Sexual Health Reports©

spring '88

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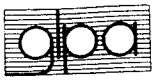

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HEALTH CONFERENCE/AIDS FORUM: JULY

by Mark Sullivan, with thanks to The Washington Blade, 2/12/88

THE NATIONAL LESBIAN/GAY HEALTH FOUNDATION AND THE AMERICAN ASSOCIATION OF PHYSICIANS FOR HUMAN RIGHTS WILL HOLD THEIR 2ND INTERNATIONAL/9TH National Lesbian & Gay Health Conference and 6th National AIDS Forum July 20-26 at Boston's Park Plaza Hotel. AAPHR will also host their annual medical meetings & seminars during the Conference. Organizers said over 100 workshops, panels, and presentations are being planned, and over 1500 registrants are expected. "The primary purpose of the conference is to encourage information sharing and networking among health care and services providers and consumers," said Ellen Ratner, president of the Foundation. For more information: Michael Weeks (202/797-3708), Greg Thomas (202/994-4285), or write: NLGHF/AAPHR Programming Committee, P.O. Box 65472, Washington, DC 20035.

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FIFTH CONFERENCE ON AIDS

THE FIFTH INTERNATIONAL CONFERENCE ON AIDS (THE SCIENTIFIC AND SOCIAL CHALLENGE) is planned for June 4-9, 1989 at the Montreal Convention Centre in Montreal. The Conference is the fifth in the series of international conferences that began in 1985 (85-Atlanta, 86-Paris, 87-Washington, 88-Stockholm) to bring together leading researchers in the various disciplines concerned with HIV infection and AIDS. The program recognizes that AIDS has become a scientific and a social challenge of global dimensions that will not be effectively addressed unless regular opportunities are presented for the integrated study of the pandemic. Deadline for abstract submission is January 31, 1989. Details concerning the conference program and accommodation, as well as registration and abstract forms will be included in a second announcement planned for June, 1988. For more information, write: Secretariat: Kenness Canada Inc., P.O. Box 120, Station B, Montreal, Quebec, Canada, H3B 3J5.

The Fourth International Conference is planned for June 12-16, 1988 at the Stockholm Convention Center. For more info: IV International Conference on AIDS, Stockholm Convention Bureau, P.O. Box 6911, @-102 39 Stockholm, Sweden.

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LEGAL, MEDICAL, ETHICAL ISSUES

"HEALTH TREATMENT RIGHTS: HIV AND AIDS," A CONFERENCE SPONSORED BY THE NATIONAL LEGAL CENTER FOR THE MEDICALLY DEPENDENT AND DISABLED and the Center for Clinical Medical Ethics at The University of Chicago, will address these questions through a series of presentations by distinguished speakers. Presentations will be especially addressed to attorneys who represent those with HIV or AIDS; health care professionals, administrators, public health authorities, and advocates for the interests of affected populations. The Conference will take place at Chicago's Congress Hotel on May 19-21. Registration fee is $150, which includes one dinner and lunch, refreshment breaks, and conference materials (reduced fees available for students and others). For more info: The University of Chicago, Center for Continuing Medical Education, 5841 Maryland, Box 139, Chicago, IL 60637 (312/702-1056).

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ADOLESCENTS & AIDS

A TWO DAY CONFERENCE, "AIDS & ADOLESCENTS: THE TIME FOR PREVENTION IS NOW" will be the first major national meeting of educators, program planners, and policy makers to address the special issues related to the prevention of HIV transmission among teenagers. The conference will bring together nationally recognized AIDS prevention experts, directors of model programs, directors of youth serving organizations, and key national, state, and local health and education leaders. Overall, the conference will:

>Stimulate thinking and provide a forum for the exchange of ideas and strategies for preventing HIV transmission among youth;
>Present effective and emerging program models for AIDS prevention among teenagers;
>Provide an opportunity to develop information and support networks for AIDS educators;
>Highlight existing model resources for educators;
>Offer skill development workshops for AIDS educators; and
>Provide new information on AIDS and its risk to adolescents.

For more information about the 2 day conference, contact: The Center for Population Options, 1012 14th St., NW, Suite 1200, Washington, DC 20005 (202/347-5700).

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FORWARD IN UNITY: CHARTING COURSE

NATIONALLY KNOWN LESBIAN AND GAY POLITICAL AND ORGANIZATIONAL FIGURES WILL BE AMONG THE DOZENS OF SPEAKERS, workshop facilitators and other resource persons providing leadership for Forward In Unity, a grassroots gay and lesbian leadership conference, May 13-15 at the University of Minnesota in Minneapolis. The goals of the the conference include --To provide skills, resources, and opportunities for networking that will facilitate participants' abilities to function as grassroots leaders in their own lesbian and gay communities; --To experience the empowerment of the wealth of cultural and spiritual resources available in a setting that crosses lines of race, sex, class, and disability; and --To build on the momentum generated by the March on Washington. Forward In Unity will employ a variety of strategies to create a setting for the achievement of its objectives: building skills, sharing strategies and resources, interacting with recognized leaders, giving and receiving support, setting the agenda for the next phases of our movement, and empowering for action. Cost of the conference is $100, which includes all events and most meals. Reduced registration fees are available for low income persons. For More Info: Forward In Unity, P.O. Box 300171, Minneapolis, MN 55403.

APRIL IS VD & FAMILY PLANNING MONTH EDUCATION & PREVENTION SEMINAR

SINCE 1968, APRIL HAS BEEN DESIGNATED NATIONAL FAMILY PLANNING AND STD AWARENESS MONTH. The goal is to involved pharmacists in each neighborhood in the grass-roots-level dissemination of educational materials relating to family planning and the use of condoms, and to alert pharmacists to their importance in the fight against sexually transmitted diseases and AIDS. Pharmacists Planning Service, along with The Population Institute and the California VD Advisory Council are the cosponsors of the project. Pharmacists Planning Service also sponsors National Condom Week in February, and National AIDS Awareness Month in October. For additional info: 415/332-4066.

They are also scheduling a small educational seminar on the education and prevention of STDs, family planning, & AIDS in Hawaii at the touffer Wailea Beach Resort--Maui Sept. 7-11. The theme is "What's Working in Education and Prevention in STDs, Family Planning, and AIDS." Papers, workshops outlines, topics, program outlines should be sent to both of the following (no papers on treatment or epidemiology): Katherine Forrest, MD, MPH, 150 Erica Way, Menlo Park, CA 94025, and Morris Wolford, PhD, PPSI/CE Chairman, P.O. Box 1336, Sausalito, CA 94966.

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ALCOHOLISM & OTHER ADDICTIONS

"FOCUSING ON SPECIAL TREATMENT NEEDS OF LESBIANS AND GAY MEN AFFECTED BY ALCOHOLISM AND OTHER ADDICTIONS is the topic of a one day conference April 29 at John Jay College of Criminal Justice in New York City. The conference is cosponsored by nine local and national groups: Pride Institute, National Association of Lesbian & Gay Alcoholism Professionals, the Office of Gay & Lesbian Health Concerns of the New York City Health Department, Alcoholism Council of Greater New York, Conifer Park & Arms acres, Gay & Lesbian Alcoholism Services, National Assn. for Children of Alcoholics--N. J., National Assn. of Social Workers--NYC Chapter, and Project Connect of the Lesbian & Gay Community Services Center, Inc. The $40 registration includes a plenary and keynote address, a selection of morning and afternoon workshops, and lunch. For more information: 10%--GLAS, P.O. Box 1141, Cooper Station, New York, NY 10276, Ron Vachon (212/566-4995), Dava Weinstein (212/799-0664).

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COMPUTER TECHNOLOGY UPDATES ON AIDS

NORTHERN LIGHTS ALTERNATIVES (NLA) ONLINE HAS LAUNCHED THE AIDS BIBLIOGRAPHIC & ABSTRACT SERVICE (ABAS). ABAS is an extensive, online index of AIDS articles available to users of personal computers equipped with telecommunications capabilities. This service is available exclusively over GayCom, the national gay communications network, with affiliates in major metro areas across the U.S. ABAS is concerned with all aspects of the AIDS crisis-- medical and holistic, political and legal, social and spiritual. Already, nearly 2000 articles have been culled from medical journals, pharmaceutical trade and government publications, as well as the general media and group handouts. Information is worldwide in scope. The valuable information in ABAS is available through a variety of search modes: general topic (such as KS or PCP), a specific subject (symptoms of, chemotherapy for, KS), publication name, article title, or author. Each entry contains the full name, volume and/or issue number of the publication, the title and author of the article, the page number it appears on, as well as a five to 15 line abstract of the article. If you have a personal computer equipped with a modem, you can logon to NLA ONLINE and ABAS through any of these GayCom affiliates:

New York, NY:	The Backroom,	718/849-7882
Freehold, NJ:	Backroom-2,	201/431-1216
Piscataway, NJ:	Super Stud,	201/968-7883
Boston, MA:	Doug's Den,	617/245-9464
Washington, DC:	GLIB,	703/578-4542
San Francisco, CA:	Fog City BBS,	415/863-9697
Boulder-Denver, CO:	Isle of Man,	303/447-1942

For those organizations wishing to install ABAS on their own in-house computer systems, NLA ONLINE can provide diskettes with updates made 6-10 times per year for $250. NLA ONLINE was launched in September, 1987 over GayCom and has since expanded to other bulletin board systems and national computer networks including CAIN, the Los Angeles based Computerized AIDS Information Network; NEWSBASE, a San Francisco based information retrieval service; and others. NLA is a New York & Los Angeles based non profit, tax-exempt, national AIDS support group that serves both the gay and straight communities through a variety of programs. Founded in 1986, its purpose is to educate, inform, and inspire people with AIDS/ARC, their friends, relatives, and health care professionals, as well as the general public. For more information: Bob Morse, 718/565-0087 or write: NLA, 2303 Bronson Hill Drive, Los Angeles, CA 90068 (213/669-5395) or NLA, 78 West 85th Street, New York, NY 10024 (212/877-4846).

BRS Information Technologies has created the AIDS Knowledge Base, a compilation of textbook-like information that can be continuously updated through computer technology. The information source is available on the BRS/Colleague online computer database. The most current clinical, research and epidemiological data is available through your personal computer and telephone. Specific topics covered in the AIDS Knowledge Base include: epidemiology, pathogenesis, diagnosis, prevention, treatment, and psychosocial aspects of the disease. The data base is organized similar to a textbook. However, the computer-based format results in the ability to search for and locate desired information immediately, as well as allowing for frequent updating to ensure currentness. For more information, contact BRS Information Technologies, call 800/468-0908.

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BUSINESS & AIDS SEMINARS

THE CENTERS FOR DISEASE CONTROL, BUSINESS COALITIONS, AIDS SERVICE ORGANIZATIONS, CORPORATIONS such as Westinghouse Broadcasting Company, Boeing, NYNEX, Pacific Northwest Bell, Equitable Life, among other companies in cooperation with the Institute for Disease Prevention in the Workplace and Georgia Institute of Technology will kick off a national seminar series on AIDS and Business in Atlanta, April 28-29. The Institute for Disease Prevention in the Workplace who will be leading and organizing these seminars has trained over 1000 managers and employees over the last 18 months. The Institute has developed a unique approach for these series which directly involves local corporate and community leaders on the second day of the event. All participants attending these seminars receive the highly acclaimed manual "Managing AIDS in the Workplace: An Executive Briefing and Training Manual, 2nd edition" and sample policies and participate in a number of workplace simulations that assist managers in developing reasonable cost efficient yet compassionate policies dealing with managing AIDS in the workplace. 15 Seminars have been scheduled coast-to-coast to increase public and private awareness as to the need for educating employees about the fears and realities regarding AIDS. The cities and dates for these seminars are:

Apr 28-29	Atlanta	Jul 7-8	San Francisco	Oct 27-28	San Diego
May 12-13	New York	Jul 21-22	Philadelphia	Nov 3-4	Newark
May 26-27	Houston	Sept 8-9	Chicago	Nov 17-18	Denver
Jun 9-10	Dallas	Sept 29-30	Los Angeles	Dec 1-2	Miami
Jun 23-24	Seattle	Oct 13-14	Washington, DC	Dec 15-16	New Orleans

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RELIGIOUS LEADERS MEET IN HOUSTON

with thanks to Detroit's Cruise, 2/17/88

THE CURRENT AIDS HEALTH CRISIS HAS BROUGHT INTO FOCUS THE COUNSELING, PRACTICAL ASSISTANCE AND ORGANIZING WORK done by gay/lesbian religious organizations. These organizations have traditionally kept a low profile within a community where religion has not generally been considered an ally. However, as the need for spiritual support and physical assistance has risen dramatically, gay/lesbian religious groups have responded with open arms, kind words, and a genuine commitment to help. "Every week, we are being asked to participate in four or five funeral services for AIDS victims, because many in the mainstream religious community just don't know how to deal with the particular issues brought up by AIDS," stated Jim Voltz, a trustee of Samaritan College in Los Angeles. In order to address these concerns, the Universal Fellowship of the Metropolitan Community Churches (MCC)— a Christian denomination known for its involvement with the gay/lesbian community— and its academic institution, Samaritan College, sponsored a nondenominational Conference on AIDS Ministry on January 15-17, 1988 in Houston. Co-sponsors of the conference were: The National Lesbian and Gay Health Foundation (NLGHF), the Pride Institute, the National Association of Persons with AIDS, and the National Coalition of Black Gays and Lesbians. Ellen Ratner, president of the NLGHF, said "It is important for us to remember that this is a task that we cannot fully accomplish as individual persons or organizations. We must rely on the strength that is found in all elements of the community to help us." The primary goals of the Conference were to provide training for those who wish to become involved in AIDS ministry, to provide personal renewal and continuing education for those currently providing AIDS ministry, as well as to encourage networking among religious organizations, and between religious and secular AIDS-oriented organizations. Attendees included lay and ordained representatives from MCC, Roman Catholics, Greek Orthodox, Jews, doctors, nurses and other health professionals, members of gay and AIDS-oriented groups, and municipal officials from Los Angeles, Seattle, Denver, and others. According to Ratner, "This conference was designated to provide support for those in AIDS ministry, helping us realize the valuable information, services and support that we can gain from one another. In my judgment, it has been a terrific success!"

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WOMEN & AIDS CONFERENCE IN BOSTON

by Elizabeth Pincus, with thanks to Boston's Gay Community News, 2/28-3/5/88

A CONFERENCE ON WOMEN AND AIDS will be held Saturday, April 9 at Suffolk University. Sponsored by Boston's Fenway Community Health Center, the day's programs will address the growing problem of AIDS, ARC, and HIV infection among women. Supported by the Massachusetts Department of Public Health and the Boston Women's Fund, the conference, entitled "Our Communities Respond," will bring together women from diverse backgrounds to share information and experiences and to provide participants with resources to take back into their communities. Concerns of women in the black, latina and other minority communities will be central to conference activities. Keynote speaker for the conference will be Constance Wofsey, co-director of the AIDS Activities Division at San Francisco General Hospital and principal investigator of San Francisco's Project A.W.A.R.E. (Associated Women's AIDS Research and Education). Veneita Porter, executive director of Rhode Island Project AIDS, will offer closing remarks. The conference will include workshops on counseling and psychotherapy with women concerned about AIDS; medical assessment and care; children and AIDS; grassroots education; strategies for reaching homeless women, IV drug users and prostitutes; and AIDS and women's sexuality. Also slated is a panel of women discussing their personal experiences relating to AIDS. Roundtable discussions will follow on topics including reproductive rights, lesbians and AIDS, cross-cultural AIDS education, and adolescent education and adolescent education and prevention strategies. All workshop sessions and roundtables will be facilitated by a team of women representing different areas of expertise and racial and cultural perspectives. The conference is open to anyone interested in learning more about the impact of AIDS on women. For more information: Vicky Nunex or Jennifer Walters at the Fenway Community Health Center, 617/267-1538 or 267-3422).

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LESBIAN AIDS RISK STUDY

with thanks to The AIDS Project Newsletter, (Portland, Maine), March, 1988

THERE IS A RESEARCH STUDY OF HIV TRANSMISSION BEING CONDUCTED IN NEW YORK CITY at NYU Medical Center which would like to include lesbians. The research involves pre-test counseling with a lesbian counselor, risk reduction for lesbians, as explanation of the HIV antibody test, and a discussion of your personal pros and cons about being tested. If you decide to take the test, it can be done at that appointment. You will then be asked to complete the research questionnaire. Three staff members from the new national magazine for lesbians, VISIBILITIES, were invited to help develop the questionnaire. All information is confidential and can be anonymous. Floow-up counseling is available. Lesbians who feel they have no risk, but would like to participate inteh study because someone cares enough to study us, are most welcome. Whether or not you have been tested, and whether you live in NYC or elsewhere, if you wish to participate, and are tested in the city where you live, you can receive a copy of the research questionnaire to complete by writing to VISIBILITIES, Dept. LRS, P.O. Box 1258, Peter Stuyvesant Station, NY, NY 10009-1258. Staff of VISIBILITIES will release no identifying information to the researchers. Inquiries about risk reduction, testing, and counseling can be obtained by sending a SASE to VISIBILITIES, Dept. TC, at the above address. Susan Chasin, Publisher and Editor-in-Chief of the journal, together with Lee Charamonte, and health educator Denise Ribble, made the landmark arrangements with AIDS researcher Michael Marmor. The magazine's concern for lesbian safety has resulted in this important study. For more information, contact Denise Ribble (212/675-3559), or Susan Chasin (212/473-4635).

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DENTAL DAMS DEBUNKED: COMMENTARY

by Marea Murray, with thanks Boston's Gay Community News, 12/27-1/9/88

A NOVEMBER SURVEY OF HEALTH PROFESSIONALS AND EDUCATORS REGARDING DENTAL DAMS REVEALED NO CONSENSUS about the use or effectiveness of the latex rubber square barriers for lesbian, bisexual, or heterosexual women who may be at risk for HIV infection. The survey consisted of a poll of ten practitioners and educators working in feminist womans' health centers, the Massachusetts Department of Public Health and other sources around the country, undertaken by the Alternative Tests Site (ATS) staff at Boston's Fenway Community Health Center (FCHC). According to ATS, no printed information is available on this subject. All of the health workers surveyed by FCHC had heard of dental dams and many said they speak with their clients about them. In a December memorandum on the survey, ATS said some of the people interviewed reported that clients raised the subject of dental dams. Some reported they were unsure about the appropriateness of recommending dams, unsure how to use the squares of latex, or unsure of agency policies about speaking with women and men about dental dams. Dams, usually six-inch squares, can be placed over a woman's vaginal area as a barrier to oral contact with the woman's vaginal secretions during oral sex. According to the memorandum, a topic apparently not covered in the survey was whether oral-anal contact (rimming) is risky behavior for women or men. And if it is, could dental dams' use prevent HIV-transmission? Educators, finding that dental dams are not readily available for purchase, said they refer their clients to the companies which manufacture dental dams or to other AIDS organizations they assumed could supply them. None of the health centers surveyed sell or are prepared to provide more than a sample dental dam to clients. Opinions among those surveyed varied about when and if dental dam use is advisable. The majority agreed that partners, regardless of risk for HIV infection, should refrain from oral sex with a woman who is menstruating in order to avoid oral contact with menstrual blood. Beyond that, those surveyed were unclear whether oral sex with a woman who is HIV-positive or with a woman who has engaged in any risky behavior is unsafe. One practitioner said the epidemiology of hepatitis B and gonorrhea have proven to be the most accurate indicators of who will be affected by HIV and by what means. She added that neither of these infections have been traditionally serious health problems for lesbians who only have sex with other women. If there is any risk of transmission through mucus, she states it would only be through the eyes since saliva kills the gonorrheal bacterium before it can travel into the body and be exposed to vulnerable unprotected membranes. She suggested undertaking research on the incidence of gonorrhea and hepatitis B as sexually transmitted disease between women who only have sex with other women. Some of those surveyed also expressed concern that discussion of dental dams deflects attention from the issue of IV-drug use among lesbians. Although statistics on the numbers of lesbians who have AIDS are not compiled by the Centers for Disease Control, lesbians do, in fact, get AIDS. The frequency of HIV transmission between lesbians through IV drug use should not be overshadowed by concern that main mode of HIV transmission between lesbians is sexual. Some health educators also view the use of dental dams as another way to complicate sex for lesbians and other women without benefit of adequate information about their effectiveness as a barrier to STD transmission. Evidence for this skepticism, one practitioner stated, is the fact that cervical caps and diaphragms better contain vaginal secretions yet have both proven ineffective as barriers to transmission of STDs between women. She pointed out that lesbian health concerns are often caught in a gap between gay men's health (and safer sex information geared to that population) or reproductive health— "either being truly appropriate." Frequent criticisms of dental dams cited by those surveyed include their thickness, smell and taste. These factors limit sensations during oral sex and thereby inhibit pleasure. Without research on dental dams' effectiveness in preventing the spread of HIV, health practitioners and lesbian, bisexual and straight women ought not to assume that dental dams are for vaginas what condoms are for penises. The ATS group concludes that there needs to be more open dialogue about dental dams among health educators, practitioners, and women. According to the memorandum, "Some level of consensus on both the role and the practicality of the dental dam needs to emerge so that women can be better informed." Comments may be directed to the Alternative Test Site staff at Fenway Community Health Center, 16 Haviland St., Boston, MA 02116. [ED NOTE: HAS ANYONE STUDIED THE ROLE OF PLASTIC FOOD WRAP (E.G. SARAN WRAP) AS AN ALTERNATIVE TO LATEX DENTAL DAMS?! WRITE TO THE NCGSTDS, P.O. BOX 239, MILWAUKEE, WI 53201.]

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LESBIAN HEALTH SURVEY RESULTS

by Peg Byron, with thanks to The Washington Blade, 1/15/88

The first half of a national survey on Lesbian health care, discussed in last week's Journal of the American Medical Association, provides a glimpse into the lifestyles and conditions of a broad range of Gay women. Reaching Lesbians in small towns and big cities in all 50 states, the largest national survey ever made of Lesbians and health care was completed with support from the National Institute for Mental Health (NIMH) and is likely to have far-reaching effects on future Lesbian-oriented research. Up until now, such research has been carried out on small scales by individuals or small groups without large-sized studies from which to draw analyses or theories.

Under contract with the National Lesbian and Gay Health Foundation (NLGHF) and coordinated by former Whitman-Walker Clinic AIDS program coordinator Caitlin Ryan, the project surveyed 1,917 Lesbians between the winter of 1984 and spring of 1985, using a 10-page questionnaire to inquire about community and social life, general physical and mental health care and services, stress, discrimination, physical and sexual abuse, and more.

Well educated, low paid

Not surprisingly, what emerged was a picture of a diverse population, with many similarities with its straight sisters and frequent problems with discrimination and abuse. However, the survey also found that the Lesbian population which responded to the questionnaire was for the most part highly educated—69 percent reported some college or advanced degrees—with most working in professional or managerial positions. Nonetheless, 88 percent earned less than $30,000 per year and a full 64 percent earned less than $20,000.

The report is the first of two to be released, Ryan told the Blade. The first one consists of findings on mental health and the demographics of the group; the second is concerned with general and gynecological health and health care.

The social findings were at least as interesting as the psychological side of the report. Most respondents lived in metropolitan areas, with few remaining in the same town or city of their birth. There was a slight migration from the northeast to the Pacific states, where 10 percent were born and 19 percent lived. Of 31 percent born in the northeast, 25 percent remained there.

Half live with lover

Half the sample were living with a lover at the time of the survey; one-fourth lived alone; 20 percent lived with a roommate or friend. In comparison with women in the general population, the numbers of Lesbians in primary relationships were comparable. About 60 percent of Lesbians reported a "primary relationship" with a woman; about 62 percent of women in the general population are married. About 17 percent of Lesbians described themselves as single but somewhat involved with a woman, while 19 percent said they were single and uninvolved.

Lesbians reported a high degree of political activism in groups for women or Gays—30 percent reported being active in women's rights groups, 38 percent in Gay rights groups. By comparison, only 11 percent belonged to neighborhood associations and 16 percent to religious organizations.

Not "a sample of convenience"

The study was first planned by NLGHF in 1982 and eventually designed and distributed, with efforts to reach Lesbians through a variety of means—not only through Lesbian events and bookstores but also through non-Gay organizations and health centers around the country.

"We tried not to make it a sample of convenience, for example, with only women on your college campus or a clinician's private practice," Ryan said.

Printing as many questionnaires as funding allowed, about 2,000 copies of a letter describing the project were distributed to Lesbian and Gay health groups and also professional organizations, including the American Psychological Association, the American Public Health Association, the Council on Social Work Education, and the National Association of Social Workers. (This, noted Ryan, could account for the high education levels of the respondents, and the low income levels may correspond with the low salaries typical of medical and social work fields that traditionally employ women.)

"We specifically tried to target as broad a group as possible, but we need to say that [the results] are only reflective of what we got," Ryan emphasized. "We don't know what is out there, or if there is something that motivates Lesbians to get more education or to seek jobs that will give them the most independence." Ryan noted that the racial diversity of survey respondents was close to U.S. Census of adult women in 1980 for Asians, Latinas, and Eskimos and American Indians. Black respondents, however, totaled just 5.6 percent, compared to 11.7 percent nationally.

The age range of the sample—80 percent were between the ages of 25 and 44—differed from that age group in the general population—barely 29 percent.

'High level of coping'

Nearly all of the respondents reported wanting help for psychological problems at some time—three-fourths had seen or were seeing professional counselors. Twenty-one percent said they had considered seeing counselors but had not done so.

Ryan said this finding was a positive sign because it "demonstrates a capacity to reach out for help and a high level of coping."

Forty-four percent of the sample said they sought help with personal relationships, while 21 percent sought help with problems related to being Gay. More than half the sample reported feeling unable to cope with ordinary responsibilities "sometimes or often" in the previous year. And 21 percent said they had had thoughts about suicide. Eighteen percent said they actually attempted suicide at some point in their lives, most of them using drugs.

One disturbing finding, which corresponds to surveys of the general female adult population, was that 37 percent of respondents had been harshly beaten or physically abused six percent both as children and as adults. Non-white women were proportionally the most often abused.

Worries: money, then love

The report compared Lesbians in the sample with other high-stress groups, such as doctors and senior medical students, and found rates of attempted suicide and levels of drug and alcohol use were similar.

The second half of the study, which will deal with gynecological and general health, will be released in a couple of months, said Ryan. With the study's principal investigator, Judith Bradford, the director of health policy at Virginia Commonwealth University in Richmond, Ryan hopes to compile the two halves of the survey into a book, making a rich resource about Lesbian lifestyles as well as health concerns.

Funding for that project has yet to be secured, but Ryan said she hopes it will materialize.

It was the pattern of what Lesbians worry about that appeared most distinctive. The top three worries were money, love, and work, in that order, for Lesbians of all ages, races, and income levels. More than twice as many Lesbians as heterosexual women were concerned about their family lives, and nearly three times as many were concerned about their jobs or the jobs of their spouses.

Given problems reported with discrimination in addition to low income levels, such worries seem understandable. A total of 13 percent reported they had lost their jobs for being Gay. Over half had been verbally attacked and eight percent physically attacked for being Gay.

Discrimination in health services was also reported. Almost eight percent said being Gay had affected the quality of health care they received.

Even survey suffered bias

"Sometimes I felt like this report would never get done," said Ryan, who at one point personally typed letters to 400 different distributors to work on the project. Had all the work of the project been funded, Ryan estimated it would have cost $300,000. With $8,000 from NIMH, she said the survey received $28,000 in funding.

The survey's completion was delayed not only by funding problems but by discrimination. Three sub-contractors who each agreed to perform data keypunching needed to code and analyze the results, abruptly refused to do the job after the questionnaires were delivered to them. In one case, the owner of one local company stated that keypunchers had walked off the job, declaring they were afraid of getting AIDS from handling the materials.

Lesbian education and employment

Education		Type of Work	
Less than high school	2%	Professional	40%
High school	9%	Managerial	15%
Vocational training	2%	Clerical	7%
Some college	16%	Craftsperson	4%
College graduate	26%	Operative	2%
Some graduate studies	12%	Service Worker	6%
Graduate degree	31%	Other	16%

Work Status		Personal Income	
Full-time	61%	Less than $10,000	27%
Part-time	10%	$10,000 to $20,000	36%
Student	21%	$20,000 to $30,000	24%
Unemployed	8%	$30,000 to $40,000	8%
		More than $40,000	4%

What Lesbians worry about

A study of 1,917 Lesbians showed the following as those problems they most worried about, in this order:

Money problems	57%
Job or school problems	31%
Relationship problems	27%
Too much work responsibility	23%
Problems with other family members	21%
Job dissatisfaction	18%
Worry about illness, death	16%
Legal problems	9%
Inability to find a job	7%
Problems with children	7%
Worries about safety	7%
Problems with friends	2%
Loneliness	2%
Stress	1%
Worries about the future	1%

ACTOR TRIES ON PWA SHOES

compiled by Johanna Stoyva, with thanks to Chicago Outlines, 7/2/87

Actor Burt Reyolds says persistent rumors that he has AIDS drove him to seek psychiatric help, according to Detroit's Cruise magazine. "I was so hurt from all the stories going around and had no place to put that anger. Finally, some friends suggested I see a psychiatrist, so I did. He put me in a group with four other guys. I was int he group one month when the shrink said, `Get out. You've got everything in perspective.'" But the AIDS rumors prevented Reynolds from getting work, he said. "Would you hire somebody you thought was terminally ill? Also, people won't pay to see you at the theaters. There's absolutely no recourse to gossip. When they say you're dying of a rare disease, people—no matter how good yo look—see you an say, `He looks bad.' And then, when I got down to 140 pounds—I'm 190 now—it only added fuel to the fire." Reynolds, 51, attributes his weight loss to a jaw disorder resulting from an injury sustained while filming a movie. "Finally," he said, "I spent weeks—10 hours a day—in a dental chair while he rebalanced every tooth in my head. I didn't work for three years." Said Reynolds of companion Loni Anderson, "If I managed to keep my head up the last three years, it was Loni who held it up."

ANTIBODY HOME TESTS WARNING

by Mark Sullivan with thanks to The Washington Blade, 2/26/88

AIDS PROJECT LOS ANGELES OFFICIALS WARNED AGAINST any form of home AIDS antibody testing at a news conference. The tests, which have yet to be approved by the Food and Drug Administration, would consist of a lancet to draw blood and a special box to send the sample to a licensed lab for testing. Companies hoping to sell the kits say they will be marketed towards people who are too embarrassed to have a doctor perform the test. "Our major concern about these tests is counseling," said Andrew Weisser, AIDS Project Los Angeles media coordinator. "We don't believe that sufficient counseling procedures have been implemented with any kind of home test. People need both pre-test and post-test counseling, which these tests don't provide." Some companies hoping to market home tests say they will provide users with a telephone number they can call to get answers to most questions people ask and to get a referral to counselors in their area. Weisser also said that the tests are a "nightmare" from the technical perspective. He said users may not properly disinfect the skin before drawing blood, or they may not draw enough to get an accurate sample. One of the handful of people hoping to market the kits is former Michigan Congressman Mark Siljander. During his three terms in the House of Representatives Siljander voted in favor of the McDonald Amendment, which sought to prevent the use of the Legal Services Corporation on gay-related matters. "It does follow an anti-gay position to market these types of tests," said Kathy Sarris, executive director of the Michigan Organization for Human Rights. "It's just taking advantage of the hysteria surrounding the disease."

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MASS SCREENING PROPOSED BY KOOP

with thanks to Detroit's Cruise, 2/17/88

U.S. SURGEON GENERAL C. EVERETT KOOP SAID HE WANTS TO SCREEN EVERY STUDENT AT A MAJOR AMERICAN UNIVERSITY this spring to study the incidence of AIDS among young adults. Koop also proposed similar mass AIDS screening at a few high schools in the U.S., but said the government had made no decision on either proposal. Officials at Michigan universities said they support Koop's efforts to learn more about the prevalence of the disease, but predicted completing such a testing program on a college campus would be difficult. Koop's plan, disclosed at a world meeting on AIDS in London, could prove controversial. The surgeon general said health officials had yet to choose a university, but it would likely be one in a large city with about 25,000 students. Koop's plans call for the screening to take place some time this spring, and it would likely be part of a one-day open-air campus program on AIDS prevention. He said the screening would not be mandatory.

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PWA SEROCONVERTS TO NEGATIVE

by Lori Kenschaft, with thanks to Boston's Gay Community News, 1/24-30/88

DR. STEPHEN CAIAZZA RECENTLY REPORTED that one of the people with AIDS he treats has tested negative for an antigen to HIV after receiving intravenous treatment with penicillin. HIV antibodies were found in frozen sera taken from the man in 1981, but now he tests negative for HIV. Caiazza uses a new test that screens for the virus itself rather than antibodies, which might be detected even after the viral infection is gone. He says the tests will appear in the "lay literature" soon. Caiazza has been treating PWAs with intravenous penicillin since 1986, and claims that "100% of these patients are significantly improved by laboratory parameters." Caiazza argues that AIDS is not caused by HIV itself, but by an interaction between the virus and syphilis. He speculates that the spirochete which causes syphilis is the true host of HIV, which speeds up the course of the syphilitic infection. Claiming that the CDC-defined test for syphilis is very inaccurate, he estimates there are 2 million undiagnosed cases of syphilis in the U.S., as opposed to the CDC's estimate of 26,000.

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HIV ANTIBODY SCREENING FOR SCHOOL

by Jennie McKnight, with thanks to Boston's Gay Community News, 1/10-16/88

APPLICANTS TO THE CITADEL MILITARY SCHOOL in Charleston, South Carolina must be tested for HIV, according to Our Times. Applicants who test positive will be denied admission, and currently enrolled cadets who test positive will be kicked out. Dr. Joseph Franz, the college's physician, was quoted as saying "It's [the incidence of AIDS at The Citadel] likely to stay very low because of the nature of the students."

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TEENAGERS WITH HIV: CORRECTION

by David Dassey, MD

In the last issue of the Newsletter (volume 8:4, page 15), in the article "Teenagers With HIV Infection," there was an error which needs to be corrected, lest the figures be repeated as truth. In the California Anonymous Testing program, over 1600 persons under the age of 20 had submitted to testing, as of January, 1987. However, it is impossible to know how many of these were confirmed to be antibody positive, since the information relating age and test result is not collected by the State. At the county level, one can collect this information directly from the lab slip, and summarize age-specific data. The State receives from all participating local health departments a composite that sorts the test outcomes by risk behavior only. As of last October, the most recent State summary report for ATS, over 4200 teens had been tested. For more information, call the California State Office of AIDS, 916/323-7415.

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HIV TESTING INACCURACIES

by Lori Kenschaft, with thanks to Boston's Gay Community News, 12/20-26/87

BLOOD TESTS FOR HIV ANTIBODIES AMONG POPULATIONS WITH LOW INFECTION RATES MAY BE EVEN LESS ACCURATE than previously feared, according to testimony before a House subcommittee in November. In particular, the Western Blot, which is the standard confirmatory test for the presence of antibodies, may have an excessive error rate when performed by an inexperienced laboratory. Using data on current laboratory conditions, Lawrence Miike of the Congressional Office of Technology Assessment estimated that 90% of the people who tested positive in a population with a low infection rate (0.01% infected) would actually not be infected with the virus. And in a population with a high infection rate (10% infected) 9.8% of those infected would be falsely diagnosed as not carrying the virus. Army researcher Donald Burke testified that 10 of the 19 laboratories which have applied for Army HIV testing contracts in the last two years failed to analyze test samples to a 95% level of accuracy on at least one occasion. Inexperience is a major cause of errors, according to the testimony. Due to increasing demand, about 70 laboratories now perform the Western Blot, as opposed to only 18 in 1985.

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HOSPITAL TESTING ABUSED

by Mark Sullivan, with thanks to The Washington Blade, 1/8/88

RESEARCHERS STUDYING THE USE OF AIDS ANTIBODY TESTING at one Minnesota hospital found that in most cases, the tests were conducted without the patients' consent and that nearly half of those tested had no identifiable risk factor that would justify their being tested. The study, published in the Journal of the American Medical Association, was conducted on records of AIDS antibody test administered at the St. Paul-Ramsey Medical Center from April 1985 to August 1986. Although the Minnesota Department of Health ruled that HIV antibody testing is only necessary when the patient is a member of a high risk group or shows symptoms of AIDS, and that a patient's consent must be obtained and risk-reduction information must be provided, less than 10% of the tests conducted during the period of the study met these criteria. The study showed that of the 264 patients tested, 63% had not given their consent. Of those patients who were members of a high risk group, 70% had not given their consent. The study also showed that 44% of the patients tested had no recognizable risk-factor recorded. Of these, only two tested positive. Risk reduction information was given to only 15% of those in a high risk group, and to none of those who were not in a high risk group. Researchers also found a great number of mistakes made by health personnel administering the antibody tests. In 6 cases, doctors interpreted a positive result on the initial ELISA test as evidence that the patient had been exposed to AIDS, even though the follow-up Western blot test, which is considered more accurate, showed otherwise. In five cases, a positive result on the ELISA test was recorded as evidence that the patient had AIDS, even though no other symptoms were recorded. In one case, a patient was incorrectly listed as positive even though he had tested negative.

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ILLINOIS CLINICS SWAMPED

by Mark Sullivan, with thanks to The Washington Blade, 2/5/88

A NEW ILLINOIS LAW REQUIRING COUPLES TO BE TESTED for exposure to the AIDS virus before they tie the knot has resulted in thousands of low-risk individuals swamping health clinics, making it difficult for high-risk individuals to get attention. The New York Times reported that because physicians charge about $70 to test a patient for the HIV antibody, many couples are seeking low cost tests at public facilities. The demand for the tests has been so great that some clinics have stopped offering the tests to engaged couples. "This is the most expensive public health program going," said Dr. Ron Sable, an AIDS counselor at the Cook County Hospital. "It's providing intensive, one-on-one counseling to people who need it least." He said the test is an ineffective way to identify potential HIV carriers and diverts attention away from people more at risk for the disease. Illinois and Louisiana are currently the only states that require prenuptual testing for HIV antibody, but several other states are considering taking such action. In Illinois, the new law has caused the number of marriages in January to fall in some places by more than half over the same period last year as couples drive to neighboring states to get hitched without the hassle.

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CONTACT TRACING IN PHILADELPHIA

by Lori Kenschaft, with thanks to Boston's Gay Community News, 2/28-3/5/88

THE PHILADELPHIA DEPARTMENT OF PUBLIC HEALTH (DPH) PLANS TO BEGIN VOLUNTARY, CONFIDENTIAL CONTACT TRACING of partners of people who test positive for HIV at its two test sites. The announcement of the plans followed debate over a resolution before the City Council calling on the health commissioner to create such a program. Although the resolution was defeated by the Council, the Commissioner decided to implement the program because, according to his executive secretary David Fair, he expects the Centers for Disease Control to require a contact tracing program in order to qualify for next year's funding. The city currently seeks $1.4 million in AIDS funding. Fair admits that the contact tracing may not be "the best use" of the DPH's limited staff, but said he believes there are both "benefits and drawbacks" to the program. He is uncomfortable about the DPH acquiring "a list of people who have a higher potential risk of HIV infection." He also warns that "we may be setting up a two tier system— the private agencies will not necessarily be pressed to identify partners. Those who are most likely to come to DPH are the poor, those who have less access to services." If the program is initiated as expected next spring, people who test positive for HIV will be asked to volunteer the names of their sexual and IV drug sharing partners during the last year. The person can choose to inform the partners themselves, or the DPH will do so. The DPH is supposed to destroy the names of the partners after contact is made to preserve confidentiality.

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HIV TESTING: CONSENSUS STATEMENT

circulated by the National Gay/Lesbian Task Force

THE PLACE OF HIV TESTING AS PART OF AN AIDS PREVENTION STRATEGY is the subject of considerable debate. We support an HIV antibody testing program that is an adjunct to counseling, is voluntary, is preferably anonymous, and is conducted with fully informed consent and education about the social, psychological, and legal ramifications of testing. HIV antibody testing measures exposure to and probably infection with the virus associated with AIDS. The HIV antibody test alone does not diagnose AIDS. The percentage or rate of individuals who test positive and go on to develop AIDS or AIDS-related conditions is not known but is significant. It will be many years before research on the natural history of HIV infection answers this question. Individuals can test positive but remain asymptomatic for an extended period of time. Research is still underway and remains inconclusive as to the success of medical interventions for those who test positive but have no symptoms. There are two legitimate purposes for the HIV antibody test: as a public health measure to aid in preventing further spread of HIV infection and as part of a medical evaluation. We oppose use of the test for other purposes, especially as a screening tool that may be used to discriminate against those who test positive. All testing should be voluntary, expect in the context of donation of organs or body fluids. We oppose so-called routine testing where the individual is not fully informed about nor given the chance to separately consent to the testing that is to take place and where institutions are capable of bringing pressure to bear on the individual. Most importantly, testing should not be made a condition of receiving other services. When testing is performed as a public health measure, it should be as an adjunct to counseling about HIV infection and prevention. The value of HIV testing as a successful tool in encouraging or reinforcing behavior changes among those at risk for AIDS or among those who are infected with HIV is uncertain. There is conflicting research data as to the behavior change, with some recent studies suggesting there is a differing, and sometimes negative, impact of testing on some populations. for some individuals, knowledge of antibody status may be helpful in preventing further transmission of HIV. All individuals who choose not be to tested who may have engaged in high-risk activity since 1978 should behave as though they are positive to assure that they do not unknowingly infect others. The value of testing for medical purposes is something each individual must assess in the context of the full health care needs of that individual (e.g., evaluating potential treatments for other diseases or in monitoring one's immune system more closely) and after an assessment of available potential medical interventions for HIV infection itself. There are several experimental treatments for asymptomatic HIV infection that an individual may want to consider at this time, though none have been approved for marketing. In light of the social, economic, and legal ramifications of being tested for HIV infection, test results should always be held strictly confidential. Since no guarantee of confidentiality is absolute, no federal AIDS anti-discrimination law exists, and since even legal guarantees can be withdrawn ex post facto by a legislative body or a court order, testing is preferably done on an anonymous basis. Any testing performed should include a full protocol of tests as recommended by the Food and Drug Administration--with repeat of an initial test and an additional confirmatory test when a blood sample tests positive. Even when the full battery of tests is performed, individuals should be aware of the false positive and false negative rates-- both due to the scientific limitations of the test and the possibility of laboratory error (see footnote below). All testing should be performed with extensive, face-to-face pre- and post-test counseling by an informed, educated health care professional. Part of the pre-test counseling process should encourage self-assessment of risk and attempt to determine whether the individual really needs to be tested to accomplish either prevention or medical goals. All testing should be performed only after full informed consent is obtained during the pre-test counseling process. That informed consent should include the following:

>Information regarding interpretation of test results including false positive rates and delays in developing antibodies after infection.

>Information regarding the possibility that testing may not result in the desired behavior change.

>Information regarding high-risk behaviors associated with HIV infection

>Discussion of the potential psychological ramifications of learning antibody status (and an assessment of the individual's ability to cope with that information).

>Recognition of the social and legal consequences that often accompany testing--including the possibility that test results may be reportable to state health departments; that contact tracing or partner notification programs may be in effect for persons who test positive; that the very act of taking the test can lead to discrimination, that persons who test positive have lost their jobs, homes, custody of their children, etc., in some circumstances; that individuals who test positive may risk losing their ability to obtain health or life insurance in the future.

>Information regarding the availability of treatments, clinical trials, and support services for those who test positive in a given community.

Footnote: "How Accurate Is AIDS Antibody Testing," by Lawrence Miike, Office of Technology Assessment, U.S. Congress, Washington, DC, 1987.

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ARMY POLICY TO PERIODICALLY TEST

by Lori Kenschaft, with thanks to Boston's Gay Community News, 1/31-2/6/88

ALL ARMY PERSONNEL ON ACTIVE DUTY WILL NOW BE TESTED for HIV antibody at least once every two years, making the Army the first military service to establish a policy of periodic retesting. The New York Times reports that personnel outside the U.S. or in certain units may be tested more often. A test every 6 months will also be required for foreign posts and for certain domestic assignments, including the Army Recruiting Command and the Military Entrance Processing Command. The new policy was announced after the Army became the first service to have tested every individual on active duty.

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CUSTODY DENIED MAN WITH DEMENTIA

by Lou Chibbaro Jr. with thanks to The Washington Blade, 1/1/88

A GAY MAN WHO HAS AIDS HAD HOPED A MONTGOMERY (MARYLAND) COUNTY CIRCUIT COURT JUDGE would give him an early Christmas present by restoring his right to joint custody of his nine-year-old son. But the gift did not materialize, when Judge Leonard Ruben ruled on Dec. 23 that the gay man, referred to in court papers as "John Roe," should be temporarily denied the joint custody because he has AIDS-related neurological symptoms that could interfere with his ability to care for the boy. Ruben, in an oral ruling from the bench, conceded that he based his decision on the "barest of evidence." However, he said that until the time of a full trial, scheduled in April, "the child's best interests are maintained by [his] staying with the birth mother." The case, known as Jane Doe v. John Roe, could prove to be important in determining how courts in the Washington area and elsewhere decide on precedent-setting child custody disputes involving a parent who has AIDS, according to gay rights attorney Susan Silber, who is representing John Roe. Silber said that although the case has the potential of causing emotional pain for both parents, some of the explosive issues have been removed, at the agreement of both sides. In a special stipulation submitted to the court at Silber's suggestion, Doe agreed that her former husband's sexual orientation should not be an issue in the case. Doe also agreed to accept the U.S. Centers for Disease Control Statement that AIDS cannot be contracted through casual contact, thus ruling out the potential accusation that the child could "catch" AIDS from his father. Silber said Doe sought the court action shortly after Roe told her he had AIDS and had entered a National Institutes of Health protocol study to determine whether he suffered from subtle neurological symptoms. The NIH study found that Roe exhibited slight signs of neurological malfunction as well as fatigue, but that subsequent treatment with the drug AZT greatly reduced the symptoms. As of mid-November, Roe's doctors determined that his symptoms had not impaired his ability to perform his normal functions, including his ability to care for his son. Nevertheless, court papers show that Doe introduced a motion for an emergency injunction to revoke the joint custody agreement that had been in effect since the divorce 5 years earlier. In support of the motion, Doe's attorney submitted an affidavit from a psychiatric social worker who urged the judge to break the existing arrangement, which allowed the child to live alternate weeks with both parents. The social worker cited a description of the symptoms of "dementia," as reported in a standard medical dictionary, as including: severe memory loss, paranoid behavior, and false accusations and verbal or physical attacks. Silbar argued that Roe is neither physically nor mentally impaired. To the contrary, evidence presented by NIH physicians who have examined Roe show that he is capable of performing all functions necessary to care for his son. Silbar cited previous court decisions in which a physical handicap or a potential handicap of a parent was determined not to be sufficient grounds to deny custody rights. The judge ruled that the child's best interests are maintained by staying with the birth mother, but that the son will be allowed to visit his father at the father's residence and in the presence of the father's lover.

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FAMILY BARS LOVER FROM HOSPITAL

by Mark Sullivan, with thanks to The Washington Blade, 2/12/88

A SAN FRANCISCO MAN WHO HAD CARED FOR HIS LOVER for more than 6 months as he fought a losing battle against AIDS was not allowed to see him for the last two weeks of his live after the lover's family checked him into a hospital. According to the city's Bay Area Reporter, Jay Wilson, a legal specialist interpreter for the deaf who has won several awards for his work, cared for Michael Fasano since June, 1987. Although Fasano reportedly asked to spend his last remaining days at his home with Wilson, Fasano's family checked him into a San Francisco hospital in January. Wilson spent time with his lover during his first two days in the hospital, but then was forced to leave by a family member who declared that only immediate family was allowed to see him. Wilson appealed to Fasano's doctor, who reiterated the family's decree. Fasano's family also forced Wilson to leave the home that he had shared with Fasano for six months while he was caring for his lover, threatening to have him evicted. Wilson said he had no legal recourse under San Francisco law, which has no laws protecting the rights of gay couples. San Francisco Supervisor Harry Britt is expected to introduce a domestic partners bill, similar to one vetoed by former Mayor Diane Feinstein in 1982.

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MYTH OF "AIDS TESTING"

Commentary by Jon Rappoport, with thanks to the New York Native, 12/28/87

THOUGH IT DOES GET TIRESOME TO DIG UP EVIDENCE ON SO-CALLED "AIDS TESTING" TIME AND TIME AGAIN, SINCE WE HAVE A GROWING NUMBER OF medical bureaucrats and politicians who are making hay out of hysteria, here is an open letter to officials seeking some form of mandatory testing for antibodies to HIV. There are so many motives for using blood testing. People want to cure an epidemic. Other people want to establish quarantines, protect their daughters, make a bundle on ELISA test kit royalties, or support the family while running a testing lab. Or help the CDC tally their AIDS cases. Or put tattoos on people's arms or issue health cards or exclude people from insurance coverage. Or save the nation or work up a registry of all American homosexuals. Or co-opt under a new rubric of old problems which have been killing Africans for decades. Or win public office. It doesn't matter. I'm sorry. "AIDS testing" won't do it for you. It won't get you off. It doesn't work. There are two types of "AIDS tests" which are currently used to gauge whether a person is "infected" with HIV: the ELISA test and the Western blot. The blot is often called a "confirmatory" test, which tells you if the ELISA was right or wrong, although not all doctors bother to use a Western blot.

(Continued)

MYTH, Continued

The following is a quick pick of medical literature, the point of which is not to prove that testing is quackery, but worse— to show that medical researchers themselves don't out much stock in it. Some do, of course. But there is dissension in the professional ranks, and it stems from the undeniably poor performance of these "AIDS tests."

*>March 1987, Journal of Clinical Microbiology, James Carlson, et al.: Carlson says that in low-risk groups the false-positive rate in ELISA tests is an overwhelming "84.2% in our study and 77.1% recently reported by the American Red Cross..." Ponder that figure. Carlson continues: "It must be noted that even though we fell the Western blot technique is presently the most acceptable method.... Western blot analysis is a subjective method with quality control limitations; the possibility of false-positive results still exists."

*>January 9, 1986, New England Journal of Medicine, Dr. Michael Saag et al: Saag studied the cases of an Alabama housewife who tested positive on an ELISA while donating blood. Four more ELISAs were done on her; they all showed positive. One backup Western blot was done. It, too, was positive. Then a new sample of blood was drawn and sent to a handful of prestigious labs. This time, all the ELISAs and Western blots were negative. So they repeated ELISAs at two of the prestigious labs. Now they were positive. Saag concluded: "Western blot tests... have been used as the `gold standard' by which other tests (e.g., the ELISA) are judged to be falsely positive...[but] the need for improved confirmatory tests... is evident."

*>December 1986, American Journal of Medicine, Dr. Rahmat Afrasiabi, et al: At the University of California at Los Angeles, three male homosexual AIDS patients with Kaposi's sarcoma turned out not to have detectable antibodies to HIV. For two years (1983-85) blood samples had been collected from these men. Using ELISAs from two different companies and a Western blot backup, Afrasiabi retrospectively tested the samples and concluded: "testing of serum from these patients [was] negative for [HIV] antibodies." In other words, AIDS without antibodies.

*>January 1987, Journal of Medical Virology, L.J. Oldham et al: Oldham checked over samples of blood which were weakly positive for HIV antibodies. "Our findings suggest that Western blot cannot be depended upon as the sole confirmatory test for [HIV]." Further down the page, Oldham adds: "As has been shown, Western blot... lacks full sensitivity and specificity." And then the capper: "...confirmatory procedures are at present beyond the scope of most screening laboratories."

*>February 1987, Journal of Clinical Microbiology, Evelyn Lenette et al: "...both of these assays [ELISA and Western blot] have drawbacks... [there are] reports of both false-positive nd false-negative results with the ELISA, necessitating the use of a second confirmatory test...[but] the immunoblot [e.g., Western blot]... has not been standardized sufficiently for clinical use, and it is also not free from false results." Lennette favors the IFA procedure, but other literature argues that the IFA compares unfavorably with the ELISA/Western blot sequence.

*>July-August, 1985, Transfusion, Paul Holland et al: This study involved 1280 blood donors. Their samples were tested by the ELISAs of two different manufacturers, Abbott Laboratories and ENI. The Abbott got 20 positives on first reading, and on re-check, five samples remained positive. However, the ENI ELISA found different numbers: 25 positives from the same samples on first reading and 14 positives on re-check. Only three samples were positive on both companies' ELISAs. None of the ELISAs from either company showed positive on a Western blot.

Most epidemiologists try to worm out of these damaging assessments by invoking the time-honored "risk groups." It's a little like sprinkling holy water. The game is played this way: "The unpredictability and error of the ELISA and the Western blot are offset by the fact that high-risk people taking the tests are probably infected with HIV. Therefore, their likelihood of already being positive eradicates the uncertainty of the blood tests." To imagine that risk factors for being antibody-positive could nullify the subjective nature of a Western blot done by different lab technicians in different labs is like comparing apples and Sherman tanks. The degree of being at-risk for HIV infection is not quantifiable, especially since, in some groups, such as male homosexuals, people are changing their risk by changing their behavior. The degree of error of these antibody tests is not expressible as a number with accuracy. There is no formula for showing, for example, how likely a male homosexual's ELISA is to be correct. Since we're talking statistics, Harvey Fineberg, dean of the Harvard School of Public Health, published a statistical study on the reliability of the ELISA shows last year. According to Fineberg, even accepting the advertised accuracy rates— 93.4% for detecting true positives, 99.78% for detecting true negatives— the chances are that a "positive" ELISA is wrong 90% of the time. "A second ELISA," Fineberg said, "won't change that. Using a Western blot as a backup, you might, at best, narrow that error down to 25%." In other words, a "positive" Western blot would be wrong 25% of the time. Take a sample of 100,000 people and assume that 30 are truly infected with HIV. At 93.4% accuracy, the ELISA would detect 28 of these true positives, leaving 99,970 who are actually negative. At 99.78% accuracy, the ELISA would find 99,750 of these true negatives, but miss 220 of them, calling them positive when they weren't. You now have 28 true positives and 220 false positives out of 100,000 people. Statistically, therefore, a "positive" ELISA is true only in about one in ten cases (28 being a little more than 10% of 220 plus 28, or 248). "If I had a person, as a doctor, who was engaging in high-risk behavior, I couldn't rely on tests at all," Fineberg said. "I'd sit down with him and try to get him to change his behavior." Congress's Office of technology Assessment recently released the following figures on "AIDS testing" (SEE U.S. News and World Report, 11/23/87): "For groups at very low risk for AIDS, nine in ten positive findings are so-called false positives... For high-risk people, on the other hand, the test produces false-negatives about 10% of the time." Even with the low-risk/high-risk assessment, that's pretty nasty stuff for advocates of mandatory testing. Medical bureaucrats and politicians are in total disarray, but they're out there anyway, posturing about the need for tests. Scientists at the CDC will reassure you that all's well, if you pick up the phone and call them. (Everyone gets their hype from the press people at the CDC and National Institutes of Health.) More honest researchers will give you some mumbo-jumbo about new, better tests in the works. But as of now, "AIDS testing" is a hoax. It simply doesn't have the research to back it up. In our society, despite the availability of more and more information via better and better systems, we still rely on hacks to ring bells and pass out news of the day.

NATIONWIDE AIDS DOCTOR GROUP

with thanks to Chicago's Windy City times, 1/7/88

THE PHYSICIANS' ASSOCIATION OF THE AIDS MEDICAL RESOURCE CENTER held its inaugural meeting January 11 at the American Medical Association in Chicago. This is the first national association of physicians exclusively active in AIDS patient management. The group is open to doctors who do not have AIDS patients currently, but who are interested in learning more about the care of PWAs. No dues are charged to individual practicing physicians, but membership assessments are made for medical directors of health care organizations. The association currently has more than 60 members, with participation expected to exceed 1000 during 1988. Some of the objectives of the organization include: the development of a national network of clinicians experienced in PWA/PWARC patient management; exchange of information and development of new protocols for patient care; development of national standards and examination of ethical issues in AIDS patient management. For more information, contact Gordon Nary, 312/916-0505.

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HOUSTON'S MONTROSE OFFERS TESTING

PROVIDING SERVICES TO THE CITY'S GAYS & LESBIANS FOR OVER TEN YEARS, HOUSTON'S MONTROSE CLINIC CONTINUES TO BE THE ALTERNATIVE HIV ANTIBODY test site. The program has been further improved with regular Western Blot confirmatory testing on positive ELISA bloods. The tests are available on a voluntary and anonymous basis, by appointment only, for a minimum donation of $10. Extensive pre- and post-test counseling accompanies the testing. In addition, a special "AIDS" battery of laboratory tests is also available, including a complete blood count, platelet count, T-helper/T-suppressor (T-4/T-8) cell counts, and master chemical panel (SMAC). Clinic fees for this battery of tests is $100, with the Clinic serving only as an intermediary between the client and their physician. For more information about the ongoing services of the Montrose Clinic: Montrose Clinic, 1200 Richmond Av., Houston, TX 77006 (713/528-5531).

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WHITMAN—WALKER CLOSES SAT. CLINIC

by Mark Sullivan, with thanks to The Washington Blade, 1/22/88

A DRAMATIC DROP IN THE NUMBER OF CASES OF PEOPLE SEEKING TESTING AND TREATMENT of venereal diseases has prompted Washington, DC's Whitman-Walker Clinic to close one of its three sexually transmitted disease clinics. Larry Medley, director of the Men's VD Clinic, said that the clinic will maintain evening clinic services on Tuesday and Thursday. Peter Hawley, medical director for Whitman-Walker, said that a 65% drop in the number of people using the VD clinic over the past seven years had made it unnecessary to have it open three nights a week. In 1980, 7500 gay men used the clinic. By 1987, that number had dropped to only 2600. "There just aren't enough people coming in to justify having three clinics operating anymore," Hawley said. The reason for the sharp decrease in the number of cases of venereal disease, Hawley said, is that gay men have begun to practice safer sex because of the AIDS epidemic. The biggest decrease, he said, has been over the past three years as more and more information about AIDS has been distributed. He said decreases in the number of cases of rectal gonorrhea and other diseases are evidence that gay men have been practicing safer sex. Since 1982, there has been an 82% decrease in the number of cases of rectal gonorrhea being treated at the clinic.

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CHICAGO'S HOWARD BROWN UPDATES

CHICAGO'S HOWARD BROWN MEMORIAL CLINIC RELEASED A SUMMARY REPORT ON AN OUTSIDE CONSULTING FIRM'S RECOMMENDATIONS for changes in the gay clinic's organization, operations and management structure. The Executive Service Corps of Chicago (ESC)— which began studying Howard Brown's operations in mid-October— recommended a number of changes in the Clinic's organization and management structure, including elimination of the position of deputy director and the creation of an ad hoc Advisory Council to broaden HBMC's input. HBMC is the primary provider of AIDS-related services in Chicago and the Midwest. Other changes recommended and approved by the Clinic's Board of Directors include additional emphasis on fund-raising, public relations and personnel. The Board also approved ESC's recommendation that a private executive search firm be retained for the purpose of recruiting candidates for the position of executive director. The not-for-profit agency has been without an executive director since October.

AN ADVISORY COUNCIL TO THE BOARD OF DIRECTORS OF THE CLINIC WILL BE MADE UP OF REPRESENTATIVES OF VARIOUS GROUPS WHICH USE OR MIGHT USE HBMC services and others who are particularly able to advise the Clinic in such areas as fund-raising, public relations, and finance. The creation of the Advisory Council was suggested in a report received by the Board by ESC, a consulting firm specializing in providing advice to non-profit organizations. Members of the Advisory Council should be qualified, responsible, and committed to the goals of the Clinic. HBMC's Bylaws now specifically provide that, to supplement the Clinic's charitable, scientific, and educational purposes, "The Howard Brown Memorial Clinic promotes the well-being of Gay and Lesbian people and enhances their lives through the provision of health care, research, education, social services and support programs."

HBMC ANNOUNCED THE APPOINTMENT OF THOMAS KLEIN, MD, AND ROSS SLOTTEN, MD AS ACTING CO-MEDICAL DIRECTORS. Both former members of the Board of Directors, Klein had been affiliated with the Clinic for 9 years and Slotten for 6 years as volunteer physicians. Both of the doctors are partners in family practice in Chicago since 1984 and bring expert skills to the medical directorship of the Clinic.

(Continued)

CHICAGO'S HOWARD BROWN, Continued

A NEW AIDS EDUCATION STUDY, THE COMPREHENSIVE AIDS PREVENTION EDUCATION PROJECT (CAPEP), IS PROVIDING SAFER SEX EDUCATION to gay men, blacks, Hispanics, and other minorities at high risk for contracting HIV infection. The new phase of the CAPEP study involves the collection of data from HBMC program participants regarding self-perceived risk, knowledge, attitudes, and behaviors of HIV transmission and infection. The Clinic will survey the participants, administering pre- and post-test questionnaires along with a 6-month follow-up questionnaire. Five programs are involved in this research: 1) HIV antibody testing; 2) HIV positive support groups; 3) the sexually transmitted disease treatment program; 4) risk reduction home parties; and 5) the Clinic's speakers bureau which addresses approximately 3000 people a month about basic AIDS education. An independent project, STOP AIDS Chicago, is also involved. The data from this project will be useful in determining how clients receive and react to the educational message HBMC is delivering, and in refining and expanding the Clinic's educational programs.

A NEW PWA SUPPORT GROUP DURING DAYTIME HOURS IS THE SEVENTH SUPPORT GROUP SPONSORED BY HBMC. The daytime session has been added to accommodate PWAs whose work schedules or health prevents them from attending evening or weekend group sessions. PWA support groups exist to help individuals living with AIDS better deal with their circumstances. They are free, unstructured, and are limited to 10 people, providing a personal and relaxed atmosphere. In addition to being informational, numerous topics are discussed, from legal services to psycho-social issues. HBMC also offers support groups for lovers, friends, and families of PWAs.

A GROUP COUNSELOR TO COORDINATE SUPPORT GROUP SERVICES FOR PERSONS WHO TEST POSITIVE TO ANTIBODY TO HIV HAS BEEN HIRED. Support groups are for anyone who tests HIV antibody positive, whether asymptomatic or symptomatic. Support groups help individuals deal with the emotional and psychological impact. Groups will meet once a week for 10 weeks, with no more than 12 people per group. A variety of topics are discussed, from legal and financial issues to alternative therapies. While information about community resources and current progress in AIDS research is discussed, the emphasis of the group is to create a support system for all the participants. The fee for the group is $50, however it may be waived under certain circumstances. HBMC also offers comprehensive psycho-social services to persons with AIDS as well as PWA support groups (see above), support manager resources, and legal, financial, housing and food assistance.

PREMARITAL HIV ANTIBODY TESTING IS NOW BEING OFFERED AT THE CLINIC, AFTER ILLINOIS STATE LAW NOW MANDATES that all applicants for marriage licenses receive the test. The charge is $65 per person, or $120 for a couple coming in together. The required premarital syphilis test will be performed at the same time at no additional cost. The fee also includes pre- and post-test counseling sessions on AIDS and risk reduction. HBMC officials indicated that a portion of the funds raised through the premarital HIV testing program may be used to help defray costs of the Clinic's direct services to people living with AIDS. "By offering this service to prospective married couples, we are able to broaden our AIDS education efforts within the general population," said Kathy Muller-Williams, the Clinic's HIV antibody test counselor. The Clinic is one of the few health facilities in Chicago that is geared up to handle large volumes of HIV tests with fast turnaround. It presently performs about 35 antibody tests weekly, and has its own state-licensed laboratory for processing the tests, which take a maximum of 1 1/2 weeks to run. A state-required certificate, signed by a physician, will be issued after the test results are given to the marriage license applicants and counseling with the couple has been completed. The certificate is good for 30 days from the date the blood was drawn. The Clinic continues to offer anonymous HIV antibody testing without the certificate and syphilis test for a fee of $56.

BROADWAY CARES, THE AIDS SUPPORT AND RESOURCE ORGANIZATION OF THE NEW YORK THEATRICAL COMMUNITY, recently awarded $1000 to HBMC's PWA Emergency Fund. BROADWAY CARES, is an organization made up and supported by over 30 leagues, unions, guilds, associations, and other groups that comprise the New York theatre community. It exists to use their available resources for long-term, on-going fund raising for their own members, as well as AIDS organizations around the country which provide care and services for people living with AIDS; to serve as a clearinghouse for all groups outside the theatre which need the help of people in the theatre and their resources; to provide information about AIDS to the theatre community; and to encourage wide participation of the theatre and its audiences in the fight against AIDS.

MEMBERS OF YOUNG ARTISTS UNITED (YAU), A GROUP OF VOLUNTEERS FROM THE ENTERTAINMENT INDUSTRY, will be making appearances at several Chicago-area schools in February. The appearances are part of the 1988 Northwestern University Dance Marathon charity fundraiser. YAU, a group of about 250 actors, actresses, producers, directors, writers, agents, and publicists, ranging in age from 18 to 28, was formed as a reaction to the many issues facing today's youth. Teen suicide, teenage runaway, drug and alcohol abuse, and AIDS are some of the topics the group addresses. They use personal experiences to encourage and motivate social responsibility on a non-political, non-partisan basis.

MISS ILLINOIS WILL APPEAR at the Northwestern University Dance Marathon. Now in its 14th year, the Marathon is one of the largest college fundraisers in the country, and will this year donate its proceeds to Howard Brown Memorial Clinic. In addition to the Marathon, there will be movies, comedy troupes, student performers, top bands, a full casino, and much more. But the main event will be 90 couples representing various campus organizations, who will raise $00 to $15,000 per couple. Last year's Marathon raised approximately $112,000 for the Cystic Fibrosis Foundation.

Howard Brown Memorial Clinic, founded in 1974, is the Midwest's primary AIDS research and resource center, currently provides services to nearly 300 persons with AIDS. These services are provided at no cost to PWAs. The Clinic also operates the states toll-free hotline for AIDS (in Illinois, 1/800/AID-AIDS). For more information: HBMC, 945 West George Street, Chicago, IL 60657-9974 (Daniel Dever, 312/871-5777).

AIDS OVERSIGHT COMMITTEE FORMED

with thanks to Columbus Ohio's Stonewall Union News, March, 1988

THE INSTITUTE OF MEDICINE AND THE NATIONAL ACADEMY OF SCIENCES HAVE APPOINTED AN 8-MEMBER COMMITTEE TO MONITOR the nation's response to the AIDS epidemic and to identify areas requiring further action. Theodore Cooper, an executive vice president for The Upjohn Co., Job will head the committee, comprised of specialists from the fields of health care, biomedical research, social and behavioral sciences, public health and health care policies. Cooper trained as a cardiologist and pharmacologist, and served as assistant secretary for health at HEW in the 19702.

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WALKATHON FOR GMHC IN NY

NEW YORK'S GAY MEN'S HEALTH CRISIS IS SPONSORING THEIR ANNUAL AIDS WALKATHON, a 10 kilometer (6.2 mile) beginning at the Fountain Plaza of the Lincoln Center, May 15th. Walkers will seek sponsors for each kilometer of walking, with proceeds to finance continuing coalition building, prevention/education, advocacy/lobbying, and support services of the agency. Walkers raising more than $100 will receive a ticket to an exclusive champagne "Thank you Celebration" June 5th. For more info: AIDSWalk New York, Old Chelsea Station, P.O. Box 10, New York, NY 10114.

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SEXOLOGICAL INSTRUCTOR TRAINING

THE INSTITUTE FOR ADVANCED STUDY OF HUMAN SEXUALITY OFFERS AN INTENSIVE PROGRAM TO TRAIN QUALIFIED APPLICANTS in sexological strategies to prevent or reduce the risk of contracting AIDS and other sexually transmitted diseases. A California state approved certificate, sexological instructor/advisor of AIDS/STD Prevention will be awarded on completion of the course. The program is designed to: 1) Teach professionals in the sex field the most advanced techniques in AIDS prevention by using an interdisciplinary approach. 2) Increase the ability of AIDS workers trained in disciplines other than sexology to help people reduce risk and cope more effectively with the sexual problems attendant to AIDS. 3) Strengthen participants' ability to develop programs which meet the specific needs of the particular groups or community they serve. 4) Provide participants extensive practical experience in the use of sexological techniques and teaching strategies. 5) Increase participant's understanding and comfort level with the divergent lifestyles and special problems of sexually active people. 6) Provide a process and an environment which will help participants to regain strength and to renew their dedication. Training is accomplished through SHAPR— The Sexual Health Attitude Restructuring Process— in both didactic and experiential forms. Lectures, panels, films, exercises, roles plays, small and large group discussions and psychodrama all are used to focus on many sexual problems and solutions. Cost of the 60 hour, 7 day workshops, which includes all materials (excluding room & board): $600. Dates of 1988 workshops: March 19-25; August 6-12; and November 5-11. For more information: Exodus Trust, 1523 Franklin St., San Francisco, CA 94109.

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DYING BEFORE THEIR TIME: PROGRAM

IS THE SAME TYPE OF COUNSELING THAT IS USEFUL FOR AN ADOLESCENT WITH LEUKEMIA USEFUL FOR A 30 YEAR OLD WITH AIDS? Can one expect the same type of depression seen in a constantly afflicting illness like cystic fibrosis that one sees in leukemia with its punctuations of wellness? Is the advice about getting the test for Huntington's Disease the same for a person at risk for AIDS? Huntington's Disease, progeria, childhood leukemia and AIDS— all lead to an early death. When a person learns that he now has one of these diseases, he knows as few others can ever know that he will die much sooner than he ever expected. Indeed, such knowledge is constantly with him and colors every decision, every relationship and every innocent fever from a cold. "Dying Before Their Time: The Role of the Medical Humanities in Early Death from Genetic Diseases, Infectious Diseases and AIDS" is the first national conference of its kind. It will study the relationship between the phenomenon of early death and the medical humanities. Speakers from such diverse disciplines and fields as anthropology, the history of medicine, nursing, psychiatry, philosophy, Judaism, English literature, psychology and infectious diseases to address this important phenomenon. Aspects of this subject include what a person's reactions are to early mortality, whether these reactions depend on the age of the person or the nature of the disease, whether just the risk of premature death may have the same effects as the established diagnosis, what the person's altered career and life choices may be, and the range of effects on relationships with others, from friends to family to health care givers. By comparing the uniquely different effects that diseases ranging from progeria to AIDS to cystic fibrosis to Huntington's Disease have on patients, we hope to create a two day exchange of information about the varied reactions of these patients. Our goals are to share knowledge about ways in which the humanities can help them live through this time, to establish lasting relatinoships between counselors in different disciplines and to demonstrate the utility of approaching a common problem like early death by using interdisciplinary solutions. We are especially interested in comparing notes about counseling and support, whether it be the nurturing care of a patient advocacy group, a professional counselor, primary care giver, or loved one. Nurses, counselors, parents and friends of persons with this type of disease, physicians, thanatologists, oncologists, sociobiologists, psychiatrists, and pastoral counselors will all find this conference interesting and practically useful. The public and anyone with these diseases are also invited. The Conference takes place April 15-16, at the Ramada Hotel in East Hartford, Connecticut. Fees: $25 registration, plus $12 for Friday lunch, $12 for Saturday lunch, and $25 for Friday dinner. For more info: Cecile Volpi, Director, Office of Continuing Education, LG006, University of Connecticut Health Center, Farmington, CT 06032 (203/679-3340). Twelve hours of continuing medical education credit are available for physicians and physician assistants.

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MASS MAILINGS NIXED

by Lisa Keen and Janice Kaplan, with thanks to The Washington Blade, 9/25/87

The San Francisco Chronicle reported that during an interview with one of its Washington correspondents, HHS Secretary Bowen revealed that the Reagan administration would not use the $20 million allocated by Congress for a mass mailing to American households for AIDS education. According to the Chronicle report, the mass mailing was stalled because key admistrtion officials opposed it. Campbell Gardett, a spokesman for Bowen, said that "the concept of the mailer is to be reviewed" by the President's AIDS commission. In the meantime, said Gardett, the $20 million allocated will be used for activities relating to AIDS Awareness and Prevention Month in October. Gardett said the funds would be spent on public service announcements, an expanded AIDS hotline, the distribution of an AIDS brochure to targeted individuals, and an additional printing of U.S. Surgeon General C. Everett Koop's AIDS report. Massachusetts Congressman Gerry Studds reacted angrily to news that the mass mailing had been stalled. Studds, who initiated the idea by sending copies of Koop's reports to his constituents in Massachusetts Congressional District 10, said he believes HHS's refusal to go through with the mailing is "criminally negligent behavior. Apparently," said Studds, "the administration finds the mailing of the Surgeon General's report somehow embarrassing." Studds noted that the Soviet Union --which has less than 200 reported cases of AIDS --announced this week that it would distribute a report on AIDS to every household in that country.

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POSTAL WORKERS DON GLOVES

by Lisa McCullough, with thanks to The Washington Blade, 11/6/87

Kansas City postal workers are now wearing rubber gloves and masks to sort blood and body fluid samples en route to a local insurance company-operated laboratory. The New York Times reported that workers received protective gear from office managers after they discovered leakage from several of the packaged samples, which were being mailed to a subsidiary laboratory of Business Men's Assurance Company. Workers were concerned that they could contract AIDS from the leaking samples, which are shipped to the laboratory from around the country to be tested for infectious diseases such as AIDS and hepatitis. Post office officials say that the danger of employees contracting AIDS or any other disease from the leaking packages is minimal. Of the hundreds of packaged samples that workers sort each day, less than 1% show any evidence of leakage, they said. Meanwhile, the insurance company is cooperating with the Postal Service in developing an imroved package that will reduce the amount of breakage and leakage of their contents.

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POST OFFICE NIXES AIDS MAIL

with thanks to Chicago's Windy City Times, 8/20/87

San Francisco's Harvey Milk Lesbian and Gay Democratic Club has had hundreds of pieces of mail returned as "unmailable" by the U.S. Postal Service, with the postage cancelled and the material marked up beyond reusability because of an obscure technicality which the Post Office itself does not follow— except when the mail in question is material about AIDS. Citing regulations which require international mail sent to Spanish-speaking countries by air to bear the words "Par Avion" instead of "Air Mail," the San Francisco Postmaster's office rejected teh mailed brochures; however a survey of 11 post offices in the city revealed that none of them had a "Par Avion" stamp and postal workers rountinely substituted the words "Air Mail" instead.

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CONFIDENTIALITY IN ARKANSAS?

by Marc Stein, with thanks to the Boston's Gay Community News, 10/4-10/87

A Pulanski County, Arkansas judge recently ordered a doctor to tell three city fire fighters whether a man they treated was infected with the AIDS virus. Dr. N.W. Riegler, Jr., citing patient-doctor confidentiality, had refused to tell the fire fighters whether the patient had the AIDS virus, according to a UPI report. The fire fighters, who administered CPR to the patient after an apparent heart attack, had received "unconfirmed reports" that patient had AIDS. Efforts to revive the patient were unsuccessful. After a 15 minute hearing, Judge Lee Munson ruled that the fire fighter's right to know outweighed privacy in this instance. He ordered the information disclosed only to those involved in the case, and issued a protective order preventing public disclosure. The Little Rock Fire Department began requiring emergency medical technicians to wear surgical gloves as a means of protection after the incident.

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JOKES RATED FOR OFFENSIVENESS

with thanks to The Washington Blade, 6/12/87

In a survey of 1000 radio listeners between the ages of 18 and 49, the highest number of respondents, 40% listed AIDS jokes told by disc jockeys as the radio subject they found most offensive. In the nationwide survey, conducted by the radio polling firm Strategic Radio Research, jokes about homosexuality tied for third place with two other categories— bathroom humor and ethnic humor. Drug jokes came in second place in the offensiveness ranking. Spokeswoman Michelle Erikson said the polling firm sought to determine listerner views about controversial radio programs following the FCC's decision to brack down on use of obscene language over the radio air waves. The survey shows that 52% are against FCC language restrictions and 60% oppose an FCC restriction on subject material.

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QUACK SUES TO KEEP "PRACTICING"

by Marc Stein, with thanks to the Boston's Gay Community News, 10/4-10/87

A man with an unusual method of treating AIDS claims a court-ordered closing of his clinics in Houston and Dallas threatens his patients' health. William Hitt's centers were temporarily closed by District Judge Sharolyn Wood on July 17. Wood found that Hitt had violated fair trade practices by claiming that the treatment, which includes urine injections, would prevent infections stemming from AIDS. She also found he had misrepresented himself as a licensed physician, and had administered a drug not approved by the FDA. Hitt has treated 100 people with AIDS for the past two years at his three clinics. During testimony, several people he treated and a doctor testified that the injections seemed to be beneficial. Other medical experts said that urine injections are not an accepted medical treatment.

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NURSING HOME DISCRIMINATION

by Marc Stein, with thanks to the Boston's Gay Community News, 10/4-10/87

Minnesota's Human Rights Department has again taken the lead in fighting against AIDS discrimination, according to Equal Times News. The agency recently charged 16 nursing homes in northeastern Minnesota with illegal discrimination against people with AIDS for refusing to admit them for care. All 16 refused in August to accept a person with AIDS referred by St. Mary's Medical Center in Duluth. This was the fourth attempt to place Duluth PWAs in nearby nursing homes in 1987. The homes were charged with discriminating on the basis of physical disability. Department commissioner Steven Cooper said, "These widespread discriminatory actions cruelly deprive the very people most in need of this type of medical facility." PWAs most often choose to either go to a nursing home further south, or stay in hospitals unnecessarily, adding to their expenses. The nursing homes will have 20 days to respond to the charges. An enforcement officer in the department will then be assigned to the case. The dept.'s claims could lead to criminal misdemeanor charges and civil suits, and the homes could lose their state licenses. Cooper said he may ask for an injunction ordering the nursing homes to admit PWAs. Federal officials could withhold federal Medicare funds. Nursing home administrators have publicly said their staffs are not trained to care for PWAs and that they have a bed shortage. Additionally, the maximum state reimbursement for each patient requiring around-the-clock care is $94/day, which they say is insufficient for caring for PWAs.

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KANSAS STATE U AIDS DISMISSAL

by Nancy De Luca, with thanks to Boston's Gay Community News, 10/18-24/87

Dennis Howard, a faculty member for 16 years at Kansas State University, claims he has been dismissed because he has AIDS. According to the Chronicle of Higher Education, Howard, an associate professor of veterinary diagnosis, was told by university officials that he was not to return to campus and that his employment would end October 13. Howard plans to fule suit charging the university with violation of his rights under the Rehabilitation Act of 1973 (which prohibits discrimination against people with handicaps) and the univeristy's own policy concerning people with AIDS. The university policy, which was adopted in May, 1986, requires that AIDS be treated like any other disability. It requires the university to make all reasonable accommodations to help a PWA continue employment.

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AIRLINE DISCRIMINATION BY TWA

by Jennie McKnight, with thanks to Boston's Gay Community News, 11/8-14/87

A TWA plane which carried several passengers from Los Angeles who were going to the October 11 March on Washington was "cleaned out" in St. Louis at the request of flight attendants worried about AIDS. When the marchers got off the plane to take a connecting flight to Washington, DC, flight attendants, who had learned of the travelers' destination during the first leg of the trip, asked that the section of the plane where the group of 30 had been seated be cleaned. The pilot of the plane agreed. The St. Louis Post-Dispatch quoted TWA public affairs vice president Don Morrison as saying "Magazines and newspapers were picked up; pillows and blankets were taken off, and new pillows and blankets were brought on [the plane]." Michael McDermott of the St. Louis chapter ofthe Independent Federation of Flight Attendants, which represents TWA's flight attendants, said the section of the plane was also scrubbed with a disinfectant. "This was almost a panic situation, and it was unnecessary," said McDermott. "The company has taken no action to educate its employees about AIDS."

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AZT DENIED TO POOR IN FLORIDA

by Marc Stein, with thanks to Boston's Gay Community News, 8/2-8/87

Five South Florida organizations have joined forces to oppose the Florida House Appropriations Committee's recent decision against state purchases of AZT (retrovir) for indigent people with AIDS (PWAs), according to Tallahassee's The Weekly News. The Appropriations Committee voted to postpone funding for a year, rejecting Governor Bob Martinez's proposal to supply about $1.3 million in state funds to help Medicaid-eligible PWAs purchase AZT. Estimated AZT costs for one PWA is $8-12,000 annually. Dade Advocates for Rights and Equality (DARE) joined with Health Crisis Network of Miami, Broward Center One, Broward Dolphin Democratic Club, and the Dade Chapter of the National Organization for Women in urging the legislators to reconsider. Some figures suggest that the House action will leave 171 otherwise people without state help in buying AZT. Many believe the figure is much higher. Marguerite Rowe, coordinator of client services for Center One, said, "We don't know who to blame, whether it's Burroughs Wellcome (who manufactures AZT), or the legislature or who. I don't want to blame anyone. I just know that our clients are having to undergo the stress of having to get this medicine and that's very wrong. They have enough trouble trying to find enough food to eat and keeping a roof over their head."

MARRIAGE BY PWAS OUTLAWED IN UTAH

with thanks to Chicago's Windy City Times, 6/18/87

In updating its common law marriage statute, the Utah legislature has tacked on a provision that people with AIDS cannot get married. The original intent of the law was to curb welfare fraud by declaring that couples who cohabitate and "have acquired a uniform and general reputation as husband and wife" shall be considered legally married.

SEARGEANT JAILED FOR UNSAFE SEX

by Mark Sullivan, with thanks to The Washington Blade, 12/4/87

A U.S. Army sergeant was sentenced to five months in an Army stockade and given a dishonorable discharge in Texas for engaging in sex without taking protective measures or telling his partners that he had been exposed to the AIDS virus. Sgt. Richard Sargeant admitted that he had sex with seven female soldiers despite warnings from his superiors that he should inform his partners of his condition. The jury of four officers and four enlisted men agreed that Sargeant should be sentenced to nine years in an Army stockade, but a plea bargain made before the court-martial called for a shorter time. In exchange for being sentenced for only five months, Sargeant agreed to plead guilty to two counts of disobeying a superior officer, two counts of adultery, and one count of sodomy. He was found not guilty of three counts of aggravated assault and three counts of reckless endangerment. This is one of two cases of a member of the armed forces being charged with not informing partners that they could be exposed to the AIDS virus. The other case is pending against a soldier in Arizona.

PARAMEDICS CLAIM PWA "FAKED"

with thanks to The Washington Blade, 9/18/87

Claiming he was "faking it," a San Francisco paramedic team refused to transport a hyperventilating man with AIDS to the hospital. The August 23 incident has prompted a city investigation. Ron Cohen, a computer consultant and AIDS activist, had recently been diagnosed with ARC and was too weak to get out of bed, according to his roommate and lover, Frank Tiberi. Tiberi called 911 for an ambulance, and when gloved paramedics arrived, they refused to take Cohen to the hospital. Tiberi said the medical team "said his hyperventilating was self-induced, and he was doing it for attention." Another paramedic team summoned later, initially refused to take cohen, but then relented. Shortly after he was admitted, doctors at San Francisco General Hospital diagnosed Cohen as having an advanced case of pneumocystis carinii pneumonia. Cohen, who was on AZT, died six days later. Abbie Wiley, quality assurance coordinator with the city's Emergency Medical Services Agency, told the city's Bay Area Reporter that an investigation was underway.

CONFIDENTIALITY BREACHED: HOSPITAL

with thanks to The Washington Blade, 11/27/87

A New York hospital which is trying to become designated as a regional facility for AIDS patients apparently has violated the state's confidentiality laws and discriminated agasint a pharmacist who tested positive for the AIDS antibody. "It's pretty strange what happened," said Mark Barnes, the Lambda Legal Defense and Education Fund lawyer representing the pharmacist who was listed only as "John Doe" in hearing documents. The New York State Division of Human Rights, after a series of hearings, ruled Oct. 23 that it had found probable cause to believe the hospital, Westchester County Medical Center, discriminated against the pharmacist by refusing to hire him after learing he had tested positive for the HIV antibody. Funding probably cause is the first step in obtaining a human rights violation ruling. Doe voluntarily submitted to an HIV antibody test at the hospital's infectious disease clinic in 1985 with the understanding the results would be kept strictly confidential. A year later, after he had already been offered the pharmacy job, the offer was withdrawn. A doctor at the hospital obtained Doe's confidential medical records from the clinic and revealed the results of his positive test to hospital administrators. "The doctor ws examining my client [for a pre-employment physical] and called up on the computer a file from the infectious disease records," said Barnes. "Someone put it in the computer. It looks like they're doing it across the board" for anyone who tests positive. In its ruling, the state's Human Rights Division criticized the hospital's laxness in maintaining confidentiality with its medical records. The agency determined that maintaining "confidential medical records and not releasing such records without consent is a term, condition, and privilege of public accommodation." This was the first time a New York State agency has ruled against an employer on the grounds that discrimination based on positive test reults violates the state's human rights law.

FRAT SELLS CONTROVERSIAL T-SHIRT

by Lori Kenschaft, with thanks to Boston's Gay Community News, 11/29-12/5/87

The front of a shirt by a University of North Carolina--Charlotte fraternity proclaims "BACK OFF." The back shows two stick figures preparing to engage in anal sex, surrounded by a circle and a slash. "Stop AIDS," it says, "None for me, thanks." According to the Charlotte Observer, UNCC's student newspaper refused to print an advertisement for the shirts. "I think it's very discriminatory and shows an obvious bias against a group of people," said Matt Brunson, the paper's entertainment editor. Kappa Sigma member Chris Murray, originator of the shirt, published a column accusing the newspaper of censorship. "I do believe these people are causing a serious problem for the rest of society," Murray worte. "Homosexuals have caused the AIDS epidemic, there's no argument about it." He explained that the shirt is intended to be humorous: "I think people like to laugh at groups causing problems." The fraternity's president, Matthew Liska, says the shirt, in addition to being funny, "brings awareness of how the disease can be contracted." Five hundred shirts have been sold, raising more money than any other project in the fraternity's history.

POLICE CHIEF BARS AIDS LISTS

by Lori Kenschaft, with thanks to Boston's Gay Community News, 12/13-19/87

Police Commissioner Kevin Tucker has prohibited officers from compiling or possessing lists of the names or addresses of people with communicable diseases. The order followed controversy over a district's posted list of residents suspected of having AIDS. Philadelphia's Gay News reports that the American Civil Liberties Union is still considering a lawsuit on behalf of people with AIDS in the 18th district. The ACLU is also ready to take action to ensure that all copies of the list have been destroyed. While official copies no longer exist, "We are concerned there are other copies still in the possession of individual officers," explained ACLU Director Barry Steinhardt.

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IMPERSONATOR OF VOLUNTEER ATTACKS

by Marc Stein, with thanks to Boston's Gay Community News, 6/28-7/4/87

A gay man was recently attacked by a person posing as a food delivery man from an AIDS group, according to the San Francisco Sentinel. The gay man was beaten and strangled with a telephone cord after opening the door to his apartment for a man claiming to be an "AIDS volunteer distributing food" for the Open Hand Project. Open Hand provides two meals daily to people with AIDS. Open Hand founder Ruth Brinker says her organization has taken action to prevent similar incidents. "We are putting warnings in the bag lunches to alert people to this man's actions and will give our volunteers an Open Hand ID."

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TRIAL IN PARKING LOT

by Marc Stein, with thanks to Boston's Gay Community News, 7/26-8/1-87

United Press International reports that Westchester County Judge Nicholas Colabella recently held court in a parking lot in White Plains, New York when officers refused to escort a person they believed had AIDS into a court. The judge heard defendant Arthur Brodie's guilty plea to drug possession charges ina parking lot next tot he county jail. Brodie had already spent 5 months in jail. Colabella said, he was worried that the defendant might go crazy and spit at or bite a staff member. State Court Administration officials are currently setting up guidelines on handling defendants suspected of having AIDS.

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FAMILY THERAPISTS PROTEST

by Lori Kenschaft, with thanks to Boston's Gay Community News, 12/6-12/87

Dr. Theresa Crenshaw, a member of the President's Commission on AIDS, drew protests at a meeting of 3400 family therapists for her public statements about AIDS testing and her belieft that children infected with AIDS should not attend public schools. Forty therapists who work with people with AIDS had threatened to walk out of a luncheon where the American Association for Marriage and Family Therapy gave Crenshaw a leadership award. Instead, the Association's president-elect read a letter protesting the award, according to the New York Times. Crenshaw did not directly respond to the protest, but stated: "The critical thing to accomplish anything in the AIDS epidemic is to start pulling in the same direction. As long as we're fighting each other instead of the virus, the virus will win."

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PARENTS OF PWA DENIED VISITS

by Lori Kenschaft, with thanks to Boston's Gay Community News, 11/29-12/5/87

Wanda and Leslie Parrish spent 18 months caring for their son before he died of AIDS last month, and now a court is preventing them from seeing their other son's children. According to Houston's Montrose Voice, the Parrishes had temporary custody of their grandsons, who are now four and seven, between 1983-86. The children's mother was than given custody. When she heard that the children's uncle had AIDS, she forbade visits with their grandparents. Wanda took the matter to the Tarrant County Master's Court in Texas, and in early November was informed that she and the rest of the family would have to undergo HIV antibody testing before she could see her grandsons. I'll do what it takes," she said, "but I'd rather not take that test." Attorney Robert Holt, an AIDS litigation specialist, has called the case "ridiculous" because of the strong evidence casual transmission of AIDS is not possible. Another hearing is scheduled for December 8.

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DALLAS G.U.T.S. COUNTERS LAROUCHE

by Mark Sullivan, with thanks to The Washington Blade, 12/11/87

About a dozen gay rights advocates gathered in the Dallas-Ft. Worth Airport on one of the busiest travel days of hte year to counter what they called the "mistruths and misconceptions" about AIDS being disseminated by supporters of political extremist Lyndon LaRouche. The Dallas Voice, a gay newspaper, reporter that members of a newly-formed group. Gays with GUTS (Gay Urban Truth/Terrorist Squad), passed out information about AIDS the day before Thanksgiving several gates away from where LaRouche supporters were handling out their own literature. The LaRouche pamphlets blamed gays for the AIDS epidemic and accused the Reagan administration of catering to gay rights groups by not releasing information about the true extent of the epidemic. LaRouche supporters have called for the quarantine of anyone who tests positive for the AIDS antibody. A referendum calling for such an action was defeated in California last year by a huge margin, but LaRouche supporters have submitted enough signatures to get a similar referendum on the ballot next year. Gays with GUTS was formed, according to officials, to fight anti-Gay bias. The group is patterned after similar organizatios in New York City (ACT UP), and Washington (The Lavender Hill Mob).

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THREAT OF AIDS USED AS WEAPON

by Kim Westheimer, with thanks to Boston's Gay Community News, 7/26-8/1-87

Charges against a woman who claimed she had AIDS and spat on an emergency medical technician (EMT) have been reduced from attempted murder to assault and battery. The woman, Celia Spence, and a female companion, were initially arrested by a security guard at a Boston hotel for shoplifting. Arresting officers were told she was pregnant and was having abdominal pains. An ambulance was called and the women became rowdy, Spence attempting assault on EMT Jamie Orsino, spitting on him and saying, "Now you have AIDS too." The EMT Employees Uion, which represents city of Boston ambulance personnel, supports prosecution of the woman, according to union president Dan White. White expressed dismay that the charges were dropped from attempted murder to assault and battery. "The threat of AIDS [was] used as a weapon," he said. "We view it as no different than a threat with a knife or a gun." White continued, that 54% of all EMTs have been injured onthe job as a direct result of violence. "Prosecution is the exception rather than the rule," he acknowledged. "The issue is not so much the assault that happened here but the continual pattern of assaults against EMTs and the lack of support by Health and Hospitals, the lack of follow-through, and lack of training to deal with these [incidents]." "There is no evience of any transmission [of AIDS] by saliva," noted Sandy Lamb, director of clinical programs for Health and Hospitals. But if anyone feels they have been exposed, they should participate in the employees' program, which is designed for staff who fear exposure to AIDS. Of the 112 employees who have undergone testing for HIV antibodies through the program in the last 3 years, one have yet tested antibody positive.

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KISSING POSES LITTLE RISK

by Oonagh Doherty, with thanks to Boston's Gay Community News, 7/26-8/1-87

Is kissing safe? Well, yes and no, says the World Health Organization. WHO announced that kissing, "up to prolonged, vigorous, wet deep kissing appears to pose no risk of transmission [of the HIV virus]." However, according to the New York Times, WHO also said that "while unproven, some theoretical risk from ...deep kissing ...may exist," especially if there are breaks, tears, or sores in the mouth's lining. There is no evidence that the virus can be spread by food, water, swimming pools, tears, sweat, insects, shared eating or drinking utencils, second-hand clothes, or telephones.

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HEIMLICH MANEUVERING FOR AIDS MONEY

with thanks to New York Native, 6/22/87

Dr. Henry Heimlich, famous for his Heimlich Maneuver to save choking victims by dislodging food from their throats, has said he thinks he can develop a treatment for AIDS. Heimlich announced his surprising position that, "In analyzing it, it's really very simple," in a speech before the Cincinnati Executives Association. Although he declined to explain his theory, saying it is "too early to spill out," Heimlich did say, "When we get the funds, we will proceed." He set the cost of further research at $500,000. Richard Buchanan, a spokesperson for Stonewall Cincinnati, a human rights organization, told United Press International the group was concerned that Heimlich did not present the information in a scientific paper, and that no trials are being conducted. "It would seem extremely unusual that he had not gone tot he international conference to provide them with this thesis," Buchanan said. He added, however, "I would not question his scientific credentials or his motive. He is extremely credible."

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CAMPAIGNING ON AIDS

by Lori Kenschaft, with thanks to Boston's Gay Community News, 12/13-19/87

A memorandum describing how Republicans could use AIDS to their advantage in the 1988 elections has created controversy over its authenticity as well as its content. Democrats released the memo, purportedly fromt he Republican consultant Charles Rand on Nov. 5. Rand denied authorship, saying "I find it pretty reprehensible that anybody would use AIDS as an issue." According to the New York Times, the memo stated that AIDS could be a "paramount" issue in the '88 elections, but that it "could easily backfire" if done "in a heavy or blatant way." "The Republican Party must never seem to be inciting a reaction, only responding to it. If we are low key, logical sounding and stressing the importance of `protecting' families from the disease, then we could find ourselves in excellent shape in '88." The memo was labelled "Confidential Note" and was addressed "To: HD, From: CR." It was staped to another memo from Rand to Harvey Dinerstein and Paul Holm, Jr. with a list of Democrats who are potentially vulnerable in the upcoming elections.

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KIDS PLAY WITH TRASHED BLOOD

compiled by Johanna Stoyva, with thanks to Chicago Outlines, 7/2/87

Children played with blood samplec infectd with HIV that they found in a trash bin outside an Indianapolis clinic, according to local health officials, who called for new regulations on the disposal of blood. Officials have located several ofthe children and believe as many as 12 have played with vials of blood and syringes discarded by the Metro-Health clinic, according to The New York Times. The children are not in danger of becoming HIV-infected, according to the director of the health department, although the blood could theoretically transmit the disease if it came in contact with open wounds or scratches. The director said the children sould be tested for HIV antibody immediately and again in 3 to 6 months. He said he would ask the board of the Marion County Health and Hospitals Corporation to enact new regulations on disposal of blood.

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COURT ALLOWS DISCLOSURE OF NAMES

by Lori Kenschaft, with thanks to Boston's Gay Community News, 11/29-12/5/87

A woman whose daughter died of AIDS contracted through a blood transfusion may be allowed to obtain the names of the blood donors, ruled the Texas Supreme Court. Belinda Jackson has sued the hospital and blood center that gave her infant daughter five blood transfusions for negligence in failing to screen the blood. In October, the Court ruled that the identify of the donors may be revealed to people associated with the lawsuit. According to Houston's Montrose Voice, however Jackson's lawyer must still show, "why it is necessary for me to interview this person" before he will be given an individual donor's name. During the trial, the Tarrant County Hospital District argued that disclosing donor's names violates their right to privacy and the confidential patient-physician relationship, while the Red Cross warned that disclosing names would cause a shortage of donors and threaten the nation's blood supply.

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TULSA PWA RESIDENCE OPENS

with thanks to The Gayly Oklahoman, December, 1987

Catholic Charities of Tulsa, Oklahoma recently anounced their plans to open a residence for persons with AIDS. After its renovation and restoration, the home will be able to accommodate four persons with AIDS. The community is now being solicited for donations of household furnishings. FOR MORE INFORMATION: call Hazel at Catholic Charities, 918/585-8167.

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POLICE ASKED NOT TO SPREAD PARANOIA

by Lori Kenschaft, with thanks to Boston's Gay Community News, 11/29-12/5/87

U.S. health and law enforcement officials say police should not spread "paranoia" about AIDS by the routine use of protective golves and masks, although they should take precautions when a real risk of infection exists. According to Houston's Montrose Voice, officials advised the Washington-based International Association of Chiefs of Police that officers should wear gloves when handling blood or certain body fluids and that they should not lick envelopes containing syringes to be used as evidence in drug cases. But they emphasized that AIDS cannot be contracted by casual contact and that no U.S. officers are known to have contracted AIDS because of their jobs. San Francisco Police Chief Frank Jordan said his officers did not wear protective gear during an October protest by 2000 gay people. "We don't throw fear and paranoia into the picture," he said.

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COLUMBUS ARTISTS PERFORM FOR AIDS

Five Columbus, Ohio arts organizations performed November 18 at the city's martin Luther King Jr. Center for Performing & Cultural Arts in "A Benefit Concert to Support AIDS Research and Care." The event, organized by Stuart Pimsler Dance & Theatre, featured performances by BalletMet, PlayersTheatreColumbus, The Jazz Arts Group Quintet, and The Ebenezer Baptist Mass Choir. The Joshua Foundation hosted a reception following the performance. Proceeds benefited the Columbus AIDS Task Force and the Joshua foundation, as well as national groups such as the Gay Men's Health Crisis and the National AIDS Research Center. The Martin Luther King Jr. Center donated their theater and technical support for the evening, enabling more money to go to the AIDS groups. Stuart Pimsler Dance & Theater, sponsor of the event, has supported the AIDS cause by donating a portion of its Columbus Spring 1987 season ticket receipts to the Columbus AIDS Task Force. The group has also performed in several concerts in support of nuclear disarmament. For additional information, contact: Stonewall Union, POB 10814, Columbus, OH 43201 (614/299-7764).

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ARTISTS: A HUNDRED LEGENDS

One hundred pieces of artwork all created by persons with AIDS, are telling thousands of stories. Using paintings, photos, poetry and other artwork, the publication "a hundred LEGENDS" will share many distinct views from the eye of the storm. The storm is AIDS. Since the dawn of history, people have told the stories of their lives through art. Guided by an inner voice, they have pictured human experience. All the artwork in "a hundred LEGENDS" will be created by people with AIDS or AIDS-related conditions. "a hundred LEGENDS" is a compilation of this work, and as its producers we recognize: 1) the creative process as a powerful tool for healing; 2) support the arts as vital to society, and as instruments of education and social awareness, and; 3) believe that "a hundred LEGENDS" will hono its participants and insure a lasting cultural legacy. The work chosen will represnet a diversity of people, reflecting the way AIDS is hitting our society. The subject matter need not relate to AIDS or AIDS-related issues. What will tie the work together is the understanding that these are expressions of diverse individuals who in the face of their illness have chosen to create. Painting, drawing, printing, stories, poetry, music, sculpture, graphics, photography, performance, installation, all will be considered. "a hundred LEGENDS" will be a beautifully bound box containing 100 single page reproductions of the selected artworks. An edition of 2500 books will be available in Spring 1988 and will sell for $75 per copy. Since the $50,000 production costs will be covered by sponsorship, all $185,000 raised from the sale of "a hundred LEGENDS" will be distributed to AIDS service organizations around the ocuntry for arts-related activities. For more information: "a hundred LEGENDS", 257 West 19th St., New York, NY 10011 (212/255-9467).

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AZT AVAILABLE THROUGH PHAMATEC

Florida's Pharmatec is responding to the perceived deficiency in the supply of AZT by the larger distributor. The company has commercial quantities of the drug that is analytically (>98% purity) and economically superior to the competition, according to Pharmatec's press release. For More Information: Pharmatec, P.O. Box 730, Alachua, FL 32615 (904/462-1210).

D.C. METRO CARDS BEING COLLECTED

by Jim Merriam, with thanks to Boston's Gay Community News, 11/8-14/87

The Florida PWA Coalition is gathering Washington, DC subway fare cards left over from the March on Washington. The group plans to convert some of the Metro cards to cash and to provide the others to PWAs visiting Washington or the National Institutes of Health. "This is a painless way for people to help PWAs help themselves," said Coalition coordinator Jim Merriam. "If enough people send cards with fare still left on them, the Coalition will be able to expand its efforts to provide educational materials to PWAs," Merriam said. People interested in donating their cards to the Coalition should mail their cards to: Florida PWA Coalition, 13967 NE 2nd Av., North Miami, FL 33161.

COUNTY FAIR FUNDRAISER IN CHICAGO

Chicago's Howard Brown Memorial Clinic AIDS Program and Carol's Speakeasy, an area gay bar, brought together hog callers and others who yearned for the "simple country live" November 7th at the County Fair '87. The bar was transformed into a country fair setting, complete with live hogs, goats, rabbits, sheep, and many blue-ribbon specimens of the two-legged variety. There were games of chance and skill along with the "midway" and many exciting contests, such as hog calling, pie eating, corn shucking, quiche judging, and the ever popular "drag" races. Prizes were awarded to contest winners, with a special crown for the "County Fair Queen '87." Proceeds from the games benefit Howard Brown Memorial Clinic and its AIDS-related services. For More Information: HBMC, 945 West George St., Chicago, IL 60657 (312/871-5777).

MAIL ORDER FIRM'S CATALOGS

by Mark Sullivan, with thanks to The Washington Blade, 11/20/87

Developmental Marketing Group, a California-based mail-order catalog firm, sent 2 million catalogs to households hoping to make money for both the firm and the National AIDS Network. Besides the merchandise found in most mail-order catalogs, this one will also contain information about the Washington-based AIDS clearinghouse. The National AIDS Network will receive about 10% of the price of every item sold and all of the donations made in the gourp's behalf. This is not the first charity that Developmental Marketing Group has supported. The year-old company has also mailed catalogs soliciting support for the International Wildlife Coalition, children of the Night, and the American Lung Association. A National AIDS Network official said that the compnay approached the AIDS group with the idea for the project. He said his group decided to accept the company's proposal because it seemed like a good way to raise money. The company has not revealed any projected sales figures for the catalog, nor has it estimated how much money NAN will make.

ACTIVITIES TO HELP AGAINST AIDS

by Ann Fry, with thanks to Boston's Gay Community News, 9/13-19/87

A new booklet entitled, "You CAN Do Something About AIDS"is being prepared as a non-profit, cooperative effort by a number of area publishers and writers. The booklet, which will be widely distributed next spring, free of charge, is intended to help people understand what they can do as individiuals to combat AIDS. Alyson Publications is coordinating the all-volunteer effort. According to Sasha Alyson, "Most...people assume there's nothing they can do [about AIDS]. The point of this booklet is to give them some ideas, to get them started, to encourage them to thik creatively about the options open to them." Some of those ideas are: writing to state and local representatives, volunteering specific skills to help local AIDS groups, or finding ways to combat AIDS within the context of your profession. Other suggestions are welcomed and can be sent c/o Sasha Alyson, Alyson Press, 40 Plympton Street, Boston, MA 02118.

RADIOTHON RAISES OVER $100,000

with thanks to Whitman Alker AIDS Program, November 1987

Washingotn, DC radio staion Q107 raised over $100,000 for the Whitman-Walker Clinic and the American Foundation for AIDS Research (AMFAR) during its 29 hour live radiothon, "Learn to Live." The radiothon was the first in the nation to benefit AIDS research and patient care ran on September 23-24. "Learn to Live" was the station's public awareness campaign to educate the community on the facts about AIDS. Senator Edward Kennedy (D-Massachusetts) and Representative Henry Waxman (D-California), the leading Congressional proponents for legislation dealing with AIDS, served as honorary co-chairmen for the radiothon. Public support from a host of celebrities: Don Johnson of Miami Vice,; Jack Lemmon; Martin Sheen; Christopher Reeve; Daniel Travanti of Hill Street Blues;, choreographer Michael Peters; Stevie Nicks of Fleetwood Mack; Los Angeles Dodgers Manage Tommy Lasorda; The Smothers Brothers; singers Dionne Warwick, Anne Murray, and Natalie Cole; Mel Kaufman and Jess Atkinson of the Washington Redskins; Marla Gibbs of 227, and many more. Miss America for 1988— Kaye Lani Rae Rafko— after hearing about the radiothon from hairdresser Robin Weir, immediately called and asked listeners to support the effort.

CHURCH REFUSES ENTRY OF PWAs

by Sharon Hasse, with thanks to Boston's Gay Community News, 1/24-30/88

PEOPLE WITH AIDS WERE ASKED NOT TO ATTEND SERVICES at a San Antonio church. The North Christian Church elders claimed they were concerned about the possibility of infecting their congregations, "no matter how minute that possibility might be," according to Philadelphia Gay News. The request for "voluntary" restraint comes in spite of the fact that the Texas Conference of Churches, which had recently met in the same city, urged compassion for people with AIDS, saying "...the church and its members must not contribute to the additional pain of persons afflicted with a disease that already causes much suffering."

RUMOR FIRING APPEALED

by Lisa Keen, with thanks to The Washington Blade, 1/22/88

A Norfolk, Virginia man has asked the Virginia Supreme Court to reverse a lower court decision which denied him $360 in back pay for the time he was not permitted to work because his employer believed he had AIDS. Michael Wolfe was fired from his job making pizza for a Domino's Pizza chain in Norfolk after his employer heard a rumor that Wolfe had AIDS. Wolfe took the HIV antibody test and was found to be negative and was then reinstated to his job. But his employer, Tidewater Pizza, refused to compensate Wolfe for $360 in wages lost during the time he was not permitted to work. A lower court judge dismissed Wolfe's suit to gain back pay, agreeing with attorneys for Tidewater Pizza that because Wolfe did not have AIDS he was not protected under Virginia's Rights of Persons With Disabilities Act. The Virginia statute does not state specifically that it covers both people with disabilities and those perceived to have disabilities. But argues Wolfe's attorney Kenneth Labowitz, courts have interpreted such statutes to protect both. Labowitz further argues that just because Wolfe's employer was "mistaken" in believing Wolfe had AIDS does not render the employer's firing of Wolfe beyond the law.

MICE WITH HIV "JAILED"

by Lori Kenschaft, with thanks to Boston's Gay Community News, 1/31-2/6/88

MICE CONTAINING THE GENETIC CODE of the human immunodeficiency virus are part of a National Institutes of Health experiment to discover how viral genes are activated to test possible treatments for AIDS. The viral DNA is injected into fertilized mouse eggs, so that every cell of the adult mouse contains a copy of the virus. The Washington Post reports that concern that a mouse might escape and establish HIV in the wild mouse population has led to the creation of a maximum-security laboratory. The mice are kept in cages inside glove boxes —cabinets with gloves built into the walls which are never opened— behind moats filled with Chlorox. "This is basically a mouse jail," says investigator Malcom Martin. Still, he promised to kill all the mice by next April to minimize the risk of the virus escaping. This is the first time the complete genetic code for the organism causing a lethal disease in humans has been introduced into animals.

SPORTS ILLUSTRATED WOMEN'S ISSUE?

by Nadine McGann, with thanks to Chicago Outlines, 1/21/88

A GROUPS OF WOMEN ATHLETES at the University of Massachusetts has founded Athletes for Equality, and have taken on their first project: working against Sports Illustrated's annual "Swimsuit Issue," Gay New Telegraph reports. According to the organization, Sports Illustrated devotes only 5% of its coverage to female athletes; only 13% of its coverage to fields in which women are major participants focuses on women's accomplishments. Beverly Smith, the group's president, says when the magazine does write about women, "they often do so offensively, emphasizing her sex appeal and trivializing her commitment to her sport." The group holds that the swimsuit issue's photos of provocatively dressed women models in skimpy bathing suits posing with fully dressed men, "encourage men to look at female athletes as a sex object, by giving the impression that, for example, women who run marathons do so to be attractive and sexy." AFE is circulating petitions to have the magazine change the issue to a "Women's Sports" issue. They are targeting major advertisers such as Eastern Airlines, Nike, Ford, Chevrolet and Wilson Sporting Goods. Petitions can be obtained by writing Smith at 98 Spring St., Amherst, MA 01002.

PHOBIA CONDEMNED BY MED SCHOOLS

by Nancy De Luca, with thanks to Boston's Gay Community News, 12/20-26/87

DEANS OF 13 NEW YORK STATES MEDICAL COLLEGES HAVE FORMULATED A POLICY WHICH WOULD DISMISS ANY FACULTY MEMBER, RESIDENT, OR MEDICAL STUDENT who refuses to treat a person with AIDS. According to The Chronicle of Higher Education, this policy is believed to be the first in the country which requires disciplinary action for refusal to treat PWAs. Under the policy, medical students, interns, and residents who refuse to give treatment will be expelled from their schools or training programs. Physicians who do likewise will lose their faculty appointments and be dismissed from affiliated teaching hospitals. Frank Jones, executive director of the Associated Medical Schools of New York, said that although no state medical faculty or students have refused to treat PWAs, "the deans determined that we need to go out in front and make an unequivocal statement about the responsibility of academic health centers." [ED NOTE: DOES THIS POLICY ALSO APPLY TO ORTHOPEDIC, HEART, AND OTHER SURGEONS RELUCTANT TO OPERATE ON HIV ANTIBODY POSITIVE PATIENTS? IF YOU WERE SUCH A PATIENT, WOULD YOU REALLY LIKE TO HAVE A FEARFUL PRACTITIONER COERCED INTO TREATING YOU, IF YOU KNOW THEY REALLY DON'T WANT TO PROVIDE YOU WITH QUALITY CARE? I'D RATHER HAVE SUCH A PRACTITIONER RECOGNIZE THEIR OWN LIMITATIONS, AND DEFER TREATMENT TO AN ACCEPTING COLLEAGUE, THAN TO RISK INFERIOR CARE FROM AN "UNCARING" CLINICIAN. THE PHOBIC PRACTITIONERS & STUDENTS WOULD BETTER BE RELEGATED INTO PSYCHOTHERAPY COUNSELING AND "REMEDIAL" NONCLINICAL COMMUNITY SERVICE PROGRAMS DIRECTED TO PWAs TO HELP THEM MORE POSITIVELY DEAL WITH THEIR FEARS, THAN TO FORCE THEM INTO SITUATIONS THAT WILL LEAD TO INFERIOR CARE AND PERSONAL RESENTMENTS.]

LESBIAN & GAY CLIENTS

with thanks to the North Carolina Lesbian and Gay Health Project, January, 1988

THE FOLLOWING ARE RECOMMENDATIONS FOR PEOPLE IN THE HELPING PROFESSIONS ON WORKING WITH GAY AND LESBIAN CLIENTS:

1) DON'T ASSUME THAT YOUR CLIENT IS HETEROSEXUAL. You see gay and lesbian clients all the time, whether you're aware of it or not. In your manner and language, try to communicated openness to the possibility that a client is homosexual. For instance, don't use pronouns that presume a client's partner is of the opposite sex, and don't assume a sexually active singe woman needs birth control.

2) LANGUAGE. Most male homosexuals want to be called gay men. Most female homosexuals want to be called lesbians or gay women.

3) CONFIDENTIALITY. Many gay men and lesbians have been discriminated against in employment, housing, child custody, etc. Many have been rejected by family and friends when their sexual orientation was made known. Consequently, some gay men and lesbians feel they must hide their sexual orientation and must use discretion in divulging that information. Confidentiality concerning sexual orientation is extremely important and should be assured to your clients.

4) PEOPLE ARE PEOPLE. Lesbians and gay men have all the same problems of heterosexuals. Don't assume that a gay men seeking medical care is there for a sexually transmitted disease. When gay and lesbian clients seek counseling, don't assume that their sexuality is the issue, or even an issue. And if it isn't an issue, don't make it one.

5) BE SUPPORTIVE. Though sexual orientation per se may not be an issue for your client, remember that gay men and lesbians do need support in dealing with a world that is frequently hostile. For instance, anxieties about coming out are often well-founded and anger is a rational response to discrimination.

6) FIGHT THE MYTHS. Fight your own prejudices. We've all got homophobia (gays and straights alike). As long as you're willing to work against it in yourself, you can still provide good care to your lesbian and gay clients. But if you're truly uncomfortable with a gay person, recognize your limitations and refer that client to someone better equipped to help.

7) FAMILIARIZE YOURSELF with all aspects of being gay in this society. Be able to give your gay clients referral phone numbers for support groups in your area.

8) A WORD ON VULNERABILITY. Remember that we all feel vulnerable when we're sick or in trouble. Recognize that this vulnerability is magnified if the problem is a sexual one and magnified further if the client is gay/lesbian, a woman, economically disadvantaged, and a person of color.

[ED NOTE: I FELT COMPELLED TO ADD A FEW POINTS!

9) NOT ALL HOMOSEXUALLY ACTIVE MEN AND WOMEN WISH TO CONSIDER THEMSELVES "GAY," "LESBIAN," "BISEXUAL," OR "HOMOSEXUAL." SOME MAY JUST ADMIT TO "FOOLING AROUND" WITH OTHER PEOPLE OF THE SAME SEX AND CONSIDER THEMSELVES "STRAIGHT" OR "HETEROSEXUAL," ESPECIALLY IF THEY ARE THE "ACTIVE" (INSERTIVE) PARTNER. THEIR MINDSET IS TOTALLY ON A DIFFERENT LEVEL WITH REGARDS TO SEXUAL ORIENTATION.]

10) THERE ARE BLACK, LATINO, ASIAN, AND NATIVE AMERICAN GAY MEN & LESBIANS (AS WELL AS THOSE WHO ARE JUST HOMOSEXUALLY ACTIVE). ALTHOUGH THIS ASSERTION MAY SOUND REMARKABLY OBVIOUS, IT'S IMPORTANT TO RECOGNIZE THAT THE SOCIAL SUPPORT AND VALUE SYSTEMS ARE DIFFERENT, BASED ON WHETHER A PERSON IS WHITE, A PERSON OF COLOR, ETC. EVEN WITHIN A PARTICULAR GROUP, THERE MAY BE VERY DIFFERENT PRESSURES TO MAINTAIN CONFORMITY, TO PROMOTE OR DISCOURAGE INDIVIDUALITY/COMMUNITY, ETC. THEREFORE, DON'T ASSUME THAT WHAT MAY BE APPROPRIATE FOR WHITE MIDDLE CLASS MEN WILL WORK WITH BLACK PROFESSIONAL MEN (VS. BLACK BLUE COLLAR) OR LATINO WOMEN, ETC.

11) ALCOHOL AND CHEMICAL ABUSE AND DEPENDENCY IS A NATIONWIDE PROBLEM OF STAGGERING PROPORTIONS, BUT DUE TO INTERNALIZED HOMOPHOBIA, COPING MECHANISMS, AND VARIOUS SOCIAL SUPPORT SYSTEMS (OR LACK THEREOF), THIS MAY BE A SIGNIFICANT ISSUE AMONG GAY/LESBIAN, & HOMOSEXUALLY ACTIVE CLIENTELE. SUSPECT IT!]

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RESORTS, GUEST HOUSES & SAFER SEX

with thanks to Detroit's Cruise, 1/27/88

ESTABLISHMENTS THAT CATER TO GAY TRAVELERS ARE TAKING AN ACTIVE ROLE IN PROTECTING THE HEALTH OF THEIR CLIENTELE, according to a new survey conducted by Key International Guide. One place in four distributes free condoms, and about the same number make condoms easily available. "We are deeply concerned about both the physical health of our readers and the economic health of the gay hospitality industry," said Stan Leehei, publisher of Key International. These concerns guided the preparation of this year's annual international survey of 635 hotels, resorts, guest houses and bed-and breakfast establishments catering to gay men and women. The questionnaire drew a 68% response (435 replies); it accompanied the annual verification of each establishment's address, guest policy and so on, which helps explain the astonishing rate of reply. Condoms are made available by 46% of those responding, with almost half (48%) providing them free. In addition to those places that put condoms on each nightstand or bed, or that offer them upon check-in, another 42% sold them at the registration desk or public washrooms. Ten percent offered free condoms and also had vending machines on the premises. Half of the responders place "safer sex" literature in their lobbies, lounges or guest rooms; most of these places cater to an exclusively gay clientele. Many of the establishments not offering brochures fall into the "primarily gay" or mixed client categories. Occupancy rates were also up every year since 1984, "...imply[ing] that the gay hospitality industry is in generally good condition," Leehei said. "Also, we are encouraged by the opening of so many new establishments, Many of these are in rural areas, perhaps signaling a trend away from the cities that were primary destinations for gay travelers."

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CLEARINGHOUSE SEEKS INFO

THE NATIONAL AIDS INFORMATION CLEARINGHOUSE OFFICIALLY BEGAN DEVELOPMENT BY THE CENTERS FOR DISEASE CONTROL IN OCTOBER, 1987. The intent of the Clearinghouse is to act as a "hub" where information and resources related to AIDS are inventoried and then used to enhance networking and sharing of information and experiences among AIDS-related organizations. Specifically, the National AIDS Information Clearinghouse will collect information about organizations currently providing AIDS-related services and resources in addition to copies of AIDS educational materials. Two separate databases will be created and maintained: one for organizations providing resources and services, and the other for listing educational materials. The databases will be searched by Clearinghouse staff when answering information requests to ensure that callers are referred to appropriate organizations for assistance and to help them locate resources. If you belong to an agency or organization that is not yet included in the database, or produce information that you believe should be brought to the Clearinghouse's attention, send the following information to them (address below): organization name, with names, addresses & phone numbers (800-lines and office) of the group and key contact people; nature of AIDS-related services offered. target audiences and geographical areas served; and procedures and costs (if any) to access your services and resources. A free review copy of informational and educational materials, such as pamphlets, brochures, guides, curricula, public service announcements, and audiovisual items would also be appreciated. If there are any costs, send ordering information first. When the database record for your organization is prepared, we will send you a copy for verification. The Clearinghouse will begin full operation in the spring of 1988. Address materials and further inquiries to: National AIDS Information Clearinghouse, Lynn Freedman, Acquisitions Dept., P.O. Box 6003, Rockville, MD 20850.

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DISABILITY & SEXUALITY

with thanks to New York's EDGE Newsletter, (Education in a Disabled Gay Environment), Winter, 1988

New York's Education in a Disabled Gay Environment (EDGE) was asked to speak by the Coalition on Sexuality and Disability at their November, 1987 meeting held at the International Center for the Disabled. EDGE members spoke about the difficulty of being in "two closets" (gay/lesbian and disabled), jeopardizing much-needed family support by coming out sexually to one's family, and the difficulties in finding support and social networks in the community.

In writing about special concerns of gay and lesbian physically disabled in the "Sexual Enhancement" chapter of Mastering Multiple Sclerosis, A Guide to Management, Bernice Gottschalk and Mike Sarette quote a psychologist who states: "Gays may be more willing to talk about sex and to try alternative sexual techniques. Many gays have learned that self-esteem and personal fulfillment do not depend on living up to society;s expectations.... It is important to recognize that (relationships) can endure despite illness and disability. The bond between lovers can be strengthened by the shared experience of extended illness." Suggested readings: Sexual Options for Paraplegics and Quadriplegics. Boston, Little Brown, 1975 ($9.95). Barret, M. Sexuality and Multiple Sclerosis. Revised, 1982. Available free from: National Multiple Sclerosis Society, 205 E. 42nd St., NY, NY 10017 (or your local MS chapter). Register, Cheri, Living With Chronic Illness. The Free Press, Macmillan, 866 Third Av., NY 10022, 1987 ($19.95). For more info about EDGE: P.O. Box 305, Village Station, NY, NY 10014 (212/989-1921 x292).

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STRATEGIES FOR THE '90s

with thanks to Network News, National AIDS Network, 3/15/88

NATIONAL AIDS NETWORK HAS JUST RELEASED "AIDS INTO THE 90s: STRATEGIES FOR AN INTEGRATED RESPONSE TO THE AIDS EPIDEMIC." This report is based on the proceedings of the October 1987 conference in Washington that NAN co-sponsored with the AMA, the CDC, and the Association of State and Territorial Health Officials. The 42-page book looks at the community-based response to AIDS— its central role in the provision of services, its cost-effectiveness as an alternative to traditional, costly in-patient medical care— and the necessity of tailoring services and programs to the political, economic, cultural and demographic makeup of a community. The report also looks at ways community based service providers can organize for the future, when the response to AIDS is expected to be concentrated within traditional mainstream institutions. The signposts point to a need for organizations to lobby for more money, seek alternative sources of funding, and build strategic partnerships as a basis for fighting this epidemic. Specific issues addressed in the report include advocacy as a means of education, the need for cultural sensitivity, technical assistance to care providers, and the role of mental health professionals. Address requests for AIDS Into the 90s to: National AIDS Network, Clearinghouse & Resource Development Program, 1012 14th Street NW, Suite 601, Washington, DC, 20005 (202/347-0390). Cost is $2 for full members, $5 for contributing members, and $10 for nonmembers.

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VIOLENCE & HARASSMENT INFO SOUGHT

with thanks to Columbus Ohio's Stonewall Union News, March, 1988

THE NATIONAL GAY AND LESBIAN TASK FORCE IS PREPARING ITS ANNUAL AUDIT OF ANTI-GAY/LESBIAN HARASSMENT AND VIOLENCE IN 1987. They are seeking information from individuals and groups about acts of violence and harassment. NGLTF published annual reports on anti-gay/lesbian violence in 1985 and 1986. Keven Berrill, Director of the Anti-violence Project, notes, "Acts of harassment and violence more than doubled in 1986 from the level documented in 1985." Information gathered by Berrill was used by the Justice Dept. in its hate violence study, and by the House Judiciary Committee for the "Hate Crime Statistics Act." Contact Berrill at NGLTF, 1517 U Street, NW, Washington, DC, 20009 (202/332-6483).

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WOMEN & AIDS ANTHOLOGY

by Sharon Hasse, with thanks to Boston's Gay Community News, 1/31-2/6/88

LITERARY CONTRIBUTIONS ARE BEING SOLICITED BY CLEIS PRESS in San Francisco from women with AIDS or women who are caring for people with AIDS. They are seeking reflections and personal accounts on the effects of AIDS on women's lives. Anyone interested in contributing should send a brief outline as soon as possible to Inew reader, Cleis Press, P.O. Box 14684, San Francisco, CA 94114.

BIBLIO: RELIGION, ETHICS, CARE

"AIDS: Issues in Religion, Ethics, and Care" is an annotated bibliography of materials concerning the religious and moral issues related to AIDS published from January 1980 through June 1987. The bibliography is intended for a wide audience including those in health care, ministry, teaching, and scholarly research. It is divided into three sections: Religious and Theological Issues; Ethical and Social Issues; Psychosocial and Medical Care. Each section lists materials from a variety of perspectives and sources, including scholarly papers, denominational statements, and government publications. To order, send $10.95 (includes postage and handling) to: Park Ridge Center, 1875 Dempster Street, Suite 175, Park Ridge, IL 60068. The Park Ridge Center is an institute for the study of health, faith, and ethics.

BODY POSITIVE

THE BODY POSITIVE IS A MONTHLY JOURNAL PUBLISHED BY A NONPROFIT COALITION OF HIV ANTIBODY POSITIVE PEOPLE. Body Positive welcomes letters, articles, and announcements relevant to the HIV antibody positive people. The March, 1988 issue has articles on nutrition, chiropractic, negotiating safer sex, seropositive women, first hand accounts of coping, and other important topics. For more information, contact: Michael Hirsch, Director, The Body Positive, 263A West 19th Street, #107, New York, NY 10011 (212/633-1782).

HEALTH CARE SOURCEBOOK

SINCE THE EARLIEST DAYS OF THE GAY/LESBIAN LIBERATION STRUGGLES, experience has shown that one of the most necessary and valuable tools for progress is the sharing and compiling of information about available resources. The National Lesbian and Gay Health Foundation is again making a contribution to the gay and lesbian community with the second edition of its Sourcebook on Lesbian/Gay Health Care, to be published in the spring of 1988. "Many people— both within and outside the lesbian and gay community— have erroneously come to view AIDS as the only health care issue that touches the lives of gay people," explained Ellen Ratner, president of the Foundation. "This book will clearly illustrate that there is a broad range of health care issues of vital concern to our community." The Sourcebook will include information on the 1988 National Lesbian/Gay Health Foundation Conference, a bibliographical section on health care issues for lesbians and gay men, as well as the fifth edition of the National Resource Directory of Lesbian Gay Health Care Providers. The editors are William Scott and Michael Shernoff, social workers with a long-standing commitment to the lesbian/gay health care movement. Several articles will be written by some of the most prominent individuals in the fields of medicine, psychology, social work, substance abuse, AIDS, sexuality and nursing. It will be "the most comprehensive volume published to date int he area of health care needs of lesbians and gay men," stated the editors. "Given the variety and scope of issues it addresses, the Sourcebook will be valuable to graduate students and professionals, and to members of the community who also are consumers of health care services," remarked Scott. "By publishing the Sourcebook this spring, we hope to generate interest in the next Lesbian/Gay Health Conference and AIDS forum, which will be held July 20-26, 1988 in Boston," added Ratner. The Sourcebook will be available from the National Lesbian/Gay Health Foundation, P.O. Box 65472, Washington, DC 20035. For more information about the Conference, contact Greg Thomas (202/994-4285).

ALCOHOLISM DIRECTORIES

"THE NALGAP ANNOTATED BIBLIOGRAPHY: ALCOHOLISM, SUBSTANCE ABUSE, AND LESBIANS/GAY MEN" by Steven Berg, Dana Finnegan and Emily McNally, is the most complete listing of resources dealing with lesbian/gay alcoholism and substance abuse in existence. Including over 900 fully annotated citations, the bibliography is fully indexed by author, title, and subject which makes it an extremely useful reference book. Annotations are descriptive and quickly summarize the main points in the article. The literature covered in the bibliography ranges from early psychological literature to the most recent studies in the field. Articles from professional journals as well as the small press are also included. All three of the authors are active in the National Association of Lesbian & Gay Alcoholism Professionals (NALGAP).

THE "NATIONAL DIRECTORY OF FACILITIES AND SERVICES FOR LESBIAN AND GAY ALCOHOLICS" lists over 300 facilities and services which report that they are lesbian/gay positive. The facilities and services are both professional and peer level. Each places some emphasis on working with alcohol dependent lesbians and gay men. Listings are alphabetized by state and city and include information on types of services which are provided, fees and hours, to whom services are provided, and whether the staff is professional, paraprofessional, peer, or volunteer. The Facilities & Services Directory is an excellent resource for anyone working in the chemical dependency field. It is particularly useful for aftercare planning in communities other than one's own and for identifying resources which are available in ones own community. Ron Vachon is the author of the Directory, and is also director of the Office of Gay and Lesbian Health Concerns for the City of New York,

For ordering information: NALGAP, 1208 E. State Blvd., Fort Wayne, IN 46805. NALGAP Bibliography costs $25 (15% discount to NALGAP members) plus $1.50 postage & handling; Facilities & Services Directory costs $5 (includes postage & handling).

RISK TAKING!

by Rick Weiss, with thanks to Science News, 7/25/87

You are desperately clinging to a sheer rock face.

Heart pounding, short of breath, you look above to a teetering sky. Far below, a dizzying impasto of green and brown – and you are frozen in the knowledge that one slip of the toe will send you hurtling to your death on the ledges below.

Sound like your idea of a good time? The scene is nothing short of a nightmare for most, but for some – that spry minority we call rock climbers – this is an ideal Sunday afternoon.

What is it about rock climbers and their kindred risk-takers – sky divers, hang gliders, drag racers and the like – that sets them apart from the average person? How is it that people perceive risk, or at least respond to risk, in such different ways? Such questions are more than academic. They are of immediate concern, for example, to public health officials trying to stem the spread of AIDS, an epidemic closely linked to risky behaviors such as unprotected sex and intravenous drug abuse. And they are of ongoing concern to a variety of specialists, from government and industry planners responsible for designing effective product warnings, to drug counselors and law enforcement officials whose task it is to lessen the individual risk-taker's toll on society.

Until recently, however, the study of risk-taking behavior – or what some have called "motivated irrationality" – has suffered from a lack of specialized attention from any single group of scientists. A recent conference on "Self-Regulation and Risk-Taking Behavior," sponsored by the National Institute of Mental Health (NIMH) in Bethesda, Md., addressed that deficit by bringing together psychologists, sociologists, brain scientists and others to pool their understanding of the more venturesome among us. They examined the spectrum of perilous behavior – from scuba diving to drunk driving to cold-blooded murder – and came to the sobering conclusion that although some degree of fearlessness is admirable, U.S. culture as a whole is in the midst of an "epidemic" of violent and self-destructive risk-taking behavior.

"Most people who become debilitated or die prematurely are not victims of disease as much as of behavioral and environmental conditions that are in principle preventable," says Lewis P. Lipsitt, visiting scientist at NIMH and the conference chairman. "Accidents, suicide and homicide are the major killers of teenagers and young adults," he notes, "while drinking, drug and eating disorders account for large numbers of additional deaths and debilities." Similarly, he says, "It is obvious that it is behavior that transmits the virus that causes AIDS."

Such conduct Lipsitt aptly calls "behavioral misadventure." It is the result of a combination of external hazards and internal "behavioral vulnerabilities and risk-taking propensities which often have origins that are as yet poorly understood."

Of the possible explanations for such behavior – which, on its face, appears almost counter-evolutionary – the biochemical rationale is perhaps the most controversial. There is, however, substantial evidence that certain people are biologically predisposed "sensation seekers," with a preference for novelty, complexity and intensity of experience. Marvin Zuckerman, a psychologist at the University of Delaware in Newark, devised a four-part sensation-seeking scale that measures a person's propensity for "thrill and adventure seeking" (the desire to engage in activities with some physical risk), "experience seeking" (the desire for new experiences through nonconforming lifestyle and travel), "disinhibition" (the penchant for drinking, partying and a variety of sexual partners) and "boredom susceptibility" (aversion to routine experience and predictable people).

"In general," Zuckerman says, "sensation-seeking scales seem to be the best predictors of risk behavior. They identify people who tend to want a 'new experience.'" Zuckerman found strong neurophysiological and biochemical correlations among people who scored high on the scale.

Compared to the population as a whole, for example, sensation-seekers tend to have lower levels of monoamine oxidase, an enzyme that normally breaks down certain neurotransmitters related to emotion and cognition. (*High* levels of monoamine oxidase are commonly associated with depression.) Sensation-seekers also tend to have lower levels of DBH, a brain chemical that, when low, has been associated with manic states. In addition, they have higher levels of gonadal hormones – known to play a role in aggressive behavior.

What's more, Zuckerman says he has found a significant genetic correlation for the trait of sensation-seeking. "What we inherit are different enzymes that regulate our nervous systems. High sensation-seeking is probably not due to high levels of neurotransmitters," he concludes, "but to a lack of certain regulatory controls."

Zuckerman's biochemical model is by no means universally accepted, but it has its appeal among scientists who are trying to understand an otherwise nebulous psychological phenomenon. And his emphasis on the role of biochemical "regulatory controls" resonates with a number of psychological models that relate risk-taking to the concept of *akrasia*, or lack of control.

Akrasia is an ancient Greek concept that some psychologists have revived in recent years in an attempt to understand why people "succumb" to risky behavior when safer alternatives are clearly available. It assumes that people normally make decisions in an essentially logical way, and that only when weakened will they let some other force get the better of them.

What makes the mind susceptible to such lapses? Some psychologists put the blame on something called "modular cognitive separation," in which packets of information are thought to become overly isolated in the mind, leading to an inability to see the connection between cause and effect, with a resulting misperception of actual risk. A recent article in the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, for example, argues that contrary to the tobacco industry's repeated assertions, teenagers who smoke do not do so on the basis of a truly "informed choice." Adolescent smokers, the study found, greatly overestimated the prevalence of smoking among adults and peers, underestimated their peers' negative attitudes toward smoking and underestimated the risk of smoking-related illness – despite what would appear to be exceedingly clear evidence to the contrary in all of these categories.

Such findings are indicative of the mind's ability to ban selected bits of information to a sort of mental Siberia. The mind is apparently willing to short-circuit itself in this way in order to fulfill certain unrecognized wishes, psychologists say, or because new information may not jive with older experiences, such as important childhood memories.

Moreover, says Leonard Zegans, a psychiatrist with the Langley Porter Psychiatric Institute at the University of California at San Francisco, "Sometimes we act not despite risk, but *because* of it. Risk itself can be seen as a positive change" for someone who needs to affirm a sense of control or a stronger sense of self. At times like that, Zegans says, "actual self-destruction is not as feared as the destruction of one's sense of self."

In addition, he says, "Risk-taking increases in times of confusion, and can even serve as a form of protest." Adolescents, for example, may use risk-taking as a means of asserting independence from – or even inflicting pain upon – their parents, he says. At its extreme, Zegans says, risk-taking can arise from an actual desire to harm oneself, perhaps as an "appropriate" punishment for an act the risk-taker feels guilty about.

Such explanations share the premise that the mind operates on basically "economic" principles, weighing all possibilities and then choosing the behavior that makes the most sense. A number of studies have shown, however, that people

(Continued)

RISK TAKING! Continued

don't routinely process information in consistent or logical ways. Decision-making studies show, for example, that people tend to give a disproportionate amount of weight to newer information, and that they usually overestimate how complete their knowledge base is. Other studies show that people prefer voluntary risks over risks that have been foisted upon them, even if the self-inflicted risk is statistically more dangerous. People also tend to disproportionately fear tragedies that involve large numbers of people, even though single-victim accidents actually result in many more injuries per year.

Why are we such poor processors of information, we who pride ourselves as rational beings? Selective media reportage is undoubtedly a factor that influences our sense of "what is really dangerous." But media bias, like biochemical and psychological imbalances, is but an ingredient in the risk-taker's decision-making recipe. Indeed, experts say, a real understanding of risk-taking behavior can come only with an understanding of decision-making itself – one of the most complex, integrative functions performed by the brain.

Unfortunately, says Baruch Fischhoff, a research associate at the Eugene (Ore.) Research Institute, very little is known about decision-making *per se*, other than that "it appears to be difficult in some objective sense, and that people often find it a difficult thing to do." Many decisions are easy, Fischhoff concedes. ("You don't find many people stuck on the curb, trying to decide whether or not to cross the street," he notes.) But other decisions can be readily confounded by a number of factors – not least of which may be the way in which the question is framed.

For example, Fischhoff says, studies show that if you give a person a choice of taking a small risk of losing $500 or incurring a "definite loss" of $50, most people will choose to risk their $500. But when people are given the option of "insuring" their $500 with a $50 "premium," most will opt to pay that $50 premium, even though a premium is the same as a definite loss.

Studies such as these show how subjective are the references by which we gauge our behavior. To make matters even more confusing, that subjectivity is not only personal (based on such variables as age, psychological history and perhaps brain biochemistry) but cultural as well, with some cultures routinely accepting certain risks that other cultures would find intolerable.

So, for example, many American visitors to China are appalled by the high percentage of Chinese men who smoke, and by the huge number of cigarettes they smoke per day. But many Chinese have equal trouble understanding why Americans are so persistent in their overconsumption of alcohol, when research has clearly shown that alcohol is associated with at least half of the traffic fatalities in the United States and with many other types of interpersonal violence. Indeed, despite overwhelming evidence to the contrary, alcohol is not perceived by most Americans as being particularly dangerous.

It is here on the cultural level, psychologists and sociologists agree, that the United States has a particular problem; for U.S. culture exhibits peculiarly ambiguous feelings toward risk-taking behavior. On the one hand, says Zegans, "This culture extols heroes – we'll overlook maladaptive behavior as long as you succeed." On the other hand, he says, we have very high expectations for personal and public health and environmental safety.

"We watch programs like 'Miami Vice,'" he says, "but then we're constantly told, 'Don't take chances.' This is a cultural contradiction we must deal with."

One of the ways we deal with that schism is to channel dangerous urges into "leisure" activities. Unfortunately, notes Lipsitt, much of the nation's obsession with risk-taking behavior never finds its way to such innocent endeavors as rock climbing and hang gliding. Too often, he says, it gets expressed through a variety of socially destructive activities that constitute "major threats to the lives and safety of large numbers of individuals."

For example, notes Louis J. West, chief of the Neuropsychiatric Institute at the University of California at Los Angeles, in the last 20 years the homicide rate in the United States has more than doubled, to more than 10 murders per 100,000 people per year – 10 times the average homicide rate in the world's other 19 most developed countries. And while some quibbling about statistics is inevitable, he says, there is "no question" that other violent crimes such as rape and child abuse are also on the rise. "We're in the midst of an epidemic of violent behavior" in the United States, and it is closely associated with our attitudes about danger and risk, West cautions.

The AIDS epidemic is no less violent, he says, and it is already the leading cause of death in a number of "high-risk" populations. "Clearly, an investment in research and an orientation toward prevention" is desperately needed, says West, referring not only to AIDS but to the phenomenon of risk-taking in general.

What kinds of approaches do the experts recommend? First and foremost, they agree, there are positive elements of risk-taking to be encouraged – elements of courage, curiosity, creativity and growth. But parents, educators and the media, they say, must take responsibility for teaching the difference between socially constructive risk-taking and self-destructive behavior.

Specifically, Fischhoff suggests, we must learn how to teach the very art of decision-making, rather than continuing to rely upon our current practice of teaching "correct" answers to specific questions. This is especially important, he says, given the vast amounts of information we must deal with today.

Michael Cataldo, director of psychology at the John F. Kennedy Institute at Johns Hopkins University in Baltimore, believes that in light of the growing likelihood of humanity's self-inflicted annihilation, the study of risk-taking behavior should become a national priority. "It's probably time to either do it or forget it," he says.

Recalling President Roosevelt's 1942 gathering of experts to develop the world's first atomic bomb, Cataldo suggests that the federal government consider "a new mechanism, like the Manhattan Project," to look intensely at the problem of maladaptive risk-taking. "We already have the methods and the knowledge base for changing the behavior of individuals in society," he says. "Now we need something that would see how to effect changes in the behavior of a society as a whole." □

QUARANTINE BILL IN VANCOUVER

by Lori Urov, with thanks to Boston's Gay Community News, 10/11-17/87

Activists in Vancouver, British Columbia Canada are fighting the passage of Bill 34, legislation which will allow the provincial cabinet to quarantine people who are HIV-positive. Bill 34 was introduced in July and is expected to pass in October unless a broad response can be mounted quickly. The opposition, which includes the Coalition for Responsible Health Car (CRHR) and the Vancouver Persons with AIDS Coalition, have organized marches and lobbied against the bill. They are also fighting to obtain funding for hospices, drugs, research and educational materials used to help prevent the transmission of AIDS.

MINORITIES AIDS CONFERENCE

by Dr. John Bush, with thanks to Boston's Gay Community News News

I attended the Centers for Disease Conference on Minorities and AIDS in Atlanta in August. I was invited by my organization, Black and White Men Together. I was initially under the impression that it would be very interesting to attend a conference on Minorities and AIDS, wherein most of the participants would be minorities and where most of the top officials handing out information and running the conference would also be minorities. But after having given it some thought, I realized that such could not be the case. My latter thought was more representative of how it really was. Basically the white leadership was telling us (Black, white, Hispanic, and women as well as white men) that AIDS was rapidly spreading in the Black and Hispanic communities, and inviting us to explore ways of educating the communities in order that the spread of the virus would be slowed.

In addition to attending the lectures and participating in the discussions, I also spent considerable time observing the participants at the conference. Another of my earlier thoughts was that there would be many homosexual men in attendence since we have all been socialized to associate AIDS with homosexuals, particularly white homosexuals, who have done so much to educated gays and non gays regarding the AIDS crisis.

There were a considerable number of gay men and some lesbians, but in the main, the conference was a mainstream affair populated with a majority of heterosexual participants, who were basically telling us that the new fight to reduce the spread of AIDS had to be centered in the IV drug using community, which is mostly Hispanic and Black. The concern expressed was not only must we reach those communities, but we must do it rapidly because the infected drug users were/are spreading the disease to the women in those communities through sexual contacts. Moreover, women in the communities were/are contracting the disease via IV drug use and are giving birth to most of the babies born with AIDS.

Certainly the aforementioned observations are more correct than incorrect, but I could not help but privately think about the IV community as it is now defined. At one time individuals in such circumstances were called junkies and left to their own devices. There was indeed a time (before AIDS) that individuals who used needles to inject drugs were viewed as "sick" people who were beyond redemption, but very few organizations of the society really cared about them; after all they were only hurting themselves and they were not contributors to society.

Now they have been reclassified as IV drug users and the larger society is extremely interested in their collective welfare, even though the interest might be characterized as selfish, such selfishness serves the greater society in a positive manner. Thus, although the drug user has not altered his/her life style he/she has been relabeled and is being observed in a new (more concerned) manner. The deliberations at the conference made that clear.

Although IV drug users were not participants at the conference, as has been mentioned, gay males were. In fact, the white heterosexual male power structure made sure that they were in attendence by not only inviting representatives from their organizations, but also contributing to transportation and hotel cost. But even though gay males were in attendence, speeches and discussions did not focus on their activities. As I recall, we were well into the conference before I heard the word homosexual mentioned by one of the official presenters. One got the impression that even though members of the "high risk group" were invited, they were not to be singled out in any way; however they were encouraged, along with all the others in attendence to share their expertise in attacking the problem of AIDS in the minority community. One may conclude that they were invited because of the experience they have gained in educating the larger population regarding the spread of AIDS.

As you have observed in this piece, I have used the terms gay and homosexual interchangeably. Although most individuals would understand that usage, I have come to the conclusion that the term gay actually implies a different meaning than the term homosexual. I know that is not a new thought, but homosexual is a term which simply defines a same sex orientation, while gay also connotes a conscious or unconscious political ideology. It is akin the term Black, which Blacks adopted in 1961 as the new definition of themselves. It was and is far more political than the old term Negro and in addition it is a self definition. The entire idea is important, because often it is the case that homosexuals are content to be homosexual and equally content to be "in the closet," while gays have no desire to be hidden away from society. Being gay is a political act, just as being Black is a political act, or being a radical lesbian feminist is a political act.

In Atlanta, it was clear that those minorities who were there participating were political individuals, leaders from the National Coalition of Black Lesbians and Gays, The National Association of Black and White Men Together, The National AIDS Network and other groups reflecting the interest of Hispanics and other minorities in the U.S. I think it is safe to say that they were invited because of their agenda and they made that known during the conference. The heterosexual groups were just as vocal about the financial inequities which minorities have suffered in the battle and the common concern gave rise to a demand for the immediate release of more funds which would be given directly to organizations at the grass roots, rather than have them channeled through state governments. Also one should not forget that the black and Hispanic caucuses which were organized at the conference were made up of all the blacks and Hispanics without regard to sexual orientation or lifestyles.

One of the provocative papers presented at the conference was presented by Dr. Julius Johnson of San Francisco. He classified Black homosexuals as representing several categories. He argued that there are Black Gays, Gay Blacks, Homosexual Blacks, and basically Heterosexual Blacks (in reality Bisexual Blacks?). Though men in these categories practice homosexual sex in varying degrees, only those who are in the Gay Black category are inclined to participate in organized gay activities. Those in the other categories would tend not to participate in organized activities of Gays. Neither would they seek help from gay organizations if they had AIDS, because it would be tantamount to admitting that they were gay. Johnson's study suggests that the labels that Black homosexuals attach to themselves often dictate how they will participate in the homosexual and/or Gay world.

The AIDS epidemic has caused many Blacks to re-examine their positions on participation, and the October March On Washington has managed to move more Blacks and Hispanics out of the closet. Lesbians, who have always been active in Liberation movements (more so than their male counterparts) have become even more active and coalitions of Black lesbians and Gay Black males have been formed, as witnessed by the People of Color Contingent, which played an active part in the organization of the March on Washington. The Hispanic community has also organized and are actively participating in coalition activities with traditionally white male groups.

Perhaps the AIDS epidemic, which has been so devastating to society, and particularly to the white male gay community, and now which is on the rise in the minority and poor white communities of the U.S., will radically alter life styles (as it has among gay males). Beyond that, the continued AIDS crisis will possibly also cause many of us to redefine ourselves, thereby creating and accepting new labels for ourselves. In that process we are going to have to immediately launch a protest to get the CDC to stop classifying homosexuals as a high risk group. That label has done much to increase the amount of discrimination and hostility which has become more pronounced since the coming of AIDS. It is the sexual practices that one engages in that puts one at risk, not the group to which one belongs. All of us, especially Blacks and Hispanics, need to decide that we are not going to be defined by others. Labels may or may not define who we are and they may or may not dictate lifestyles, but the thoughtful individual who is guided by an inner strength will not let others dictate who or what he or she should be; he or she will simply strive to live a life that guarantees as much freedom as possible with or without labels.

'I have come to the conclusion that the term gay actually implies a different meaning than the term homosexual. I know that is not a new thought, but homosexual is a term which simply defines a same sex orientation, while gay also connotes a conscious or unconscious political ideology. It is akin the term Black, which Blacks adopted in 1961 as the new definition of themselves. It was and is far more political than the old term Negro and in addition it is a self definition. The entire idea is important, because often it is the case that homosexuals are content to be homosexual and equally content to be "in the closet," while gays have no desire to be hidden away from society...Perhaps the AIDS epidemic, which has been so devastating to society, and particularly to the white male gay community, and now which is on the rise in the minority and poor white communities of the U.S., will radically alter life styles (as it has among gay males).'

--John Bush

John Bush is Professor of Sociology at Southeastern Massachusetts University. His fields of interest are race and human sexuality. He is advisor to the Black Student Union and the Gay and Lesbian Alliance. He is a founding member of Black and White Men Together of Boston and is co-chair of the national BWMT 1988 convention to be held in Boston.

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ILLINOIS PASSES MIXED BAG OF LAWS

by Lisa Keen, with thanks to The Washington Blade, 9/25/87

After poring over a package of 17 AIDS-related bills for several weeks, Republican Governor James Thompson of Illinois signed 10, vetoed 4, and changed 3, reports the Associated Press. Neither conservatives nor gays are entirely satisfied with the mixed bag of legislation, according to Chicago's Windy City Times. On the plus side for AIDS activists, Thompson vetoed a bill spearheaded by Presidential AIDS Commissioner Penny Pullen which would have required reporting people who test positive for the AIDS antibody. He also signed bills to implement AIDS educvation in grades 6 through 12, AIDS training for law enforcement workers and school counselors, and a confidentiality act to protect the results of people taking the antibody test. On the down side, Thompson also signed a Pullen bill which requires that people seeking marriage licenses take the antibody test, another bill which requires the teaching of sexual abstinence, and bills which give health authorities the power to conduct tracing of sexual contacts, quarantine of people with AIDS who endanger public welfare, and test persons arrested for sex or drug crimes.

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BLACK NETWORKING

by Elizabeth Pincus, with thanks to Boston's Gay Community News, 2/21-27/88

A growing network of organizations is mobilizing to fight AIDS in the Black community and in other communities of color. The formation of the National Minority AIDS Council (NMAC) over the last two years helped unite the efforts of educators around the country concerned with the disproportionate incidence of AIDS among people of color. According to recent figures on AIDS cases in the U.S. reported by the Centers for Disease Control (CDC), approximately:

- 40 percent of all people with AIDS are people of color
- 74 percent of all women with AIDS come from communities of color
- 80 percent of all children with AIDS are either Black or Latino

Despite these figures — and estimates that percentages of people of color exposed to HIV are similarly disproportionate — a glaring lack of resources has been directed towards people of color since the AIDS epidemic was identified over seven years ago. AIDS organizations were slow to respond to the needs of communities of color — much as the mainstream medical establishment was slow to show concern for gay men and IV drug users, other so-called "marginal" people highly impacted by the AIDS crisis. There are as yet no effective programs for Asians and Native Americans, and some "minority outreach" programs within white AIDS groups inadvertently imply that the concerns of people of color are a lesser priority.

Increasingly, this situation is being remedied. A handful of projects have worked to promote education and awareness of AIDS within Black and Latino communities, such as the Minority Affairs division of the National AIDS Network in Washington, D.C., and the Minority AIDS Project in Los Angeles. These well-established programs have been joined in the last few years by other organizations run by and for people of color, including: Chicago Kupona Network, Spectrum AIDS Project in Washington, D.C., Blacks Educating Blacks About Sexual Health Issues (BEBASHI) in Philadelphia, and San Francisco's Black Coalition on AIDS.

Activists from these and other groups have been instrumental in creating and sustaining the NMAC, an organization that came together following the first national "AIDS in the Black Community" conference in July 1986, sponsored by the National Coalition of Black Lesbians and Gays (NCBLG). The idea for NMAC had originated about six months earlier, when a group of AIDS professionals met under the auspices of the National Institute of Mental Health (NIMH) to discuss improving coordination among those working to combat AIDS in communities of color. Since then, NMAC has evolved, coalition-style, into a non-profit advocacy and educational group concerned with both local organizing and national leadership. The group established a national office in D.C. last July.

A recent bulletin distributed by the NMAC states, "A leadership focus is desperately needed to excise the myth that 'AIDS is a white gay male disease,' and to release the untapped human and material resources of minority communities that have been used against past threats and could be used now to fight the continued expansion of the epidemic."

Don Edwards, executive director of NMAC, explains, "We are raising consciousness about the status of health concerns of Blacks and other minorities. We need organizations run by people of color... If a person is Black or Latino, they're going to grant a lot more authority to a program that has their needs as a number one priority. We need institution-building among people of color. Institutions form the fiber for the process of community empowerment."

Amanda Houston-Hamilton, chair of San Francisco's Black Coalition on AIDS, says her organization brings together Black people with AIDS and others working to fight the disease. Houston-Hamilton states, "Organizations need to be more integrated than they are. There's also a need for groups limited to people of color — it's important to get away from focusing on other people's agendas."

Other activists stressed the importance of working within general AIDS groups to ensure accountability. Paula Johnson, co-chair of the Multicultural Concerns Committee of Boston's AIDS Action Committee (AAC), says, "We try to play a major role in decision-making and in shaping the focus of AAC so it always bears in mind the diversity of people affected by the disease. We want to make sure that people of color receive an equitable share of AAC's resources and finances."

Johnson explains that the Multicultural Concerns Committee has struggled to show that IV drug use is not the only mode of AIDS transmission among people of color, and to raise awareness of gay issues. Similarly, the NMAC reports a special focus on people of color most affected by AIDS: women, gay or bisexual men and IV drug users.

According to Edwards, the formation of NMAC has forced the government to fund an otherwise underrepresented constituency. "By organizing a national effort," he says, "we've helped local groups gain visibility. Our position as a leadership and advocacy group has ensured that people of color have a voice in Washington pushing for a comprehensive response to AIDS."

NMAC describes its goal as follows:

"It is a vision of responsibility — of people of color responding to a life-threatening crisis from a historic tradition of self-reliance and self-care.

"It is a vision of creativity — of long experience using meager human and material resources creatively, efficiently and effectively.

"It is a vision of determination — of organizing to make positive change occur in the promotion of personal and community health consistent with the protection of human and civil rights.

"It is a vision of spirit — of Black, Latino, Asian and Native American people drawing on the life force which has sustained them through other trials and tribulations to overcome adversity."

The following is a partial listing of AIDS organizations run by and for people of color. For further referrals contact NMAC at (202) 544-1076.

National Minority AIDS Council
714 G Street S.E.
Washington, D.C. 20003
(202) 544-1076

Minority Affairs Division
National AIDS Network
1012 14th Street N.W.
Washington, D.C. 20009
(202) 347-0390

Spectrum — See the Light
Koba Associates
1156 15th Street N.W.
Washington, D.C. 20005
(202) 775-1770

Minority AIDS Project
c/o Carl Bean
5882 W. Pico Blvd.
Los Angeles, CA 90019
(213) 936-4949

Black Coalition on AIDS
P.O. Box 11908
San Francisco, CA 94103
(415) 822-7228

Third World AIDS Advisory Task Force
c/o San Francisco AIDS Foundation
54 10th Street
San Francisco, CA 94103
(415) 864-4376

Minority Task Force on AIDS
92 St. Nicholas Ave., Suite 1-B
New York, NY 10026
(212) 749-2816

Multicultural Concerns Committee
AIDS Action Committee
661 Boylston Street
Boston, MA 02116
(617) 437-6200

Kupona Network
P.O. Box 11493
Chicago, IL 60611
(312) 235-6123

BEBASHI
1319 Locust Street
Philadelphia, PA 19107
(215) 546-4140 □

BLACK PWAs TELL STORY ON VIDEO

reviewed by Dwight McGhee, with thanks to Boston's Gay Community News, 2/21-27/88

"Being Black in America has always had its special challenges. AIDS is the latest of these." So states Paul Berry, the host *AIDS in the Black Community* (*ABC*), a comprehensive two-hour documentary. The first hour features several Black PWAs discussing the impact of AIDS on their lives. In the second hour of the program, originally aired on cable's Black Entertainment Television, Berry hosts a panel discussion.

You have probably never heard as much frank talk or seen as many images about being Black and gay as are shown in *ABC*. The program is an important first step toward breaking down some of the language barriers that have made education about AIDS a real challenge among those of us who are Black and part of other "alienated communities." As the show states, we must get over these hang-ups about what being a "man" is and get rid of our own stereotypes about who is and isn't gay, so we can talk about this problem openly. One of the participants in the documentary points out, "A lot of Black men are deluding themselves into thinking they're not homosexual or bisexual, even though they are having sex with other men. They're not 'gay,' but sure, they've 'popped some sissies.' "

AIDS in the Black Community makes it clear that not only do Black people have to deal with our own stereotypes, but with racism in the larger society. Andre, a PWA in the documentary, says, "I was one of the first Black persons with AIDS in San Francisco to start going to the agencies, and I had to fight tooth and nail for everything I got." Of course services vary from city to city, but *ABC* reveals that their availability also varies according to one's race and class.

Not only are the service groups unresponsive; often the PWA's families and friends lack understanding. "I can't express the sadness, the loneliness, the fear and rejection," said a woman ex-prisoner speaking of her family. "The rejection hurts the most."

The most visible presence of Black women in the program is in a very intense youth education session. The point that comes home here is that even when we know the facts about AIDS transmission, when faced with a "passionate" scene they may well be forgotten. The females, however, had the sense to be more concerned about safer sex than did the image-conscious young males.

ABC also discusses the difficulty of finding homes for babies born with AIDS. Foster care for Black children in general is scarce, scarcer yet for those with AIDS.

All of the above is discussed in the first hour by Black PWAs — all male except one, and their friends and service workers — which of course include many women. The second hour of the documentary is a panel discussion among several people, including a PWA, Black AIDS educator Billy Jones, a representative from the Reagan administration Department of Health and Human Services ("the highest placed Black woman in the administration"), and a few doctors. They discuss at length the transmission and prevention of AIDS, but have little to say about the lack of treatment. Their discussion brings home the political nature of emphasizing "at risk groups" rather than "at risk behaviors." Also included is a very explicit and entertaining demonstration of the use of condoms and talk of how the TV networks have refused to allow this material to be shown.

The panel raises the issue of who should be in control of AIDS education monies — the feds or local communities. Billy Jones speaks strongly in favor of community control, of the importance of "speaking the language" of the various "alienated" people — Blacks, gays, IV drug users, teenagers and prisoners, for example. A frank discussion ensues about how common it is for young Black men to spend some time in prison, and about the need to do AIDS education while they are imprisoned and having a lot more sex and drugs than the authorities ever admit.

The Department of Health and Human Services apparently has the rights to this comprehensive program, and has no plans to rebroadcast it. The Administration's foot-dragging in the AIDS education effort is all too apparent; not making *ABC* more available is just another example. Perhaps some "popular demand" would help. Write Madeline Lawson, 200 Independence Ave., SW, Rm. 640D, Washington, D.C. 20201 or call her at (202) 245-6221 for more information. Free copies of *ABC* are available from the above address. □

CONDOM GIVEAWAY IN NEWSPAPER

with thanks to Chicago Outline, 6/11/87

The Boston Phoenix, an alternative weekly newspaper, distributed a "safer sex" guide and condom in each copy of its paper recently, as did the Harvard Perspective, a student-run newspaper. In New York, a team from the City Department of Health will give out free condoms at singles bars, pornographic movie theaters, massage parlors and sex clubs throughout the city in 1987 to warn of the dangers of casual sex.

BLACK EDUCATION: SPEAKING LANGUAGE, STREET OUTREACH

by Chris Bull & Billy Jones, with thanks to Boston's Gay Community News, 2/21-27/88

Billy Jones is a health educator with the Whitman-Walker Health Clinic in Washington, D.C. He provides education to "alienated communities and subcultures" — populations he says are "observed from afar by society." Incarcerated populations, which include prisoners in detention centers, jails, community correctional centers, pre-release and work furlough programs, IV drug users, prostitutes and transpersons, including crossdressers, transsexuals, transvestites, gender fucks and male and female impersonators, are often looked at from a theoretical rather than personal perspective by health care professionals, leaving these groups without proper health care and AIDS information. Jones also works with gay and bisexual men who engage in high-risk sexual activity. He says the most effective and innovative AIDS education programs are "street outreach" projects, where outreach workers share their personal experiences with people on the streets. As a gay Black man and "ex-con," Jones has earned a reputation as an innovative educator, reaching out to previously ignored and stigmatized populations.

Bull: From your work with alienated communities and subcultures, is it possible to estimate the extent of the AIDS epidemic in these communities?

Jones: It is our belief that the rate of infection is pretty high in every subculture. What we are talking about is subcultures that are indeed involved in high-risk practices. Most groups have multiple risk-factors through sharing works and participating in parts of the commercialized sex industry. What we are also taking about are communities where not a great deal of education has been directed, subcultures that are stigmatized, misunderstood, typecast and feared. These are subcultures people would really prefer not talking about. And the reason the government, mainstream society and professionals are dealing with them at all is because they perceive the only way to protect mainstream society is to deal with fringe communities. And even then, the response is to arrest, test and isolate.

Bull: Explain the methods you use to identify and educate alienated communities. Where do you find them and how do you get them to practice safe sex and use clean needles?

Jones: Well, with gay men we identify cruise areas and what goes on in them. Cruising per se does not put them at risk, but when it is clear that they are not practicing safe sex, we must have non-threatening intervention by people who understand the cruise techniques. We can playfully but responsibly intervene. We can say that sucking cock is OK, but that tools such as condoms are necessary. People must be taught to take lubricants and condoms along when they leave home just like you would never go out without your wallet. When we deal with prostitutes we must make it clear we are not dealing with a moral issue. We should respect them professionally. We remind them about the deadly virus and give them tools while listening and encouraging. Or when we go into shooting galleries it is best to know the leaders and their body and verbal language. Many on the street see us as their friends — as their advocates. Sometimes they even warn us about cops and jump outs — when police arrest everyone in a certain area. We have built up respect and rapport. We work through the trust factor.

Bull: How accessible to alienated communities are AIDS treatments, services and education?

Jones: They are available, on a surface level, but not particularly utilized. They are often introduced only when politics or media or funding sources ask why education and services are not in place. Otherwise, the status quo would rather not rock the boat. And even when the boat is rocked, it is addressed on a very superficial level to appease the media. Unless someone is closely monitoring the programs that are proposed in terms of quality, effectiveness and outreach, then they die by the wayside. For example, in a prison setting, prison authorities put their best foot forward when you come in to visit. But once you leave it goes back to the same old situation. Prison administrators claim to show AIDS education videos but they show them at three, four and five in the morning, waking people up to watch them. And then when I come in to talk about the videos all they want to do is go back to sleep. Also, HIV testing in prisons is confidential, but there is no one making sure of this. A prisoner jacket [file] may have AIDS written all over it. Guidelines are set but no one has tested or worked through them.

On the streets, top police officials assure us we have their cooperation in distributing bleach and condoms. But this is often not communicated to local precincts, who refuse to cooperate. They see store fronts we set up to distribute bleach as attracting drug users. They see users congregating there and then they make our jobs more difficult. What happens at the top is not same as what happens at the bottom.

Bull: How does governmental and societal opposition to using sexually explicit language inhibit AIDS education in alienated communities?

Jones: There is a part of me that would say it does not. The real problem is that institutions (drug treatment and correctional facilities) that are supposed to be rehabilitating people, providing skills to people, helping people recover, are not taking a wholistic approach to the individuals' well-being. Detention centers do just that. They detain people, but they do not help people cope when they go back into society. Drug treatment programs are often not effective because they are not innovative enough — not providing people skills to deal with the real world. If we have quality educational programs I do not feel the literature has to use the crude language of the street. In fact it is an ideal opportunity to teach people a new language. There are times when using street terms makes sense, but that is different from using profanity or degrading terminology. Every culture has its own language. I use a different language with my gay friends than with the Black people in my neighborhood. We need to understand the similarities and differences of the various cultures and improve communication between them and ourselves. The test of your acceptance in a subculture is when they give you a different name from your own. On the streets, people speak in codes, especially about drugs.

This is a society that is uptight about sex, relationships and intimacy. That hinders addressing the AIDS crisis. And what people are saying about sex and what they are doing are not necessarily the same. Overall we have to come to the conclusion that since we live in a society of diverse communities and cultures, we must come up with a pluralist, and creative approach to bring us all to the same place — a place where we can all protect ourselves from a deadly virus. For example, if I want to get across the message, I may say something really crude but basic. "To the same extent that you would never think about sharing toilet paper or sharing a sanitary napkin, you must never share a needle." And there are always silences and pauses. It so grosses them out that they can't even comment, but they get the message.

Bull: Many mainstream health educators are promoting monogamy or abstinence as the primary means of avoiding infection. How can AIDS education be addressed in a sex-positive manner?

Jones: I don't think it is appropriate to be scaring people about sexuality issues. I don't want to retrogress where people are neurotic and frigid and men are impotent and whenever sex comes up they think of disease and death and dying. We have to do it in a positive way, but also by getting people to be responsible. When we are talking about sex we are talking about pleasure, and value systems vary from group to group. But again, there is no one message for the Black community or for the religious community or the women's community or the gay community. We need to try multiple approaches. We have to keep changing the messages because people change, and sexuality changes. We must keep up with the times and the cultures we are working with.

Bull: What do you think about the way government has addressed the health care needs of alienated communities?

Jones: I am concerned about the government's focus on alienated populations. Some of it is very good. I mean who would have ever thought that an agency such as the National Institute of Drug Abuse would be advocate sterilizing works with bleach? What makes me nervous is when I hear that what is attached to these programs is registering treatment programs. I don't trust the government to register people. At some point someone is going to say, "OK, we have to round these people up and quarantine them." We need to be careful about expecting the government to be the leader in developing messages and programs. I would much rather see community-based programs, and private fundraising efforts — keeping the government out of it. Look at all the money the presidential candidates are spending. Where did they get that money? Where do these religious fanatics get their money from? They get much of their money from grassroots people. They yell and scream and pass the plate and we have to do the same thing. If we get dependent on government funds, then they start dictating what you can and can't use the money for. It doesn't bother me when someone criticizes a pamphlet for having cocks on it or whatever, what bothers me is when they also control the purse strings.

Bull: Would you talk about how the criminal justice system and incarcerated populations are ignored by the lesbian and gay community?

Jones: Society as a whole is conditioned to believe that everyone that is incarcerated deserves to be. And often it is a way of getting people we do not want to deal with out of sight — out of sight, out of mind. And once they are there we don't deal with them. The criminal justice system has been almost a total failure in rehabilitating people. The gay community fails to make the linkage with gays and non-gays who find themselves incarcerated for crimes that should not be crimes. Substance abuse, for example, is a medical problem, not a criminal one. We accept laws against prostitution without challenge. We are often not making the connections or addressing the roots of the problem.

The gay and lesbian movement has often been single-issue rather than addressing multiple movements and common oppression. After all, sodomy laws make gay people criminals in many states. If at some point there was to be a crackdown and they began to round people up, as the Supreme Court's *Hardwick* decision, which upheld Georgia's sodomy law, allows, it would demonstrate how fragile we all are. The history of the gay and lesbian community, "the movement" as we call it — whether it be the Mattachine movement or Stonewall — has focused on trying to convince everyone that we are just like everyone else, dealing with professional groups and dealing with professional society. As long as people don't identify themselves with the incarcerated population, then they tend not to get involved in issues that directly affect incarcerated people. I don't know what it takes to get our movement to realize that there are a significant number of gay and lesbian people that are incarcerated and should not be. Our community does not in any way help those people get back into society or to look after them while detained.

Bull: How do prejudices that exist in society — classism, racism, sexism and homophobia — inhibit efforts to educate people about AIDS?

Jones: The "isms" are clear blocks to effective education and services. We have to continue to sensitize people to different lifestyles; we have to remain out of our closets as who we are. We can't stifle diversity. If anything we must be much more adamant. For example, the gay and lesbian community is serving as a role model for many to follow by showing that a community can respond to a crisis. But I am still hearing a lot of resistance to the gay community, from private and government agencies wanting to cut the gay community out of educational efforts. Many people are only now getting involved in providing AIDS services only because they see money, forcing community-based efforts out. We have been put in a situation where we are competing for the same funds, instead of looking for new funding sources. Many groups should have a part of the pie to complement one another, but some groups want the entire pie. I see consulting firms getting involved that have not even bothered to sensitize themselves about AIDS, they are out only to make a buck.

Society wants to push minorities out of the way. And what is happening is that minorities of all types — sexual and racial — that find themselves vulnerable to the virus are finding there are many issues connecting them in terms of their oppression. And the only solution is to pull together. Racial minority communities especially need to empower themselves and be supported by existing organizations to take some leadership in health issues. Minorities must address the AIDS crisis within the minority communities. Unfortunately, people are dumping some limited funding into these communities and then saying "Well, that's it, it is their problem now." That is not enough. Agencies with the best resources must be willing to also provide technical assistance to community-based groups. And existing non-minority organizations also must take responsibility to address minority communities. The fact that there are minority agencies doing minority work does not mean that mainstream organizations do not have to help. Many minorities cross over. Some Blacks identify with the gay community, for example. Again it gets back to a multiple approach and communities and organizations supporting one another, rather than competing with each other. ❙❙

MMWR COVERAGE

Reprints of several MMWR articles on sexually transmitted diseases, and HIV/AIDS are reprinted on the following pages. Three supplements have not been reprinted due to their size: *>"Human Immunodeficiency Virus (HIV) Infection Codes Official Authorized Addendum ICD-9-CM (effective 1/1/88)" MMWR, 36:S-7, 12/25/87, 20 pp. *>"Guidelines for the Prevention and Control of Congenital Syphilis," MMWR, 37:S-1, 1/15/88, 13 pp. *>"Guidelines for Effective School Health Education to Prevent the Spread of AIDS," MMWR, 37:S-2, 1/29/88, 14 pp. *>"1988 Agent Summary Statement for Human Immunodeficiency Virus and Report on Laboratory-Acquired Infection with Human Immunodeficiency Virus," MMWR, 37:S-4, 4/1/88, 22 pp. To obtain these supplements, contact your nearest medical, hospital, or municipal library, your municipal or state health department, or the Centers for Disease Control directly (404/639-3311).

CENTERS FOR DISEASE CONTROL

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

April 1, 1988 / Vol. 37 / No. 12

Recommendations of the Immunization Practices Advisory Committee (ACIP)

Immunization of Children Infected With Human Immunodeficiency Virus – Supplementary ACIP Statement

The Immunization Practices Advisory Committee (ACIP) recently reviewed data both on the risks and benefits of immunizing children infected with human immunodeficiency virus (HIV) (*1*) and on severe and fatal measles in HIV-infected children in the United States (*2*). Since this review, the committee has revised its previous recommendations for measles vaccination and for mumps and rubella vaccination.

Previously published ACIP statements on immunizing HIV-infected children have recommended vaccinating children with asymptomatic HIV infection, but not those with symptomatic HIV infection (*3*). After considering reports of severe measles in symptomatic HIV-infected children, and in the absence of reports of serious or unusual adverse effects of measles, mumps, and rubella (MMR) vaccination in limited studies of symptomatic patients (*4,5*), the committee feels that administration of MMR vaccine should be considered for all HIV-infected children, regardless of symptoms. This approach is consistent with the World Health Organization's recommendation for measles vaccination (*6*).

If the decision to vaccinate is made, symptomatic HIV-infected children should receive MMR vaccine at 15 months, the age currently recommended for vaccination of children without HIV infection and for those with asymptomatic HIV infection. When there is an increased risk of exposure to measles, such as during an outbreak, these children should receive vaccine at younger ages. At such times, infants 6 to 11 months of age should receive monovalent measles vaccine and should be revaccinated with MMR at 12 months of age or older. Children 12-14 months of age should receive MMR and do not need revaccination (*7*).

The use of high-dose intravenous immune globulin (IGIV) (approximately 5 gm% protein) administered at regular intervals is being studied to determine whether it will prevent a variety of infections in HIV-infected children. It should be recognized that

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CENTERS FOR DISEASE CONTROL

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

December 18, 1987/Vol. 36/No. 49

Human Immunodeficiency Virus Infection in the United States

The following report summarizes the review of current knowledge on human immunodeficiency virus (HIV) infection in the United States that was presented to the Domestic Policy Council. The review was conducted during the period September-November 1987, by CDC in conjunction with the National Institute on Drug Abuse of the Alcohol, Drug Abuse, and Mental Health Administration and the National Institutes of Health. Although the various studies reviewed differ in design and cannot be precisely compared, the review yielded a description of the approximate patterns and trends of HIV infection in this country.

Background

Over 46,000 cases of acquired immunodeficiency syndrome (AIDS), which is a result of HIV infection, have been reported to CDC since 1981. The mean interval between infection with HIV and the onset of AIDS exceeds 7 years. Thus, information on the number of currently infected individuals (prevalence) and the rate at which new HIV infections occur over time (incidence) is vital to monitoring the progression of the HIV epidemic.

Transmission of HIV infection can be slowed or halted by reducing or eliminating the behaviors that place individuals at risk for acquiring the infection. Better and more extensive information is essential for targeting and evaluating control and prevention efforts at local and state levels, for predicting future health-care needs, and for understanding where the HIV/AIDS epidemic is headed. Surveillance of the prevalence and incidence of HIV infection through continually monitoring sentinel populations, expanding focused seroprevalence studies, and developing models to help interpret the data remains a critical element of the nation's response to this major public health crisis.

HIV Infection in the United States

Infection Among Groups at Recognized Risk. Observed prevalence of infection remains highest in those groups that account for the vast majority of AIDS cases. In 50 studies throughout the country, seroprevalence among homosexual and bisexual men has ranged from under 10% to as high as 70%; however, most findings have been between 20% and 50%. In 88 studies of intravenous (IV) drug abusers, HIV antibody prevalence has ranged from 50% to 65% in the New York City vicinity and Puerto Rico to rates that, although varied, have been mostly below 5% in areas other than the East Coast.

HIV antibody prevalence among persons with coagulation disorders requiring clotting factor concentrates (hemophiliacs) has varied according to the type and

severity of the disorder. The overall prevalence among hemophilia A patients has been approximately 70%; for hemophilia B patients, it has been 35%. These rates appear uniform throughout the country and reflect the national distribution of clotting factor concentrates.

The prevalence of HIV infection among regular heterosexual partners of infected persons has ranged from under 10% to 60%. Among partners of those who are at risk but whose HIV status is unknown, the prevalence has generally been under 10%.

Infection Among Groups Within the General Population. In selected groups within the general population—blood donors, civilian applicants for military service, Job Corps entrants, sentinel hospital patients, and women seen in family planning and other women's health clinics—the prevalence of HIV infection has generally been a fraction of 1%. However, seroprevalence rates have varied considerably and have been found to be much higher among selected inner city populations.

Persons at increased risk for HIV infection are asked not to donate blood; therefore, the prevalence and incidence rates of donor groups underrepresent the actual rates in the population. The overall prevalence of HIV antibody among Red Cross blood donors who have not been previously tested has averaged 0.04%. Applicants for military service, who underrepresent persons in the principal risk groups for HIV infection, have had a crude HIV antibody prevalence of 0.15%, which, when adjusted to the age, sex, and racial composition of the 17- to 59-year age group of the U.S. population, is 0.14%. Job Corps entrants (disadvantaged youths 16 to 21 years of age) have had a prevalence of 0.33%. Patients without AIDS-like conditions who have been tested anonymously at four sentinel hospitals have had a prevalence of 0.32%; the sex- and age-adjusted prevalence for military applicants from the same cities has been 0.11%.

Childbearing women in Massachusetts who were tested anonymously through filter-paper blood specimens from their newborn infants had an HIV antibody prevalence of 0.21%. Female applicants for military service from the same state have had a prevalence rate of 0.13%. The findings from surveys in women's health clinics have ranged from 0 to as high as 2.60% positive.* The higher prevalences have occurred in areas where the incidence of AIDS is high among women.

HIV Antibody Prevalence by Geographic Location, Age, Sex, and Race or Ethnicity. The geographic distribution of HIV antibody prevalence among blood donors and applicants for military service and, to a limited extent, among homosexual men and IV drug abusers has been similar to the geographic distribution of AIDS cases (i.e., highest on the East Coast and West Coast and lowest in the northern Midwest and Mountain states). In addition, HIV antibody prevalence, like AIDS case incidence, has been greater in urban than in rural areas. Like AIDS cases, HIV infection among groups within the general population and among high-risk groups has been concentrated among young to early middle-aged adults and has consistently been more common among men and among blacks and Hispanics.

Heterosexuals. Information on the extent of HIV infection among persons who are exclusively heterosexual, do not use IV drugs, and have no known sexual exposure to persons at increased risk for HIV infection comes from two principal sources: 1) evaluation of the risk factors of seropositive blood donors and applicants for military service and 2) HIV surveys among heterosexuals attending sexually transmitted disease (STD) clinics.

*These surveys exclude pregnant drug users, whose prevalence reached nearly 30.0%.

Limited studies of the exposure risks of seropositive blood donors, military applicants, and active duty military personnel suggest that approximately 85% of such individuals have identifiable risks for HIV infection. If the risk factor data from these limited studies prove to be consistent in more extensive national studies, then HIV antibody prevalence levels in persons without acknowledged or recognized risks would be below 0.02% for military applicants and below 0.01% for blood donors. However, more extensive studies on risk factors are urgently needed, particularly in inner city areas where AIDS case surveillance data suggest that heterosexual HIV transmission occurs.

In limited studies in which the subgroup of heterosexuals at highest risk (those being treated for STD) have been rigorously interviewed and those who are seropositive have been reinterviewed, the prevalence of HIV infection has generally ranged from 0 to 1.20% for persons without specific, identified risk factors. By contrast, the prevalence of infection among homosexual men at the same clinics has ranged from 12% to over 50%.

HIV Infection Trends Over Time and the Incidence of New Infection. Much less information exists on the trends and incidence of HIV infection than on its prevalence, and such data are much more difficult to develop. In the two general population groups tested over time (applicants for military service and first-time blood donors) HIV antibody prevalence rates have remained stable for 2 years, although the prevalence among donors has fluctuated seasonally. Increased self-exclusion of persons who know that they either are at risk or are already infected may have contributed to this observed prevalence pattern. The apparent stability may reflect the competing effects of self-exclusion by infected persons and the continued occurrence of new HIV infections.

There is evidence that new infections continue to occur among blood donors, military personnel, and groups at increased risk. However, in some groups, the rate of new infection may have declined somewhat from the rates that prevailed in the early 1980s. This interpretation is supported by the following observations: 1) declines in incidence of new infections have been observed in eight cohorts of homosexual men (the current principal risk group); 2) the net seroprevalence among military applicants and donors no longer appears to be rising; and 3) serologic screening of blood products and heat treatment of clotting factor concentrates have significantly reduced new infection in transfusion recipients and hemophiliacs. However, insufficient trend and incidence data are available to evaluate recent patterns in IV drug abusers or heterosexually active persons or in local geographic areas such as the inner cities.

The HIV/AIDS epidemic is a composite of many individual, though overlapping, smaller epidemics, each with its own dynamics and time course. The incidence of new infection in certain subgroups may have declined somewhat; however, in the absence of specific information, incidence rates cannot be assumed to have declined in all subgroups or in all geographic areas. It is important that trends be monitored among the various groups at increased risk, with particular emphasis on the groups and settings in which the pattern of transmission may be changing (i.e., IV drug abusers and heterosexually active persons and in localized areas such as inner cities). Data are insufficient to determine precisely the overall trends and incidence of HIV infection.

In 1986, public health and medical specialists from within and outside the government were convened by the Public Health Service to develop a working estimate of the number of Americans with HIV infection. They estimated that between 1 and 1.5 million persons were infected. This conclusion was based on the estimated sizes of populations at risk and the estimated average seroprevalence values for those populations. Since then, this computation has been reexamined in light of recently available data; other data, on AIDS cases and disease progression, have been used to explore mathematical models. The resulting estimates vary widely, but they are consistent with the 1986 figures. The estimation of the total number of infected persons will remain complex and inexact. There is no substitute for carefully obtained incidence and prevalence data. Additional surveys and studies are needed to determine the current extent of spread of HIV through the population.

The full report on the review of HIV infection in the United States is being published as an *MMWR* supplement (Vol. 36, No. S-6) and will be dated December 18, 1987.

Epidemiologic Notes and Reports

Adult T-Cell Leukemia/Lymphoma Associated With Human T-Lymphotropic Virus Type I (HTLV-I) Infection — North Carolina

A case of adult T-cell leukemia/lymphoma (ATL) associated with human T-lymphotropic virus type I (HTLV-I) has been reported from North Carolina. The patient, a black adult male, developed jaundice in December 1986, after several weeks of anorexia, fatigue, and fever.

When admitted to the hospital, he had an enlarged liver, a serum bilirubin level of 15.5 mg/dL, and an SGOT level of 279 IU/L, but serologic tests for hepatitis B markers and hepatitis A antibody were negative. Ultrasound examination revealed no evidence of intra- or extra-hepatic obstruction. He was thought to have alcoholic hepatitis. During the next week, he became pancytopenic, and bone marrow biopsy revealed hypocellularity of all cell lines but no malignant infiltrates. He was given transfusions of red blood cells and platelets and was discharged in February 1987, despite continued clinical and laboratory abnormalities. The diagnosis upon discharge was resolving hepatitis.

In March 1987, the patient returned to the hospital because of abdominal pain, nausea, vomiting, and somnolence. Laboratory studies revealed a leukocytosis with abnormal lymphocytes, a calcium level of 20.5 mg/dL, and an amylase level of 1,209 IU/L. He was thought to have ATL with hypercalcemia and consequent acute pancreatitis. His condition deteriorated despite chemotherapy and treatment for hypercalcemia, and he died on March 22. Autopsy revealed leukemic infiltrates in the spleen, bone marrow, and kidneys. When peripheral blood mononuclear cells obtained before the patient's death were subjected to flow cytometric analysis, 95% of the cells were of the CD4+ (T-helper cell) phenotype. Antibodies against HTLV-I were detected in several serum samples by radioimmunoassay and by Western blot. HTLV-I was isolated from the man's peripheral blood lymphocytes.

The patient had served in the U.S. Army in South Vietnam, Korea, and Germany and had gone to North Carolina after discharge. He was divorced at the time of his illness. He had used intravenous drugs and had shared needles with a woman with whom he had had sexual contact for 2 years before his illness. He had never had a blood transfusion.

Serum specimens were obtained from 28 family members and sexual contacts of the patient. Five of these persons had antibodies against HTLV-I. They comprised the woman with whom the patient had had sexual contact and had shared needles, this woman's former husband, another former female sexual partner of the patient, the patient's sister, and the sister's daughter. None of these persons had lived outside the United States or had received blood transfusions, and none other than the woman with whom the index patient had shared needles were known to have used intravenous drugs.

A serosurvey of 245 attendees at sexually transmitted disease and family planning clinics in the county in which the patient had resided revealed no persons seropositive for antibody against HTLV-I.

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Editorial Note: HTLV-I, the first human retrovirus to be discovered, was first isolated and reported in the United States in 1980 (*1*) and in Japan in 1981 (*2*). Infection with HTLV-I, like infection with other retroviruses, probably occurs for life and can be inferred when antibody against HTLV-I is detected in the serum. Studies of HTLV-I antibody indicate that the virus is endemic in southern Japan (*3*), in the Caribbean (*4*), and in Africa (*5,6*).

HTLV-I infection in the United States appears to be rare. Although little serologic data exist, prevalence of infection is thought to be highest among blacks living in the Southeast (*7*). A prevalence rate of 30% has been found among black intravenous drug abusers in New Jersey, and a rate of 49% has been found in a similar group in New Orleans (*8*). It is possible that prevalence of infection is increasing in this risk group.

ATL is usually a highly aggressive non-Hodgkin's lymphoma with no characteristic histologic appearance except for a diffuse pattern and a mature T-cell phenotype. Circulating lymphocytes with an irregular nuclear contour (leukemic cells) are frequently seen. Several lines of evidence suggest that HTLV-I causes ATL. This evidence includes the frequent isolation of HTLV-I from patients with this disease and the detection of HTLV-I proviral genome in ATL leukemic cells (*9*). ATL is frequently accompanied by visceral involvement, hypercalcemia, lytic bone lesions, and skin lesions (*10*). Most patients die within 1 year of diagnosis.

ATL is relatively uncommon among those infected with HTLV-I. The overall incidence of ATL is estimated at about 1 per 1,500 adult HTLV-I carriers per year (*11,12*). Those cases that have been reported have occurred mostly among persons from the Caribbean or blacks from the Southeast (National Institutes of Health, unpublished data).

The presence in this investigation of family members and sexual contacts who are seropositive for HTLV-I is consistent with current knowledge concerning trans-

mission of HTLV-I infection. Transmission occurs from mother to child; by sexual contact; and through exposure to contaminated blood, either through blood transfusion or sharing of contaminated needles. The source of the patient's sister's infection is obscure. She and her brother may have acquired infection from their mother, who is deceased.

Because of the rarity of ATL in the United States and the potential for learning more about the transmission of HTLV-I in the United States, physicians who see adults with diffuse non-Hodgkin's lymphoma with at least two features consistent with ATL (abnormal lymphocytes on peripheral blood smear, T-cell phenotype of malignant cells, visceral involvement, hypercalcemia, lytic bone lesions, and skin lesions) are encouraged to report these cases through their local and state health departments to the Retrovirus Diseases Branch, Division of Viral Diseases, Center for Infectious Diseases, CDC, telephone number (404) 639-3091.

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Notices to Readers

Revision of HIV Classification Codes

CDC has updated the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes for human immunodeficiency virus (HIV) infection for use with United States morbidity and mortality data. The revised coding scheme is effective January 1, 1988. This scheme will allow public health officials, clinical researchers, and agencies that finance medical care to accurately monitor HIV diagnoses on death certificates and medical records. The codes appear in the *MMWR* supplement dated December 25, 1987, and entitled "Human Immunodeficiency Virus (HIV) Infection Codes, Official Authorized Addendum, ICD-9-CM (Revision No. 1)."

Copies of the supplement (*MMWR*, Vol. 36, No. S-7) may be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, telephone (202) 783-3238, or from MMS Publications, C.S.P.O. Box 9120, Waltham, Massachusetts 02254, telephone (617) 893-3800.

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Current Trends

Update: Serologic Testing for Antibody to Human Immunodeficiency Virus

Tests to detect antibody to human immunodeficiency virus (HIV), the virus that causes acquired immunodeficiency syndrome (AIDS), were first licensed by the Food and Drug Administration (FDA) in 1985, primarily as screening tests for blood and plasma donation. Since that time, millions of HIV antibody tests have been performed in laboratories of blood and plasma collection centers, in counseling and testing centers, and in clinical facilities as well as for purposes such as screening active duty military personnel and applicants for military service. Assuring accurate test results requires continued attention to both the intrinsic quality of the tests and the performance of the technical personnel doing the tests.

Given the medical and social significance of a positive test for HIV antibody, test results must be accurate, and interpretations of the results must be correct. For these reasons, the Public Health Service has emphasized that an individual be considered to have serologic evidence of HIV infection only after an enzyme immunoassay (EIA) screening test is repeatedly reactive* and another test such as Western blot (WB) or immunofluorescence assay has been performed to validate the results (*1*).†

*The terms "reactive" or "nonreactive" are used to describe serum or plasma specimens that give reactive or nonreactive test results and to describe the test results from EIA or WB tests before final interpretation. The terms "positive" and "negative" are used to describe the interpretation of EIA test results indicating that the specimen tested is 1) repeatedly reactive (positive) or 2) nonreactive or not repeatedly reactive (negative). The terms "positive," "indeterminate," and "negative" are used to describe the interpretation of WB test results that indicate that the specimen tested is reactive with a specific pattern of bands (positive), reactive with a nonspecific pattern of bands (indeterminate), or nonreactive (negative).

†Blood and plasma are not accepted for transfusion or further manufacture when the EIA screening test is positive, regardless of the results of other tests that may be performed.

Licensed test kits currently available in the United States for HIV antibody testing comprise seven EIAs and one WB. All of these tests use HIV antigens derived from disruption of whole virus cultured in human-derived cell lines. In addition, many laboratories produce their own WB test reagents using viral antigen purchased from commercial sources. A variety of other test procedures are in use or under development or are being evaluated for licensure.

Criteria for interpretation of a reactive anti-HIV EIA test are based on data from clinical studies performed under the auspices of each manufacturer. Since licensure of the first EIA test kits in 1985, the manufacturers have worked to improve the sensitivity, specificity, and reproducibility of their assays.[§] Clinical data submitted by the manufacturers to FDA for licensure indicate that the sensitivity and specificity of the EIA tests currently marketed in the United States are >99.0%. Other laboratories performing comparative analyses of licensed anti-HIV EIA test kits have found similar or slightly lower sensitivity and specificity (*2-5*). In routine use, both the sensitivity and specificity of the tests depend on the quality of testing in the laboratory. In addition, false-positive test results are observed when nonspecific serologic reactions occur among uninfected persons who have immunologic disturbances or who have had multiple transfusions. False-negative test results are observed among persons who have recently become infected with HIV and who have not yet developed detectable antibody (*6*).

Repeating each initially reactive EIA test increases the specificity of the test sequence by reducing the possibility that technical laboratory error caused the reactive result. In the American Red Cross Blood Services laboratories, a specificity of approximately 99.8% has been consistently achieved during screening of donated blood (*7*, unpublished data). However, in a population with a low prevalence of infection, even a specificity of 99.8% does not provide the desired predictive value[¶] for a positive test. For this reason, it is particularly important not to rely solely on EIA testing to determine whether a person is infected with HIV. Rather, EIA test results should be validated with an independent supplemental test of high specificity conducted by a laboratory with high performance standards. In the United States, the validation test used most often is the WB. Some laboratories also use radioimmunoprecipitation assays and indirect immunofluorescence assays.

For the licensed WB test, interpretation of reactive and nonreactive tests is based on data from clinical studies submitted to FDA for licensure. The manufacturer states that, for a test to be considered positive with this WB, antibody must be reactive with multiple virus-specific protein bands, i.e., p24, p31, and either gp41 or gp160 (Table 1). If fewer bands are present, the test is considered indeterminate; it is interpreted as negative only if no bands are present on the blot. When the manufacturer's stringent criteria are used for interpreting test results, the probability of either a false-positive or a false-negative result is extremely small. In clinical trials for licensure of this WB, however, as many as 15% to 20% of tests on persons at low risk for HIV infection were described as indeterminate. Sera from persons recently infected with HIV also may produce an indeterminate WB pattern. For such persons, a repeat WB on a second specimen obtained after the initial specimen often yields a positive blot pattern within 6 months. Conversely, follow-up testing of uninfected persons whose serum had an indeterminate blot pattern on initial testing usually will show no change in the banding pattern. Serum from some HIV-infected persons who have advanced immunodeficiency may have an indeterminate pattern because of a loss of antibodies to non-*env* proteins (*8*). To reinstate donors with a history of a positive EIA test, blood and plasma centers may use only results from the licensed WB test performed in the FDA-approved test sequence.

The performance characteristics of the unlicensed tests used by many laboratories, whether WB, immunofluorescence assays, or other procedures, have not been uniformly subjected to the same rigorous scrutiny required for licensure by FDA. Recommendations for standardization have been published (*9*), but the extent to which these are followed is unknown. Information about production standards, inter-lot variability, or validation of criteria used for interpretation often is not available. Absence of standardization and appropriate quality controls may result in a lower sensitivity or specificity and, thus, a higher probability of inaccurate results (*10*).

Despite the existence of a licensed WB test, many laboratories continue to use unlicensed WB tests because of cost and the stringent criteria required for interpreting the licensed test. The potential problems in using and interpreting unlicensed WB tests have been openly debated (*11,12*). Although unlicensed WB tests can be highly accurate and reproducible when done with appropriate quality controls in laboratories with established performance standards (*9*), not all laboratories meet acceptable performance standards. Ten of 19 laboratories bidding for contracts to perform WB tests for the Department of Defense failed the required proficiency panel on one or more occasions (*13*). Two of the laboratories satisfying the performance standards were awarded contracts by the U.S. Army. Both of these laboratories use well-validated techniques for WB that yield virus-specific bands at p17, p24, p31, gp41, p53, p55, and p64. The U.S. Army considers these WBs to be positive if bands are present either at gp41 or at both p24 and p55 (*14*). In comparison with multiple

TABLE 1. Description of major gene products of human immunodeficiency virus (HIV)

Gene Product*	Description
p17	*gag*[†] protein
p24	*gag* protein
p31	Endonuclease component of *pol*[§] translate
gp41	Transmembrane *env*[•] glycoprotein
p51	Reverse transcriptase component of *pol* translate
p55	Precursor of *gag* proteins
p66	Reverse transcriptase component of *pol* translate
gp120	Outer *env* glycoprotein
gp160	Precursor of *env* glycoprotein

*Number refers to molecular weight of the protein in kilodaltons; measurement of molecular weight may vary slightly in different laboratories.
[†]*gag* = core.
[§]*pol* = polymerase.
[•]*env* = envelope.

[§]Sensitivity is the probability that the test result will be reactive if the specimen is a true positive; specificity is the probability that the test result will be nonreactive if the specimen is a true negative; and reproducibility (reliability) is the ability to replicate qualitative results with the same or similar test procedures on blindly paired samples.
[¶]The predictive value of a positive or negative test is the probability that the test result is correct.

validation procedures, WBs in these contract laboratories have an estimated specificity of 99.4%, and the laboratories have consistently performed accurately on all pre- and post-award quality assurance serum panels (*14*). These and other laboratories have demonstrated that the achievable false-positive rate of sequentially performed EIA and WB tests can be <0.001% (<1/100,000 persons tested) (*13,15*).

The College of American Pathologists (CAP), in conjunction with the American Association of Blood Banks, conducts an open proficiency testing program** for laboratories performing HIV antibody tests. Each quarter, more than 600 laboratories that participate voluntarily report results from testing five coded samples of plasma that have various known levels of anti-HIV reactivity or that are nonreactive.

In the CAP survey conducted in October 1987, the results of EIA tests at the participating laboratories correlated well with results from the referee laboratories (Table 2). For the three reactive samples (W-21, W-23, W-24), correlation ranged from 99.5% to 100%. For the single nonreactive sample that could be adequately evaluated (W-25), correlation was 98.3%. The nonreactive W-22 sample that was sent with the October 1987 serum panel had been prepared with a pool of processed plasma that caused an unexplained, nonspecific reaction with one of the EIA test kits. Consequently, the EIA results for this sample could not be evaluated.

The individual participating laboratories used their own criteria for interpreting WB results. WB results for two of the three reactive specimens were reported as indeterminate by one referee laboratory each, while results for the two nonreactive specimens in the CAP survey were reported correctly by all 10 referee laboratories (Table 3). One of the 73 participating laboratories reported a nonreactive sample (W-22, the sample that gave artifactual reactions with one of the EIA test kits) as reactive, while approximately 5% reported the two nonreactive samples as indeterminate, and 12% to 15% reported two of three reactive specimens as indeterminate.

For the three reactive samples, the results of 241 repeatedly reactive EIA tests could be compared with WB results (Table 4). For 215 (89.2%) of these, the WB tests were reported as positive; for 23 (9.5%), the WBs were reported as indeterminate; and, for 3 (1.2%), they were reported as negative. Of 58 WB results performed on nonreactive samples found nonreactive by EIA, 55 (94.8%) were reported as negative by WB, and 3 (5.2%) were reported as indeterminate. None of the nonreactive samples were read as positive by WB.

Because criteria used to interpret WB varied by laboratory, banding patterns reported in the 299 WB tests conducted in the October 1987 survey were examined (Table 5). Two or more virus-specific protein bands were reported in 215 blots, 208 (96.7%) of which were interpreted as positive. Eighteen (60.0%) of 30 blots with only a single virus-specific protein band were considered positive. When the single protein band was from the *env* gene, 12 (85.7%) of 14 were read as positive. These data demonstrate that different laboratories may report different WB results for samples with the same banding patterns.

Results of CAP proficiency tests from more than 500 laboratories participating in the 1986 and 1987 surveys indicate the following performance for the anti-HIV EIA test. Of 6,946 tests on reactive samples, 99.5% were reported as positive. Of 1,142

**The laboratories know that the samples have been supplied for proficiency testing.

TABLE 2. Comparison of responses by referee and participant laboratories on samples tested for anti-HIV by enzyme immunoassay (EIA), by sample number — College of American Pathologists Proficiency Testing, 1987

Sample Number	Reactivity	Percentage of Laboratories Reporting Correct Result	
		Referee Laboratory*	Participant Laboratory†
W-21	Reactive	100.0	99.8
W-22§	Nonreactive	80.0	51.4
W-23¶	Reactive	100.0	99.5
W-24¶	Reactive	100.0	100.0
W-25	Nonreactive	100.0	98.3

*Results reported by 15 laboratories selected because of extensive experience and excellent long-term performance in proficiency testing programs.
†Results reported by 601 other laboratories that voluntarily participated.
§Sample W-22 was prepared with a pool of processed plasma that caused an artifactual, nonspecific reaction with one EIA test kit.
¶Samples W-23 and W-24 were identical.

TABLE 3. Comparison of responses on samples tested for anti-HIV by Western blot (WB) by referee and participant laboratories,* by sample number — College of American Pathologists Proficiency Testing, 1987

Sample Number	Reactivity	Interpretation of WB Test Results (Percentage of Responses)					
		Positive Test		Indeterminate Test		Negative Test	
		Referee Laboratory	Participant Laboratory	Referee Laboratory	Participant Laboratory	Referee Laboratory	Participant Laboratory
W-21	Reactive	100.0	100.0	0.0	0.0	0.0	0.0
W-22	Nonreactive	0.0	1.6	0.0	4.9	100.0	93.4
W-23	Reactive	90.0	80.8	10.0	15.1	0.0	4.1
W-24	Reactive	90.0	84.9	10.0	12.3	0.0	2.8
W-25	Nonreactive	0.0	0.0	0.0	5.6	100.0	94.4

*Results reported by the 10 referee and 73 participant laboratories that performed both EIA and WB tests.

TABLE 4. Relationship between results on samples tested for anti-HIV by enzyme immunoassay (EIA) and Western blot (WB), by sample number — College of American Pathologists Proficiency Testing, 1987

Sample Number	Reactivity	Results by EIA*		Results by WB*		
		Positive	Negative	Positive	Indeterminate	Negative
W-21	Reactive	76	0	76	0	0
W-23	Reactive	83	0	69	13	1
W-24	Reactive	82	0	70	10	2
W-25	Nonreactive	0	58	0	3†	55
Total		**241**	**58**	**215**	**26**	**58**

*Number of responses reported by both referee and participant laboratories. Sample W-22 was excluded because of an artifact of the sample.
†One sample by WB had only p24 bands reported; one sample had both p24 and p32 bands reported; and one sample had no bands reported.

tests on nonreactive samples, 98.3% were interpreted as negative. Based on results from 601 laboratories on a pair of identical reactive samples (W-23 and W-24), reproducibility was 99.5%.

For the WB test, calculations were based only on positive or negative results divided by the total number of tests in the October 1987 CAP survey (Table 4). For the reactive samples, 89.2% of 241 results were correctly interpreted as positive, and, for the nonreactive samples, 94.8% of 58 results were correctly interpreted as negative. Reproducibility, which was based on 83 tests on a pair of identical reactive samples (W-23 and W-24), was 95.2%. The performance of the referee laboratories was more accurate for the EIA and much more accurate for the WB than was the performance of the participating laboratories. The performance of the licensed and unlicensed WB tests could not be compared because the data were not collected.

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Editorial Note: Quality laboratory testing for HIV antibody is a critically important element for surveillance and detection of HIV infection. The laboratory testing process requires quality assurance for each step including: 1) collection, labeling, and transport of specimens; 2) laboratory reagents and procedures; 3) interpretation of analytical results; and 4) communication from the laboratory scientist to the clinician and then to the person being tested. Quality performance is promoted by using licensed or standardized tests in proper sequence and by developing consensus about interpretation of analytical results.

Proficiency testing benefits participating laboratories by identifying problems with particular types of samples, with particular tests, or with interpretation of results. However, results of proficiency testing programs should be interpreted cautiously. Data from proficiency testing measure only the operational performance of participating laboratories but cannot be used to measure the sensitivity or specificity of a given test. Samples provided for testing in the HIV antibody surveys may be pooled human plasma samples with known levels of anti-HIV reactivity, or they may be dilutions of a single reactive plasma sample in HIV-negative serum. They are rarely fresh serum specimens from a person who is or is not infected with HIV. Some samples are selected because they exhibit nonspecific reactivity or are otherwise difficult to test and interpret; they are not typical of the vast majority of specimens that will be handled by the participating laboratories. For instance, in normal practice, samples W-22 and W-25 would not be tested by WB because the EIA was nonreactive. The nonspecific reactivity of the type that occurred with specimen W-22 cannot always be predicted; a similar unexplained nonspecific reaction occurred in a proficiency testing program conducted by CDC (*16*) and with several samples used by the American Association of Bioanalysts (unpublished data).

The number of specimens commonly used in proficiency testing programs (five in each CAP survey) sent to each laboratory also limits the application of survey results. This number of specimens is not sufficient to measure adequately the performance of any single laboratory. The number of specimens tested per month in different laboratories varies enormously, and no attempt is made in the survey to select a representative sample of laboratories performing the test; those that choose to participate in the survey do so voluntarily.

Laboratories in the surveys reported indeterminate WB results on some reactive and nonreactive samples. An indeterminate result is not a final result; it requires additional laboratory testing on the same specimen and often entails asking the person from whom the specimen was obtained to provide one or more additional specimens. The final interpretation of an indeterminate result frequently will also require additional epidemiologic, clinical, or corroborating laboratory information.

Even among the diverse laboratories participating in the CAP survey, none performing the EIA and WB tests in sequence would have reported false-positive test results. However, performance and interpretation of WB tests vary among laboratories. The Public Health Service is convening a meeting to address these issues. A nationwide performance evaluation program for HIV antibody testing has been started by CDC's Training and Laboratory Program Office and Center for Infectious Diseases (*17*). The first sample shipment, consisting of reference materials, was mailed in November 1987 to more than 700 participating U.S. laboratories.

The predictive values of both positive and negative test results for HIV antibody are extremely high in laboratories that have good quality control and high performance standards and that use licensed EIA tests and the licensed WB or other well-standardized tests. Physicians or other health-care providers who request HIV antibody tests and who counsel persons about test results must have a clear understanding of the significance of the test results and the potential pitfalls of the testing process. When test results are indeterminate or inconsistent with other information, additional information should be obtained to try to confirm whether the person is infected with HIV. The counseling procedure should include a careful assessment of the person's potential risks or exposures to HIV. As for all medical tests, results should be interpreted in concert with all the historic, epidemiologic, clinical, and other pertinent laboratory information available.

TABLE 5. Distribution and interpretation of HIV-specific protein band patterns on Western blot* (WB) — College of American Pathologists Proficiency Testing, 1987

HIV-Specific Bands†	WB as Interpreted by Referee and Participant Laboratories					
	Positive		Indeterminate		Negative	
	No.	(%)	No.	(%)	No.	(%)
None	0	(0.0)	9	(7.1)	118	(92.9)
Single Band	18	(60.0)	9	(30.0)	3	(10.0)
gag	6	(42.9)	7	(50.0)	1	(7.1)
pol	0	(0.0)	2	(100.0)	0	(0.0)
env	12	(85.7)	0	(0.0)	2	(14.3)
Multiple Bands	208	(96.7)	4	(1.9)	3	(1.4)
gag, pol	8	(80.0)	1	(10.0)	1	(10.0)
gag, env	125	(98.4)	0	(0.0)	2	(1.6)
pol, env	2	(40.0)	3	(60.0)	0	(0.0)
gag, pol, env	73	(100.0)	0	(0.0)	0	(0.0)
Total	**226**	**(60.8)**	**22**	**(5.9)**	**124**	**(33.3)**

*Samples tested and reported include reactive samples W-21, W-23, and W-24 and nonreactive samples W-22 and W-25.
†Bands may be any proteins or glycoproteins that are products of the genes listed. HIV-specific gene products are shown in Table 1.

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Epidemiologic Notes and Reports

AIDS Due to HIV-2 Infection — New Jersey

The first reported case of AIDS caused by human immunodeficiency virus type 2 (HIV-2) in the United States was diagnosed in December 1987. The patient, a West African, came to the United States in 1987. In December, the patient visited a physician because of a 3-year history of weight loss and recent onset of neurologic symptoms. A CAT scan of the head revealed mass lesions that biopsy showed to be caused by *Toxoplasma gondii*. Biopsy of a lymph node revealed acid-fast bacteria.

The patient did not give a history of sexual intercourse, use of nonsterile needles, or donation of blood while in the United States. All family members and household contacts, both in the United States and abroad, are reported to be well.

Because the diagnosis of cerebral toxoplasmosis without other underlying cause of immunodeficiency fits the CDC surveillance definition for AIDS, laboratory evidence of infection with HIV was sought. Testing of the patient's serum revealed a negative enzyme immunoassay (EIA) for antibody to HIV-1 with an indeterminate HIV-1 Western blot. However, EIA for antibodies to HIV-2 (Genetic Systems Corporation, Seattle, Washington [research test kit]) was repeatedly reactive and HIV-2 Western blot revealed bands for antibodies to *gag* (p26), *pol* (p34), and *env* (gp140) proteins. DNA amplification by the polymerase chain reaction technique with HIV-1-specific and HIV-2-specific DNA probes (*1*) revealed HIV-2 DNA but not HIV-1 DNA in the patient's lymphocytes and confirmed the diagnosis of HIV-2 infection.

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Editorial Note: This patient represents the only documented case of HIV-2 infection in the United States. HIV-2 is closely related to HIV-1 and was first reported to be associated with AIDS in 1986 in West Africa, where the virus is believed to be endemic (*2-8*). Several well-documented cases of HIV-2 infection have also been reported among Europeans and among West Africans residing in Europe (*3,4,8*). The spectrum of disease and modes of transmission of HIV-2 are similar to those of HIV-1 (*2-5*). These modes of transmission include sexual intercourse; however, infected persons present no risk to nonsexual household contacts (*9*). The present case undoubtedly represents infection acquired in West Africa since illness began before the patient's arrival in the United States. The patient has had no known activities that would have exposed others in this country to HIV-2.

Because of the reports of HIV-2 infection in West Africa and Europe, CDC and the Food and Drug Administration (FDA) initiated surveillance for HIV-2 in the United States in January 1987. To date, CDC, FDA, and collaborating investigators have screened 22,699 serum samples with anti-HIV-2 EIA (*10*). Of these specimens, 14,196 (63%) were from individuals whose activities placed them at increased risk for HIV-1 infection and who would, therefore, potentially be at risk for HIV-2 infection. The remaining 8,503 were from asymptomatic blood donors randomly selected from three areas of the United States, two of which have reported large numbers of AIDS patients. Overall, 35 (0.2%) of the serum samples were reactive by anti-HIV EIA using HIV-2 antigens but not by anti-HIV EIA using HIV-1 antigens. However, none of these EIAs could be confirmed when tested by HIV-2-specific Western blot. An additional 70 (0.3%) of the samples were reactive by Western blot with *gag*, *pol*, and *env* antigens of both HIV-1 and HIV-2. All of the dually reactive specimens were from individuals whose activities placed them at increased risk for HIV-1 infection. None were from the randomly selected blood donors. Sera from these dually reactive subjects were studied for the presence of type-specific neutralizing antibody to HIV-1 or HIV-2, antibody to synthetic peptides specific for HIV-1 or HIV-2 (Genetic Systems Corporation, Seattle, Washington [research test kit]), or HIV-1 and HIV-2 DNA by DNA amplification (*1*). Sixty of the subjects were shown to be infected with HIV-1 but not HIV-2. Ten are still under investigation.

It is reassuring that HIV-2-specific tests on sera from 22,699 persons, including 8,503 randomly selected U.S. blood donors, failed to reveal HIV-2 infection. However, the occasional presence of this virus in the United States, as in Europe, should be anticipated. The anti-HIV-1 EIA tests currently used for screening all U.S. blood donors are estimated to detect 42% to 92% of HIV-2 infections (*4,11*). Surveillance for HIV-2 in the United States is being continued to monitor the frequency of infection. Because the modes of transmission of HIV-1 and HIV-2 are similar, preventive measures for these related viruses are the same (*12*).

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Current Trends

Continuing Increase in Infectious Syphilis — United States

Through the first 46 weeks of 1987, 31,323 cases of infectious (primary and secondary) syphilis were reported to CDC through the *MMWR* Morbidity Surveillance System. This total exceeds the number of cases reported for the same period in 1986 by 32%. The projected annual incidence of infectious syphilis for 1987 is 14.7/100,000, which would be the highest rate since 1950. While 56% of all cases and 83% of the increase were reported from Florida, New York City (NYC), and California, 25 of the other 49 reporting areas also had increases. Nine areas had absolute increases of over 100 cases; in two of these areas, the relative increases were over 100% (Table 1). With the exception of Oregon and Connecticut, areas with high incidence rates experienced the greatest increases. Texas, with a 22% decrease in reported cases, and Louisiana, with a 9% decrease, were notable exceptions to the overall pattern of increase.

Fourteen areas reporting increases and five reporting decreases during the first 8 months of 1987 were asked to provide data on patients' race, sex, and sexual preference for further analysis. Overall, the areas providing this supplementary information contain 51% of the U.S. population and 79% of the syphilis cases reported through the first 46 weeks of 1987.

In the 14 areas reporting increases (13 states and NYC), relative increases were greatest for females and heterosexual males of all racial/ethnic backgrounds (Table 2). The greatest absolute increases occurred among blacks. The increase for males occurred among heterosexual males, and the decrease among homosexual/bisexual males occurred primarily among white males (*1*). Exceptions to this overall pattern occurred in Connecticut and Georgia. In Connecticut, the relative and absolute increases were greatest among white heterosexual males. In Georgia, increases occurred only among white and black males, and a substantial portion of the increase appeared to be among homosexual/bisexual males.

In the five states reporting decreases, the only exception to the overall pattern of decrease occurred among white females. The number of reported cases increased by 51% (20 cases) in this group.

The pattern of increase differed among reporting areas. In some areas, such as Philadelphia and Los Angeles, the increase appears to have plateaued in the middle of 1987. However, in other areas, such as NYC, Florida, and Oregon, the increase continued to climb. In still others, such as Pennsylvania (excluding Philadelphia), the increase began during this period.

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Editorial note: These increases in infectious syphilis not only reverse the downward trend of the past 4 years, they also suggest an important shift in the epidemiology of the disease in the United States. As infectious syphilis has decreased among homosexual and bisexual males, largely because of changes in sexual behavior due to AIDS, a sizeable increase has occurred among heterosexuals. A similar shift was documented earlier in two small outbreaks (*2,3*).

While the cause of this increase is unknown, several hypotheses have been proposed. First, anecdotal reports from persons interviewing syphilis patients and their sexual partners indicate that prostitution in which nonintravenous drugs (especially "crack" cocaine) are exchanged for sex may be partially responsible for outbreaks of syphilis as well as other sexually transmitted diseases. A review of

TABLE 1. Reporting areas with the largest absolute increases in infectious syphilis — United States, weeks 1-46, 1987

State	Number of Cases		Increase		1987 Rate*
	1986	1987	Absolute	(%)	
Florida	3,747	6,674	2,927	(78)	65.9
New York City	1,870	4,327	2,457	(131)	67.8
California	4,837	6,533	1,696	(35)	27.8
North Carolina	461	650	189	(41)	11.7
Georgia	1,333	1,506	173	(13)	28.3
Oregon	103	269	166	(161)	11.2
Maryland	403	556	153	(38)	14.2
Connecticut	147	282	135	(92)	10.0
Tennessee	566	672	106	(19)	15.8
Washington, D.C.	268	353	85	(32)	63.3
Mississippi	486	564	78	(16)	24.2
Nevada	91	142	51	(56)	17.0
New York State	173	223	50	(29)	2.4
Arizona	219	268	49	(22)	9.4
South Carolina	619	662	43	(7)	22.2

*Per 100,000; based on 1985 Bureau of the Census projections.

records of interviews in Philadelphia showed that the proportion of patients associated with both prostitution and drug use increased significantly between 1985 and 1987 (*4*).

Second, some investigators have suggested that routine use of spectinomycin (which does not appear to cure incubating syphilis [*5,6*]) in areas where a sizeable proportion of gonorrhea infections are caused by β-lactamase-producing organisms may explain the increase in infectious syphilis.* Events in NYC, Florida, and Los Angeles are compatible with this theory; however, for several other areas† with sizeable increases in reported syphilis, spectinomycin was not in common use before the increases began. While this mechanism may play a role in some areas, it alone cannot account for the nationwide increase.

Third, a decrease in the resources available for syphilis control programs has been suggested as a contributing factor. Twenty reporting areas provided data on the number of staff available for syphilis control during 1985 and 1986. Ten of these areas reported increases in the number of persons interviewing patients with early syphilis between 1985 and 1986; four reported no change; and six reported decreases. Areas reporting increases in total syphilis morbidity were somewhat more likely to report a decrease in the number of interviewers; however, the association was not statistically significant.

The increases in infectious syphilis among females and heterosexuals are disturbing for three reasons. First, an increase in the number of females with syphilis will likely be followed by increased morbidity and mortality from congenital syphilis. Second, the marked increase among inner-city, heterosexual minority groups suggests that high-risk sexual activity is increasing in these groups despite the risk of HIV infection, which is already elevated because of the high prevalence of intravenous drug abuse. Third, studies in Africa and in the United States suggest that genital ulcer diseases such as primary syphilis increase the risk of HIV transmission (*8,9*).

*Parenteral penicillin regimens used to treat gonorrhea have been shown to cure incubating syphilis acquired at the same time as gonorrhea infection (*7*).
†Arizona, Baltimore, Connecticut, North Carolina, Oregon, and Philadelphia.

TABLE 2. Cases of infectious syphilis from 14 reporting areas,* by race, sex, and sexual preference — United States, January-August, 1987

Category	Number of Cases 1986	Number of Cases 1987	Change Absolute	Change (%)
Heterosexual Males†				
Total	**5,503**	**9,727**	**+4,224**	**(+77)**
White	647	940	+293	(+45)
Black	3,461	6,436	+2,975	(+86)
Hispanic	1,200	1,874	+674	(+56)
Other	195	477	+282	(+145)
Homosexual/Bisexual Males†				
Total	**1,691**	**1,441**	**−250**	**(−15)**
White	650	430	−220	(−34)
Black	750	795	+45	(+6)
Hispanic	158	161	+3	(+2)
Other	133	55	−78	(−59)
Females				
Total	**3,302**	**5,761**	**+2,459**	**(+75)**
White	376	629	+253	(+67)
Black	2,480	4,317	+1,837	(+74)
Hispanic	332	580	+248	(+75)
Other	114	235	+121	(+106)

*Arizona, California, Connecticut, Florida, Georgia, Maryland, Massachusetts, Mississippi, North Carolina, Oregon, Pennsylvania, South Carolina, Tennessee, and New York City. Data for California (other than Los Angeles and San Francisco) are for the first 6 months only.
†Males naming at least one male sexual partner were classified as "homosexual/bisexual"; those not naming any were classified as "heterosexual." Overall, 87% of males were interviewed in 1986 and 85%, in 1987. Over 80% of males were interviewed in all reporting areas except New York City, where 55% were interviewed in 1986 and 45%, in 1987.

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MORBIDITY AND MORTALITY WEEKLY REPORT

Perspectives in Disease Prevention and Health Promotion

Semen Banking, Organ and Tissue Transplantation, and HIV Antibody Testing

The following recommendations regarding storage and use of semen were prepared by the Food and Drug Administration and the Centers for Disease Control with the endorsement of the American Association of Tissue Banks, the American Fertility Society, and the American College of Obstetricians and Gynecologists.

The Public Health Service published its initial recommendations regarding screening prospective donors of semen, organs, or tissues for the presence of antibody to human immunodeficiency virus (HIV) in 1985 (*1*). The role of donated semen in the transmission of HIV infection was confirmed later that year (*2*). In late 1986 and early 1987, transmission of acute viral hepatitis B resulting from artificial insemination with donated semen was reported (*3,4*). In April of 1987, an allogenic skin graft was implicated in the transmission of HIV infection (*5*). A month later, a cadaveric organ donor was found positive for antibody to HIV after his organs were transplanted (*6*). Most recently, the House of Delegates of the American Medical Association, at its meeting held June 21-25, 1987, adopted a recommendation that testing for antibody to HIV be performed for all donors of blood, organs, or tissues intended for transplantation and for donors of semen or ova (*7*). Other professional organizations, such as the American Association of Tissue Banks and the American Fertility Society, have published standards and guidelines designed to prevent or minimize the possibility of transmitting disease through artificial insemination or allotransplants (*8,9*).

Based on current knowledge, the following recommendations are made with respect to organ and tissue transplantation and artificial insemination:

Prospective donors of organs, tissues, and semen should be tested for antibody to HIV (*1,6*). Tests for hospitalized donors should be run on a serum sample taken prior to the donor's receipt of any blood transfusions to avoid situations in which multiple transfusions might result in an antibody loss due to hemodilution (*6*). Organs and tissues from prospective donors found seropositive for HIV antibody should not be used except when the transplantation of an indispensable organ is necessary to save a patient's life.

In the past, fresh sperm has been routinely recommended for use in artificial insemination and may still be appropriate when semen is from a donor in a mutually monogamous marriage/relationship with the recipient. However, it is now considered prudent to freeze samples from all other donors and store them in that state for a minimum of 6 months. Before frozen semen is used for artificial insemination, a blood sample taken at the time the semen was collected and a second blood sample taken aminimum of 6 months later should be tested for HIV antibody. Responsible medical personnel must be certain that the blood samples are from the same donor, and the donor's identity must be assured. Frozen semen should be used only if both of the tests are negative. These special safeguards should be observed in addition to the preliminary precautions that the donor had 1) no history of risk factors for HIV infection and 2) a physical examination, properly documented by a licensed physician at the time of donation, that showed no obvious evidence of HIV infection.

The American Fertility Society has already modified its guidelines in accordance with these recommendations (*10*), and these revised guidelines have been accepted by the American College of Obstetricians and Gynecologists. The American Association of Tissue Banks is in the process of similarly revising its standards (personal communication).

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MORBIDITY AND MORTALITY WEEKLY REPORT

Perspectives in Disease Prevention and Health Promotion

Condoms for Prevention of Sexually Transmitted Diseases*

Introduction

Prevention is the most effective strategy for controlling the spread of infectious diseases. Prevention through avoiding exposure is the best strategy for controlling the spread of sexually transmitted disease (STD). Behavior that eliminates or reduces the risk of one STD will likely reduce the risk of all STDs. Prevention of one case of STD can result in the prevention of many subsequent cases. Abstinence and sexual intercourse with one mutually faithful uninfected partner are the only totally effective prevention strategies. Proper use of condoms with each act of sexual intercourse can reduce, but not eliminate, risk of STD. Individuals likely to become infected or known to be infected with human immunodeficiency virus (HIV) should be aware that condom use cannot completely eliminate the risk of transmission to themselves or to others.

Efficacy

For the wearer, condoms provide a mechanical barrier that should reduce the risk of infections acquired through penile exposure to infectious cervical, vaginal, vulvar, or rectal secretions or lesions. For the wearer's partner, proper use of condoms should prevent semen deposition, contact with urethral discharge, and exposure to lesions on the head or shaft of the penis. For infectious agents spread from lesions rather than fluids, condoms may offer less protection because areas of skin not covered by the condom may be infectious or vulnerable to infection.

*This summary includes data presented at a conference entitled "Condoms in the Prevention of Sexually Transmitted Diseases" sponsored by the American Social Health Association, Family Health International, and the Centers for Disease Control and held in Atlanta, Georgia, February 20-21, 1987. The following consultants assisted in the formulation of these data and strategies: J Cohen, PhD, M Conant, MD, University of California; L Pappas, San Francisco AIDS Foundation, San Francisco, California. F Judson, MD, Disease Control Service and University of Colorado, Denver, Colorado. J Graves, M Rosenberg, MD, American Social Health Association; M Potts, MD, Family Health International, Research Triangle Park, North Carolina. P Harvey, Population Services International, Washington, DC. L Liskin, Johns Hopkins University, Baltimore, Maryland. M Solomon, Solomon Associates, Sudbury, Maine.

Laboratory and epidemiologic studies have provided information about the effectiveness of condoms in preventing STD. Laboratory tests have shown latex condoms to be effective mechanical barriers to HIV (*1*), herpes simplex virus (HSV) (*2-4*), cytomegalovirus (CMV) (*5*), hepatitis B virus (HBV) (*6*), *Chlamydia trachomatis* (*2*), and *Neisseria gonorrhoeae* (*4*). Latex condoms blocked passage of HBV and HIV in laboratory studies, but natural membrane condoms (made from lamb cecum), which contain small pores, did not (*6-8*). The experimental conditions employed in these studies may be more extreme than those encountered in actual use; however, they suggest that latex condoms afford greater protection against viral STD than do natural membrane condoms.

The actual effectiveness of condom use in STD prevention is more difficult to assess. It is difficult to determine if a user has been exposed to an infected partner or whether the condom was correctly used. However, several cross-sectional and case-control studies have shown that condom users and/or their partners have a lower frequency of gonorrhea, ureaplasma infection, pelvic inflammatory disease, and cervical cancer than persons who do not use condoms (*9*). Consistent previous condom use was associated with seronegativity during the 1- to 3-year follow-up period in a recent study of HIV antibody-negative heterosexual spouses of patients with acquired immunodeficiency syndrome (AIDS) (*10*). Another recent investigation of prostitutes in Zaire has also suggested a protective association between a history of condom use and HIV seronegativity (*11*).

Condoms are not always effective in preventing STD. Failure of condoms to protect against STD is probably explained by user failure more often than by product failure. User failure includes failure to: 1) use a condom with each act of sexual intercourse, 2) put the condom on before any genital contact occurs, and 3) completely unroll the condom. Other user behaviors that may contribute to condom breakage include: inadequate lubrication, use of oil-based lubricants that weaken latex, and inadequate space at the tip of the condom. Product failure refers to condom breakage or leakage due to deterioration or poor manufacturing quality. Deterioration may result from age or improper postmanufacturing storage conditions. No scientific data on the frequency or causes of condom breakage are available. Likewise, no data are available comparing the susceptibility to breakage of condoms of various sizes, thicknesses, or types, i.e., natural versus latex, lubricated versus nonlubricated, or ribbed versus smooth. Experimental methods need to be developed to test the factors associated with breakage. Such information is necessary to provide users with accurate instructions on proper condom use.

Quality Assurance

Since 1976, condoms have been regulated under the Medical Device Amendments to the Federal Food, Drug, and Cosmetic Act. Within the Food and Drug Administration (FDA), the Center for Devices and Radiological Health is responsible for assuring the safety and effectiveness of condoms as medical devices. Beginning in the spring of 1987, FDA undertook an expanded program to inspect latex condom manufacturers, repackagers, and importers to evaluate their quality control and testing procedures. In its testing of condoms, FDA uses a water-leak test in which a condom is filled with 300 mL of water and checked for leaks. The FDA has also adapted its inspection sampling criteria to conform with the American Society for Testing and Materials Standard D3492-83 for latex condoms. FDA criteria and the industry acceptable quality level (AQL) for condoms specify that, in any given batch, the failure rate due to water leakage cannot exceed four condoms per thousand. Batches exceeding the specified rejection criteria are recalled or barred from sale. Among batches of condoms that have met the AQL, the average failure rate observed was 2.3/1,000.

As of February 1988, FDA had examined samples from 430 batches of domestically produced and foreign-made condoms. These examinations have resulted in the testing of over 102,000 condoms. In FDA's sampling methodology, the sample size is determined by the size of the batch of condoms introduced into the market, the inspection level, and the AQL. Approximately 38,000 domestically produced condoms from 165 different batches of condoms were tested. Nineteen of those batches (approximately 12%) had leakage rates of over 4/1,000 and failed the test. By contrast, approximately 21% of the 265 foreign-manufactured batches failed to meet AQL standards. Thus far, as a result of both FDA's sampling program and the manufacturers' quality assurance programs, four domestic manufacturers have conducted 16 condom recalls.

FDA samples foreign-made condoms before they are passed through U.S. customs. If two or more of a given foreign manufacturer's batches offered for import are found to have leakage rates of more than 4/1,000, future shipments from that manufacturer are automatically detained at the port of entry. Seven foreign firms are presently on this automatic detention list. FDA also has the authority to seize any lot that is found to be violative if the manufacturer or importer does not take appropriate action.

Use of Spermicides with Condoms

The active ingredients (surfactants) in commercially available spermicides have been shown in the laboratory to inactivate sexually transmitted agents, including HIV (*9,12,13*). Vaginal use of spermicides is associated with a lower risk of gonorrhea and chlamydial infection in epidemiologic studies of women (*9,14*). The use of spermicide-containing condoms may provide additional protection against STD in the event of condom leakage or seepage. However, the spermicidal barrier would no longer be in place if the condom breaks. If extra protection is desired, vaginal application of spermicide is likely to afford greater protection than the use of spermicide in the condom because a larger volume of spermicide would already be in place in the event of condom breakage. Neither the safety nor the efficacy of spermicides in preventing sexually transmitted infections of the anal canal or oropharynx has been studied.

Prevalence of Use

Recent studies suggest that condom use for STD prevention is increasing in selected populations but is still infrequent. In 1985, a sample of New York City male homosexuals reported a significant increase in condom use with both insertive and receptive anal intercourse after the respondents became aware of AIDS (*15*). In the year before learning of AIDS, the men used condoms an average of 1% of the time when engaging in insertive anal intercourse; in the ensuing year, 20% of respondents reported consistent condom use. In 1984, 39% of the men in a prospective study in San Francisco reported having anal intercourse; 26% of these men used condoms (*16*). In April 1987, 19% of the San Francisco respondents reported anal intercourse; 79% used condoms. The trends in condom use for STD prevention among heterosexual men and women are unknown. In a 1986-87 survey of female prostitutes in the United States, 4% reported condom use with each vaginal exposure (*17*).

Proper Selection and Use

The Public Health Service has previously made recommendations on reducing the risk of HIV infection through consistent use of condoms (*18*). Additional recommendations include a guideline for manufacturers published by FDA that recommends proper labeling of condoms to include adequate instructions for use (Center for Devices and Radiological Health, FDA; letter to all U.S. condom manufacturers, importers, and repackagers, April 7, 1987). Users can increase the efficacy of condoms in preventing infection by using a condom properly from start to finish during every sexual exposure. It is unknown whether brands of condoms with increased thickness offer any more protection for anal or vaginal intercourse than thinner brands. Even with a condom, anal intercourse between an infected individual and an uninfected partner poses a risk of transmitting HIV and other sexually transmitted infections because condoms may break.

The following recommendations for proper use of condoms to reduce the transmission of STD are based on current information:

1. Latex condoms should be used because they offer greater protection against viral STD than natural membrane condoms (*7*).
2. Condoms should be stored in a cool, dry place out of direct sunlight.
3. Condoms in damaged packages or those that show obvious signs of age (e.g., those that are brittle, sticky, or discolored) should not be used. They cannot be relied upon to prevent infection.
4. Condoms should be handled with care to prevent puncture.
5. The condom should be put on before any genital contact to prevent exposure to fluids that may contain infectious agents. Hold the tip of the condom and unroll it onto the erect penis, leaving space at the tip to collect semen, yet assuring that no air is trapped in the tip of the condom.
6. Adequate lubrication should be used. If exogenous lubrication is needed, only water-based lubricants should be used. Petroleum- or oil-based lubricants (such as petroleum jelly, cooking oils, shortening, and lotions) should not be used since they weaken the latex.
7. Use of condoms containing spermicides may provide some additional protection against STD. However, vaginal use of spermicides along with condoms is likely to provide greater protection.
8. If a condom breaks, it should be replaced immediately. If ejaculation occurs after condom breakage, the immediate use of spermicide has been suggested (*19*). However, the protective value of postejaculation application of spermicide in reducing the risk of STD transmission is unknown.
9. After ejaculation, care should be taken so that the condom does not slip off the penis before withdrawal; the base of the condom should be held while withdrawing. The penis should be withdrawn while still erect.
10. Condoms should never be reused.

Condoms should be made more widely available through health-care providers who offer services to sexually active men and women, particularly in STD clinics, family planning clinics, and drug-treatment centers. These same facilities should become more assertive in counseling patients on STD prevention. Recommendations for prevention of STD, including HIV infection, should emphasize that risk of infection is most effectively reduced through abstinence or sexual intercourse with a mutually faithful uninfected partner. Condoms do not provide absolute protection from any infection, but if properly used, they should reduce the risk of infection.

Reported by: Center for Devices and Radiological Health, Food and Drug Administration. Div of Sexually Transmitted Diseases, Center for Prevention Svcs; AIDS Program, Center for Infectious Diseases, CDC.

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MMR vaccine may be ineffective if administered to a child who has received IGIV during the preceding 3 months.

Immune globulin (IG) (16.5 gm% protein) can be used to prevent or modify measles infection in HIV-infected children if administered within 6 days of exposure. IG is indicated for measles-susceptible* household contacts of children with asymptomatic HIV infection, particularly for those under 1 year of age and for measles-susceptible pregnant women. The recommended dose is 0.25 mL/kg intramuscularly (maximum dose, 15 mL) (*7*).

In contrast, exposed symptomatic HIV-infected patients should receive IG prophylaxis regardless of vaccination status. The standard postexposure measles prophylaxis regimen for such patients is 0.5 mL/kg of IG intramuscularly (maximum dose, 15 mL) (*7*). This regimen corresponds to a dose of protein of approximately 82.5 mg/kg (maximum dose, 2,475 mg). Intramuscular IG may not be necessary if a patient with HIV infection is receiving 100-400 mg/kg IGIV at regular intervals and received the last dose within 3 weeks of exposure to measles. Based on the amount of protein that can be administered, high-dose IGIV may be as effective as IG given intramuscularly. However, no data exist on the efficacy of IGIV administered postexposure in preventing measles.

Although postexposure administration of globulins to symptomatic HIV-infected patients is recommended regardless of measles vaccine status, vaccination prior to exposure is desirable. Measles exposures are often unrecognized, and postexposure prophylaxis is not always possible.

While recommendations for MMR vaccine have changed, those for other vaccines have not (*3*). A summary of the current ACIP recommendations for HIV-infected persons follows (Table 1). These recommendations apply to adolescents and adults with HIV infection as well as to HIV-infected children.

*Persons who are unvaccinated or do not have laboratory evidence or physician documentation of previous measles disease (*7*).

TABLE 1. Recommendations for routine immunization of HIV-infected children — United States, 1988*

Vaccine	HIV Infection	
	Known Asymptomatic	Symptomatic
DTP†	yes	yes
OPV§	no	no
IPV¶	yes	yes
MMR**	yes	yes††
HbCV§§	yes	yes
Pneumococcal	no	yes
Influenza	no	yes

*See accompanying text and previous ACIP statement (*3*) for details.
†DTP = Diphtheria and tetanus toxoids and pertussis vaccine.
§OPV = Oral, attenuated poliovirus vaccine; contains poliovirus types 1, 2, and 3.
¶IPV = Inactivated poliovirus vaccine; contains poliovirus types 1, 2, and 3.
**MMR = Live measles, mumps, and rubella viruses in a combined vaccine.
††Should be considered.
§§HbCV = *Haemophilus influenzae* type b conjugate vaccine.

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Epidemiologic Notes and Reports

Measles in HIV-Infected Children, United States

The Centers for Disease Control has received reports of six cases of measles that occurred among children infected with human immunodeficiency virus (HIV) in the United States during the period 1986-1987 (Table 1). Two of these children died from measles. Like many other infections, measles appears to be more severe in persons with HIV infection.

Patients 1-3 became ill during a nosocomial outbreak in a New York City hospital (*1*). These patients had acquired HIV infections perinatally. None had received measles vaccine nor were they receiving intravenous immune globulin

TABLE 1. Cases of measles in children infected with HIV — United States, 1986-1987

Case	Age	City	HIV Classification	Measles Vaccine	Acquired	Typical Rash	Complication	Outcome
1	7 mo	NYC	P-0*	no	hospital	yes	none	survived†
2	2 yr	NYC	P-2/D-2*	no	hospital	no§	pneumonia	survived¶
3	4 yr	NYC	P-2/D-1*	no	hospital	yes	pneumonia	died
4	2 yr	NYC	P-2/A*	no	hospital	yes	otitis media	survived
5	4 yr	Miami	P-2/C*	no	ER††	no	pneumonia	died
6	14 yr	NYC	IV/E**	yes	community	yes	pneumonia	survived

*For classification criteria, see *MMWR* 1987;36:225-35(*2*).
†Postexposure prophylaxis with immune globulin more than 6 days after exposure.
§Evanescent rash with Koplik spots.
¶Postexposure prophylaxis with varicella-zoster immune globulin more than 6 days after exposure.
**For classification criteria, see *MMWR* 1986;35:334-9 (*3*).
††Probable exposure in an emergency room.

(IGIV). All were assumed to have had a common source of exposure to measles in the hospital, but the source was never identified. A medical student, who probably acquired disease from the same source, developed a rash several days before the children did. The medical student, whose rash illness was initially thought to be varicella because she recently had been exposed to a patient with varicella, had contact with the HIV-infected patients. Consequently, Patient 2 received varicella-zoster immune globulin (VZIG), and Patient 1 received intramuscular immune globulin (IG). Both patients developed measles within several days of globulin administration and thus may have received globulins more than 6 days after exposure. Patient 1, a 7-month-old with HIV class P-0 infection (indeterminant), and Patient 3, a 4-year-old with HIV class P-2, subclass D-1 infection (cryptosporidiosis) (*2*), had typical measles illnesses with cough, coryza, conjunctivitis, Koplik spots, and rash. Patient 1 had a measles hemagglutination-inhibition (HI) antibody titer of 10 on the first day of rash (due either to residual, passively transferred maternal antibody or to passive immunization). Patient 2, a 2-year-old with HIV class P-2, subclass D-2 infection (recurrent bacterial infections), had only a transient rash and Koplik spots. Both Patients 2 and 3 developed severe pneumonia and were treated with aerosolized ribavirin (*4*). Patient 3 died, and autopsy showed diffuse giant-cell pneumonia typical of measles infection consisting of multinucleate giant cells with nuclear and cytoplasmic inclusions (*5*).

Patient 4, a 2-year-old with perinatally acquired HIV infection, had HIV class P2, subclass A infection (hepatosplenomegaly, generalized lymphadenopathy, and herpes stomatitis) at the time of onset of measles. She acquired measles during hospitalization at a different hospital in New York City. The source of her infection was not determined. This patient had never been vaccinated against measles and was not receiving IGIV. She developed generalized rash, fever, coryza, conjunctivitis, Koplik spots, and otitis media but no other complications.

Patient 5, a 4-year-old child with perinatally acquired HIV class P-2, subclass C infection (lymphoid interstitial pneumonitis), was admitted with fever and pneumonia to a hospital in Miami, Florida. The patient had never been vaccinated against measles but was receiving IGIV (200 mg/kg) prophylactically every month. The last dose had been received 3 weeks before onset of illness. Her measles antibody titer at the time of onset of illness is not known. The patient developed respiratory failure and died 8 days after admission. There was no history of rash. The diagnosis of measles pneumonia was made on postmortem examination of lung tissue that showed multinucleate giant cells with nuclear and cytoplasmic inclusions. This patient was not isolated during her hospitalization, and nosocomial transmission of measles resulted: a pediatric nurse and a patient, neither of whom had been vaccinated, acquired measles from the child. One additional patient acquired infection from the nurse.

Patient 6, a 14-year-old with HIV Group IV infection (thrombocytopenia) (*3*), had acquired HIV as a result of a blood transfusion. He had been immunized with live, attenuated measles vaccine at 15 months and again at 9 years of age. The patient was admitted to a hospital with fever and later developed rash and pneumonia. Measles was serologically confirmed. The patient was treated with aerosolized ribavirin and recovered without sequelae.

Reported by: K Krasinski, MD, W Borkowsky, MD, S Chandwani, MD, R Lawrence, MD, New York Univ Medical Center-Bellevue Hospital Center; S Friedman, MD, MPH, New York City Dept of Health; DL Morse, MD, MS, State Epidemiologist, New York State Dept of Health. C Mitchell, MD, G Scott, MD, K Roach, E Roldan, MD, M Saldana, MD, Jackson Memorial Hospital, Miami; MH Wilder, MD, State Epidemiologist, Florida Dept of Health and Rehabilitative Svcs. AIDS Program, Center for Infectious Diseases; Div of Immunization, Center for Prevention Svcs, CDC.

Editorial Note: In addition to these six measles cases in children with HIV infection, CDC has received reports of two measles cases in HIV-infected adults. Both survived the acute measles infection, although one was hospitalized. The two measles deaths involving HIV-infected children in 1987 were the first deaths due to measles in the United States to be reported to CDC since 1985. While there may be underreporting of nonhospitalized or nonfatal measles cases in persons with HIV infection, the case-fatality rate for measles in HIV-infected children is clearly higher than the case-fatality rate for measles in recent years in the United States, 0.1% (*6*).

Severe measles infections have been reported in other immunocompromised patients. Measles infection without rash has also been described (*7*). Physicians caring for patients with HIV infection should be aware that measles can be severe and may occur without the typical rash. This may preclude diagnosis and, thus, delay or prevent initiation of treatment, outbreak control measures, or appropriate hospital isolation. The fact that an unimmunized medical worker acquired measles from one of these cases and was involved in transmission to a hospitalized patient is noteworthy. In addition, five of the six measles cases in HIV-infected children were acquired in medical settings. Since hospital workers may acquire and/or transmit measles, hospitals should ensure that employees who may have occupational exposure to measles have proof of measles immunity (*8*).

During 1986 and 1987, large measles outbreaks occurred in urban areas of the United States among preschool-age children with low immunization levels (*9*). These areas (New York City, Jersey City, and Miami) also have high incidence rates of pediatric acquired immunodeficiency syndrome. Since HIV-infected children may live in areas where measles virus circulates because of low preschool measles immunization levels, they may be at higher risk of exposure to measles than other children in the United States.

As a result of these recent reports of measles in HIV-infected children, the Immunization Practices Advisory Committee (ACIP) now recommends that measles vaccine be considered for symptomatic as well as asymptomatic children with HIV infection (*10*). This approach to protect the HIV-infected child is consistent with the World Health Organization's recommendation to provide measles vaccination for all children in developing countries regardless of HIV and symptom status because of the high risk of measles and the severity of measles infection in general (*11*).

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FLORIDA FOUNDATION INVESTIGATED

by Mark Sullivan, with thanks to The Washington Blade, 1/1/88

THE FOUR-MONTH-OLD FOUNDATION FOR AIDS RESEARCH, INC., A NON-PROFIT CORPORATION based in Cooper City, Florida, is the target of investigations by both the Broward County Sheriff's Office of Economic Crimes Unit and the Broward State Attorney's Office, according to the Miami-based The Weekly News. Al Gordon, spokesman for the Sheriff's Office, said both agencies were investigating the foundation's fundraising activities because of numerous complaints from the public. He said that several of the donation canisters the foundation had placed in hundreds of businesses in Dade and Broward Counties have been confiscated as part of the investigation. The organization's founders, Larry Straus and Robert Fischer, said the foundation was formed to raise money for AIDS research. But several of the research centers that the foundation said it is helping to fund told reporters that they have no ties to the foundation. Four of the 11 research centers listed in foundation pamphlets-- Georgetown University Hospital, Duke University Medical Center, Cornell Medical Center, and Northwest University Medical Center-- said they had been contacted by the foundation, but had not agreed to take money from the foundation or allow it to use their names in fundraising efforts. The Weekly News also reported that the foundation has not acquired either the occupational license or the solicitor's license required by law.

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EMBEZZLED FUNDS BUYS PWA HOME

by Mark Sullivan, with thanks to The Washington Blade, 1/1/88

THE FATE OF A HOME FOR PEOPLE WITH AIDS IN DALLAS WAS PUT IN JEOPARDY in December when it was discovered that a man with AIDS who donated most of the money to purchase the building had embezzled it from the bank where he worked, according to Houston's This Week in Texas. Mike Meridan, a Dallas resident who was diagnosed with AIDS in 1986, founded the People With AIDS Coalition last year in an effort to raise enough money to purchase a home for PWAs because there were no such facilities in the area. Patrick Debenport, a branch manager of the First Texas Savings and Loan Association, allegedly made several anonymous donations totaling $175,000 to the group which were used to make a down payment on a run-down 32-room apartment building and extensive renovations. But the bank filed suit against Debenport in August, claiming that he had "wrongfully misappropriated" approximately $1.7 million from the branch where he had worked until July. And bank officials say they want their money back from the People With AIDS Coalition, even if it means closing down the house. "I have personal sympathy for the residents of the facility," said J. Livingston Kosbergs, chairman of the bank and also chairman of the Texas Department of Human Services, which handles state AIDS funding. "But you can't allow that individual sympathy to get in the way of issues dealing with the interests of an institution." The home, which now houses 25 people with AIDS, has drawn praise from local and national groups as a model residential center for people with the disease.

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PARENTS PSA LAUNCHED

with thanks to Boston's AIDS Action Committee Update, February, 1988

A NEWS AIDS EDUCATION AND OUTREACH PUBLIC SERVICE CAMPAIGN THAT FEATURES THE FAMOUS 1951 PAINTING by Norman Rockwell, titled "The Facts of Life," has been launched by Boston's AIDS Action Committee and has been distributed to newspapers, magazine and television stations throughout Massachusetts, AAC Executive Director Larry Kessler has announced. Created by the award-winning Boston advertising firm Clarke Goward Fitts, the campaign consists of a poster and print public service announcement that depicts the image of a father, with an open textbook titled "The Facts of Life" on his lap, earnestly engaged in a frank discussion with his son. In the campaign, the image is captioned "Don't Forget the Chapter on AIDS." The campaign also includes a 30-second television spot directed by Henry Sandbank of Sandbank Films Co., Inc., which places a similar "Facts of Life" theme in a contemporary framework and states that AIDS education is a parent's responsibility. The state-sponsored AIDS Action hotline number is also included in the public service announcements. "We re grateful to the Saturday Evening Post Marketing Company for allowing us to reprint "The Facts of Life" in our campaign," Kessler said. "We think it will serve as an effective tool in communicating to parents their special place in fighting the AIDS epidemic." The "Don't Forget the Chapter on AIDS" public service campaign is one of several specifically targeted education and outreach efforts initiated and sponsored by AAC. Others include programs tailored to specific segments of heterosexuals, homosexuals, and IV drug users as well as the general public.

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BROCHURES GO OUT DESPITE OPPOSITION

by Mark Sullivan, with thanks to The Washington Blade, 2/12/88

THE ON AGAIN, OFF AGAIN MAILING OF A PAMPHLET about AIDS to every household in America by the Public Health Service is apparently on again, despite continued opposition from the Reagan administration. The Chicago Tribune reported that Robert Windom, Assistant Secretary of Health and Human Services, said the mass mailing to 89 million homes is now set for May or June. Windom, who was in London leading the U.S. delegation to an international meeting on AIDS, said the brochure would contain factual information about AIDS, the ways it can be spread, and "the importance of abstinence before marriage and faithfulness after marriage." The massive mailout had been slated for last October, but the Reagan administration did not use the $20 million allocated for the project by Congress, calling the project "ill-advised and a waste of federal money." But the Reagan administration's stamp of approval may not be necessary this year, Windom said. The item was inserted into one of three budget resolutions passed by Congress in December, requiring PHS to begin the project. A White House official, who declined to be identified, told the Tribune that the mailing would be "a total waste of money because the only people catching the infection now are people who don't read the mail or even have an address-- they're junkies."

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DEAF COMMUNITY AIDS OUTREACH

by Lori Kenschaft, with thanks to Boston's Gay Community News, 12/20-26/87

SAN FRANCISCO'S RAINBOW DEAF SOCIETY (RDS) HAS CALLED FOR AN AIDS OUTREACH PROGRAM TO THE GAY DEAF COMMUNITY. This program would work with AIDS groups, provide sign language interpreters, and coordinate referrals with community agencies to assure full services for deaf people. According to the Bay Area Reporter, the early phase of the program will focus on consultation and training of RDS staff members by existing AIDS organizations. A committee will be selected to research and develop community services. These plans were announced at the 10th Convention of the Rainbow Alliance of the Deaf in Ft. Lauderdale, Florida, were 250 gay men and lesbians gathered from deaf organizations around the country. For more information, contact: RDS, P.O. Box 1601, San Francisco, CA 94101.

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HOTLINE CALLS SPURRED BY AIDS ADS

by John Perry with thanks to Boston's Bay Windows, 1/21/88

The American Social Health Association (ASHA) which operates the federal government's national, toll-free AIDS information line reports that incoming calls have tripled since Ogilvy & Mather Inc. (O&M) launched its national AIDS ad campaign. According to ASHA's December 22, 1987 press release, the number of calls rose from 20,497 in September to 67,392 in November. The O&M public service announcements, which feature the hotline number, have run on cable, radio, and television since October. All three networks have run the AIDS spots across the country during prime-time, and on November 19, NBC-TV donated "the equivalent of $900,000 of air-time during The Cosby Show to air a 60-second campaign PSA," according to the ASHA press material. That day, the hotline received 2838 calls, an increase of 50% over previous Thursday tallies. "Most hotline callers continue to ask questions about how the AIDS virus is transmitted," explains the ASHA press packet. "Hotline operators supply specific information to callers, give referrals to local organizations for educational, testing, or counseling service."

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CD4 PROTEIN HALTS INFECTION

by Mark Sullivan, with thanks to The Washington Blade, 1/8/88

Researchers at Genetech Inc., a San Francisco-based bio-technology firm, have developed a protein that apparently "sops up the AIDS virus like a sponge" and prevents it from infecting healthy cells, according to the San Francisco Sentinel, a gay newspaper. The protein, called CD4, is found naturally on the outer coat of T-cells, the white blood cells that are the key sentries of the immune system. When the AIDS virus attacks the T-cells, a protein on its outer coat fuses with the CD4 protein. But researchers at at Genentech, who have found a way to duplicate the CD4 protein, say they believe that injecting the synthetic protein into the bloodstream of a person infected with the AIDS virus causes the virus to fuse with the decoys and leave the healthy T-cells alone. Daniel Capon, a Genetech researcher, said that the protein would not eliminate the AIDS virus from the body altogether, but would slow or halt the progression of the disease. Capon said there is some evidence that anti-viral drugs could be attached to the synthetic protein to kill the virus.

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NEW DRUGS, TREATMENTS HIGHLIGHTED

by Mark Sullivan, with thanks to The Washington Blade, 2/5/88

INTEREST IN ALTERNATIVE TREATMENTS FOR AIDS has prompted Gay Men's Health Crisis of New York to begin publishing a newsletter promising new drugs and experimental treatment regimens. The new newsletter, called Treatment Issues, began publication in November, 1987 after officials at the GMHC medical information program realized that there were a great many people interested in alternative therapies. The mailing list for the newsletter is already up to about 7000. A recent edition of the newsletter, which is published about every 6 weeks, contains detailed information about testing of Carrisyn, a drug derived from the aloe plant that some researchers think can be used safely as an immune stimulant. Also reported is information about the antiviral effects of dextran sulfate, and the disappointing results of tests for the antibiotic drug fusidic acid. The newsletter also lists several experimental treatment regimens for people with AIDS and ARC. For more information, call GMHC: 212/627-7737.

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AZT PRICE LOWERED

by Lori Kenschaft, with thanks to Boston's Gay Community News, 1/10-16/88

BURROUGHS WELLCOME HAS CUT BY 20% the price of AZT, which is the only AIDS treatment currently licensed by the FDA. The drug previously cost up to $10,000 a year. The Greenville, North Carolina company has justified the high cost by citing its own substantial development and production costs. According to the New York Times, Burroughs Wellcome now reports that it will be able to produce more of the drug at less cost, and that the savings will be passed on to people with AIDS taking the drug. The price reduction was announced two days before a scheduled meeting to discuss AZT prices with the New York State Consumer Board and Assemblyman Gerrold Nadler (D-Manhattan). The company has previously refused to discuss the price of AZT. After company officials failed to attend an October hearing, Nadler, who is chair of the assembly's consumer affairs committee, warned that if they failed to justify the price he would issue a subpoena to gain the information.

TRIMETREXATE FOR PCP

by Lida Vislisel, with thanks to The Washington Blade, 2/19/88

THE FOOD AND DRUG ADMINISTRATION and the National Institute of Allergy and Infectious Diseases announced the first distribution of an AIDS-related experimental drug under its new drug approval guidelines. The drug, trimetrexate, is to be used for treatment of pneumocystis carinii pneumonia (PCP), a potentially life-threatening infection which often afflicts people with AIDS. Manufactured by the Warner-Lambert Co. of Morris Plains, N.J., trimetrexate was developed as an anti-cancer drug in 1969, but was not considered for use against PCP until the summer of 1985 by a scientist at the National Cancer Institute. Although two approved drugs— trimethoprim-sulfamethoxazole and intravenous pentamidine— already exist to treat PCP, they are toxic to some patients and not always effective. trimetrexate, which is administered intravenously, must be used with another approved drug, leucovorin, to make it less toxic. The treatment investigational new drug (IND) program was instituted June, 1987 to enable patients with immediate life-threatening conditions to receive promising experimental drugs before testing is completed. Under the new guidelines, AIDS patients with PCP who are intolerant of the already approved therapies are eligible to receive trimetrexate. Those persons interested in this new drug should have the **NIAID Hotline at 1/800/426-7527**, or may call themselves for more details.

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AZT RESULTS DISAPPOINTING

by Mark Sullivan, with thanks to The Washington Blade, 1/29/88

MOST PARTICIPANTS IN A SIX-MONTH-OLD STUDY ON THE EFFECTS OF THE DRUG AZT on people who have tested positive for the AIDS antibody but have not yet developed the disease are showing significant deterioration of their immune systems, reports the Miami News. Dr. Margaret Fischl, head of Jackson Memorial Hospital's AIDS Research Unit, said that most participants in the study have suffered a decrease in their T-cells, which help ward off infection. "Most investigators had the general feeling that the majority of the asymptomatic would have normal T-cells," Fischl said. "That has turned out not to be true." Fischl said, however, that it is too early to write off the effectiveness of AZT for people who have tested positive for the AIDS antibody. The study is slated to last three years. Jackson Memorial, in Miami, is one of 19 centers across the country testing the effectiveness of AIDS on people who show no symptoms of AIDS.

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CHILDREN ON AZT IN TRIALS

IN THE FIRST EXPANDED TRIALS IN THE U.S., INVESTIGATORS at The Johns Hopkins Medical Institutions have begun testing the safety and effectiveness of the drug AZT in children infected with HIV. Hopkins is one of seven initial centers designated by the National Institute of Allergy and Infectious Diseases (NIAID) and Burroughs Wellcome Pharmaceuticals to conduct the trials. Nationally, 50 to 70 children are expected to participate. "There is no specific therapy available for treatment of HIV infections in children in the U.S.," says John Modlin, MD, associate professor of pediatrics and principal investigator of the study at Hopkins. "The AZT study is an important beginning," he adds. Children with HIV infection have a poor prognosis: 70% younger than one year and 50% of older children die within a year of diagnosis. Intervening with an antiviral therapy, such as AZT, may alter the course of the disease and decrease the death rate among these children, Modlin says. Although pediatric AIDS patients share some adult patients' symptoms— such as diarrhea, swollen lymph glands and Pneumocystis carinii pneumonia— children are more likely to develop bacterial infections and often have lymphoid interstitial pneumonia, a pneumonia unique to children. AZT (azidothymidine/retrovir/zidovudine) has delayed development in adults of serious AIDS-related infections. AZT inhibits HIV's ability to replicate.

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MEDICAL THERAPY: PARTNERSHIP

from a letter to the editor by Richard Keeling, MD, with thanks to The Washington Blade, 1/15/88

THE DISCUSSION OF ALTERNATIVE TREATMENTS FOR AIDS...should not end...citing the lack of scientific evidence proving that any alternative therapies lengthen or improve the quality of lives of people with HIV infection. HIV infection is not just a problem of science, and not all knowledge is quantifiable. The enemies of people with HIV infection include besides HIV and opportunistic infectious agents: despair, hopelessness, and depression; silence, uncertainty, and resignation; prejudice and discrimination. We who care for them may compound their suffering with ignorance, rigid thinking, and limited vision. The proper management of HIV infection involves managing a person's encounter with all of these things. Medical care becomes a framework of concern and participation within which specific issues are addressed. It is important to acknowledge pain, not just to fix what hurts; to restore self-esteem, not just to treat diseases; to promote power and hope, not just to shrug meaninglessly at the "natural history" of AIDS; and to accept the cycles of life, without being enslaved by resignation to inevitable death. We must balance not just quality and quantity of life, but "scientific proof" and hope. There are many alternative therapies. Some are poorly documented in this country; many are inadequately tested in scientific terms. But science, technology, and numbers can only measure some kinds of information. The alternative therapy that promotes self-esteem, gives a sense of control and power, allows a blooming of spirit, and fosters hope is very valuable indeed, though it may not produce "publishable" numbers. recognizing that some knowing is not grounded in data does not discredit medical science. On the other hand, some alternative therapies, like some medical therapies, are unreasonably costly, unacceptably toxic, or clearly unhelpful. An effective and trusting partnership between an individual and a health care provider enables the risks and benefits of traditional and alternative treatments to be weighed and discussed openly and dispassionately. No doubt it is difficult for people with HIV infection to trust a health care system that has been too long silent and contemplative; too long inclined to document, and not so fast to respond. One does not have to ignore scientific data to listen to other information as well. Medical care for people with HIV infection must be a partnership, not a battle.

[Dr. Keeling is the chairman of the Task Force on AIDS, American College Health Association, and the Director, Student Health Service. University of Virginia—Charlottesville.]

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PROFITEERING IN AIDS?

an editorial, with thanks to Boston's Bay Windows, 11/5/87

Profiteering has existed since the dawn of time. Pervasive, yes--pretty, no. And one of the ugliest recent examples is a spate of money-making schemes taking advantage of people's concern about AIDS. Bay Windows recently declined advertising space to a company marketing commemorative AIDS medallions. The company trumpeted the fact it wold donate money--$26, to be exact-- to AIDS projects nationwide for each two-coin set sold. At first glance, this might seem a philanthropic gesture. After we checked with area coin dealers, however, the company's halo began to tarnish. Even after production costs, packaging, advertising, and charitable donations, the company was probably making at least a 50% profit off of the $98.50 AIDS medallion offer. No matter how you cut it, the medallion offer was a sweet deal for the company concerned. And the company emphasized, we were the only "major" gay paper that declined their ad. Making maoney from pain and suffering is unpardonable, especially when cloaked as a gesture of concern. According to the medallion manufacturer, it became involved with marketing AIDS medallions "...simply because we care...offering financial support to not-for-profit agencies that extend care for persons with AIDS, and their families, is the way we choose to help." Miracle cures, immunity boosters, self-help books --the list goes on and on. AIDS is being merchandized relentlessly. A typical pitch runs: if you care about AIDS, buty this product. Unfortunately, since gays and lesbians have played such a large part in the fight against AIDS, many people from our community assume anything having to do with AIDS or AIDS fundraising must be good and well-intentioned. In the words of Gershwin, however, it ain't necessarily so. Our publisher is currently working with AIDS Action Committee to develop guidelines for accepting advertising for AIDS fundraisers. Until then, decisions will be made on a case-by-case basis. Why are we doing this? Simply because we care. The ultimate responsibility for avoiding AIDS profiteers, though, falls on all of us. With a federal government largely unresponsive, every dollar our community can raise to end this crisis is precious. AIDS is becoming big business for speculators in tragedy-- it's time we become sophisticated consumers.

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DOCTOR REINSTATED IN CHICAGO

by Michael Botkin, with thanks to the Boston's Gay Community News, 10/4-10/87

As part of an out-of-court settlement reached between his attorneys and Cook County Hospital (CCH), Dr. Renslow Sherer was reinstated as Director of AIDS services at CCH. The hospital also acknowledged that all of its 4000 employees can give information to the media on matters of public concern without prior clearance from its Office of Public Affairs. Sherer was removed from his post by hospital director Terrance Hansen on July 23 after revealing that CCH was soon going to open an AIDS ward. Although Sherer's dismissal was seen by the gay community as punsihment for his gay-affirmative stance, Hansen claimed that this action was taken because Sherer failed to seek administration approval for his statement before makingit. However, a local court immediately struck down CCH's attempt to establish a "gag law" as clearly unconstitutional. The hospital has agreed to send letters to all its employees announcing the elimination of the gag law.

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MONEY CONTROVERSY

with thanks to Detroit's Cruise, 9/2/87

Time Incorporated's Money Magazine has a backlash on its hands. Reacting to a story about a homosexual man with AIDS and his lover that ran in the magazine's popular "One Couple's Finances" column, 21 readers canceled their subscriptions within two weeks of the article's appearance. By mid-July the number of cancellations had risen to 33. 85% of over 100 letters to the editor expressed outrage or disappointment. It is more mail than the magazine has ever received for a single article, according to Money editor Landon Jones. Although the piece, titled "Paying AIDS Cruel Cost," focuses on the financial ruin that often afflicts AIDS victims, the initial negative response came mainly from readers in Middle America who felt "that the magazine seemed to be accepting something that they did not condone," says Jones. "We in New York tend to get very insulated," he says. "We thought the rest of the contry would be more sympathetic." Alarmed by the vituperation of some of the responses, the article's writer, Suzanne Seixas, telephoned the couple with whom she hd spent two days while researching the story. They reported that they had also received several letters. But they said, all were compassionate, including offers of money, lodging, and moral support. Jones says he will continue to combine social conscience and personal finance. "We're proud of the story," he says, "and will probably run another article on AIDS before the year is out."

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CHICAGO MED SOCIETY PRINTS FLIER

by Tracy Baim, with thanks to Chicago Outlines, 8/27/87

Despite its release of a comprehensive AIDS service directory, including many gay resources, the Chicago Medical Society continues to refuse placement of an ad by the Gay and Lesbian Physicians of Chicago in the Society's magazine, Chicago Medicine, and GLPC is not mentioned in the AIDS pamphlet. GLPC submitted a paid advertisement for publication in the magazine in December, 1986, and it took two months for the Society to "decline" the ad without reason. Chicago Medical Society Presidnet Dr. robert Vanecko, who is also chair of the editorial advisory staff of the magazine, has refused comment. The resource pamphlet is produced solely by the CMS and has been distributed to all 11,000 members physicians, bound into the magazine, and sent to many social service and AIDS organizations. And while the pamphlet of AIDS organizations includes many gay/lesbian groups and gay AIDS organizations, there is one notable organization missing--GLPC. Dr. Frank Pierl, GLPC president, in his numerous letters to CMS, questions the Society's commitment to eradicating AIDS given its refusal to place the ad and given that they have not placed GLPC-- which offers a physician referral service and other services related to AIDS-- in the AIDS pamphlet.

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EARLY AIDS CASES IN NYC, 1977-78

by Lori Kenschaft, with thanks to Boston's Gay Community News, 2/28-3/5/88

RESEARCHERS HAVE IDENTIFIED WHAT THEY BELIEVE may be four of the earliest and longest-living AIDS cases in New York. According to the New York Times, all four were gay men who had the form of Kaposi's sarcoma characteristic of AIDS. Two were diagnosed in 1977, and two in 1978. Other studies have found KS does not usually develop until at least three years after infection, indicating that HIV was probably present in New York as early as 1974. Two of the men were known to be alive in 1987, making them among the longest-lived people with AIDS. The others died in 1983 and 1986. The average survival after diagnosis witharchers have asked the ethics board of the state health department for permission to try to reach the two men who may still be alive, something that is not normally allowed under the rules of confidentiality. They say they hope to identify biological factors that may have helped the men fight the disease for so long.

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SAN FRANCISCO STUDY: MORE AIDS

by Mark Sullivan, with thanks to The Washington Blade, 2/12/88

A NEW STUDY BY THE SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH INDICATES that while the spread of the AIDS virus by sexual contact in that city has virtually come to a halt, the number of people exposed who will eventually develop the disease is higher than previously thought. San Francisco's Bay Area Reporter said that the study, conducted by Dr. George Lemp, an epidemiologist specializing in AIDS at the public health department, shows that a dramatic change in sexual behaviors has resulted in very few new cases of the disease being spread through sexual contact. But Lemp's study also indicated that between 52-100% of those testing positive for the AIDS antibody will eventually develop the disease. These figures are considerably higher than those of the federal Centers for Disease Control in Atlanta. Chuck Falls, a CDC spokesman, said that the CDC currently estimates that about 30% of those testing HIV antibody positive will develop full-blown AIDS, and another 30% will develop lesser forms of disease. Lemp said that his projection is different from the CDC projection because in addition to data on past AIDS cases, he also considered detailed studies of the rate of infection and the rate of the development of the disease in other studies conducted on gay men in the city, as well as a study of the development of the disease among I.V. drug abusers. Lemp said that the numbers of AIDS cases in San Francisco will continue to grow until the mid-1990s, when the number of new cases will decline because of the lower number of people becoming newly infected with the disease now.

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COMMISSION'S PROPOSALS PRAISED

by Lisa Keen, with thanks to The Washington Blade, 2/26/88

GAY AND AIDS ACTIVISTS REACTED VERY FAVORABLY to recommendations proposed by White House AIDS Commission Chairman Admiral James Watkins. The recommendations— 180 specific proposals in all— range from increasing the numbers and amounts of grants and financial incentives to health care providers and researchers, to decreasing the amount of time and paperwork required to get new drugs tested and out to people who need them. Watkins said he will present his recommendations to the full AIDS Commission and expects to present the finalized recommendations to President Reagan by the middle of March. A White House spokesperson said the the President's only reaction to Watkins' recommendations thus far is that he believes the AIDS Commission is doing "an excellent and dedicated job." Watkins said he believes his recommendations on drug abuse treatment and education alone would cost the federal government about $950 million per year for each of 10 years. He said he did not have an estimate yet on how much his proposals concerning drug development and increased personnel would cost, and added that the $950 million figure should be "new dollars" added to what the federal government is already spending. Watkins declined to comment on how the Reagan administration might react to the price tag but added, "It's only seven-tenths of a percent of the Defense [Department] budget." It's pretty good," said National Gay & Lesbian Task Force Executive Director Jeff Levi in reaction to Watkin's recommendations. "He's asking for so much money, and there's an overall recognition for both financial resources and people resources." Steve Smith, lobbyist on AIDS issues for the Human Rights Campaign Fund, said he was "pleased and impressed" with Watkins' recommendations. Among the 180 recommendations, noted Smith, are about half a dozen recommended by HRCF Executive Director Vic Basile at a recent hearing in New York City. Among them, he said, is a recommendation to include representatives of the Office of Personnel Management and Office of Management and Budget on the public Health Service's Executive Task Force on AIDS and to require these agencies to respond within 21 days to requests from the Centers for Disease Control and National Institutes of Health. A large number of Watkins' recommendations appeared to address complaints aired by gay and AIDS activists for months now that the new drug approval process is too slow and prevents terminally ill people from obtaining drugs which could be of potential benefit. Among the 43 recommendations addressed at "Drug Development" were proposals that:

>New drug approval reviews be speeded up by using computer communications, rather than just paperwork interaction between the Food and Drug Administration and drug sponsors.

>A special approval process process be used for medical foods, such as the egg-based AL-721, especially those substances which have been long used for other diseases.

>The number of full-time drug application reviewers be "immediately doubled" to meet the doubled number of new drug applications.

>The number of full-time employees working on federal clinical drug trials be "immediately increased from 47 to 120."

>A direct grant program be "immediately funded" to help support community-based drug trial sponsors.

>Placebo-controlled studies be used only with persons who test positive for the AIDS antibody, not with people with AIDS.

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AIDS INSTITUTE AT JOHNS HOPKINS

by Mark Sullivan, with thanks to The Washington Blade, 1/15/88

OFFICIALS AT BALTIMORE'S JOHNS HOPKINS UNIVERSITY ANNOUNCED PLANS for the creation of an AIDS Institute at the University. The present 10-bed unit for PWAs at Johns Hopkins Hospital will be expanded to 20 beds by the middle of the year, and a hospice and long-term care facilities will be added. More AIDS laboratories for current and future research projects are also planned, including a center dedicated solely to research on retroviruses. Steven Miller, president of the university, said that the new institute will help to "expand vigorous efforts in research, public education, and patient care." He added that the institute would serve as "an umbrella over the AIDS research effort already under way at Johns Hopkins, and a framework which should enhance our ability to compete for more funding." Johns Hopkins already had $42 million in AIDS-related research grants, the most of any academic center in the country.

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ADVERTISEMENT IS DEATH DEFYING

with thanks to Detroit's Cruise, 2/3/88

THE OREGON HEALTH DEPARTMENT HAS PRODUCED A MILDLY SARCASTIC TELEVISION MESSAGE ABOUT AIDS. As a voice-over tells us "Americans love flirting with death," we see a man going over Niagara Falls, another being shot out of a cannon and another flying from one ramp to another on a motorcycle. Then we see a woman's clothes scattered on the floor as the voice-over explains that Americans "even perform death-defying acts nightly: they make love without using a condom." The sardonic tone makes an interesting change form the earnestness of most advertising about AIDS.

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TRANSVESTITES IN GREECE ORGANIZE

file by John Perry, with thanks to Boston's Bay Windows, 2/25/88

GREEK TRANSVESTITES HAVE FORMED A POLITICAL PARTY, the Panhellenic Nonaligned movement of Equality (PNME), reports the February 19 Montrose Voice. President of the new party, Haralambos Tamoutsides, a.k.a. "Aloma," explains that the transvestites hope to counter police harassment, which has risen sharply since Greece reported its first case of AIDS in 1987. Currently organized in an unofficial union, Greek transvestites hold meeting and an annual ball and pageant of beauty. Greek law requires that PNME apply to the Supreme Court for approval of the party's name and constitution. PNME's five-member executive board stated in its application that the party "will not undertake any actions against the state and that they will not try to overthrow the country's democratic regime."

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SEXUAL ASSAULT IN MEN

abridged from an article by Mark Perigard, with thanks to Boston's Bay Windows, 2/18-24/88

OVER 10% OF ALL SEXUAL ASSAULTS in Boston in 1987 were attacks on males, according to information supplied by the Boston Police Department (BPD). Of the 501 sexual assault complaints recorded, 64 cases were assaults on men. Police reported 21 rapes of youths under the age of 16, and 14 complaints of indecent assault and battery on youths under 16. Local experts agree, however, that the problem is vastly underreported. Men who are sexually victimized suffer severe traumas complicated by the "macho" ethic in this society and are unlikely to step forward, according to Mike Lew, a psychotherapist with Next Step Counseling. Straight men may go through a period of doubting their own sexuality. Gay men may react by thinking that they brought the assault on themselves by simply being gay, he said. The assault may inflame their own internalized homophobia. "Men aren't used to thinking of themselves as being raped. They think it's something that only happens to women. they think they should be able to fight off their attackers," commented Joyce Collier, coordinator of the Victim Recovery Project at Boston's Fenway Community Health Center. Victims of assault invariably blame themselves, Lew said. "It doesn't yield to logic, something so traumatic, yet the person" will find a way to castigate himself, he said, by telling himself that he was too cute, that he dressed too provocatively, that he somehow "asked for it." Victims may also suffer from a "great difficulty in sustaining any kind of intimacy, not just sexual, in a relationship," he added. Some gay men may begin seeking out relationships with men who will be abusive to them. Lew explained, "Sometimes it's easier to accept the victim role because it's easier, you know how to do it. When someone shows real tenderness and caring, you get suspicious. You don't know how to deal with it." And then there's the worst-case scenario, where a rape could ultimately be fatal, as in the case of a man who transmits HIV to his victim. Key to a healthy recovery for any victim of a sexual assault, Collier said, is the willingness to talk about the incident. "It's very difficult for men to come forward to report a rape, but it's very important for that to happen. When people are left alone with these feelings they become very isolated. It's very important to call and get help," Collier stressed. According to Jim Jordan of the BPD, most rapes fall into two categories, the "blitz" attack, where the victim doesn't know her or his assailant, and the "confidential rape," where the victim is acquainted with the perpetrator. About one-third of all rapes fall into the "blitz" category, he said. Collier stated that little attention has been paid to the phenomenon of "date rape" in the gay male community. Many gay men make arrangements to go home with someone and agree to some sort of particular sexual activity--only to have their partners coerce them into something else— such as s/m or unsafe sex— she said. While this description may not fulfill the classic "date rape" scenario— with one partner steadfastly refusing to engage in sexual activity— it still qualifies as a sexual assault, Collier argued. "If one partner is resisting and the other one forces himself on him, that's rape," she declared.

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NEW TEST CONFIRMS OTHER DISEASES

by Mark Sullivan, with thanks to The Washington Blade, 1/22/88

A NEW TEST HAS BEEN DEVELOPED WHICH CONFIRMS whether people whose blood contains AIDS antibodies are actually infected with the virus, according to researchers at the federal CDC. The new test, called the polymeres chain reaction test, pinpoints small pieces of the virus' genetic material in the blood. By causing the virus' DNA to duplicate itself, scientists can more easily detect the virus' DNA even if it is present in only one cell in every 100,000. Because so few cells are infected in any stage of the disease, searching for the AIDS virus' DNA is like "looking for a needle in a haystack," said Gerald Schochetman, chief of the CDC's AIDS program. "The best way to do it is if you can multiply the number of needles." Besides the AIDS virus, Schochetman said the new test could be used to detect other diseases such as herpes and hepatitis. It can be used to test not only blood cells, but cells from the semen, brain, or other organs. Janice Cuiper, a spokeswoman for the Cetus Corporation which developed the test, said that the procedure should be made available to some laboratories for more testing this summer. Pending approval by the Food and Drug Administration, the tests should be available for widespread use by 1989.

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NEW PRECAUTIONS URGED IN LABS

by Nadine McGann, with thanks to Chicago Outlines, 1/7/88

NEW PRECAUTIONS FOR SCIENTISTS AND TECHNICIANS WORKING WITH THE AIDS VIRUS were urged in a report published in Science by Dr. Stanley Weiss of the New Jersey Medical School. It was determined that a laboratory worker working with a solution containing a high concentration of the virus who had become infected did not contract the infection through an "accident," such as being pricked by a contaminated needle or acquiring the virus through cuts or abrasions in the skin, according to The New York Times. While there have been some cases involving such "accidental" infection of health care workers, Weiss said this is the first case reported in which none of these circumstances were present, and suggested that the infection may have occurred if the laboratory worker touched his or her eyes, nose, or mouth with a glove that had been in contact with the virus. Weiss said the report of his study "has no bearing on the question of casual transmission... this is an occupation-related infection," and emphasized the virus is thousands of times more concentrated in a laboratory solution than in its natural form. The report recommends the use of double gloves and masks by some workers because a mask will decrease the chance of a worker touching his/her mouth with a gloved hand.

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UNDERESTIMATES OF IV USER DEATH

by Marea Murray, with thanks to Boston's Gay Community News, 1/24-30/88

New York Department of Health epidemiologist Rand Stoneburner and several colleagues report there are 150% more AIDS-related deaths among IV drug users in New York City than previously thought. Speaking at a recent American Public Health Association meeting in New Orleans, Stoneburner reported new data are based partly on a revised definition of AIDS as of September, 1987. Pneumonia, endocarditis, tuberculosis, and other diseases previously separated from an AIDS definition by CDC standards are now considered the "opportunistic infections" connected with a diagnosis of AIDS. According to The Drug Abuse Report, (a newsletter for professionals who treat addiction), it's "safe to conclude" that the number of AIDS-related deaths among New York City IV drug users for the 1981-86 period comprised 53% of all AIDS deaths, rather than the 31% previously reported. The City's health department reviewed 8,477 narcotic related deaths from 1978-86 in the survey. Deaths increased from 492 in 1981 to 1996 in 1986. Those fitting the usual AIDS definition went from 9 in 1982 to 904 in 1986. However, pneumonia-related deaths rose from 32 to 283, endocarditis-related deaths jumped from 29 to 122; and tuberculosis-related deaths rose from 3 to 32 during that period. In addition, a high percentage of these IV drug users died with oral thrush and lymphadenopathy--also now considered AIDS-related by the CDC.

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NEEDLES TO BE GIVEN OUT BY NY STATE

by Elizabeth Pincus, with thanks to Boston's Gay Community News, 2/7-13/88

NEW YORK WILL BECOME THE FIRST STATE in the country to distribute clean needles and syringes to IV drug abusers in an effort to curtail the spread of AIDS. Under the program, which is slated to begin this spring on a one-year trial basis, IV drug users will be given new needles and syringes by government health agencies when they return used equipment issued in a previous visit, according to the Boston Globe. Similar needle-exchange programs in Europe provided the model for the New York Project, which was adopted by New York City health commissioner Stephen Joseph. His proposal recommends that IV drug users be encouraged to seek methadone treatment to accompany their participation in the clean-needle program. Health officials said they plan to require photo-ID cards of those using the program, but may wave the rule if it appears to keep participants away. Gov. Mario Cuomo, who initially expressed resistance, has since acknowledged grudging support for the needle-exchange plan, according to state health department spokesman Peter Slocum. Cuomo's reversal drew sharp criticism from John O'Connor, the Roman Catholic Cardinal of New York, and from New York City's narcotics prosecutor Sterling Johnson, who said that state health officials had no legal authority to launch a clean-needle program, and that he may prosecute officials if they proceed with the project. Boston health authorities are also considering the implementation of a similar program, despite the opposition of Massachusetts Governor Michael Dukakis and state health commissioner Deborah Prothrow-Stith. The federal CDC estimates that approximately 25% of the nation's cases of AIDS are attributable to sharing contaminated needles during IV drug use.

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PROSTITUTE CHARGED

by Lori Kenschaft, with thanks to Boston's Gay Community News, 1/17-23/88

A JUDGE SET BAIL AT $204,000 for Elizabeth Kay Sherouse after her arrest in Orlando, Florida on two charges of attempted manslaughter for practicing prostitution with knowledge that she is infected with HIV. "We are talking about hundreds of victims, there's no doubt," said sheriff's spokesperson Randy Means, who described Sherouse as a "very active" prostitute who may have had sex with up to five men a night, seven nights a week. According to the Montrose Voice, the charges include only two counts of attempted manslaughter because only two of her clients are willing to cooperate with her prosecution. Both men said they wore condoms. People arrested on prostitution charges are tested three times before they are labeled as carriers. Sherouse was notified last year of her antibody status and was again arrested for prostitution in July and August. A warrant for her arrest was issued in October, after investigators and state prosecutors researched the legal basis for bringing such charges against an HIV-infected prostitute.

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BURROUGHS DEMONSTRATORS ARRESTED

by Lida Vislisel, with thanks to The Washington Blade, 2/19/88

NINETEEN DEMONSTRATORS, INCLUDING SEVERAL PWAs, WERE ARRESTED at the California offices of Burroughs-Wellcome, the producer of the medication AZT. The protesters were part of a crowd of over 100 who were demonstrating against the high cost of the life-prolonging AIDS drug, AZT. Most of those arrested climbed onto the roof of the company's office building, and were planning to shut down the company's warehouse, which had already been shut down by company officials on the day of the protest. Protesters covered the lawns around the building with fake $100 bills in the non-violent protest. As people were being arrested, others shouted, "Arrest the profiteers, not the angry queers!" The protest began the day before in San Francisco as a 15 mile march, with an overnight rest at a Catholic Church in San Bruno. Organizers of the march and protest called on Burroughs-Wellcome to open its financial books to independent investigators to reassure those buying the drug AZT that they are not being price-gouged by the company. The cost of AZT, the most expensive prescription drug in the United States, is estimated at between $8-10,000 per person annually.

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SURVIVAL STATISTICS

by Michael Helquist, from "The Helquist Report," with thanks to The Advocate, 2/2/88, and
with thanks to AIDS Digest, the AIDS Response Program of Orange County (California), February, 1988

PEOPLE WITH HIV INFECTION, ARC, OR AIDS MAY FEEL CAUGHT IN THE CROSS FIRE as scientists, educators, and the media debate the prospects for their continuing survival. On the one hand, statistics from New York and San Francisco suggest that real advances in therapies have occurred, ensuring a longer life span for many diagnosed people. At the same time, many health officials and much of the media have adopted an unproven notion that everyone with HIV infection will die. The conflict can result in emotional trauma for people threatened by AIDS as they try to exert some control over the disease. Scientists from the New York City Dept. of Health and the Centers for Disease Control have reported (The New England Journal of medicine, 11/19/87) that 15% of people with AIDS in NYC survived for at least five years after diagnosis. This finding was higher than expected, leading the researchers to comment that less than a decade's experience with the disease was insufficient to conclude that AIDS was uniformly fatal. Gay white men fared the best in these statistics; IV drug users, women, blacks, and hispanics with AIDS tended to have much shorter life spans after diagnosis. [ED NOTE: Probably related to lack of earlier access to health care, distrust of medical systems & bureaucracies, and economics?] In San Francisco, a related study of the 3600 people diagnosed with the disease between 1981 and 1986 found that the median life span had extended four months. This means that those individuals diagnosed with AIDS in 1987 and later have a statistically better chance to survive longer than those diagnosed in earlier years. The median length of survival rose from 10.2 months to 14.14 months during the first five years of the disease in that city. Health officials noted that this was the first time that improved survival has been noted among people with AIDS in San Francisco. Another study in San Francisco led researchers to estimate that AIDS will develop in 57% of people infected with HIV within 16 years of their initial infection. Although this is still grim news, it is better than earlier predictions that AIDS would develop in 36% of HIV seropositives within 7 years. Other officials have suggested that the rate would increase sharply each year. Other officials have suggested that the rate would increase sharply each year. One of the SF researchers concluded during an AIDS conference in that city, "It's possible people could live their lives infected and die without every getting AIDS." The encouraging news from these three studies has been offset somewhat in the media by pronouncements from health officials and government bureaucrats. For example, in The New York Times on December 18, 1987, State Health Commissioner Dr. David Axelrod was quoted as saying that "virtually all those infected are doomed." In his nationally syndicated newspaper column, Jack Anderson garnered headlines by reporting that the CIA has determined from medical reports that all HIV seropositives will die. [ED NOTE: And all "seronegatives" will never die??] TV and radio newscasters have taken to repeating glibly these dire predictions, seemingly without any notion of the effect of their statements on those whose lives are threatened. This callousness occurs at a time when the media have also renewed their characterization of people with AIDS as "AIDS victims." Author and reporter Randy Shilts contributed to this stance with his facile and superficial description of "AIDS-peak" in his book nd the Band Played On. Some of the first AIDS activists in San Francisco-- Gary Walsh, Bobbi Campbell, and Mark Feldman-- provided a profound personal theme to Shilts's volume. They chose to go public with their diagnoses and to define themselves not as victims but as determined and committed "people with AIDS." However, Shilts in effect dismisses their courage and their desire not to be victimized as an example of AIDSspeak in its "psychologically reassuring" form. A rebuttal to his descriptions would certainly have come from them if they had lived long enough to do so. People with HIV infection, ARC, or AIDS face a challenge today similar to that encountered by others in 1982 and 1983: They must understand their predicament, absorb all the medical information that is relevant, defend their rights, and create a life with as much meaning and happiness as is possible. Their courage is as inspiring today as it was in the early years of the epidemic.

MINORITY COUNCIL NEEDS VOLUNTEERS

with thanks to The Washington Blade, 2/26/88

THE NATIONAL AIDS MINORITY COUNCIL IS LOOKING for volunteers to expand its AIDS education programs serving people of color across the country. People with typing and word processing skills are especially needed, as are men and women of color. For more information, call Executive Director Don Edwards (202/544-1076) or visit the Council's new office at 714 G. Street, S.E., Washington, DC.

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HETERO "CRISIS:" MASTERS & JOHNSON

by Bruce Voeller, PhD, with thanks to the Mariposa Education & Research Foundation, 3/6/88

MASTERS & JOHNSON'S NEW BOOK, CRISIS: HETEROSEXUAL BEHAVIOR IN THE AGE OF AIDS IS JUST HITTING THE STREETS. I regret to say that, distinguished sex researchers though they are, M & J and their co-author, Kolodny, are not AIDS experts. Their new book will cause much needless mischief and public fright. It and its press coverage, show how dangerous it is for specialists in one area to opine outside their expertise. Regrettably, both Nobel Prize winners and the public forget that deserved celebrity for unique knowledge in chemistry, for example, does not in itself guarantee the same expertise in biology or physics, never mind in the social, moral or political arenas. M & J's book alludes to `theoretical' possibilities of the spread of AIDS virus through saliva, from contact with toilet seats, from kissing, etc. Many of us have been concerned about such questions in the recent past. But those issues are now settled for all practical purposes. Among the evidences are the results of the celebrated "MACS" studies which have been extensively discussed in recent issues of the Mariposa Newsletter. A large, additional body of data contradicts such `theoretical' risks as M & J raise. there are: data from infected hemophiliac boys and their uninfected classmates, living together in a French boarding school; major studies of the safety of the families and housemates of persons infected through transfusion, through drug use, ...of infected gay or bisexual men, et. ALL these studies from around the world demonstrate reasonable doubt that AIDS is not transmitted to household members of someone with AIDS or ARC... neither by sharing dishes, towels or bedding, nor by sharing a toilet or sink or kitchen, nor by sleeping in the same bed. AIDS is transmitted by significant forms of sexual contact such as [unprotected] vaginal or anal intercourse (the possibility of infection of newborns by mother's milk is still unsettled). While rare, isolated cases may arise by other routes, they are exceptions proving the rule. With great respect for my friends Bill Masters and Ginny Johnson as sex researchers, they have unwisely gone beyond their expertise in CRISIS, failed to avail themselves of their colleagues' counsel prior to publication, and caused unwarranted fear and confusion to the public. They have also undermined the headway which was being made among AIDS researchers by those of us attempting to establish the relevance of sex research to solving the AIDS crisis.... For more information about Mariposa: P.O. Box 36835, Los Angeles, CA 90036 (818/704-4812). [ED NOTE: Dr. Voeller is all too kind to Masters & Johnson. I almost can't imagine two respected scientists doing more harm than these two, in confusing the public as well as medical professionals, and creating needless concern & hysteria. Watching Masters & Johnson stumble through a televised interview with ABC-TVs Ted Koppel and Dr. Timothy Johnson on Nightline gave me the distinct impression that they were irresponsible and incompetant— a sad perception of such notable sex researchers. Was the shrewd Kolodny the instigator, trying to make a buck by associating with them? I'm outraged! Their just desserts will be for the book to be a flop!]

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INSURERS ASK ABOUT SEX ORIENTATION

by Lou Chibbaro Jr. with thanks to The Washington Blade, 2/26/88

AT LEAST 18 OF THE NATION'S LARGEST HEALTH INSURANCE COMPANIES consider sexual orientation a factor in determining whether or not to grant insurance to applicants, according to a Congressional report released in February. The 60-page report, prepared by the Congressional Office of Technology Assessment, said the 18 companies were among 62 firms that responded to a detailed survey on their practices in dealing with AIDS. All of the firms offer health insurance to individuals. The report said that a separate questionnaire sent to the country's largest health maintenance organizations (HMOs) showed that out of 16 HMOs that issue insurance to individuals, 4 said they also consider an applicant's sexual orientation a factor in approving insurance. 86% of the insurance companies responding to the survey said they either screen or plan to screen individual applicants for the AIDS antibody. About half of the companies routinely require male applicants to take an AIDS antibody test as a condition for insurance. In some states where antibody tests are prohibited, such as in California, the companies require applicants to take a T-cell test, the report stated. Other firms that have not begun requiring the antibody test ask detailed questions related to AIDS on their application forms and in interviews, the report said. The report noted that the practice of considering an applicant's sexual orientation in insurance underwriting violates voluntary guidelines established last year by the National Association of Insurance Commissioners, a group that represents commissioners of insurance in all 50 states and in the District of Columbia. Jill Eden, an OTA official who helped prepare the report, said the Congressional Office will not release the names of the companies who participated in the survey. "We assured them their identities will be kept in strict confidence," said Eden. The report said insurers appear to obtain information about an applicant's sexual orientation through "indirect" means, such as interviews with an applicant's neighbors. One official with a firm that responded to the survey said the firm examines all references to an applicant's sexual orientation in the records sent to the firm by attending physicians. Jeff Levi, executive director of the National Gay and Lesbian Task Force, said many physicians treating gay patients routinely note the patient's sexual orientation in their reports, all of which must be sent to insurance companies when a patient signs a waiver form to enable the patient to apply for insurance policies. Physicians should take precautions to avoid exposing their patients to discrimination, Levi said, by not including information about sexual orientation in records. The Health Insurance Association of America, meanwhile, issued a statement criticizing the practice of using sexual orientation as a factor in underwriting. "The HIAA believes the best way for insurance companies to identify AIDS risk is by HIV antibody testing, with proper safeguards on confidentiality of test results," the statement said.

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HAWAII'S LIFE FOUNDATION HOSTS LAWS

abstracted with thanks to Lifelines, Newsletter of the Life Foundation, July-August, 1987

Out of a total of 36 AIDS-related bills introduced during the 1987 Hawaii legislature, seven bills were passed into law. Of the 7 bills enacted into law, five were sponsored by Honolulu's Life Foundation and the remainig two were sponsored by the Department of Health. One of the most important bills enacted is the informed prior consent law, which requires that before a person is subjected to a test for HIV infection, the person must give written consent. There are exceptions for organ donors, scientific research, and anonymous HIV antibody testing, the latter of which only requires verbal consent. Only a few other states have enacted similar laws and the Hawaii law probably affords the greatest protection that any other law in the country. The new law requires that third parties (such as insurance companies) that order tests must first obtain the consent of the person to be tested before a doctor or clinic can perform the test nd release the results. As a whole, the Life Foundation is encouraged by the number of Foundation-sponsored bills actually enacted into law. The legislature has created a climate where the rights of the individual are protected and where educational and testing programs stand the best chance of success. Summaries of the 7 bills: **Testing: Informed Consent.** All persons must provide written consent before a test for HIV infection can be performed (SB 1007). **Discrimination: Housing.** Prohibits housing discrimination against persons based on HIV infection. Prohibits sellers/landlords from requiring HIV testing (SB 830). **Discrimination: Insurance.** Prohibits insurance companies from inquiring about prior HIV testing or test results. Requires the insurance commissioner to adopt guidelines to regulate the prospective use of HIV testing (SB 833). **Confidentiality.** Strengthens current law which requires that all records and information relating to AIDS including that a person has been tested for AIDS be kept strictly confidential and imposes substantial fines for a breach. The information cannot be subpoenaed and a person cannot be compelled to consent to the release of the information in order to obtain or retain housing, employment, or education. (HB 889). **Disclosure: Blood Banks.** Permits the Dept. of Health to disclose to blood banks that a person has been exposed to HIV. (SB 993). **Reporting.** Requires that doctors and other health care professionals report all diagnosed AIDS cases to the Dept. of Health. Gives the director of the Dept. of Health the authority to declare ARC or positive HIV antibody test results reportable by administrative rule, although he has not done so. (SB 994). **Appropriations: AIDS Research.** Appropriates $200,000 to the Dept. of Health for epidemiological research on AIDS. Funds will be expended to support current research at the University of Hawaii, Dept. of Tropical Medicine. (SB 994). **Testing: Marriage Licenses.** Requires that the Dept. of Health make available to all applicants for marriage licenses in the state information about the availability of free, anonymous and voluntary antibody testing at STD clinics. (SB 1126).

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FRIENDS FOR LIFE AWARDS IN CHICAGO

Chicago's Howard Brown Memorial Clinic announced the recipients of its first annual "Friends for Life" Awards, to honor individuals who have made significant contributions to the clinic and to the community, particularly in the fight against AIDS. Their were four recipients for this year's awards. Dr. John Phair, chief of infectious diseases at Northwestern University Medical School and one of the foremost AIDS researchers in the nation, serves as the principal investigator of the Clinic's federally-funded AIDS research project, and heads a team of researchers that has already added significantly to our understanding of AIDS. Mary Featherston, a volunteer who has faithfully served the Clinic and its patients for some 8 years, was also honored. Dan Dileo and Ralph Paul Gernhardt were recognized for their work as co-publishers of Gay Chicago magazine who have helped raise hundreds of thousands of dollars for the Clinic and other AIDS organizations in the city. The awards presentation will take place at Howard Brown's annual black-tie benefit dinner October 17 at the Hyatt Regency Chicago.

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EDUCATION DEPT. IGNORES MORAL ISSUE

by Lou Chibbaro Jr., with thanks to The Washington Blade, 10/9/87

U.S. Secretary of Education William Bennett announced the release of a Department of Education pamphlet on AIDS which declares that the "moral compass" of the nation's young people must serve as the most important factor in preventing AIDS among teenagers and young adults. Jeff Levi, executive director of the National Gay & Lesbian Task Force, said the Bennett pamphlet "ignores the highest moral issue of all--the saving of lives of youths by accepting that teen sexuality is a reality." In a forward to the pamphlet, called "AIDS and the Education of Our Children: A Guide for Parents and Teachers," Bennett writes that adults must tell yong people the truth about AIDS, including the "risks and dangers-- moral, physical, and psychological --of irresponsible sex, of heedless, careless use of one's own or another person's body." DOE officials said nearly 300,000 copies ofthe 28-page pamplhelt will be sent fress of charge to school principals, school boards, heads of parents' groups, and other education specialists. Bennett's press secretary Loye Miller said the pamphlet is not intended to usurp the AIDS pamphlet released last year by U.S. Surgeon General C. Everett Koop. Bennett and white House domestic policy advisor Gary Bauer have attacked Koop's pamphlet for failing to stress moral values over mechanical methods as a means of preventing AIDS. Koop has said his pamphlet does stress moral values but also contains needed for those who decline to abstain from sex outside of heterosexual marriage. Although the Bennett pamphlet lists the modes of transmission for AIDS as reported by the U.S. Centers for disease Control,, it urges education to discourage condom use, claiming condoms are highly ineffective in preventing AIDS. It stresses that students should be taught to overcome peer pressure leading to premarital sex. NGLTF's Levi said that while discourging teen sexuality is one approach in combating AIDS, an effective AIDS prevention program cannot work unless young people are informed of the specific sexual practices that may lead to the transmission of AIDS and the practices that help prevent the transmission. The Bennett pamphlet states, "We must give young people the facts, but we must remember it is their sense of right and wrong, their internal moral compass, that determines their actions."

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FEDERAL HEALTH AGENCIES SUED

by Anne-Christine d'Adesky, with thanks to The New York Native, 7/13/87

The first civil class-action lawsuit of its kind has been filed against the federal health agencies by people with AIDS. On June 24th, California plaintiffs Randall Mark Klose, Donald C. Knutson, and the National Gay Rights Advocates (NGRA) filed a legal complaint in the U.S. District Court of Columbia agaisnt the National Institutes of Health (NIH), the Food and Drug Administraion (FDA), dn the U.S. Department of Health and Human Services (HHS), for the agencies' alleged "improper conduct" in the area of testing and approval of experimental AIDS drugs. The complaint was made on behalf of the 1.5 million Americans who have been exposed to HIV. "We know that the HHS, FDA, and the NIH are well aware of a numbe of encouraging drug therapies and treatments," said Jean O'Leary, Executive director of the San Francisco-based NGRA. "We also know that they are not doing enough to make them available to seriously ill and dying people. We demand an accountable system which will ensure public access to, and public scrutiny of, the tesinf of these drugs." The lawsuit charges that the NIH has deliberately favored drug companies which manufacture NIH-sponsored drugs, and blocked other promising drugs by setting stricter standards for their testing and approval. A dozen drugs, including ampligen, AL-721, ribavirin, and isoprinosine, were listed as drugs the FDA has "deliberately delayed or ignored," the NGRA complaint said. While plaintiffs praised the FDA's fast tract record for the speedy release of the FDA-approved AZT, and for DDC, it accused the agency of "arbitrary and capricious behavior" in its overall drug-testing policy. The NIH was singled out for allegedly failing to spend $47 million of Congressionally-approved funds for the treatment of PWAs with promising drugs. The complaint was filed as a class-action suit because the NGRA believes "There are questions of law or fact common to the class" of HIV antibody positive individuals. Current statistics from the CDC indicate that 60 Americans a day are diagnosed as having been exposed to HIV, while 35 PWAs die each day. The NGRA argues that without early treatement with experimental AIDS drugs, "every person diagnosed as having AIDS will die of the disease, on average, within less than two years." The specific charges are that NIH has favored drug companies with NIH contracts, such as Burroughs-Wellcome and Hoffman-LaRoche, which would legally constitute "conflicts of interest," says the NGRA. These conflicts take the form of "royalty payments from manufacturers licensed to develop NIH-sponsored drugs, and the NIH researchers' desire for self-aggrandizement," the lawsuit states. By contrast, the successful manufacture of drugs by companies without a contract with NIH would threaten "the individual work and reputation of NIH researchers," plaintiffs argue. Many people believe that AZT has set a new standard of approval of experimental AIDS drugs. But the NGRA says the FDA has applied stringent procedures for the approval of non-NIH-sponsore drugs which were not applied to AZT or DDC. An example of the FDA's alleged erratic behavior in testing drugs is ribavirin, considered by many to be an effective antiviral drug and which is less toxic than AZT. Ribavirin, the NGRA states, has been on "clinical hold" by the FDA, despite the fact that the U.S. Customs Service allows teh importation of a one month supply of the drug from Mexico. Such contradictory policies "are forcing the law-abiding citizens to become criminals in a desperate effort to save their own lives," says the NGRA. Government agencies and their respective leaders are being demanded to adopt, publish, and implement appropriate rules for NIH government research into drug testing to which the public would have access. They also want co-defendants Otis Bowen, the U.S. Secretary of Health and Human Services, and James Wyngaarden, director of the NIH, to account for the expenditure of the $47 million. The FDA should establish the same standards for all Investigational New Drugs that it did for AZT. Finally, NGRA is asking the FDA and Commissioner Frank Young to implement and publish regulations that would allow Citizens Petitions for the emergency investigation of new drugs. "We refuse to tolerate one further day of confusion, delays, and scientific secrets," said O'Leary. "It is our intent with this lawsuit to ensure that therapeutic drugs are made available to people with AIDS quickly and safely."

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REAGAN = NO BIAS PROHIBITIONS

by Janice Kaplan, with thanks to The Washington Blade, 9/25/87

The Reagan Administration, under fire for its opposition to federal legislation to protect persons infected with the AIDS virus, sought to clarify its position. The legislation, which was debated at a Capitol Hill hearing, wold greatly expand voluntary AIDS testing programs, would make test results confidential, and would prohibit discrimination against people who test positive for the AIDS antibody. The bill is sponsored by Rep. Henry Waxman (D-California) and Sen. Edward Kennedy (D-Massachusetts). Health and Human Services Secretary Otis Bowen told the congressional panel, "We do not think that federal intervention is necessary" and "each state shoud be abel to set its own rules." Bowen's office issued a statement, saying "...It was left unclear that HHS is already taking steps to support states in their efforts to ensure confidentiality and to protect against discrimination for those with AIDS or HIV infection, and that eventual federal action was not precluded." However, Bowen had told the House Subcommittee on Health and the Environment that Congress should not "rush in" before states can act. Acknowledging that persons infected with the AIDS virus have suffered discrimination in employment, school admissions, and housing, Bowen went on to say the states should be free to adopt or reject laws protecting people with AIDS. Bowen told the congressional panel that the administration also opposes several mandatory testing measures sponsored by anti-gay Congressman William Dannemeyer of California. Bowen later outlined a number of measures the administration has "already underway" to support state efforts to ensure confidentiality and protect against discrimination. Among these:

> HHS is soliciting from state governors "ideas and cooperation on issues of disclosure, discrimination, and protections for the public;"

> HHS is working with the state health officials to develop model legislation to protect confidentiality and prevent discrimination;

> HHS agencies are reviewing and "if necessary" strengthening of various protections in federal regulations under existing law;

> HHS is undertaking several studies—one to compare existing and pending state laws and another to document the nature and extent of confidentiality and antidiscrimination problems.

"I do not rule out the possibility of federal legislation on this issue, if it is shown to be needed," Bowen said. "But now is not the time to leap beyond our current supportive role nor to override states' current active efforts to protect confidentiality and prevent discrimination while encouraging testing, counseling,and other steps to reduce the risk of additional infection."

PRESIDENTIAL CANDIDATES QUIZZED

by Lou Chibbaro Jr. and Lisa M. Keen, with thanks to The Washington Blade, 12/4/87

Democratic candidate Jesse Jackson mentioned the Gay rights March on Washington and Republican candidate Robert Dole asked that partisan politics be removed from the AIDS controversy during the first nationally televised debate among the 12 presidential candidates of both parties. Although each of the 6 Democratic contenders expressed support for increased efforts in AIDS research and prevention programs, Republican candidate Robert dole, the Kansas senator, surprised some observers when he called on all candidates to refrain from using AIDS as a political issue. The two-hour debate was aired from 9-11 pm (EST), December 1, by NBC-TV, with news anchorman Tom Brokaw serving as moderator. When Brokaw asked the Democratic candidates about their views on the AIDS epidemic, civil rights leader Jesse Jackson quickly challenged the other candidates to "match" what he said was demonstrated commitment to assisting people with AIDS. Jackson said one measure of his commitment was his appearance as the "only presidential candidate" at the Nationa March on Washington for Lesbian and Gay Rights, which Jackson drew "600,000 to 800,000 people." Jackson also suggested that "those who are searching for a moral foundation" with which to address the AIDS epidemic should note that "Jesus the Christ stayed with Simon the leper who was quarantined with the so-called sickness of his day." A few minutes later, Republican candidate Al Haig argued that AIDS "must be dealt with at the moral level" and the medical level. The contrasts between views of the Democratic and Republican candidates on AIDS was stark. While all six Democratic candidates argued against mandatory testing, two of the three Republicans who spoke on AIDS called for more, including Vice-President George Bush. Bush defended the Reagan administration's response to AIDS and called for education "with a little bit of emphasis on local values and on interest there at the local and family level." He accused the Democratic candidates, who were uniformly critical of the administration's response, of "wringing their hands" about AIDS and jokingly suggested he would rather "switch over to see `Jake and the Fat Man' on CBS" rather than listen to their complaints. The Democrats aggressively criticized the Reagan administration's failure to take a leadership position in the fight against AIDS. Massachusetts Gov. Michael Dukakis said he favored an explicitly worded AIDS education pamphlet sent to state residents, but did not mention that he had recently criticized an explicit safer sex brochure produced by a Boston AIDS service group. Several of the Democrats mentioned that British Prime Minister Margaret Thatcher had produced more in terms of national AIDS education than the Reagan administration has done in the U.S. "A conservative prime minister of England, Margaret Thatcher, saw only 350 cases of AIDS and launched a nationwide comprehensive education and prevention campaign. We've had more than 40,000 cases of AIDS, and still [the Reagan Administration has done nothing." Sen. Paul Simon (D-IL), and Rep. Richard Gephardt (D-MO), and former Gov. Bruce Babbitt of Arizona all spoke strongly against mandatory testing. Simon expressed concern that some people have to wait up to three months to take the antibody tests voluntarily-- a situation he labelled "dynamite." Gephardt said he would approve of mandatory testing in some "limited areas." Babbitt said he agreed with all the other Democratic candidates on AIDS issues, then added, "[W]e ought to spend less time listening to the right wing politicians and more time listening to the medical people."

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ADVERTISEMEMTS AGAINST HELMS

by Nadine McGann, with thanks to Chicago Outlines, 12/10/87

The Human Rights Campaign Fund, a national gay rights political action committee, ran a full-page advertisement in seven major daily newspapers that condemned Senator Jesse Helms and Congress for passing an amendment to the federal appropriations bill that restricts the financing of of AIDS education materials, and called on the public to protest the action. The ad said Helms opposed "the only known way to stop AIDS" and read "Education is our only answer," according to The Advocate, "Yet Jesse Helms said no and Congress went along." The ad also urged readers to call or write their representatives and senators to criticize the amendment, and gave a toll-free number for people to order a mailgram prepared by the Fairness Fund. The ads appreared October 28 in The New York Times, The Washington Post, the Los Angeles Times, The Boston Globe, The Columbus Dispatch, The Dallas Morning News, and The Providence Journal and cost over $100,000. According to HRCF executive director Vic Basile, the group hopes to convince a House-Senate conference committee to delete or reduce the severity of the legislation. Reportedly more than 2000 people have contacted elected officials throught the prepared Mailgrams alone. Basile also said that the ads were designed to demonstrate the "clout and economic power" of the gay community. While the group's usual activities include contributing to campaigns of congressional candidates and lobbying, Basile said he has heard no criticism of the media campaign. Funds were raised through specific appeals for ad money, and through fundraising dinners.

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BUDGET FOR '88 REACHES BILLION $$

by Peg Byron, with thanks to The Washington Blade, 11/27/87

A hard-won record $1 billion AIDS budget threatened by a federal deficit reduction plan as Congress left for Thanksgiving break. The AIDS budget for Fiscal 1988, as passed in early October, is a rcord amoungt since the epidemic was recognized and doubles last year's allocation with increases in all areas, including drug research and preventive education. A budget slashing plan produced by an unprecedented budget summit beteen the white House and congress convened after the Oct. 19 stock market crash and expected to win congressional approval, would cut about $2.6 billion from FY 88 domestic programs. The plan would supersede the Gramm-Rudman balanced budget law, which requires automatic, across-the-the board cuts of 8.5%, totally $23 billion, including $85 million for AIDS. "We are very concerned about this," said Ann McFarren, executive director for the AIDS Action Countil which lobbies to expand the AIDS budget. "Congress very carefully looked at the budget and the expenditures for AIDS and has increased AIDS spending dramatically." Under Gramm-Rudman, she noted, AIDS spending levels are now being held at last year's amount, a decrease given inflation, and half the amount approved for this fiscal year, which began Oct. 1. "The worst-case scenario would be that they maintain the current [fixed] numbers." said McFarren, who is hopeful swift congressional action will prevent delays in AIDS research contracts.

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NEW EDUCATION, HEALTH FUND

by Mark Sullivan, with thanks to The Washington Blade, 2/12/88

SINGER DIONNE WARWICK ANNOUNCED THE CREATION OF A NEW FOUNDATION to raise money for groups providing AIDS education and health care services. The new foundation, called The Warwick Foundation, will make grants to community-based organizations or national organizations with effective local outreach programs which provide AIDS education and health care. Warwick, whose chart-topping single "That's What Friends Are For" has already raised more than $1.5 million for Elizabeth Taylor's American Foundation for AIDS Research, said most money now raised for AIDS is directed at research. "Almost all the money now being raised is going, and rightly so, for AIDS research," Warwick said. "But AIDS education and health care services are either underfunded or not funded at all." She said the money would be specifically directed at the minority community, which has been disproportionately affected by the AIDS epidemic. She noted that blacks, who make up 12% of the population in the U.S., account for 25% of all AIDS cases. Hispanics, who make up 7% of the population, account for 14% of AIDS cases. Warwick also noted that of all women with AIDS, 70% are minorities. Of all children with AIDS, more than 80% are minorities. Warwick said part of the problem is the characterization of AIDS as a "white gay male disease." She said although it is a delicate issue, the news media must work harder to inform the minority community about the risks it faces with AIDS. "It is not racist to awaken those people who are asleep at the moment," Warwick told the crowd of about 300. To raise money for the new foundation, Warwick, who was named honorary "Ambassador of Health" by the Dept. of Health and Human Services last year, announced a gala benefit to be held in Washington, June 10-12 at the Grand Hyatt Hotel. The gala weekend, which will include such diverse events as an auction and a golf tournament to be hosted by Bob Hope and Sammy Davis Jr., will be capped off by a concert at the Kennedy Center featuring Whoopi Goldberg, Robin Williams, Oprah Winfrey, Lionel Richie, Gladys Knight, Stevie Wonder and Elton John.

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PUBLISHER MAKES AIDS PLEDGE

with thanks to Boston's Bay Windows, 2/18-24/88

Sasha Alyson, president of the Boston-based Alyson Publications Inc., has pledged one third of his firms direct mail income for the month of March to benefit two AIDS organizations— The American Foundation for AIDS Research (AmFAR) and the People With AIDS Coalition (PWARC) in New York City. Alyson, who estimates that the two groups will split "at least $3000," explains, "We've been looking for more ways to help in the fight against AIDS, and this seems like a good one. For every dollar that comes to us in the mail during March from individuals buying books, one third of it will be divided equally between [the two recipients].... In addition to getting money to two important AIDS groups, we hope to set a precedent for AIDS fundraising.... I think it's great for business to donate a part of their sales to important causes." The company's contributions will be certified by Boston CPA Ray Faulkner. For a free catalog, or additional information, write to Alyson Publications, 40 Plympton St., Boston, MA 02118 (617/542-5679).

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MCDONALDS, CHREVRON DONATE TO AIDS

by Mark Sullivan, with thanks to The Washington Blade, 1/15/88

JOAN KROC, OWNER OF THE SAN DIEGO PADRES and the major stockholder in McDonald's restaurants, donated a total of over $1 million to three AIDS organizations in December, 1987, according to Update, a southern California gay newspaper. Kroc, the widow of McDonald's restaurant chain founder Ray Kroc, gave $1 million to Elizabeth Taylor's American Foundation for AIDS Research. In addition, Kroc gave $25,000 to the San Diego AIDS Assistance Fund, which provides emergency food and shelter for people with AIDS, and $25,000 to the San Diego AIDS Project, which provides AIDS prevention education. It is the third donation Kroc has made to that institution. "The AIDS virus does not discriminate," Kroc said at a news conference when she announced the donations. "It is striking sons, daughters, brothers, sisters, fathers, and mothers across the United States and around the world."

Also in December, Chevron Inc. donated $125,000 to Project Open Hand, the first and only meal service in the nation for people with AIDS, according to the San Francisco Sentinel. The donation, said project founder Ruth Brinker, would allow the organization to purchase permanent headquarters with kitchen facilities. The organization, which every day feeds almost 300 people with AIDS or ARC, is currently operating out of a kitchen at a church in San Francisco, but must move because the church needs the facilities.

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TEXAS AIDS FUNDING BEGINS

by Elizabeth Pincus, with thanks to Boston's Gay Community News, 1/10-16/88

FOR THE FIRST TIME, TEXAS HAS EARMARKED STATE FUNDS TO COMBAT AIDS, according to Houston's Montrose Voice. Health officials announced that $1.5 million in grants has been allocated for AIDS education to to assist local service organizations in caring for people with AIDS. State Health Commissioner Robert Bernstein announced that the department received 135 applications requesting more than $7 million in assistance. Selection of grantees was based, he said, "on the way the applicant dealt with problems and whether we thought they were competent to accomplish those things." Bureau of AIDS Control Chief C.E. Alexander added, "We have made every effort to distribute these funds as broadly as possible, especially in the areas of the state where few services exist." The largest awards of about $109,900 each went to the AIDS Foundation Houston and AIDS Services of Austin. The grants will be distributed in January and are renewable after one year.

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GRANTS FROM ROBERT WOOD JOHNSON

THE NATION'S LARGEST HEALTH CARE PHILANTHROPY INVITED COMMUNITY-BASED ORGANIZATIONS throughout the U.S. to be "bold and imaginative" in seeking its funds for projects in AIDS prevention and services. In an unprecedented move, officials at the Robert Wood Johnson Foundation said that no predetermined limit had been placed on the number of grants or the size of individual grant to be awarded under the new national initiative. "We're looking for creative solutions to the problems posed by AIDS— preventing its spread and caring for the people it already affects," said Leighton Cluff, MD, foundation president. "We don't have these solutions, but we believe they can be found in the communities where so many people are fighting the epidemic's impact on their families, friends, and neighbors." Cluff noted that the initiative was designed "to fill some of the significant unmet needs in AIDS funding at the community level, whether the projects are large or small." He noted that all applications will be reviewed by an expert panel during the competitive funding process. Tax-exempt community institutions, organizations, and agencies throughout the U.S.— including government agencies— are eligible for funding under the national initiative, Cluff said. The foundation is among the largest private philanthropies in the nation, awarding grants totally approximately $100 million annually to improve health care in the U.S., Cluff said. To date, it has awarded more than $20 million in grants for AIDS-related efforts, making it the nation's leading private funder in that area. According to the guidelines released in English and Spanish, the foundation will give priority to prevention and health or health-related services projects that:

>Represent "innovative approaches" in their communities and may serve as models for programs elsewhere;

>Are operated by organizations with strong experience in working with the population to be served by the project; and

>Plan to document the project's development and effectiveness.

In addition, eligible prevention projects must:

>Target people at greatest risk for transmitting or contracting the virus;

>Provide both information and access to the services and emotional support people at risk may need to act on that information; and

>Have successfully tried the prevention approach with other populations at risk or with another health problem in the same population.

For a copy of the call for proposals, contact: Communications Office, The Robert Wood Johnson Foundation, P.O. Box 2316, Princeton, NJ, 08543-2316 (Denise Graveline, 609/452-8711).

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PICKETS REAP PLEDGES

by Greeta Sharma-Jensen, with thanks to Wisconsin's Racine Journal, 12/22/87

IT SEEMS TO BE A CATCH 22 SITUATION. PLANNED PARENTHOOD OF WISCONSIN'S RACINE OFFICE IS COLLECTING PLEDGES from supporters every time the pro-life pickets set up outside the office for their weekly protest. And to let the pro-life pickets know how they're doing, Planned Parenthood staff also unfurls a banner thanking the pickets for raising money for the pro-choice faction. One banner read, "Thanks for picketing! You are being sponsored by Friends of Planned Parenthood! Tonight your picketing raised $156 for pro-choice. Thanks for your contribution!" Marsha Connet, community services coordinator for Planned Parenthood's Racine office said the idea to sponsor a picket for raising money for pro-choice took hold in the fall, after about six months of weekly picketing. "They picket against abortions," Connet said. "But we don't do abortions...at any of our Wisconsin clinics. We had a number of supporters who felt the privacy of our patients was being invaded and we put our heads together and came up with this response. Connet said their response helps give Planned Parenthood a higher profile and also helps raise money for those who cannot afford medical services but have the right to medical services from professions interested in their health.

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ROCKEFELLER FAMILY GIVES $25,000

by Mark Sullivan, with thanks to The Washington Blade, 1/29/88

THE ROCKEFELLER FAMILY FUND HAS DONATED $25,000 to the Lambda Legal Defense and Education Fund to help the organization's fight against AIDS-related discrimination, Lambda officials announced. "The importance of this grant cannot be overstated," said Thomas Stoddard, Lambda's executive director. "This is the first time that a prominent national foundation has given money to a gay organization for any purpose." Stoddard said that the money was donated to the organization's AIDS Project, which defends people who have been discriminated against because of AIDS.

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UNSPENT AIDS $$ IN LOS ANGELES

by Lori Kenschaft, with thanks to Boston's Gay Community News, 1/31-2/6/88

THE LOS ANGELES COUNTY BOARD OF SUPERVISORS HAVE CALLED FOR AN INVESTIGATION into why the Dept. of Health has failed to spend the $1.5 million allocated last July to help people with AIDS. Conservative supervisor Mike Antonovich has accused the department of "foot dragging," reports the Advocate. County officials blame the delay on the complicated requirements that must be met when they contract for health programs. They also say they are waiting for the results of a study, which is not due until February, about what kinds of alternative care are most needed. In addition, county Health Services Director Robert Gates waited until September to grant permission to spend the money. The alternative care programs covered by the allocation include hospice facilities, home nursing, home attendants for those not yet seriously ill, daycare facilities to take some of the burden off families, and more clinic-oriented care for ambulatory patients.

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DUTCH SUBSIDIZES SAFER SEX JOURNAL

by Jon David Nalley, with thanks to the New York Native, 12/21/87

IN CONTRAST TO THE SITUATION OF THE HELMS AMENDMENT IN THE UNITED STATES, THE DUTCH GOVERNMENT, through its Office of Health Education and Information (GVO), has been subsidizing a gay "safer-sex" literary journal which Helms would probably consider pornographic. Published three times since its inception in 1986, Vrijbeeld (Free Image) grew out of an "eroticizing safer sex workshop." Sandro Kortekaas, an editor of the journal, said that the group started discussing safer-sex fantasies and then writing them down. "What ensured was a discussion of whether our group should share the stories just within the group or whether we should share them with others. When we discussed sharing the stories with others, the next logical step was to attempt a magazine." Stories for the first issue, printed for distribution at annual Dutch lesbian and gay pride activities in June, 1986, came from within this group. Jan van Stralen, Vrijbeeld's design editor, said that at that point the discussion centered on enlarging the scope of contributions to the journal. "We didn't want to write all the stories ourselves," Van Stralen commended, adding that the magazine also includes advertisements and poetry. "Not `I want to meet you and I want this kind of person,' but rather a fantasy in which the one who places the ad must be creative." Printed by a lesbian-owned firm in Groningen, Vrijbeeld has published works by both unknowns and by better known Dutch gay writers. In addition to subsidies from the Dutch government, this publication of pornographic fantasy without "exchange of bodily fluids" is also supported by AIDS Fonds of the Netherlands, and through sales to the public. For more information: Vrijbeeld, Postbus 803, 9700 AV Groningen, Netherlands.

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CUBANS TESTING POSITIVE IN CAMPS

by Lou Chibbaro Jr., with thanks to The Washington Blade, 2/19/88

REPRESENTATIVES OF INTERNATIONAL HUMAN RIGHTS GROUPS EXPRESSED CONCERN over reports that the Cuban government is forcibly sending Cubans who test HIV antibody positive to an "isolation" center outside Havana. Cuban Premier Fidel Castro and Cuba's deputy minister of public health. Dr. Hector Terry, discussed the existence of the isolation center last September at public forums, but the two did not say whether those sent to the facility were being held against their will. However, Radio Marti, the U.S. sponsored agency that broadcasts messages opposing the Castro government to Cuba, is charging that Cubans who decline to "volunteer" to enter the isolation facility are taken there by security police who place a nylon bag over their heads. Ernest Betancourt, director of Radio Marti, reported in a New York Times column that Cuban emigrants, refugees, and defectors claim there are between 300-400 people in the facility, which is believed to be in the town of Boyeros, just south of Havana. Betancourt said Cubans interviewed by Radio Marti claim the facility appeared clean and that the conditions there were humane. But he said that police must accompany all visitors and that there have been reports of escape attempts, which promoted "huge police mobilizations." Miguel Numez, press attache for the Cuban Mission to the United Nations in New York strongly denied Betancourt's claims, saying persons residing at the isolation facility regularly visit their homes. Numez did not say specifically that persons assigned to the facility are free to discontinue their stay there and he declined to comment when asked about the rules for terminating a person's residence at the center. Spokespersons for Amnesty International, Americas Watch, and the International Committee of the Red Cross— organizations that monitor human rights violations— each said their groups have just begun to examine the issue of AIDS discrimination. None of the groups, the representatives said, currently consider AIDS-related discrimination or forced AIDS quarantines as a human rights violation as defined by their charters or guidelines. Rosanna White, a representative of Amnesty International's Washington office, said her organization strictly limits its mission to monitoring "prisoners of conscience" --persons imprisoned by countries because of their political beliefs. White said officials within AI are divided over whether imprisonment on grounds of sexual orientation should be declared a protected class by the groups. Currently, sexual orientation discrimination, including the imprisonment of gays is not one of the areas monitored by the group, she said. Michael Posner, a representative of the Lawyer's Committee for Human Rights, another human rights organization, said he just returned from Cuba where he and representatives of the Bar of the City of New York toured several Cuban jails. Posner said his group visited several political prisoners but did not make any inquiries about forced isolation of persons testing HIV antibody positive. Posner revealed that his group has yet to include AIDS discrimination in its stated mission. Several Cuban prisoners told him that the government's treatment of gays and members of the "artistic community" remains hostile both inside and out of Cuba's prisoners, Posner said. The Castro government has long held the policy that homosexuality was an unacceptable practice and contrary to the Cuban revolution. In 1980, when several thousand Cuban gays and non-gays left the country on the Mariel boat lift for Key West, Florida, Castro called the departing gays "scum." Castro mentioned the existence of the isolation center in a speech in Havana on Sept. 9, 1987, according to a report in the Miami Herald's Spanish language edition. Castro was reported as saying the isolation facility would be the most effective and humane way of stopping the spread of the virus. Cuban health official Dr. Terry, described the facility as a "sanatorium" during a presentation before an AIDS forum in Quito, Ecuador on September 17, 1987. Terry said that at that time, 147 Cubans were HIV infected, and that less than 40 people had actually developed AIDS. In spite of its low incidence, he announced government plans to test 7 million people for HIV antibody in 1988. The country's 1988 population is slightly more than 10 million. Radio Marti charges the Cuban government with grossly under-reporting the number of people infected with the virus as well as the number with the disease. The broadcast agency, which operates under the auspices of Voice of America, says most of Cuba's AIDS cases stem from the nation's 400,000 soldiers who have served in West Africa over the past 10 years or more. Currently there are 40,000 Cuban soldiers stationed in Angola. The World Health Organization and the Centers for Disease Control have reported extensive AIDS outbreaks in Angola and other West African nations, despite official reports by those countries that AIDS is not widespread. Betancourt, in a telephone interview, said Radio Marti began broadcasting safer sex messages into Cuba in 1985, long before the Cuban government began warning its citizens of the dangers of AIDS. Judy Greenspan, a lesbian activist and a member of the Worker's World Party in Washington, DC, called Radio Marti a "reactionary" agency of the U.S. government that only intends to undermine the Cuban government. Greenspan, who said she was not aware of forced isolation facilities in Cuban to combat AIDS, said underdeveloped nations such as Cuba could be devastated by the costs associated with AIDS. She said underdeveloped countries may have to take some measures that others may consider extreme to fight AIDS.

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ISRAELI AIDS GAME FOR KIDS

by Wendy Elliman, with thanks to the World Zionist Press Service & the Wisconsin Jewish Chronicle, 10/9/87

In an effort to give Israeli youngsters a better knowledge of AIDS and in order to contribute to the gloval war against the disease, a 26-year-old Israeli medical student has come up with an innovative AIDS teaching program. The program has so far achieved high acclaim and may soon be officially adopted by the World Health Organization. The man, Inon Schenker, is a student at the Hadassah-Hebrew University Faculty of Medicine and School of of Public and Community Health. His ideas about teaching sixth graders and up about AIDS have been approved by Israeli's Education Ministry for use in every Israeli school, hailed by the World Union of Health Education, and requested by 35 European governments for further study. "Israel, happily, has no significant AIDS problem as yet," he said. "Nor, with our 40 recorded cases, are we likely to make any major breaktrhough in the epidemiology or virology of the disease. But in education, at least, we have a chance to contribute." For the past three years, Schenker has volunteered as a school health educator under the `Perach Big Brother' project, one of 45 Hadassah students who has taken part. He began preparing his AIDS teaching program in response to questions he encountered in the classroom. "Most kids have heard of AIDS by now and know that it's something very threatening," he said. Schenker sent his first draft of the course to 26 Israeli authorities-- physicians, pediatricians, psychologists, psychiatrists, biologists, heads of universities, schools of education, educators, and parents of teenage children. Their suggestions were incorporated into the draft. Although there have been few initiatives in building children's AIDS education programs, Schenker said that the program was different from those that do exist because of its focus: examining AIDS as a disease that primarily attacks the immune system, rather than concentrating on its sexual transmission. AIDS, in fact, is not even mentioned until the fifth of the course's six units. By then, youngsters have been provided with the knowledge to understand the disease better.

Unit 1 is a game which teaches how the immune system functions. Youngsters stand in a circle, reprsenting skin. Two guards inside the circle represent antibodies. Those outside the circle ae the invaders --viruses and bacteria-- trying to break through the skin. Deficiencies in the immune system are demonstrated by blindfolding the guards. Unit 2 continues to explain the immune system --this time in the classroom-- through slides, worksheets, and cartoons of scowling `bad guys' (viruses) and glowing `good guys' (antibodies). The third Unit is an optimistic view of medicine and its defeat of scourges like small pox and plague. The fourth Unit personalizes medical protection --urging youngsters to bring their immunization records to class, and discussing the protection they have been given against polio, tetanus, diptheria, and measles. AIDS enters the program in Unit 5. Cartoons --a non-menacing tool for a menacing disease-- explains AIDS to the students, who discuss the 8-year history of the disease and look at its virology. Pupils are akded to name the ways that you can and can't contract AIDS, and misconceptions about transmission (shaking hands, sharing a cup, coughing, etc.) are clarified. The course's final Unit deals with the possibility of a student with AIDS in school. It is built on role-play, with children taking the parts of a person with AIDS, friends who are for and against continuing to see people with AIDS, parents, teachers, and doctors. The final Unit helps to recap the course, and encourages empathy, and of course, prepares the school population with coping with the possibility of an AIDS virus-infected peer. For older students, a seventh Unit, "Safer Sex," is taught. It opens with a statistic --the risk of contracting the human immunodeficiency virus in Israel is one in 100,000. Then, it goes on to discuss why people are so frightened, how you can protect yourself (condoms, closed, unwrapped and open are shown), and ends with a reading list, and the phone numbers and addresses of Israel's seven HIV antibody testing centers. "Health education isn't the same as health information," said Schenker. "What I've tried to do is build an education program based on health concepts." The Hadassah program has been taught so far in many Israeli high school classes and won excelent reactions in all of them. It was also presented at the WHO/World Union of Health Education/Spanish Government Health Education Conference in Madrid last March, where a resolution was passed urging all European countries to adopt the program. WHO requested that copies be sant to all its European members. Schenker is naturally delighted that his program has been so well received. "I see it as Israel's opportunity to make a real contribution to the global war against AIDS," he said. For more information: AIDS Project, School of Public Health, P.O. Box 7956, Jerusalem 91077, ISRAEL.

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AUSTRALIA'S GRIM REAPER CAMPAIGN

by Kendall Lovett, with thanks to Boston's Gay Community News, 5/17-23/87

The Australian federal government launched its three million dollar AIDS educational campaign in Sydney April 5. Unfortunately, the capaign sets out to shock and frighten rather than educate. In the campaign's television commercial, the "grim reaper" is depicted in an outer space bowling alley with human beings as the pins to be knocked down and swept into the gutter amid clouds of smoke. The male voice over the visual emphasizes sexual abstinence or sex with only one monogamous "faithful" partner. Condoms are mentioned as a last resort, but there is no attempt to show or explain how to use a condom. Nowhere in the campaign is any mention made of mutual masturbation and how to make it an enjoyable alternative. According to the Sydney Coalition for Safe Sex, whose members demonstrated outside the cinema hosting a media briefing on the campaign, the challenge of AIDS is to teach everyone to enjoy sex safely, not to re-define safe sex in "moral" terms. On a somewhat more positive note, one of the radio commercials directed at 12 year olds and adolescents generally, is not in the least judgemental. It is, however, sensational in tone. The adult male voice advises... "If you use needles think about this... sharing needles is the easiest way to pass on AIDS... one shot from an infected syringe can kill you... (sound of gun shots)... If you think it can't happen to you, you're wrong. Already there are hundreds of needle users carrying and spreading the AIDS virus.... Most of them don't even know they've got it... (sound of more gunshots)."

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COLUMBIA AIDS INFORMATION

by John Hubert, with thanks to Boston's Gay Community News, 11/8-14/87

A group has formed in Bogota, Columbia to offer educational services, information and help to people with AIDS, those who have tested HIV-positive, and people at risk for AIDS. Grupo de Ayuda E Informacion (GAI), translated: the Gay Help and Information Group, also maintains contact with the Columbian press to provide correct information about AIDS. GAI has already presented three 30 minute specials on Bogata's principal TV station, produced articles for scientific and medical journals as well as audiovisual and video tapes on AIDS. GAI includes lesbians, gay men and nongays. GAI is interested in receiving material from other groups and individuals who provide help and information services to lesbians and gay men concerning AIDS. Write to: Manuel Antonio Velandia Mora, Apdo. Aereo 25770, Bogota 1, Columbia.

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CUBAN AIDS EPIDEMIC

by John Kyper, with thanks to Boston's Gay Community News, 5/17-23/87

The Cuban government is minimizing the advance of AIDS in Cuba, according to Radio Marti, station of the United States Information Agency transmitting to Cuba, and according to many Cuban exiles living in the U.S., as cited in the Washington Post via El Mundo of Cambridge, Massachusetts. Cuba, which claims the U.S. is the origin of the virus, only reports one case of AIDS, a person who had returned from a trip to New York. According to sources cited by the Post, Cuba may have many more cases of AIDS, spread principally by means of the 300,000 or 400,000 Cuban soldiers who have returned from Angola or other areas of Africa when AIDS is rampant. The Director of Radio Marti, Ernesto Betancourt, believes that the quarantine imposed on soldiers returning from Africa and the sending of blood from Cuba to soldiers wounded in that continent, is evidence that Cuba faces a massive AIDS epidemic.

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DUTCH PWAs COMMIT SUICIDE

by Martin Heggestad, with thanks to Boston's Gay Community News, 5/17-23/87

A respected Dutch physician, Sven Danner, recently acknowledged that a number of PWAs in the Netherlands have chosen to end their suffering by having their doctors administer lethal drug doses to them, according to the New York Times. Danner confirmed that two PWAs in the hospital where he works ahve died by this means, and that he knew of about two others who have received lethal injections in their homes. The Dutch are openly tolerant of voluntary euthanasia, which is legal under limited circumstances. The person in question must be terminally ill and must be judged to be in unbearable pain. Gay activists say that although euthanasia is becoming an increasingly important issue as the AIDS crisis grows, most PWAs who wish to die do so by passive means such as refusing life-prolonging treatment.

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EUROPEAN RESPONSES TO AIDS EPIDEMIC

by Marc Stein, with thanks to Boston's Gay Community News, 6/7-13/87

The World Health Organization (WHO) estimates that 4000 Western Europeans have AIDS, according to the New York Times. This number is expected to double every 9 to 11 months. The WHO also estimate that half a million to one million West Europeans have already been infected by the virus. "If 10-30% of the affected people actually develop AIDS, which seems likely, there will be anywhere from 50-300,000 deaths in Europe during the next five years," according to Jonathan Mann, head of the WHO's AIDS Task Force in Geneva. At the end of 1983, 232 cases of AIDS have been reported int he 12 nations of the European Common Market. The numbers at the end of 1986 stood at 3354. France has the largest number of cases, with 1221. West Germany has 875, and Britain 686. The incidence of AIDS relative to population is highest in Switzerland, Denmark and Belgium. Only 17 cases had been reported in eastern Europe by the end of 1986. Responses to the disease in Europe have ranged from demands for quarantine of people who test HIV-positive to comprehensive AIDS education campaigns. The response of the Bavarian state government in West Germany has been the most negative. The central government has backed away from proposed national registration of people testing positive for HIV, but Bavarian Interior Minister announced in February, 1987 that testing would become mandatory for prostitutes, prisoners, and some foreigners who wish to live in Bavaria. Gay bathhouses will be banned and those arrested in raids on bathhouses will be tested for HIV. "The state must have the right to break the chain of infection," according to Peter Gauweiler of the Interior Ministry.

Over 10,000 people marched through Munich on April 4, 1987 to protest the government's plan according to the Star Ledger of Newark, NJ. Protesters carried banners saying, "We homosexuals protect ourselves— Who's protecting us against AIDS policy?" and "Against the police state— Bavaria is renovating Dachau." Dachau was the site of one of the former Nazi death camps. Some conservatives in Swedan and West Germany have demanded that those who test positive for HIV antibodies be tatooed for easy identification. Julien Peto, an epidemiologist at the Institute of Cancer Research in Britain, has proposed that all people should be required to carry cards showing that they have been tested for AIDS. "How many people can honestly say that they would prefer to see AIDS continue to spread until it dominates many people's sexual and social lives, rather than isolating 30,000 homosexuals or drug addicts, and perhaps a further 10,000 who have caught the disease in other ways?" Dr. Peto recently asked in a newspaper column. On the other hand, British Health Secretary Norman Fowler has called for the creation of hospices to care for people with AIDS. The Dutch government has initiated a masive educational campaign, focusing on safer sex counseling in small groups. The Dutch authorities also dispense disposbale syringes, leading to a low rate of HIV infection among IV drug users. Private groups, gay activists and people with AIDS have also begun taking steps to care for those who are sick and to provide education. The French Help Association, founded by gay people, currently maintains apartments for people with AIDS not tended by friends or family. The private Swiss AIDS Association has developed a new condom and began marketing it directly in gay bars, clubs, and bathhouses.

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AFRICAN LEADERS AFFECTED BY AIDS

with thanks to Insight, 8/31/87

Diplomatic sources report that about half the military personnel in Zambia and Zimbabwe have tested positive for the HIV virus. It is suspected the proportion may be even higher in Zaire, where testing has been much more limited. One son of Zambia's President Kenneth Kaunda is said to have died of AIDS; a second has reportedly contracted it. The "slim disease," as it is called in Africa, is cutting a swath through the political and military elites of central and eastern Africa. Strategic implications could be immense. A number of Western governments already are growing concerned over the increasingly erratic conduct of policy by regional leaders who fall victim to AIDS-related dementia, now known to be a common symptom of the virus's activity in the brain and nervous system. The syndrome is already said to be evident among top officials in the Zambian capital Lusaka. The predicted large death toll may set off messianic religious movements, blaming city life and secular governments for bringing on "God's punishment."

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AFRICA HAS NEGLIGIBLE FUNDS

by Nancy De Luca, with thanks to Boston's Gay Community News, 8/16-22/87

Recent studies indicate that about 50,000,000 Africans are HIV positive, according to a letter in off our backs from Hanna Edemikpong of the Women's Centre in Eket, Nigeria. Although the virus has reached epidemic proportions in Central, East and Southern Africa, funding for health care in these regions is miniscule in relation to the need. The combined health care budget for all Central African countries afflicted remains near the 1982 level of $1 million. Although severely underfunded in the U.S., AIDS related projects and care have been allocated $411 million for 1987, up from $15.5 million in 1982. In Africa, heterosexual transmission and female genital mutilation are the major routes of AIDS transmission, according to Edimikpong. In recent studies of 370 pregnant women in Uganda and Equatorial Guinea, 75% of the women were shown to have AIDS or carry the HIV virus, and half to 2/3 of these women had been genitally mutilated.

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YUGOSLAVIA POSTPONES GAYFEST: AIDS

by John Hubert, with thanks to Boston's Gay Community News, 9/13-19/87

Government officials postponed the 4th Gay and Lesbian Festival in the Slovenian capital on the pretext of AIDS prevention. Magnus, the four-year-old gay group in Ljubljana, Yougoslavia, organized an AIDS Information Week in response, including exhibitions, films, and panel discussions. The annual festival will be rescheduled. Magnus would like to receive AIDS information form other groups. Write Magnus, c/o Aldo Ivancic, SKUC, Kersnikova 4, YU-61000, Ljubljana, Yugoslavia.

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JAPANESE TRAGEDY: NO COUNSELING

by Chizuko Ikegami, with thanks to Lifelines, Newsletter of the Life Foundation, October, 1987

In Japan, May 5 is a national holiday—Children's Day. Two brothers, aged 9 and 13, were looking forward to a visit to the zoo in Tokyo promised by their parents. The boys were stabbed to death along with their father, by a mother distraught at the thought of AIDS. She then committed suicide. The mother mistakenly believed that she had AIDS. She was not at "high risk" or in a transmission group. She even took the HIV antibody test and found out that she was negative. Unfortunately, she was not given pre- or post-test counseling. The only information she had was that AIDS was an awful disease without cure, that the first symptoms of infection could be similar to a common cold, and that the antibody test results could be false. Consequently, she felt ill, and she believed her test was false. The night before the murder-suicide, her husband and sons complained that they might be catching a cold. Nobody imagined how desperate she was, believing that she infected her family. But what terrified her even more was her cultural belief that her husband and especially her young sons would be ostracized by the community. In desperation and panic, she grabbed for the knife. The woman's misguided intention of protecting her sons from the stigma that she believed she caused and from which there was no way to escape is partly understandable, knowing Japanese cultural values and mores. The mother did not receive counseling prior to or following her test, and this lack of information is common among the Japanese. This writer was a special guest on Honolulu's KOHO radio, one of two Japanese broadcasting stations in Hawaii. Many listeners include students from Japan, family members of businessmen assigned to Hawaii, and thousands of Japanese tourists. Dozens of questions were asked, one of the more frequent topics on the possibility of HIV infection through casual contact. Pamphlets provided by the Japanese Ministry of Health give no practical information. Just recently the Japan AIDS Prevention Association was established but they are not ready to offer education information to the general public. Pamphlets in Japanese are available through the Life Foundation. For more information, contact: The Life Foundation, P.O. Box 88980, Honolulu, HI 96830-8980 (808/924-2437).

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SOVIETS DISTRIBUTE AIDS INFO

by Stephanie Poggi, with thanks to Boston's Gay Community News, 10/18-24/87

The Soviet Health Ministry has begun distributing the first of five milion brochures warning about the spread of AIDS. According to the Chicago Tribune, the new brochure explains how the HIV virus can be contracted and how to avoid exposure. No further details were available. A year ago the Soviets said HIV was the product of secret U.S. germ warfare research.

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BAVARIA CONVICTS AMERICAN WITH AIDS

by Nadine McGann, with thanks to Chicago Outlines, 11/26/87

A court in the city of Nuremberg has sentenced a former U.S. Army cook with AIDS to two years in prison for attempting to inflict "grievous bodily harm" by practicing unsafe sex practices, according to the New York Times. The ruling is the first conveiction of a person with AIDS for knowingly exposing sex partners to the disease in West Germany. The amn was charged under a law which prohibits causing bodily harm with a weapon or with "dangerous treatment;" the latter providison is usually used to refer to poisons. The man, who has not been identified by name, does not deny that he had sexual intercourse after learinging of his infection, but says he was not deliberately trying to pass on the infection. The judge ruled that evidence showed the accused had had oral and anal intercourse without regard for the danger to his partners; while it was not proven that he infected them, he had threatened them with grievous injury. The judge decided the right to freedom from injury is higher than the right to free sexual practices. A spokesperson for the prosecutor's office said American authorities brought the case to the attention of the police on the grounds that the man might spread the disease. The Bavarian government has ordered mandatory blood tests for prostitutes, drug users, prison inmates, civil servants and some foreigners seeking residence.

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IMMIGRANTS TESTED IN US

with thanks to Chicago's Windy City Times, 8/20/87

The Reagan administration issued final regulations barring aliens who test positive for infection with the alleged AIDS virus from immigrating to the U.S., the New York Times reported. On Aug. 28, the U.S. Public health Service issued a regulation requiring HIV antibody tests for all potential immigrants and refugees seeking permanent U.S. residency. The regulation takes effect Dec. 1 and means that the tests will be required of approximately 600,000 people who seek to immigrate to the U.S. each year or who are already here on temporary visas, as well as the estimated 60,000 refugees who seek entry to the U.S. annually. People who test positive for the virus would be denied residency. The requirement would not be applied to tourists or visitors, nor would it be used to deny a temporary visa to a foreign citizen seeking treatment for AIDS, said a spokesman for the Immigration and Naturalization Service. A Federal Register report said that the government does not "anticipate false positive testing to be a particular problem in enforcing the new rules." The report also said that while confidentiality of test results "will be safeguarded to the extent possible," the U.S. government "can neither guarantee confidetiality of all HIV test results nor assume responsibility for any possible consequences of a positive test result."

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NEEDLE PROGRAM DOWN UNDER ATTACKED

by Kendall Lovett, with thanks to Boston's Gay Community News, 8/16-22/87

A free needle program for intravenous drug users is under attack from police. The program, sponsored in December, 1986 by the Pharmacy Guild and the Health Department in New South Wales allows chemists to issue free needles and syringes. However, plain-clothes police, particularly in Sydney's Kings Cross, wait outside chemists' shops to arrest users for possessing implements to administer illicit drugs. The NSW Deputy Chief Magistrate admits knowledge of the police practice, which is expected to force the government to review laws on the possession of hypodermic needles. Dr. Alex Wodak, a member of NACAIDS working party on AIDS and intravenous drug use, reports that the number of people with AIDS among Sydney's intravenous drug users have virtually doubled in the past four months in line with world trends.

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SOVIETS LEGALIZE TESTING

with thanks to Chicago Outlines, 9/3/87

A government decree published August 25 authorizes HIV antibody testing of anyone Soviet officials suspect of carrying the virus, and establishes prison terms for individuals who knowingly expose someone else to the virus, according to The New York Times. Police are permitted to bring in anyone who resists testing. Carriers of the virus who deliberately expose someone else to the virus through sexual intercourse or through sharing of intravenous needles could incur a sentence of up to five years, even if the second person does not contract the virus. Foreigners who refuse testing may be expelled from the country. According to Dr. Vadim Pokrovsky, an AIDS specialist in the Soviet Union, the law is aimed mainly at testing prostitutes, and at preventing them from working after positive test results, and will not result in random widespread forced testing. While public Soviet response to the AIDS epidemic has been to consider it primarily a concern of the West, in recent months the press has been covering the disease more extensively, and several diagnostic clinics have opened. Dr. Pokrovsky has appeared on a night-time television program recommending the use of condoms to reduce the risk of transmitting the AIDS virus. The specialist said that the government is considering a condom distribution and promotion campaign, and that a new clinic will be opened in Moscow for treatment and study of the disease. He alleged that only 17 cases of the infection have been found, oly one of which includes symptoms of AIDS; 100 foreigners, most of whom are African students, have tested positive for the virus. Details ofthe law will not be known until the Ministry of Health publishes rules through which the decree will be put into operation. A representative of the World Health Organization siad that the law appear to be the most stringent adopted by any country to date.

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SEXUAL HEALTH REPORTS

Articles for the Summer, 1988 issue of Sexual Health Reports, volume 9:2, are being collected. Publication and mailing is anticipated in late June. Address inquiries, subscription information, and articles to: NCGSTDS, P.O. Box 239, Milwaukee, WI 53201. Thanks for your support!

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AZT ACCESS IN AUSTRALIA PROTESTED

by Ken Davis, with thanks to Boston's Gay Community News, 12/20-26/87

THE GOVERNMENT OF NEW SOUTH WALES, AUSTRALIA ANNOUNCED MAJOR CHANGES IN ITS FUNDING OF AZT IN RESPONSE TO AN ANGRY DEMONSTRATION by 300 people with AIDS and their supporters outside Parliament on November 24. This protest marked a rupture in what has been a long period of cordial cooperation between the government and the relatively well-funded local gay AIDS organizations. Over 200 people with AIDS and AIDS-related conditions receive AZT currently in the province, with a waiting list of nearly 50. The government was allocating 20 new places per month, yet between 40 and 60 new people are being diagnosed each month with conditions that make them medically eligible for AZT. In response to the rally, New South Wales Health Minister Anderson abandoned the quota system to accommodate those waiting. However, without a greater allocation of federal funding, existing money will run out by February. Warnings that AZT may then be means tested—requiring that those able to pay for it be charged the full amount billed by Burroughs Wellcome— have been met with widespread anger. Although AZT is not licensed in Australia, sale of such a drug would set a dangerous precedent in a country whose public health system provides medications either free or heavily subsidized. 69% of Australia's 648 cases of AIDS are in NSW, with 200 people with AIDS living in Sydney.

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SWEDISH AIDS WORK

by Lori Kenschaft, with thanks to Boston's Gay Community News, 1/24-30/88

THE SWEDISH RED CROSS and the community-based AIDS service group Noah's Ark have joined together in an inspiring commitment to coordinated action throughout the country. The Advocate reports that the Red Cross has guaranteed up to 13.5 million crowns over three years to Noah's Ark. One of the first priorities of the coalition is to educate all Red Cross personnel about AIDS prevention. Swedish officials have reported more than 145 cases of AIDS, and the number of people in the country infected with HIV is estimated to be between 5-10,000. Noah's Ark already has more than 500 volunteers helping people with HIV infection or AIDS.

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KOREA PASSES AIDS LAW

by Lori Kenschaft, with thanks to Boston's Gay Community News, 2/21-27/88

THE KOREAN NATIONAL ASSEMBLY HAS PASSED A LAW intended to prevent the spread of AIDS by detecting who in the population tests positive for HIV and strictly controlling their activities. According to Chicago Outlines, the bill permits the imprisonment of people who have AIDS or who are HIV-positive if they are found guilty of engaging in activities which could transmit HIV. In addition, medical doctors and clinics are required to report all HIV-positive tests to health centers immediately; HIV-antibody tests will be mandatory for prostitutes and those working at nightclubs, discos, bars, and other entertainment establishments; and the government may isolate PWAs and virus carriers. The law will apply to all foreigners staying in the country. Originally it also included a provision requiring foreigners who come to Korea for employment to carry an AIDS-free certificate, but this regulation was dropped after it was opposed by the Foreign and Justice ministries. Some organizations opposed to the deletion cited statistics that show that of the 12 Koreans who have tested positive for HIV, eight are prostitutes whose customers were mostly foreign servicemen.

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CHINA'S MEASURES TO THWART AIDS

by Mark Sullivan, with thanks to The Washington Blade, 1/8/88

CHINESE OFFICIALS HAVE ADOPTED STRINGENT MEASURES designed to curtail the spread of AIDS in that country, including testing foreigners and Chinese citizens who have been abroad, as well as renewed efforts to discourage casual sex between foreigners and Chinese citizens, according to the New York Times. Although there have been only 3 AIDS-related deaths in the country of more than a billion people, the Ministry of Health regards AIDS as one of the most serious diseases confronting China. China has strengthened its AIDS prevention work "because of the accelerating occurrence of AIDS in other countries," said Qi Xiaoqiu, a senior official in the Department of Disease Prevention. "Our main job is preventing AIDS from coming into China." China now requires all foreigners who seek to live in the country for more than a year to be tested for exposure to the disease or prove that they were tested in their own country. All Chinese people who spend time abroad are required to be tested when they return to the country. Police have been instructed to prevent foreigners from coming into contact with Chinese prostitutes, and many large cities, including Beijing, have instituted rigorous rules that keep foreigners and Chinese people from coming into social contact with each other in places like dance halls and discos. The Ministry of Public Health has also begun to broadcast warnings about the disease on Chinese television.

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CONDOMS IN SCHOOL COLORS

by Mark Sullivan, with thanks to The Washington Blade, 1/29/88

Members of the College of William and Mary Gay and Lesbian Alumni Association are encouraging people to show their school spirit in a rather unorthodox way. The group is distributing condoms in green and gold, the William & Mary school colors, as part of its AIDS education and awareness program. Along with the condoms in school colors, the "Safer Sex" kits contain two foil packets of K-Y water-soluble lubricating jelly and a pamphlet called "How to Use a Condom." The free kits may be obtained by sending a self-addresses, stamped envelope to William and Mary Gay & Lesbian Alumni, P.O. Box 15141, Washington, DC, 20003. Donations will be applied to the group's education and awareness program.

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CONDOM MACHINES DISAPPEAR

with thanks to Detroit's Cruise, 1/20/88

OFFICIALS AT WASHINGTON UNIVERSITY IN ST. LOUIS BLAME MISGUIDED PRANKSTERS FOR THE DISAPPEARANCE OF NEARLY A FIFTH of the condom machines recently installed at the school. Machine sales of condoms have been slow and school authorities said they think the machines were stolen for their novelty value rather than any money found inside. There is no evidence "that the vandalism is related to any protest regarding the dispensing machines or the use of condoms," the university's police department said. Six of the 32 machines installed in campus restrooms, laundry rooms and locker rooms are gone, officials said. Three were stolen and three were removed from service because they were damaged. Dr. Mary Parker, director of the university's health service, said the vandalism is unfortunate. "I know about pranks and about antlers on the mantelpiece, but I don't think this is funny," Parker said.

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CONDOM INVENTED FOR WOMEN

with thanks to the New York Native, 2/29/88

According to a federal Centers for Disease Control weekly reported dated January 25, 1988, in Vejle, Denmark, a gynecologist has invented a condom for women. Dr. Erik Gregerson of the St. Mary Hospital says he has "successfully" tried the device with his wife over the past two years. The condom, described as being between a diaphragm and the standard male condom, will be known as Femshields in Great Britain and the United States. It may also be known by its code name, WPC-333. It resembles an oversized condom whose closed tip is attached to a flexible polyurethane ring. It is inserted into the vagina much like a tampon, with the open entry end extending slightly outside the vagina. The thin polyurethane sheath hugs the natural contours of the vaginal wall. Polyurethane is 40% stronger than the latex used in condoms. Gregorson says the device will protect against AIDS. If tests are successful, he says, marketing would begin in 6 months, adding that the World Health Organization has shown interest in the condom and proposes testing it on prostitutes in Asia, South America, and Africa. "It was inspired by the colostomy bag," says Dr. Malcolm Potts, director of Family Health International, a family planning organization based in North Carolina, who says he has heard favorable reports about the condom in England. "People who are testing it say it's an acceptable way for women to prevent AIDS and unwanted pregnancies. Although it's unlikely this device will be the best contraceptive option available, it's the first of a new kind. It gives women more control over sex, which is useful." "This appliance would allow women to have more control over condom use and thus offer them better protection against [HIV] and other [sexually transmitted] infections," says Dr. Robert Hatcher, professor of obstetrics and gynecology at the Emory University School of Medicine in Atlanta. Hatcher says only about 10% of men in the U.S. regularly use condoms, as opposed to 43% in Japan.

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QUILT ON THE ROAD

by Peg Byron, with thanks to The Washington Blade, 1/1/88

SAN FRANCISCO IS SENDING THE REST OF THE COUNTRY A PRESENT— THE ENORMOUS AND UNIQUELY DESIGNED QUILT which organizers hope to unfold in 24 major cities in a national commemoration of the people behind the AIDS statistics. The 75,000 square-foot tapestry of both grief and tribute was first displayed October 11 during the National March for Lesbian and Gay Rights. The AIDS quilt, also known as "The Names Project," is a seemingly endless expanse containing the names of people who have died from AIDS, embroidered by friends, lovers, and families on 6x3 foot rectangles of cloth that range from silk and leather to linen and denim. San Francisco activist Cleve Jones originated the idea as "a needed, physical memorial." He began organizing it in July 1987 and from around the country have come colorful, personalized patches, which a cadre of volunteers sew together and maintain. Since the March, the quilt has grown one-third larger, to about 100,000 square feet, with about 4000 panels. In the first post-March appearance it was displayed in early December in the city's George Moscone Memorial Convention Center. Crowds often waited 90 minutes to see the display, which drew 100,000 people. "This is a gift from San Francisco," Jones said of the national tour, which he estimates will raise "millions of dollars," all to be donated to local groups that provide direct services to people with AIDS. Jones said $100,000 has already been raised toward the estimated $300,000 needed for the tour, which a road crew will operate, moving the quilt from city to city by truck. The only outdoor display of the quilt is expected to be in Washington, DC on October 8-9, a month before the Presidential election, when the quilt is expected to be 3 or 4 times its size the year before. Said Jones, "We want the quilt out there as a very powerful symbol of passion and unity and we hope the American People will base their decisions on the humanity of each individual."

NAMES PROJECT CONTINUES

by Dell Richards, with thanks to New York Native, 11/30/87

Steve Newberger, a volunteer at the Names Project, is sending an information packet to a woman whose brother recently died of AIDS. Although there's no panel bearing her brother's name yet, the woman placed a frantic phone call to Newberger. She is afraid her brother's name will be added to the giant memorial quilt. Newberger hopes that the brochure will help the woman understand her grief --and her anger. But he's not sure it will make a difference. Cleve Jones, executive director of the Names Project, already knew about the call. He'd talked to the woman a few days before. "I tried to tell her that her brother had two families," Jones said. "The sister belongs to one family; the man's gay friends and lovers belong to the other. I told her that his gay family has the right to express their frief in any way they feel is appropriate." It is a moot point,since there is no panel with the brother's name on it. But the call does raise an important issue: Should homosexuals be kept in the closet even after death, to protect their relatives? Jones insists that the quilt is only a community arts project, a way for friends and lovers to work through grief. But the Names Project has much broader implications. Bearing the names of almost 2000 dead, the quilt was the size of two football fields when it was first unveiled October 11, 1987 during the National March on Washington for Lesbian and Gay Rights. Each day since then, the quilt has continued to grow. Panels are pouring into the San Francisco headquarters of the Names Project from cities all over the country. And it isn't just the gay community that is responding. Members of organizations such as the Internatioal Ladies Garment Workers Union are also donating funds and support. Although at present gay men are bearing the brunt of the AIDS epidemic in America, people from all walks of life are dying. And as they die, their loved ones are turning to the only place they know for comfort in this crisis: The Names Project. The Projct is gaining so much momentum that a major New York publishing house is planning to put out a book about the quilt to coincide with its planned national tour. But notoriety isn't what The Names Project is after. It serves a much higher purpose, creating a memorial as a means for friends and relatives alike to work through the grief that AIDS is a bringing to thousands of people across the nation. "We have men and women, gay and straight, young and old," Jones said. "We've got senior citizens involved, teenaged kids. We have the mothers and fathers of people who have died of AIDS, and their lovers and friends." In the midst of colorful, sequined banners, middle-aged, middle-class Republicans sit at sewing machines in the Project's storefront headquarters, making panels for the deceased. "It's a gift of love," Jones said. "The people who work here are trying very hard to express to the world what it means to face this epidemic. A lot of that is negative. There's a lot of fear, a lot of sorrow, loss, and grief. But there's also great courage, great love, incredible sacrifices, and an absolute commitment to the community. that's what this quilt represents: the good and the bad. When you boil it down, this quilt is a symbol of love. it has the power to touch all different kinds of people." The quilt may be a beautiful symbol, but it also is the means of raising money to fight AIDS. Beginning in April, 1988, the quilt will make a sweep of the country, touring the 25 largest cities for four months, and raising money for local organizaitons which provide services to people with AIDS. On October 8 and 9, 1988, the quilt will return to Washingotn, DC, to be spread out again on the Mall. Jones expects the number of names then --an anticipated 14,000--to cover the entire area from the Washington Monument to the Capitol-- almost a mile. Reminiscent of the list of names on the Vietnam Memorial, the quilt undoubtedly will arouse equally strong emotions. By then, perhaps there will be panel for the brother of the woman who called the Project out of fear; perhaps someone who knew him will have made it, out of love. But perhaps not. Perhaps the man will remain an unknown martyr to AIDS.

THE NAMES PROJECT QUILT ON TOUR IN 1988:

If you live in one of the following cities, and are interested in being one of the local contact persons for The Names Project, to help with local arrangements for the display of the gigantic quilt (now almost 5 tons and the length of 2 football fields!), contact them in San Francisco immediately: 415/863-5511. Here is the tentative tour list of the quilt.

LOS ANGELES	4/7	MIAMI	5/18	BOSTON	6/30
SAN DIEGO	4/12	ATLANTA	5/25	DETROIT	7/5
PHOENIX	4/15	CINCINNATI	6/3	CHICAGO	7/8
DENVER	4/20	CLEVELAND	6/7	MILWAUKEE	7/11
KANSAS CITY, MO	4/25	PITTSBURGH	6/10	MINNEAPOLIS	7/14
ST. LOUIS	4/28	BALTIMORE	6/14	SEATTLE	7/22
DALLAS	5/3	PHILADELPHIA	6/17	PORTLAND, OR	7/27
HOUSTON	5/6	NEW YORK	6/21	WASHINGTON, DC	10/8
NEW ORLEANS	5/11				

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ADHESIVE CONDOM

by Jim Fauntleroy, with thanks to Boston's Gay Community News, 5/17-23/87

The Menter Corporation has started manufacturing a "two-piece condom system," featuring an adhesive condom with an applicator hood for easy on-- but not off. With the use of condoms expected to increase by 20-30% a year, according to the San Juan Star, the company felt it "had a product that offered a significant advantage over what was currently available. "The adhesive was very carefully designed to provide enough tack and yet come off very easily," said Al Mannino, vice president of health care products. "By rolling it off, it comes off very easily, but when it's secured in position, pubilling on it will not remove it." The sticky rubbers won't be inexpensive, though. They'll sell for $25-30 per dozen compared to the $5 or so that can get you twelve traditional latex prophylactics.

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CONDOM RIGHTS IN MICHIGAN

compiled by Nadine McGann, with thanks to Chicago Outlines, 10/29/87

Traverse City Commission members are proposing the repeal of a city ordinance that restircts the sale of condoms by anyonter other than a licensed physician or pharmacist. The move to change the law was suggested after a resident requested permission to install vending equipment in public facilities to sell condoms last August, as part of an effort to reduce the spread of AIDS. The proposal, which failed to pass a preliminary vote by a narrow margin, became controversial when two commissioners made anti-gay remarks during the debate. Jasper Weese reportedly blamed the country's problems on "homosexuals and pre-marital sex;" John Markly called gays "mentally unbalanced," and late said that "a quick cut of the scalpel" could be as effective as using condoms in stopping the spread of AIDS. Friends North, a gay organization, was moved by these and other remarks to consider beginning a campaign to have Markly recalledfrom his position onthe commission. Mayor Geraldine Greene as well as civil rights lawyer Dean Robb denounced Markl publicly. Robb also offered his facilities as a temporary center for collecting petitions inthe event of a recall effort. Although Friends North had decided against spearheading such a move, signature gathering reportedly began after Markly sarcastically agreed to step down if 1000 signatures requesting his recall were obtained from residents.

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CONDOMMANIA AT STANFORD UNIVERSITY

America just barely inched out the Japanese in Stanford University's First Annual Great Condom Rating Contest. "Stanford students narrowly selected the Gold Circle Condom manufactured in New Jersey as overall best," said senior Ken Ruebush, "but a Japanese brand walked away with honors in the most categories. Let's hope American condom makers learn a few lessons from the experiences of Detroit, and rise to the challenge." Ruebush, coordinator of the Stanford AIDS Education Project, opened the condom contest by declaring that "all condoms are not created equal." He said the contest was intended to "teach students about what's available in the marketplace in a fun sort of way." Student organizers distributed packets containing over 6300 condoms in two hours as condommania seized the campus. Each packet contained 7 brands of condoms, brightly colored information sheets, and an "absolutely official ballot" which was used for voting for favorites. The campus reacted to the promotion with enthusiasm and scooped up all 500 packets prepared for the scheduled 2-day promotion of National Condom Week within the first hour of the first day. "We spent most of the night putting together another 400-plus packets," said Stanford junion Daniel Bao. "Those went just as quickly!" While passers-by debated the fine points of condom etiquette, there was some griping about the 3 day deadline for inspection and balloting. Although it wasn't much time to thoroughly test all seven condoms, "...we figured they would wait 'til the last minute and end up pulling an all-nighter anyway," conceded Ruebush. Stanford senior Meg Richman said the contest did not promote sex. "We just want you to have safer-sex, if and when you're ready!" Fuji Latex walked away with most honoes. Its Yamabuki #1 swept "Best Feel," "Best Taste and Smell," and "Best Looking." Blacky, a black condom also made by Fuji, won "Most Versatile--Formalwear to Swimwear." Gold Circle was selected "Best Overall" and "Easiest to Use," with several ballots noting commendations for its foil-coin packaging "that can be opened using only one hand." Rough Rider, a textured condom, was voted "Biggest Turn-On to Partner." Ramses was judged "Best Lubricated," and Tahiti as "Best Fit." Prime, lubricated with the spermicide non-oxynol 9, was voted "Strongest," but a number of students complained about its strong taste. Testees were encouraged to write comments about the brands and the contest on the back of the ballots. Buebush read several at the Awards Banquet, including one signed "Ladies in Engineering," which said these days condom makers should stop promoting thinness and should have "steel-belted radial construction printed on the wrappes instead." The contest was organized by the Condom Promotion Committee of the Stanford AIDS Education Project. Ruebush said his group is working with students from other campuses to form the University and College AIDS Network (U-CAN). "Next year, we hope to run an even better contest on campuses all around the world," he said. FOR MORE INFORMATION: Stanford AIDS Education Project, P.O. Box 8265, Stanford, CA 94305 (415/723-0258, 328-7182).

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CONDOM CASES TO BE NEW HANKY CODE?

with thanks to Chicago's Windy City Times, 8/20/87

The owner of a Vancouver leader store has begun a promotion encouraging gay men to let potential partnes know they practice safer sex by wearing a condom case on their epaulets or belt. the leather case is offered by mail for $1 plus a donatio to the Vancouver PWA Coalition. J.R. NacKinnon, owner of Mack's Leathers donates the mateials from his overstock and PWAs provide the labor for this fundraising activity. Interested persons may write to Mack's Leathers at P.O. Box 76827, Station S, Vancouver, B.C. V5R 5St CANADA, enclosing a donation made payable to Vancouver PWA Coalition.

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LUBRASEPTIC RECALLED

with thanks to Chicago Outlines, 6/25/87

The federal Food and Drug Administration has banned the sale of a lubricant claiming to be effective in killing the AIDS virus. The makers of the product, Lubraseptic, were ordered in April, 1987 to pull their product from store shelves after the FDA ruled that advertising claims that the luybricant aided the prevention of sexually transmitted diseases were questionable, according to San Francisco's Bay Area Reporter.

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CLERKS ARRESTED FOR SELLING CONDOMS

by Robert Halfhill, with thanks to Boston's Gay Community News, 9/6-12/87

Two clerks at St. Paul, Minnesota movie theatres were arrested August 17 for violating a Minnesota law which prohibits the sale of condoms by persons not in a health realted business. The clerks, Peter Hafiz and Gennaro Sposito, were released the morning after their arrest when the City Attorney discovered the law had been declared unconstitutional in 1980. Randall Tigue, attorney for the theater owners, charged that the arrests were retaliatory because the theaters had recently obtained a court order blocking the enforcement of a city ordinance requriign the doors be removed from movie booths in adult theatres. both theaters had been the target of protests by neighborhood groups organized by City Council member Bill Wilson, charging that sex occurred in the booths. "Why enforce [the law] against the bookstores and not against gas stations or hotels wehre you can buy condoms from dispensers?" asked Tigue, who charged the enforcement as retaliatory. St. Paul Police Chief William McCutcheon said he was shocked that the law apparently was void but commended his officers for attempting to reduce prostitution in the neighborhood. "I don't expect my officers to know what goes on in every court in this land," he said.

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MEDICAL DEVICES ARE CONDOMS

with thanks to Detroit's Cruise, 12/23/87

"Condoms are considered to be medical devices and are therefore subject to the Food and Drugs Act and medical regulations," says the Health Protection Branch of the Canadian government, which insists that AIDS education groups must cease and desist from distributing free prophylactics. The governemnt equates "distribution" with "sale," and prohibits the sale of condoms unless labeling requirements (showing lot number and directions for use) are met. AIDS education groups mounting safer sex campaigns have distributed individual condoms (which do not bear the lot number, although the boxes do) along with instructional material geared for the gay male community (information not contained in the standard directions for condom use). Government medical inspectiors have informed them that they are in violation of the law by doing so. The AIDS-prevention groups will have to lobby for a special exemption, or may have to accomodate the regulations by preparing some sort of label for the individual condoms. In the meantime, however, distribution has not stopped.

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CONCERN OVER CONDOM QUALITY

with thanks to Chicago Outlines, 8/27/87

A study by the FDA indicates that one out of every five batches of latex condoms failed to meet minimum standards for leaks, according to the Los Angeles Times. Almost 51,000 comeoms were filled with water and examined for leaks; a batch `failed' if four or more leaked. Eleven of 106 U.S.-made condom batches failed, along with 30 of 98 imported batches, reflecting a minimum of about one of every 50 condoms. The FDA has suggested that the government and condom makers consider the reported failure rate to be surprisingly high, but officials would not discuss the results of the inspection or the ongoing program. Officials did however admit that despite the recent focus on condoms as a preventive measure against AIDS, there are no mandatory manufacturing requirements for condoms, and such standards that do exist are voluntary and industry-sponsored.

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BOMB CONDOM

by Kendall Lovett, with thanks to Boston's Gay Community News, 6/7-13/87

Over 250 lesbians and gay men massed behind the banners: "Dykes for Disarmanet" and "Gays Against the Bomb," chanting and singing in the April 12 march to break Australia's link in the nuclear war chain. Enola Gay— Australia's anti-war group for lesbians and gay men— carried their familiar sculpture of a silver bomb broken in two by a large pink triangle. But this year "Put a condom on the bomb, safer sex means everyone" and "bases out, condoms on! U.S. out, rubbers on!," yelled the marchers. Police estimated that 130,000 people marched in Sydney and 80,000 in Melbourne.

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WELCOME TO OUR NEW LOOK: SHR

HELLO! WELCOME TO THE FIRST ISSUE OF SEXUAL HEALTH REPORTS, actually the first issue of volume 9 of the previously titled Official Newsletter of the National Coalition of Gay Sexually Transmitted Diseases. We hope to publish quarterly, with graphic & technical changes implemented gradually. In spite of our staff being an essentially all volunteer-staffed operation, we will still try to provide you with efficient newsletter services. Unexpected problems and errors may still occur— for example, our last issue (volume 8:4), was erroneously labeled WINTER, 1987, instead of WINTER, 1988. Sorry about the confusion! We've recently added a hard disk drive to our computer, and upgraded our word processing program to release 3 of WordStar 2000, which should facilitate the publication of Sexual Health Reports, however, it was a real job getting used to the new equipment and installing the software, so please bear with any little glitches that may still be apparent! Although we anticipate improvements with time, we may not notice all the problems, so feel free to drop us a line to let us know how we're doing. Please also keep us informed of any news in your community about sexual health (including sexually transmitted diseases and AIDS, of course) or anything else you think we'd find interesting. We do need more subscribers! So, please send us the names of anyone who you'd like us to send subscription information. Our subscription rates will probably have to change in the near future, to reflect the recent increases in U.S. postage rates. Thanks for your support and understanding!

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BISHOPS OKAY CONDOM EDUCATION

by Lori Kenschaft, with thanks to Boston's Gay Community News, 1/17-23/88 and by Marie Rohde of The Milwaukee Journal, 1/24/88

IN ITS FIRST MAJOR STATEMENT ON AIDS, THE UNITED STATES CATHOLIC CONFERENCE has endorsed instruction about condoms in educational programs intended to halt the spread of AIDS. The bishops emphasized that their statement did not in any way represent an acceptance of either homosexuality or contraception. "Human sexuality is essentially related to permanent commitment in love and openness to new life," they wrote. "[It] is to be genitally expressed only in a monogamous, heterosexual relationship of lasting fidelity in marriage." According to the New York Times, the bishop's paper calls on Catholic schools— from elementary schools to colleges and seminaries— to develop materials to teach about AIDS prevention. The paper attracted criticism from more conservative Catholics. New York Archbishop John Cardinal O'Connor promptly characterized the paper as a "very grave mistake" and forbade instruction about condoms in the Archdiocese's AIDS education programs in schools, hospitals, and youth programs. "I think what will happen is that all over the United States you will find bishops issuing statements similar to mine, O'Connor said.

Cardinal John O'Connor did irreparable damage to the ability of the U.S. Catholic bishops to work together when he repudiated a statement on condoms issued by the bishops' leadership, Milwaukee Archbishop Rembert Weakland said. O'Connor and several other bishops have spoken out against the statement. Weakland was one of the first to applaud it. "This is one that will affect the future very much," Weakland said of O'Connor's comments. "I regret very much that Cardinal O'Connor publicly took issue with the statement. I think he had done irreparable harm to all of us by doing that." Weakland said he feared that the bishops would be taking all of their disputes to the press rather than working things out behind closed doors at meetings as has been the recent tradition. He added that one advantage of having a conference of bishops was that issues are well-researched before they are discussed. Weakland called the document on AIDS "magnificent" when read in its entirety, but said it probably would be discussed in March when the executive board of the bishops meet. He said he would not be opposed to the preparation of another document that dealt with the condoms issue. The bishops must continue to reiterate that the use of condoms does not mean safe sex, he said. "We should continue to say that the only real way to prevent AIDS from spreading is by having one partner in marriage," he said.

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FOOD REPLACES SEX?!

with thanks to Detroit's Cruise, 1/20/88

WITH AIDS DAMPENING AMERICA'S SEXUAL ARDOR, "FOOD HAS CHANGED FROM JUST BEING FUEL. NOW IT'S NEWS, FUN, SEX, entertainment, self-expression, and art," Laurel Cutler, the "futurist" told The New York Times. "Food has replaced sex," she explained. "I don't mean love sex, but sex as sport." Cutler predicts that such insights may fundamentally change the way new specialty foods will be marketed. She declines to be more specific, saying that such information is "reserved for my clients," which includes Nabisco and Campbell Soup. She asserts that her advice has boosted factory sales for her clients by over $2.5 billion. Cutler states that the new sexual self-consciousness will spark a trend toward "comfort food"— dishes that calm, relax, and deliver emotional warmth.

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FANTASIES BY MEN & WOMEN

with thanks to Detroit's Cruise, 2/3/88

YOUNG MEN THINK ABOUT SEX MORE THAN WOMEN AND HAVE ALMOST TWICE AS MANY SEXUAL FANTASIES AS WOMEN EACH DAY, suggests a study of college freshmen. Jennifer Jones, a graduate student in clinical psychology at the State University of New York in Albany, collected data on almost 100 students for a week and found women had an average of about 4.5 fantasies a day while men averaged almost eight fantasies. Jones told a meeting of the Association for Advancement of Behavior Therapy that both sexes had two or three spontaneous fantasies each day— not stimulated by outside influences, but men had more than twice as many fantasies prompted by something they saw, read, or heard, she said. Her research didn't address the content of the fantasies or explain why men had more, but Jones says the difference may be because of different cultural influences on men and women, genetic differences between the sexes or a combination of the two.

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LAWYER'S PENALIZES SODOMY STATES

with thanks to The Gayly Oklahoman, January, 1988

THE NATIONAL LEGAL AID AND DEFENDER ASSOCIATION ADOPTED A PRO-GAY RESOLUTION at its annual meeting in Miami. The resolution, sponsored by National Gay Rights Advocates (NGRA) and Gerry McIntyre of the Southern Tier Legal Services in Bath, New York, requires the NLADA to give preference to those states that have repealed their sodomy laws when selecting a site for its annual meeting. Jean O'Leary, NGRA Executive Director, hailed the adoption of the resolution, saying "These archaic sodomy laws are frequently used by bigots to support their discrimination against gay men and women. It's important for lawyers to raise their level of awareness on this issue and to take action helpful to efforts to repeal sodomy laws." NGRA is working on a model legislation to reform the sodomy laws around the country. NLADA is comprised of over 1100 organizations representing more than 15,000 lawyers. Last year, the Association adopted three NGRA sponsored resolutions requiring it to support the repeal of all sodomy laws, the enactment of legislation prohibiting discrimination based on sexual orientation, and protection of the civil rights of people with AIDS and related conditions. This year, McIntyre organized a gay and lesbian issues section for the Association. Attorneys interested in joining should contact him directly at Southern Tier Legal Services, 56 Liberty St., Bath, NY 14810.

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TRANSMISSION, PREVALENCE OF AIDS

with thanks to Science News, 3/12/88
and the New York Times, 3/4/88

ALTHOUGH HETEROSEXUAL TRANSMISSION OF THE AIDS VIRUS (HIV) and passage of the virus from HIV-infected women to their newborns account for a small percentage of U.S. AIDS cases, all are considered serious issues by health care officials. Among the latest studies dealing with these routes of transmission are two reported by researchers in Massachusetts. In one study, scientists at the Massachusetts Department of Public Health laboratory in Jamaica Plain looked at the prevalence of antibodies against HIV among nearly 31,000 newborns, in order to estimate the number of women infected (newborns share their mothers' antibodies). They report in the March 3 New England Journal of Medicine that, based on averages from the newborn screening program, 1 of every 476 Massachusetts women (2.1 per 1000) giving birth has HIV antibodies. The highest prevalence was found in inner-city hospitals (8 per 1000), the lowest in rural areas (1 per 1000). In another study, at Massachusetts General Hospital and Boston University School of Medicine, researchers found HIV antigens inside specific types of cells taken during biopsies of the cervix. The virus had already been isolated from cervical secretions.

But the authors say that the latest study— reported in the March Annals of Internal Medicine— suggests that cervical cells being sloughed off may be the real culprits in heterosexual transmission, as well as in the infection of infants during delivery. HIV has been found to infect blood vessels in the inner lining of the cervix as well as sperm, and cells of the brain, rectum and colon, as well as the blood.

[ED NOTE: Several times we have stated the belief that one of the major factors in HIV transmission to and from women is the friable (easily bleedable) cervix, secondary to infection by chlamydia or human papilloma virus (warts). The sloughing of cervical cells, as is suggested in this article, in conjunction with cervicitis (muco-purulent cervicitis from chlamydia; warts from HPV) is probably what constitutes real danger in heterosexual transmission.]

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HERPESVIRUS GENES OFF SWITCH

by Diana Van Pelt, with thanks to Insight on the News, 1/11/88

SCIENTISTS HOPE THAT A GENE ASSOCIATED WITH THE HERPES SIMPLEX VIRUS CAN BE MANIPULATED TO KEEP THE VIRUS DORMANT IN THE BODY, eliminating the skin sores that usually result during flare-up periods. The newly described gene is one of about 80 involved in the growth cycle of the herpes virus. When this gene is "turned on," the virus and its other genes appear to go into a latent phase. Exactly how this gene becomes active is not known. One possibility is that the gene's "antisense RNA," or opposite effect, allows the virus to become dormant, says Dr. Kenneth Croen of the National Institute of Allergy and Infectious Diseases. Another speculation is that the RNA manufactures a protein that interferes with the virus's growth. If further study confirms that the antisense RNA actually does establish and maintain latency, it may be possible to devise methods of keeping the RNA permanently active in the herpes simplex virus and in other viruses that exhibit latency periods, such as the microbes responsible for shingles and AIDS. Croen speculates that future immunization could involve using a mutant virus containing a catalyst that keeps the nullifying gene always active. This kind of vaccine would be given to people who have never been exposed to the herpes simplex virus.

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LASER ZAPS VIRUS IN VITRO

with thanks to Detroit's Cruise, 2/3/88

A MEDICAL RESEARCH TEAM IN TEXAS HAS CONCLUDED THAT LASERS CAN BE USED TO CLEANSE DONATED BLOOD OF HIV and other infectious agents. Dr. James Matthews said his team had demonstrated that the combination of non-toxic dye and laser light could destroy a number of viruses in the blood, including HIV— without harming the blood itself. The procedure— for blood samples and not blood in the body— remains experimental and has been tested only on a small scale in the laboratory, Matthews said. With follow-up work, he said, it appears the laser-dye procedure could be used to cleanse blood at a "flow rate" of about one pint every 15 minutes— sufficient to allow its use by blood banks. The team was from the staff of Baylor University Medical Center and Baylor Research Foundation in Dallas. The procedure, under development since 1984, takes advantage of the fact that tumors and certain viral cells absorb or retain dyes to a greater extent than surrounding tissue or cells. If the dye-laden tumors or cells are irradiated with laser light, a chemical process is set off that destroys the viral cells, the researcher said. A scientific paper written by Matthews and his team explaining the work was published in Transfusion, the journal of the American Association of Blood Banks.

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HIV BINDING THERAPY

with thanks to Science News, 1/16/88

Treatment with cell-surface molecules that bind the AIDS-causing HIV virus may at least partially block infection by the virus may at least partially block infection by the virus, according to recent results from five independent research groups. CD4 receptors— proteins that seem to serve as "docking sites" for HIV on certain lymphocyte cells-- are thought to play a pivotal role in HIV infection. Adding excess CD4, made with genetic engineering techniques, apparently can trick the virus-to-cell binding system and adsorb viruses before they can attack cells, say the scientists. Commenting on CD4 in the January 7 Nature, Robin Weiss at London's Institute of Cancer Research at Chester Beatty Laboratories says his studies show the CD4 preparations can inhibit multiple strains of HIV-1, HIV-2, and monkey immunodeficiency viruses. All the authors emphasize that studies using the protein preparations in humans, while a hoped-for consequence of the current work, may show that CD4 is not an appropriate treatment for AIDS.

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NERVOUS SYSTEM EFFECTS FROM HIV

by S. Eisenberg, with thanks to Science News, 1/2/88

IN 1985, WHEN SCIENTISTS ISOLATED THE AIDS-CAUSING HIV IN BRAIN TISSUE AND SPINAL FLUID, they realized that the virus directly affected the nervous system as well as the immune system. But a new study is providing some of the first clues about when HIV begins to affect the nervous system, causing dementia and other impairments. The answer may mean earlier detection and treatment of HIV-infected individuals. The study, which is the first to detect neurological impairment at various stages of HIV infection, appears in the December, 1987 Annals of Internal Medicine. After giving neurological and psychological tests to a group of 55 homosexually active men, Igor Grant and his colleagues at the University of California and Veterans Administration Hospital in San Diego evaluated the subjects' mental abilities and found that HIV appears to have an early impact on the nervous system. In the group with fully developed AIDS, the impairment rate was 87%; AIDS-related complex, 54%; HIV antibody positive, 44%; and HIV negative (controls), 9%. "In the Grant study, we don't know how long they [the neurologically impaired but asymptomatic subjects] were infected with HIV and how far away they are from ARC," says Richard Johnson, a neuropsychiatric investigator for the Multi-center AIDS Cohort Study (MACS), which involves 5000 homosexually active men in Baltimore, Pittsburgh, Chicago, and Los Angeles who were tested for HIV two years ago but who had not developed ARC or AIDS at that time. At the centers, investigators are monitoring the neurological and psychological characteristics of those who have tested HIV antibody positive since entering the program. This will help determine when HIV first affects the nervous system and also the effect's prevalence at each stage of infection. Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases in Bethesda, says Grant's study is valid, but better controls are needed. "Psychiatrists have said the anxiety of knowing you're positive for HIV may cause neurological abnormalities, so correct controls would be people who have stress, such as cancer patients." In a similar sense, some MACS participants who have elected not to know their HIV status are acting as controls, says Johnson, of the Johns Hopkins School of Medicine in Baltimore. Grant says one implication of his study is that physicians should know that HIV may cause neurological problems in otherwise healthy patients. In addition, knowing the stage of HIV's impact on the nervous system is important because scientists want to know when to begin therapy with drugs such as AZT (zidovudine), which is the only AIDS drug commercially available. But they first must know whether early intervention would be beneficial. A study of 1600 asymptomatic, HIV-positive people is underway by Burroughs Wellcome, to test the effects of AZT. Because of HIV's apparent effect on the nervous system, U.S. Navy Surgeon General J.A. Zimble in July recommended reassigning flight-crew personnel who test positive for HIV. His recommendation was based on earlier studies that suggested a tie between HIV and neurological problems but that did not specify at what stage of the infection this would occur. [ED NOTE: Note that HIV negative controls the impairment rate was 9%! Why?!]

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EUTHANASIA AS ALTERNATIVE?

by Pat Califia, with thanks to The Advocate's Adviser, 3/29/88

QUESTION [by unnamed reader]: I am HIV-positive and have reason to believe that my health is deteriorating. Although I intend to do everything possible to prolong my life and make it as productive as possible, I do not want to linger in great pain if I am terminally ill. I am especially afraid of having my mental faculties impaired and literally not being the same person I am today. It seems to me that either euthanasia or suicide is an ethical alternative to the suffering I have seen dear friends of mine undergo while well-meaning medical people could do nothing for them but prolong their agony. There has been no discussion of this in the gay magazines I subscribe to. I need more information. Could you point me in the right direction?

ANSWER: Contact the National Hemlock Society, Box 66218, Los Angeles, CA 90066. Its phone numbers are 213/391-1871 and 390-0470. This non-profit organization provides education about voluntary euthanasia for the terminally ill. It does not advocate suicide in other cases— for example, in cases of emotional distress. For a $20 annual membership fee, you get a quarterly newsletter, forms for making a living will and a durable power of attorney for health care, a card you can keep in your wallet that expresses your wishes for medical treatment, and discounts on books on all aspects of euthanasia. These publications include handbooks on suicide and discuss ethical, religious, and legal aspects of this issue. You should also consult with an attorney to find out if dying by your own hand would affect your personal arrangements, e.g., your will, life insurance benefits, etc. This is a thorny moral dilemma for many of us. But I agree with you that the time to become informed and make decisions is before one becomes seriously ill (and possibly unable to make an informed choice or act upon it.) I absolutely do not advocate suicide; life is too precious. But death without dignity can be a mockery of life, and I believe the individual— not the state or a hospital— should have the authority to decide when to let go.

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ARTISTS' RESPONSE: EXHIBITION

THE WEXNER CENTER FOR THE VISUAL ARTS/UNIVERSITY GALLERY OF FINE ART WILL PRESENT AIDS: THE ARTISTS' RESPONSE, an exhibition of artwork addressing AIDS. Curated by Jan Zita Grover, a critic and AIDS activist from San Francisco, the show will open in February 1989 and run through March 1989, in Columbus, Ohio. Artists producing film, video, photographs, paintings, drawings, sculpture, performance, installations, or other AIDS-related visual/audio projects are encouraged to submit their work. Please send 35mm slides or VHS tapes with SASE mailers, resume and/or cover letter to the University Gallery. Pamphlets, posters, and other materials from AIDS service organizations are also being solicited. The deadline for submissions is July 1, 1988. The Ohio State University exhibition will be accompanied by a spectrum of related programming including: panel discussions, workshops, and community events concerning AIDS education and prevention, and health, legal, and social issues as they relate to the AIDS crisis. For additional information: Lynette Molnar, University Gallery of Fine Art, 1880 N. High Street, Columbus, OH 43201 (614/292-0330).

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HIV-2 AIDS CASE IN NEW JERSEY

by Mark Sullivan, with thanks to The Washington Blade, 2/5/88

RESEARCHERS IN NEW JERSEY HAVE DIAGNOSED THE FIRST CASE OF AIDS IN THIS COUNTRY CAUSED BY THE HIV-2 VIRUS, according to the Washington Post. Doctors at the University of Medicine and Dentistry of New Jersey, located in Newark, said the case involves a West African woman who arrived in the U.S. about a year ago. Although there have been many cases of persons testing positive for exposure to the HIV-2 virus, the woman is the first person to develop AIDS who did not also test positive for HIV-1, the virus thought to cause AIDS. HIV-2 was first discovered in West Africa, then in Europe and South America. In those places, the virus appears to cause AIDS, but not as frequently as HIV-1, and not as severely. "I don't think this is a cause for worry," said Dr. Phyllis Kanki of the Harvard School of Health. "We have been expecting it to arrive. It is still a question of whether it will be a cuase of [significant] disease here...." If more cases of AIDS are related to the HIV-2 virus, health officials said it might be necessary to begin using a screening test that has already been developed for HIV-2 and is awaiting final FDA approval.

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HTLV-5 DISCOVERED

by Mark Sullivan, with thanks The Washington Blade, 12/18/88

RESEARCHERS AT THE UNIVERSITY OF ROME HAVE DISCOVERED A FIFTH VIRUS in the family of viruses that are believed to cause leukemia and AIDS, according to The Washington Post. The newly discovered virus, which is called HTLV-5, has already been linked to a rare form of leukemia that causes severe skin eruptions. About 1000 cases of the disease are reported in the U.S. annually, but it is not clear yet how many are caused by the HTLV-5 virus. Viruses in the HTLV family attack white blood cells called T-cells, which are the body's primary defense against disease. When infected by one of the viruses in the HTLV family, the T-cells become unable to defend the body against disease.

>HTLV-1 and HTLV-2 are believed to cause different forms of leukemia.

>HTLV-3, or HIV-1, is thought to cause AIDS.

>HTLV-4, or HIV-2, is thought to cause a disease similar to AIDS that also damages the body's immune system, but to a lesser extent.

>HTLV-5 as stated above, is linked to a rare form of leukemia.

The newly-discovered virus is thought to bridge the gap between the tow types of viruses because it possesses qualities of both the leukemia-causing viruses and the immune deficiency viruses. The virus causes a form of leukemia, like HTLV-1 and HTLV-2, but there also seems to be evidence that it can be transmitted sexually-- a trait common to HTLV-3 and HTLV-4 but not to HTLV-1 and HTLV-2.

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GENITAL ULCERS INCREASE

by Mark Sullivan, with thanks to The Washington Blade, 12/18/88

FEDERAL OFFICIALS ARE ALARMED THAT THEE HAS BEEN A SHARP RISE OF CHANCROID, a sexually transmitted genital ulcerative disease that makes it easier for the AIDS virus to gain entry to the body and cause infection, according to The Washington Post. "Coming at a time when we are tying to increase the public's understanding of AIDS, the implications of these reports are very grave," said Dr. Ward Cates, director of the STD Control Division of the CDC in Atlanta. In 1985, there were about 2000 cases of chancroid reported in the U.S. Last year, the number jumped 65% to 3418. Chancroid is a bacterial infection caused by the germ Hemophilus ducreyi which health officials blame for the rapid spread of AIDS among heterosexuals in Africa. In the U.S., it has been concentrated in metropolitan areas among Hispanic and black heterosexuals. But chancroid is not the only sexually transmitted disease that is on the rise. Officials also reported a 32% jump in the number of syphilis cases in the first nine months of 1987, and a 62% jump in the number of cases of penicillin-resistant gonorrhea. [ED NOTE: AND WHAT ABOUT CHLAMYDIA? AND VENEREAL WARTS (HUMAN PAPILLOMA VIRUS)?] Federal officials said the problem is only going to get worse, since funds for STD control have remained virtually the same since 1981.

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MENTAL IMPAIRMENT

by Sharon Haase, with thanks to Boston's Gay Community News, 2/7-13/88

A California study recently published in Annals of Internal Medicine by Igor Grant reports that a decrease in the functioning of some mental facilities may be an early symptom of AIDS. The study included 55 gay men who either had AIDS, ARC, were HIV-antibody positive but asymptomatic, or HIV-antibody negative. Of the 16 seropositive men with no known symptoms of AIDS, 44% showed impaired coordination and cognitive difficulties. According to Philadelphia Gay News, Edmund Tramont, director of AIDS at the Walter Reed Army Base Institute for Research, claims the disease could manifest itself early as a form of Alzheimer's Disease. However, Bradford Navia of Massachusetts General Hospital stresses the need to do further, long-term studies before any definitive conclusions may be drawn.

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BLOOD ART RECORDS SUFFERING

with thanks to Detroit's Cruise, 2/10/88

A BRAZILIAN PAINTER WHO HAS DEVELOPED AIDS IS MAKING A RECORD OF HIS SUFFERING IN PAINTINGS DRAWN WITH HIS OWN BLOOD. Luis Cardosi, a hemophiliac, attracted widespread attention three years ago when he married a 19 year-old woman even though he was carrying the AIDS virus. Since then, Cardoso has developed the disease. On his bedroom wall, Cardoso has hung one of his works "as a symbol of my own suffering."

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PRINCESS DIANA IN PAINTING

by Lisa Keen with thanks to The Washington Blade, 8/28/87

The London daily newspaper The Guardian reported that Princess Diana apprently gave tacit approval for a painting to include her likeness in a effort to raise money for AIDS. The 12 x 6 foot painting depicts the Princess standing over the bed of Sunnye Sherman, a DC area woman who was active in AIDS efforts here and who succumbed to the disease in 1985. The Guardian noted that the Princess never met or knew of Sherman and did not give the artist, Canadian Anre Durand, a sitting. "But," said the newspaper, "she has helped to destroy myths over the killer disease by visiting 12 victims in hospitals earlier this year." Princess Diana was contacted about the benefit painting by former Labor Minister Lord Ennals. She reportedly wished the project success but did not endorse the painting nor know that she was to be so prominently featured in it.

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VIRUSES IN SEARCH OF DISEASES

by Diane Edwards, with thanks to Science News, 10/17/87

Despite masive efforts by medical science to match diseases with specific casuse, new agents of disease can appear without warning and disrupt any scientific self-confidence. The viral cause of AIDS, for example, existed for many years, yet researchers only recently identified the human immunodeficiency virus (HIV) and its devastating results. Scientists emphasized that there are other "new" viruses whose complete medical cconsequences are undiscovered. These viruses include those that may be responsible for fetal death, the controversial chronic fatigue syndrome and lymph node cancers, according to participants of the Intersicence Conference on Antimicrobial Agents and Chemotherapy held in New York City. One such agent, human parvovirus B19, was "a virus looking for a disease" until 1981 — when it was first associated with aplastic crisis, a shutdown of the bone marrow's production of blood cells, says Larry Anderson of the CDC in Atlanta. Researchers later tied the virus to severe skin rashes and arthritis. This year, says Anderson, reports to the CDC indicate that the virus also may be responsible for some fetal deaths, as well as for bone marrow failure amongh patients with defective immune systems. Scientists now think the threat of parvovirus B19 may be most severe for people with AIDS, who cannot defend themselves against additional infections. Studies are underway at CDC, says Anderson, to determine the prevalence of B19 infection in the general population and to confirm the link between the virus and specific diseases. The human B-lymphotropic herpesvirus (HBLV), first described in 1986, is another example of a virus with an incomplete medical history. The virus is unusual in that it is released from infected cells in membrane-bound packets, rather than through disruption of the cell. But this lack of cell "lysis" during HBLV infection does not mean the virus is harmless. Preliminary studies by Zaki Salahuddin of the National Cancer Institute and others have found HBLV in patients with various lymph node cancers, although no direct association between the virus and malignancy has been established. The new virus also may be a factor int he course of AIDS, suggest Salahuddin. A random screening of subjects without detectable disease found about 16% had low levels of antibodies against the virus, while a survey of PWAs found that up to 70% had high HBLV-antibody levels. Salahuddin says the antibody profile produced in response to HBLV is "very confusing and interesting." Antibodies from humans infected witht he virus unexpectedly cross-react with the chicken herpesvirus, but not with herpesviruses from other animal sources. This cross-reactivity — which usually signals some similarity between two viruses —coupled with the fact that there is no satisfactory way to detect the virus, leaves many unanswered questions about HBLV. "We're really nowhere near drawing a conclusion regarding [HBLV's] pathological role," says Salahuddin. Scientists at CDC are developing an assay for a herpesvirus they recently isolated, which appears to be identical to the HBLV found by Salahuddin's group, says CDC's Carlos Lopez. "We do not know what disease it causes, but I think we can fairly assume tht this virus can cause human disease," he says. Using the test the scientists are tracking the virus, which they call human herpesvirus VI (HHV-VI). On the basis of these studies, Lopez says that "first and foremost, this is a disease of children." Antibody production against HHV-VI apparently peaks sometime early in life, then "dwindles" as a person ages, says Lopez. Despite its apparent affinity for children, the virus is being considered by CDC, also with Epstein-Barr virus (EBV), as a possible cause of the adult condition called chronic fatigue syndrome, which scientists say may or may not be a distinct medical disorder. Officials at CDC currently are writing a description of the disease to be used for diagnosis, says Lopez. Other early data suggest that HHV-VI can be sexually transmitted, and that in the general population, women are more likely than men to be infected. Lopez suggests that this higher incidence among women may be due to mothers' handling of infected children, or to the fact that the virus can be passed sexually from men to women more easily than from women to men. [ED NOTE: Another possible reason for women's greater liklihood to become infected is due to chlamydial induced mucopurulent cervicitis. Easily induced bleeding from the cervix due to this subclinical infection can make the transmission of other sexually transmitted viruses much more efficient.] Another curious aspect of the new herpesvirus is that it apparently inhibits HIV replication in cell cultures by 50%. But Lopez says the significance of this observation is still unclear.

Calling Kawasaki syndrome another "disease in search of a virus," Jane Burns of Boston's Childrens Hospital said that her "very preliminary" studies suggest that a virus producing the enzyme reverse transcriptase may be responsible. About 70% of 33 Kawasaki patients tested showed an elevated level of enzyme activity typical of reverse transcriptase. Viruses making this enzyme are broadly classified as retroviruses, a group that includes the AIDS virus. Since it was first reported in a Japanese journal in 1967, a relatively rare childhood disorder called Kawasaki syndrome has stubbornly rebuffed scientists' efforts to understand it, and the disease's incidence may be increasing in the U.S. Characterized by fever, rash and occasional damage to coronary arteries, the syndrome is thought to be an infectious disease — given its cyclic epidemics that vary with the seasons. But Marian Melish of the University of Hawaii in Honolulu says that the enzyme activity seen by Burns "probably came from the patients' cells" and that her own studies do not support a human retrovirus as the cause. Melish, who was one of the first to describe Kawasaki syndrome in the U.S., also reports that the incidence of the disease in Hawaii has stabilized in the past few years, yet continues to affect primarily those of Asian ancestry. "Kawasaki syndrome is now considered teh leading cause of acquired heart disease in [U.S.] children," said Stan Shulman of Children's Memorial Hospital in Chicago.

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AIDS EPI/SURVEILLANCE UPDATE

abstracted from AIDS Weekly Surveillance Report, CDC AIDS Activity

As of March 21, 1988, the Centers for Disease Control AIDS Activity reports a total of 57,024 adult and pediatric cases of AIDS in the U.S. (CDC strict case definition; this includes 4905 patients who meet only the 1987 revised surveillance definition for AIDS). PATIENT RISK GROUP: Homosexually active men account for 64% of all cases; 18% from IV drug abusers; 7% 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; 46% from ages 30-39; 21% from ages 40-49; and 10% from ages over 49. RACIAL/ETHNIC BACKGROUND: 60% of the cases are white; 26% are black; 14% are hispanic/latino; 1% are other or unknown. Note that 54% of the pediatric (under age of 13 at time of diagnosis) cases are black, 22% hispanic, 23% white, and 1% are other/unknown. GEOGRAPHICAL DISTRIBUTION: 54 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 25.3% & 21.8%, respectively; Florida, Texas, & New Jersey report 7.1%, 6.9% & 6.7%, respectively; Illinois, Pennsylvania, Georgia, & Massachusetts, each report: 2.8%, 2.6%, 2.1%, & 2.1% respectively, of the cases; all other areas each report less than 2%. OVERALL MORTALITY: 56%.

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CHRONIC FATIGUE SYNDROME DESCRIBED

by C. Vaughan, with thanks to Science News, 3/12/88

FACED WITH CONFUSION AND CONTROVERSY ABOUT THE DEFINITION AND CAUSE OF CHRONIC EPSTEIN-BARR VIRUS SYNDROME, a group of 16 physicians and researchers from around the United States has published a working definition of the mononucleosis-like illness, renaming it "chronic fatigue syndrome." By doing so they hope to begin finding out if this is one disease or many diseases and what might be causing it. In 1985 medical researchers first made a case for a connection between Epstein-Barr virus and a mysterious collection of symptoms— including fever and persistent fatigue— which seemed unconnected to any specific illness. Since then, extensive media coverage has led to wide interest in -

have called it a "fad" disease. "A lot of people were diagnosed in error," says one of the researchers, medical epidemiologist Gary Holmes of the Centers for Disease Control in Atlanta. Doctors were mistakenly under the impression that a diagnosis of Epstein-Barr syndrome required only a non-specific illness and a positive test for the virus, says Holmes. The authors of the new definition, which is published in the March Annals of Internal Medicine, point out that while there seems to be some correlation between the syndrome and Epstein-Barr virus, the virus is not found in all people diagnosed with the syndrome, and there are equally strong or stronger associations between the syndrome and other viruses, such as herpes simplex and measles viruses. Furthermore, an estimated 90% of the adult U.S. population harbors the Epstein-Barr virus and most of these never become ill, according to psychiatrist Leonard Zegans of the University of California School of Medicine in San Francisco, a coauthor of the report. "There's a real question about whether this has an organic basis or whether it's a variant of depression," he says. The working definition states that a diagnosis of chronic fatigue syndrome can be made only when the physician notes persistent fatigue over six months. The patient should have no prior history of these sorts of symptoms, and the physician must rule out infections, parasites, endocrine diseases, AIDS and other diseases that might cause similar symptoms. In addition to these major criteria, the patient must report at least eight of 11 symptoms that persist or recur over six months:

>mild fever
>sore throat
>painful lymph nodes
>general muscle weakness
>muscle discomfort
>fatigue for more than 24 hours after light exercise
>headaches
>joint pain without swelling
>depression or other neuropsychological complaints
>sleep disturbances

The development of the initial symptoms over a few hours to a few days is also an important aspect of the diagnosis. The diagnosis can also be made if the patient reports 6 of the 11 symptoms and the physician observes at least two of three physical signs:

>low-grade fever
>inflammation of the pharynx
>noticeably swollen lymph nodes

The definition is intended mostly as a restrictive diagnostic tool for researchers so that they can study only the most clear-cut cases and maximize the chance of finding a causative agent. "In order to identify a disease agent you have to have a clear clinical syndrome," says Zegans. "Once you answer the question of whether there is a phenomenon, then you can begin to ask the question of what causes the phenomenon."

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