A Constant Increase: AIDS In Ethnic Communities

Amanda Houston-Hamilton, DMH

Despite the public perception of AIDS as a white, gay male disease, four out of every ten Americans diagnosed with AIDS is non-white. The proportion of AIDS cases among people of color has remained the same since 1983 when the Centers for Disease Control (CDC) described the first 1,000 cases. At that time, 60% of those total cases were white, 25% Black, 14% Latino, and 1% consisted of Asian, American Indian, and other ethnically-identified groups.

AIDS is not a new phenomenon among people of color. The first report of AIDS among these groups occurred in New York in 1980, two years after the earliest report of AIDS in the gay population. The following year the CDC noted 21.5% of the first 107 cases of previously healthy persons with Kaposi’s sarcoma and Pneumocystis carinii pneumonia were Black and Hispanic men, most of whom identified themselves as gay and bisexual. Although in sheer numbers the great majority of these people with AIDS were gay and white and male, minorities were represented in far greater proportion than their presence in American society. This situation still holds today: Blacks represent 11.7% of the total population but 25% of AIDS cases; Latinos represent 6.4% of the population but 14% of AIDS cases.

The ethnic differences are even more stark among women and children. At this time 52% of women with AIDS are Black, 7% are Latinas, and 7% are white. Most of these women are of childbearing age. Consequently, of the pediatric cases reported to the CDC in July 1986, 59% are Black, 22% are Latino, and 18% are white. Three-quarters of these babies are from New York, New Jersey, Florida, and California. The CDC reported the first pediatric cases of AIDS in 1982, and others have been identified retrospectively to 1980. Almost all these infants became infected in utero; 86% of diagnosed children have at least one intravenous (I.V.) drug using parent.

A more ominous picture appears with estimates of the live births to high risk women. Based on calculations by Peter Selwyn, MD of Albert Einstein School of Medicine in New York City, of the estimated 20,000 to 30,000 high-risk babies, mostly Black and Puerto Rican, born in the New York area alone since 1982, 6,000 of them have been reported to have AIDS or ARC. It is unclear whether more than these 6,000 babies have been born with AIDS and ARC and have simply not been reported. Furthermore, these figures are only for women who are themselves I.V. drug users; the numbers do not reflect births from women who are partners of I.V. drug users.

Information on Asian populations whether Chinese-, Korean-, Japanese-, Filipino-Americans is extremely limited as is data on American Indians. In most statistics these groups are reported as a single category. Not only do these people resent being called “other”, the blurred ethnic distinction misses trends in these populations. A few of these communities, for example, recent Indochinese refugees and urban Indians, may be at great risk for AIDS. According to Sally Jue of the AIDS Project / Los Angeles, there were fewer than 100 Asian people with AIDS nationwide and fewer than 40 cases in California (22 cases or 1.2% in San Francisco) as of April 1986. Of these Americans, 77 were gay and bisexual men, 5 were I.V. drug users, 6 cases resulted from transfusions, and the illness of 9 others was of unknown etiology. Some observers have suggested that community caregivers may choose to mask causes of death due to concern about family sensitivities and neighborhood sentiment, thus underreporting incidence of AIDS morbidity and mortality.

Risk Groups in Black and Latino Communities

Robert Redfield, MD at Walter Reed Medical Center in Washington, D.C. has analyzed the results of mandatory testing of Army recruits, most of whom are Black. His study found 3.9 of 1,000 Black and 2.6 of 1,000 recruits from other racial groups tested positive for AIDS antibodies compared to 0.9 of 1,000 white recruits. Demographically the Black recruit may be younger, more likely to be from a "street" background, sexually active and a drug user or experimenter, and less likely to seek health care or health education than the general population.

"Black and Latino people are found in every risk group: gay and bisexual men with and without a history of I.V. use; heterosexual I.V. drug users, heterosexual contacts of people with AIDS, hemophiliacs, babies of women with AIDS, and recipients of blood products."

Wayne Greaves, MD, Chief of the Department of Infectious Diseases at Howard University Hospital, has found in his preliminary studies of the Washington, D.C. Black community that most ARC cases were I.V. related and most AIDS cases were among gay men. His ongoing study may provide the first tracking of risk behaviors among this group.

New data are emerging from work with I.V. drug users. The widely varying incidence of AIDS in minority communities around the nation may reflect regional differences in drug and sexual practices. Eddie King, director of Health Education Resource Organization in Baltimore, recently noted that having multiple sexual partners is an important part of the "be cool" ethic of Baltimore users. Moreover, the state's gonorrhea rate is highest in 15-24 year old Black youth.

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Black and Latino people are found in every risk group: gay and bisexual men with and without a history of I.V. use, heterosexual I.V. drug users, heterosexual contacts of people with AIDS, hemophiliacs, babies of women with AIDS, and recipients of blood products. The majority of AIDS cases in three risk groups are adult Blacks and Latinos. These are I.V. drug users, heterosexual contacts, and that vague “other” category which includes foreign born and those with no identified risk behavior. There are also large numbers of ethnic minorities among growing potential risk groups not yet delineated in the statistics: prisoners, the homeless, and undocumented workers.

Haitians, once considered the source of AIDS and later removed from the risk group list, have again been included. Although their exposure is much lower than other risk groups, at 8% the prevalence of seropositivity is high enough for concern. Use of non-sterile needles, rituals and medical practice, prostitution, a high rate of bisexuality (37% in one study) and a high incidence of STDs in that country have all been implicated for spreading HIV.

Bakeman et al. showed graphically the overlap of I.V. and gay populations. As of January 1986, 77% of I.V. cases in the nation were in New York City where the incidence of AIDS from all sources is 0.4 per thousand whites, 7.1 per thousand Blacks, and 75.5 per thousand Latinos. Also, 95% of prisoners with AIDS are I.V. drug users, and 50% of Blacks and 15% of Latinos with AIDS are users.

Retrospective examination of stored serum samples of I.V. drug users in New York City has shown an increase in seropositivity similar to that seen in white gay men. Current statistics reveal that AIDS is quickly becoming the leading cause of death of young men in Harlem. AIDS is also the second highest cause of death for New York City women aged 30 to 34. Again, most of these are women of color. Despite these facts, there are no prevention and education programs in that major Black and Latino neighborhood.

Only recently have federal and a few state AIDS reporting systems begun to recognize the I.V. drug use in the gay community. Many Blacks and Latinos are in this dual group. Bakeman et al showed graphically the overlap of I.V. and gay populations among people with AIDS. A larger number of Black men at risk for AIDS are bisexual, and more of these gay or bisexual men are I.V. drug users. These higher rates of bisexuality and I.V. use suggest that the Black and Latino heterosexual community are at greater risk than whites. These factors make case reporting and intervention much more complicated and sensitive in ethnic communities.

Clinical Findings

The average survival rate of Blacks with AIDS is 8 months compared to 18-24 months for whites, according to Walter R. Dowdil, PhD, AIDS Coordinator for the U.S. Public Health Service. Participants at the recent “AIDS in the Black Community” forum held in Washington, D.C. agreed that one explanation for this difference is the tendency of Blacks to postpone medical care until very late in the illness. A second reason is the long-established trend of infectious disease to lodge in poor, non-white populations — due primarily to economic and nutritional differences. Finally, the higher incidence in ethnic communities of pneumocystis pneumonia, one of the most lethal diseases seen with AIDS, may help explain the difference in survival rates.

Although Kaposi’s sarcoma (KS) is more frequently seen among gay and bisexual men with AIDS, the cancer does appear in the nongay or bisexual Black population with AIDS in the United States and in other countries. People with AIDS and their advocates have reported the difficulties encountered when physicians are unaccustomed to looking for or recognizing KS lesions on dark skin. The lesions do have a different appearance: they are bluish rather than the dark-reddish purple typically seen on white skin.

International Comparisons

Information on people of color with AIDS on other continents has not shown much relationship to their situation here. The most recent studies indicate AIDS appeared in America, Africa, and Europe at about the same time. Although the risk typology of white Europeans parallels that of whites in the U.S., the epidemiology of AIDS among Blacks looks different in Europe where 12% of diagnosed cases are African-born and 81% of these people have no known risk factor.

Similarly in the so-called “AIDS Belt” of Central Africa, the disease varies from white, American models. High levels of seropositivity are coupled with at least 50% absence of T-cell abnormalities. In addition, the disease appears to be transmitted equally between heterosexual partners. However, outside Central Africa few cases of AIDS have been confirmed on the continent despite high seropositive reactions.

Summary

Epidemiological and clinical studies of AIDS in the United States have focused primarily on the white male while there is no statistical model for understanding or predicting AIDS among people of color. However, using the projections of the CDC and the current proportions of AIDS among ethnic populations, between 300,000 and 500,000 people of color may be infected with HIV. At the same time the example of Belle Glade, a small town in Florida with the largest per capita incidence of AIDS in the nation and with ill-defined risk factors, indicates that local, state, and federal epidemiologists may be missing or underreporting large numbers of Black and Hispanic people with AIDS who live in isolated or medically unsophisticated rural communities.

The problem of rising numbers of cases is compounded considerably by the lack of prevention programs for Blacks, Latinos, Asians, and American Indians — even in those areas where people of color represent a substantial proportion of AIDS cases and HIV seropositivity. Education campaigns and anonymous HIV antibody test site programs should be developed by and provided to ethnic communities to guarantee sensitivity to the diversity of lifestyles, support systems, and risk behaviors found within ethnic neighborhoods.

Amanda Houston-Hamilton, DMH, a faculty member in the Department of Psychiatry at UCSF, is a psychotherapist in private practice and serves as the chair of the Black Coalition on AIDS. She is also a staff member of the UCSF AIDS Health Project in San Francisco. In July Houston-Hamilton attended the “AIDS in the Black Community” forum held in Washington, D.C.

REFERENCES


Diagnosis/Treatment

Predicators of AIDS/ARC

Michael Helquist

With more than one million Americans and several million others around the world infected with HIV, researchers face one of the most pressing questions from the public. The question is simple: "Which individuals infected with HIV will go on to develop AIDS, ARC, or other disease symptoms?"

Ever since the appearance of AIDS, scientists have studied the natural history of the disease. They hope to determine, among other things, which early symptoms might indicate eventual development of ARC and AIDS. During the International Conference on AIDS in Paris, researchers reported on the possible role of herpes zoster viral infections and hairy leukoplakia as such indicators.

Herpes zoster is uncommon before the age of 50 years in people with healthy immune systems; it is characterized by inflammation and skin eruptions along certain spinal and cranial nerves. A. M. Friedman-Kein, MD, AIDS researcher in New York City, reviewed the medical records of 300 patients with Kaposis' sarcoma and found that 8% of them had prior bouts of zoster. That rate is seven-fold greater than historic controls of a similar age group. He also looked at 48 patients with zoster; 41 of them had known risk factors for AIDS, and 35 were AIDS antibody positive. Eight of this latter group developed AIDS from 1 to 28 months after their bouts of zoster. Friedman-Kein concluded, "In patients at risk for AIDS, the occurrence of zoster may be one sign that heralds the marked depression of cellular immunity associated with AIDS or ARC."

David Hardy, MD and his associates at UCLA School of Medicine conducted a similar review of the medical records of patients with HIV exposure risks and histories of zoster outbreaks. Of 27 such patients, all were HIV seropositive. Although 24 of them showed no previous symptoms or signs of immune deficiency, 13 developed AIDS at an average of 12.4 months after their zoster infection. Fourteen of the remaining 15 developed ARC at an average of 12.5 months after the zoster infection. Hardy interpreted this data to mean that bouts of zoster occurring in HIV seropositive, asymptomatic individuals "can be considered to be an early indicator of impending cellular immunodeficiency."

The ongoing studies of oral hairy leukoplakia were also presented at the Paris conference. This rare mouth fungus appears as raised white areas on the tongue that has a corrugated or "hairy" surface. The lesions do not rub off as do those associated with the common "hairy tongue" related to cigarette smoking. While the lesions are usually without symptoms, some patients have reported soreness at lesion sites.

Deborah Greenspan, MD and her colleagues at the University of California San Francisco found that 100 of 101 blood samples taken from immunosuppressed gay men with hairy leukoplakia contained HIV antibodies. Further analysis of the study data led Greenspan to estimate that the probability of developing AIDS for patients with hairy leukoplakia was 48% within 16 months and 83% within 30 months. She concluded that the mouth fungus is "highly predictive of the subsequent development of AIDS."

If an effective treatment or even a stop-gap therapy becomes available for those with AIDS, ARC, or HIV infections, researchers will struggle to determine at what point an individual can most benefit from the intervention. These and other studies of "predictive" signs and symptoms will contribute importantly to that knowledge.

Michael Helquist is the editor of FOCUS.

BRIEFS

IN REVIEW


Scientists have long studied and speculated about the interrelationships among the immune system, the nervous system, and psychological stress. The current AIDS epidemic has prompted many medical researchers as well as the lay public to take even a closer look at how specific states of mind affect the body. In this new book Steven Locke, MD, a Harvard Medical School psychiatrist and researcher, and Douglas Colligan, science writer and editor of Omni magazine, provide a highly readable account of the current studies of mind-body relationships that have been dubbed psychoneuroimmunology or PNI.

The challenge for PNI researchers is to reveal through scientific evidence the dynamic between the mind and body. The authors trace the historical, empirical, and philosophical antecedents of PNI and the mysteries of healing that have existed as long as medicine itself. Locke and Colligan document the struggle of researchers to establish PNI as a new approach to healing, and they explore the clinical applications of PNI and behavioral medicine.

A highly enjoyable feature of The Healer Within is the authors' use of case reports and vignettes to illustrate poignant medical phenomenon. In addition, the chapter on the immune system provides a helpful guide to the complexity and interrelatedness of immune functioning.

While the authors refer to pertinent AIDS studies, their analysis of the research is too brief, providing only a hint of the scope of AIDS research currently underway. In this respect, readers primarily interested in AIDS will be disappointed.

The chapter on cancer is more extensive with discussions of factors associated with cancer causation and other factors — such as personality and depression — that are suspected of influencing cancer onset and progression. The analysis of psychosocial factors considers not only relevant findings but also the problems and complexities encountered with this type of research. Important for both medical and lay readers, the authors address some of the pitfalls involved in making unwarranted leaps from research to medical practice or self-care applications.

The last few chapters consider the challenges posed by holistic medicine to the medical establishment. Surveying some of the more publicized holistic therapies, Locke and Colligan charge that belief is often substituted for good science by various adherents of holistic therapies. They assert that the chasm between practitioners of holistic and traditional medicine cannot be bridged unless each group abandons an inflexible belief that they alone offer "the one true medicine." Within this context the authors believe that PNI with its emphasis on the interplay between the mind and the body may narrow the gap between holistic and traditional medicine.

Overall, this book offers a readable account of recent advances in PNI and medicine in general which are currently, albeit slowly, re-defining concepts of disease causation and treatment.

— Reviewed by Ralph DiClemente, PhD and Jaylene Kent, PhD
No Evidence for Nonsexual Transmission of HIV in Zaire Households. Several research studies have revealed the different epidemiological patterns of AIDS in Central Africa compared to those in the United States and Europe. To study these differences more closely, the Government of Zaire formed Project SIDA in collaboration with American and Belgian researchers. A recent study (JAMA, Aug. 8, 1986) revealed data that is consistent with evidence that HIV is transmitted by sexual contact and perinatally; the data did not support the hypothesis that nonsexual HIV transmission occurs in households.

Researchers studied HIV seroprevalence among household contacts of people with AIDS and of controls, that is, people who were seronegative. The study subjects represented 21 different tribes and represented virtually all of the neighborhoods of Kinshasa, Zaire. Researchers found that spouses of people with AIDS had higher rates of HIV infection than spouses of controls, but the seropositivity of other household members did not appreciably differ between the two groups.

Amid concerns that environmental factors directly influence development of AIDS symptoms, the researchers in Zaire found just the opposite. They reported, "Unlike living conditions in the United States and Europe, living conditions in households in Kinshasa are more likely to include environmental factors favoring person-to-person transmission of infectious agents, including crowding, lack of modern sanitary systems, and substantial numbers of mosquitoes and other arthropods." They concluded that their study provided evidence against nonsexual transmission among household members under conditions common in the developing world.

Neurological Problems with Lymphadenopathy Syndrome. Researchers and caregivers have become increasingly aware of the neurological complications that occur for people with AIDS. Scientists from the Centers for Disease Control and the University of Pennsylvania School of Medicine have begun a study among subjects with lymphadenopathy syndrome (LAS) to see if they also develop neurological difficulties. From a cohort of 75 gay men with unexplained lymphadenopathy, Robert S. Janssen and his colleagues evaluated 15 men with neurological examinations, symptom questionnaires, and a screening battery of neuropsychological tests. Since the onset of LAS, 7 of the 15 men have developed complaints of memory loss, 4 developed signs of herpes zoster radiculitis (inflammation of spinal nerve roots), and 2 developed symptoms of peripheral neuropathy (a disease of the nerves). The screening battery revealed mild cognitive abnormalities for 6 of the men, mild to moderate symptoms for 2, and severe depression for one subject. The researcher noted during a presentation at the Paris AIDS Conference that abnormalities on these tests did not correlate with age, education, duration of LAS, drug or alcohol use, complaints of memory loss, anxiety, or depression.

Reports from Asia. The Japanese Ministry of Health and Welfare has reported that approximately 30 percent of hemophiliacs and 5 percent of healthy gay men in Japan have been exposed to HIV. Retrospective studies conducted by the AIDS Surveillance System in Japan determined that the first cases in that country appeared in 1981. By the end of 1985, 11 cases had been confirmed. All patients were male, 10 were Japanese, and one was Caucasian.

AIDS testing in Thailand revealed only one case of seropositivity among 101 gay prostitutes, 99 1-V drug users, 100 patients with thalassemia (hereditary anemia), 100 female prostitutes, 100 male STD patients, and 100 consecutive blood donors. Despite the single case of HIV infection, Thai researcher Y. Wangroongsarb and his associates concluded that prevalence of HIV infection among sexually active gay men in Thailand in 1985 appeared to be similar to the 1% rate among gay men in San Francisco in 1978.

Public health officials from the Medical and Health Department of Hong Kong tested more than 7,000 blood specimens during 1985 and found 56 HIV positive. From these results they concluded that hemophiliacs with a history of imported factor VIII transfusions, gay and bisexual men, and heterosexual men with histories of sexual contact with prostitutes constitute high risk groups for HIV infection in Hong Kong.

Each of these reports was presented during the Paris AIDS Conference.

The amount of research information now appearing in the medical and lay press staggers most AIDS health care and service providers. This newsletter represents an attempt to place much of the data and press reports in a context that will prove meaningful and useful to its readers. Suggestions and comments are welcome and encouraged. Please address correspondence to Editor, AIDS Health Project; 333 Valencia Street, 4th Floor, San Francisco, CA 94103. For information about other AIDS Health Project programs, call (415) 626-6637.

NEXT MONTH

Suicide among people with AIDS thrusts upon everyone involved serious philosophical, legal, and ethical dilemmas. Health professionals often find that these profound questions of life, death, and choice disrupt their sense of professional obligations and force a review of moral responsibilities and legal restrictions.

Very little epidemiological data exist to gauge the extent of suicidal ideation, attempts, and suicide completions among people with AIDS. However, numerous anecdotal reports from health care workers confirm the relevance of the problem. In the November issue of FOCUS, Peter Goldblum, PhD and Jeffrey Moulton, PhD discuss the dilemmas that AIDS-related suicide bring to health care workers. They will look at the legal and ethical implications of malpractice, the meaning of "aiding and abetting," and the decision of when to hospitalize.

In addition, Goldblum will analyze countertransference issues for health care workers, risk factors for suicide among people with AIDS-related concerns, and important considerations for clinical interventions.

Goldblum, a psychologist in private practice, is the Education Development Specialist at the UCSF AIDS Health Project. Moulton, also in private practice, is a NIMH Postdoctoral Fellow in Clinical Services Research in the Department of Psychology, University of California San Francisco.