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HIV Infection and AIDS in China

HIV infection in developing countries represents a major global public health challenge, as more than 90% of HIV infections are estimated to occur in such countries. The article by Yu et al. describing HIV infection and AIDS in China from 1985 through 1994 is a much-needed addition to the HIV/AIDS literature. As is the case in many African and South Asian countries, HIV infections are on the rise in China. In 1995, China reported 1567 new HIV infections and 52 new AIDS cases, representing threefold and twofold increases, respectively, over the number reported during the previous year. As of September 1, 1996, another 964 new HIV infections and 14 new AIDS cases had been reported. Although such increases may partly be due to increased surveillance and reporting, it should be recognized that these numbers represent only a minimum estimate of the number of people infected with HIV.

In light of the rapid spread of HIV infection in China, a good understanding of transmission modes is important. Interpreting the data and drawing inferences from the report by Yu et al. require some caution. It is not surprising to see that the current approach of selected testing yielded most of the HIV cases from drug-using populations, because the HIV epidemic started in China among injection drug users. However, as illustrated by the consistent decline in recent years in the proportion of HIV patients who are injection drug users, other modes of transmission are becoming increasingly prevalent and may even have greater public health effects.

First, heterosexual contact may indeed be the most important transmission mode. The rapid rise of sexually transmitted diseases in recent years sheds light on potential implications of the spread of HIV infection. Fear of and discrimination toward HIV infection, low awareness of AIDS in the general population, and a lack of efficient education on HIV/AIDS and on the safe sex campaign further worsen the situation.

Second, contamination of medical devices and the blood supply remains a serious problem. The recent report on HIV infection in commercial plasma donors with no known risk factors in a rural village of Anhui Province highlights the underrecognized risk of medical equipment contamination. We suspect that this may also have contributed to the high proportion of HIV cases among hospital or clinic patients reported by Yu et al. Although HIV screening is mandatory for blood donations in China, a brand of albumin was recently banned because some of the product vials were found to contain HIV antibodies. These cases underscore the serious deficiencies of China's current system of paid blood donations, which may attract high-risk individuals, and the weakness in implementing HIV screening policy. The extent to which HIV may be transmitted by blood supply and use of blood products is largely unknown and is probably underestimated, in part because of the sensitive nature of the issue.

Third, because of social attitudes and cultural traditions and constraints, identifying homosexuality is a tremendous challenge. Therefore, misclassification of homosexual persons may have occurred. Although we do not know the magnitude of the misclassification, the relative importance of homosexual contact is likely to be greater than currently reported.

We agree with Yu et al. that a standardized surveillance system is needed to provide nationwide epidemic information on which a disease control and prevention strategy may be based. More epidemiological studies are needed to characterize the epidemic in China. Most important, given China's huge size in terms of both population and territory, a persistent, long-term, massive public campaign against HIV/AIDS and rigorous prevention and control measures should be implemented.

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Breast Cancer Mortality Declining but Screening among Subpopulations Lags

Recent reports indicate that breast cancer statistics for 1992 (the most recent year
for which Surveillance, Epidemiology, and End Results data are available) continue the
trend of a stable incidence rate and a declining
mortality rate that began in 1989.1,2 It is
well accepted that regular mammography
can reduce the risk of death from breast can-
cer, especially in women 50 years old or
older, and it appears that early diagnosis as a
result of this procedure may account for the
decreasing rate. According to Donna Sha-
lala, secretary of the US Department of
Health and Human Services, “it is important
that we reach every American woman with
this message. And it is especially important
that we reach racial and ethnic minority
women throughout our country because
breast cancer mortality among these women is
disproportionately high.”3 Thanks in large
part to the efforts of the Breast and Cervical
Cancer Early Detection Program of the Cen-
ters for Disease Control and Prevention, the
screening gap among minority women has
been narrowing.4 Reported use of mammog-
raphy “in the prior 3 years” among Hispanic
women 50 years of age or older increased
from 17.7% to 44.7% between 1987 and
1992.5 However, Hispanic women are still
less likely to participate in breast and cervi-
cal cancer screening than women of other
racial and ethnic groups.6

While it is encouraging that breast can-
cer mortality is declining and mammogra-
phy use among Hispanics is increasing, we
have concerns regarding the generalizabil-
ity of these trends to high-risk Hispanic
subpopulations. Hispanic health data are
typically generated from general population
samples such as the National Health Inter-
view Survey, and through random-digit
dialing methodology and mail-out surveys.
These methods consistently miss those who
are illiterate, those with language barriers,
and those without telephones, thus over-
looking a large segment of the most med-
ically underserved individuals for inclusion
in screening statistics.

We recently completed a series of stud-
ies in migrant health clinics in eastern
Washington state to establish baseline
breast and cervical cancer screening rates
and determinants among Hispanic immi-
gants.7-10 Although these women, on aver-
age, had resided in the United States for
more than 9 years, 85% reported Spanish as
their language of preference, 30% had no
telephone in their home, and the average
educational attainment was 5.5 years. Only
61.3% of women 50 years of age or older
had ever heard of a mammogram, and only
38.7% had undergone the procedure (32.4% in
the prior 2 years). These rates are well
below those obtained for the general His-
panic population. We hypothesize that our
findings are a best-case scenario as to the
true level of underscreening in Hispanic immi-
gants, because the women we inter-
viewed were using the health care system.

It is predicted that Hispanics will be
our largest minority group by the year
2000, with much of this growth resulting
from immigration. While we applaud the
overall trend of declining breast cancer
mortality, we also recognize that the actual
number of deaths for those most at risk of
underscreening may be rising. Without a
continued focus on our most vulnerable cit-
izens, their mortality rates will continue to
be disproportionately high.

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CDC at 50: Lessons to Be
Learned

David Satcher1 presents a cogent argu-
ment for the indispensability of the social
and behavioral sciences and primary pre-
vention in his review of Centers for Disease
Control and Prevention (CDC) activities
over the past 50 years. A large portion of
CDC’s efforts devoted to understanding
risk behaviors and developing behavioral
interventions has occurred in the recently
reorganized National Center for HIV, STD,
and TB Prevention, where approximately
$15 million (2.4%) of the $632 million fisc-
al year 1996 allocation for HIV prevention
was spent on social and behavioral research
and demonstration projects.2 Currently, the
Behavioral Intervention Research Branch
oversees 22 cooperative agreements and
four contracts to develop, implement, and
evaluate social and behavioral interventions
to stop the spread of HIV, the virus that
causes AIDS.3

The 22 projects listed by the Behav-
ioral Intervention Research Branch as ongo-
ing are being conducted in 15 major metro-
politan areas of the United States (Table 1).
The only behavioral research projects being
carried out by the Department of Psy-
chology at Georgia State University in
Atlanta, the headquarters of CDC. Appar-
ently, no behavioral research projects are
being supported by CDC in 3 of the 6 cities
reporting the greatest incidence of AIDS in
1996: Miami (99.4 per 100,000), West Palm
Beach (85.4 per 100,000), and Ft. Laud-
erdale (83.6 per 100,000), Florida.4

Although the US Congress has
expressed reservations about how CDC
oversees its grants for HIV prevention,5
CDC has never evaluated the process by
which it (1) awards grants and contracts to
eligible applicants, (2) monitors cooperative
agreements to guarantee quality perfor-
mance, or (3) demonstrates the effectiveness
of its cooperative agreement program in
serving the health needs of our nation. For-
mal evaluations by independent evaluators