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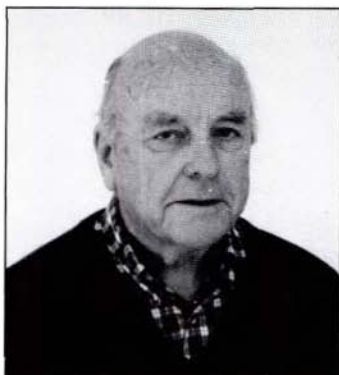
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A Study of AIDS

by

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A World War II veteran of the Royal Navy, Dr. Flanagan graduated in Medicine at Trinity College, Dublin, in 1942. A past president of the San Francisco Catholic Physicians' Guild, Dr. Flanagan has defended Catholic prolife teaching on radio and television.



This paper describes the epidemiology of the AIDS epidemic, and then gives the summary of the conclusions of the 1993 National Research Council's Report on "The Social Impact of AIDS in the United States."

Three sources of information on the AIDS epidemic are then examined.

1. The medical literature on HIV infection in non-intravenous drug using prostitutes.
2. Studies on the transmission of the Human Immunodeficiency Virus (HIV) in disparate couples (where a partner is HIV+).
3. The 1993 Annual HIV/AIDS Surveillance Report from the Center for Disease Control (CDC).

In the Conclusion these three sources are shown to confirm the Medical Research Council's Findings.

Comparison of U.K. and U.S.A. AIDS Statistics

AIDS statistics for the year 1991 offer an opportunity to compare the United States and United Kingdom figures, since they occurred in convenient multiples. At the end of 1991 the United Kingdom with over 50 million population had had

about 4000 cases of AIDS.¹ At this rate the U.S.A. with over 250 million population should have had about 20,000 cases but the figure was about 200,000. San Francisco with 750,000 population had had 12,000 cases, three times as many as the United Kingdom.² Why? Because there were 50-100,000 homosexuals in San Francisco who provided the vast majority of the cases. The U.K. has, no doubt, the same proportion of homosexuals as the U.S.A. but they had not congregated in such large numbers in certain areas and as a result, gay bars, bath-houses and other meeting places had not opened, and opportunities did not arise to spread the disease in the same volume.

Epidemiology of Homosexual HIV Infection

In order for one fresh case of any sexually transmitted disease (STD) to occur it is necessary that an individual transfer the causative organism from an infected source to an uninfected recipient, which requires intercourse with multiple partners. Intercourse with multiple partners is called promiscuity. Promiscuity is a necessity for the spread of STD. The STD rate in any community is a measure of the promiscuity rate.

As is clear from the STD rates, promiscuity is a part of the homosexual condition.^{3,4,5} If all individuals confine their sexual activity to one permanent uninfected partner, not one fresh case of STD would occur.

95% of homosexual AIDS cases contract the infection by being the recipient partners in anal copulation.⁶ The Human Immunodeficiency Virus (HIV) is present in quantity in the lymphocytes in blood and semen. And the recipient partner gets a much larger quantity of virus in the seminal fluid of an infected individual than the active partner could get from bleeding from the anus or rectum of the recipient. Secondly, the rectum, an organ of elimination is lined by one fragile layer of high columnar epithelium which is easily rubbed off, allowing direct access to the bloodstream. HIV is not transmitted by the juxtaposition of genital organs as are the Herpes and Human Papilloma Virus. HIV like Hepatitis B needs access to the bloodstream. Semen entering the bloodstream through the rectal wall causes the production of antibodies to the various constituents in semen including lymphocytes and this may result in T cell suppression by autoimmunity and compromise of the immune system.^{7,8,9} Semen antibodies are present in most homosexual men and are the cause of aspermatogenesis and testicular fibrosis that are common in Homosexual AIDS patients.^{10,11,12} In the homosexual community, then, HIV/AIDS was transmitted by anal intercourse and spread by promiscuity. This was the original AIDS epidemic. It was predominantly in the white middle class in New York, San Francisco, Los Angeles and some other cities.

The Spread of Homosexual HIV Infection to Intravenous Drug Users. (IVDUS)

About ten percent of homosexuals with AIDS in the U.S.A. are IVDUS.¹³ The sharing of syringes containing drug solution, and each participant drawing blood into the solution to confirm intravenous placement and then injecting a portion was a major cause of the spread, along with the sharing of needles. The disease spread by this means is predominantly in the black and Hispanic slum dwellers in the large inner cities and the vast majority are men.¹³ They are the second largest group of male AIDS patients and the largest group in females.¹⁴

The Spread from IVDUS to their Sexual Partners

Since the majority of IVDUS are minority men in the large cities, the majority of their sexual partners are women in the same communities, and these women are the largest group of heterosexually transmitted AIDS cases in the U.S., and the primary reason why women outnumber men in heterosexual AIDS statistics. This is an unreliable group for estimating the risk of heterosexual transmission as they may be sharing drugs with sex.

The second avenue of heterosexual secondary infection from the homosexual epidemic is bisexual men. This is a smaller group amounting to 3% of female AIDS cases.¹⁴ Infection of blood products by homosexual males and later by IVDUS gave rise to hemophiliac and blood transfusion AIDS. These were the most reliable group for the study of heterosexual transmission because the date of infection could be determined and they were usually in stable marriages. They totaled 6,000 cases, 3,500 males and 2,500 females.^{13,14} This is a group diminishing in size and few if any fresh cases should occur.

All HIV cases are categorized by the history they gave. No one with HIV infection will claim to be a homosexual or IVDU who is not, but some of either will claim to have heterosexually acquired HIV/AIDS and so the heterosexual male group will always be exaggerated.

Michael Fumento¹⁵ educated his readers on the AIDS epidemic by introducing them to a basic tenet in the epidemiology of HIV infection, that is dividing cases into those of primary, secondary and tertiary spread. Primary Spread Cases are intravenous drug users (IVDUS), hemophiliacs, blood transfusion cases, and bisexual men. Secondary Spread Cases are their sexual partners. Tertiary Spread Cases are those occurring in the general population at no known risk of HIV infection.

A heterosexual AIDS epidemic cannot occur if it is confined to Secondary Spread Cases, or as long as Secondary Spread Cases outnumber Tertiary.

National Research Council Report

In 1993 The National Research Council's 300 page report on "The Social Impact of AIDS in the United States" was published by the National Academy Press. General findings and conclusions on Page 7 reads: "The convergence of evidence shows that the HIV/AIDS epidemic is settling into spatially and socially isolated groups and possibly becoming endemic with them. Many observers have recently commented that instead of spreading out to the broad American population, as was feared, HIV is concentrating in pools of persons who are caught in the 'synergism of plagues': poverty, poor health and lack of health care, inadequate education, joblessness, hopelessness and social disintegration converge to ravage personal and social life. These coexisting conditions foster and aggravate HIV infection and AIDS. Our study of New York City illustrates this dramatically for one epicenter of the epidemic. We believe that the patterns shown there are repeated throughout the country: *many geographical areas and strata of the population are virtually untouched by the epidemic and probably never will be*: certain confined areas and populations have been devastated and are likely to continue to be."

This report received scant attention from the national media who did not like what they read.

Prostitutes and HIV/AIDS Transmission

At the Third International Conference on HIV/AIDS held in Washington D.C. in June 1987, many papers were presented showing the very low rates of HIV/AIDS in non-drug using prostitutes. The most compelling was that by Nancy Padian and her group from U.C. Berkeley who tested 535 licensed non-drug using prostitutes in the brothels of Nevada. Not one was HIV positive.¹⁶

A paper was also read by William W. Darrow, M.D., on HIV Antibodies in U.S. Prostitutes who had no evidence of I.V. drug use. This was a nationwide survey by the C.D.C. of 707 prostitutes; 36 (5%) were HIV+. Darrow concluded, "Sexual activities with large numbers of clients . . . was not associated with HIV-1 infection, in our study." HIV infection in prostitutes with no evidence of I.V. drug use was associated with having been infected with Hepatitis B, recent infection with Syphilis, and activities with nonpaying partners, i.e. their pimps and boy friends, one third of whom are IVDU's.¹⁷

U. Tirrelli tested 36 prostitutes in two Italian cities, 12 were HIV positive and all of those were IVDU's. None of the remaining 24 were positive, and all were non-IVDU's.¹⁸

In that year 1987 M. Seidin reported on a study of 78 call girls in New York City. Each one averaged 200 clients over the previous year, 1,000 in a lifetime. They had used condoms sporadically. Vaginal intercourse was common and anal rare. One woman was HIV+ and she admitted to I.V. drug use.¹⁹

The IV International Conference on AIDS was held in Stockholm in 1988.

Joyce Wallace, M.D., of New York, presented a paper on a study of the HIV Status of the clients of prostitutes. 340 men who denied drug use or homosexuality agreed to be questioned.

In 10 years they averaged a total of 94 visits to prostitutes. 50% never used a condom. Six of these men were HIV+. They were reinterviewed and three admitted to intravenous drug use or homosexuality.²⁰ Therefore prostitutes rarely transmit HIV to their clients. And this is why they are not categorized as a high risk AIDS group by the C.D.C. or Public Health Authorities.

Rand Stoneburner M.D. of New York City, Public Health Department, noted that 60% of men with AIDS who originally said the source was prostitute contact, will on reinterview admit to homosexuality or drug use.²¹ New Jersey does not reinterview and showed 151 men with HIV from prostitutes in 1989, as against 7 from New York City.²²

In 1989 Drs. Plant & Plant and Associates wrote "Several British studies have concluded that prostitute-associated HIV transmission is almost always due to illicit drug use by the client rather than sex with the prostitute."²³ The most recent such paper was in the British Medical Journal in 1993 in which Helen Ward and Associates reported on 228 female prostitutes in London with two (0.9%) HIV+.²⁴

Down the years these and many similar papers have appeared in the medical literature with similar findings and none that refute them. There are many HIV+ prostitutes, particularly in cities with high drug use, but the risk of passing the disease to their clients is demonstrably remote. At much greater risk is the monogamous individual with an infected partner.

Men claiming HIV infection from prostitutes should be viewed with doubt and searchingly interviewed. In only a handful of cases are prostitutes known to have transmitted HIV to their clients.

The usual army of reporters attended the III and IV International Conference and presumably sent reports of these studies to their editors but few if any saw the light of day, either in the press or on television, and in those years AIDS hysteria was at its height from numerous newspaper accounts of HIV going through the heterosexual population and teenagers in particular. The knowledge that prostitutes who did not use drugs were rarely HIV+ and more rarely still passed the infection to their clients, clearly showed that the infection is very difficult to transmit heterosexually and would have had a calming effect on the public if disclosed.

Disparate Couples

More knowledge of heterosexual transmission will be gained by studying the various research papers on HIV transmission when one partner is infected in a longtime partnership. Generally, the most reliable group are the hemophiliacs and blood transfusion victims, and the least reliable are the IVDU's and their sexual partners. Those who are or became HIV+ and deny homosexual contact or IVDU should be searchingly interviewed.

Stoneburner and Peterman, et al at the C.D.C. in 1988 reported on a study of 80 couples in which one partner had transfusion-related AIDS or was HIV+. This was a stable group of married couples whose date of infection was known and were followed for a mean of 31 months or 250 acts of intercourse. 10% of husbands became HIV+ and 20% of wives. 80% remained uninfected. One woman stated that only one act of intercourse occurred after her husband's transfusion. This is the only

recorded case of HIV having been transmitted by one act of heterosexual intercourse.²⁵

Dr's Curran and Jaffe at the C.D.C. reviewed the literature on Heterosexual HIV transmission in "Science" in 1988. They reviewed 22 published papers. Nine percent of the wives of 288 HIV+ hemophiliacs were HIV+. 25% of the partners of bisexual men were infected. This was considered due to the common practice of anal intercourse by bisexual men. This can be confirmed by testing these women for semen antibodies. 50% of the partners of IVDU's were infected. This can be confirmed by testing these women for semen antibodies. 50% of the partners of IVDU's were infected, the most likely explanation being that they are sharing I.V. drugs as well as sex.²⁶

Nancy Padian, et al at U.C. Berkeley has been studying heterosexual transmission of HIV since 1985. The most recent study was on 307 female partners of infected men of whom 20% became infected, and of 72 male partners of infected women of whom one became infected. The risk of infection per act of intercourse is reckoned by this group to be 1 in a thousand male to female, and much greater than that in the reverse order.²⁷

Some papers have been published showing a much higher rate of heterosexual transmission. The most frequently quoted studies with high heterosexual transmission rates are those of Dr. Margaret Fischl of Miami,²⁸ Thomas Quinn of Baltimore²⁹ and Masters, Johnson and Kolodny.³⁰ Michael Fumento has made a thorough study of these papers in his informative book "The Myth of Heterosexual AIDS".¹⁵ Fischl had only 17 qualified couples amongst her group of 45 couples. (28 were disqualified by abstaining from sex, using condoms or were already HIV+). The majority of the groups were I.V. drug users, and 17 were immigrants from Haiti. The Baltimore group relied on self-administered questionnaires and patients were not interviewed if HIV positive. This rendered the paper unreliable and Fumento had the same criticism for Masters, Johnson and Kolodny.

Review of the National (CDC) Statistics

Those who insist that HIV/AIDS is spreading through the heterosexual community and is a special threat to adolescents should make the effort to study the CDC's Quarterly Surveillance Reports on HIV/AIDS.

On table 4 for the year 1993 are the statistics for male AIDS cases divided into five racial groups, the sixth column headed "Cumulative Totals" gives the National figures for all groups since the start of the epidemic in 1981. This shows a total of 311,000 cases of which 169,000 are white, 88,000 black and 51,000 Hispanic. Note the sources of the infection entitled "Exposure Category". The largest group "Homosexual intercourse" has 194,00 cases. 132,00 were white, 36,00 black and 23,000 Hispanic. "Injecting drug use" is the second largest group, but here the distribution changes. There were 65,000 total of which 32,000 were black and 20,000 Hispanic indicating residents of the inner city where the majority of IVDU's live.

The third line consists of homosexual IVDU's who were the means of transferring the infection from the first group to the second.

Table 4. Male adult/adolescent AIDS cases by exposure category and race/ethnicity, reported in 1993, and cumulative totals, through December 1993, United States

Exposure category	White, not Hispanic		Black, not Hispanic		Hispanic							
	Cumulative total		Cumulative total		Cumulative total							
	1993		1993		1993							
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)		
Men who have sex with men	32,188	(73)	131,617	(78)	10,509	(36)	36,446	(41)	6,519	(43)	23,146	(45)
Injecting drug use	4,634	(11)	13,493	(8)	10,961	(38)	32,218	(37)	5,872	(38)	19,516	(38)
Men who have sex with men and inject drugs	3,296	(7)	12,933	(8)	1,871	(6)	6,762	(8)	853	(6)	3,458	(7)
Hemophilia/coagulation disorder	868	(2)	2,490	(1)	110	(0)	270	(0)	71	(0)	238	(0)
Heterosexual contact:	707	(2)	1,795	(1)	1,833	(6)	4,207	(5)	752	(5)	1,628	(3)
<i>Sex with injecting drug user</i>	267		875		744		2,256		213		650	
<i>Sex with person with hemophilia</i>	7		14		1		4		4		6	
<i>Sex with transfusion recipient with HIV infection</i>	26		76		29		60		20		42	
<i>Sex with HIV-infected person, risk not specified</i>	407		830		1,059		1,887		515		930	
Receipt of blood transfusion, blood components, or tissue	408	(1)	2,521	(1)	178	(1)	662	(1)	83	(1)	390	(1)
Risk not reported or identified ¹	1,886	(4)	4,231	(3)	3,330	(12)	7,627	(9)	1,151	(8)	2,566	(5)
Total	43,987	(100)	169,080	(100)	28,792	(100)	88,192	(100)	15,301	(100)	50,942	(100)

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals ²			
	1993		Cumulative total		1993		Cumulative total		1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	509	(77)	1,699	(80)	177	(63)	432	(63)	49,963	(56)	193,652	(62)
Injecting drug use	33	(5)	87	(4)	27	(10)	74	(11)	21,571	(24)	65,512	(21)
Men who have sex with men and												
inject drugs	24	(4)	63	(3)	46	(16)	122	(18)	6,098	(7)	23,360	(7)
Hemophilia/coagulation disorder	12	(2)	36	(2)	8	(3)	18	(3)	1,069	(1)	3,058	(1)
Heterosexual contact:	16	(2)	29	(1)	6	(2)	12	(2)	3,317	(4)	7,679	(2)
<i>Sex with injecting drug user</i>	6		12		1		5		1,232		3,799	
<i>Sex with person with hemophilia</i>	—		—		—		—		12		24	
<i>Sex with transfusion recipient</i>												
<i>with HIV infection</i>	1		2		—		—		76		181	
<i>Sex with HIV-infected person,</i>												
<i>risk not specified</i>	9		15		5		7		1,997		3,675	
Receipt of blood transfusion,												
blood components, or tissue	13	(2)	73	(3)	1	(0)	5	(1)	686	(1)	3,660	(1)
Risk not reported or identified ¹	58	(9)	148	(7)	16	(6)	25	(4)	6,461	(7)	14,657	(5)
Total	665	(100)	2,135	(100)	281	(100)	688	(100)	89,165	(100)	311,578	(100)

¹See Figure 7.

²Includes 541 men whose race/ethnicity is unknown.

Source:
Vol. 5, No. 4

Table 5. Female adult/adolescent AIDS cases by exposure category and race/ethnicity, reported in 1993, and cumulative totals, through December 1993, United States

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	1993		Cumulative total		1993		Cumulative total		1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Injecting drug use	1,889	(46)	4,836	(44)	4,428	(48)	12,459	(52)	1,458	(44)	4,317	(48)
Hemophilia/coagulation disorder	16	(0)	51	(0)	7	(0)	16	(0)	3	(0)	7	(0)
Heterosexual contact:	1,557	(38)	3,910	(35)	3,139	(34)	7,613	(32)	1,474	(44)	3,795	(42)
<i>Sex with injecting drug user</i>	670		1,864		1,368		4,432		762		2,518	
<i>Sex with bisexual male</i>	231		680		194		486		81		188	
<i>Sex with person with hemophilia</i>	56		154		9		21		4		10	
<i>Sex with transfusion recipient with HIV infection</i>	50		182		33		70		21		58	
<i>Sex with HIV-infected person, risk not specified</i>	550		1,030		1,535		2,604		606		1,021	
Receipt of blood transfusion, blood components, or tissue	235	(6)	1,429	(13)	187	(2)	659	(3)	90	(3)	362	(4)
Risk not reported or identified ¹	406	(10)	824	(7)	1,459	(16)	3,063	(13)	299	(9)	585	(6)
Total	4,103	(100)	11,050	(100)	9,220	(100)	23,810	(100)	3,324	(100)	9,066	(100)

Exposure category	Asian/Pacific Islander		American Indian/Alaska Native		Cumulative totals ²	
	1993		1993		1993	
	No.	Cumulative total (%)	No.	Cumulative total (%)	No.	Cumulative total (%)
Injecting drug use	17 (18)	38 (16)	18 (33)	54 (47)	7,827 (47)	21,746 (49)
Hemophilia/coagulation disorder	1 (1)	1 (0)	—	—	27 (0)	75 (0)
Heterosexual contact:	54 (56)	108 (45)	24 (44)	37 (32)	6,253 (37)	15,487 (35)
<i>Sex with injecting drug user</i>	17	35	14	24	2,833	8,889
<i>Sex with bisexual male</i>	15	30	1	3	522	1,389
<i>Sex with person with hemophilia</i>	—	2	2	2	71	189
<i>Sex with transfusion recipient with HIV infection</i>	7	11	—	—	111	322
<i>Sex with HIV-infected person, risk not specified</i>	15	30	7	8	2,716	4,698
Receipt of blood transfusion, blood components, or tissue	13 (13)	59 (25)	3 (5)	9 (8)	529 (3)	2,521 (6)
Risk not reported or identified ¹	12 (12)	34 (14)	10 (18)	14 (12)	2,188 (13)	4,528 (10)
Total	97 (100)	240 (100)	55 (100)	114 (100)	16,824 (100)	44,357 (100)

¹See Figure 7.

²Includes 77 women whose race/ethnicity is unknown.

Source:

Vol. 5, No. 4

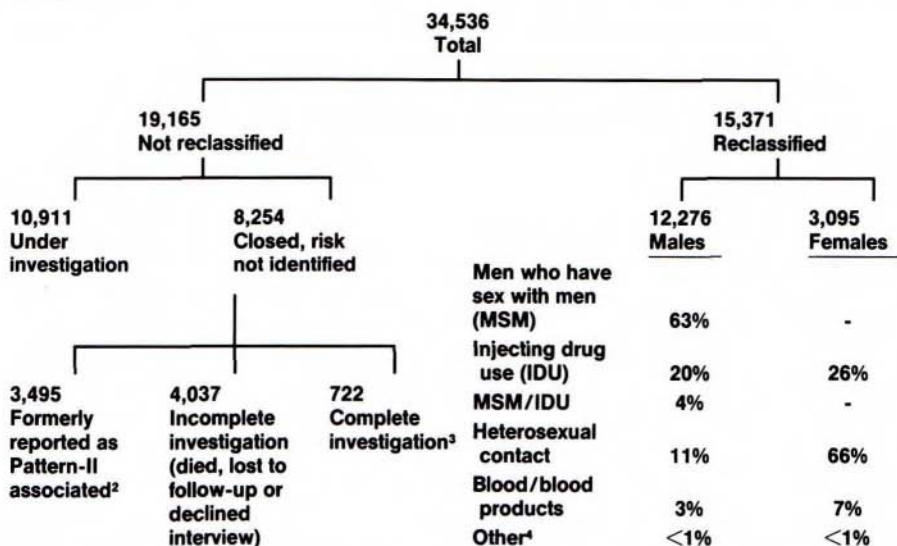
Page 10

HIV/AIDS Surveillance Report

Under Heterosexual Contact, the first line is male AIDS cases from sex with a female IVDU 3,800 cases. This is secondary spread, and is the largest male heterosexually transmitted group. The fourth line, "Sex with HIV-infected person, Risk not specified" means a person known to be HIV+ but in whom the classification has not been disclosed.

If we now turn to table 5, at the bottom of column 6, entitled "Cumulative Total", we find the total female AIDS cases since 1981, which is 44,000. 21,700 (49%) of these are IVDU's (Line 1) of which 12,500 are black and 4,300 Hispanic. The first line under Heterosexual Contact in cases of AIDS from sex with an IVDU (Secondary Spread) which amounts to 9,000 of which 1,800 are white, 4,500 black and 2,500 Hispanic, the racial distribution again indicating that there are predominantly inner city residents where most IVDU's are to be found.

Figure 7. Results of investigations of adult/adolescent AIDS cases ever classified as risk not reported or identified, through December 1993, United States¹



¹Excludes 53 children under 13 years of age whose risk is not identified. An additional 255 children who were initially reported without risk information have been reclassified after investigation.

²Cases associated with persons born in Pattern-II countries are no longer classified as heterosexual transmission. See technical notes.

³Investigations of these persons included patient interviews. Based on available information, these persons could not be reclassified into an exposure category. This group includes persons possibly infected through heterosexual contact with a partner who is not known to be HIV infected or at high risk for HIV infection; persons who may choose not to disclose high-risk information; and persons with possible occupational exposure. These 722 persons report heterosexual contact, sexually transmitted disease infections, non-injecting drug use, hepatitis infections and occupational exposures to blood or body fluids.

⁴Twelve are health-care workers who developed AIDS after occupational exposure to HIV-infected blood, as documented by evidence of seroconversion; 4 are patients who developed AIDS after exposure to HIV within the health-care setting, as documented by laboratory studies; 3 are persons who acquired HIV infection perinatally and were diagnosed with AIDS after age 13; and 1 is a person with intentional self-inoculation of blood from an HIV-infected person.

These tables then contain 65,000 male IVDU's with AIDS and 9,000 female sexual partners of IVDU's. And 21,700 female IVDU's and 3,800 men who were the sexual partners of female IVDU's (These are all Secondary Spread cases). This does not indicate a high rate of transmission. In order for a heterosexual AIDS epidemic to occur, 100 cases must transmit the disease to 100+. If 100 transmit the infection to 80, you have a disease of declining numbers.

It will be noted on Table 4 that there is no line that reads "sex with low risk heterosexual" (Tertiary spread cases). Root Bernstein in his book "Rethinking AIDS"³² asserts that there has never been a documented case in the U.S. of low risk to low risk transfer of HIV. Such cases as do exist will be included in the bottom line of Table 4 and 5 which reads "Risk Not Reported or Identified." This group is investigated in detail in Figure 7. On the right side are 15,000 cases that have been reclassified. They contain 12,000 males and 3,000 females. This indicates that they are predominantly homosexuals and IVDU's as in heterosexually transmitted AIDS females outnumber males. The heterosexual contacts were reclassified, so they were secondary spread cases who had contact with individuals in the primary exposure groups on Tables 4 and 5 (i.e. UVDA's, bisexuals, blood transfusion cases). But 722 (5%) cases remained unclassified after investigation and they are found on the left side of Figure 7 with the 11,000 still under investigation and 4,000 dead, a lot to follow up, and it is reasonable to assume that this 15,000 would also have 5% unclassified, about 750, if they all could be interviewed, and this total of about 1,500 unclassified after investigation must contain the tertiary spread or low-risk to low risk heterosexual AIDS cases. So after 13 years of the AIDS epidemic and out of 361,000 cases, tertiary spread cases if any are some unknown fraction of 1,500 in number.

Conclusions

In the epidemiology of homosexual HIV infection, the wall of the rectum has been shown to be an avenue to the blood stream. If anal intercourse is as widespread amongst heterosexuals as stated, AIDS would be a heterosexual disease widespread in the general population, and semen antibodies would be commonly found in women.

The many reports on clinical investigations that found absence or low evidence of HIV infection in non-drug using female prostitutes and their clientele demonstrates that promiscuous heterosexual behavior rarely results in HIV infection. This difficulty in transmitting HIV heterosexually is further attested to by the studies on disparate couples, and confirmed by the CDC statistics showing that prostitutes are not in the high risk group for spreading HIV, and there is no line for their clients in the Annual Report, who therefore must be few in numbers.

The CDC's Annual Reports show that male IVDU's are by far the largest group of heterosexuals with AIDS in the U.S.A. and their female sexual partners are the largest group with heterosexually transmitted AIDS in the U.S. and these are predominantly minority dwellers of the inner cities. These women are secondary spread cases.

There have been few if any tertiary spread cases in the U.S. or other Western countries as shown in the CDC Statistics which correspond precisely with the National Research Council Report, and there is no justification to use the fear of heterosexual AIDS to promote condoms in the schools.

While the wall of the rectum has been an avenue to the bloodstream, the wall of the vagina has been a barrier. The distinction should be made clear in AIDS education so that young people understand the risk of anal intercourse. In AIDS education vaginal and anal intercourse are usually included in the term "sexual intercourse", which is politically correct and is used in teachers manuals on AIDS including the one used by the National Catholic Education Association.³¹

George Will in one of his syndicated columns introduced the term the "democratization" of AIDS. There has been a persistent deception of the public on heterosexual AIDS because there is a large and very vocal AIDS industry and bureaucracy with a vested interest in keeping money flowing by presenting AIDS as "everybody's disease". This AIDS group consists of those involved in AIDS research, education and public health, as well as condom manufacturers. Homosexuals being the predominant group with AIDS are the predominant group in the AIDS bureaucracy. It is very much in their interest that AIDS be democratized as a threat to the general population to keep the funding at a high level.

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