Dr. Mervyn Silverman, Director of Public Health, for the city and county of San Francisco will host "AIDS: A San Francisco Update," a call-in program on Viacom Cablevision's local origination channel, Cable 6. The program airs Friday, January 27 at 8:30 PM and will feature guests Dr. Marcus Connant, Co-Director, Karposi’s Sarcoma Clinic, UCSF and Dr. Paul Volberding, Chief of Oncology, San Francisco General Hospital. The phone number for viewers to call in is (415) 864-2921.
Silverman bars sex at gay baths

—From Page A1

more than 20 gay political leaders, physicians and activists yesterday to garner support for his policy. People leaving the meeting described it as "very constructive" with a lot of "give and take."

In a brief statement on the steps of the Health Department's Grove Street building before the meeting, Silverman said he already had made his decision and wanted to inform gay leaders to "hopefully gain their support."

The overriding issue is, and has always been, behavior, not just in the bathhouses but everywhere," he said. "The facilities we are talking about play a small role in the lives of the gay community."

Silverman said he was "surprised" and reassured by the results of an Examiner poll published yesterday showing 44 percent of 554 adult San Franciscans surveyed favored banning sex in the baths while 36 percent favor closing them. In a survey of 132 gays, 34 percent felt sex in the baths should be banned, while 18 percent called for closing the baths.

About 53 percent of all respondents said the situation should be handled by the city health department. Only 11 percent of those queried said they had moral objections to the bathhouses, where it's possible for a gay male to have a dozen or more sexual liaisons in a night.

"It confirmed my belief that it is a

health issue and that we were right to be in there, trying to address it," Silverman said in a brief interview yesterday.

Some apprehension followed Silverman's once-delayed announcement of the City's latest effort to curb the spread of AIDS, which occurs mostly in gay men. Gay leaders were concerned that he would close the bathhouses or use police to inspect them, raising issues of civil rights and privacy.

Health officials have focused on bathhouses and private sex clubs because communal and anonymous sexual activities are allowed there. Researchers believe AIDS, which incapacitates the immune system, is spread in the exchange of semen and blood. There is no cure for the disease.

Since city officials and the gay community launched their campaign a year ago to promote changes in gay sexual practices, rectal gonorrhea has dropped 50 percent, indicating gays are being more cautious with their sexual contacts. The incidence of AIDS, however, continues to rise.

About nine new cases of AIDS are reported in San Francisco each week, health department records show. New York City registers more cases of the disease, but a greater portion of San Francisco's smaller gay population has been struck. San Francisco has had 477 cases of AIDS with 175 deaths since the problem started three years ago, Silverman said.

While many details of Silverman's new plan are not yet in place — such as specific responsibilities placed on bath owners — the meeting late yesterday afternoon reportedly found a general consensus among leaders of various camps within the gay community who are concerned over what one described as a "crisis."

Those leaving the meeting yesterday seemed to support Silverman's plan.

"I agree with what Dr. Silverman wants to do," said Ron Huberman of the district attorney's office. "I think it's an excellent suggestion and a compromise."

"I think 90 percent of the gay community is 100 percent behind him," said Tom Odell. "I support what he's doing."

"It's a great way of doing things," said Phyllis Lyon, co-chair of the Lesbian-Gay Advisory Commission of the San Francisco Human Rights Commission.

The issue is not open and closed. The issue is that people have to change some of their high-risk behavior," said Edward Morales, a psychologist and program administrator of the AIDS health program.

Mayor Feinstein had said she favored closing the bathhouses, but would defer to Silverman's decision. Supervisor Harry Britt also initially had called for closing the bathhouses. But when asked about Silverman's compromise, Britt legislative aide Dana Van Gorder said, "We support Dr. Silverman's decision, and we think it

will save lives. We're very glad the police will not be involved, and we think this will help protect people's privacy."

"But we think its very important that it's vigorously enforced, so we don't face this crisis again in six months."

Sal Accardi, a bathhouse owner who also represents an association of 15 to 20 baths in Northern California, said owners are committed to "learn and grow to what is developing medically."

Accardi said that bathhouse owners have implemented "every" change the city health department and the

San Francisco AIDS Foundation has suggested to them over the past year. These include displaying poste on "safe" sex, and distributing literature and condoms. He also said many bathhouse owners are boarding rooms previously used for group sex.

"He's (Silverman) also going to make further recommendations that we will take to make the bathhouses safer in the eyes of the medical establishment, he said. However, Accardi warned the

owners might resort to legal action. The City's "scapegoats" them and ignores private sex clubs and bookstores where sexual activity is also popular.
City bars sex at baths

‘Fix-it’ shuttle will try again
— See story, Page B1

Gay leaders support policy, Silverman says

By Seth Rosenfeld and Richard F. Harris
Examiner staff writers

San Francisco’s bathhouses will remain open, but any sexual activity conducive to the spread of AIDS will be prohibited, city health director Dr. Mervyn Silverman announced today.

The City’s new program to combat acquired immune deficiency syndrome includes periodic visits by health department inspectors to make sure that no proscribed sexual activity is taking place at the dozen or so bathhouses and other establishments frequented by The City’s gays, Silverman said at a press conference today.

Bathhouses where sexual activity continues could lose their licenses, with Silverman himself making the decision in each case.

Silverman said the action taken today “is being taken with the support of AIDS experts and gay leaders and is but one part of a program to reduce the incidence of AIDS... It is by no means the perfect answer.”

Silverman said he will ask the Board of Supervisors to pass legislation making The City’s 150 to 25 private...
TO: Mervyn Silverman, M.D.
FROM: Leon McKusick, M.S.
       Steve Morin, Ph.D.
DATE: April 3, 1984
SUBJECT: Bathhouses and Public Policy

The issue of closing bathhouses in San Francisco has produced a debate which seems to us has lost track of data that could reasonably be used to make a public policy decision. Frequently discussions have moved from medical issues to political or rights issues without an examination of medical, behavioral and epidemiological data. The following are some thoughts.

Medical Issues

The proper policy question to be directed to medical advisors is: What is the most probable means of AIDS transmission? The medical consensus regarding AIDS transmission appears to be leaning toward the following: (1) blood to blood, e.g. transfusion cases; (2) semen to blood, e.g. cluster studies of sexual contacts; and (3) viral agent, e.g. SAIDS retrovirus model.

In that public policy decisions on bathhouses must be based on the medical issue of sexual transmission, a very high consensus that AIDS can be transmitted from semen to blood would be needed. Public policy decisions would follow directly from this medical consensus.

Behavioral Issues

If semen to blood transmission is widely accepted by the medical advisors, then certain target behaviors could be identified with prevention efforts directed toward lowering the incidence of AIDS transmission, e.g. frequency of anal intercourse, receptive without condom. The proper question to be directed to behavioral science advisors is: Does the environment at bathhouses promote an increased frequency of high risk sexual behaviors (semen to blood transmission)?

McKusick, Horstman & Carfagni (1984) conducted a study comparing men recruited from bathhouses to those recruited from bars, couple networks, and newspaper
Behavioral Issues (continued)

advertisements for those who did not attend bars or baths. Some of the following findings are relevant to public policy determinations:

**Disease transmission:** Men sampled from bathhouses were significantly more likely than other groups to have had hepatitis B. Those sampled from bathhouses and bars were more likely than the other two groups to have had either gonorrhea or syphilis in the last year.

**Number of sexual partners:** Men sampled from the bathhouses demonstrated a higher frequency of sexual partners than the other groups. Sixty-one percent of the men sampled in the baths reported 5 or more sexual partners in the last month; 32% reported 10 or more partners.

**High risk activity:** Men sampled from bathhouses and bars were more likely than the other two groups to demonstrate high risk sexual behaviors. Forty-four percent of the bathhouse respondents reported anal intercourse, receptive without condoms with a new or secondary partner in the last month; 11% reported this behavior with 5 or more partners in the last month.

Have Educational Efforts Been Successful?

One argument that is frequently used by those opposing bathhouse closure is that gay bathhouses offer an opportunity to prevent the spread of AIDS through public education. However, the data collected on men sampled from bathhouses indicates a very high level of awareness regarding AIDS transmission. In this sample there was a 92% agreement with the statement that "AIDS is transmitted through body fluids." There was a 95% agreement with the statement "reducing the number of sexual partners overall helps reduce AIDS risk." These data suggest that men attending bathhouses have a very high recognition of risk reduction guidelines even though these behaviors do not conform to these recommendations.

Would Closing or Altering the Baths Make a Difference?

There appears to be strong belief (possibly a myth) on the part of many people that closing the baths would not change high risk sexual behaviors. This argument to some extent ignores the issue that many behaviors are situation specific and that people behave in different ways in different environments. High risk and high frequency sexual behaviors are directly related to environmental factors which support such behaviors.
The American Association of Physicians for Human Rights (AAPHR) has released a statement on baths indicating "There is no evidence, at this time, that closing bathhouses would reduce the risk or incidence of AIDS." It is unclear whether the behavioral data above have been considered.

Further, the AAPHR statement indicates "attempts at legislating sexual behavior have only changed locations of that behavior, not curtailed it." Although this statement may have validity regarding statutes, it is not relevant to the current issue for determination.

Going back to the McKusick, et. al. data, respondents of who do attend bathhouses (n=281) were asked if there were no bathhouses how their sexual behavior might be expected to change. They responded as follows:

- Would probably have the same kind of sex somewhere else: 47%
- Would stop having the sex he now has in bathhouses: 7%
- Would reduce the kind of activity he now has in a bathhouse but would still have some of this behavior elsewhere: 26%
- Other changes: 19%

Self-report data on those attending bathhouses thus indicate that 53% would make significant changes if there were no bathhouses.

Given the high probability that the number of behaviors such as multiple partners is easier in bathhouses and the opportunities as well as social skills necessary to engage in the same type of activities elsewhere may not be a part of the person's current social skills, the 45% who would not predict changes in their sexual behavior may be overestimating other options. To a large extent the policy issue of closing/altering bathhouses depends upon whether or not frequency of sexual partners and high risk activities are situation specific. The above data would suggest that they are.

Conclusion

This memo was prepared in part to refute the notion that there are no data indicating that the closing of the baths would reduce the incidence of AIDS. The above medical, behavioral and epidemiological data can be interpreted to suggest that closing or altering bathhouses could have a major impact on reducing high risk sexual behaviors and therefore the incidence of AIDS transmission. High risk and high frequency sexual behaviors appear to be situation specific. Current bathhouse environments appear to promote high volume and high risk behaviors.

Most public policy decisions are made with far less data than are available on this issue. Although these data do no dictate one particular decision over another, they are are brought to your attention to help focus the public policy debate.
August 18, 1984

University of California
AIDS Behavioral Research Project
4627 17th Street
San Francisco, California 94117
415 731 7468

Mervyn Silverman, MD
Director, Department of Public Health
Room 302
101 Grove Street
San Francisco, California 94102

Dear Mervyn;

I am sending some preliminary results from our May 1984 wave of data collection on gay men's sexual behavior in San Francisco. A more comprehensive report will be forwarded to you in September. I hope these data are helpful to you in policy decisions or discussions in the interim. I would appreciate discretion in your use and distribution of this letter.

Here is how I have organized this preliminary report:

I. Analysis of Longitudinal Change in 454 Continuing Respondents
   Table 1. Analysis of Non-participation and Attrition
   Table 2. Changes in Sexual Activity in the Sample

II. Reactions to the Health Department's Proposed Bathhouse Policy
   Table 3. Level of Agreement with the Policy by Sample Group
   Table 4. Changes in Location and Frequency of Sex Partners for the Bathhouse Group
   Table 5. Level of Agreement with the Policy against Numbers of Sexual Partners.

III. Cross sectional Analysis of Health Beliefs and Risk Behavior—May 1984
     Table 6. One-Way Analysis of Variance Across Samples
     Table 7. Multiple Regression: Risk Score
     Table 8. One-way Analysis of Variance Across Risk Groups
I. Longitudinal Change in Continuing Respondents

In November 1983 we surveyed men in four sampling locations: bathhouses, bars, advertising for men who had not used bathhouses and bars, and committed primary relationships (Couple sample drawn May 1983). 655 men from these four groupings responded to the November 1983 questionnaire. Of these men, 557 volunteered to be re-contacted in May 1984 for another measure of their sexual behavior and attitudes. 454 of these volunteers returned the May questionnaire. Because of attrition in the panel sample, it was necessary for us to determine whether there were any significant differences between groups of respondents due to this attrition on data collected in November 1983 which would indicate bias. Table 1 displays comparisons between these longitudinal groupings on demographics, sexual behavior, and numbers of VD infections.

TABLE 1. Analysis of Non-Participation and Panel Attrition

<table>
<thead>
<tr>
<th>Characteristics as of November 1983</th>
<th>All respondents November survey N=655</th>
<th>Volunteers for follow up N=557</th>
<th>Panel Sample N=454</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% #</td>
<td>% #</td>
<td>% #</td>
</tr>
</tbody>
</table>

1. Mode of recruitment

- Bathhouse: 23.1 151 19.9 111 20.3 92
- Bar: 20.4 134 17.2 96 16.4 75
- No Bar/No Bath (advertising): 27.6 181 31.8 177 33.3 151
- Couples: 28.9 189 31.1 173 30.0 136

100.0 655 100.0 557 100.0 454

2. Number of sexual partners in last month

0: 7.5 48 8.2 45 7.9 36
1: 34.9 224 36.7 201 37.7 171
2-5: 37.0 237 36.1 197 35.9 163
6+: 20.6 132 19.0 104 18.5 84

100.0 641 100.0 547 100.0 454

3. Number of times infected with syphilis and/or gonorrhea in last year

0: 73.1 468 73.0 398 74.1 330
1: 15.5 99 16.3 89 15.8 70
2+: 11.4 73 10.7 58 10.1 45

100.0 640 100.0 545 100.0 445
TABLE 1 (contd)

Analysis of Non-Participation and Panel Attrition

<table>
<thead>
<tr>
<th>Characteristics as of November 1983</th>
<th>All respondents November survey N=655</th>
<th>Volunteers for follow up N=557</th>
<th>Panel Sample N=454</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>4. Years of schooling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school grad or less</td>
<td>6.9</td>
<td>44</td>
<td>6.8</td>
</tr>
<tr>
<td>Some College</td>
<td>25.3</td>
<td>162</td>
<td>25.2</td>
</tr>
<tr>
<td>College graduate</td>
<td>33.9</td>
<td>217</td>
<td>34.3</td>
</tr>
<tr>
<td>Post graduate education</td>
<td>33.9</td>
<td>217</td>
<td>33.7</td>
</tr>
<tr>
<td>All cases</td>
<td>100.0</td>
<td>650</td>
<td>100.0</td>
</tr>
</tbody>
</table>

5. Relationship status

| In primary relationship more than 1 year | 37.4   | 244   | 39.5   | 219   | 38.5   | 174   |
| In primary relationship less than one year | 17.4   | 113   | 17.8   | 99    | 18.8   | 85    |
| Not in a primary relationship          | 45.2   | 295   | 42.7   | 237   | 42.7   | 193   |
| All cases                              | 100.0  | 652   | 100.0  | 557   | 100.0  | 452   |

There were no significant differences between conditions for the variables we measured in Table 1, which indicates that our longitudinal sampling procedure was not biased by attrition.

* * *

In our November questionnaire we gathered retrospective data on relationship status and sexual activity in November 1982. Table 2 describes changes in numbers of sexual partners, relationship status, and frequency of specific sexual practices both with primary partners and with secondary or anonymous sexual contacts.
Table 2. Changes in Sexual Activity in the Panel Sample
November 1983 to May 1984
N = 454

<table>
<thead>
<tr>
<th>Sample and Type of Activity</th>
<th>November 1982 (retrospective)</th>
<th>November 1983 (current)</th>
<th>May 1984 (current)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>#</td>
<td>%</td>
</tr>
</tbody>
</table>

A. ALL PANEL RESPONDENTS (N=454)

1. Number of sexual partners last month

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1-5</th>
<th>6+</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6.1</td>
<td>34.2</td>
<td>59.6</td>
</tr>
<tr>
<td>0</td>
<td>27</td>
<td>151</td>
<td>263</td>
</tr>
<tr>
<td>1</td>
<td>8.1</td>
<td>36.4</td>
<td>18.9</td>
</tr>
<tr>
<td>2-5</td>
<td>10.5</td>
<td>162</td>
<td>163</td>
</tr>
<tr>
<td>6+</td>
<td>47</td>
<td>169</td>
<td>173</td>
</tr>
</tbody>
</table>

2. Relationship status

<table>
<thead>
<tr>
<th></th>
<th>In primary rel, r. monogamous</th>
<th>In primary rel, r. non monogamous</th>
<th>Not in primary rel</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>26.1</td>
<td>116</td>
<td>24.6</td>
</tr>
<tr>
<td></td>
<td>290</td>
<td></td>
<td>137</td>
</tr>
</tbody>
</table>

3. Number of prodromal symptoms

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1-2</th>
<th>3-5</th>
<th>6+</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>67.3</td>
<td>27.7</td>
<td>5.0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>304</td>
<td>125</td>
<td>23</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>66.4</td>
<td>28.7</td>
<td>4.0</td>
<td>0.9</td>
</tr>
<tr>
<td></td>
<td>299</td>
<td>129</td>
<td>18</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>100.0</th>
<th>100.0</th>
<th>100.0</th>
<th>100.0</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>452</td>
<td>450</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
TABLE 2 (contd)

| Sample and Type of Activity | Reference Period | | |
|-----------------------------|------------------|---|---|---|
|                             | %     | #    | %     | #    | %     | #    |
| B. PERSONS IN RELATIONSHIP IN NOV83 and MAY84 |
| N= 225 |
| 1. Number of times had sex with person other than primary partner in last month |
| 0   | 42.4  | 87   | 48.8  | 106  | 50.9  | 114  |
| 1   | 15.6  | 32   | 12.4  | 27   | 10.7  | 24   |
| 2-5 | 22.4  | 46   | 26.2  | 57   | 26.8  | 60   |
| 6+  | 19.6  | 40   | 12.6  | 27   | 11.6  | 26   |
| All cases | 100.0 | 215  | 100.0 | 217  | 100.0 | 224  |
| Average # | 3.5   | 2.1  | 2.0   |
| 2. Number of times had sex with primary partner in last month |
| 0   | 9.0   | 19   | 8.0   | 18   | 12.1  | 27   |
| 1   | 2.8   | 6    | 3.1   | 7    | 4.0   | 9    |
| 2-5 | 23.1  | 49   | 29.9  | 67   | 27.3  | 61   |
| 6-10 | 33.0  | 70   | 28.1  | 63   | 31.4  | 70   |
| 11+ | 31.1  | 68   | 30.9  | 69   | 25.2  | 56   |
| All cases | 100.0 | 212  | 100.0 | 224  | 100.0 | 223  |
| Average # | 10.8  | 9.7  | 8.5   |
| 3. Average number of times within last month with primary partner respondent did: |
| Receptive anal intercourse w/o condom | 3.3  | 2.6  | 2.2  |
| Active rimming | 1.8  | 1.1  | 1.2  |
| Swallow semen  | 4.4  | 3.2  | 2.5  |
| Mutual Masturbation | 4.4  | 5.0  | 4.7  |
### TABLE 2 (contd)

<table>
<thead>
<tr>
<th>Sample and Type of Activity</th>
<th>Reference Period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>November 1982</td>
</tr>
<tr>
<td></td>
<td>(retrospective)</td>
</tr>
<tr>
<td></td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>#</td>
</tr>
<tr>
<td>C. PERSONS WHO WERE NOT IN RELATIONSHIPS OR HAD SEX OUTSIDE A RELATIONSHIP IN BOTH NOV83 AND MAY84</td>
<td></td>
</tr>
<tr>
<td>N= 288</td>
<td></td>
</tr>
<tr>
<td>1. Total number of partners last month</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>8.2</td>
</tr>
<tr>
<td>1</td>
<td>17.8</td>
</tr>
<tr>
<td>2-5</td>
<td>37.0</td>
</tr>
<tr>
<td>6+</td>
<td>37.0</td>
</tr>
<tr>
<td>All cases</td>
<td>100.0</td>
</tr>
<tr>
<td>Total Average #</td>
<td>6.3</td>
</tr>
<tr>
<td>2. Average number of partners known from before</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.6</td>
</tr>
<tr>
<td>3. Average number of times last month respondent engaged in new or secondary partners:</td>
<td></td>
</tr>
<tr>
<td>Receptive anal intercourse without condom</td>
<td>1.9</td>
</tr>
<tr>
<td>Active rimming</td>
<td>1.1</td>
</tr>
<tr>
<td>Swallowing semen</td>
<td>2.8</td>
</tr>
<tr>
<td>Mutual masturbation</td>
<td>2.5</td>
</tr>
<tr>
<td>4. Number of times respondent went to a bathhouse</td>
<td>2.4</td>
</tr>
<tr>
<td>Number of sexual encounters each time (for those who went)</td>
<td>2.1</td>
</tr>
</tbody>
</table>
Table 2 demonstrates that significant changes have occurred in all behaviors considered to be high risk over the past 1 1/2 years. Men are having less sex outside their relationships, less high risk sex inside primary relationships, fewer numbers of sexual partners, and a lower frequency of high risk sex with secondary or anonymous contacts. What is interesting to note is that the total level of sexual activity has diminished, not just specific sexual acts. Although mutual masturbation, a low risk activity, has remained relatively stable, it has not increased significantly. This suggests that men are less likely to substitute low risk sex for high risk, but may be more likely to inhibit sexual activity altogether, even in primary relationships, in response to the epidemic.

The level of monogamy in existing relationships has remained stable, and the proportion of men in relationships continues to remain relatively the same over time. Although this may be due in part to sampling bias, it indicates that beginning and maintaining a primary relationship has not become an adaptive response to AIDS threat, at least by May 1984.

As expected the level of prodromal symptomatology has increased slightly from November 1983 to May 1984.

Attendance at bathhouses has decreased significantly over the period of measure, as well as numbers of sexual partners encountered in bathhouses. (Note— the mean total of sexual partners drawn from bathhouses for the entire month preceding the May 1984 sampling was .6)

* * *

II. Reactions to the Proposed Department of Health Policy toward Bathhouses

In April 1984, just after Dr. Silverman's announcement of his intention to close the bathhouses, a new sample of subjects was drawn from the three sampling locations: bathhouses, bars, and advertising for men who had not been using bars or baths. The addition of these subjects increased the mailout size of the sample to 1008. 814 subjects returned the questionnaire in time for the data analysis reported here. There were no demographic differences between subjects sampled in May and November in each sampling location that would unduly bias the results of the measures taken.

The overwhelming majority (95.9%) of the May 1984 sample had heard of the proposed policy.
Table 3. Level of Agreement with the Proposed Policy by Sample Group.

<table>
<thead>
<tr>
<th>Sample Group</th>
<th>Bath</th>
<th>Bar</th>
<th>No Bath or Bar</th>
<th>Couple</th>
<th>Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Men</td>
<td>196</td>
<td>269</td>
<td>205</td>
<td>144</td>
<td>814</td>
</tr>
<tr>
<td>Do you agree with the proposed bathhouse policy?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree</td>
<td>16%</td>
<td>28%</td>
<td>27%</td>
<td>24%</td>
<td>24%</td>
</tr>
<tr>
<td>Neither Agree nor Disagree</td>
<td>16%</td>
<td>18%</td>
<td>15%</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Disagree</td>
<td>68</td>
<td>54</td>
<td>58</td>
<td>59</td>
<td>59</td>
</tr>
<tr>
<td>The policy has influenced the respondent's behavior?</td>
<td>36%</td>
<td>18%</td>
<td>12%</td>
<td>8%</td>
<td>19%</td>
</tr>
</tbody>
</table>

As expected, disagreement with the policy is highest in the bath group, but marked across groups.

Most men who disagreed with the city policy cited civil rights rationales for their opposition. Interestingly, some men from the bar group opposed bathhouse alteration because they feared bathhouse goers would shift their sexual activity to the bars and increase perceived risk. Many who disagreed with the policy were not engaged in sex in bathhouses but disagreed on principle.

When asked to explain changes in behavior, respondents provided these reasons:

- Decreases in sexual activity--
  - Have limited partners to one or two;
  - The proposed policy has forced closure of their favorite club;
  - Have shifted to video release of anonymous fantasies;
  - Policy has induced fear about possible AIDS transmission at bathhouses;
  - Policy has induced guilt about use of these facilities;
  - Saw the need for external controls because he could not stop himself from bathhouse activity;
  - Became aware that someone else is concerned about the need for health and appreciated the inducement to reduce high risk activity;
  - Stopped going to bathhouses when diagnosed with AIDS;
  - Since many attractive men have stopped going to the bathhouses, the respondent is less excited about going;
  - Used the inducement to seek more intimate relationships.
No changes—
Have shifted to bookstores or peep shows;
Doesn't believe that the policy will make any difference
in his risk level;
Has always been careful in his anonymous sexual
activity and doesn't feel the need for monitoring;
Argues that bathhouses provide cleaner sexual outlet than parks
or bookstores;
Already felt compelled to reduce sexual activity
before the epidemic became apparent;
Argument that the activity is more essential than the place
one engages in it.

Increase in sexual activity—
Angry reaction against governmental restriction.

* * *

Table 5 depicts the changes in frequency and location
of sexual partners for those men from the bath group who responded
to both the November 1983 and May 1984 questionnaires.

Table 5. Bathhouse Group--Frequency and Location of Sexual Partners
Last Month (N=92)

Mean Number of Sexual Partners

<table>
<thead>
<tr>
<th>Place of Sexual Activity</th>
<th>November 1982</th>
<th>November 1983</th>
<th>May 1984</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Partners</td>
<td>8.6</td>
<td>7.8</td>
<td>5.9</td>
</tr>
<tr>
<td>Men Known From Before</td>
<td>1.5</td>
<td>1.6</td>
<td>1.7</td>
</tr>
<tr>
<td>(boyfriends buddies, etc)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Times</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>went to a Bathhouse</td>
<td>(4.0)</td>
<td>(3.4)</td>
<td>(1.5)</td>
</tr>
<tr>
<td>Number of sexual</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>contacts from bathhouse</td>
<td>3.0</td>
<td>2.5</td>
<td>1.9</td>
</tr>
<tr>
<td>--------------------------</td>
<td>---------------</td>
<td>---------------</td>
<td>----------</td>
</tr>
<tr>
<td>Number from</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bookstore, sex club</td>
<td>1.5</td>
<td>1.2</td>
<td>.6</td>
</tr>
<tr>
<td>Park</td>
<td></td>
<td></td>
<td>.7 1.6</td>
</tr>
<tr>
<td>T-room</td>
<td></td>
<td></td>
<td>.3</td>
</tr>
<tr>
<td>Bar or Dance Club</td>
<td>.9</td>
<td>.9</td>
<td>.5</td>
</tr>
<tr>
<td>Other Place</td>
<td>.7</td>
<td>.6</td>
<td>.8</td>
</tr>
<tr>
<td>--------------------------</td>
<td>---------------</td>
<td>---------------</td>
<td>----------</td>
</tr>
</tbody>
</table>

================================================================================================
Table 4 indicates that some shifts may have occurred in place of sexual activity for bathhouse users although the total number of sexual contacts has decreased for these men. A slight increase in use of parks and other locations is demonstrated by the table.

* * *

Table 5. Cross Tabulation of Level of Agreement with Proposed Department of Health Policy against Total Number of Sexual Partners
Previous Month—May 1984 N=814

<table>
<thead>
<tr>
<th>Percent of Respondents who:</th>
<th>0</th>
<th>1 or monogamous</th>
<th>2-5</th>
<th>6+</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGREE</td>
<td>37</td>
<td>30</td>
<td>20</td>
<td>17</td>
</tr>
<tr>
<td>HAVE NO OPINION</td>
<td>17</td>
<td>18</td>
<td>17</td>
<td>11</td>
</tr>
<tr>
<td>DISAGREE</td>
<td>46</td>
<td>52</td>
<td>63</td>
<td>72</td>
</tr>
<tr>
<td>All cases</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

p < .01  x² = 24.2  df = 6

Table 5 demonstrates that those who disagree with the proposed city policy are more likely to have greater numbers of sexual partners per month. No significant relationship was found between level of agreement with the policy and number of times the respondent engaged in mutual masturbation, anal intercourse receptive without condom, or swallowing semen with secondary or anonymous partners. However, those who perform rimming active with secondary partners were significantly more likely to disagree with the policy.

III. Analysis of Health Beliefs and AIDS Risk Reduction (May 1984)

In order to assist with AIDS prevention efforts, we have developed a model to be used in AIDS education efforts. The model addresses psychological variables that may play an important part in determining whether or not a person engages in lower risk behavior. The model has the following points:

1) Perceived Threat: A belief that one is potentially at risk of exposure to AIDS, coupled with a firm belief that this is an outcome to be feared.
   (Example: "I am fearful of getting AIDS.")
2) Response Efficacy: A belief that AIDS can be avoided by taking specific protective actions.  
(Example: "AIDS can be prevented.")

3) Personal Efficacy: A belief that one is capable of taking recommended action that would lessen the risk of exposure to AIDS.  
(Example: "I am able to refrain from having anonymous sex.")

4) Skills Attainment: Social contracting skills necessary to negotiate low-risk sexual behaviors.  
(Example: "I am comfortable discussing sexual limits with a potential partner.")

(Example: "I am likely to get a lot of support from others for being cautious about sexual behavior.")

Four questionnaire items were developed to assess each of the five variables. In addition, a measure of self esteem was administered (Rosenburg, 1965). A measure of agreement with specific health guidelines (ie "that swallowing semen is a high risk activity") was also placed in the questionnaire. Statistical analysis was then performed to see the extent to which each of these constructs were related to an individual's overall sexual risk behavior.

Risk Score--To determine level of risk, the recommendations of medical experts at the UCSF AIDS Symposium were used, which rated sexual behavior into four levels of risk. Although the assigned level of risk was expected to change with additional scientific data, the consensus of these experts represented thinking with regards to AIDS transmission at that time. Risk levels were assigned to behaviors based on their probable risk of disease transmission:

3 points-- Documented High Risk
anal intercourse without a condom
fisting

2 points-- Suspected High Risk
rimming
swallowing semen
insertion of objects into rectum

1 point-- Unknown Levels of Risk
wet kissing
fellatio without swallowing semen
drinking urine
insertion of finger into rectum

0 point-- Probable Safe
dry kissing
mutual masturbation
massage
frottage
cuddling

Each of the above values was multiplied with the number of times the individual reported doing this behavior in the past month with new or secondary partners. The sum represents the individual's risk score. Although not completely without risk, those men who were monogamous or celibate the previous month were assigned a zero risk score.
The four subgroups varied considerably on risk score and on perceived threat and response efficacy, as shown in Table 6.

Table 6. Comparison of Sample Groupings on Health Belief and Risk
May 1984 N=824

<table>
<thead>
<tr>
<th></th>
<th>Bath (N=189)</th>
<th>Bar (N=262)</th>
<th>No Bath (N=208)</th>
<th>No Bar (N=155)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceived Threat*</td>
<td>15.7</td>
<td>16.9</td>
<td>17.6</td>
<td>17.4</td>
</tr>
<tr>
<td>Response Efficacy</td>
<td>18.7</td>
<td>18.3</td>
<td>18.7</td>
<td>18.7</td>
</tr>
<tr>
<td>Personal Efficacy*</td>
<td>17.2</td>
<td>17.4</td>
<td>20.1</td>
<td>19.3</td>
</tr>
<tr>
<td>Skills Attainment</td>
<td>19.7</td>
<td>18.9</td>
<td>20.1</td>
<td>20.2</td>
</tr>
<tr>
<td>Peer Support</td>
<td>19.4</td>
<td>19.1</td>
<td>18.8</td>
<td>20.1</td>
</tr>
<tr>
<td>Self Esteem*</td>
<td>24.5</td>
<td>24.7</td>
<td>23.7</td>
<td>25.5</td>
</tr>
<tr>
<td>Health Guidelines</td>
<td>25.1</td>
<td>25.6</td>
<td>25.8</td>
<td>25.7</td>
</tr>
<tr>
<td>Risk Score*</td>
<td>24.8</td>
<td>20.6</td>
<td>8.5</td>
<td>11.5</td>
</tr>
</tbody>
</table>

*p, .001

In terms of overall risk the bath sample continued to be considerably higher than the other groups. The no bar/no bath group was by far the lowest in terms of their risk score.

Perceived threat differed significantly across groups. The lowest perceived threat was in the bath group. The bath and bar groups were lower in personal efficacy than the other two groups. The couples group was higher in self esteem than the other groups.
To further understand which aspects of health belief and self esteem most strongly predicts lowering risk, a regression was performed on risk score. This is shown in Table 7.

Table 7. Risk Score, as Predicted by Aspects of Health Belief and Self Esteem  May 1984
N= 824

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Multiple R</th>
<th>F Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Efficacy</td>
<td>.35</td>
<td>84.08**</td>
</tr>
<tr>
<td>Health Guidelines</td>
<td>.38</td>
<td>11.55*</td>
</tr>
<tr>
<td>Self Esteem</td>
<td>.39</td>
<td>4.03</td>
</tr>
<tr>
<td>Peer Support</td>
<td>.39</td>
<td>1.03</td>
</tr>
<tr>
<td>Perceived Threat</td>
<td>.39</td>
<td>.90</td>
</tr>
<tr>
<td>Skills Attainment</td>
<td>.39</td>
<td>.01</td>
</tr>
<tr>
<td>Response Efficacy</td>
<td>.39</td>
<td>.01</td>
</tr>
</tbody>
</table>

* p,.05  ** p,.01

As can be seen from the table above, personal efficacy and strength of belief in health guidelines accounted for most of the variance of risk score.

* * *

The respondents were then divided into three groups according to their risk scores:

Low Risk
- Monogamous = 166
- Celibate = 75
- Totally safe sex = 30
- N =271

Moderate Risk
- (Risk score less than median) =258

High Risk
- (Risk score greater than median) =257
Table 8. Comparison of Three Risk Groups on Health Beliefs and Self Esteem  
N = 786

<table>
<thead>
<tr>
<th></th>
<th>Low Risk N=271</th>
<th>Moderate Risk N=258</th>
<th>High Risk N=257</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceived Threat</td>
<td>16.3</td>
<td>17.4</td>
<td>16.5</td>
</tr>
<tr>
<td>Response Efficacy*</td>
<td>18.9</td>
<td>18.8</td>
<td>18.0</td>
</tr>
<tr>
<td>Personal Efficacy**</td>
<td>16.6</td>
<td>14.9</td>
<td>12.5</td>
</tr>
<tr>
<td>Skills Attainment**</td>
<td>20.5</td>
<td>19.5</td>
<td>18.9</td>
</tr>
<tr>
<td>Peer Support</td>
<td>19.4</td>
<td>19.2</td>
<td>19.3</td>
</tr>
<tr>
<td>Self Esteem</td>
<td>24.4</td>
<td>25.0</td>
<td>24.4</td>
</tr>
<tr>
<td>Health Guidelines</td>
<td>25.7</td>
<td>26.0</td>
<td>25.1</td>
</tr>
</tbody>
</table>

*p, .05  **p, .01

Again, personal efficacy was shown to differ significantly among risk groups with greater personal efficacy associated with lower risk. Skills attainment was also found to be significantly related to lower risk.

Looking at specific questionnaire items, the low risk group was the most likely to believe that saliva can transmit AIDS and that someone could be capable of transmitting AIDS while appearing very healthy. The moderate risk group was most likely to endorse health guidelines such as the belief that people should reduce the number of partners, avoid fisting, and use condoms. The moderate risk group was the most likely to be satisfied with their sex life. The high risk group was the most likely to believe that one can relax about risk reduction because a vaccine will be available soon, and that they had already been exposed to AIDS and had successfully fought it off. This group was also the most fearful that they could transmit AIDS.

Across the risk groups a correlation was found between risk reduction and a belief that life has changed and we have to adjust to AIDS. There was also high agreement with a statement that AIDS can be transmitted in one sexual contact, which was also correlated with lower risk.

These data could be useful in understanding what aspects of gay men's psychology and health belief are most relevant to risk reduction and those aspects which still need targetting by primary and secondary prevention efforts.

*I hope this is helpful*