

HIV Impact

Spring 2000

A Closing the Gap newsletter of the Office of Minority Health, U.S. Department of Health and Human Services

The Toll of HIV/AIDS on Minority Women

By Kendra Lee

Monica Johnson received a blood transfusion during a hospital stay in 1984. In 1985, she received a letter saying the person who donated that blood had died of AIDS.

Johnson, who was 19 at the time, trusted in her faith. "It was not a time to cry, just a praying time," Johnson says. Back then, her HIV test came back inconclusive, which she assumed meant negative.

She married her college sweetheart in 1989 and thought little of the tainted transfusion until she got pregnant later that same year. "I told my obstetrician about the transfusion. She retested me for HIV, and the test came back positive. Not a big surprise," Johnson says.

What was tougher to deal with was what to do about the baby she was carrying; she knew there was a 25 percent chance she could transmit the virus to the unborn child. But Johnson played the odds, and her son Vaurice was born in April 1990. When the baby was five months old, he developed a stubborn case of thrush, and the family soon found out he too was HIV positive.

Dealing with discrimination and death

Residents of the small Louisiana town where Johnson makes her home had no idea how to handle the news and began treating the family as outcasts. Johnson was the mother of the first child known to have HIV in the surrounding 12 counties.

In 1993, Johnson's son died from AIDS-related complications. And Johnson's marriage ended years ago. All she will say about her ex-husband is that he's HIV negative and that they stayed together as long as they did for their son.

Johnson lost her job, and her mother-in-law's job was threatened. Friends say Johnson was ostracized as much for her race as for her HIV status. "Monica was the first person most people in the town knew with HIV, and she was black. It was more a racial thing than anything," says Richard Womack, her case manager.

Still, Johnson says she was maintained by faith. She has adopted another child, her nephew Avery. She's found the support system, absent in the town where she lives, in another town 35 miles away. In that town, she's very active in the church, and has organized a buddy program for other people living with AIDS.

She had gone for a dozen years without treatment because of fear over tales she heard about negative side effects. But now Johnson takes a triple combination cocktail and experiences no side effects. Her most recent CD4 count (a type of T-cell involved in protecting against infection) was 800, and her viral load was undetectable. "I've just been blessed," she says.

Perceptions of risk

The reasons for skyrocketing HIV rates among women are numerous and complicated, experts say (See sidebar on p.2). "HIV/AIDS, even in the early years, started to be a big problem for women," says Frances Page, a science public health advisor in the Office on Women's Health, U.S. Department of Health and Human Services (HHS).

"The numbers have steadily increased largely because women didn't realize they could get it. They saw all the messages for white gay men, and if you're a woman of color you think, 'This doesn't pertain to me.'"

In fact, women's perceptions of themselves as not being at risk have been among the bigger obstacles to overcome in HIV-prevention efforts, according to Debra Katz, an AIDS program coordinator with the Connecticut Department of Health's Stamford AIDS Program.

"More women are currently being infected through heterosexual sex than drug use, yet they often don't understand that in many cases their risk is their partner," Katz says. "Women are not protecting themselves."

The latest data from the Centers for Disease Control and Prevention (CDC) show that the AIDS epidemic among gay men of color is rising. For the first time African-American and Hispanic gay men with AIDS now outnumber white gay men with the disease. And these same gay men often don't come clean with their girlfriends and wives about their sexual orientation.

Another problem in HIV-prevention efforts is a basic question of anatomy. Women's reproductive anatomy makes them highly suscep-

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The Office of Minority Health Resource Center provides free information on various health issues affecting U.S. minorities.

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tible to contracting sexually transmitted diseases (STDs); they are about eight times more susceptible than men to contracting HIV during intercourse, according to Janet Cleveland, a public health educator with CDC.

“We know that treating STDs, such as syphilis, reduces the risk of getting and spreading HIV infection,” says Helene Gayle, M.D., director of CDC’s National Center for HIV, STD, and TB Prevention. But because many of the women who contract HIV are poor, they are much more likely to seek health care in clinics or emergency rooms—places that usually provide limited diagnostic services.

Traditional societal roles also contribute to HIV’s increasing presence in the female population. Women are accustomed to placing the needs of others before their own health needs.

“Some women are afraid to open up when they find out they have HIV,” says Page. “They worry about the impact on their family, their health insurance, their job.” As caretakers, HIV-infected women are often saddled with planning not only for themselves, but also for other family members. Feelings of shame and grief, and fears of stigmatization, rejection, and death can overwhelm them.

If they have children, they worry about losing custody, unaware that there are laws in place that allow them to choose a guardian for their kids. Others, like Monica Johnson, must watch their infected children die while worrying about their own fate.

Paying more attention to women

Some of the initial prevention programs at the federal level were “men specific or family specific or pediatric specific,” says Page of the Office on Women’s Health. “It’s all about who presented first with the disease.” The policies that did target women tended to focus on perinatal care, and with emphasis on the child, not the woman and the child.

But that’s changing, Page says: “Now there are programs for women—and not just from a reproductive standpoint.” One such program is the Collaborative Group on Women and HIV/AIDS, for which the Office on Women’s Health and the HHS Office of HIV/AIDS Policy are facilitators.

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HIV Rate Increasing for Women



Here are some facts from the Centers for Disease Control and Prevention (CDC).

- Between 1991 and 1995, the number of women in this country diagnosed with AIDS increased by more than 63 percent.
- In nine cities, it is the leading cause of death for women between the ages of 22 and 44. The nine cities are: Chicago, Houston, Los Angeles, Miami, New York, Newark, Philadelphia, San Francisco, and Washington, DC.
- African American and Latina women, often without resources or health insurance, are shouldering much of the epidemic’s economic burden.
- Compared to white women, African American women are 20 times more likely to contract AIDS; Latinas are 7 times more likely.
- Eighty-one percent of the new AIDS cases among women in this country in 1998 were among African Americans (62 percent) and Latinas (19 percent).
- And according to Dr. Dawn Smith, CDC, those rates are likely to become even higher due to the disease’s average incubation period.
- Though the epidemic initially spread mainly through homosexual sex and intravenous drug use, from 1993 to 1998 the number of women infected by heterosexual contact increased by 243 percent. 

OMH Launches *HIV Impact*; Our Commitment to You

By Nathan Stinson, Jr., PhD, MD, MPH
Deputy Assistant Secretary for Minority Health. U.S. Department of Health and Human Services

Welcome to our first issue of *HIV Impact*. For years, we have spread the word about minority health through a newsletter called *Closing the Gap*. Each issue focuses on a different health topic, and recent editions have covered cultural competency, disabilities, oral health, and health care access. *Closing the Gap* will continue to be an important source of information and education on the health of African Americans, Hispanics/Latinos, American Indians/Alaska Natives, Asian Americans, and Pacific Islanders.

This month we are pleased to announce the launch of the quarterly *HIV Impact*—a companion newsletter to *Closing the Gap*. Both newsletters promote an exchange of information that contributes to narrowing health disparities between whites and minorities. *HIV Impact* is a key part of our efforts to share information with those who are involved or interested in HIV/AIDS prevention, service, and research.

Every quarter, you will receive news on HIV/AIDS activities that impact minority communities. We'll keep you informed of what's happening at agencies within the U.S. Department of Health and Human Services (HHS), along with other organizations representative of all levels—international, national, state, and local.

Other highlights include:

- information on programs in minority communities that have proven promising or successful in reducing the occurrence or severity of HIV/AIDS in minority populations;
- current data on HIV/AIDS in minority populations; and
- sections on new research, conferences, funding opportunities, legislation, and publications.

We encourage your feedback in this endeavor and welcome ideas that can help us improve our publication and serve you better. Please take a few minutes to fill out the Reader Survey on page 15 and fax it back to: Linda Quander, PhD, Editor, *HIV Impact*, 301-495-2919.

OMH-RC expands information services on HIV/AIDS

HIV Impact is part of a larger effort we have initiated to expand information services on HIV/AIDS through our Office of Minority Health Resource Center (OMH-RC). This expansion was made possible with funding from a partnership between HHS and the Congressional Black Caucus.

OMH-RC has been providing invaluable information and education resources on HIV/AIDS since its inception in 1987, but now we will be able to respond to an increasing number of requests and create even more partnerships. We have added a team of HIV/AIDS experts to the center's staff, including outreach and information specialists.

This expansion is critical for decreasing the disproportionate AIDS death rate of African Americans, which remains nearly 10 times higher than whites. While African Americans and Hispanics respectively represent approximately 13 percent and 12 percent of the U.S. population, approximately 36 percent of the reported AIDS cases are African American and 18 percent are Hispanic. Some 57 percent of all new HIV cases involve African Americans while Hispanics account for 20 percent of new such cases.

Although the proportion of Asian Americans and Pacific Islanders and American Indians and Alaska Natives living with HIV has remained 1 percent and less than 1 percent respectively, since 1993, the number of persons of these races living with AIDS has increased, according to the Centers for Disease Control and Prevention.

From 1993 to 1998, the number of Asian Americans and Pacific Islanders living with AIDS increased from approximately 1,284 persons to 2,320. The number of American Indians and Alaska Natives with AIDS increased from approximately 559 to 971 persons.

OMH-RC's expansion on HIV/AIDS will increase collaborations between community-based organizations, national organizations, and federal and state agencies.

Among top priorities are improving education about funding sources for HIV/AIDS programs and research, and bringing messages to consumers and health professionals about the most effective strategies for HIV/AIDS prevention and treatment.

*“A journey of a
thousand miles
begins with
a single step.”*

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Research on HIV/AIDS Among the Severely Mentally Ill

The National Institute of Mental Health's (NIMH) Center for Mental Health Research on AIDS supports research on the risk of HIV infection among those who are severely mentally ill. NIMH is part of the National Institutes of Health (NIH). Research is encouraged within the following priority areas for severely mentally ill persons:

- Epidemiology of HIV infection
- Epidemiology of sexual and drug-use behaviors and other relevant risk behavior patterns
- Interventions on risk reduction and transmission prevention.
- Treatment and the medical and neuropsychiatric manifestations of HIV.
- Effective service delivery and financing

For more information, visit <http://www.nimh.nih.gov/oa/announce.htm> and click on PA-98-054. 

Scientist Development Award for New Minority Faculty

NIMH has announced the availability of awards for minority scientists. The goal is to enable new minority faculty members to have the necessary time and assistance early in their academic careers to initiate a program on mental health research. The next application deadlines are June 1, 2000, and October 1, 2000.

Applications may be submitted on behalf of the proposed candidate by domestic, non-profit, public and private universities, colleges, and professional schools that are engaged in mental health research. The applicant's institution must provide evidence that a commitment of a full-time faculty position has been made to a candidate.

For more information, visit <http://www.nimh.nih.gov/grants/career.htm> and click on PAR-99-169. 

Our expanded HIV/AIDS information activities include:

- resources in English and Spanish (available through our toll-free line, 1-800-444-6472);
- new web pages;
- a new team of outreach specialists who will provide technical assistance to organizations that deliver HIV/AIDS services;
- more funding information;
- new databases and library holdings; and
- our new quarterly publication, *HIV Impact*.

The HHS commitment to HIV/AIDS among minorities

We are pleased that overall funding for AIDS-related programs within HHS has increased by 131 percent over the last six years, with funding for AIDS care under the Ryan White CARE Act increasing by 314 percent. The FY 2000 budget includes \$8.5 billion in total HIV/AIDS funding within HHS.

With the support of the Congressional Black Caucus (CBC), we secured \$245 million to fund President Clinton's initiative to improve the nation's effectiveness in preventing and treating HIV/AIDS in minority communities.

HHS Secretary Donna Shalala announced in September 1999 the award of \$3.9 million in planning grants to 79 public and private organizations to bolster HIV/AIDS care to African Americans in rural and underserved communities.

HHS also announced that Detroit, Philadelphia, and Miami will be the first of 11 cities to receive special technical assistance from HHS teams of experts to help fight spread HIV/AIDS among minorities. Other efforts are being regularly announced by HHS, and we will bring you the information.

The Office of Minority Health operates demonstration and technical assistance programs related to minorities and HIV/AIDS. Recently, we announced 30 new HIV/AIDS grantees. These grants will foster the development of effective service delivery for HIV prevention and treatment and support health promotion and education activities for minorities across the country. Grants were awarded under the following areas:

1. Technical Assistance and Capacity Development: Demonstration Program for HIV/AIDS-Related Services in Highly Impacted Minority Communities
2. Minority Community Health Coalition Demonstration Program, HIV/AIDS
3. State and Territorial Minority HIV/AIDS Demonstration Grant Program

OMH's goal for FY 2000 is to concentrate efforts on preventing new cases of HIV infection, improving data on minority communities impacted by HIV/AIDS, increasing awareness of safe lifestyle practices to reduce transmission of the disease, and improving access to drug therapies for those who are infected with HIV.

We also encourage health professionals who specialize in HIV/AIDS to request an application for the Resource Persons Network, a group of health experts who volunteer to provide technical assistance on minority issues.

OMH will continue its commitment to easing the burden of HIV and AIDS on minority communities. We hope you will join us in developing more effective strategies to reach our most vulnerable populations.

As one Chinese Proverb states: "A journey of a thousand miles begins with a single step." Join us in this journey.

If you are not already on our mailing list, call us at 1-800-444-6472, or visit our website at <http://www.omhrc.gov>. 

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Six Ways to Improve HIV/AIDS Outreach for Non-English Speakers

By Kendra Lee

Without a doubt, education is critical for HIV/AIDS prevention and treatment. But a common mistake is taking a “one-size-fits-all” approach. To be effective, education and outreach strategies should be tailored to meet the unique needs of non-English speaking populations.

Of course this can be challenging, especially because of the diversity that exists within populations. Asian Americans and Pacific Islanders (AAPI) in the United States, for example, represent more than forty countries and territories and speak more than 100 languages and dialects. The millions of people placed within the AAPI category form a community marked by distinct cultures, histories and voices.

According to Kiyoshi Kuromiya, director and founder of Philadelphia’s Critical Path AIDS Project, a main question is: “How do you get lifesaving AIDS information to such a linguistically, culturally and geographically diverse group?” Not having education materials available in appropriate languages is one issue. In fact, some recent immigrants and refugees are becoming infected with HIV long before they can obtain prevention materials in their first language, Kuromiya says.

We talked with experts in HIV/AIDS outreach for minorities to uncover challenges and came up with these tips.

1. Be aware that literal translations from English to another language for brochures and other publications may be culturally inappropriate. “Human reproductive anatomy, for example, may be discussed in ways that won’t bother Anglos, but will shock Latinos,” says Heriberto Crespo, director of health education at the Latino Health Institute in Boston.

2. Consider sub-populations in your outreach efforts rather than lumping groups together. “We’re a very small, but complex population,” says Ronald Rowell, executive director of the National Native American AIDS Prevention Center. “We’re not one people,” he says, noting the great tribal diversity of American Indians.

Maria Cristina Vlassidis, also of the Latino Health Institute, finds that although some organizations produce publications, fact sheets, and other materials in Spanish, “not all Latinos speak Spanish. Many speak Portuguese or indigenous languages. Moreover, Spanish speakers have hundreds of different dialects.” This means that careful consideration of your target audience is important.

3. Keep in mind that language sensitivity is an issue for both written and oral communications. Crespo offers this example: “If I’m giving a workshop on HIV to Puerto Ricans, I can use the word *condones* for condoms. But if the audience is Dominican, I must use the euphemism *profilacticos*. Otherwise, they will be offended and I will lose them.”

4. Ensure quality interpreter services for patients. Some hospitals don’t employ appropriate interpreters, which threatens accurate communication between patients and staff. “I know of cases where doctors asked cleaning people to interpret,” says Crespo. “While they may be bilingual, they don’t have the skills to convey medical information and choices,” he says. Their involvement is also a serious breach of confidentiality.

In some cases, Hispanics are asked to bring a bilingual family member along to help interpret, which makes the designated interpreter responsible for communication. This may put an infected individual in the awkward position of having a family member know sensitive medical information before he or she is ready to disclose it.

5. Consider the influence of culture on attitudes about health. For example, some American Indians turn to spiritual leaders for medical advice.

Some American Indians and Asians, for example, prefer a more homeopathic or naturopathic approach to medicine. For many groups, including some segments of Asians, sexual issues are considered taboo.

6. Use an effective messenger. Representatives of AIDS prevention programs for non-English speakers say finding the right person to deliver education messages is a challenge. The most effective messages are presented by someone within the same culture.

According to Peou Lakhana, a case management supervisor with the Living Well Project in San Francisco, “With prevention, it doesn’t necessarily follow that Filipinos will have legitimacy when talking to the Chinese community, or vice versa. You have to fine-tune and find the best approach for each situation.”

Karen Soto, a Yupik from Alaska who is HIV infected, puts it this way: “In my village, if an Eskimo says AIDS is a problem, then it’s true. That’s much better than having the message delivered by a white person coming to our snow-bound village wearing high-heeled boots.” 

“How do you get lifesaving AIDS information to such a linguistically, culturally and geographically diverse group?”

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This group was formed partially in response to the way women responded—or failed to respond—to antiretroviral therapies. After the advent of antiretrovirals, between 1996 and 1997, AIDS incidence decreased by 15 percent in the general population, but only decreased by 8 percent for women.



The Collaborative has formed five work groups—care/treatment, primary prevention/education, secondary prevention/education, research, and young women—all charged with identifying the issues and coming up with solutions in the particular focus area. The research work group, for example, has been tasked with finding a way to study the implications of the differences in viral load for men and women (for some reason, women with the same viral load as men progress to full-blown AIDS more quickly).

This group is also trying to translate federally-funded research into everyday language. “We want a woman walking into a health care provider’s office to be able to ask questions about her own health and the latest treatments,” says Vickie Mays, Ph.D., chair of the research group and a professor at the University of California at Los Angeles (UCLA).

The research group is also responsible for providing feedback on side effects and other issues specific to women and for helping to develop chemical and physical barrier methods which can aid in preventing the spread of HIV.

The federal government, in partnership with other work groups and community organizations, has also had its hand in developing communication prevention campaigns (written for women by women); funding local prevention efforts for high-risk communities; designing school-based education programs; providing technical assistance, policy guidance, and human resources for national and regional minority organizations; and recruiting more women for clinical trials.

But in many respects, we’ve got a long way to go with HIV prevention for women. Female-controlled contraception methods are rare. Although condoms remain the most effective means of preventing infection, many women forego them because they fear their partner’s reaction.

The good news is that outreach approaches seem to be getting better. “We’ve gotten wiser about forming partnerships with community-based organizations,” Mays says. And more organizations are using “sister-to-sister” outreach. “We’ve gotten wiser about the context of women’s lives and who the important contacts are to get those messages across.”

UCLA’s AIDS Institute Researches Minority Women and Mental Health

The AIDS Institute of UCLA is conducting the only National Institute of Mental Health (NIMH)-funded study on women of five racial and ethnic groups.

The Women and Family Project is a five-year study that includes 250 African American, white, and Latina women and 30 Asian and Native American women living with HIV. The study also includes 150 of their male or female partners, along with a demographically comparable group of the same number of HIV-negative women.

Researchers monitor the immunologic and clinical aspects of HIV/AIDS every six months, which includes face-to-face interviews and physical exams. Of special interest to researchers are psychosocial issues such as stress, sexuality, relationships, and mental health issues that affect women with the disease.

Unlike most longitudinal or cross-sectional studies of AIDS, project participants range in education, income, relationship status, source of infection, prior and current use of AIDS-related agencies, HIV treatment, and care.

This study inspired a documentary film called “Women and HIV: Four Stories.” The film chronicles how four Los Angeles women of different ages and ethnicities approach life after learning they are HIV-positive.

For more information, call the Women and Family Project at the UCLA AIDS Institute at 310-794-9929. For information about the video, contact Julie Axelrod at 310-794-9947.

H.H.S. News Briefs

New Goals for Healthy People 2010: Health and Human Services (HHS) Secretary Donna Shalala and Surgeon General David Satcher released the Healthy People 2010 initiative at the HHS-sponsored conference Partnerships for Health in the New Millennium in Washington D.C. on January 24-28, 2000. Healthy People 2010 sets national health goals for the first decade of the new century. New goals aim to eliminate racial and ethnic disparities in health by the year 2010. For more information, visit HHS on the web: <http://www.health.gov/healthypeople>.

Surgeon General’s First Report on Mental Health: HHS released the first Surgeon General’s report on mental health on December 13, 1999. *Mental Health: A Report of the Surgeon General* addresses the connection between mental health and physical health, barriers to receiving mental health treatment, and the mental health issues of special populations such as children and elderly persons. For an executive summary of the report, call 877-9-MHEALTH. A full-copy of the 500-page report can be purchased from the Government Printing Office, 202-512-1800.

What Every Employer Should Know

By Kendra Lee

Because of increasing infection rates and longer life expectancies among HIV infected workers, employers can expect to deal with HIV/AIDS in the workplace at some point. Experts say that some of the issues involved can present big challenges, and it's wise to be prepared.

For example, "if people have a deathly fear of working with someone with HIV, they make their decisions based on that fear," says Sheryl Zemo, a department director with the Business and Labor Resource Center of the Centers for Disease Control and Prevention (CDC). "That's why a strong workforce policy and employee education are so important."

Here are some common questions, along with tips to ensure a professional and fair workplace.

Q: What is an HIV/AIDS policy?

A: An HIV/AIDS policy defines a company's position and practices as they relate to an employee with HIV infection. According to Zemo, a good policy sets forth standards of behavior expected by all employees and establishes compliance with federal, state, and local laws. It also lets employees know where to go for assistance if they have questions about HIV/AIDS.

Q: What do company managers need to know?

A: Managers should work with company human resources staff in order to make necessary and reasonable accommodations for workers with HIV/AIDS. AIDS is considered a disability under the Americans with Disabilities Act (ADA), and in 1998, the Supreme Court decided that people infected with HIV can also be protected under the ADA.

Q: Is it necessary to tell other employees, including managers and supervisors, about an HIV-infected employee's status?

A: No. In fact, unless the infected employee requests that an employer inform others at the company, the employer is required by law to maintain the employee's privacy. If the employee asks the employer to tell the rest of the company's workers, the National AIDS Fund recommends that the employer get that request in writing.

Q: What kind of HIV/AIDS education programs should be implemented?

A: Employers should conduct education programs that make clear to employees how HIV is transmitted and how it isn't. Inform employees about the equal opportunity laws that govern fair work places. Also bring in HIV/AIDS experts to explain the possible changes in an HIV-infected person's physical appearance and emotional state.

Q: Are there specific physical limitations and working conditions with which employers should be concerned?

A: If there are any limitations, they typically will come from the infected person's treating physician in the form of a letter. This letter won't state the person's diagnosis, but will state such conditions as the need to use a secure refrigerator at work to store medications and the freedom to leave a work station at regular intervals to take medication.

Q: An HIV-infected employee has used all sick and vacation leave, but continues to call in sick or leave early. Other employees are starting to resent the shift in workload. How should this be handled?

A: The Americans with Disabilities Act states that an HIV-infected employee should be able to perform the "essential functions of his job with or without reasonable accommodation." If no accommodation enables him to perform

the essential functions, there are two options, says Nancy Breuer of The Positive Workplace. An employer could either offer a less demanding job or one that requires fewer hours, or the employer can move to disability leave.

Q: Can an employer terminate an employee because of HIV status?

A: No. It's illegal to fire someone because of a positive HIV status.

Q: Should an employer limit the benefits of a person living with AIDS?

A: There is no reason to limit an HIV-infected employee's benefits, says Mark King, former director of education and communication at AID Atlanta. "A well-managed case of HIV disease is no more costly than many forms of cancer, and much less costly than premature birth or paraplegia resulting from an accident," King says. &

See page 13 for workplace resources.

HIV/AIDS Report to the Secretary

Report to the Secretary on HIV/AIDS in Racial and Ethnic Communities contains more than 70 action steps to guide the federal government in enhancing its efforts to meet the HIV prevention, service, and research needs of racial and ethnic minorities.

Developed by a community/federal workgroup, the report focuses on issues of inclusion, representation, data needs, infrastructure development, and technical assistance.

Access the report on the website of the Office of Minority Health Resource Center, <http://www.omhrc.gov/minhiv.htm>. &

Barriers to Finding Out HIV Status

By Kendra Lee

Despite the gains being made by current AIDS therapies, the HIV/AIDS epidemic is far from over—especially among young people and racial and ethnic minorities.

The Centers for Disease Control and Prevention (CDC) estimates that 650,000 to 900,000 Americans are living with HIV, and roughly one in three of those people don't know they are infected. Up to half of all new infections in this country are among those under age 25. And though the numbers of HIV-infected gay white males has been on a decline, the numbers of HIV-infected gay men of color is increasing. In fact, for the first time in the two-decade epidemic, more minority homosexual men are HIV infected than white gay males.

So why are we still not getting tested?

For some, the stress of learning a positive result seems unbearable. Some believe that the potential issues raised with family members, friends, sex partners, and employers would be more harmful than not knowing their HIV status.

"Fear is a powerful force, especially in communities of color," says Helene Gayle, M.D., director of CDC's National Center for HIV, STD, and TB Prevention. "Many people continue to die alone rather than be shunned by their families."

Still some people fear others would find out and the doors to discrimination would be opened. For example, they may worry about being denied housing or insurance.

In close-knit American Indian communities, some people at risk of HIV infection don't get tested because friends or relatives work in village or reservation health centers. And "many Latinos fail to get tested for fear of being deported," says Rafael Campo, M.D., who practices at Harvard Medical School and Beth Israel Deaconess Medical Center in Boston.

Attitudes of American teens

Testing is seen as unnecessary by some, especially young people. A 1999 report from the Henry J. Kaiser Family Foundation found that many American teenagers underestimate their risk of contracting HIV, particularly teens from cities with high rates of AIDS.

In the report, teens who had not been tested for HIV (roughly 75 percent) did not see themselves or their partners as at risk for HIV. Many lacked knowledge about treatment options or worried that they would be seen as "dirty" or "promiscuous" simply for getting tested. Others didn't know where to go to get anonymous testing or were afraid testing might cost them a lot of money. Many rationalized risky behaviors, stating that they only had sex with virgins or monogamous "clean" partners.

Of critical importance to teens in the Kaiser report was receiving respect from healthcare providers. Teens who did go to medical facilities and clinics to get tested were less likely to follow through with the test if they felt mistreated.

Stereotypes impact doctors' actions

A recent study at the University of California at Los Angeles (UCLA) found that some testing ignorance comes from within the medical profession. In the study, HIV-infected women, especially white and Asian women, often failed to receive an accurate diagnosis or medical attention because they didn't fit doctors' stereotypes of people perceived to be at risk for HIV infection. As a result, white women were the most likely to be infected, and not aware of that infection, for the longest time periods—an average of 63 months.

Dorothy Chin, UCLA psychologist and co-author of the UCLA study, says Asian women rarely received early treatment because of this medical bias. "As a result they did not enter the health care system until they developed full-blown AIDS, significantly undermining their chances for survival," she says.

Approximately 25 million people are estimated to be tested each year in this country, including 8 million blood donors.

To find a local HIV counseling and testing site, call the CDC National AIDS Hotline at 800-342-AIDS. Spanish-speakers can call 800-344-SIDA.

HHS Awards \$527 million for HIV/AIDS Care in High Incidence Areas

HHS Secretary Donna Shalala announced on January 21, 2000, that \$527 million will go to Ryan White Comprehensive AIDS Resources Emergency Act (CARE) Act grants to fund primary health care and support services for low-income individuals in the 51 eligible metropolitan areas (EMAs) hardest hit by the HIV/AIDS epidemic. For the second year, each EMA will also receive funds that target communities of color under the Clinton Administration initiative that addresses the increasing burden of HIV/AIDS among minorities.

Under Title I of the Ryan White CARE Act, EMAs receive formula and supplemental grant awards based on the number of people in the EMA living with the HIV disease. Title I grants provide essential HIV/AIDS health care and a wide range of support services to those who lack or are only partially covered by health insurance. Services include physician visits, case management, assistance in obtaining medications, home-based and hospice care, substance abuse and mental health services, and other needed services.

CDC Releases New Guidelines for HIV Monitoring and Surveillance

In December 1999, the Centers for Disease Control and Prevention (CDC) published new guidelines on national HIV surveillance to help states monitor the course of their local epidemics.

Since the beginning of the epidemic, CDC has used AIDS cases to monitor the course of HIV and AIDS. In the wake of treatment advances, which have slowed the progression from HIV to AIDS for many people, data on AIDS cases alone are no longer reflective of new HIV infections. So CDC recommends that all states collect HIV data then report the findings to the CDC.

• All state and local programs should collect a standard set of surveillance data for all cases that meet reporting criteria for HIV infection and AIDS. The standard data set includes:

- a) patient identifier;
- b) earliest date of diagnosis of HIV infection;
- c) earliest date of diagnosis of an AIDS-defining condition;
- d) demographic information (date of birth, race/ethnicity, sex) and residence at diagnosis of HIV infection and of AIDS;
- e) HIV risk exposure;
- f) facility of diagnosis; and
- g) date of death and state of residence at death.

In addition to this information, the date of HIV diagnostic testing, testing results, and exposure to antiretroviral treatment for reducing perinatal HIV transmission should be collected for all infants with perinatal exposures to HIV.

- CDC advises that state and local surveillance programs use the same confidential name-based approach that is currently used for AIDS surveillance nationwide. CDC recognizes that some states have adopted, and others may elect to adopt, coded case identifiers for public health reporting and HIV infection.
- HIV and AIDS surveillance should be used to identify rare or previously unrecognized modes of HIV transmission, unusual clinical or virologic manifestations, and other cases of public health importance. Physicians are encouraged to promptly report atypical cases to local, state, or territorial public health officials for follow-up.
- HIV and AIDS case surveillance efforts should result in collection of data from all public and private sources of HIV-related testing and care services.
- Local and state surveillance programs should regularly publish, in print or electronically, aggregated HIV/AIDS surveillance data in a format that facilitates use of the data by federal, state, and local agencies, and other groups.
- Surveillance programs should conduct regular, ongoing assessments of the performance of the surveillance system.
- State and local programs should document their security policies and procedures and ensure their availability for review.

Here's just a glimpse of CDC's recommended surveillance practices. For the full report called *Guidelines for National Human Immunodeficiency Virus Case Surveillance, Including Monitoring for Human Immunodeficiency Virus Infection and Acquired Immunodeficiency Syndrome*, visit CDC's website: <http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/rr4813a1.htm>

State by State HIV Testing as of 9/98

	Confidential Testing	Anonymous Testing	State Health Department Tracks Confidential Positive Test Results
Total	50	39	32
Alabama	X		X
Alaska	X	X	
Arizona	X	X	X
Arkansas	X	X	X
California	X	X	
Colorado	X	X	X
Connecticut	X	X	X
Delaware	X	X	
Florida	X	X	X
Georgia	X	X	
Hawaii	X	X	
Idaho	X		X
Illinois	X	X	
Indiana	X	X	X
Iowa	X		X
Kansas	X	X	
Kentucky	X	X	
Louisiana	X	X	X
Maine	X	X	
Maryland	X	X	
Massachusetts	X	X	
Michigan	X	X	X
Minnesota	X	X	X
Mississippi	X		X
Missouri	X	X	X
Montana	X	X	
Nebraska	X	X	X
Nevada	X		X
New Hampshire	X	X	
New Jersey	X	X	X
New Mexico	X	X	X
New York	X	X	
North Carolina	X		X
North Dakota	X		X
Ohio	X	X	X
Oklahoma	X	X	X
Oregon	X	X	X
Pennsylvania	X	X	
Rhode Island	X	X	
South Carolina	X		X
South Dakota	X		X
Tennessee	X		X
Texas	X	X	X
Utah	X	X	X
Vermont	X	X	
Virginia	X	X	X
Washington	X	X	
West Virginia	X	X	X
Wisconsin	X	X	X
Wyoming	X		X

Confidential and Anonymous Testing

HIV testing is either confidential or anonymous:

Confidential HIV testing. A person's name is recorded along with test results. Confidential results are made available to medical personnel and, in 32 states, the state health department.

Anonymous HIV testing. No name is associated with test results. As of September 1998, anonymous testing was available in 39 states plus the District of Columbia and Puerto Rico.

Source: The Kaiser Family Foundation, Fact Sheet on HIV Testing, 1999

Editor's Note

Each issue of *HIV Impact* will feature research news from a variety of sources. Our goal is to bring you up-to-date information that impacts racial and ethnic minorities. Some research sources may be regular contributors, but we are always on the look-out for new contributors to this section. &

Defining "Consistent" and "Correct" Condom Use

According to CDC, "consistent" use means using a condom during each act of sexual intercourse. Using a condom "correctly" includes all of the following:

- Use a new condom for each act of vaginal, anal, or oral intercourse.
- Put on the condom as soon as erection occurs, and before any vaginal, anal, or oral contact with the penis.
- Hold the tip of the condom and unroll it onto the erect penis, leaving space at the tip of the condom, yet ensuring that no air is trapped in the condom's tip.
- Adequate lubrication is important to prevent condom breakage, but use only water-based lubricants, such as glycerine or lubricating jellies (which can be purchased at a pharmacy). Oil-based lubricants, such as petroleum jelly, cold cream, hand lotion, or baby oil, can weaken the condom.
- Withdraw from the partner immediately after ejaculation, holding the condom firmly to the base of the penis to keep it from slipping off.

Benefits of Consistent and Correct Condom Use

Nearly a million Americans are infected with HIV, most of them through sexual transmission, according to the Centers for Disease Control and Prevention (CDC). And about 12 million cases of other sexually transmitted diseases (STDs) occur each year.

Not having sex with an infected partner is the best route to prevention. But for those who have sex, latex condoms are highly effective when used consistently and correctly (see sidebar this page for definitions).

According to CDC, recent studies show compelling evidence that latex condoms are highly effective in protecting against HIV infection when used for every act of sexual intercourse.

The strongest proof is research on couples in which one member is infected with HIV and the other isn't—also known as "discordant couples." In one two-year study of discordant couples in Europe, among 124 couples who reported consistent use of latex condoms, none of the uninfected partners became infected. In contrast, among the 121 couples who didn't use condoms or didn't use them consistently, 12 (10 percent) of the uninfected partners became infected.

But despite such information, myths about condoms persist. According to CDC, a few common myths are:

Myth #1 Condoms don't work. Some have expressed concerns about condom failure rates among couples using condoms for pregnancy prevention. Analysis of these studies show that the large range of efficacy rates is related to incorrect and inconsis-

tent use. Research shows that only 30 to 60 percent of men who claim to use condoms for contraception actually use them for every act of intercourse. Further, even people who use condoms every time may not use them correctly.

Myth #2 Condoms frequently break. Some have questioned the quality of latex condoms. Condoms are classified as medical devices and are regulated by the U.S. Food and Drug Administration. Every latex condom manufactured in the United States is tested for defects before it is packaged. Several studies show that condom breakage rates are less than 2 percent. And according to CDC, most breakage is likely due to incorrect use rather than poor quality. Using oil-based lubricants can weaken condoms. Condoms can also be weakened by age, by exposure to heat and sun, or they can be torn by teeth or fingernails.

Myth #3 HIV can pass through condoms. Lab studies show that intact latex condoms provide a highly effective barrier to sperm and micro-organisms, including HIV and the much smaller hepatitis B virus.

For more information, look up the CDC fact sheet "Condoms and Their Use in Preventing HIV Infection and Other STDs", 1999. http://www.cdc.gov/nchstp/hiv_aids/pubs/facts.htm &

HIV/AIDS Cases Among Women and Minorities

From July 1998 through June 1999, a total of 47,083 AIDS cases were reported, compared with 54,140 and 64,597 cases reported in the two preceding 12-month periods, July 1997 through June 1998 and July 1996 through June 1997. But despite the decrease in the number of cases reported, health departments continue to report a large number of AIDS cases.

Women account for 10,841 (23 percent) reported adult AIDS cases. Among women, African Americans and Hispanics account for 80 percent of cases; among men, African Americans and His-

panics account for 61 percent of cases.

Women account for 32 percent of adult cases of HIV infection reported from July 1998 through June 1999. Among women, African Americans, and Hispanics account for 77 percent of HIV cases. Among men, African Americans and Hispanics account for 58 percent of cases. Persons aged 13-24 account for 15 percent of reported HIV cases, and women account for 49 percent of cases in this age group. &

Source: CDC's HIV/AIDS Surveillance Report, Vol 11, No. 1

Primary HIV Infections Associated with Oral Transmission

In the most definitive study to date, researchers have found evidence that a significant percentage of new HIV infections in some groups of men who have sex with men are due to oral sex, a mode of transmission too often regarded as posing little or no risk.

At the 7th Conference on Retroviruses and Opportunistic Infections in early February 2000, the Centers for Disease Control and Prevention (CDC) reported that among a group of HIV-infected men, 7.8 percent were infected through oral sex.

The study was conducted by CDC's Beth Dillion, in collaboration with researchers at the University of California, San Francisco's Options Project. Researchers assessed risk behavior for 102 gay and bisexual men recently infected with HIV and found that oral sex was the only risk behavior for eight of these men. Most of these men stated they believed oral sex was represented either no or minimal risk.

For some, oral sex is equated with safe sex. However for the individuals in this study, and for countless others, this false assumption has led to tragic lifelong consequences, according to CDC officials. Public health officials fear that many gay men may be increasing the frequency of oral sex as a replacement for higher-risk behaviors, but may assume that oral sex is a risk-free activity. While oral sex may carry a

much lower risk of transmitting HIV than other forms of sex, this study suggests that repeated exposures may add up to pose a more significant risk.

This study was designed to help assess how many new infections may have been transmitted by oral sex within a group of recently HIV-infected men. Researchers conducted extensive interviews with the men and their partners about risk behaviors around the time of infection.

In the past, it has been difficult to assess whether people were infected through oral sex because most individuals do not engage exclusively in oral sex and because it has not been possible to pinpoint the time of infection. But CDC recently developed Serologic Testing Algorithm for Recent HIV Seroconversions (STARHS), a new testing technology that can pinpoint recent infections and helped to identify the men to be interviewed in this study.

If any other risk behaviors were identified by the infected individual or their partner, oral sex was excluded as the route of transmission. Because of these stringent requirements, 7.8 percent may be an underestimate of transmission through oral sex in this group. 

HIV Vaccine Trials and Community Outreach

Since 1988, the Johns Hopkins Center for Immunization Research (CIR) has been involved in the search for a vaccine that prevents new HIV infections. With funding from the National Institutes of Health (NIH), the CIR has embarked on a public information campaign to increase awareness of HIV vaccines, vaccine trials, and the potential benefits a preventive HIV vaccine would have on future generations.

As part of the campaign, the education and outreach staff at the CIR has set out to build and create community partnerships. To date the staff has worked with approximately 30 high schools, colleges, churches, community based organizations, and HIV/AIDS service organizations to introduce the concept of HIV vaccines and the research trial process.

Outreach efforts include information on the general science of vaccines and HIV vaccine trials. The CIR Community Advisory Board oversees and advises all activities of its AIDS Vaccine Evaluation Unit.

Historically, vaccines have been used to boost the body's immune system against a specific disease before the person has been infected. This way, a person can fight off infection from a disease with an already established defense mechanism provided by the vaccine. In the case of HIV, a vaccine would work the same way. But, unlike other vaccines, HIV vaccines for humans only use a small, man-made copy of one of the HIV virus' components, such as a single protein or part of the virus' genetic material in order to stimulate the body's immune system. Therefore, no one can become infected with HIV or get AIDS from taking the vaccine because no actual HIV virus is ever used.

Several types of vaccine strategies are used in HIV vaccine research. Examples are recombinant vector vaccines and subunit vaccines. Subunit vaccines include a genetically engineered vaccine that uses one or more parts of the disease causing bacteria or virus to stimulate the body's immune system. The proteins gp160 and gp120, located on the outer shell of the HIV virus, have frequently been used.

For additional information, please call the Johns Hopkins Center for Immunization Research at 1-877-863-1374 or visit the CIR website at <http://jh.jhsph.edu/cir/aveg> 

Glossary of Terms

cell-mediated immunity (also called cellular immunity): the branch of the immune system that targets host cells infected with micro-organisms such as viruses, fungi and certain bacteria. It is coordinated by helper T-cells and CTLs.

CTL (cytotoxic T-lymphocyte; also called killer T-cells): immune cells that destroy host cells infected with viruses, fungi or certain bacteria, in contrast to B-lymphocytes, which generally target free-floating viruses in the blood. CTLs carry the CD8+ surface marker and are thought to play an important role in immunity to HIV.

priming (also called prime-boost): giving one vaccine dose to induce certain immune responses, to be followed by or together with a second type of vaccine (booster).

recombinant vector vaccines: a vaccine used to prime the immune system and then to boost the immune response with a recombinant protein.

subunit vaccine: a vaccine consisting of only one protein from the virus or other pathogen. HIV subunit vaccines produced by genetic engineering are called recombinant subunit vaccines.

New FDA Website Gives Tips on Buying Prescription Drugs Online

In December 1999, the Food and Drug Administration (FDA) launched a new Internet website to give consumers easy-to-understand information on buying prescription drugs and medical products online. The website is part of FDA's action plan to increase public awareness about the health, economic, and legal risks of online sales of prescription drugs and medical products.

This issue is becoming increasingly important as more consumers use the Internet to buy medical products. Because of the ease with which a website can be created, an illegitimate pharmacy may appear legitimate to prospective buyers. Under the Food, Drug, and Cosmetic Act, FDA has the legal authority to regulate the safety, effectiveness, manufacturing, labeling, and advertising of prescription drugs.

Visit FDA's website at <http://www.fda.gov> and click on the "Buying Medical Products Online?" banner. The site has information on FDA's enforcement efforts, how to spot health fraud, and a list of answers to frequently-asked questions about Internet drug sales.

Consumers who suspect that a website is illegally selling human or animal drugs, medical devices, biological products, foods, dietary supplements, or cosmetics over the Web can also fill out an electronic complaint form provided at this site, and e-mail it directly to FDA. [✉](#)

FTC Charges Supplier with Misrepresenting Accuracy of HIV Tests

The Federal Trade Commission (FTC) announced on January 18, 2000, that it has charged a supplier of HIV tests with falsely representing that its HIV tests accurately detected HIV, the virus that causes AIDS. The company, Alfa Scientific Designs, Inc., has agreed to a stipulated preliminary injunction that, among other things, halts all sales of HIV tests.

According to the FTC, Alfa Scientific was the supplier of faulty HIV tests to Medimax, Inc. and its owner David M. Rothbart. Medimax was charged by the FTC last December for falsely representing on the Internet that its HIV tests accurately detected HIV. Medimax agreed to a preliminary injunction as well and is no longer marketing its test kits.

Alfa Scientific's web site claimed that its HIV tests detected antibodies in human whole blood or serum "with high specificity and sensitivity." The tests were marketed and distributed as "Alfa HIV-1/2 Rapid Tests." The FTC reported, in most instances, when tested with HIV-positive whole blood samples, Alfa Scientific's tests produced false negative results. Alfa Scientific does not sell directly to consumers, but to distributors like Medimax.

"This case is especially troubling because the company's deceptive actions may have delayed HIV positive users of the test from seeking the medical treatment they need," said Jodie Bernstein, director of FTC's Bureau of Consumer Protection.

This is the third time the FTC has taken law enforcement action against a marketer of HIV tests. In addition to the Medimax case, on November 17, 1999, the agency announced that Cyberlinx Marketing, Inc., of Las Vegas, NV, made false representations on the Internet that its HIV home test kits accurately detected HIV. Cyberlinx agreed to be banned from marketing any HIV test kits and to pay back the money it received from the sale of the kits. [✉](#)

Some HIV/AIDS Sites

AEGIS

<http://www.aegis.org>

AIDS Clinical Trials Information Service

<http://www.actis.org>

AIDS Treatment News

<http://www.aidsnews.org>

Centers for Disease Control and Prevention National Prevention Information Network

<http://www.cdcnpin.org>

HIV/AIDS Treatment Information Service

<http://www.hivatis.org>

National Association of People with AIDS

<http://www.napwa.org>

National Minority AIDS Council

<http://www.nmac.org>

U.S. Department of Justice

<http://www.usdoj.gov/crt/ada/pubs/hivqanda.txt>

NMAC Puts Newsletter Database Online

The National Minority AIDS Council (NMAC) has collected HIV/AIDS treatment newsletters and put them together in a searchable database. NMAC obtained the newsletters from various sources, including AIDS Treatment Data News and the Bulletin of Experimental Treatments for AIDS.

By entering the topic of your choice, newsletters that correspond to that topic will be highlighted for your review. You can also access a pop-up dictionary to look up unfamiliar terms. In the next phase of this project, NMAC will post low-literacy fact sheets on HIV/AIDS in four languages: Chinese, Creole, English, and Spanish.

Access the treatment newsletter database by visiting <http://nmac.s3.com/publist.htm>. If there are other treatment newsletters you would like to suggest for inclusion, contact NMAC at info@nmac.org; 1931 13th St., N.W., Washington, D.C. 20009. [✉](#)

New Publications

■ AIDS Treatment Information Service, *Guidelines for Prevention of Opportunistic Infections in Persons Infected with HIV*, 1999 report. Provides recommendations for HIV/AIDS prevention and care. Available by contacting the AIDS Treatment Information Service at 1-800-448-0440.

■ Centers for Disease Control and Prevention (CDC), *HIV/AIDS Among Racial/Ethnic Minority Men Who Have Sex with Men*, January 14, 2000 report. Provides 1989-1998 information concerning HIV/AIDS among minority men who have sex with other men. Available by contacting the CDC National Prevention Information Network at 1-800-458-5231 or downloading from <http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/mm4901a2.htm>.

■ CDC, *Tuberculosis: A Guide for Adults and Adolescents with HIV*, 1999 brochure. Defines tuberculosis and how it is contracted and provides tips on avoiding it. Available by contacting the CDC National Prevention Information Network at 1-800-458-5231.

■ CDC, *You Can Prevent Cytomegalovirus (CMV) Infection*, 1999 brochure. Provides a general overview of CMV and ways to avoid contracting the infection; part of a series of opportunistic infection prevention brochures. Available by contacting the CDC National Prevention Information Network at 1-800-458-5231.

■ Food and Drug Administration (FDA), *How to Protect Yourself from AIDS*, 1999 brochure. Provides tips on safer sex, HIV testing, and food preparation for people with AIDS. Available by contacting the FDA at 301-827-4460.

■ Kaiser Family Foundation, *Medicaid and HIV/AIDS Policy: A Basic Primer*, August 1999 report. Presents in-depth information on Medicaid, the federal/state program that provides health coverage for low-income families and people with disabilities and is the largest source of public financing for HIV/AIDS care in the U.S. (Package Code: 2136). Available by contacting the Kaiser Family Foundation at 1-800-656-4533 or visit <http://www.kff.org>.

■ National Center for HIV, STD, & TB Prevention, *Compendium of HIV Prevention & Interventions with Evidence of Effectiveness*, 1999 report. Provides summaries of interventions in high-risk communities. In order to be included in the compendium, interventions must have evidence of reducing sex- and drug-related risks and the rate of HIV infections. Available by downloading from <http://www.cdc.gov>.

■ National Institutes of Health (NIH), *AIDS Research and Minority Populations*, 1999 report. Provides information concerning HIV/AIDS research, including clinical trials, among minority populations. Available by contacting the Office of AIDS Research, NIH at 301-402-3357. 

Workplace Resources

American Red Cross, HIV Workplace Program: Offers a brochure called "Your Job and HIV" and a video called "America at Work: Living with HIV." 703-248-4222; <http://www.redcross.org>.

Centers for Disease Control and Prevention, Business and Labor Responds to AIDS: Offers "The Manager's Kit." 1-800-458-5231; <http://www.brta-ltra.org/>

National AIDS Fund: Offers "A Health and Medical Checklist Developed by the National AIDS Fund Return-to-Work Initiative"; "Return to Work Issues for Persons with HIV and AIDS: A Personal Assessment Tool"; and "What About My Rights? Guidelines for Employers and Employees Living with HIV/AIDS." 1-800-234-AIDS; <http://www.aidsfund.org>.

National Association of People with AIDS: Offers "Return to Work Issues." 202-898-0414; <http://www.napwa.org>.

U.S. Department of Justice: Offers "Questions and Answers about the Americans with Disabilities Act." 1-800-514-0301; <http://www.usdoj.gov/crt/ada/pubs/hivqanda.txt>. 

HRSA Announces HIV Funding Opportunities

The Ryan White C.A.R.E. Act Title III Early Intervention Services (EIS) Grants (CFDA#: 93.918 B): This program supports organizations in providing early intervention services to people with HIV on an outpatient basis. Funding preference will be given to approved/unfunded applicants who submitted an application for funding in FY 1999 and to applicants who previously received Title III planning grants. Preference will also be given to applicants providing services in rural and underserved communities. The application deadline is **July 17, 2000**.

The Ryan White C.A.R.E Act Title III HIV Planning Grants (CFDA#: 93.918 C): This program supports communities and health service entities in planning comprehensive outpatient primary care services for people with HIV or at risk for HIV. Funding priority will be given to applicants in rural or underserved areas, and applicants proposing to build primary care capacity in communities of color. The application deadline is **June 2, 2000**.

To obtain application kits for both grant programs, contact the Health Resources and Services Administration's Grants Application Center at 1-877-477-2123. 

U.N. Issues Warning on AIDS Crisis in Africa; Number of AIDS Orphans Continues to Grow

On January 10, 2000, the United Nations Security Council (UN) held a meeting on AIDS—the first ever UN meeting on a health issue. One main message from the meeting: AIDS is on the way to becoming Africa's top human security issue.

The Security Council's decision to address AIDS underscores the rapid evolution of the epidemic. Twenty-three million people in Africa have HIV or AIDS; 90 percent of the world's 11 million AIDS orphans are in Africa. In 1998, 200,000 Africans died from war, but 2.2 million died from AIDS. About half of these HIV infections occur before the age of 25, with young Africans typically dying of AIDS before age 35.

Children are being hit hard by the epidemic. By the year 2000, the estimated cumulative number of AIDS orphans will rise to 13 million, according to the Joint United Nations Program on HIV/AIDS (UNAIDS). Ninety-five percent of these orphans—defined as children under the age of 15 who have lost either their mother or both parents to AIDS—are in sub-Saharan Africa. Compared with children orphaned by other causes, AIDS orphans are at increased risk of abuse and illness. These children are often stigmatized, leaving them socially isolated and deprived of basic education and social services.

"The scale of the orphan crisis is almost unimaginable," says Carol Bellamy, executive director of the United Nations Children's Fund (UNICEF) at a United Nations World AIDS Day Symposium in December 1999. "Before AIDS, about two percent of all children in developing countries were orphans. By 1997, that figure jumped to seven percent in many African countries—in some countries the figures run as high as 11 percent." 

International Association of Physicians in AIDS Care to Hold Annual Meeting

The International Association of Physicians in AIDS Care (IAPAC) will hold its annual meeting on May 19-21, 2000, in Chicago, Illinois. The IAPAC is accepting abstracts until March 15, 2000. Abstracts should relate to HIV or HIV coinfection with other diseases such as hepatitis, and fall within these categories: education and prevention; mother-to-child transmission; drug resistance; diagnostic technologies; disease management; and disease management within special populations such as adolescents, migrant workers, and the homeless. The non-profit group has more than 6,000 members in 43 countries. Association committees cover such topics as migrant worker health, patient education, and prison health.

For more information, contact IAPAC at 33 North LaSalle St., Suite 2600, Chicago, IL, 312-795-4930; <http://www.iapac.org>. 



Source: Children Orphaned by AIDS, Joint United Nations Program on HIV/AIDS (UNAIDS), 2000

HIV Breastfeeding Risk Highest in Early Months After Birth

An infant's risk of becoming infected with the AIDS virus through breastfeeding is highest during the first few months of life, according to a new National Institutes of Health (NIH) study conducted among HIV-infected mothers and their babies in the African nation of Malawi. A mother's inexperience with breastfeeding may increase HIV transmission risk.

Lead author Paola Miotti, M.D., of the National Institute of Allergy and Infectious Diseases (NIAID), senior author Robert J. Biggar, M.D., of the National Cancer Institute (NCI), and their colleagues investigated the timing of and risk factors for HIV infection among breastfed infants of HIV-infected mothers.

Breastfeeding is the recommended method of infant feeding in Malawi and other developing countries, where alternatives to breast milk are often scarce, unsafe, or culturally unacceptable. In the United States, where safe alternatives to breast milk are plentiful, HIV-infected women are advised against breastfeeding their infants.

The NIH researchers tested infants for HIV infection during visits to the postnatal care clinic of a large urban hospital in Malawi. Only babies who tested negative for HIV at their first visit, six weeks after birth, were included in the study. Subsequent HIV tests conducted over the next two years revealed that 47 of the 672 infants in the study became HIV-infected from breastfeeding. Nearly half of those infections occurred within five months after birth. Another 15 babies became infected between postnatal months 6 and 11, and seven more between months 12 and 17 of follow-up. Only four HIV infections occurred between months 18 and 23.

No babies became infected with HIV after they stopped breastfeeding. Researchers conclude that breastfeeding recommendations in developing countries must carefully balance the risk of HIV transmission with the well-known nutritional and health benefits of breastfeeding. 

Tell us what *you* want to read in *HIV Impact*:

Please take a few minutes to tell us what you think and fax or mail it back to: Linda Quander, PhD, Editor, HIV Impact, Fax: 301-495-2919. Mailing address: Linda Quander, Office of Minority Health Resource Center, P. O. Box 37337, Washington, DC 20013-7337.

Your feedback will allow us to understand your needs and serve you better. Thank you.

NAME & TITLE _____

ORGANIZATION _____

ADDRESS _____

CITY, STATE, ZIP _____

PHONE/E-MAIL _____

Please check the category which most accurately reflects your responses to the questions below:
Strongly Agree = SA; Agree = A; Uncertain = U; Disagree = D; Strongly Disagree = SD.

1 Which of the following regular sections do you find to be useful?

	SA	A	U	D	DS
Minority Health Perspective, p.3	<input type="checkbox"/>				
Funding, p.7	<input type="checkbox"/>				
International News, p.9	<input type="checkbox"/>				
On the Internet, p.10	<input type="checkbox"/>				
Research News, p.13	<input type="checkbox"/>				
Conferences, p.16	<input type="checkbox"/>				

2 Which of the following additional sections would you find to be useful in the future?

	SA	A	U	D	DS
Book Reviews	<input type="checkbox"/>				
Consumer Updates	<input type="checkbox"/>				
Legislative Updates	<input type="checkbox"/>				
Professional/Organizational Activity Updates	<input type="checkbox"/>				

3 What other suggestions for useful sections or articles do you have?

4 Do you read other HIV/AIDS publications? If so, please list the publications which you find to be useful.

5 What do you consider the most pressing HIV/AIDS issue for minorities today?

6 What is the best strategy you've developed or participated in to improve HIV/AIDS prevention, education, or treatment?

Comments:

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HEALTH & HUMAN SERVICES
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HIV Impact

Upcoming Conferences

APRIL

12-14: *3rd International Workshop on Salvage Therapy for HIV Infection.* To be held in Chicago, Illinois. Sponsored by the International Medical Press. Contact: 404-233-6446.

16-21: *International Conference on Antiviral Research.* To be held in Baltimore, Maryland. Sponsored by the International Society for Antiviral Research. Contact: 202-973-8690.

28-30: *PFLAG National Conference: Family Voices for Equality.* To be held in Arlington, VA. Sponsored by Parents, Families, and Friends of Lesbians and Gays (PFLAG). Contact: 202-638-4200; Website: <http://www.pflag.org>.

4/30- 5/2: *3rd Annual Conference on Vaccine Research.* To be held in Washington, DC. Sponsored by the National Foundation for Infectious Diseases (NFID). Contact: 301-656-0003; Website: <http://www.nfid.org/conferences>.

MAY

4-7: *10th Annual Clinical Care Options for HIV Symposium.* To be held in Scottsdale, Arizona. Sponsored by Northwestern University Medical School. Contact: 888-391-3996; Website: <http://hiv.medscape.com/symposium2000>.

9: *HIV Update 2000.* To be held in Hagerstown, MD. Sponsored by Washington County Health System Education Department. Contact: 301-790-8627.

25-27: *2nd Millennium Infectious Disease in Corrections: A Coordinated Approach.* To be held in Scottsdale, AZ. Sponsored by Correctional HIV Consortium (CHC). Contact: 415-439-5285; Website: <http://www.silcom.com/~chcl/>.

31: *13th Annual HIV/AIDS on the Front Line Conference.* To be held in Costa Mesa, CA. Sponsored by University of California, Irvine Pacific AIDS Education and Training Center. Contact: 714-834-8020.

5/31- 6/3: *12th Annual National Conference on Social Work and HIV/AIDS - HIV/AIDS 2000: The Social Work Response.* To be held in San Diego, CA. Sponsored by Boston College Graduate School of Social Work. Contact: 617-552-4038.

JUNE

7-11: *1st International Conference - Rural Aging: A Global Challenge.* To be held in Charleston, WV. Sponsored by U.S. Human Resources and Services Administration. Contact: 304-293-0628; Website: http://www.hsc.wvu.edu/rural_aging.

10-12: *7th Latino HIV/AIDS Conference 2000: Help Yourself. Be Part of the Solution.* To be held in Los Angeles, CA. Sponsored in part by Aliaza Los Angeles County Latino Caucus on HIV/AIDS. Contact: 800-400-7432 (SIDA).