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Focus on Gender: Women and HIV

Even after a quarter century of HIV/AIDS, and despite all of the education programs about how the virus is transmitted and who is vulnerable, many people still regard the disease as affecting mostly gay white men and (usually male) intravenous drug users. One of the most overlooked populations, in everything from education to prevention to treatment, is women.

In the U.S. today, depending on where you live, women account for between a quarter and a half of people living with HIV. But few programs are designed with women's specific needs in mind. Worldwide, women are even more vulnerable, and have even fewer options.

In this issue, we describe some of the issues involving women who are living with HIV or at risk of infection. In "HIV and Women Around the World," Luis Scaccabarozzi provides an overview of the epidemic as it affects women in the United States and abroad. His insightful article highlights several specific vulnerabilities women face, from powerlessness to negotiate safer sex practices, to domestic violence, to lack of easily accessible healthcare. The facts are brought to life in a Personal Perspective written by Mary, a brave South African woman living with HIV and stigma and helping other women do the same.

Important policy issues are explored in an article by Kimberleigh Smith, while articles by Dr. Mark Brennan and Rosa Bramble Weed examine depression in older HIV-positive women and HIV among immigrant women. Jane Fowler offers a concise listing of some facts and tips for women who are infected or at risk.

Finally, one of the thorniest topics for women with HIV is pregnancy. Can an HIV-positive woman have a successful pregnancy and a healthy baby? What about a negative woman whose male partner has the virus? Can a woman with HIV pass the virus to the fetus in her womb? Should she have a vaginal birth, or plan a C-section? What about breastfeeding? Vaughn Taylor and Hanna Tessema examine the many complex issues facing pregnant women with HIV and those who are considering having children. And Delia G. shares her deeply personal story of learning first her HIV status and then that she was pregnant, how she coped, and how she went on to build a stable, loving – and healthy – family.

We hope that this special issue of *ACRIA Update* will help dispel some myths about women and HIV and offer insights into their special needs. As always, we welcome your thoughts and comments.

Daniel Tietz, Editor-in-Chief

HIV and Women Around the World *by Luis Scaccabarozzi*

Worldwide, approximately as many women as men are living with HIV, but there are important differences between women and men in the underlying mechanisms of HIV infection and in its social and economic consequences. These stem from biology, sexual behavior, and socially constructed gender differences between women and men in roles and responsibilities, access to resources, and decision-making power.

Women are more susceptible than men to infection from HIV in heterosexual encounters, because of the greater area of mucous membrane

exposed in women during sex; the greater amount of fluids transferred from men to women; the higher viral content in male sexual fluids; and the micro-tears that can occur in vaginal (or rectal) tissue from sexual penetration.

Gender norms influence women's vulnerability to HIV. In many places, these norms allow men to have more sexual partners than women and encourage older men to have sexual relations with much younger women. This contributes to higher infection rates among young women compared with young men. Women may want

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ACRIA, a collaborative and independent not-for-profit organization, studies new treatments for HIV/AIDS and related diseases, and conducts a comprehensive HIV health literacy program.

Bulk copies of *ACRIA Update* are available free to agencies that provide services to people living with HIV/AIDS. For more information, call 212-924-3934 ext. 129.

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Crofelemer for Diarrhea

People 18 and older who have persistent diarrhea will first take crofelemer or placebo tablets for 6 weeks. Then everyone will take crofelemer for 5 months.

Avandia and Serostim

People with insulin resistance will take Avandia (rosiglitazone), or Serostim (growth hormone), or both for 6 months to see how they affect glucose, insulin levels and body shape.

KP-1461

People aged 18-60 who have taken an NRTI, NNRTI and PI, and have developed resistance or stopped the drugs for other reasons, will take KP-1461 (a new type of NRTI) with no other ARVs for four months.

SPRING: Aptivus in Diverse Populations

People 18 and older (half white and half non-white, half men and half women) who have taken an NRTI, NNRTI and PI (not Aptivus) and who have resistance to at least two PIs, will take a standard dose of Aptivus or receive therapeutic drug monitoring to find the best dose for them.

IMPACT: Reyataz Resistance

People who have developed resistance to Reyataz will come in for one day of blood tests to study the I50L mutation.

CHAMPS

People aged 18 and over who have resistance to at least three classes of HIV meds will take either maraviroc (Selzentry) or INCB 9471, a new once-per-day CCR5 inhibitor.

Ibalizumab

In addition to oral HIV meds, people will be given IV infusions of placebo or one of four doses of ibalizumab, a monoclonal antibody designed to block HIV entry.

Prezista Dosing

People 18 and older who have been taking HIV meds for at least 12 weeks will take Prezista with Norvir either once a day or twice a day, along with other HIV meds.

For more information on these trials, contact us at 212-924-3934 ext. 121.

Etravirine (TMC 125) Expanded Access (closed to enrollment)

People 18 and older who have limited treatment options and resistance to approved NNRTIs, and who have taken an NRTI, NNRTI and at least two PIs, may qualify for early access to this experimental NNRTI.

Transacin (NGX-4010) (closed to enrollment)

People with HIV who have peripheral neuropathy will use either Transacin (capsaicin) patches or very low-dose patches for 30 or 60 minutes a day for 3 months. Participants must be 18 or older and have had pain in both feet for at least 2 months.

TH9507 (closed to enrollment)

People aged 18-65 who have excess abdominal fat will take either TH9507 (an investigational growth hormone releasing factor), or a placebo for 26 weeks. The two groups will then switch for 26 more weeks.

Editor's Note

All material in *ACRIA Update* is presented for educational and informational purposes only, and is not intended as medical advice. All decisions regarding one's personal treatment and therapy choices should be made in consultation with a physician.

HIV and Women Around the World *(continued from first page)*

their partners to use condoms (or to abstain from sex altogether), but often lack the power to make them do so.

The violence (physical, sexual, and emotional) that many women experience at some point in their lives increases their HIV/AIDS vulnerability in several ways:

- Forced sex can contribute to HIV transmission because of the tears and lacerations that can be caused by the use of force.
- Violence and fear of violence can prevent women from negotiating safer sex and getting treatment.
- Fear of violence can prevent women from learning their HIV status or disclosing a positive test result.

Women generally assume the major share of caretaking in the family, including for those living with HIV. The widespread assumption that caretaking is women's "natural" role only adds to their burden.

Many of the clinical manifestations of HIV/AIDS in women are similar to those seen in men; there remain, however, significant gender-based differences in the disease, which this article will explore.

HIV Today

In 1985, 7% of AIDS cases were in women; in 2005, 27% were, and 60% of those were African-American. Also in 2005, heterosexual contact was identified as the risk factor in over 72% of AIDS cases among women in the U.S.

Heterosexual contact is now the most common reported risk factor for women, overtaking injection drug use, and increasing numbers of women with AIDS are from rural and smaller metropolitan areas rather than large urban centers.

What Do We Know?

The gap in HIV prevalence rates among men and women is narrowing.

In the early stages of the pandemic, HIV infection was predominantly among men in

many industrialized and some developing countries. By the end of 2002, however, almost half of the adults living with HIV globally were women. In sub-Saharan Africa, 58% of adults with HIV are women.

The latest estimates (2001) also show a higher prevalence rate for young women aged 15–24 years as compared with young men of the same age. A 1998 study in Kisumu, Kenya, showed that the preva-

“Heterosexual contact is now the most common reported risk factor for women, and increasing numbers of women with AIDS are from rural and smaller metropolitan areas rather than large urban centers.”

lence of HIV infection among young women was 23%, while among young men of the same age it was 3.5%. This is probably due partly to biological factors (see below), but perhaps more importantly to the fact that social norms dictate marriage at an early age for women in many places, and that the sexual partners of younger women are often significantly older men.

There are differences between women and men in rates of HIV sexual transmission.

Studies conducted in the early 1990s in the U.S. and several European countries have shown that, controlling for other risk factors such as sexually transmitted infections (STIs), it is much easier for a woman to contract HIV from heterosexual contact than it is for the man. This is thought to be because women have a larger surface area

of mucous membrane exposed during sexual intercourse, and also because they are exposed to a larger quantity of infectious fluids (semen) than the men are.

The evidence on this subject, however, is still not complete. For example, a recent study from Uganda showed that the rate of male-to-female transmission of HIV was not very different from that of female-to-male transmission. Viral load (the amount of HIV in the blood) was the chief predictor of rates of heterosexual transmission of HIV. More virus means higher rates of transmission.

Anal penetration can occur in both male-male and male-female sex. This poses an especially high risk of HIV infection for the receptive partner because the lining of the rectum is thin and can easily tear.

The presence of an untreated STI can make a person up to 10 times more likely both to get and to transmit HIV. Since the majority of STIs do not give rise to any symptoms in women, they are less likely not to be recognized or treated. STIs located in the anus and rectum also often display no symptoms, so they are unlikely to be treated, implying an enhanced risk of HIV through penetrative anal sex.

Pregnancy and childbearing raise specific issues for women.

Studies from industrialized countries have found that pregnancy does not affect the progress of HIV infection in women with no symptoms or in women who are in the early stages of disease. Care should be taken, however, not to generalize these results to the developing world, where there has been little research done on this topic. On the other hand, a recent study indicates that, in developing countries, there is a high risk of infant death associated with maternal HIV infection. Pregnancy-related complications, such as hemorrhage, expose women to the risk of infection from blood transfusions.

Since HIV can be transmitted through breast milk, breastfeeding presents a dilemma for many women. Those who decide against breastfeeding in favor of infant formula may reduce the risk of HIV

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HIV and Women Around the World *(continued from previous page)*

transmission to their children, yet may expose the infants to diseases resulting from unclean water and from malnutrition. The use of infant formula can alert others to the mother's HIV status and lead to stigma and discrimination, mainly in developing countries.

Gender norms increase vulnerability to HIV infection, especially in young people.

In almost all cultures masculinity is associated with virility. A UNAIDS report based on research conducted in seven countries (Cambodia, Cameroon, Chile, Costa Rica, Papua New Guinea, the Philippines, and Zimbabwe) found that notions of masculinity encourage young men to view sex as a form of conquest. Other research found that ignorance is construed as a sign of weakness, and that men are therefore often reluctant to seek out correct information on safer sex.

The role of same-sex relations among young men in enhancing risk of HIV infection is often ignored in many developing countries, where sex between men is socially stigmatized and often illegal. The limited availability of data contributes to the invisibility of this issue. Data for 1999 from the U.S. show that 50% of all AIDS cases reported among males of 13–24 years of age involved men who have sex with men. According to the 2005 CDC surveillance, of the estimated 341,524 male adults and adolescents living with HIV/AIDS, 61% had been exposed through male-to-male sexual contact.

Early initiation of sexual activity among girls is directly related to the practice of early marriage for girls in many developing countries. Furthermore, the sexual partners of young women are often much older than the women themselves: research from 16 countries in sub-Saharan Africa indicates that husbands of 15- to 19-year-old girls are on average ten years older than their wives. Early marriage may expose girls to an increased risk of STIs and HIV, especially if their partners are older and have had more sexual exposure. HIV prevalence among young (15–24) pregnant women attending prenatal clinics, however, has

declined since 2001 in 11 of the 15 most affected countries.

For many women, being vulnerable to HIV can simply mean being married. Many societies accept extramarital and premarital sexual relationships in men, creating a risk even for women who have had only one partner in their entire lives. For such women, “remaining faithful” is no protection.

“A UNAIDS study found that men with HIV were hardly questioned about how they became infected. In contrast, women were often accused of having had extramarital sex and received lower levels of support.”

Information from countries such as Thailand and South Africa indicates that poverty, lack of education, and limited income-earning opportunities often force women into commercial sex work, exposing them to a high risk of HIV/STI infection.

Violence is an important factor in the transmission of HIV.

Some women experience the threat of, or actual, physical violence when attempting to negotiate safer sex through the use of condoms. Research conducted in Guatemala, India, Jamaica, and Papua New Guinea found that women often avoided bringing up condom use for fear of triggering a violent male response.

Violence in the form of coerced sex or rape may also result in HIV infection, especially as coerced sex may lead to the tearing of sensitive tissues and increase the risk of contracting HIV. Studies in adolescents from several countries have found that many report that their first intercourse was forced, and this is particularly the case for women. Sexual minorities such as homosexual men also encounter sexual coercion in many countries, and are similarly at risk of HIV infection.

Conflict situations such as wars aggravate some of the factors that fuel the HIV crisis. These include the breakdown of families and communities, forced migration, poverty, the collapse of health services, and physical and sexual violence. Women more than men are at risk of rape and sexual assault in conflict situations, and consequently of HIV infection. Tens of thousands of women were raped in the Balkan conflict. In Rwanda, 3% of all women were raped during the genocide. The proportion of women testing HIV positive among those who were raped was 17%, as compared to 11% among women who were not.

Gender is a factor in health-seeking behavior.

Stigma associated with HIV is a major factor preventing many women and men from seeking and obtaining services. Women may be more affected by stigma and discrimination than men because of social norms concerning acceptable sexual behavior in women, and because women are often more economically vulnerable than men.

Gender differences in decision-making may also affect access to health facilities. For example, a study conducted in Tanzania found that, while men made independent decisions to seek HIV testing, women felt obligated to discuss testing with their partners before having it done.

Health program and service issues are affected by gender.

Much of the resistance to condom use is

gender-related. Several studies report that young women are reluctant to carry or suggest condoms for fear of being seen as promiscuous. Many young men dislike condoms because of their interference with the pleasure of sex, while some may actually enjoy risk-taking behavior.

It is estimated that perfect use of the female condom may reduce the annual risk of acquiring HIV by more than 90% among women who have intercourse twice weekly with infected males. The price of the female condom, however – up to ten times that of the male condom – makes it inaccessible to most women.

Stand-alone HIV services may deter women and young people from seeking care, since their use may be seen as an admission of having an STI, leading to stigmatization.

Health providers need to be aware of and sensitive to the possibility that women can be subjected to violence and other serious consequences within households or communities as a result of revealing that they have HIV. In a 2001 survey in Kenya, more than half of the women surveyed who knew that they were HIV positive had not disclosed to their partners. They feared that disclosure would expose them to violence or abandonment. These adverse consequences of disclosure have also been documented in other settings.

In many countries HIV information and services are provided primarily through family planning, prenatal, and child health clinics, which are typically not designed to reach men or meet men's needs. As a result, men may be less likely than women to receive HIV information, testing, or treatment.

There are gender differences in the social and economic consequences of HIV.

A UNAIDS study across seven sites found that men with HIV were hardly questioned about how they became infected and that they were generally cared for. In contrast, women were often accused of having had extramarital sex (whether or not this was the case) and received lower levels of support.

Men, on the other hand, may be under pressure to keep their HIV infection status secret for fear of dismissal from work and of being unable to play their traditional gender roles as breadwinners.

In studies in India, Mexico, and the U.S., women much more than men had to shoulder the burden of providing care to household members suffering from AIDS, as well as of supporting their households financially when other earners were disabled.

What Research Is Needed?

More research is needed in these areas:

- Microbicides or other effective female-controlled methods that do not prevent pregnancy and do not involve the use of a condom.
- Gender differences in risk perception and behavior across different age groups.
- The role of nonconsensual sex in increasing the risk of HIV infection in adolescent girls and boys.
- Gender differences in the barriers adolescents face in gaining access to health services.
- Women's and men's perspectives on HIV treatment and care, including opinions on individual versus couples counseling, disclosure and partner notification, location of services, etc.
- The impact of masculinity on vulnerability to HIV, and the factors that impede men's access to HIV testing and treatment.
- How to design programs that address the risk of disclosure leading to violence against HIV-positive women.

What Needs to Change?

Gender roles around the world pin women into positions where they lack the power to protect themselves from HIV infection and where, if they are infected, they lack opportunities to receive treatment. Negative assumptions about women's roles and discrimination against them must be challenged, and women

must be empowered to help themselves and to protect themselves.

Women who have been raped need to have access to post-exposure prophylaxis – medical techniques that can reduce the chances of HIV infection if they are treated quickly. In many (mainly African) countries with high levels of sexual violence against women and high HIV prevalence, this treatment is not freely available to women.

Protecting women from HIV is **not solely women's responsibility**. Preventing infection is the responsibility of **both** partners, and men must play an equal role in this.

Even in the U.S., much more needs to be done to protect women. There has been criticism that **sex education** in schools in the U.S. is based on the idea that sexual abstinence until marriage and fidelity afterwards is the best way to prevent STIs. This won't protect a woman if she is infected by the man she marries, and it leaves her ignorant – and thus more vulnerable – if she has sex before marriage. Young women must be taught about **condoms**, which must be easily obtainable.

Violence against women, discrimination, gender-based inequalities, prostitution – these are all issues that must be addressed but that might take decades to alter. Women who have HIV need **access to treatment**, and women who don't have the virus need to be able to protect themselves. If it is impossible in the short term to empower women to be able to insist on condom use, then efforts must be made to find an alternative solution.

Many women may not think they are at risk for HIV infection. There is still, in some places, a myth that HIV infection is something that happens only to other people – to gay men, injecting drug users, or people from other ethnic groups. This myth needs to be cleared up, and countries around the world must work to empower women to protect themselves.

Luis Scaccabarozzi is Director of the HIV Health Literacy Program at ACRIA.

Depression and Older Women with HIV *by Mark Brennan, PhD and Stephen Karpiak, PhD*

People living with HIV are often confronted with a variety of physical ailments related to the disease or as a result of receiving treatment. Many may not realize, however, that dealing with a serious illness like HIV can also involve threats to one's mental and emotional health. One of the most serious issues for people living with HIV is depression. While the public is bombarded by advertising for drugs to treat depression, few people understand what depression is, the negative impact that it can have on quality of life, or the many treatments available. Moreover, the experience and treatment of depression can vary significantly depending on age, gender, or other life circumstances. In this article, we will focus on the causes of and treatments for depression among older women with HIV, one of the fastest growing groups of individuals living with the virus.

What Is Depression?

Depression is a common mental health issue that may affect upwards of 121 million people worldwide. The World Health Organization defines depression as low mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite (either too much or too little), low energy, and poor concentration. These symptoms may point to depression if they last for two or more weeks. People may experience all or only a few of these symptoms. Depression can become recurrent and lead to difficulties in the ability to take care of daily responsibilities. Depression may affect physical functioning, and it is one of the leading causes of disability among persons of all ages. At its worst, depression can lead to suicide, which results in the loss of nearly one million lives around the world every year.

Depression and People with HIV

Depression has long been recognized as a very common problem among persons with HIV. The reported rate of depression for people with HIV ranges anywhere from 5% to 60%, depending upon how it is defined and measured. The smaller figure refers to a clinical assessment by a psychiatrist or psychologist, while the larger figure is associated with depression screening tools and self-reports of depressive symptoms. Trying to obtain an accurate picture of the extent of depression among persons living with HIV is further complicated by the fact that many of the symptoms of depression, such as change in appetite or fatigue, may also be symptoms of HIV disease or treatment. In addition, people with HIV may also use alcohol and other drugs, and the effects of these substances can mimic the symptoms of depression. To complicate things further, depression is also common among former substance users. Whatever definition of depression is used, however, even the minimal experience of depressive symptoms can interfere with a person's life and make coping with HIV more difficult.

Depression and Women with HIV

Women with HIV are about seven times more likely to be depressed than those who are not infected. They are more often affected by depression compared with men at every stage of the disease. Depression may also be more life-threatening for women with HIV than for men. One study, conducted at Johns Hopkins,

found that women with HIV are at a heightened risk for suicide. In this study, nearly one-third of women reported thinking about suicide, and 16% had actually attempted it. But even with suicide out of the picture, depression has been linked to a greater risk of mortality for women with HIV. Another study, at the Yale School of Medicine, found that, among women with HIV and CD4 counts below 200, 54% of those with chronic depression died compared with only 21% of those who were not depressed. Several research studies have documented that women with HIV who are depressed are less likely to be taking HIV medications and less likely to adhere to their regimens than those who are not. Women who are not taking HIV treatment may be shortening their lives by delaying this life-saving therapy, and those who do not adhere to treatment risk developing drug-resistant strains of HIV.

What accounts for the high rate of depression among women with HIV? Depression is a frequent consequence of trying to cope with a chronic illness like HIV. Despite the fact that effective treatments are available today, an HIV diagnosis can still be devastating. Because HIV is an infectious disease with no cure, it can potentially change the life of anyone who has it. Some people are overwhelmed and unable to cope with the diagnosis or feel helpless when faced with living with the condition, and feelings of helplessness are often at the root of depression. An HIV diagnosis can also provoke anxieties leading to depression, often around fear of disclosing HIV status to friends, family, and significant others and the stigma people with HIV still face. Stigma, in turn, can lead to feelings of loneliness and social isolation, which have been linked to depression among persons with HIV.

Much can also be explained by looking at life circumstances. HIV affects women of color disproportionately; African-Americans and Latinas account for 77% of women diagnosed with AIDS in the U.S. These women are prone to a large number of stressful conditions, including poverty, violence, overcrowding, racism, unemployment, sexual victimization, and being single parents. In addition, they are disproportionately likely to have experienced traumatic life events, including sexual assault, partner abuse, and separation/divorce, all of which can result in depression in their own right. Thus HIV often adds to the burden of stress many women of color faced prior to diagnosis. A University of Wisconsin study that focused on low-income, minority women with HIV quoted one woman who said, "You know, HIV is not my biggest problem."

While problems such as stigma, loneliness, and social isolation can lead to depression among people with HIV, there are things that can help. Social support – or companionship, help, and affection from family and friends – has been repeatedly found to help people with HIV avoid depression. Members of a social network not only provide day-to-day help with things like shopping or housework but also serve as caregivers in the case of illness. Contact with members of the social network helps to relieve feelings of loneliness and isolation. Family and friends also provide substantial emotional support, invaluable for people

facing life-threatening illness. Another positive force against depression is a sense of spirituality. Although not all people are spiritual or religious, some find their beliefs help them to cope with HIV, lessening feelings of depression. Spirituality is thought to guard against depression by providing a sense of hope, which is to say an expectation of a good future. Thus, for people with HIV, a good support system as well as spiritual and religious coping may prevent or reduce depressive symptoms.

Why Single Out Older Women with HIV and Depression?

Older women with HIV need to be considered as a special case because age can affect the experience of depression. Growing older can also bring additional life challenges, such as a greater chance of having one or more chronic illnesses, transitions such as retirement, and other major changes, such as the loss of a spouse, friend, or other family member. For older women with HIV, these may increase feelings of sadness and depression. While studies have found that older people in general are not more prone to depression than younger adults, this may not be the case among people with HIV. Although the research is limited, findings do suggest that depression may be more common among older people with HIV as compared with younger adults. Whether this is a result of HIV or its treatments is not known. The simplest explanation is that the challenges of aging increase the level of stress beyond what is usually experienced due to HIV and the life circumstances of many of these women. Unfortunately, there is very little research that has looked at older women with HIV. A notable exception is the *Research on Older Adults with HIV* (ROAH) study conducted by ACRIA.

Findings from ROAH

The ROAH study was conducted in 2005 in New York City, then the U.S. epicenter of the HIV pandemic, where almost one-third of those with HIV were over 50, 32% of those women. The participants included 264 women from 50 to 76 years old, with an average age of 55 years. These women mirrored the city's population of HIV-positive women in terms of race and ethnicity: 58% were African-American and 34% Latina. Only one-third had education beyond high school, which reflects the diminished economic resources for many of these women. The average time since HIV diagnosis was approximately 11 years.

ACRIA was interested in how physical and mental health, economic resources, loneliness, stigma, social support, and spirituality were related to depressive symptoms among these women. Overall, HIV-positive older women reported high levels of depressive symptoms; over 60% reported symptoms suggesting the need for clinical treatment of depression. In addition, their heightened levels of depressive symptoms were associated with

greater numbers of health conditions in addition to HIV, greater need for assistance with day-to-day activities, greater degrees of emotional loneliness, and higher levels of perceived stigma. On the other hand, women who remained mentally active were less likely to suffer from depression, and those women who reported higher levels of spirituality were less likely to have high levels of depressive symptoms.

The impact of aging on people with HIV may lead to greater depression, given that the study found that women with a greater number of health conditions and a greater need for assistance were more depressed: Since health conditions and disability both increase with age, they may compound any physical difficulties stemming from HIV, thus increasing the risk for depression. Stigma is also a strong predictor of depression, and much needs to be done to change public attitudes about people with HIV. On a more optimistic note, these findings suggest that staying mentally active – reading, doing crosswords, or engaging in other kinds of mental activities – may help to protect older women with HIV from feeling depressed. For those who are religious or spiritual, keeping those beliefs alive may protect against depression as well. The high degree of depressive symptoms reported by older women with HIV in New York City, however, with over 60% having significant levels of depressive symptoms, suggests that much more needs to be done in terms of identifying and treating depression.

Treatment of Depression

The most extensive evidence-based research in the treatment of elderly depression comes from studies of antidepressant medications. Hundreds of studies have confirmed the usefulness of these drugs to relieve or prevent depression.

But elderly patients often take longer to respond to treatment than younger patients, and six to twelve weeks of treatment may be needed before benefits begin to be seen. Poor adherence to antidepressants is the most frequent cause of poor response, but a poor response among persons who do adhere to antidepressant therapy can be addressed by trying alternate medications.

Many older people, including women with HIV, have coexisting medical conditions for which they are taking medications. Thus it is vital to give careful consideration to safety when choosing an antidepressant medication – some antidepressants should not be combined with medications used to treat HIV or other diseases, or will require their doses to be adjusted. Plus, other psychiatric medications might be required to treat other conditions such as anxiety, psychosis, insomnia, and dementia.

In rare cases that do not respond to psychotherapy and medication, or when antidepressant drugs cannot be used because of

“In ACRIA’s ROAH study, women who remained mentally active were less likely to suffer from depression, and those who reported higher levels of spirituality were less likely to have high levels of depressive symptoms.”

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Personal Perspective: One Woman's Story by Mary, South Africa

On August 27, 2001, I found out that I was HIV positive. I was surprised, hurt, confused, and angry, all at the same time.

A friend of mine who is a nurse told me that she had noticed visible lymph nodes behind my ears and on the back of my neck. She examined them and suggested that my lymph nodes were swollen. While I was concerned, the possibility of HIV was not on my mind.

Working in the health field, I started looking into “swollen lymph nodes.” Among the many possible causes, HIV was mentioned. However, it was on the bottom of my list.

I mentioned my swollen lymph nodes to some members of my family and they suggested that it was probably due to stress. While my mom told me not to stress any more, we all know that this is easier said than done. “As soon as you calm down and take things easier,” she said, “the swelling will go away.”

I went to see my doctor and he also asked if I had been under stress. However, he decided to run some blood tests, including a test for HIV that he didn't tell me about.

I found out I was being tested for HIV in a terribly roundabout way. My brother learned that I was being tested for HIV from the receptionist at my doctor's office and proceeded to ask me in front of my mother why I was being tested. Naturally, I denied that I was being tested for the virus, as I honestly didn't know that my doctor had drawn blood for this purpose.

Now that I think about it, I was ashamed to learn that I was being tested for HIV. The fact that my family found out I was being tested for HIV would likely open the doors to too many questions about my sex life that I wasn't ready to answer. But I was a divorced woman who

had had only one sexual partner to speak of since separating from my ex-husband four years earlier.

I returned to my doctor ten days after my initial visit, and was told that there was a “problem” with my bloodwork and that another round of testing would be necessary. Meanwhile, I was becoming even more stressed and my swollen lymph nodes were becoming painful. I thought I was dying.

“My brother learned that I was being tested for HIV from the receptionist at my doctor's office and proceeded to ask me in front of my mother why I was being tested.”

I decided to call my insurance company because I was tired of waiting. They told me that my life coverage had been changed to accidental coverage due to my blood results, but didn't provide any specific details. That afternoon, I received a letter from the insurance company with the same vague news.

I went to see my doctor that evening, told him about my phone conversation with my insurance company, and showed him the letter. I learned then that I was HIV positive. He told me not to stress, that it wasn't a death sentence.

I was bombarded by a lot of feelings, but fear was not one of them. Perhaps more out of anger, I remember telling my doctor that I would never die from AIDS, not in this lifetime. It took some dealing with, but I learned that there are so many people living with HIV who are happy and

healthy. I intended to do everything in my power to make sure that I remained a survivor.

I have a beautiful, bubbly, and very intelligent daughter who will be turning ten years old in April. She's my reason for living. My brother, who I told about my HIV status the day I found out, has been very supportive and I love him for it.

It took some time after my diagnosis to tell my mother. It took some courage to tell her, and she received the news very well. I even told a friend of mine, and she was very happy I told her. She told me that she'll be

there for me any time of the day. Ever since I told people around me about my status, I've felt much better and freer. I would say my life is back to normal.

I also befriended a doctor who works at the clinic I work at, and he's been a great friend so far and he's also been supportive. He explained everything about my disease and helped me understand much more about it.

What inspired me is all the personal letters I read on a website for women living with the HIV. I think that I am going to live for as long as God wants me to live, and I am going to live my life the way I want. I told myself that I am not going to allow anyone to judge me. I began to take better care of myself and decided to go back to the gym and eat healthier. I'm not ready to give up on life.

I would like to tell all those women who are struggling to cope with the disease that it is not a death sentence and that you can have a long life, as long as you take your medication and live a healthy lifestyle. Don't be ignorant about HIV. Gather as much information as you can – this is what I did and it helped me to accept my situation very quickly.

Don't be afraid to ask your doctor questions, especially when you feel you don't understand. I live in a country where hundreds of people are still dying of AIDS every day because they are not well informed about the disease. Some are ashamed and afraid to go to the hospitals to get antiretrovirals (ARVs) and other life-saving medications, and some don't have access to the ARVs because they live in rural areas where hospitals are far from their homes. I hope this will change with time.

Soon after my diagnosis I also began to work at my clinic with women like me living with HIV, by providing information and education. My hope is to provide as much support as I found when I was diagnosed. Support is very important to living a healthy life.

Lots of love!

Depression *(continued from page 7)*

other medical conditions, electroconvulsive therapy has been shown to be effective and safe. Finally, peer or self-help groups for older people with depression are related to improved outcomes, and may be more acceptable to older women with HIV than clinical mental health services.

Policy Considerations for Older Women with HIV

Despite the high rates of depression among older women with HIV, many do not take advantage of mental health services. One possible explanation for this is a lack of clear communication between people with HIV and their healthcare providers about depression. There may also be a lack of mental health services that are appropriate for older women with HIV. These problems cannot be addressed without the following changes to public policy:

Education

Increased efforts to educate people with HIV, along with their physicians, religious leaders, educators, and others who serve them, are necessary to address ignorance about mental illness, its diagnosis, and the effectiveness of treatment. Public education efforts are also needed to address stigma around mental illness and depression, as well as stigma concerning HIV.

Outreach, Home-Based, and Nontraditional Services

Mental health services are generally designed, structured, and financed on a medical model. People are expected to come to a place where mental health services are provided by professionals, who rarely provide services in the community or in people's homes. The services provided are generally a combination of counseling and medication. A fundamentally new vision of services for persons with HIV should be developed, one that emphasizes outreach in community settings and the provision of a variety of support services.

Cultural and Clinical Competency

Problems of what is referred to as clinical and cultural competency – basically the inability of professionals to communicate with people from different cultural and educational backgrounds, or with limited abilities in English – are commonplace in the mental health system. While some attempts are being made to address these issues, a serious push with regard to cultural competency and appropriateness is needed. This calls for changes in professional education, major training initiatives, changes in organizational structure and culture, and new regulatory requirements that make licensing dependent on improvements in serving people of diverse cultures.

Conclusions

Depression is a serious problem for many older women with HIV. Even relatively low levels of depressive symptoms have been found to have negative consequences with, for example, HIV treatment adherence. It is therefore important that older women with HIV, as well as their medical and social service providers, be aware of this issue and be prepared to address depression as one of the many ways for improving life quality in the face of this illness.

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Current HIV Prevention Policy: Initiatives that Affect Women

by Kimberleigh Smith

Increased attention to the HIV epidemic globally has encouraged HIV policy advocates to look at HIV prevention efforts among women in the U.S. and to explore how they can be improved.

This article will highlight three major prevention efforts that may have a profound effect on HIV infection rates among women in the U.S.: the Microbicides Development Act (MDA); the Centers for Disease Control and Prevention's (CDC) HIV tracking system; and HIV prevention intervention strategies that integrate factors that increase vulnerability to HIV, such as poverty, domestic violence, and poor education.

AIDS Is a Women's Issue

AIDS is a women's issue here in the U.S., and certainly in New York City. It is a disease with great differences in different groups. The CDC reports that the percentage of new HIV and AIDS cases in the U.S. among women has more than tripled in the last two decades. Furthermore, rates of HIV infection differ greatly by race. A few facts:

- Women of color represent the majority of new HIV cases among women, and the majority of women living with HIV.
- In 2004, HIV infection was the leading cause of death for black and African-American women aged 25 to 34.
- Latinas accounted for an alarming 82% of total AIDS diagnoses for women in 2005, although Hispanic men and women make up just 24% of the U.S. population.
- Data from the NYC Department of Health from 2004 show that women make up 32% of new HIV diagnoses.
- Females comprise a greater proportion of new HIV cases among blacks, compared with other groups, although the number of new diagnoses has declined slightly for both men and women.
- The death rate in 2004 among persons with HIV or AIDS was 25% higher in females than in males.

"Gender in relation to the AIDS epidemic is huge and under-explored," says Dr. Judy Auerbach, of the San Francisco AIDS Foundation. "Our response has been very limited though it's more possible than ever to put HIV in the larger context of women's lives."

Dr. Auerbach and others attribute this new attention to the devastation of HIV among young women in sub-Saharan Africa. Women here share many of the same vulnerabilities with women across the world: poverty, violence, education, gender inequality, etc. Further, the very way we perceive risk for women has become a point of discussion.

Female-Controlled Prevention: The Microbicides Development Act

Microbicides are products currently being developed that women could apply to prevent transmission of HIV and other infections.

Microbicides could come in a variety of forms, including gels, creams, or rings that would release a drug slowly over days or weeks. The impact of a microbicide (though still many years away) is far-reaching. Women's vulnerability to HIV increases in situations of poverty, abusive relationships, sexual violence, or other circumstances in which women cannot control their sexual encounters or cannot insist on abstinence, mutual monogamy, or condom use. Negotiation about safer sex can be even more difficult for young women. Development of a safe, effective microbicide holds the promise of a new HIV-prevention technology that takes into account the realities of women's lives.

"As we start to get more numbers from the CDC," says Anna Forbes of the Global Campaign for Microbicides, "we can expect that the current rates of infection among women, especially women of color, will go up. These data point very clearly and unequivocally to the need for a microbicide."

If passed, the Microbicide Development Act (MDA) will increase the U.S. government's commitment to microbicide research and development. Right now, barely 3% of the national budget for HIV research is spent on the development of microbicides. Forbes explains further: "A big part of the MDA would assure, by Congressional mandate, that microbicide research be prioritized." The legislation is deliberately simple, she adds, to increase the likelihood of passage, but also to create this priority and ensure coordination as we get closer to an actual microbicide.

The MDA would establish a dedicated unit for microbicide research and development within the National Institutes of Health (NIH). Right now, microbicide research at NIH is conducted under several institutes with no single path of accountability, no funding coordination, highly variable levels of interest and commitment, and a degree of competition. Over the last two years the CDC and the U.S. Agency of International Development (USAID) have expanded their microbicide efforts. Without the coordination required by the MDA, costly inefficiencies and duplication of effort may result.

The legislation would also authorize funding increases as needed at the CDC, NIH, and USAID for the development of microbicides. Finally, it would require coordination between NIH and other Federal agencies supporting microbicide development, including the CDC and USAID.

Risk and the HIV Surveillance System

Women's organizations and HIV coalitions across the U.S. are waging a campaign to change the CDC HIV Surveillance System to reflect more accurately the reality of the HIV epidemic and prevention needs of women in the U.S. These groups are tackling the issue of the "no identified risk" (NIR) exposure category.

Women who are unable to identify the risk behavior of their male partners or that their partners have HIV are automatically placed in the NIR category. Correctly classifying women's HIV infec-

tion risks is essential, given that the CDC's system affects funding allocation, monitors trends, aids in the development and evaluation of prevention programs, and helps identify new or emerging risk groups.

The National Women and AIDS Collective (NWAC) contends that the CDC's HIV surveillance system might be a key reason that women are unaware of, or choose not to believe, their own risk for HIV infection, thereby fueling a growing crisis of HIV and AIDS among American women. They state it is "based on an outmoded understanding of the epidemic from the early 1980s and ... has only been minimally revised once during the 1990s... As such, it does not accurately report or reflect why women are increasingly becoming infected with HIV."

NWAC reports that, among women testing HIV positive in their local and state programs, as many as 60% are classified as NIR by the CDC. And, according to the CDC, 47% of all women testing HIV positive in the U.S. are assigned to the NIR group. Providers and advocates widely acknowledge that women are contracting HIV because they believe they are in monogamous relationships with their male partners or they are unaware of their male partners' sexual history, risk behavior, or HIV status.

NWAC also reports that women are sometimes denied HIV testing because they do not fit into current risk categories. This is, in part, because testing sites often receive federal funding that allows them to target only high-risk groups as determined by the CDC. Therefore, the current approach has an impact not only on funding decisions but on testing. This ultimately has an impact on care, diagnoses of other illnesses, health outcomes, and HIV transmission.

The critiques of the CDC's surveillance system are especially relevant given the much-anticipated release of new data that are expected to reveal higher rates of HIV in the U.S. It's been estimated for several years that the number of new infections has been holding at about 40,000 each year, but the CDC has announced it may soon increase this estimate to 60,000.

NWAC and others propose updating the CDC's surveillance system so that an "acquisition" category is added to the system to capture information on factors known to elevate women's – particularly women of color and low-income women's – risk of HIV infection, regardless of presumed or identified behavioral risks. An acquisition category would allow the CDC to collect data on how women acquire HIV (including factors such as where one lives, prevalence of HIV, and poverty, among other things) as opposed to focusing solely on how HIV is transmitted via high-risk behavior.

Better Interventions to Stem the Epidemic Among Women

"At this point in the HIV/AIDS pandemic, there is general consensus ... that a comprehensive, multi-level approach to HIV prevention and the science that guides it is essential. This consensus comes from an understanding – after 26 years of research and lived experience – that HIV is a pathogen that is transmitted in the course of human relationships that take place in social and cultural contexts. This means that equal attention to biological, behavioral and social factors – individually and in relation to each other – is required in order to have a real impact on the spread of HIV," *Dr. Judy Auerbach*

Intervention approaches cannot be aimed solely at changing individual behavior; they must work also to change communities – their programs, practices, laws or policies that place certain groups of people at increased risk of becoming infected. Further, these interventions must be based on science.

For instance, it is widely acknowledged that poverty and gender inequality are two core factors that shape HIV risk among women, yet there are very few HIV and economic interventions in the U.S., and few that integrate health concerns into them. Similarly, while there has been considerable work about how gender roles shape sexual negotiations and HIV risk, there has been much less on how these roles are reinforced through broader factors such as inequality and privilege.

There is, however, a growing movement to advance science-based prevention, meaning strategies that have been proven in clinical studies to reduce the transmission of HIV in specific groups. Despite scientific and political challenges, the HIV community is coming together to make the case that a multilevel approach is needed to advance the HIV prevention agenda for women and others. The San Francisco AIDS Foundation, in partner-

ship with the Caucus for Evidence-Based Prevention, is spearheading discussions like these over the coming year.

Conclusion

Domestic advocates, providers, and consumers alike are eager to take advantage of a growing openness among decision makers to respond to the U.S. HIV epidemic among women, within the social and cultural contexts in which it exists and, unfortunately, continues to thrive.

As advocates, providers, and consumers our job going forward will be to mobilize communities to affect policy changes like the MDA; to advocate for public health systems that reflect the realities of women's lives; to bolster prevention research; and to bring our best thinking to bear on the structural drivers of the epidemic. It is through these efforts that we can have a deeper and more sustained impact on the HIV epidemic among women.

Kimberleigh Smith is Director of the Women's Program at GMHC.

“Women who are unable to identify the risk behavior of their male partners or that their partners have HIV are automatically placed in the ‘No Identifiable Risk’ category by the CDC.”

Personal Perspective: My Babies and Me

by Delia G.

I found out I was positive in 1994 when I tried to sell my blood. I thought this was an easy way to get extra cash and help others at the same time. I never would have guessed what I was about to learn.

A grave-looking doctor gave me the news. A million thoughts rushed through my head. I couldn't breathe, or even think. Before that second, I had believed that all people with HIV should go to an island somewhere to prevent others from getting it. Now I had it. The doctor encouraged me to get a second opinion, then gave me a pamphlet of referrals. I went home, closed myself in my room, and cried for hours. How could I tell my family? My boyfriend? My child?

I called one of the health clinics from the referral sheet to schedule an appointment. It was torture waiting for the test results. I kept telling myself it was some sort of horrible mistake. When the news was delivered, it was too much for me and I broke down.

I was consoled with a strong hug and given a flyer with some numbers for support groups. There wasn't anything specially geared for someone hearing the news for the first time, and there was only one support group specifically for women. I had so many questions. How long was I going to live? When would I get all skinny and skeletal? When would I get AIDS? How contagious is it? Do I need a will? Who will take care of my son? Does he have it? What about my boyfriend? I felt my needs and questions could best be answered by the women's support group.

When I went to my first support meeting I had a notepad with questions, and the women were very kind and patient and answered every one of them. There was a library of materials, including videos and books explaining the disease to children. I grabbed all I could carry and spent three days going over the information. I looked for other support groups and services, but they were all geared toward gay

white men and people in recovery. There was barely anything written about or for straight women, and nothing at all for black women.

When I met my doctor to go over my treatment and schedule an appointment to test my son, I got another shock: I was pregnant! The doctor asked when I wanted to schedule the pregnancy termination – just like that! When I hesitated, he said, “You aren't planning on having the baby!? It will die!” I scheduled the appointment in tears, got the prescription for my medicines, and left. I went to a support group meeting to see how the others dealt with this issue.

When I shared what the doctor had said, the room went berserk! The women told me that there was a good chance that I could deliver a healthy baby if I started my medicines right away. I was ecstatic and furious at the same time! What if I hadn't gone to the support group and went to the appointment?! I was relieved and worried to know that I didn't have to abort my baby and that I could know the joys of pregnancy again. I was only 22 years old – pretty young to learn you will never have another baby.

The women were very warm and offered all the peer support I could dream of. We discussed how to deal with the side effects of the medicines I was going to be taking. We talked about dealing with the psychological and emotional issues around the disease from a female perspective, and disclosure. I was still coming to grips myself and needed time to decide how

and when I told my family. But I had to tell my partner I was positive and pregnant.

That was so hard to do. I really felt like my boyfriend and I had a magical connection and that he would be the man I would grow old with. I would have loved to share the joy of raising a child with him instead of telling him there is a good chance I will be dead in five years. I was already a widow. My husband had died a few years earlier after complications from a motorcycle accident and a flu-like cold.

“The doctor asked when I wanted to schedule the pregnancy termination – just like that! When I hesitated, he said, ‘You aren't planning on having the baby!?’ It will die!’”

Immigrant Women with HIV

by Rosa Bramble Weed

I met my boyfriend after work and told him that we needed to go our separate ways. I told him I was positive and had just found out I was pregnant, but there wasn't anyone else. I told him he needed to get tested for the virus. We went over how the virus is spread, and about having a healthy baby even if the mother is infected. He said he loved me and wasn't going anywhere. I was dazed. It never dawned on me that he would even consider it. I helped him find an anonymous testing center and tried to help prepare him for testing positive.

We went to the same clinic where I had my terrible news and prepared for the worst. He came out with a frown and told me he tested negative. I was very surprised, and a little resentful. I felt horrible that I really was alone in this battle, but relieved that he didn't pass it to me.

When the baby came, the first test was positive like we expected, but the next tests came back negative. The pregnancy was a little much on my body and immune system, so we postponed the planned surgery to get my reproductive organs severed. I was given a bag of condoms and shots to prevent pregnancy and left the program after six months.

So here I was, 23 years old, with a steady boyfriend, a four-year-old, and a newborn, and I was the only one with the virus. I didn't get to breastfeed, but it was a small sacrifice to have a healthy baby. I became active in the HIV community, going to schools to discuss HIV prevention, and I started a support group for HIV-positive women of color. I got a job at the mall.

Then one day I was unable to button my pants. A coworker joked that perhaps I was pregnant. I laughed and said, "That's impossible. I always use a condom, and besides I'm . . ." and I caught myself. I stammered that I am on the shots which prevent pregnancy.

Nevertheless I went to get a pregnancy test on my lunch break and was told I was indeed pregnant. I had cheated the odds last time and I didn't want to press my luck. I prayed that if this baby was healthy, I'd get the surgery whatever the costs.

Now my boys are 16, 12, and 9. All are healthy and HIV negative and my boyfriend is now my husband of eight years. He is negative as well. I got my tubes tied as I promised and have no regrets.

As if living with HIV, as a woman, weren't hard enough, numerous HIV-positive female immigrants – documented or undocumented – living in the United States face significant obstacles. Not only must HIV-positive immigrants contend with fears of deportation or losing their residential status, they may also face significant challenges procuring lifesaving healthcare and social services in a foreign country where immigration policies are in a state of flux.

Immigrant women are especially affected by the epidemic and have unique challenges with regard to treatment and prevention. As of 2005, there were 126,964 women with AIDS in the U.S. Latinas, including immigrants, are disproportionately affected by HIV. Although they make up 14% of the U.S. population, they are 19% of women with HIV. Immigrant women are often hard to reach due to their unique needs and challenges.

Immigrant Women in New York City

In New York City, 36% of the population is foreign-born, compared to 12% of the total U.S. population. Despite the fact that there are over 3 million foreign citizens temporarily or permanently residing in New York City, there is very little research on immigrants and HIV, let alone immigrant women and HIV. A needs assessment, conducted by the HIV Health and Human Services Planning Council of New York, found that there are no surveillance tools to measure the occurrence of HIV among either documented or undocumented immigrants.

New York City has one of the highest HIV rates in the country and is home to a large number of HIV-positive immigrants. According to a 2004 report from the New York City Department of Health and Mental Hygiene (DOHMH), 12,000 persons living with HIV in the city were born outside the United States. Of the 3,653 newly diagnosed cases in that year, 23% were foreign-born.

One of the most disturbing findings of the report was that by the time foreign-born persons with HIV received care, most had progressed to AIDS.

Immigration Trauma and HIV

Key reasons for immigrants' reluctance to come forward are fear of deportation, fear of stigma, and the language barrier. The desire to come to the U.S. and find a better way of life, whether to stay short-term or permanently, can lead to a stressful and traumatic immigration process. Immigrants experience pressure to succeed in the new country, difficulties in communication, and a loss of family and friends. Studies have linked their low acculturation levels and mental health problems to leaving their support systems and entering a new society armed with minimal or no English-language skills, making it difficult to establish a new social network. For immigrant women, their loss of identity and familiar support

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Immigrant Women with HIV *(continued from previous page)*

networks places them at risk for HIV. But the most important factor for immigrant women is that they do not perceive themselves to be at risk for HIV.

Immigrants may have left their native countries voluntarily, or may have been forced to leave. Many HIV-positive women arrive in the U.S. having already been diagnosed in their home countries, while others arrive without awareness of their HIV status. Those who emigrate knowing their HIV status may do so in response to the lack of treatment in their home countries, as well as the discrimination and stigma encountered there. One such woman described her experience when she was hospitalized in Ecuador: A sign reading “AIDS” was hung above her bed, inviting many negative comments.

Since very few women have the resources to participate in official “bridge” programs that permit foreign citizens to travel to New York to obtain medical care, women risk their lives to immigrate illegally to the U.S. or other countries. Once in New York, they struggle with the decision to live here with an undocumented status or to return to their home countries.

For many immigrant women, learning about their diagnosis is directly related to their immigration status. In order to obtain permanent residency in the United States an individual must take an HIV test. If positive, the individual can be denied permanent residency. Unfortunately for many women, the HIV test for residency is how they first learn their status. The following is an example of this journey:

Alejandra lived in Peru with her child while her husband came to the U.S. Eventually they decided she should join him here. When she arrived, he was hospitalized. He then left her. So, like many immigrants she opted to marry to obtain legal residency. She was told to take an HIV test and, not knowing what HIV was, agreed. When she returned in two weeks, the nurse told her, “Did you know you are HIV positive? You might as well go back to your country – otherwise you will just die here.”

Alejandra became depressed, isolated, and fearful of telling her family. She confided in her sister and made the decision that the best place for her was to go home to Peru. She returned to her country and was treated with indifference by her family. Then she found a doctor – her “angel” – who was supportive and told her she did have an opportunity to live, but that their country did not have the medications necessary. For her daughter, she found the courage to live and returned to the U.S., where she found a wonderful social worker and medical facility where she has thrived.

Intimate Partner Violence

Immigrant women like Alejandra find that their options have diminished. As a result of the stigma that continues to surround HIV, they feel they are different. They may remain in violent

situations or become involved with men who tell them, “No one else will want you now.” The feeling of being “damaged goods” is virtually universal for women living with HIV and often leads to their remaining in high-risk relationships and behaviors.

Women account for approximately two-thirds of immigrants living in the U.S. Violence against women, particularly intimate partner violence (IPV), has specific and disproportionate effects on immigrant women. Claudia Moreno of the School of Social Work at Rutgers University and other researchers have shown how HIV and IPV share risk factors that are important in both HIV treatment and prevention. Women dealing with IPV often have a history of childhood sexual abuse or physical and verbal abuse, and are often witnesses to violence and death in war-torn countries. This trauma affects how they relate to the world, shatters trust, and lowers their sense of self-worth. Women are also less able to negotiate sex in relationships that include IPV. The fear of violence, intimidation, and threats inhibit their ability to demand safer sex practices. For many women, disclosing their HIV status to their partners increases the risk of violence. Social isolation is increased, making it difficult to reach out to them.

Immigrant women with HIV have an even higher risk of living in abusive relationships. Based on clinical experience and supported by research, HIV and IPV are interwoven in the lives of many immigrant women. Recent studies show that Latinas living in the U.S. account for 34% of those experiencing IPV. The National Family Violence Survey found that the rate of Hispanic partner abuse was 54% greater than in non-Hispanics. Although there is little research on immigrant women from African and Asian countries, evidence indicates that women worldwide endure abusive relationships.

For many undocumented immigrant women, the threat of being reported to the Department of Homeland Security – with its overarching power to deport and revoke immigration statuses – is the thing they fear most. The thought of having to return to their countries without medication is terrifying. They are often unaware of their rights as immigrants, and think they have no options.

In addition, their partners may withhold medication and may force unsafe sexual behavior. One immigrant woman reported living with an abusive male partner for two years and not being allowed to go to medical appointments. Consequently her viral load rose and her CD4 count dropped considerably. She was fearful of leaving and, like many women, was dependent financially on the partner. Upon having the courage and support to speak in her community church, she was able to get her partner out of her home.

Another vulnerable group are lesbians who are forced to emigrate from their home countries because of persecution. They may be at increased risk for substance abuse and, more than other immigrant women, can place themselves at risk for HIV. Prevention campaigns must be designed to address their needs.

Long-Distance Disclosure

Research has demonstrated the stress associated with the decision to disclose one's HIV status. This stress is heightened for immigrant women when they are physically separated from partners, children, and family. The dilemma of whether to stay and receive care or return to their families is a constant stress in their lives, especially when they have children in their native countries. They may have planned to save money and return, but their options become severely limited once they are diagnosed.

Making the decision to disclose is very difficult for these women. They develop a long-distance relationship with families and children asking, "When will you return?" Women begin to protect themselves and their children by saying they are sick, or working, or having difficulty with their legal status. There is an enormous sense of guilt, shame, and sadness associated with disclosure. The frustration and sadness of not seeing their children, which they already face, is compounded by the fear of dying before have the opportunity to see them again. This can contribute to depression and anxiety.

Limited Resources

Immigrant women with HIV have an additional responsibility, especially if undocumented, of caring not only for themselves, but for their children and families overseas. They experience anxiety stemming from the fear of becoming ill and losing the ability to work. In addition, undocumented women have few options with regard to vacation time and sick leave: "If I don't work, I don't get paid." Working long hours interferes with medication adherence. Women also overcompensate for their diagnosis by working long hours to provide for their children. The feeling that they can at least provide their children with good clothing, school, and extra money leads them to work extra hours, which also affects their need for rest. After-work and evening hours are important for immigrant women receiving medical services.

Changes in immigration laws have had an enormous impact on services for immigrant women with HIV. Prior to September 11, 2001, immigrants living with HIV were able to apply for PRUCOL (Permanent Residence Under Color of Law), letting immigration authorities know of their presence and enabling them to obtain basic entitlements. It alleviated some of the stress of working very long hours. New immigration laws have made this option virtually nonexistent, thereby burdening these women with longer hours, higher stress levels and depression, increased anxiety, and putting them at greater risk for alcohol and substance use. The importance of integrating substance abuse treat-

ment and harm reduction in both treatment and prevention efforts cannot be overstated.

Immigrant Women and Empowerment

Immigrant women also learn about their status when being tested for pregnancy. Young women usually have no family members in this country and are in need of many supportive services. They are at risk for HIV when engaging in survival activities such as commercial sex work, or when they are involved with older men who provide for them financially. The following is one story:

“Immigrant women with HIV have an additional responsibility of caring for their families overseas. The feeling that they can at least provide their children with good clothing, school, and money leads them to work extra hours.”

Fernanda is a 24-year-old woman who was infected by her first boyfriend in El Salvador. She was not aware of her status until she went to get a pregnancy test at a city hospital. The diagnosis led to a sense of confusion, shame, and isolation. She didn't know where to turn. She was afraid the child she was being paid to care for would get the virus, so she obsessively cleaned her silverware, bathroom, and even clothing. At the time of her diagnosis the Positive Life Program at the Child Center of Woodside, Queens, had started a support group for Latinas. Fernanda would go once in a while but was very timid and just listened. The ice-breaker came one day when staff brought bagels and she said, "We don't eat that – Can you bring empanadas instead?" There began a process for Fernanda in a group that brought respect, warmth, and acceptance to her process of transformation.

Through group she worked through her feelings of loss, pain, and anger, and shed many tears. Slowly she realized she had choices, began to ask about medication, and took advantage of literacy classes.

Fernanda began to understand that knowledge gave her more control. She learned how to express her pain – to put words to what she felt. Her narrative began to shift to a woman of hope. She learned about the use of condoms, including the female condom, and became a peer educator and a community activist. Fernanda states, "I have learned that I have a voice, a voice that can now be heard."

Reclaiming their voice, dignity, and respect is a healing and transformative process for immigrant women living with HIV. Providers can be vehicles to allow the process to unfold and can be part of the journey that reshapes their lives, leading to a hopeful and productive future. When immigrant women feel and own their empowerment, they are able to live more fulfilling lives and value their contribution to being in this country, as opposed to feeling that they are a burden.

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Immigrant Women with HIV *(continued from previous page)*

The Program Needs of Immigrant Women with HIV

The approach used in the Positive Life Program in Queens, New York, is one of validation, affirmation through music, story telling, and embracing the cultural “familismo” that women need to feel supported. In women’s centers across this country and globally there is a valuable lesson: Women have a voice and story to share. Funding support for full meals, not just snacks, is needed, especially for immigrant women working long hours. Providing a safe, confidential environment with a respectful and warm approach is essential for women to feel safe, and facilitates a process of “confianza,” or trust.

At the Positive Life Center, we coordinate a women’s retreat for women living with HIV, which is very healing and transformative. Funding is needed for women and their children to experience a day or weekend of reparation, and for children’s groups as well as groups for couples of mixed HIV status.

The new stringent immigration laws in the U.S., coupled with lack of funding for medical and supportive services, will further increase the vulnerability of immigrant women with HIV. We need to work together to advocate for women’s programs, increase funds for microbicide research, and increase women’s access to clinical trials. At the local and global level, we need to put an end to the gender violence that hinders women from seeking treatment. We need to address their lack of knowledge that they have the right to treatment regardless of their immigration status.

Grassroots prevention efforts need to be supported in order to connect with this vulnerable and hard-to-reach population. Voces Latinas is one such program that aims to reduce transmission of HIV among Latina immigrants in Queens. Voces Latinas integrates workshops, peer education, and health promotion, to reach women who otherwise would not come forward. The program successfully integrates valuable information on domestic violence, nutrition, housing, assertiveness training, cancer, and HIV within a culturally competent context. As in Asian and African cultures, sexuality is not talked about openly, so providing informal gatherings is the most effective and least threatening approach for immigrant Latinas.

Recommendations

- HIV providers who serve immigrants and immigrant women need to gather and develop strategies on what is most effective and to identify gaps in services.

- Legal services and collaboration with mental health services need to be increased, housing opportunities improved, especially for undocumented immigrant women with HIV.
- Additional supportive services are needed, such as mental health, food and nutrition counseling, drug and substance abuse services, English as a Second Language classes, domestic violence programs, and emergency assistance.

“Funding support for full meals is needed, especially for immigrant women working long hours. Providing a safe, confidential environment with a respectful and warm approach is essential, and facilitates a process of ‘confianza,’ or trust.”

- Alternative/holistic approaches and interventions such as women’s retreats, art therapy, dance movement interventions, and cooking are needed.
- Human trafficking, in particular of young women, needs to be addressed, as well as the exploitation of commercial sex workers.
- Educational forums to address the issues affecting migrant workers and immigrant women are needed, including linkages to prevention programs in the Americas and New York.
- Cross-cultural studies of the impact of intimate partner violence among immigrant women with HIV receiving care in the U.S. should be undertaken.
- Partnerships between providers and community-based programs that serve immigrants should be strengthened.

- Case managers and direct service providers must be trained with regard to the immigrant experience and perceptions of governmental agencies and services.
- The availability of gynecological care must be increased for undocumented immigrants and women who are uninsured or underinsured.
- Campaigns raising awareness among immigrant women of their risk of HIV, including collaboration with the various immigrant communities to develop these campaigns, would be beneficial.

Rosa Bramble Weed, LCSW, is Director of the Positive Life Program of the Child Center of Woodside in Queens, New York.

Older Women and HIV

- About 18% of AIDS cases in the U.S. female population are said to be in women older than age 50, and numbers of cases are expected to increase as women of all ages survive longer due to improved drug therapy and other treatment advances.
- In the last decade, AIDS cases in women over 50 were reported to have tripled, while heterosexual transmission rates in this age group may have increased as much as 106%.
- “Older women,” according to UNAIDS, “appear to have higher incidence than older men, and during a recent five-year period the number of new cases in this group increased by 40%. More than half of the infected over 50 are of African-American and Hispanic origin, indicating greater risks among minority groups.”
- In the U.S., older African-American women are disproportionately affected; in 2001 they comprised 11% of the population of women older than 50 but accounted for more than 50% of the AIDS and 65% of the HIV cases in this age group.
- While all older individuals with HIV infection or AIDS usually are invisible, isolated, and ignored, this is particularly true of women, who are often unable to disclose their HIV status even to family and friends and, certainly, their community.
- Despite myths and stereotypes, many senior women are sexually active, and some are drug users; therefore their behaviors can put them at risk for HIV infection.
- Healthcare and service providers – and older women themselves – do not realize that they are at the same risk as other age populations; professionals often are reluctant to discuss or question matters of sexuality with their aging patients/clients.
- Most women (and all older persons) are first diagnosed with HIV at a late stage of infection, and often become ill with AIDS-related complications and die sooner than their younger counterparts; these deaths can be attributed to original misdiagnoses and immune systems that naturally weaken with age.

SPECIAL CONSIDERATIONS

- HIV/AIDS educational campaigns and programs are not targeted at/to older women (and men); how often does a wrinkled face appear on a prevention poster?
 - Rates of HIV infection (not AIDS) in all seniors, including women, are especially difficult to determine because older people are not routinely tested
 - Older people, especially women, with HIV/AIDS face a double stigma: ageism and infection with a sexually or drug-injecting transmitted disease; in addition, they are sensitive to a cultural attitude that assumes “Elderly people have lived their lives – so what if they die from AIDS?”
 - Seniors of both sexes are unlikely to use condoms consistently during sex because of a generational mindset and unfamiliarity with HIV/STD prevention methods.
 - For older women, there are special considerations: After menopause, condom use for birth control becomes unimportant, and normal aging changes such as a decrease in vaginal lubrication and thinning vaginal walls can put them at higher risk during unprotected sexual intercourse.
- As HIV symptoms often are similar to those associated with aging (fatigue, weight loss, dementia, skin rashes, swollen lymph nodes), misdiagnosis is frequent in older women/people who are, in fact, infected.
 - Women and older males may confront social and professional bias regarding the allocation of limited healthcare services and resources available to the AIDS community (i.e., “why waste money on the elderly?”)
 - Because the aging process itself lowers energy levels and results in restrictions in social routines that can cause emotional/psychological problems, the older woman/adult additionally infected with HIV may feel another “loss” and endure more severe depression.
 - Senior women often are less likely to find support and comfort among family and friends, and because they are traditionally not comfortable in support groups, they may be less inclined to join them, citing lack of shared experiences concerning different issues.
 - Due to the general lack of awareness of HIV/AIDS in older adults – in particular, women – this segment of the population, for the most part, has been omitted from research, clinical drug trials, educational prevention programs, and intervention efforts.

NECESSARY ACTIONS

- Specific programs must be implemented for older adults, especially women, who need to be informed about the transmission and prevention of HIV.
- Outreach should include workshops and trainings devoted to basic HIV/AIDS information, “safe” sexual and drug-using practices, testing, negotiation skills – all in relationship to aging.
- More research is needed to study seniors’ sexual and drug-using behaviors and to determine HIV disease progression and treatments in the over-50 population.
- Healthcare and service providers on all levels should be educated on HIV risk behaviors and symptoms of HIV infection; they need to conduct thorough sex and drug-use risk assessments with their older clients/patients.
- Programs aimed at reaching healthcare and service providers should cover misdiagnoses, testing technologies, treatments, support groups, case management, and the importance of being actively involved in the health and well-being of their older clients/patients.
- Successful media and social marketing campaigns can raise awareness of HIV/AIDS in older people and reinforce the need for educational programs, while promoting respect and validation for the elderly as a group.

Jane P. Fowler compiled much of this tip sheet, based primarily on personal perspectives and experiences of consumers and professionals, while she was co-chairperson of the National Association on HIV Over Fifty. Now director of the national HIV Wisdom for Older Women program, she can be reached at: jane@hivwisdom.org. The website is www.hivwisdom.org.

Positive Pregnancy

by Vaughn Taylor and Hanna Tessema

Many HIV-positive women are reluctant to become pregnant because they fear they will pass the virus to their fetuses or that they will become too sick or disabled to care and provide for their children properly. But with counseling and guidance, along with comprehensive healthcare and treatment, many HIV-positive women can have healthy, HIV-negative children.

The key to a successful pregnancy is the health of the mother-to-be. The HIV-positive woman who is pregnant – or is considering having children – has an additional reason to take care of herself. Living well with HIV isn't just about antiretrovirals – it's also about adequate nutrition, quitting smoking, getting enough exercise, and not using recreational drugs (especially those that involve needles). These recommendations will become even more vital during pregnancy, and will be joined by others – avoiding alcohol and caffeine, for example. The aim is a healthy pregnancy, an HIV-negative baby, and a long, healthy life as a caring mother.

The prospective mother needs to learn everything she can about risks to the fetus during pregnancy and to the baby after delivery. She needs to discuss her options with both her HIV specialist and her obstetrician (and later her baby's pediatrician), in order to determine the choices that are best for her. This article will explore some of those options.

The Importance of Prenatal Care and Counseling

Researchers are not sure exactly when HIV is transmitted during pregnancy. While some fetuses can be infected with HIV while developing inside their mothers' uteruses (wombs), the vast majority of infections occur during labor (the time of delivery) or after the baby is born and is breastfed by an HIV-infected mother.

Ideally, preparation for reducing risks to mother and child begins before conception, when the woman and her partner are

deciding if, when, and how to have a baby. Without treatment, there is a 25% to 30% chance of an HIV-positive woman passing the virus to her child – so-called “vertical transmission.” Risk of mother-to-child transmission is generally dependent on the pregnant woman's viral load – the higher the amount of virus during pregnancy and delivery, the greater the higher the chance of transmitting the virus to her baby.

Throughout pregnancy, a developing fetus has its own blood supply. In other words, the developing fetus generally does not come into contact with the blood of the mother. This helps protect the fetus from infections, such as HIV, in the mother's blood. Developing fetuses do, however, receive nutrients and various proteins, such as immune system antibodies, from their mothers. While a mother's HIV may not enter the fetus, her antibodies to the virus will. These antibodies cannot harm the fetus, but will cause the baby to test “positive” to an HIV antibody test at birth.

At the time of birth (labor), a baby often comes into contact with his or her mother's blood. If the mother's blood enters the baby's body, HIV can be transmitted. But with good prenatal care and antiretroviral treatment, the risk of transmission can be reduced to less than 2%.

Sperm Washing

Sperm washing is a process that was developed to reduce risk of transmission from an HIV-positive man to his HIV-negative partner, and subsequently to the fetus, while enabling them to conceive a child. If both partners are positive, sperm washing also reduces the risk of cross-infection with a different strain of HIV.

HIV is carried primarily in the seminal fluid rather than in the sperm itself. Sperm washing involves separating the sperm from the seminal fluid, then using it to impregnate the woman when she is ovulating and most likely to become preg-

nant, or to fertilize her egg through in vitro fertilization.

Integrated Pregnancy Care

A comprehensive approach to care is the most effective way for a pregnant woman with HIV infection to have a healthy pregnancy and delivery. While an obstetrician and an HIV specialist are safely and effectively managing the woman's pregnancy, she should also be provided with professional support to help manage psychological, social, and economic challenges should they arise. This might include assistance from a social services agency to help her with counseling, housing, food, and childcare needs, both during pregnancy and after delivery.

Professional counseling before pregnancy can also be extremely helpful. Working closely with her healthcare provider, an HIV-positive woman and her partner can learn a great deal about the risks and benefits associated with pregnancy, including treatment options, and different ways of achieving conception.

Antiretroviral Therapy

Women who are HIV positive can drastically reduce the risk of transmitting HIV to their babies with the use of antiretroviral drug treatment during pregnancy and at the time of delivery. Deciding when to begin antiretroviral therapy during pregnancy, however – if it's not already being taken – and which medications to use can be confusing.

Working with a healthcare provider, HIV-positive women can make important perinatal treatment decisions that best suit their individual needs, while at the same time following state-of-the-art recommendations from the U.S. Department of Health and Human Services (DHHS), the federal agency responsible for setting healthcare policies in the United States. The most recent version of the agency's guidelines, entitled *Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the*

United States, was published on November 2, 2007.

When to Use Treatment During Pregnancy

Generally speaking, if an HIV-positive woman requires treatment to protect her own health – if her CD4 cell count is below 350, for example – she should not be denied therapy, regardless of whether she is pregnant or plans to become pregnant.

There are lingering questions about the safety of antiretrovirals when used during the first three months (first trimester) of pregnancy, when a developing fetus is believed to be most susceptible to drug toxicity. According to the DHHS, antiretrovirals can be avoided during this three-month period provided the woman does not require treatment to maintain her own health. Otherwise, HIV treatment should be continued throughout pregnancy.

HIV-positive pregnant women who do not require antiretroviral therapy to maintain their own health may be able to stop treatment after giving birth – a decision that should only be made in consultation with her healthcare team.

Which HIV Drugs to Use During Pregnancy

As for specific HIV medications, the DHHS guidelines spell out a number of important considerations that HIV-positive pregnant women and their healthcare providers should be aware of.

First, the nucleoside reverse transcriptase inhibitor (NRTI) Retrovir (zidovudine) has been studied extensively in HIV-positive pregnant women and has been shown to be safe and effective at reducing the transmission of HIV from mother to fetus. In turn, it is almost always recommended as a treatment component during pregnancy and delivery (and given to the infant after birth), even when the woman has HIV that is resistant to it.

The non-nucleoside reverse transcriptase inhibitor (NNRTI) efavirenz, found in

Sustiva and Atripla, should not be used by pregnant women and only cautiously by women who might become pregnant. Because efavirenz may cause birth defects if taken during the first trimester – the first three months of pregnancy – it is recommended that HIV-positive women have a pregnancy test before starting efavirenz and use adequate birth control while using the drug.

“C-sections can greatly reduce an HIV-positive woman’s risk of passing the virus to her baby. It is still not known, however, if C-sections are any more effective than if the woman takes a powerful combination of antiretroviral drugs throughout her pregnancy.”

The NNRTI Viramune (nevirapine) has been shown to reduce the risk of mother-to-child HIV transmission, but it is recommended only for women with CD4 counts below 250 cells. There is a higher risk of serious allergic reactions, including liver damage, occurring in women who start Viramune with CD4s higher than 250.

The protease inhibitor Viracept (nelfinavir) should also be avoided during pregnancy, until further notice. In September 2007, Pfizer reported the discovery of a manufacturing impurity, ethyl methanesulfonate (EMS), in U.S. batches of Viracept. As EMS has been found to

be cancerous and capable of causing birth defects in animals, the U.S. Food and Drug Administration (FDA) recommends avoiding Viracept during pregnancy until Pfizer has found a way to remove EMS from the drug.

It is also a good idea to switch off medications known to cause serious side effects in women during pregnancy. For example, the FDA has warned that HIV-positive pregnant women should not take Zerit (stavudine) and Videx (didanosine) at the same time. Some pregnant women who took these drugs together developed lactic acidosis – a serious and sometimes fatal buildup of lactic acid in the blood, which can cause fatigue, nausea/vomiting, painful inflammation of the pancreas, and liver damage.

Other Considerations During Pregnancy

It is important to remember that pregnancy-related complications typically seen in women who are not living with HIV, such as hypertensive disorders, ectopic pregnancy, gestational diabetes, psychiatric illness, preterm delivery, and STDs, also can occur in pregnant women living with HIV.

Finally, there are some aspects of typical prenatal care that might not be suitable for HIV-positive pregnant women. For example, amniocentesis, used to test for genetic defects in the baby, is done with a needle that passes through the mother’s abdomen and into the womb. While this test may be necessary to look for any genetic problems that a developing baby may have, it can also increase the risk of transmitting HIV. Before undergoing amniocentesis, HIV-positive pregnant women may want to discuss its benefits and risks with their healthcare provider.

Labor and Delivery

Labor and delivery are believed to be riskiest time for HIV transmission during pregnancy, as babies are most likely to be exposed to their mother’s blood during the birthing process. To reduce this risk, healthcare providers should avoid performing amniotomies – intentionally rupturing the amniotic sac to “make the water break” and induce labor. The risk of

(continued on next page)

Positive Pregnancy *(continued from previous page)*

transmission increases by 2% for every hour after membranes have been ruptured.

An episiotomy – a surgical incision through the perineum made to enlarge the vagina and assist childbirth – can also expose the infant to the mother’s blood and increase the danger of transmission. What’s more, the use of birthing instruments and common procedures, such as forceps/vacuum extractors, scalp electrodes, scalp blood sampling, and internal fetal monitoring, can cause small tears in the baby’s skin and increase the risk of transmission further.

Cesarean Sections vs. Vaginal Delivery

A Cesarean section – also referred to as C-section – is delivery via a surgical incision through the maternal abdomen and uterus. It is one of the oldest documented surgical procedures. A C-section is performed when a vaginal birth is not possible or is not safe for the mother or child. Because of a variety of medical and social factors, C-sections have become fairly common – about 26% of all births in the United States in 2002 were C-sections.

C-sections can greatly reduce an HIV-positive woman’s risk of passing along the virus to her baby at the time of birth, as they greatly reduce the amount of time a baby remains in contact with his or her mother’s blood and other fluids during delivery. It is still not known, however, if C-sections are any more effective than if the woman takes a powerful combination of antiretroviral drugs throughout her pregnancy. It is also not known if a woman who takes a powerful HIV drug combination *and* has a C-section has a lower chance of passing along the virus to her baby than a woman who takes HIV drugs and has a vaginal delivery.

Some experts do not like the idea of C-sections used solely to reduce the risk of mother-to-child HIV transmission. Because C-sections are a type of surgery, there are risks of infection and other complications. In fact, HIV-positive women may be at a higher risk for infection while

undergoing C-section delivery or other complications than HIV-negative women. It is also important to remember that combination HIV treatment might do a better job of stopping transmission than a C-section. According to some studies, in HIV-positive pregnant women who have an undetectable viral load at the time of birth, the risk of delivering a baby infected with the virus is less than 2%, even with vaginal delivery. It is not known if C-sections reduce this risk further.

In its perinatal treatment guidelines, the DHHS says that C-sections are only recommended for the purpose of reducing the risk of mother-to-child HIV transmission when the mother’s viral load is higher than 1,000 at week 36 of the pregnancy. A woman with a viral load below 1,000 should be counseled that her risk of transmitting the virus to her baby is low and that there is currently no information concluding that performing a scheduled cesarean section will lower her risk further. DHHS also says that, if C-section delivery is chosen, it should be scheduled for week 38 of the pregnancy.

Postnatal Treatment

The months following delivery of a baby by an HIV-positive woman are also crucial to keeping the risk of vertical transmission to a minimum.

After the baby is born, the doctor will likely advise that he or she take anti-HIV drugs for four to six weeks, usually a liquid form of Retrovir taken two or four times a day, possibly in combination with other HIV medications. Studies suggest that the use of antiretroviral treatment during the first few weeks of life plays a role in further lowering the risk of HIV infection in a newborn baby. No significant side effects of Retrovir have been observed, other than a mild anemia in some infants that cleared up when the drug was stopped. Follow-up studies show that the HIV-negative treated babies continued to develop normally.

Learning the Baby’s HIV Status

An HIV-positive new mother usually

wants to know right away whether her baby is infected. It can take several months to learn definitively the HIV status of a newborn. Moreover, it is important to keep in mind what an HIV test is. The standard test looks for *antibodies* to HIV; it does not look for the virus itself. Because a fetus is exposed to the mother’s HIV antibodies, the baby will automatically test “positive” after birth. These antibodies can remain in the baby’s body for more than 18 months after birth.

Most hospitals now conduct nucleic acid testing, which looks for the virus itself, on babies born to HIV-infected women. This test can be performed within a few days after delivery and looks for HIV itself in a blood sample collected from the baby. If the test is negative, it should be repeated within a few months after the birth.

Breastfeeding

Breast milk also carries HIV, and breastfeeding adds considerable risk of transmission. As with transmission via blood, there’s some indication that risk increases along with viral load (the amount of HIV in the mother’s blood). So far, research shows that the risk of breast milk transmission is highest in the first six months of life. There’s no threshold, however, or point beyond which it becomes absolutely safe to breastfeed.

Wherever clean water and formula are available, ***it is recommended that HIV-positive women exclusively formula feed their infants.***

In recent years, studies have also looked at breast milk pasteurization, a procedure that allows women to express their breast milk and treat it themselves so that it becomes safe for their infants to drink. Right now, these studies have been done in resource-poor settings; your doctor may have more information about this strategy.

Vaughn Taylor is Manager and Hanna Tessema Associate Manager of ACRIA’s Older Adults Training and Technical Assistance Program.

ACRIA Regional Training Center AIDS Institute Registration Form

Prospective Participant Information: (Please type or print and complete all the information requested)

First Name: _____ MI: _____ Last Name: _____
 Agency Name: _____ Title/Position: _____
 Department Name: _____
 Agency Address: _____ Room/Floor/Suite/Dept.: _____
 City: _____ State: _____ Zip: _____
 Daytime Telephone: _____ Fax: _____
 Email: _____ Alternate Phone Number: _____

PRIMARY WORK SETTING (Please check one:)

- Family Planning/PCAP
- Health Center
- CBO/Community Agency
- Alcohol/Drug Treatment Program
- Non-Institutional Nursing Services
- Child Welfare Services/Foster Care
- Health Department
- Educational Institution
- AIDS Treatment Center
- EMS/Police/Fire
- Correctional Facility/Jail
- Mental Health Services
- Hospital
- Physician's Office/Lab
- Nursing Home/Adult Day Care
- Senior Center
- Other

PRIMARY OCCUPATION (Please check one):

- COBRA – CM/CMT
- COBRA – CFW
- Social Worker/Case Manager
- Community Educator/Outreach Worker
- Nurse
- Administrator
- Nurse Practitioner/Physician's Assistant
- Teacher/Trainer/Student
- HIV Test Counselor
- Physician
- MR/MH Worker
- Criminal Justice/Law Enforcement
- Counselor/Therapist
- Emergency Personnel
- Domestic Violence Provider
- Other

EDUCATION LEVEL (Please check one):

- Less than 12 Years of Education
- High School/GED
- One year of college
- Two years of college
- Three years of college
- Four years of college
- Graduate Degree

RACE (Please check one):

- American Indian or Native Alaskan
- Asian
- Black or African American
- Native Hawaiian or Pacific Islander
- White
- Unknown/unreported
- More than one race

ETHNICITY (Please check one):

- Hispanic or Latino(a)
- Not Hispanic or Latino(a)

NUMBER OF YEARS IN CURRENT OCCUPATION (Please check one):

- 0 – 1 2 - 4
- 5 – 7
- More than 8

Please mail, fax or email this registration form to:

AIDS Community Research Initiative of America
 230 W. 38th St., 17th Floor
 New York, NY 10018
 (Attention: Gustavo Otto)

Phone (212) 924-3934 x129

Fax (212) 924-3936

GOtto@acria.org

www.acria.org

HOW DID YOU LEARN ABOUT THESE TRAININGS? (Please check one):

- AIDS Institute Website
- ACRIA Website
- ACRIA Treatment Update
- Email/Listserv
- ACRIA staff
- Mailing
- Other: _____

WHAT BOROUGH/COUNTY DO YOU WORK IN THE MOST? (Please check one)

- Manhattan/New York
- Bronx/Bronx
- Brooklyn/Kings
- Queens/Queens
- Staten Island/Richmond
- Other: _____

January-June 2008 Training Calendar

Place a check next to the training(s) that you wish to attend:

- | | |
|---|--|
| <input type="checkbox"/> Friday, January 18, 9am-5pm, Manhattan, 1 day. | <i>Enhancing the Partnership between Client and Case Manager</i> |
| <input type="checkbox"/> Thursday, January 24, 1-5pm, Bronx, ½ day. | <i>Overview of HIV/AIDS Infection</i> |
| <input type="checkbox"/> Thursday, February 7, 1-5pm, Bronx, ½ day. | <i>HIV/AIDS Treatment Update</i> |
| <input type="checkbox"/> Friday, February 22, 1-5pm, Queens, ½ day. | <i>Overview of HIV/AIDS Infection</i> |
| <input type="checkbox"/> Thursday, March 6, 1-5pm, Queens, ½ day. | <i>HIV/AIDS Treatment Update</i> |
| <input type="checkbox"/> Friday, March 21, 1-5pm, Brooklyn, ½ day. | <i>Overview of HIV/AIDS Infection</i> |
| <input type="checkbox"/> Thursday, March 27, 1-5pm, Bronx, ½ day. | <i>HIV Testing in NYS: 2005 Guidance</i> |
| <input type="checkbox"/> Friday, March 28, 9am-5pm, Bronx, 1 day. | <i>HIV Testing Skills: Practice Session</i> |
| <input type="checkbox"/> Friday, April 4, 1-5pm, Brooklyn, ½ day. | <i>HIV/AIDS Treatment Update</i> |
| <input type="checkbox"/> Friday, April 18, 1-5pm, Bronx, ½ day. | <i>Promoting Adherence to HIV Treatment</i> |
| <input type="checkbox"/> Friday, April 25, 9am-5pm, Bronx, 1 day. | <i>Building Bridges to Cultural Competency</i> |
| <input type="checkbox"/> Thursday, May 1, 1-5pm, Bronx, ½ day | <i>HIV/AIDS Confidentiality Law</i> |
| <input type="checkbox"/> Mon-Thurs, May 12-15, 9am-5pm, Manhattan, 4 days | <i>Treatment Education Integration Training</i> |
| <input type="checkbox"/> Friday, May 23, 9am-5pm, Bronx, 1 day. | <i>Basic Information on Domestic Violence</i> |
| <input type="checkbox"/> Friday, May 30, 9am-5pm, Bronx, 1 day. | <i>Domestic Violence in LGBT Communities</i> |
| <input type="checkbox"/> Thursday, June 5, 1-5pm, Queens, ½ day. | <i>Promoting Adherence to HIV Treatment</i> |
| <input type="checkbox"/> Thursday, June 19, 1-5pm, Manhattan, ½ day | <i>HIV/AIDS Confidentiality Law</i> |
| <input type="checkbox"/> Thursday, June 26, 1-5pm, Brooklyn, ½ day. | <i>Promoting Adherence to HIV Treatment</i> |



Our training sites are handicapped accessible. Please contact us ahead of time if you require any other special accommodations (e.g. hearing, visual, language needs, etc.)

ACRIA at USCA

ACRIA played a prominent role in last year's United States Conference on AIDS, held in Palm Springs, California, in November 2007.

Associate Director for Research Stephen Karpiak, Ph.D., who was co-principal investigator of ACRIA's groundbreaking *Research on Older Adults with HIV* (ROAH) study, chaired and spoke at a roundtable presentation on "The Graying of HIV." Other participants in the discussion were ACRIA Executive Director Daniel Tietz and consultant J. Edward Shaw.

We also had our first-ever USCA exhibit booth, staffed by HIV Health Literacy Program Administrative Coordinator Gustavo Otto. Conference attendees who visited our booth were able to learn a lot about ACRIA's work and were given a CD that contained a large sampling of educational materials and a complete copy of the ROAH report.

A broad range of the HIV Health Literacy Program's educational materials was displayed, including several issues of *ACRIA Update* and copies of all five of our existing educational publications—all in both English and Spanish versions—along with order forms. Of special interest was information about our newest booklet, the soon-to-be-published *Older Adults and HIV*, which generated a large number of prepublication orders.

Welcome, Robert!

ACRIA is pleased to welcome Robert Burke, founder and principal of the leading New York City luxury consulting business Robert Burke Associates, to our Board of Directors. Before founding RBA in early 2006, Burke spent eleven years at Ralph Lauren, overseeing that company's fashion operations in the U.S. and abroad, and in 1999 moved on to become senior vice president of fashion and public relations at Bergdorf Goodman.

Congratulations, Martha!

At its April meeting, ACRIA's Board of Directors elected Martha Nelson as its president, and she was welcomed to her new post at a special reception held on November 19. Over fifty Board members, donors, and friends of ACRIA attended this event, held at Donna Karan's Urban Zen boutique.

A recognized leader in the magazine industry, as Group Editor at Time, Inc., Ms. Nelson supervises five titles, including *People* and *InStyle* magazines. She has been an ACRIA supporter since 1997 and a Board member nearly that long. She succeeds long-time ACRIA Board president Ross Bleckner.

Dinner Benefits ACRIA

ACRIA's Twelfth Annual Holiday Dinner benefit, held on December 11, raised a record-breaking \$300,000-plus to support our vital research and health literacy services for people with HIV and those at risk.

Over 200 guests joined ACRIA in honoring National Advisory Council member Bob Colacello for his longstanding support for ACRIA and his deep commitment to the fight against HIV/AIDS. Donna Karan once again hosted this very special evening at her Stephan Weiss Studio, along with co-hosts Ross Bleckner, Reinaldo and Carolina Herrera, Charla Lawhon, and Martha Nelson. Grammy-nominated singer/songwriter Vanessa Carlton was on hand for a special performance. Special thanks for the success of the evening go to supporters *InStyle* magazine; Paul Beirne; Urban Zen; Altria; Andre Balazs Properties; HL Group; John Hardy, Ltd.; and Calvin Klein, Inc.

Thank You, Partners

ACRIA's HIV Health Literacy Program wants to thank staff of our partner agencies that have provided sites for our staff and client workshops: Denise Mauro of the Salvation Army; Janice Sinkler of the Jamaica Hospital Medical Centers;

Patrick Dolby of Housing Works in Brooklyn and Robin Lutz of Housing Works in Manhattan; Cesar Barreto of Hostos Community College; Carlene Numa of FACES; and Lorena Flores of Steinway Child and Family Services.

Artists' Foundations Support ACRIA Study

ACRIA's ongoing research into issues important to people with HIV over the age of 50 has gained support from the estates of two prominent artists lost to AIDS. The Robert Mapplethorpe Foundation and the Keith Haring Foundation have each contributed \$50,000 to ACRIA to conduct a study aimed at demonstrating that depression can be rapidly identified and given sustained treatment in a high-risk population of HIV-positive people over 50.

Robert Mapplethorpe was a photographer whose black-and-white images ranged from flowers and portraits of famous people to explicitly homoerotic and sadomasochistic themes. It was the latter that made him a lightning rod for controversy, particularly in frequently acrimonious debates over public funding for the arts. Keith Haring's subway-style art and "radiant" images are instantly recognizable and often imitated.

Both artists died of AIDS-related illnesses during what was perhaps the darkest period of the epidemic, Mapplethorpe in 1989 and Haring in 1990. As Julia Gruen, Executive Director of the Keith Haring Foundation noted in her letter notifying ACRIA of the award: "Had they been fortunate enough to survive, both Keith and Robert would have been among the older adults living with HIV targeted by the study. The Board felt it appropriate that the generosity and foresight of these two artists would benefit their peers who survived them."

The study, which is already under way, is being led by ACRIA's Associate Director for Research Stephen Karpiak, Ph.D., and Senior Research Scientist Mark Brennan, Ph.D. It is being conducted in cooperation with Harlem United.

generous contributions

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