HIV/AIDS: New Jersey's Dilemma

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Overview

Thirty years ago, the typical person knew nothing of HIV/AIDS; and ultimately had no reason to fear it. However, today the vast majority of people around the globe have heard of it and most, if not all, dislike even its mentioning. What happened? To put it in basic context, this global epidemic came and began to change the way we live today (from a medical standpoint). Today, there are millions of people infected by HIV/AIDS, and many more on a daily scale have been affected by it. (*Knight, 2008*) This potent virus has protracted throughout the human population initially due to the negligence of its existence and the methods of transmission between different parties. So, from a contemporary perspective, what do we know about HIV/AIDS today? Diffusing what medical scholars have told us in rudimentary terms, we know that there is no vaccine that prevents HIV. We know that once infected with this disease, medications can only allow a person to slow-down death for a certain amount of time (much longer today than in the past where life span lasted from five to seven years). We are aware that once someone is diagnosed with AIDS, the infected person's ailment declines far more promptly and worst of all presently there is no cure. In other words, HIV infection creates much suffering and hardship for those who come into contact.

HIV/AIDS is an epidemic that affects both men and women of all ages. It has impacted on many people's lives either by themselves being infected, knowing someone who is infected, or being a health care worker. HIV is a virus that assaults one's body's immune system. It also attacks the blood cells (lymphocytes) and cells of the organs (bone marrow, spleen, etc.). In the mid-1990s, AIDS was a leading cause of death. At this time, AIDS was mostly only infecting homosexual men, but now it has spread to men and women. Since the viruses' arrival, newer and more contemporary treatments have sliced the AIDS death rate substantially. Through extensive research and statistical analysis, the purpose of this paper is to travel through the world of the Human Immunodeficiency Virus from an historical standpoint, examine it from an urban perspective, observe how this virus has directly impacted urban sectors of New Jersey, and explain some of the steps and procedures politicians and other various awareness groups have helped battle this disease. The evolution of this epidemic over the last 30 years has had its share of devastation and also hope, but only time can tell how far this disease has come and how this phenomenon will continue.

I. Introduction: 1983

From the outset, AIDS was associated with a high level of stigma and discrimination. This prejudice arose in part because AIDS was linked to groups, such as gay men and intravenous drug users, that were already highly stigmatized, but also because evidence-based information about what was causing AIDS, and how it might be passed on, was in short supply. During early parts of the 1980s, there were some developments of a rare form of cancer (called Kaposi Sarcoma) and by the spring of 1981 there were also numerous cases of "Pneumocystis Carinii Pneumonia". At the time, both of these diseases were considered to be extremely uncommon and "with an extensive review of two hospitals in New York area, only three known previous cases of Kaposi Sarcoma were discovered from 1961-79". (*Stolley, and Glass, 2009*)

During this time, majority of these (once rare) cases were found in young gay men. Due to this, many referred to this early epidemic as "GRID" (Gay-Related Immune Deficiency). Eventually the disease would be medically identified as Acquired Immune Deficiency Syndrome (or what we know as AIDS) due to its unbias nature to infectiously spread to anyone. By the beginning of July 1982, there had been over 500 cases across 23 states which had actually been reported to the CDC (U.S. Center for Disease Control). In retrospect, we now acknowledge these early AIDS patients having HIV for years prior to 1981 (as we know a person without treatment can have HIV for five to ten years before the conversion of AIDS). (*Stolley, 2009*)

By December of 1982, there had been a case of a 20-month old infant, who received numerous transfusions of blood prior, died from infections connected to this newly recognized disease. This case in particular created a clearer warning that AIDS was transmitted by an infectious person involved with an uninfected person either through intercourse, bodily fluid (a mother's milk/blood, semen) etc., which created many worries about the state of blood supply locally and even nationally. As a result, by the end of 1982 many more people were taking time to understand this newly documented disease, as it became clear the severity of what was blossoming, and the effect it will have on people to come in future.

As HIV/AIDS reached the surface and was identified in 1983, researchers tried to comprehend and piece back where it came from, when did it originate? How fast did it spread? Were they too late to stop it? To further understand and develop solutions, doctors would have had to take a back seat and observe the fruition of virus as it progressed. Nowadays, Scientists can trace these new similar pathogens because of their similar production of visible indicators almost instantaneously. *(Knight, 2008)* But what makes HIV difficult to monitor, is its stealth like ability to infect and ultimately kill people. In some cases, the virus can take as long as 10 years to present symptoms; and by the time researchers knew enough information about its origins, this phenomenon took flight.

II. New Jersey's Dilemma: Growing Urban Struggle

After three decades into the HIV epidemic, it seems as though there is still much rejection and uncertainty about the disease especially in urban communities. When we examine urban communities, many victims are minorities. For instance, in New Jersey, Blacks embody 14 percent of the population but alarmingly, 53 percent of those have HIV, according to the NJ Department of Health. Hispanics, meanwhile, signify 18 percent of population and 23 percent of HIV cases. The issue in many urban communities, especially the black community, there is not a huge discussion or a conversation regarding sex and HIV. *(Layton, 2013)* While many people still associate HIV with homosexuals, drug users, and sex workers, this virus has spread far beyond those preliminary labels. In 1980s, the disease was being found mainly in white, young gay men who patronized the gay bars. But in the early 1990s, the HIV specialists started seeing more injectable drug users and their partners being diagnosed. Some of the major contributors are discussed below.

Poverty is a one of the key contributors to the HIV and AIDS epidemic among urban communities in New Jersey. Poverty in combination with a troubled upbringing often influence young adolescents to leave school, which can prevent them from obtaining access to stable employment and proper surroundings which can cause them to lose a sense of responsibility and be drawn into illegal or socially deplorable activities which when the dominos fall can put them in risk of such diseases. The characteristics of poverty also correlate with sexual relationship patterns that encourage the spread of HIV. Even figures have grown in the prison populace over the last couple decades, and the effects of social, economic and education inequality have contributed. Also, discrimination and stigmas create an extremely difficult lifestyle for those living with HIV, and kind of

prohibits open discussions about the behaviors/lifestyles which can result in infections, and the practices that could be taken to prevent it. It also leaves people fearful to be tested, meaning many may not seek treatment until they are extremely sick, and will not take sufficient precautions to prevent onward transmission.

Another factor is Healthcare which in New Jersey and even America is principally subsidized through isolated insurance payments. This either means that those who do not have insurance may have to be insured by the government through some type of state Medicare or Medicaid schemes or in fact they remain uninsured completely leaving them to pay for every distinct treatment or consultation they receive. These costs plus costs of treatment (as well as a number of other factors), means that people in these poor urban communities may not visit a clinic/hospital or doctor until they are severely ill; which in many cases can be too late. This can have consequences for HIV prevention, because it means many will avoid taking an HIV test until it is clear that there is something seriously wrong. By this point, an individual may have had unprotected sex with numerous people, and due to their lack of knowledge in regards to their status; could pass this disease to others in the communities.

Throughout the nation, HIV/AIDS has excessively affected the African-American community and research supports this. Studies have shown that African-American and gay/bisexual men (despite race and ethnicity) continue to bear the burden of HIV infections in the US. Although African-Americans represent thirteen percent of the U.S. inhabitants, they represent forty-six percent of the people living with HIV. Since African-American AIDS cases exceeded that of Whites in 1994, the variance between the two race groups has progressively increased. *(Layton, 2008)* Moreover, African-Americans encompass the greatest percentage of HIV/AIDS cases across many categories, including among heterosexual men, women, injection drug users, and newborns. These statistics are quite shocking and reveal how the virus has affected many African-American relationships and other communities across the America. Out of all these statistics, the one that is most disturbing is rates of infection for African-American women. HIV/AIDS case rates among African-American women are nearly twenty times higher than among White women. Despite significant efforts by the Division of HIV/AIDS Services to target HIV infection through prevention and treatment; HIV is still a major threat in African American communities. Despite declines in infection and death due to HIV/AIDS, African Americans represent the majority of those infected, many do not know that they are infected and many of those at risk do not get tested for HIV. "The death due to HIV/AIDS ranks sixth among African Americans. Furthermore, African Americans are more likely to test late; and when determined to be infected, either do not access care in a timely manner or intermittently participate in treatment." *(Layton, 2013)* The public sector alone cannot successfully combat HIV and AIDS in the African American community. Community-based efforts help to overcome the current barriers to HIV prevention and treatment, it requires that local leaders acknowledge the severity of the continuing epidemic among African Americans and help reduce the spread of HIV/AIDS. Additionally, HIV prevention strategies known to be effective must be available and accessible for all populations at risk.

III. New Jersey V.S HIV

There is no doubt that AIDS is a national crisis but New Jersey is more severely impacted than others. In fact, New Jersey ranks fourth in the Nation in the number of reported cases. By the end of 2012, there were 36,000 diagnosed cases of AIDS in New Jersey. New Jersey has the highest percentage of women with HIV infection in the entire Nation.

These raw numbers translate into an ordeal of terrible anguish, not only for patients but for their families and loved ones left behind. Like other urban areas, the city of Newark has been particularly hard hit by

the AIDS outbreak. Newark just like many other urban sectors has many similar characteristics, which play in favor of diseases like HIV and many other STDs. Researchers supports the notion that heterosexuals in areas with a high AIDS burden, also are considered to have low-socioeconomic status, which they defined as having a salary below the poverty level or no more than a high school diploma. As with the epidemic among other groups, a complex set of socioeconomic factors influence the course of HIV and AIDS among African Americans. No single cause explains why black Americans are disproportionately affected by AIDS although there are a number of overlapping factors that no doubt play their part. Addressing the 'social determinants of health' such as poverty, poor access to healthcare, and unemployment is now seen as an integral part of tackling the disproportionate impact of HIV on the black population.

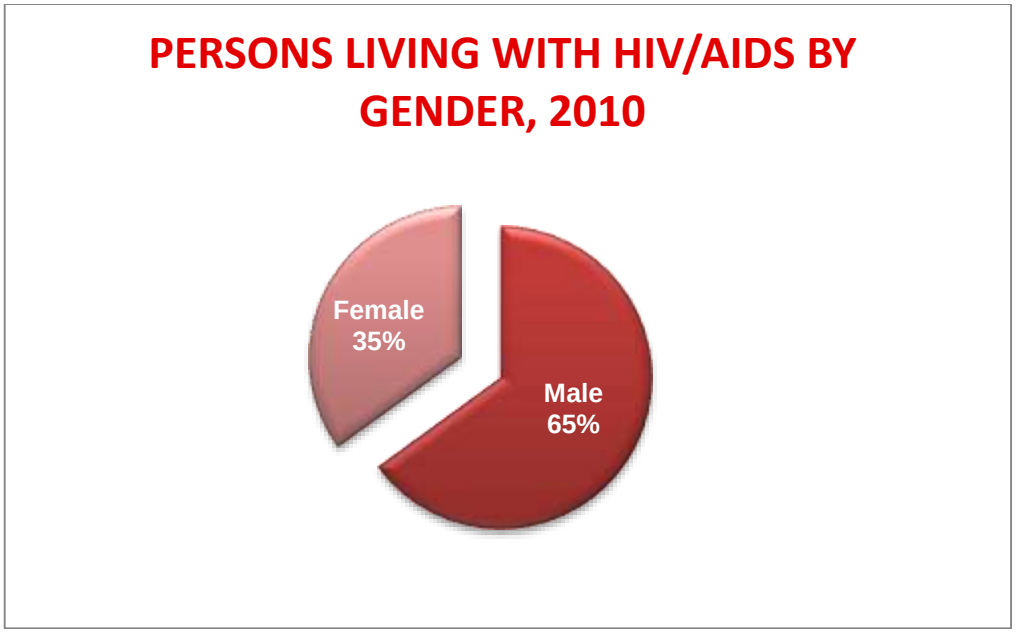
As of December 31, 2011, 76,506 (cumulative) HIV/AIDS cases were reported in New Jersey including 1,363 pediatric cases (younger than 12 years old) and 3,893 cases reported among inmates. More than half (40,763) of the cumulative cases have died, leaving 35,743 persons living with HIV/AIDS in New Jersey which includes 1,734 incarcerated persons. In 2009, the latest complete year of diagnosis data, there were 1,385 new HIV and AIDS diagnoses and 841 deaths reported among persons with HIV/AIDS. In 1990, a nationwide observation of hospital patients supported that one of every four men 25 to 44 years old in the area served by a northern New Jersey hospital is infected with the AIDS virus.

Despite the progress, troubling trends remain on all levels. On a national scale, there are nearly 50,000 new cases of HIV infection diagnosed each year in the U.S. In the African-American community, the statistics are even grimmer: The virus continues to strike a disproportionate number of blacks, and their death rates are higher than other ethnic groups. In New Jersey, African-Americans make up 14 percent of the population but constitute 53 percent of the people living with HIV or AIDS, according to the state Health Department. Although great strides have been made over the years in reducing transmission of HIV, every day more people become infected. “More than 36,000 New Jersey residents are living with HIV or AIDS, and statistics tells us that too many of them are African-American. *(Layton, 2013)* Meanwhile, new infections among gay and bisexual men between the ages of 13 and 24 were up 22 percent in 2010 compared with 2008.

More than half of these were among young black gay and bisexual men, who now account for more new infections than any other subgroup, according to an HIV surveillance report from 2007-10 released by the federal Centers for Disease Control and Prevention in December. (Layton, 2013) Experts cite a number of reasons why HIV/AIDS disproportionately affects African-Americans. Socioeconomic factors plays a role due to higher rates of poverty within African-American community tend to impede there access to prevention education and testing. Going through various perspectives and statistics, being a resident of this state and looking/comprehending the numbers is quite alarming. People around me and my community have a complete negligence for such diseases but it’s quite obvious that even though we believe this disease is not out there, many people are still obtaining these diseases we discredit. The charts I have obtained below helps to break down the disease by gender, race, and even county to help connect current trends that have been mentioned in throughout my research.

Demographic Trends

Based on the statistics obtained from AIDS united, the HIV/AIDS epidemic disproportionately affects those at risk from social factors such as income disparity and discrimination. These numbers are from the New Jersey Department of Health and Senior Services as of December 31, 2010.



Black	**19,150**	**54%**
Hispanic	**8,047**	**23%**
White	**7,903**	**22%**
Asian/Pacific Islander	**350**	**1%**
Other/Unknown	**238**	**<1%**

Source IN New HIV/AIDS AIDS Jersey." United.

www.aidsunited.org/uploads/docs/New_Jersey_2010_FINAL.pdfhttp:// (accessed April 17, 2013)

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Persons Living With HIV/AIDS by County, 2010

** These statistics above (AIDS per county) following are also from the New Jersey Department of Health and Senior Services as of December 31, 2010.

	Number
Essex County	9,644
Hudson County	4,599
Union County	2,628
Passaic County	2,546
Middlesex County	2,017
Monmouth County	1,784
Camden County	1,721
Bergen County	1,562
Mercer County	1,497
Dept. of Corrections	1,575

Source: HIV/AIDS IN New Jersey." AIDS United

IV. "Know Your Status!" HIV Awareness

In the United States, the first HIV prevention efforts took place in 1984 by gay advocacy groups in big cities like New York and San Francisco, who were reacting to the crisis affecting members of many gay communities. Of course, with little data available at the time, they primarily focused on raising awareness; providing basic information about symptoms, probable modes of transmission, and risk-reduction; and quelling fears. "Government-instituted prevention-oriented programs took numerous forms through the 1980s. Early plans mainly focused on groups considered at high-risk for contracting HIV, adolescents, racial/ethnic minority populations, and health-care workers. An attempt to reach mainstream America was to educate about the atrocities of HIV in the form of an eight page pamphlet

titled 'America Responds to AIDS'. These brochures were mailed to more than one million households in 1989. " *(Lambert, 2013)* Locally in New Jersey, political support and funding has been put in place to help tackle this epidemic head on. "These Centers for Disease Control and Prevention provided New Jersey with about $23,000,000 for HIV prevention programs in 2010. These funds were allocated to state and local health

At-a-Glance Program	Department	Agency	Amount
HIV Prevention	Health & Human Services	Centers for Disease Control & Prev.	**$22,455,047**
Ryan White - Part A	Health & Human Services	Health Resources & Services Admin	**$27,519,363**
Ryan White - Part B	Health & Human Services	Health Resources & Services Admin	**$45,062,969**
Base			**$12,392,196**
ADAP			**$32,258,048**
Ryan White - Part C	Health & Human Services	Health Resources & Services Admin	**$5,789,964**
Ryan White - Part D	Health & Human Services	Health Resources & Services Admin	**$2,298,550**
AETC	Health & Human Services	Health Resources & Services Admin	**$810,000 (national)**
Ryan White - Dental	Health & Human Services	Health Resources & Services Admin	**$576,895**
Ryan White - SPNS	Health & Human Services	Health Resources & Services Admin	**$428,696**
HOPWA	Housing & Urban Dev.	Office of HIV/AIDS Housing	**$15,658,279**

departments and community-based organizations to finance counseling, testing programs, health education/risk reduction activities, and surveillance/ monitoring programs". *(NJDOH, 2010)*

FISCAL YEAR 2010 FUNDING FOR HIV/AIDS IN NEW JERSEY

** Above is a breakdown of all the organizations and the funds in which they received from New Jersey. Once again these organizations are used to help with any counseling, testing programs, surveillance/ monitoring programs, health education/risk reduction activities

Source

HIV/AIDS IN New Jersey." AIDS United. www.aidsunited.org/uploads/docs/New_Jersey_2010_FINAL.pdfhttp:// (accessed April 17, 2013).

Ryan White CARE Act

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, was endorsed in 1990 and reauthorized in 96', 00', 06', and 09' is the focus of the federal government's agenda to improve the conditions and available of care for medically underprivileged individuals/families ravaged by HIV/AIDS.

- **Part A – Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAS):** provides funding to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs), areas which are disproportionately affected by the HIV epidemic. To be considered EMAs, metropolitan areas must have more than 2,000 cumulative AIDS cases over the last five-years and a population of 50,000 or more.

  [In Fiscal Year 2010, New Jersey received ***$27,519,363*** in Part A funding. Of that, ***$14,416,548*** went to its EMAs (Newark) and ***$13,102,815*** went to its TGAs (Bergen-Passaic, Jersey City, and Middlesex-Hunterdon).]

- **Part B – States and Territories:** helps state health departments improve the quality, availability, and organization of HIV health care and support services. In additional to base grant, Part B funds support the AIDS Drug Assistance Program (ADAP) which provides medications to individuals with low income cities reporting between 500 and 1,999 cumulative AIDS cases in the past five years.

  [In Fiscal Year 2010, the state received ***$45,062,969*** in CARE Act Part B funds.]

- **Part C – Early Intervention Services:** supports competitive grants to provide medical treatment and medical support services for people living with HIV including HIV testing, early intervention services, risk reduction counseling, case management, outreach, oral health, nutrition, and mental health services. These amenities provide services for HIV positive individuals with low income who are uninsured or underinsured.

  [In Fiscal Year 2010, the state received ***$5,789,964*** in Part C funds.]

- **Part D – Capacity Building and Women, Infants, Children, Youth and Their Families:** focuses on the operation and development of primary care systems and social services for women and youth, who represent a growing share of the epidemic.

  [In Fiscal Year 2010, New Jersey received ***$2,298,550*** in Part D funds].

Other CARE Act Funding Programs:

AIDS Education and Training Centers (AETC) Program: provides training, consultation, and information to HIV health care providers through a network of one international center; and several national centers. This funding is assigned to each of the national and regional centers, which then distributes resources to local performance sites in each state.

Such data obtained from the Department of Health (which I received from my family doctor) does a very candid job of displaying efforts of local endeavors on behalf of the local government and specialized

departments. These are their efforts to help develop and progresses past this epidemic, but it's still up to us to promote more vigilant and responsibility attributes.

V. Modern State of HIV: What's Being done Today

As the saying goes, knowledge is power, and for many in these urban cities, being aware of their HIV status is taking responsibility and making choices, for themselves and for others. Since the discovery of this disease, there have been nearly about 20 million deaths worldwide. For recognition for those who have died, December constitutes what is known as World AIDS Day; which was put aside to bring awareness of HIV/AIDS and hope to educate and highlight prevention. A red ribbon symbolizes the support of this occasion and has become an immediately recognizable symbol for this day. As the third decade since AIDS was first recognized ends, significant advances have occurred in the understanding, treating, and the prevention of HIV infection and AIDS. With these developments, it is now time to focus on future challenges. With the modern developments in science and technology, an average 20-year-old diagnosed with HIV or AIDS today can expect to live 50 years, since the discovery of the virus. The biggest success among these goals is the ability to monitor and controlling the virus, which going in the right direction of ultimately ending the disease. To that end, AIDS experts on a global scale are aggressively pursuing three key areas of scientific investigation. Given the availability of highly effective therapeutic treatments for HIV infection, the first challenge is efficiently classifying a large number of HIV-infected persons through voluntary HIV testing and initiating anti-retroviral therapy (also known as ART). Second, scientists are trying to develop a cure for HIV infection, which would improve the need for applying a lifelong anti-retroviral. Lastly, the plan is to prevent new cases of HIV infection, which is currently sitting at approximately 2.6 million per year globally (in **2011**), is essential in any attempt to prevent spreading pandemic. (Dieffenbach, 2011) Even on a local scale, many New Jersey based organizations are helping create awareness in many of these urban communities. Organizations like the Hyacinth AIDS Foundation (offices in Jersey City, Patterson, and Trenton), African-American Office of Gay Concerns, and the North Jersey Community Research Initiative (both located in Newark) are designed to create awareness and help support those who have been affected by the disease. These are the types of ventures that will help fight AIDS and with a coalition of science and sustenance help mankind come out on top and become successful.

VI. What's Next? : Future to Come

The main reason for the extended life expectancy of HIV cases is the improvement in antiretroviral drugs and combination of such drugs in treatment. But in my opinion, the biggest push in the war with HIV is the rapid tests. Society is attempting to create this relaxed approach to HIV removing that once tarnishing image that it once carried. These new fresh and speedy tests allow results to appear almost instantaneously whereas in prior times, it took days to test and receive results. On a global scale, government organizations should allocate resources for the cause. This serves as a key forecaster of how AIDS funding could grow in the years to come. Just in July of 2012, the Joint United Nations Program on HIV/AIDS (UNAIDS) released verdicts displaying low and middle class countries had pledged about $8.6 billion in their HIV efforts, which has passed previous amounts given by an international donor organization or nation for the first time. These politicians understand that by pursuing an aggressive scientific investigative proposal to help develop the necessary involvements, along with a full-scale execution of effective approaches, there is a light at the end of the tunnel, for the long-term notion of someday ending this HIV and AIDS epidemic.

The paper has shown that AIDS is a serious problem in New Jersey particularly among African-Americans. This could be associated with socioeconomic factors as well as lifestyle. The major strategies to

address the problem is to provide funding for AIDS awareness programs which could emphasize preventive measures, coping with the disease, as well as treatment meetings and costs.

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