From: Nancy Stoller Shaw
Women's Program Coordinator
San Francisco AIDS Foundation

To: San Francisco Human Rights Commission

Re: AIDS/ARC Discrimination Hearings
February 4 and 5, 1986

In addition to the health consequences faced by all people with AIDS or ARC, women suffer additional problems of access to education and services. One aspect of the problem faced by women is that the health and social service system of San Francisco is already inadequate to meet their needs. There are three areas of specific inadequacy in regard to AIDS: preventive education, health and social services for women infected with the HTLV-III virus or with ARC or AIDS, and overall service and civil liberties protections for special populations of women. I will address each area in turn.

I. Preventive Education:
Because the number of women with AIDS is much smaller than the number of men, most preventive education is directed at men. For example, in San Francisco most AIDS education is directed at gay men. While extensive funds are appropriately expended to protect this highest risk community, at the same time, only a tiny amount is spent for AIDS prevention among women. This means that the women who are at risk have very limited access to education programs. A minimum range of programs needs to be provided.

Since last year, the Women's Program of the San Francisco AIDS Foundation and the Women's AIDS Network have been working to establish support and education groups for women through the AIDS Health Project, Shanti and other organizations. Many women are extremely uncomfortable in predominantly male groups and their discomfort prevents them from getting the education they need. We have finally been able to establish one drop-in group at the AIDS Health Project, but much more is needed. In addition, the fact that the women at most risk currently are I.V. users means that AIDS education projects need special tailoring. They cannot simply be all-women versions of what is offered to the gay community. The issues of drug use, sexuality, women's reproductive systems, and maternal roles are crucial for such programs. There is a lack of education concerning the special needs of women in regard to AIDS among OB/Gyn practitioners, and at the health and drug clinics of San Francisco. In response to this ignorance, the Women's Program has initiated a special Women's Health Outreach (WHO). However, for economic reasons, the program is staffed only parttime by one staff member. It has been necessary to recruit student interns and community volunteers to bring the program into existence.

Recommendation: Review existing AIDS education programs located in the public and private sectors and at city jails and other institutions to
be certain that women have access to programs to the same extent that men do. The review should include the issue of relevance in terms of content and language.

II. Services for Women with Positive HTLV-III Antibody Tests, or ARC or AIDS:

Many of the services for people with AIDS or ARC are organized with the gay male in mind. If the organizer is not thinking about gay men, he or she may be thinking of "drug users." And, unfortunately, most drug services are designed with the male user in mind. What are the consequences of this male orientation in AIDS services? There is no AIDS screening clinic for women; there is no referral list of doctors who are knowledgeable in both AIDS and women's health (because there are so few practitioners that they are essentially unknown or unavailable). Emergency housing is also less available for women. Provisions in emergency housing and in other services may not be made for children.

Recommendations:
1. That the city establish a primary AIDS screening and outpatient clinic specifically for women. This clinic should be at a site with a full range of women's health care services, including perinatal care and pediatric services. HTLV-III testing should be available anonymously, as well as in a confidential form.
2. The right to complete health and social services throughout the City for mothers and their infants should be guaranteed independently of antibody tests and test results.
3. AIDS clinical and social services in the City should be reviewed with regard to their relevance and availability to women.
4. The Commission should encourage the City to establish an office for Women's Services which should monitor and supervise the provision of both social services and health care to women.

III. Services to and Civil Liberties for Special Populations:

The following special populations of women have faced discrimination in regard to AIDS:

1. Women in the Criminal Justice System. Even though there are few AIDS services and limited educational programs for women in the general community, these programs, especially education, are even less accessible to women in the jail system. Whatever education women get in jail must be provided by jail staff. Although some AIDS education has taken place in the Bryant Street jail and at San Bruno, it is inadequate for the numbers of women who pass through these institutions on a daily, weekly, and monthly basis. Meanwhile, social workers estimate that over 60% of the women in either institution have I.V. drug problems.

Many women in jail are fearful of the legal consequences associated with the admission that they might be in risk categories associated with AIDS. For example, they are afraid that they may lose their children to the Department of Social Services if they admit to drug use. They are also afraid of police harassment if they admit to prostitution. Therefore, there are special civil liberties and confidentiality aspects involved in any AIDS educational program for women in jail.

Recommendations:
1. That the City expend funds for the education of women in its jails.
2. That there be adequate legal protection for women in the jail system who are interested in AIDS education, screening, or services, so they do not suffer from their requests for assistance.

2. Prostitutes. Although there has been no evidence of specific harassment of prostitutes in San Francisco to date, the evidence from other cities
indicates that this could easily occur if vigilance is not maintained. In regard to AIDS, a prostitute is, and should be treated, the same as any other woman who has multiple sexual contacts. It is the type of contact, not the exchange of money, that puts a person at risk. Prostitutes need protection of their civil liberties. Like other women they also need education about AIDS. Delivery of this education requires special programs which are neither moralistic nor discriminatory. Because many prostitutes' primary language is not English and many are immigrants, special cultural aspects are also very important.

Recommendation: That the Commission make prostitutes aware of their rights and that the City develop an educational program directed at this group of women.

3. Drug Users. Women who are drug users suffer a series of problems with discrimination in services. This discrimination is most apparent in residential services. Currently there are NO residential treatment programs in San Francisco which will accept a woman in late stages of pregnancy. Most will not take a woman in any stage of pregnancy, and none will allow a woman to complete a pregnancy while a resident. Additionally, no program allows women to bring their children, even children who are very young. The programs forbid visitors for weeks and sometimes months after admission. This proscription includes the resident's children. Such requirements effectively exclude many women from use of services. Where women decide to participate anyway, they face the additional burdens of arranging childcare and the emotional stress of leaving their children. What is further distressing is that the number of beds, even in these programs with their discriminatory requirements, are grossly inadequate to meet the requests by women for space in them. Proportionate to requests, much more space is available to men.

It is well known among those of us who provide AIDS services that none of the residential drug programs in San Francisco will admit people with positive AIDS antibody tests, or with ARC or AIDS. This exclusion is clearly in violation of local law. It has the same negative impact on women as it does on men.

Recommendations:
1. That all drug programs, residential and otherwise, be required to provide full access to services to persons with positive HTLV-III antibody tests, or with ARC or AIDS.
2. That residential drug treatment programs be required to provide services to pregnant women and that residential programs allow visiting with children within the first few weeks of admission.
3. That the City provide at least one residential drug treatment program for women and their children. This program could be modeled on the program provided for women with alcohol problems by the Women's Alcoholism Center.
4. Women of Color. Women of color suffer from the same institutional racism that affects men of color in AIDS program delivery. Materials, educational forums, and free local health services all come to them later than to the predominantly white community. People of color are less likely to see their images, hear their ways of talking, or find their concerns reflected in the literature, forums, and services that do arrive. I believe that this problem is caused by a combination of inadequate funding, weak affirmative action programs, and sexism in the AIDS service sector. It is compounded by the homophobia in all San Francisco ethnic communities which prefers to locate AIDS among gay men and refuses to acknowledge that AIDS in the gay community and AIDS in the drug community are exactly the same disease and originated at the same time in the same place.
For women of color, a further complication is that their needs are sometimes different from the needs of men of color. For example, women at risk are much more likely than men to be single heads of households with children. They may even speak different languages than the men at risk. Many prostitutes in San Francisco today speak Vietnamese and they are much more at risk of exposure than are Vietnamese men.

Recommendations:
1. That the Human Rights Commission initiate and foster a dialog on AIDS that will encompass the leaders of the gay community and the leaders of the major ethnic groups in San Francisco, so there can be shared commitment and support across these "interest group" lines.
2. That all city public health agencies, not just "AIDS agencies", be required to provide culturally relevant services to women, as well as men, in AIDS risk categories, and that their services to special populations, such as women of color, prostitutes, and drug users, be monitored on a regular basis.
TESTIMONY ON AIDS DISCRIMINATION
San Francisco Human Rights Commission Hearings
February 5, 1986
Priscilla Alexander, Education Coordinator

The Problem: Prostitutes are being Scapegoated for AIDS

Ever since it has been clear that AIDS is a sexually transmitted disease, there has been widespread concern about the possibility that AIDS could become a heterosexual disease. Since the syndrome was first identified, there have been scattered reports of prostitutes who were diagnosed with AIDS, and there is some evidence that at least a few prostitutes may have been infected with the virus as long ago as the mid- to late 1970s. Studies of prostitutes done in this country, however, have found the incidence of antibodies among prostitutes to vary widely, depending on the site of the study. Virtually all of the prostitutes who have been found to be seropositive, whether in New York, Miami, Seattle, Santa Ana, or San Francisco, have been IV users or, to a lesser extent, regular sex partners of men with AIDS or men who are members of high risk groups (i.e., IV users or bisexuals).

Although there have been a few reports of men with AIDS in this country who claimed contact with prostitutes as their risk factors, there is little or no documentation of actual transmission of AIDS from prostitutes to their customers. There have been reports from Central Africa (Rwanda, Zaire, and Kenya, in particular) that seemed to suggest that female prostitutes were transmitting the AIDS virus to men. That is, in a study of male AIDS patients, there was a significant history of contact with prostitutes as compared with male controls who did not have AIDS. This study received a good deal of press attention, as did studies that found a high incidence of antibodies among female prostitutes in Rwanda and Kenya (80-88% and 54%, respectively). Except for one article in the New York Times, however, virtually no attention has been given to studies of the incidence among customers of prostitutes in those Rwanda and Zaire (men who did not have AIDS), where the incidence was 28% and 9%, respectively, with an average of 30 contacts with prostitutes per year reported.

Most researchers believe, at this time, that female to male transmission is much less efficient than male to female transmission. The lower incidence of antibodies among customers than among prostitutes in Central Africa may support this contention. What is clear in this country, is that heterosexual transmission does not appear to be occurring. According to the Centers for Disease Control, as of January 13, 1986, only 28 men had gotten AIDS through heterosexual transmission, compared with 154 women. And yet, the press continues to refer to prostitutes in this country as a high risk group, with the potential for infecting the men of this country.

There are several reasons for the differences between the U.S. and Central African data. First, the practice of prostitution, and even the definition
of who is a prostitute, is different. In Rwanda and Zaire, any woman who is single and who has sex with a number of men is considered to be a prostitute, whether or not she receives money or considers her sexual activity to be work. In this country, prostitution is clearly defined as the exchange of money for sexual activity. Condoms are unknown in Central Africa, both because of their expense and, according to a number of anthropologists, for a variety of cultural reasons. Condom use has always been common among prostitutes in this country, and the use has increased dramatically since the beginning of the AIDS epidemic. Finally, it appears that sexual intercourse is common in Central African prostitution, as it is in some other countries. In the United States, however, hand jobs and blow jobs are more common, whether the prostitute works on the street, in a massage parlor, or as an escort.

**Facts about Prostitutes**

COYOTE estimates that there are approximately one million women currently working as prostitutes in this country (including an unknown number of juveniles). About 100,000 people are arrested a year, 73 percent of them women. The approximately 73,000 women who are arrested (and another 80-90,000 women arrested for "loitering") virtually all work on the street. According to Don Des Jarlais, of the New York State Substance Abuse Services, approximately 1/3 to 1/2 of street prostitutes in New York use IV drugs. Paul Goldstein, in a study of prostitutes and drugs, found that 70 percent of the street prostitutes he interviewed used heroin (before, during, or after their involvement in prostitution), but that none of the high-level prostitutes did. Street prostitutes represent approximately 10-15 percent of prostitutes. Thus, it is possible that only about three to seven percent of all prostitutes use IV drugs.

If prostitutes were transmitting AIDS to heterosexual men in this country, by this time thousands, tens of thousands, or even hundreds of thousands of heterosexual men would have antibodies, or even AIDS, for whom there were no other identifiable risk factors. As of January 13, 1986, the CDC has reported 28 men who got AIDS through heterosexual transmission, and 745 for whom the risk factors have not been identified. For comparison, 454 women got AIDS through heterosexual transmission and 239 with unknown risk factors.

**Reason: Women are viewed as Vectors, not Victims**

I believe the reason for the scapegoating of prostitutes is that women who get AIDS, or who become infected with the AIDS virus, are viewed as vectors for the disease, not its victims. A contributing factor may be that most of the spokespersons for the various research projects and the public health community have been men, and as men, they view the disease and its epidemiology in terms of the risk to them. In general, women have been more likely to recognize the bias. For example, there was a scene in the television film, *Early Frost*, in which AIDS patients were sitting in a group discussing the disease and how they got it. The one heterosexual man referred to contact with hookers. Every woman I know caught that line and was bothered by it. Not one man I spoke with remembered the line.

AIDS is a terrifying disease for a number of reasons: 1) full-blown AIDS has an extremely high fatality rate in the first two years of the disease, 2) no one knows for sure what percent of people who have been infected with the virus
will eventually come down with the disease, 3) no one knows for sure the maximum length of the incubation period, 4) the disease is sexually transmitted, and 5) it is not possible to tell, just by looking, who is carrying the virus. The extreme fear associated with AIDS has created the perfect conditions for scapegoating, and I am here today to talk about the scapegoating of prostitutes for a possible expansion of AIDS into the "heterosexual" population.

**Discrimination: Examples**

The issue of discrimination comes up most significantly in the way the issue of prostitutes and AIDS has been discussed by doctors (particularly male doctors), and the way this discussion has been reported in the press. This problem is not confined to San Francisco, rather it is nationwide, and perhaps global. However, I will focus on San Francisco. I would like to say, however, that the response of the media has not been uniform. Some media outlets have, for example, contacted COYOTE for a response whenever a story about prostitutes and AIDS came in, others have never contacted COYOTE, while reporting on stories that have the potential for harming all prostitutes. In addition, while some media outlets have consistently confined their coverage to warnings to stay away from prostitutes, others have gone to great lengths, at least on some programs, to provide information about condoms and spermicides (e.g., ABC's 20/20 and Channel 7 news, locally). However, all of the television networks have informal, but ironclad, policies against accepting ads for condoms. Similarly, mainstream newspapers do not accept ads for condoms or spermicides, although both have been proven to reduce the risk of transmission at least under laboratory conditions.

**San Francisco Chronicle**

On January 5, 1985, Randy Shilts wrote a story in the San Francisco Chronicle, about a prostitute who had been arrested by the San Francisco Police Department and taken, in handcuffs, to San Francisco General to be tested for AIDS. The reason the police gave was that her lover had AIDS and she was an IV user. The clinic was closed, so she was asked to return for testing when it reopened. A major focus of the story was that the woman had said that she had no choice but to continue working because she had no money. On January 8, 1985, Shilts wrote a second story, indicating that she had been tested, although the results were not known, and that she had been put on General Assistance and had enrolled in a drug treatment program. There are two points of discrimination involved: 1) that the police forced her to be tested, thinking they could get away with it because she was a prostitute, even though public health had not recommended such mandatory testing; and 2) that the story was headlined in such a way as to imply that because she was a prostitute, she was transmitting AIDS. There was no discussion of what she did as a prostitute, i.e., what kinds of sexual activity was involved and whether or not she used condoms. Although Shilts worked on the story for several days, he made no attempt to contact COYOTE (either Margo St. James or Priscilla Alexander) for a comment.

On February 18, 1985, the Chronicle ran a story by Randy Shilts on AIDS in New York City with a major headline concerning fear of hookers. Again, there was no attempt to get a comment from COYOTE, or from any of the organizations in New York City that work with prostitutes or for prostitutes' rights.
During the summer of 1985, Shiits wrote another article in the Chronicle concerning the balance test between public health interests and civil rights. In that article he wrote about a gay man in Alameda County who had been diagnosed with AIDS, and who had several times publicly refused to change his sexual practices or to use condoms. As a second example of the problem, Shiits referred to the woman who had been forcibly tested in January, saying that she had returned, in the meantime, to working on the street. There was no mention, again, of her sexual practices or her use or non-use of condoms. The implication was that since she was a prostitute she was engaging in high risk behavior.

In the fall of 1985, the New York Times ran a number of articles on AIDS, including one on the risk to women, and another on November 8, concerning the increasing consensus among researchers that prostitutes were not transmitting AIDS to heterosexual men. Neither of these articles was picked up by the Chronicle, although the paper has published other NYT articles about AIDS.

In the middle of November, Randy Shiits left a message on my answering machine, and a similar message on Margo St. James’ answering machine, saying that we were right that prostitutes were not transmitting AIDS, and that he was sorry for his role in scapegoating prostitutes.

On January 3, 1986, Katy Butler wrote an article in the Chronicle on the studies of prostitutes and AIDS being funded by the Centers for Disease Control in Atlanta, one of which is Project AWARE, in San Francisco. Butler interviewed both Margo St. James and me at length, although much of the story was edited out before it was run, including a substantial section dealing with prostitutes’ efforts to protect themselves and their customers from AIDS. The story was a good one, including extensive comments from Judith Cohen, PhD and Constance Wolfry, MD, the co-chief investigators of the project. However, unfortunately Butler misunderstood the statistic about heterosexual transmission, listing it as 27 men who got AIDS from prostitutes, not from women. I spoke with Butler about the error and she tried to get her editors to run a correction. However, her editors 1) have a policy against running retractions unless a libel suit is likely, and 2) did not feel the error was important. I wrote a letter to the editor and, after talking to Randy Shiits about the problem, sent him a copy so that he could walk it through the Letters to the Editor office to get it printed. When it did not run after several days, I called him again. He said he thought a second article, in which he did state the statistic correctly, was sufficient. I explained that without specifically stating that there was no direct evidence of prostitutes transmitting AIDS, the implication was still there. He promised to get my letter printed. It never ran. I tried to speak to him today to find out why, but he is out of town.

On January 7, 1986, I testified at the Public Health Commission hearings on perinatal transmission. The report under consideration deliberately did not list prostitutes as members of a high risk group (since the risk factor is IV use, not prostitution). However, the next day, the Chronicle ran a story by Reginald Smith that did list prostitutes as a high risk group. I tried to reach Reginald Smith at the time, leaving him a message, but he did not return my call. I also spoke to Randy Shiits about the error. This morning’s Chronicle carried a second article about the perinatal transmission report, again listing prostitutes as a high risk group.
Coming Up!

The straight press is not alone in scapegoating prostitutes. Coming Up! has done a pretty good job of covering the AIDS epidemic from the point of view of the gay men who are its primary victims in San Francisco. Michael Helquist has been covering the developments in medical research, summarizing what has appeared in such journals as The New England Journal of Medicine and the Journal of the American Medical Association. During the summer of 1985, Helquist summarized the contents of a major review article that had appeared in the New England Journal. When he cited the data on gay men and AIDS, his comments reflected a healthy skepticism regarding bias in research. However, when he discussed the assumptions about prostitutes, he accepted them at face value. Although he had phone numbers for people at COYOTE, he did not attempt to find out COYOTE’s interpretation of the data.

In addition, after discussing the idea with Kim Corsaro, the editor, I submitted an article on Project AWARE’s study of the risk factors for women who have sex with men, including prostitutes. The article was submitted in the early summer. When it did not appear, I tried to contact Kim Corsaro to find out why. After I left several messages, she finally got back to me and requested some rewrites, which I did, submitting the revised article in early September for an October publication date. When the article did not appear in October, November, or December, I contacted Corsaro again, only to be told it would run in January. It did not, nor did it run in February. Given the fact that AIDS has been a major topic for discussion in Coming Up!, and given the fact that a significant minority of lesbians have worked as prostitutes, as have an even percentage of gay men, considered along with the fact that Helquist’s scapegoating of prostitutes went unchallenged in the newspaper, it seems to me that the failure to publish the article, or to replace it with another article on the same subject, represents discrimination against the prostitute part of the lesbian/gay community.

San Francisco AIDS Foundation

In a paper presented to AIDS Antibody Alternative Test Site Counselors at the AIDS Health Project by Chuck Frutchey on August 20, 1985, Frutchey stated that there were "about 750 cases that are unexplained ('none of the above'). A great many of these men are regular customers of prostitutes or sexually active, which may account for their transmission." This statement assumes that all of the "unknown risk patients" are men, which was not true then and is not true now. In addition, in my conversations with various representatives of the Centers for Disease Control I have been told numerous times that contact with prostitutes is not considered to be a risk factor. Frutchey did not make any effort to check his information with COYOTE or with Project AWARE, or even with Nancy Shaw, who works on women’s programs for the Foundation and is quite knowledgeable about prostitutes.

Solutions/Recommendations

The Department of Public Health should hire someone with a great deal of expertise about prostitutes and prostitution, if possible an ex-prostitute, to develop or assist in the development of AIDS prevention education programs aimed at prostitutes and their customers. This person should also have the respon-
sibility of working closely with the press to ensure that the press has accurate information about prostitutes and AIDS. In other words, the job would be a combination of prevention education and rumor control.

It will be very difficult to address the problem of scapegoating of prostitutes, however, so long as prostitution remains a crime. I have not addressed the impact of prostitution's illegal status on AIDS. However, police practices, which include the confiscation of condoms following an arrest, can increase the risk of AIDS transmission. The illegality also will make it difficult to disseminate information to prostitutes and their customers. For example, hotel and bar owners are leery of providing space for AIDS prevention information, or to stock condoms for sale (either over the bar or through vending machines in the rest rooms), at least in part because of the risk of being charged with pandering or running a disorderly house, and ultimately closed under the red light abatement acts.
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NOTES:

1. Miami, FL: The women were voluntarily tested in an AIDS screening clinic, as reported in the Los Angeles Times, December 8, 1985.

2. New York, NY: These figures are based on two studies, one of 20 female IV users in a drug treatment program, 2/3 of whom tested positive, and one of 75 prostitutes in jail, 1/3-1/2 of whom were IV users, although they were not tested for the AIDS virus antibodies. 2/3 of 1/3-1/2 of 75 women is equivalent to 17-25 women, for a seropositivity rate of 22-33%. Based on personal conversations with Don Des Jarlais, of the New York State Division of Substance Abuse Services.

3. Seattle, WA has been forcibly testing all people (i.e., women) arrested for prostitution for several months. The figures have been reported in a number of publications, including the December 6, 1985 MMWR.

4. The Orange County, CA study was done in jail. The women were invited, but not required, to participate. Based on personal conversations with the office of Tom Prendergast, PhD, of the Orange County Department of Public Health.

5. The San Francisco figures are from a study by Project AWARE that was reported at the National Public Health Association meeting in Washington, DC, November 20, 1985. The co-chief investigators are Judith Cohen, PhD and Constance Wofsy, MD.

6. The Los Angeles study was done in Sybil Brand Institute for Women, on a voluntary basis, as reported in the December 8, 1985 Los Angeles Times.
7. Walter Reed Army Hospital, Washington, DC: This study was reported on in an article by Robert R. Redfield, MD, et al, in the October 18, 1985 issue of the Journal of the American Medical Association.

8. Los Angeles, CA: As reported in an article by Miles Corwin in the Los Angeles Times, December 8, 1985, and confirmed in a personal conversation. Corwin told me that at least one of the men only had had sexual contact with prostitutes.


MEMORANDUM

From: Don Hesse

To: Esta G. Solar, Chairperson
    Jackie Winnow, Lesbian-Gay Coordinator

From the Office of the
HUMAN RIGHTS COMMISSION

1095 Market Street #501
San Francisco 94103
558-4901

Date: February 11, 1986

Re: Recommendations based on AIDS testimony of February 5, 1986.

Because of the time constraints, I left the following recommendations off of my testimony at the Hearing last week.

1) That the HRC request and support legislation which would include physical disability as a category under Section 12955 of the California Government Code, so that the Department of Fair Employment and Housing can accept AIDS based housing discrimination complaints.

2) That the HRC support legislation to prohibit real estate salesperson, rental agents and managers, and all persons connected with real estate transactions from disclosing whether any person (buyer, seller, applicant, resident, etc.) involved in any real estate transaction (sales, rental, financing) had, has or may be thought to have or may be perceived as being at risk for AIDS.

   It is my impression that the California Association of Realtors is pursuing this.

3) That the HRC encourage the use of and provide or make available speakers on the issue of AIDS transmission at seminars and conferences for Real Estate Salespersons, managers, rental agents and the like.

cc: Earl Sullaway
    Deputy Director for Enforcement
    DFEH
SHANTI PROJECT
890 Hayes Street • San Francisco, California 94117 • 558-9644
Support Services for People with AIDS and Their Loved Ones

SHANTI AIDS RESIDENCE PROGRAM

Testimony on Housing Discrimination
presented to the Human Rights Commission
AIDS/ARC Discrimination Public Hearings
February 5, 1985
by Helen Schietinger, MA, RN
Director, AIDS Residence Program

My name is Helen Schietinger and I am the Director of the Shanti AIDS Residence Program. The Residence Program provides permanent, low cost independent housing to people with AIDS (PWA's). The settings are small group living situations—apartments or flats with 3 to 6 bedrooms. Each resident has his or her own bedroom and shares the kitchen, living room, and bathroom with other housemates. At present our capacity is 33 people, in 8 houses. We have had an application list averaging 15 people for several months.

When Shanti asked me to develop a housing program for PWA's almost 3 years ago, it was clear that an epidemic of fear was the reason many PWA's were homeless. The public's irrational fear of contagion has been the basis for much of the rejection which PWA's experience. The other reason people were homeless was because of the financial devastation caused by their catastrophic illness.

In preparation for the hearing, I reviewed the records of over 130 people whom we have housed since the beginning of the program. I was surprised to find less documentation of overt housing discrimination than was my recollection. In looking at individual cases, I realized that discrimination is something which occurs in a context, and individual cases are the example which are highlighted against the relief of generalized, subtle and unspoken discrimination. For example, rape cases which come to trial are only a small percentage of the huge numbers of rapes which occur against women, most of which are perpetrated by men who are known to the victim, and many of which are not clearly identified as rape by the woman herself, as she assumes the responsibility for the assault. I think that in the same way, much of the di-
crimination against PWA's is couched in language which is difficult for them to decipher.

Of all the PWA's we have housed, seven percent said they needed housing because they were evicted by their landlords. Fifteen percent said their roommates made them move out. Many of the other 75% were also evicted, but because they were unable to pay their rent, not because they had AIDS. We will never know what other sort of discrimination contributed to their needing housing. Also, I speculate that much housing discrimination occurs months prior to the person applying to our program. It is not uncommon for a person to have lived in several places by the time he or she applies to the Residence Program. The stable living situation the person was in prior to a diagnosis is thus not the accommodation we ask about in our intake interview.

I would like to describe a couple of specific examples of what I call roommate discrimination. One person found anonymous notes on his hotel room door waring him to leave. The manager knew he had AIDS and said she didn't have any problems with it, but the other hotel residents found it unacceptable and pressured him to leave. He found it difficult to leave, having lived for several years in this hotel, but he had to accept that he was being ostracized by his old buddies. He felt that the hotel manager was relieved when he left, and this was validated when she told him he couldn't ever come back.

Another person was told after he was hospitalized that he couldn't come back to the apartment. His roommates simply moved his belongings out onto the street and had someone else move in. Imagine his feelings of helplessness at not being able to protect any of his belongings, and his humiliation when he came to us with nothing. Fortunately this extreme reaction is not common. However, being told to leave and being given until the end of the month to get out is fairly common. In fact, that is exactly what what happened to most of the 20 people who were kicked out of their apartments by their roommates.

The Residence Program is structured in such a way that we can only take PWA's who are able to live cooperatively with others. The living situations are shared, and each person is part of a household. There is no staff at the houses to assure that behavior is appropriate. Therefore, we screen people who have active substance abuse problems or serious mental
health problems. We attempt to refer people to drug or alcohol treatment facilities or mental health treatment programs, so that they can be stabilized and we can then house them. I very quickly discovered the resistance of residential treatment facilities to accepting PWA's. Initially, the Alcoholism Evaluation and Treatment Center at San Francisco General Hospital, directed by Tom Smith, was the only residential program of any kind which would accept PWA's. That means that the alcoholic could receive inpatient rehabilitation, but that the drug addict could not, and that the mentally ill person had to either require acute psychiatric hospitalization or be out on the street. A great deal of energy has gone towards opening up substance abuse and community mental health services to PWA's, and I think progress is being made. People with AIDS have a right to have help with their other problems. Staff education and client advocacy require the resources of AIDS services organizations on an ongoing basis, and I feel they are making an impact.

In summary, within the records of the Shanti AIDS Residence Program, there are 20 cases of PWA's being forced to leave their homes by their roommates, and 9 cases of landlords evicting people with AIDS, as a direct response to their having AIDS. I'm sure many more who come to us because of financial problems were discriminated against because of their diagnosis. Just as documented rape cases are an indicator of the all pervasive but subtle sexism experienced by all women in our society, these cases of housing discrimination which I can document are a barometer of the ongoing rejection and scapegoating which people with AIDS learn to anticipate everyday.
January 30, 1986

Commissioner Esta G. Soler
Human Rights Commission
Office of Contract Compliance
1095 Market Street
Suite 501
San Francisco, California
94103

Dear Esta:

RE: AIDS/ARC Discrimination Public Hearings

I am enclosing the testimony Operation Concern presented at a recent State public hearing regarding treatment barriers for AIDS/ARC clients.

Anyway, I'll be out of town next week and unable to send a representative to the hearing. Yet I thought the materials enclosed might prove useful to you.

Regards,

Carole Migden
Executive Director

CM/cm

Enclosures
DATE: November 26, 1985

TO: Stephen Morin, Ph.D.
Chair, California Council on Mental Health

FROM: William Vitiello, Ph.D./L.C.S.W.
Operation Concern/AIDS Health Project
1853 Market Street
San Francisco, California 94103
(415)626-7000

RE: Recommendations to the California AIDS Strategic Planning
Commission/Mental Health.

Given the increasing AIDS epidemic among people of all sexual orientations,
its alarming incidence in their world communities, as well as its increase
among prostitutes, I.V. substance abusers and its threat to youth, it is
recommended that the State Department of Mental Health be allotted monies
to release to densely populated counties impacted by the epidemic through
a process of competitive bidding (RFP) in order that specialized AIDS Mental
Health Services be developed to meet the mental health needs of these popu-
lations within the following guidelines:

1) Proposals address the mental health needs of the Worried Well,
People with AIDS-Related Conditions and People with AIDS,
across the aforementioned populations with emphasis on outreach
and accessibility of services.

2) Proposals include the opportunity for inservice training on the
transmission of the virus and the psychosocial implications of
AIDS for all direct service professionals within county mental
health systems.

3) Proposals include the training and development of AIDS Mental
Health Specialists whose responsibilities would include imple-
mentation of a range of specialized therapy services for the
impacted populations.

4) Given the increasing incidence of ARC (AIDS-Related Conditions),
the existing gap in services for this population, as well as
their high psychosocial needs, service priority be given to first
establishing a range of mental health services for this group.

WV/crm
DATE: November 26, 1985

TO: Stephen Morin, Ph.D.
    Chair, California Council on Mental Health

FROM: Carole Migden, Executive Director
    Operation Concern
    1853 Market Street
    San Francisco, California 94103
    (415)626-7000

RE: Recommendations to the California AIDS Strategic Planning Commission/Mental Health.

I would like to address the need for a range of therapy services to AIDS and ARC clients. Although up until this date the focus of services funded on federal and local levels has been education, prevention and group support, as well as health and social services to diagnosed clients, this focus has not recognized a major mental health need. Operation Concern, as the only gay-identified mental health agency in the city, has been inundated by requests for services by AIDS/ARC clients. While we can channel some of these clients into groups, many clients request and are clinically more appropriate for 1 to 1 psychotherapy. The objection to funding these services is that they are not cost-effective. I challenge this assumption on several levels:

1. Many of these clients, particularly persons with AIDS, have complicated psychological reactions to diagnosis, including severe depressive reactions, suicidal ideation, neurological involvement affecting emotional lability, sexual acting out, denial, substance abuse, problems with family and significant others, etc. Paraprofessional staff and medical providers have neither the training nor time to address these issues. Many of these clients then end up in acute-care or crisis clinics at high cost to the city. Or, they attempt to get services at clinics such as ours and are frustrated at waiting lists, the system's insistence on group modality, and our inability to absorb this ever-increasing client load into an already under-funded, over-utilized facility.

2. This problem will only increase, given recent statistics of geometrically increasing prevalence of AIDS. Our focus must shift from prevention and education, which at least in this area is at maximum impact, to direct services to the affected population. Group education services must also include individual and group psychotherapy to those individuals who can no longer utilize education, but must deal with the impact of AIDS on their lives. This effort will cost us much less in dollars and human suffering if this need is
recognized and implemented at an outpatient level as soon as possible.

I urge you to recommend allocating funds to individual psychotherapy for AIDS/ARCS clients.

CM/crm
THE STONES
A STORY OF SURVIVING PARENTS

(Editors note: Michael Stone, aged 19, was diagnosed on September 30, 1984 with AIDS and died less than two months after his diagnosis on November 25, 1984. Both Michael and his mother, Judi, were Shanti clients and Judi has since gone on to take the Shanti emotional support volunteer training, and is a spokesperson for Shanti. The following is an interview of Judi and Ralph Stone, almost a year to the date of Michael's death.)

WHEN DID YOU FIRST KNOW YOUR SON, MICHAEL, HAD AIDS?

R: We had just taken Michael back to UC Santa Cruz where he was entering his last year of school there. We got a call on Saturday morning from a doctor at Dominican Hospital in Santa Cruz, saying Michael had been admitted to the hospital and that he was seriously ill. He gave me the impression that to save his life he had to give him medication that had very serious side effects and he wanted our permission to administer it. The doctor told me Michael had pneumocystis and was cautious about whether we knew he was gay or not. We told him that if that was the only thing that was going to save his life, “You obviously have to give it to him.” So we said yes and got into the car and rushed down there.

J: Not in these words, but the doctor said that if I wanted to see Michael alive we had better get down there quickly and that Michael had asked him not to say anything to us, but he felt Michael's condition was critical. The reason they needed our permission was because Michael was not fully conscious at the time.

When we arrived there, Michael seemed better and was able to talk. We stayed there while they did the bronchoscopy under general anesthesia, which was probably not the greatest way to do it considering he was at risk. The doctor told us immediately upon arrival that Michael had pneumocystis and said, “Yes, Michael does have AIDS,” and then left it up to us to tell Michael. We had talked to Michael a little bit about it when we first arrived, “The doctor thinks you have AIDS.” And Michael did tell us that, “I didn’t want you to know anything until all the tests results were in.”

When Michael woke up he asked what the test result was and we told him, “Yes.
(Cont. on Page 2)
(Parents Continued)

It was AIDS. He didn’t react much to it and I tried to reassure him by saying, “Well, I guess you have AIDS, but that doesn’t mean anything.” He was pretty tired so we let him rest. There was a lot of commotion going on. The medical staff was reacting to a lot of contagion hysteria: gowned and masked up. The nurse would not let me take my purse into the room. I could never figure that out. The orderly that was cleaning down the gurney that brought Michael back was dressed like he was from outer space. One of the nurses insisted that we get someone religious in to see Michael. She had written Michael off. They figured that Michael was going to die and they couldn’t get him out of there fast enough.

R: They wanted someone religious to go in so he could give Michael last rites so or so that he could make peace with God. I said, “Hell no, Michael is not religious and it’s not the time for that.” We finally had to take the nurse aside and say, “Listen, he’s getting all upset with all these precautions and especially your attitude toward him.” It was obvious to us this was their first AIDS patient and even the doctor’s bedside manner left a lot to be desired. He had about as much sensitivity as a rock. All he could harp on was that Michael was going to die and, “You had better start preparing yourself for it.” Michael was picking all this up from the people around him. He made one comment, “The nurses think I have the Black Plague.”

DID HE HAVE ANY OF THE OTHER SYMPTOMS OF AIDS?

J: Yes, he did have night sweats. I think he had diarrhea for over three years. The doctor’s reply to that was it was just the Gay Bowel Syndrome. His weight stayed steady all those years. He didn’t start declining or getting sick until he went to South America. Of course, there he saw doctors and we all assumed that it was parasites. Basically he was having digestive problems with constant diarrhea. I went down to see him after he had been there for about six months. He looked terrible. He had lost a lot of weight. When he came back he had thrush. He had problems with his gums, all fungal diseases, herpes was going haywire, yet he went to the doctor and he got a clean bill of health. His dermatologist was looking for exciting South American diseases. His dentist said, “Well, he obviously has a gum problem.” But no one looked for AIDS. Before he went back to school we talked to him about taking better care of his health, not to stay up all night, etc. We did notice that his energy level was down, he just wasn’t partying as much and was coming home much earlier than he normally would have.

DID HIS DOCTOR HAVE HIM TRANSFERRED TO KAISER?

J: Yes, it was much better, all of the gowning and masking stopped. At the hospital in Santa Cruz we could not visit him unless we were gowned and masked up. He stayed in Kaiser for three weeks. The pneumocystis was treated with septa, then he developed an allergic reaction to the drug. They put him on pentamidine and he came home for three weeks. As soon as he got to Kaiser, someone from Shanti or the AIDS Foundation was really on the ball. He had all his paperwork filled out, they even processed his social security papers. The next thing I knew he had a Shanti counselor.

HOW DID HE FEEL ABOUT HIS SHANTI COUNSELOR, SHEERA?

J: He loved Sheera. He told me, “You have to overlook what she looks like. She rides a motorcycle and looks real punk, but she is real neat.”

At this point he was making plans about not going back to Santa Cruz. He was considering transferring to State and going part time. His latest thing was that he was going to graduate in Latin American Studies and then go to London and study drama, or he was considering majoring in business and going on to law school.

DESCRIBE THE THREE WEEKS HE WAS HOME.

J: Sheera would come over and that was nice. They would lay in the back yard together. He just had to get a suntan. He and Sheera would go to Cafe Flore together. She would take him to buy records and he was still buying clothes at this time, too. He would lay on the couch here or stay up in his room and watch television. He just didn’t have much energy to do many things, but he didn’t complain a lot.

I took him down to the support group because he couldn’t have made it by bus. We took him to the movies. His friend Albert came and also took him to movies. Albert
and I talked afterward about how terrible that cough of Michael's was.

I took him to the doctor as he was just not getting better. He would lay around in bed coughing. He couldn't breath very well. He couldn't lie down without coughing. He was coughing the whole time. Finally he was admitted again and he was put on pentamidine immediately because they figured it was pneumocystis again.

WOULD HE SLEEP AT NIGHT?

J: I think he would doze in between but he would cough all night. The same as during the day, he would swallow all this cough syrup but none of it would work. Once he was back in the hospital and they started doing all sorts of tests, he started complaining to me about the doctors; some of the residents were not doing things right. He told the doctor that he wanted to go home. Everyday he would ask the doctor about leaving and when he saw us he would say that he wanted to go home.

R: If his temperature would stay down he could go home but it never would. Then he would say, "Well, maybe tomorrow I'll go home."

J: He finally convinced the doctor to let him go home. I brought him home at six o'clock. He was released with medications. He went straight to bed. We had cleaned his room. We got a machine to clean out the air because of his allergies and really cleaned the room so there was no dust. He started to act funny. He said, "I have to go to the bathroom and brush my teeth." He came out carrying my toothbrush and he was getting cranky and disoriented. There was something that was not all there. He was sitting on his night stand all these different pills, including sleeping pills, and I remember picking them up and saying, "I'm going to take these because you don't remember and you'll take too many." He said, "What do you think, that I'm going to commit suicide or something?" I said, "No, but you're not going to remember and it is better that I give them to you any time you want them, I'll know when you have taken them." That didn't seem to be any problem. He started slurring and I called Ralph then. He started really shaking then, too. His eyes were completely unfocused and at that point I realized something was seriously wrong. I called Kaiser and got an ambulance and of course I was transferred to a doctor and explained to him that he had AIDS and was just released. Finally the doctor asked me, "Do I know what this means?" and I said, "I know what this means. I just want him back in the hospital."

WHAT DID IT MEAN?

J: The doctor probably thought, as did the first doctor, that he was going to die, and he was trying to prepare me. It turned out that the pentamidine had lowered his blood sugar so low that he went into diabetic shock. When the medics came, they were really good, no complaints, they got him on the bed. He was in a daze but knew what was going on. We got him to the hospital and the doctor looked at him, saying "Well, if it is what I think it is, he should be okay in a few minutes." They gave him glucose. They asked us to step out for a few minutes and then after they said, "Now you can come in." We walked in and he was wide awake. "Why am I here? What am I doing in the hospital?" He couldn't remember anything. "I want to go back home." The doctor said, "You have to stay here tonight."

We stayed for a little while, then Michael said that he wanted us to go because he wanted to go to sleep. We got some more covers since he was cold. We felt good at that point. He would say, "I'm so tired, it's okay if you leave," and because he was so independent about everything, we respected his wishes.

HOW DID YOU FEEL GOING THROUGH THAT EXPERIENCE?

J: The doctor apologized about that. "I never expected that to happen. You should never have had to go through that." He had never had a patient have a reaction that many hours later. Michael stayed in the hospital the remainder of his life. The next day he was tested and they decided he had pneumonia but it was cytomegalovirus (CMV). There was nothing they could treat him with and that is when the cryptococcal meningitis came in and all different kinds of funguses. At one point he also had herpes on his back, and diarrhea. Through all of that he was adamant about going to the bathroom by himself. He had a nurse take him to the bathroom everyday to wash his hair because of the IV's. He just kept saying, "When can I go home?" He kept riding the doctor and the doctor kept saying the same thing.

R: We humored him and said, "Maybe we can try a day pass. You can come out during the day and come back at night." That was what we were shooting for. From early on, I was pessimistic. I thought he had a death sentence. We always talked in terms of "a couple of years." I knew, realized, and probably broke down a couple of times, but finally accepted that he was not going to live. At first I didn't realize that he was not going to have a couple of years; we knew when we took him to the Shanti dinner on Thanksgiving. When we saw him dress up trying to get into the car with his oxygen tank, we realized how sick he was; he was going downhill. I remember when he went to the support group and I guess there were several people who had a lot of KS lesions all over them. He made some comment like, "I don't look as bad as them." Kind of like, "Those guys are really bad, but not me." He went back a couple of times. Maybe he didn't want to go back because he didn't want to look like them.

J: He couldn't go back because he was only home for three weeks. He did go to the Shanti Halloween Party. Ralph took him there and someone brought him home.

R: It took him a long time to get ready for that.

J: He went as a pirate. He got dressed up in red clam diggers, and a big shirt and whatever pirates wear. He had some makeup on, and earrings. He was so funny. We had a young woman staying here at the time, a prearranged situation, and he didn't want her to see him. He made a comment about the party. "What kind of a party does not have booze?" Sheera went down, too. Sheera did not go to the hospital a lot, just a few times. We wondered why he had started to alienate his friends. They would call and he would say he was tired and would call them back later and then he wouldn't. Sheera spent a lot of time with Michael when he was here at home.

DO YOU THINK THAT HE WOULD TELL HER THAT HE DID NOT WANT TO SEE HER?

J: Yes. The relationship was that he had to call her and say that he wanted to see her. It wasn't Sheera, it was him. He didn't like that many people visiting him in the hospital. We never really talked about the fact that Michael was going to die. One night Ralph broke down and cried saying Michael was going to die. I kept assuring him that he was not going to die. I truly did not think Michael was going to die, but I was also taking care of things somehow knowing he was going to die. When he started getting worse, at the beginning of November, he told me very seriously to do his Christmas shopping. I tried to shrug it off and said, "We don't have to do this." He said, "You know I'm not going to be around. I can't do the shopping because I won't be around, so, please, do it for me."

HOW DID YOU FEEL WHEN HE SAID THAT?

J: Well, I figured I had better listen. I didn't really process it. I was still humoring him in whatever he wanted to say and went along with it, because it was difficult for him to talk. He didn't want to have to repeat it. Then I started to talk to him about the possibility of dying. "Are you afraid, or are you giving up, or are you afraid of what is happening? I mean you don't seem to want to talk about it. Our concern is that you are not telling us how you feel." He answered that he was not afraid or concerned, but there were things "you cannot talk about." He said, "It looks like I am going to die and that's that."

(Cont. on page 6)
RAH, TELL SOME OF THE THINGS THAT YOU AND HE TALKED ABOUT.

R: Well, I always got the feeling that he was waiting for me or us to tell him "We told you so. You knew your health was bad and if you had taken care of yourself you would not have gotten AIDS." I tried to reassure him that I didn't feel that way.

WERE YOU VERY CLOSE TO HIM?

R: Not in the sense of demonstrating affection. I had been very disapproving of his lifestyle. Going out and partying all the time and not studying. I guess I had been too demanding on him. On Friday night instead of saying, "Great that you did that," I would say, "Why didn't you do that, too?" I guess that is the kind of thing we talked about those last few weeks. I told him I really wasn't disappointed in him and that I was proud of him. It seemed that I did all the talking. I tried to tell him all the things I should have told him all of his life. I talked about my family and my relationship with my parents. So, I guess we had a chance to make peace.

I had a hard time adjusting to his homosexuality. When he was fourteen, he came in scared and told us he was gay. I remember thinking I wasn't surprised. It's funny, you get signals that just hit you in the face. We didn't make a big issue of it. We said he might want to talk to someone about it. I never openly disapproved of him but I guess I was adjusting to it and I am sure my own adjusting to his sexuality carried over. He knew I was having a difficult time with it.

TOWARDS THE END YOU HAD MADE TIME TO MAKE AMENDS.

R: Yes. He said something jokingly about AIDS being God's punishment on gays, and I think maybe he thought it was some kind of lesson to him. I tried to tell him that he had nothing to feel sorry about. He also wondered how I felt about him dying. It was during this period of time we got it all talked out. It was a good feeling for me to have done that. I didn't feel great that he died, but I am grateful that we had a chance to talk before he died. We could have spent all our lives having never said the things that we said to each other in those last two weeks. I told him I loved him very, very much.

J: He told Sheera and me that he did not want to linger on for a couple of years. He just wanted to get something massive and get it over with. He started saying these things in tidbits here and there; he didn't say them all at once. I was making arrangements to get oxygen at home since he wanted to come home. He was sick and tired of all the medications. I said, "Okay, you can come home." He then began to want to live like "this," feeling so bad and coughing all the time.

TELL ME ABOUT THOSE LAST FEW DAYS.

J: Ralph got there early the next day because he thought something was the matter. Michael started hanging onto him, especially during the test and the spinal tap. A friend he had not seen in awhile had come to the hospital and he sent him away. That's when the doctor was really concerned and anxious for me to get there so he could talk to Michael, explaining that he was going to make him comfortable and asking whether Michael wanted to go on a respirator. That's when he decided that he didn't need the medication for the cryptocoecal meningitis anymore. Ralph explained the purpose of the medication again to him while Michael held onto Ralph's hand for dear life. Ralph had to go to the bathroom and Michael didn't want Ralph to leave him.

R: One of the residents said that he didn't have much time left, because of his blood gases. They had to get a decision from him as to whether he would want a life support system if he became unconscious or if he say, "Well, wait now, and see about Thanksgiving." I think that's when he decided, "that was it," because he was having such a hard time.

J: This was Friday. At this point we stayed the rest of the time. Ralph stayed until nine. Then Michael rallied again. He was coughing but sitting up and watching television, and we stopped talking about death and put it aside.

HE WAS STILL ENJOYING WATCHING TELEVISION?

J: He watched television until the last day. I stayed overnight and he didn't sleep. By this time he was on morphine. The next
February 12, 1986

The Human Rights Commission
1095 Market Street, Suite 501
San Francisco, CA 94103

Dear Commission Members:

My name is Deborah Jones and I am the Supervising Social Worker with the San Francisco AIDS Foundation. The following documentation is testimony prepared by three of the Foundation's social workers. However, the testimony represents only a fraction of the constant harassment directed toward People with AIDS and People with ARC as evidenced by last week's hearings. Suffice to say that we as social workers have worked with PWA and PWARC on every issue of concern addressed by the Commission. While some progress has been made, the deleterious effects of AIDS hysteria and its impact on direct services remains of paramount importance. Thus significant inroads into existing systems such as residential drug and alcohol treatment programs, board and care homes, emergency housing, and residential psychiatric facilities has not occurred on a mass scale.

The lack of appropriate and sensitive referrals for PWA and PWARC makes our job at the San Francisco AIDS Foundation a difficult one if not impossible one. We therefore urge you, as the Human Rights Commission of San Francisco, to advocate for the creation of adequate services for PWA and PWARC in all areas of need as well to pressure existing services to provide non-AIDS phobic delivery.

Sincerely,

Deborah A. Jones
Supervising Social Worker

DAJ/et

S.F. HUMAN RIGHTS COMM.

FEB 13 1986
Human Rights Commission Hearings
February 5, 1986

Testimony Given By:
Alan Johnson
Social Worker
I know a place in this country where people are not so free to admit in public places that they are gay, as I am. I know a place in this State of California where it is a struggle to admit to another person that they have, or have had "homosexual relations". And I know of a place here in this great City of San Francisco where a person still has a hard time admitting that he or she is diagnosed with an AIDS related condition or with AIDS. I know of individuals who, for whatever reasons, do not talk freely of their sexual practices, and who are uninformed about unsafe sex or AIDS transmissibility.

I feel very fortunate to have the privilege of working almost exclusively day after day with people who are diagnosed with AIDS and ARC. We do a lot of sitting and talking about discrimination and I do a lot of referring to Eileen, Jackie and the Human Rights Commission. I have made an observation tonight, and during last night's testimony at the obvious (to me) lack of PWA/PWARC here to tell their stories. In case the Human Rights Commission is also curious about this, I assure you that it is not because discrimination is not out their happening on a daily basis; rather, several other factors are at work:

I. Many PWA/PWARC that I know do not function well in the afternoon.
II. Many PWA/PWARC have such a busy time of fighting discrimination on a daily basis in their own lives they have no time or energy left to come and tell us about it.
III. Some simply do not wish to come here and tell you and I and the press and the world that after living a full life as an oppressed "homosexual" they are now facing discrimination as a PWA/PWARC.

I, as a person with a position as a Social Worker working with PWA and PWARC, am here tonight to tell you that discrimination is happening, and you can come sit in my office at the AIDS Foundation and hear the stories I hear and see the results of discrimination that I see. I hope that my being here this evening will help since so many are unable to be here.

I speak for a person who was discriminated against because of his diagnosis and lost his job - he now lives on General Assistance and Food Stamps and I
can't help him to find any decent place to live out the rest of his life on an income of $288.00 a month in San Francisco. He does not qualify for Social Security Disability.

- I speak for someone who paid for his medical bills out of his savings because he was afraid his employer would find out he had AIDS through his insurance company. He went broke and then what he feared most would happen did; but he had no savings left to help.
- I speak for someone who died before he ever saw any Social Security Benefits.
- I speak for another person who wants to find a roommate, but can't because no one wants to live with a person with AIDS.
- I speak for someone who paid into the State of California Disability System for 16 years, but because last year he tried something new as a freelance person and did not pay into it, he gets no help at all from them.
- I speak for someone who called for help from the San Francisco Police Department, who upon learning that this person had AIDS rolled up the windows of the squad car and made the person tell his story through the glass.
- And I can speak for many many people who are just too sick to follow any of this up; and some who, after a lifetime of discrimination and of oppression are too sick of it to try to change it once diagnosed with ARC or AIDS.

There are terrible gaps in the systems when it comes to serving people with AIDS:

- PWARC do not get Social Security Disability.
- Waiting lists for Home Care Team from Hospice (who can wait when they need home care?).
- A tolerance for Substance Abuse Programs not accepting people with AIDS and ARC, when we have heard the relation of substance abuse and these diagnoses.
- And a mirad of City, County and State funded agencies operating in San Francisco simply saying no to people who have the wrong diagnosis.

AIDS and ARC discrimination is happening - 'Did I swear to tell the truth here?' YES IT IS! There are people demonstrating outside at the United Nations building right now for over 100 days who have been saying that they are being discriminated against. I know some of those people - I know that they have better things to do with their time. The Human Rights Commission must be made
aware that discrimination occurs ongoing, everywhere, on a daily basis and there is not one or two groups or settings to be brought to blame or be made to change. This is a motion picture phenomenon not a snapshot and it is turned into a horror film.
Human Rights Commission Hearings

Testimony Given By:
Catherine Maier
Social Worker
On Friday afternoon January 31, 1986 I was told by Deanna Pan a supervisor at the Department of Social Services that they had emergency housing available. When I identified myself as a Social Worker with the San Francisco AIDS Foundation she stated that, "Mr. Stallcamp and Molly Williams pay the bills and they told us not to accept anyone with AIDS for housing." When I pointed out to her that this was discriminating against people with AIDS she stated, "Mr. Stallcamp and Molly Williams made this decision and we follow it." I was unable to find housing for my client that day. His housing situation like his health, remains tenuous.
Human Rights Commission Hearings

Testimony Given By:
Larry L. Saxxon
Social Worker/Housing Coordinator
Human Rights Commission Hearings
February 11, 1986

The problems facing people with AIDS and people with AIDS-related conditions within the City and County of San Francisco at present are exacerbated with ongoing discrimination in the area of housing. Working within the AIDS Foundation I witness people being barred from adequate housing on a daily basis.

The fiscal year has seen over 30 PWA and PWARC go through the Emergency Housing Program of the Foundation alone. Most if not all of these 30 people could not or would not be served by the traditional homeless program sponsored by the City and County of San Francisco. This department has been told on many occasion by many professionals of note that the DSS Homeless Program is in fact a "closed system". PWA are not to be referred to the Housing Hotline or the subcontracted Support Services Program that is funded to assist the homeless population. The end result is tantamount to placing a small bandage on a festering sore. The referring agencies are suffering from a chronic lack of referral sources and the clients inevitably suffer from this rigidly enforced "closed system". This situation coupled with no increase in funding for the existing housing programs willing to work with PWA and PWARC is creating an avalanche of need and no notable response.

We strongly urge the Human Rights Commission to intervene in assisting this population in accessing their basic fundamental rights under the law.
February 10, 1986

Ms. Jackie Winnow
Human Rights Commission
Suite 501
1095 Market St.
San Francisco, California 94103

Dear Ms. Winnow:

I am sorry that I was unable to attend the Human Rights Commission's AIDS/ARC Discrimination Public Hearings on February 5th as I had originally intended. I hope that the hearings were successful. I would like at this time to make some comments which would have been included in my oral presentation, had I been able to be present to give testimony.

Specifically, I think that it is imperative that the Human Rights Commission recognize that the current definitions of AIDS and ARC are under review. Committees have been established at the Centers for Disease Control and other national levels in an attempt to redefine what is best considered as the spectrum of disease resulting from AIDS retroviral infection. Certainly we in San Francisco have long recognized that those people with AIDS only constitute the tip of the iceberg. By far and away the largest number of people who have responded to infection with the AIDS retrovirus are currently healthy without any symptoms of disease. Somewhere between this group of patients and those who do have bona fide AIDS diagnoses, are the large number of people who are currently classified as having AIDS-related complex, AIDS-related conditions or ARC. Put simplistically, people with ARC are those who have been infected with the virus who show some evidence of dis-ease or disturbance in their immune systems which removed them from the category of "healthy seropositives."

The majority of patients with ARC suffer from conditions as benign lymphadenopathy or immune thrombocytopenic purpura. Some patients may have further evidence of immune dysfunction with oral Candida. A small subset of ARC patients have profound constitutional symptoms with debilitating fatigue, recurrent fevers often quite elevated, drenching night sweats and significant weight loss. Chronic and persistent diarrhea is also often part of the picture. Despite attempts of investigators to diagnose an underlying infection which might be amenable to antibiotic therapy, such a diagnosis remains elusive. These patients often are disabled for a time and then experience remission of their symptomatology. However, some patients continue with relentless symptoms and a progressive deterioration. In
spite of persistent attempts to diagnose one of the opportunistic infections or unusual malignancies which constitute an official AIDS diagnosis, many of these patients fail to move into a category defined by the CDC as officially AIDS. Oftentimes, these patients may ultimately develop central nervous system dysfunction, even dementia. A small number of patients with ARC may even die of this symptom complex without ever having evolved into an official AIDS diagnosis. It is these patients who definitely deserve close evaluation with regards to available benefits and support services.

In general, when an ARC patient develops such severe symptomatology that he becomes disabled, disability benefits are often obtained without problem. However, unlike the AIDS patients who qualify for presumptive disability, a person with ARC may have to wait a prolonged period of time before benefits become available. In those patients with severe ARC, death is a possibility in a short period of time. Therefore, I think it is imperative that any patient deemed by a physician to have ARC and be disabled be considered eligible for presumptive disability. Similarly, such patients, despite their absence of a bona fide AIDS diagnosis, should qualify for support services that are normally available to those patients with AIDS. Specifically, Shanti services and care from the AIDS Unit of the Hospice of San Francisco should not be denied a person with severe ARC.

At the AIDS Clinic at San Francisco General Hospital, we see an equal number of people with ARC as our AIDS patient population. Both groups are eligible for enrollment into treatment protocols with experimental therapies. Patients with severe ARC in general are eligible for the same treatment as those patients with actual AIDS. Patients with milder forms of ARC are often enrolled in placebo-controlled trials. This is done because the natural history of people with ARC is as yet unclear. We know that a percentage of them are at greater risk of developing AIDS. However, exactly what percentage that is is unknown. Therefore in order to ascertain that any beneficial effect is actually secondary to an experimental drug and not to chance alone, patients with mild ARC are often enrolled in a study where a placebo group is concurrently followed to compare natural histories of the treated and untreated populations.

I am hopeful that with the current attention being given to redefining the spectrum of diseases and disorders related to infection with the AIDS retrovirus that perhaps some of the unintentional discrimination felt by persons with ARC can be effectively eliminated.
Thank you for inviting me to participate in the Public Hearings. If I can answer any further questions, please feel free to call.

Sincerely yours,

[Signature]

Donald I. Abrams, M.D.
Assistant Director, AIDS Clinic
San Francisco General Hospital

DA/nc
30 January 1986

Esta G. Soler, Chairperson
AIDS/ARC Discrimination Public Hearings
Human Rights Commission
City and County of San Francisco
Suite 501, 1095 Market Street
San Francisco, California 94103

Dear Ms. Soler:

Dr. Sande asked that I respond on his behalf in his absence to your letter of 9 January regarding the public hearings on AIDS/ARC discrimination that are to be sponsored by the Human Rights Commission of San Francisco. Dr. Sande will be out of town 4-7 February and therefore will not be able to attend the hearings on the 4th and 5th. However, he asked that I forward to you the enclosed copy of his editorial that was recently submitted to the New England Journal of Medicine. The editorial will be published in the 6 February 1986 issue of the Journal. (The enclosed copy of the editorial is as it was submitted by Dr. Sande to the Journal and does not reflect changes made in the text by the editor.)

Thank you.

Sincerely,

Rebecca Brooks-Fournier
Secretary to Merle A. Sande, MD

Encl. (1)
AIDS TRANSMISSION: THE CASE AGAINST CASUAL CONTAGION

Merle A. Sande, M.D.

From: The Department of Medicine, University of California, San Francisco and The Medical Service, San Francisco General Hospital, San Francisco, California.

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AIDS TRANSMISSION: THE CASE AGAINST CASUAL CONTAGION

The epidemic of AIDS has become an epidemic of fear (1). While progress in our understanding of the disease has been rapid, the new knowledge has often produced more public concern than relief. The identification of the etiologic agent as a virus -- while of critical scientific importance -- did little to quell the fears of either the medical community or general population. Instead, the fact that this disease is caused by a virus created a reaction of hysteria reminiscent of another viral infection -- the polio epidemic of the early 1950s.

As each new observation gained public attention concern intensified. Isolation of the virus from semen logically explained the rapid spread of the disease in the sexually active, homosexual male population but also aroused the fear of potential spread in the heterosexual population. The recognition of an asymptomatic carrier state further amplified the fear of sexual contagion in our society, and this was intensified by reports of widespread transmission of the AIDS virus by heterosexual activity in Africa. The recognition that contaminated blood and blood products were the vectors for transmission of the virus to transfusion recipients and hemophiliacs and that intravenous drug users acquired the infection by sharing needles raised the possibility that health care workers could be at similar risk from occupational exposure. Probably the most sensational, and perhaps most misleading, information was that the virus had been isolated from saliva and then tears. This promoted the idea in the public's mind that the disease might be spread by food handlers, by kissing or handshaking, or even by contact with fomites. The media did little to dispel these notions; on the contrary, the public was led to believe that AIDS is a
highly contagious disease.

The perceived potential for transmission of the AIDS virus by casual contact has produced numerous political, legal, and ethical dilemmas. Responses have been varied, including calls for quarantine, mass screening of all potentially infected individuals, expulsion from military service of all antibody-positive personnel, and exclusion of infected children from schools. In some cases refusal to care for AIDS patients was condoned.

Throughout the epidemic the Centers for Disease Control (CDC) has played a critical role in countering these reactions. Rational guidelines (based on the best available data on the modes of transmission) for preventing AIDS virus transmission were developed and widely publicized early in the course of the epidemic (2). Some public officials have accepted the responsibility of analyzing the epidemiologic data and formulating policies based on a rational appraisal of this information, regardless of the prevailing public sentiment. Others have avoided this responsibility, and a few have used the hysteria of the epidemic of fear to fan the flames of their own political fortunes.

Where are we now, five years after the epidemic became evident? What do we know about the transmission of the AIDS virus? Is the data sufficient to permit a consensus statement to the public? Can we then mount effective public health measures to stop the epidemic? The AIDS epidemic is no longer a new epidemic. We have learned an enormous amount about the transmission of this disease. What, then, are the relevant facts?

(1) While the epidemic is still increasing at an alarming rate nationwide, there is some indication that the rate of increase is slowing in certain areas such
as New York City, and in San Francisco the number of new cases has actually been constant for the last year. This observation may reflect a slowing of the rate of viral acquisition. In one epidemiologic survey in San Francisco only five percent of seronegative homosexual males acquired evidence of infection between 1984 and 1985 (A.R. Moss, personal communication).

(2) Surprisingly, the disease has remained confined to the high risk groups (homosexual men, intravenous drug users, hemophiliacs and transfusion recipients prior to screening of blood, and the offspring and sexual partners of members of these groups), and the distribution of cases among these groups has been remarkably constant throughout the epidemic. In only five percent of cases is the mode of transmission unknown. Thus, there is no evidence that the disease is spreading to other populations.

(3) Certain factors have been shown to potentiate transmission of the AIDS virus in the high risk groups. Very early in the epidemic studies from the CDC demonstrated that the risk of spread correlated with the number of different sexual partners in the homosexual male population (2). This behavior accounted for the rapid dissemination of the disease throughout the country. Rectal receptive intercourse and exchange of blood by sharing of needles are activities that promote viral transmission. These activities may allow access of fluids containing infected cells to the circulation of the uninfected recipient (3).

(4) Intrauterine spread or vertical transmission of the disease from mother to fetus is an established mode of transmission (2). Chances of an infected mother transmitting the virus to her unborn offspring may be as high as fifty percent. Unfortunately, an infected infant is much more likely to develop clinical AIDS than an
infected adult. The virus has been isolated from breast milk, and breast feeding could represent another mode of transmission.

(5) There seems to be no doubt that the disease can be spread by heterosexual sex. Although heterosexual transmission has been postulated as the predominant mode of transmission in equatorial Africa, studies conclusively documenting this remain to be published. That the virus can be transmitted from man to woman during vaginal intercourse is supported by the fact that female prostitutes in Africa appear to be at extremely high risk of infection. The total number of such cases in the United States in whom heterosexual transmission has been implicated remains low — only 180 — and the disease in 152 of these cases was transmitted from male to female. On the other hand, examples of transmission from woman to man are more difficult to document; only twenty-eight cases have been reported in the United States. Of these twenty-eight men, all had engaged in sexual activities with women in a bona fide risk group, predominantly intravenous drug users (i.e., not prostitutes without other risk factors) (AIDS Program, Centers for Disease Control, personal communication). It is possible that the differences in the transmission between the two sexes is due to the fact that there are more male intravenous drug users and bisexuals capable of transmitting the disease to females than there are infected women capable of transmitting the virus to men. While it would appear that the potential for future spread of this disease in the heterosexual community remains a serious problem, we still do not know the relative efficacy of spread of the virus through vaginal intercourse and bisexualsexuals are even less secure in our knowledge about transmission from women to men. To date there is no evidence of spread by oral intercourse or by kissing. One of the health profession's greatest challenges now is
to clarify this issue and to continue to educate our population regarding the potential significance of these observations.

(6) Based on current data (all of which have been remarkably consistant), occupational exposure to patients infected with the AIDS virus does not pose a significant risk to health care workers. Over 1,750 health care workers with intense exposure to patients with AIDS have been studied for evidence of antibody to the AIDS virus (4). Of those individuals not otherwise in high risk groups (e.g., homosexual men or intravenous drug abusers), less than one-tenth of one percent was found to be antibody positive. (This in itself is remarkable in light of the well-documented problems and accepted rate of misinformation associated with data collected by questionnaire or interview.) In our institution (San Francisco General Hospital) more than 300 health care workers with intense and sustained exposure to AIDS patients for nearly four years have been studied; all are antibody negative, with the exception of fourteen of fifty homosexual male hospital workers (JL Gerberding, personal communication).

Can the disease be contracted by an accidental needlestick with an AIDS-blood contaminated needle? Probably yes, but with extremely low frequency (less than 0.5%). Only one documented case, in which a British nurse acquired the virus after actually receiving a microinjection of blood after an arterial puncture, has been reported (5). Three additional cases in the United States of possible needlestick transmission have been suggested, but not conclusively proven (6). One worker was not available for follow-up, the other two denied high risk activity, and it is possible that in each of these three cases acquisition of the virus could have been from the more well-described routes. In addition, over 660 subjects (including one who
acquired hepatitis B) who sustained needlesticks from infected needles have been studied and did not seroconvert (4). The low frequency of transmission of the AIDS virus by accidental needlestick compared to that of hepatitis B, in which twenty to thirty percent of those so exposed acquire the virus, may be due to the large differences in concentrations of infectious particles in the blood (up to $10^{13}$ viral particles/ml for hepatitis B vs. $10^4$ viral particles/ml for AIDS) (3). One can therefore conclude that caring for AIDS patients, even when intensive exposure to contaminated secretions occurs, is not a high risk activity. Infection control committees should therefore implement policies to minimize accidental needlesticks and develop infection control procedures based on the current CDC recommendations.

The article by Friedland et al., reported in this issue of the New England Journal of Medicine, offers strong supporting evidence that the AIDS virus is not transmitted by casual contact, even within a family unit in which intimate contact with infected individuals occurs (7). Of 101 subjects tested who were living in a household with a documented AIDS-virus carrier, none acquired the virus, and it seems clear that the one antibody-positive subject was infected by vertical transmission in utero or at the time of birth. The impact of this study is further increased by the fact that infection control procedures followed by many health care workers were obviously not employed in the family units evaluated. The duration of exposure reported was certainly long enough, and the interactions great enough, to provide every opportunity for the virus to be spread within the family, if such transmission were likely. Other smaller family studies have produced results consistent with those presented by Friedland et al. Only one of thirty-five household members associated with fourteen seropositive Danish hemophiliacs had serum antibody to the AIDS virus (HTLV-III). This individual had engaged in vaginal, oral, and anal intercourse with one of the infected hemophiliac patients (8). The failure of the virus to spread in
the "secretion rich" environment of the family may in part be explained by the very low isolation rate recently reported in samples of saliva (9). Ho and his colleagues could isolate the AIDS virus (HTLV-III) from only one of eighty-three saliva samples cultured from antibody-positive subjects, although the virus was detected in twenty-eight of the fifty blood samples tested from the same population (9). Others have confirmed these studies (3).

The picture is therefore clear. The AIDS virus is spread sexually, by the injection of contaminated blood, and vertically from mother to fetus. Other modes of transmission are extremely rare. Individuals at high risk of acquiring the virus are homosexual and bisexual sexually active men, intravenous drug abusers, individuals receiving infected blood products intravenously, and children born of infected mothers. At intermediate risk are persons, especially women, engaging in heterosexual sex with members of high risk groups. Groups to which the virus is highly unlikely to be transmitted (i.e., virtually "no risk" groups) include health care workers caring for AIDS patients and all casual contacts of individuals with the AIDS virus infection, including food handlers, school children, coworkers, and family members. Based on these facts the keys to preventing transmission of the virus are 1) the screening of all donated blood and 2) education and attempts at behavior modification about risky sexual behavior and intravenous drug abuse.

Clearly, it is now time for members of the medical profession, armed with this knowledge, to take a more active and influential role in quelling the hysteria concerning the casual transmission of AIDS. We need to give enormous support to those public and medical officials who set policy opposing universal screening, quarantine, restriction of students from classrooms, and the removal of employees, including health care workers, from the workplace (10). The evidence presented by Friedland et al. is a powerful argument with which to counter the fear and alarm of the general population regarding the potential for casual contagion and should be used to thwart attempts to discriminate against persons in the so-called high risk groups.
References


Addendum to "Ethics of Discrimination in AIDS Research," Thom Mullin

American Association for the Advancement of Science

May 29, 1985

Research Methodologies and Heterosexual Bias In AIDS Research

Stephen F. Morin, Ph.D.
Division of Internal Medicine
University of California, San Francisco

Heterosexual Bias Defined:

- Heterosexual bias is defined as a belief system that values heterosexuality as superior to and/or "more natural" than homosexuality.

- A reconceptualization of homosexuality as a valid option for an adult lifestyle would suggest changes in the questions formulated, the data collected, and interpretation made in AIDS research.

Heterosexual Bias in AIDS Research Assumption #1:

- Research reflects the value system of its investigators and the social climate within which it takes place.

- Most research is conducted within the institutional framework of funding, prestige, and scientific respectability.

- Investigators are most likely to do research that is acceptable to others and that, above all, is publishable.

Heterosexual Bias in AIDS Research Assumption #2:

- An analysis of research questions being asked in AIDS research is a useful indicator of the values of the individual investigators.

- Research questions being asked in research funded by the National Institutes and the Centers for Disease Control (CDC) reflect national priorities and attitudes towards gay men.

Limitation #1:

- Conclusions with regard to heterosexual bias in AIDS research is limited because much of the research is yet to be published.
Research Methodologies and Heterosexual Bias in AIDS Research

- An exact analysis of the research questions and interpretations made is not possible without a detailed assessment of published research findings.

Limitation #2:

- In the absence of published research, values and bias can be assessed by assessing the priorities of research questions funded through the National Institutes.

The Priorities of Gay Men:

- A methodology for assessing the priorities that gay men would assign to research is to simply ask them about their concerns.

  This is a common practice in advertising and is conducted through the form of focus groups.

- Gay men are primarily interested in knowing what is safe and what is unsafe. This includes basic research on how the virus is transmitted.

  To what extent is saliva capable of transmitting the virus?
  Are condoms effective in preventing the transmission of the virus?
  Are spermicides alone or in combination with condoms effective in preventing the transmission of the virus?

- Once basic research has addressed these issues it is incumbent upon federal agencies and others to communicate this information in an understandable fashion.

- Gay men list the development of a vaccine, another form of prevention, as a high priority.

- For those people with AIDS, the highest priority is assigned to treatment.

- The role of investigating various forms of treatment has largely been left to the National Institutes of Health and the National Cancer Institute.

- Funding for these agencies has not been adequate.
Method:
- It is assumed that the values of the federal government are reflected in budget data of the Public Health Service (PHS).
- See Tables 1 and 2.

Findings:
- Until FY 85, less than two percent of funding for PHS AIDS activity was allocated for public education and prevention.
- Now primary prevention accounts for 4.1 percent.
- Only 14.8 percent of the PHS AIDS budget for FY 85 was to be used for studies of therapeutic interventions.
  - 8.8 percent for AIDS
  - 6 percent for opportunistic infections
- Only 2.1 percent of the budget is allocated to psychosocial factors.
- Gay men are likely to list prevention and treatment as the highest priorities for research. These priorities are not reflected in the federal budget.
- A study conducted by the U.S. Conference of Mayors found that one of the greatest needs at the local level was funding for training and technical assistance in community education with regard to safe sex guidelines and the implications of AIDS antibody testing.
- In the absence of effective treatment for AIDS the only hope at this point is an effective prevention program.
- The National Gay Task Force (NGTF) has criticized PHS for its lack of willingness to target messages to specific audiences because of fear of becoming associated too directly with the gay community.
- NGTF points out that if PHS does not want to become involved in the prevention effort, they should at least supply funding for those organizations that wish to conduct primary prevention campaigns.

Centers for Disease Control:
- Prevention of communicable diseases is a primary activity assigned to the CDC.
Research Methodologies and Heterosexual Bias In AIDS Research

- Prior to FY 85 CDC's funding has not included any significant allocations for prevention programs.

- A major shift has occurred in the FY 85 budget allocating significantly more funds.

- These funds for CDC prevention programs ($3,260,000) are less than those being proposed by the State of California alone ($4,250,000).

- Federal efforts to fund prevention programs have been completely inadequate.

- As one gay marketing expert put it, "if we waited for the federal government to conduct health education, we would all be dead."

Priorities at NIMH:

- An analysis of research questions and grants funded by the National Institutes of Mental Health to some extent reflects the national research priorities.

- NIMH has listed 14 AIDS-related research grants (See Table 3).

- Five grants address the psychological impact of AIDS on the functioning of gay men, including changes in sexual behavior.

- Only one grant was funded to study the psychological consequences of an AIDS diagnosis.

- The remaining research grants have only a peripheral relationship to AIDS or the central questions being asked by gay men.

  Three studies were funded to find a relationship between stress and immune responses in rats.

  Three research grants were funded to address the relationship between psychotropic medications and immune functioning.

  One grant was funded to address the relationship between depression and immune response.

  One grant sought to assess the genetic and hormonal origins of homosexual orientation.

- No request for proposals have been issued by the National Institutes of Mental Health to date to focus research efforts in this area.
Research Methodologies and Heterosexual Bias in AIDS Research

- Only six of the fourteen funded research grants address issues that have emerged as being of primary concern to gay men.

- Of these six research grants, all have research advisory committees including gay men.

How Could Research on AIDS Improved?

- It is imperative that gay men be involved in major research grants in an advisory capacity.

- It is further imperative that gay men be involved in discussions that generate the questions that drive basic and applied research on AIDS.

- If we have learned anything in the last three years, it is that the gay community must be involved, and if anything is to be done, the gay community must take the lead in advocating for appropriate AIDS research and treatment.

- The system just won't work otherwise.
CONCERNED REPUBLICANS FOR INDIVIDUAL RIGHTS

February 4, 1986

Senator John Doolittle
State Capitol, Rm. 5082
Sacramento, CA 95814

Dear Senator Doolittle,

At its January membership meeting, Concerned Republicans for Individual Rights, the oldest chartered predominantly Gay Republican volunteer organization in the Nation, went on record opposing SB-1513.

We acknowledge that there is a problem of the transmission of AIDS in California's jails and prisons — although 99.6% of the cases of AIDS in our State have been diagnosed outside our penal system, but we feel that there are more viable solutions to that problem than the mandatory testing of all individuals convicted of a felony or misdemeanor who are sentenced to more than three days of imprisonment that you propose.

If SB-1513 became law, given the present policy of the Department of Corrections that anyone who tests positive for the HTLV-III antibody will be sent to Vacaville and placed in one of two segregated AIDS-related wards, the mandatory testing of all prisoners could swell the population of those wards from 30 to over 500, possibly 1,000. Such a result would be unmanageable and extremely costly to the taxpayers of our state and would require additional facilities, trained personnel, and related expenses.

The solution to the problem of AIDS in California's penal institutions will not be simple or inexpensive. The first line of defense is education — both of the inmate population (particularly those at risk of contracting AIDS) and custodial and medical personnel in the prisons — about how AIDS is and is not transmitted, and how one can reduce the risk of contracting AIDS.

For those diagnosed with AIDS or severe AIDS-related complex, every effort should be made (where the prisoner does not have a history of violent behavior) to release the prisoner to a secured medical facility outside the prison system where adequate care can be provided.

Those who have been diagnosed with AIDS or AIDS-related complex should be provided medical counseling on the nature of the disease and measures they can take to improve their health and chances of survival. They should also be afforded emotional support groups to address anxiety.

The widespread existence of IV drug abuse, heterosexuals raping homosexuals and other heterosexuals, and consensual homosexual relations poses a more difficult dilemma. All such activities are currently illegal under California law in our prisons. To prevent the transmission of AIDS, either the current laws must be enforced effectively and perpetrators...
placed into isolation from the main prison population, or the laws
can be changed — placing rapists into isolation, but providing pro-
phylactics and issuing clean needles and clorox bleach to prisoners
likely to engage in otherwise unsafe behavior. The former will require
much more staffing to detect illegal activities and the construction
of hundreds if not thousands of additional isolation cells. The latter
raises other medical concerns, at least in the case of IV drug users.

Finally, there is a need to examine whether or not it is necessary
to isolate individuals who are positive for the antibody from the rest
of the prison population. Once effective education takes place among
the inmate population, it is arguable that people diagnosed with AIDS
or AIDS-related complex or those who are asymptomatic, but are positive
for the AIDS antibody could be mainstreamed if their physical condition
allows it. They should be treated no differently than those who are
negative for the antibody. They should be required to work and allowed
to eat in common dining halls, meet visitors in common visiting areas,
and participate in recreational programs available to other prisoners.
Restrictions should be based solely on behavior, not antibody status.

Thank you for your consideration.

Cordially,

CHRISTOPHER L. BOWMAN
President, CRIR
SENATE BILL No. 1478

Introduced by Senator Doolittle

January 6, 1986

An act to amend Section 4300 of the Civil Code, relating to marriage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1478, as introduced, Doolittle. Marriage.

Existing law requires that in order to be issued a marriage license a person must file a certificate issued by a physician attesting to the results of tests relating to the presence or absence of syphilis, and, in the case of a woman, whether she has laboratory evidence of immunological response to rubella, except as specified.

This bill would require such a certificate also to state the results of a blood test to detect antibodies to the probable causative agent of acquired immune deficiency syndrome, as specified.


The people of the State of California do enact as follows:

1 SECTION 1. Section 4300 of the Civil Code is amended to read:
2 4300. (a) Before any person, who is or may hereafter
3 be authorized by law to issue marriage licenses, shall issue
4 issues any such license, each applicant therefor shall file
5 with him or her a certificate from a duly licensed
6 physician which certificate shall state stating that the
7 applicant has been given such examination, including a
8 standard serological test, as may be necessary for the
9 discovery of syphilis, made not more than 30 days prior
10 to the date of issuance of such the license, and that, in the
opinion of such the physician, the person either is not
infected with syphilis, or if so infected, is not in a stage of
that disease which is or may become communicable to
the marital partner.
(b) Such The certificate shall also state whether the
female applicant has laboratory evidence of
immunological response to rubella (German measles).
Such The certificate shall not contain such evidence of
response to rubella where the female applicant (1) is
over 50 years of age, or (2) has had a surgical sterilization
or (3) presents laboratory evidence of a prior test
declaring her immunity to rubella.
This subdivision shall not become operative in a county
until January 1, 1974, if the State Department of Health
Services determines on or before the effective date of this
act that there are not sufficient laboratory facilities in the
county to perform the test required by this subdivision.
In making this determination, the State Department of
Health Services shall consider the number of people in
the county, and the availability of facilities and qualified
personnel.
(c) The certificate also shall state the results of a blood
test to detect antibodies to the probable causative agent
of acquired immune deficiency syndrome. Consent to
release the results of the blood test for the purpose of this
section shall be in accordance with Section 199.21 of the
Health and Safety Code and shall be in a form which shall
be prescribed by the State Department of Health
Services.
(e)
(d) Any person who by law is validly able to obtain a
marriage license in the State of California is validly able
to give consent to any examinations and tests required by
this article. In submitting the blood specimen to the
laboratory the physician shall designate that this is a
premarital test.
An act to add Section 1202.1 to the Penal Code, relating to sentencing.

LEGISLATIVE COUNSEL'S DIGEST

SB 1513, as introduced, Doolittle. AIDS: testing of prisoners.
Existing law prohibits the testing of a person's blood for evidence of antibodies to the probable causative agent of acquired immune deficiency syndrome (AIDS) without the written consent of the subject of the test. Existing law also provides for a civil penalty, as specified, for any person who discloses the results of a blood test to detect AIDS without written authorization from the subject of the test.

This bill would, notwithstanding the above provisions of law, require every person convicted of a misdemeanor or felony who is sentenced to county jail for a term exceeding 3 days, or to a term in the state prison, which term is not suspended, to submit to a blood test administered by the county for evidence of AIDS and would also require that the results of the test be disclosed to the sheriff of the county jail or the warden of the state prison where the person is incarcerated, there by imposing a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates which do not exceed $500,000 statewide and other procedures for claims whose statewide costs exceed $500,000.

This bill would provide that reimbursement for costs
mandated by the bill shall be made pursuant to those statutory procedures and, if the statewide cost does not exceed $500,000, shall be payable from the State Mandates Claims Fund.


The people of the State of California do enact as follows:

1 SECTION 1. Section 1202.1 is added to the Penal Code, to read:
2 1202.1. (a) In every case in which a person is convicted of a felony or a misdemeanor and is sentenced to a term in the county jail exceeding three days or to a term in the state prison, and the imposition or execution of sentence is not suspended, the person shall, notwithstanding Section 199.22 of the Health and Safety Code, immediately submit to a blood test administered by the county for evidence of antibodies to the probable causative agent of acquired immune deficiency syndrome (AIDS).
3 (b) Notwithstanding Section 199.21 of the Health and Safety Code, the results of the blood test to detect antibodies to the probable causative agent of AIDS shall be disclosed to the sheriff of the county jail or the warden of the state prison where the person is incarcerated.

SEC. 2. Reimbursement to local agencies and school districts for costs mandated by the state pursuant to this act shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code and, if the statewide cost of the claim for reimbursement does not exceed five hundred thousand dollars ($500,000), shall be made from the State Mandates Claims Fund.
GAY/LESBIAN COMMUNITY YOUTH ADVOCACY COUNCIL

SUBJECT: POLICY ON AIDS (Acquired Immune Deficiency Syndrome)

WHEREAS: AIDS has been declared our nation's top health priority, and more than one San Franciscan dies of AIDS and two new cases are diagnosed every day in our city, and

WHEREAS: The Human Rights Commission reports increasing discrimination against AIDS patients, and the Community United Against Violence reports anti-gay violence has increased 86% recently, and

WHEREAS: Hysteria, homophobia, and misinformation continue to impede progress, and

WHEREAS: The world looks to San Francisco to provide a model of humane response, quality services and public education, and

WHEREAS: The Board of Education wishes to be pro-active in providing constructive leadership to students, staff, parents, and the community, and

WHEREAS: The U.S. Department of Health and Human Services, Public Health Department, Centers For Disease Control have declared the scientific and medical evidence clear that AIDS is not transmitted by casual contact such as occurs in schools and the workplace, they officially recommend that no one, child or adult, be required to take the AIDS antibody test or excluded from school sites, functions, or employment because of AIDS. Special problems are to be handled by ordinary medical and public health guidelines.

THEREFORE BE IT RESOLVED: That the Board of Education adopt as policy for the San Francisco Unified School District that:

1. Since AIDS (Acquired Immune Deficiency Syndrome) is not spread by casual contact, no one, child or adult, shall be required to take the AIDS antibody test; automatically barred from enrollment, employment, participation, or attendance at school sites or in school functions; have their confidentiality violated; or be discriminated against, because of AIDS or AIDS related conditions. Special problems are to be handled by ordinary medical and public health guidelines.

2. The Superintendent shall provide staff, students, and parents with an ongoing AIDS education program, in cooperation with the AIDS Health Project of the University of California, the AIDS Foundation, the Department of Health, and the Bay Area Physicians For Human Rights, including: information about transmission and prevention, safe sex guidelines, IV drug risk, resources for services, homophobia, anti-gay violence, and human rights. The Superintendent shall furnish each student and staff member some AIDS information and educational material each school year. A saturation program shall be implemented to reach each district student, staff, and family by the end of the Spring 1986 school session.

11/18/85 (this updates and supersedes the one from Hunter Morey 11/14)
STATEMENT of R. HUNTER MOREY, MSW, IHS on 2-5-86 to the SAN FRANCISCO HUMAN RIGHTS COMMISSION HEARINGS ON AIDS DISCRIMINATION

I am a sexologist and social worker with the Gay/Lesbian Youth Advocacy Council, San Francisco Sex Information, the AIDS Foundation, San Francisco Suicide Prevention, the Institute For Advanced Study of Human Sexuality, have been appointed to the Health and Family Life Education Committee of the San Francisco Board of Education, and am a member of the Youth and Education Committee of the Human Rights Commission.

AIDS is still a growing crisis. San Francisco has over two people being newly diagnosed with full blown AIDS each day, over one person dies from AIDS each day, and untold additional people get newly diagnosed with ARC each day. This isn’t happening just to adults. The increases of AIDS in children and youth are shocking. Nationally, 146% more children ages 0 to 12 got AIDS in this last year, 85% more youth ages 13 to 19, and 106% more youth ages 20 to 29. (As of January 20, 1986, there were 231 cases in ages 0–12, 74 cases in ages 12–19, and 3,452 cases in ages 20–29.) In San Francisco, while only 8 people have gotten AIDS diagnosis here who are under 20 years old, 243 have gotten AIDS who are from ages 20 to 29. This represents a 79% increase in AIDS cases in the 20 to 29 year old age group here since last year. Since the incubation period seems to average from two to five years, many of the youth ages 20–29 must have gotten the AIDS virus in their teenage years.

However, this growing AIDS crisis has not been met with enough AIDS prevention education, especially not enough directed to the children and youth population. Information is power. Denial of information is denial of power, denial of equal opportunity. Denial of information is discrimination. How can our children and youth defend themselves against AIDS and ARC, the hysteria about it, and homophobia, unless they have information?

Our San Francisco young people are being denied adequate information about AIDS. Many schools, such as Lowell High School, have no sex education classes except for sporadic large assemblies during gym class. Most students will finish out this school year without having any AIDS education at all. As much information as has been in the media, as much good work as is being done by educators such as Joan Haskin with the public schools and Marcia Quackenbush with the AIDS Health Project and by the AIDS Foundation, it still remains that the vast majority of children and youth have not been given nor are planned to receive any quality education about AIDS, ARC, prevention, and homophobia.

Another aspect of AIDS discrimination is anti-gay violence, which had an 86% increase recently reported by the Community United Against Violence. Students still ask questions and make remarks showing great ignorance about AIDS. I frequently speak in the schools and see this first hand. Teachers are looking for
resources to educate themselves, other staff, parents, and students about AIDS. There aren’t enough resources available to do the job. The AIDS Health Project, the AIDS Foundation, and the school district all have budget problems. There is no children and youth AIDS education program as such. I am frequently asked to give talks for free because there is no budget, and I am not funded by anyone. The middle, elementary, and high schools, both public and private, need education programs for teachers, staff, parents, and children.

We know that the combination of education and services works to cut down on unsafe sexual behavior. It has worked in San Francisco. After receiving extensive safe sex education, gay and bisexual men have so greatly reduced having anal sex without a condom, that the rectal gonorrhea rate went down by 86% from early 1980 to 1985. Let’s give children and youths the same intensive education to protect their health also.

Children and youths ARE sexually active. Planned Parenthood has found that a majority of youths, both male and female, are sexually active before they finish their teenage years. Homosexual and bisexual activity is much more widespread than we usually realize. Even in Kinsey’s day, 60% of preadolescent boys and 33% of preadolescent girls reported some homosexual experiences. Kinsey found that 28% of males and 17% of females were having at least incidental homosexual experiences by the end of their teenage years. More information about this may be found in my book Demystifying Homosexuality: A Teaching Guide About Lesbians And Gay Men, available from San Francisco Sex Information. (By the way, thanks to the HRC and others, the SFUSD Board of Education has adopted the book as a teacher resource, but the district only purchased 84 copies.)

Children and youths are also getting other sexually transmitted diseases. There were 1,145 children and youth under 20 who got gonorrhea in San Francisco this last year, 83 cases in people 14 years old and younger. Chlamydia cases also peak in the late teens and early twenties, as does syphilis.

Our present programs are only a start and the schools cannot do it alone. Our children and youth are sexually active, are getting sexually transmitted diseases, sharing drug needles, and are beating up others perceived of as gay, or are suffering from being hassled for not living up to sex role stereotypes. Suicide is about the main cause of death among youth, with many cases relating to fears and pressures around sexuality. Let’s provide youngsters with a comprehensive program of sex education, safe sex guidelines, and homophobia prevention. Every student at every grade level in San Francisco should have at least one quality AIDS education presentation before the end of this current school year and should be given at least one quality piece of AIDS educational material to take home. Why wait until some stupid incident occurs? Let’s be proactive and have a model AIDS education program for our children and youth in San Francisco and the nation.
Assembly Bill No. 403

CHAPTER 22

An act to add Chapter 1.11 (commencing with Section 199.20) to Part 1 of Division 1 of the Health and Safety Code, relating to health, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor April 3, 1985. Filed with Secretary of State April 4, 1985.]

LEGISLATIVE COUNSEL'S DIGEST

AB 403, Agnos. Health.

(1) Existing law provides that the results of specified blood tests shall be confidential and not open to public inspection.

This bill, in addition to existing law, would provide that no person shall be compelled, as specified, to identify any individual who is the subject of a blood test to detect antibodies to the probable causative agent of acquired immune deficiency syndrome. The bill would provide penalties for disclosure, as defined, of the results of the blood test, as defined, except as specified, including the assessing of civil penalties and the creation of a new misdemeanor. It would establish a right of action for actual damages. Creation of a new misdemeanor constitutes a state-mandated local program. This bill would permit the State Department of Health Services to require blood banks and plasma centers to submit reports summarizing data concerning tests to detect the presence of viral hepatitis and antibodies to the probable causative agent of AIDS, as specified.

It would prohibit a person, except as specified, from testing a person's blood for evidence of antibodies to the probable causative agent of AIDS without the written consent of the subject.

This bill would prescribe that the results of the blood test not be used in any instance for the determination of insurability or suitability for employment.

It would also prescribe that neither the state department nor any blood bank or plasma center, including a blood bank or plasma center operated by a public entity, be liable for any damages resulting from a specified notification of test results.

(2) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates which do not exceed $500,000 statewide and other procedures for claims whose statewide costs exceed $500,000.

This bill would provide that no reimbursement shall be made from the State Mandates Claims Fund for costs mandated by the state
pursuant to this act, but would recognize that local agencies and
school districts may pursue any available remedies to seek
reimbursement for some of these costs.

This bill would provide that, notwithstanding Section 2231.5 of the
Revenue and Taxation Code, this bill does not contain a repealer, as
required by that section; therefore, the provisions of the bill would
remain in effect unless and until they are amended or repealed by
a later enacted bill.

The bill would take effect immediately as an urgency statute.

The people of the State of California do enact as follows:

SECTION 1. Chapter 1.11 (commencing with Section 199.20) is
added to Part I of Division I of the Health and Safety Code, to read:

CHAPTER 1.11. MANDATED BLOOD TESTING AND
CONFIDENTIALITY TO PROTECT PUBLIC HEALTH

199.20. To protect the privacy of individuals who are the subject
of blood testing for antibodies to the probable causative agent of
acquired immune deficiency syndrome (AIDS) the following shall apply:

Except as provided in Section 1603.1 or 1603.3, as amended by AB
488 of the 1985–86 Regular Session, no person shall be compelled in
any state, county, city, or other local civil, criminal, administrative,
legislative, or other proceedings to identify or provide identifying
characteristics which would identify any individual who is the
subject of a blood test to detect antibodies to the probable causative
agent of AIDS.

199.21. (a) Any person who negligently discloses results of a
blood test to detect antibodies to the probable causative agent of
acquired immune deficiency syndrome to any third party, except
pursuant to a written authorization, as described in subdivision (g),
or except as provided in Section 1603.1 or 1603.3, as amended by AB
488 of the 1985–86 Regular Session, shall be assessed a civil penalty
in an amount not to exceed one thousand dollars ($1,000) plus court
costs, as determined by the court, which penalty and costs shall be
paid to the subject of the test.

(b) Any person who willfully discloses the results of a blood test
to detect antibodies to the probable causative agent of the acquired
immune deficiency syndrome, to any third party, except pursuant to
a written authorization, as described in subdivision (g), or except as
provided in Section 1603.1 or 1603.3, as amended by AB 488 of the
1985–86 Regular Session, shall be assessed a civil penalty in an amount
not less than one thousand dollars ($1,000) and not more than five
thousand dollars ($5,000) plus court costs, as determined by the
court, which penalty and costs shall be paid to the subject of the test.

(c) Any person who willfully or negligently discloses the results of
a blood test to detect antibodies to the probable causative agent of acquired immune deficiency syndrome to a third party, except pursuant to a written authorization, as described in subdivision (g), or except as provided in Section 1603.1 or 1603.3, as amended by AB 488 of the 1985-86 Regular Session, which results in economic, bodily, or psychological harm to the subject of the test, is guilty of a misdemeanor, punishable by imprisonment in the county jail for a period not to exceed one year or a fine of not to exceed ten thousand dollars ($10,000) or both.

(d) Any person who commits any act described in subdivision (a) or (b) shall be liable to the subject for all actual damages, including damages for economic, bodily, or psychological harm which is a proximate cause of the act.

(e) Each disclosure made in violation of this chapter is a separate and actionable offense.

(f) The results of a blood test to detect antibodies to the probable causative agent of acquired immune deficiency syndrome shall not be used in any instance for the determination of insurability or suitability for employment.

(g) "Written authorization," as used in this section, applies only to the disclosure of test results by a person responsible for the care and treatment of the person subject to the test. Written authorization is required for each separate disclosure of the test results, and shall include to whom the disclosure would be made.

(h) Nothing in this section limits or expands the right of an injured subject to recover damages under any other applicable law.

(i) Nothing in this section shall be construed to impose liability or criminal sanction for disclosure of a blood test to detect antibodies to the probable causative agent of AIDS in accordance with any reporting requirement for a diagnosed case of AIDS by the state department or the Centers for Disease Control under the United States Public Health Services.

(j) The state department may require blood banks and plasma centers to submit monthly reports summarizing statistical data concerning the results of tests to detect the presence of viral hepatitis and antibodies to the probable causative agent of AIDS. This statistical summary shall not include the identity of individual donors or identifying characteristics which would identify individual donors.

(k) "Disclosed," as used in this section, means to disclose, release, transfer, disseminate, or otherwise communicate all or any part of any record orally, in writing, or by electronic means to any person or entity.

(l) "Results of a blood test," as used in this section, means to identify or provide identifying characteristics of the person to whom the results apply.

199.22. No person shall test a person's blood for evidence of antibodies to the probable causative agent of AIDS without the written consent of the subject of the test, and the person giving the
test shall have a written statement signed by the subject confirming that he or she obtained the consent from the subject.

This requirement does not apply to a test performed at an alternative site, as established pursuant to Article 8 (commencing with Section 1630) of Chapter 4 of Division 2. This requirement also does not apply to any blood and blood products specified in paragraph (2) of subdivision (a) of Section 1603.1, as amended by Assembly Bill 488 of the 1985–86 Regular Session.

199.23. Neither the state department nor any blood bank or plasma center, including a blood bank or plasma center owned or operated by a public entity, shall be held liable for any damages resulting from the notification of test results, as set forth in paragraph (3) of subdivision (a) of, and in subdivision (c) of, Section 1603.3, as amended by AB 488 of the 1985–86 Regular Session.

SEC. 2. (a) No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because part of the costs which may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, changes the definition of a crime or infraction, changes the penalty for a crime or infraction, or eliminates a crime or infraction.

(b) No reimbursement shall be made from the State Mandates Claims Fund pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code for costs mandated by the state pursuant to this act. It is recognized, however, that a local agency or school district may pursue any remedies to obtain reimbursement available to it under Part 7 (commencing with Section 17500) and any other provisions of law.

SEC. 3. Notwithstanding Section 2231.5 of the Revenue and Taxation Code, this act does not contain a repealer, as required by that section; therefore, the provisions of this act shall remain in effect unless and until they are amended or repealed by a later enacted act.

SEC. 4. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to protect the confidentiality of persons undergoing a blood test for the detection of antibodies to acquired immune deficiency syndrome, and to encourage individuals who are stricken with the disease to undergo treatment which would ultimately benefit the health and welfare of all citizens of the State of California, it is necessary that this act take immediate effect.
Thank you for the opportunity to present this testimony. The Commission is performing an outstanding service to the community by providing a forum to discuss the critical issues surrounding discrimination against people with AIDS and ARC.

We in San Francisco have a special responsibility to formulate enlightened and progressive approaches to preventing discrimination against those afflicted with AIDS. I know that my colleagues in Washington often look to the City for guidance in dealing with the many problems associated with this disease.

Confidentiality in blood testing and research will go a long way in preventing discrimination. Legislation is being prepared in Congress to assure that the results of blood tests do not become readily available to employers, insurance companies and others who may use the information improperly. I will, of course, support this legislation.

A recent article in the San Francisco Examiner indicated that problems of discrimination in the workplace have been declining. I hope that is true -- and hope these hearings will provide further evidence of the extent of the problem.

While federal, state and local civil rights laws already in place provide protection for AIDS victims, the lengthy and costly legal process discourages many from pursuing that course. We must ensure that AIDS victims know their rights and have access to affordable legal assistance.

It is also important that efforts go forward to educate the general public about the impossibility of contacting AIDS through casual contact. The misguided fears about this disease are at the root of discrimination against its victims.

-more-
But fear of AIDS is not the only cause of discrimination. The cost of caring for and insuring victims has led many insurance companies to seek ways to avoid providing life and health policies for not only AIDS victims, but many people who are only thought to have AIDS. This pernicious practice must stop.

The cost of AIDS is enormous and will continue to grow -- I have a real concern not only that insurance companies will avoid paying part of this cost, but that the federal government, operating under the constraints of the Gramm-Rudman budget legislation, will be reluctant to bear those costs. As a result, we may find that people unable to obtain private insurance must fall back on government programs that will be seriously under-funded. It is just such dilemmas that government officials at all levels will be facing in the coming months and years.

Again, I commend the Commission and offer my strong support for efforts to end discrimination against people who are already the victims of a terrible disease.
Ms. Esta G. Soler  
Chairperson  
Human Rights Commission  
Suite 501  
1095 Market Street  
San Francisco, California  94103

Dear Ms. Soler,

My staff has informed me that your Commission has scheduled a hearing to study AIDS and AIDS RELATED COMPLEX/ARC.

My staff and I have monitored the AIDS problem closely in California and at the national level. In June of 1985, Senator D'Amato and I cosponsored an AIDS briefing for Republican health staffers on Capitol Hill to provide them with facts about the problem, allowing them to make informed decisions. More recently, I wrote to Dr. Bowen, Secretary for HHS, asking him to use a portion of HHS discretionary funds to study the growing problem of pediatric AIDS. This is an area I hope your hearing will shed more light on.

I have consistently supported appropriations funding for AIDS research and education projects, and will attempt to maintain the funding at present levels. As you develop programs as a result of your hearings, please keep me informed so that I may be of assistance at the federal level.

Sincerely,

PETE WILSON  
United States Senator
SUBJECT: HTLV-III

SEE DISTRIBUTION

1. On 30 Aug 85, the Deputy Secretary of Defense directed testing for HTLV-III antibodies be started at the Military Entrance Processing Station (MEPS) by 1 Oct 85. He further directed that the laboratory testing be conducted by local civilian facilities.

2. The contract for testing is anticipated to be awarded on 27 Sep 85. Our goals for HTLV-III antibody testing are to minimize the impact on processing flow while ensuring quality test procedures are followed.

3. Enclosed is an information packet for the Commanders on HTLV-III. Also, included is a copy of the briefing delivered to the JCS by Brigadier General Archer, USMEPCOM Commander.

4. In order to facilitate smooth implementation of this plan, the MEPS staff will be on call to assist you with the training of your personnel.

5. Point of contact for this action is CPT Burton, (415) 273-6263/7346.

H. D. Krueger
LtCol, USMC
Commanding

DISTRIBUTION:

1-ea IRC Member
FACTS ABOUT HTLV-III

1. What is "HTLV-III"?

"HTLV-III" is a virus. The term "HTLV-III" is an abbreviation of the full name of the "Human T-cell Lymphotropic Virus, Type III." This name was given to the virus because it infects humans and grows in a type of white blood cells called "T-cells." There are two other types of "HTLV" viruses, types "I" and "II," but these viruses are less common than HTLV-III in the United States.

2. Why is a positive HTLV-III test disqualifying for military service?

There are several reasons. First, all new military people get their "shots." These immunizations are needed to give protection from the diseases which service members might be exposed to around the world. Because some people with HTLV-III have a damaged immunity protection system, they can actually develop the disease they are being vaccinated for—smallpox, for example. People with HTLV-III cannot donate blood, and every military member is a potential blood donor on the battlefield or at sea.

3. How does a person become infected with HTLV-III?

The virus is present in the blood and other body fluids of an infected person. There are three ways the virus is definitely known to spread from one person to another: (1) by having an injection of the infected blood. This could happen through a blood transfusion or by sharing contaminated needles used for drug abuse. Although there have been reports of accidental needle sticks among medical personnel caring for AIDS patients, there is only one reported case of a person later developing the disease from this cause; (2) by having sexual intercourse with an infected person, either heterosexual (male-female sex) or homosexual; or (3) through the womb, from an infected mother to her infant. HTLV-III can be found in the saliva and tears of an infected person, but contact with saliva or tears has not been shown to transmit the virus. Thousands of health care workers have been taking care of AIDS patients for years, and there has not been one other case of AIDS developed among these workers, except for the case mentioned above.

4. How does the blood test for HTLV-III work?

The blood test for HTLV-III detects antibodies to the virus. Antibodies are large molecules in the blood that stick to germs that have invaded the body. When a person becomes infected with HTLV-III, the virus grows and multiplies in his/her blood. The body's immune defenses respond to the infection by making antibodies against HTLV-III in an effort to kill the virus. In most kinds of viral infections, the antibodies are effective in killing the virus; in HTLV-III infections, they are not, and the virus continues to multiply. A positive blood test for antibodies to HTLV-III is strong evidence that a person has had the virus in his/her blood.
5. What does a confirmed positive blood test for HTLV-III antibodies mean?

It means the person was exposed to HTLV-III sometime in the past and has now infected with the virus. Beyond that, no one knows for sure. The incubation period (the time from exposure and infection until the time symptoms develop) is typically several years. Most HTLV-III-infected persons are perfectly well for years, even though the virus is in their blood. It is still not certain exactly what proportion of infected persons with the antibody will eventually go on to become ill; in the few studies done so far, 10-40 percent have developed signs and symptoms of the disease within 3 years.

6. Does everyone infected with HTLV-III eventually get the Acquired Immune Deficiency Syndrome (AIDS)?

Again, the answer is unknown. Some HTLV-III-infected persons become ill within 1-2 years of infection, while others may go on feeling well for 5-10 years or longer. It is not known why some persons develop symptoms relatively quickly while others remain feeling well much longer.

7. Is there a cure for HTLV-III infection?

Not yet. There is an enormous research effort underway in the United States and other countries to find a cure. Several drugs have been found which kill HTLV-III in the test tube, and some of these have been tested in humans with encouraging results. However, the drugs may have significant, life-threatening effects. Each must be carefully tested in humans to be sure it does more good than harm. These tests are underway.

8. What should a person infected with HTLV-III do?

See a doctor, preferably one who specializes in HTLV-III infections or infectious diseases in general. He/she can do tests to determine if a person's immune system has been damaged by the virus. If it has, the doctor can keep a close watch for early signs of complications, such as pneumonia or meningitis. Even though there is no cure, as yet, for the HTLV-III virus infection itself, the complications can be managed if they are caught early.
WHO WILL REQUIRE AN HTLV-III ANTIBODY TEST?

1. Individuals requiring HTLV-III antibody testing.
   a. Individuals who take a complete medical examination on or after 1 October 1985 (see note 1).
   b. Individuals who underwent a complete medical examination prior to 1 October 1985 (but did not enlist in the DEP, Reserve, or National Guard) and who return to the MEPS for a physical inspection on or after 1 October 1985 (see note 2).
   c. Individuals taking medical examinations for agencies other than DOD and the Coast Guard, if the agency requests (see note 3).
   d. Individuals who completed a medical examination and enlisted in the DEP, Reserve, or National Guard prior to 1 October 1985, but who are changing service or component on or after 1 October 1985.
   e. Individuals who completed a medical examination prior to 1 October 1985, were QNE, and are now enlisting in the DEP, Reserve, or National Guard without requiring a physical inspection (see note 4).

2. Individuals not requiring HTLV-III antibody testing (see note 5).
   a. Non-DOD agencies (unless requested by agency) (see notes 3 and 6).
   b. Individuals already in the DEP prior to 1 October 1985 who are continuously in the DEP for the same service and component and who report for shipping after 1 October 1985.
   c. Individuals who are second phase split options.
   d. Individuals with HTLV-III antibody test results recorded on the SF 88 of non-MEPS physicals which are acceptable for MEPS processing. (The only non-MEPS physicals we currently accept are those for Air Force officer candidates in flight training programs and those conducted in overseas military facilities.)

NOTE 1: Includes all applicants for enlistment in the Armed Forces (including the Coast Guard); officer candidate programs (ROTC, OCS, etc.); active duty personnel; and Reservists and Guardsmen (accessions/quadrennials).

NOTE 2: Includes prior service individuals not requiring a full medical examination; individuals who enlist in the DEP (Reserve or National Guard) more than 30 days after a full medical examination; and flight program candidates.
NOTE 3: No agency has yet requested HTLV-III antibody testing. In the event that any agency indicates a desire to commence HTLV-III antibody testing, they should submit a written request to HQ USMENCUS so that all necessary followup coordination may be accomplished.

NOTE 4: Will not apply on or after 30 October 1985.

NOTE 5 Individuals not required to be tested by the MEPS will be identified to the recruit training centers by attaching a notice (see encl 2 to the LOI) to the front of the SF 88.

NOTE 6: Includes physicals for the FBI, Peace Corps, etc.
MEDICAL PROCESSING FOR HTLV-III ANTIBODY TESTING

1. These procedures apply to all individuals who are required to be tested at a MEPS for the HTLV-III antibody starting 1 October 1985. This additional testing will require some additions/modifications to the current medical processing.

2. Procedures preparatory to drawing the blood sample:

   a. If the blood sample is drawn before the medical briefing, the following procedure applies:

      (1) Distribute a pen and medical folder containing the required medical forms to each examinee.

      (2) Brief the examinees on HTLV-III antibody testing. The briefing is at encl 1 to this enclosure.

      (3) Have each examinee read, fill out, and sign the HTLV-III antibody testing acknowledgement (see encl 2 to this enclosure).

      (4) Have each examinee fill out item 1 (Name), item 3 (SSN), and item 6 (Date) of the SF 88.

      (5) Proceed to drawing and recording the blood sample on each examinee as described in paragraph 3 below.

   b. If the blood is drawn after the medical briefing, the following procedure applies:

      (1) After the medical briefing is completed and the examinee has signed the SF 93, give the HTLV-III antibody testing briefing at encl 1 to this enclosure.

      (2) Have each examinee read, fill out, and sign the HTLV-III antibody testing acknowledgement (see encl 2 to this enclosure).

      (3) Proceed to drawing and recording the blood sample as described in paragraph 3 below.

3. To obtain/record two individuals may be used: one to draw the blood sample and the other to do the labeling and recording. The following sequence may be altered, but all steps must be carried out. Particular attention must be devoted to the proper matching of specimens, roster entries, and examinees to avoid mixups.

   a. Record the examinee's name, SSN, and test date in the HTLV-III control log (see encl 3 to this enclosure).

   b. Affix the contractor-supplied identification labels to the control log entry, blood tubes, and SF 88 pertaining to each applicant.
c. Confirm the identification of the examinee and draw a 7-milliliter blood sample.

d. If using the regular tube (red top), wait 25 minutes; spin the specimen for 5 minutes. Verify the identifying information and then pipette 3 milliliters of serum into the second tube.

e. If using the anticoagulant tube (purple top), the tube may be spun immediately. Spin the specimen for 5 minutes. Verify the identifying information and then pipette a 3-milliliter specimen of serum or plasma into the second tube.

f. Accomplish an RPR on the remainder of the original specimen.

4. At no time will the specimens be left unattended at the MEPS unless secured in a locked container.

5. The contractor's representative will package, receipt for, and transport specimens to the contract laboratory. A hand-receipt will be completed for each batch of specimens picked up, using the form at encl 4 to this enclosure.

6. Periodically, blind specimens will be provided to each MEPS. These blind specimens may consist of either positive or negative HTLV-III antibody samples. These samples will be randomly interspersed with examinee samples, using contractor-provided labels, and entered into the HTLV-III control log (encl 3 to this enclosure). Instead of the name and SSN, the entry "blind sample" and the blind sample identification will be entered under the headings "Name" and "SSAN" in the HTLV-III control log.
USMEP COM

PLAN

- IMPLEMENT 1 OCT 85

- MEPS WILL TEST
  - FULL PHYSICALS ON/ AFTER 1 OCT 85
  - INSPECTS WHO COMPLETED PHYSICAL BUT DID NOT DEP/ACCESS BEFORE 1 OCT 85
  - CHANGING SERVICE OR COMPONENT ON/ AFTER 1 OCT

- MEPS WILL NOT TEST
  - IN DEP OR ACCESS PRIOR TO 1 OCT 85
  - SECOND PHASE SPLIT OPTION RESERVE GUARD
  - NON-MILITARY SERVICES UNLESS REQUESTED

- PROCESS AS USUAL
  A. ENLIST IN DEP
  B. ACCESS IN RESERVE & GUARD

- DO NOT SHIP WITHOUT RESULTS
  - GUARD & RESERVES - (HD(394) 1-5)
  - UNIT MUST HOLD FOR RESULTS

- NOTIFY POSITIVES IN PERSON
USMEPCOM
HTLV-III TESTING
GOALS

MINIMIZE IMPACT ON PROCESSING FLOW

MINIMIZE IMPACT ON SHIPPING
ACCURATE MEPS HANDLING AND ADMINISTRATION
CARE IN NOTIFYING TESTED INDIVIDUALS OF POSITIVE RESULTS

ELISA: 24 HR
DOOR-TO-DOOR (NEGOTIABLE)

WESTERN BLOT: 7 DAYS
DOOR TO DOOR

Run 3 tests
2 out of 3+ = Western Blot
MEPS PROCESSING

INDIVIDUALS

PHYSICAL EXAMINATION
- PHYSICAL EXAMINATION COMPLETED
  1. QUALIFIED
  2. INCOMPLETE
  3. DISQUALIFIED

- ENLIST IN DEP
- ACCESS TO GUARD/RESERVE
- QNE
- DISQUALIFIED

RETURN HOME

ADMINISTRATION

CENTRIFUGED 3ML OF PLASMA/PLASMA SEPARED AND PLACED INTO THE SECOND COLLECTION TUBE

LOG ENTRY TUBE
- MEDICAL FORMS ANNOTATED
- CONTROL #
- MEDICAL INTERNAL
- $27 CONTROL
- $27 BLK 6-12

SF 88 ANNOTATED (COPY TO SERVICE)
(ORIGINAL RETAINED MEDICAL)

SF 88 FILED IN MEDV-311 FILE

MEPS FLAG ENTERED - 10

BLOOD SPECIMEN

MEPS BLOOD SPECIMEN PACKAGED (3-10° C)
W/TEST SAMPLE RECEIPT

PACKAGE TO COURIER

TRANSPORTED TO LAB

THE FIVE LABELS WILL BE USED FOR:

SPECIMEN TUBE

SHIPPING TUBE

STANDARD FORM 88

LOG BOOK

EXTRA
TESTING FLOW IN THE CONTRACT LABORATORY

SPECIMEN

RESULTS TO MEPS
HARD COPY REQUIRED

ELISA

SPECIMEN TESTING PATHWAY

--- TESTED ---

NEGATIVE

--- TESTED ---

POSITIVE

--- REPEAT TEST ---

NEGATIVE

--- REPEAT TEST ---

NEGATIVE

--- TESTED ---

POSITIVE

--- REPEAT TEST ---

NEGATIVE

--- REPEAT TEST ---

POSITIVE

WESTERN BLOT
CONFIRMATION TESTING

--- TESTED ---

POSITIVE

--- REPEAT TEST ---

POSITIVE

--- TESTED ---

POSITIVE

--- REPEAT TEST ---

POSITIVE
**MEPS PROCESSING**

**ELISA RESULTS**

- **ELISA RESULTS RECEIVED**
  - MEDICAL MATCH RESULTS & LOG IN
  - FILE LAB REPORT. AND IF...
  - POSITIVE: RETAIN SF BB; RETAIN 5A FLAG STOP
  - NEGATIVE: ANNOTATE SF BB-PASS TO OPS

- OPS
  - SIGN SF CONTROL LOG (1727)
  - MEPS SF 5A DELETED-5B ENTERED
  - OPS PASS TO FILE ROOM

  **LIAISON FOR**
  - FILE ROOM
  - QNE
  - TOQ
  - PDQ

  **DEP ACCESSION**

**WESTERN BLOT RESULTS**

- **NEGATIVE**
  - MED-ANNOTATE SF BB-PASS TO OPS

- OPS
  - SIGN MEDICAL CONTROL LOG (1727)
  - MEPS SF 5A DELETED-5C ENTERED

  **LIAISON FOR**
  - FILE ROOM
  - QNE
  - TOQ
  - PDQ

  **DEP ACCESSION**

- **POSITIVE**
  - MED-ANNOTATE SF BB-PASS TO OPS

- OPS
  - SIGN MEDICAL CONTROL LOG (1727)
  - MEPS SF 5A DELETED-5D ENTERED

  **OPS PASS TO**

**MEPS CON START NOTIFICATION PROCEDURES**

**TJR TO LTMNPCON**

**NOTIFICATION PROCEDURES**

- **OPTION A** - FACE TO FACE
- **OPTION B** - NOTIFY AIR LTR
- **OPTION C** - LTR NOTIFICATION
- **OPTION TO RETURN**
ACCOUNTABILITY

PRELAB

- SEQUENTIAL CONTROL NUMBERS (SCN)
- LOG BOOK - DATE/NAME/SSAN/SCN#/RESULTS
- INDIVIDUAL ASSIGNED SEQUENCE CONTROL # BY MEDICAL
- DRAW BLOOD/ENSURE ALL MATCH (SF 88/VIALS/SHIPPING MANIFEST/CONTROL LOG/727.)
- VERIFY CONTROL OF DOCUMENTATION PENDING RESULTS. RECONCILE SF 88/LOG BOOK/727/SHIPPING MANIFEST - MEPS CDR

LAB

- TRANSFER CUSTODY TO LAB-MED NCOIC
- RETURN PACKING LIST (TEST SAMPLE RECEIPT)
- HANDLE LAW CONTRACT SPECIFICATIONS

POSTLAB

- WRITTEN RESULTS TO MEPS
- VERIFY SCN#/RESULTS/LOG BOOK/SF 88/727
- ANNOTATE RESULTS ON SF 88/LOG/727
- TRANSFER CUSTODY OF SF 88 TO OPERATIONS (OPERATIONS UPDATE MEPRS)*
- RESULTS NEG. TRANSFER CUSTODY OF SF 88 TO RECRUITING SERVICE OR OTHER AGENCY
- POSITIVE WESTERN BLOT: TRANSFER CUSTODY OF SF 88 TO MEPS COMMANDER FOR NOTIFICATION *
- NOTIFICATION LOOP COMPLETE: SF 88 & ALL ASSOCIATED DOCUMENTS RETURNED TO MEPS FILE

*TRANSFER ACCOUNTABILITY VIA 727/SIGN
Automated System Coding

**No Go**

FOR ALL AT INITIAL PHYSICAL:
5A HTLV-III RESULTS PENDING

**No Go**

ELISA POSITIVE:
5A PENDING STATUS CONTINUES

**No Go**

WESTERN BLOT POSITIVE:
5B FINAL STATUS

ELISA NEGATIVE:
5B FINAL STATUS

WESTERN BLOT NEGATIVE:
5C FINAL STATUS

GO!
MEPS AUTOMATED SYSTEM

SUPPORT FOR HTLV-III TESTING

- CODES
  (TO BE ENTERED IN MEDICAL FAILURE AREA):
  -- 53. FINAL HTLV-III ANTIBODY TEST
     RESULTS PENDING
  -- 52. ELISA TEST RESULTS NEGATIVE
  -- 44. WESTERN BLOT TEST RESULTS
     NEGATIVE
  -- 43. WESTERN BLOT TEST RESULTS
     POSITIVE

- FLAGS
  -- SHIPMENT NOTED ONLY IF CODE 38, 3C PRESENT (EXCEPT
    FOR THOSE NOT REQUIRING HTLV-III TYPING)
  -- CODE 3A ASSIGNED AUTOMATICALLY FOR ALL POST-30 SEP
     TRANSACTIONS INCLUDIGN FULL PHYSICALS
  -- Edit PROCEDURES ENSURE MANUAL ENTRY OF APPROPRIATE
     PHYSICALS FOR THOSE WITH PRE-OCT 85

- SYSTEM EDITS
  -- IF FULL PHYSICAL TAKES PLACE OR ON
    AFTER 1 OCT 85, 34 OR 38 MUST
    ACCOMPANY INITIAL MEDICAL ENTRY
  -- IF PHYSICAL TAKES PLACE PRE-
    OCT 85 AND HTLV-III TEST REQUIRED AND
    PHYSICAL INCOMPLETE/INCOMPLETE, CODE 5B OR
    3C WILL BE ENTERED BEFORE SHIPPING
    CODE CAN BE ACCEPTED
  -- IF PHYSICAL PRE-OCT 85 AND
    HTLV-III TEST REQUIRED BUT
    PHYSICAL NOT REQUIRED TO DEP/
    ACCESS CODE 5A MUST BE PRESENT
    BEFORE ENLISTMENT
    TRANSACTIONS WILL BE ACCEPTED
  -- IF PHYSICAL PRE-OCT 85 AND
    HTLV-III TEST REQUIRED AND PHYSICAL
    INCOMPLETE/INCOMPLETE, CODE 5B OR
    3C WILL BE ENTERED BEFORE SHIPPING
    CODE CAN BE ACCEPTED
  -- IF HTLV-III TEST NOT REQUIRED, WILL
    CHECK TO VERIFY ENLISTMENT DATES AND
    ACCEPT SHIPPING CODES WITHOUT HTLV-III
    TEST CODE

- STUDIES

*** CAN SUPPORT DEMOGRAPHIC RESEARCH ON PRESENCE OF
HTLV-III ANTIBODY IN AMERICAN YOUTH POPULATION

*** USE PC DATA BASE WILL EVENTUALLY HAVE MORE THAN 1
MILLION RECORDS WITH HTLV-III ANTIBODY TEST RESULT DATA
RESOURCE ISSUES

Major contract features

- Vendor will furnish shipping containers and specimen tubes
- Vendor will pack and pick up specimens
- NEPS will use vendor supplied identification label. Provides positive control and receipt to NEPS
- Vendor will perform ELISA and provide written report 24 hours after specimen pick up
- Vendor will store specimens for one year. If new contract custody can be transferred
- Quality assurance is built into the Statement of Work

MANPOWER

CENTRALIZED CONTRACT WILL REQUIRE
A FULL TIME CONTRACTING OFFICER
A TECHNICAL REPRESENTATIVE AT
HEADQUARTERS (NEPS)COM
A LABORATORY BACKGROUND WILL BE
NEEDED

NEPS:
- MD TECH
- 24 HR TRANSCRIBER

COSTS

4 MILLION FIRST 120 DAYS

EQUIPMENT REQUIREMENTS

- MD J3 CERTIFIERS WILL BE NEEDED AT EACH NEPS
- LOCKABLE FILING CABINETS
- COPIERS IN MEDICAL
Medical Section

Mr. John Doe  
212 Main Street  
Detroit, Michigan  70272  

Dear Mr. Doe:

As part of your medical examination taken at the Chicago Military Entrance Processing Station (MEPS) to determine your eligibility for military service, a blood sample was taken for testing. This letter reaffirms the verbal notification you received indicating your blood test shows there is a substance called an antibody to the HTLV-III virus, technically known as Human T-cell Lymphotropic Virus, Type III, present in your blood. A positive test for the HTLV-III antibody is disqualifying for military service, and your test is positive. To make sure, we repeated the test and got the same results, and we also performed a different, even more specific test on your blood sample and, again, we got positive results.

I am sure this information raises a concern about your health. The only thing the test tells us is that you have evidence of past contact with the virus which is believed to be capable of causing Acquired Immune Deficiency Syndrome, which is usually called AIDS. I am not telling you that you have AIDS. I want to be very clear on that point. The only thing the test tells us is that you have evidence of past contact with the virus.

You are disqualified for military service, which I know is a disappointment to you. But more importantly, you must seek professional medical advice and guidance in order to get the proper evaluation of your medical situation. I urge you to do this as soon as possible. Neither the MEPS in Chicago nor your recruiter can provide you the advice and help that you need. It must come from a physician or clinic that can evaluate your total situation and give you detailed advice, which is not part of your examination for military service. Take this letter with you when you go to your physician or clinic. They need to know that your blood sample tested repeatedly ELISA positive with positive Western Blot confirmation. Copies of your physical examination can be obtained from the Chicago MEPS upon request.

Encl 10
I am sorry that you have been disqualified for military service, and I again strongly urge you to seek further medical advice in your local community.

Sincerely,

John J. Smith, M.D.
Chief Medical Officer

(NOTE: This letter is to be used to notify individuals who were previously disqualified, for whatever reason(s), and subsequently test positive for the HTLV-III antibody. It must be an individually typed original; signed by the CMO or acting/assistant CMO; and handed to the individual after he/she has been verbally notified of his/her positive test results.)
Medical Section

Mr. John Doe
212 Main Street
Detroit, Michigan 70272

Dear Mr. Doe:

As part of your medical examination taken at the Chicago Military Entrance Processing Station (MEPS) to determine your eligibility for military service, a blood sample was taken for testing. This letter reaffirms the verbal notification you received indicating your blood test shows there is a substance called an antibody to the HTLV-III virus, technically known as Human T-cell Lymphotropic Virus, Type III, present in your blood. To make sure, we repeated the test and got the same results, and we also performed a different, even more specific test on your blood sample and, again, we got positive results.

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I am sorry that you have been disqualified for military service, and I again strongly urge you to seek further medical advice in your local community.

Sincerely,

John J. Smith, M.D.
Chief Medical Officer

(NOTE: This letter is to be used to notify individuals disqualified only due to HTLV-III antibody positive test results. It must be an individually typed original; signed by the CMO or acting/assistant CMO; and handed to the individual after he/she has been verbally notified of his/her positive test results.)
Medical Section

Mr. John Doe  
212 Main Street  
Detroit, Michigan 70272  

Dear Mr. Doe:

As part of your medical examination taken at the Chicago Military Entrance Processing Station (MEPS) to determine your eligibility for military service, a blood sample was taken for testing. Your blood test shows that there is a substance called an antibody to the HTLV-III virus, technically known as Human T-cell Lymphotropic Virus, Type III, present in your blood. A positive test for the HTLV-III antibody is disqualifying for military service, and your test is positive. To make sure, we repeated the test and got the same results, and we also performed a different, even more specific test on your blood sample and, again, we got positive results.

I am sure this information raises a concern about your health. The only thing the test tells us is that you have evidence of past contact with the virus which is believed to be capable of causing Acquired Immune Deficiency Syndrome, which is usually called AIDS. I am not telling you that you have AIDS. I want to be very clear on that point. The only thing the test tells us is that you have evidence of past contact with the virus.

You are disqualified for military service, which I know is a disappointment to you. But more importantly, you must seek professional medical advice and guidance in order to get the proper evaluation of your medical situation. I urge you to do this as soon as possible. Neither the MEPS in Chicago nor your recruiter can provide you the advice and help that you need. It must come from a physician or clinic that can evaluate your total situation and give you detailed advice, which is not part of your examination for military service. Take this letter with you when you go to your physician or clinic. They need to know that your blood sample tested repeatedly ELISA positive with positive Western Blot confirmation. Copies of your physical examination can be obtained from the Chicago MEPS upon request.
I am sorry that you have been disqualified for military service, and I again strongly urge you to seek further medical advice in your local community.

Sincerely,

John J. Smith, M.D.
Chief Medical Officer

(Note: This letter is to be used to notify individuals disqualified only due to HTLV-III antibody positive test results. It must be an individually typed original; signed by the CMO or acting/assistant CMO; and sent via registered mail.)
MEPCC-CHI

SUBJECT: Medical Disqualification of John Doe, 385-31-4723

Commander
U.S. Marine Corps Recruiting Station
2500 East Main
Chicago, IL 60063

1. John Doe, 385-31-4723, sponsored by your service, was disqualified at this
MEPS for military service. Subsequent to his original disqualification, labo-
atory tests revealed a medical problem. We have sent him the enclosed letter
of notification, which advises him of a medical problem and directs him to
contact his recruiter. Under no circumstances will the recruiter suggest to
the applicant what the medical problem might be. Even though Mr. Doe has
already been disqualified, it is our responsibility to notify him of his medi-
cal problem.

2. Request you coordinate telephonically directly with me to schedule Mr. Doe's
return to the MEPS for personal notification of his medical problem. Once an
appointment date and time has been established for the individual's return to
the MEPS, request necessary transportation arrangements be made for the appli-
cant and have the recruiter accompany the applicant's return to the MEPS. If
the applicant does not respond or indicates to the recruiter that he will not
return to the MEPS for whatever reason, request you indicate that by endorse-
ment back to me.

Encl

MARK R. SIMMONS
Lieutenant Colonel, USA
Commanding

(NOTE: This letter is to be used regarding individuals who were previously
disqualified, for whatever reason(s), and subsequently test positive for the
HTLV-III antibody. It is intended as notification to the IRC-level commander;
adapt it for other situations. Place it in an envelope stamped "EYES ONLY
COMMANDER" in the lower left corner.)
MEPCC-GHI

SUBJECT: Medical Disqualification of John Doe, 385-31-4723

Commander
U.S. Marine Corps Recruiting Station
2500 East Main
Chicago, IL 60663

John Doe, 385-31-4723, sponsored by your service, has been notified by this MEPS that he is medically disqualified for military service. Enclosed are copies of this individual's USMEPCOM PCN 714ADP and SF 88. At this time, you may begin action to cancel any training seat this individual may occupy. Request you also begin action to discharge this individual from the DEP, using discharge code "ZAA." Please send us a copy of the discharge paperwork by 30 days from the date of this letter.

Encl

MARK R. SIMMONS
Lieutenant Colonel, USA
Commanding

(Note: This letter is to be used regarding individuals disqualified only due to HTLV-III antibody positive test results. It is intended as notification to the IRC-level commander to begin discharge action; adapt it for other situations. Place it in an envelope stamped "EYES ONLY COMMANDER" in the lower left corner.)
DEPARTMENT OF DEFENSE
CHICAGO MILITARY ENTRANCE PROCESSING STATION
65 EAST 9TH STREET
CHICAGO, ILLINOIS 60605-2187

MEPCC-CHI

SUBJECT: Request for Assistance in Locating John Doe, 385-31-4723

Commander
U.S. Marine Corps Recruiting Station
2500 East Main
Chicago, IL 60063

1. A complete physical examination given to Mr. Doe by this MEPS on 1 October 1985 has uncovered a medical problem. He gave 212 Main Street, Detroit, Michigan 70272, as his current address; however, we have been unable to contact him and now require your assistance.

2. Please notify me by endorsement below of this individual’s status.

MARK R. SIMMONS
Lieutenant Colonel, USA
Commanding

MCRS-CHI (MEPCC-CHI/7 Oct 85) 1st End
Maj Jones/sr/AUTOVON 555-6742
Cdr, U.S. Marine Corps Recruiting Station, 2500 East Main, Chicago, IL 60063
TU: Cdr, Chicago MEPS, 65 East 9th Street, Chicago, IL 60605-2187
☐ 1. Unable to locate individual.
☐ 2. Individual has been located; his address is ____________________________
☐ 3. An appointment will be made to return individual to the MEPS.
☐ 4. Individual does not desire to return to the MEPS.
☐ 5. Other (specify):

JOHN SMITH
Lieutenant Colonel, USMC
Commanding

(NOTE: Use this letter to request the assistance of the IRC-level commander in locating an individual; adapt it for other situations. Place it in an envelope stamped “EYES ONLY COMMANDER” in the lower left corner.)

Encl 12
APPLICANT NOTIFICATION CHECKLIST

1. The purpose of the physician-applicant interview is to notify the applicant that he/she has an HTLV-III antibody positive test.

2. The HTLV-III virus is believed to be the cause of the Acquired Immune Deficiency Syndrome (AIDS).

3. An HTLV-III antibody positive test does not mean the individual has AIDS. It also does not mean the individual does not have AIDS.

4. A positive test for the HTLV-III antibody, by itself, has no predictive value for the present or future health of the individual.

5. Each individual with an HTLV-III antibody positive test must have further evaluation by a physician before any specific advice or instructions can be given to that individual.

6. The MEPS physician may not counsel nor advise the applicant except for the results of the HTLV-III antibody test and the need to seek further physician evaluation in his/her local community.

7. The classic physician-patient relationship or bond does not exist between the applicant and the notifying physician. The notifying physician must not allow the applicant to draw him/her into discussions, advice, or guidance beyond the above noted information.

8. Questions from the applicant which seek a prognosis, assessment of contagiousness, or other similar personal guidance cannot be answered by the MEPS physician.

9. The notifying physician must strive to reassure the applicant that there is no need for hasty actions and that the applicant should make no assumption about his/her present or future health based only on the information just given to him/her.

10. Casual contact with the HTLV-III antibody positive individual is not hazardous and no special precautions need to be taken for his/her return visit to the MEPS.
MEPCC-CHI

SUBJECT: Medical Disqualification of John Doe, 385-31-4723

Commander
U.S. Marine Corps Recruiting Station
2500 East Main
Chicago, IL 60603

1. John Doe, 385-31-4723, sponsored by your service, has been medically disqualifed by this MEPS. We have sent him the attached letter of notification (encl 1), which advises him of a medical problem and directs him to contact his recruiter. Under no circumstances will the recruiter suggest to the applicant what the medical problem might be.

2. Request you coordinate telephonically directly with me to schedule Mr. Doe's return to the MEPS for personal notification of his medical problem. Once an appointment date and time has been established for the individual's return to the MEPS, request necessary transportation arrangements be made for the applicant and have the recruiter accompany the applicant's return to the MEPS. If the applicant does not respond or indicates to the recruiter that he will not return to the MEPS for whatever reason, request you indicate that by endorsement back to me.

Encl

MARK R. SIMMONS
Lieutenant Colonel, USA
Commanding

(NOTE: This letter is to be used regarding individuals disqualified only due to HTLV-III antibody positive test results. It is intended as notification to the IRC-level commander; adapt it for other situations. Place it in an envelope stamped "EYES ONLY COMMANDER" in the lower left corner.)
Medical Section

Mr. John Doe  
212 Main Street  
Detroit, Michigan  70272  

Dear Mr. Doe:

We would like you to return to the Chicago Military Entrance Processing Station to discuss the results of your medical examination taken on October 1, 1985. Please contact your recruiter within the next 10 days to make an appointment with the Military Entrance Processing Station physician and to arrange for your transportation.

Sincerely,

John J. Smith, M.D.  
Chief Medical Officer

(NOTE: This letter must be an individually typed original; signed by the CMO or acting/assistant CMO; and sent via registered mail.)
PUBLIC AFFAIRS OFFICE GUIDANCE

Below is the basic guidance provided for use by the MEPS commander when answering press questions about HTLV-III:

a. Under no circumstances allow members of the media access to the facility without prior approval from the HQ USMEPCOM Public Affairs Office.

b. No members of the media are to be allowed at any time into the Medical Section of the facility.

c. No cameras, video, or stills will be allowed into the medical area without prior approval.

d. Do not speculate, if asked by the media, on any ramifications of the HTLV-III testing or on AIDS.

e. Members of the media may tour the station, minus the Medical Section, during normal duty hours. They may, if they obtain prior permission from the applicant, question applicants about how they feel about the test.

f. Submit an after-action report on any media on HTLV-III from a local point of view.

g. No MEPS employee, military or civilian, will appear on television, radio, or in print commenting on HTLV-III testing.

h. A list of questions and answers is being prepared by the HQ USMEPCOM Public Affairs Office, in conjunction with the U.S. Army Recruiting Command, the Office of the Assistant Secretary of Defense Public Affairs Office, and the Office of the Chief of Public Affairs, to serve as press guidance on common questions.
LEGAL GUIDANCE

1. The Supremacy Clause of the U.S. Constitution limits the power of States to enact legislation, by declaring that federal statutes and treaties are the supreme law of the land and, therefore, preempt conflicting State statutes. HTLV-III antibody testing will be done pursuant to federal statutes which provide for the enlistment of qualified applicants. State laws which conflict or unduly interfere with the achievement of this federal objective might address such matters as confidentiality requirements, limits on release of results only to treating physicians, rigid consent requirements, etc. Generally, States can legitimately control the licensing of laboratories as a function of their police powers.

2. Any interference with processing IAW this LOI by a State which seeks to enforce statutory or regulatory requirements on a MEPS should be reported immediately to the Command Judge Advocate. Commanders should be prepared to DEX copies of the appropriate State statute or regulation to HQ USMEPCOM.

3. Some States may require that MEPS release HTLV-III antibody positive test results to State or local authorities; e.g., State Department of Public Health. Before releasing positive test results pursuant to State request, coordination must be accomplished with the Command Judge Advocate.

4. Whether HTLV-III antibody positive test results for a minor are released to the minor or the parent/guardian is a function of State law. In all cases, coordination must be accomplished with the Command Judge Advocate.

5. All inquiries from attorneys and Department of Public Health officials representing States and political subdivisions which raise substantial questions as to the legality of HTLV-III testing procedures will be immediately turned over to the Command Judge Advocate for answer.

6. MEPS commanders should review security procedures for demonstrations. Coordination should be accomplished with local law enforcement authorities.

7. MEPS commanders may find that applicants who are notified of an HTLV-III antibody positive test result in a face-to-face meeting may become upset. Physical confrontation should be avoided. An applicant should not be prevented from leaving the MEPS under such circumstances.
HTLV-III ANTIBODY TESTING ACKNOWLEDGEMENT

I acknowledge that I have been informed by verbal briefing and by the contents of this document of the following:

1. My medical examination includes a blood test for the presence of antibody to the Human T-cell Lymphotropic Virus, Type III, also called HTLV-III virus.

2. HTLV-III virus is believed to be the cause of the Acquired Immune Deficiency Syndrome, also called AIDS.

3. The HTLV-III antibody test is not a test for AIDS. A positive test does not mean that a person has AIDS. A positive test only means that an individual has had contact with the HTLV-III virus and has built antibodies to the virus in his or her blood.

4. Positive tests will be repeated and also rechecked by a separate and different laboratory test which will confirm the positive result.

5. A negative test means that the individual has no detectable antibodies to the HTLV-III virus. It is not a guarantee against the possibility of having a positive test at some later date.

6. A positive test for the presence of antibody to the HTLV-III virus is disqualifying for entry into the Armed Forces.

7. Results of the test, either positive or negative, will be recorded on my physical examination form.

8. If my HTLV-III antibody test is positive, I will be informed.

_________________  __________________
Signature        Date

Print Name: ________________________________
  Last   First   Middle

__________________________
SSN

Encl 2 to Encl 2
MEDICAL BRIEFING ADDENDUM FOR HTLV-III ANTIBODY TESTING

The following briefing will be given to all examinees required to undergo HTLV-III antibody testing, before the blood sample is drawn. If used as part of the medical briefing, this addendum will be given after the SF 93 has been filled out and signed by the examinees. The addendum is as follows:

"Please remove from your folder the form titled "HTLV Antibody Testing Acknowledgement" (exhibit the form). I will read the contents aloud while you follow silently:

My medical examination includes a blood test for the presence of antibody to the Human T-cell Lymphotropic Virus, Type III, also called HTLV-III virus.

HTLV-III virus is believed to be the cause of the Acquired Immune Deficiency Syndrome, also called AIDS.

The HTLV-III antibody test is not a test for AIDS. A positive test does not mean that a person has AIDS. A positive test only means that an individual has had contact with the HTLV-III virus and has built antibodies to the virus in his or her blood.

Positive tests will be repeated and also rechecked by a separate and different laboratory test which will confirm the positive result.

A negative test means that the individual has no detectable antibodies to the HTLV-III virus. It is not a guarantee against the possibility of having a positive test at some later date.

A positive test for the presence of antibody to the HTLV-III virus is disqualifying for entry into the Armed Forces.

Results of the test, either positive or negative, will be recorded on my physical examination form.

If my HTLV-III antibody test is positive, I will be informed.

Are there any questions? If not, and you understand the contents, please sign and date the form, enter your social security number, and print your name as indicated."

(Note: The briefer should avoid becoming involved in detailed discussions of the significance of a positive test, its relationship to AIDS, AIDS in general, and any other detailed information beyond the scope of the purpose of the acknowledgement form.)
AIDS APARTHEID: CONDITIONS OF OPPRESSION WHICH CONTRIBUTE TO THE SPREAD OF AIDS

William W. Paul, Ed.D.
Educational Psychologist
Faculty of Ethnic Studies and Student Affirmative Action
San Francisco State University
Testimony presented to the San Francisco Human Rights Commission: February 5th 1986

Introductory Summary

Pervasive conditions of hatred, fear and oppression directed against Gay men and Lesbians have inflicted well documented social and personal injury. This includes widespread self hatred and furtive, covert sexual lives of personal and social isolation. For some, this leads to socially marginal behavior and conditions which contribute to high rates of substance abuse, anonymous sexual encounters and other forms of high risk behaviors and environments. For Gay men, these conditions now also generate conditions of high risk for the transmission of AIDS.

Social oppression and the threat of it can therefore contribute to the spread of AIDS among those most gravely threatened by homophobia. This dimension of the AIDS epidemic is presented in an important Amicus Curae to the U.S. Supreme Court by the American Psychological Association and the American Public Health Association (Attachment A).

As a contributor to this brief, I present these data to the Commission with some additional observations derived from field research on AIDS prevention among IV needle users, work in helping to develop the ARC/AIDS Vigil in San Francisco since Oct. 25th 1985, and a variety of tasks related to AIDS information impact.

Defining AIDS Apartheid as conditions of isolation, separation, social stigma and oppression, helps to understand several grave implications of oppression as a contributing factor in the dissemination of AIDS among underserved populations. Several of these underserved high risk populations are discussed in prior testimony presented to the San Francisco Board of Supervisors (Attachment B). One implication is that Black and Latino populations in California are at high risk and underserved. Another consequence is that San Francisco is developing an AIDS underclass of socially marginal people with ARC and AIDS, many of whom are AIDS refugees fleeing oppression.
There is currently a mass migration of AIDS refugees to this city, some of whom have AIDS or ARC. Many however, are simply targets of AIDS inspired oppression as members of a stigmatized high risk population. Many who are educated, middle class, or have positive Gay community identity, simply melt into the population. Others, however, come out of conditions of oppression, isolation or poverty (often recently imposed by job discrimination or ostracism).

The conditions they live in tend to interact in highly destructive combinations with other personal problems and high risk behaviors, which in turn tend to spread AIDS and impose other social costs on the people of San Francisco. Hatred, fear and oppression elsewhere in America generates consequences for San Francisco, in large part because federal neglect of a national epidemic displaces a human and social burden in the form of a migration.

The narrowly stereotyped public image of people at risk as white upper middle class Gay men has several dangerous consequences for at least three underserved populations: 1) Gay men of lower class or working class origins, and covert bisexual or homosexual men. 2) IV needle users. 3) Black and Latino males who do not identify themselves at risk. Latino and Black men and women also have relatively high rates of IV needle use, as one consequence of oppressed social conditions.

Conclusions

1) Homophobia is an integral part of the AIDS epidemic.

2) Conditions of oppression contribute to the spread of this epidemic and pose serious obstacles to education and prevention.

3) Related conditions of separation and isolation produced in part by narrowly defined stereotypes comprise an AIDS Apartheid consciousness, which impedes prevention.

4) There is also an actual underclass of people with AIDS or ARC, many of whom are AIDS refugees, living in socially marginal conditions of poverty and isolation.

5) There is a migration of AIDS refugees to San Francisco, many of whom have been impoverished by AIDS - inspired job discrimination.

6) IV needle users comprise an underserved high risk population, and source of contagion

7) Black and Latino populations are potentially high risk groups now underserved.
UNRECOGNIZED SOCIAL AND HUMAN COSTS OF AIDS & ARC IN SAN FRANCISCO

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Background

As indicated in my attached resume, I have a considerable background of experience in community service projects serving social and human problems of multi-ethnic and under-served populations of San Francisco. I have had specific professional experience in research, development and education efforts on AIDS, including service as a liaison representative to the Committee on Lesbian & Gay Concerns of the American Psychological Association (Board of Social & Ethical Responsibility). In this capacity, I have been able to review a variety of current data on the psychological and social conditions related to AIDS, particularly in regard to transmission, misinformation, conflict and social consequences. I was also an early volunteer with the SF AIDS Foundation.

My testimony today is based primarily on this background and on recent direct observations in two settings:

1) Under the direction of Dr. John Newmeyer, I have conducted field research on AIDS prevention and information among IV needle users in San Francisco. This state funded research was based at the Haight Ashbury Free Medical Clinic, and included field interviews in the Tenderloin, South of Market, Polk Street, Mission and Castro areas of San Francisco.

2) Since October 27th, I have been involved in positions of responsibility with the AIDS & ARC Vigil at U.N. Plaza. As a member of the Service Team, I have worked together with a number of people with AIDS and ARC, and learned much from their personal experience. I have also consulted with many AIDS medical & service experts.

The following is a summary of my observations in these settings, with particular emphasis on some of the largely unrecognized social and human consequences of AIDS and ARC in San Francisco. Many of the people observed lead covert socially/marginal lives.
Summary of Conditions

Below are brief summaries of conditions I have directly observed:

1. Substantial numbers of people with AIDS and ARC are living in conditions of poverty and neglect in the inner city, especially the Tenderloin and South of Market areas. Conditions include low nutritional standards, isolation, lack of social support services, unemployment, and vulnerability to crime, violence, and discrimination. These conditions impede prevention & education efforts.

2) In my view, these conditions are due in large part to a lack of federal response to what is essentially a federal responsibility: a national epidemic.

3) The City of San Francisco, and the private AIDS agencies the city funds has an excellent record of innovative services for people with AIDS and ARC, and these observations should in no way be construed as a criticism of the City's role.

4) Since the inception of the Vigil, individuals, businesses and institutions in this downtown area have contributed substantial and warm hearted support to the Vigil, as they have toward other impoverished people in the area.

5) Conditions described above also tend to combine and interact with other existing conditions. Hence, people with life threatening illness forced to live in poverty and isolation are placed at higher risk for substance abuse, prostitution, crime and other forms of behavior that are both personally and socially destructive.

6) This imposes a magnified burden on existing human services already severely reduced.

7) Drug use and prostitution are particular threats to all of us, as a likely means of transmission to the general population - but especially to other high risk groups. In California, these high risk groups include Black and Latino people, who suffer from social oppression and consequent high rates of IV drug use and prostitution which are a likely means of AIDS transmission.

8) ARC (AIDS Related Complex) is a particular problem imposed by federal inaction. Some people with ARC report a lack of social and medical services, specifically in their exclusion from Medicare and Social Security Disability Insurance.
Recommendations

1) I recommend that the City increase the amount of general assistance allocated to people with AIDS and ARC. This relatively modest level of funding will ultimately save the city money by reducing the huge social costs imposed by the conditions described above.

2) The City, through our elected federal representatives, and by resolutions, should point out the huge social costs of federal neglect imposed on local communities.

3) These actions should place special emphasis on ARC as critical dimension of AIDS.

4) The city should increase funding, and solicit even larger federal and state funding on AIDS prevention projects in the following crucial areas:
   a) Prevention programs dealing with IV needle user populations and subcultures,
   b) Multi-cultural and bilingual prevention programs aimed at minority communities.
   c) Prevention programs aimed at covert and socially marginal at-risk populations.
To Whom it May Concern,

In July of 1985, through Elizabeth Dubin, Rees began writing to five inmates with AIDS at C.M.I. They complained of no food, care, medical help, or emotional support or education about AIDS. Soon, I began communicating with ten then 13 then 25. I received approval forms to visit 6 and started to make weekly visits, visiting one at a time. There was no high level of fear about the disease, and no neglect or treatment.

In October 13 of the AIDS+BPC cases were moved to an open dorm with 2 toilets, no淋浴室, and one shower.

There are approx. 17 in that unit.

At that point in October, the Catholic Chaplain started a volunteer service and an emotional support group with outside help from a group from Shanti. The volunteers and the Shanti help came to an end after a few weeks because of the fear of public scandal over the conditions. I am still in contact with many of the inmates and several them have called me to please get some outside help. We must realize that prison conditions at this facility on a whole are very poor and add AIDS to it and it's worse.

We must know that outside scandal + newspaper articles only make it tighter for people inside. Their must be newer legislation that makes
emotional support and humane and up-to-date medical facilities for the terminally ill in California correctional institutions mandatory. To take 17 people in all different stages of disease and lock them away with 2 toilets, 1 shower, and virtually unsanitary conditions; a doctor that rarely visits and medical treatment that may or may not come is inhumane and asking for disease trouble within the unit. These men have been locked out since March 9, 1985 and deserve to have their basic human needs met.