

# the good health guys



A12

THE NEW

## Deadly Virus Is Identified in Outbreak

By LAWRENCE K. ALTMAN

Scientists have found preliminary evidence that the Ebola virus, one of the deadliest infectious agents known, is the cause of a mysterious disease that has broken out in Zaire, officials of the World Health Organization and the United States Centers for Disease Control and Prevention said last night.

The disease has killed at least 50 people in Zaire, and health officials fear that panic may be making the situation there worse. Perhaps as many as 200 patients, doctors, nurses and other health care workers

diseases in developed countries. A major reason for the spread in poorer countries appears to be that hospitals often lack adequate supplies of sterile needles and syringes, making their reuse necessary. In addition, doctors and nurses may not always obey two cardinal principles of medicine: washing their hands and using aseptic techniques, because clean water is not always available.

Federal and international health officials said the risk of the spread of the Ebola virus outside of Zaire from the current outbreak was very small. Nevertheless,

They work at the Harvard School of Public Health, and they are determined to eradicate disease from the planet. It may sound crazy, but they think they've got a shot at it.

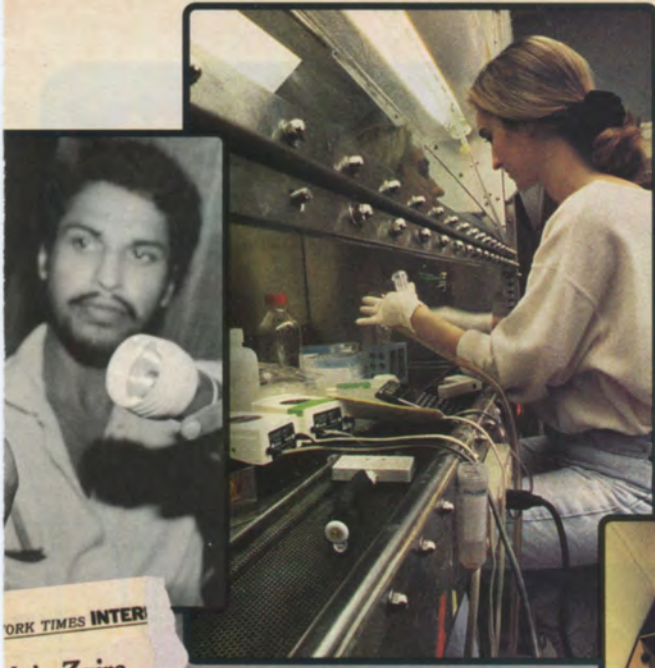
by John Sedgwick

**O**n Huntington Avenue, on the far edge of Boston's prestigious medical district, a narrow high-rise looms over the pizza shops and grimy public-housing complexes of the Mission Hill District. This is the Harvard School of Public Health (HSPH). No patients come here, but the building houses plenty of disease all the same: Samples are stored in freezers or incubated in laboratory animals or recorded on vast computer databases. There are no patients because public health provides no cures. It is like an immune system that operates outside the body. It seeks to eradicate diseases altogether—to rip them out of the landscape by the roots—before they can do us harm. And in this, the HSPH

has had considerable success: Its researchers were the first to formulate a vaccine for polio and to identify the hazards of secondhand smoke, among other things.

If you've never heard of public health or would have trouble defining the term, you're not alone. The reason owes a lot to those other doctors, the individual M.D.'s whose skills are celebrated year in and year out on television shows from *Dr. Kildare* and *Marcus Welby, M.D.* of the Sixties and Seventies to this season's *ER* and *Chicago Hope*. These are the so-called "real" doctors. As they transplant hearts, save half-pound premature babies and remove brain tumors, they seem to defeat, at least temporarily, death itself. They are as American as cowboys and private eyes.

photographs by Ken Schles



Clockwise from far left: Man used as bait to attract malaria-carrying mosquitoes in Kuala Lumpur; AIDS research at the HSPH; signs for decontamination stations; Andrew Spielman with one of his disease-spreading bugs; the Ebola virus; CDC scientists in full protective gear; oddly beautiful mold cultures; warning sign.



**NEW YORK TIMES INTERVIEW**  
**Man in Zaire**  
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PHOTOGRAPHS: TOP LEFT, AP/WIDEWORLD; CENTER RIGHT, SCOTT CAMAZINE/PHOTORESEARCHERS; BOTTOM RIGHT, AP/WIDEWORLD

Public health, on the other hand, is as un-American as socialism, which it somewhat resembles. To understand it, you have to turn your mind inside out, for public health derives much of its meaning—and its motivation—from its dissimilarity to what may be thought of as the “private” health of current medical practice. Private health takes on one patient at a time, works for a cure and is high-tech, expensive and inclined to bestow its greatest favors on the rich. Public health, by contrast, handles entire populations, focuses on prevention and is low-tech, cheap and sympathetic to the poor. Its heroes—Jonas Salk, Albert Schweitzer—are not the stuff of TV melodrama, but of history.

Perhaps the best way to grasp the public health enterprise as it is presently conducted is to take the elevator to the ninth floor

of the HSPH, one of the best of the 27 public health graduate schools in the United States. The students here are drawn from around the world, and their work reaches from one extreme of life to the other, from tiny microorganisms to vast populations of human beings. Theirs is a career that combines low pay, long hours and high risk.

The cinder-block corridors at the HSPH are lined with metal doors emblazoned with triangular biohazard warning signs. At regular intervals, showerheads protrude from the ceiling and emergency eyewash stations poke out from the walls, looking like drinking fountains with inverted spigots. Should a scientist accidentally be contaminated with one of the deadly organisms that are being studied behind all these closed doors, his first

## what public health scientists are fighting

Old infectious diseases like malaria and tuberculosis are taking on new, antibiotic-resistant forms at the same time that emerging viruses like HIV and Ebola are wreaking havoc. Here, some of the more dangerous bugs and the hot spots where they are thriving.

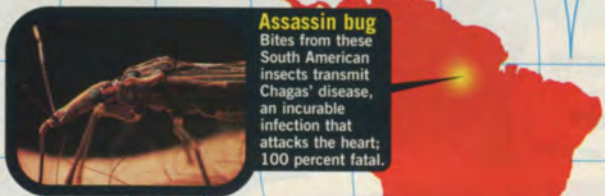
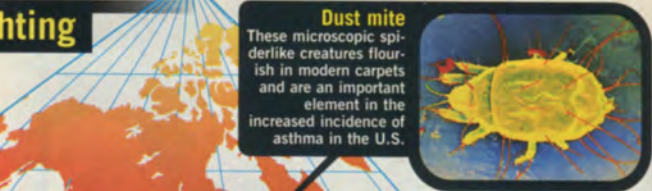
move would be to hit the showers—fast.

The door to Andrew Spielman, Sc.D.'s office is usually open. He is a scientist and a professor of tropical public health, and his lab is an ominous reminder of the power of tiny organisms to produce horrendous diseases. In a small plastic box sit the dried husks of some assassin bugs from South America. They deliver Chagas' disease, an incurable infection that invades and eventually stops the victim's heart. Drifting about inside another case are sandflies that cause a gruesome skin disease called leishmaniasis. Clouding a third container are the wispy *Aedes aegypti* mosquitoes that carry yellow fever and dengue, otherwise known as breakbone fever. But Dr. Spielman's prized possession is fluttering about inside a netted box: the feathery *Anopheles* mosquito, carrier of the malarial parasite plasmodium. Malaria is a dreadful illness. It produces such powerful chills that a patient's shivering can move his bed across the floor; then come raging fever, burning thirst and drenching sweats. "Malaria and hemorrhage are two things that get a doctor to run," says Spielman. Now 65, he has spent much of his life working to contain the spread of malaria, not that it poses much of a threat in Boston. Yet.

The idea of contracting malaria is about as likely to pop into the head of most Americans as the notion of getting elephantiasis, another Spielman interest. But malaria is currently the most rapacious of all the infectious diseases, far outpacing AIDS; it kills 2 million people a year worldwide. Nearly eradicated in the Sixties, it has over the past few years returned with a vengeance. Indeed, in one of the paradoxes that make public health so challenging, malaria is dangerous now precisely because it was nearly eradicated. The parasite and the mosquitoes that spread it have outfoxed health officials by developing a resistance to most of the chemicals we use to control them. Now we are running out of chemicals, and many parts of the world are almost defenseless against the disease.

In Sri Lanka, for example, the annual number of cases went from approximately 1 million in the early Fifties down to exactly 18 in 1963, back to half a million last year, and it is growing uncontrollably. Africa is also a "big problem," says Spielman, as is the Indian subcontinent; Papua, New Guinea; Indonesia; and South and Central America. Spielman is working on projects in many of these places: along the border between Thailand and Cambodia, where a rapidly increasing concentration of immigrants drawn by jobs in the gem mines has produced the most frightening outbreak of malaria on the planet; in Chad, where an Exxon project has had to evacuate half of its workers due to malaria every year; and along the Amazon, where the primitive Yanomami Indians—"you see them walking around with poisoned arrows"—are being overwhelmed by the disease.

To most people, such places may seem remote. To public health professionals, they are all part of an extended here. Infectious diseases have a way of overlooking national bound-

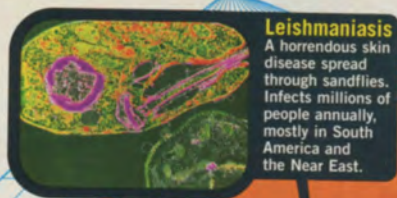


aries, especially now that everywhere is just a day's plane ride away from anywhere. And some of the most troublesome diseases have developed antibiotic-resistant strains. There are new bugs for malaria, tuberculosis, gonorrhea, pneumonia and staph infections (including the so-called flesh-eating bacteria that appear sporadically in the U.S.). Add the threat of HIV and such emerging viruses as Marburg and Ebola, which erupted so terrifyingly in Zaire in April, and anyone can see the value of the worldwide monitoring that only public health can provide. We are all in the hot zone now.

**a**t heart, public health is a medical version of the Strategic Defense Initiative: a network of sentries constantly on the lookout for hazards to our health, ever ready to zap the next plague before it gets us. The methods and scope may have changed, but the essential impulse of public health has remained the same for the past 150 years. The enterprise grew out of the sanitation movement of the mid-nineteenth century, and it still betrays a powerful urge to cleanse.

The Marine Hospital Service, the forerunner of today's Public Health Service, brought a military fervor to the public health mission in 1798. Its officers actually wore military uniforms—as the Surgeon General of the U.S. still does—to convey the full authority of the state in battling outbreaks of cholera, smallpox and even bubonic plague. If anything,

## Emerging viruses like Ebola get the headlines with their hit-and-run attacks, but malaria remains the deadliest plague.



**Leishmaniasis**  
A horrendous skin disease spread through sandflies. Infects millions of people annually, mostly in South America and the Near East.



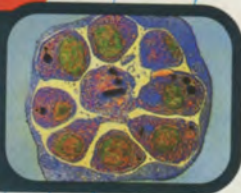
**Hantavirus**  
Spread in rodent feces; infects 100,000 people a year in China. A recent outbreak in the U.S. caused a rash of deaths. U.S. strain 50 percent fatal.



**Ebola**  
Among the deadliest of the emerging viruses, it kills 80 percent of those infected within days. Three known outbreaks occurred in the past two decades, all in Africa.



**HIV**  
The virus that causes AIDS currently infects 119 million people around the world. It is spreading at the rate of 31 million cases per year; 100 percent fatal.



**Malaria**  
Spread by the *Anopheles* mosquito. Antibiotic-resistant strains and insecticide-resistant mosquitoes make it the most dangerous infectious disease today. Kills 2 million people annually.

public health has merely broadened its conception of filth since then to include such modern contaminants as radioactivity, air pollution, toxic chemicals and self-destructive behavior.

With the development of bacteriology near the turn of the century, however, public health ventured perilously close to terrain that, in the U.S. at least, had always been the preserve of private enterprise. It began to organize free dispensaries—clinics, really—in poor neighborhoods, where vaccines and serums were distributed to prevent the spread of such previously uncontrollable diseases as tuberculosis, smallpox and diphtheria. And it pushed for regulations requiring private practitioners to notify local health boards when a patient was carrying an infectious disease, something that doctors had always viewed as privileged information. Because of these efforts, the death toll from most infectious diseases started to fall in the early part of this century.

Now that noninfectious conditions like heart disease and cancer have taken over as the country's leading killers, public health has gone on to promote behavioral changes that can reduce mortality rates—changes in the way we eat, for instance, and whether we smoke. But the underlying tensions between public and private health remain, as demonstrated by last year's debate over President Clinton's health bill and the threats from the new Republican majority to cut back on the power of the Food and Drug Administration to regulate business. Public health might be considered a victim of its own success. It is everywhere in our lives, but it is nowhere, too.

Although public health has generally thrived on the near metaphysics of statistical analysis as a means of detecting modern-day perils, Harriet A. Burge, Ph.D., is a medical detective from the old school of microbe hunters. She explores the world with her five senses. Right now, in a little office made homey with a throw rug, she is immersed in a study of childhood asthma, another disease on the rise. Between 1980 and 1987, the number of children under 20 years of age with asthma increased from 35 per 1,000 to 50 per 1,000, and between 1979 and 1992, asthma-related deaths for all ages doubled, to 5,000 a year (see "Waiting to Exhale," SELF, June 1995). What has happened? "The indoor climate has changed," says Dr. Burge matter-of-factly. Shoddy construction and congested living arrangements, especially in poor neighborhoods, have exposed residents to molds, mildew, cockroaches and dust mites that may well contribute to the disease.

Private homes are a bigger problem than workplaces largely because so many of them are exposed on all sides to potentially irritating, spore-laden outdoor air. They also tend to be poorly insulated, allowing various molds to form on cool, damp walls and ceilings. And wall-to-wall carpeting—a fixture in private houses since the invention of the vacuum cleaner—makes a perfect nest for dust mites. These microscopic spiderlike creatures settle in to munch on the scales of dried skin that the human residents shed at the astounding rate of 5 million per minute. Burge finds it ironic that many Americans (continued on page 140)

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scrub down their kitchen counters nightly but leave their carpets unvacuumed for weeks. "Germs are much more likely to survive in the carpet than on the kitchen counter," she says.

Working with a professor at Harvard Medical School who shares her passion for public health, Burge will be testing the environmental hypothesis for the rise in asthma. A team of researchers will visit 500 greater Boston households in which there are babies who have at least one parent with asthma or allergies. The researchers will take samples of the air and household dust to identify any allergens. Eventually they'll be able to correlate what they find with the development of asthma in the newborns.

The air and dust samples are being examined at the School of Public Health in a brand new laboratory that Burge calls her playroom. It is filled with oddly shaped paraphernalia. There are a few petri dishes on the counter in which the researchers are growing whatever spores are in the air samples they've collected. The spores have grown like bread mold: They might be powder puffs inside clear-plastic compacts, some olive, some deep blue, some chalk white. Hazardous to our respiratory health or not, Burge can't take her eyes off them. "Pretty, aren't they?" she says.

**W**hen public health experts seize on a pathogen, they want to eliminate it, to suck it out of the world as they did smallpox, a once-terrifying disease that was brought to heel in 1796 when Edward Jenner, M.D., developed a vaccine against it. (The very last case of smallpox occurred in 1977, and the last specimens of the virus itself are kept in high-security containment centers in Russia and the U.S. while governments and scientists decide whether they should be destroyed.) Spielman's malaria research, then, isn't about curing patients; it's about controlling the *Anopheles* mosquitoes that, like flying hypodermic needles, spread the disease. Burge is concerned about asthmatics, but if her hypothesis is right, she'd press for changes in the building code to keep the spore count down. And when the School of Public Health works on AIDS, it seeks to protect the public from the disease, instead of treating patients after they get it.

That, at least, is what Myron E. Essex, D.V.M., Ph.D., is at work on. In princely quarters that reflect the value of AIDS research to the people who give out grants, surrounded by gaunt African masks he has collected on his many research trips to Africa, Dr. Essex is working on an AIDS vaccine. He was one of the early entrants in the AIDS war; the first to show that a retrovirus (such as HIV) could cause disease, a

laughable idea when it was first proposed in the early Seventies. His current vaccine project is partly based on the discovery he and his longtime associate Tun-Hou Lee, Ph.D., made in 1984 of a protein known as gp 120 on the surface of the virus. This protein has already proved useful as the target for a variety of blood screens, but after more than a decade of effort, there is still no vaccine.

Although Essex believes that a vaccine is now only a year or so away, he cautions that the first version will have limited effectiveness. One reason is that there is not just one HIV, but many. Eight subtypes have been identified, designated A through H, each of them flourishing in a separate part of the world. Even more problematic, HIV also varies from individual to individual. "One of the things that distinguishes HIV is its high rate of genetic variation and mutation," he says. "Believe it or not, the flu virus used to be the reference point for how much a virus can vary. That's why you need a different flu shot each year, because the virus that causes it is different each year. The kind of changes we've seen from year to year with the flu, we see from one individual to the next with HIV." Essex believes the best we can hope for is to find a vaccine that offers some protection, say 20 percent to 40 percent, and then try to build its effectiveness up from there.

The first vaccine is scheduled to be tested in Thailand, which, although it had virtually no AIDS cases until the late 1980s, is experiencing a shocking outbreak of HIV subtype E, which spreads by heterosexual transmission and has now infected about a million people. (Essex fears that the United States could witness a similar explosion of this strain.) He has chosen Thailand for the research precisely because HIV is spreading so rapidly; it provides a lot of virus for study.

Having worked on such a rampant disease for more than 15 years, Essex says he has learned to pace himself. "The pressure is not as oppressive as it was a few years ago, when many of us were thinking that whatever we did that day or that week would make a big difference for the population at large," he says. "We still think that a breakthrough could cut 10, 20, 30 percent off the time a cure or a vaccine might take, but we now know that nothing is going to solve the situation completely next month."

Instead, Essex sees the process as a gradual one. The first round of vaccines and drugs will do some good; later rounds will do more. "My goal is to have a vaccine that is as effective as the hepatitis B vaccine—an 80 to 90 percent protection rate," he says. "That would be a major accomplishment."

**I**n the end, public health is a state of mind, a philosophy, an attitude. It doesn't breed researchers so much as missionaries, and one of the most persuasive at the HSPH is Richard Levins, Ph.D., a Marxist, an ecologist and a complexity theorist whose clairvoy-

ance is so sharp he seems almost holy.

Like all missionaries, Dr. Levins is not universally appreciated, although those who love him, love him dearly. If space were the only measure of his value to the school, he would be in a very sorry position. Books bulge out from bookcases on either side of the narrow walls of his one tiny room and threaten to swallow him. He had more space when he first arrived at Harvard in 1975, but his political beliefs interfered with his grant-getting, and little by little his office was cut back. "I guess you could say that enthusiasm for my work has been erratic," Levins says benignly.

To talk to him is to take a mind-expanding drug. In the course of an hour he discourses on the frightening possibility that the new 10-million-plus-population "megacities" now studing the planet will produce rapacious new viruses, on how a change of one degree in the average global temperature would release vast numbers of "nasty mosquitoes" into the ecosystem, on the effects of international monetary policy on the spread of disease, and on the peculiar fact that there are no diseases exclusive to bears.

"My role is to step back and squint and look for patterns," he says. The patterns that particularly absorb him are the paradoxes that result from Westerners taking a too-limited approach to large problems. "Think of the Green Revolution where you have the anomaly of pesticides producing pests," he says, "or of medical science where antibiotics give us new microbes, or agriculture where flood control only increases flood damage, or governmental policy where economic development ends up worsening poverty."

Public health is certainly not free of such unintended consequences. It was, after all, in the name of public health that the malaria-bearing mosquitoes were attacked with such disastrous results. That was because, Levins argues, the right questions weren't asked. (The biggest one, of course, was simply how would the mosquitoes respond to the pesticide.) But, he points out, public health at least has an appropriately wide-angled perspective—a true world view—on disease. Conventional medicine, by contrast, is much too restricted. "If a doctor suspects a woman has breast cancer, he might ask if the disease runs in her family," Levins says. "But I've never heard a doctor ask what potentially hazardous substances she has been exposed to, what city she grew up in and what chemicals were in the air."

Ultimately, the strength of public health lies in its ability to see the big picture, the vast entanglement of one thing with another. "As a society, we are hooked on the molecular myth, that when you've dealt with the molecules, you know it all," Levins says. "But epidemics are as much social as they are biological. While we are sophisticated at the small level of the laboratory, we are still irrational at the level of the system as a whole. And that's where the problems come

from." A large percentage of illness in society, he believes, stems from the increasingly dense concentrations of people in certain pockets of society—in prisons, old age homes, schools, public-housing high-rises and day-care centers—where the stress of living, combined with the close quarters, encourages disease to spread. At the same time, much of the medical response is dictated by narrow convention. "Medical procedures are not dictated by rates of disease so much as by social practice," he says. "That's why we have more cesareans in America than in Europe. Here, there is a belief system that childbirth is a disease and it needs intervention."

A final advantage of public health, then, may lie simply in its ability to draw in other perspectives to challenge and to enlarge our belief system. Health is not just a matter of medicine; it is a matter of economics, technology, communication, engineering, politics. Nor can it ever again be local. If a disease is deadly, virulent and in Africa, it will inevitably bring its virulence here. That is why, for good health to be achieved the world over, it will originate, at least in part, in Boston, in this cramped tower, and in the graduates it sends forth into the world like missionaries. □

## fashiondetails

**Spa wars Page 42** Robe by Bellora at Ad Hoc, NYC. Bra and panties by Hanro. Mules by Jacques Levine at Lingerie on Lex. Shorts by Keiko. Boots by Merrill. Socks and towels from Lands' End. His sweatpants by Adidas.

**Style news Page 78** White tennis dress, \$50, by Nike. Call 503-671-3939 for stores. White tennis sweater, \$185, by DKNY. At Dillard's in the Midwest. White tennis skirt, \$48.99, by Converse. At Bloomingdale's and Macy's. White tank, \$21, by CK Calvin Klein. Helmet by Giro. Glasses by Oakley.

**The high-energy eating plan Page 92** Yellow shorts by Randy Kemper. Red shorts by Krizia. Cardigan by Russell Bennett. **Page 94** Tank top and vest by Joan Vass. Sweater shorts by Krizia.

**Our rivalries, ourselves Page 104** Left: Sweater by Salvatore Ferragamo. Pants by T et B by Ter et Bantline. Shoes by Adrienne Vittadini. Right: Dress by J. Crew. Shoes by Patrick Cox.

**Play ball Page 107** Pink T-shirt and briefs by Wearable Energy. Orange skirt by Anne Cole of California. **Page 108** Orange T-shirt by Wearable Energy. Shorts by Body Glove. **Page 109** Orange and green T-shirts and orange skirt all by Stephen Sproule. Pink T-shirt by Wearable Energy. Shorts by Body Glove. Green skirt by Anne Cole of California.

**Fall's must-haves Page 120** Black wool knit tank dress, sold in stores with belt and matching cardigan (not shown), \$260, by Adrienne Vittadini. At Lord & Taylor and Dillard's nationwide. T-strap black shoes, \$158, by Anne Klein Footwear. At Neiman Marcus and Nordstrom. Houndstooth pantsuit, \$1,380, by Isaac Mizrahi. Chocolate patent leather loafers by Prada. **Page 122** Black cardigan, \$68, by J. Crew. Call 800-562-0258. Black bra by Donna Karan Intimates. Gray A-line skirt, \$295, by T et B by Ter et Bantline. At Acacia, Beverly Hills; In Toto, Minneapolis. Black leather boots, \$485, by Calvin Klein Footwear. At Neiman Marcus. Graphite-colored cable twinset: short-sleeve crew neck, \$145, cardigan, \$205; both by Ellen Tracy. At Bloomingdale's and Saks Fifth Avenue. Gray pencil pants, \$205, by T et B by Ter et Bantline. At Betsey Bunky Nini, NYC; Knit Wit, Philadelphia. **Page 124** Camel hair robe coat, \$695, by RALPH by Ralph Lauren. At Polo Ralph Lauren. Sacramento, CA, Madison Avenue, NYC; Saks Fifth Avenue. Navy pea coat, \$345, by CK Calvin Klein. At Bloomingdale's and Nordstrom. Black stretch satin boot-leg pants, \$255, by Gemma Kahng. At Saks Fifth Avenue and Neiman Marcus. Black heeled loafers, \$133, by Adrienne Vittadini. At Nordstrom and Bloomingdale's.

## beautydetails

**Editors' choice Page 32** Here's where to find these must-have items: To order a catalog for *Ozone Aware* by Wendy Heather, call 800-293-5985. *Christian Dior's Diorlisse Ridge-Filler for Nails* is available at department stores nationwide. *Princess Marcella Borghese's Active Mud Soap* is available at department stores nationwide. To order *BeneFit's Light Switch or Depth Charge*, call 800-781-2336. *Donna Karan New York's Mist to Go* is available at most major department stores nationwide or call 800-647-7474 to order.

**A guide to specialty sunscreens Page 38** Two other sunscreens designed especially for sensitive skins are *Donna Karan New York's Formula for Facial Moisture SPF 20 Moisturizer* and *Guinot's Total Sunscreen 14 Sun Sensitive Skin*.

**No more zits Page 114** Here are some suggestions for additional help with breakout-prone skin: *Trish McEvoy's Glycolic Cream* moisturizes and exfoliates to clear pores; *L'Oréal's Plénitude Active Daily Moisture Lotion Oilfree* is light and nongreasy; *Lancôme's HydraContrôle Oil-Free Fresh Gel* contains sunscreen and antioxidants.

Salicylic acid is the active ingredient in the following products: *Prescriptives' Rx As Needed Blemish Specialist* also contains lactic acid (an alpha-hydroxy acid); *Exact's New Pore Treatment Gel* unclogs pores and reduces oil buildup; *Yves Rocher's Soin Clarifiant Purifiant Astringent* contains grapefruit extracts (to order, call 800-321-3434); *Repêchage's SR 26 (Sebum Reduction 26)* claims to decrease oil by 26 percent in seven days (to order, call 800-284-5044); *Neutrogena's Oil-Free Acne Wash* soothes skin with aloe and chamomile; *Chanel's Day Lift Plus With SPF 8* smooths and moisturizes without irritating.

If you prefer plant extracts, look for: *Clarins' Blemish Gel* with tea tree oil; *Desert Essence's Blemish Treatment Stick* also contains tea tree oil (available at health food stores); *Hydron's Best Defense Tri-Activating Skin Clarifier* uses green tea and sugarcane extracts (to order, call 800-345-1515); *Physicians Formula's II Oil Control Shine Away Facial Primer* is specifically designed for sensitive skin; *Swisscare for Givenchy's Regulating Mist* has Asian plant extracts; *Paul Mitchell's White Oak Facial Cleanser* contains white oak bark (call 800-321-JPMs for a salon in your area); *Guerlain's Alphabella Renewal Care With AHA* exfoliates with lemon and orange citric acids; *Pond's Age Defying Complex With Alpha Nutrium* contains vitamins and AHAs; *Yves St. Laurent's Gommage mask* is a nonabrasive exfoliator.

For acne-prone complexions, oil-free makeup is a must. Look for: *Lancôme's Maquicontrôle Oil-Free Liquid Makeup*; *Almay's Clear Complexion Light and Perfect Makeup*; *Max Factor's Balancing Act Makeup*; *Cover Girl's Balanced Complexion Liquid Make-Up and Pressed Powder*. Several of these oil-free cosmetics also contain UV protection: *Ultima II's Wonderwear* has SPF 6; *Elizabeth Arden's Flawless Finish Everyday Makeup SPF 10*; *Chanel's Teint Pur Mat Matte Makeup* has SPF 8.

**Haircolor makeover Page 128** There are many shampoos and conditioners available to maintain, enhance and protect color-treated hair. Here are some of the best: *Schwarzkopf's Iqofleur Prescription Color Shampoo* (to order, call 800-234-4672); *Paul Mitchell's Color Infusing Shampoo*; *Aussie Intermixions' Color Enhancing Conditioner*; *ARTec's Color Enhancing Shampoo*; *Claireof's Colorhold Color Refresher*; *Aveda's Pure Plant Shampoo*; *TRESEMME's Color Treated and Permed Conditioner*; *Matrix Essentials' Essential Color Therapy Revitalizing Conditioner*; *L'Oréal's Colorvive Performance Gentle Shampoo and Cream Conditioner*; *Klorane's Henna Shampoo*; *Sebastian's Sheen Instant Conditioner*.

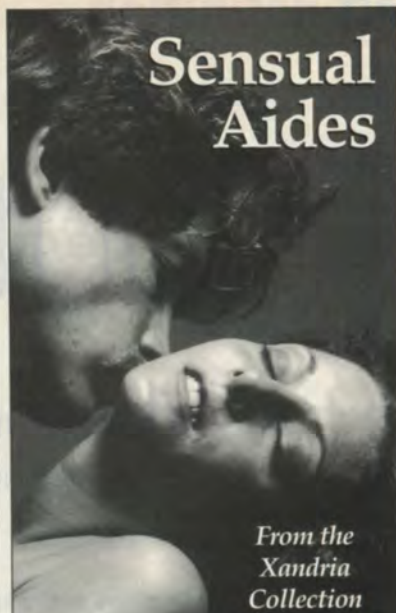
Two more shampoos that effectively remove chlorine without stripping the color are *ABBA's Pure & Natural Hair Care Mollasses Purifier* (to order, call 800-848-4475) and *Chenzo & Co.'s Aqua-Pure De-Chlorinating Pre-Treatment and Shampoo* (to order, call 800-390-1171).

Address all editorial, business and production correspondence to SELF, 350 Madison Avenue, New York, NY 10017.

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