THE OFFICIAL NEWSLETTER OF THE

NATIONAL COALITION OF GAY STD SERVICES

Volume 5 #5 May-June, 1984

 Articles for the Newsletter, or inquiries about membership in the Coalition may be addressed to Mark P. Behar, PA-C, NCGSTDS, PO Box 239, Milwaukee, WI 53201-0239 (414/277-7671). Please credit the NCGSTDS when reprinting items from the Newsletter. We're eager to hear from you! We will try to answer all correspondence! The NCGSTDS is the proud recipient of the National Gay Health Education Foundation's JANE ADDAMS-HOWARD BROWN AWARD, for outstanding effort and achievement in creating a healthier environment for lesbians and gay men, June 12, 1983.

GPA GAY PRESS ASSOCIATION

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* NEXT NEWSLETTER: VOLUME 6:1, *
* AUGUST/SEPTEMBER, 1984 *
* Article Deadline: August 3rd! *
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NCGSTDS ANNUAL MEETING AT NEW YORK NATIONAL LESBIAN/GAY HEALTH CONFERENCE

The NCGSTDS plans to host its annual meeting at the 6th National/1st International Lesbian/Gay Health Conference in New York, Sunday, June 17, 5:15pm - 7:30pm, at Eisner and Lubin Auditorium, Loeb Student Center, 566 LaGuardia Place. Several topics will be discussed: 1) Reports from NCGSTDS members; 2) Current Aspects of Sexually Transmitted Diseases Symposium-III with American Association of Physicians for Human Rights Annual Medical Symposium, August 22-25, at Chicago's Marriott Hotel; 3) NCGSTDS Scenic Elevated Train Ride Party fundraiser in Chicago, August 23; 4) approval of purchase of a computer/word processor; 5) corporate & 501(c)(3) issues; 6) approval of reimbursements; 7) support of the Federation of AIDS Related Organizations; 8) Budget & membership; 9) Guidelines & Recommendations for Healthful Gay Sexual Acitivity--4th Edition brochure; 10) Creation of a Board of Advisors/Directors; 11) Other issues. In order to reach out to more Coalition members, a similar meeting may take place during the CASTDS-III Meeting in Chicago in August. ALL NCGSTDS MEMBERS PLANNING TO ATTEND ARE ASKED TO BRING SAMPLES OF PATIENT EDUCATION & RISK REDUCTION MATERIALS FOR DISTRIBUTION AT THE MEETING, ALONG WITH A WRITTEN REPORT OF THEIR CLINIC'S ACTIVITIES FOR LATER DISTRIBUTION TO MEMBERS! APOLOGIES TO ALL WHO RECEIVED NOTICE OF THIS MEETING TOO LATE TO PLAN TO ATTEND.

GUIDELINES & RECOMMENDATIONS FOR HEALTHFUL GAY SEXUAL ACTIVITY--4TH EDITION AVAILABLE

The NCGSTDS is proud to announce the availability of the 4th edition of the widely acclaimed "Guidelines & Recommendations for Healthful Gay Sexual Activity." A sample of the brochure, along with bulk ordering information is included with this Newsletter. Several changes distinguish the brochure from the 1983 3rd edition. Most noteably (but least important) is the type style and color; their are notable additions addressing lesbian sexual activity; their are factual corrections (e.g., deleting erroneous statement about low yield of oral GC from asymptomatic patients); emphasis of role of condoms & sharing of body secretions in disease (especially AIDS) transmission/acquisition; clarification of the "sexual practices" test & scoring section; and additional information abut health maintenance, self examinations, and confidentiality of medical records, among other things. The Coalition receives a one year guaranteed price quote from its printer for publication of the brochure; although prices have gone up for 1984-85, the increases will be absorbed by the NCGSTDS, and 1983-84 prices will be maintained. Almost 25,000 copies of the 3rd edition of the G&Rs have been distributed by the NCGSTDS, compared to about 15,000 copies of the 2nd edition. Many more brochures custom printed by local gay STD services have been distributed. Let us know what you think of the newly revised 4th edition! As always, constructive criticisms are reviewed for consideration in future revisions. Write: NCGSTDS, PO Box 239, Milwaukee, WI 53201. Contents of the brochure are formally reviewed twice yearly--during the National Lesbian/Gay Health Conference (this year in New York, Monday, June 18, 1984, 9-10:30 am, with Dennis Passer, Richard Berkowitz and Michael Callen as co-panelists in a workshop entitled, "What Is Safe Sex?") and in November, during the American Public Health Association's annual meetings in Anaheim, California. Please join us if you plan to be in New York or Anaheim!

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TRAIN RIDE FUNDRAISER PARTY SPONSORED BY NCGSTDS IN CHICAGO

The NCGSTDS will be sponsoring a "Scenic Elevated Train Ride Party" in Chicago, August 23, 1984, during the Current Aspects of STDs Symposium-III and AAPHR's Annual Medical Symposium. The Train Ride will begin at about 6:30 pm, touring Chicago's beautiful Loop, north and south sides on the elevated mass transit rails of Chicago Transit Authority. Complimentary refreshments with limited open bar (no beer) will facilitate meeting new and old friends during the daytime to nighttime ride. Partygoers are reminded to bring their cameras, because the modern, air conditioned train's routes were selected for their spectacular views of the Chicago skyline. Advance tickets will be $20 donation (after August 3, $25), and may be ordered directly through the NCGSTDS, PO Box 239, Milwaukee, WI 53201, or by marking the approriate box on the enclosed CASTDS-III/AAPHR Final Program & Registration Form. Profits from the Train Ride and CASTDS will help the Coalition purchase a much needed computer/word processor, which will facilitate publication of the Newsletter and expedite membership and other NCGSTDS business. Hope to see you there!!

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CURRENT ASPECTS OF STDs SYMPOSIUM-III & AAPHR MEDICAL SYMPOSIUM, AUGUST 22-24, CHICAGO

Enclosed with this Newsletter is important information about a joint medical symposium cosponsored by the National Coalition of Gay STD Services and the American Association of Physicians for Human Rights. The gray brochure describes activities of the 3 day meeting, which includes a one day basic STD course that focuses on an algorithmic approach to STDs; a two day medical symposium that highlights important gay & lesbian health issues, especially AIDS; general membership meetings of AAPHR (and if there is interest, NCGSTDS; the NCGSTDS annual meeting was previously scheduled for New York, June 17) and a Train Ride Party fundraising event. [See elsewhere in Newsletter for related articles.] We need your support and attendance!! For additional brochures, write: NCGSTDS/CASTDS, PO Box 239, Milwaukee, WI 53201. The Conference will be held in the downtown Chicago Marriott Hotel. Housing & registration information is included with the brochure.

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MS FOUNDATION FUNDS LESBIAN HEALTH CARE SURVEY

with thanks to The Washington Blade

The Ms. Foundation recently awarded $10,000 to the National Gay Health Education Foundation (NGHEF) to fund a survey of lesbian health care in the United States. The 12 month survey is designed to identify where lesbian health services are needed throughout the country, with a large emphasis being given to Third World and working class lesbians, according to Minneapolis' GLC Voice.

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INEXPENSIVE HEPATITIS B VACCINE BEING DEVELOPED

with thanks to Boston's Gay Community Blade

Scientists say they may have discovered a way to develop a hepatitis B vaccine for only a few dollars per patient, as compared to the current cost of about $100 per patient, according to the Washington Post. Researchers at the California Institute of Technology and at the New York Blood Center reported that protein parts that help coat the hepatitis B virus triggered an immune reaction when mixed with the blood of human carriers of the virus. The next step in the research will be to produce a vaccine from artificial protein parts and then test the vaccine on animals and later, on people. If the tests are successful, a new, inexpensive vaccine may be available by 1987.

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SEATTLE GAY CLINIC SPONSORS THIRD "MOONLIGHT ON THE SOUND" FUNDRAISER

Seattle Gay Clinic is proud to announce the 3rd Moonlight on the Sound Boat Cruise Benefit, for Friday, July 6, 1984. Moonlight remains the Clinic's premier fundraising event, and has happily become a Seattle tradition, providing an enjoyable evening for new and old friends to meet, dance, and play amid the spectacular beauty of a midsummer night's cruise on the Puget Sound. This year's cruise will be aboard the newly refurbished Steamship Virginia V, and will hold a maximum of 300 passengers. For more information, contact the Seattle Gay Clinic, PO Box 20066, Seattle, WA 98102.

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CHEAP HEPATITIS B VACCINE AT COLUMBIA U

by Matthew Stadler, New York Native, June 4-17, 1984, with thanks

The health services program at Columbia University has begun offering low-cost vaccinations for hepatitis B. All Columbia students who pay their regular health services fee are eligible for the vaccine for only $30 (costing $100-200 elsewhere) and are entitled to free pre- and post-inoculation screening. Although the program began in April, it has been used by only 20-25 students, so far. Health services program manager & student David Fleiss said that Columbia is the first school to offer subsidized vaccinations as part of the special program. Fleiss said that the vaccine's manufacturers, Merck, Sharp, and Dohme, is interested in helping other schools implement programs similar to Columbia's.

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NONOXYNOL-9 EFFECTIVE AGAINST HERPES, GONORRHEA

Balwant Singh, PhD, from the University of Pittsburgh reported that in in vitro tests with the new contraceptive sponge containing the spermicide, nonoxynol-9, infectious particles of herpes simplex type II and neisseria gonorrhoeae were totally inactivated on exposure. Although well-designed, and well-documented clinical trials are still needed to prove the prophylactic benefits of nonoxynol-9, this is another piece of important evidence demonstating its efficacy. [Reported in Contraceptive Technology Update, March, 1984, p. 32; from a report presented at the American Public Health Association Annual Meeting, Dallas, Nov., 1983.]

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COMPUTER INFORMATION NEEDED

In preparation for the acquisition of a computer system, the NCGSTDS is seeking information from member services & friends about their experiences with computers and specific recommendations about different systems. The Coalition's needs include Newsletter publication & distribution, membership renewals, address labels, membership lists, budgeting & finance, information sharing & "electronic networking," letter writing, updating of the Guidelines brochure. Can you think of other possible uses? Can you recommend any books, magazines, or other resources that may facilitate the understanding of computerize to a relative novice? (My first & only computer course taught Fortran 4 about 15 years ago! They're teaching Fortran 77 now!!) Thanks to those of you who already have written with suggestions. But we need more input, especially from those member services using computers. Thanks!
Write: NCGSTDS, PO Box 239, Milwaukee, WI 53201

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ALCOHOLISM & SUBSTANCE ABUSE AMONG GAY/LESBIAN CLIENTELE: ISSUES FOR STD WORKERS

The NCGSTDS is cooperating with members of the National Association of Lesbian/Gay Alcoholism Professionals (NALGAP) to provide ongoing articles about alcoholism and substance abuse problems in gay people, and how STD workers (who frequently are the first contacts with health professionals that gay/lesbian clients may have) may learn how to recognize the problem and learn how to intervene. These articles provide only a framework that requires additional and direct assistance of preferably NALGAP and gay/lesbian Alcoholics Anonymous & Alanon members for guidance, consultation, and staff sensitivity training and inservices. Although the articles may specify "alcohol/alcoholism," you are free to generalize to all substance abuse and addictive behaviors. Your comments and input are important--please share them with us and your local gay STD clinic/service! NALGAP's address is: 204 West 20th St., New York, NY 10011 (212/807-0634); your membership there will be beneficial! Our series of articles begins with the January, 1984 issue of the Newsletter (volume 5:3), and continued in the March/April issue (vol. 5:4). Due to limited time and space, we reproduce only two articles in this issue. Watch for additional articles in future Newsletters! If you'd like to help write an article, or saw one of especial interest, send it to us: PO Box 239, Milwaukee 53201.

GAY ALCOHOLISM: "THE SLEDGEHAMMER APPROACH" AND THE "YOU DON'T CARE" RESPONSE

by Tom M. Smith, MD, with many thanks

The "Sledgehammer Approach" is the direct confrontation of the alcoholic with some probable outcomes of their life if change is not made. Examples: "You're headed for skidrow;" "You look like hell (awful, a mess);" "Your life is unmanageable." The confrontation may be harsh or given softly, however, the desired effect is that the alcoholic is knocked out (actually awakened from) his denial. The sledgehammer technique, even when fully accepted by the alcoholic, is met with some anger, which may be expressed openly, as "You are a shit counselor," or indirectly with mild or no irritation at the time of the confrontation, but great anger expressed about the counselor later after the session to friends, or as a resentful memory while drinking. The counselor must previously have come to grips with the fact that not all counseling will be seen as positive and friendly, and that success sometimes means that the alcoholic leaves angry, but makes a change and stops drinking, or at least begins to seriously think about the problem. This approach is often consistent with reality therapy (saying it like it is), principles in co-alcoholism (the spouse/partner may have to leave the alcoholic), and strategic therapy (emphasizing helplessness to overcome helplessness). Because of the anger response to this technique (all confrontations are usually met with anger), misunderstanding of the benign intent on the part of the counselor and unresolved resentment, the sledgehammer approach can be softened, and still remain effective. Softening implies that the counselor still uses the sledgehammer, however in such a way that the alcoholic has either openly given permission for the confrontation, or the confrontation is disguised. One softened method is to ask the alcoholic if it is okay for the counselor to be very honest and direct, that the honesty may not be comfortable; i.e., permission is sought with a forewarning that what will be said may not be comfortable to hear. "Would it be okay if I am very direct and

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GAY ALCOHOLISM: SLEDGEHAMMER, Continued

honest with you?" Another method is to say, "Some counselors would say to you that you are a mess and headed for skidrow [the hospital's cirrhosis ward, etc.], but I find that too harsh, so I won't say that." The counselor confronts, yet doesn't confront. Another method is called the "Once I had a client that...." technique. The counselor talks about an alcoholic that he once knew who had a similar story, became a mess, hit skid row, than made a change; or was a mess and changed before hitting skid row. This technique employs the use of analogy, which can be very obvious, or very disguised (the story of an opposite sexed alcoholic, e.g.). The analogy can be very detailed. "This alcoholic was very bad off, yet he denied this vehemently, even to himself. He got worse and worse, yet wouldn't face the deterioration of his life. He came to me (or another counselor) and I pointed out that he was a mess, hitting bottom. He became angry, not wishing to see the obvious reality. However, he forced himself to take a true look at himself, and after some ups and downs, quit drinking." Everything the counselor would like to say directly can be said indirectly within the story with this method. Another method is to ask about confrontations by friends, family, etc.-- perhaps of confrontations difficult to take. Usually friends or family have already pointed out grim reality. In recounting what they have said, the counselor can ask for the alcoholic's responses, thoughts, or resentments. Another method is to point out the split within the alcoholic--part of him that doesn't feel that he is an alcoholic, another part that realizes he has a problem--that part that made him come for help. The counselor can than inform the alcoholic that he will address both parts (the self destructive side and the growth side).

The "You Don't Care" response is offered by some alcoholics, usually when denial is high, and is related to the sledgehammer approach. The counselor is told that they are heartless, doesn't care about alcoholics, and is just in the job for the money [!!]. This defensive counter-attack is much like the harsh verbal beating that the alcoholic uses on himself. Many counselors become stunned and defensive when alcoholics say that they don't care; after all, caring is a very basic ingredient in being effective. However, "co-alcoholism," alcoholics anonymous, and other experiences teach us that caring involves "hear" love as well as "soft" love. Caring sometimes means being direct and honest, rather than pampering or being hoodwinked (the counselor believing the denial). One "hard" approach in response to "you don't care" is for the counselor to say, "You're right, your drinking is your responsibility, and is killing you, not me. I have enough problems in my own life, I don't need to run yours; besides, I really couldn't even if I tried." Another response is a deep apology for having offended the alcoholic, realizing that life has enough irritations without the counselor adding to them. The counselor admits to being careless and overly harsh, because, after all, the counselor can only conjecture as to the destructiveness of booze in the person's life and that the alcoholic knows more about themselves than the counselor does. In this technique, the counselor takes a one down position and at the same time over minimizes the abusive drinking. The anger would then have to change to an attitude of agreeing with the counselor and the denial or the alcoholic continues the defensiveness and disagrees with the counselor, which would mean admitting to the problem. Another technique is for the counselor to point out the two types of caring and to explain the principles of co-alcoholism (don't do for the alcoholic what they can do for themselves). "I care about you as a person, your difficulties, to which I am empathetic; however, to your self-destructive tendencies, I am concerned in a different way--that you probably need change." Another technique is to explain the difference between "caring" and "taking care of." "I care for you but cannot and shouldn't try to take care of you." "Taking care of you may seem okay for awhile, but soon turns into resentments." One last technique is to shift the focus from the counselor's not caring to the alcoholic's not caring about himself. The responsibility is put back on the alcoholic. "You say that I don't care, and that may or may not be true; however, you caring about yourself may be the real issue, the important issue. For when you get over your anger with me, you will still be with yourself and issues of how much you care about yourself--and those issues are your concerns. I can only help you to explore those issues if that is what you want. My opinion means little in the course of your life. Together, if that is what you want, we can take a look and see how life could become more satisfactory."

[Again, we stress the importance of working with professionals in sensitizing your STD clinic staff in how to confront and intervene with those patients suspected of having alcohol/drug abuse problems, but who present for STD information, diagnosis, & treatment.--ED]

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GAY ALCOHOLISM: "STAGES" OF ALCOHOLISM

[The following 26 questions may be used as a rough screening tool; an "early stage" of alcoholism is suggested by answering "yes" to questions 1-8; a "middle stage" by answering "yes" to questions 9-21; beginning of the "final stage" of alcoholism by answering "yes" to questions 22-26. This is obviously a simplistic approach, but it does have validity. Consult your gay/lesbian alcoholism professional to learn more about recognition & intervention of alcoholism!]

		Yes	No
1	Do you occasionally drink heavily after a disappointment, a quarrel, or when the boss gives you a hard time?	___	___
2	When you have trouble or feel under pressure, do you always drink more heavily than usual?	___	___
3	Have you noticed that you are able to handle more liquor than you did when you were first drinking?	___	___
4	Did you ever wake up on the "morning after" and discover that you could not remember part of the evening before, even though your friends tell you that you did not "pass out"?	___	___
5	When drinking with other people, do you try to have a few extra drinks when others will not know it?	___	___
6	Are there certain occasions when you feel uncomfortable if alcohol is not available?	___	___
7	Have you recently noticed that when you begin drinking you are in more of a hurry to get the first drink than you used to be?	___	___
8	Do you sometimes feel a little guilty about your drinking?	___	___
9	Are you secretly irritated when your family or friends discuss your drinking?	___	___
10	Have you recently noticed an increase in the frequency of your memory "blackouts"?	___	___
11	Do you often find that you wish to continue drinking after your friends say they have had enough?	___	___
12	Do you usually have a reason for the occasions when you drink heavily?	___	___
13	When you are sober, do you often regret things you have done or said while drinking?	___	___
14	Have you tried switching brands or following different plans for controlling your drinking?	___	___
15	Have you often failed to keep the promises you have made to yourself about controlling or cutting down on your drinking?	___	___
16	Have you ever tried to control your drinking by making a change in jobs, or moving to a new location?	___	___
17	Do you try to avoid family or close friends while you are drinking?	___	___
18	Are you having an increasing number of financial and work problems?	___	___
19	Do more people seem to be treating you unfairly without good reason?	___	___
20	Do you eat very little or irregularly when you are drinking?	___	___
21	Do you sometimes have the "shakes" in the morning and find that it helps to have a little drink?	___	___
22	Have you recently noticed that you cannot drink as much as you once did?	___	___
23	Do you sometimes stay drunk for several days at a time?	___	___
24	Do you sometimes feel very depressed and wonder whether life is worth living?	___	___
25	Sometimes after periods of drinking, do you see or hear things that aren't there?	___	___
26	Do you get terribly frightened after you have been drinking heavily?	___	___

Recovery is Possible: Although much remains to be learned about the cause, scope, treatment and prevention of the disease of alcoholism, it has definitely been shown that recovery from this devastating illness is possible. Hundreds of thousands have recovered and are leading happy successful, productive lives without alcohol. It is no longer regarded, as it once was, as an incurable hopeless condition beyond the reach of one to help another.

LEADERSHIP IN LESBIAN & GAY COMMUNITY: VIRGINIA APUZZO

by Kathy Tepes, Cruise Special Report (Volume 6:19, May 18, 1984) with thanks

Greater Gotham Business Council invited Virginia Apuzzo, Executive Director of the National Gay Task Force, to speak on the topic of "Leadership," recently in New York City. Apuzzo made the following remarks:

I would have given anything to have a different topic, including "Dieting & Loving It", "Fidelity & Passion in the Long Term Relationship", etc. Anyone of these topics would be easier and safer than discussing "Leadership".

As a leader you can't always look for the easy and you can't always look to be safe. Ask yourself, what are you going to uniquely bring to the leadership, to make your contribution something significant? An agenda has to be collectively worked on, because the members are responsible to hold you accountable. Leadership is not a solo trip. Accountability is not seen as an opportunity to shoot you down, but an opportunity to enhance the job you are doing and to move us further along. Now, I have met some accountability opportunists, let me tell you. And they stink! Unless the line of communication is open, the response is always going to be defensiveness. Each and everyone must make a commitment to do something, make an agreement to be a part of a group. Lots of folks stand on the sidelines and wait for the leader to trip. Its a national passtime, its a local passtime, too. I really find two negative schools of thought. First, you watch the leader do something differently from how you would do it. That little piece of information, that perspective that you have, how something could be done or improved, that information is vital. The leader may need to hear it. What we do next is start to fester. Criticism is a very important part of moving us all ahead. But nobody likes to take it raw. The context in which we share that perspective is so important, that is a part of our responsibility as members of the lesbian and gay community. Anyone who doesn't know how, or is unwilling, to listen doesn't really care for the community as a whole.

Second negative that happens is what sociologist call "Diffusion of Responsibility." You make believe that s/he has some unbelievable attributes such as longevity, genius, creativity, purity of spirit, etc. You have invested all that to him/her, so that allows you not to be responsible. That may be a little humorous, but it really keeps so many of our efforts, our organizations, from going the full distance that we could go. It takes many of our leaders and burns them out, because they have to do it all by themselves or with a very small group of the people. You are desperately needed for any number of efforts right now. And I can't tell you enough about the power this organization, in this movement, in this city, would have if it had your input. I am urging you to look at the equation and know about important of getting involved.

I'm not talking about leadership in terms of the "old boy network." To fellas in particular, I want to say, that is over, it doesn't happend anymore. We are a community and we are looking to involve more people. Many of you forget lesbians, third world and women's groups. If we go, as we do, after the slogan 'We are everywhere', it can not be only young, white, middle class and many of us ain't male. We as women, as minority, want to know that if we get the gay rights tomorrow all of you men won't go home and say its done. We desperately need each other. We have power as a group, not as an individual or a single organization. Diversity is our strength. Think of the issues on the larger scale than just an individual vision. We seek consensus.

In my generation, I learned not to say who I was. Now we have a movement, a community, where we could say "I am me, I am a lesbian." What we have done is, we took our anger and rage and put it to work in our quest to be able to say not only am I who I am, but we are who we are. I spent the last 14 months making 73 trips. What have I seen? I can recite to you triumph after triumph. Do you think that the NGTF or the Gay Rights Lobby did that? Grassroots people did it. Working, believing they could do it. That is the quality of leadership coming up. Having the passion for possibility that is percolating out there. It happens because women and men in the lesbian and gay community say, "Look at us, we are part of this community, we have a point of view, we have a perspective." The big enemy out there isn't Jerry Falwell. People like Falwell are vicious, hostile, they are smaller than life. Our enemy out there is ignorance and a sense that we don't make a difference. But we do make a difference, every time we make an effort. Ignorance requires a marathon caliber effort and that is a painful endeavor. But lets look what is at stake. Its our lives. It is our visibility. They wouldn't mind that we were around as long as we were back in the closet.

As a leader you will get frightened and you will be attacked and you will lost heart, and you will feel not supportive, you will feel burnout, you will feel "they don't appreciate me," and you will feel that you didn't get credit for something you did, but you will get credit for something that a lot of people did. You will find the support if you look for it and create an atmosphere in which people can provide you with that support and keep those lines of communication open. But, the attack is inevitable, there is no question about that. I get packages of attack. One of my favorites said "fagit." Do you know how offensive it is to me to be called a "faggot" and on top of that to spell it wrong? For those of you who will assume some leadership position, I think its terribly important to understand a couple of things. First of all if people select you to have a privilege to serve them, the operative words are: privilege and serve, because the leader serves. When people provide you with the confidence and the support that says "I'm loaning you this confidence, speak on our behalf." That is the most precious thing your peer group can give you. But it is a loan, and you are responsible to give it back. And I like to focus on how you might give it back. It should be enhanced and enlarged, insured in its potential. Because if you diminish it in any way or violate, when you give it back, the next generation of leadership that comes to receive that support and confidence, receives it with suspicion.

To be a leader, it takes an extra ordinary amount of time. I take a lot of crap and an awful lot of love and affection and support. It is an exquisite experience. Let me tell you that the response of the commuity has been the most sustaining, rewarding, unbelievable expression of affection that I have ever thought would be possible in my life.

There is no perfect candidate or perfect leader. It is a process of developing. But I want to point out and I will take a risk here, because leadership is also about risking. Throughout our community we have people, whether you agree with them or not, whether you like them personally or not, whether they have done it your way or not, we have people in the lesbian and gay community who have one or more characteristic of leadership. Those are, for example, tenacity, building creative vision, the essence, the substance of what inspires. We have people with credibility and integrity. I want us to celebrate, I want us to see it. So, before you criticize and say so and so is just interested in this or that. Think about it! What about leaders who don't want to give up their leadership? To know when to leave is every bit as important as to know when to come aboard. We have come to a point where a single institution no longer determines whether the lesbian and gay movement is alive and well. We are the sum of, but not as great as, the local groups, the grassroots. And no one is going to kill the grassroots movement. It is alive, mobilized and moving. There is no way that NGTF or the Gay Rights National Lobby can do all that. And that is the way it should be. I will end by quoting a proverb of ancient philosopher "When the best leader is finished, the people will look at each other, smile, and say, We have done it ourselves."

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BOOK: HUMAN SEXUALITY IN MEDICAL SOCIAL WORK

The Haworth Press recently announced the publication of the book, Human Sexuality in Medical Social Work, edited by Larry Lister, PhD, University of Hawaii School of Social Work, and David Shore, Associate Director, Accreditation Program for Psychiatric Facilities, Joint Commission on Accreditation of Hospitals, Chicago. This 130 page monograph is also published as the Journal of Social Work & Human Sexuality (volume 2:1), and serves as an important resource for social workers for helping to bridge the gap between people and the services which should exist to meet their needs as fully as possible. Cost--$19.95, hardbound. For more information, contact: The Haworth Press, 28 East 22nd St., New York, NY 10010 (212/228-2800).

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SMALL NEWSLETTER!

Although the NCGSTDS has received many items suitable for including in its Newsletter, inadequate time for rewriting, editing, typing, pasteup, etc., are the reasons for this issue's proportionately small size. The acquisition of a computer/word processor later this year will help to remedy the situation. Hopefully, this issue will still provide useful information--just less of it! Your comments are still invited--write: NCGSTDS, PO Box 239, Milwaukee, WI 53201.

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SPERM & POPPERS LINKED ONCE AGAIN TO AIDS

with thanks: Gay Men's Health Crisis Health Letter/3, May 1984, and
James E. D'Eramo, PhD, New York Native, June 4-17, 1984

Further evidence has appeared supporting the theory that some form of immune defect is detect able in men but not women who are repeatedly exposed to sperm. Gene Shearer, MD, and Alan Rabson, MD, of the National Cancer Institute, point out in the March 15 issue on Nature, that there are substancial mucosal tissue differences between the vagina and rectum. Women who engage in anal intercourse probably do so with much reduced frequency than homosexually active men, they maintain. It is also possible that the semen of some homosexually active men may have greater immunosuppressive potential, possibly due to autoimmune-induced changes in the cellular and/or soluble components of semen. In the May 24, 1984 issue of the New England Journal of Medicine (p. 1349), certain kinds of inhalable substances were found to reduce the numbers of helper (T4) cells; substances to which asthmatic patients were sensitized to, mixed grass extract, produced the decreased number of T4 cells. Amyl nitrite inhalation also temporarily depletes T4 cells. In a recent issue of Science, heavy inhalation of nitrites was associated with development of AIDS in lymphadenopathy patients in New York. Evidence seems to be mounting that both sperm and nitrites may be important "co-factors" in the development of AIDS; i.e., they seem to facilitate the development of AIDS with the presence of other factors, the putative viral agent, possibly other factors as well.

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DISABILITY & AIDS: AAPHR STATEMENT

The American Association of Physicians for Human Rights (AAPHR) recognizes that there are numerous individuals who are severely disabled with AIDS-like symptoms but who do not currently meet the Centers for Disease Control criteria for being diagnosed as having AIDS. It should be noted that the CDC criteria were developed solely for surveillance rather than for clinical diagnostic purposes. These individuals are currently being denied disability benefits by the Social Services Administration because they do not meet these surveillance diagnostic criteria even though they are ill and severely disabled. Therefore, we strongly urge the Social Services Administration to develop an appropriate set of clinical criteria to include as disabled those individuals who are clinically disabled with AIDS-like symptoms whether or not they meet the CDC surveillance criteria. These would then be used to determine disability and the needs of all disabled individuals with AIDS-like symptoms to be better met. We offer the expertise of AAPHR members Drs. Evelyn Fisher, MD, Paul Paroski, MD, and Dennis Passer, MD, to assist in the development of these criteria by the Social Services Administration. [Statement approved by the AAPHR Board of Directors, 4/27/84.]

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RESEARCH DIRECTIONS IN AIDS: AAPHR STATEMENT

The American Association of Physicians for Human Rights (AAPHR) is the national organization of gay and lesbian physicians and medical students. We feel strongly that research into the natural history of AIDS needs to be carried out in a timely and organized manner with sensitivity to the individuals being studied. The availability of "a blood test for AIDS" can have incredible medical and social implications. These must be carefully considered and satisfactorily resolved prior to informing those tested that they have been exposed to the virus that apparently causes AIDS. We strongly urge cooperation among governmental and nongovernmental researchers and research efforts. Further, to obtain maximal results from research dollars, this cooperation should lead to research being done by those best qualified to do it along with collaborative efforts among the various research agencies and extramural programs. We continue to caution about the need for privacy and confidentiality in any studies being conducted. In this situation, a major educational effort is essential so that participants in studies understand the implications of a test indicating prior exposure to the virus, so they may agree to participate with fully informed consent. AAPHR will continue to carefully monitor these efforts to make certain that these recommendations are fully implemented.

AAPHR applauds the recent Health and Human Services announcement of the characterization of the probable agent of AIDS (Lymphadenopathy Associated Virus [LAV]/Human T-cell Lymphotropic retroVirus [HTLV]-3), techniques for its culturing and the development of potential tests for exposure to this virus. While we encourage the continued biologic characterization of this agent at the National Cancer Institute and other laboratories equipped to work with such retroviruses, we feel compelled to suggest other avenues of vital research which will most quickly lead to the eradication of the cause of "our number one health priority." We therefore make the following four recommendations:

Recommendation 1: The Natural History of AIDS. While the probable AIDS agent has been found, characterization of the natural history of the syndromes it causes must now be investigated. Current as well as future research efforts in dissecting the clinical disorders of AIDS in relation to the putative agents must include the following areas:

a) Criteria for the classification of AIDS and the AIDS-related disorders must be re-evaluated in light of these new markers for continued epidemiologic surveillance as well as clinical and laboratory evaluations.
b) Information with regard to routes of transmission, infectious dose, cofactors, and host factors must be tied to clinical and epidemiologic observations.
c) Existing and potential animal models must be studied for clarification of retrovirus pathobiology and for assessing efficacy and safety of potential vaccines.
d) Carefully designed prospective cohort case-control studies are requisite to the comprehension of AIDS-related disorders.
e) Estimates of risk must be devised for the various routes of transmission to develop appropriate information to counsel patients.
f) Studies of individuals exposed to the agent who have not subsequently developed disease must be undertaken (for example, sexual contacts, transfusion recipients, & hemophiliacs).
g) Studies of epidemiologic aspects of sexual behavior should continue with the goal of facilitating effective risk reduction advice. We call, however, for particularly sensitive and confidential handling of these data concerning private behavior.
h) Risk groups should be redefined on the basis of serologic markers.
i) The pattern of opportunistic disease must be understood to determine host factor susceptibility; for example, the presence of Kaposi's sarcoma primarily in homosexually active men or cerebral toxoplasmosis primarily in Haitians.
j) Accurate data with regard to incubation boundaries need to be established; windows of infectivity need to be defined.
k) Longitudinal approaches to data collection and analysis, rather than cross-sectional study methods need to be undertaken to understand effectively these conditions.

Recommendation 2: Evaluation of New Laboratory Tests for AIDS. AAPHR believes that great caution must be exercised in the availability, interpretation, and reporting of results of the announced "blood test for AIDS" which will be "widely available in about 6 months." As it

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RESEARCH DIRECTIONS IN AIDS: AAPHR STATEMENT, Continued

is likely that these tests will correlate with exposure to the AIDS agent rather than with the presence of clinical AIDS, it should be the goal of the researchers developing these tests to define clearly under what circumstances a test is positive or negative, and to be sensitive to the implications of a positive test in an individual person. We ask that:

a) These tests should be thoroughly evaluated by the FDA prior to clinical implementation for the usual parameters applied to clinical measurements including sensitivity, specificity, predictive value of a positive test, etc.

b) The results of these tests should not be reported to individuals until the meaning of a positive test is known and appropriate counselling can be offered. This not only applies to members of high risk groups, but also to blood donors and recipients, and those medical and laboratory workers exposed to the blood of persons with AIDS.

c) After meaningful data have been collected and analyzed so that proper interpretative guidelines have been established, these tests should be available to high risk groups at a nominal cost.

d) Culture techniques for LAV/HTLV-III should be available to all researchers who have adequate skills and containment facilities to work with retroviruses so that the tests will be consistent and reliable.

e) Tests which will detect antibody or viral antigen by RIA, ELISA procedures, etc., should be rapidly developed with special care to analyze the results to see which viral antigens correlate with communicability, which may represent asymptomatic carrier states, and which may correlate with the future development of AIDS.

f) The use of tests to detect antibody to LAV/HTLV-III should be preceded by a massive educational effort both within the medical community and in the general public concerning what is known about the presence of antibody and its relationship to immunity, predictive value for developing later disease and communicability, etc.

Inherent social ramifications of a positive test must be extensively considered in light of the above testing procedures. Experience to date, of persons with AIDS, involving loss of employment, denial of insurability, loss of residence, etc., mandates sensitive consideration to avoid similar outcomes in those persons found positive to such tests.

Recommendation 3: Interagency Collaborative Research Efforts. With the identification of the first cases of AIDS, governmental agencies (CDC, NIH, FDA) have played a major role in the continued surveillance, research, and containment of this epidemic, along with private researchers and clinicians. Communities affected by this syndrome have led the way in public education and lobbying for increased funding allocations. Much of the research odyssey of AIDS has been plagued by competition among the groups for limited resources, non-sharing of research materials, a duplication of effort, and lack of a central overview and coordination. Calls for a coordinated research effort among the CDC, NIH, and FDA were answered by an internally constituted interagency task force. Events surrounding and subsequent to the announcement of the LAV/HTLV-III data, point out the ineffectiveness of this task force. The competition for primacy in discovering the cause and cure for AIDS should not be allowed to eclipse the urgency for immediate dissemination of research data. The importance of the interdependence of the scientific community cannot be underestimated. The lack of a fully-concerted and cooperative effort heretofore (recently underscored editorially in the New York Times of April 26, 1984) subverts not only the ultimate efficacy of those efforts, but also the perception of government's ability to coordinate these tasks. Given the apparent ineffectiveness of the present method of coordination of these research efforts, we mandate:

a) The immediate formation of a workshop consisting of the involved agencies, at risk communities, and the administration, convened by the Assistant Secretary for Health, to develop a review board to oversee the effective development and employment of collaborative research efforts in AIDS.

b) That the above board should be charged with the ongoing review of all presnet and proposed research projects in AIDS in light of the current findings.

c) That the CDC continue to perform and coordinate all epidemiologic surveillance aspects of AIDS.

d) That the NCI continue to work with qualified extramural research efforts in elucidating the biology of LAV/HTLV-III.

e) That the NIAID continue its work on the immunologic and therapeutic studies in those

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RESEARCH DIRECTIONS IN AIDS: AAPHR STATEMENT, Continued

afflicted with AIDS.

f) That the affected communities continue and expand their educational efforts with increased government funding.

Only with well-coordinated efforts can the understanding of the cause, prevention and ultimate cure of AIDS be assured. To do otherwise is unacceptable.

Recommendation 4: Human Issues. While AIDS is a medical disorder, the social ramifications implicit in the groups affected raise issues that challenge traditional scientific and medical research. Broad-based issues of confidentiality of information in minorities judged to be socially unacceptable, behavioral patterns of innate biological drives (sexuality), prevention and interruption of disease spread, and economic burdens imposed by requirements for intensive care and experimental therapeutic approaches must be addressed with the affected communities. We reiterate that while the cause of this disorder may be apparent, the effective cure(s) and methods of prevention are not at hand. AIDS will not disappear overnight just because the causative agent has been found. Efforts with regard to the human aspects of this disease need to continue and increas in the following areas:

a) Education. Risk reduction guidelines and safe sexual practices need to be communicated and encouraged in light of data regarding transmission rather than by opinion. Blood donation recommendations in light of data with regard to screening for the agent need to be developed and/or modified.

b) Sociologic. Detailed information regarding lifestyle behaviors and practices has been important in early surveillance and determination of potential etiologic factors. Continued work along these lines must be focused and limited to clarification of routes of transmission, while preserving the individual's rights to privacy and confidentiality.

c) Confidentiality. Routine safeguards concerning confidentiality must be strengthened to ensure that information obtained in AIDS research and surveillance efforts is not released in any manner which may compromise the confidentiality of individuals. This is of particular importance in AIDS research since various specific behaviors being investigated are still considered illicit and/or illegal in many regions.

d. Surveillance. Systematic surveillance of definite AIDS cases must continue both to ensure accurate monitoring of the incidence of the disease and as the only practical means of evaluating the efficacy of risk reduction and preventive measures. In addition, as further information on the natural history of AIDS and related conditions and the etiologic role of specific viral agents is obtained, thoughtful efforts at surveillance of possible AIDS-precursor conditions will be needed.

e) Economic. Government, medical, and social services to people with AIDS must be expanded to help combat the devastating financial and social effects of this disease. These should include support for medical costs, housing for those who have been disenfranchised because of fear surrounding their disease, and networking for emotional support to those who have become isolated because of their illness. The definition of AIDS for disability and SSI entitlement purposes should be expanded beyond the CDC surveillance definition (see AAPHR statement on Disability and AIDS, elsewhere in this Newsletter). The definition should be updated continually to reflect changes in knowledge as a result of newer information.

The American Association of Physicians for Human Rights stands ready to work with the Department of Health and Human Services in all of these areas so that we may continue the progress that has already begun. AAPHR will continue to carefully monitor these efforts to make certain that these recommendations are fully implemented. [Approved by the AAPHR General Board, 27 April 1984, Neil Schram, MD, President.)

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HARVEY MILK GAY DEMOCRATIC CLUB DISTRIBUTES NEW "CAN WE TALK?" BROCHURE

San Francisco's Harvey Milk Gay Democratic Club recently announced the availability of a newly revised brochure describing risk reduction and gay health information, primarily on AIDS. For more information, contact: HMLGDC AIDS Education Committee, PO Box 14368, San Francisco, CA 94114.

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PUBLIC HEALTH WORKERS SUGGEST AIDS SCENARIOS FOR GROUP DISCUSSIONS

The Centers for Disease Control recently sponsored four nationwide AIDS Update Workshops, "Action for Public Health," in Atlanta (April 30-May 1), Chicago (May 7-8), Philadelphia (May 9-10), and Los Angeles (May 14-15). The goals of the workshops were to orient select public health officials to the scope of the AIDS problem and how to more effectively deal with media, community organizations, and educational & risk reduction information. Nine different scenarios were presented in one of the workshops, with a few questions that need to be addressed. They are presented for your review:

1) Explicit Materials. A local gay coalition conducted a needs assessment and has developed a set of educational materials on AIDS for gay males. The materials include sexually explicit graphics and words. They promote AIDS prevention through "safe-sex." They have been field tested among gay males and have been very well received. The coalition has requested that your state health department provide funds to have the material reprinted and that they then be distributed statewide through the state's health education network. a) What factors should your agency consider in deciding how to respond to this request? b) Which individuals or groups could assist you in making this decision? c) What the the health education implications of this issue? d) How would you respond to press inquiries on this matter? e) What would be the best decision on this matter and with what justifications?

2) Gay Establishments. A bill has been introduced in your state legislature that would require local governments to close all business establishments that encourage or permit sexual activities on their premises. Authors of the legislation have publicly promoted their bill as a measure to prevent the spread of AIDS and have suggested that it will lead to the closures of gay bathhouses, bars, and some bookstores. The legislature has asked for your agency's position on this legislation. a) What factors should your agency consider in taking a position on this issue? b) What individuals or groups could assist you in making this decision? c) What are the health education implications of this issue? d) How would you handle press inquiries on this matter? e) What would be the best decision on this matter and with what justifications?

3) Disclosure, AIDS Death. A reporter with a large city newspaper has been tracking rumors that a community college student, who was a member of his varsity wrestling team, has dies of AIDS. The newspaper has run several critical editorials demanding that full disclosure be made on the case, if it is true. They have argued that the teammates and opponents of this student may have been exposed and have the right to know if their health is in jeopardy. Your surveillance director has documented such a case, and has requested advice on what action to take. a) What factors should be considered in deciding what course of action to take? b) Which individuals or groups could assist you in reaching a decision? c) What are the health education implications of the issue? d) How would you respond to further press inquiries? e) What would be the best decision in this matter and with what justifications?

4) Case Reporting. A large hospital that specializes in treating cancer patients in your state, has announced that it is opening a special clinic for diagnosing, treating, and studying AIDS patients. As part of the announcement, the hospital has stated that they will not report any diagnosed cases to public health authorities in order to protect the privacy of patients and their families. They also feel that their approach is justified since the diagnosis cannot be based on any absolute or definitive test. a) What factors should be considered in determining a course of action? b) Which individuals or groups could offer assistance in this issue? c) What are the health education implications of this issue? d) How will you respond to press inquiries on this issue? e) What is the best course of action on this matter and with what justifications?

5) Directed Blood Donations. Some prominent surgeons in several communities in your state have been pressuring their hospital administrators to permit selective, specifically directed blood donations by family and friends of thier patients as an AIDS prevention measure. The state hospital administrators association has asked your agency to provide a speaker on this topic for their annual meeting. The association will issue a policy paper following the session. a) What factors should influence what your speaker will say at this meeting? b) Which individuals or groups could assist you on this matter? c) What are the health education implications of this issue? d) How would you respond to press inquiries on this matter? e) What would be the best position that your agency could take on this issue?

6) Discrimination. A number of AIDS patients have lost their jobs and have been evicted from their apartments. Several communities have requested state health funds so that group homes can be leased to provide these patients with room, board, and live-in supportive care.

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PUBLIC HEALTH WORKERS SUGGEST AIDS SCENARIOS, Continued

There are also reports that some AIDS patients and members of high risk groups have been denied medical care at several hospitals in these same communities. a) What factors should your agency consider in determining how to handle these problems and requests? b) Which persons or groups could assist you in dealing with these issues? c) What are the health education implications of this issue? d) How would you respond to press inquiries on this issue? e) What would be the best course of action in this issue and with what justifications?

7) AIDS Blood Test. On April 23, 1984, Secretary of Health Margaret Heckler announced that "we now have a blood test for AIDS which we hope can be widely available within about six months. We have applied for the patent on this process today. With the blood test we can now identify AIDS victims with essentially 100% certainty. Thus, we should be able to ensure that blood for transfusion is free from AIDS. We should be able to prevent transfusion-related AIDS cases, as well as those which might appear in hemophiliacs." a) How can your state prepare for the availability of this test, and what decisions will have to be made before the test is offered? b) How can it be used in a prevention program? c) What persons or groups can assist you on these decisions? d) What are the health education implications of this issue? e) How would you handle press inquiries on this matter?

8) Blood Donor. A hospital in your state has reported a case of AIDS to your agency. Two years prior to diagnosis, the patient donated a pint of blood. Subsequent investigation has identified four different persons in your state who received blood products from that donation. a) What factors should you consider in determining a course of action? b) What persons or groups couls assist you in this matter? c) What are the health education implications of this issue? d) How would you respond to press inquiries on this matter? e) What is the best course of action that your agency could take on this matter and with what justifications?

9) Displaced Fear. The announcement that the causative agent for AIDS has been found, and that a screening test and vaccine are imminent, has received wide media coverage. Anecdotal information from several blood banks and gay organizations suggest that prevention recommendations related to blood donations and sex practices by members of high risk groups are being ignored. a) What factors should you consider in determining what course of action to take on this matter? b) What persons or groups could assist you on this matter? c) What are the health education implications on this issue? d) How would you respond to press inquiries on this matter? e) What would be the best course of action that your agency could take on this matter and with what justifications?

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KEY WEST HOSTS AIDS CONFERENCE, AUGUST 15-17

Allan O'Hara, Coordinator of the AIDS Education Program, Florida Keys Memorial Hospital, recently announced the forthcoming conference, "Issues & Answers: A Practical Approach," August 15-17, 1984, at Casa Marina Resport, Key West, Florida. The conference features a wide variety of AIDS health care providers and researchers providing updates on AIDS, understanding gay sexuality, counseling AIDS patients, significant others & family members, staff support for people working with persons with AIDS, infection control and reporting procedures, nursing care, ancillary services, nutrition guides, finding financial support, minimizing length of hospital stay, the doctor's perspective, and a panel of persons with AIDS sharing "AIDS from the Inside." For additional information, contact: Allan O'Hara, Coordinator, AIDS Education Program, Florida Keys Memorial Hospital, 600 Junior College Road, PO Box 990, Key West, FL 33040 (305/294-5531).

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AID ATLANTA UPDATE

Caitlin Ryan, clinical social worker, and Glenn McGahee, southeastern representative to People With AIDS, have recently been appointed AID Atlanta part-time executive director and part-time administrative assistant, respectively. AID Atlanta has been extremely busy, providing public education; services for 19 people with AIDS, their families and friends; and lobbying the county for financial support. Forty thousand dollars has been awarded to AID Atlanta from Fulton County (Atlanta) Public Health Department, to help pay ofr two half-time salaries and portions of rent, printing costs, phone bills, postage, and public education programs for 1984. Fundraising efforts will be continued, since these funds can only be used for specifically agreed upon items and additional monies are still needed for the Emergency Assistance Fund, which helps people with AIDS with emergency, non-medical expenses, and other items. For additional information, contact: AID Atlanta, 404/872-0600, or write, 1801 Piedmont Rd., #208, Atlanta, GA 30324.

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BLOOD TEST "FOR AIDS" TO ALLOW RED CROSS SCREENING OF BLOOD DONATIONS

by David Lamble, Boston's Gay Community News, June 9, 1984 with thanks

The American Red Cross has announced plans to begin an experimental test for AIDS in blood donated for transfusions. The test is the first step in a process of developing a screening method for AIDS in all donated blood, according to the Red Cross, and is similar to tests now routinely performed for hepatitis B and certain other infections. Dr. Alfred Katz, executive director of blood services for the Red Cross, explained that the test will aim to detect antibodies specific to human T-cell lymphotropic/leukemia retrovirus (HTLV-3), the putative AIDS agent. Antibodies are the proteins produced by the body to resist viruses and other foreign substances. A unit of blood testing positive for HTLV-3 Antibody (Ab-HTLV-3 or HTLV-3 Ab) would be removed from the pool of eligible blood because of the possible risk that a person receiving it would develop AIDS, he said. Researchers are proceeding on the assumption that HTLV-3 will prove to be biologically identical to the lymphadenopathy associated virus (LAV) found May, 1983 in AIDS patients at the Pasteur Institute in Paris. But Katz warned that should the two viruses not be the same, "then we will have to start all over again." The initial screening will take place at the Red Cross's main lab in Bethesda, as well as from one to three regional blood centers, probably in New York or California, where the greatest concentrations of AIDS cases are found. It will take about 6 months to evaluate the accuracy of the test. Should the screening procedure prove successful and should there be enough biological material available to mass-produce it, Red Cross officials might consider using it routinely to screen donated blood. There was no indication what the test might cost. Katz admitted that the new test would raise a number of difficult questions. At the current state of knowledge about AIDS, scientists are not certain exactly what a positive test would mean. Presence of antibody might indicate an active, transmissable infection, a past infection followed by recovery without developing AIDS, or the possibility that the person tested might contract AIDS at some future time. And because the incubation period of AIDS apparently ranges to more than 5 years, new cases might continue to develop in those receiving transfusions before the test is instituted. Blood bank officials have also not yet worked out a policy for notifying donors if their blood tests positively for the HTLV-3 Ab. Katz said a decision on these procedures awaits a determination of the accuracy of the test by a human experimentation review committee yet to be organized. People with AIDS and gay community activists have expressed fears that new blood screening methods might provide the basis for a blanket quarantine of people having or even suspected of having the disease. Katz said that blood banks were coming "under considerable pressure to do something in the way of lab testing" for AIDS. One instance of such pressure is in California, where an attorney and hemophiliac has sued a local blood bank for $3 million, claiming it gave him blood that caused him to contract AIDS. Daniel Gallagher of Los Gatos, CA, has charged that Cutter Laboratories of Emeryville was negligent in screening the blood it obtained from donors. "The Cutter Laboratories know that narcotic addicts and homosexuals are a suspect group for AIDS and are not acceptable to commercial [labs] selling blood for transfusions," said Gallagher in a suit filed in Santa Clara County Superior Court. Spokespersons for Cutter Labs had no immediate comment. Gallagher's attorney, W. Robert Morgan, declared that "when and if my client dies [presumably from AIDS], I intend to sue Cutter for compensation to his heirs. They may discover a cure for AIDS. Let's hope they do. But if they don't, this transfusion may have given him a disease that may be fatal." For non-hemophiliacs, the danger of contracting AIDS from blood transfusions is only about 1:100,000 transfusions, according to Dr. James Curran, head of the AIDS Activity of the Centers for Disease Control.

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ADVICE ABOUT AIDS DIRECTED TO PUBLIC SAFETY AND EMERGENCY PERSONNEL

The Seattle-King County Department of Public Health has recently published a brochure designed to reduce apprehensions by public rescue personnel who may deal with people with communicable diseases such as AIDS. "Advice About AIDS and Some Other Communicable Diseases for Public Safety and Emergency Personnel" is available from the Department's AIDS Project (206/587-4999), 14th Floor, 1200 Public Safety Building, Seattle, WA 98104.

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CENTERS FOR DISEASE CONTROL

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

June 1, 1984 / Vol. 33 / No. 21

Recommendation of the Immunization Practices Advisory Committee (ACIP)

Postexposure Prophylaxis of Hepatitis B

*The following statement supplements and updates certain sections of two previous statements on hepatitis B virus prophylaxis (*MMWR *1981;30:423-35 and* MMWR *1982;31: 317-28* [1,2]). *Those statements should be consulted regarding preexposure use of hepatitis B vaccine and prophylaxis of hepatitis A.*

INTRODUCTION

Prophylactic treatment to prevent hepatitis B (HB) infection after exposure to hepatitis B virus (HBV) should be considered in several situations: perinatal exposure of an infant born to a hepatitis B surface antigen (HBsAg)-positive mother, accidental percutaneous or permucosal exposure to HBsAg-positive blood, or sexual exposure to an HBsAg-positive person. In each of these settings, the risk of HB infection is known to be high and justifies preventive measures. Previous recommendations for postexposure prophylaxis have relied on passive immunization with specific hepatitis B immune globulin (HBIG) (*1*). However, the recent demonstration of high efficacy of HB vaccine combined with HBIG in preventing chronic HB infection in infants of HBsAg-positive mothers requires the revision of recommendations for postexposure prophylaxis (*3*) (Table 1).

Passive immunization with HBIG alone has been partially effective in preventing clinical HB in studies of medical personnel after needlestick accidents (*4*) and sexual exposure to partners with acute HB (*5*). In addition, HBIG prophylaxis has been shown to significantly reduce the percentage of infants who become chronic HBV carriers after perinatal exposure to HBsAg-positive mothers (*6*). For perinatal and needlestick exposures, however, HBIG alone is only about 75% effective even when given very soon after exposure, may provide only temporary protection, and is costly (over $150 per adult dose).

With the development of HB vaccine, the possibility arose that HB vaccine, alone or in combination with HBIG, might be useful for postexposure prophylaxis. Studies have shown that response to HB vaccine is not impaired by concurrent administration of HBIG and that the combination of HB vaccine and one dose of HBIG produces immediate and sustained high levels of protective antibody to the hepatitis B surface antigen (anti-HBs) (*7*). A recent study examining the efficacy of HB vaccine combined with a single dose of HBIG in preventing perinatal transmission from HBsAg carrier mothers who were also positive for hepatitis B "e" antigen (HBeAg) showed this combination to be highly effective in preventing the HBV carrier state in infants and significantly more effective than multiple doses of HBIG alone (*3*).

PERINATAL TRANSMISSION

Transmission from mother to infant during birth is one of the most efficient modes of HBV transmission. If the mother is positive for both HBsAg and HBeAg, about 80%-90% of infants will become infected. Although infection is rarely symptomatic in the acute phase, approximately 90% of these infected infants will become chronic HBV carriers. It has been estimated that 25% of these chronic carriers may die of cirrhosis or primary hepatocellular carcinoma (*3*). In addition, such persons are infectious, and female carriers may subsequently perpetuate the cycle of perinatal transmission. If the HBsAg-positive carrier mother is HBeAg-negative or if anti-HBe is present, transmission occurs in less than 25% and 12% of cases, respectively. Such transmission rarely leads to chronic HBV carriage; however, severe acute disease, including fatal fulminant hepatitis in the neonate, has been reported (*8,9*). Even if perinatal infection does not occur, the infant may be at risk of subsequent infection from other family contacts. For these reasons, prophylaxis of infants from all HBsAg-positive mothers is recommended, regardless of the mother's HBeAg or anti-HBe status.

The primary goal of postexposure prophylaxis for exposed infants is prevention of HBV carrier state. In addition, there is a need to prevent the rare occurrence of severe clinical hepatitis in some of these infants. Administration of 0.5 ml HBIG to an infant of an HBsAg, HBeAg-positive mother soon after birth and repeated at 3 months and 6 months reduces the probability of chronic infection from about 90% to about 25% (efficacy about 75%). The concurrent use of HB vaccine and various combinations of HBIG increases the efficacy to close to 90%. Since approximately 5% of perinatal infection may occur in utero, it appears likely that no form of postnatal prophylaxis will be 100% effective in this circumstance.

Concurrent HBIG and vaccine administration does not appear to interfere with vaccine efficacy. HB vaccine has been shown to be equally immunogenic in neonates, whether given in 10-μg or 20-μg doses. The use of HB vaccine in combination with HBIG in the perinatal setting has the advantages of increasing efficacy, eliminating the need for the second and third doses of HBIG, and providing long-term immunity to those who are not infected during the perinatal period.

TABLE 1. Hepatitis B virus postexposure recommendations

	HBIG		Vaccine	
Exposure	Dose	Recommended timing	Dose	Recommended timing
Perinatal	0.5 ml IM	Within 12 hrs of birth	0.5 ml (10 μg) IM	Within 7 days*; repeat at 1 & 6 mos
Percutaneous	0.06 ml/kg IM or 5 ml for adults	Single dose within 24 hrs.	1.0 ml (20 μg) IM†	Within 7 days*; repeat at 1 & 6 mos
		or§		
	0.06 ml/kg IM or 5 ml for adults	Within 24 hours; repeat at 1 mo	—	—
Sexual	0.06 ml/kg IM or 5 ml for adults	Within 14 days of sexual contact	¶	—

*The first dose can be given the same time as the HBIG dose but at a separate site.

†For persons under 10 years of age, use 0.5 ml (10 μg).

§For those who choose not to receive HB vaccine.

¶Vaccine is recommended for homosexually active males and for regular sexual contacts of chronic HBV carriers.

THE OFFICIAL NEWSLETTER OF THE NOSSTDS - VOLUME 5, NO. 5 - MAY/JUNE, 1984 - PAGE 15.

Maternal Screening

Since efficacy of this regimen depends on administering HBIG on the day of birth, it is vital that HBsAg-positive mothers be identified before delivery. Mothers belonging to groups known to be at high risk of HB infection (Table 2) should be tested routinely for HBsAg during a prenatal visit. If a mother belonging to a high-risk group has not been screened prenatally, HBsAg screening should be done at the time of delivery or as soon as possible thereafter.

Management of HBsAg-Positive Mothers and Their Newborns

The appropriate obstetric and pediatric staff should be notified directly of HBsAg-positive mothers, so the staff may take appropriate precautions to protect themselves and other patients from infectious material, blood, and secretions, and so the neonate may receive therapy without delay after birth.

Recent studies in Taiwan and the United States have confirmed the efficacy of the following regimen (Table 3). Other schedules have also been effective (*3,10,11*). The major consideration for all these regimens is the need to give HBIG as soon as possible after the infant has physiologically stablized after delivery.

HBIG (0.5 ml) should be administered intramuscularly (IM) after physiologic stabilization of the infant and preferably within 12 hours of birth. HBIG efficacy decreases markedly if treatment is delayed beyond 48 hours. HB vaccine should be administered IM in three doses of 0.5 ml of vaccine (10 μg) each. The first dose should be given within 7 days of birth and may be given concurrently with HBIG but at a separate site. The second and third doses should be given 1 month and 6 months, respectively, after the first (Table 1). HBsAg testing at 6 months may be done for counseling purposes, since HBsAg-positivity at 6 months indicates a therapeutic failure, and the third vaccine dose need not be given if HBsAg-positivity is found. If a mother's HBsAg-positive status is not discovered until after delivery, prophylaxis should still be administered if a venous (not cord) blood sample from the infant is HBsAg-negative. Testing for HBsAg and anti-HBs is recommended at 12-15 months to monitor the final success or failure of therapy. If HBsAg is found, it is likely the child is a chronic carrier. If HBsAg is not detectible, and anti-HBs is present, the child has been protected. Since maternal antibody to the core antigen (anti-HBc) may persist for more than 1 year, testing for anti-HBc may be difficult to interpret during this period. HB vaccine is an inactivated product, and it is presumed that it will not interfere with other simultaneously administered childhood vaccines (*12*). HBIG administered at birth should not interfere with oral polio and diphtheria-tetanus-pertussis vaccines administered at about 2 months of age (Table 3).

TABLE 2. Women for whom prenatal HBsAg screening is recommended

1. Women of Asian, Pacific Island, or Alaskan Eskimo descent, whether immigrant or U.S.-born.
2. Women born in Haiti or Sub-Saharan Africa.

and

Women with histories of:

3. Acute or chronic liver disease.
4. Work or treatment in a hemodialysis unit.
5. Work or residence in an institution for the mentally retarded.
6. Rejection as a blood donor.
7. Blood transfusion on repeated occasions.
8. Frequent occupational exposure to blood in medico-dental settings.
9. Household contact with an HBV carrier or hemodialysis patient.
10. Multiple episodes of venereal disease.
11. Percutaneous use of illicit drugs.

ACUTE EXPOSURE TO BLOOD CONTAINING HBsAg

There are no prospective studies directly testing the efficacy of a combination of HBIG and HB vaccine in preventing clinical HB following percutaneous or mucous-membrane exposure to HBV. However, since health-care workers at risk to such accidents are candidates for HB vaccine and since combined HBIG plus vaccine is more effective than HBIG alone in perinatal exposures, it is reasonable to recommend both HB vaccine and HBIG after such exposure. This combination will provide prolonged immunity to subsequent exposures and may also increase efficacy in preventing HB in such postexposure situations. In addition, because the second dose of HBIG is not considered necessary if the vaccine is used, the cost of combination treatment is usually less than that of two HBIG doses alone. If exposure to blood occurs in situations where the HBsAg status of the blood is unknown, refer to "Immune Globulins for Protection against Viral Hepatitis" (*1*). If HBsAg testing reveals the source of the blood to be positive, the following treatment schedule should be instituted as soon as possible.

For percutaneous (needlestick), ocular, or mucous-membrane exposure to blood known to contain HBsAg and for human bites from HBsAg carriers that penetrate the skin, a single dose of HBIG (0.06 ml/kg or 5.0 ml for adults) should be given as soon as possible after exposure and within 24 hours if possible. HB vaccine 1 ml (20 μg) should be given IM at a separate site as soon as possible, but within 7 days of exposure, with the second and third doses given 1 month and 6 months, respectively, after the first (Table 1). If HBIG is unavailable, immunoglobulin (IG [formerly ISG or "gamma globulin"]) may be given in an equivalent dosage (0.06 ml/kg or 5.0 ml for adults). If an individual has received at least two doses of HB vaccine before an accidental exposure, no treatment is necessary if serologic tests show adequate levels (> 10 S/N by RIA) of anti-HBs. For persons who choose not to receive HB vaccine, the previously recommended two-dose HBIG regimen may be used (*1*).

HBIG FOR SEXUAL CONTACTS OF PERSONS WITH ACUTE HBV INFECTION

Sexual contacts of persons with acute HB infection are at increased risk of acquiring HB infection. Two published studies have assessed the value of postexposure prophylaxis for regular sexual contacts of persons with acute HB infection. One showed that HBIG was significantly more effective than IG that contained no measureable anti-HBs in preventing both HB infec-

TABLE 3. Routine pediatric vaccination schedule and HBV prophylaxis for infants of HBsAg-positive mothers

Age (months)	Hepatitis B prevention schedule		HBV marker screening	Routine pediatric schedule
Birth	HBIG*	HB vaccine†		
1		HB vaccine		
2				DPT§, Polio
4				DPT, Polio
6		HB vaccine	HBsAg test¶ **	DPT
12-15			HBsAg** & anti-HBs†† test	
15				MMR§§
18				DPT, Polio

*Hepatitis B immune globulin 0.5 ml IM within 12 hours of birth.

†HB vaccine 0.5 ml IM within 7 days of birth.

§Diphtheria-tetanus-pertussis.

¶Optional. If positive, indicates infection, and a third HB vaccine dose need not be given.

**HBsAg-positive indicates therapeutic failure.

††Anti-HBs-positive indicates therapeutic success.

§§Measles-mumps-rubella.

tion and clinical illness (*5*). The second study, however, showed comparable disease rates in persons receiving HBIG and IG containing the increased levels of anti-HBs found in currently available lots (*13*). Because data are limited, the period after sexual exposure during which HBIG is effective is unknown, but extrapolation from other settings makes it unlikely that this period would exceed 14 days. The value of HB vaccine alone in this setting is unknown. However, since about 90% of persons with acute HB infections become HBsAg-negative within 15 weeks of diagnosis, the potential for repeated exposure is usually self-limited. HB vaccine is not routinely recommended for such exposures.

Prescreening sexual partners for susceptibility before HBIG treatment is recommended if it does not delay HBIG administration beyond 14 days after last exposure. In one study, 27% of regular sexual partners (heterosexual) were positive for HBsAg or anti-HBs at the time they presented for evaluation (*5*). Among homosexually active males, over 50% have markers indicating prior infection, and 5%-6% are HBsAg positive (*2*). Testing for anti-HBc is the most efficient prescreening test to use in this population group.

A single dose of HBIG (0.06 ml/kg or 5 ml for adults) is recommended for susceptible individuals who have had sexual contact with an HBsAg-positive persons if HBIG can be given within 14 days of the last sexual contact, and for persons who will continue to have sexual contact with an individual with acute HB before loss of HBsAg in that individual (Table 1). In exposures between heterosexuals, a second HBIG dose should be given if the index patient remains HBsAg-positive 3 months after detection. If the index patient is a known HBV carrier or remains HBsAg-positive for 6 months, HB vaccine should be offered to regular sexual contacts. For exposures among homosexual men, the HB vaccine series should be initiated at the time HBIG is given following a sexual exposure, since HB vaccine is recommended for all susceptible homosexual men (*2*). Additional doses of HBIG are unnecessary if vaccine is given. Because current lots of IG contain anti-HBs, it remains an important alternative to HBIG when HBIG is unavailable.

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Declining Rates of Rectal and Pharyngeal Gonorrhea Among Males—New York City

The rates of rectal and pharyngeal gonorrhea for New York City males aged 15-44 years* has declined from 129 per 100,000 males in that age group in 1980 to 74/100,000 in 1983—the lowest level in the past 7 years. This decrease is most evident in the area with the highest rates—Manhattan—where reported rectal and pharyngeal gonorrhea rates declined from 485/100,000 in 1980 to 201/100,000 in 1983—a 59% decrease (Figure 1). In other areas of New York City, the rates of rectal and pharyngeal gonorrhea have declined slightly since 1980, but the initial rates outside Manhattan were much lower. Gonorrhea rates for females 15-44 years old have risen over the same period from 587/100,000 females in that age group to 624/100,000 in 1983 (Figure 1).

*1980 Census data.

The majority of New York City rectal and pharyngeal gonorrhea was reported from one New York City Department of Health sexually transmitted disease (STD) clinic in Manhattan, whose patients are primarily homosexual males. At this clinic, culture testing for pharyngeal and rectal gonorrhea is provided to all males identified as being at risk for contracting gonorrhea due to same-sex contact. Based on analyses of second- and fourth-quarter data from each year, the percentage of positive rectal cultures declined from 30.3 in 1980 to 16.5 in 1983, and the percentage of positive pharyngeal cultures declined from 6.8% in 1980 to 2.4% in 1983 (Table 4). First clinic visits by males decreased by 4.3% from 18,434 in fiscal year 1980 to 17,635 in fiscal year 1983.

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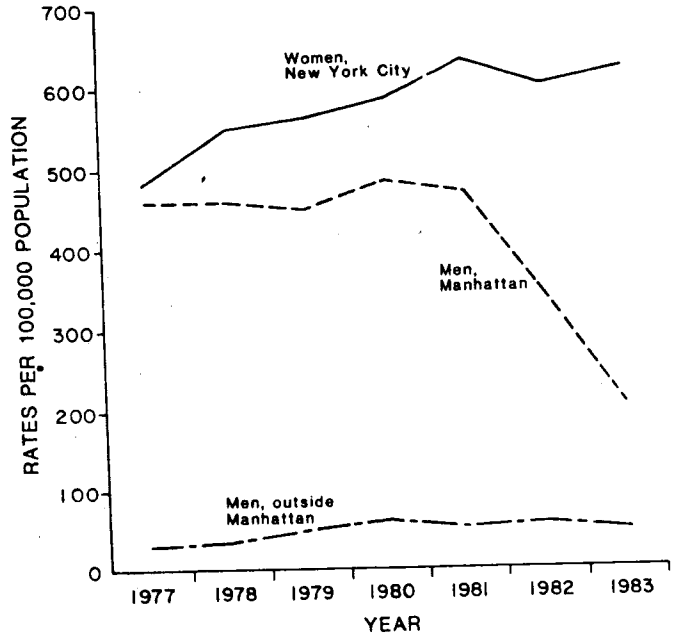
Editorial Note: Since 1980, reported pharyngeal and rectal gonorrhea rates among New York City males 15-44 years old have shown consistent annual decreases, while the reported rates of gonorrhea for females in the same age group have increased during the same period.

FIGURE 1. Reported rates of rectal and pharyngeal gonorrhea among males 15-44 years old and rates (all sites) of gonorrhea among women 15-44 years old — New York City, 1977-1983



In Manhattan, the greatest decreases in male pharyngeal and rectal gonorrhea rates occurred in 1982 and 1983.

The percent decreases in infection were substantially greater than either the percent decreases in clinic attendance or total cultures taken. Hence, it is unlikely that changes in testing or clinic attendance account for a large portion of the declines. A similar decrease in gonorrhea incidence has been reported among homosexual males attending a public clinic in Denver, Colorado (*1*).

The major gonorrhea decreases in 1982 and 1983 coincide with the period of heightened awareness and concern about the incidence of acquired immunodeficiency syndrome (AIDS) among homosexual males. U.S. Public Health Service recommendations stress the importance of reducing the numbers of sexual partners for preventing AIDS among homosexual males (*2*). Similar recommendations have been developed and widely distributed by the American Association of Physicians for Human Rights and many local groups concerned with the health of homosexual males. Recently, a reduction of the number of sexual partners among homosexual males has been documented in Madison, Wisconsin (*3*). The substantial and persistent declines in gonorrhea among homosexual males in New York City suggest that prevention efforts have succeeded in reducing the incidence of this short-incubation-period sexually transmitted infection. Further sustained efforts should help in reducing the incidence of AIDS among homosexual males.

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TABLE 4. Results of rectal and pharyngeal cultures on males at a sexually transmitted diseases clinic — New York City, combined second and fourth quarters, 1979-1983

	Rectal			Pharyngeal		
Year	Total no. of cultures	No. of positive cultures	Percent positive	Total no. of cultures	No. of positive cultures	Percent positive
1979	3,850	940	24.4	3,384	184	5.4
1980	3,388	1,025	30.3	2,755	188	6.8
1981	4,078	1,062	26.0	3,717	163	4.4
1982	4,324	930	21.5	4,361	217	5.0
1983	3,202	529	16.5	3,359	81	2.4

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Notice to Readers

Pentamidine Methanesulfonate to be Distributed by CDC

Pentamidine is used to treat patients with *Pneumocystis carinii* pneumonia (PCP) who have failed to respond or who have had adverse reactions to trimethoprim/sulfamethoxazole. Because of the unavailability of an approved product and the infrequent demand for the drug in the United States, CDC has supplied pentamidine through its Parasitic Disease Drug Service as an Investigational New Drug. The current incidence of acquired immunodeficiency syndrome (AIDS) has created an unprecedented demand for pentamidine (approximately 60% of AIDS patients develop PCP).

Starting in late May or early June 1984, CDC will distribute pentamidine methanesulfonate instead of pentamidine isethionate. Physicians and pharmacists should be aware of the change, because the dosages of the two pentamidine salts are calculated differently (Table 1). The change from one pentamidine salt to another is necessary because CDC has been unable to obtain assurances that the manufacturer of the isethionate salt can meet the increasing U.S. demand for pentamidine.

The indications for using pentamidine methanesulfonate are the same as those for pentamidine isethionate. Physicians in France and Canada have used pentamidine methanesulfonate to treat AIDS patients with PCP. Although results of such therapy have not been published, conversations by CDC with Canadian physicians concerning the outcomes of 13 AIDS patients with PCP treated with pentamidine methanesulfonate indicate that the efficacy and toxicity of the methanesulfonate salt appear similar to those of the isethionate salt. One published report has suggested that hypoglycemia occurs more commonly with pentamidine methanesulfonate than with pentamidine isethionate, but the number of patients described

TABLE 1. Comparison of pentamidine methanesulfonate to pentamidine isethionate

	Pentamidine isethionate	Pentamidine methanesulfonate
Manufacturer	May & Baker (England)	Specia (France)
FDA* status	Investigational New Drug	Investigational New Drug
Supplied as	Powder	Solution (3 ml/ampule)
Amount indicated on label	200 mg (of salt)/vial	120 mg (of base)/ampule
Equivalent pentamidine base	115 mg per vial	120 mg per ampule
Daily dose	4 mg (of salt)/kg body weight	2.3 mg (of base)/kg body weight (0.0575 ml/kg)

*U.S. Food and Drug Administration.

Pentamidine – Continued

was small (*1*). The LD_{50} for mice is approximately the same for the two salts (*2*).

The doses of the two drugs are calculated differently because of the way the manufacturers have labeled their products (Table 1). Pentamidine isethionate is labeled to reflect the weight of salt present (pentamidine base moiety plus isethionate salt moieties), whereas pentamidine methanesulfonate is labeled according to the weight of only the pentamidine base present. Thus, 2.3 mg/kg of pentamidine base is equivalent to 4.0 mg/kg of pentamidine isethionate salt. Each ampule of pentamidine methanesulfonate solution contains the equivalent of 120 mg of pentamidine base dissolved in 3.0 ml of sterile water for injection. Expressed in terms of volume, the dose of pentamidine methanesulfonate is 0.0575 ml/kg.

The procedure for obtaining pentamidine methanesulfonate from CDC will be the same as that used in the past to obtain pentamidine isethionate.

Reported by Div of Anti-Infective Drug Products, National Center for Drug and Biologics, US Food and Drug Administration; Div of Parasitic Diseases, Center for Infectious Diseases, CDC.

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CENTERS FOR DISEASE CONTROL

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Notice to Readers

U.S.-Manufactured Pentamidine Isethionate Cleared for Investigational Use

A U.S.-manufactured preparation of pentamidine isethionate has undergone satisfactory completion of chemical and biologic tests, and CDC is now able to include this preparation in its claimed investigational exemption for a new drug for treatment of *Pneumocystis carinii* pneumonia. The Investigational New Drug status for the U.S.-manufactured preparation makes it unnecessary for CDC to distribute the foreign-produced product (pentamidine methanesulfonate) described in the May 4, 1984, issue of the *MMWR* (33:225-6). The U.S. preparation is being synthesized by Aldrich Chemical Company, Milwaukee, Wisconsin, and packaged for pharmaceutical use by LyphoMed, Inc., Melrose Park, Illinois.

There are two minor differences between the LyphoMed-manufactured product and the previously used May & Baker preparation of pentamidine isethionate. First, the LyphoMed product contains more pentamidine per vial than the May & Baker product (300 mg, compared with 200 mg). Second, the two preparations differ in their physical appearance. May & Baker uses a "dry fill" manufacturing process that leaves a fluffy white powder in the vial, whereas LyphoMed uses a "wet fill" process, followed by lyophilization, leaving a dry "plug" of white powder at the bottom of the vial.

The dosage of the LyphoMed product is the same as for the May & Baker product (4 mg [salt]/kg body weight).

Reported by Div of Parasitic Diseases, Div of Host Factors, Center for Infectious Diseases, CDC.

UPDATE: AIDS EPIDEMIOLOGY/SURVEILLANCE

As of May 28, 1984, the Centers for Disease Control AIDS Activity report a total of 4615 cases of AIDS in the United States (CDC definition). Homosexually active men account for 72.1% of all cases; 17.2% from IV drug users; 3.9% from Haitians; 0.7% from hemophiliacs; and 6.1% from those in no apparent risk/unknown risk group. 22.4% are from individuals aged 29 or less; 46.7% from ages 30-39; 21.4% from ages 40-49; and 8.8% from ages 50 or greater; the remainder are in unknown age groups. 58.3% of the individuals are white; 25.2% are black; 14.3% are hispanic; 2.2% are other racial/ethnic groups or unknown. 47 states (including Puerto Rico and the District of Columbia) have reported cases to the CDC; New York and California have the most cases, with 42.3% and 22.8%, respectively; Florida, 6.8%; New Jersey, 6.3%; Texas, 3.4%; Illinois, 2.1%; Pennsylvania, 1.9%; Massachusetts, 1.7%; Georgia, 1.2%; Connecticut, Maryland, District of Columbia, and Puerto Rico all have about 1.0%; the remaining states account for less than 1% each. Overall case-mortality is 43.3%. AIDS cases per million of population for the entire US is 20.4, ranging from 199.7 cases per million in New York City and 167.7 in San Francisco, 108.9 in Miami, 64.6 in Newark, 51.2 in Los Angeles, to "elsewhere" where is is 7.7 cases per million. These figures represent only those cases meeting the CDC's strict criteria of case definition.

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[End of Volume 5.]