A Model for Pastoral Nurture and Care to African American Persons Who Are HIV Infected or Living With AIDS

Marcus Eldred Harris

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ABSTRACT

A MODEL FOR PASTORAL NURTURE AND CARE TO AFRICAN AMERICAN PERSONS WHO ARE HIV INFECTED OR LIVING WITH AIDS

by

Marcus Eldred Harris

Adviser: James North
Title: A MODEL FOR PASTORAL NURTURE AND CARE TO AFRICAN AMERICAN PERSONS WHO ARE HIV INFECTED OR LIVING WITH AIDS

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Date completed: May 1995

Problem

Current statistics reveal that the African American community is disproportionately affected by the AIDS epidemic. The rate of infection for other groups is being impacted by the community education programs, prevention strategies, and service organizations. Messages and service relevant to the African American context are needed. A resource guide and a training model for pastoral care to
better serve the Black AIDS patient could address this problem.

Method

Published rates of HIV infection for the general public and specific groups in the United States are examined to understand of the impact of AIDS on the Black community. Two pastoral-care training programs are examined for strengths and weaknesses in responding to the African American AIDS patient. Issues impacting the Black community, relative to AIDS, are examined to reveal strategies for providing care. Issues relevant to the pastoral caregiver's response to the African American AIDS patient are discussed. The model for pastoral care is based on the preceding research. A model for training pastoral caregivers to effectively respond to the African American AIDS patient is proposed with recommendations for implementation.

Results

Relevant issues of African American life give some indication as to why the Black AIDS numbers are increasing, and the appearance of AIDS denial in the Black community.

Current training prepares pastoral caregivers to provide care for AIDS patients in general. Training for the African American context is not provided.

This project presents a resource guide and a model for training caregivers for the African American context.
Conclusions

Special training to respond to the African American AIDS patient is needed. Black life in America presents specific challenges impacting the Black AIDS patient's ability to cope.

Training for caregivers has been in existence for approximately ten years. This project can provide the specific training needed to prepare caregivers to help the Black AIDS patient.

African Americans must lead in providing care for the Black AIDS patient. The Black church and the Black pastor are central in this process.

Use of the guide, the training model, evaluation, and adjustments over time will result in the effective care and intervention needed in the Black community in response to the AIDS epidemic.
A MODEL FOR PASTORAL NURTURE AND CARE TO AFRICAN AMERICAN PERSONS WHO ARE HIV INFECTED OR LIVING WITH AIDS

A Project Report
Presented in Partial Fulfillment of the Requirements for the Degree Doctor of Ministry

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Marcus Eldred Harris
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TO AFRICAN AMERICAN PERSONS WHO ARE HIV INFECTED OR
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All that I am, and all that I could ever hope to be, is due to the grace that God, my Heavenly Father, has bestowed upon me. My deepest gratitude comes to God in response to His love for me, His guidance, courage, and strength. All the glory for all of my accomplishments belongs to Him.

To many I am indebted for support, encouragement, prayers, and for reminding me from time to time that I can do all things through Christ. I give special recognition to the following:

Dr. James North, my committee chair, who has been my guide, counselor, and advocate in this major accomplishment in my life. His encouragement was a part of the energy I needed when discouragement stood in my path.

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My colleagues in ministry, special friend, and members of churches I have pastored or who have been touched by my ministry, a special thanks for your continued support in ways perhaps unknown to you.

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Eddie Mae Harris, my mother, who dedicated me for service to God at my birth and nurtured me for that service. Mama, I love you.

Squire Lee Harris, my deceased father, who lived his life with sacrifice in order that his four sons would have every benefit of home, church, and school. I still hear his voice encouraging me. His counsel still guides me and there are times now when I wish I could tell him, "Daddy, you were right."

The persons living with AIDS who have allowed me the privilege of sharing their journey have taught me more about God’s love for us all than I could have ever hoped to know.
CHAPTER I

INTRODUCTION

Purpose of the Project

The purpose of this project was to design a training process for pastors to equip them with skills for providing pastoral nurture and care to African Americans who are Human Immunodeficiency Virus (HIV) infected or have Acquired Immune Deficiency Syndrome (AIDS). This project will result in the development of a resource guide and a model for an AIDS pastoral care seminar: "Caring for the African American with HIV or Living with AIDS."

Justification of the Project

Since the early 1980s the medical field and related support service providers have been in the position of constantly adjusting to the needs and demands caused by a new virus, HIV, and a new disease called AIDS. This pandemic, because of its comprehensive impact upon the individual, has presented a challenge to the field of

1"HIV" is the acronym for Human Immunodeficiency Virus and will be used throughout this project to identify the virus that causes the condition called AIDS. "AIDS" is the acronym for Acquired Immune Deficiency Syndrome and will be used throughout this project to identify this disease.
helping professionals, which is unparalleled by any other disease encountered to date.

Initially, this disease was considered to be a dilemma that was solely the plight of the male gay community. It was first discovered in gay White males who were succumbing to opportunistic infections resulting in death. In the late eighties however, the infection rate of the heterosexual community was on the increase. New cases of infection among heterosexuals were increasing faster than that of the gay community. The implications for the future would suggest that perhaps more persons of the non-gay community will be the ones in need of care.

The effects of this disease touch every part of the life of the infected individual. Several psychosocial issues impact the challenge of living with AIDS and HIV infection. Not only do persons with AIDS face the challenge of coping, but its effects are felt by their family members, friends, and those who provide care, including the pastoral caregiver. As the disease is confronted in its various stages, everyone involved will need the coping skills necessary to enhance the quality of living for the patient.

The impact of AIDS and HIV infection on the general population is well noted and sobering. In contrast, the crisis within the African American community gives cause for great alarm. Some estimate that although White males still comprise the largest numbers of those infected, Blacks are
3.2 times more likely to have AIDS or to become infected than Whites per 100,000 individuals.¹

References can be found in a survey of the current literature that document the African American AIDS crisis. However, only a few books mentioned the crisis in the African American community—and only within the general discussion about AIDS. A few journal articles focus on this group in particular. Literature that addresses the pastoral care needs of the African American community could not be found.

The absence of material in this area becomes significant in that the whole person must be considered in order to give effective care. The personal history, value systems, beliefs, education level, economics, social status, environment, health-care needs, and access to resources for help are factors that determine responses to sickness or any other challenge, and are often culturally driven. The pastoral caregiver who is involved in the treatment and education process of this epidemic must be culturally sensitive and competent.

As we mark the beginning of the second decade in which the world tries to cope with this dilemma, the existence of ignorance, indifference, hysteria, callous disregard, and abandonment of those infected only serves to intensify the

present tragedy. The improper response to AIDS exacerbates the already limited resources for help, places a lowered value on human dignity, and causes questions to be raised about the integrity of a God supposedly in touch with and concerned about human suffering. Hoffman and Grenz document the sentiments of the scientific community as it responds to the negative reaction of the church by stating, "AIDS researchers are increasingly looking at evangelicals as idiots and bigots."¹

Thus, this project report attempts to explore the challenge AIDS presents to the African American, and how the pastoral caregiver can acquire proficiency in serving this community. I contend that AIDS is one of the most critical issues facing the African American community and is a new community need, with roots in existing community ills. The Black church and clergy can no longer deny this disease--AIDS goes to church too.

Limitations of the Project

This project focuses primarily on the pastoral care issues related to serving African Americans who are HIV infected or are living with AIDS. It is not intended that a comprehensive and exhaustive discussion of the health care issues of this disease be given. Health-care issues are discussed only as they are a part of pastoral care.

¹Ibid., 19.
Pastoral caregivers who already possess a knowledge of the basic information about AIDS are the target group of this project to enhance their attending skills to this specific population. A brief review of HIV/AIDS is a part of this project.

It is impossible to cover in detail all of the cultural issues of the African American community in this project. The issues discussed should only be held as general at best. The elements of culture are as varied as geography, education, employment, family, experiences, recreation, religion, and age, to name a few. Cultural competence realizes that within the culture there are sub-cultures that are just as significant if not greater. It would be a grave mistake to categorize all African Americans alike, and would cause the caregiver to proceed with a false sense of being in touch.

Definitions

AIDS: Acquired Immunodeficiency Syndrome; the condition caused by HIV that results in the loss of protection from the immune system of the body.

HIV: Human Immunodeficiency Virus; the virus that causes AIDS.

HIV-Asymptomatic: The state of being infected by the virus but having no symptoms of sickness.
**HIV-Symptomatic:** The state of being affected by opportunistic infection, without the full compromise of the immune system. The final stage before an AIDS diagnosis.

**Opportunistic Infection:** Infections that are usually handled by a healthy immune system and medication.

**PWA:** Persons (Living) With AIDS.

**Transmission:** The passing of the virus from one person to another.

**Risk Behaviors:** Actions, behaviors, or practices that would present the opportunity for a person to be infected by another person.

**Unprotected Sex:** Sexual activity such as vaginal, anal, or oral sex without the use of a barrier, usually in the form of a latex condom.
CHAPTER II

OVERVIEW OF THE EPIDEMIC

A Brief History

Several years passed before the general population began to pay attention to this new disease, which was well into its epidemic stage. After finally beginning to come to terms with the herpes panic, some were wondering where and how this new crisis had come about. The truth of the matter is that HIV infection has been with us longer than we first realized.

It was in 1981 when the CDC (Centers for Disease Control) reported the manifestation of a rare form of pneumonia, Pneumocystis, caused by the virus Pneumocystis Carinii, in five young White males. The cases appeared unrelated in that these young men did not know each other. However, there were some similarities. Each of the young men had been physically healthy homosexual men, had been with more than one sexual partner; did not have relationships with partners known to be unhealthy; and each had experimented with inhalants, with one reporting that he had used drugs intravenously.⁷ All were from California

⁷Hoffman and Grenz, 36.
Almost simultaneously, on the East Coast in the New York area, Homosexual men were being diagnosed as having a rare skin cancer known as Kaposi’s Sarcoma. By July of 1981, twenty-six men on both coasts had been identified as having this cancer, with the only link being the admission of practicing a gay lifestyle. The medical community was baffled in that this cancer and sexuality had no known link.¹

By 1982, along with Pneumocystis and sarcoma, other opportunistic infections were identified among this group that now included heterosexual drug abusers. Cytomegalovirus, fungal infections, tuberculosis-like illness, and lymphadenopathy were now showing up in men in these groups in Atlanta, New York City, and San Francisco. Seventy percent of these men had other symptoms, including fatigue, fever, night sweats, rapid and sudden weight loss and chronic nausea. Eventually, because of the multiplicity of infections, and examination of the immune system was conducted. As a result, it was found that the level of T-helper cells of these patients was significantly lower than that of a healthy immune system.²

Researchers found that a new virus was now working in the bloodstream of humans. Called HIV, this virus attacks

¹Ibid., 37.
²Ibid., 38.
the white blood cells of the immune system, destroys them and replicates itself. The end result is often a fully compromised immune system that is ineffective in fighting off the weakest of infections—the condition known as AIDS.

The majority population affected by this virus was the homosexual male, with intravenous drug users second, and those who received infected blood through transfusions from the general donated blood supply before 1985, third. Focus on these risk groups was the thrust of the early prevention, education, and treatment agendas.

The AIDS crisis was first considered as a gay problem. Subsequent research and the growing numbers in the heterosexual community proved that this pandemic was a crisis for humanity. The American Red Cross has adopted the slogan, "It's not who you are, but what you do!" as a part of its education message to call everyone to stop and take notice.

Despite the public service announcements, the literature, the community education programs, the movies, magazine articles, talk-show programs, and an entire battery of attempts to get individuals to modify their behavior to keep them safe, the numbers continue to grow.

The CDC's annual report for 1993 reveals the following statistics:

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1. Total AIDS cases: 361,509
2. Adult male cases: 311,872
3. Adult female cases: 44,403
4. Pediatric cases: 5,234

The statistics reflect that HIV/AIDS is a problem that all of us must be aware of. The notion that this is or was a gay disease quickly disappeared with the evidence of new cases in the heterosexual community. By the spring of 1989, approximately 18,000 people ages 20-29 had been diagnosed with AIDS. The incubation period from the point of infection to the manifestation of the disease by symptoms is from five to ten years. The conclusion to be drawn from these numbers is that the individuals with AIDS in this age bracket were probably infected in their teen years. These numbers were found primarily in the heterosexual community. This reality, coupled with more disturbing facts, clearly points out the urgency of the matter. Surveys have found:

1. The average age for a girl in the United States to have sexual intercourse for the first time is eighteen. The average age for a boy is 15.5.

2. It is estimated that 2.5 million teens are infected with sexually transmitted diseases (venereal disease--VD, etc.) each year. The virus that causes AIDS is

\[ ^1 \text{Pediatric cases reflect children 13 years of age and under. A variance of 363 cases in the totals reflects the number of AIDS cases attributed to unknown or unidentifiable exposure categories.} \]
transmitted sexually.

3. Sixty percent of all American high-school seniors have used illegal drugs. Some of these drugs are injected. The virus that causes AIDS is spread through sharing of IV drug needles or syringes with an infected person.¹

Not only are adults who we generally hold as responsible for their own destinies vulnerable, but teens and even children born to infected mothers are a part of the epidemic's statistics. A careful search of medical literature reveals that there were cases of HIV infection as early as the 1950s that were not diagnosed as being a part of this disease. Sporadic cases of AIDS (fifteen have now been identified) were unrecognized as such in nine separate countries including the United States, Canada, West Germany, Belgium, Denmark, Uganda, Israel, Sweden, and the United Kingdom, in those early years.²

The earliest post-case identification of HIV infection in the United States is reported to have been found in a fifteen-year-old Black male admitted to the St. Louis, Missouri, City Hospital. The young man was known to have been sexually promiscuous with no history of drug use. Over a period of sixteen months, this patient's condition

²Hoffman and Grenz, 60.
deteriorated rapidly ending with death due to Kaposi's Sarcoma. Because of the uniqueness of the case, after the autopsy, specimens of the patient's serum and tissue were frozen. The specimens were tested using current techniques to detect the presence of HIV antibodies. The test results were positive.

Hoffman and Grenz report:

The history of AIDS is a dramatic story of the explosion of a truly new disease syndrome, which has been extremely rapid in progression, worldwide in scope, and devastating in consequence. The story will continue to grow as increasing numbers of persons are infected.

Perhaps the most sobering reality surrounding this disease is that there is no cure, and researchers do not see the possibility of a cure in the foreseeable future. However, we can be protected. It has been the strategy of health departments nationwide, and all related organizations involved in the AIDS battle, to educate the population in an effort to stop the epidemic.

As the education process continues, special attention must be given to developing effective strategies. All people do not hear the same message in the same way. Blacks must hear this message from a familiar voice.

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1Ibid., 61.

2Ibid.
AIDS: The Basics

The information in this section is based on materials used by American Red Cross HIV/AIDS Instructors in community education presentations.¹

When HIV enters your bloodstream, you may become infected with HIV. A special blood test, the ELISA or the Western Blot, can detect antibodies in the system designed to attack this particular virus. There is no method available to test for the condition AIDS--only a method to determine if the body is responding to the viral invasion. The presence of these antibodies is the indicator of HIV infection.²

A person who has no symptoms but who is infected can infect others. You cannot tell by looking at someone whether he or she is infected with HIV. Infected persons can and often do appear completely healthy.

Anyone infected with HIV would do well to be under a doctor’s care even when no symptoms are visible. By doing so, the individual increases his or her chances of survival, receiving early treatment that will aid in the quality of life.

People infected with HIV can develop serious health


problems. These include extreme weight loss, severe pneumonia, a form of cancer, and damage to the nervous system, often known as AIDS Dementia. These illnesses may develop within a year or two. Some persons have stayed healthy for as long as ten years. This is due primarily to the ten-to-fifteen year incubation period of the virus. It must be noted that only when there is HIV infection can the AIDS condition develop.

Transmission

HIV infection occurs in two main ways: first, by having unprotected vaginal, anal, or oral sexual intercourse with an infected person; second, through the sharing of HIV-contaminated needles or syringes in intravenous drug use.

HIV can be spread through sexual intercourse, from male to female, female to male, or male to male. Female to female transmission has been known to produce only two cases thus far. Thus, the female to male transmission rate is much lower than male to female and male to male.

HIV may be in an infected person's blood, semen, or vaginal secretions. It is thought that it can enter the bloodstream from tissue in the vagina, penis, rectum, or possibly the mouth, and through cuts or sores, some of which are so small one does not know they are there. Anal intercourse with an infected person is one of the ways HIV has been most frequently transmitted.

Since many infected people have no apparent symptoms of
the condition, it is hard to be sure who is or is not infected with HIV. Thus, the more sexual partners a person has, the greater the chances of encountering one who is infected and becoming infected oneself.

Any woman infected with HIV can pass the virus to her fetus during pregnancy or during the actual birth process. In some cases, it can be passed on through breast-feeding. If a woman is infected before or during pregnancy, her child has about one chance in three of being born with the virus. There is no treatment to prevent this transmission. Women considering having a baby and think they might have placed themselves at risk for HIV infection, even if the infection might have occurred years ago, should seek counseling and testing before they get pregnant.

Sharing needles or syringes, even one time, is a very easy way to be infected with HIV and other germs. Needle sharing to inject drugs and steroids is the most dangerous form of needle sharing. Blood from an infected person can remain in or on a needle or syringe and then be transferred directly into the bloodstream of the next person who uses it. It has long been held that if the works (needles and syringes) were flushed with chlorine bleach three times, followed by flushing with water three times, that the infection risk was virtually eliminated. A recent update by the American Red Cross states:

The CDC strongly asserts that flushing or sterilization of syringes (needles) used by IV drug
users may not absolutely deactivate HIV in the syringe. Therefore, during presentations, instructors are to advise listeners that all sharing of syringes is unsafe, and that a sterile syringe should be used every time. If syringes are shared, the CDC advises that multiple flushing occur using full-strength bleach, followed by water, and that during one of those flushing the bleach remains in the syringe for at least 30 seconds. This procedure does not guarantee that the syringe will be completely safe, but that it could cut down on the number of HIV infections.

Sharing or re-use of other types of needles, such as for tattooing and ear piercing, also may transmit HIV and other germs.

Some people have been infected while receiving blood transfusions, especially before 1985, the year when careful screening and laboratory testing of the blood supply began. Since that time, blood donors have been screened for the detection of HIV infection, and donated blood has been tested for evidence of HIV.

**How You Cannot Get HIV or AIDS**

HIV infection does not just happen. You cannot simply "catch" it like a cold or flu. Unlike cold or flu viruses, HIV is not spread by coughs or sneezes. You cannot get HIV through everyday contact with infected people at school, work, home, or anywhere else.

You cannot get the infection from clothes, phones, or

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1American Red Cross, Health and Safety Instructor News (Southeastern Michigan Chapter: Winter/Spring 1994).

toilet seats. It cannot be passed on by things like spoons, cups, or other objects that someone who is infected with the virus has used. You cannot get it from everyday contact with an infected person.

Mosquito bites will not give you AIDS. The AIDS virus does not live in a mosquito's salivary glands like other diseases such as malaria or yellow fever. You will not get the infection from bed bugs, lice, flies, or other insects.

The infection cannot be contracted from sweat, tears, or sneezes. Even in the rare event that these contain any of the virus, they do not contain enough to infect.¹

The experts are not completely certain about HIV transmission through deep, prolonged, or "French" kissing. While scientists believe it is remotely possible, there has never been a known transmission of HIV through kissing. Most scientists agree that transmission of HIV through deep or prolonged kissing may be possible, but would be extremely unlikely.

Experts are less sure about HIV transmission through oral intercourse. It may be possible. The virus is present in semen, vaginal secretions, blood, and occasionally, in low concentrations in saliva. During oral intercourse, the person who ingests the body fluids with high concentrations of the virus is at risk. The infecting substances might enter the bloodstream through micro sores.

¹Ibid.
All blood found to contain evidence of HIV is discarded. Currently in the U.S., there is almost no chance of infection with HIV through a blood transfusion. You cannot get HIV from giving blood at a blood bank or other established blood collection centers. The needles used for blood donations are sterile. They are used once, then destroyed.

In the midst of the fear about AIDS, the American Red Cross promotes this message: You can protect yourself from the virus.

The best ways to prevent HIV infection are:

1. Do not have sex. One experience can cause infection.
2. Avoid contact with another person’s bloody fluids.
3. Do not shoot drugs.
4. Never share any kind of needle or syringe.
5. Do not use drugs or alcohol. They can keep you from thinking clearly.¹

Each day the information about AIDS is increasing as we learn more and live with this disease longer. Some have even stated that they do not trust the information because it seems to change from one day to the next. The challenge then becomes how to encourage individuals to take the information that is available and use it to live responsibly and to keep themselves HIV-free.

The African American Dilemma and Risk Profile

One group that is experiencing more than its fair share of this new crisis is the African American community. According to the 1990 U.S. Census report, there are 31,026,000 Americans of African descent in the United States.\(^1\) This figure says that this community is at least 12 percent of the total population. It could be assumed that naturally the percentages would be replicated in other facets of American life. The sad truth is that it does not.

According to the CDC, in its 1992 annual report, there were 253,448 Americans who were known to have AIDS. This number includes 249,199 adults and adolescents thirteen years of age and older. In the United States, 4,249 children under the age of thirteen have AIDS.\(^2\) These children are primarily the offspring of infected mothers. The crisis for the African American as it relates to AIDS is reflected in the numbers. Of the total numbers for AIDS, 75,997 cases (33%) are African Americans. For African American adults there are 73,686 cases, and 2,311 cases (50%) among African American children, thirteen and under. In the four categories of race and ethnicity that the CDC tracks, African American children have the largest total.


\(^2\)Centers for Disease Control and Prevention, 1993, 10.

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For Caucasian children the total is 871; Hispanic, 1,027; Asian/Pacific Islander, 19; American Indian/Alaska Native, 13.¹

Tables 1-4 indicate the exposure categories for adults and children by race and ethnicity. The tables give the statistics for cases cumulative for 1991 and 1992. I relied on the data gathered by the Centers for Disease Control and Prevention, in Atlanta, Georgia. Three attempts were made to secure the tables for the 1993 totals. This information was in the process of being printed for an August 1994 distribution release to the public. The tables that are presented in this project were a part of the CDC’s annual reports for the years 1991 and 1992. Information in these reports breaks down the existing reported cases of AIDS in the United States in the following categories:

1. Sex
2. Race
3. Age
4. Exposure or risk behavior
5. Reported deaths
6. Cases of AIDS exposure related to occupation (e.g., health care workers, etc.).

The 1993 CDC annual report, located in the appendix of this project report, has information that reports the number of HIV infection cases as well.

¹Ibid.
Table 1.--AIDS cases by age group, exposure category, and race/ethnicity, reported through December 1991, United States

<table>
<thead>
<tr>
<th>Male exposure category</th>
<th>White, not Hispanic</th>
<th>Black, not Hispanic</th>
<th>Hispanic</th>
<th>Asian/Pacific Islander</th>
<th>American Indian/Alaska Native</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Man who have sex with man</td>
<td>83,205 (80)</td>
<td>20,540 (44)</td>
<td>13,240 (80)</td>
<td>326 (81)</td>
<td>172 (64)</td>
<td>118,362 (55)</td>
</tr>
<tr>
<td>Injecting drug use</td>
<td>7,017 (7)</td>
<td>16,796 (35)</td>
<td>11,083 (39)</td>
<td>40 (3)</td>
<td>33 (12)</td>
<td>35,046 (19)</td>
</tr>
<tr>
<td>Man who have sex with man and inject drugs</td>
<td>7,547 (7)</td>
<td>3,578 (8)</td>
<td>1,825 (7)</td>
<td>28 (2)</td>
<td>41 (15)</td>
<td>13,135 (7)</td>
</tr>
<tr>
<td>Hemophilia/coagulation disorder</td>
<td>1,373 (1)</td>
<td>127 (0)</td>
<td>137 (0)</td>
<td>18 (2)</td>
<td>8 (3)</td>
<td>1,671 (1)</td>
</tr>
<tr>
<td>Heterosexual contact:</td>
<td>813 (1)</td>
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<td>548 (2)</td>
<td>9 (1)</td>
<td>3 (1)</td>
<td>4,667 (3)</td>
</tr>
<tr>
<td>Sex with injecting drug user</td>
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<td>1,077</td>
<td>313</td>
<td>5</td>
<td>3</td>
<td>1,882</td>
</tr>
<tr>
<td>Sex with person with hemophilia</td>
<td>7</td>
<td>1</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>10</td>
</tr>
<tr>
<td>Born in Pattern-II country</td>
<td>8</td>
<td>1,779</td>
<td>11</td>
<td>2</td>
<td>-</td>
<td>1,805</td>
</tr>
<tr>
<td>Sex with person born in Pattern-II country</td>
<td>40</td>
<td>48</td>
<td>9</td>
<td>1</td>
<td>-</td>
<td>98</td>
</tr>
<tr>
<td>Sex with transfusion recipient with HIV infection</td>
<td>43</td>
<td>19</td>
<td>16</td>
<td>-</td>
<td>-</td>
<td>79</td>
</tr>
<tr>
<td>Sex with HIV-infected person, risk not specified</td>
<td>232</td>
<td>363</td>
<td>197</td>
<td>1</td>
<td>-</td>
<td>813</td>
</tr>
<tr>
<td>Receipt of blood transfusion, blood components, or tissue</td>
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<td>259 (1)</td>
<td>55 (5)</td>
<td>1 (0)</td>
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<tr>
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<td>1,432 (5)</td>
<td>87 (6)</td>
<td>11 (4)</td>
<td>6,114 (3)</td>
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<tr>
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<td>28,624 (100)</td>
<td>1,153 (100)</td>
<td>269 (100)</td>
<td>181,696 (100)</td>
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<table>
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<th>Female exposure category</th>
<th>White, not Hispanic</th>
<th>Black, not Hispanic</th>
<th>Hispanic</th>
<th>Asian/Pacific Islander</th>
<th>American Indian/Alaska Native</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injecting drug use</td>
<td>2,258 (41)</td>
<td>6,185 (55)</td>
<td>2,191 (50)</td>
<td>16 (15)</td>
<td>25 (56)</td>
<td>10,705 (50)</td>
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<tr>
<td>Hemophilia/coagulation disorder</td>
<td>29 (1)</td>
<td>10 (0)</td>
<td>3 (0)</td>
<td>-</td>
<td>-</td>
<td>42 (0)</td>
</tr>
<tr>
<td>Heterosexual contact:</td>
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<td>3,754 (34)</td>
<td>1,694 (39)</td>
<td>37 (35)</td>
<td>10 (22)</td>
<td>7,249 (34)</td>
</tr>
<tr>
<td>Sex with injecting drug user</td>
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<td>1,343</td>
<td>14</td>
<td>7</td>
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<td>Sex with bisexual male</td>
<td>343</td>
<td>216</td>
<td>78</td>
<td>11</td>
<td>1</td>
<td>651</td>
</tr>
<tr>
<td>Sex with person with hemophilia</td>
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<td>40</td>
<td>4</td>
<td>2</td>
<td>-</td>
<td>94</td>
</tr>
<tr>
<td>Born in Pattern-II country</td>
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<td>708</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>718</td>
</tr>
<tr>
<td>Sex with person born in Pattern-II country</td>
<td>10</td>
<td>63</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>76</td>
</tr>
<tr>
<td>Sex with transfusion recipient with HIV infection</td>
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<td>28</td>
<td>28</td>
<td>2</td>
<td>-</td>
<td>161</td>
</tr>
<tr>
<td>Sex with HIV-infected person, risk not specified</td>
<td>303</td>
<td>514</td>
<td>235</td>
<td>8</td>
<td>2</td>
<td>1,065</td>
</tr>
<tr>
<td>Receipt of blood transfusion, blood components, or tissue</td>
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<td>220 (5)</td>
<td>35 (33)</td>
<td>5 (11)</td>
<td>1,568 (8)</td>
</tr>
<tr>
<td>Other/undetermined</td>
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<td>828 (7)</td>
<td>292 (7)</td>
<td>17 (16)</td>
<td>5 (11)</td>
<td>1,561 (7)</td>
</tr>
<tr>
<td>Female subtotal</td>
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<td>4,400 (100)</td>
<td>105 (100)</td>
<td>45 (100)</td>
<td>21,225 (100)</td>
</tr>
<tr>
<td>Total</td>
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<td>58,193</td>
<td>33,024</td>
<td>1,258</td>
<td>314</td>
<td>202,921</td>
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Table 2. -- Adult/adolescent AIDS cases by sex, exposure category, and race/ethnicity, reported through December 1991, United States

<table>
<thead>
<tr>
<th>Age at diagnosis (years)</th>
<th>Males</th>
<th>White, not Hispanic</th>
<th>Black, not Hispanic</th>
<th>Hispanic</th>
<th>Asian/Pacific Islander</th>
<th>American Indian/Alaska Native</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 5</td>
<td>248 (0)</td>
<td>820 (2)</td>
<td>367 (1)</td>
<td>6 (1)</td>
<td>5 (2)</td>
<td>1,449 (1)</td>
<td></td>
</tr>
<tr>
<td>5-12</td>
<td>194 (0)</td>
<td>128 (0)</td>
<td>95 (0)</td>
<td>5 (0)</td>
<td>-</td>
<td>424 (0)</td>
<td></td>
</tr>
<tr>
<td>13-19</td>
<td>271 (0)</td>
<td>175 (0)</td>
<td>119 (0)</td>
<td>7 (1)</td>
<td>5 (2)</td>
<td>577 (0)</td>
<td></td>
</tr>
<tr>
<td>20-24</td>
<td>3,361 (3)</td>
<td>2,065 (4)</td>
<td>1,269 (4)</td>
<td>42 (4)</td>
<td>13 (5)</td>
<td>8,766 (4)</td>
<td></td>
</tr>
<tr>
<td>25-29</td>
<td>15,618 (15)</td>
<td>7,355 (15)</td>
<td>4,826 (17)</td>
<td>160 (14)</td>
<td>59 (22)</td>
<td>28,080 (15)</td>
<td></td>
</tr>
<tr>
<td>30-34</td>
<td>24,350 (22)</td>
<td>11,667 (24)</td>
<td>7,311 (25)</td>
<td>230 (20)</td>
<td>72 (26)</td>
<td>43,715 (24)</td>
<td></td>
</tr>
<tr>
<td>35-38</td>
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<td>11,160 (23)</td>
<td>6,430 (22)</td>
<td>264 (23)</td>
<td>54 (20)</td>
<td>41,664 (22)</td>
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<tr>
<td>40-44</td>
<td>16,141 (15)</td>
<td>6,730 (14)</td>
<td>4,037 (14)</td>
<td>190 (16)</td>
<td>35 (13)</td>
<td>27,202 (15)</td>
<td></td>
</tr>
<tr>
<td>45-49</td>
<td>9,538 (9)</td>
<td>3,616 (8)</td>
<td>2,132 (7)</td>
<td>116 (10)</td>
<td>17 (6)</td>
<td>15,464 (8)</td>
<td></td>
</tr>
<tr>
<td>50-54</td>
<td>5,155 (5)</td>
<td>2,026 (4)</td>
<td>1,186 (4)</td>
<td>62 (5)</td>
<td>5 (2)</td>
<td>8,456 (5)</td>
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</tr>
<tr>
<td>55-59</td>
<td>3,216 (3)</td>
<td>1,196 (2)</td>
<td>723 (2)</td>
<td>40 (3)</td>
<td>4 (1)</td>
<td>5,196 (3)</td>
<td></td>
</tr>
<tr>
<td>60-64</td>
<td>1,873 (2)</td>
<td>633 (1)</td>
<td>356 (1)</td>
<td>12 (1)</td>
<td>4 (1)</td>
<td>2,882 (2)</td>
<td></td>
</tr>
<tr>
<td>65 or older</td>
<td>1,609 (2)</td>
<td>415 (1)</td>
<td>235 (1)</td>
<td>30 (3)</td>
<td>1 (0)</td>
<td>2,295 (1)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
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<td>29,086 (100)</td>
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<td>274 (100)</td>
<td>183,569 (100)</td>
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<table>
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<th>White, not Hispanic</th>
<th>Black, not Hispanic</th>
<th>Hispanic</th>
<th>Asian/Pacific Islander</th>
<th>American Indian/Alaska Native</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
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<td>240 (4)</td>
<td>782 (6)</td>
<td>323 (7)</td>
<td>1 (1)</td>
<td>3 (6)</td>
<td>1,353 (6)</td>
<td></td>
</tr>
<tr>
<td>5-12</td>
<td>57 (1)</td>
<td>113 (1)</td>
<td>69 (1)</td>
<td>5 (5)</td>
<td>-</td>
<td>245 (1)</td>
<td></td>
</tr>
<tr>
<td>13-19</td>
<td>112 (1)</td>
<td>117 (1)</td>
<td>32 (1)</td>
<td>1 (1)</td>
<td>1 (2)</td>
<td>212 (1)</td>
<td></td>
</tr>
<tr>
<td>20-24</td>
<td>1,011 (18)</td>
<td>2,093 (17)</td>
<td>992 (21)</td>
<td>8 (7)</td>
<td>7 (15)</td>
<td>4,122 (18)</td>
<td></td>
</tr>
<tr>
<td>25-29</td>
<td>1,257 (22)</td>
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<td>1,149 (24)</td>
<td>20 (18)</td>
<td>15 (31)</td>
<td>5,762 (25)</td>
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</tr>
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<td>30-34</td>
<td>907 (16)</td>
<td>2,514 (21)</td>
<td>888 (19)</td>
<td>15 (14)</td>
<td>5 (10)</td>
<td>4,340 (13)</td>
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</tr>
<tr>
<td>35-39</td>
<td>522 (9)</td>
<td>1,237 (10)</td>
<td>465 (10)</td>
<td>21 (19)</td>
<td>5 (10)</td>
<td>2,252 (10)</td>
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</tr>
<tr>
<td>40-44</td>
<td>279 (5)</td>
<td>565 (5)</td>
<td>222 (5)</td>
<td>9 (8)</td>
<td>3 (6)</td>
<td>1,063 (3)</td>
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</tr>
<tr>
<td>45-49</td>
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<td>134 (3)</td>
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<td>1 (2)</td>
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<td>-</td>
<td>495 (2)</td>
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<tr>
<td>55-59</td>
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<td>122 (1)</td>
<td>46 (1)</td>
<td>8 (7)</td>
<td>2 (4)</td>
<td>361 (2)</td>
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</tr>
<tr>
<td>60-64</td>
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<td>139 (1)</td>
<td>51 (1)</td>
<td>5 (6)</td>
<td>1 (2)</td>
<td>679 (3)</td>
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</tr>
<tr>
<td>Total</td>
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<td>4,792 (100)</td>
<td>111 (100)</td>
<td>48 (100)</td>
<td>22,823 (100)</td>
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Table 3. --AIDS cases by sex, age at diagnosis, and race/ethnicity, reported through December 1991; United States

<table>
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<tr>
<th>Age at diagnosis (years)</th>
<th>White, not Hispanic</th>
<th>Black, not Hispanic</th>
<th>Hispanic</th>
<th>Asian/Pacific Islander</th>
<th>American Indian/Alaska Native</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 5</td>
<td>248 (10)</td>
<td>820 (2)</td>
<td>367 (1)</td>
<td>6 (1)</td>
<td>5 (2)</td>
<td>1,449 (1)</td>
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<tr>
<td>5-12</td>
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<td>5 (0)</td>
<td>-</td>
<td>424 (0)</td>
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<tr>
<td>13-19</td>
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<td>119 (0)</td>
<td>7 (1)</td>
<td>3 (2)</td>
<td>577 (0)</td>
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<td>28,080 (15)</td>
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<td>30-34</td>
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<td>7,311 (25)</td>
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<td>6,400 (22)</td>
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<td>27,202 (15)</td>
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<tr>
<td>45-49</td>
<td>9,538 (9)</td>
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<td>17 (8)</td>
<td>15,464 (8)</td>
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<td>5 (2)</td>
<td>8,456 (5)</td>
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<tr>
<td>55-59</td>
<td>3,216 (3)</td>
<td>1,196 (2)</td>
<td>723 (2)</td>
<td>40 (3)</td>
<td>4 (1)</td>
<td>5,196 (3)</td>
</tr>
<tr>
<td>60-64</td>
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<td>632 (1)</td>
<td>356 (1)</td>
<td>12 (1)</td>
<td>4 (1)</td>
<td>2,882 (2)</td>
</tr>
<tr>
<td>65 or older</td>
<td>1,609 (2)</td>
<td>415 (1)</td>
<td>235 (1)</td>
<td>30 (3)</td>
<td>1 (0)</td>
<td>2,295 (1)</td>
</tr>
</tbody>
</table>

Females

<table>
<thead>
<tr>
<th>Age at diagnosis (years)</th>
<th>White, not Hispanic</th>
<th>Black, not Hispanic</th>
<th>Hispanic</th>
<th>Asian/Pacific Islander</th>
<th>American Indian/Alaska Native</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 5</td>
<td>240 (4)</td>
<td>783 (6)</td>
<td>323 (7)</td>
<td>1 (1)</td>
<td>3 (6)</td>
<td>1,353 (6)</td>
</tr>
<tr>
<td>5-12</td>
<td>57 (1)</td>
<td>113 (1)</td>
<td>69 (1)</td>
<td>5 (5)</td>
<td>-</td>
<td>245 (1)</td>
</tr>
<tr>
<td>13-19</td>
<td>61 (1)</td>
<td>117 (1)</td>
<td>32 (1)</td>
<td>1 (1)</td>
<td>1 (2)</td>
<td>212 (1)</td>
</tr>
<tr>
<td>20-24</td>
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<td>692 (6)</td>
<td>343 (7)</td>
<td>6 (5)</td>
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<td>992 (21)</td>
<td>8 (7)</td>
<td>7 (15)</td>
<td>4,122 (18)</td>
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<tr>
<td>30-34</td>
<td>1,257 (22)</td>
<td>3,148 (26)</td>
<td>1,149 (24)</td>
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<td>15 (31)</td>
<td>5,651 (25)</td>
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<td>35-39</td>
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<td>2,514 (21)</td>
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<td>4,342 (19)</td>
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<tr>
<td>40-44</td>
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<td>1,237 (10)</td>
<td>465 (10)</td>
<td>21 (19)</td>
<td>5 (10)</td>
<td>2,252 (10)</td>
</tr>
<tr>
<td>45-49</td>
<td>279 (5)</td>
<td>565 (5)</td>
<td>222 (5)</td>
<td>9 (8)</td>
<td>3 (6)</td>
<td>1,083 (5)</td>
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<tr>
<td>50-54</td>
<td>204 (4)</td>
<td>336 (3)</td>
<td>134 (3)</td>
<td>7 (8)</td>
<td>1 (2)</td>
<td>565 (3)</td>
</tr>
<tr>
<td>55-59</td>
<td>219 (4)</td>
<td>191 (2)</td>
<td>78 (2)</td>
<td>5 (5)</td>
<td>-</td>
<td>495 (2)</td>
</tr>
<tr>
<td>60-64</td>
<td>183 (3)</td>
<td>122 (1)</td>
<td>46 (1)</td>
<td>8 (7)</td>
<td>2 (4)</td>
<td>361 (2)</td>
</tr>
<tr>
<td>65 or older</td>
<td>481 (8)</td>
<td>139 (1)</td>
<td>51 (1)</td>
<td>5 (5)</td>
<td>1 (2)</td>
<td>679 (3)</td>
</tr>
</tbody>
</table>

Females subtotal: 5,753 (100) 12,052 (100) 4,792 (100) 111 (100) 48 (100) 22,823 (100)

Total: 110,385 60,037 33,878 1,275 322 206,392

Table 4.--AIDS deaths by race/ethnicity, age at death, and sex, occurring in 1989 and 1990, and cumulative totals reported through December 1991, United States

<table>
<thead>
<tr>
<th>Race/ethnicity and age at death</th>
<th>Males</th>
<th>Females</th>
<th>Both Sexes</th>
</tr>
</thead>
<tbody>
<tr>
<td>White, not Hispanic</td>
<td></td>
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</tr>
<tr>
<td>Under 15</td>
<td>46</td>
<td>33</td>
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</tr>
<tr>
<td>15-24</td>
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<tr>
<td>25-34</td>
<td>4,186</td>
<td>3,573</td>
<td>22,444</td>
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<tr>
<td>35-44</td>
<td>5,160</td>
<td>5,736</td>
<td>27,341</td>
</tr>
<tr>
<td>45-54</td>
<td>2,217</td>
<td>2,426</td>
<td>11,540</td>
</tr>
<tr>
<td>55 or older</td>
<td>1,082</td>
<td>1,079</td>
<td>5,738</td>
</tr>
<tr>
<td>All ages</td>
<td>12,967</td>
<td>13,843</td>
<td>68,250</td>
</tr>
<tr>
<td>Black, not Hispanic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 15</td>
<td>80</td>
<td>103</td>
<td>485</td>
</tr>
<tr>
<td>15-24</td>
<td>206</td>
<td>164</td>
<td>1,091</td>
</tr>
<tr>
<td>25-34</td>
<td>2,172</td>
<td>2,223</td>
<td>11,545</td>
</tr>
<tr>
<td>35-44</td>
<td>2,529</td>
<td>2,630</td>
<td>11,974</td>
</tr>
<tr>
<td>45-54</td>
<td>784</td>
<td>852</td>
<td>3,941</td>
</tr>
<tr>
<td>55 or older</td>
<td>370</td>
<td>403</td>
<td>1,750</td>
</tr>
<tr>
<td>All ages</td>
<td>6,141</td>
<td>6,375</td>
<td>30,846</td>
</tr>
<tr>
<td>Hispanic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 15</td>
<td>45</td>
<td>41</td>
<td>232</td>
</tr>
<tr>
<td>15-24</td>
<td>126</td>
<td>101</td>
<td>547</td>
</tr>
<tr>
<td>25-34</td>
<td>1,452</td>
<td>1,402</td>
<td>7,114</td>
</tr>
<tr>
<td>35-44</td>
<td>1,460</td>
<td>1,526</td>
<td>7,028</td>
</tr>
<tr>
<td>45-54</td>
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<td>502</td>
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</tr>
<tr>
<td>55 or older</td>
<td>204</td>
<td>210</td>
<td>1,005</td>
</tr>
<tr>
<td>All ages</td>
<td>3,833</td>
<td>3,762</td>
<td>18,492</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-24</td>
<td>4</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>25-34</td>
<td>43</td>
<td>42</td>
<td>222</td>
</tr>
<tr>
<td>35-44</td>
<td>60</td>
<td>67</td>
<td>298</td>
</tr>
<tr>
<td>45-54</td>
<td>31</td>
<td>30</td>
<td>131</td>
</tr>
<tr>
<td>55 or older</td>
<td>14</td>
<td>19</td>
<td>71</td>
</tr>
<tr>
<td>All ages</td>
<td>152</td>
<td>156</td>
<td>726</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 15</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>15-24</td>
<td>2</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>25-34</td>
<td>13</td>
<td>16</td>
<td>75</td>
</tr>
<tr>
<td>35-44</td>
<td>11</td>
<td>12</td>
<td>58</td>
</tr>
<tr>
<td>45-54</td>
<td>4</td>
<td>3</td>
<td>22</td>
</tr>
<tr>
<td>55 or older</td>
<td>-</td>
<td>-</td>
<td>9</td>
</tr>
<tr>
<td>All ages</td>
<td>31</td>
<td>36</td>
<td>179</td>
</tr>
<tr>
<td>All racial/ethnic groups</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 15</td>
<td>172</td>
<td>181</td>
<td>985</td>
</tr>
<tr>
<td>15-24</td>
<td>614</td>
<td>648</td>
<td>3,246</td>
</tr>
<tr>
<td>25-34</td>
<td>7,690</td>
<td>8,068</td>
<td>41,507</td>
</tr>
<tr>
<td>35-44</td>
<td>9,245</td>
<td>9,988</td>
<td>46,779</td>
</tr>
<tr>
<td>45-54</td>
<td>3,581</td>
<td>3,624</td>
<td>18,103</td>
</tr>
<tr>
<td>55 or older</td>
<td>1,674</td>
<td>1,710</td>
<td>8,588</td>
</tr>
<tr>
<td>All ages</td>
<td>23,178</td>
<td>24,239</td>
<td>119,370</td>
</tr>
</tbody>
</table>

In 1990, Blacks accounted for more than 28 percent of the AIDS cases in the United States. Predictions held that future African American AIDS numbers would be based on an HIV population of 280,000 Blacks. The fact that Blacks were accounting for more than 36 percent of the new AIDS cases cast doubt on the predictions.¹ For the population in which this disease was initially discovered, gay White men, the new infection numbers were declining, yet the opposite was true for the Black population. Mitchell cites that between 1980 and 1988 the AIDS death rate for African American women increased from 4.4 to 10.3 per 100,000. AIDS became the third leading cause of death among Black women ages fifteen to forty-four.² Of the total number of women with AIDS, Black women were 52 percent of the total and nine times more likely to die of AIDS than White women.³ The Public Health Service predicted 1993 AIDS totals would number between 390,000 to 400,000 in the U.S. Of that figure, African Americans would number between 109,000 to 134,000.⁴

The following statistics are presented in tables 5-8.

¹Angela Mitchell, "AIDS: We Are Not Immune," Emerge, November 1990, 32.
²Ibid.
³Ibid.
⁴Ibid.
Table 5.--AIDS cases by age group, exposure category, and race/ethnicity, reported through December 1992, United States

<table>
<thead>
<tr>
<th>Adult/adolescent exposure category</th>
<th>White, not Hispanic</th>
<th>Black, not Hispanic</th>
<th>Hispanic</th>
<th>Asian/Pacific Islander</th>
<th>American Indian/Alaska Native</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. (%)</td>
<td>No. (%)</td>
<td>No. (%)</td>
<td>No. (%)</td>
<td>No. (%)</td>
<td>No. (%)</td>
</tr>
<tr>
<td>Man who have sex with man</td>
<td>89,016 (75)</td>
<td>25,547 (35)</td>
<td>16,342 (40)</td>
<td>1,161 (73)</td>
<td>240 (55)</td>
<td>142,626 (57)</td>
</tr>
<tr>
<td>Injecting drug use</td>
<td>11,798 (8)</td>
<td>28,860 (38)</td>
<td>18,347 (40)</td>
<td>88 (4)</td>
<td>77 (18)</td>
<td>57,412 (23)</td>
</tr>
<tr>
<td>Man who have sex with man and inject drugs</td>
<td>9,044 (7)</td>
<td>4,407 (6)</td>
<td>2,334 (6)</td>
<td>35 (2)</td>
<td>61 (14)</td>
<td>15,869 (6)</td>
</tr>
<tr>
<td>Hemophilia/leukemia disorder</td>
<td>1,851 (1)</td>
<td>167 (0)</td>
<td>169 (0)</td>
<td>24 (2)</td>
<td>9 (2)</td>
<td>2,028 (1)</td>
</tr>
<tr>
<td>Heterosexual contact</td>
<td>3,366 (3)</td>
<td>9,583 (13)</td>
<td>3,181 (9)</td>
<td>86 (4)</td>
<td>16 (4)</td>
<td>16,254 (7)</td>
</tr>
<tr>
<td>Sex with injecting drug use</td>
<td>1,756</td>
<td>4,501</td>
<td>2,173</td>
<td>24</td>
<td>13</td>
<td>4,481</td>
</tr>
<tr>
<td>Sex with bisexual male</td>
<td>425</td>
<td>278</td>
<td>101</td>
<td>16</td>
<td>5</td>
<td>620</td>
</tr>
<tr>
<td>Sex with person with hemophilia</td>
<td>104</td>
<td>17</td>
<td>8</td>
<td>2</td>
<td>-</td>
<td>131</td>
</tr>
<tr>
<td>Born in Pattern-II country</td>
<td>10</td>
<td>2,626</td>
<td>17</td>
<td>3</td>
<td>-</td>
<td>2,862</td>
</tr>
<tr>
<td>Sex with person born in Pattern-II country</td>
<td>58</td>
<td>136</td>
<td>14</td>
<td>1</td>
<td>-</td>
<td>206</td>
</tr>
<tr>
<td>Sex with transfusion recipient</td>
<td>1,183</td>
<td>62</td>
<td>61</td>
<td>3</td>
<td>-</td>
<td>311</td>
</tr>
<tr>
<td>Sex with HIV-infected person, not specified</td>
<td>864</td>
<td>1,006</td>
<td>787</td>
<td>19</td>
<td>3</td>
<td>3,341</td>
</tr>
<tr>
<td>Receipt of blood transfusion, blood components, or tissue</td>
<td>3,371 (3)</td>
<td>908 (1)</td>
<td>578 (1)</td>
<td>106 (7)</td>
<td>7 (2)</td>
<td>4,990 (2)</td>
</tr>
<tr>
<td>Other/undetermined</td>
<td>3,480 (3)</td>
<td>4,113 (6)</td>
<td>2,181 (3)</td>
<td>128 (8)</td>
<td>22 (3)</td>
<td>10,002 (4)</td>
</tr>
<tr>
<td>Adult/adolescent subtotal</td>
<td>131,754 (100)</td>
<td>73,888 (100)</td>
<td>41,172 (100)</td>
<td>1,561 (100)</td>
<td>435 (100)</td>
<td>248,189 (100)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pediatric (&lt;13 years old) exposure category</th>
<th>128 (15)</th>
<th>25 (1)</th>
<th>30 (3)</th>
<th>5 (16)</th>
<th>1 (9)</th>
<th>188 (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother with or at risk for HIV infection:</td>
<td>508 (85)</td>
<td>2,103 (94)</td>
<td>928 (86)</td>
<td>9 (47)</td>
<td>12 (82)</td>
<td>3,065 (96)</td>
</tr>
<tr>
<td>Injecting drug use</td>
<td>257</td>
<td>1,021</td>
<td>429</td>
<td>4</td>
<td>2</td>
<td>1,808</td>
</tr>
<tr>
<td>Sex with injecting drug user</td>
<td>108</td>
<td>321</td>
<td>382</td>
<td>2</td>
<td>1</td>
<td>722</td>
</tr>
<tr>
<td>Sex with bisexual male</td>
<td>34</td>
<td>27</td>
<td>17</td>
<td>1</td>
<td>-</td>
<td>79</td>
</tr>
<tr>
<td>Sex with person with hemophilia</td>
<td>12</td>
<td>6</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>20</td>
</tr>
<tr>
<td>Born in Pattern-II country</td>
<td>3</td>
<td>273</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>278</td>
</tr>
<tr>
<td>Sex with person born in Pattern-II country</td>
<td>-</td>
<td>15</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>18</td>
</tr>
<tr>
<td>Sex with transfusion recipient with HIV infection</td>
<td>4</td>
<td>4</td>
<td>7</td>
<td>-</td>
<td>-</td>
<td>17</td>
</tr>
<tr>
<td>Sex with HIV-infected person, not specified</td>
<td>41</td>
<td>110</td>
<td>56</td>
<td>2</td>
<td>1</td>
<td>211</td>
</tr>
<tr>
<td>Receipt of blood transfusion, blood components, or tissue</td>
<td>34</td>
<td>38</td>
<td>20</td>
<td>-</td>
<td>-</td>
<td>80</td>
</tr>
<tr>
<td>Has HIV infection, risk not specified</td>
<td>83</td>
<td>360</td>
<td>80</td>
<td>2</td>
<td>4</td>
<td>542</td>
</tr>
<tr>
<td>Receipt of blood transfusion, blood components, or tissue</td>
<td>118</td>
<td>118</td>
<td>72</td>
<td>7</td>
<td>37</td>
<td>368 (7)</td>
</tr>
<tr>
<td>Undetermined</td>
<td>18 (2)</td>
<td>55 (2)</td>
<td>17 (2)</td>
<td>-</td>
<td>-</td>
<td>90 (2)</td>
</tr>
<tr>
<td>Pediatric subtotal</td>
<td>871 (100)</td>
<td>2,311 (100)</td>
<td>1,027 (100)</td>
<td>19 (100)</td>
<td>13 (100)</td>
<td>4,248 (100)</td>
</tr>
<tr>
<td>Total</td>
<td>132,636</td>
<td>75,897</td>
<td>42,198</td>
<td>1,810</td>
<td>648</td>
<td>253,448</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Male exposure category</th>
<th>White, not Hispanic</th>
<th>Black, not Hispanic</th>
<th>Hispanic</th>
<th>Asian/Pacific Islander</th>
<th>American Indian/Alaska Native</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Man who have sex with men</td>
<td>98,016 (78%)</td>
<td>25,547 (43%)</td>
<td>18,342 (48%)</td>
<td>1,161 (80%)</td>
<td>240 (94%)</td>
<td>142,526 (54%)</td>
</tr>
<tr>
<td>Injecting drug use</td>
<td>8,865 (7%)</td>
<td>21,100 (36%)</td>
<td>13,613 (36%)</td>
<td>50 (3)</td>
<td>42 (11)</td>
<td>43,788 (20%)</td>
</tr>
<tr>
<td>Men who have sex with men and inject drugs</td>
<td>9,044 (7%)</td>
<td>4,407 (7%)</td>
<td>2,334 (7%)</td>
<td>36 (2)</td>
<td>61 (18)</td>
<td>15,989 (7%)</td>
</tr>
<tr>
<td>Hemophilia/Coagulation disorder</td>
<td>1,818 (1%)</td>
<td>158 (0%)</td>
<td>166 (0%)</td>
<td>24 (2)</td>
<td>8 (2)</td>
<td>1,983 (1%)</td>
</tr>
<tr>
<td>Heterosexual contact:</td>
<td>1,121 (1%)</td>
<td>4,392 (7%)</td>
<td>881 (2%)</td>
<td>14 (1)</td>
<td>4 (1)</td>
<td>6,418 (2%)</td>
</tr>
<tr>
<td>Sex with injecting drug user</td>
<td>616</td>
<td>1,522</td>
<td>438</td>
<td>6</td>
<td>3</td>
<td>2,565</td>
</tr>
<tr>
<td>Sex with person with hemophilia</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>10</td>
</tr>
<tr>
<td>Born in Pattern-II country</td>
<td>8</td>
<td>2,050</td>
<td>10</td>
<td>3</td>
<td>-</td>
<td>2,078</td>
</tr>
<tr>
<td>Sex with person born in Pattern-II country</td>
<td>44</td>
<td>58</td>
<td>11</td>
<td>1</td>
<td>-</td>
<td>115</td>
</tr>
<tr>
<td>Sex with transfusion recipient with HIV infection</td>
<td>48</td>
<td>28</td>
<td>23</td>
<td>-</td>
<td>-</td>
<td>99</td>
</tr>
<tr>
<td>Sex with HIV-infected person, risk not specified</td>
<td>367</td>
<td>732</td>
<td>367</td>
<td>4</td>
<td>1</td>
<td>1,532</td>
</tr>
</tbody>
</table>

| Receipt of blood transfusion, blood components, or tissue | 2,170 (2%) | 490 (1%) | 307 (1%) | 80 (4) | 2 (1) | 3,038 (1%) |
| Other/Undetermined | 2,967 (2%) | 3,040 (3%) | 1,794 (5%) | 102 (7) | 18 (4) | 7,855 (4%) |

| Male subtotal | 124,827 (100%) | 50,135 (100%) | 35,427 (100%) | 1,448 (100%) | 374 (100%) | 221,714 (100%) |

<table>
<thead>
<tr>
<th>Female exposure category</th>
<th>White, not Hispanic</th>
<th>Black, not Hispanic</th>
<th>Hispanic</th>
<th>Asian/Pacific Islander</th>
<th>American Indian/Alaska Native</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injecting drug use</td>
<td>2,901 (42%)</td>
<td>7,680 (56%)</td>
<td>2,864 (48%)</td>
<td>19 (13)</td>
<td>35 (57)</td>
<td>13,828 (50%)</td>
</tr>
<tr>
<td>Hemophilia/Coagulation disorder</td>
<td>32 (0%)</td>
<td>8 (0%)</td>
<td>3 (0%)</td>
<td>-</td>
<td>-</td>
<td>43 (0%)</td>
</tr>
<tr>
<td>Heterosexual contact:</td>
<td>2,275 (33%)</td>
<td>5,191 (38%)</td>
<td>2,290 (40%)</td>
<td>54 (36)</td>
<td>15 (25)</td>
<td>9,635 (38%)</td>
</tr>
<tr>
<td>Sex with injecting drug user</td>
<td>1,139</td>
<td>2,979</td>
<td>1,725</td>
<td>18</td>
<td>-</td>
<td>5,886</td>
</tr>
<tr>
<td>Sex with bisexual male</td>
<td>425</td>
<td>178</td>
<td>101</td>
<td>16</td>
<td>3</td>
<td>823</td>
</tr>
<tr>
<td>Sex with person with hemophilia</td>
<td>87</td>
<td>6</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>115</td>
</tr>
<tr>
<td>Born in Pattern-II country</td>
<td>2</td>
<td>376</td>
<td>7</td>
<td>-</td>
<td>-</td>
<td>888</td>
</tr>
<tr>
<td>Sex with person born in Pattern-II country</td>
<td>11</td>
<td>76</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>90</td>
</tr>
<tr>
<td>Sex with transfusion recipient with HIV infection</td>
<td>134</td>
<td>38</td>
<td>38</td>
<td>3</td>
<td>-</td>
<td>212</td>
</tr>
<tr>
<td>Sex with HIV-infected person, risk not specified</td>
<td>457</td>
<td>834</td>
<td>390</td>
<td>15</td>
<td>-</td>
<td>1,908</td>
</tr>
</tbody>
</table>

| Receipt of blood transfusion, blood components, or tissue | 1,201 (17%) | 419 (3%) | 271 (5%) | 45 (31) | 5 (8) | 1,844 (7%) |
| Other/Undetermined | 518 (7%) | 1,073 (7%) | 407 (7%) | 25 (17) | 6 (10) | 2,037 (7%) |

| Female subtotal | 8,927 (100%) | 14,531 (100%) | 5,745 (100%) | 143 (100) | 61 (100) | 27,455 (100%) |

| Total | 131,754 | 72,688 | 41,172 | 1,591 | 435 | 248,199 |

Table 7.--AIDS cases by sex, age at diagnosis, and race/ethnicity, reported through December 1992, United States

<table>
<thead>
<tr>
<th>Males</th>
<th>White, not Hispanic</th>
<th>Black, not Hispanic</th>
<th>Asian/Pacific Islander</th>
<th>American Indian/Alaska Native</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age at diagnosis (years)</td>
<td>No. (%)</td>
<td>No. (%)</td>
<td>No. (%)</td>
<td>No. (%)</td>
<td>No. (%)</td>
</tr>
<tr>
<td>Under 5</td>
<td>296 (0)</td>
<td>1,013 (2)</td>
<td>426 (1)</td>
<td>7 (0)</td>
<td>6 (2)</td>
</tr>
<tr>
<td>5-12</td>
<td>221 (0)</td>
<td>154 (0)</td>
<td>121 (0)</td>
<td>8 (0)</td>
<td>1 (0)</td>
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Male subtotal | 125,346 (100) | 60,302 (100) | 35,974 (100) | 1,461 (100) | 383 (100) | 223,971 (100) |

Females | | | | | |
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Female subtotal | 7,270 (100) | 15,605 (100) | 6,225 (100) | 149 (100) | 65 (100) | 29,477 (100) |

Total | 12,635 | 75,967 | 42,199 | 1,610 | 448 | 253,448 |

Table 8.--AIDS deaths by race/ethnicity, age at death, and sex, occurring in 1990 and 1991, and cumulative totals reported through December 1992, United States

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The statistical information gathered to date clearly reveals that African Americans are facing a dilemma in confronting this epidemic. Disproportionately, Blacks have been affected by AIDS. What is interesting to note is the "at risk" profile for this community.

"At risk" refers to the behavior categories that a person engages in that cause exposure to the virus. Earlier category specifications were more "labeling" (e.g., gay men, prostitutes, etc.) than identifying specific behaviors (e.g., needle sharing, unprotected sex, etc.). Those involved in the education process about this disease quickly realized that "labeling" allowed individuals who were practicing risk behaviors but had not accepted the lifestyle associated with the behavior to filter themselves out of the warning messages. The most common example is found in the cases where men who label themselves as heterosexual but were either bisexual or having occasional sex with men. These men do not consider themselves as gay and therefore erroneously believed that they were safe. The message was not clear. The risk of HIV infection is not an issue of being gay or not, or being a drug addict or not. The risk is directly linked to having unprotected anal, vaginal, or oral sex with anyone who is already infected. Heterosexuals practice anal sex on occasion as well. Heterosexual or gay, the risk is with the behavior not the orientation. What the infection numbers do suggest is that anal sex appears to
be an easier avenue for transmission, and that any lifestyle
that promotes promiscuity heightens the risk factor.

The numbers by category of infection for African
Americans give some insight as to where the problems can be
found. For African American men, the second highest
numbers, 36 percent, of the infected are found in the
category of men who have the risk "injecting drug use."
These are men who through their drug-use practices are
either sharing needles with infected persons, or, due to
impaired decision making through using drugs or being
"high," are having sex with infected individuals. (See
tables 1 and 5.) Drug use in this regard does not mean
"drug addiction" or "drug addict." It is clearly an
identification of any drug user--recreational, occasional or
habitual--who engages in these risk behaviors.

The highest category, which tends to surprise African
Americans, is the at-risk behavior of men who have sex with
men. There is a great deal of denial that homosexuals exist
within the African American community. This is due in part
to the group disdain that is held towards this lifestyle.
The reality is that there are gay men and women, brothers
and sisters, aunts and uncles, cousins, nephews, and nieces
in the Black family. Again, the emphasis must rest with the
risk behavior and not the lifestyle. It would appear that
because of the taboo that exists within this group for the
gay lifestyle, many find themselves practicing sexually "in
the closet" and are living other lives to cloak their orientation. This secret sexual life tends to create a greater risk situation not only for the male but for his female sexual partner who is unaware of his other activity. Of the infected African American males, 43 percent are men who have sex with men.

For African American females, injecting drug use is the category with the highest numbers. Of the Black women infected with HIV, 54 percent were exposed due to their drug use. It must be stated again that the inference is not that the Black women who are in this category are all addicts. Clearly, some of them are. As stated before, the focus rests with the specific behaviors associated with drug use that put a person at risk.

Heterosexual contact becomes the second highest exposure category for African American women, 36 percent. Within this category, the highest exposure numbers are found in the subgroup of "sex with injecting drug users." Of the women in this risk group, 57 percent were exposed through their heterosexual contact with a person who was an infected injecting drug user. The victimization that takes place in this situation is that often the woman is unaware of the drug use of her partner.

Finally, the risk factor for African Americans that is the saddest--the children who are infected are the purest of victims. Ninety-four percent of Black children infected
with HIV were born to mothers with or at risk for HIV infection. Infected Black women were responsible for the largest number of infected children. The second group in terms of the numbers are the children whose mothers were infected by their infected, injecting, drug-using sexual partners. A case for further investigation would be the third category with the highest numbers, the HIV infection from unspecified risks.\(^1\) Due to underdeveloped immune systems at birth, life is short for these children.

**Pastoral Care Designs**

Accusations of Christian hostility, inactivity, and apathy in the midst of the AIDS crisis may, of course, be grossly overstated. It is generally uncontestable that the people of God repeatedly display care and concern for persons in need. Yet, in many ways, the AIDS epidemic has presented a dilemma. The situation calls for a response, but it offers no obvious indication as to the direction such a response should take. In sensing this quandary, the church has been not unlike society in general, wanting to do something but not knowing quite what to do.\(^2\)

It is in response to wanting to know what to do that the whole area of AIDS pastoral care training has developed. The nature of the AIDS disease affects every aspect of the individual's being. Thus, the medical community had to learn to meet the needs of this new patient. Counselors and social workers had to discover how to meet and service the

\(^1\)The CDC refers to cases with "unspecified" risk behaviors as being those cases where the infection or the disease is present, but the cause of the infection or route of transmission could not be conclusively identified.

\(^2\)Hoffman and Grenz, 19.
needs of these new clients. This epidemic has challenged politicians, insurance providers, employers, landlords, the legal system, public safety officials, pharmacists, nutritionists, researchers, and just about everyone who has an impact on an individual's quality of living. Included in this group are those men and women who have been called and have dedicated their lives to the spiritual nurture and care of humanity. It is not enough to say that pastors are to respond—knowing how to respond is imperative.

The challenge to be met before training can take place is to motivate pastors and pastoral caregivers to take up this special ministry. In 1992, sixty-one Chicago ministers were surveyed and asked if they felt that AIDS was a "very serious" problem. Forty-four of the ministers said yes. However, only fourteen of the churches in this group had sponsored AIDS outreach activities. Of the ministers, fifty-one said that they would welcome gay or lesbian couples to their worship services. Fifty-six of the ministers said that persons with AIDS would be welcome at their churches.

The percentage of the pastors that responded positively is encouraging on the surface. A closer look as to what each pastor meant or intended to say (that these people are

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2Ibid.
welcome) is unsettling. Within the number of those who responded positively, there was a counter-productive agenda in place. Several ministers in this group hold the viewpoint that AIDS is God's response of retribution against those who break His laws.¹ Some ministers believe that an AIDS ministry's agenda is to point out the sins of the sufferer and to call them to repentance. What is grossly missing in this approach is compassion, which is lost in an effort to point out moral correctness. Pastors who hold this viewpoint tend to feel no need for specialized training to be an effective caregiver to the AIDS patient. To the credit of the Christian church as a whole, there are those who are on the front line, providing care and proper training for those who will take up this work.

My initial AIDS training began in 1988 with the Michigan Health Department. The focus of this training was to give factual information concerning HIV infection and AIDS along with prevention strategies. Techniques for pre- and post-test counseling were a part of this seminar, with time set for demonstrating one's counseling skills with critique and feedback. Those who completed the training were certified as HIV/AIDS counselors and qualified to work at HIV testing sites. In 1992, I completed training and was certified with the American Red Cross as a Community AIDS

¹Ibid., 9.
Educator and African American AIDS Specialist.

My AIDS pastoral care training came through two organizations dedicated to preparing pastoral care volunteers to give care to anyone impacted by AIDS: the AIDS Interfaith Network of Detroit, Michigan, and the AIDS Pastoral Care Network of Chicago, Illinois. I analytically discuss the training programs of each organization.

The AIDS Interfaith Network (AIN)

The AIDS Interfaith Network was co-founded by Sister Marilyn Bergt and Rabbi Marc Blumenthal in December, 1986, in Detroit, Michigan. Since 1989, Sister Marilyn, a member of the sisters of Divine Providence since 1960, became the full-time Executive Director for the organization. AIN is a volunteer organization that provides spiritual care and support to people with HIV disease, their families, friends and loved ones. This organization holds the following as its mission statement:

AIDS Interfaith Network is an organization of volunteers from many different religious traditions, whose mission is to offer compassionate, non-judgmental spiritual support and care to anyone touched by HIV disease.¹

AIN offers a comprehensive training program for its pastoral care volunteers. Typically, the entire training runs for eight sessions over an eight-week period. Each session takes place on a Tuesday evening for approximately

three hours. The first session, which is an orientation to the organization, lasts for two hours. When the prospective volunteers come to a session, they are led in a focused discussion of a predetermined topic.

The session topics are presented as follows: Session 1: AIN Orientation; Session 2: Aspects of AIDS; Session 3: Homosexuality as a Ministry Issue; Session 4: Substance Abuse as a Ministry Issue; Session 5: Bereavement Issues; Session 6: Ministering to the Family Living with HIV; Session 7: Pastoral Issues in Ministering to the Person with HIV; Session 8: The AIN Volunteer-Commissioning Ceremony.

Worship or spiritual reflection is an important part of the training. Each session is generally opened with a selected reading or a passage of Scripture, with time for reflection, meditation, sharing, and prayer. A special candle is lit to symbolize the hope and faith that a permanent cure will be found for this disease.

Each area of training for AIN volunteers is facilitated by a skilled and well-prepared professional in the specialized area. To the credit of the AIN director and staff, an excellent group of qualified faculty has been developed to carry out the training sessions. Those who participate as trainees, in my opinion, are exposed to some of the best. The classes are informal and the instructors allow for questions and discussion as the need arises.
At the end of the training session, closure is brought in somewhat the same manner in which it was opened, with a particular emphasis on the subject at hand. A selected reading or group sharing about what volunteers have been confronted with during the session is followed by prayer and the extinguishing of the candle. Upon completion of the entire training, and having been commissioned by AIN, the next step is to be assigned to a case as a spiritual or pastoral caregiver. The director of AIN evaluates the volunteer and considers the profile of both the caregiver and the one needing care, which includes the faith heritage of each. It is hoped that a pairing is made that is compatible. Volunteers are reminded of the importance of commitment and dependability in this work and are always given an opportunity to decide if they are able or willing to fulfill the assignment. Upon acceptance and establishing contact with the client, the volunteer is given a reporting form that serves not only to track pastoral care activity, but to foster accountability to the mission, duty, client, and organization.

Volunteer support meetings are a part of the AIN program to allow for affirmation of the importance and significance of the volunteer, to help relieve burnout, and to discuss and receive help with difficult situations arising out of giving care. Careful thought, testing methods, and organization with a vision have caused
the AIDS Interfaith Network to be a model organization for anyone interested in providing the necessary preparation and support for those who have a desire and commitment to care for those with HIV disease. Further information on AIN can be found in the appendix of this report. An entire manual outlining the AIN program was secured, but was too lengthy to include in this project. Selected information has been provided.

**AIDS Pastoral Care Network**

The AIDS Pastoral Care Network, based in Chicago, Illinois, started out as a group of concerned clergy who found themselves in the unfamiliar situation of ministering to persons with AIDS. Because of the comprehensive impact of the disease, issues surrounding the care of the affected can be complex. Responding to the notion that this pastoral care should be long term for those who wanted it, twenty people attended the first meeting that initiated this organization.

The first meeting was called together by Father James Corrigan, who was the Director of Pastoral Services at Rush-Presbyterian-St. Luke Hospital, and Steve Martz, a volunteer at the Howard Brown Memorial Clinic. The group met monthly, with new attendees at each meeting. The number grew to over one hundred people by the year’s end. A core group formed the Steering Committee, which later became the Board of
Directors for the formally organized AIDS Pastoral Care Network in the fall of 1985.

After clarifying APCN's mission, four priorities for ministry were identified: (1) direct pastoral services to persons with AIDS or living with HIV; (2) spiritual nurture; (3) education about HIV/AIDS; (4) development of public relations. Sub-committees to guide the work in these four areas were comprised of board and staff members. The Executive Director chairs the Development and Education Committee, and the Director of Pastoral Services oversees recruitment, screening, and the training of volunteers.

APCN's training program is divided into two sections. The first phase is the screening process. In this phase, the potential volunteer is taken through a process to determine his or her suitability for this ministry. It is APCN's position that great care should be taken in who is selected to work as a caregiver--several well-intentioned volunteers have created more pain in the act of helping.

The screening seminar is a six-hour process that is started on a Thursday evening for two hours and is concluded with a four-hour session on Saturday morning. The screening sessions always begin with a moment of meditation and reflection on an inspirational reading or passage of Scripture. A brief look at the history of this volunteer organization, the philosophy for ministry, and the guiding
principles give the potential volunteer a frame of reference as he or she enters into partnership with APCN.

The training begins with a segment devoted to the clarification of the expectations of volunteers and the various support mechanisms offered by this organization. The expectations include:

1. Regular, dependable contact with the client
2. Regular reporting to APCN of visits, phone calls, and reporting of a death
3. Providing information to families, partners, and friends on bereavement support available following the death
4. Participation in peer support and supervision
5. Participation in continuing education events offered by APCN.

The second half of the session is devoted to the sharing of faith journeys by those present. Small groups are formed, and the leader of each group initiates the disclosure of the personal experience of faith as it manifests itself in the life of the individual. The leader's modeling sets the tone, the level of openness and the atmosphere for safe sharing. The issue at the core of this exercise is to demonstrate the importance and necessity for developing and communicating trust in a caring ministry.

Closing activities include the opportunity for feedback and the answering of questions that the participants may
have. Materials that will be needed for the next session are distributed at this time. The small groups reassemble into the large group for this session, and it is ended with a brief prayer.

The second part of the screening on Saturday morning begins with prayer and is followed by an "AIDS 101" seminar. It is understood that many of those who have expressed an interest in becoming a pastoral care volunteer have some knowledge of the disease and the impact of the epidemic. APCN holds that volunteers are not expected to be experts, but a cohesive overview of the subject is beneficial in the carrying out of this ministry.

Language is a powerful tool for help or destruction when used correctly or incorrectly. Because our words create images and expose attitudes, APCN has determined that this is an area that must be addressed when screening volunteers for service. A word-association exercise follows the overview on AIDS.

The large group is divided into smaller groups and word pairs are distributed to the groups. Examples of the word pairs would be; Cocktails/Alcoholic; Aspirin or Tranquilizer/Drug Addict; Marriage/Gay Lovers. The groups are then asked to write down the words that come to mind without thinking long and hard about each of the words in the pairs. The word associations are shared with the larger group and a discussion follows.
The third part of the morning session, through the use of a case study, is focused on examining issues relevant to various views about God's relationship to the sufferer and suffering. This session also allows for dialogue and discussion. It is hoped that the participant would begin to think about how he or she experiences God in everyday life.

The screening process is concluded with a lecture and discussion on substance abuse and addictions. As a method of bringing some empathy of the volunteer towards the one who may be addicted, the participants are invited to live without something they consider to be necessary in their lives (T.V., ice cream, music, etc.) for an undetermined length of time. The exercise is a powerful tool for insight. Once again, as the session began with prayer, it ends with inspiration and prayer.

Approximately one month later, the full-day volunteer training takes place. Those who are present for this session have been evaluated for their potential as pastoral care volunteers. Participation is by invitation only. Pre-session materials that are to be read are sent in the mail as well.

The full-day training begins with a simple and brief liturgy to set the tone and atmosphere of the day. An introduction follows that not only introduces the participants to one another but is a way of exploring why they have chosen to be involved in this ministry.
The purpose for APCN's existence is to provide pastoral nurture to those with HIV disease. However, the focus on pastoral care issues is not singular in this training. The introduction is followed by recalling, reflecting, and sharing an event in their lives when the participants felt isolated, rejected, vulnerable, and helpless. This exercise helps to prepare one for responding to those who are experiencing these same feelings.

The next segment is the sharing of the personal story of a person with AIDS. Being able to attach a face and a body to the disease takes the volunteers to a deeper level of confronting themselves as they relate to HIV/AIDS. Great care is taken by APCN in this matter to protect the one sharing the story.

The afternoon session is devoted to the discovery and discussion of the issues involved in this specialized ministry. Usually one and a half hours is allowed for this activity.

The large group gathers together one last time for final questions and sharing. There is time allowed for feedback, and an evaluation of the training is conducted to help APCN to better prepare future volunteers.

African American AIDS Ministry Organizations

Prior to my investigation of this subject, I had no knowledge of any organization that addressed the specific
needs of the African American with AIDS or were owned and operated by African Americans. It appeared that not only was the community at large in denial about this epidemic, but African Americans were waiting for someone else to come and address their needs. My research reveals that there are those within the community who have recognized and have assumed the responsibility of providing the help needed in this crisis hour. The following is a short list of African American owned and operated organizations involved in providing service to the African American AIDS community, their families, and signicants.

1. **African American Ministers United To Save Tomorrow—A*MUST** is an organization of African American clergy who have joined together to address HIV/AIDS in the African American community. Based in Chicago, its mission is to "save the lives of our brothers and sisters who are being struck down with diseases endemic to the African American community and developing a new paradigm of health care services to the African American community." Though primarily focused upon HIV/AIDS, the organization addresses some of the long-standing health problems of the African American community, such as diabetes, high blood pressure, and sickle-cell anemia.

2. **The Balm In Gilead** is a New York organization dedicated to healing the African American community through

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1Pamphlet.
prayer, health education, and advocacy. This organization was incorporated in 1992 as the parent organization of The Harlem Week of Prayer for the Healing of AIDS and is also the national sponsor of the Black Church National Day of Prayer for Healing of AIDS. Its mission is to enlighten the community and community leaders about the various diseases that plague the African American community and to encourage community institutions to establish programs that will assist in the eradication of these health problems.

3. **Ministerial Crisis Center's** goal is to provide pastoral and culturally sensitive social services to the African American community within the greater Cleveland, Ohio, area in an effort to strengthen families affected by the crisis of living with AIDS. Clergy are trained and certified through the Ohio State Health Department to provide counseling and other social services to individuals and families within their church community. Referrals and requests are made specifically in the areas of housing, clothing, food, and transportation.

4. **The Ark Of Refuge** is based in San Francisco, California, and has several HIV programs for the African American community including (a) permanent housing and supportive services for persons with HIV disease, (b) education and training to churches, organizations, and individuals, and (c) advocacy and support services for persons living with HIV disease, caregivers, and clergy.
Ecumenical HIV education also includes technical assistance in the development of HIV-related ministries.

5. Religious Roundtable Of Washington Metropolitan Area On HIV/AIDS is sponsored by the Carolina Missionary Baptist Church. This Washington, D.C., group is a private non-profit voluntary association of clergy and religious organizations committed to: (a) identify gaps in services and programs for those affected and infected with HIV disease; (b) advocate for those impacted by HIV/AIDS from a spiritual perspective; and (c) increase the knowledge of the religious community about HIV/AIDS and to encourage their participation in providing services to families affected by HIV/AIDS.

6. Rophe’ Ministries is a Christian-based AIDS ministry in Philadelphia, Pennsylvania. Through seminars, workshops, and forums, the organization is committed to educating all members of the community. Through education, the Rophe’ Ministries plans to destroy the myths about HIV/AIDS and to increase the awareness and sensitivity levels of workshop participants about HIV disease.

This ministry is extremely unique in that it is run by an African American married couple, both of whom are HIV positive and who have decided to dedicate their lives to ministering to and being intercessors for persons living with HIV disease. They were recently featured on one of the television talk shows focusing on the topic of HIV couples.
who have decided to stay together after learning of their HIV-positive diagnosis.

The work of providing pastoral care to the HIV-infected and the person with AIDS has become an integral part of the care for these special patients. With the acceptance of the work of pastoral care as being essential, the training efforts of the various organizations have sought to provide a clergy or caregiver who is equipped to effectively serve. No longer is the patient to be victimized by the unskilled who has good intentions. Pastors and the church can respond with a dignified, qualified, and committed ministry.
CHAPTER III

ISSUES: THE AFRICAN AMERICAN WITH AIDS

Once a person discovers that he or she is infected or has AIDS, several emotions immediately take control. Often these emotions (usually fears) can be overwhelming. The focus of all helping exercises should target the needs of the one being served. In order for there to be effective care given to persons with AIDS, a grasp of prevailing issues is imperative. However, when considering the African American with AIDS, the general issues impact on the patient, with ethnicity now factoring into the equation.

A review of the literature about AIDS reveals six prevailing issues that the HIV infected and the person living with AIDS often confront. The following is a discussion of those general issues as they impact the African American AIDS patient.

Fear of Infection and Impairment

We live in an increasingly health and fitness conscious society. In reality, most people take health or wellness for granted. Thus, the onset of an illness is usually accompanied by denial. Considerable pain and discomfort are often tolerated and carefully hidden from those who are
closest. Family members, friends, and even spouses are often led to participate in the denial with the sick. It is clear that something is wrong, but denial allows us to postpone the confrontation of what might be a devastating truth.

There seems to be an unspoken taboo against sickness that tends to have an impact on the definition of the worth of an individual. It seems to be manifested in a strong internal drive in all of us to resist the reality of mortal frailty. Parsons notes that the very undesirability of the state of ill health seems to include an obligation to get well.¹ Ablon suggests that the sick person is reduced in our minds from a whole and usual person to a tainted, discounted one.² Such an attribution is a stigma. Thus, sickness in our health-obsessed society is to be avoided at all costs.³

This avoidance of sickness lends to the putting off of needed treatment and/or medical attention to the detriment of the individual. Usually the disease, unattended, is allowed to develop until medical intervention when sought is either nominally effective or completely useless. Permanent impairment or premature death is often unavoidable.

¹Sunderland and Shelp, 19.
²Ibid.
³Ibid.
Society's view of the less than "beautiful," the less than "perfect or "whole," is that these persons are expendable or a burden to society. The usefulness of a productive person is often called into question or devalued once there is the presence of a disease or handicap. This is most markedly experienced by those who are HIV-infected or have AIDS.

One of the greatest fears of the HIV-infected is the fear of future infection. HIV disease affects the effective operation of the human immune system. When this system is compromised or destroyed, the individual is left virtually helpless to other diseases. If sickness is to be avoided at all costs, then one who has no defense against sickness is destined to become that expendable burden to society.

I became poignantly aware of this fear as it relates to the patient in an early visit to a hospital bed of an infected individual. The instructions on the door to the room required that anyone going into the room to see the patient had to wear a gown, gloves, and face mask. Immediately, my mission was to find out why this individual was so contagious and what health risk I was being exposed to. The head nurse informed me that the precautions were not to protect me from the patient but rather to protect the patient from me. I assumed that I was the one in danger, while the opposite was true.

James Vander Zanden profiles the African American
dilemma by stating that, in general, Black babies are four times as more likely than White children to be born poor and twice as likely to die within their first year of life.¹ Black children generally are twice as likely to have no regular source of medical care and 25 percent more likely to die from illness during childhood.² These issues that relate to the lack of access to proper health care continue into adulthood to be real for the African American. Social scientists note that Blacks are more reluctant to seek early medical care for health problems. This is often a survival behavior. Health care costs money. If a Black person or family is struggling to provide basic needs, often the treatment of a disease or the preventive measures necessary to combat sickness are sacrificed for the moment. Thus, Blacks are less likely to survive cancer five years after the disease has been detected. Apparently Blacks are less likely to get the most up-to-date treatment and follow-up care.³ A positive diagnosis of HIV infection now compounds an already weak health-care profile for the African American. Despite the seriousness of the disease, the same health care responses are seen for the Black who is HIV infected or living with AIDS.

²Ibid.
³Ibid.
Fear of Uncertainty

To have a life that is filled with questions and few answers is a challenging proposition to the healthy. When our routine living is disrupted, despair, frustration, grief, and hopelessness become daily companions. The feeling of desperation is compounded when the answer or relief cannot be found. In essence, there is relief.

If a disorganized life, for any reason, is a challenge for the healthy, it becomes a hundredfold for the sick. The one living with HIV disease faces an existence greatly marked with questions about tomorrow. Patients that I have visited on one day appear to be strong, vibrant, and full of life. A day or two later, they appear to be fighting for their lives, on the brink of death. The uncertainty of healthy living is clear, but uncertainty for the one with HIV disease encompasses every aspect of his or her life.

Economic security is uncertain because often there is a loss of employment with the onset of HIV disease. Earlier in the epidemic, it was extremely difficult for anyone who was even suspected to be HIV infected to maintain his or her job. Due to public hysteria related to personal safety issues, born out of ignorance and blatant prejudice for stigmatized groups, careers were destroyed and productive people were reduced to dependents of the State.

Economic hardship is compounded in regard to financing health care for the HIV-infected. Many insurance
carriers canceled policies upon learning of a positive HIV diagnosis and would not accept new policies for those infected. Medicare or Medicaid, when available, would not cover the expenses for necessary care.

One characteristic that is often seen in the Black family as a behavior pattern, which is classified as adaptive, is the disrupted family structure. Due to economic realities, lifestyles that are often labeled as dysfunctional are in essence survival strategies that African Americans have employed historically to address issues such as economics or unemployment.

It is well documented that many Black homes are headed by a single Black female.¹ This woman generally works outside of the home and is caring for at least two children. The absence of the Black male is not as it may appear on the surface (Black male abandonment of the home), but rather a way for the family to survive financially.² Clarence Walker states:

Whatever the financial pressures on the black counselee, there is usually some kind of adaptive response. That response may be a two edge sword--it may reduce economic pressure while increasing interfamilial conflicts. . . . Men especially may experience considerable personal anguish about unemployment. Unable to provide for their families, they may even leave their families so that their wives

¹Asante and Mattson, 164.

will be able to obtain support from public assistance.¹

Contrary to the assertions of stereotype, Walker further states that Black men have three economic concerns:

1. Having a job helps Black men to feel they are responsible men earning a decent living.

2. Black men are concerned about being accepted on their jobs without discrimination, commended for doing good work, and feeling as though they are making a significant contribution. They want salaries and benefits commensurate with the work they are doing.

3. Black men are concerned about how money is spent and will impose restraints on spending.

African Americans live in an economic crisis that raises anxiety under normal situations, and the crisis is not a result of some inherent deficiency of Black people in general, especially the Black man. When HIV infection impacts the African American and his family, the results can be devastating to an already desperate economic situation. Uncertainty becomes a larger enemy.

Uncertainty can be experienced in interpersonal relationships, residence, economics, health care, and spirituality, to name a few. The challenge then is how does the patient cope in the midst of so many questions. It is critical that the caregiver understands the very real and

¹Ibid.
often overwhelming sense of being out of control felt by the HIV infected.

The beginning of a health crisis through disease or physical disability is a serious threat to stability and everyday functioning. The patient anxiously awaits the moment to pass so that, with the threat removed, he or she can return to normal activities. The deeper the crisis, the stronger will be the desire to find resolution to the disorganization that has resulted. Regardless of the specifics, the crisis results in emotional stress associated with significant changes in outlook in a short time period. While there may be opportunities for growth, often regressive responses are the result. Gordon Allport noted that, by definition, a person in crisis cannot stand still.¹ The fear of uncertainty creates a crisis that must be resolved if the person is to take back at least some minimal level of self-control and the ability to make basic decisions. This process may be a painful one.²

Fear of Stigmatization and Ostracism

Stigmatization and ostracism are two of the greatest fears that confront the person with AIDS. Certain illnesses like venereal disease evoke a moralistic judgment of blame because the ill person is seen as being responsible

¹Sunderland and Shelp, 21.

²Ibid.
for the sickness. Elliott Friedson suggests that such medical problems may be stigmatized to the extent that by social taxonomy the illness becomes a crime in the eyes of the community.\(^1\) Of no disease has this been more true than AIDS, as indicated by community responses. The community hysteria manifested in ostracism and overt persecution of AIDS patients is subsiding as fears are answered by scientists and physicians. But a subtler and less publicized isolation is springing up. For instance, industrial companies retain AIDS employees on their payrolls but refuse them admission to their places of employment. This is often coupled with the social ostracism that reminds the person with AIDS that he or she is persona non grata.\(^2\)

The stigma experienced by the HIV-infected is added to the stigma and ostracism of being Black. The profound reality of the stigma of being Black in America is a root cause for the self-hate that has historically been a part of the African American psyche. The stigma of being Black is externally generated primarily by White racism. When that stigma is internalized, it becomes self-hate.\(^3\) To be HIV-infected and Black can be considered the ultimate curse.

Racism is held to be the motivation for the belief that the existence of this disease is an African phenomena. In

\(^1\)Ibid., 22.

\(^2\)Ibid., 23.

\(^3\)Vander Zanden, 327.
the search to discover the origin of HIV, Africa has been identified as the place of origin and blame. Without fail, whenever I make an AIDS presentation, the question of the origin of AIDS and its connection with Africa and other third-world Black countries or Black people in general is raised. This area becomes extremely sensitive when making a presentation to a Black audience. The media has given great focus to this position, and it has found rootage in the minds of many. The stigma of being the cause of the most devastating epidemic to date is a heavy burden.

In recent years, however, there has been a change in the way that Blacks see themselves:

Social scientists now recognize that a good many factors blunt the impact of the negative racist feedback minority groups receive. First, blacks do not necessarily judge themselves by the standards of the white group; assessment by the black group is much more relevant. Second, the situation that blacks confront (e.g., institutional racism) allows them to blame the system rather than themselves should they be unable to attain American success goals. And third, an increase in black militancy has contributed to enhanced feelings of black pride and unity.¹

Perhaps a further development is that many within the African American community no longer blame the system, but rather acknowledge it as being an obstacle to be overcome. Hopefully, the skills developed to overcome the stigma of being Black can serve in developing and maintaining a positive self-image as a person who is HIV-infected.

¹Ibid., 328.
Fear of Sexuality

Although the HIV virus may be spread by a number of methods, sexual transmission remains the primary threat to the greatest number of people. The virus is believed to have entered the United States through the gay communities on the East and West Coasts. It spread quickly through the gay community throughout the United States and now is well established among prostitutes. In New York, for example, it is estimated that as many as 6,000 prostitutes are infected. Unless there are substantial changes in sexual behavior both in the gay community and among heterosexuals, the AIDS virus may become as prevalent as the herpes virus. The current numbers tell us that is becoming reality.

Because AIDS remains primarily a sexually transmitted disease, and because of widespread sexual taboos relating to gay lifestyles and to prostitution, the disease evokes deep-seated fears regarding sexuality. No other disease, infection, or moral issue has had such an impact on public sexual behavior.

For the African American, two issues in regard to sexuality often dominate to the point of causing fear. Walker says that the first and most common concern is the extramarital affair of the husband.

\[\text{Sunderland and Shelp, 26.}\]
\[\text{Ibid., 27.}\]
\[\text{Walker, 32.}\]
Current figures indicate that sexual infidelity accounts for more than 40 percent of the breakups in Black marriages.¹

Walker further contends:

Marriages of black men are often disrupted by the "other woman" because competition among black women for the low supply of educated black males is keen. This is a predicament for single black women who already outnumber their men by 1.4 million. They recognize that the most desirable black males are already married. Many single women seek married men to fulfill their longings for male companionship. Ironically, as long as they continue financial support, many married black women resign themselves to their husbands' infidelity.²

I agree with Walker with regard to the dilemma that the Black female faces in finding compatible Black males. Homicide, drug addiction, homosexuality, and prison have claimed a large number of potential suitors. Some have taken the position that the single Black female, desperate for companionship, has become a marital predator. Caution is in order to ensure that the Black female is not typed or that Black male infidelity is not excused.

The infidelity issue is a legitimate concern not only for the destruction it brings to the Black home, but also in regard to increased HIV risk. Monogamy with an uninfected sexual partner is the safest defense against becoming infected, second to complete abstinence. When either partner exposes him/herself by becoming sexually intimate with anyone outside of the marriage, the risk of HIV

¹Ibid.
²Ibid.

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infection is multiplied by the number of unknown previous or current sexual partners of the other individual. When the partner guilty of infidelity returns home and continues sexual intimacy, he/she exposes his/her mate to the risk.

The tragedy is that for Black women, who have some of the fastest growing numbers of new infection, the second leading risk factor is exposure by their mates who are either infected IV drug users or have extramarital bisexual and heterosexual affairs. Often the Black female is unaware of the drug use or the extramarital sexual activity.

The second area of concern focuses on the Black homosexual. As stated earlier, gay Black men are the largest number of infected African Americans. Walker asserts that these men are probably the most isolated group of people in America.¹ "Black homosexuals are rejected by blacks because of sexual preference and by white society on the grounds of race and sexual preference."²

**Fear of Death**

Death and dying is a reality that generally causes preoccupation to some degree in humankind. There is a determined effort to avoid death at all cost. As aging reminds us that we are all slowly dying, millions of dollars have been made, and empires built, to either counter the

¹Ibid., 34.
²Ibid.
process of dying or to disguise it. From cosmetics to plastic surgery, vitamins, dietary supplements, and fitness schemes, the search for extended mortality is big business.

Death is an unknown. When something is unknown, it generates fear in the human heart. We know how death happens, but we have not fully accepted its inevitability, and have not yet found a way to contain it. Death remains the ultimate enemy and is greatly feared.

The fear of death is an extension of the fear of infection and impairment. In this view, the sick person has fallen under death's power not only because sickness possibly brings death, but because, on the basis of allegorical thinking, sickness belongs to death's domain. Sickness, as a manifestation of the threat of death, belongs to the dark side of human existence. Patients or families whose lives have been devastated by AIDS, or who are afraid that their lives may be devastated, tend to feel they are living in the valley of the shadow of death.

The problem faced by AIDS patients, their family members, and those who support them is that the diagnosis has thrust all of them into a confrontation with death from which there is no escape. While medical researchers and scientists are struggling to make the public aware that cancer is no longer an inescapable death sentence, there is

1Ibid., 27.
2Ibid., 29.
at present and for the foreseeable future no cure for AIDS. Most AIDS patients have already watched at least one of their friends die this slow and torturous death.

The AIDS epidemic exacerbates an already bleak mortality picture for African Americans. According to Pinkney, the Black community in the United States resembles a developing nation rather than a highly industrialized one. There is a clear and distinct difference between the mortality rates of Whites and Blacks. In 1974, Black males had a life expectancy of 62.9 years, and White males had a life expectancy of 68.9 years. For Black women, it was 71.2 years, and for White women 76.6 years.¹

A contributing factor to the death rates of Blacks is that they continue to die in disproportionately high rates from diseases that are easily treated by modern technology.² In 1974, the death rate from tuberculosis for Blacks was four times higher than that of Whites. Blacks died of diabetes at a rate of 22 per 100,000, compared to 17 per 100,000 for Whites. Hypertension is a major cause of death in the African American community, with Blacks dying twice as quickly as Whites of this disease. Cirrhosis of the liver claimed the lives of 20.4 Blacks per 100,000, as compared to 15.1 per 100,000 for Whites. For Pinkney, the

²Ibid.
reason for the differences is racism that denies equal access to health care.¹

Figures from 1990 reveal the following death rate totals. The United States Public Health Service reported a total of 265,498 deaths for all causes for African Americans in 1990. Of that number, 75,111 died of heart disease; 57,077 died of cancer; 5,795 died of liver disease; 8,114 died of diabetes; and 12,144 deaths were due to homicide or legal intervention.²

Spirituality

The positive diagnosis for HIV infection causes a confrontation with a person’s spiritual beliefs or the lack of. The linking of AIDS with death, which leads to questions about the afterlife, requires a spiritual inventory. When the epidemic of AIDS is associated with behaviors that have moral implications, spirituality issues must be addressed. For the Christian, spirituality focuses on religion, church, a relationship with God, and relationships with others. The fear is that in each of these areas, AIDS permanently makes an individual ineligible for a positive spiritual life. The focus is often centered on the judgment associated with moral conduct.

¹Ibid.
Central to the discussion of religion or spirituality for the African American is the Black church, the most viable institution in the Black community. Robert Staples says the Black church has been a buffer institution that provided many Blacks with an outlet for their frustrations in a society which penalized them daily for their racial membership.\(^1\) With the diagnosis of HIV, losing membership and connection with the church becomes an overwhelming fear. This membership is critical in the context of the racial struggle of the African American in the United States.

Religion or spirituality is vital to Black survival. Cobbs and Grier are quoted:

> The misery of African American life was too much to endure, so they reached into religious experience to extract a black mystique—a soul. They used the weapon of religion to survive an attack on their lives. African Americans took a Jesus bag shaped like a noose and reshaped it into a black cornucopia of spiritual riches.\(^2\)

The fear of being isolated from the church is best understood in light of what the church provides. Wimberly characterizes the function of the Black church as the ministry of pastoral care. In his estimation, pastoral care has not been a function of the Black pastor alone, but rather a sustaining work historically carried on by the whole body of the Black congregation historically. He states:

\(^1\)Walker, 63.

\(^2\)Ibid., 64.
Sustaining may therefore be defined as bringing to bear upon the person in crisis the total caring resources of the church in such a way that the person is enabled to transcend and endure circumstances that are not immediately alterable.¹

**Interpersonal Relationships**

The devastating impact of AIDS reaches far beyond the individual patient. Parents, children, and spouses of these victims are touched profoundly. Each group has its own peculiar set of questions and concerns that must be addressed so that complete help may be afforded. One of the first things families need is basic information about the disease itself. Regardless of how well informed people may be, the presence of a crisis often calls for the reintroduction of information.

Families usually have many questions whose answers are crucial to their understanding. When the family is trying to process all the implications of the disease, these questions will run the gamut from death to personal hygiene. People in the medical community are not always able to take the time to go into the kind of detail that is needed. The issue of confidentiality is usually as important to family members as to the person with AIDS.² At death this issue is often brought into focus around the question of


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where to have the funeral. In situations where the church and the minister have the opportunity to relate to both the AIDS patient and the family, some unknown realities can surface (e.g., the AIDS patient was a homosexual). Often during the illness, the church is not aware of the lifestyle of the patient. Upon disclosure, the tendency for the church to be judgmental is very real.¹

The African American Family

The African American family has been studied and re-examined over the years. Most of the information written has cast the Black family in a negative light and has branded it as a lost cause. Recent social scientists have taken a different approach in trying to understand this American phenomenon.

The first point of reference is the historical roots of the African American family to West Africa. West Africans were deeply rooted in a sense of strong family bonds. Contrary to the individualistic philosophy of the Eurocentric mind, Africans were concerned with the group. Land was not owned by an individual, but rather it was owned by the tribal or familial group.² Walker further writes:

Various African tribes shared in the area of kinship an intra-tribal sense of collective unity and adopted the philosophy 'we are; therefore I am.' Consequently, an individual was nobody because the self

¹Ibid.

²Walker, 14.
was defined in relationship to others. One was a son, a daughter, a parent, or a grandparent, and had a large or small place in the village. One was known in relationship to others and shared the reputation of kin. A wastrel or cowardly brother was one’s own shame; a relation who brought glory to himself was one’s own pride; and the kinsman whose name one shared carried force and qualities of others. Each person was linked through family to others in the village so that, to the West African mind, the village became the family writ large.¹

African families were characterized by a strong extended network of grandparents, aunts, uncles, cousins, brothers, and sisters. When an individual married, the new spouse now owned membership in this family network. This family network is both intergenerational and multigenerational.

An interesting note to be considered is that the Black male held a prominent role in the family. That role carried the veneration of spouse and children. Thus we see the family orientation that was brought by the African on the slave ships to America.² This is far from the stereotypical notion of and absent, inconsequential role of the Black male in the home.

We are now able to take a look at the African American family in the 1990s. It is commonly held that the African American family has held onto many of its West African family values. The differences that exist between the two speak to survival adaptation as the Black community copes

¹Ibid.

²Ibid., 15.
with the effects of racism in America. With their West African roots and American adaptation, the following is offered as a snap shot of the modern African American family.

1. Black families may be comprised of several individual households with the family definition and lines of authority and support transcending or going beyond any one household unit that comprises the family.

2. They maintain elasticity—that is they are structurally expanding and diminishing in response to external conditions.

3. They have a child-centered system (the general organization often requires and focuses on children).

4. They often have a close network of relationships between families not necessarily related by blood.

5. They have flexible and interchangeable role definitions and performance.

6. They have multiple parenting and interfamilial consensual adoptions.¹

It is with this family support system that the African American family faces the challenges of AIDS.

Parents of AIDS Patients

Parents with grown sons or daughters who are dying with AIDS generally fall into one of two categories. The first is those who are in the same location with their child. Often that child has to come home because there is no other place to go. The second is those parents who are living in

¹Ibid., 16.
one place while the child who is suffering with AIDS is living somewhere else, primarily in another city, town, state, or across the country.\(^1\) Parents whose children have been diagnosed with AIDS often first need to decide whether or not that child can come home. For some parents, this will not be an issue at all. Their child is ill and needs to be cared for, and their home is open. For others, it is a bit more complicated, especially in those situations where an adult child has been gone from home for some time and has not maintained close contact. Many times children who are gay or heavily into the drug scene have consciously distanced themselves from their parents to protect the parents from having to deal with a lifestyle with which they might not agree, or to protect the child from having to deal with the hassle of possible rejection by the parents. It is not uncommon for children to leave home and assume lifestyles that are never disclosed to their parents.\(^2\)

Children of AIDS Patients

One of the most prominent issues to be dealt with in children is the fear of losing the other parent. The dynamic of fear is naturally laced with the strong thread of anger. Children who have an understanding of how AIDS is

\(^1\)Amos, 83.

\(^2\)Ibid., 84.
contracted have a heightened sense of fear, rooted in anger. To lose a parent or stepparent is bad enough. To face the possibility of becoming orphaned is almost overwhelming to a child or young person. To have that death come because of AIDS makes anger very understandable and real.¹ In her article, Mitchell states that, according to one New York City epidemiologist, an estimated 30,000 to 40,000 of that city's Black and Hispanic children will be orphaned in five to ten years due to AIDS.²

Another area of concern will require greater attention in the future, namely the large number of young teenage girls who have been victims of incest.³ As AIDS spreads throughout the heterosexual community, inevitably there will be teenager girls who have been sexually assaulted by fathers or other men in their families who have been exposed to AIDS. The victims of incest are going to have to deal with the fear that they might get AIDS. This group will also include boys who are incest victims.⁴

Spouses of AIDS Patients

The spouses of those with AIDS present yet another unique opportunity. They are the persons who must maintain

¹Ibid., 87.
²Mitchell, 32.
³Amos, 89.
⁴Ibid.
family stability once AIDS is disclosed. In the future, as the disease spreads in the heterosexual community, more and more spouses--most of them wives--will have to carry this burden.\(^1\) They will be emotionally and relationally involved as well as legally responsible for making many decisions as the illness progresses. As with the children of persons with AIDS, another very special issue will be facing spouses in their future. After the death of the spouse, the survivor is not only widowed but becomes marked.\(^2\) As the survivor contemplates the possibility of dating and even future marriage, the fact that their mate died with AIDS will become a real issue in their interpersonal relationships. Given the moral reactions of a cross section of people in society, there is a real risk that many will be immediately turned off at the news of their dates having become widowed through AIDS. It will take an unusually non-prejudiced person for deepened relationships to develop once this issue is in the open. To disclose is to risk rejection by those with whom real relationships seem possible. Yet not to disclose is to run the risk of perhaps added questions centering around issues of dishonesty and integrity.\(^3\)

\(^1\)Ibid.
\(^2\)Ibid., 93.
\(^3\)Ibid.
CHAPTER IV

ISSUES: THE PASTORAL CAREGIVER

Ministering to people touched by AIDS differs in several ways from ministering to people with other illnesses. The objectives in both instances may be similar, but the negative moral attitudes, poor medical prognoses, and harsh social judgments associated with AIDS set it apart from other situations of ministry. Personal hysteria, misinformation, and a general characterization of this illness being a "gay disease" are evidence enough of the unusual dilemma we face. As a result, before embarking on a ministry in this area several considerations of self-examination should take place. Critical to an effective ministry to those who are HIV infected or living with AIDS is a well-formulated theology for caring.

Toward a Theology For Caring

The Christian world often views HIV infection in light of the means by which one is infected. Primarily transmitted through sexual activity, the most noted being homosexual sex, AIDS is generally considered to be a sinner’s disease that somehow deserves distinction from sin in general. Some pastors and members of the church at large
hold that AIDS is simply the just results of sinful sexual behavior and in the final analysis is God’s justice toward the sinner. This position stands as a major barrier to the extending of care and compassion to those who are suffering with this dreadful disease. The thought is strongly held by some that because this disease is so directly linked to "sinful" acts that care and pastoral nurture are not necessary, nor deserving of those affected. If left to our own surmising, perhaps the Christian world would justify its actions of noncompassion. The good news is that we are not left to feel or determine who should and should not receive the care of the church. Jesus Christ has shown us a more excellent way in his personal example of ministry.

Jesus went throughout Galilee, teaching in their synagogues, preaching the good news of the kingdom, and healing every disease and sickness among the people. News about Him spread all over Syria, and people brought to Him all who were ill with various diseases, those suffering pain, the demon-possessed, those having seizures, and the paralyzed, and he healed them (Matt 4:23-24, NIV).

Jesus went through all the towns and villages, teaching in their synagogues, preaching the good news of the kingdom and healing every disease and sickness. When he saw the crowds, He had compassion on them, because they were harassed and helpless, like sheep without a shepherd. Then He said to His disciples, The harvest is plentiful but the workers are few. Ask the Lord of the harvest, therefore, to send out workers into His harvest field (Matt 9:35-38, NIV).

The preceding texts have served to guide my pastoral responses to those who find themselves in difficulty or in the midst of human suffering. These two passages describe the manner in which Christ responded to the sick sinner.
Christ's ministry was one of proclamation coupled with service in response to the needs of those being served. The Bible declares that Jesus had some "good news" to share with those who would hear. The good news was then demonstrated in the healing of their diseases. Throughout His ministry, He not only preached, He served and met needs as well. The core of Christ's ministry was a focus on alleviating human suffering. The need for healing was all around Him. Thus, He had the opportunity to heal. He had the will to do it. He had the power to do it. Without reservation, He did it.

The passages further declare that He healed every disease and all sickness. As the sick came, he ministered to them. We do not see a picture of a line of hurting people waiting to be seen by the healer from Nazareth, but being screened first by the disciples to see if their malady was on Jesus' list of ills to treat. In His ministry to sickness, He attended all who were sick without qualification or discrimination. Jesus' only inquiry in essence was, "Where do you hurt?"

Jesus' response to sickness is a preview to how He responds to sin in the human heart. "So I tell you, every sin and blasphemy will be forgiven men (Matthew 12:31, NIV). Heaven's concern in dealing with sin is that man is able to bring it all to the cross of salvation and there find forgiveness for all sin. It is a demonstration of the power
of grace as Paul declares: "But where sin increased, grace increased all the more, so that, just as sin reigned in death, so also grace might reign through Jesus Christ our Lord" (Rom 5:20, 21, NIV).

It was divine wisdom to use the human response to sickness as a means to inform man of the operation of grace. It has long been held that sin is God's way of registering His displeasure with man's sinful or rebellious ways. The natural conclusion is that if we are obedient to God then we will be free from sickness. Sickness then becomes the unmistakable voice of God's disapproval.

Perhaps the admonition given to the children of Israel while on their quest for the promised land, laid the foundation for this understanding:

If thou wilt diligently hearken to the voice of the Lord thy God, and wilt do that which is right in his sight, and wilt give ear to His commandments, and keep all his statutes, I will put none of these diseases upon thee, which I have brought upon the Egyptians: For I am the Lord that healeth thee (Exod 15:26).

The New International Version gives a similar rendering:

If you listen carefully to the voice of the Lord your God and do what is right in His eyes, if you pay attention to his commands and keep all his decrees, I will not bring on you any of the diseases I brought on the Egyptians, for I am the Lord, who heals you. (Exod 15:26).

A clear message of warning against disregarding God's law in order to avoid the consequences of disobedience is unmistakably a key to the mind-set that sees the relationship between sickness and sin as God's tool to
Hoffman and Grenz offer this observation:

The sickness-and-sin issue constituted an important question in biblical era. Perhaps nowhere in the Old Testament is it more vividly presented than in the Book of Job. Although Job’s friends came to console him in his misfortunes, they resolutely maintained that Job’s calamities were due to his own sinfulness or to that of his family.¹

Earlier literature reveals that this notion of suffering being God-directed can be seen in the theological writings of the middle ages. Shelp and Sunderland use the positions of Calvin as an example:

Calvin identified two purposes served by suffering caused by such events as pestilence, disease, poverty, or any other suffering in body or mind. First, suffering is punishment for high crimes and misdemeanors against God, a punishment justly deserved. Calvin prayed that God’s chastisements--the affliction of disease or poverty, for example--would be effective for the reformation of the sufferer’s life. In this sense, suffering has an expiatory force that imparts the assurance to the believer that guilt is thereby atoned, reflecting the Talmudic statement that the one who has suffered in this life is thereby assured of rewards in the life to come.²

Calvin’s second position states that suffering comes to the life as a way of teaching lessons. In short it has an teaching dimension. Calvin believed that especially in the life of the believer, pain and anguish were used by God to instruct His people.³ This position has its influence __________

¹Hoffman and Grenz, 160.


³Ibid., 91.
even in modern thinking. The tragic death of a young athlete was attributed by his parents to God, who was using the tragedy to teach others and perhaps save them.\(^1\) If the foregoing notions are true, then it becomes difficult to convey the truth about a God who is interested in the pain and suffering of a world in direct rebellion against Him and His universal order. This is the beginning of the understanding about the nature, power, and essence of grace.

What is needed is a viewpoint that sees the world in the context of what sin has done to our world in every aspect. In short, an understanding that there is a cause-and-effect relationship between behavior and consequences and not God’s deliberate retribution could pave the way for compassionate caring for the sufferer.

The church’s response to the AIDS crisis has led some to say that it was "at best, hesitant and ambivalent and, at worst, negligent. Some church leaders have called AIDS God’s punishment on homosexual people."\(^2\) One noted church leader was quoted as saying: "God has created the AIDS epidemic to indicate his displeasure over America’s acceptance of the homosexual lifestyle."\(^3\)

As the church as well as pastors confront this

\(^1\)Ibid.


\(^3\)Ibid., 9.
disease, attitudes are changing for the better. In contrast
to the condemnation of some church leaders, Bishop William
E. Swing, Episcopal bishop of California, wrote:

This AIDS crisis is of such gruesome proportions
in terms of human suffering that it would be immoral
for the church not to enter the arena of pain with
thoughtfulness as well as caring.¹

Through the example of Jesus and repeated admonitions
throughout biblical writing, the church and pastors must
have a moral obligation to respond to all suffering,
wherever it may be found, regardless of how the suffering
came about. How one becomes sick is not a criterion for
caring. Kirkpatrick states:

If we are to be faithful to the continuing
pastorship of Jesus, we should behave as he behaved
towards sufferers of every kind, especially those
branded as lepers. Through his example, we have no
choice but to embrace all those infected with the HIV
virus and those who suffer with them. This is with the
work of God in Christ and of Christ in us. It is also
the work of love’s compassionate endeavoring towards
all who suffer... If one member of the human family
suffers, all suffer. If one member is infected with
the HIV virus, all are infected. To the extent that
one member of the Body of Christ is infected, then the
Body of the Church is also infected.²

Hans Kung’s quote could be used as we consider the one
living with HIV disease:

This people, a flock without a shepherd, feeling
misunderstood by both the establishment and the rebels,
despised by the pharisaical devout individuals of the
towns and villages and by the ascetics of the desert,

¹Ibid.

²Bill Kirkpatrick, AIDS: Sharing the Pain, A Guide for

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useless for either temple or military service, incapable of exact observance of the law and still less of major ascetic achievement; this is the people on whom Jesus has compassion—these who are called blessed, who are not enfranchised, who can be neglected and abused with impunity at all times by the ruling parties and authorities, these must feel he understands them. They are for Him.¹

Finally, Kirkpatrick notes:

The main issue of this infection for the minister and other carers is whether or not we are prepared to offer unconditional compassion as an expression, not only of our own love, but also the love of God in us.²

We are under a biblical mandate to care. For most pastors, retraining is necessary.

**Attitude and Understanding about AIDS**

Challenge presents itself whenever we approach a situation that is new or calls for going outside of our routine. The one who would engage in this new field of ministry will eventually have to confront his or her own beliefs, religious convictions, prejudices, fears, emotions and level of comfort. AIDS will bring the caregiver face to face with one’s self. The inner heart will invariably reveal itself in the type of care rendered. In short, the quality of the care given and its effect will rest on where we are about this disease.

Smith contends that the greatest obstacle faced by pastors is their own fear and often hysteria of becoming

¹Ibid., 36-37.

²Ibid.
81

personally infected if they engage in the kind of contact pastoral care requires.¹ This fear continues to live in spite of the facts that are reiterated over and over again. Transmission of the HIV infection does not occur through casual contact such as hand shaking, hugging, talking or or being in the same room with someone who is infected. Transmission is primarily the result of sexual contact with an infected person's blood, semen, or vaginal fluids. Normal pastoral-care contact is safe.

My introduction to this ministry was born out of my own personal hysteria as it relates to HIV infection. I was involved in a discussion with several of my ministerial colleagues about a hypothetical situation of how to handle the request for baptism from a person who has AIDS or is HIV infected. At that particular time no one in the group, all seminary trained, was knowledgeable enough to offer any rational options to this situation. The solutions offered were embarrassing at best. The solutions were varied from breaking confidentiality of the infected one and informing the other candidates that one of the persons to be baptized has AIDS, baptizing that person last to protect the others, to standing outside of the pool and pronouncing the baptism commitment, or wearing a full rubber suit. The reality in

trying to find a solution was that there was a great deal of fear within me as to what were the issues of my personal safety. My response to my fear was education, and is what separated me from my colleagues and has contributed to my personal and professional growth.

Other issues related to the attitude of the caregiver focus on moral judgement, AIDS as a sinner’s disease, and determining whether or not this is a medical problem alone, i.e., that spirituality is not an issue. How these issues are addressed is a key to being able or available to give care to the sufferers of this disease.

**Attitude about the AIDS Patient**

Along with confronting attitudes towards the disease, perhaps a larger issue with personal implications is the attitude of the caregiver towards the AIDS patient. This disease takes on a personal identity as it consumes every facet of the sufferer’s life. The caregiver is drawn into an intimate encounter that will test personal and often deep-seated hidden notions held about the patient. Unresolved conflict about the person being cared for can cause more harm than good. Because of the nature in which HIV is transmitted from person to person and its tie to lifestyle and personal behavior, labeling people and developing negative attitudes about them is a major obstacle. With the discovery of the disease, the connection between the disease and certain groups of people preoccupied
all discussion related to AIDS.

According to Smith:

In any helping relationship, it is important for the helper to pay attention to feelings he or she experiences toward the person seeking assistance. It is difficult to be effective in a helping relationship if one has strong negative feelings and judgments toward the individual seeking help. To attempt to provide care without attending to and resolving personal issues related to the individual is irresponsible. Sometimes helpers create more problems for the helpee than they solve. In medicine, these problems are termed iatrogenic, meaning they have their origin in the attitudes and behaviors of physicians toward their patients.¹

Pastoral caregivers must confront and resolve their personal issues of prejudice regarding the patient. Perhaps, this is the root of the problem. Far too often we still see people who are hurting, in trouble, or a part of the group called the unlovely, through our eyes and not God's eyes. The caregiver's view of the patient must align with God's response to sinners. Self-check will always be necessary.

**Homophobia and Race Consciousness**

Homophobia and race consciousness are two issues critical in rendering pastoral nurture and care to the African American who is HIV infected. As the caregiver attempts to meet the spiritual needs of the patient, a confrontation focused on the issues of sexual orientation and race prejudice will challenge preconceived notions and

¹Ibid., 21.
deep-rooted feelings.

Homophobia is the fear often demonstrated as a hatred of homosexuals and homosexuality. Phobias are generally based upon some underlying fear or insecurity. In the phobia towards the homosexual, the fear and insecurity center around sexuality. Within the church it is often difficult to discuss or come to grips with human sexuality. Due to issues of sin and immorality the subject of sex has been restricted to the list of "thou shalt nots." No sex before marriage and sex only with the marriage partner is the position held by most Christians. The prohibition of engaging in the act of sex often leads to "we don't talk about that." Erroneously, sexuality has been reduced to the sexual act. Sexuality, which includes sexual identity, roles, development, mores and values, is a normal and healthy part of the human experience. Difficulty in addressing sexuality in general will determine the ability to deal with that which departs from the norm—homosexuality. We fear what we do not know. As with all issues of earthly existence, we need guidance from God, who created us and our sexual nature, as to how to please Him in our sexual life.

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The AIDS epidemic received notoriety through its first identifiable victims, the homosexual community. Homosexuals were stigmatized, blamed, cursed, and held responsible for causing this plague to be poured out on mankind. Many, especially in the church, were insensitive to the suffering of these first patients and excused themselves from compassionate service citing that AIDS was God’s way of punishing these individuals for sexual sin.

One of the end products of the callousness, blaming, and fear is the move to affirm the gay lifestyle as an acceptable way of life supported by Scripture. This drive is primarily headed by those within the gay community almost as a matter of self-preservation. The arguments to support those who declare that being gay was never a choice for them, that they were always attracted to the same sex, were well thought out and often very compelling. The dilemma for me was, if sexual orientation is not an issue of personal choice, then how can one be held accountable as a sinner for a gay person’s sexual lifestyle? I reached a point where I was unable to defend my traditional perspectives of homosexuality being sin against the positions that affirmed the lifestyle. The debate continues as so-called evidence is presented from the scientific field to support the normalcy of homosexuality--to a redefining of theological dogma to support the lifestyle scripturally by some groups.
My greatest tension was to reconcile giving non-judgmental compassionate care while holding to my beliefs concerning what the Scriptures teach about the sinfulness of homosexuality. The fear of many that I have shared with in this ministry is that somehow it is communicated that we affirm the gay lifestyle by caring. Often this becomes a barrier to rendering the kind of care that all who are sick deserve. The pastoral caregiver must see caring in the light of affirming the personhood of the sinner, not affirming the sin. This was Christ’s way.

To compromise integrity of Scripture in order to appear compassionate is a dangerous proposition for the church.

Springett states:

The prohomophile literature written in a Christian context overemphasizes love and the Spirit at the expense of the Word. It is true that without these the church is a dry, lifeless husk. But it is equally true that the church without the objective Word of God is a ship without a rudder. It simply rides out the swells of world events, fads, and opinions with all the other flotsam and jetsam until it is beached or smashed on the rocks. Uncontrolled and drifting, it has no means of directing its course.¹

The spiritual caregiver has the challenge of remaining faithful to biblical truth and rendering compassionate care. It is a comfort to know that it is not necessary to compromise scriptural integrity in order to be caring. In fact, without scriptural integrity there would be an absence of Christ-like caring.

¹Ibid., 161.
Springett concludes:

The church must accept the individual of homosexual orientation who needs help and support and struggles against same-sex tendencies. But those who insist on and promote the active homosexual lifestyle as normal, natural, or even superior to heterosexual relations by that very act disregard and undermine the sole authority upon which the church's very existence and mission is based, namely, the Scriptures.

The issue of race consciousness is a challenge that has been a part of the history of American society since the days of its inception. In 1619 the first African settlers arrived on a ship that landed in the harbor of Jamestown, Virginia. These first African settlers lived and gained their freedom in the same manner as White indentured servants. However, by 1641 Massachusetts became the first colony to give statutory recognition to slavery with the African as the target. The year 1664 brought the first antimiscegenation law preventing marriages between the English and the African. Since that time, in areas of housing, education, employment, politics, economics, and social interaction, racial issues matter.

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1Ibid., 164.


3Ibid., 36.

4Ibid., 361.

5Ibid.
Issues of race and race relations have been debated for decades. We have developed seminars and training sessions for cultural sensitivity aimed at causing people to relate to each other harmoniously. Talk shows have centered their attention on this issue, books have been written, and we still cannot get along with one another.

In an effort to answer the question to the problem of racial tension, the focus has invariably been placed on the African American community as the problem. Somehow Blacks need to be fixed in order for things to get better between the races. Cornel West writes in his book, *Race Matters*:

To engage in a serious discussion of race in America, we must begin not with the problems of black people but with the flaws of American society—flaws rooted on historic inequalities and longstanding cultural stereotypes. How we set up the terms for discussing racial issues shapes our perception and response to these issues. As long as black people are viewed as a "them," the burden falls on blacks to do all the "cultural" and "moral" work necessary for healthy race relations. The implication is that only certain Americans can define what it means to be American—and the rest must simply "fit in."¹

The perspective of seeing a problem as the sole responsibility of the victim is to place the total blame on the rape victim for the rape and to ignore or minimize the aggression of the rapist. The end result would be to exonerate the rapist and leave the perpetrator with a sense that the victim deserved or asked to be assaulted. As it relates to the plight of the Black community, William

Ryan states:

Billingsley shows—as I and so many others have tried to show—that those who emphasize Negro family pathology have crucial defects in their position: They leave out of the equation for current action two important elements—racism and conflict. They do not incorporate an attack on racism as a necessary element in the achievement of Negro equality, and they do not seem to perceive that an equalization of status will necessarily be accompanied by conflict.1

The pastoral caregiver engaged in the work of helping the African American AIDS patient must confront personal issues of racism and prejudice. Each of us is a product of our time, environment, family values and traditions, and personal experiences. Where we are in racial matters will influence the care that is rendered to Blacks or if we will attempt to reach them at all. Simply to rely on a profession of being Christian and being involved in spiritual work will not address issues of personal racism. As sinners, all are racists and fall short of the glory of God.

As the caregiver confronts his or her own issues of racism, perhaps an equally challenging reality to come to terms with is the issue of Black rage. This rage is something that individuals of other race groups, who have no personal experience with systemic injustice impacting every area of life, have a difficult time understanding. A common response to manifestations of Black rage is that


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Blacks ought to simply "get over it" and move on. To move on becomes difficult when the very ones who make that declaration are the culprits of the injustice. In order to reach the African American, Black rage and the primary reason contributing to that rage--White racism--must be acknowledged and addressed. West writes:

The proper starting point for crucial debate about the prospects for black America is an examination of the nihilism that increasingly pervades black communities. Nihilism is to be understood here not as a philosophic doctrine that there are no rational grounds for legitimate standards or authority; it is, far more, the lived experience of coping with a life of horrifying meaninglessness, hopelessness. The frightening result is a numbing detachment from others and a self-destructive disposition toward the world. Life without meaning, hope, and love breeds a coldhearted, mean-spirited outlook that destroys the individual and others.

Personal Mortality

The HIV-infected person knows death is a possibility much sooner than would be generally anticipated. The AIDS patient faces death day by day. These individuals know that at any moment they could loose the battle. For the caregiver, this confrontation with death presents a challenge. Aiding the patient through his or her journey magnifies the realization that our personal death is ever so real.

As AIDS patients are forced to confront their personal mortality, the ones providing ministry must also resolve

\(^{1}\)West, 22-23.
mortality issues for themselves in order to be able to render affective and effective care. Naturally, when one invests the kind of time and personal energy to provide care for these patients, the caregiver will have grief issues that must be addressed when the individual eventually dies. The drain on personal resources may even cause the caregiver to experience burnout. However, the realization of personal mortality is one of the greatest issues. Walter J. Smith states:

Chronic illness necessarily raises the issues of personal mortality. It is extremely difficult to imagine ourselves as dead. Dr. Elisabeth Kubler-Ross in her workshops on death and dying issues with hospital personnel has frequently commented that many of us perpetuate the illusion, "And thou and thou, but never me." It is an understandable defense. Dying persons, however, have a way of eroding the thin protective barrier, and make us come to terms with our personal mortality.¹

Commitment

Rendering care and spiritual guidance to the AIDS patient is one of the most demanding ministries. The impact of the disease touches the whole being of the patient. The destructive effect of this disease reaches to family members, friends, co-workers, spouses, lovers and anyone who has personal involvement with the patient either before or after infection. The caregiver must be prepared to be inconvenienced and to have the limits of personal time taxed. The care giver will experience a level of dependency

¹Walter Smith, 25.
from the patient much higher than with most other illnesses. According to Shelp and Sunderland:

Failing to respond to legitimate calls for help may intensify a person's sense of being out of control, isolated, and abandoned. Loyalty to persons and keeping promises are important components for building secure relationships with people touched by AIDS. Alternately, the trust and confidence that persons with HIV/AIDS and their loved ones have in those who minister to them provide important bases for deepened relationships and expanded opportunities for ministry. Being clear in advance about the general type and number of ministries that may be requested allows people to determine whether their commitment to AIDS ministries is equal to the task.¹

**Burnout**

Burnout is an ever-present threat to the continuance and survival of AIDS ministries. As it has already been stated, the pressures are multi-faceted as one attempts to care for this group of patients. Time, energy, and personal resources are taxed for the sake of the one being helped. Often, the caregiver, in intense zeal to take care of others, breaks the first rule of caring--taking care of oneself. Kirkpatrick reminds us that all forms of ministry, of pastoral care, begin with oneself.²

Mechanisms of support for the caregiver must be in place and utilized if the caregiver is to survive giving the care. Support groups for caregivers have been an effective

¹Sunderland and Shelp, *AIDS and the Church, The Second Decade*, 131.
²Kirkpatrick, 39.
away from the ministry to heal personally. A lack of support made the healing process for me much slower and more difficult than usual.

**Summary of Pastoral Care**

Initiating an AIDS ministry will require courage. The threat does not come from people with AIDS or with a related diagnosis. Rather, people involved in this kind of ministry may require courage to deal with those who oppose the ministry. Criticism and withdrawal may be faced. Subtle and overt messages of disapproval may be encountered. The isolation and ostracism common to AIDS patients may be experienced by those who participate in hands-on ministries to these men, women, and children.¹

An assessment of how comfortable one is with this particular illness is very necessary. This will take into account the related realities associated with AIDS such as wasting bodies, anguish, death, and grief. People with AIDS tend to have repeated acute illnesses that result in an ever-increasing level of dependency for medical, social, psychological, and spiritual support. Their care can be very demanding. Care providers can grow weary and frustrated as one acute illness ends and another soon appears. The physical and emotional toll is even greater for the ill person. The patient's loss of control over

daily activity, environment, and body may be sudden or gradual. Whatever the speed, patients generally feel trapped in a process of irreversible debilitation and degeneration.¹

One's willingness to be exposed to settings and lifestyles that are unfamiliar is very important. Some features of male homosexual culture, for example, may be provocative to our curiosity or they could be a barrier to those previously unaware of them. The IV drug users may create a similar range of reactions. It is important to remember, however, that meeting people in their own environment certifies declarations of concern and affirms their value under God. Considering ministry to persons with AIDS often conjures imagined horrors that may be worse than reality. However, in some cases the reality is much worse. If a caregiver feels that withdrawal is the course for him or her, there is no disgrace, especially if to pursue the course would be counterproductive for all concerned.²

Another area is one's capacity to separate compassion from condoning the conduct by which a person was infected with the AIDS virus. Some people will resist participation in supportive ministries because they do not wish their compassion to be interpreted as approving homosexuality, heterosexual marital infidelity, or IV drug use. These

¹Ibid., 95.
²Ibid., 96.
activities are widely condemned in church declarations and by individual Christians. Giving pastoral support to people who engage in these activities but who are now ill ought not be seen as an endorsement of their conduct.\(^1\)

Before being involved in an AIDS ministry an assessment needs to be made of the degree of one's commitment to the task. The needs of each case may fluctuate greatly over short intervals of time. Ministering successfully in this situation requires individual and organizational flexibility, capacity to tolerate changes, and the ability to persevere for an indefinite time. People who commit themselves to an AIDS ministry should be willing to be inconvenienced and to sacrifice personal interest for the needs of those served.\(^2\)

Coupled with this is the availability of one's time. People with AIDS may feel that the church and Christians generally are unconcerned about them as persons or about their welfare. They often feel rejected and despised because of their sexuality, lifestyle, and disease.\(^3\) People considering AIDS ministries should realize in advance that establishing quality relationships and providing

\(^{1}\)Ibid., 97.

\(^{2}\)Ibid.

\(^{3}\)Ibid.
quality ministries often require many hours of preparation and activity.¹

An ability to maintain objectivity is generally important for ministry to persons in crisis situations. People should anticipate that the activities undertaken will involve them in intimate, highly personal, and private situations. There must be sufficient commitment to enable caregivers to meet the challenges and a balancing objectivity that will ensure their effectiveness. There is a liberation for service when this balance between commitment and objectivity is maintained. The caregiver is now able to be involved without being overwhelmed, to feel without needing to insulate.²

Finally for the helper, building positive perspectives to the preceding areas of concern is needed.³ People who have the appropriate dispositions, traits, and opportunities to participate in AIDS ministries must be educated and trained for this specialized ministry. AIDS and its effects on people, both as a consequence of the disease itself and society's reaction to it, have created an unprecedented situation. Much is known and much more is being learned.

¹Ibid., 100.
²Ibid.
³Ibid., 101.
Becoming informed about the destructive forces set in motion by HIV and how to respond in a healing, consoling, constructive manner are necessary conditions for embarking upon ministries to people touched by AIDS.¹

¹Ibid.
CHAPTER V

A MODEL FOR TRAINING PASTORAL CAREGIVERS
FOR THE AFRICAN AMERICAN AIDS PATIENT

In every state and in most cities, training is available to pastoral caregivers to gain the skills needed to render the care necessary for those affected by AIDS. The quality of these training programs has developed in a positive direction for approximately ten years. The two Pastoral Care designs discussed earlier in this project are examples of the commitment to provide quality training. A decade of analyzing and adjusting the training models has made an impact on the preparation available to caregivers.

The present training for pastoral care addresses the issues of the HIV/AIDS patient from a general perspective. It has become increasingly clear to me that additional training is needed to address the impact of this disease on specific culture groups, in particular, the African American. This project proposes the following model for specialized training in pastoral care for the African American AIDS patient.

A four hour training track, based on the information previously discussed in this project (which serves as the
CARING FOR THE AFRICAN AMERICAN AIDS PATIENT

I. Overview of the Epidemic 1 Hour

This section of the training seminar will focus on the facts, statistics and implications of the current HIV infection numbers as they relate to the impact of the epidemic on the African American AIDS patient. It is not intended that this session would simply rehash information given during the general instruction on HIV/AIDS. The focus will be to help the trainee to understand the epidemic in the context of African American life. The data and information shared will crystalize the dilemma for this specific cultural group. The African American crises is not a separate problem, but rather, a unique manifestation of the general crisis. The topics to be discussed are:

A. A brief history of AIDS
B. The African American dilemma and risk profile
C. The African American Community response
D. The African American Church response.

II. Issues--The African American with AIDS 1 1/2 Hours

This section will focus on the general issues confronted by the AIDS sufferer with specific emphasis on the particular impact on African American life. As a way of
equipping the caregiver to render effective, relevant care to the Black AIDS patient, cultural survival strategies, often mistakenly viewed as chosen lifestyles, are highlighted. The areas of discussion are:

A. The Six Fears 45 minutes

1. Infection and impairment
2. Uncertainty
3. Stigmatization and ostracism
4. Sexuality
5. Death
6. Spirituality

B. Interpersonal Relationships 45 minutes

1. Parents
2. Children
3. Spouses/Lovers
4. Friends
5. Church

III. Issues--Pastoral Caregiver 1 Hour

As the pastoral caregiver approaches this special ministry, several issues will impact the one giving the care. Effective ministry, which facilitates the building of a trusting, supportive, and sharing relationship, can be impeded by unresolved personal issues. The greatest preparation the trainee will need is the honest confrontation with self. These issues are general in nature, yet, for the purposes of this special training, focus will again center on the African American AIDS patient. Along with homophobia, the caregiver must confront personal issues, past experiences, and preconceived notions held about people of African decent. Race consciousness and
relations is a constant in American life. A claim to Christianity is not always enough to resolve deeply rooted positions. The topics are:

A. A theology for caring
B. Attitude toward and understanding about AIDS
C. Attitude regarding AIDS patients
D. Homophobia and race consciousness
E. Personal mortality
F. Commitment
G. Burnout.

IV. Conclusion

To foster a sense that the trainee is involved in and investing time and energy to be properly trained in a significant ministry, the training is concluded with a time of reflection, sharing, and commitment to service. This technique has been used in several of the training programs in which I have been involved.

A selected reading or passage of Scripture will be read, and the seminar leader will lead in a time of reflection and sharing with the fellow trainees-their impressions, concerns, fears, and hopes as they relate to the selected reading and/or a personal related experience. This exercise will help the trainees to get a sense of what the patient will experience in sharing feelings, fears, or their inner thoughts with another person. Creating an environment of trust, where it is safe
to be who you are, is of critical importance when a caregiver seeks to render care. Simply because we are "there" it is easy to think that trust is automatic. It is not.

Finally, using a candle symbolizing the light of hope, a service of commitment is used to affirm those who are dedicated to this ministry. Properly carried out, this commitment service can encourage a decision to serve in those who are uncertain if this ministry is for them.
CHAPTER VI

CONCLUSION

Faced with actually having to give pastoral care to patients with AIDS, it is very clear that it is impossible to produce an exhausted list of issues surrounding this very special ministry. Involvement in this kind of care is very intense and tends to spiral. Every case is different because every individual comes with a different set of circumstances.

Current data that reflect the numbers of those who are infected with the AIDS virus in the African American community continue to give cause for alarm. The crisis within the Black community calls for education, intervention, and helping strategies relevant to the particular needs of African Americans as they confront this disease.

Pastoral care plays a vital role in the process of caring for the whole person as he or she struggles with AIDS. Medical care, financial support, housing, and emotional support systems are all keys to the quality of living for the AIDS patient. Spiritual nurture is also an important need for those confronting a disease that promises death at any moment. Training to provide spiritual
caregivers with skills necessary to provide pastoral care has been in existence for more than a decade with excellent results. Those involved in the training process have reevaluated and redesigned their programs to meet the changing needs of pastoral care.

Existing training for pastoral care effectively provides skills for rendering general care to the AIDS patient. Special training is needed in order to address the African American AIDS sufferer. My American Red Cross training that resulted in a certification as an African American AIDS specialist was not adequate in identifying and addressing the specific needs of the Black community in the AIDS crisis.

Being Black does not exempt the one infected from the general issues that must be confronted in this disease. However, these issues have a different impact on Black life. African American life in America is already taxed with the negative residuals of societal racism. HIV infection or living with AIDS challenges existing strategies for survival. New levels of despair, hopelessness, and frustration are seen as the root of denial of the disease evidenced in the Black community. AIDS impacts all of Black life.

The pastoral caregiver must have a theological understanding and basis for being involved in this ministry. It will be the key to surviving the professional ostracism...
that many experience in the midst of rendering care. Personal issues must be resolved that include confronting homophobia and race consciousness. Failure to do so will result in the existence of barriers to pastoral care.

This project has resulted in the development of a manual for pastoral care to the African American AIDS patient. It is intended that use of the manual alone will increase awareness and competency of the caregiver in responding to the Black AIDS patient. An overview of the problem, an analysis of existing pastoral care designs and an investigation of the relevant issues involved in HIV infection and Black life are the topics of discussion in this manual.

A proposed model for training, based on the information presented in the manual, is suggested for equipping caregivers in this ministry. It is intended that this training would be a part of a larger comprehensive training program of any one of the pastoral-care training organizations. Specialized training for care to African American AIDS patients is a needed yet missing element in current training programs. This project along with my experience in rendering care to Black AIDS patients will allow me to offer myself as a consultant and seminar facilitator for the existing AIDS pastoral-care training organizations.
Recommendations

1. The second decade of the AIDS epidemic should be marked by an increased concentration on identifying and targeting the issues relevant to specific cultural groups that impact on the coping skills of the infected. The behavior patterns, which are often strategies for survival in a particular social context, must be considered when attempting to render care to culturally specific groups.

2. As the numbers of infected African Americans continue to increase, African American leaders in the community, health care, and the church must come to the forefront to lead the work of educating and providing care in regard to HIV/AIDS. The presence of members of the same group presenting the prevention message and administering care allows for greater acceptance of help and education. African Americans working for African Americans will help to eliminate the barrier of skepticism often demonstrated by the African American community when others take an unsolicited interest in their well-being.

3. This training manual can serve as written resource material to aid and assist those who are already involved in this ministry. The scarcity of material in this particular area can become a frustration for those seeking to respond to the urgent needs of the Black AIDS patient.

4. Organizations that are currently involved in the
training of pastoral caregivers could offer specialized training for providing care for specific cultural groups. This specialized training can be a part of the general training program.

5. This manual and model for training should be tested and evaluated, with adjustments made to improve on what has been presented in this project. Effective training in the area of cultural specific groups can only reach the quality level of the general training in AIDS with time, testing, evaluation, and redesign. This project is an attempt to contribute to the resource pool for rendering pastoral nurture and care to a cultural specific group--the African American.

Reflections

I consider the issues discussed in this project to be basic to approaching this ministry. I was better equipped and able to serve after having a grasp of the basics. Learning the basics came through the training I received from the Michigan Department of Health, where I received certification as an HIV Counselor, the AIDS Interfaith Network, the AIDS Pastoral Care Network, and the American Red Cross. The fact of simply being informed about the disease and its stages did a tremendous amount of personal good in resolving my personal hysteria. As with all issues of life, nothing comes in a tight, orderly package. Several
issues can come to bear at once and the need for the appropriate response is urgent. A second chance is often not available.

Mark was a twenty-year-old Black man who was now in the final stages of his struggle with AIDS. His denial and anger was so strong that he deliberately tried to infect his mother by inflicting a wound by grabbing her lip and tearing the flesh, while his hands were covered with his own feces and blood. To protect the other family members from the possibility of infection, she cared for him exclusively. I was at Mark’s bedside when he drew his last breath. The funeral and subsequent intervention with his surviving family members, including a mother who must consider being tested for exposure to the virus, left me emotionally, physically, and spiritually exhausted. The drain upon my personal resources was great and caused me to reconsider the path I had chosen. What I am convinced of is the need for this ministry and that there is an undeniable sense of gratification for those truly committed to this service.

I have experienced professionally some of the ostracism from those who are skeptical and filled with hysteria as I was. What has helped to stabilize me in the midst of being misunderstood is my clarity of purpose, which all who enter in this service must have. I see an imperative for
the church to deliberately reach out to this sector of our society, for until death has made its claim there is still a soul to be delivered and a relationship with the Savior that is possible. To deny this in any area of human suffering is to call into question the purpose and the nature of the church body--thereby casting a shadow upon the Head of that body, which is Christ.

The subsequent challenge before us is to develop adequate and relevant training for our professional clergy to recognize the impact of this disease upon the person and his or her family and significant other, which includes the individual's relationship to the church. AIDS awareness education is necessary for pastors, that they might be informed and able to lead their congregations in a compassionate response to these patients. A direct ministry to the AIDS sufferer is not for all pastors. An awareness of the issues and the needs surrounding this disease will allow the pastor to make referrals when necessary.

The next challenge would be to enable local churches to become informed and organized with qualified and gifted individuals to develop ministries of outreach, support, quality of life, and loss counseling with the AIDS patient in mind. This will allow for an atmosphere of acceptance and support in the church for the AIDS victim. This must be done until God "makes all things new."
APPENDIX A

AIDS INTERFAITH NETWORK (AIN)
Please check all that are applicable about your background with AIDS:

☐ Have a basic knowledge of AIDS information ("AIDS 101")
☐ Have little or no knowledge of AIDS (need "AIDS 101")
☐ Know a person(s) with AIDS
☐ Don't know any person(s) with AIDS
☐ Have worked with a person with AIDS
☐ Have worked with the family/friend(s) of a person with AIDS
☐ Other ________________________________

_________________________  __________________________
SIGNATURE                  DATE

TRAINING PROGRAM

Sandra -

"Comprehensive, very well presented and quite helpful. I look forward to learning more about AIDS and its impact on the community."

Mary -

"Thank you for bringing us together to help our people. We need this so much!"

James -

"Wonderful information. I learned so much. I feel proud to be a part of this wonderful organization."

Winnery -

"Helpful and informative material presented in a friendly, supportive manner. I look forward to learning even more."

What Our Volunteers Have Said About Their Training:

AIDS INTERFAITH NETWORK of Michigan

AN INTERFAITH GROUP...
• MAKING SPIRITUALITY A RESOURCE IN TIME OF CRISIS
• PROVIDING A BRIDGE OF UNDERSTANDING

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AIN is...
...a network of professional men and women of different faith traditions, including clergy, trained to offer spiritual care to people touched in any way by Human Immunodeficiency Virus (HIV/AIDS).

A IN TRAINING is...
...a program of six (6) required sessions, one full-day session and five evening sessions, covering the medical, psychosocial and spiritual aspects of HIV/AIDS in detail. Individuals within the various stages of the HIV/AIDS syndrome, family members and caregivers will share their stories and discuss their spiritual/pastoral needs. Many aspects of pastoral issues regarding HIV/AIDS will then be considered.

A IN TRAINING is...
...only for clergy and laity from different faith traditions willing and able to be available to offer non-judgemental, compassionate spiritual care to individuals within the HIV/AIDS syndrome, their families and friends.

A IN TRAINING is NOT...
...a general AIDS education program for everyone. AIDS education programs are now offered to the general public by many types of civic and religious groups. Unless you are willing to serve as an AIN pastoral volunteer, we ask you not to register for this training. Attendance at the AIN Training alone does not constitute being an AIN member/pastoral volunteer.

AIN Training Schedule

**Session 1**
Date: April 8, 1991 (Full-Day Session)
Time: 8:30 a.m. - 4:30 p.m.

**Sessions 2, 3, 4, 5 and 6**
Dates: April 15, 22, 29, & May 6, 13, 1991
Time: 6:30 - 9:30 p.m.

The Training Sessions will be held at:
Unitarian Universalist Church
4605 Cass
Detroit, MI 48201, (313) 833-9107

**Fee:**
$35.00 - This includes training materials, lunch for Session 1 and light refreshments for sessions 2 - 6. Limited scholarships are available upon request.

Other information:
- A selection of books will be available for sale at Session 1.
- Pre-registration for the AIN Training is required.
- There will be no registration at the door on the day of Session 1.

AIN Training Registration Form

Return this registration form and a check or money order for $35.00 made payable to AIDS Interfaith Network, postmarked no later than Wed., April 3, 1991 to: AIDS Interfaith Network, P.O. Box 24561, Detroit, MI 48224-0561.

☐ I am attending the AIN Training.
☐ I cannot attend this AIN Training, but I am interested in future AIN Trainings. Please keep me on the mailing list.
☐ I cannot attend the AIN Training, but would like to pay for a scholarship for someone.

NAME
ADDRESS
CITY
STATE
ZIP
PHONE: DAY
EVENING
PROFESSION
CHURCH
DENOMINATION

All registration information is held in strict confidence. Please complete other side.

AIDS Interfaith Network • P.O. Box 24561 • Detroit, Michigan 48224-0561 • (313) 863-5700

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BACKGROUND

Few people or organizations in Michigan, particularly from the religious sector, have responded to the needs of HIV infected individuals despite a dramatic increase in the number of AIDS cases in the state. Religious bodies, at neither the congregational nor judicatory level were addressing the spiritual needs of people with HIV, their families, friends and loved ones. The AIDS Interfaith Network was founded in December, 1986 to meet the need for compassionate and non-judgemental spiritual care.

MISSION STATEMENT

AIDS Interfaith Network is an organization of volunteers from many different religious traditions, whose mission is to offer compassionate, non-judgemental spiritual support and care to anyone touched by HIV disease.

May, 1991

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BRIEF BIOGRAPHY

Marilyn Bergt, C.D.P.

Sister Marilyn has a MS in Biology from St. Mary's College in Winona, Minnesota. She taught High School and College biology for a total of 13 years; was a college administrator for four years and was Director of Catholic Campus Ministry at Wayne State University for 6 years. From 1983 through 1989 she served on the Board of Directors of Wellness Networks, Inc., developing their volunteer training, their AIDS hotline and serving as president of the Board for two years. Marilyn has worked closely with people with AIDS, counseled them and their families and spoken extensively on spiritual, ethical and psychosocial issues regarding AIDS. In December, 1986 Sister Marilyn co-founded the AIDS Interfaith Network (AIN) with Rabbi Marc Blumenthal and since June, 1989 has served as its full-time Executive Director. AIN is an organization available for the spiritual support and care of people with HIV disease, their families, friends and loved ones.

A member of the Sisters of Divine Providence since 1960 Sister Marilyn is active in on-going formation programs within her own community and is coordinator of the Sisters of Divine Providence CoMembership program in Detroit.
AIDS INTERFAITH NETWORK TRAINING
Sept. 28, 1993 - Nov. 16, 1993

SESSION I: AIDS Interfaith Network Orientation
Tuesday, September 28, 1993, 6:30 - 8:30 PM
AIDS Interfaith Offices
16260 Dexter, (Corner of Dexter and Florence)
Detroit, MI 863-5700

SESSION II: Various Aspects of AIDS
Tuesday, Oct. 5, 1993; 6:30 - 9:30 PM
Westminster Presbyterian Church
17567 Hubbell, Detroit, MI
(Corner of Outer Drive & Hubbell across from Sinai Hosp)

Medical and Preventative Aspects of AIDS
** Jan White, R.N., Visiting Nurse, HFH; Red Cross Trainer
   AIN Volunteer

Psychosocial Issues of AIDS
** Winnie Kerwin, Residential Nurse, Wellness House
   AIN Volunteer

Living with HIV Our Journey
** TBA

SESSION III: Homosexuality as an Issue in Ministering to the Person
HIV
Tuesday, Oct. 12, 1993; 6:30 - 9:30 PM
- The personal spiritual journey of the gay/lesbian person
- AIDS as a life issue to the gay/lesbian person
- Gay Spirituality

** Joseph Lempicki, M.A., Counselor

** Rev. Rene McCoy, Detroit Health Department AIDS Project;
   H.O.P.E.S. Inc.; Pastor, Full Truth Fellowship Church

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SESSION IV: Substance Abuse as an Issue in Ministering to the Person with HIV
Tuesday, Oct. 19, 1993

- General substance abuse information
- Pastoral needs of the IV drug user
- The 12 Steps as it applies to spirituality

** Joseph Monachino, O.F.M. Counselor
AIN Volunteer

SESSION V: Bereavement Issues: Coping with Grief and Loss
Tuesday, Oct. 26, 1993

** Bev Harris, Ph.D., Grief Counselor
AIN Volunteer

SESSION VI: Ministering to the Family Living with HIV
Tuesday, Nov. 2, 1993

** Tory Horton, M.S.W., Social Worker

** Mildred Harvin, R.N., Children’s Hospital
AIN Volunteer

SESSION VII: Pastoral Issues in Ministering to the Person with HIV
Tuesday, Nov. 9, 1993

- Giving care out of religious conviction; the art of listening
- Defining terms: spirituality and “Pastoral”
- Getting started with the client
- Spiritual issues of the client and the volunteer

** Sister Sheila Flynn, AIN Volunteer Coordinator

SESSION VIII: The AIN Volunteer - Commissioning Ceremony
Tuesday, Nov. 16, 1993

- AIN Volunteers share their experiences
- What AIN expects of its volunteers
- Commissioning Ceremony

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We are frequently asked, *Just what does AIN do?* It would be easy for me to give the finely tuned, frequently repeated answer that the *boss* is supposed to give. However, you would get a clearer picture by asking some of our pastoral, respite and auxiliary volunteers. In fact, it would probably be wise not to ask them this question unless you are prepared to listen for a minimum of fifteen minutes!

We did ask a few of our volunteers: *What do you do as an AIN volunteer? Why? What does it mean to you? Would you write this in a paragraph or two?* I almost got shot on the last question!!! As I reread what our volunteers said about their AIN ministry, I was very inspired and grateful for the gift they are to us and to those of you with whom they journey. It also once again refocused for me how dependent we, and you, are on their committed service.

Even though several case managers, hospitals and individuals refer individuals with HIV or AIDS to us; even though we regularly collaborate with at least nine other AIDS agencies in the city; even though we speak to a couple thousand people in churches each year, *we could not function* without our volunteers. We would be a staff of three trying to coordinate a system of service that might look good on paper, but would be an empty shell without committed volunteers offering the loving service of their skills to help people with AIDS and their loved ones in some way.

Without our volunteers, there would be fewer congregations responding pastorally to the AIDS pandemic because many fewer Pastoral Volunteers would be out there encouraging a compassionate response to individuals with HIV/AIDS and families affected by AIDS; there would be far fewer speaking engagements to groups interested in the pastoral and spiritual issues of AIDS; there would be no MAINLINE as you see it now; there would be almost no fundraising events to keep us afloat financially; there would be no ... you get the picture!

If AIN does a good job, it's because our volunteers do a good job as ministers of love, compassion, healing and supporting the mission of AIN. People helping people is what we are about. I invite you to experience AIN ministry through the eyes of those working in the trenches. I invite you to volunteer in whatever way you can. Come and see *What good things the Lord has done!*

*Marilyn Bergt, C.D.P.*

*Executive Director*

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**VOLUNTEER COORDINATOR**

The ministry of coordinating and training volunteers at AIN is a multifaceted job. Who are our volunteers? Where do they come from? What will they be doing? How much time does it take?

AIN volunteers are women and men from differing Christian and non-Christian traditions who represent many walks of life such as clergy, nurses, nuns, pastoral ministers, moms and dads, and chaplains to name a few. They are wonderful persons motivated by their faith to share in the spiritual journey of a person living with HIV/AIDS.

Every volunteer must participate in a thirty hour training program in which basic information is presented by professionals who bring an awareness of the issues to the prospective volunteer. At the end of the training, volunteers may make a statement of commitment continued ... page 3
You may be wondering why this issue of MAINLINE is different from past issues. AIN volunteers are frequently asked, What do you do as an AIN volunteer? or What can I do to help persons living with HIV/AIDS? We decided to highlight some of the services our volunteers directly or indirectly provide our clients, and, in keeping with our aim of personalizing the HIV/AIDS issue, we've asked some of our volunteers to share their experiences with us. Hence, the slightly different format of this issue. We hope you find it interesting and that it inspires you to do what you can to help those who are living with HIV/AIDS.

AIN looks forward to the day when our services will no longer be needed, but until there's a cure for AIDS, we hope to be there to minister to those affected in any way by the virus. To do so, we need the assistance of concerned and compassionate people, people like you! As Sister Marilyn wrote, ... we could not function without volunteers.

We need persons of faith who are willing to be trained as pastoral volunteers or as respite care volunteers for one-to-one service. Not everyone is able to or comfortable with working as a pastoral or respite care volunteer. We encourage such persons to consider becoming auxiliary volunteers.

In the next few pages, we hope to give you a little insight into the various opportunities that are open to those who want to share their time and their gifts as AIN volunteers.

In addition, we encourage people to come up with creative ideas. As an example, a good friend of mine, Eleanor Widlak, told me that her prayer group was looking for a Christian service project they could get involved with. Eleanor knew of my involvement with the AIDS community and invited me to come speak to the group about what they could do to help. I spoke to them of the various foodstuffs and personal items that some with HIV/AIDS need. The group decided to approach their pastor at St. Rene Goupil Catholic Church with the idea of asking parishioners to bring one specified item on the first Sunday of each month. They, also, thought it would be good to educate people about HIV/AIDS with various articles they would write each week and print in the parish bulletin. The pastor gave his approval and the group launched AIDS Awareness Days. The first month, they asked parishioners to bring a can of tuna; the second month, a toothbrush, toothpaste, or deodorant; the third month, diapers for babies with AIDS; and this month, hearty canned soups or stews. The response of the parishioners has been very good and I know the agencies that have received the donated items are very appreciative (I know because I'm the delivery boy).

If you or your congregation would be interested in establishing a similar program in your congregation or if you would like more information, please call the AIN office or give me a call at 237-5865 during normal business hours. Some people don't have the time or they don't feel qualified to volunteer, but they still want to contribute to the AIDS effort in some way. We suggest they consider becoming financial angels. It takes money to run AIN: for the training programs that prepare our volunteers; for educational talks to organizations and groups; for office rental, salaries, supplies, etc.; and to print and mail MAINLINE. As I've said over and over again, AIN fills a need that other AIDS organizations are not equipped to meet. To insure that AIN will continue to be able to meet this need, donations are very much needed, appreciated, and tax deductible!

If you can't be a volunteer and you can't afford to be a financial angel, you can still participate in the work of AIN by contributing your prayers. As people of faith, we believe in the power of prayer. Pray that those who are living with HIV/AIDS might receive the strength and the courage they need to live fulfilling lives. Pray for our volunteers who share their faith and their love. And pray for a cure!

Rev. Robert Hayes Williams
Editor

PASTORAL CARE VOLUNTEERS

Like everyone else, persons living with HIV/AIDS have their own wants and needs, hopes and dreams. Each individual has his or her own unique spiritual relationship, so the client sets the agenda. Pastoral care volunteers are trained to offer non-judgemental, compassionate pastoral care that is respectful of the background and faith tradition of the individual. In time of crisis; when serious illness strikes; when fear, pain and loneliness strike;

when one questions God's presence in one's life; when one needs love and support, AIN pastoral volunteers offer understanding and hope.

One of our pastoral volunteers, Michael Lofton, shares the following as to why he works with AIN:

Everyone has a purpose in life. Before I came in contact with being an AIDS Interfaith Network and hospice volunteer, it seemed like I was lost and searching for a purpose in life. The most beautiful and rewarding thing was when the Lord directed me to be of help to others who no longer have their health and strength. My prayer each and everyday is, Lord, as long as you grant me my health and strength each day, let me be of help to someone who no longer has theirs.
VOLUNTEER COORDINATOR
... from page 1

to one or more levels of service. They may serve with a client through respite care or as an auxiliary volunteer. Thus, the volunteers are ready for the ministry of compassion and the service of responsibility.

Where do the clients we serve come from? There are three referral sources: AIDS Consortium, AIDS Care Connection, and self-referral. With the permission of the client, case managers review the necessary information about the person. After reviewing the information available, I, the AIN Volunteer Coordinator, assess the client’s needs, geographic location, and religious tradition, and decide which volunteer is best suited in this situation. Dialogue follows with the volunteer, who then makes the decision to receive the client and then makes the contact.

How much time do our volunteers invest? Time is a variable because the client will set the type of contact he or she is open to. A level of trust must be built. The discussion is between the client and the volunteer as to the type of communication and contact.

A volunteer is responsible for monthly reports to the Volunteer Coordinator. If additional assistance is needed, volunteers are expected to contact the Coordinator; a volunteer is never out there alone.

The most difficult part of this ministry is the grief of the client. Our volunteers need time to grieve their loss, too. Therefore, a space of time must elapse for this healing to take place. As a norm, the volunteer will let me know when he or she is ready for active involvement again. There will be monthly support group meetings for volunteers from September to June of each year to help during rough times. I believe we can help one another. To date, the AIN staff has trained 199 volunteers in the Detroit area who are placed or willing to be placed with a client. We presently serve 72 clients.

There are frequently many side roads that a Coordinator travels down. Lots of networking with other organizations and everyone from the St. Vincent de Paul Society to a food pantry in the suburbs to prison chaplains to criminal lawyers. Are there surprises? Indeed, there are many and varied surprises. What I like best are the beautiful, compassionate, caring people that come into my life, the growth in understanding of other religious traditions, and being able to say to volunteers, "God love you for what you do to make a difference in peoples’ lives in the HIV/AIDS community!"

Sheila Flynn, O.P.

RESPITE CARE VOLUNTEERS

Respite care volunteers offer assistance to primary care-givers of persons with AIDS. It’s easy to forget that the suffering and fear of the seriously ill person with AIDS is often shared by his or her primary care giver. Care-givers often need help, too! Respite care volunteers assist by staying with the seriously ill person in order to give the care giver a break or by bringing in a meal every so often or by sitting and talking with the care-giver. Bill and Ethel Dixon have been part of a few different respite teams. They explain what their ministry means to them:

As volunteers giving spiritual support and being part of two respite care teams, we have truly experienced the blessings of receiving more than we can give. We have witnessed so much love and compassion of caregivers, family, friends, and people with HIV/AIDS.

Our faith grows as we witness their faith and love. We also witness so much pain and sorrow. Sometimes we are asked, “Why? How can you do it?” Our answer is, “How can we not? There is so much need!”

AUXILIARY VOLUNTEERS

It takes a great deal of support to insure that any organization runs smoothly. In the office phones have to be answered, the various 9 to 5 clerical tasks taken care of; someone has to input and update the computer files, and mailings have to be prepared. Fund raising efforts, such as the Put Your Heart Into AIN Dinner Dance and the weekly Bingo, need persons who will commit themselves to making sure they are successful and fun. Our auxiliary volunteers share their specific skills and ideas in these areas and more:

COMPUTER

Ira Brandon shares his expertise with AIN as a volunteer computer consultant. He tells us what he does and why:

I am the director of PC services at a mid-sized North American corporation so I have knowledge of computers. I advise the AIN staff on computer equipment and software to meet their growing needs and I help to set it up. I also run interference when we have a computer emergency.

I offered my services to AIN because I like helping others and I enjoy working with the AIN gang. What little help I contribute seems so unimportant... nevertheless... Thy will be done.
BINGO

Brenda Majeski has been volunteering her secretarial services in the AIN office since March. She explains why she recently agreed to serve as the chairperson of AIN's weekly Bingo:

You might be wondering why someone would want to volunteer their time and services. Well, I'll tell you why I have made a personal commitment to this organization. It was a little more than a year ago when I first heard of AIN. I found out that a gentleman I had recently met at church had the AIDS virus. I was told of AIN's mission statement and how the volunteers were there for him on his journey toward God. Being from a very large family, the gay and lesbian lifestyle has touched me. I feel AIN is a very positive organization that helps the gay and lesbian community know they do have a place in God's heart! AIN's mission is to offer compassionate, non-judgmental spiritual support and care to anyone touched by HIV and this is why I choose to volunteer my services and help in any way I can further AIN's mission.

At this time, I would like to make a plea for volunteers for AIN's bingo. The Bingo is AIN's largest, most consistent fundraiser. That is why it is so important for all of us who believe in AIN's mission to give a little of our time. For the bingo to run smoothly and efficiently, we need twelve to fourteen volunteers every Saturday. If you can help on one, two, three, or four Saturdays a month (depending on your schedule), please contact me at 863-5700 or 465-0707. AIN needs you and we all need AIN!

OFFICE VOLUNTEER

Jean Corby-Corbin has a very special reason for assisting in the AIN office in various capacities. She writes:

For the past two years, I have been an auxiliary volunteer in the AIN office. I answer the phones, send out information packets to interested clients, input and update computer data for our growing mailing list, assist with the usual office details, and help with various meetings and projects. I've had many rewarding opportunities to speak with new clients and family members and other volunteers and to share our common goal of helping people with HIV/AIDS and their families.

The work has been a real education for me. I've had the opportunity to watch Sister Marilyn and Sister Sheila reach out to so many disheartened, scared, and needy clients and families not only with God's love but, also, with a hands-on approach to help in bringing comfort and spiritual guidance so needed by most of these persons. The sisters train the ongoing classes of volunteers, they tell the AIN story at churches, schools, hospitals, and to various groups so the much needed understanding, compassion and love for our clients is made known through their work.

Almost three years ago, my beloved son, Bill, died from AIDS and AIN was there for me and my family. Being an AIN volunteer is my opportunity to say thanks to AIN and to promise that we will never forget Bill and so many of his friends!

REV. JOHN BARTICO

Minister at Ecorse Presbyterian Church and an AIN volunteer, died 14 June 1993 after a brief illness.

We extend our condolences to his family and friends.

HIV/AIDS CONFERENCE FOR ADOLESCENTS

The Macomb County Health Department is co-sponsoring an HIV/AIDS conference for adolescents (9th - 12th grades) in the tri-county area. There will be two tiers and three tracks. The first tier will be held on October 2nd and October 4th at the Center Campus of Macomb Community College. Track one, the parent track, will be held on October 2nd. The presenters are from Cornell University's College of Human Ecology. They have developed a curriculum for teaching parents to talk to their children about HIV/AIDS. This track will be a training of trainers so parents who attend will be equipped to go back to their school/community and train others. On October 4th, tracks two and three will take place simultaneously, in the same location. Track two is directed at staff and will equip them with the information and skills to form a peer listening group in their school, whose focus is HIV/AIDS education. The Cornell team will again be the presenters. Track three is directed at the students themselves and will review basic HIV/AIDS information and provide practice in decision making and problem solving to allow students to: 1) avoid situations that might put them at risk; 2) escape from those situations they have been unable to avoid; and 3) modify their behavior where they have chosen to neither avoid nor escape. The second tier of the conference will be held in early December and will provide the staff and students with a cookbook on forming the peer listening groups and generating enthusiasm for the task. No dates are set at this time, but the location will be the same.

For more information, contact Marilyn Keeslar at 749-5173 or Beverly Sandoval at 469-5492.
Janet Chabon  Pastoral and Office Volunteer

John Truitt, Mildred Curry, Frank Ross, Sr. Marilyn, Fr. Bob
Part of the AIN Dinner Dance Committee

Michael Lofton  Pastoral Volunteer

Beverly McFadyen  Dinner Dance Chairperson

Computer Volunteer  Ira Brandon
Office Volunteer

AIN Secretary
Bingo Chairperson

Jean "Mom Corby" Corbin

Brenda Majeski

Volunteers
the "Heart" of AIN

Bingo Volunteer

Ann Rogers

Page 5
**BINGO**

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---

**IN MEMORIAM**

**REV. JOHN BARTICO**

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---

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ANNOUNCEMENTS

AIDS PASTORAL VOLUNTEER TRAINING

Next Training Session
September 28 through November 16 6:30 p.m. - 9:30 p.m. (Tuesdays)
(For more information call Sister Sheila at 863-5700.)

INTERDENOMINATIONAL AIDS HEALING SERVICE

Saturday, September 18 - 5:00 p.m. - Fort Street Presbyterian Church
(For more information call Jim Beates at 335-7961.)

STEPPIN' OUT '93

3rd Annual Royal Oak Walk for AIDS
Sunday, September 19

3RD ANNUAL, PUT YOUR HEART INTO AIN DINNER DANCE

Saturday, February 12, 1994

---

PLEASE FILL OUT THIS FORM FOR THE FOLLOWING:

Please contact me about:

... up-coming Pastoral Volunteer Training Sessions ___
... becoming a Respite Care Volunteer ___
... becoming an Auxiliary Volunteer ___

Please accept my donation of___________ to continue the work of AIN or as a donation in the name of a friend or a loved one or to celebrate a birthday, wedding, good fortune, etc.

Please put me on the MAINLINE mailing list ___

and mail to:

AIDS INTERFAITH NETWORK, 16260 Dexter, Detroit, MI 48221

Name_____________________________________ Phone__________________

Address____________________________________

City________________________ State__________ Zip______________
This newsletter is published by:
AIDS Interfaith Network
16260 Dexter
Detroit, MI 48221

Mission Statement
AIDS Interfaith Network is an organization of volunteers from many different religious traditions, whose mission is to offer compassionate, non-judgmental spiritual support and care to anyone touched by HIV disease.

MAINLINE
Through the newsletter, AIN aims to offer a clearer understanding of what it means to reach out in compassion and love to our neighbor, when that neighbor is touched by HIV/AIDS. Through personal stories, book reviews, statistical updates and a calendar of upcoming events, we hope to spread the WORD. If you would like more information on the services provided by AIN, please call 313-863-5700. If you would like to submit an article or news item for this newsletter please write to the above address.

Rev. Joseph Harmon
President
Marilyn Bergt, C.D.P
Executive Director
Rev. Robert Hayes Williams
Editor
Sheila Flynn, O. P.
Volunteer Coordinator

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APPENDIX B

AIDS PASTORAL CARE NETWORK (APCN)
Date: June 19, 1992
To: APCN Pastoral Volunteers
From: Ernest Vasseur
Director of Education and Volunteer Services
Re: APCN Training Workshop

You are invited to participate in the Pastoral Training Workshop for APCN volunteers. Participation in the workshop is not limited to APCN volunteers. Other professionals who wish to prepare for work with those affected by HIV/AIDS are welcome. Workshop registration is limited to twenty (20) persons by prior registration only.

DATE: Saturday, June 27, 1992
TIME: 8:45am - 3:45pm
PLACE: St. Joseph Hospital Manor Building - First Floor Classroom
        2913 North Commonwealth
        Chicago

The resource team for the day includes:
- Don Wink, a Lutheran Pastor from Arlington Heights,
- Judith Kelsey-Powell, APCN Board Chair and a United Methodist Pastor,
- Carol Reese, APCN’s Executive Director,
- a person with AIDS,
- and myself.

----------------------------------------
REGISTRATION
APCN PASTORAL TRAINING WORKSHOP
Saturday, June 27, 1992

NAME: ___________________________________________

ADDRESS: ___________________________________________

CITY, STATE: ___________________________ ZIP+4: ________

DAY PHONE: ___________ EVE PHONE: ___________

(over, please-)

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There will be an opportunity for questions that may arise from your reading the medical booklet you have received. No additional medical information will be covered.

A $25.00 registration fee covers the expense of lunch, coffee breaks and all printed materials. Please complete the lower portion of this letter and return it with your registration fee by June 25. I hope to see you on June 27!

If I am unable to attend at the last minute,
[ ] Please refund my registration fee
[ ] Please contribute my registration fee to APCN

(Signed)
SCREENING SEMINAR AGENDA

Wednesday, June 17, 1992
7:00 - 9:30 p.m.

Judith Kelsey-Powell  Carol Reese  Ernest Vasseur
(Facilitators)

1. Overview of Screening Seminar - Ernest

2. Volunteer Expectations - Ernest

3. History of APCN - Judith

4. Small Groups - Carol
   A. Introductions
   B. Sharing of Faith Journeys

5. Questions and Wrap-up

6. Closing Prayer
SCREENING SEMINAR AGENDA

Saturday, June 20, 1992

8:45 a.m. - 1:15 p.m.

Jean Lubekis  Carol Reese  Roger Sullivan
Ernest Vasseur

(Facilitators)

8:45 a.m. Coffee, juice, and rolls

9:00 Addiction, Substance Abuse and HIV/AIDS - Jean

10:00 "HIV/AIDS - 101" - Roger

Break

11:00 Exploring Myths About Homosexuality and Drugs - Ernest

Noon Break

12:15 p.m. Reflection and dialogue: (Where is God in this?)

Theological article: AIDS: What does God have to do with it?
Case Study: Scott

1:15 Adjournment
MISSION STATEMENT OF THE AIDS PASTORAL CARE NETWORK (APCN)

The AIDS Pastoral Care Network, an interfaith organization founded in 1985, ministers from an interfaith and intercultural perspective to any person affected by the HIV/AIDS epidemic.

Our ministry includes not only people actually infected with HIV, their families of origin or election, partners, caregivers and friends, but also the interfaith community at large within the greater Chicago area.

Our ministry to such persons includes a wide range of pastoral support services and the development of educational programs and of spiritual/liturgical resources.

Our ministry stems from our commitment to educate people about the pastoral, spiritual and religious dimensions of AIDS and to provide direct pastoral services to them as needed.

Our commitment to ministry continues to encompass the gay and lesbian community as well as the faith communities because we believe such a commitment is the only way to provide effective pastoral care, and because we are fully cognizant of the deep divisions and tensions which often exist between members of the gay and lesbian community and many faith communities.

Furthermore, as the epidemic encompasses more persons of color, drug users, women and children, we commit ourselves to be, wherever possible, a pastoral bridge between them and their faith communities.

Although much of the suffering connected with HIV/AIDS is unavoidable, nevertheless, we affirm the presence of hope and meaning in such a situation by seeking to empower persons we serve pastorally to locate hope and meaning in places appropriate to their spirituality.

We reaffirm our commitment to work for social justice because we are aware that fear, prejudice, discrimination, poverty, marginalization and alienation continue to increase in unconscionable ways the already heavy burden of suffering of people affected by HIV/AIDS. Since 1985 we have done this mainly through our pastoral and educational services.
In the future we will seek additional ways because we believe that authentic pastoral care proceeds from a wholeness that addresses political and religious issues, avoidable and unavoidable suffering, social justice and pastoral care.

Finally, since 1985 we have established connections to and influence with religious leaders and institutions on the local, regional and national levels that require us to play an assertive role in opposing actions of these leaders or institutions which adversely affect those with whom and for whom we minister.

Revised and adopted by the Board of Directors: March 6, 1990
The AIDS Pastoral Care Network, founded in 1985, ministers from an interfaith and intercultural perspective to persons affected directly or indirectly by the HIV/AIDS epidemic in an open and non-judgmental way, respecting each person's background and faith tradition.

APCN's ministry includes a wide range of pastoral support services and the development of educational programs and of spiritual/liturgical resources.

DIRECT PASTORAL SERVICES

- Workshops to screen and train volunteers
- One-on-one pastoral assistance
- Crisis counseling
- Support groups for parents, partners, friends
- Bereavement support groups
- Bereavement workshops

EDUCATIONAL PROGRAMS

- Workshops/seminars for clergy and lay professionals
- Workshops on pastoral issues and AIDS
- Consultation on policy issues and AIDS
- Consultation on legislative issues
- Monthly newsletter

LITURGICAL RESOURCES

- Public, interfaith services
- Interfaith consultation
- Liturgical gatherings

For more information: 2913 North Commonwealth Avenue
Chicago, IL 60657
312/975-8057

Ms. Carol Reese, M.Div.
Executive Director

Mr. Ernest Vasseur
Director of Education and
Volunteer Services

Mr. Juan Alegria, M.Div.
Director of Outreach to
Communities of Color

Mr. Kurt J. Swanson
Administrative Assistant

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El Equipo de Cuidado Pastoral Contra el SIDA, un organismo que fue fundado en 1985, ministra a personas afectadas directa o indirectamente por el Virus de Inmunodeficiencia Humana, en una forma abierta y sin hacer juicios, respetando el trasfondo y la tradición de fe de cada quien.

Voluntarios pastorales entrenados hacen de la espiritualidad un recurso que en medio de la epidemia provee un puente de entendimiento entre personas, comunidades de fe y todos los que aman a Dios. Para alcanzar estas metas los trabajadores y voluntarios proveen servicios pastorales directos, programas educacionales, y celebraciones litúrgicas.

SERVICIOS PASTORALES DIRECTOS

- Sesiones de entrenamiento para voluntarios
- Asistencia pastoral de uno-a-uno
- Consejería en tiempos de crisis
- Grupos de respaldo para padres, amigas/os, campaneras/os
- Grupos de respaldo para los que han perdido a un ser amado
- Sesiones para "condolientes"

PROGRAMAS EDUCACIONALES

- Conferencias/seminarios para cléricos y laicos
- Conferencias sobre asuntos pastorales y el SIDA
- Consultas sobre asuntos de política y el SIDA
- Consultas sobre asuntos legislativos
- Boletín informativo mensual

CELEBRACIONES LITURGICAS

- Servicios públicos semi-anuales sobre el SIDA desde varias tradiciones de fe
- Consultas denominacionales con otras tradiciones de fe
- Reuniones litúrgicas mensuales

Para más información: 2913 North Commonwealth Avenue
Chicago, IL 60657
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Expectations of Volunteers

A. Client Contact:
   1. Volunteer needs to be available at least two hours per week.
   2. Volunteer is expected to take initiative in establishing and maintaining the relationship. Think of it as building a friendship.
   3. Be dependable so that the person can count on you. It is often desirable to establish a regular time for contact.
   4. Be sensitive to the needs and desires of the person. It is alright to ask what the person wants/needs.
   5. People sometimes feel ambivalent and retreat from relationship. Phone calls and cards are nice ways to say you care.

B. Regular Reporting:
   1. Activity Forms are for recording phone calls, visits and attendance at support group.
   3. Supply address of family and/or partner to APCN at time of death.
   4. Provide bereavement support information.

C. Participation in support/supervision:
   1. Attend monthly peer/supervision group, or
   2. Report to APCN office via phone call

D. Participate in basic training and continuing education events.

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Geographic distribution of AIDS cases reported in 1993, United States
(N=106,949)

Each point represents 10 cases. All points are displaced slightly to preclude identification of counties with small numbers of reported cases.

Acquired immunodeficiency syndrome (AIDS) is a specific group of diseases or conditions which are indicative of severe immunosuppression related to infection with the human immunodeficiency virus (HIV).

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control
and Prevention
National Center for Infectious Diseases
Division of HIV/AIDS
Atlanta, Georgia 30333
Table 3. AIDS cases by age group, exposure category, and sex, reported in 1992 and 1993; and cumulative totals, by age group and exposure category, through December 1993, United States

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Male who have sex with women</td>
<td>24,716 (61)</td>
<td>48,983 (58)</td>
<td>24,716 (53)</td>
<td>48,983 (47)</td>
<td>182,522 (54)</td>
<td>182,522 (54)</td>
<td>207,238 (25)</td>
<td></td>
</tr>
<tr>
<td>Injecting drug use</td>
<td>8,780 (33)</td>
<td>21,571 (24)</td>
<td>2,958 (47)</td>
<td>7,827 (47)</td>
<td>29,388 (28)</td>
<td>29,388 (28)</td>
<td>48,725 (23)</td>
<td></td>
</tr>
<tr>
<td>Male who have sex with men and inject drugs</td>
<td>2,469 (7)</td>
<td>6,096 (7)</td>
<td>2,469 (6)</td>
<td>6,096 (6)</td>
<td>23,381 (7)</td>
<td>23,381 (7)</td>
<td>25,841 (7)</td>
<td></td>
</tr>
<tr>
<td>Hemophiliac/coinfected disorder</td>
<td>319 (1)</td>
<td>1,069 (1)</td>
<td>332 (1)</td>
<td>1,086 (1)</td>
<td>3,122 (1)</td>
<td>3,122 (1)</td>
<td>3,454 (1)</td>
<td></td>
</tr>
<tr>
<td>Heterosexual contact</td>
<td>1,458 (4)</td>
<td>3,177 (4)</td>
<td>2,464 (39)</td>
<td>6,253 (27)</td>
<td>9,382 (4)</td>
<td>9,382 (4)</td>
<td>18,764 (7)</td>
<td></td>
</tr>
<tr>
<td>Sex with injecting drug user</td>
<td>702</td>
<td>1,232</td>
<td>1,428</td>
<td>2,862</td>
<td>2,120</td>
<td>4,085</td>
<td>6,205</td>
<td></td>
</tr>
<tr>
<td>Sex with bisexual male</td>
<td>—</td>
<td>—</td>
<td>174</td>
<td>522</td>
<td>174</td>
<td>522</td>
<td>348</td>
<td></td>
</tr>
<tr>
<td>Sex with person with hemophilia</td>
<td>2</td>
<td>12</td>
<td>24</td>
<td>71</td>
<td>28</td>
<td>83</td>
<td>111</td>
<td></td>
</tr>
<tr>
<td>Sex with transfusion recipient</td>
<td>—</td>
<td>—</td>
<td>18</td>
<td>111</td>
<td>66</td>
<td>187</td>
<td>253</td>
<td></td>
</tr>
<tr>
<td>Sex with HIV-infected person, risk not specified</td>
<td>739</td>
<td>1,997</td>
<td>798</td>
<td>2,716</td>
<td>1,524</td>
<td>4,713</td>
<td>6,237</td>
<td></td>
</tr>
<tr>
<td>Receipt of blood transfusion, blood components, or tissue 3</td>
<td>375 (1)</td>
<td>696 (1)</td>
<td>284 (5)</td>
<td>529 (3)</td>
<td>680 (1)</td>
<td>1,213 (1)</td>
<td>1,891 (2)</td>
<td></td>
</tr>
<tr>
<td>Other risk not reported or specified 4</td>
<td>1,978 (5)</td>
<td>6,481 (7)</td>
<td>586 (9)</td>
<td>2,168 (12)</td>
<td>2,564 (5)</td>
<td>8,046 (8)</td>
<td>19,185 (9)</td>
<td></td>
</tr>
<tr>
<td>Adult/adolescent total</td>
<td>40,498 (100)</td>
<td>98,165 (100)</td>
<td>42,935 (100)</td>
<td>16,824 (100)</td>
<td>48,791 (100)</td>
<td>105,990 (100)</td>
<td>155,936 (100)</td>
<td></td>
</tr>
</tbody>
</table>

Pediatric (+13 years old) exposure category

| Hemophiliac/coinfected disorder | 20 (5) | 21 (4) | — | 2 (0) | 20 (3) | 23 (2) | 209 (4) |
| Mother with risk for HIV infection | 353 (91) | 435 (91) | 360 (67) | 460 (88) | 733 (94) | 825 (92) | 4,137 (86) |
| Injecting drug use               | 118 | 140 | 144 | 162 | 282 | 322 | 2,054 |
| Sex with injecting drug user     | 56 | 81 | 60 | 67 | 116 | 144 | 805 |
| Sex with bisexual male           | 5 | 6 | 8 | 4 | 13 | 10 | 89 |
| Sex with person with hemophilia  | 4 | — | 3 | 2 | 7 | 2 | 22 |
| Sex with transfusion recipient   | 2 | 1 | 2 | 1 | 4 | 2 | 18 |
| Sex with HIV-infected person, risk not specified | 35 | 58 | 45 | 54 | 81 | 112 | 373 |
| Receipt of blood transfusion, blood components, or tissue | 19 | 14 | 7 | 11 | 26 | 25 | 116 |
| No HIV infection, risk not specified | 114 | 135 | 110 | 159 | 224 | 254 | 1,058 |
| Receipt of blood transfusion, blood components, or tissue | 12 (3) | 15 (3) | 5 (1) | 9 (2) | 18 (2) | 24 (3) | 329 (6) |
| Risk not reported or identified  | 4 (1) | 8 (2) | 6 (2) | 8 (2) | 10 (1) | 17 (2) | 53 (1) |
| Pediatric total                  | 390 (100) | 482 (100) | 391 (100) | 479 (100) | 781 (100) | 953 (100) | 5,226 (100) |
| Total                            | 40,888 | 89,645 | 8,684 | 17,303 | 47,772 | 106,949 | 361,164 |

1Includes 1 person whose sex is unknown.

2Includes 7 persons known to be infected with human immunodeficiency virus type 2 (HIV-2). See JAMA 1992;267:2775-3.

3Includes 2 children developed AIDS after receiving blood screened negative for HIV antibody. Six additional adults developed AIDS after receiving tissue, organs, or artificial insemination from HIV-infected donors. Three of the 6 received tissue or organs from a donor who was negative for HIV antibody at the time of donation. See N Engl J Med 1992;326:726-33.

4Other refers to 12 health-care workers who developed AIDS after occupational exposure to HIV-infected blood, as documented by evidence of seroconversion; 10 patients who developed AIDS after exposure to HIV within the health-care setting; 3 persons who acquired HIV infection perinatally and were diagnosed with AIDS after age 13; and 1 pion with intentional self-inoculation of blood from an HIV-infected person. "Risk not reported or identified" refers to persons under investigation, persons who died, were lost to follow-up, or who declined interview; and persons who do not report one of the exposures listed above after interview. See Figure 7.
Table 9. AIDS cases by sex, age at diagnosis, and race/ethnicity, reported through December 1993, United States

<table>
<thead>
<tr>
<th>Male</th>
<th>White, not Hispanic</th>
<th>Black, not Hispanic</th>
<th>Hispanic</th>
<th>Asian/Pacific Islander</th>
<th>American Indian/Alaska Native</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at diagnosis (years)</td>
<td>No. (%)</td>
<td>No. (%)</td>
<td>No. (%)</td>
<td>No. (%)</td>
<td>No. (%)</td>
<td>No. (%)</td>
</tr>
<tr>
<td>Under 5</td>
<td>348 (0)</td>
<td>1,247 (1)</td>
<td>527 (1)</td>
<td>9 (0)</td>
<td>8 (1)</td>
<td>2,142 (1)</td>
</tr>
<tr>
<td>5-12</td>
<td>247 (0)</td>
<td>191 (0)</td>
<td>158 (0)</td>
<td>7 (0)</td>
<td>1 (0)</td>
<td>605 (0)</td>
</tr>
<tr>
<td>13-19</td>
<td>510 (0)</td>
<td>330 (0)</td>
<td>308 (0)</td>
<td>11 (1)</td>
<td>11 (2)</td>
<td>1,070 (0)</td>
</tr>
<tr>
<td>20-24</td>
<td>5,098 (3)</td>
<td>3,982 (4)</td>
<td>2,142 (4)</td>
<td>79 (4)</td>
<td>31 (4)</td>
<td>10,947 (3)</td>
</tr>
<tr>
<td>25-29</td>
<td>24,294 (15)</td>
<td>12,901 (14)</td>
<td>8,437 (16)</td>
<td>280 (13)</td>
<td>142 (20)</td>
<td>48,530 (15)</td>
</tr>
<tr>
<td>30-34</td>
<td>39,828 (23)</td>
<td>20,371 (22)</td>
<td>12,933 (24)</td>
<td>461 (21)</td>
<td>192 (22)</td>
<td>73,349 (22)</td>
</tr>
<tr>
<td>35-39</td>
<td>37,545 (22)</td>
<td>20,782 (22)</td>
<td>11,285 (22)</td>
<td>482 (22)</td>
<td>135 (19)</td>
<td>70,439 (22)</td>
</tr>
<tr>
<td>40-44</td>
<td>27,949 (16)</td>
<td>14,313 (16)</td>
<td>7,549 (15)</td>
<td>381 (18)</td>
<td>98 (14)</td>
<td>49,378 (16)</td>
</tr>
<tr>
<td>45-49</td>
<td>15,948 (9)</td>
<td>7,402 (8)</td>
<td>4,097 (8)</td>
<td>222 (10)</td>
<td>35 (3)</td>
<td>27,743 (9)</td>
</tr>
<tr>
<td>50-54</td>
<td>8,541 (5)</td>
<td>4,065 (5)</td>
<td>2,164 (4)</td>
<td>110 (5)</td>
<td>22 (3)</td>
<td>14,928 (5)</td>
</tr>
<tr>
<td>55-59</td>
<td>4,867 (3)</td>
<td>2,301 (3)</td>
<td>1,242 (2)</td>
<td>67 (3)</td>
<td>10 (1)</td>
<td>8,534 (3)</td>
</tr>
<tr>
<td>60-64</td>
<td>2,985 (2)</td>
<td>1,227 (1)</td>
<td>649 (1)</td>
<td>24 (1)</td>
<td>10 (1)</td>
<td>4,791 (2)</td>
</tr>
<tr>
<td>65 or older</td>
<td>2,417 (1)</td>
<td>928 (1)</td>
<td>478 (1)</td>
<td>28 (2)</td>
<td>4 (1)</td>
<td>3,679 (1)</td>
</tr>
<tr>
<td>Male subtotal</td>
<td>169,675 (100)</td>
<td>89,630 (100)</td>
<td>51,627 (100)</td>
<td>2,151 (100)</td>
<td>697 (100)</td>
<td>314,325 (100)</td>
</tr>
</tbody>
</table>

Female

| Age at diagnosis (years) | No. (%) | No. (%) | No. (%) | No. (%) | No. (%) | No. (%) |
| Under 5 | 337 (3) | 1,223 (5) | 494 (5) | 1 (0) | 1 (0) | 2,079 (1) |
| 5-12 | 82 (1) | 195 (1) | 110 (1) | 6 (2) | 402 (1) |
| 13-19 | 104 (1) | 300 (1) | 77 (1) | 1 (0) | 1 (1) | 484 (1) |
| 20-24 | 724 (6) | 1,508 (6) | 679 (7) | 15 (6) | 13 (11) | 2,943 (6) |
| 25-29 | 2,031 (18) | 4,181 (17) | 1,754 (19) | 23 (9) | 24 (20) | 8,083 (17) |
| 30-34 | 2,633 (22) | 6,084 (24) | 2,374 (25) | 49 (20) | 35 (20) | 11,208 (24) |
| 35-39 | 2,043 (18) | 5,531 (22) | 1,838 (19) | 41 (17) | 15 (12) | 9,490 (20) |
| 40-44 | 1,195 (10) | 3,147 (12) | 1,091 (11) | 40 (16) | 11 (9) | 5,493 (12) |
| 45-49 | 658 (6) | 1,314 (5) | 532 (6) | 20 (6) | 6 (5) | 2,538 (5) |
| 50-54 | 399 (3) | 743 (3) | 297 (3) | 14 (3) | 3 (2) | 1,454 (3) |
| 55-59 | 351 (3) | 425 (2) | 191 (2) | 9 (4) | 2 (2) | 979 (2) |
| 60-64 | 270 (2) | 278 (1) | 92 (1) | 12 (5) | 3 (2) | 655 (1) |
| 65 or older | 650 (6) | 283 (1) | 100 (1) | 18 (6) | 1 (1) | 1,051 (2) |
| Female subtotal | 11,476 (100) | 25,235 (100) | 9,570 (100) | 247 (100) | 121 (100) | 46,838 (100) |
| Total | 181,151 | 114,868 | 61,297 | 2,358 | 818 | 361,164 |

1Includes 545 males, 86 females, and 1 person of unknown sex whose race/ethnicity is unknown.
2Includes 1 male and 1 female whose age at diagnosis is unknown, and 1 person whose sex is unknown.
Table 14. Deaths in persons with AIDS, by race/ethnicity, age at death, and sex, occurring in 1991 and 1992; and cumulative totals reported through December 1993, United States.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>White, not Hispanic Under 15</td>
<td>53 50</td>
<td>360</td>
<td>32 27</td>
<td>250</td>
<td>85 77</td>
<td>610</td>
</tr>
<tr>
<td>15-24</td>
<td>218 172</td>
<td>1,905</td>
<td>36 37</td>
<td>270</td>
<td>254 209</td>
<td>2,175</td>
</tr>
<tr>
<td>25-34</td>
<td>5,055 5,162</td>
<td>34,300</td>
<td>358 344</td>
<td>2,149</td>
<td>5,413 5,506</td>
<td>36,449</td>
</tr>
<tr>
<td>35-44</td>
<td>7,275 7,448</td>
<td>44,525</td>
<td>297 325</td>
<td>1,765</td>
<td>7,572 7,803</td>
<td>46,290</td>
</tr>
<tr>
<td>45-54</td>
<td>3,064 3,255</td>
<td>19,114</td>
<td>123 158</td>
<td>672</td>
<td>3,187 3,411</td>
<td>19,786</td>
</tr>
<tr>
<td>55 or older</td>
<td>1,213 1,266</td>
<td>8,755</td>
<td>137 132</td>
<td>1,040</td>
<td>1,450 1,398</td>
<td>9,795</td>
</tr>
<tr>
<td>All ages</td>
<td>16,981 17,354</td>
<td>109,127</td>
<td>983 1,051</td>
<td>8,156</td>
<td>17,964 18,405</td>
<td>115,283</td>
</tr>
<tr>
<td>Black, not Hispanic Under 15</td>
<td>108 119</td>
<td>768</td>
<td>104 105</td>
<td>749</td>
<td>212 224</td>
<td>1,517</td>
</tr>
<tr>
<td>15-24</td>
<td>202 212</td>
<td>1,562</td>
<td>109 102</td>
<td>620</td>
<td>311 314</td>
<td>2,162</td>
</tr>
<tr>
<td>25-34</td>
<td>2,582 2,776</td>
<td>17,932</td>
<td>838 852</td>
<td>5,210</td>
<td>3,420 3,828</td>
<td>23,142</td>
</tr>
<tr>
<td>35-44</td>
<td>3,520 4,087</td>
<td>21,720</td>
<td>815 1,126</td>
<td>5,028</td>
<td>4,345 5,213</td>
<td>26,748</td>
</tr>
<tr>
<td>45-54</td>
<td>1,262 1,490</td>
<td>7,623</td>
<td>264 255</td>
<td>1,309</td>
<td>1,528 1,745</td>
<td>8,932</td>
</tr>
<tr>
<td>55 or older</td>
<td>542 678</td>
<td>3,337</td>
<td>118 143</td>
<td>684</td>
<td>660 821</td>
<td>4,021</td>
</tr>
<tr>
<td>All ages</td>
<td>8,227 9,363</td>
<td>53,027</td>
<td>2,248 2,583</td>
<td>13,624</td>
<td>10,475 11,946</td>
<td>66,651</td>
</tr>
<tr>
<td>Hispanic Under 15</td>
<td>44 52</td>
<td>359</td>
<td>41 34</td>
<td>319</td>
<td>85 88</td>
<td>678</td>
</tr>
<tr>
<td>15-24</td>
<td>115 98</td>
<td>867</td>
<td>52 37</td>
<td>289</td>
<td>167 133</td>
<td>1,158</td>
</tr>
<tr>
<td>25-34</td>
<td>1,751 1,775</td>
<td>11,449</td>
<td>338 360</td>
<td>2,074</td>
<td>2,090 2,135</td>
<td>13,523</td>
</tr>
<tr>
<td>35-44</td>
<td>2,050 2,174</td>
<td>12,425</td>
<td>321 335</td>
<td>1,724</td>
<td>2,371 2,509</td>
<td>14,149</td>
</tr>
<tr>
<td>45-54</td>
<td>707 854</td>
<td>4,457</td>
<td>115 112</td>
<td>839</td>
<td>822 965</td>
<td>4,996</td>
</tr>
<tr>
<td>55 or older</td>
<td>318 307</td>
<td>1,814</td>
<td>45 55</td>
<td>283</td>
<td>363 382</td>
<td>2,077</td>
</tr>
<tr>
<td>All ages</td>
<td>4,987 5,260</td>
<td>31,465</td>
<td>913 933</td>
<td>5,258</td>
<td>5,900 6,193</td>
<td>36,873</td>
</tr>
<tr>
<td>Asian/Pacific Islander Under 15</td>
<td>— 1</td>
<td>12</td>
<td>1 —</td>
<td>5</td>
<td>1 1</td>
<td>17</td>
</tr>
<tr>
<td>15-24</td>
<td>3 1</td>
<td>24</td>
<td>2 —</td>
<td>5</td>
<td>5 1</td>
<td>29</td>
</tr>
<tr>
<td>25-34</td>
<td>71 55</td>
<td>354</td>
<td>4 3</td>
<td>28</td>
<td>75 58</td>
<td>380</td>
</tr>
<tr>
<td>35-44</td>
<td>67 97</td>
<td>518</td>
<td>6 7</td>
<td>43</td>
<td>93 104</td>
<td>561</td>
</tr>
<tr>
<td>45-54</td>
<td>36 50</td>
<td>245</td>
<td>6 5</td>
<td>25</td>
<td>41 55</td>
<td>270</td>
</tr>
<tr>
<td>55 or older</td>
<td>18 10</td>
<td>101</td>
<td>4 4</td>
<td>25</td>
<td>22 14</td>
<td>128</td>
</tr>
<tr>
<td>All ages</td>
<td>215 214</td>
<td>1,255</td>
<td>22 19</td>
<td>130</td>
<td>237 233</td>
<td>1,385</td>
</tr>
<tr>
<td>American Indian/Alaska Native Under 15</td>
<td>4 —</td>
<td>8</td>
<td>— —</td>
<td>4</td>
<td>4 —</td>
<td>12</td>
</tr>
<tr>
<td>15-24</td>
<td>1 1</td>
<td>15</td>
<td>1 —</td>
<td>2</td>
<td>2 1</td>
<td>17</td>
</tr>
<tr>
<td>25-34</td>
<td>31 34</td>
<td>158</td>
<td>6 4</td>
<td>20</td>
<td>37 38</td>
<td>178</td>
</tr>
<tr>
<td>35-44</td>
<td>27 15</td>
<td>112</td>
<td>3 2</td>
<td>11</td>
<td>30 17</td>
<td>123</td>
</tr>
<tr>
<td>45-54</td>
<td>7 6</td>
<td>44</td>
<td>— —</td>
<td>4</td>
<td>6 6</td>
<td>48</td>
</tr>
<tr>
<td>55 or older</td>
<td>6 4</td>
<td>21</td>
<td>— —</td>
<td>2</td>
<td>6 4</td>
<td>23</td>
</tr>
<tr>
<td>All ages</td>
<td>78 60</td>
<td>359</td>
<td>11 6</td>
<td>43</td>
<td>87 66</td>
<td>402</td>
</tr>
<tr>
<td>All racial/ethnic groups Under 15</td>
<td>209 222</td>
<td>1,508</td>
<td>178 168</td>
<td>1,330</td>
<td>387 390</td>
<td>2,838</td>
</tr>
<tr>
<td>15-24</td>
<td>541 482</td>
<td>4,399</td>
<td>200 176</td>
<td>1,167</td>
<td>741 658</td>
<td>5,566</td>
</tr>
<tr>
<td>25-34</td>
<td>9,503 9,820</td>
<td>64,271</td>
<td>1,545 1,565</td>
<td>9,488</td>
<td>11,048 11,285</td>
<td>73,759</td>
</tr>
<tr>
<td>35-44</td>
<td>13,001 13,848</td>
<td>79,441</td>
<td>1,445 1,631</td>
<td>8,591</td>
<td>14,445 15,879</td>
<td>86,032</td>
</tr>
<tr>
<td>45-54</td>
<td>5,062 5,667</td>
<td>31,529</td>
<td>510 529</td>
<td>2,553</td>
<td>5,592 6,196</td>
<td>34,094</td>
</tr>
<tr>
<td>55 or older</td>
<td>2,202 2,271</td>
<td>14,053</td>
<td>304 334</td>
<td>2,016</td>
<td>2,506 2,505</td>
<td>16,069</td>
</tr>
<tr>
<td>All ages</td>
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<td>195,534</td>
<td>4,182 4,603</td>
<td>25,202</td>
<td>34,724 36,917</td>
<td>220,736</td>
</tr>
</tbody>
</table>

1Data tabulations for 1991 and 1992 are based on date of death occurrence. Data for deaths occurring in 1993 are incomplete and not tabulated separately, but are included in the cumulative totals. Tabulations for 1991 and 1992 may increase as additional deaths are reported to CDC.

2Data tabulated under "All races/ethnicity groups" include 368 persons whose race at death is unknown. Data tabulated under "All racial/ethnic groups" include 342 persons whose race/ethnicity is unknown.
Table 22. HIV infection cases (not AIDS) by sex, age at diagnosis, and race/ethnicity, reported through December 1993, from states with confidential HIV infection reporting.

<table>
<thead>
<tr>
<th>Male</th>
<th>White, not Hispanic</th>
<th>Black, not Hispanic</th>
<th>Hispanic</th>
<th>Asian/Pacific Islander</th>
<th>American Indian/Alaska Native</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at diagnosis (years)</td>
<td>No. (%)</td>
<td>No. (%)</td>
<td>No. (%)</td>
<td>No. (%)</td>
<td>No. (%)</td>
<td>No. (%)</td>
</tr>
<tr>
<td>Under 5</td>
<td>64 (0)</td>
<td>192 (1)</td>
<td>37 (2)</td>
<td>1 (1)</td>
<td>1 (0)</td>
<td>302 (1)</td>
</tr>
<tr>
<td>5-12</td>
<td>75 (0)</td>
<td>48 (0)</td>
<td>12 (1)</td>
<td>—</td>
<td>3 (1)</td>
<td>143 (0)</td>
</tr>
<tr>
<td>13-19</td>
<td>488 (2)</td>
<td>535 (3)</td>
<td>44 (2)</td>
<td>2 (1)</td>
<td>7 (3)</td>
<td>1,058 (2)</td>
</tr>
<tr>
<td>20-24</td>
<td>3,186 (15)</td>
<td>2,764 (15)</td>
<td>327 (14)</td>
<td>20 (25)</td>
<td>53 (20)</td>
<td>6,824 (15)</td>
</tr>
<tr>
<td>25-29</td>
<td>5,591 (27)</td>
<td>4,313 (23)</td>
<td>600 (26)</td>
<td>32 (33)</td>
<td>80 (30)</td>
<td>10,923 (25)</td>
</tr>
<tr>
<td>30-34</td>
<td>4,327 (22)</td>
<td>4,249 (22)</td>
<td>566 (25)</td>
<td>16 (18)</td>
<td>58 (22)</td>
<td>10,128 (23)</td>
</tr>
<tr>
<td>35-39</td>
<td>3,209 (13)</td>
<td>3,389 (18)</td>
<td>368 (16)</td>
<td>13 (13)</td>
<td>31 (12)</td>
<td>7,227 (16)</td>
</tr>
<tr>
<td>40-44</td>
<td>1,773 (8)</td>
<td>1,940 (10)</td>
<td>194 (9)</td>
<td>7 (7)</td>
<td>18 (7)</td>
<td>4,038 (9)</td>
</tr>
<tr>
<td>45-49</td>
<td>891 (4)</td>
<td>785 (4)</td>
<td>77 (3)</td>
<td>4 (4)</td>
<td>6 (3)</td>
<td>1,836 (4)</td>
</tr>
<tr>
<td>50-54</td>
<td>425 (2)</td>
<td>398 (2)</td>
<td>34 (1)</td>
<td>3 (3)</td>
<td>4 (1)</td>
<td>893 (2)</td>
</tr>
<tr>
<td>55-59</td>
<td>191 (1)</td>
<td>170 (1)</td>
<td>12 (1)</td>
<td>—</td>
<td>2 (1)</td>
<td>381 (1)</td>
</tr>
<tr>
<td>60-64</td>
<td>119 (1)</td>
<td>87 (0)</td>
<td>13 (1)</td>
<td>—</td>
<td>1 (0)</td>
<td>238 (1)</td>
</tr>
<tr>
<td>65 or older</td>
<td>98 (0)</td>
<td>75 (0)</td>
<td>5 (0)</td>
<td>—</td>
<td>—</td>
<td>198 (0)</td>
</tr>
<tr>
<td>Male subtotal</td>
<td>21,047 (100)</td>
<td>18,945 (100)</td>
<td>2,239 (100)</td>
<td>96 (100)</td>
<td>267 (100)</td>
<td>43,945 (100)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Female</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Age at diagnosis (years)</td>
<td>No. (%)</td>
<td>No. (%)</td>
<td>No. (%)</td>
<td>No. (%)</td>
<td>No. (%)</td>
<td>No. (%)</td>
</tr>
<tr>
<td>Under 5</td>
<td>57 (2)</td>
<td>177 (2)</td>
<td>30 (5)</td>
<td>3 (1)</td>
<td>3 (4)</td>
<td>280 (2)</td>
</tr>
<tr>
<td>5-12</td>
<td>16 (1)</td>
<td>39 (1)</td>
<td>7 (1)</td>
<td>1 (4)</td>
<td>1 (1)</td>
<td>69 (1)</td>
</tr>
<tr>
<td>13-19</td>
<td>180 (8)</td>
<td>830 (8)</td>
<td>31 (5)</td>
<td>—</td>
<td>4 (16)</td>
<td>663 (7)</td>
</tr>
<tr>
<td>20-24</td>
<td>620 (20)</td>
<td>1,347 (18)</td>
<td>91 (15)</td>
<td>6 (22)</td>
<td>11 (16)</td>
<td>2,119 (18)</td>
</tr>
<tr>
<td>25-29</td>
<td>828 (26)</td>
<td>1,725 (22)</td>
<td>161 (27)</td>
<td>9 (33)</td>
<td>14 (20)</td>
<td>2,793 (24)</td>
</tr>
<tr>
<td>30-34</td>
<td>662 (21)</td>
<td>1,604 (21)</td>
<td>143 (24)</td>
<td>4 (15)</td>
<td>14 (20)</td>
<td>2,469 (21)</td>
</tr>
<tr>
<td>35-39</td>
<td>408 (13)</td>
<td>1,006 (14)</td>
<td>61 (10)</td>
<td>13 (19)</td>
<td>1,385 (14)</td>
<td></td>
</tr>
<tr>
<td>40-44</td>
<td>164 (3)</td>
<td>543 (7)</td>
<td>42 (7)</td>
<td>1 (4)</td>
<td>8 (11)</td>
<td>777 (7)</td>
</tr>
<tr>
<td>45-49</td>
<td>109 (3)</td>
<td>151 (3)</td>
<td>16 (3)</td>
<td>1 (4)</td>
<td>2 (3)</td>
<td>355 (3)</td>
</tr>
<tr>
<td>50-54</td>
<td>36 (1)</td>
<td>71 (1)</td>
<td>12 (2)</td>
<td>2 (7)</td>
<td>—</td>
<td>129 (1)</td>
</tr>
<tr>
<td>55-59</td>
<td>28 (1)</td>
<td>67 (1)</td>
<td>4 (1)</td>
<td>—</td>
<td>104 (1)</td>
<td></td>
</tr>
<tr>
<td>60-64</td>
<td>19 (1)</td>
<td>30 (0)</td>
<td>2 (0)</td>
<td>—</td>
<td>51 (0)</td>
<td></td>
</tr>
<tr>
<td>65 or older</td>
<td>43 (1)</td>
<td>45 (1)</td>
<td>1 (0)</td>
<td>—</td>
<td>93 (1)</td>
<td></td>
</tr>
<tr>
<td>Female subtotal</td>
<td>3,170 (100)</td>
<td>7,230 (100)</td>
<td>603 (100)</td>
<td>27 (100)</td>
<td>70 (100)</td>
<td>11,687 (100)</td>
</tr>
<tr>
<td>Total*</td>
<td>24,218</td>
<td>25,477</td>
<td>2,892</td>
<td>125</td>
<td>337</td>
<td>55,649</td>
</tr>
</tbody>
</table>

*See Table 18 for states with confidential HIV infection reporting.
**Includes 1,299 males and 287 females whose race/ethnicity is unknown.
***Includes 17 persons whose sex is unknown.
Table 23. Persons living with HIV infection (not AIDS) and with AIDS, by state, reported through December 1993

<table>
<thead>
<tr>
<th>State of residence</th>
<th>Living with HIV (not AIDS)</th>
<th>Living with AIDS</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Date HIV reporting initiated)</td>
<td>No. (%)</td>
<td>No. (%)</td>
<td>No. (%)</td>
</tr>
<tr>
<td>Alabama (Jan. 1988)</td>
<td>3,281 (6)</td>
<td>1,070 (1)</td>
<td>4,351 (2)</td>
</tr>
<tr>
<td>Alaska</td>
<td>176 (0)</td>
<td>76 (0)</td>
<td>252 (0)</td>
</tr>
<tr>
<td>Arizona (Jan. 1987)</td>
<td>2,619 (5)</td>
<td>1,203 (1)</td>
<td>3,822 (2)</td>
</tr>
<tr>
<td>Arkansas (July 1989)</td>
<td>1,004 (2)</td>
<td>721 (1)</td>
<td>1,725 (1)</td>
</tr>
<tr>
<td>California</td>
<td>23,502 (17)</td>
<td>25,502 (12)</td>
<td></td>
</tr>
<tr>
<td>Colorado (Nov. 1985)</td>
<td>4,942 (10)</td>
<td>5,875 (3)</td>
<td></td>
</tr>
<tr>
<td>Connecticut (July 1992)</td>
<td>42 (0)</td>
<td>2,387 (2)</td>
<td>2,429 (1)</td>
</tr>
<tr>
<td>Delaware</td>
<td>420 (0)</td>
<td>420 (0)</td>
<td></td>
</tr>
<tr>
<td>District of Columbia</td>
<td>2,340 (2)</td>
<td>2,340 (1)</td>
<td></td>
</tr>
<tr>
<td>Florida</td>
<td>14,833 (11)</td>
<td>14,833 (8)</td>
<td></td>
</tr>
<tr>
<td>Georgia</td>
<td>4,043 (3)</td>
<td>4,043 (2)</td>
<td></td>
</tr>
<tr>
<td>Hawaii</td>
<td>536 (3)</td>
<td>536 (0)</td>
<td></td>
</tr>
<tr>
<td>Idaho (June 1986)</td>
<td>201 (0)</td>
<td>201 (0)</td>
<td></td>
</tr>
<tr>
<td>Illinois</td>
<td>86 (0)</td>
<td>86 (0)</td>
<td></td>
</tr>
<tr>
<td>Indiana (July 1988)</td>
<td>2,170 (4)</td>
<td>3,405 (2)</td>
<td></td>
</tr>
<tr>
<td>Iowa</td>
<td>306 (0)</td>
<td>306 (0)</td>
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</tr>
<tr>
<td>Kansas</td>
<td>381 (0)</td>
<td>381 (0)</td>
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</tr>
<tr>
<td>Kentucky</td>
<td>418 (0)</td>
<td>418 (0)</td>
<td></td>
</tr>
<tr>
<td>Louisiana (Feb. 1993)</td>
<td>1,723 (3)</td>
<td>3,292 (2)</td>
<td></td>
</tr>
<tr>
<td>Maine</td>
<td>2,066 (2)</td>
<td>2,066 (2)</td>
<td></td>
</tr>
<tr>
<td>Maryland</td>
<td>3,301 (2)</td>
<td>3,301 (2)</td>
<td></td>
</tr>
<tr>
<td>Massachusetts</td>
<td>3,218 (2)</td>
<td>3,218 (2)</td>
<td></td>
</tr>
<tr>
<td>Michigan (April 1992)</td>
<td>1,104 (2)</td>
<td>3,350 (2)</td>
<td></td>
</tr>
<tr>
<td>Minnesota (Oct. 1988)</td>
<td>1,863 (4)</td>
<td>3,405 (2)</td>
<td></td>
</tr>
<tr>
<td>Mississippi (Aug. 1988)</td>
<td>2,214 (4)</td>
<td>3,005 (2)</td>
<td></td>
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<tr>
<td>Mississippi (Oct. 1987)</td>
<td>2,810 (5)</td>
<td>3,288 (3)</td>
<td></td>
</tr>
<tr>
<td>Montana</td>
<td>221 (0)</td>
<td>221 (0)</td>
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</tr>
<tr>
<td>Nebraska</td>
<td>796 (1)</td>
<td>2,292 (1)</td>
<td></td>
</tr>
<tr>
<td>Nevada (Feb. 1992)</td>
<td>1,496 (2)</td>
<td>1,496 (2)</td>
<td></td>
</tr>
<tr>
<td>New Hampshire</td>
<td>197 (0)</td>
<td>197 (0)</td>
<td></td>
</tr>
<tr>
<td>New Jersey (Jan. 1992)</td>
<td>5,162 (10)</td>
<td>11,291 (6)</td>
<td></td>
</tr>
<tr>
<td>New Mexico</td>
<td>361 (0)</td>
<td>361 (0)</td>
<td></td>
</tr>
<tr>
<td>New York</td>
<td>21,000 (15)</td>
<td>21,000 (11)</td>
<td></td>
</tr>
<tr>
<td>North Carolina (Feb. 1990)</td>
<td>3,949 (6)</td>
<td>5,609 (3)</td>
<td></td>
</tr>
<tr>
<td>North Dakota (Jan. 1988)</td>
<td>32 (0)</td>
<td>48 (0)</td>
<td></td>
</tr>
<tr>
<td>Ohio (June 1990)</td>
<td>965 (2)</td>
<td>3,012 (2)</td>
<td></td>
</tr>
<tr>
<td>Oklahoma (June 1988)</td>
<td>1,423 (3)</td>
<td>2,255 (1)</td>
<td></td>
</tr>
<tr>
<td>Oregon</td>
<td>1,009 (1)</td>
<td>1,009 (1)</td>
<td></td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>4,226 (3)</td>
<td>4,226 (2)</td>
<td></td>
</tr>
<tr>
<td>Rhode Island</td>
<td>401 (0)</td>
<td>401 (0)</td>
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</tr>
<tr>
<td>South Carolina (May 1985)</td>
<td>4,978 (10)</td>
<td>6,542 (3)</td>
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<tr>
<td>South Dakota (Jan. 1988)</td>
<td>125 (0)</td>
<td>154 (0)</td>
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</tr>
<tr>
<td>Tennessee (Jan. 1992)</td>
<td>1,783 (3)</td>
<td>3,301 (2)</td>
<td></td>
</tr>
<tr>
<td>Texas</td>
<td>10,275 (7)</td>
<td>10,275 (5)</td>
<td></td>
</tr>
<tr>
<td>Utah (April 1989)</td>
<td>723 (1)</td>
<td>1,113 (1)</td>
<td></td>
</tr>
<tr>
<td>Vermont</td>
<td>96 (0)</td>
<td>96 (0)</td>
<td></td>
</tr>
<tr>
<td>Virginia (July 1989)</td>
<td>4,697 (9)</td>
<td>6,700 (4)</td>
<td></td>
</tr>
<tr>
<td>Washington</td>
<td>2,166 (2)</td>
<td>2,166 (1)</td>
<td></td>
</tr>
<tr>
<td>West Virginia (Jan. 1989)</td>
<td>234 (0)</td>
<td>380 (0)</td>
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<tr>
<td>Wisconsin (Nov. 1985)</td>
<td>1,723 (3)</td>
<td>2,555 (1)</td>
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</tr>
<tr>
<td>Wyoming (June 1989)</td>
<td>64 (0)</td>
<td>111 (0)</td>
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</tr>
<tr>
<td>Subtotal</td>
<td>51,439 (100)</td>
<td>184,125 (97)</td>
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<tr>
<td>Guam</td>
<td>4 (0)</td>
<td>4 (0)</td>
<td></td>
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<tr>
<td>Pacific Islands, U.S.</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Puerto Rico</td>
<td>4,736 (3)</td>
<td>4,736 (3)</td>
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<tr>
<td>Virgin Islands, U.S.</td>
<td>103 (0)</td>
<td>103 (0)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>51,439 (100)</td>
<td>188,568 (100)</td>
<td></td>
</tr>
</tbody>
</table>

1Persons reported with vital status "alive" as of the last update.
2Excludes only persons reported from states with confidential HIV reporting. Includes 1,079 persons reported from states with confidential HIV infection reporting whose state of residence is unknown or are residents of other states.
3Excludes 180 persons whose state of residence is unknown.
4Connecticut has confidential HIV infection reporting for pediatric cases only.

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VITA

Marcus E. Harris

Marcus E. Harris was born in Cincinnati, Ohio, reared on the south side of Chicago, and finished his senior year of high school in Houston, Texas. In 1975 entered Oakwood college and graduated with a B.A. degree with majors in psychology and theology. In 1979 entered the Seventh-day Adventist Theological Seminary, Andrews University and received his Masters of Divinity.

For fifteen years served as a Pastor and Departmental Director with the Lake Region Conference of Seventh-day Adventist.

Certified as a HIV Counselor with the Michigan Health Department and is a HIV - AIDS educator and an AIDS specialist for African Americans with the American Red Cross. Provided service as a Pastoral Care Giver to persons infected with HIV or who have AIDS. In 1992 was a Fellow with the Minority Health Care Professions Foundation in a clinical fellowship on "Addiction Medicine and HIV Infection."