1985.

Although the risk index for receptive orogenital contact with nonsteady partners declined by 68% from 1978 to 1985, the decrease was not as striking as the decline in receptive anal intercourse. The risk index for receptive orogenital contact with steady partners remained low and relatively constant during this 7-year period.

Indices of exposure risk for insertive sexual contacts were also estimated. The risk index for insertive anal intercourse with nonsteady partners decreased 93% from 1978 to 1985, while the risk index for insertive orogenital contact with nonsteady partners declined 83% during the same period. Exposure risk for both insertive anal and orogenital contact with steady partners remained low and relatively constant between 1978 and 1985.

Information on condom use among these 126 men is unavailable; however, data collected during a pilot study in 1983 suggested that >95% of the men in the cohort did not use condoms during anal intercourse at that time (CDC, unpublished data). Preliminary data collected since November 1986 on a group of 104 cohort members indicate that approximately 33% of this group had anal intercourse at least once in the previous 4 months without using a condom (CDC, unpublished data). The majority (73%) of these unprotected sexual contacts were with steady partners.

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Editorial Note: Examination of trends in self-reported behavioral change provides an opportunity to indirectly evaluate educational efforts aimed at reducing high-risk behaviors. Within the time frame of this study (1983-1985), the Public Health Service recommended that members of high risk groups reduce their number of partners and avoid sexual contact with anyone known or suspected of having AIDS (*4*). In addition, the San Francisco Department of Public Health, in cooperation with the San Francisco AIDS Foundation, has implemented an extensive risk reduction program aimed at reducing high-risk sexual behavior in homosexual and bisexual men during this time period (*5*). Participants from this and other studies report significant reductions in certain high-risk behaviors (*6-8*). Ninety percent of the sample from this study reduced their number of nonsteady partners. The median number of partners declined from 16 in 1978 to 1 in 1985. Thirty-four percent of the men reported having only one or no partners during the preceding 4 months in 1985.

However, in 1985, some of the men in this survey still reported having sexual contact with multiple partners or engaging in high-risk behaviors. The results from this study suggest that the major source of exposure to HIV in 1978, 1984, and 1985 may have been unprotected sexual contacts with nonsteady partners. However, unless steady partners are known to be seronegative for HIV infection, the potential for exposure through sexual contacts with steady partners cannot be discounted either. Because of the high prevalence of HIV infection in homosexual men (*9*), the Public Health Service recommendations presently state that high-risk individuals should abstain or limit their sexual contact to one steady partner. Furthermore, those at risk should protect themselves during sexual activity with any possibly infected person by taking precautions against contact with the person's blood, semen, urine, feces, saliva, or cervical or vaginal secretions (*10*).

Although homosexual and bisexual men in San Francisco are generally aware of the guidelines for avoiding transmission of HIV, there is, for some men, a discrepancy between their knowledge of these guidelines and their behavior (*6,7*). These individuals need to be studied more intensively so that educational programs appropriate for this subgroup may be developed. Additional study of those who have already changed their behavior may also be helpful in identifying key factors motivating reductions in high-risk sexual behaviors.

References

1. Schreeder MT, Thompson SD, Hadler SC, et al. Hepatitis B in homosexual men: prevalence of infection and factors related to transmission. J Infect Dis 1982;146:7-15.
2. Jaffe HW, Darrow WW, Echenberg DF, et al. The acquired immunodeficiency syndrome in a cohort of homosexual men: a six-year follow-up study. Ann Intern Med 1985;103:210-4.
3. Darrow WW, Echenberg DF, Jaffe HW, et al. Risk factors for HIV infections in homosexual men. Am J Public Health 1987;77:479-83.
4. CDC. Prevention of acquired immune deficiency syndrome (AIDS): report of inter-agency recommendations. MMWR 1983;32:101-3.
5. San Francisco Department of Public Health. AIDS in San Francisco: status report and plan for 1987-88. San Francisco: San Francisco Department of Public Health, 1987.
6. Research and Decisions Corporation. Designing an effective AIDS prevention campaign strategy for San Francisco: results from the third probability sample of an urban gay male community. San Francisco: Research and Decisions Corporation, 1986.
7. McKusick L, Wiley JA, Coates TJ, et al. Reported changes in the sexual behavior of men at risk for AIDS, San Francisco, 1982-84—the AIDS Behavioral Research Project. Pub Health Rep 1985; 100:622-9.
8. CDC. Self-reported behavioral change among gay and bisexual men—San Francisco. MMWR 1985;34:613-5.
9. Winkelstein W Jr, Lyman DM, Padian N, et al. Sexual practices and risk of infection by the human immunodeficiency virus: the San Francisco men's health study. JAMA 1987;257:321-5.
10. CDC. Additional recommendations to reduce sexual and drug abuse-related transmission of human T-lymphotropic virus type III/lymphadenopathy-associated virus. MMWR 1986;35:152-5.

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Epidemiologic Notes and Reports

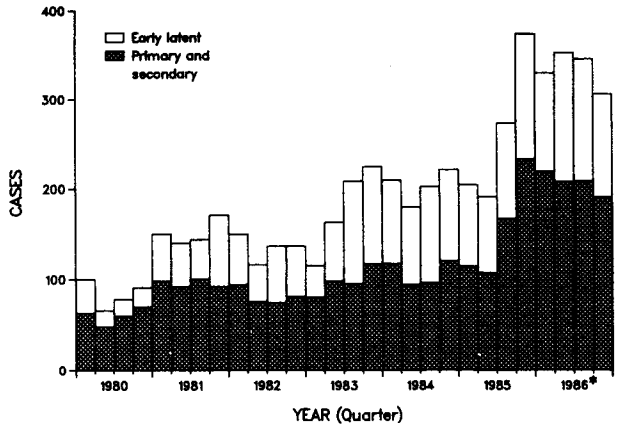
Early Syphilis — Broward County, Florida

During the 1980s, the number of early syphilis (primary, secondary, and early latent) cases in Broward County, Florida, has increased—from 328 in 1980 to over 1,150 in 1986 (Figure 2), with a peak in the last half of 1985. From 1984 to 1985, primary and secondary (P&S) syphilis accounted for most of the increase in Broward County.

This upward trend in P&S syphilis in Broward County contrasts with the general downward trend observed from 1982 to 1985 in both Florida and the rest of the United States (Figure 3). However, Florida, with 37.6 cases per 100,000 population in 1986, still has the highest rate of P&S syphilis in the country.

In 1985, rates of early syphilis in Broward County were highest in the 20- to 24-year-old age group and were 446/100,000 for men and 290/100,000 for women in this group. Rates

FIGURE 2. Early syphilis cases, by quarter and stage — Broward County, Florida, 1980-1986



*Control measures began in 1986.

of early syphilis adjusted for race were 730/100,000 for blacks, 21/100,000 for whites, and 50/100,000 for Hispanics. Ninety-six percent of cases among women occurred among those of childbearing age (15-44 years of age). As a result, the number of cases of congenital syphilis increased to 25 in 1986; 10 had been reported in 1985, and six, in 1984.

Two studies were performed to identify characteristics of patients reported during the months of greatest increase. First, surveillance data routinely gathered on all patients with early syphilis from 1980 through 1985 were reviewed. Second, detailed clinical and behavioral data were collected from interview records of a systematic 25% sample of patients diagnosed with syphilis in 1985. These data included reason for seeking medical attention, address of residence, sexual preference for males, and history of prostitution for females. These two data sets were compared with surveillance data from previous years.

In 1985, early syphilis cases occurred primarily among heterosexual blacks in Broward County. Eighty percent (836) of reported cases occurred among blacks; 18% (187), among whites; and 2% (20), among Hispanics. In contrast, the percentage of syphilis cases among blacks had ranged from 48% to 64% during the 4 previous years. Heterosexual males, who represented 39% of reported male patients in 1982, constituted 80% of male patients by 1985. Over 70% of early syphilis patients reported in 1985 lived in 11 census tracts that together contained less than 15% of the 1,162,031 residents of Broward County. The median income in these census tracts is < $15,000 per year. The concentration of cases clustered in these census tracts was greater in the latter part of 1985 than in the earlier part of that year.

These results prompted further investigation. The systematic 25% sample collected for 1985 was extended to include a similar sample of cases reported in the last 6 months of 1984 and the first 3 months of 1986. The sample was then divided into two periods: July 1, 1984, through June 30, 1985, the interval immediately preceding the rapid increase in reporting of cases (endemic cases), and July 1, 1985, through March 31, 1986, the interval of greatest increase (epidemic cases). Female patients diagnosed during the epidemic months were significantly more likely to be prostitutes than those reported during the prior 12 months (odds ratio [OR] = 2.5, 95% confidence interval [CI] = 1.1-6.1). Male patients were significantly more likely to be exclusively heterosexual than those reported in prior months (OR = 2.07, 95% CI = 1.1-3.9). During the 9 epidemic months as compared with the previous endemic months, more patients were examined for lesions and symptoms, and fewer patients were identified either during screening or as sexual partners of infected persons (OR = 1.87, 95% CI = 1.2-2.8). Thus, the ratio of symptomatic (P&S) to asymptomatic (early latent) patients increased from 0.9 : 1 in the endemic period to 1.3 : 1 in the epidemic period.

The Broward County Department of Health responded to these increases in early syphilis by intensifying surveillance efforts, including active surveillance of laboratories that perform serologic tests for syphilis. Moreover, serologic screening was increased in the high-prevalence census tracts and in high-risk populations, including jail inmates of both sexes. County facilities providing prenatal care intensified their rescreening program for asymptomatic women during the third trimester. The ratio of symptomatic to asymptomatic patients decreased, from 1.9 : 1 in the first quarter to 1.4 : 1 in the second quarter of 1986. In the last quarter of 1986, a decrease in early syphilis was observed.

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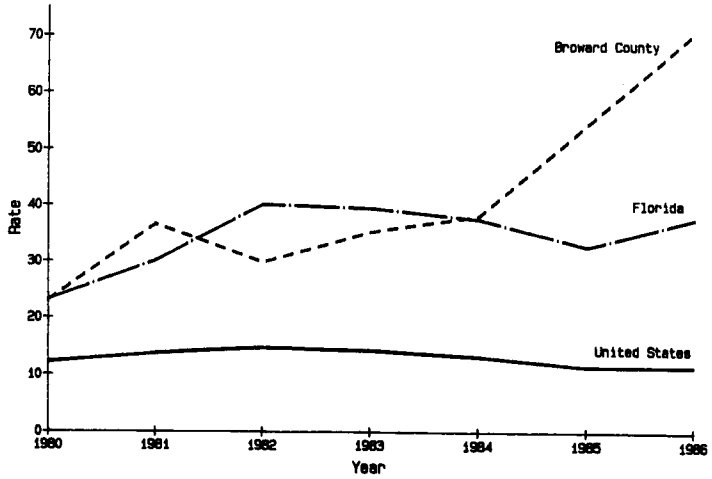
Editorial Note: The increase in early syphilis in Broward County, as in another outbreak in the 1980s (*1*), was largely due to heterosexual transmission. In addition, female prostitution, which has contributed to syphilis transmission in other outbreaks (*1,2*), appears to have played an increasing role in early syphilis occurring in Broward County. Moreover, early syphilis cases are concentrated largely in low-income areas of the county.

FIGURE 3. Rates of primary and secondary syphilis — United States, Florida, and Broward County, 1980-1986



Along with national trends (*3*), early syphilis cases among male homosexuals in Broward County are decreasing both in absolute numbers and in the percentage of total cases. This may be partially explained by changes in lifestyle among male homosexuals in response to the threat of acquired immunodeficiency syndrome. Such changes may reduce their acquisition of syphilis, as it may have reduced their rate of infection with other sexually transmitted pathogens (*4,5*).

The high rate of early syphilis in women of childbearing age has contributed to increases cases of congenital syphilis. Prenatal serologic testing for syphilis at the initial visit and in the third trimester (*6*) has been widely implemented and should increase the identification of asymptomatic infected women and prevent congenital syphilis infections. High priority is being given to identifying and treating sexual partners of heterosexual male patients to interrupt transmission to women within the community and to detect infections in women before they become pregnant.

The syphilis problem in Florida is not restricted to Broward County. However, serologic screening of sexually active residents of high-incidence areas and in high-risk populations is increasing the number of diagnoses of asymptomatic cases in Broward County. Throughout Florida, contact tracing (*7*) and serologic screening (*8*) of populations at risk are being used to identify asymptomatic infected persons and thereby to control the spread of syphilis.

References

1. Lee CB, Brunham RC, Sherman E, Harding GKM. Epidemiology of an outbreak of infectious syphilis in Manitoba. Am J Epidemiol 1987;125:277-83.
2. Kinsie PM. Impact of prostitution on syphilis control. In: Proceedings of the world forum on syphilis and other treponematosis. Atlanta, Georgia: US Department of Health, Education, and Welfare, Public Health Service, CDC, 1962:149-52.
3. CDC. Syphilis—United States, 1983. MMWR 1984;33:433-6,441.
4. CDC. Declining rates of rectal and pharyngeal gonorrhea among males—New York City. MMWR 1984;33:295-7.
5. Judson FN. Fear of AIDS and gonorrhoea rates in homosexual men [Letter]. Lancet 1983;2:159-60.
6. Mascola L, Pelosi R, Blount JH, Binkin NJ, Alexander CE, Cates W Jr. Congenital syphilis: why is it still occurring? JAMA 1984;252:1719-22.
7. Brown WJ, Donohue JF, Axnick NW, et al. Syphilis and other venereal diseases. In: Vital and Health Statistics Monographs. Cambridge, Massachusetts: Harvard University Press, 1970.
8. Hart G. Syphilis tests in diagnostic and therapeutic decision making. Ann Intern Med 1986; 104:368-76.

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MORBIDITY AND MORTALITY WEEKLY REPORT

Current Trends

Classification System for Human Immunodeficiency Virus (HIV) Infection in Children Under 13 Years of Age

INTRODUCTION

With the identification of the causative agent of the acquired immunodeficiency syndrome (AIDS), a broad spectrum of clinical manifestations has been attributed to infection with the human immunodeficiency virus (HIV). With the exception of the CDC surveillance definition for AIDS (*1,2*), no standard definitions for other manifestations of HIV infection have been developed for children. Classification systems published to date have been developed primarily to categorize clinical presentations in adult patients and may not be entirely applicable to infants and children (*3-5*).

Physicians from institutions caring for relatively large numbers of HIV-infected children report that only about half of their patients with symptomatic illness related to the infection fulfill the criteria of the CDC surveillance definition for AIDS (*6,7*).

To develop a classification system for HIV infection in children, CDC convened a panel of consultants* consisting of clinicians experienced in the diagnosis and management of children with HIV infection; public health physicians; representatives from the American Academy of Pediatrics, the Council of State and Territorial Epidemiologists, the Association for Maternal Child Health and Crippled Children's Programs, the National Institute on Drug Abuse/Alcohol, Drug Abuse and Mental Health Administration, the National Institute of Allergy and Infectious Diseases/National Institutes of Health, and the Division of Maternal and Child Health/Health Resources and Services Administration; and CDC.

GOALS AND OBJECTIVES OF THE CLASSIFICATION SYSTEM

The system was designed primarily for public health purposes, including epidemiologic studies, disease surveillance, prevention programs, and health-care planning and policy. The panel attempted to devise a simple scheme that could be subdivided as needed for different purposes.

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DEFINITION OF HIV INFECTION IN CHILDREN (Table 1)

Ideally, HIV infection in children is identified by the presence of the virus in blood or tissues, confirmed by culture or other laboratory detection methods. However, current tests—including culture—for detecting the virus or its antigens are not standardized and are not readily available. Detection of specific antibody to the virus is a sensitive and specific indicator of HIV infection in adults, since the majority of adults with antibody have had culture evidence of infection (*8-10*). Similar studies involving children have not been reported. Also, the presence of passively transferred maternal antibody in infants limits the interpretation of a positive antibody test result in this age group. Most of the consultants believed that passively transferred maternal HIV antibody could sometimes persist for up to 15 months. For this reason, two definitions for infection in children are needed: one for infants and children up to 15 months of age who have been exposed to their infected mothers perinatally, and another for older children with perinatal infection and for infants and children of all ages acquiring the virus through other means.

Infants and children under 15 months of age with perinatal infection—Infection in infants and children up to 15 months of age who were exposed to infected mothers in the perinatal period may be defined by one or more of the following: 1) the identification of the virus in blood or tissues, 2) the presence of HIV antibody as indicated by a repeatedly reactive screening test (e.g., enzyme immunoassay) plus a positive confirmatory test (e.g., Western blot, immunofluorescence assay) in an infant or child who has abnormal immunologic test results indicating both humoral and cellular immunodeficiency (increased immunoglobulin levels, depressed T4 [T-helper] absolute cell count, absolute lymphopenia, decreased T4/T8 ratio) and who meets the requirements of one or more of the subclasses listed under class P-2 (described below), or 3) the confirmation that a child's symptoms meet the previously published CDC case definition for pediatric AIDS (*1,2*).

The infection status of other perinatally exposed seropositive infants and children up to 15 months of age who lack one of the above immunologic or clinical criteria is indeterminate. These infants should be followed up for HIV-related illness, and they should be tested at regu-

TABLE 1. Summary of the definition of HIV infection in children

Infants and children under 15 months of age with perinatal infection

1) Virus in blood or tissues
   or
2) HIV antibody
   and
   evidence of both cellular and humoral immune deficiency
   and
   one or more categories in Class P-2
   or
3) Symptoms meeting CDC case definition for AIDS

Older children with perinatal infection and children with HIV infection acquired through other modes of transmission

1) Virus in blood or tissues
   or
2) HIV antibody
   or
3) Symptoms meeting CDC case definition for AIDS

lar intervals for persistence of antibody to HIV. Infants and children who become seronegative, are virus-culture negative (if blood or tissue samples are cultured), and continue to have no clinical or laboratory-confirmed abnormalities associated with HIV infection are unlikely to be infected.

Older children with perinatal infection and children with HIV infection acquired through other modes of transmission—HIV infection in these children is defined by one or more of the following: 1) the identification of virus in blood or tissues, 2) the presence of HIV antibody (positive screening test plus confirmatory test) regardless of whether immunologic abnormalities or signs or symptoms are present, or 3) the confirmation that the child's symptoms meet the previously published CDC case definition for pediatric AIDS (*1,2*).

These definitions apply to children under 13 years of age. Persons 13 years of age and older should be classified according to the adult classification system (*3*).

CLASSIFICATION SYSTEM (Table 2)

Children fulfilling the definition of HIV infection discussed above may be classified into one of two mutually exclusive classes based on the presence or absence of clinical signs and symptoms (Table 2). Class Pediatric-1 (P-1) is further subcategorized on the basis of the presence or absence of immunologic abnormalities, whereas Class P-2 is subdivided by specific disease patterns. Once a child has signs and symptoms and is therefore classified in P-2, he or she should not be reassigned to class P-1 if signs and symptoms resolve.

Perinatally exposed infants and children whose infection status is indeterminate are classified into class P-0.

Class P-0. Indeterminate infection. Includes perinatally exposed infants and children up to 15 months of age who cannot be classified as definitely infected according to the above definition but who have antibody to HIV, indicating exposure to a mother who is infected.

Class P-1. Asymptomatic infection. Includes patients who meet one of the above definitions for HIV infection but who have had no previous signs or symptoms that would have led to classification in Class P-2.

These children may be subclassified on the basis of immunologic testing. This testing should include quantitative immunoglobulins, complete blood count with differential, and T-lymphocyte subset quantitation. Results of functional testing of lymphocytes (mitogens, such as pokeweed) may also be abnormal in HIV-infected children, but it is less specific in comparison with immunoglobulin levels and lymphocyte subset analysis, and it may be impractical.

Subclass A - Normal immune function. Includes children with no immune abnormalities associated with HIV infection.

Subclass B - Abnormal immune function. Includes children with one or more of the commonly observed immune abnormalities associated with HIV infection, such as hypergammaglobulinemia, T-helper (T4) lymphopenia, decreased T-helper/T-suppressor (T4/T8) ratio, and absolute lymphopenia. Other causes of these abnormalities must be excluded.

Subclass C - Not tested. Includes children for whom no or incomplete (see above) immunologic testing has been done.

Class P-2. Symptomatic infection. Includes patients meeting the above definitions for HIV infection and having signs and symptoms of infection. Other causes of these signs and symptoms should be excluded. Subclasses are defined based on the type of signs and symptoms that are present. Patients may be classified in more than one subclass.

Subclass A - Nonspecific findings. Includes children with two or more unexplained nonspecific findings persisting for more than 2 months, including fever, failure-to-thrive or weight loss of more than 10% of baseline, hepatomegaly, splenomegaly, generalized lymphadenopathy (lymph nodes measuring at least 0.5 cm present in two or more sites, with bilateral lymph nodes counting as one site), parotitis, and diarrhea (three or more loose stools per day) that is either persistent or recurrent (defined as two or more episodes of diarrhea accompanied by dehydration within a 2-month period).

Subclass B - Progressive neurologic disease. Includes children with one or more of the following progressive findings: 1) loss of developmental milestones or intellectual ability, 2) impaired brain growth (acquired microcephaly and/or brain atrophy demonstrated on computerized tomographic scan or magnetic resonance imaging scan), or 3) progressive symmetrical motor deficits manifested by two or more of these findings: paresis, abnormal tone, pathologic reflexes, ataxia, or gait disturbance.

Subclass C - Lymphoid interstitial pneumonitis. Includes children with a histologically confirmed pneumonitis characterized by diffuse interstitial and peribronchiolar infiltration of lymphocytes and plasma cells and without identifiable pathogens, or, in the absence of a histologic diagnosis, a chronic pneumonitis—characterized by bilateral reticulonodular interstitial infiltrates with or without hilar lymphadenopathy—present on chest X-ray for a period of at least 2 months and unresponsive to appropriate antimicrobial therapy. Other causes of interstitial infiltrates should be excluded, such as tuberculosis, *Pneumocystis carinii* pneumonia, cytomegalovirus infection, or other viral or parasitic infections.

Subclass D - Secondary infectious diseases. Includes children with a diagnosis of an infectious disease that occurs as a result of immune deficiency caused by infection with HIV.

Category D-1. Includes patients with secondary infectious disease due to one of the specified infectious diseases listed in the CDC surveillance definition for AIDS: *Pneumocystis carinii* pneumonia; chronic cryptosporidiosis; disseminated toxoplasmosis with onset after 1 month of age; extra-intestinal strongyloidiasis; chronic isosporiasis; candidiasis (esophageal, bronchial, or pulmonary); extrapulmonary cryptococco-

TABLE 2. Summary of the classification of HIV infection in children under 13 years of age

Class P-0. Indeterminate infection

Class P-1. Asymptomatic infection

- Subclass A. Normal immune function
- Subclass B. Abnormal immune function
- Subclass C. Immune function not tested

Class P-2. Symptomatic infection

- Subclass A. Nonspecific findings
- Subclass B. Progressive neurologic disease
- Subclass C. Lymphoid interstitial pneumonitis
- Subclass D. Secondary infectious diseases
  - Category D-1. Specified secondary infectious diseases listed in the CDC surveillance definition for AIDS
  - Category D-2. Recurrent serious bacterial infections
  - Category D-3. Other specified secondary infectious diseases
- Subclass E. Secondary cancers
  - Category E-1. Specified secondary cancers listed in the CDC surveillance definition for AIDS
  - Category E-2. Other cancers possibly secondary to HIV infection
- Subclass F. Other diseases possibly due to HIV infection

sis; disseminated histoplasmosis; noncutaneous, extrapulmonary, or disseminated mycobacterial infection (any species other than leprae); cytomegalovirus infection with onset after 1 month of age; chronic mucocutaneous or disseminated herpes simplex virus infection with onset after 1 month of age; extrapulmonary or disseminated coccidioidomycosis; nocardiosis; and progressive multifocal leukoencephalopathy.

Category D-2. Includes patients with unexplained, recurrent, serious bacterial infections (two or more within a 2-year period) including sepsis, meningitis, pneumonia, abscess of an internal organ, and bone/joint infections.

Category D-3. Includes patients with other infectious diseases, including oral candidiasis persisting for 2 months or more, two or more episodes of herpes stomatitis within a year, or multidermatomal or disseminated herpes zoster infection.

Subclass E - Secondary cancers. Includes children with any cancer described below in categories E-1 and E-2.

Category E-1. Includes patients with the diagnosis of one or more kinds of cancer known to be associated with HIV infection as listed in the surveillance definition of AIDS and indicative of a defect in cell-mediated immunity: Kaposi's sarcoma, B-cell non-Hodgkin's lymphoma, or primary lymphoma of the brain.

Category E-2. Includes patients with the diagnosis of other malignancies possibly associated with HIV infection.

Subclass F - Other diseases. Includes children with other conditions possibly due to HIV infection not listed in the above subclasses, such as hepatitis, cardiopathy, nephropathy, hematologic disorders (anemia, thrombocytopenia), and dermatologic diseases.

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Editorial Note: This classification system is based on present knowledge and understanding of pediatric HIV infection and may need to be revised as new information becomes available. New diagnostic tests, particularly antigen detection tests and HIV-specific IgM tests, may lead to a better definition of HIV infection in infants and children. Information from several natural history studies currently under way may necessitate changes in the subclasses based on clinical signs and symptoms.

A definitive diagnosis of HIV infection in perinatally exposed infants and children under 15 months of age can be difficult. The infection status of these HIV-seropositive infants and children who are asymptomatic without immune abnormalities cannot be determined unless virus culture or other antigen-detection tests are positive. Negative virus cultures do not necessarily mean the child is not infected, since the sensitivity of the culture may be low. Decreasing antibody titers have been helpful in diagnosing other perinatal infections, such as toxoplasmosis and cytomegalovirus. However, the pattern of HIV-antibody production in infants is not well defined. At present, close follow-up of these children (Class P-0) for signs and symptoms indicative of HIV infection and/or persistence of HIV antibody is recommended.

The parents of children with HIV infection should be evaluated for HIV infection, particularly the mother. The child is often the first person in such families to become symptomatic. When HIV infection in a child is suspected, a careful history should be taken to elicit possible risk factors for the parents and the child. Appropriate laboratory tests, including HIV serology, should be offered. If the mother is seropositive, other children should be evaluated regarding their risk of perinatally acquired infection. Intrafamilial transmission, other than perinatal or sexual, is extremely unlikely. Identification of other infected family members allows for appropriate medical care and prevention of transmission to sexual partners and future children (*11,12*).

The nonspecific term AIDS-related complex has been widely used to describe symptomatic HIV-infected children who do not meet the CDC case definition for AIDS. This classification system categorizes these children more specifically under Class P-2.

The development and publication of this classification system does not imply any immediate change in the definition of pediatric AIDS used by CDC for reporting purposes (*1,2*). Changes in this definition require approval by state and local health departments. However, changes in the definition for reporting cases have been proposed by CDC and are awaiting state and local approval.

Written comments are encouraged. They should be mailed to the AIDS Program, Center for Infectious Diseases, Centers for Disease Control, Atlanta, GA 30333.

References

1. CDC. Update: acquired immunodeficiency syndrome (AIDS)—United States. MMWR 1984;32:688-91.
2. CDC. Revision of the case definition of acquired immunodeficiency syndrome for national reporting—United States. MMWR 1985;34:373-5.
3. CDC. Classification system for human T-lymphotropic virus type III/lymphadenopathy-associated virus infections. MMWR 1986;35:334-9.
4. Redfield RR, Wright DC, Tramont EC. The Walter Reed staging classification for HTLV-III/LAV infection. N Engl J Med 1986;314:131-2.
5. Haverkos HW, Gotlieb MS, Killen JY, Edelman R. Classification of HTLV-III/LAV-related diseases [Letter]. J Infect Dis 1985;152:1095.
6. Pawha S, Kaplan M, Fikrig S, et al. Spectrum of human T-cell lymphotropic virus type III infection in children. JAMA 1986;255:2299-305.
7. Scott GB, Anisman L, Zaldivar ML, Parks WP. Natural history of HTLV-III/LAV infections in children. Presented at the International Conference on AIDS, Paris, June 1986.
8. Ward JW, Grindon AJ, Feorino PM, Schable C, Parvin M, Allen JR. Laboratory and epidemiologic evaluation of an enzyme immunoassay for antibodies to HTLV-III. JAMA 1986;256:357-61.
9. Peterman TA, Jaffe HW, Feorino PM, et al. Transfusion-associated acquired immunodeficiency syndrome in the United States. JAMA 1985;254:2913-7.
10. Jaffe HW, Feorino PM, Darrow WW, et al. Persistent infection with human T-lymphotropic virus type III/lymphadenopathy-associated virus in apparently healthy homosexual men. Ann Intern Med 1985;102:627-8.
11. CDC. Recommendations for assisting in the prevention of perinatal transmission of human T-lymphotropic virus type III/lymphadenopathy-associated virus and acquired immunodeficiency syndrome. MMWR 1985;34:721-6,731-2.
12. CDC. Additional recommendations to reduce sexual and drug abuse-related transmission of human T-lymphotropic virus type III/lymphadenopathy-associated virus. MMWR 1986;35:152-5.

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MORBIDITY AND MORTALITY WEEKLY REPORT

Epidemiologic Notes and Reports

Enterically Transmitted Non-A, Non-B Hepatitis — East Africa

Outbreaks of enterically transmitted non-A, non-B hepatitis occurred in 1985 and 1986 at refugee camps for Ethiopians in Somalia and the Sudan.

Somalia. From January 1985 to September 1986, more than 2,000 cases and 87 deaths occurred at four refugee camps in Somalia; 40 (46%) of the persons who died were pregnant women. The first outbreak among refugees occurred in Bixin Dhule, a holding camp in northwestern Somalia. During the period January-March 1985, there were 699 cases of acute hepatitis and 13 deaths. Adults accounted for 81% of the cases and 92% of the deaths. From April-June 1985, Gannet refugee camp had more than 400 cases and 16 deaths, including nine (56%) among pregnant women.

After an outbreak was recognized at the Tug Wajale B refugee camp in northwestern Somalia, intensive epidemiologic investigation and serologic testing of cases were begun. In January 1986, there had been 2,500 refugees in this camp; an influx of new refugees had increased the population to approximately 32,000 by August 1986. Starting in April 1986, medical personnel at Tug Wajale B noticed a sharp increase in the number of hepatitis cases among adult Ethiopian refugees. In addition, a number of staff members had contracted hepatitis. Cases of hepatitis (diagnosed by the presence of scleral icterus) were identified by reviewing camp medical records. The peak number of cases occurred from mid-May to mid-June (Figure 1), about 6 to 7 weeks after the beginning of a rainy season. The majority (89%) of these persons with clinical cases were young adults; an equal number of males and females were affected. Symptoms associated with hepatitis were nausea, vomiting, dark urine, fever, abdominal pain, itching, fatigue, and headache.

During this period, there were 30 deaths due to hepatitis. Sixteen of those who died were pregnant women; four were non-pregnant women; nine were men; and one was a child. Only four maternal deaths from other causes were recorded in these months. The fatality rate for second- and third-trimester women with hepatitis was 17%.

A tent-to-tent survey involving 2,000 refugees revealed a 3% point prevalence of jaundice in adults and an overall attack rate (April to mid-June) of 8%. Among children < 15 years of age, the point prevalence of jaundice was 0.2%, and the overall attack rate was 1.8%. Estimates indicated that over 2,000 cases of clinical hepatitis occurred during the study period. Among the Somali national staff the attack rate was 17%, whereas in expatriate medical personnel, the attack rate was 42%.

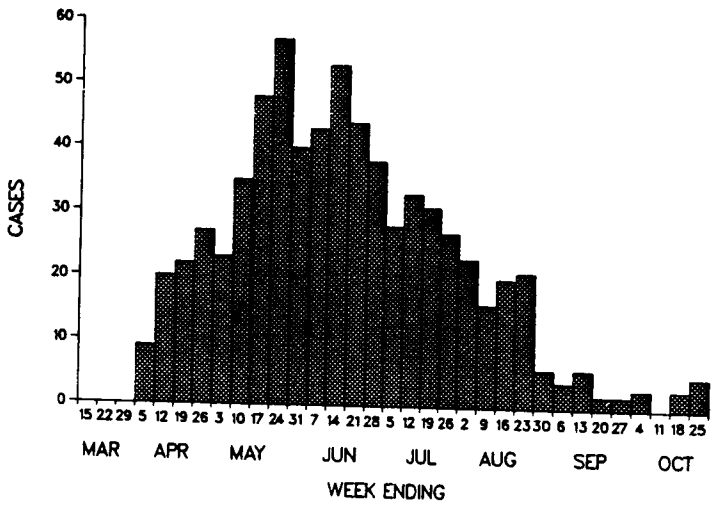
Serum samples were obtained from 84 patients and 50 age- and sex-matched controls, and stool specimens were obtained from 21 patients who had been jaundiced for ≤1 week. Nine patients (10%) and two controls (4%) were positive for hepatitis B surface antigen. Of these, only one patient was positive for IgM anti-core antibody, which is indicative of recent hepatitis B infection. None of the patients or controls were positive for IgM class antibody to hepatitis A virus. Stool specimens were examined by immune electron microscopy (IEM) using serum from a Pakistani patient with known enterically transmitted non-A, non-B hepatitis (*1*); 27-nm virus-like particles, similar to those seen by IEM in cases from Central Asia, Nepal, and Burma, were found in 13 of 21 samples. These particles cross reacted with sera from patients of enterically transmitted non-A, non-B hepatitis from Central Asia.

Sudan. In mid-1985, when outbreaks of hepatitis were occurring at the refugee camps in Somalia, there were reports of an increase in cases of acute jaundice in Eritrean and Tigrean refugees from Ethiopia residing in refugee camps in eastern Sudan. The investigation of this occurrence included intensified surveillance in four large reception centers (Wad Sherife, Shagarab East 1, Shagarab East 2, and Wad Kowli) and a case-control study in one camp (Wad Kowli).

Active case detection by expatriate health staffs, refugee health workers, and refugee organizations revealed an increase in cases of acute illness with scleral icterus among refugees from June-October (Figure 2), beginning approximately 6 weeks after the onset of heavy rains in eastern Sudan. The majority of patients were adults >15 years of age (66%); only 6.3% were children <5 years of age. There were almost twice as many cases reported among males as among females. Reported fatality rates ranged from 1.3%-4.7% and averaged 3.1% in the four camps. Eleven of the 63 persons who died were pregnant women.

Serum samples were obtained from 175 acutely jaundiced refugees. Seven patients (4%) were positive for hepatitis B surface antigen, and one of these was positive for IgM anti-core antibody. Three other patients (2%) had only IgM anti-core antibody, also indicative of recent hepatitis B infection. Eleven patients (6%) were positive for IgM-class antibody to hepatitis A virus and were considered to have acute cases of hepatitis A. The remaining 154 patients were considered to have non-A, non-B hepatitis. A pool of serum collected from non-A, non-B hepatitis patients cross reacted with stool samples from a Pakistani patient with known enterically transmitted non-A, non-B hepatitis (*1*).

FIGURE 1. Cases of non-A, non-B hepatitis, by week — Tug Wajale, Somalia, March 15-October 25, 1986



A questionnaire regarding the onset of acute jaundice among expatriate staff while working in eastern Sudan refugee camps during 1985 has been distributed to 17 agencies involved. In addition, epidemiologic and clinical data are still being collected.

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Editorial Note: Non-A, non-B hepatitis, which continues to be a diagnosis of exclusion, is considered to have two distinct forms, which are transmitted by different routes and presumably caused by different viruses. The first, initially recognized as post-transfusion non-A, non-B hepatitis, is seen commonly in North America and Europe, is epidemiologically similar to hepatitis B, and is recognized most commonly after blood transfusions and parenteral drug abuse. The second, enterically transmitted non-A, non-B hepatitis, is transmitted by the fecal-oral route. This disease is known to cause large outbreaks of viral hepatitis and has been reported in the Indian subcontinent (*2-7*), Burma (*8*), and Algeria (*9*). Frequently, large outbreaks have been linked to a fecally contaminated water source or have occurred after heavy rains in areas without systems for adequate sewage disposal. Person-to-person transmission can occur.

Enterically transmitted non-A, non-B hepatitis has several characteristic epidemiologic features. Its incubation period is approximately 40 days (as opposed to 30 days for hepatitis A and 60-180 days for hepatitis B). Clinical disease is common among adults, but infrequent among children. Pregnant women have a dramatically high mortality rate. Large outbreaks of acute viral hepatitis among adults in areas where the population is immune to hepatitis A should alert public health authorities to the presence of enterically transmitted non-A, non-B hepatitis.

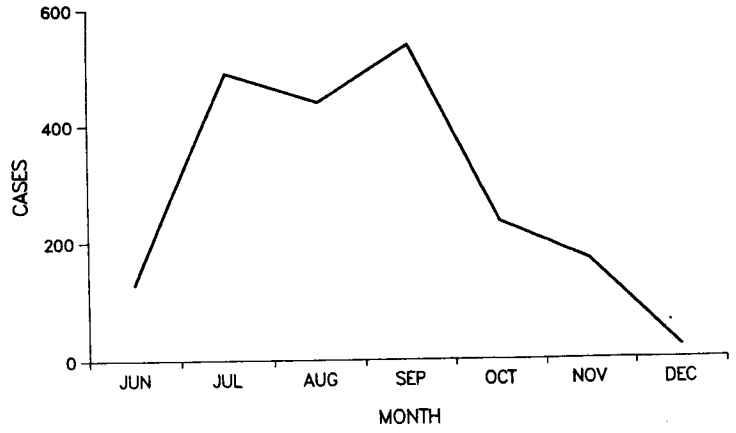
Signs and symptoms of enterically transmitted non-A, non-B hepatitis are similar to those of other forms of viral hepatitis, although generalized pruritus may be more common. The majority of patients who are not pregnant recover completely, and there is no evidence of chronic liver disease as a long-term sequela. Outbreaks of disease may be identified by the suggestive epidemiologic pattern (especially the high mortality rate among pregnant women) and the exclusion, through serologic testing, of other forms of viral hepatitis. Post-transfusion non-A, non-B hepatitis has not been documented in communitywide outbreaks.

Currently, no serologic test is available for diagnosis; however, 27- to 30-nm virus-like particles have been found by IEM in stool samples of patients in the early acute phase of infection (*1,7,10*), and hepatitis can be induced in two different species of primates with this agent. Acute-phase antibody in sera may also be demonstrated by IEM.

In an outbreak situation, emphasis must be placed on preventing transmission. Water sources should be examined for fecal contamination. If the water supply is contaminated, all water should be boiled or chlorinated before consumption. Efforts to reduce person-to-person transmission by improving sanitation should be stressed. Immune globulin (IG) manufactured in the West does not appear to be effective in preventing disease. The efficacy of IG from endemic areas is unknown.

These reports mark the first time that this disease has been described as a problem in refugee camps and the first time that the characteristic virus-like particles have been identified in Africa. Refugee camps represent a fertile setting for the transmission of enterically transmitted non-A, non-B hepatitis. These camps usually have inadequate sanitation and are overcrowded. While contaminated drinking water was not a factor in this outbreak, this problem may exist in other refugee camps. Fecally contaminated, standing rainwater may have facilitated transmission of disease at Tug Wajale B. Finally, refugee camps are sites of contact between susceptible refugees, who may have come from remote areas, and refugees who have come from areas where this virus is endemic. Staff members working in refugee camps are also at risk for acquiring this disease and should be careful to wash their hands after contact with patients and before eating and smoking. Because of poor sanitary conditions in these camps, enterically transmitted non-A, non-B hepatitis, like other enteric diseases, is likely to be difficult to control.

FIGURE 2. Reported cases of jaundice among Ethiopian refugees, by month — eastern Sudan, June-December 1985



References

1. Decock KM, Bradley DW, Sandford NG, et al. Epidemic non-A, non-B hepatitis in patients from Pakistan. Ann Intern Med 1987;106:227-30.
2. Viswanathan R. Infectious hepatitis in Delhi (1955-56): a critical study—observations in pregnant women. Indian J Med Res 1957(suppl);45:1-76.
3. Sreenivasan MA, Banarjee K, Pandya PG, et al. Epidemiological investigations of an outbreak of infectious hepatitis in Ahmedabad City during 1975-76. Indian J Med Res 1978;67:197-206.
4. Wong DC, Purcell RH, Sreenivasan MA, Prasad SR, Pavri KM. Epidemic and endemic hepatitis in India: evidence for non-A, non-B hepatitis virus etiology. Lancet 1980;2:876-8.
5. Tandon BN, Joshi YK, Jain SK, Gandhi BM, Mathiesen LR, Tandon HD. An epidemic of non-A non-B hepatitis in north India. Indian J Med Res 1982;75:739-44.
6. Khuroo MS. Study of an epidemic of non-A, non-B hepatitis: possibility of another human hepatitis virus distinct from post-transfusion non-A, non-B type. Am J Med 1980;68:818-24.
7. Kane MA, Bradley DW, Shrestha SM, et al. Epidemic non-A, non-B hepatitis in Nepal: recovery of a possible etiologic agent and transmission studies in marmosets. JAMA 1984;252:3140-5.
8. Myint H, Soe MM, Khin T, Myint TM, Tin KM. A clinical and epidemiological study of an epidemic of non-A non-B hepatitis in Rangoon. Am J Trop Med Hyg 1985;34:1183-9.
9. Belabbes H, Benatallah A, Bouguermouh A. Non-A, non-B epidemic viral hepatitis in Algeria: strong evidence for its water spread [Abstract]. In: Vyas GN, Dienstag JL, Hoofnagle JH, eds. Viral hepatitis and liver disease. Orlando Florida: Grune and Stratton, Inc, 1984:637.
10. Balayan MS, Andjaparidze AG, Savinskaya SS, et al. Evidence for a virus in non-A, non-B hepatitis transmitted via the fecal-oral route. Intervirology 1983;20:23-31.

Current Trends

Tuberculosis Provisional Data — United States, 1986

In 1986, a provisional total of 22,575 tuberculosis cases was reported to CDC. This was an increase of 374 cases (1.7%) over the 1985 final total of 22,201 cases (Figure 4). In 1986, the provisional incidence rate was 9.4/100,000 population, a 1.1% increase from the 1985 final rate of 9.3/100,000.

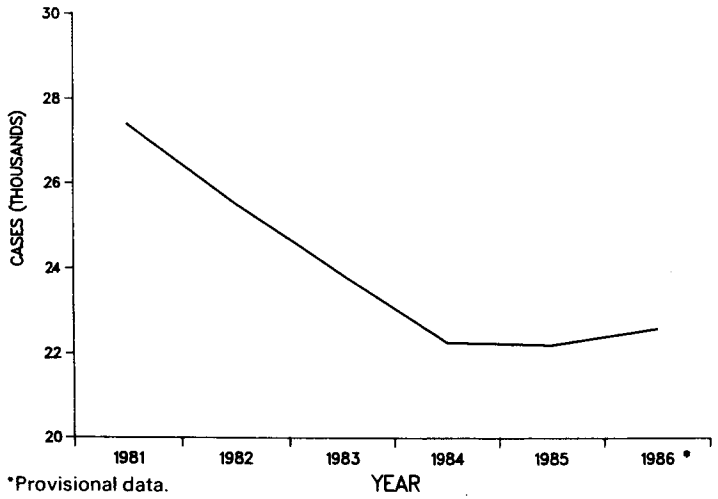
Reported by: Div of Tuberculosis Control, Center for Prevention Svcs, CDC.

Editorial Note: For the period 1982-1984, the incidence of tuberculosis declined an average of 1,706 cases (6.7%) a year. In 1985, this steadily downward trend halted when there was a decline of 54 cases (0.2%). The increase in cases in 1986 marks the first substantial rise in indigenous tuberculosis morbidity in the United States since 1953, when national reporting of tuberculosis was fully implemented.

While the reasons for this increase are not fully known, available evidence suggests that persons infected with both the human immunodeficiency virus (HIV) and the tubercle bacillus account for part of the change in morbidity (*1-6*). Matching of AIDS and tuberculosis registries in 24 states and four localities indicates that 645 (4.2%) of 15,181 patients with AIDS have also had tuberculosis. In addition, an increase in tuberculosis among minorities (*4*), the homeless, and persons born in foreign countries may be contributing to the overall increase in morbidity.

The impact of AIDS and HIV infection on tuberculosis morbidity in the United States would be better understood if all health departments would match AIDS and tuberculosis registries. Health departments should routinely offer HIV testing and counseling to patients with tuberculosis, and the confidentiality of results should be assured. Individuals with both HIV and tuberculous infection should be managed according to recently published guidelines (*7*).

FIGURE 4. Reported tuberculosis cases — United States, 1981-1986



*Provisional data.

References

1. CDC. Tuberculosis and acquired immunodeficiency syndrome—Florida. MMWR 1986;35:587-90.
2. Stoneburner RL, Kristal A. Increasing tuberculosis incidence and its relationship to acquired immuno deficiency syndrome in New York City. Presented at the International Conference on the Acquired Im munodeficiency Syndrome (AIDS), Atlanta, Georgia, April 1985.
3. CDC. Tuberculosis—United States, 1985—and the possible impact of human T-lymphotropic viru type III/lymphadenopathy-associated virus infection. MMWR 1986;35:74-6.
4. CDC. Tuberculosis—United States, 1985. MMWR 1986;35:699-703.
5. Chaisson RE, Theuer CP, Schecter GF, Rutherford GW, Echenberg DF, Hopewell PC. Clinical aspect of tuberculosis in AIDS patients: a population based study. Presented at the Second Internationa Conference on the Acquired Immunodeficiency Syndrome (AIDS), Paris, France, June 1986.
6. Sunderam G, McDonald RJ, Maniatis T, Oleske J, Kapila R, Reichman LB. Tuberculosis as a manifestation of the acquired immunodeficiency syndrome (AIDS). JAMA 1986;256:362-6.
7. CDC. Diagnosis and management of mycobacterial infection and disease in persons with human T-lymphotropic virus type III/lymphadenopathy-associated virus infection. MMWR 1986;35:448-52.

CENTERS FOR DISEASE CONTROL

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Epidemiologic Notes and Reports

Trends in Human Immunodeficiency Virus Infection Among Civilian Applicants for Military Service — United States, October 1985-December 1986

Since October 1985, the U.S. Department of Defense has routinely tested civilian applicants for serologic evidence of infection with human immunodeficiency virus (HIV) as part of their preinduction medical evaluation (*1*). Results from the first 6 months of testing have been reported previously (*2,3*). Results for the first 15 months provide the opportunity to observe trends of infection in this population.

Between October 1985 and December 1986, 789,578 civilian applicants for military service were screened. Of these, 1,186 were confirmed as HIV-antibody positive by enzyme immunoassay and Western blot immunoelectrophoresis, for an overall rate of 1.5/1,000 individuals tested. Seroprevalence per 1,000 varied by age, sex, race and ethnicity, and region of residence. By age, it was 0.6 for 17-20 year-olds, 2.5 for 21-25 year-olds, and 4.1 for those ⩾ 26 years of age. By sex, it was 1.6 for males and 0.6 for females. By race and ethnicity, seroprevalence per 1,000 was 0.8 for whites, 4.1 for blacks, 2.3 for Hispanics, 1.0 for American Indians or Alaskan Natives and Asian or Pacific Islanders. Table 1 shows the seroprevalence among civilian applicants by region of residence.

TABLE 1. Prevalence of HIV antibody* among civilian applicants for military service, by age group and region of residence — October 1985-December 1986

Region†	Age Group (Years) 17-20	21-25	⩾26	All Ages
New England	0.4	1.0	3.8	0.9
Middle Atlantic	0.7	4.6	10.0	2.9
EN Central	0.4	1.8	1.9	0.9
WN Central	0.2	1.0	1.8	0.6
South Atlantic	0.9	3.4	5.4	2.1
ES Central	0.4	1.9	1.3	0.9
WS Central	0.6	2.7	3.0	1.6
Mountain	0.3	1.5	1.9	0.9
Pacific	0.8	1.5	4.0	1.5
US Territories	1.6	6.3	12.3	5.8
All Regions	0.6	2.5	4.1	1.5

*Repeatedly reactive enzyme-linked immunosorbent assay (ELISA) test confirmed by Western blot immunoelectrophoresis; reported as the number of antibody-positive applicants per 1,000 tested.
†Defined in notifiable diseases table (Table III).

During the 15-month observation period, the seroprevalence did not change significantly, either in the aggregate or when analyzed by age, sex, race and ethnicity (Figure 1), or geographic region. However, seroprevalence among white males showed a small but significant decline of 0.02/1,000 applicants tested per month ($p = 0.016$ by Chi Square test for trends in proportions using a logistic regression linear model).

Reported by: Health Studies Task Force, Office of the Assistant Secretary of Defense (Health Affairs), US Dept of Defense, Washington, DC. Div of Preventive Medicine and Div of Communicable Diseases and Immunology, Walter Reed Army Institute of Research, Washington, DC. Surveillance and Evaluation Br, AIDS Program, Center for Infectious Diseases, CDC.

Editorial Note: AIDS cases reported to CDC continue to increase*. However, because of the lengthy incubation period of AIDS (*4*), these cases represent infection occurring at least several years prior to the report of disease. There has been little information to indicate current trends in HIV infection. Analysis of the results of the testing of civilian applicants thus far basically shows neither an increase nor a decrease in infection level for the group as a whole or for individual subgroups. The significance of this apparent absence of change in antibody prevalence during the 15-month period studied is not yet clear.

Volunteers for military service, who are verbally screened by the recruiting official prior to arrival at the medical evaluation center, are not fully representative of the overall population in that they underrepresent the three groups in the United States with the highest prevalence of HIV infection†. Moreover, applicants do not equally represent all socioeconomic and demographic groups in the population. A growing awareness of the military serologic screen-

bias. One such surveillance approach, in which anonymously tested sample populations without AIDS-like disease are monitored at participating hospitals, has been initiated recently by CDC. Trends in exposure risks among seropositive individuals should also be monitored to assess possible changes in the relative frequency of the various modes of transmission. Follow-up interviews of a small number of seropositive applicants have found a high proportion with typical risk exposures for AIDS (*5*). CDC is collaborating with the U.S. Department of Defense, the National Cancer Institute of the National Institutes of Health, and certain state and local health departments to develop a systematic follow-up evaluation of seropositive civilian applicants in selected cities and states.

References

1. Herbold JR. AIDS policy development within the Department of Defense. Milit Med 1986;151:623-7.
2. CDC. Human T-lymphotropic virus type III/lymphadenopathy-associated virus antibody prevalence in U.S. military recruit applicants. MMWR 1986;35:421-4.
3. Burke DS, Brundage JF, Bernier W, et al. Demography of HIV infections among civilian applicants for military service in four counties in New York City: a preliminary analysis. New York State Med J [In press].
4. Lui KJ, Lawrence DN, Morgan WM, Peterman TA, Haverkos HW, Bregman DJ. A model-based approach for estimating the mean incubation period of transfusion-associated acquired immunodeficiency syndrome. Proc Natl Acad Sci 1986;83:3051-5.
5. Stoneburner RL, Chiasson MA, Solomon K, Rosenthal S. Risk factors in military recruits positive for HIV antibody [Letter]. N Engl J Med 1986;315:1355.

*An average of 38.3 AIDS cases per day were reported for the period October-December 1986, compared with an average of 26.3 per day for the period October-December 1985.

†Active intravenous drug abusers, homosexual men, and hemophiliacs.

§Long-term data are not yet available for this group.

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Epidemiologic Notes and Reports

Update: Human Immunodeficiency Virus Infections in Health-Care Workers Exposed to Blood of Infected Patients

Six persons who provided health care to patients with human immunodeficiency virus (HIV) infection and who denied other risk factors have previously been reported to have HIV infection. Four of these cases followed needle-stick exposures to blood from patients infected with HIV (*1-4*). The two additional cases involved persons who provided nursing care to persons with HIV infection. Although neither of these two persons sustained needle-stick injuries, both had extensive contact with blood or body fluids of the infected patient, and neither observed routinely recommended barrier precautions (*5,6*).

CDC has received reports of HIV infection in three additional health-care workers following non-needle-stick exposures to blood from infected patients. The exposures occurred during 1986 in three different geographic areas. Although these three cases represent rare events, they reemphasize the need for health-care workers to adhere rigorously to existing infection control recommendations for minimizing the risk of exposure to blood and body fluids of all patients (*7-9*).

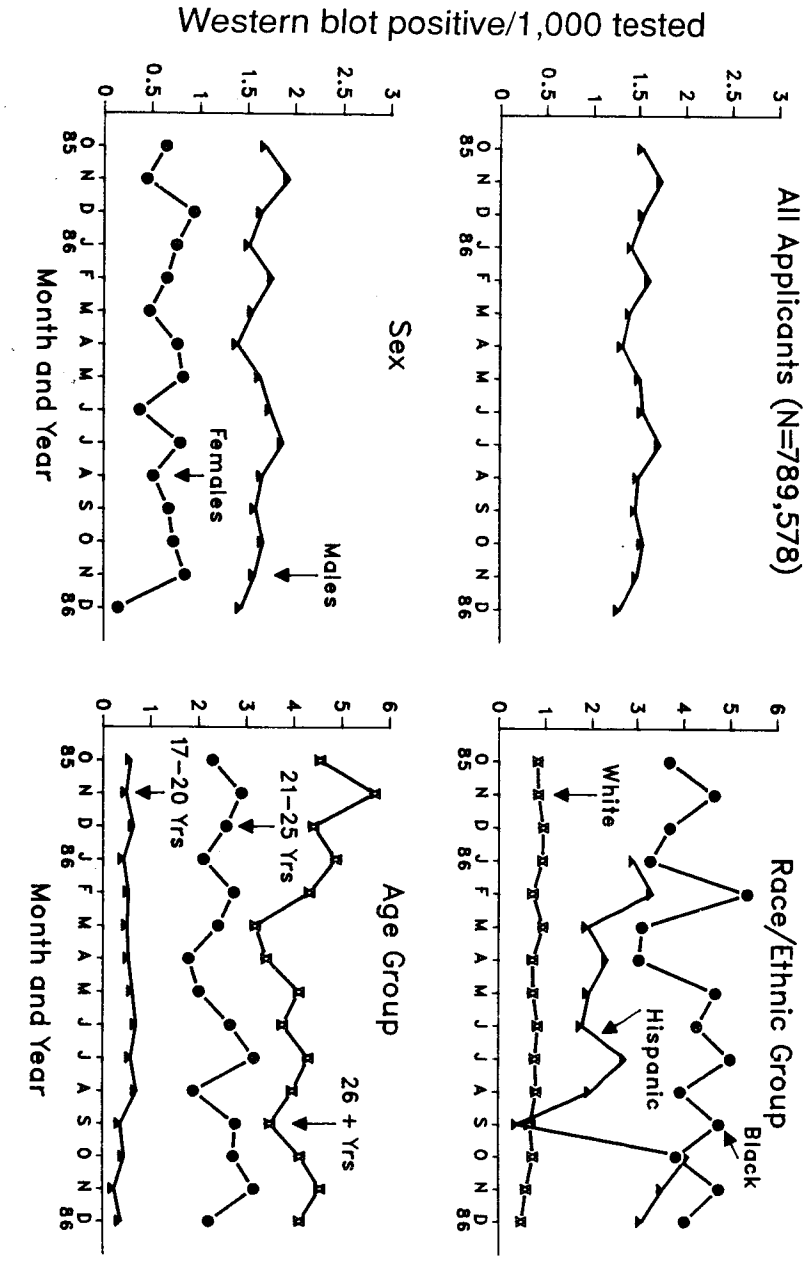

FIGURE 1. Human immunodeficiency virus antibody among civilian applicants*, by month — United States, October 1985-December 1986

*U.S. Department of Defense data.

ing program may have increased self-deferral by persons who are HIV-antibody positive or who feel they may have been exposed to the virus. If so, this could have masked an increased frequency of infection in the population from which the applicants are drawn.

Monitoring trends in infection among civilian applicants for military service as well as among blood donors[§] remains important. It is also critical to compare trends in infection among these volunteer groups with similar trends among groups not affected by self-selection

Health-Care Worker 1: A female health-care worker assisting with an unsuccessful attempt to insert an arterial catheter in a patient suffering a cardiac arrest in an emergency room applied pressure to the insertion site to stop the bleeding. During the procedure, she may have had a small amount of blood on her index finger for about 20 minutes before washing her hands. Afterwards, she may also have assisted in cleaning the room but did not recall any other exposures to the patient's blood or body fluids. She had no open wounds, but her hands were chapped. Although she often wore gloves when anticipating exposure to blood, she was not wearing gloves during this incident.

The patient with the cardiac arrest died. A postmortem examination identified *Pneumocystis carinii* pneumonia, and a blood sample was positive for HIV antibody by enzyme immunoassay (EIA) and Western blot methods. Twenty days after the incident, the health-care worker became ill with fever, myalgia, extreme fatigue, sore throat, nausea, vomiting, diarrhea, a 14-pound weight loss, and generalized lymphadenopathy which her physician diagnosed as a viral syndrome. That illness lasted 3 weeks. She felt much better 9 weeks after the incident, and, when she was examined 6 months after the incident, all signs and symptoms had resolved. She had donated blood 8 months before the incident and was negative for HIV antibody by EIA. She donated again 16 weeks after the incident and was positive for HIV by EIA and Western blot (bands p24 and gp41). Serum samples obtained 20 and 23 weeks after the incident were also positive for HIV antibody. She stated that for over 8 years her only sexual partner had been her husband, who denied risk factors for HIV and was seronegative for HIV antibody. She denied ever receiving a blood transfusion, ever using intravenous drugs, or having any needle sticks or other significant exposures to blood or body fluids in the past 8 years. Her serologic test for syphilis was negative. Fifteen other employees who assisted in the care of the patient were seronegative at least 4 months after the exposure.

Health-Care Worker 2: A female phlebotomist was filling a 10 ml vacuum blood collection tube with blood from an outpatient with a suspected HIV infection when the top of the tube flew off and blood splattered around the room, on her face, and in her mouth. She was wearing gloves to protect her hands and was wearing eyeglasses so she did not think she got any blood in her eyes. She had facial acne but no open wounds. She washed the blood off immediately after the exposure. The outpatient's blood sample was positive for HIV antibody by EIA and Western blot, and a hepatitis B surface antigen test was negative. The phlebotomist's EIA was negative the day after the incident and again 8 weeks later. When she donated blood 9 months after the exposure, she was positive for HIV antibody by EIA and Western blot (bands p24 and gp41). She has had no symptoms. She denied having any sexual contact during the previous 2 years, ever using drugs intravenously, or ever receiving a transfusion. Two months after the incident, she scratched the back of her hand with a needle used to draw blood from an intravenous drug abuser of unknown HIV-antibody status. She did not bleed as a result of the scratch and has not had any needle-stick injuries in over 2 years. Her serologic tests for syphilis and hepatitis B were negative. A coworker who was splattered with blood on the face and in the mouth during the same incident remains seronegative 1 year after the incident.

Health-Care Worker 3: A female medical technologist was manipulating an apheresis machine (a device to separate blood components) to correct a problem that developed during an outpatient procedure when blood spilled, covering most of her hands and forearms. She was not wearing gloves. She does not recall having any open wounds on her hands or any mucous-membrane exposure. However, she had dermatitis on one ear and may have touched it. She washed the blood off herself and the machine several minutes after the spill. The patient undergoing the apheresis had denied risk factors for HIV infection. However, a blood sample from the patient was positive for HIV antibody by EIA and Western blot methods and negative for hepatitis B surface antigen the next day. The technologist's HIV-antibody tests were negative 5 days after the exposure and again 6 weeks later. Eight weeks after the exposure, she had an influenza-like illness with fever, myalgia, diarrhea, hives, and a pruritic red macular rash on her arms and legs. The illness resolved after a few weeks, and her physician thought the illness was probably a viral syndrome. Three months after the incident, she was positive for HIV antibody by EIA and Western blot methods (band p24 alone). Four months after the incident, a Western blot was positive (bands p24 and gp41). She indicated that for more than 8 years her only sexual partner had been her husband, who denied risk factors for HIV infection and was seronegative for HIV antibody. She denied ever receiving a transfusion, ever using intravenous drugs, or having any needle-stick injuries in over 2 years. Her serologic tests for syphilis and hepatitis B were negative. She has an immunologic disorder which had been treated with corticosteroids in the past, but she had not taken any immunosuppressive medication for the past year. A coworker with a similar exposure during the same procedure remains seronegative after 3 months.

Reported by: Hospital Infections Program and AIDS Program, Center for Infectious Diseases, CDC.

Editorial Note: Three instances of health-care workers with HIV infections associated with skin or mucous-membrane exposure to blood from HIV-infected patients are reported above. Careful investigation of these three cases did not identify other risk factors for HIV infection, although unrecognized or forgotten needle-stick exposures to other infected patients cannot be totally excluded. The exact route of transmission in these three cases is not known. Health-Care Worker 1 had chapped hands, and the duration of contact with the blood of the patient experiencing a cardiac arrest may have been as long as 20 minutes. Health-Care Worker 2 sustained contamination of oral mucous membranes. This individual also had acne but did not recall having open lesions. In addition, she had sustained a scratch from a needle used to draw blood from an intravenous drug abuser of unknown HIV-infection status. Health-Care Worker 3 had a history of dermatitis involving an ear. Health-Care Workers 1 and 3 were not wearing gloves when direct contact with blood occurred. Health-Care Worker 2 was wearing gloves, but blood contaminated her face and mouth.

Three ongoing prospective studies provide data on the magnitude of the risk of HIV infection incurred when health-care workers are exposed to blood of infected patients through needle-stick wounds or contamination of an open wound or mucous membrane. In a CDC cooperative surveillance project (*10*), a total of 1,097 health-care workers with parenteral or mucous-membrane exposure to the blood of patients with AIDS or other manifestations of HIV infection had been enrolled as of March 31, 1987. Needle-stick injuries and cuts with sharp objects accounted for 969 (89%) of the exposures to blood; 298 of these had paired serum samples tested for HIV antibody. One (0.3%) seroconverted (*2*), indicating that the risk of transmission during these exposures is very low. In addition, 70 health-care workers had open wounds exposed to blood, and 58 had mucous membrane exposed to blood. Postexposure serum samples from 82 of these 128 workers have been tested for antibody to HIV; none was seropositive.

In a study at the National Institutes of Health (*11*) through April 30, 1987, none of the 103 workers with percutaneous exposures and none of the 229 workers with mucous-membrane exposures to blood or body fluids of patients with AIDS was seropositive. At the University of California (*12*), none of 63 workers with open wounds or mucous membranes exposed to blood or body fluids of patients with AIDS was seropositive. Although the precise risk of transmission during exposures of open wounds or mucous membranes to contaminated blood cannot be defined, these studies indicate that it must be very low.

The three cases reported here suggest that exposure of skin or mucous membranes to contaminated blood may rarely result in transmission of HIV. The magnitude of the risk is not known since data on the frequency with which such exposures occur are not available. Skin and mucous-membrane exposures are thought to occur much more commonly than needle sticks, and the risk associated with skin or mucous-membrane exposures is likely to be far lower than that associated with needle-stick injuries. Nonetheless, the increasing prevalence of HIV infection increases the potential for such exposures, especially when routinely recommended precautions are not followed.

It is unlikely that routine serologic testing for HIV infection of all patients admitted to hospitals would have prevented these exposures since two of the three exposures occurred in the outpatient clinic setting, and one occurred during a resuscitation effort in an emergency room shortly after the arrival of the patient. At the time of exposure, Health-Care Worker 2 suspected that the source patient was infected with HIV, but Health-Care Workers 1 and 3 did not. The hospital where Health-Care Worker 3 was exposed has a protocol for apheresis which normally involves HIV-antibody testing of donors; however, such testing was not done in advance of the procedure. Previous CDC recommendations have emphasized the value of HIV serologic testing for patient diagnosis and management and for prevention and control of HIV transmission (*13*) and have stated that some hospitals in certain geographic areas may deem it appropriate to initiate serologic testing of patients (*7*). Such testing may also provide an opportunity to reduce the risk of HIV infection to health-care workers, but it has not been established that knowledge of a patient's serologic status increases the compliance of health-care workers with recommended precautions.

These cases emphasize again the need to implement and strictly enforce previously published recommendations for minimizing the risk of exposure to blood and body fluids of all patients in order to prevent transmission of HIV infection in the workplace and during invasive procedures (*7-9*).

1. As previously recommended, routine precautions must be followed when there is a possibility of exposure to blood or other body fluids. The anticipated exposure may require gloves alone (e.g., when placing an intravascular catheter or handling items soiled with blood or equipment contaminated with blood or other body fluids). Procedures involving more extensive contact with blood or potentially infective body fluids (e.g., some dental or endoscopic procedures or postmortem examinations) may require gloves, gowns, masks, and eye-coverings. Hands and other contaminated skin surfaces should be washed thoroughly and immediately if accidentally contaminated with blood (*7*). These precautions deserve particular emphasis in emergency care settings in which the risk of blood exposure is increased and the infectious status of the patient is usually unknown (*14*).
2. Previous recommendations have emphasized management of parenteral and mucous-membrane exposures of health-care workers*. In addition, health-care workers who are involved in incidents that result in cutaneous exposures involving large amounts of blood or prolonged contact with blood—especially when the exposed skin is chapped, abraded, or afflicted with dermatitis—should follow these same recommendations. Moreover, serologic testing should be available to all health-care workers who are concerned that they may have been infected with HIV.

References

1. Anonymous. Needlestick transmission of HTLV-III from a patient infected in Africa. Lancet 1984; 2:1376-7.
2. Stricof RL, Morse DL. HTLV-III/LAV seroconversion following a deep intramuscular needlestick injury [Letter]. N Engl J Med 1986;314:1115.
3. Oksenhendler E, Harzic M, Le Roux JM, Rabian C, Clauvel JP. HIV infection with seroconversion after a superficial needlestick injury to the finger. N Engl J Med 1986;315:582.
4. Neisson-Vernant C, Arfi S, Mathez D, Leibowitch J, Monplaisir N. Needlestick HIV seroconversion in a nurse. Lancet 1986;2:814.
5. Grint P, McEvoy M. Two associated cases of the acquired immune deficiency syndrome (AIDS). PHLS Commun Dis Rep 1985;42:4.
6. CDC. Apparent transmission of human T-lymphotropic virus type III/lymphadenopathy-associated virus from a child to a mother providing health care. MMWR 1986;35:76-9.
7. CDC. Summary: recommendations for preventing transmission of infection with human T-lymphotropic virus type III/lymphadenopathy-associated virus in the workplace. MMWR 1985; 34:681-5, 691-5.
8. CDC. Recommendations for preventing transmission of infection with human T-lymphotropic virus type III/lymphadenopathy-associated virus during invasive procedures. MMWR 1986;35:221-3.
9. CDC. Recommended infection-control practices for dentistry. MMWR 1986;35:237-42.
10. McCray E, The Cooperative Needlestick Surveillance Group. Occupational risk of the acquired immunodeficiency syndrome among health-care workers. N Engl J Med 1986;314:1127-32.
11. Henderson DK, Saah AJ, Zak BJ, et al. Risk of nosocomial infection with human T-cell lymphotropic virus type III/lymphadenopathy-associated virus in a large cohort of intensively exposed health-care workers. Ann Intern Med 1986;104:644-7.
12. Gerberding JL, Bryant LeBlanc CE, Nelson K, et al. Risk of transmitting the human immunodeficiency virus, hepatitis B virus, and cytomegalovirus to health-care workers exposed to patients with AIDS and AIDS-related conditions. J Infect Dis 1987;156:1-8 (In press).
13. CDC. Recommended additional guidelines for HIV antibody counseling and testing in the prevention of HIV infection and AIDS. Atlanta, Georgia: US Department of Health and Human Services, Public Health Service, 1987.
14. Baker JL, Kelen GD, Sivertson KT, Quinn TC. Unsuspected human immunodeficiency virus in critically ill emergency patients. JAMA 1987;257:2609-11.
15. CDC. Prevention of acquired immune deficiency syndrome (AIDS): report of inter-agency recommendations. MMWR 1983;32:101-3.
16. CDC. Provisional Public Health Service inter-agency recommendations for screening donated blood and plasma for antibody to the virus causing acquired immunodeficiency syndrome. MMWR 1985;34:1-5.

*If a HCW [health-care worker] has a parenteral (e.g., needlestick or cut) or mucous membrane (e.g., splash to the eye or mouth) exposure to blood or other body fluids, the source patient should be assessed clinically and epidemiologically to determine the likelihood of HTLV-III/LAV [sic] infection. If the assessment suggests that infection may exist, the patient should be informed of the incident and requested to consent to serologic testing for evidence of HTLV-III/LAV [sic] infection. If the source patient has AIDS or other evidence of HTLV-III/LAV [sic] infection, declines testing, or has a positive test, the HCW should be evaluated clinically and serologically for evidence of HTLV-III/LAV [sic] infection as soon as possible after the exposure, and, if seronegative, retested after 6 weeks and on a periodic basis thereafter (e.g., 3, 6, and 12 months following exposure) to determine if transmission has occurred. During this follow-up period, especially the first 6-12 weeks, when most infected persons are expected to seroconvert, exposed HCWs should receive counseling about the risk of infection and follow U.S. Public Health Service (PHS) recommendations for preventing transmission of AIDS (*15,16*). If the source patient is seronegative and has no other evidence of HTLV-III/LAV [sic] infection, no further follow-up of the HCW is necessary. If the source patient cannot be identified, decisions regarding appropriate follow-up should be individualized based on the type of exposure and the likelihood that the source patient was infected (*7*).

CENTERS FOR DISEASE CONTROL

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Epidemiologic Notes and Reports

Human Immunodeficiency Virus Infection Transmitted From an Organ Donor Screened for HIV Antibody – North Carolina

In August 1986, a cadaveric organ donor was found positive for antibody to the human immunodeficiency virus (HIV) by both enzyme immunoassay (EIA) and Western blot methods after some of the donated organs had been transplanted. A blood sample, which was taken after the donor had received a large number of blood transfusions, had been negative for HIV antibody. Two days later, when the organs

were removed, more blood samples were collected. These were forwarded with the donated organs to the various transplantation centers. At one of these centers, one of these later samples was found to be seropositive.

Three persons received organs from this donor. Two of them were subsequently found to be seropositive for HIV antibody. The third, who had received the donor's heart, did not survive the transplant procedure. This is the first report of HIV transmission by organ transplantation from a donor screened for HIV antibody. A summary of the investigation of the donor and the two surviving recipients follows.

Donor. A 30-year-old man who was involved in a motor vehicle accident was admitted, while in a coma, to a North Carolina hospital. He was hypotensive because of bleeding from multiple head and neck lacerations. On admission, a blood sample was collected for type- and cross-matching, and blood transfusions were started within 1 hour. The donor's bleeding persisted despite surgery to improve hemostasis. Approximately 11 hours after admission, he had received a total of 56 units of blood and blood components (1 unit of whole blood, 28 units of packed red blood cells, 7 units of fresh frozen plasma, and 20 units of platelets). At this time, another blood sample was collected and tested for HIV antibody. The specimen was negative by EIA (Abbott Laboratories, North Chicago, Illinois; optical density ratio, sample/control = .103/.131). The donor's condition did not improve, and he was declared brain-dead 2 days after testing for HIV antibody. Family members consented to organ donation and denied any knowledge of the donor's having a risk factor for HIV infection.

The donor's kidneys, heart, and liver were removed and transported to other medical centers for transplantation. Samples of the donor's blood, which were collected when the organs were removed, were sent with each organ. As part of one center's routine procedure, one of these blood samples was tested for HIV antibody and was found positive by EIA (Genetic Systems, Seattle, Washington; optical density ratio = .95/<.30) and was subsequently found positive by Western blot assay. The transplantation teams were notified of the test result, but the heart, liver, and one kidney had already been transplanted.

Personnel from the hospital where the organs had been removed were contacted. They located both the serum sample collected on admission and the serum sample previously found negative for HIV antibody. The serum collected at the time of admission, before any transfusions were administered, was highly reactive on the Abbott EIAs performed at the hospital (optical density ratios = .766/.126, .556/.126) and at the North Carolina State Laboratory of Public Health (optical density ratios = .842/.108, .698/.137) and was also positive by Western blot assay at the state laboratory. When testing was repeated, the serum collected after the blood transfusions was again seronegative by EIA at the hospital and by both EIA and Western blot methods at the state laboratory.

Recipient 1. A man with end-stage renal disease received the donated kidney that was transplanted. The recipient is married and denied risk factors for HIV infection. He was negative for HIV antibody 3 days after transplantation. A blood specimen collected 10 weeks after transplantation was positive for HIV antibody by EIA, and a specimen collected 1 week later was positive by both EIA and Western blot assay. The recipient had a fever 8 days after receiving the renal allograft, and a biopsy of it showed acute rejection. He improved with additional immunosuppressive therapy. To date, he has not developed any opportunistic illness and continues to feel well.

Recipient 2. A man with sclerosis of the bilary ducts and progressive liver failure received the donated liver. He is married and denied risk factors for HIV infection. He was tested 4 days after transplantation and was negative for HIV antibody. Twelve weeks after the procedure, he was positive for HIV antibody by EIA, and a specimen collected 4 weeks later was positive by both the conventional EIA and an EIA using recombinant viral proteins (ENVACORE, Abbott Laboratories). Four months after transplantation, the recipient developed fever and malaise. A liver biopsy showed moderate allograft rejection. The recipient's condition improved with an adjustment in immunosuppressive therapy, and he returned home the following month.

Reported by: TW Lane, MD, Univ of North Carolina, Chapel Hill, and Moses H Cone Memorial Hospital, Greensboro; R Meriwether, MD, FV Crout, PhD, JN MacCormack, MD, MPH, State Epidemiologist, North Carolina Dept of Human Resources. L Makowka, MD, Univ of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania. SA Lobel, PhD, PA Bowen, MD, RJ Caruana, MD, Medical College of Georgia, Augusta, Georgia. AIDS Program, Center for Infectious Diseases, CDC.

Editorial Note: Previous reports have linked kidney-transplant recipients who have subsequently become HIV-seropositive with donors who were later found to have risks for HIV infection (*1-4*). However, this is the first report of transplantation-associated HIV transmission from a cadaveric organ donor screened for HIV antibody. This donor appears to have been false-negative for HIV antibody by EIA as a result of the large number of transfusions he received before serum was collected for testing.

The Public Health Service recommended in May 1985 that potential organ donors be screened for HIV antibody (*5*). In January 1986, CDC conducted an anonymous survey of representatives from 44 transplantation programs attending a meeting of the Southeastern Organ Procurement Foundation. All of the 26 representatives who responded reported that their centers screened donors for HIV antibody. Three of these representatives (12%) also reported identifying at least one potential organ donor who was positive for HIV antibody by EIA and Western blot methods.

Organs from donors who are HIV-seropositive should not be used for transplantation except in very unusual circumstances. If an urgent need requires considering transplantation of an organ from a seropositive donor, the potential recipient or the appropriate family members should be informed of the risks of acquiring HIV infection. Such transplantation should not take place without the consent of either the potential recipient or the appropriate family members. When donors have been transfused before their organs are removed, testing for HIV antibody should be conducted on serum collected at the time of admission rather than on serum obtained after multiple transfusions. If donor serum collected at the time of admission is not available from other sources, a pretransfusion sample may be available from the blood bank since many blood banks hold specimens collected for compatibility testing for at least 7 days (*6*).

References

1. Prompt CA, Reis MM, Grillo FM, et al. Transmission of AIDS virus at renal transplantation [Letter]. Lancet 1985;2:672.
2. L'age-Stehr J, Schwarz A, Offermann G, et al. HTLV-III infection in kidney transplant recipients [Letter]. Lancet 1985;2:1361-2.
3. Margreiter R, Fuchs D, Hansen A, et al. HIV infection in renal allograft recipients. Lancet 1986;2:398.
4. Kumar P, Pearson JE, Martin DH, et al. Transmission of human immunodeficiency virus by transplantation of a renal allograft, with development of the acquired immunodeficiency syndrome. Ann Intern Med 1987;106:244-5.
5. CDC. Testing donors of organs, tissues, and semen for antibody to human T-lymphotropic virus type III/lymphadenopathy-associated virus. MMWR 1985;34:294.
6. American Association of Blood Banks. Standards for blood banks and transfusion services. 12th ed. Washington, DC: American Association of Blood Banks, 1987:31.

FORESKIN PRESENCE MAY INCREASE RISK

with thanks to Medical Aspects of Human Sexuality—Sexuality Update, February, 1987

An uncircumcised penis may predispose heterosexual men to female-to-male transmission of AIDS. The mucosal inner layer of the foreskin is delicate and easily abraded, increasing the risk that HIV in cervical secretions will gain entry to the man's body through skin break. When the penis is erect, this mucosal lining can represent nearly 50% of the surface area of the penile shaft. The AIDS virus could thus be transferred in much the same way as herpes and syphilis pathogens, which can enter the body through a skin tear or scrape. [Presumably the same mechanism applies to uncircumcised men not using condoms being the insertive partner during anal intercourse.]

Reference: Fink, A.J. "A possible explanation for heterosexual female infection with AIDS." New England Journal of Medicine, 315:1167, 1986. Comments in brackets ([]) are from the NCGSTDS editor.

COSTS OF AIDS

AIDS, a phrase never uttered until less than 8 years ago, is now, tragically, a household word. Over 1 million Americans are believed already infected with the virus thought to cause the disease, and the U.S. Public Health Service predicts more than 270,000 full blown AIDS cases by 1991. What is AIDS costing our country in lives? In dollars? What are the social costs? And how are physicians dealing with this disease? These are the questions addressed in the April 1987 issue of The Internist: Health Policy in Practice, the magazine of the American Society of Internal Medicine. According to co-authors Richard M. Selik, MD, Ann M. Hardy, DrPh, and E. Thomas Starcher II of the Centers for Disease Control in Atlanta, almost all people with AIDS may ultimately die from a complication of the disease. Projected trends indicate that the number of PWAs reported in 1991 alone will be 74,000 and that about 54,000 people will die from the disease that year. They note, "For men aged 25 to 44 years in the United States who had never married, AIDS ranked just below cancer as a cause of years of potential life lost in 1984. For the same populations in Manhattan and San Francisco, AIDS was the leading cause of years of potential life lost." The financial burden that the AIDS epidemic is imposing on individuals, on society in general, and in particular on the metropolitan centers where the disease is concentrated has caused widespread concern. Co-Authors Anne A. Scitovsky and Dorothy Rice, of the Research Institute of the Palo Alto Medical Foundation in California, have calculated both the direct costs of this disease (the costs for expenditures for hospital services, physician inpatient and outpatient services, outpatient ancillary services, and nursing home, home care and hospice services, research, blood screening and testing, replacement of blood, health education and support services) and the indirect costs (productivity losses because of illness and disability, and the value of future earnings lost for those who died prematurely as a result of AIDS). The 1986 figure for the total direct and indirect costs of AIDS is $8.7 billion. They write, "The annual costs of the AIDS epidemic to date have been relatively low when compared with the economic costs of all illness as well as the costs of some other diseases. These comparisons are in no way intended to belittle the burden that the epidemic imposes on its victims and society in general. If the epidemic spreads as forecast by the CDC, its burden will be very heavy and, unlike the situation today, will be felt throughout the nation." There are other "costs" associated with the AIDS epidemic that are not as well documented, but are just as real. Author June E. Osborn, MD, dean of the University of Michigan's School of Public Health writes, " The cost of the disease AIDS is measured in a currency of physical wasting and neurologic deterioration; the cost of its care is expressed in health care dollars; the cost of those thousands of young lives prematurely terminated is assessed in years of productive life lost; but the cost to humanity of blighted creativity and ablation of trained talent has no currency at all, for it is a priceless loss.... And yet, from the time of diagnosis, it not before, some of them have experienced barbaric things in large or small measure. PWAs have been evicted from their homes by landlords or by loved ones; they have been been abruptly deprived of their livelihood by subterfuge or direct confrontation with employers or fellow employees. Ambulance drivers have balked at helping when they become too ill to cope alone.... Fear outpaces reassurance in startling ways." How do physicians deal with their patients' terminal diagnosis and the fear and alienation that comes with it? Jerome E. Groopman, MD, chief of the division of Hematology/Oncology at New England Deaconess Hospital in Boston, believes, "Although caring for [PWAs] is at times stressful and depressing, it is also extraordinary gratifying. The greatest strengths that patients have are often shown throughout their struggle with their illness." and he notes, "The physician has a challenging and complex role int he care of [PWAs]. He must learn a new body of clinical knowledge in order to diagnose and teat the infectious and neoplastic manifestations of the syndrome. As important as the scientific information is in the care of AIDS patients, the sensitivity and ability to cope with a severely debilitating and emotionally stressful illness must also be developed." C. Burns Roehrig, MD, editor of The Internist: Health Policy in Practice, agrees. He concludes, "There is a great opportunity for the medical profession in this challenge. In response to it, we can begin to reaffirm our social contract as physicians, to restore some of the image of altruism and service lost in this era of high incomes and competition, of third party payors and high technology. We have the opportunity to stand tall, to assert leadership in a domain that is proper for us, to provide knowledge and care with compassion and concern to a society that is groping for some answers and for protection from a new epidemic disease." Also in this issue are articles on how to educate and counsel patients about AIDS (which includes a comprehensive resource list) and the legal implications of caring for PWAs. The monthly "InnerView" focuses on Robert E. Windom, MD, Asst. Secretary for Health in the Dept. of Health and Human Services, and his views on AIDS, physician oversupply and the Administration's stand on tobacco issues. For a copy of the April issue of The Internist: Health Policy in Practice, send $3 to ASIM, 1101 Vermont Av. N.W., Suite 500, Washington, DC 20005-3457. One year's subscriptions are also available for $24 (10 issues).

AZT AFFORDABILITY--HOW?

with thanks to Rick Harding and The Washington Blade, 3/27/87

Although the promising AIDS drug AZT was recently approved for marketing by the federal Food and Drug Administration, the question remains unclear as to how many people who need the extremely expensive drug will not be able to afford it, and what will be done to help them. At nearly $2 per pill, AZT is one of the most expensive drugs ever produced. It will cost the average user $8-10,000 per year, not including costs for recommended biweekly blood tests, nor blood transfusions for those who experience toxic anemia while using the drug. AZT's manufacturer attributes the drug's high cost to a multi-million dollar research effort which they say preceded its development and release. Although no official figures exist, Jeff Levi, executive director of the National Gay & Lesbian Task force, says that using the "most conservative estimates," at least 10% of those needing AZT will not be able to afford it, either because they do not have health insurance which covers prescriptions, or they do not qualify for federal assistance programs. Using the 10% estimate, which insurance experts agree may be very conservative, at least 500 people who currently receive free AZT through government regulated testing programs will not be able to afford the drug. That number is expected to grow rapidly as more people apply for the drug under its expanded applicability recommendations which permit AZT use by both AIDS and AIDS-related conditions patients. The staff of Rep. Henry Waxman (D-California), who heads the House Health and Environment Subcommittee, is "scrambling" to gather data on the scope of the AZT affordability problem, said Waxman aide Tim Westmoreland. He criticized the Public Health Service for not having gathered its own information on the issue. "With all the statistical data the administration has gathered on AIDS," Westmoreland said, "they don't have any statistics on how AIDS treatments will be paid for." According to the Health Insurance Association of America, most people who have health insurance plans which include prescriptive benefits will be covered when purchasing AZT. Association spokeswoman Amy Bidderman said that "most" health insurance plans include some kind of prescription coverage that "kicks in after the member pays a deductible." Representatives of the DC area's major health insurance organizations confirmed that the cost of AZT is covered for their members who have prescription coverage. Jim Stoker, a spokesman for Blue Cross and Blue Shield, said 70% of its members, including all who are federal employees, have prescription coverage. Under a typical Blue Cross program, he said, 75 to 80% of prescription costs are paid after a $50 to $250 deductible. Katherine McKay, spokeswoman for the area's largest health maintenance organization, Kaiser Permanente, said about 80% of its members have a plan which typically provides for free prescriptions after a $50 deductible. A spokesman for the Chicago consulting firm Charles Spencer and Associates, which studies employment benefits including health insurance plans, said that "no accurate data exists" on what portion of the population is covered by health insurance. He said those usually not covered are the self-employed; part-timers; workers in service-related occupations, such as waiters and bartenders; or workers in small organizations. for people without health insurance and who cannot afford medical treatment, the federally-subsidized health assistance program Medicaid is available with restrictions which vary from state to state. Some states will not cover prescription costs at all, others cover only certain drugs, and others cover all FDA-approved drugs. According to James Harris of the DC Health Care Financing Office, AZT is covered under the District's Medicaid program. Restrictions are so stringent, however, that only the extremely destitute can qualify. Current DC regulations require net assets of under $2500 and a monthly income of under $361. The allowable income is slightly higher for those supporting families. Medicaid programs in both Maryland and Virginia also cover most FDA-approved prescription drugs, and will cover AZT unless a special exception is made. But, spokespersons from health agencies in both states said they knew of no effort to exclude AZT from the programs. People with ARC, whom some AZT researchers believe may be helped most by the drug because of their less damaged immune systems, rarely qualify for Medicaid because they do not meet the program's definition of medically disabled. Locally, the Metropolitan Washington Committee on AIDS Issues, a coalition of gay organizations, is planning a forum to bring together health care professionals and government officials to discuss the AZT affordability problem. Meanwhile, according to city officials, no programs have yet been proposed to assist those who cannot afford the drug. On the national level, Rep. Waxman is asking that $60 million be appropriated for fiscal 1988 to help pay for AIDS drugs for the indigent and is asking the House Appropriations Committee to set aside AIDS drug assistance funds for this year. In a speech before the National Press Club In March, Surgeon General C. Everett Koop said "the time has come for us as federal, state, and local authorities to get together and decide how we're going to pay for [AZT]." He said that as Surgeon General, he does not have the power to call such a meeting, but that he has suggested it numerous times. Kathy Bartlett, a spokeswoman for AZT manufacturer Burroughs Wellcome, said that AIDS patients currently receiving free AZT under the testing program will soon be sent one last month's supply of the drug, and advised that they must start purchasing it at a commercial pharmacy. She said the company will be able to supply approximately 15,000 people with the drug--including the 5000 who now receive it free--and expects to double that supply by the end of the year. If requests for the drug exceed the supply, Bartlett said, a Burroughs Wellcome committee in consultation with the Infectious Disease Society of America will decide who should receive it first, based on degree of illness. She said for patients who notify the company that they cannot afford AZT, Burroughs Wellcome will provide reduced cost or free drug supplies on a case-by-case basis. But she said there is "no way that Burroughs Wellcome can begin to handle the problem alone."

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SKIN GRAFT TRANSMITTED HIV IN U.K.

with thanks to Detroit's Cruise, 3/11/87

A badly burned British man contracted HIV through the application of a skin graft at a London hospital, the first known incident of its kind, health officials said. The man underwent a donor skin-graft operation at Queen Mary's Hospital, said plastic surgeon John Clark, who runs the hospital's burn unit, and the tissue apparently was infected. [ED NOTE: It was not reported whether the donor graft came from a cadaver, a pig, or another source.]

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FDA PROPOSAL ON DRUG RELEASE HIT

by Lou Chibbaro Jr., with thanks to The Washington Blade, 5/1/87

Medical researchers and several scientists with the National Institutes of Health joined Rep. Ted Weiss (D-NY) in expressing serious reservations over new rules proposed by the Food & Drug Administration. Weiss and the medical researchers, at a hearing of the House Subcommittee on Human Resources and Intergovernmental Relations, said the FDA's proposed rules would most likely fail to achieve their objective of securing the rapid development of drugs for the seriously ill, such as AIDS patients, and they could actually hamper the development of drugs for the seriously ill, such as PWAs, and they could actually hamper development of such drugs. Weiss, the chairman of the subcommittee, said the proposed rules appeared to be influenced by the US Office of Management and Budget (OMB) to foster the philosophy of drug industry deregulation. Weiss said medical experts have told him the rules, as currently worded by the FDA, could lead to the premature, uncontrolled release of unproven and possibly dangerous experimental drugs. FDA Commissioner Frank Young told the Weiss subcommittee that FDA officials will consider changing the proposed drug rules to take some of the criticisms into consideration. The period of public comment on the rules ended May 5.

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RIBAVIRIN & AZT ANTAGONISTIC

by Kim Westheimer, with thanks to Boston's Gay Community News, 3/29-4/4/87

AZT and Ribavirin may antagonize each other when combined, according to researchers at Massachusetts General Hospital (MGH) in Boston. Research to determine whether the two drugs together would be more powerful than each one individually (known as a synergistic effect) was conducted via test tube studies. "A synergistic effect might allow us to lower drug doses to less toxic but still effective levels," said Markus W. Vogt, MD, principal author of the study which was published in the March 13 issue of Science. "Unfortunately, our findings, which we reproduced in several different cell systems, consistently showed that the very strong antiviral effect of AZT was inhibited when ribavirin was added." Ribavirin has reportedly been successful in reducing the transition from early stage lymph node disease into the full blown AIDS. AZT has prolonged the lives of certain people with AIDS who have recovered from PCP and some people with ARC. Dr. Martin Hirsch, head of AIDS research at MGH cautioned people with AIDS against mixing drugs indiscriminately. "It is a natural temptation for people who are desperate and fear for their lives to attempt to combine these drugs. Until we have studied this combination further, those who combine them may be doing themselves real harm," said Hirsch. Other drug combinations, such as AZT and interferon, are potentially useful for people with AIDS, according to MGH researchers. Interferon does not cross the blood-brain barrier but when combined with AZT--which does--may be useful against the neurological affects of the virus.

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AL 721 DISTRIBUTED BY NYC GROUP

by Mike Salinas, with thanks to New York Native, 5/4/87

A coalition of PWAs calling themselves the "PWA Health Group" announced April 23 that it intends to begin distributing the promising new AIDS treatment, AL 721. AL 721 (active lipids in a 7:2:1 ratio) has been the subject of clinical tests by Dr. Yehuda Skornick of Tel Aviv, who believes its membrane fluidization action is effective in stemming the progression of the supposed viral activity of AIDS. AL 721 extracts cholesterol from invading viruses in the body, rendering them unable to penetrate host cells and reproduce. The patent on the compound, which is actually a natural food extract of lecithin from the yolks of eggs, is held by Praxis Pharmaceuticals of Los Angeles, who are not producing the substance at this time. Plans are underway for future testing of the drug at several universities and hospitals worldwide, but only Rokach (Hadassah) Hospital in Israel is presently testing the formulation. The technique for creating AL 721 in a home laboratory has been disseminated among the PWA community, but the procedure generally requires the heating of the volatile liquid acetone. The drug will cost approximately $200 per kilogram for a 3 month supply, considerably less than the $1000 per month cost through the underground. For additional information, contact: Steve Gavin, 201/677-2795; Tom Hannan or Carl Goodman, 212/989-3167; or John Fox, 415/524-5210. Information about the forthcoming clinical trials may be obtained by calling St. Luke's Hospital, at 212/870-6000 and speaking to Drs. Engelard, McKinley, or Lang.

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HEREDITARY FACTOR IN AIDS?

with thanks to Science News, 5/16/87

A person's relative susceptibility to infection with the AIDS virus, as well as how rapidly the fatal disease progresses in the body, may be associated with genetic differences in a particular protein found in blood and on cell surfaces, say scientists at St. Mary's Hospital Medical School in London. They report their preliminary study in the May 2 Lancet, saying that homosexually active men with a particular variation of the protein called group specific component (Gc) were more vulnerable to both infection with the AIDS virus and subsequent appearance of the disease. For example, in the study of 203 homosexuals at risk of infection or infected with the AIDS virus, plus 172 healthy heterosexual and homosexual controls, 30% of the patients with AIDS had inherited from both parents genes for the protein's Gc 1f form, compared with only 0.8% of the controls. The authors suggest that the Gc protein, which binds vitamin D and transports calcium, helps regulate viral entry into host cells, in a process that may be affected by the form of protein found in an individual.

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PENTAMIDINE AEROSOL: PROPHYLAXIS?

by John S. James, with thanks to AIDS Treatment News, #23, 1/16/87

AIDS Treatment News has learned of a new treatment which may be a major advance in preventing pneumocystis carinii pneumonia (PCP) in persons with AIDS. About 100 patients in New York and 30 in San Francisco are now using this experimental therapy, but so far there has been little publicity and most physicians are unfamiliar with it. Until the current trials are finished, the treatment must be considered unproved; but so far it appears to be close to 100% effective in preventing pneumocystis, with few if any side effects. Meanwhile, a completely different study in San Francisco is now enrolling patients for aerosol pentamidine treatment after PCP has been diagnosed. The new prevention procedure was developed by Edward Bernard, MD, and other investigators; he is a researcher in infectious diseases at New York's Memorial Sloan-Kettering Cancer Center, where aerosol pentamidine prophylactic treatment has been used for about 11 months. Due to the great demand and interest, the Sloan-Kettering team has provided information to other physicians who are interested. The site of the treatments in San Francisco is Pacific Presbyterian Medical Center. Pentamidine has been used for over 40 years as an anti-parasite drug. In Africa, it was learned that one treatment every 6 months could prevent sleeping sickness. Pentamidine stays in the tissues and is eliminated from the body very slowly. Pentamidine is effective against pneumocystis, but when sufficient amounts are given in the conventional intravenous or intramuscular ways, it can cause severe side effects. Studies have shown that only a very small portion of the injected drug reaches the lungs. Much more of it goes to the liver, spleen, and other organs, where it is useless for preventing pneumocystis and may cause toxicity. To deliver the medicine more selectively to where it is needed, a fine aerosol spray which could be deeply inhaled into the lungs was found effective, with a half-life at 35 days and with minimal side effects. Treatments are administered to patients for 15-30 minutes every week for the first month of treatment with a nebulizer, an ultrasonic fine misting machine. Thereafter, one treatment every two weeks is administered for prophylaxis. The treatment has no effect on the underlying immune deficiency or on the HIV virus, or other opportunistic infections. Some New York researchers doubt that aerosol pentamidine would be effective after PCP has developed, fearing that congestion would prevent the medicine from reaching the parts of the lung where it is more needed. However San Francisco researchers working on animals found that the aerosol treatment may be effective if the PCP was not severe. Almost nothing about this treatment has appeared in print, except for two references in the abstracts of the Paris International AIDS Conference last spring, and a few other very obscure references. If your local physicians cannot find out about aerosol pentamidine, contact this writer for the phone number of the research team at Sloan-Kettering in New York.

For subscription information about AIDS Treatment News, send $25 per quarter ($8 for PWAs or PWARCs) to John S. James, P.O. Box 411256, San Francisco, CA 94141 (or call 415/282-0110).

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HOMEMADE MEDICINES FOR AIDS Rx

by John Kyper, with thanks to Boston's Gay Community News, 5/10-16/87

A series of clandestine clinics in more than 40 North American cities are distributing experimental medicines to people with AIDS, according to information published in the Chicago Sun-Times, via El Diario-la Prensa of New York City. The clinics, which operate underground to avoid legal problems and elude anti-gay groups, are directed by volunteers. They reportedly prepare cheap versions of experimental formulas and distribute prescriptions for AIDS that have not yet been approved by the government. Unidentified sources said that thousands of persons are being treated through the clinics.

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LIGHT THERAPY MAY HOLD PROMISE?

by J. Silberner, with thanks to Science News, 2/14/87

An out-of-body blood treatment can control cutaneous T-cell lymphoma (CTCL), a potentially deadly cancer, according to an international group of researchers. Because of the treatment's success with this white blood cell cancer, the scientists are now investigating it for other diseases, including AIDS. In the therapy, a light-activated drug is triggered in blood cells removed from the patient's body; when the cells are returned to the patient, they appear to act as a type of vaccine. In 27 of 37 people with advanced CTCL, the approach cleared up the redness and scaling caused by cancer cells in the skin, report researchers from several U.S. and European institutions in the February 5 New England Journal of Medicine. One of the researchers, Richard Edelson of Yale University, had previously described positive results in eight patients. The average survival time for people with advanced CTCL is about 30 months. Since most patients studied haven't been on the drug that long, the researchers aren't ready to call the experimental treatment a cure. But they do claim the therapy, called photopheresis, is the best way to deal with advanced CTCL. Patients receive a series of treatments, starting each treatment by swallowing an inactive form of the drug psoralen, normally, used in treating psoriasis. After the blood cells have absorbed the psoralen, blood is drawn and the white cells, including cancerous ones, are isolated. The rest of the blood goes back into the body; the white cells are exposed to ultraviolet light. The light activates the psoralen, which lethally damages the cells. The cells are then injected into the patient. The benefits of photopheresis are evidently due not to the immediate damage to the treated cells--only 10-15% of the white cells are dealt with per therapy session--but to vaccination. The dying cells, when reinfused into the body, set off an immune system reaction against other cancer cells. Photopheresis may also be useful in dealing with autoimmune diseases, where white blood cells mistakenly attack the body. The researchers have just begun a trial against pemphigus, a rare autoimmune disease. Bruce Wintroub, who was involved in the CTCL study, is also part of an effort to determine whether photopheresis has any value in treating AIDS. He and his coworkers at the University of California at San Francisco have found that in the laboratory, photopheresis somehow inactivates the AIDS virus in human white blood cells. Whether the approach will work in people with AIDS remains to be determined.

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COFACTORS AND AIDS?

by Joanne Silberner, with thanks to Science News, April 4, 1987

One of the great mysteries of AIDS is why some people who have been infected by the AIDS virus go years – if not their lifetimes – without developing the syndrome. Many AIDS researchers believe one or more additional elements, or cofactors, are necessary to turn an AIDS-virus infection into actual disease.

According to the U.S. Public Health Service, about 1 million to 1.5 million people in the United States are infected by human immunodeficiency virus (HIV), and roughly 20 to 30 percent of them will develop AIDS within five years. Who among the infected individuals will get the syndrome and when that will happen are open questions. Finding a cofactor would enable physicians to identify these people and possibly show how to prevent the progression from infection to illness.

Among the many possible cofactors that have been proposed, two of the strongest candidates are the presence of specific, genetically determined proteins in the infected individuals, and exposure to other viruses. If the virus co-infection hypothesis, whose proponents include researchers from the National Institute of Allergy and Infectious Diseases (NIAID) in Bethesda, Md., is true, avoidance of a second virus could be the key to health. But a genetic predisposition, as suggested by researchers at the University of California at San Francisco, would be more difficult to counter.

With most viruses, infection does not always mean a person becomes sick – for example, the majority of people infected with hepatitis B virus or with poliovirus don't develop symptoms. But while cofactors are evidently an element in these and other serious viral infections, there has not been a lot of research into the issue, says epidemiologist Harold Jaffe of the Centers for Disease Control in Atlanta. Questions about cofactors "could be asked for lots of other diseases," he says. The sudden, mysterious and deadly onset of the AIDS epidemic has lent the question "a sense of urgency," he says.

Because many members of the two highest-risk groups, male homosexuals and intravenous drug abusers, have histories of frequent sexually transmitted or blood-borne diseases, some researchers have been investigating whether a second infection can somehow "awaken" the AIDS virus. Recent results from Malcolm Martin and his co-workers at the NIAID provide biological support for the possibility.

Martin, Howard E. Gendelman and their co-workers studied the interaction of HIV and other viral infections in cells growing in culture. To avoid the hazards of working with the entire AIDS virus, they used only a segment of HIV's genetic material, linked to a bacterial gene that directs the construction of an easy-to-test-for enzyme.

Martin and his colleagues introduced the combination genes into a cell line and followed its activity by monitoring the marker enzyme. When they added any one of several viruses that commonly infect people, they found more of the marker enzyme, indicating that the AIDS virus material was much more active. Martin says subsequent experiments using the entire AIDS virus have confirmed the initial results, which were published in the December PROCEEDINGS OF THE NATIONAL ACADEMY OF SCIENCES (Vol.83, No.24).

The viruses, Martin says, could push the AIDS virus in an infected person from a quiet to a lethal stage. "By simultaneous infection, there's a real possibility [of] inducing or activating latent virus."

The viruses used in the experiment are so different from one another that they couldn't possibly all be acting in the same way, he says. Rather than all the viruses producing an identical protein that travels to the AIDS virus and causes it to reproduce, Martin suggests the non-HIV viruses somehow induce the cell itself to stimulate HIV, perhaps by making the cell produce an HIV-stimulating protein.

Several laboratories, including Martin's, are searching for such a protein. Unfortunately, if the infected cell's own protein is responsible, interceding in the process may be difficult. "They [the proteins] are probably there for some important normal function," says Martin. Interrupting that function to keep the proteins from stimulating the AIDS virus could cause other problems. "The more we know," he says, "the less we know."

On the other hand, the cell may also be capable of producing other proteins that inhibit the system, Martin suggests. If so, stimulating those proteins could keep HIV quiet. And whatever the mechanism of action of other viral infections, if they are what's kicking off HIV, avoiding them would be a way to avoid getting AIDS.

While Martin's theory holds that a second infection kicks off AIDS, John Ziegler and Daniel P. Stites of the University of California at San Francisco suggest that the cofactor is a genetic one. They base their theory on the paucity of active AIDS virus found in full-blown, or "frank," disease.

"It's very difficult to find infected lymphocytes [white blood cells] in infected blood," Ziegler says. In frank AIDS, only 1 in 10,000 to 1 in 100,000 lymphocytes show evidence of viral infection.

To explain how so few viruses could cause such a devastating disease, Ziegler and Stites have suggested that the virus sparks an immune reaction that attacks not only the virus but also the body's own healthy cells (SN: 12/20&27/86, p.388). According to the theory, what controls whether this autoimmune reaction occurs is the degree of similarity between certain immune-system components and HIV itself, and what determines the similarity is genetics.

The AIDS virus attacks and infects the CD4 cell, a type of white cell, at the location where the CD4 normally "docks" with other cells in the immune system. This docking process is a necessary step in a cascade of events that results in the recognition and neutralization of foreign substances.

In order to attach to the CD4 dock, Zeigler and Stites suggest, the virus must in some way "look" like the second set of cells. And this similarity results in the virus affecting the immune system not only by destroying the cell it infects but also by generating antibodies that attack the immune system in two separate ways.

First, antibodies to the virus also attack the cells that normally link up with the CD4 cells, since the virus and the second set of cells have something in common. According to the hypothesis, these antibodies block the interaction of the CD4s and the other cells – even though neither may be infected by the virus. Second, the virus-prompted antibody also triggers the production of other antibodies against both itself and the CD4s, again including those that have not been infected by the AIDS virus. As a result, an entire and vital arm of the immune system is wiped out.

"In this way," says Ziegler, "just a handful of HIV could kick off immune system self-destruction."

Genetics comes into play because the proteins on the immune system cells to which the CD4s attach differ from person to person, and these proteins are inherited. People whose proteins "look" like proteins on the surface of HIV would develop the two sets of antibodies that attack the immune system, and go from infection to full-blown AIDS. People whose proteins differ markedly from the HIV strain would be spared.

If the hypothesis is proven true, it has both positive and negative implications for therapy. The immune self-attack aspect suggests that toning down the immune response could help. Therapeutically, "you'd want to think of ways to remove antibodies to see what happens to patients," says Ziegler. French researchers already have tried damping

(Continued)

COFACTORS, continued

the immune response with cyclosporine, and a small U.S. trial with cyclosporine began recently.

But it would also throw a wrench into vaccine development. If the part of HIV that is similar to the antigen-presenting cells were used as a vaccine, the antibodies generated against the vaccine material would also be capable of attacking the antigen-presenting cells themselves. Such a vaccine would have the unfortunate result of destroying a normal, necessary arm of the immune system.

Two discoveries would help prove the genetic hypothesis: identifying a single antibody that attacks both HIV and the cells to which the CD4s attach, and the preponderance in AIDS patients of particular classes of proteins on white cells that differ from those in people who are infected but have not developed the syndrome. Collaborators of Ziegler's at UCSF are now in the process of looking for similar classes of proteins among people with AIDS, and there have already been several reports from other laboratories indicating that such clustering exists. Ziegler's collaborators and other U.S. laboratories are also checking an antibody against white cells found in people with AIDS to see if it attacks HIV as well.

"My guess is that everybody who is exposed is capable of being infected, but the progression to illness may well reside in immunogenetic mechanisms," says Ziegler. "Obviously everything isn't going to be explained by genetics. But if it lies there we should be able to find it."

Ziegler's and Martin's theories aren't mutually exclusive – they could each be at work in different people. Nor are genetics and viral infections the only candidates that have been suggested. Ziegler, in fact, has worked with UCSF's Jay Levy on a study showing that some people have a white blood cell capable of suppressing HIV activity. This cell could be producing a protein that counteracts the co-infection effect of Martin's hypothesis.

Other research has pointed to the frequency of AIDS among infected individuals after they were exposed to herpesviruses or hepatitis B. With millions of people infected but not yet showing signs of illness, the problem is more than academic.

But for the moment, what causes infection to develop into AIDS, says Ziegler, "is a biological black box." □

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SICK OF STRESS!

by Kenneth J. Epstein (Chicago), as a letter to the editor of Science News, 5/16/87

Joanne Silberner's very incisive article, "What Triggers AIDS?" suggests that the ultimate trigger may be stress, which is already known to trigger a great many diseases, ranging from the common cold to schizophrenia to heart attacks. Stress researcher Hans Seyle and others have found that the efforts of stress are cumulative, so that a long series of small stressors can add up to a big problem, which may appear to occur suddenly, but is really a long time developing. Homeostasis--the staying power of the body--is gradually eroded by chronic stress, until something gives. In arthritis, it is the cartilage of the joints that deteriorates (possibly attacked by the body's own antibodies). In schizophrenia, it is mental function. In AIDS, it is the immune system. The implication of AIDS research seems to be that the victims are not only infected by the virus, but are also allergic to it or to chemicals it produces. Any stress, ranging from coinfection to a dental X-ray, could be "the last straw" that triggers the allergy. It gives insight into why babies are born without antibodies, which could be more dangerous to an infant than the diseases children have to go through to get the antibodies. As Einstein said about the origin of the earth's magnetic field, the cumulative effects of stress may be one of the most important unsolved problems.

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WINNING & LOSING IN THE AIDS FIGHT

by D.D. Edwards, with thanks to Science News, April 25, 1987

Which groups in the population are at risk for developing AIDS and why some individuals infected with the AIDS virus do not develop the fatal disease are among the key unanswered questions in the spread of AIDS. More possible answers came in two published reports--one saying that the proportion of female AIDS patients who acquired the disease through heterosexual contact more than doubled from 1982 through 1986, the other suggesting that a substance involved in cellular protein production may be the trigger that turns a latent viral infection into a case of AIDS. In a study reported in the April 17 Journal of the American Medical Association (JAMA), Mary E. Guinan and Ann Hardy of the CDC in Atlanta considered all reported cases of AIDS in women as of November 7, 1986. (Reporting of AIDS cases to the CDC began in mid-1981.) While the development of AIDS in nearly half of the 1819 female cases was due to intravenous drug use, the proportion of women with AIDS due to heterosexual contact with men considered at risk for AIDS increased from 12% in 1982 to 26%. Guinan and Hardy describe high-risk men as being primarily intravenous drug users or bisexual. This dramatic increase, say the authors, has implications for the spread of both heterosexual AIDS and pediatric cases caused by infected mothers. The prevalence of heterosexually spread AIDS has been an issue of some controversy. It's a matter not merely of which groups are at risk, but also of which individuals. Scientists are actively seeking one or more cofactors that might explain why AIDS viruses that lie quietly inside the body's cells for perhaps as long as 15 years suddenly burst forth with a deadly vengeance. One factor activating virus production may be a cellular protein called NF-kappa B, according to a report in the April 16 Nature by Gary Nabel and David Baltimore of the Whitehead Institute for Biomedical Research in Cambridge, Massachusetts. The researchers found that NF-kappa B, which as a role in DNA's control of protein production in cells, increases in concentration when the body is challenged by infection. Based on their study, Navel and Baltimore suggest that increased levels of NF-kappa B, formed in response to other viral or bacterial attacks, may activate the genetic mechanism of cells already containing the genetic code for the AIDS virus--resulting in a flood of AIDS virus being produced.

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INSURANCE SUITS UNDERWAY

by Lisa M. Keen, with thanks to The Washington Blade, 4/24/87

Two national gay litigation groups have filed separate suits against separate insurance companies which they charge with discriminating against gays. The Lambda Legal Defense and Education Fund in New York has filed suit in federal court against the Prudential Insurance Company. Lambda charges that the company told an insurance applicant that his blood would not be tested for the HIV antibody but tested it for the antibody anyway. When the applicant tested antibody positive, said Lambda, the insurance company denied the man's application and even spoke about his case in public in the community in which the man resides. The National Gay Rights Advocates in San Francisco has filed a complaint with the Texas State Board of Insurance charging that the National Home Life Assurance Company wrongfully refused to sell life insurance to a man because he named, as his beneficiary, an unrelated male roommate.

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NURSE FIRED FOR DENYING CARE TO PWA

by Barbara Siegel, with thanks to Boston's Gay Community News, 3/15-21/87

In Hutchinson, Kansas, the Reno County Commission has upheld the firing of a public health nurse who refused to care for a person with AIDS, according to Another Voice. "I feel a little sick...I'm not sure if I'll ever get another job in nursing," nurse Margaret Durr said after the 3-0 vote upholding the Public Health Department's decision. Durr had been instructed to check the general condition of the PWA and decide if he was eligible for home health care. Initially, she said, she planned to carry out he instruction, but changed her mind after talking with her husband. The PWA, who was determined to need care by Durr's supervisor, has thus far not taken advantage of the agency's services. Durr told the County Commission that she should have the right to refuse a case that she didn't think she could handle and that she considered dangerous. "At the time, I did what I felt was right [based on] my knowledge and education. At the time, I felt unsafe," Durr contended. The Public Health Department, however, denied that she was in any danger and maintained that she had a professional responsibility to the PWA and that she was asked to do routine tasks she was well trained to carry out. "The nurses in our health department are expected to perform the duties that come with the scope of their prime responsibility," said Health Dept. attorney Joe O'Sullivan. Durr's lawyer said no decision had been made regarding an appeal.

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BIAS BANNED IN AUSTIN, TEXAS

by Barbara Siegel, with thanks to Boston's Gay Community News, 2/1-7/87

The Austin (Texas) City Council unanimously approved an ordinance banning AIDS-related discrimination in December 1986. According to The Calendar, the ordinance prohibits discrimination in employment, housing or by public, business and medical services. It also makes mandatory HIV testing illegal. PWAs and PWARC as well as people who are HIV antibody positive are protected under the ordinance.

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BAN GAY BLOOD IN NEW HAMPSHIRE

by Kim Westheimer, with thanks to Boston's Gay Community News, 2/1-7/87

Although the issue had been debated and resolved years ago in the rest of the nation with the advent of the HIV antibody test, a bill to prohibit gay and lesbian blood donors has been filed in New Hampshire's Senate. The bill's sponsor, Den. John Chandler, claims that the legislation would protect blood from being contaminated with the HIV virus. Chandler's bill does not ban blood donations from intravenous drug users, hemophiliacs, or prostitutes, all of whom are classified as high-risk groups for AIDS by public health authorities. Chandler, who is the vice-chair of the Senate Judiciary Committee, reportedly told the committee he would amend the bill to "allow a homosexual to donate blood if he donates all of it.... If he wanted to give all his blood, boy, I'd be willing to let him." The bill has received criticism from the American Red Cross, state health officials, and the New Hampshire Citizens' Alliance for Gay and Lesbian Rights. [ED NOTE: Do you think the reaction against such hate-mongering would be more noticeable if the bill were directed against Blacks or Latinos? Or Jews or Catholics? When will others speak up?!]

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MINNESOTA GOVERNOR BANS BIAS

by Barbara Siegel, with thanks to Boston's Gay Community News, 2/1-7/87

Minnesota Governor Rudy Perpich has issued an executive order prohibiting the state from discriminating against gay men, lesbians, and people with AIDS, according to Equal Times. The order, issued November 19, 1986, was not made public until December 3, when it was disclosed by openly gay State Senator Allan Spear. The order bans state employers from discriminating on the basis of sexual orientation in recruitment, hiring, promotion, tenure and salary, and compels them to "provide a work environment free of harassment, which is a form of discrimination." The order covers all agencies, departments, boards and commissions that are part of the executive branch of state government. The ban is based on state rights of privacy and freedom from discrimination or harassment based on sexual orientation. Under the order, the state is also required to treat employees with AIDS as it treats workers with other long-term diseases such as cancer, according to commissioner of employee relations, Nina Rothchild. Workplace HIV-testing is banned as is "removal from normal or customary status...except for clearly stated and specific medical and/or public health reasons."

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DOCTORS THOUGHTS ABOUT AIDS

with thanks to the New York Native, 2/2/87

MD magazine recently polled its readership of 145,000 physicians [ED NOTE: response rate not reported] to find out what doctors think about AIDS. The results were surprising, indicating that many physicians do not agree with official positions about the disease and how to deal with it. The following are some of the statistics gathered from the study. *****Close to 48% of American physicians in private practice have encountered one or more AIDS patients. *****As a specialty, psychiatrists encounter PWAs most frequently—65% of psychiatrists polled had encountered one or more PWAs. *****78% of the survey respondents favor confidential antibody testing and contact tracing for "high risk" individuals. *****28% favor some form of quarantine. *****51% recommend a test for antibodies to HIV, as a prerequisite for obtaining a marriage license. *****79% advocate special high school classes on how to avoid AIDS and other STDs. *****25% suggest providing drug users with sterilized hypodermic needles. *****78% would not disguise the cause of death on a death certificate if asked to by an AIDS sufferer or family member.

When asked about antibody testing of specific groups: *****43% favored testing military personnel. *****40% favored testing dentists. *****37% favored testing doctors. *****37% favored testing hospital employees. *****34% favored testing food handlers. *****31% favored testing life insurance applicants. *****45% of physicians would not accept hospital blood supplies if a member of their family were facing major elective surgery, in which a transfusion would likely be required. An additional 9% did not know what they would do.

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MDs WORRY ABOUT TRANSFUSIONS

with thanks to Detroit's Cruise, 1/28/87

Nearly half the doctors in private practice are so worried about AIDS contamination in the public blood supply they would refuse transfusions for family members undergoing surgery, according to a national survey. According to the results, 45% of doctors said if a family member were about to have elective surgery they would shun public donated blood and make arrangements to have their own blood, or that of other family members, used instead. All donated blood is tested for antibodies that indicate the presence of AIDS according to the Red Cross, which calls the nation's blood supply safe. A significant number of the 4000 doctors who responded to the poll also said they favored tough measures to confine the spread of the disease.

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DALLAS POLICE WANT BUG REPELLANT

with thanks to The Advocate, and People With AIDS Update, May, 1987

Dallas police officers, fearful of contracting AIDS, have armed themselves with masks, gloves and insect spray to ward off the disease. Police officials acknowledge the street cop's concerns. "If it makes them feel more comfortable in their jobs, we'll get them whatever they need," said Lt. D. L. Goelden. "With summer coming...some officers who are concerned about AIDS being carried by [mosquitoes] have asked for bug repellent." The Dallas Police Department has even developed a policy allowing officers to document incidents where they may have handled suspected AIDS carriers. Should an officer contract the disease, or be able to prove that he/she was infected on the job, he/she would be eligible for workers compensation payments. Bill Nelson, president of the Dallas Gay Alliance, called the officer's fears unfounded: "I find it ironic that someone who is in such a dangerous profession as police work has this unreasonable, irrational fear about a disease that is transmitted by intercourse—which, I believe, is not a part of a police officer's work."

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ARRESTED FOR "SPREADING" AIDS

by Martin Heggestad, with thanks to Boston's Gay Community News, 4/5-11/87

A retired U.S. Army Sargeant who has AIDS has been arrested in the Bavarian city of Nuremburg for allegedly spreading the disease to sexual partners, according to the New York Times. The man, who is said to be bisexual, was working as a cook. His name has not been revealed, nor is it known whether he practiced "safer" sex with his partners, or whether the partners became infected with HIV. He has been charged with causing "bodily harm" to others, and could face a five-year prison sentence. This is the first time someone has been arrested in West Germany for allegedly "spreading" AIDS.

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OKLAHOMA REPUBLICANS: QUARANTINE

with thanks to Rick Harding and the The Washington Blade, 4/3/87

In its annual platform adopted February 21, the Oklahoma Republican Party urged quarantine of people with AIDS, recommended that gays should not be allowed to work in restaurants, and opposed AIDS education in schools and "safer-sex" education in the mass media. According to the gay newspaper, The Gayly Oklahoman, the platform recommends closing gay bars and asserts that "homosexuals are a behavioral group and not a racial, ethnic, or religious minority deserving of any protection against discrimination." Despite the recommendations of the party, Governor Henry Bellmon, a Republican, has called for an intensive state-supported AIDS education effort, including sex education in the public schools. Bellmon said his AIDS programs "might not be popular" with the party, but AIDS "is a dangerous epidemic" and "there's no point putting [education] off until [AIDS] is out of control."

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AIRLINE HOMOPHOBIA SURFACES AT TWA

by Rick Harding, with thanks to The Washington Blade, 2/20/87

A gay Minneapolis man who was supporting the boycott of Trans World Airlines (TWA) called by the airline's striking flight attendants, said he was assaulted by a TWA pilot and barraged with anti-gay insults by a flight attendant in February after he arrived at Washington, DC's National Airport for a visit to the city. Jim Schnobrich said he arrived at the airport on a non-TWA flight the night of February 12, and was carrying his suitcase displaying a "Boycott TWA" sticker when, in the airport's concourse, he walked past a TWA flight attendant. The attendant, apparently hired to replace one of the striking workers, allegedly said to Schnobrich, "Are you one of those faggots I was hired to replace?" When he asked the woman for her name so he could report her to the airline, she removed her badge and continued to shout anti-gay epithets at him. He said he followed the attendant to a bus, which was to shuttle the TWA crew to a local hotel, and again asked for her name. A TWA pilot who was on the bus and who had witnessed the incident allegedly shouted at Schnobrich and then punched him in the face. Other passengers ont he bus restrained the pilot while Schnobrich left. He said he notified Federal Aviation Administration airport police about the incident and filed a report. At the suggest of airport police, he returned the next morning to identify the pilot as the crew returned to the airport. He said police stopped the pilot and questioned him about the allegations, delaying the pilot and his flight for nearly an hour. The complaint was turned over to FAA detectives but no arrests have been made. The plaintiff, who was also unable to get the pilot's name said he is consulting with attorneys and plans to file a civil lawsuit against the pilot and TWA. A Los Angeles spokeswoman for the Independent Federation of Flight Attendants which represents the nearly 6000 TWA attendants who walked off the job in March 1986, said Schnobrich's incident is not the first report of violence they have received during the sometimes hostile employment dispute. IFFA New York spokeswoman Diane Karpus said TWA Chairman Carl Icahn told the attendants they could afford a 45% pay cut because they were not the "breadwinners" of their families, a statement which she said offended many of the women, gay men, and unmarried attendants.

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DELTA AIRLINES AGREE TO DEMANDS

by Kathryn Diaz, with thanks to Boston's Gay Community News, 2/22-28/87

A national boycott against Delta Airlines was called off in February when the San Francisco-based Mobilization Against AIDS announced that the air carrier had agreed to all four of the group's demands. Last August, the airline prohibited a man with AIDS, Mark Sigers, from boarding a flight. According to the San Francisco Sentinel, Delta agreed to: 1) Publicly apologize for representatives who argued that gay men killed in airline crashes have lives of less "value" than other people, because gay men might have AIDS; and formally declare that neither the company nor any of its representatives will ever make such statements again. 2) Establish a policy that people with infection are welcome as passengers on Delta and that any person with HIV infection who is in the judgment of that person's physician able to travel unaccompanied will be allowed to do so. 3) Honor its 1986 commitment to educate Delta Airlines employees about AIDS by contracting with AIDS education experts to create an appropriate program. 4) Make a gesture of support to the national struggle to end AIDS, as a means of offsetting the effort and funds expended to correct Delta's past actions.

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BIOLOGIST INVESTIGATED FOR VACCINE

by Craig McDaniel, with thanks to the New York Native, 4/20/87

A Houston biologist who charges as much as $5000 a year to treat AIDS patients with a vaccine made from their own urine is being investigated by the Texas Attorney General's Office. The biologist, William Hitt, says he is treating 144 patients (144 x $5000 = $720,000) with a product made from purified urine. The product is injected into patients weekly, allegedly prompting the body to produce antibodies to fight diseases. "We have had patients with us who have had AIDS for 3 years," Hitt said. "We have been keeping our patients extremely stabilized for long periods." The attorney general's investigation is aimed at determining whether Hitt is engaging in deceptive trade practices or violating food and drug laws, according to the Assistant Attorney General Rose Ann Reeser.

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SEX TAX, TAX CREDITS PROPOSED

by Jim Fauntleroy, with thanks to Boston's Gay Community News, 4/26-5/9/87

The on-going battle between Lyndon LaRouche and Paul Cameron for rights to the most outrageous ideas about homosexuality has taken a dramatic turn in Cameron's favor with his latest proposal for curing the world: sex stamps. Yes, that's right, stamps. You see, Dr. Cameron thinks that tax stamps costing $1000 should be required on any published picture of lesbian or gay sex. He seems to value heterosexually somewhat more cheaply, asking only $25 for these pictures. To the inquiring mind, the proposal raises many questions. Would magazines start reserving a small area on each page for the sticker, as they do now for the UPC symbol on their covers? If not, who would decide what the valuable seals would cover? Would the glue on the stamps be flavored, and how? Who would get to lick and attach them? But Cameron breezed by all these queries to unveil a second weapon against promiscuity: a tax credit for couples who marry while both are still virgins. To prevent cheating, Cameron said the names of couples applying for the credit would be published, allowing anyone with contradictory evidence to speak rather than forever holding their peace. It seems surprising that Cameron would advocate measures encouraging anonymous sex, but even if the proposal were made law, few couples would be likely to apply for the credit anyway. I mean, how many "modern Americans" do you know who are willing to advertise their sexual inexperience?

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PILOT TO TOWER: AIDS ON BOARD!

with thanks to Detroit's Cruise, 3/11/87

British air traffic controllers, monitoring routine radio transmissions recently, overheard a Delta Airlines captain say one of his flight attendants was infected with AIDS. Immigration officials were alerted and detained the man overnight when the flight from Chicago landed at Heathrow Airport. After Delta confirmed he had evidence of exposure to the AIDS virus, authorities put him on the first plane back home. That could happen more often under new rules. The British Home Office, which has jurisdiction over immigration, announced that AIDS soon will be placed on a list of contagious diseases used to deny entry into Britain. Under the plan, which drew immediate criticism, known or suspected AIDS carriers could be detained and expelled if medical tests show exposure to the deadly virus. Spotting carriers will be difficult since AIDS has no specific symptoms, but the Home Office said customs inspectors will be given guidelines about whom to question and detain. "It is not a system of screening everyone," said Peter Rose, a government spokesperson. Following the American flight attendant's expulsion, immigration authorities tightened scrutiny of visitors from Central Africa and the United states, where AIDS is more widespread than in Europe. The prime minister's cabinet is expected to approve the formal policy soon, despite an outcry within the government and from airlines. Without objective medical criteria, critics say, AIDS screening at airports could result in arbitrary decisions, as well as discrimination based on race or presumed homosexuality. The move invites massive legal challenges, opponents warn. AIDS among flight attendants has become a public issue in Britain and elsewhere in Europe. British Airways has reported that nine of its male flight attendants have died of AIDS, and major international airlines are considering screening all cabin crews for exposure to the virus.

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DOCTOR WITH AIDS OUSTED IN CHICAGO

by William Burks, with thanks to the New York Native, 3/16/87

A united Chicago medical community continued its criticism of the Cook County Board's decision to remove a doctor who has AIDS from all patient contact at the county hospital, and the physician continues to treat patients while his attorneys consider what steps they will take to overturn the board's decision. The doctor, whose name has not been disclosed to protect his privacy, is being represented by the American Civil Liberties Union on Illinois. ACLU legal director Harvey Grossman said his client is considering the alternatives of hearings before the board or a lawsuit in federal court, in order to maintain his right to continue seeing patients. Area health care experts said they believe the case is the first in the U.S. of a physician with AIDS being restricted from practice, although they estimate 1200 health care workers in the US are infected with HIV. In addition, the board directed that any hospital employee out sick for more than 3 days must submit to a medical examination by hospital staff to determine if AIDS is the cause of illness. Cook County Hospital is the 700 bed public health facility serving over 5 million residents of the metropolitan Chicago area. If the ACLU takes the doctor's case directly to federal court, Grossman said his case would likely be based on federal handicap discrimination laws and the equal protection clause of the 14th Amendment. The Cook County Board to allow the physician only technical, diagnostic, consultative, teaching, or administrative and quality-care duties, but no contact with patients. Board members said concern over patients' fears of contracting AIDS played a role in their decision. Board President George Dunne stated that the Board's vote reflected its concern over litigation by any of the hospital's 700 patients who might have been exposed to AIDS. The Board heard no testimony from medical experts before reaching its decision at the closed-door meeting. But doctors at the hospital's House Staff Association raised questions about the "ambiguous wording" of the decision, since doctors with consultation privileges can ordinarily conduct physical examinations. Dr. Stuart Levin, Director of the Section of Infectious diseases at Rush-Presbyterian St. Luke's Hospital, said he and his colleagues at principal hospitals and medial schools in Chicago "are unanimous in totally rejecting [the Board's] conclusion and their logic. They said, 'We'll only lose $100,000 in a suit with the ACLU, but we could lose millions if a patient got AIDS from this doctor and a creative lawyer sued the county.' "If people in leadership are willing to do the wrong thing, which they know to be the wrong thing, just because they're afraid of being sued for doing the right thing, even though they know they would be right—then they shouldn't be in positions of leadership," Levin asserted. Levin and five other specialists in infectious diseases from Northwestern University Medical School, the Chicago Infectious Disease Society, Loyola University Hospital, the University of Chicago Medical School, and the University of Illinois Medical School held a press conference the day before the Board's vote, urging it not to suspend the doctor with AIDS. Illinois director of Public Health Dr. Bernard Turnock and Chicago Health Department infectious disease specialist Dr. K. T. Reddi also spoke in favor of the doctor's being allowed to continue his medical practice. "A survey of the public turned out 9 to 1 against the doctor," Levin said. "The public could vote that the earth were flat, but it wouldn't make it so. We have failed either in our ability to transfer information to the public or to have the public believe us...." Levin further asserted, "We've put our lives and the lives of our families on the line over this fact" that AIDS cannot be transmitted by casual contact. James Delacerda, a nurse practitioner and assistant to Dr. Renslow Sherer of Cook County Hospital's Sable/Sherer AIDS Clinic, said the hospital's medical director, Dr. Agnes Lattimer, was to his knowledge the only physician who supported the County Board's decision. "I'm disappointed that Dr. Lattimer, a physician and pediatrician, would go along with a group of politicians. For that decision to have been made by politicians—with no one having any medical degree or training—is insane." Speaking on condition that his statements be identified as his opinions as an individual and not as representative of the hospital, Delacerda continued, "The decision was totally inappropriate, totally reactionary, totally against all federal and state guidelines set up by people who know infectious disease, from Dr. [C. Everett] Koop, the US Surgeon General, to Dr. [Renslow] Sherer, head of our AIDS program here." Levin suggested broader implications to the decision. "It plays upon ignorance, and will fire up the prejudices of many individuals. The potential for a fascist uprising exists high enough up that it should be shown for what it is. And if we don't have an informed populace, they'll strike out, feeling they have the right to strike out." Public policy should be based on the medical facts because, "There will be enough fear and terror as more people get [AIDS]," Levin said. "Soon enough, everybody will have a son or daughter or friend who will die. That's what is going to happen."

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HAIRY LEUKOPLAKIA HALTED WITH Rx

by Mike Salinas, with thanks to the New York Native, 5/4/87

A dental researcher at the University of California at San Francisco has announced findings that indicate hairy leukoplakia, an early indicator of AIDS, can be treated successfully with a new experimental drug. The researcher, Dr. Deborah Greenspan, recently presented her research to the International Association of Dental Research in Chicago, as part of its annual convention. According to Greenspan, eight patients who took the anti-viral agent desciclovir remained free of hairy leukoplakia's characteristic tongue lesions, while the condition continued to develop in the control group of six. Patients who were given desciclovir orally for two weeks remained "lesion-free, or nearly so, for up to 3 months," according to the April 20 issue of Physician's Weekly. Significantly, the treatment also eliminated the Epstein-Barr virus (EBV) from the site of the patches. EBV has been discussed repeatedly as a possible factor in the development of AIDS. New York University dermatologist Alvin Friedman-Kien, who believes suppressing EBV activity may help delay or prevent the onset of AIDS, called Greenspan's research "terribly important." Desciclovir is a "prodrug" of acyclovir, an anti-herpes medication also known under the trade name Zovirax. Both are produced by Burroughs-Wellcome, the pharmaceutical company which manufactures Retrovir (AZT), the first AIDS treatment authorized by the federal Food & Drug Administration. The future of desciclovir was not known at press time.

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DENTAL CLINIC IN NEW YORK OPENS

The first hospital-based dental clinic in the United States for the treatment of people with AIDS and AIDS-related conditions (ARC) opened April 2 at the Spellman Center for the Treatment of Persons With AIDS at New York's St. Clare's Hospital. "The establishment of the dental program is in response to an urgent need," says Dr. Mario Andriolo, Jr., DDS, Director of Dentistry. "People with AIDS/ARC are almost universally denied dental treatment in the private sector." Andriolo, an authority on the oral manifestations and dental management of people with AIDS stated, "Many of the early manifestations of AIDS are present in the mouth and may require biopsy, medications, or other treatment. The dentist is an important member of the medical and support team caring for those with AIDS." Also, there are other special dental considerations involving proper nutrition and an ability to chew food, since the syndrome is a wasting disease. Dental care in the form of frequent cleanings, home care reinforcement, eliminating any sources of pain, providing prosthetic devices such as dentures, bridges, etc. are essential to prevent rapid deterioration of pre-existing periodontal conditions. The dental service adds an important component to the Spellman Center's comprehensive AIDS program. The dental program will provide direct inpatient and outpatient care and will be involved in clinical research and education dealing with oral manifestations of AIDS. Funding for the renovation and equipment for the clinic is being provided for by the Alfred E. Smith and the Altman Foundations. The Spellman Center for the Treatment of Persons with AIDS offers a comprehensive program. The Center has a discrete acute care unit, a full service outpatient clinic and a hotline for AIDS information (1/800/433-AIDS). St. Claire's is operated under the auspices of the Catholic Archdiocese of New York and is affiliated with New York Medical College. For more information: The Spellman Center, St. Claire's Hospital & Health Center, 415 West Fifty-First Street, New York, 10019 (212/586-1500).

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MDs OPPOSE MANDATORY HIV AB TESTING

Federal proposals calling for mandatory HIV antibody testing have met with vigorous opposition by a national organization of physicians treating thousands of people with AIDS and people with HIV infection. Opposition comes from the American Association of Physicians for Human Rights (AAPHR), whose president, David G. Ostrow, MD, PhD, of Chicago, believes the proposals "do not appear to meet any reasonable standards of efficacy in controlling the spread of HIV infection." The mandatory testing proposals for hospital admissions and persons seeking marriage licenses have been advanced by the Centers for Disease Control in Atlanta. The proposals were reviewed during CDC meetings February 23-24. Ostrow, who is an associate professor of psychiatry at the University of Michigan School of Medicine, and other AAPHR representatives participated in those sessions. Ostrow stressed AAPHR's position to CDC AIDS Coordinator Dr. Walter Dowdle. Among the major points:

>Mandatory hospital admission testing programs will discourage individuals in need of medical care and counseling concerning AIDS and HIV infection from availing themselves of those services. This will contribute to the unavailability of services and counseling to those most in need of them, thereby limiting our ability to control the spread of HIV infection.

>Mandatory pre-marital testing would impose a form of de facto discrimination on HIV seropositive individuals seeking marriage. It could discourage monogamy and the practice of `safer sex' by married couples, thus again being counterproductive to our mutually-held goal of reducing the spread of HIV infection.

> The U.S. Public Health Service cannot adequately guarantee the confidentiality of HIV serology results obtained through these proposed screening programs, nor can it mandate anti-discrimination protections which must be enacted at the state and local level.

"The combination of widespread mandatory HIV screening programs, continued widespread ignorance and fear concerning the casual spread of HIV, and the lack of adequate anti-discrimination safeguards for HIV seropositive individuals will cause severe hardship and suffering by hundreds of thousands of persons," Ostrow said. He added, "AAPHR has long advocated massive public education programs as the only effective and ethical means of controlling the spread of HIV infection, a position recently endorsed by both the Surgeon General and the National Academy of Sciences." He proposed a plenary session at the upcoming International AIDS Conference where the evidence for the efficacy of the gay community's AIDS education efforts can be more completely presented.

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GAY DAD CAN VISIT DAUGHTER--NO TEST

by William Burks, with thanks to The Washington Blade, 4/10/87

"John Doe," the gay father living in San Francisco whose Chicago ex-wife had refused to allow their two daughters to visit him because of fear of AIDS, can visit his children as a result of a settlement entered March 31 in Cook County Circuit Court. Under the settlement "Susan Doe"--the litigants used pseudonyms to protect the privacy of themselves and their children--discontinued her efforts to prevent visitation by the children. She had argued that even though her ex-husband does not have AIDS, he is a member of a "highrisk" group and might infect their two daughters, ages 9 and 11, with the disease.

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FALSE AIDS ALARM ENDS IN DEATH

by Martin Heggestad, with thanks to Boston's Gay Community News, 3/29-4/4/87

A man who mistakenly thought he had AIDS shot himself, his pregnant wife, and their 2-year old daughter, according to the UPI via the Advocate. Bruno Anselmi wrote in a suicide note that he had diagnosed himself as having AIDS after hearing radio reports about the disease. He feared that he had contracted AIDS from having sex with a prostitute 3 years ago. In reality, he was suffering from the flu, according to the report.

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PEACE CORPS REQUIRES NEGATIVE AB

by Lou Chibbaro Jr., with thanks to The Washington Blade, 3/13/87

The Peace Corps implemented a new AIDS antibody testing policy which requires applicants to submit a doctor's report stating that the applicant has tested negative for the antibody. The new policy, described in an internal Peace Corps memorandum, states that applicants who do not submit such reports will be disqualified from joining the Peace Corps, but notes that the policy ensures that neither the Peace Corps nor anyone in the federal government need find out that the applicant has tested positive. "As applicants need only provide negative [test] results, they can withdraw their applications at any time without explanation (or exercise the option of not applying until they test negative)," states the memorandum, prepared by Peace Corps Associate Director Linda Rae Gregory. Under the new testing policy which took place March 1, Peace Corps volunteers who currently are serving overseas assignments will not be required to take the AIDS antibody test unless a Peace Corps medical officer determines that a volunteer shows AIDS-related symptoms. Volunteers who test positive will be returned to the U.S. and discharged from the Peace Corps. Jeff Levi, director of the National Gay & Lesbian Task Force, said that while the Corps' testing procedure appears to protect the confidentiality of applicants, he opposes adoption of any mandatory AIDS antibody testing. Levi and other gay rights leaders have maintained that persons testing positive but who do not show signs of illness are capable of overseas work assignments and should not be subjected to discrimination. All overseas workers, whether they test positive or not, must avoid engaging in "high-risk" sexual activity. Avoidance of such activity is the best method of curtailing the spread of AIDS. However, Peace Corps press spokeswoman Alice Glen said the AIDS antibody testing policy was approved by the Peace Corps to protect the health of its volunteers, who are often subjected to infectious diseases in developing countries. Glen noted that all Peace Corps volunteers are given vaccinations prior to leaving the U.S., and that AIDS researchers have discovered that such vaccinations could bring about serious illness to persons whose immune systems are compromised due to infection with the AIDS virus. The Peace Corps, created in the early 1960s, provides some 60 Third World countries with American volunteers skilled in such areas as agriculture, public health, forestry, and fishery management. About 5000 Peace Corps volunteers are currently serving overseas, according to the agency's literature. While the February 19th memo prepared by Gregory mentions health concerns for volunteers as an important reason for adopting the testing policy, the memo also raises the issue of "political consequences" that may arise if overseas volunteers are found to be AIDS "carriers." "The health of our in-country hosts is a crucial consideration and it is important, in terms of the credibility of our programs, that host country governments know that we have done everything we can [to curtail the spread of AIDS]," the memorandum states. Karl Pulley, administrator of the Peace Corps' medical services division, said officials went to "great lengths" to implement antibody testing policy in a way that protects the confidentiality of persons applying to become volunteers. Unlike some other government agencies, Pulley said, the Peace Corps testing policy provides for instructing applicants on how to avoid disclosure of their test results to the government. While appearing to take steps to ensure confidentiality to Peace Corps applicants, the Peace Corps' AIDS antibody testing policy provides less discretion for volunteers who are already working in foreign countries. The Corps' memo also states that the medical officer could order a test if he or she observes "physical manifestation of disease symptoms" or obtains "specific information leading reasonably to the conclusion that an individual has been exposed to the infection." Overseas volunteers who test positive will be immediately "evacuated" from their duty stations and, following further medical testing, they will be "medically separated" or offered a chance to "resign" from the Corps. Pulley said knowledge of a volunteer's sexual orientation will be "irrelevant" to a decision of whether or not an overseas volunteer should take the test. The testing program does not affect Peace Corps employees who, unlike the volunteers, fall under the jurisdiction of the State Dept., which adopted its own mandatory AIDS antibody testing program for overseas personnel. Pulley noted that information packets sent to all applicants will coach the applicants on seeking out the test at the numerous alternate site test centers established within the past two years. Pulley said Peace Corps applicants traditionally have withdrawn from the program for reasons ranging from career changes or a realization that overseas work in developing countries is not suitable for them.

HOME AIDS ANTIBODY TEST

with thanks to The Baltimore Gay Paper, February, 1987

A Norcross, Georgia biomedical firm has developed a new portable test that can detect AIDS antibodies in a blood sample within 10 minutes, a spokesperson for the company said. It may be marketed for home use in the future. Officials of Murex Corporation said they are discussing details with the U.S. Food & Drug Administration and hope to market the test in the United States sometime in 1987. A home version which would sell for about $10 could be available by 1988. Presently available ELISA antibody testing takes 2 to 4 hours to process in specially equipped laboratories. The home test designated the "Single Use Diagnostic System" (SUDS), was developed at San Francisco's Institute of Cancer Research, and consists of a small cartridge-like device resembling a telephone mouthpiece, that contains a substance that reacts with AIDS antibodies in a test blood sample. In the second step, a detector antibody is added, and changes color in the cartridge if antibody is actually present.

INSURANCE TESTS BANNED BY CUOMO

by Peg Byron, with thanks to The Washington Blade, 4/24/87

New York Governor Mario Cuomo surprised hundreds of lesbians and gay men at an emotion-choked ceremony by announcing a plan to stop health insurers from using an AIDS antibody test as a condition for coverage. The governor, who ruled out running for the presidency earlier this year, made the announcement during ceremonies honoring his former aide, veteran gay activist Peter Vogel, who died from AIDS last year. Cuomo also used the occasion to sign an amendment to his executive order that prohibits anti-gay discrimination in state government jobs. The amendment to Executive Order 28, originally issued in 1983, is intended to beef up enforcement by placing its authority with the state Division of Human Rights instead of the Office of Employee Relations. But Cuomo surprised the crowd at Manhattan's Lesbian & Gay Community Services Center by announcing that the State's Insurance Department would take steps to prohibit health insurers from requiring applicants to take the AIDS antibody test before getting coverage. Cuomo's statement drew loud applause from the nearly 400 people at the event, and praise from gay rights groups, even though the proposed regulation would apply to health insurance only and not to life insurance. Cuomo had tears in his eyes as he spoke of Vogel, who for years worked closely with former National Gay and Lesbian Task Force Director Virginia Apuzzo, who shared the stage with Cuomo. "He was an extraordinary public servant," Cuomo said of Vogel, "and to me a very good friend," he said, his voice choking with emotion. "His death has deepened our love of life and freedom."

MURDER THREAT FOR POSITIVE AB TEST

with thanks to New York Native, 5/11/87

A gay man in Portland, Oregon has been the subject of terrorizing telephone calls and attempted assaults, reports Just Out, an Oregon gay monthly newspaper. The man, who prefers to remain anonymous, received a telephone call several weeks ago from a male who allegedly said he "was going to get" the man. Some days later, at a bar, the man was confronted by a sexual partner from three years' past, who revealed that it was he who had made the call. The acquaintance said he was undergoing a test for antibodies to HIV, the so-called "AIDS virus," and that, "If it's positive, I'm going to kill you and your lover." Two weeks later, another call was received, from someone saying he was coming over to kill the man. The caller also said he had spent $500 to make a videotape depicting the "rape" of the caller by the man, apparently intended as justification of the caller's intended violence. Poice responded to the threat, but left when the caller did not appear. shortly thereafter, the man heard someone at his door, who broke two windows in an apparent attempt to gain entry, but fled when he cut himself. Just Out reports that a large butcher knife was found among the shards of broken glass and blood. Portland police responded with "inertia" to the man's attempt to prefer charges against his assailant. After one week of "run-around," a poice report on the incident was finally filed.

DATING REGISTRY FOR ANTIBODY NEGS

with thanks to Rick Harding and The Washington Blade, 3/27/87

A San Francisco based dating registry for single men and women who have tested negative to antibody for HIV is drawing criticism from local safer-sex educators, according to San Francisco's Bay Area Reporter. According to registry organizer John McAfee, participants in the "Life Guard Screening Program" are entered into a computerized list, and receive an identification card stamped "AIDS Negative." T participate in the program a person must provide a physician's statement that he or she had tested negative for the HIV antibody within the past six months. Safer sex educators have criticized the program, saying it is not a replacement for safer-sex practices. According to American Red Cross blood services director Dr. J. Lawrence Naiman, a negative antibody test is accurate only if the person tested has not "exchanged body fluids" for six months preceding the test. The test result is also irrelevant if the person has unsafe sex at any point after the test was taken, he said. McAfee said, "We do not guarantee that sex with these people [participating in the registry program] is safe. What we do say is that if you only have sex with card-carrying members of this program, your chances of contracting AIDS are substantially reduced." McAfee said the program is attempting to reach "single dating people of any sex and orientation" and he hopes to enroll 20,000 participants from the San Francisco and Seattle areas within the next four months.

Lest that people from outside of San Francisco or Seattle feel jealous for not being able to "document their health," other entrepreneurs have established similar programs elsewhere. "Care/Card" in Chicago provides a plastic embossed card through a physician's office; the card is "validated" with a scissors cutting off either the antibody negative or antibody positive end of the card.

PEOPLE OF COLOR AIDS REPORT

compiled by Stephanie Poggi, with thanks to Boston's Gay Community News, 4/5-11/87

The National AIDS Network (NAN) has released its report on "AIDS Education and Support Services to Minorities: A Survey of Community Based AIDS Services Providers." The report was compiled by Gilberto Gerald, Director of Minority Affairs for the NAN. "Minorities with AIDS are victims of a health care system that has always put minorities at a great disadvantage, as documented in the federal government's Report of the Secretary's Task Force on Black and Minority Health (January, 1986). This creates a very bleak picture for the future of the minority community with respect to the AIDS crisis," says Gerald. "A black woman is 13 times more likely than a white woman to contract AIDS. There is a desperate need for risk-reduction information targeted at minority communities." Copies of the report can be obtained by sending $25 to NAN, 1012 14th Street NW Suite 601, Washington, DC 20005.

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MINORITIES & LEGAL CONFERENCE

with thanks to Los Angeles Computerized AIDS Information Network (CAIN), 5/9/87

It is hoped that those involved with legal issue regarding AIDS and those involved in service areas directed at minorities can share experiences and strategies aimed at AIDS related problems suffered by minorities. To highlight the problem of AIDS as it impacts minorities, a legal conference on AIDS and people of color is being planned at the Thurgood Marshall School of Law, Texas Southern University in Houston, Texas on September 11-12, 1987. It is hoped that we can solicit established local and national AIDS-related organizations to lend their names as "co-sponsors." If interested, please contact: Professor E.M. Harrington, Texas Southern University, Thurgood Marshall School of Law, 3100 Cleburne St., Houston, TX 77004.

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WOMEN IN ATLANTA: SAFER SEX PARTIES

by Louise Maret, with thanks to The Journal of AID Atlanta, April, 1987

Today, women are asking the same question gay men asked years ago. How do I remain sexually active yet safe from AIDS? Heterosexually transmitted AIDS cases rose 132% among people born in the U.S. last year. Since AIDS is not confined to any risk group, but is a threat to anyone who is sexually active, women are wanting to know how to protect themselves. The Play Safe Atlanta (P.S. Atlanta) campaign, formerly known as P.S I Love You, introduced Safe Sex Home Parties for gay men in 1985 as a fun way to learn how to play safe. Now P.S. Atlanta has expanded its outreach to include safer sex parties for women. Last November, Sharon Kricun, secretary to the AID Atlanta Educational Dept., formed a development committee of women in the health and social services fields to adapt the gay men's party format to address the needs of women. There are now ten trained facilitators who have sponsored parties. The Women's Safe Sex Home Parties began with a media splash. Committee members put on parties for the benefit of television stations and newspapers. The coverage offered free advertising and increased public awareness. A film of the safer sex party will be aired 8 times after its premier on the Playboy Channel program, "Sexetera, The News According to Playboy." A tupperware party format first used for gay men's parties, is also used for women. A volunteer hostess provides the house and refreshments for a group of 10-20 invited guests. AID Atlanta facilitators arrive equipped with condoms, games, and the "Safe Sex Erotic Potential Box" to sell the concept of safer sex. The parties provide an upbeat and comfortable atmosphere for women to learn how to make sex both erotic and safe. This includes learning more about condoms--and how to get men to use them. We want women to walk away with hope: that they don't have to hide in their bedrooms and be celibate," said Sharon Kricun. "We are trying to make condoms more erotic and more familiar to women." Facilitators usually use a type of "Dr. Ruth" question and answer session to break the ice. Bananas are used for the condom demonstration and "Survival Kits" containing a variety of condoms and dental dams are distributed. Roleplays help women learn how to introduce the concept of safe sex in a variety of sexual relationships whether it's a chance encounter at the airport or a long-term partnership. Finally, there is the "Safe Erotic Potential Box," filled with common household items meant to inspire creative use of safer sex principles. Gay women are also interested in safer sex and a special party format has been designed for this group. "There are no high risk groups, just high risk behaviors," says Kricun. "So all women need to be careful." Response to the parties has been favorable. According to Kricun, "Women have been as receptive as gay men and seem to need for information." So far, there are no safer sex parties for heterosexual men. "It's realistic to say that straight men are not interested," says Kricun. "Women have taken the responsibility for sex ever since Eve allegedly ate the apple--it'll be through women that information reaches the heterosexual population. The person being penetrated is t most risk. Therefore, women need to be concerned." Someday, however, there may be parties for heterosexual men or for groups of both men and women. Women on the development committee have discussed bringing in male partners or friends for a trial party.

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DETROIT AIDS IN BLACK COMMUNITY

with thanks to Detroit's Cruise, 4/1/87

AIDS has no respect, and can affect anyone regardless of age, race, nationality or other factors. That was part of the message delivered to 150 Detroit community leaders attending a recent day-long symposium on "AIDS in the Black Community" at McGregor Conference Center on the Wayne State University campus. The symposium was convened by Detroit Health Dept. Director John B. Waller Jr. and local and national experts in response to growing evidence that Blacks are disproportionately represented among persons with AIDS. The symposium was put together as a way to help sensitize Black leaders to the impact of AIDS in the Black community, according to Linda Williams, Detroit Health Department AIDS coordinator. "Recognizing the status and influence of the participants, we believe that these individuals will be of valuable support in helping educate and in some instances re-educate the Black community about AIDS as an issue of vital concern," she said.

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LATINO EDUCATIONAL CAMPAIGN

with thanks to Southern California Cares News

In an effort to provide factual and accurate information about AIDS to Southern California's latino communities, Southern California CARES (Cooperative AIDS Risk Reduction Educational Service) recently introduced a Spanish-language educational program. The campaign consists of a series of Spanish language radio and television public service announcements, a print advertisement and a regional, toll-free hotline. The television PSAs, featuring entertainer Vicki Carr, briefly discuss the AIDS virus and how it can and cannot be transmitted. The radio PSAs encourage interested and concerned individuals to contact a toll-free hotline for medical and social service referrals. The print advertisement also outlines high-risk behaviors and describes the symptoms of AIDS. The Spanish language hotline, funded by the State of California and the City of Los Angeles, will initially operate from 5-7 pm, weekdays, and will be staffed by bilingual volunteers. The hotline will provide accurate, up-to-date information about AIDS and the methods by which the disease is transmitted, as well as referral services to health care providers and social service organizations. The toll-free hotline number for the Southern California counties of Imperial, Inyo, Los Angeles, Orange, Mono, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara, and Ventura is 800/222-SIDA (222-7432). The Spanish language program is one component of an effort to better educate and inform people of color communities in Southern California about the risks associated with AIDS. News briefings directed toward the black and Asian/Pacific communities are scheduled to take place in early 1987 as part of Southern California CARES' continuing outreach campaign to people of color.

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GYNECOLOGISTS URGED TO INFORM WOMEN

with thanks to AIDS Bulletin, of the Tidewater AIDS Crisis Taskforce of Norfolk, Virginia, January, 1987

Although researchers disagree on how great an AIDS risk our nation's women face, they do agree on two major points: It's as important for women to practice safer sex as it is for men, and gynecologists should be responsible for telling them so. "I think gynecologists have a very important role," says Judith Cohen, PhD. "They are the most regular source of health care most women have. If they are reluctant to raise the issues of self-protection and responsibility, then women aren't going to hear about those issues as regularly or from as important a source." But Cohen, co-director of the San Francisco-based Association for Women's AIDS Research and Education, believes most gynecologists don't discuss with their patients the sensitive sexual issues important to AIDS prevention. "I think gynecologists get very little education about how to talk to their patients about being sexual. Most of them aren't very comfortable doing it. And something that doesn't get asked doesn't get answered," she says. Steve Margolis, PhD, with the Centers for Disease Control, agrees. Like all physicians, gynecologists should learn everything they can about AIDS, whether they've encountered a patient with AIDS or not, Margolis says. And an AIDS risk assessment should be part of each medical history they take, he adds. "As physicians, gynecologists should understand how the AIDS virus is and is not transmitted. And after doing a patient history, they should know what the real risk is to that patient," says Margolis, assistant director of the AIDS program in CDC's Center for Prevention Services. Gynecologists also should be familiar with economic, social, and psychological resources available to people with HIV infections or AIDS, Margolis suggests, adding "tragically, very few physicians have any of that information."

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BLACK/AFRIKAN—AMERICAN PWAs

by Rev. Charles Angel, with thanks to the PWA Coalition Newsline, April, 1987

It finally happened. After years of seeing friends, close and distant, buried, my news came. Or as so many PWAs can attest, "the news" finally came. At the age of 35, having lived through the "do as you please, have who you want, '70's," it was not IF I get AIDS, but when. I hoped early years of Gay Men's Health Crisis volunteer work, condoms and tears shed at "AIDS in the Black Community" conferences would save me. Walking through the African American and Caribbean communities in New York, I didn't see people I used to see, and nobody seems to want to discuss where they have gone. Finally, it happened. The lesion on my arm wasn't a blemish or an insect bite. At 10:30 am, January 7, 1987, I was diagnosed with Kaposi's sarcoma. I'm shocked. I'm scared. I'm numb. But at the same time, it is not as horrible as the constant fear of AIDS. It's finally here. Like so many PWAs, I'm really able to say that the diagnosis isn't as bad as the anxiety. My initial terror was almost unspeakable. All the questions: When will I die? How will I die? Should I commit suicide? How should I commit suicide? Then finally, after a day or so, I made a decision. I reached into my experiences and I began to listen to all the inner voices that have kept me alive as an openly gay, Afrikan man born as an American in New York City. I now need the strength I received in numerous spirit-filled church services. Now, more than ever, all the fiery sermons I had ever preached will now, as a preacher with AIDS, have to keep me alive. The inner guides of rich family roots deep in the black life of New York have to support me. Defeating AIDS has meant that I will have to reach out and gather all of the strength that has carried my people through second-class citizenship, segregation, reconstruction and far into the memories of my slave ancestors. My American roots alone are not enough. The fortitude and glory of my West African beginnings must be employed in a battle to defeat AIDS. I need all of this plus the modern memories of grand, black gay times in Manhattan streets and Brooklyn sidewalks. While our lives will never be the same, we must not forget to laugh and have the strength to live. There comes a point in dealing with AIDS that one must take control and decide to live. I am going to live and like every other human being, one day I shall die. But I've made the choice that I will not die of AIDS. It no longer has power over me.

[Rev. Charles Angel is a gay, black person with AIDS who is founding member of Gay Men of Afrikan Descent (GMAD) and a member of the PWA Coalition in New York City.]

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NATIVE AMERICANS GETTING AIDS

with thanks to Detroit's Cruise, 4/29/87

At first it was thought a was a non-Indian problem, but 32 cases have been reported among Native Americans since 1981, according to the government's Indian Health Service and Centers for Disease Control. The cases were reported in 14 states according to Pat Johannes, a communicable disease activities coordinator for the CDC. The total number of deaths from AIDS was 17, with 44% of them in California and New York. Age of PWAs ranged from 17 to 53 years old. "There is enough evidence to suggest that despite the remoteness of many Indian reservations, even those communicable diseases dependent upon lifestyle for transmission will affect Native Americans, and considerable effort must be put into their identification, treatment and prevention," Johannes wrote in an Indian Health Service Newsletter.

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BLACK PWA CHARGES AIDS FUNDING BIAS

by Chris Bull, with thanks to Boston's Gay Community News, 4/19-25/87

A Black man with AIDS filed suit against the Los Angeles County Board of Supervisors and Health Department, charging that he could have avoided the disease had they done more to educate Black and Latino communities in the city. Greg Baker is joined in the suit by the National Association for the Advancement of Colored People (NAACP), the Southern Christian Leadership Conference, Rev. Carl Bean of the National Minority AIDS Council, and Dr. Anthony Lopez of the Hispanic AIDS Education Foundation. The groups hope to get federal and local governments to step up AIDS education for people of color. Lawyers from the American Civil Liberties Union (ACLU) are representing Baker and the coalition of organizations. Kate Cameron of the ACLU says that the suit attempts to align itself with US Surgeon General C. Everett Koop's report, which also cites a lack of funding for communities most heavily hit by AIDS. She explained that this tactic will legitimate the suit in the eyes of those who think the ACLU is a "crazy leftist outfit." The country has given lip service but not funds to minority communities. It is unfortunate that we must litigate, but there seems to be no other way of getting the country to address a problem that is reaching epidemic proportions," Cameron said. Los angeles has the second highest number of people with AIDS, after New York City, and prevention through education will be less expensive for the country in the long run anyway, Cameron insisted. Craig Harris of the National Minority AIDS Council and the National Coalition of Black Lesbians and Gays said that A funding has failed to address the specific needs of people of color. the most effective programs, according to Harris, are those in which a community received education from its own members. However, he said, health officials and mainstream foundations have used educators from outside communities of color, and materials that are culturally inappropriate. "Education that might work perfectly well for a gay white male will have little affect on a Black person even if he happens to come into contact with it." Harris also cited institutional racism and the lack of contact between groups of people of color as prime problems in achieving education for people of color. Harris and other experts in the field agreed, however, that people of color are gradually achieving more power to fight for funds. "This lawsuit is only one of the measures being taken in terms of raising the funding issue with legal and legislative authorities. It is unfortunate that the monies have historically been directed toward minority outreach and inclusion projects of the more established service organizations. Clearly more funding needs to go to ethnic minority and minority/community based programs." Ernest Andrews of the Multi-Cultural Alliance for the Prevention of AIDS in San Francisco, agreed with Harris. "Health officials argue that there are not enough people in these communities to justify more funding, but in San Francisco, the AIDS Foundation has a budget of several million dollars and spends only about $100,000 between all the communities [of color] here," he told GCN. Federal and state health officials refused to comment on the suit but agreed that new approaches to education may be necessary. Robert Saltzman, Administrator of the Los Angeles County Dept. of Health Services, said that their AIDS education program has six full-time health educators, two of whom are dedicated to the Black and Latino communities. Forty percent of their one million dollar annual education budget goes to these communities, he claimed. Saltzman also pointed out that the Health Dept. has a variety of contracts with community organizations to facilitate education for Black and Latino communities. "We are doing everything we can with the resources we have to reach a variety of communities. We are working on different approaches for these areas that do not respond to our standard approach," Saltzman said. Los Angeles County Supervisor Mike Antonovich, named as a defendant in the suit and a target of criticism by gay and lesbian groups for alleged homophobic remarks, does not believe that people of color have been harder hit by the disease in Los Angeles County. Therefore, he says, they do not deserve "special consideration." Antonovich's press secretary, Dawson Oppenheimer, told GCN that gay and lesbian activists appear to have their own agenda that has nothing to do with stopping the disease. "There are many homosexual and many heterosexual people in the country, but only the gay activists seek more than fair treatment." Oppenheimer accused the ACLU of ignoring the public interest in stopping the spread of AIDS. "What about the rights of wives of men with the disease. The ACLU believes that they do not have the right to know their situation," he alleged. He also claimed that Blacks and Latinos in Los Angeles county actually contract the disease less often than their white counterparts. "Somebody [in the County Health Dept.] must be doing something right." According to the Los Angeles County Health Services AIDS report, 29 percent of AIDS cases are Black or Latino, although the groups represent nearly 40% of the population. The figures do not include the substantial population of illegal immigrants in Los Angeles. Jim Brown of the Federal Public Health Service in Washington, DC, denied that spending on AIDS education has been discriminatory. "As we go along, we find that we need to stress certain areas and this is one of them. But AIDS is a killer no matter what community it is in." New techniques are being tried to reach Black and Latino communities, including public service announcements on popular radio stations, in churches and at drug rehabilitation centers, he said. So far, however, these new approaches have been inadequate, Black and Latino leaders assert. The ACLU's Kate Cameron listed some of the problems: speakers bureaus that do not reach a large enough audience, health brochures designed for white middle-class males, drug rehab centers that put people right back onto the streets, a lack of health care for the poor, little or no counseling for people of color with AIDS, and language barriers, among others. For example, Latinos in Los Angeles with questions about AIDS are referred to a Spanish rape hotline because it is the only organization that has the proper information in Spanish. the suit, Cameron explained, is an attempt to get the government to address these serious problems one by one. Suki Ports of the New York Minority AIDS Project believes that discrimination in AIDS funding is simply a reflection of white male power in this country. "I am saddened that it takes legal action to create concern for AIDS and ARC victims, but if this is the only route we have it must suffice."

COLLEGE AIDS EDUCATION MANUAL

The University of California at Berkeley has recently produced the manual "AIDS Education on the College Campus" as part of the university's AIDS Education Program. The 64 page manual costs $8 and is offered as a guide for other campuses in developing or expanding their AIDS education activities. A successful education campaign will be tailored to fit the needs of each campus community. Therefore, this manual provides a "menu" of AIDS education activities that can be selected as needs dictate and campus resources allow. Sections on program planning and educational principles provide a foundation for quality assurance in the design of campus AIDS prevention programs. Information on educational materials and other resources can assist campuses to gather AIDS-related information and stay current on the epidemic. The manual was developed in anticipation of the need for universities and colleges across the country to provide leadership in the nationwide response to AIDS. The overview includes problems faced by a campus community concerned with AIDS; models for developing an institutional response to AIDS; strategies for a wide range of educational programs; methods for student involvement; state and national resources; an argument for the importance of AIDS education on the college level. For more information, write: AIDS Education Manual, Student Health Service, 381 Cowell Hospital, University of California, Berkeley, CA 94720.

PARENTS SUE HOSPITAL OVER BABY AIDS

by Craig C. McDaniel, with thanks to the New York Native, 3/16/87

The parents of a four-year old boy who has AIDS are suing Texas Children's Hospital in Houston, claiming that their son contracted the disease from blood used in a transfusion. Roy and Pam Jurica say in their suit that the hospital repeatedly refused to take blood from family members, and that their son, Phillip, contracted AIDS after a 1983 transfusion when he was born premature. The transfusions had occurred before routine screening for HIV antibody had been implemented by blood banks in 1985.

POOR OUT OF LUCK AT HOUSTON HOSP'L

by Craig McDaniel, with thanks to the New York Native, 4/20/87

Houston's Institute for Immunological Disorders, the nation's first AIDS hospital, has stopped taking indigent patients. Officials for the hospital, which opened in Sept. 1986, say it has lost $2 million in caring for patients unable to pay their bills. The decision does not mean the hospital will close. Institute spokesperson Lynn Walters said treatment for patients already at the hospital would continue and only new patients would be affected by the decision. "The highest priorities of the Institute are to continue to provide care of the highest quality to its current patients, as well as to continue its research programs directed toward eventual elimination of this disease," the hospital's board said in a statement. The AIDS hospital, operated by American Medical International and affiliated with the University of Texas System, expects costs of indigent care to reach $5 million by August. Only $250,000 was committed to such care at the hospital's outset.

INSURANCE SURVEY RELEASED

with thanks to the New York Native, 3/16/87

National Gay Rights Advocates (NGRA) has announced that a substantial number of state insurance departments have instituted non-discriminatory AIDS-related insurance policies. In 14 states, insurers cannot exclude AIDS as a covered condition. In 13, they may not ask applicants about the results of prior antibody testing, and in 7, insurers cannot test applicants for HIV antibodies. NGRA's findings come as part of a nationwide educational campaign encouraging insurers and regulators to develop fair policies and practices with regard to AIDS. NGRA, the national public interest law firm working for gay rights, serves as an AIDS policy adviser to the National Association of Insurance Commissioners (NAIC). "NGRA actively uses litigation, education, and administrative action to combat AIDS discrimination," noted Benjamin Schatz, director of NGRA's AIDS Civil Rights Project. "And we will continue working closely with state insurance regulators on a state-by-state basis to ensure that the industry responds fairly to AIDS." A majority of the 40 states in correspondence with NGRA forbid discrimination on the basis of sexual orientation. This number is expected to rise with the recent passage of NAIC guidelines banning anti-gay discrimination in insuring and underwriting. NAIC's guidelines specifically prohibit health insurers, life insurers, and investigative agencies from using gender, marital status, living arrangements, occupation, medical history, beneficiary, and zipcode as proxies in determining sexual orientation.

STATES FORBIDDING ANTI-GAY DISCRIMINATION—NGRA INSURANCE SURVEY RESULTS: Arizona, California, Delaware, Washington DC, Florida, Illinois, Kansas, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nevada, New Jersey, North Dakota, Oregon, Pennsylvania, South Dakota, Tennessee, Wisconsin.

STATES FORBIDDING QUESTIONING ABOUT PRIOR HIV TEST RESULTS—NGRA INSURANCE SURVEY RESULTS: Arizona, California, Connecticut, Delaware, Washington DC, Maine, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, North Dakota, South Dakota.

STATES FORBIDDING HIV ANTIBODY TESTING—NGRA INSURANCE SURVEY RESULTS: Arizona, California, Delaware, Washington DC, Massachusetts, Michigan, North Dakota.

STATES WHERE INSURERS CANNOT EXCLUDE AIDS FROM COVERAGE—NGRA INSURANCE SURVEY RESULTS: Arizona, California, Delaware, Washington DC, Florida, Kansas, Maryland, Michigan, Minnesota, Missouri, Oregon, Pennsylvania, South Dakota, Tennessee.

HOUSTON MEDICAL OFFICER OPPOSES CDC

by Craig C. McDaniel, with thanks to the New York Native, 3/16/87

Widespread testing for antibodies to HIV would be a waste of money that should be used for education, says Houston Health Director Dr. James Haughton. "If we truly believe education is the most important tool we have against this disease, then instead of spending millions testing to find the positives, we would be better off spending a fraction of that to prevent those from becoming [infected]," he said. To support his argument, Haughton cited statistics that show 32% of people screened at a clinic that treats STDs have been exposed to HIV. Fewer than 1% of people taking the same test at Houston blood donation centers show exposure. Only 0.8% of the 296,023 units of blood collected in Houston since June 1985 have been found to contain HIV antibodies. All but 500 of the 3264 people tested at the Montrose Clinic identified themselves as members of a "high-risk" group, officials said. Of the 2764 high-risk group members tested last year, 878 tested positive. Only 22 people of the 500 not in a high-risk group tested positive. Haughton says this shows community-wide exposure to AIDS is limited, and that efforts should therefore be directed at educating high-risk groups. The city's health director said he opposes the Centers for Disease Control proposal to impose mandatory testing on hospital patients and people applying for marriage licenses. "We're not going to accomplish anything by testing that we couldn't do better by a more aggressive and better funded education program," Haughton said.

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"VENUS BUTTERFLY" EVOKES FANTASIES

with thanks to Medical Aspects of Human Sexuality—Sexuality Update, March, 1987

If patients ask you about a sexual spicer-upper called the "Venus butterfly," tell them it's an example of no-core pornography. On the NBC-TV series LA Law, one of the attorneys mentions learning of it from a client, but the dialog gives no hint as to what it entails. The lawyer and his inamorata try it (offscreen, of course). They report that it's fantastic, without describing it further. After the episode was aired, viewers flooded the show with questions about whether the Venus butterfly was a technique, position, aphrodisiac or what. Actually, it's nothing. The suggestive phrase was a writer's concoction, deliberately left to the audience's imagination.

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ILLINOIS AWARENESS AND ATTITUDES

with thanks to the Illinois Alcoholism and Drug Dependence Association, 2/28/87

Illinois residents believe AIDS will become an epidemic for the general public, but many say they have not changed their sexual behavior to reduce the risk of catching the deadly disease, according to the survey conducted for the Illinois Dept. of Public Health. The majority of people polled were very knowledgeable about the ways in which AIDS can and cannot be spread. However, those giving the most inaccurate answers to the ways in which AIDS is spread were the youngest (16 and 17 year olds), the oldest (53-64 year olds), Chicago residents, blacks and hispanics. These are but two of the important and interesting findings of the survey which Dr. Bernard J. Turnock, Director of the state's Department of Public Health, said supported the urgent need for educating the public on the facts about AIDS. You can order the entire survey by calling the AIDS Unit, Illinois Department of Public Health (312/917-2608), or by writing to: The AIDS Unit, IL Dept. of Public Health, 100 West Randolph, Suite 6-600, Chicago, IL 60601. For more information about IADDA, write: P.O. Box 148382, 859 W. Wellington, Chicago, IL 60614-8382 (312/472-0731).

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CHILD'S STORY

with thanks to the Baltimore Gay Paper, March, 1987

Hi, my name is Roland. I'm gonna tell you my story because this is AIDS Awareness Month (in March) and I might not be around next month to tell you all about me. See I am three years old and I got AIDS. I am an orphan now. My mama had this sad joke about how me and her were having a race to see who would die first. Well she won. Her family won't have nothing to do with me. See she took drugs and that was o.k. and she was a prostitute and that was o.k. but then she got AIDS when she was pregnant with me and that was not o.k. See AIDS is "that Gay disease." Except I am three years old and I have it. Except I am not the only kid that has it. Except a lot of people have it now that are not gay and there will be a lot more because there is no cure and folks still think only Gays get it. My mama did not known anything about AIDS when she got it. All she knew about it she learned after it was too late. She used to try to talk to people about it, even warn folks to take precautions, but she got worn out trying and then she died. You would think seeing how sick she was folks would listen, but they didn't, generally, they was busy pretending that if they ignored her they would be safe. Sometimes grownups make no sense at all. I don't have an easy time of it. I don't get the cuddles I should. Some folks are afraid of me. I know. I can see it in their eyes sometimes. These great big tall grownups scared of little me—and I'm about the skinniest kid you ever saw—because they are so blame stupid about the thing that's gonna kill me sooner or later. I ought to be scared of them. The germs they might have. What's a cold for them could be pneumonia for me. But I'm not scared. The nurses who take care of me when I'm bad sick say I got a lot of guts. The guys from H.E.R.O. [Baltimore's Health Education Resource Organization) that bring me toys sometimes, they tell me I got to hang in there. The lady from Social Services give me a pat on the head and a smile and turns away quick before I can see her crying. Before I go, I got something to say. You know somebody that does needle drugs, tell them about AIDS and not to share needles. You know any Gays, any prostitutes, anyone at all with lots of bed partners, you tell them to play it safe. I'm so young I don't really know what sex is, and I won't live long enough to find out, but I know from what I heard the grownups say that anybody having sex got to take precautions not, Gay or not. Because AIDS is bad. I know. Thank you for listening to my story.

AMERICAN VD ASSOCIATION AWARDS

The American Venereal Disease Association (AVDA) presents two awards, usually on an annual basis: The Thomas Parran Award recognizes an individual for contributions made to t he field of venereology over a significant period of time, frequently a lifetime. The 1985 awardee was Dr. James N. Miller. The AVDA Achievement Award recognizes contributions or significant achievements made during the previous year or two. This award may be presented to individuals who do not work primarily in the area of STD control. Workers in any discipline should be considered. Previous awards have recognized scientists, administrators, educators, and persons concerned with the direct delivery of health care. The 1985 winner was Dr. Eric Sandstrom. Nominations for both awards are now open and will be considered until May 1, 1987. Nominations including supporting statement and a curriculum vitorum, if possible, should be sent to: Robert B. Jones, MD, PhD, 545 Barnhill Dr., #435, Indianapolis, IN 46223. The AVDA publishes the journal Sexually Transmitted Diseases. For more information: AVDA, P.O. Box 22349, San Diego, CA 92122. Yearly membership includes the quarterly journal as well as other benefits, for $35 in North America ($42 oversees).

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CHICAGO'S HOWARD BROWN NAMES CEO

After a three month search and selection process, Chicago's Howard Brown Memorial Clinic (HBMC) has named Reuben Dworsky of Brooklyn, New York as its new executive director. The nonprofit health and social services organization, which has become one of the Midwest's primary AIDS resource centers, has operated without a chief officer since former Executive Director Jon Weiss left the post in early March. Dworsky, who will assume the duties of executive director May 18, currently holds the position of director of programs and field operations for the New York State Department of Health, AIDS Institute. Dworsky's background in devising and monitoring AIDS programs for the state of New York and his success in managing community-based organizations were some of the major factors in his selection, said Steve Wakefield, acting executive director. "Mr. Dworsky's experience in dealing with a wide range of service providers and government bodies, his familiarity with the issues HBMC faces and his skills as a leader and a communicator make him an ideal choice for our organization," said John Charles, president of HBMC's Board of Directors. Dworsky, who holds a MA degree from Syracuse University, was chosen from a field of more than 120 applicants from across the US. Founded in 1974 as a community center for the diagnosis and treatment of sexually transmitted diseases, HBMC has, in recent years, assumed a national leadership role in the fight against AIDS. The Clinic is currently involved in several AIDS research projects in conjunction with the National Institutes of Health, the Centers for Disease Control and major universities. Additionally, HBMC provides AIDS clinical screening and diagnosis, low-cost medications and social services for persons with AIDS (including emotional and psychological counseling), as well as an extensive AIDS education program. The Clinic also operates the Illinois State AIDS Hotline (1/800/AID-AIDS) under a grant from the Illinois Dept. of Public Health. For additional information, contact: HBMC, 2676 N. Halsted St., Chicago, IL 60614 (312/871-5777).

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AIDS ACTION HIRES NEW DIRECTOR

with thanks to AIDS Action Council Update, March, 1987, and the PWA Coalition Newsline, April, 1987

Ann E. McFarren became the new executive director of the AIDS Action Council, on March 1, succeeding Gary B. MacDonald who accepted a position as ex-officio member of the Council's Board. McFarren was most recently vice-president for affiliate development and education of Planned Parenthood Federation of America, based in New York. She has also worked extensively with service, health and government organizations, trade associations and small businesses as a private consultant. During her career, McFarren has been deeply involved in advocacy for health education and public health programs involving sexual issues. As a woman, nurse, and parent, she believes that se brings a unique perspective to AIDS, "...A perspective this society needs," she stated. "I am also aware that as we go forward to address issues related to all people affected by AIDS, we must never forget the special contributions, concerns and needs of the gay community," she added.

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CHICAGO'S CLINIC TO MOVE

It is now official!! Chicago's Howard Brown Memorial Clinic will move its entire operation from 2676 N. Halsted to 945 W. George St. this summer. In a formal ceremony held May 8 at the new site, HBMC officers signed a ten-year lease for the two top floors of the former Niedermaier Displays warehouse. "This is a very important step, both for our organization and our community," said John Charles, president of HBMC's Board of Directors. "The new facility will not only provide us with much-needed space, more importantly, it will allow us to serve more clients and increase our commitment to AIDS research, education, social services and medical care," he added. The nonprofit health care organization has dramatically expanded its programs in recent years to meet the increasing need for AIDS-related services. It is now one of the primary AIDS resource centers in the MIdwest. The Clinic currently administers to some 175 persons with AIDS in the greater Chicago area. It also operates the statewide AIDS Hotline under a grant from the Illinois Dept. of Public Health. "As public concern about AIDS increases and the number of AIDS cases in Chicago continues to grow, so does the need for our specialized services," Charles said. for these reasons, he said, HBMC has far outgrown its current home. Many staff are jammed into makeshift offices located in three small apartments above the present clinic facilities. The new George Street location provides nearly three times the space of the Halsted site. Construction work to convert the former warehouse into clinical, office and laboratory facilities is currently underway. Charles said the Clinic has raised nearly $10,000 from community contributions to help pay the cost of renovation, but that more than seven times that amount is needed to cover the total relocation costs.

WHITMAN—WALKER CLINIC HAS NEW HOME

A new home for Washington, DC's Whitman-Walker Clinic, as well as the first corporate grant and creation of a prestigious fundraising committee, were recently announced by Clinic President Mary Jane Wood. The new building at 1407 S Street, N.W., will nearly double the Clinic's size to 12,500 square feet on four floors and a basement. Ms. Wood said the Clinic plans to occupy the building, now under renovation, by April. She also announced the organization of a Committee of Honorary Sponsors for the Clinic. Co-chair persons are: Effie Barry, the Mayor's wife, and D.C. City Councilmember Frank Smith. The Committee will assist in establishing an endowment for the new building. The American Council of Life Insurance and the Health Insurance Association of America have provided the first corporate donation for the new facility with a grant of $47,000 for the purchase of medical and dental equipment. "Thanks to this grant, we will be able to open one of the first community based, volunteer-staffed dental clinics in the nation," said Whitman-Walker Medical Director Jack Killen. He explained that the Clinic will provide a fully equipped dental office for routine dental care and AIDS-related diagnostic work. In addition to the dental facility, the grant will be used to furnish and equip rooms for medical examinations, treatment and nursing care. There will also be additional space and equipment for the Clinic's federally-licensed lab. Other facilities will include seven conference rooms; the D.C. AIDS InfoLine and Gay Hotline; offices and work areas for an alcoholism program; the Women's Issues Office and the Clinic's AIDS program; and a lounge for volunteers and staff. The lease for the new building contains a right-to-purchase agreement at a specified amount. Clinic Administrator Jim Graham said he is optimistic that money for a down-payment on the building can be raised within the first year through out the endowment campaign. The Commission of Public Health, D.C. Department of Human Services has provided additional funding in fiscal year 1987 to cover a significant portion of the cost differences between the current facilities on 18th Street and the new building. Mayor Marion Barry announced the funding in September.

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WRITER—IN—RESIDENCE SELECTED

The Fund for Human Dignity (FHD) has announced the appointment of Darrell Yates-Rist as its 1987 Writer-in-Residence. The position, funded by the New York State Council on the Arts, will support the writer's work on Heartlands: A Gay man's Odyssey Across America, a chronicle of the lives and politics of gay men in the United States during the late 1980s and in the middle of the AIDS epidemic. During his residency, Yates-Rist will be traveling throughout the country interviewing gay men for the book, which will be published by E.P. Dutton in the fall of 1988. Distinguished for his articles on AIDS and gay politics as well as the arts, Yates-Rist frequently publishes in the New York Native, Christopher Street, the Advocate, and the Village Voice. Yates-Rist's work has also appeared in such journals as Harper's and Paris Match. He is represented in the recent collection of essays Gay Life (Doubleday, 1986) and in the short story collection Hot Living (Alyson, 1985). His Going to Paris to Live, a 6 part, 1985 Native series on people with AIDS who sought treatment with the drug HPA-23 at the Pasteur Institute, drew intense national media attention upon the death of film star Rock Hudson, who had gone to France for the experimental therapy. And the 1986 Advocate cover story The AIDS Slur--a stringent critique of the homophobic myths surrounding the epidemic and the gay community's response to it--and numerous national media appearances concerning AIDS, such as those on NBC's Today Show and on Frontline's "AIDS: A National Inquiry" on PBS, have established the writer as one of the leading critics on the politics of the epidemic. In 1985, Yates-Rist cofounded the Gay and Lesbian Alliance Against Defamation (GLAAD) to combat homophobia in the New York and national media. During his tenure with GLAAD, he helped organize and lead major protests against the New York Post for its anti-gay editorial policies and against William F. Buckley, Jr., of the National Review for his proposal to tattoo people with AIDS. In the summer of 1986, Yates-Rist met with Buckley and secured a retraction of the right-wing ideologue's statements on AIDS, and on July 4th the writer was among the activists who led some 10,000 marchers through the Statue of Liberty Centennial celebration to protest the Supreme Court's ruling upholding sodomy laws. Yates-Rist currently appears weekly as a panelist and commentator on the Gay Cable Network's Gay Week in Review, which is aired in some 12 cities across the country. As part of his responsibilities as the Fund's Writer-In-Residence, Yates-Rist will host EPIDEMIC, Center Stage, a forum on the theater's response to the AIDS epidemic, on April 27th in New York City. Co-sponsored by Gay Men's Health Crisis (GMHC), the program will feature live and videotaped excerpts from several plays dealing with AIDS and a panel of playwrights including William Hoffman (As Is), Larry Kramer (The Normal Heart), Robert Chesley (Jerker, or the Helping Hand), and Robert Patrick (Blue Is For Boys). Producers Joseph Papp, Ellen Stewart (on videotape) and actress Colleen Dewhurst, President of Actor's Equity, will also serve as panelists. According to Yates-Rist, "Historically the stage has used epidemics as a thematic back-drop— as in Moliere or Ibsen. But never before have playwrights written serious drama that, while entertaining us, seeks to educate us about the particulars of an illness, sometimes attempting to tutor us in the ways the disease is spread or in the techniques of safe[r]-sex, other times increasing our consciousness about the social or political ramifications of the epidemic. It is gay playwrights who have taken the lead in this kind of theater, and they've been highly successful in walking the literary tight-rope between entertainment and didacticism. EPIDEMIC, Center Stage is an evening that will both celebrate their accomplishments and explore ways they and other playwrights can bring this sort of drama to a broader audience as the epidemic spreads."

The Fund for Human Dignity is the educational foundation of the national gay and lesbian community. Established in 1974, the Fund works to educate all Americans about their gay and lesbian community, culture and heritage. This year marks the 5th anniversary of the Fund's National Gay & Lesbian Crisisline/AIDS 800, the nation's first national AIDS hotline and the only national toll-free gay and lesbian hotline in the country. The Fund also operates the National Gay and Lesbian Clearinghouse and AIDS Education Program which provide information on gay, lesbian and AIDS issues to a variety of educational, health care, corporate, religious and government institutions in every state of the country. To arrange press interviews with Darrell Yates-Rist or schedule speaking engagements, contact: Fund for Human Dignity, Sherrie Cohen, 666 Broadway, 4th Floor, New York, NY 10012 (212/529-1600). For additional information about EPIDEMIC, Center Stage, contact Lori Behrman, Gay Men's Health Crisis (212/645-5368).

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AIDS NETWORK LAWYERS GUILD

The National Lawyers Guild has established an AIDS Network to assist members of the legal community to become involved in AIDS-related issues. The National Lawyers Guild is an organization of nearly 9000 members in 135 chapters nationwide. It has a fifty year history of defense of civil rights and advocacy for progressive social and political change. The purpose of the AIDS Network is to encourage lawyers and legal workers to represent people with AIDS and AIDS-related conditions, to take part in advocacy and public education about the law and AIDS, and to assist local AIDS organizations. The Network publishes a 100-page Practice Manual and a bimonthly newsletter as well as provides participants with a consultant list of over 115 lawyers in 18 legal areas. There are currently over 270 participants in 39 states. The Practice Manual covers medical and social aspects of AIDS as well as such legal areas as wills and powers of attorney, employment, public benefits, and military law. It is in loose leaf format and is available for $10. The newsletter, The Exchange, focuses on one topic each issue (such as testing/quarantine, prisons and jails, and insurance.) It includes a resource list and sections for the exchange of ideas and developments. A one year subscription is $10. For more information, or to order materials, contact the NLG AIDS Network t 211 Gough Street, Suite 311, San Francisco, CA 94102 (415/861-8884).

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FEAR OF AIDS REJECTED AS DEFENSE

by Peg Byron, with thanks to The Washington Blade, 4/24/87

A drifter who blamed AIDS hysteria for murdering his gay partner was sentenced to 7 to 21 years in prison by a Nassau County, Long Island, Judge. Lorenzo Owens, 20, who pleaded guilty to first-degree manslaughter for the April 20, 1985 stabbing death, faced a minimum term of 2 years and a maximum of 25 years. Owens was believed to be the first defendant to use fear of AIDS as a murder defense. He said he killed Kenneth Grice, 24, after he had sex with him and then allegedly learned Grice was infected with the AIDS virus. Owens testified that he was "very upset" and felt he was "under a death sentence" when he grabbed a kitchen knife and slashed his long-time friend's throat. Judge Richard Delin acknowledged Owen's emotional state during the murder but noted that Owens stole property from Grice's apartment and scrawled anti-gay slogans on the wall, as well as reports that Owens had sex with his girlfriend seven hours after Grice's murder. Owens' trial on 2nd degree murder charges ended abruptly March 23 when he pleaded on reduced charges before his 16-year old girlfriend could testify, which defense attorney Lewis admitted "would have killed our case." Tom Stoddard, executive director of the Lambda Legal Defense and Education Fund called the sentence appropriate. "This is clearly the first time such a murder defense was used," he said, "and I am pleased the defense was not vindicated."

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ACLU BRIEFING PAPER ON AIDS

with thanks to Detroit's Cruise, 5/6/87

The American Civil Liberties Union (ACLU) has announced the publication of a briefing paper on "AIDS and Civil Liberties," which contains medical and legal information about the disease and explains the organization's position on such controversial proposals as compulsory HIV antibody testing. "The most effective response to AIDS, aside from supporting medical research, is education and prevention," said ACLU staff attorney Nan D. Hunter, a nationally recognized expert on AIDS and author of the briefing paper. "Trying to 'teach' abstinence is not the answer. Trying to pretend that only certain people can get infected is both wrong and dangerous. People need to know the facts about exactly what behaviors are dangerous and how they can protect themselves." The flyer "AIDS and Civil Liberties" contains basic information on the policy implications of AIDS, and answers the questions most frequently asked of the ACLU in a question and answer format. The following are some of the important points made in the flyer:

>Medically, there is no evidence to suggest that the AIDS virus can be spread through normal workplace contact.

>Legally, firing an employee who has AIDS or a positive HIV antibody test will, in most instances, violate state or federal law, which prohibits discrimination based on disability.

>Most federal or state court cases involving a person with AIDS or a person with antibody to HIV have restored the person to work, and in most cases, school children similarly afflicted have been permitted to attend school.

>AIDS is not a "gay disease;" infection can occur between two men or between a man and a woman.

The ACLU supports access to voluntary testing for the AIDS virus, but opposes compulsory testing and the non-anonymous collection by the government of names or other information about people who test positive. Such measures are counterproductive, driving away people who need counseling but who fear discrimination and reprisal. The ACLU recommends education about sexual and drug use practices that spread the disease; the easy availability of condoms for all sexually active persons, including teenagers; and the distribution if necessary, of clean, disposable hypodermics to drug addicts. "And we need to pass strong anti-discrimination laws so that people will not have to fear that their efforts to seek counseling or treatment will lead to loss of their jobs or housing or insurance." "AIDS and Civil Liberties" is recommended for use by schools, employers, health departments and civic groups. A single copy is free from: ACLU, AIDS Briefing Paper, 132 West 43rd Street, New York, NY 10036.

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HIGH SCHOOL STUDENTS IN MOCK TRIAL

by Doug Hinckle, with thanks to The Washington Blade, 4/17/87

Washington, DC high school students became players in a "mock trial" on AIDS discrimination in the Moot Courtroom of the Georgetown University Law Center. The students, playing lawyers, clients, and witnesses, participated in the hypothetical trial of a DC Corrections Officer who said he was wrongfully discharged from his job at a local medium security jail because he tested positive for the AIDS antibody. Social studies students from 26 DC high schools participated in the initial rounds of mock trials at the DC Superior Court April 8. The Finalists--students from Coolidge and Ballou senior high schools--argued their cases before a real judge--Associate Judge Reggie Walton--at the competition. During the two hour "trial," a courtroom full of DC public school students, their families, and friends listened as the Ballou team defended the jail's administration. The administrator testified that the corrections officer was dismissed because the inmates were afraid of catching AIDS and were rioting to have him removed from the facility. The administrator also charged that the corrections officer presented a risk of transmitting AIDS to others at the prison. The Coolidge team, representing the "plaintiff," argued that AIDS cannot be spread through casual contact and that to dismiss the corrections officer because he tested positive was a violation of the city's Human Rights Act. Coolidge's leading "counsel," James Brooks, drew applause from the crowded courtroom when he argued that the corrections officer had been victimized twice--once in contracting the AIDS virus and again in being fired. "If justice is not served here," said Brooks, the corrections officer "will become a victim for the third time." Judge Walton ruled in favor of the corrections officer and awarded him back pay and reinstatement to his job. The Coolidge team will now compete in the national finals, sponsored by the National Institute for Citizen Education in the Law. The subject of the national competition, which will be held at Georgetown on May 17, is the Alien and Sedition Acts of 1798, concerning the power of the president to deport undesirable aliens and persons who criticize the government. The topic of the DC competition was chosen by the DC Street Law Project of the Georgetown University Law Center, which sponsored the local mock trial.

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HEALTH INSURANCE EXPLORED: LAWYERS

with thanks to The Exchange National Lawyers Guild AIDS Network, February, 1987

This issue of The Exchange explores the complexities of financial and health insurance aspects of the AIDS crisis. Attorney Ben Schatz, Director of the AIDS Civil Rights Project of the National Gay Rights Advocates, and Brent Nance, president and founder of the Concerned Insurance Professionals for Human Rights (CIPHR) are interviewed by National Lawyers Guild staff member Mark Vermeulen.

Also reported in this issue is information about Congress' recently passed "Consolidated Omnibus Budget Reconciliation Act (COBRA), 26 U.S.C. Sec. 162(k), which requires employers of 20 or more employees to grant terminated employees continued coverage under a group health insurance plan for at least 18 months from their date of termination. The Treasury Dept. will be issuing regulations interpreting COBRA in the spring or summer. COBRA is particularly helpful for employees with AIDS who are terminated or must leave work due to health reasons. Senator Kennedy, the sponsor of the bill, is planning to introduce additional legislation this session which among other things, will extend the advantages of COBRA to 22 months after discontinuance of work.

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SOUTHEASTERN CONF. COVERS HEALTH

The XII Annual Southeastern Conference for Lesbians and Gay Men is scheduled for May 14-17, 1987 in Fort Lauderdale, Florida. The Conference will feature nationally prominent speakers, exciting workshops, lively entertainment and a host of other events for your enjoyment, education and growth. As lesbians and gay men, we are faced with some of the most serious and dangerous times in history. Our health, happiness and lives depend upon unity and knowledge and action. The Conference provides a forum and classroom for sharing and solidifying common goals and ways to attain those goals. Together we can work "Today for Tomorrow." Some of the keynote speakers include: Chris Riddiough, president of the National Gay & Lesbian Democratic Clubs; Steve Schulte, Mayor of West Hollywood, California; Todd Shuttleworth, person with AIDS; Dr. Ron Wright, Broward County Medical Examiner. In addition to numerous AIDS-related workshops covering a wide range of topics (e.g., legal, psycho-social issues, services, residential programs, safer sex, fundraising/grantswriting), other topics include: grassroots organizing, homophobia, politics, campus organizing, children of gay parents, coming out, lesbian/gay parents, fundraising, religion, literature, alcohol & substance abuse, police relations, media, legal issues, racism, helplessness, lesbian health, violence, ageism, networking, burnout, feminism. The registration fee is $27 after April 15 ($22 before, and $35 at the door). For more information about the Conference or housing, write: Southeastern Conference, PO Box 22508, Fort Lauderdale, FL 33335 (305/761-3961).

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SUPPORT SYSTEMS CONFERENCE PLANNED

by Larry Killian

At the recent National AIDS Forum and National Lesbian & Gay Health Conference in Los Angeles, a number of representatives of AIDS service organizations brainstormed on how AIDS service organization staff and volunteers working in the supporting areas of management, finance, information systems and fundraising & development, can increase productivity and decrease isolation through the exchange of ideas, skills, and practical how-to expertise. A[nother!] conference bringing us all together seems to be a good first step, and a questionnaire to determine everyone's priorities has been written. Paul Kawata of the National AIDS Network is supporting the planning effort, and with your input and support, a successful and constructive conference will take place. Please contact me if you have any additional ideas, questions or suggestions: Larry Killian, Director of Finance & Development, AIDS Action, 661 Boylston St., Boston, MA 02116 (617/437-6200, 648-1227 or CAIN Email: AAC).

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LIFE, DEATH & CHALLENGE OF AIDS

Minneapolis' The Aliveness Project is happy to announce a 3 day residential workshop July 30-August 2 at Hamline University in St. Paul, lead by London's Christopher Spence. "Life, Death and the Challenge of AIDS" is designed for people affected by AIDS: People with AIDS and AIDS-related conditions; people infected by HIV; people close to those in these groups; people who have been or expect to be bereaved because of AIDS; people working with those affected by HIV infection; and people not in these groups who know that this is an important issue for everyone. The workshop will use experimental methods of working in large and small groups, and in pairs, and will be an intensive, enjoyable and exciting experience. Some of the workshop's goals include:

>Examining the current social context of death, dying, bereavement, loss and separation, and of AIDS, including contemporary contributions to thinking and practice;

>Looking at the extent to which our own attitudes and responses are conditioned by fear, of loss in general and of death, pain disfigurement and disease in particular, both for ourselves and for other people;

>Considering the issues surrounding the particular susceptibility of gay men to HIV infection;

>Sharing personal experiences of these issues and the way our feelings about them tend to influence our attitudes and behavior in the present;

>Developing counseling skills in working effectively with people who have HIV infection, including those who have AIDS, with people who are dying and with people who are about to be, or who have been, bereaved; and

>Extending the challenge and how we meet it into our everyday lives.

The workshop fees for PWAs/PWARCs is $85, for everyone else $175, and includes room and meals. Financial assistance is available—please inquire. The Aliveness Project, 5307 Russell South, Minneapolis, MN 55410.

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INMATE EDUCATION BY BALTIMORE HERO

with thanks to HERO News, February, 1087, of Baltimore's Health Education Resource Organization

The State of Maryland has contracted with Baltimore's Health Education Resource Organization (HERO) to provide AIDS education to inmates in the state's corrections system and to train prison staff to do the same. The program, which began in October and runs for six months, has three basic parts. first, to provide an AIDS education session, complete with written materials and discussion opportunities, to each new inmate as s/he enters prison through the reception process. Second, as part of the pre-release, HERO will provide appropriate AIDS education to inmates leaving the prison system. In both of these phases of the program, inmates are required to attend at least one session. The final aspect of the program is the training of corrections personnel to carry on, and eventually expand, the inmate education process. Twenty-seven employees will complete an intensive two-day orientation session, then observe actual education sessions and take them over under HERO supervision, and finally attend review sessions as needed. It is not known how many inmates might be infected with the HIV virus, and no testing is now done. There are four inmates with full-blown AIDS, and they are in isolation. The acknowledged sexual activity of prisoners makes it imperative that they are adequately informed about the virus, as well as safer sex practices. Once the HERO education program is complete, the state hopes to expand it beyond the reception and pre-release areas to include AIDS education for the general inmate population. Bobbi Lishis is directing this project for HERO. For additional information, contact: Bobbi Lishis, HERO, Medical Arts Building, Suite 819, Cathedral and Read Streets, Baltimore, MD 21201 (301/685-1180).

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PRISONERS DEAD FROM AIDS NY STUDY

by Kim Westheimer, with thanks to Boston's Gay Community News, 3/15-21/87

A demographic study of 177 New York State prisoners who died of AIDS between 1981 and 1985 has been released by the New York State Commission of Correction. The study's results, as printed in the National Institute of Justice Reports, reveals the following profile of a "typical" prisoner who has died of AIDS: he was most likely a Hispanic or Black single male heterosexual, 34 years old, with a history of intravenous drug use prior to incarceration. He was probably born in the New York City area and convicted of robbery, burglary or drug-related offenses. He spent an average of 21.7 months in the prison system prior to death. He probably developed pneumocystis carinii pneumonia and died after spending approximately 35 days in a hospital. The study is available free of cost from the New York State Commission of Corrections, 60 South Pearl Street, Albany, NY 12207.

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GEORGIA INMATES MUST HAVE KNOWLEDGE

with thanks to Chicago's Windy City Times, 3/12/87

The State Board of Pardons and Paroles has announced that inmates who have tested positive for the HIV antibody will not be paroled unless they demonstrate an understanding about AIDS and agree to participate in a prevention program, according to the March 17 issue of The Advocate. Under the policy, inmates up for parole must agree to cooperate with health officials, undergo regular medical check-ups and disclose their antibody status to those living with them.

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PRISONS ISSUE CONDOMS IN NEW YORK

by Martin Heggestad, with thanks to Boston's Boston's Gay Community News, 4/26-5/9/87

The Koch administration has announced that city prison officials will begin issuing condoms to a small group of gay prisoners upon request, and to all prisoners upon release, according to the New York Times. In an "experiment," 90 gay prisoners who are housed in a separate unit on Rikers Island will be able to obtain condoms through medical prescriptions. Prison officials say that this unit has existed for many years and that only gay prisoners who request separate housing are placed there. In announcing the program, city Health Commissioner Stephen Joseph said that although sexual actively is forbidden in city jails, "it would be naive to think it did not take place at all." The program also includes education about safe sex and drug use practices. Kits containing condoms and educational materials will be distributed to prisoners upon release. Joseph said he "would like to think about" expanding condom distribution within city jails. But there are apparently no plans to distribute disposable syringes. Needle sharing is generally held to be the most common means of HIV transmission within prisons.

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POLICE AIDS POCKET CARD

with thanks to Detroit's Cruise, 3/25/87

In response to reports of growing fear by law enforcement officials about contracting AIDS on the job, the Human Rights Resource Center (HRRC) has published a pocket-size card with concise information about the disease. HRRC gathered the information from medical experts, law enforcement officials, and community service providers. The pocket card describes tasks that are commonly required of police officers and identifies the level of risk (if any) associated with these activities. Simple procedures to guard against infectious diseases are suggested for performing certain job activities that may present a health hazard. An accompanying training bulletin provides more information on AIDS and infection control measures. According to Trish Donahue, Law Enforcement Specialist at the Human Rights Resource Center, "The AIDS pocket card provides at a glance information that police officers need, and enables them to perform their jobs without delay." AIDS pocket cards are available from the Human Rights Resource Center, 1450 Lucas Valley Road, San Rafael, CA 94903 (415/499-7463). Cards are $20 per 100; a copy-ready original is available free of charge for agencies wishing to produce their own cards. Packets of sample police department AIDS policies and training curricula are also available free from HRRC.

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VERMONT PRISONS DISTRIBUTE CONDOMS

by Stephanie Poggi, with thanks to Boston's Gay Community News, 3/8-14/87

The Corrections Commissioner of Vermont, Joseph J. Patrissi, told the Boston Globe he will defend his decision to dispense condoms as a means of preventing the spread of AIDS "no matter how many bullets I have to deflect around it." He added, "Who's kidding who? For a corrections official to say that [homosexual activity] doesn't exist in a jail facility is totally absurd.... [It] does exist, notwithstanding the rules... I'm not condoning homosexuality but I'm not going to stand in the way of best medical practices, because I don't want this deadly disease in my system." Besides Massachusetts Commissioner Fair, detractors of the condoms-to-prisoners plan include the Maryland-based American Correction Association. Executive Director Anthony Travisono stated, "If proper supervision is maintained, there would be no need to distribute contraceptives [sic!!] because there would be no homosexual activity." There have been no confirmed cases of AIDS in Vermont's 6 regional corrections facilities. The decision to dispense condoms was triggered by a male prisoner's contraction of syphilis in February. There have been 11 cases of AIDS in Massachusetts prisons, and 1232 confirmed cases within the entire U.S. prison population.

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NIGHT OF A THOUSAND GOWNS IN NY

"Night of a Thousand Gowns" is the first of its kind charity ball to benefit the national gay community. "Night" will occur in New York's Waldorf-Astoria Hotel's historic Grand Ballroom, the very place where royalty, heads of state and industry, celebrities, and many a debutante have danced the night away for over half a century. No charity ball held there can equal this festive event. We expect 3000 queens, kings, dukes, duchesses, princesses, princes, and other lovely people from throughout the U.S. and Canada, all resplendent in gowns and tuxedos, to make their debuts. A full orchestra will play for those who wish to dance. You, your escort, and your entourage will be announced to society as you descend the grand staircase. Champagne and drinks will flow all night, and you may nibble away from a royally stocked buffet. The ball will honor drag and impersonators who have added both color and grass roots political clout to our movement. Special to the occasion will be a salute to the Imperial Courts of North America and for the first time, the Coronation of Emperor I and Empress I of New York City. The evening will be one of grandeur, splendor, and storybook fantasy in the most famous ballroom in the country. Do keep in mind that your attendance and the attendance of your friends will assist the gay community on a national level as well as your local city and state. All proceeds will benefit the following benefactors: AIDS Action Council, Human Rights Campaign Fund, National Gay and Lesbian Task Force, March on Washington Committee, and the New York Lesbian & Gay Community Center. "Night of a Thousand Gowns" is taking place March 28th. Cost of the tickets are $250 each, with reserved tables for 10 at $3500. For additional information, contact: Night of a Thousand Gowns, 106 1/4 Lexington Av., New York, NY 10016.

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WHY LIZ TAYLOR SPOKE UP

with thanks to Detroit's Cruise, 5/27/87

Elizabeth Taylor says her involvement with fund raising for AIDS research was not prompted by the death in 1985 of close friend Rock Hudson. "I was involved 7 months before I even knew Rock was ill," she told Good Morning America's Ron Reagan, Jr., in a 3-part interview. "I didn't know anyone that had it yet. I was just angry that no one was doing anything, that no one was getting up and saying anything...It had such an unbelievable stigma...and I thought, 'Well, somebody has to start saying something.' There was such a void, such a silence. So I just started opening my mouth."

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PATTI LABELLE RAISES $80,000

by Doug Hinckle, with thanks to The Washington Blade, 4/3/87

Singer Patti LaBelle's special AIDS benefit concert at Washington's Warner theatre raised an estimated $80,000. Some 2000 guests packed the Warner for the two-hour midnight concert. Earlier in the evening, 600 guests paid $100 each to attend a preconcert champagne reception in the Old Post Office Pavilion. The reception was hosted by Effi Barry, wife of DC Mayor Marion Barry, and New York fashion model Beverly Johnson. Other celebrities were in the audience. Proceeds from the concert will be divided among the American Foundation for AIDS Research (80%), Whitman-Walker Clinic (15%), and RAP, Inc. (5%).

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BETTE MIDLER HELPS FIGHT AIDS

with thanks to Detroit's Cruise, 4/1/87

Entertainer Bette Midler helped to raise approximately $10,000 for AIDS Project Los Angeles on January 28 with a benefit screening of her new movie, Outrageous Fortune. She stated to the crowd of 500 that there was "no worthier cause in the world" than the battle against AIDS. She has already donated more than $10,000 on her own to the Project. Midler cooed over the "tasteful" key chain condom holder presented to her from the group.

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GRANTS FROM STAMP OUT AIDS

with thanks to the New York Native, 4/27/87

STAMP OUT AIDS, the national campaign to help people with AIDS through the sale of stamps similar to Easter and Christmas Seals, has announced grants totaling $18,000 to AIDS service organizations throughout the country. At a luncheon sponsored byt the National AIDS Network as part of the National Lesbian and Gay Health Conference in Los Angeles, STAMP OUT AIDS project director John Glines read a list of grant recipients. They were: AIDS Foundation of Houston, Arizona Stop AIDS Project, Billings AIDS Support Network, Aliveness Project (Minneapolis), Kupona Network (Chicago), National Association of People with AIDS (Washington), AIDS Resource Center (New York), Chicago House and Social Service Agency, Good Samaritan Project (Kansas City), Nashville Cares, Central Valley AIDS Team (Fresno), Topeka AIDS Project, Whitman-Walker Clinic AIDS Program (Washington), PWA Coalition--New York City, Being Alive (West Hollywood), PWA Coalition Dallas, Minority Task Force on AIDS (New York), and Community Relief for PWAs (New Orleans). STAMP OUT AIDS also announced that, through their special arrangement with participating organizations, they have given immediate funding of over $5000 to 12 service-providing groups. STAMP OUT AIDS is the only national organization which directly helps the thousands of men, women, and children living with AIDS. None of the money raised through the sale of stamps goes towards research, education, or administrative costs. Stamps sell in sheets of six for $1 and may be obtained by sending a self-addressed, stamped envelope with your check and order to STAMP OUT AIDS, 240 West 44th Street, New York, NY 10036.

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INSURANCE CO. DONATES TO FORT WAYNE

with thanks to Fort Wayne's (Indiana) The Torch, 2/15/87

Negotiations between Fort Wayne (Indiana) AIDS Task Force members and community relations representatives from Lincoln National Life Insurance Company has resulted in a donation of $28,100 to the AIDS Community Education and Service Project, an activity of the Task Force. Objectives of the project include: the television broadcast of an educational tape on the AIDS epidemic; the radio broadcast of public service announcements; the placement of guest columns by AIDS Task Force members in area newspapers; the printing and distribution of 10,000 informational pamphlets; presentations to community groups; dissemination of AIDS information with utility bills; the recruitment and training of additional direct service volunteers; a seminar in cooperation with the Indiana State Board of Health targeted to the general public and individuals at high risk for acquiring AIDS; a seminar and the creation of a physicians' referral service designed to provide persons with AIDS, ARC, positive HIV antibody tests, or persons who suspect they may be ill with AIDS or ARC. Jack Ryan was selected as part-time administrator for the project. Ryan is also active in the National Association of Lesbian & Gay Alcoholism Professionals (NALGAP). For more information, contact: Jack Ryan, Fort Wayne AIDS Task Force, 1208 E. State Street, Fort Wayne, IN (219)484-2711.

DRUGS TO SPICE SEX OFTEN TURN SOUR

with thanks to Medical Aspects of Human Sexuality—Sexuality Update, February, 1987

If patients report using illicit drugs to add spice to sex, tell them not to be surprised if the drug backfires. Notes John Buffum, PharmD, of the University of California, San Francisco:

*Marijuana may heighten sensations so that users can feel more sensual. But it also may dry the vaginal mucosa [and other mucosal membranes like eyes and throat], cause panic attacks, and impair concentration on anything, including sex.

*Cocaine can inspire some with "raging libido." But chronic use often impedes erection and inhibits orgasm even while increasing sexual desire. Buffum tells of a male user winding up in the emergency room "with a macerated penis from eight hours of going at it." [It can also cause potentially fatal cardiac arrhythmias.]

*Amyl nitrate ("poppers") may prolong the sensations of orgasm. But if brought out too soon, it may deflate an erection for 30 minutes or more by diverting blood from the penis to the body's dilated capillary beds. [Chronic use can result in a blood condition known as methemaglobinemia, where the red blood cells have an impaired oxygen holding ability; some clinicians still bring up a possible association of poppers with AIDS or Kaposi's sarcoma, however an article printed elsewhere refutes this connection.]

Reference: Friedman, R. "Drugs and sex: users beware." Sexual Well-Being, 2:9:1, 1986. Comments in brackets ([]) are from the NCGSTDS editor.

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EPIDEMIOLOGY LINK: KS & POPPERS?!

by Harry W. Haverkos, MD, with thanks to Medical Aspects of Human Sexuality—AIDS Report, March, 1987

The use of large amounts of nitrite inhalants or "poppers" has been linked to the development of Kaposi's sarcoma (KS) among homosexual men with AIDS in several epidemiologic studies. In one study, we analyzed the results of questionnaires and laboratory tests of 87 homosexual men who participated in studies conducted by the Centers for Disease Control in 1981 and 1982 (Haverkos, HW, Pinsky, PF, Drotman, DP, et al: Diseases manifestation among homosexual men with AIDS: A possible role of nitrites in Kaposi's sarcoma. Sexually Transmitted Diseases, 12:203, 1985). Homosexual men who developed KS, the most common malignancy associated with AIDS, were compared with homosexual men who developed Pneumocystis carinii pneumonia (PCP), the most common life-threatening opportunistic infection in AIDS. Patients with KS reported more different male sexual partners [relative risk (RR) = 2.0], more "recreational" drug use [relative risk (nitrites) = 6.1, relative risk (marijuana) = 1.4, higher incomes (relative risk = 4.4), and higher rates of non-B hepatitis (relative risk = 2.8) than did patients with PCP. Multivariate analysis showed that the variable most strongly associated with KS was the use of large quantities of nitrite inhalants. Two other epidemiologic studies have found a strong association between KS and the use of large quantities of nitrites. One was conducted at Mt. Sinai School of Medicine, and the other in San Francisco (presented at the International Conference on AIDS in Atlanta in April, 1985 by A.R. Moss (Mathur-Wagh, U., Mildvan, F., Senie, R.T.: Follow-up at 4-1/2 years on homosexual men with generalized lymphadenopathy. New England Journal of Medicine, 313:1542, 1985). Conversely, three epidemiologic studies presented at the International AIDS meeting in Paris in June, 1986 do not support the association. In the three latter studies, however, investigators had not collected information as detailed in terms of nitrite use as in the former studies. For example, the earlier studies reported lifetime nitrite exposure; the latter studies only reported nitrite usage in the six months or two years prior to interview.

There are several hypotheses concerning the possible mechanism by which nitrites may promote the likelihood of KS in homosexual men infected with the AIDS virus. First, nitrites may act directly on the immune system. Second, nitrosamines, a metabolite of nitrites, may be carcinogenic. Third, the vasodilatory action of nitrites on blood vessels may, in some unknown way, promote KS. Finally, nitrites may be merely a marker for other behaviors or exposures, e.g., unidentified viruses, associated with their use. At present, persons at risk of AIDS should refrain from using nitrites until more data are available to ascertain their role, if any, in the development of KS.

[Harry Haverkos is Opportunistic Infections Program Officer, National Institute of Allergy and Infectious Diseases, Bethesda, Maryland.]

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HUEY LEWIS SETS UP MD TRAINING CTR.

with thanks to Detroit's Cruise, 4/22/87

Huey Lewis and the News have donated $225,000 to set up a first-of-its-kind center to teach doctors how to deal with AIDS patients. The program will be set up at San Francisco General Hospital and the University of California at San Francisco and will be called the HLNL Physicians AIDS Training Center— with the HLN standing for Huey Lewis and the News. The band became especially interested in AIDS after the manager, Bob Brown, saw a "60 Minutes" broadcast about AIDS and San Francisco General. "This is a disease that affects the whole country, not just a single element of the population, and Huey and the band wanted to start helping here at home," Brown said. The band members are all from the San Francisco area.

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POPPERS LINKED TO TEEN DEATHS

with thanks to the New York Native, 2/2/87

Amyl nitrites, popularly known as "poppers," has been linked to a spate of overdose deaths among British teenagers, according to a report in The Sunday Telegraph. The drug is being manufactured in "back-street laboratories" and is widely and openly available in cities throughout England. Alarmed parents have been contacting drug agencies, and the Scotland Yard-based National Drugs Intelligence Unit has received a "flurry of calls" from police officers reporting that the drug has been found in locations around the country. A loophole in English law leaves police powerless to clamp down on the craze for the drug. Two years ago, amyl nitrite was investigated by the Home Office Advisory Body on the Misuse of Drugs Act, and subsequently excluded from controls because it was felt at the time that poppers were not "capable of causing harmful effect sufficient to constitute a social problem." As a result, it is legal to produce the drug in Britain. The National Campaign Against Solvent Abuse has called for the banning of the drug. But Alan Billington, the campaign's director, admitted, "We have found it on general sale in pubs and shops, but there is nothing we can do about it because the law is not being broken." In the United States, poppers have been linked to the development of AIDS. The British government recently instituted a $30 million public education campaign on AIDS prevention.

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VOLATILE NITRITES ROLE DISPUTED

a letter to the NCGSTDS editor by Bruce Voeller, PhD, President, Mariposa Education & Research Foundation

Dear Editor: In your Newsletter, you have featured Hank Wilson's (John Lauritsen's and Neil Schram's) views that volatile nitrites are linked with AIDS and/or KS (e.g., vol. 6:5, May-July 1985, p. 33). I hope you will, consequently, in fairness, give `equal time' to the belief of nearly all AIDS scientists that there is no such link. As I think you are aware, I reviewed and evaluated the papers these three popper-ban lobbyists cited as the focal evidence of an AIDS or KS link (Mariposa Occasional Paper #6, 1986). I showed that these key studies were so flawed as to invalidate any of their authors' conclusions. Indeed, in the laboratory studies cited, similar quantities of common household aspirin, such as used by tens of millions of Americans, could be expected to have had an even greater damaging effect than the exorbitant doses of nitrites tested on mice and tissue cultures. While recognizing the correlation between nitrite use and AIDS, one of the cited researchers, Goedert, in 1985, revised his earlier claim of a causal link (Goehert, J.J., and W.A. Blattner, 1985, "The epidemiology of AIDS and related conditions." In DeVita, V.T., S. Hellman, and S.A. Rosenbert, AIDS: Etiology, Diagnosis, Treatment, and Prevention, J.B. Lippincott Co.) Goedert & Blattner state (page 16), "it now appears that frequent use of nitrite inhalants simply may be a surrogate marker of frequent receptive anal intercourse." This perceptive prediction of the central role of receptive anal intercourse in AIDS (among gay men) has been firmly established in a newly published watershed paper by Winkelstein, et al. (Winkelstein, W., D.M. Lyman, N. Padian, et al., 1987, "Sexual practices and risk of infection by human immunodeficiency virus," JAMA, 257, 321), who studied a cohort of over 1000 San Francisco men. Lauritsen and Wilson do not reveal the important change in Goedert's perception, either to their gay readers, health care providers, or legislators. Indeed, they continue to cite Goedert's initial claim, aware he has revised it (Lauritsen, J., and H. Wilson, 1986, Death Rush: Poppers & AIDS, New York: Pagan Press).

I think your readers should know that leading AIDS researcher, Dr. Cladd Stevens, MD, at the New York Blood Center, has conducted an exhaustive, large epidemiologic study of nitrite use by about 800 gay men in New York. She found no link between `popper' use and AIDS or KS. [A brief excerpt of her work has been published in the Mariposa Occasional Paper #7 (Stevens, C.E., P. Rubinstein, and P. Taylor, 1987, "Cellular immune deficiency and AIDS in human immunodeficiency virus (HIV) infection: role of recreational drugs and volatile substances).] Stevens, et al. wrote, "In brief, to date we have not found the use of recreational substances, such as amyl nitrite or butyl nitrite, to be causally connected with either defects in cell mediated immunity or in the subsequent development of AIDS." Stevens' full results will be published in peer reviewed scientific journals. Similarly, the large "MACS" (Multicenter AIDS Cohort Study) study of 1835 HIV-infected gay men, just published in the January 8, 1987 New England Journal of Medicine, repeatedly underscores the absence of any link between either AIDS or KS and the use of volatile nitrites (Polk, B.F., R. Fox, R. Brookmeyer, et al., 1987, Predictors of the acquired immunodeficiency syndrome developing in a cohort of seropositive homosexual men, NEJM, 316, 61). The study notes: "The following were not significantly associated with the development of AIDS--...age, race,....the use of nitrites ("poppers") during sex in the previous two years." Indeed, the issue was considered significant enough that the researchers reiterated their observations in the highly condensed abstract section of their paper: "Separate analyses of risk factors for Kaposi's sarcoma and opportunistic infections failed to support previously reported associations between the use of nitrites or an elevated cytomegalovirus-antibody titer and Kaposi's sarcoma."

The message is clear: no connection between nitrite use and AIDS has been found by competent researchers in carefully conducted studies. Meanwhile, much time and scientific effort has gone into conducting, then disproving, this dead-end research which attempted to link AIDS and `poppers.' Resources of time, talent and funds were burned up which might have gone to more productive efforts to identify bona fide co-factors for AIDS and to creating a firebreak to the epidemic. [For more information, contact: Bruce Voeller, PhD, President, Mariposa Foundation, P.O. Box 36 B 35, Los Angeles, CA 90036.]

COMICS FOR YOUTH CALLED COMMIE PLOT

by Kendall Lovett, with thanks to Boston's Gay Community News, 3/1-7/87

Despite favorable reaction from the Federal Minister for Health and the National Advisory Committee on AIDS, a series of comic strips that provide basic information for kids on a variety of issues, including AIDS, have come under fire. Streetwize Comics, earlier banned by the Department of Education for use in the schools of New South Wales, are now also under attack in two states. In Sydney, the Rev. Fred Nile of the Festival of Light called the Streetwize health issue on sexually transmitted diseases, including AIDS, a Red ploy. In Melbourne, Inspector Rippon of the Victorian Police Association likened distribution of the comics to the activities of the Viet Cong. Rippon also said a Streetwize issue on the legal rights of youth has the same intent as Marxist doctrine--in his opinion, the destruction of the organized structure of society. Streetwize researchers who have been surveying young people who read the comics find that the series has been useful. The most commonly recalled message by kids concerned not making statements to the police. The next most commonly recalled was the danger of sharing needles. The latest addition to the Streetwize team of cartoonists is 16-year old Frank McLeod.

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B.A.R.E. FACTS IN CALIFORNIA

with thanks to Southern California CARES News, edition two

Aid for AIDS and the Cooperative AIDS Risk-Reduction Education Service (CARES) Team have joined together to form an unusual educational program called Bar, Bathhouse and Restaurant Employees (BARE) Facts designed to disseminate pertinent information about AIDS to targeted establishments in Los Angeles County. The two organizations have divided the county into 7 geographical regions and have identified those bars, bathhouses, and restaurants in the Los Angeles area which have a large concentration of gay and bisexual male patrons. Every 2 weeks, letters of invitation are sent to the staff of these establishments encouraging waiters, bartenders, bathhouse attendants, managers and owners to attend an informative BARE Facts presentation. BARE Facts programs are conducted in a local bar, bathhouse, or restaurant and provide information about AIDS transmission and prevention, safer sex guidelines and risk-reduction behaviors. The objectives of these presentations is to sufficiently educate the staff members of the targeted businesses so they may in turn pass the information along to interested patrons.

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FOCUS GROUPS DEVELOP MESSAGE

with thanks to Southern California CARES News, edition two

The first round of focus group research conducted by Southern California CARES, cites the need to develop "hard-hitting," factual messages targeting gay and bi-sexual men. Black and Latino respondents cited the need to dispel misconceptions about casual virus transmission and the belief that AIDS is "just a gay disease." Asian respondents favored utilization of schools, community organizations, and all available communication channels in order to get risk-reduction information out to the community. "While teenagers and gay men were the most knowledgeable of how to reduce their risks, adult heterosexuals were far less familiar with safer-sex practices," stated researcher Jim Kleckner of Universal Communications.

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DOONESBURY, RON HEADREST & SAFE SEX

with thanks to Detroit's Cruise, 5/6/87

The popular political cartoon strip "Doonesbury" by Gary Trudeau, is up to its mischief again, this time using his stuttering Max Headroom caricature of President Reagan, "Ron Headrest," to incite telephone calls to the White House about "safe sex." In the comic strip published May 7, Ron Headrest will urge youths seeking "rock-solid info on safe sex" to call the White House, Trudeau's editor at the Universal Press Syndicate said. The White House's actual telephone number then will be printed on Ron Headrest's supposed television set in the cartoon. The next frame will show a picture of the White House, surrounded by the ringing of unseen telephones, with a disembodied voice exclaiming, "That does it!"

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COMPUTER SOFTWARE ON AIDS

with thanks to Detroit's Cruise, 3/25/87

A small software company in Edwardsville, Kansas, is trying the cloud of confusion over AIDS, and turn a profit at the same time, with a $50 program for IBM-compatible personal computers. When it's available this spring, students will be able to run through an electronic quiz containing 20 questions. If the student gets an answer wrong, the computer lists the right answer and explains the rationale for it. Animated graphics show how the virus destroys the immune system. Students can also type in questions anonymously, and the teacher can retrieve the questions to answer them in class discussions. The developer, a company called Substance Abuse Education, has programs on several medical topics, including alcohol and drug abuse.

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PWA ORGANIZATIONS

with thanks to People With AIDS Update, February, 1987

People with AIDS are organizing in the United States, Canada, and England. It's very exciting to see people in other parts of the world who are willing to work together, to stand tall and speak out for their rights. Recent groups have formed in London, England, Ottawa and Montreal, Los Angeles, Houston, Dallas, Boston, Indianapolis, New York, and of course, San Francisco. I would appreciate hearing about any other group that has organized. Please send their name, address and phone number to me, Allen Pugh, c/o Shanti Project, 525 Howard Street, San Francisco, CA 94105 (415/777-CARE).

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UNSAFE SEX FORBIDDEN IN GAY MEDIA

with thanks to the New York Native, 4/27/87

Gay Chicago, a weekly gay publication has announced that they no longer will accept personal ads containing references to acts which the editors feel constitute "unsafe" sex. Elsewhere, the Gay Producers Association, an alliance of the producers of erotic gay films, have announced their commitment to "produce only videos that do not have unsafe sex in them, until this health crisis is over." Future films which conform to the new guidelines will carry a "trailer" in the beginning, reading, "This film depicts acts which are considered "safe" according to current AIDS criteria."

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INTERNATIONAL LIVE RADIO CALL IN

The first international live radio call-in show, "The AIDS Phone-In," was broadcast March 1 on American Public Radio in the U.S. Produced by British Broadcasting Corporation, the 90-minute broadcast will be heard throughout the rest of the world on shortwave. Listeners will be able to voice their concern and ask questions about AIDS and current strategies to combat it. They will learn the problems and plans of other countries as systems are implemented to control the spread the disease while the search for a vaccine continues. The program began with a 30-minute feature offering an up-to-date analysis of the current status of AIDS, and will cover the history of the disease and identify the countries with the highest levels of infection. Listeners will learn what has been done, what needs to be done, and what might happen if nothing is done. Following the half hour feature, BBC began taking questions from callers phoned or written in earlier. Two noted experts will be responding to queries--Dr. Tony Pinching, an immunologist at London's St. Mary's Hospital, and Jonathan Mann, director of the World Health Organization's AIDS Program listening in from Geneva. For more information, contact Diane Engler, American Public Radio, 700 Conwed Tower, 444 Cedar Street, St. Paul, MN 55101 (612/293-5417).

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EXPLICIT AIDS VIDEO

by Katie Tyndall, with thanks to Insight, 5/18/87

A Minnesota company has developed an educational videodisc about AIDS that offers information based on the viewer's sexual preference. The videodisc provides explicit information on the risks of various types of sexual activities. A control allows the viewer to move to the portion of the program that best addresses his or her life-style. The videotape deals with AIDS risks as they relate to male-female, male-male and female-female sexual activity. So far, about 60 copies of the AIDS disc have been sold by its creator, Health EduTech Inc., an Edina firm that specializes in making educational and training programs on videodisc. The AIDS disc, priced at $995, is also available for lease.

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EDUCATIONAL VIDEOS AVAILABLE

National AIDS Network (NAN) has recently acquired three exciting AIDS education videos that are being made available to their membership. The first video is An Interview with Dr. Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases (NIAID), and was put together by HOUR Magazine, and is free to NAN members. Funding for this project was provided by NIAID and HOUR Magazine. The second video, Sex, Drugs and AIDS is one of the favorite AIDS educational videos of NAN's executive director Paul Akio Kawata. The producers of this film just received grants from the Charles H. Revson foundation and the Public Welfare Foundation to underwrite a special offer to AIDS service organizations. The grants make it possible for low budget (less than $75,000/year) nonprofit community organizations to buy a videotape of "Sex, Drugs and AIDS" for only $35. This video was produced for New York City schools, and is hosted by Rae Dawn Chong and speaks in a direct candid manner on the issues of risky behavior and how young people can protect themselves. Please write to ODN Productions, 74 Varick Street, Suite 304, New York, NY 10013 (212/431-8923) for an application form to receive the reduced price. The third video is The AIDS Movie but has not been subsidized by grants for distribution. It is a strong film and the response across the country has been terrific. It takes a personal, real approach, and it has been shown on ABC News and the program 20/20. Durrin Films is offering a 10% discount on any purchase of the video by NAN members. Call NAN for additional information about these exceptional opportunities--one of the many benefits of the National AIDS Network! NAN, 1012 14th NW, Suite 601, Washington, DC 20005 (202/347-0390).

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POPULATION REPORTS AVAILABLE

Population Reports--AIDS: A Public Health Crisis was prepared at the Johns Hopkins University to alert health care workers worldwide to the threat of AIDS and the importance of educational and service efforts to combat it. It also gives everyone concerned about AIDS a succinct, complete, accurate, up-to-date, and readable review of all aspects of the AIDS situation, from epidemiology to policy issues. Copies of Population Reports are available for $1 each from Population Information Program, The Johns Hopkins University, 624 N. Broadway, Baltimore, MD 21205.

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JOUR. OF GAY & LESBIAN PSYCH

New York's Haworth Press, publishers of the Journal of Homosexuality, announced the forthcoming publication of the new quarterly Journal of Gay & Lesbian Psychotherapy. The new journal is under the editorship of David Scasta, MD, a psychiatrist in private practice in Philadelphia, and who holds medical faculty appointments at Temple University and the University of Pennsylvania. He is an attending psychiatrist at the Graduate Hospital at the Philadelphia Psychiatric Center, and he is also an active member of the Association of Gay & Lesbian Psychiatrists, serving as editor of their caucus newsletter. The Journal will focus on practical, interdisciplinary issues in clinical practice related to the use of psychotherapy for gay, lesbian, and bisexual patients and clients. The goal of the Journal will be to facilitate the quality of life of gay and lesbian people who may benefit from emotional, psychological, and psychotherapeutic support. Additional topics to be covered include: the process of "coming out;" gay & lesbian relationships; family relationships of gays and lesbians; mental health aspects of AIDS and sexually transmitted diseases; psychopathology encountered in gay, lesbian, and mixed groups; inappropriate and unethical uses of psychotherapy with gay people; psychodynamics in clinical practice with gay people; efficacy of different types of psychotherapy with gay people; job stress, performances, and satisfaction among gay people; and development of homosexuality identity. A complete "Instructions for Authors" is available from: David Scasta, MD, Editor, JGLP, 1721 Addison Street, Philadelphia, PA 19146. The charter issue of the new journal is scheduled for publication in early 1987. The Haworth Press will provide a complimentary sample copy on request: write to: Haworth Press, 12 West 32nd Street, New York, NY 10001. An advertising brochure for the Journal is included with this Newsletter.

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DEATH PLANNING BOOK AVAILABLE

with thanks to People With AIDS Update, April, 1987

"Remembering Me" is a practical and helpful journal used to prepare yourself and your family for an impending separation. The Journal offers assistance in planning for the financial, emotional and legal aspects of death. Elisabeth Kubler-Ross feels that, "If everyone would prepare themselves with this little book, many families would be more at peace and wouldn't have to make difficult decisions at the time of sorrow and stress." The cost for 1-5 copies is $7.95 each and 6-10 copies is $6.75 each plus 75 cents per book for postage (and 6% sales tax for California residents). For ordering write: Mt. Shasta Publications, P.O. Box 436, Mt. Shasta, CA 96067, or call the author, Danielle Light, 916/926-5653.

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SURVIVING & THRIVING--HINTS

"Surviving and Thriving With AIDS: Hints for the Newly Diagnosed," the People With AIDS Coalition's comprehensive guide to dealing with the experience of AIDS, is now available. The 160-page book includes more than 60 articles drawn from the pages of the PWA Coalition Newsline, the most widely read publication written by and for PWAs in the U.S., plus material written especially for the guide. The message of the book is straightforward: AIDS is not a death sentence. The book's articles stress that the path to personal empowerment--not of being the helpless victim of one's situation--lies in an understanding of the choices to be made in both conventional and alternative treatments for AIDS. Other sections include "Emotional Responses to Diagnosis," "Doctor/Patient Relationships," "AIDS and Sex, Love, & Friendship," "Telling Family and Friends You Have AIDS," and AIDS-related articles about the "Afrikan-American" perspective, spirituality and religion, intravenous drug use, and prison life. A final section includes national resources for PWAs and a useful index. Publication of Surviving and Thriving was made possible by funding from the National Association of People With AIDS, the National AIDS Network, Gay Men's Health Crisis, Inc., Community Health Project of New York City, and the North Star Foundation. The book is available to PWAs and organizations serving PWAs in the New York area by contacting the People With AIDS Coalition at 263A West 19th Street, New York, NY 10011. Outside the New York area, contact the National AIDS Network, 1012 14th Street, NW, #601, Washington, DC 20005. The People With AIDS Coalition (PWAC) is an organization created by and for people with AIDS (PWAs), people with AIDS-related conditions (PWARCs), and concerned friends. We publish Newsline, a 4500 circulation monthly newsletter; hold monthly forums on issues of living with AIDS; provide hot meals to PWAs three times a week at our drop-in Living Room (located in Greenwich Village on West 11th St.); and participate innumerous lobbying and advocacy activities. We also provide space for meetings of such groups as Spanish-speaking PWAs, mothers of PWAs, women with AIDS, and other support groups.

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HOLISTIC AIDS NEWSLETTER

A new newsletter, Healing AIDS, has just been released in its third edition in San Francisco. Publishers Ed Sibbett and Doug Yagaloff report on holistic healing tools, resources, AIDS and alternative therapies for people with AIDS or ARC, the worried well, those who are HIV antibody positive and those interested in self-healing. Healing AIDS, published monthly, is distributed free and individuals are encouraged to copy and pass it along. Each issue includes informative and practical articles on healing, a suggested reading list, a calendar of events for the month, listing of groups, programs, workshops and classes, a comprehensive directory of books, cassettes and videos, and classified and display advertisements. Subscriptions are available for $7 per year for PWAs, PWARCs, or low incomes, and $12 for others. For additional information, write Healing AIDS, 3835 20th Street, San Francisco, CA 94114 (415/864-6870).

AIDS EPI/SURVEILLANCE UPDATE

abstracted from AIDS Weekly Surveillance Report, CDC AIDS Activity

As of July 13, 1987, the Centers for Disease Control AIDS Activity reports a total of 38,312 adult and pediatric cases of AIDS in the U.S. (CDC strict case definition). [The present estimate of all those infected with antibody to the AIDS virus in the United States is 3,831,200 based on those currently diagnosed multiplied by 100; those with AIDS-related conditions but without a specific diagnosis of AIDS is conservatively estimated to be 383,120, based on those currently diagnosed multiplied by 10. --NCGSTDS Editor] PATIENT RISK GROUP: Homosexually active men account for 66% of all cases; 16% from IV drug abusers; 8% from homosexually active men and IV drug abusers; 1% from hemophiliacs; 4% from heterosexual cases; 2% from transfusion, blood/components; and 3% from those in no apparent risk or unknown risk group due to incomplete investigations. [The CDC, finally reacting to the persistent criticism for their unusual "hierarchical" listing-- wherein if homosexually active men are also IV drug users or hemophiliacs, they were only counted in the top, i.e., homosexual, category, therefore confusing and misrepresenting the data. CDC statisticians have finally "reconstituted" the data to make it more accurate.--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: 61% of the cases are white; 24% are black; 14% are hispanic/latino; 1% are other or unknown. Note that 54% of the pediatric (excluding adolescents) cases are black, 25% hispanic, 21% white, and 1% are unknown. GEOGRAPHICAL DISTRIBUTION: 55 states and territories, including the District of Columbia, Puerto Rico, Guam, and the Virgin Islands have reported cases to the CDC; New York & California have the most cases, with 28.5% & 23.1%, respectively; Florida, Texas, & New Jersey report 6.7%, 6.6% & 5.9%, respectively; Illinois, Pennsylvania, Massachusetts, & Georgia each report: 2.7%, 2.3%, 2.2%, & 2.1% respectively, of the cases; all other areas each report less than 2% or less. OVERALL MORTALITY: 58%.

THE TRUE AGE OF AQUARIUS? OPINION

by Mark Behar, PA-C, Editor, NCGSTDS Newsletter

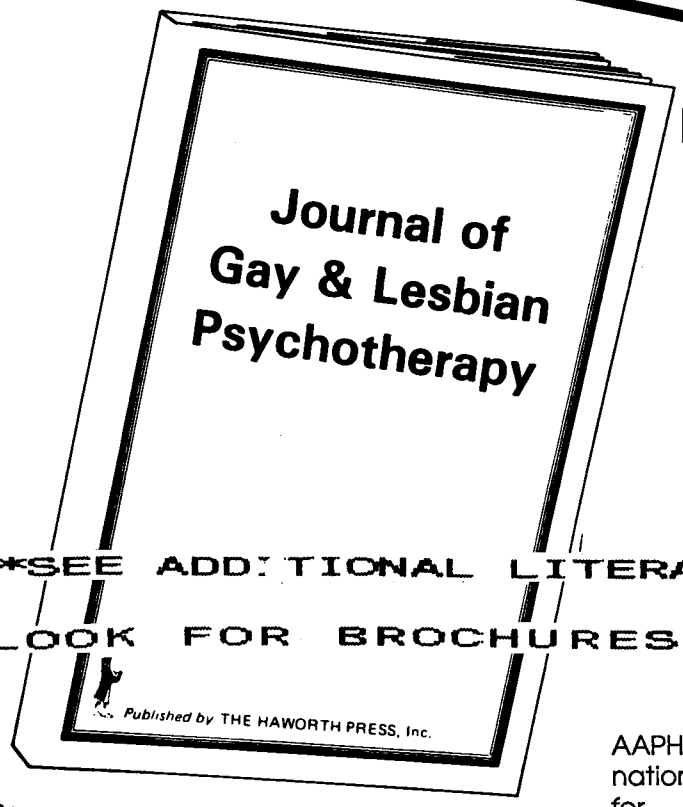
Each of us, whatever our generation, grew up with our own special hope for the future and brand of youthful idealism. For me, that time was in the 1960s and 70s--the times of Martin Luther King and race riots in the cities, Viet Nam & Cambodia and the campus protests against the war and racism, for women's rights and the equal rights amendment, against nuclear power and for disarmament, for zero poulation growth and saving the environment, among a myriad of other important and worthy causes. It was also the time of the Stonewall Revolution, when latino and black gay men and transvestites fought against police harassment at a New York bar that ushered in the latest chapter of the modern day gay/lesbian liberation movement. Like so many of my friends, I too had that special feeling about peace, hoping to make the world-- or at least my little corner of it-- a better place, free from hunger and unnecessary suffering, equal opportunity without discrimination based on any unfair criteria, toleration and desire to understand communication with others, etc. If people just practiced what they (and we) preached! If there could only be some "messianic" force that could initiate those changes! But that "messianic era," that "heaven on earth," could only be brought about by people, not by some divine intervention. (Hopefully with "divine" guidance, however!)

Could the human immuno-deficiency virus be that special force to usher in the new age that that we hoped for? AIDS, as nightmarish as it is, is challenging us to accept the new sexual revolution that includes a special brand of responsibility toward our loved ones; AIDS is also forcing us to examine and change almost every social system that has been part of present human societies. Although it may be difficult for us to fully realize the scope of this revolution, it is profoundly disrupting the very fabric of civilization as we know it, especially more apparent among the poorer Third World. AIDS is pulling us-- kicking and screaming-- into the 21st century. What changes are taking place? The role of health insurance and society's responsiblity to care for those who are ill; police officers, fire fighters, and other emergency first responders always having to consider whether rubber gloves or other protective gear may be necessary when responding to an emergency; learning a realistic assessment of risk, and evaluating how a certain behavior or activity compares with others before engaging in it (e.g., risk of acquiring HIV infection from a blood transfusion, vs. postponing elective surgery, etc.); how to balance civil rights & liberties vs. the public health considerations (e.g., how to ensure that sociopaths who are also HIV antibody positive, won't infect others); role of big business (banks, industry, academia, government, military, etc.) in maintaining an economically, socially, and medically healthy sociey; family planning to ensure not only economic independence, but also healthy babies without infection from HIV; the disruption of political, economic, and social futures of 3rd World countries who have heavily invested in the young professional and technical elite, who are now HIV infected and dying of AIDS ("slim"). Can you think of others?!

Some of the lessons we are mastering include: sexual intercourse (anal or vaginal) is unthinkable without adequate barrier protection (condoms with spermicides & virucides), except under few exceptions (desiring pregnancy without AIDS virus infection); fairly dealing with inequities, injustices, discrimination; understanding the concept of "community" and dedicating oneself to the betterment of whatever we choose to define for ourselves as that community; and for accepting the greater value of philanthropy over self-indulgence. Each of us, dear reader, could continue these lists indefinitely.

Like aliens wishing to dominate earth in the old science fiction movies, AIDS is the force that is challenging humanity, impossible to have fabricated under any other conditions. We can let ourselves be dominated by fears, superstitions, misinformation, and driven to inhumanity and hysteria, or like those old movies, cooperate among each other-- across national/political, racial/ethnic, sexual/affectional, religious, cultural, and economic barriers to fight the "alien." HIV and AIDS merely brought out this second "alien" in ourselves. Whether we accept this challenge, modify our thinking and behaviors, our social systems, the very institutions that have grown as a part of us-- whether these times will be followed by a new era of better times for all humans everywhere, really depends on all of us. How are you ushering in this "New Age of Aquarius?"

INSTRUCTIONS FOR AUTHORS



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AAPHR

American Association of Physicians for Human Rights

1987 ANNUAL MEETING AND AIDS UPDATE

August 4-7, 1987
Hyatt Regency Hotel
Minneapolis, Minnesota

SEE ADDITIONAL LITERATURE FOR DETAILS!

LOOK FOR BROCHURES WITH NEWSLETTER!

AAPHR was founded in San Francisco in 1981 as the first national organization of physicians and medical students for

- the elimination of discrimination in the health professions on the basis of sexual or affectional orientation, and
- the delivery of supportive and unprejudiced medical care for gay and lesbian patients.

4TH ANNUAL LESBIAN PHYSICIANS CONFERENCE

The 4th Annual Lesbian Physicians Conference will be held July 30-August 2, 1987, at Spring Hill Conference Center in Minneapolis. A variety of issues important to the health and well-being of lesbian physicians, their significant others, and their patients will be covered: coming out at work, political and legal concerns of lesbians, lesbian health issues, and personal development. Special entertainment is being planned as well. For further information and registration materials, please contact the

Women's Issues Committee
C/O AAPHR
Box 14366
San Francisco, CA 94144

MORE INFO ABOUT AAPHR MEETINGS & JGLP IN THIS MAILING!