AIDS in Minority Populations in the United States

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This paper is based on Dr. Hopkins' keynote address at the National Conference on AIDS in Minority Populations held August 8-9, 1987, in Atlanta. Dr. Ken Castro and Dr. Richard Selik, medical epidemiologists with CDC's AIDS Program, tabulated many of the statistics. Ms. Katherine Lord, with CDC's Office of Public Affairs, located several sources of data from public opinion polls.

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Synopsis

Among ethnic minorities in the United States, blacks and Hispanics, who compose 12 percent and 7 percent of the U.S. population, respectively, constitute 24 percent and 14 percent of the cases of AIDS. Seventy-eight percent of all children with AIDS are black or Hispanic, as are 71 percent of all women with AIDS. In the black and Hispanic communities, intravenous (IV) drug abuse is associated with much of the AIDS transmission, and parenterally acquired infections are spread secondarily by sexual and perinatal transmission. Almost two-thirds of black and Hispanic persons with AIDS in the United States reside in New York, New Jersey, or Florida.

Important differences in the understanding of AIDS and human immunodeficiency virus infection and control measures in minority communities must be considered in devising information and intervention programs for those communities. Programs intended specifically for minorities, especially greatly intensified prevention and treatment of IV drug abuse, are needed to supplement programs aimed at the U.S. population in general. Combatting AIDS offers black and Hispanic populations an opportunity to greatly reduce IV drug abuse, other sexually transmitted diseases, and teenage pregnancy.

FOR MINORITY POPULATIONS in the United States, the occurrence of AIDS is greatest among blacks and Hispanics. For that reason and because the relative risk of AIDS is small—at least so far—for Native Americans, Asians, and Pacific Islanders residing in the United States, most of the data I report in this paper pertain to blacks and Hispanics. I do not want to imply, however, that Native Americans, Asians, and Pacific Islanders do not need to be alert to this threat and take steps to protect themselves. They do.

Problem

Of the cases of AIDS reported in the United States as of August 3, 1987, 24,012 were among whites, 9,699 were among blacks, and 5,508 were among Hispanics. Thus, although a majority, 61 percent, of these cases were among whites, the proportions of blacks and Hispanics with AIDS were twice what would be expected. Blacks, who compose 12 percent of the U.S. population, constitute 24 percent of the AIDS cases. Hispanics, who compose 7 percent of the U.S. population, constitute 14 percent of the AIDS cases. If, in the United States, the rates of AIDS cases were the same for blacks and Hispanics as for whites, there would have been, as of that August date, 3,477 cases among blacks, not 9,699, and 1,945 cases among Hispanics, not 5,508.

Of the AIDS cases among persons less than 13 years of age at the time of diagnosis, 54 percent are among blacks; 24 percent among Hispanics. Thus, 78 percent of all children with AIDS are minorities. Of cases among women, 52 percent are among blacks and 19 percent are among Hispanics.

Persons in minority communities who are infected with HIV became infected by one of the same ways that other AIDS victims did: sexually, perinatally, or parenterally (through intravenous (IV) drug abuse or transfusion). However, there are important differences in the proportions of persons infected by the different modes of trans-

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mission. Whereas 12 percent of white men with AIDS are IV drug abusers or had sex partners who were IV drug abusers, fully 40 percent of black and Hispanic men with AIDS fall in that category. Among women with AIDS, the proportion who were IV drug abusers or whose sex partners were IV drug abusers is 47.8 percent for whites, 69.9 percent for blacks, and 82.5 percent for Hispanics.

Among children with AIDS, 30.8 percent of white victims were born to mothers who themselves had, or whose sex partner had, a history of IV drug abuse. The comparable percentages for black and Hispanic children with AIDS are 60.8 percent and 75.7 percent, respectively.

Thus, IV drug abuse is associated with much of the AIDS transmission among blacks and Hispanics in the United States. That association is maintained by parenterally acquired infections that are mostly due to IV drug abuse and sharing of needles and paraphernalia, as well as by secondary sexual and perinatal transmission.

Geographically, almost two-thirds of black (57.9 percent) and Hispanic (61.3 percent) adults who have AIDS live in New York, New Jersey, or Florida, versus 29.5 percent of white adults with AIDS. Also in those States are 73.3 percent of the black children and 63.0 percent of the Hispanic children with AIDS.

All of the data mentioned so far are derived from persons diagnosed with AIDS. But the real problem, in terms of the spread of AIDS, is from infected, asymptomatic, infectious persons. The prevalence rates of seropositivity to the AIDS virus among the 780,000 civilian applicants for military services who were tested between October 1985 and December 1986 are 0.8 per 1,000 for whites; 1.0 per 1,000 for Native Americans, Asians, and Pacific Islanders; 2.3 per 1,000 for Hispanics; and 4.1 per 1,000 for blacks. Moreover, Dr. John Ward and his colleagues in the AIDS Program at the Centers for Disease Control (CDC) as well as the American Red Cross Blood Services have found that among blood donors tested between March 1985 and July 1986 at Red Cross facilities in Atlanta, Baltimore, and Los Angeles, the rates of seropositivity were 2 per 10,000 among whites, 9 per 10,000 among Hispanics, and 31 per 10,000 among blacks.

Dr. James Curran, Director of the AIDS Program in the Center for Infectious Diseases at CDC, has calculated that if the estimated 1.5 million infected Americans are distributed similarly to the 40,000 persons diagnosed with AIDS so far, the results show that about 0.5 percent of the white U.S. population are infected with HIV, and about 1.5 percent of the Hispanic and black populations are infected. Indeed, in a predominantly black and Hispanic population of women seen at a prenatal clinic in Brooklyn in 1986, Dr. S. Landesman and coworkers found 2.4 percent to be serologically positive for HIV (unpublished abstracts, Volume III, International Conference on AIDS, p. 75).

Since infection with HIV is known to exacerbate tuberculosis infections, which were already more prevalent among minority populations in the United States, some increase in tuberculosis is another dimension of the problem posed by AIDS among minorities. In New York City, Dr. Rand Stoneburner and Dr. Don DesJarlais, with the city's health department, have documented increases in death rates from tuberculosis, pneumonia, endocarditis, and other unexplained deaths among drug abusers paralleling increases in deaths from AIDS and suggesting that infection with HIV is probably associated with many other deaths not directly attributed to it.

Relevant Differences in Black and Hispanic Communities

In addressing the problem of AIDS and HIV infection among blacks and Hispanics, we need to consider carefully what aspects of those communities or cultures are different in any way that is relevant to the struggle against this disease.

As we have already seen, the higher rates of IV drug abuse, which are related to higher rates of unemployment and inadequate education in the two groups, are associated with disproportionately high rates of infection with HIV. That is, drug abuse—not homosexual activity—is to blame for the higher prevalence of HIV infection among blacks and Hispanics. In fact, nearly half of the black and Hispanic persons with AIDS are hetero-

sexual, compared with less than 15 percent of whites with AIDS. Thus, AIDS may be said to already be a problem in black and Hispanic heterosexual communities (*1*).

Even among IV drug abusers in New York City, there appear to be important differences associated with race. A study by Schoenbaum and others showed that only 14 percent of white IV drug abusers tested seropositive for HIV, whereas 42 percent of black and Hispanic drug abusers in the same area were seropositive (*2*). This finding was associated with the fact that 18 percent of the white addicts, but only 8 percent of the black and Hispanic addicts, reported using new needles at least half of the time.

Among Hispanics affected by AIDS in the northeastern United States, 80–90 percent were born in Puerto Rico. In Florida, 33 percent of the black persons with AIDS were born in Haiti.

Potential barriers to reaching black and Hispanic groups in the United States include language and differences in the print news media and radio channels that they patronize. Other barriers may be a heightened suspicion of "government" and its representatives, as well as fear of anything that may provide another excuse for discrimination.

It is crucial that we heed certain indications, also, of important differences in the understanding and perception of AIDS-HIV infection, and control measures in minority communities. Dr. Susan Blake at the American Red Cross National Headquarters conducted a study of all published national public opinion polls on AIDS since 1983. In her preliminary analysis, a few areas of differences between responses of white versus other races are of interest:

1. Minorities are more likely to have misconceptions about some alleged modes of transmission. In 1987, 12 percent of whites versus 25 percent of minorities thought casual contact could result in AIDS. According to a poll of 1,015 New York City adults conducted by the Gallup Organization, 28 percent of whites believed a person could catch AIDS by donating blood; among black and Hispanic respondents, 54 percent and 60 percent, respectively, were similarly misinformed. (All were well aware of the risks of sharing needles and of homosexual activity among men.) These misconceptions need to be corrected.

2. Not surprisingly, then, many more minorities than whites reported feeling personally vulnerable, fearful, and concerned about AIDS: typically, 32 percent of minorities polled in 1987 versus 15 percent of whites. Two specific recent polls that support that conclusion were conducted by the Illinois Department of Public Health, which found blacks and Hispanics to be among the least knowledgeable and most fearful of AIDS, and a nationwide poll of 2,095 persons conducted for the Los Angeles Times, which found anxiety about AIDS was highest among blacks. These fears need to be channeled into constructive action.

3. One positive difference is a reportedly higher level of interest in reading or watching programs about AIDS. In 1987, 64 percent of minorities versus 42 percent of whites said they would read or watch an entire article or program about AIDS.

4. Even more important, when asked in a 1986 poll whether they had altered their sexual behavior in any way to protect themselves against AIDS, 4 percent of whites said yes, whereas 25 percent of minorities said yes. In particular, these responses appear to have referred to limiting the number of sexual partners.

Finally, Dr. Blake reports that recent polls indicate that more minorities express an interest in doing more to help in the fight against AIDS, but they also advocate quarantine and other restrictions as control measures.

These and other such data must be verified and related to specific populations and geographic areas, but they can provide some valuable leads in addressing the problem of AIDS and HIV infection in minorities. Clearly, some important messages appear not to be getting through to some minority populations as well as to the white population, while other messages apparently are.

What's Being Done

Before turning to a few of my own thoughts about what needs to be done, I want to review quickly some of the actions that already are being taken. Of the prevention and control activities being funded by CDC, several have been directed specifically toward black or Hispanics populations. For example:

• Of the 55 AIDS Health Education/Risk Reduction (HE/RR) Programs, 15 (28 percent) have activities aimed at their Hispanic populations and 21 (38 percent) have targeted informational services to the black community. When these grants were renewed in fiscal year 1987, a stipulation was made that all grantees be required to explicitly address the problem in their black and Hispanic

populations and to involve representatives of those groups.

- Two of the five HE/RR community demonstration projects (Chicago, IL, and Long Beach, CA) include specific elements concerning minorities (total award to these two: $2 million).
- The fiscal year 1987 prevention of perinatal AIDS initiative ($1.9 million) is targeted mainly at black and Hispanic populations in New York City, northern New Jersey, and Miami.
- The school health initiative includes $100,000 specifically for one Hispanic and one black national organization to help increase involvement of schools and related agencies in AIDS health education.
- The Request for Proposal (RFP) for a national AIDS clearinghouse has a requirement concerning a specific focus on minorities.
- The $4.6 million contract signed recently with Ogilvy and Mather Public Affairs, a leading advertising and public relations company, to develop a national media campaign on AIDS, includes a subcontractor, the Lockhart and Pettus Agency of New York, to help with advertising aimed at black audiences, and another subcontractor, Sosa and Associates of San Antonio, TX, for Hispanic audiences.
- An additional $7 million was made available for AIDS education and prevention among minorities in fiscal year 1987, with a similar amount expected in fiscal year 1988 plus $3 million more in direct funding to be awarded competitively to minority organizations for the same purpose.
- The August 8-9 National Conference on AIDS in Minority Populations was another milestone in our efforts to draw more attention to this aspect of the AIDS problem, seek solutions, and help mobilize the affected communities on the issue of AIDS among minorities.

While minorities also benefit from programs aimed at the U.S. population in general, programs of the type just cited are clearly needed to supplement those other efforts.

What Should Be Done?

Given that AIDS and HIV infection is such a serious problem, especially in some black and Hispanic communities, how best can it be addressed? How can the increasingly evident interest and concern be focused most effectively?

First, we must be careful to understand the enemy clearly. As I have tried to indicate, we are faced with a formidable combination of a deadly virus, IV drug abuse, and sexual promiscuity. We cannot ignore any one of these three factors if we hope to succeed in our battle against AIDS. All three must be attacked as vigorously as we can. We must not let sensitivity or embarrassment about discussing drug abuse and sexual promiscuity in minority communities impede our ability to address those urgent problems. They are not pleasant topics, but the alternative—not facing up to them—is worse.

Second, we need to use the same interventions being used in the white community, although in different proportions because of variations in the distribution of behavioral risks. Some different channels of communication are also needed. Whatever the channel, however, these interventions must be based on science, not sentiment. This challenge calls for reason and resources, not rhetoric or rationalization.

Third, we need to urge people who are, or may be, at risk to be voluntarily tested. The greatest source of new infections are the hundreds of thousands of asymptomatic infected people who do not know they are infected. Far too little has been made of the importance of such knowledge to the health of infected persons, besides its critical importance to preventing further spread of infection sexually, perinatally, and by sharing needles.

Fourth, there is a great need to promote cooperation. There is more than enough work to go around. It was gratifying to see the range of organizations and groups represented by the 1,100 attendees at the August conference on AIDS in Minority Populations. We must ask not only what the Federal Government can do for us, but also what we can do for ourselves and for all those infected people. Some of what we can do includes helping to provide social and medical support, as well as *informed* advocacy. For example, AIDS will not be controlled in black and Hispanic communities without more effective prevention of drug abuse and widespread access to treatment centers for drug abusers.

Fifth, we should remember that this is an international problem. As bad as our situation is in the United States, some of our kinsmen abroad are even worse off. Our problem will not be solved until their problem is solved. And not one of us chose to be born in San Francisco rather than São Paulo, or in Kinshasa rather than Kansas City.

Sixth, we must also remember that this is not the only important public health problem in

minority communities. The report of the Secretary's Task Force on Black and Minority Health, on which I served, was published 2 years ago (*3*). At that time, infectious diseases were not even ranked among the six most important causes of excess death in minorities. Those other problems have not disappeared. AIDS is a seventh Horseman of the Apocalypse. Someone who dies of lung cancer caused by cigarette smoking is just as dead, and that death is just as preventable, as someone who succumbs to pneumocystis pneumonia. Indeed, if we could only persuade all cigarette smokers to quit and donate the money they formerly spent on cigarettes to organizations working against AIDS, we could really turn this terrible epidemic to improving the public's health.

Finally, we must keep our eye on the ball—which is to prevent infection with this virus. To do so, we must distinguish the beef, as in "Where's the beef?" from the baloney, as in the recent story, which originated in Atlanta, again exhorting people to the supposed dangers of mosquito-borne transmission of AIDS. There are many other such distractions. Every hour spent focusing on nonsense is an hour not spent dealing with parenteral, sexual, and perinatal transmission, which is what we need to be concerned about.

If we who are concerned about the health status of minorities do what we need to do about AIDS, we shall not only rid our communities of AIDS, we shall also greatly reduce IV drug abuse, other sexually transmitted diseases, and teenage pregnancy. Then, we will indeed rejoice at being free at last.

References

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Establishment of an Exposure Level to Tetrachloroethylene in Ambient Air in Vermont

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Synopsis

Where environmental contaminants pose potential health hazards, health departments are involved in complex and often controversial situations. Often the rapid formation of a threshold exposure level is required to protect public health. A decision making process was implemented in Vermont when it became necessary to have an interim ambient air exposure level to test for tetrachloroethylene contamination in the water, air, and soil of a community. Contamination of public and private drinking water and ambient air in schools and homes was discovered as a result of uncontrolled waste disposal from an industrial uniform laundry and drycleaning plant.

A telephone survey was conducted to determine action taken by the other 49 States regarding emission standards for tetrachloroethylene into ambient air. There were no guidelines in 25 States, and there were guidelines in the remaining 25.

Vermont's Commissioner of Health convened a multidisciplinary group of public health professionals to review various approaches to the establishment of an ambient air standard. A decision making action using modified Delphi and nominal group consensus methods set the interim standard at 67 micrograms per cubic meter in ambient air. The drycleaning plant had been closed voluntarily before the standard was established, and the interim standard was used to prevent reopening of the plant through a health order issued by the Vermont Health Department. The standard was also useful for guidance during environmental remediation.