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Learning objectives
- List and describe the populations with increasing rates of HIV in the U.S.
- Explain five factors that lead to the increase in new HIV cases among minority women.
- Discuss five factors that lead to the increase in HIV among the over-50 age group.
- List and describe five preventative measures to reduce HIV transmission.
- List and refute 10 myths surrounding the transmission of HIV.
- Explain five methods to eliminate the stigma associated with HIV.
- List and discuss five examples of the critical role of the social worker to help clients with the prevention and treatment of HIV.
- Describe the role social workers have in the ACO, and list five examples of education and collaboration the social worker could implement.

Introduction
Social workers practice in a variety of settings and work with diverse populations of all ages, gender, sexual orientation, cultures, ethnic groups, races, religions, geographic or demographic regions, immigration status, countries of origin and socioeconomic levels. Unfortunately, none of these individuals are immune to HIV, and social workers practicing in the United States, or anywhere around the world, will inevitably encounter a client or family member faced with HIV.

In 2012, more than 1 million people were diagnosed with HIV in the United States, and 50,000 Americans became infected with the disease (CDC, 2012). The Centers for Disease Control (CDC) estimates that 20 percent of those Americans are unaware they are infected with HIV.

Human immunodeficiency virus (HIV) is defined by the CDC as a virus that affects specific cells of the immune system that are called CD4 cells, or T cells. HIV may destroy so many of these cells that the body is left with no ability to prevent or attack infection or disease. When the body has no immunity to disease, HIV leads to AIDS, which stands for acquired immunodeficiency syndrome. In the case of AIDS, infections or diseases may freely invade the body and may lead to a serious and complex combination of illnesses. The HIV virus stays in the body forever, unlike other viruses that pass in time.

HIV/AIDS can be transmitted through the exchange of bodily fluids through unprotected sex with someone with HIV, and the virus can be detected in the blood, semen or vaginal fluids. The virus can enter the body through cuts or tears in the penis, vagina, rectum or mouth that may be microscopic in size and therefore undetected. Unprotected sex with multiple partners has been found by the CDC to increase the risk of acquiring HIV.

Transmission of the virus does not require sexual intimacy; many individuals are infected by sharing needles or other drug paraphernalia. Blood transfusions between 1978 and 1985 are suspect because screening for HIV/AIDS was not perfected during that time, and having transfusions outside the U.S. warrant HIV/AIDS testing.

There is no cure for HIV/AIDS at this time, but with specialized medical treatment by physicians, using a combination of drugs called highly active antiretroviral therapy (HAART), HIV can be controlled so that it may not lead to AIDS. With proper treatment and prevention, individuals may lead normal lives without infecting others with the virus. When HIV is treated early and consistently, the individual may have a normal life expectancy (CDC, 2013).

There are many myths and false information about the transmission of HIV/AIDS. HIV cannot be spread by:
- Being near someone with HIV.
- Contact with saliva, sweat, tears, sneezes, clothes, drinking fountains, phones, swimming pools, hot tubs chairs, toilet seats or shaking hands, hugging, or touching a person with HIV.
- Insect bites and stings.
- Donating blood.
- Having a conversation or a meal with someone with the HIV.

(CDC, 2012)

Geographic data
The CDC noted in 2012 that HIV was not found in equal proportions across the United States, with higher concentrations found in states with large, urban centers. It was thought that large metropolitan centers were conducive to the spread of the epidemic because of the close proximity of large numbers of people in the urban setting.

But a closer look at the population with HIV/AIDS as measured by the number of patients per 100,000 showed the greatest number of individuals of all ages living with AIDS were in the south, 45 percent, which does not have the largest urban population. The northeastern states represented 24 percent of AIDS cases, followed by the west at 19 percent and the Midwest at 13 percent.

Data from the CDC across the U.S. in 2010 indicated African Americans showed the greatest number of AIDS cases across the country except for the western states, where the rate of AIDS was highest for Caucasians. It is important to note that HIV/AIDS has a devastating impact on small and remote populations, including American Indians and Alaskan Natives, where the percentage of AIDS diagnoses within these populations showed numbers similar to those of the larger white population in the same area. These groups were also identified in the Affordable Care Act as being underserved by health care providers in general.

Numbers for HIV in 2008 were highest in the south and northeast, which may have implications for prevention and treatment of HIV before it progresses to AIDS. These numbers may reflect better education, prevention, and access to treatment in the northeast metropolitan areas, because in 2010, more AIDS cases were noted in the south. The Centers for
Disease Control, National Institute of Health and other state and federal agencies monitor these numbers to address prevention and treatment programs that will be discussed later in this course (CDC Surveillance Reports, 2007-2012).

Prevalence
Although having HIV in the United States today does not necessarily lead to AIDS, and it is not the automatic death sentence it was in the 1980s and 1990s, it is a serious problem that is present around the world today.

The CDC in 2012 provided the following statistics:
- More than 34 million cases of HIV were reported in 2010.
- An estimated 1 million Americans in the U.S. are HIV-positive.
- Another 20 percent of U.S. citizens are unaware that they are infected with the virus.
- More than 16,000 Americans with AIDS die each year.
- In the U.S., men who have sex with men account for more than half of all new HIV infections each year.
- Men who have sex with multiple partners should be tested more frequently.
- African Americans and women are at high risk for HIV/AIDS as are the elderly.
- Adolescents comprise 50 percent of new HIV cases diagnosed today.

HIV and older adults
The incidence of HIV is increasing among those 50 years old and older, especially women. This is due to a number of factors, including increased longevity for women compared to men; improved medical care leading to longer life expectancy; and the rising rate of divorced, separated and widowed women re-entering the dating population.

These factors lead to increased HIV transmission because of a lack of awareness and undetected disease. Women post-menopause may not consider using condoms because they are not concerned about pregnancy and mistakenly believe that HIV is a disease of the young. Older individuals also may have weaker immune systems, which may increase their susceptibility to HIV/AIDS.

The NIH estimates that one-fourth of all HIV/AIDS cases in the U.S. are among the over-50 age group. As in younger populations, women over 50 in high-risk groups, such as African American and Latino populations, are showing a sharp increase in the rate of new HIV infections.

Many doctors may miss the symptoms of HIV/AIDS and do not think to test older people for the disease, and older patients may be uncomfortable discussing their sexual activity or drug use. The symptoms of HIV may be overlooked or misdiagnosed as the flu or other diseases that affect older adults, such as the aches and pains of arthritis or the cognitive changes of aging.

Older adults may not have close family or friends for communication and support and tend to suffer privately with illness. Many older adults also do not have access to medical care or refuse it; may not have insurance; or may be ashamed or afraid to be tested for STDs or HIV.

Adults over age 50 are not the targeted population for education on HIV, do not realize they are at risk, and do not know preventative methods, let alone recognize symptoms they may have. Many older people live alone in poverty and social isolation after losing a spouse, and their family members may not be close by to check on them. This increases the risk that their health may deteriorate and symptoms of HIV may go unnoticed.

The NIH notes additional burdens on the over-50 population that are the outcome of HIV/AIDS. Even though an older adult is not infected with the disease, he or she may become the caregiver of grandchildren, children, spouses, or other loved ones suffering from the HIV/AIDS. This adds stress, depression, sadness or grief from dealing with the loved one’s illness along with the expected physical and mental changes the person is facing through the aging process. Some also will have the added burden of seeking HIV treatment and managing complex medical care plans for their loved ones with HIV.

This may also add a financial burden on older individuals who are living on a fixed income. Social workers can have a critical role in helping older adults obtain services for themselves and their families.

Adolescents and HIV
UNAIDS, a global initiative of United Nations partners on HIV/AIDS, is a program that works at all levels of society and involves multiple disciplines. The goal is to “lead and inspire the world in achieving universal access to HIV prevention, treatment, care and support” (UNAIDS, 2012).

The following information is supplied by UNAIDS:
- In 2009, 30 percent of young adults ages 19 to 29 reported they had been tested for HIV in the past 12 months (Kaiser Foundation, 2009).
- In 2010, young people aged 15-24 accounted for 42 percent of new HIV infections in people aged 15 and older.
- In 2012, this number increased to more that 50 percent of new HIV infections among the adolescent population.
- Of youths 12 through 17 years of age who responded to a national household survey in 1999, approximately 1.3 million reported dependency on illicit drugs or alcohol (Office of National AIDS Policy, 2000).
- Drug injection led to 6 percent of HIV diagnoses in young people 13 through 24 years of age from 1994 to 1997; 57 percent of HIV cases were attributed to sexual transmission, of which 26 percent were contracted through heterosexual sex; and 31 percent through male-to-male sex (American Association for World Health, 1999).
- In 2011, 84 percent of high school students reported they had been taught about AIDS or HIV infection in school (CDC, 2011).
- Globally, young women aged 15-24 have HIV infection rates twice as high as young men.
- Young adolescent girls are not only biologically more susceptible to HIV infection, they are more likely to have older sexual partners who use injecting drugs, thus increasing their potential exposure to HIV.
- Violence and the threat of violence interfere with young women’s and adolescents’ ability to protect themselves from HIV infection and to make smart decisions about sexual health.
• The prevalence of forced first sex among adolescent girls younger than 15 years ranges between 11 percent and 48 percent globally.
• Adolescents who sell sex or use drugs are at higher risk of HIV infection. They also may not have access to information, sterile injecting equipment, and services such as HIV testing and support.
• Adolescents often engage in behaviors that put them in high risk for HIV. Age-appropriate sexuality education can increase knowledge and contribute to more responsible sexual behavior and has showed decreased sexual risk-taking among participants.
• Sexual activity is initiated in early adolescence, before age 15. Evidence shows that sexual activity among young people is a reality, and there is a need to take action to empower them to make responsible and informed decisions about sexual and reproductive health, HIV and gender equality, and to address gender-based violence.
• Programs to prevent HIV infections in young people are more effective if they include prevention approaches that are youth-friendly and promote comprehensive services that include sexuality education, knowledge of HIV, access to sexual and reproductive health services, and discussion on harmful sexual norms and practices.
• Actively engaging young people in the design, implementation, monitoring and evaluation of HIV policies, services and programs will enhance their leadership skills to equip them to demand youth-friendly health services and programs.
  Source: UNAIDS, 2010

Women, minorities, and sexual preferences

Women from certain minority groups are at a higher risk for HIV and are especially vulnerable to circumstances that may lead to HIV/AIDS. CDC statistics specific to these women include the following:
• In 2010, HIV was among the top-10 leading causes of death for black/African American women aged 15 to 64 and Hispanic/Latino women aged 25 to 44.
• By 2011, one in four people 13 and older living with a diagnosis of HIV infection in the United States was a woman.
• Black/African American women and Latinas are disproportionately affected by HIV infection compared with women of other races/ethnicities.
• Babies born to women with HIV can become infected during pregnancy, birth, or breast-feeding, so the CDC has suggested that pregnant women be tested.
• New HIV infections among black/African American women decreased in 2010, and although black/African American women continue to be more affected by HIV than women of other races/ethnicities, current data show signs of a decrease in new HIV infections.
• 15 percent of women who are HIV-positive are unaware of their status.
• In 2010, women accounted for an estimated 9,500, or 20 percent, of the 47,500 new HIV infections in the United States. Of these, 8,000, or 84 percent, were from heterosexual contact with a person known to have or to be at a high risk for HIV infection.
• In 2010, the fourth largest number, at 5,300, of all new HIV infections in the United States occurred among black/African American women with heterosexual contact.
• Of the total number of new HIV infections among women in the United States in 2010, 64 percent occurred in blacks/African Americans, 18 percent were in Caucasians, and 15 percent were in Hispanics/Latinas.
• Young women aged 25 to 44 accounted for the majority of new HIV infections among women in 2010.
• In 2011, an estimated 10,257 women aged 13 years or older received a diagnosis of HIV infection in the United States, down from 12,146 in 2008. (Recall that the numbers are going up in the adolescent population.)
• Women accounted for 25 percent (7,949) of the estimated 32,052 AIDS diagnoses in 2011 and represent 20 percent (232,902) of the 1,155,792 cumulative AIDS diagnoses including children in the United States from the beginning of the epidemic through the end of 2011.
• Unprotected vaginal sex is a much higher risk for HIV for women than for men, and unprotected anal sex is riskier for women than unprotected vaginal sex.
• Rates of gonorrhea and syphilis are higher among women of color than among white women and correlate with the higher numbers of HIV.

The high rate of HIV in minority women can be explained by a number of factors. Women may assume they are in a monogamous relationship and therefore unaware of multiple partners their partner may have, which increases their risk for HIV. Certain cultures carry beliefs that women are to be submissive to men with the double standard that women must be monogamous while men are allowed to have multiple partners.

Women may not know that their partner is at high risk for HIV because they are unaware that their partner uses injected drugs or has unprotected sex with men. In some populations, men have sex with men covertly and women overtly because of the lack of acceptance of homosexuality in the community. Likewise, women may keep their partner’s secret and not seek HIV testing or treatment because of shame or fear of abandonment.

Women may engage in unprotected sex without a condom because of coercion by their partner and fear that the partner will leave or abuse them. Studies by the CDC show that women who have been sexually abused are more likely to engage in high-risk sexual activity, and at an earlier age. CDC studies show minority women may have limited or no access to reproductive health care, including appropriate contraceptives, annual gynecological exams, treatment for STDs, and prenatal care, which greatly affects their ability to prevent, detect and treat HIV at early stages of the disease. This leads to increased transmission of the disease to partners, family members and unborn babies (CDC, 2012).

Barriers to health care for women and minorities

The Intercultural Cancer Council (2001), a multicultural coalition, lists five reasons for disparities in health status for racial and ethnic minorities and medically underserved populations:
Unequal socioeconomic status, resulting in unequal availability, accessibility, and use of health services.
Unequal diagnostic workup and treatment after entering into the health care system.
Unequal scientific research, resulting in unequal data collection.
Unequal understanding of their medical needs including social, racial, and environmental injustice.
Individual and institutional prejudices and discrimination.

Fortunately these disparities are being addressed today through the ACA, and social workers are part of the team who will play a crucial role in remediating these issues, which will be reviewed in subsequent sections.

For many women and minorities, issues associated with poverty and lack of insurance are additional factors relevant to higher numbers of HIV/AIDS. Women are more likely to experience poverty than men, according to the NIH and the NASW research.

A study presented to the Office of Human Rights and International Affairs by Rita Webb (2001) of the National Association of Social Workers found that nearly 16 million women are uninsured. Women without insurance often have illness that goes untreated, cannot afford medications and do not have regular preventative care, such as well-women visits, annual mammograms, and gynecological exams and other health screenings.

When women do not have contact with health care providers, there is little chance that symptoms of HIV will be detected or addressed. Social workers may have contact with impoverished women through social service agencies or through contact with children and families in the school system. So social workers serve as a crucial link to help women access critical health care, including HIV prevention and treatment. Low-income young women of color are particularly at risk of being uninsured (Misra, 2001).

Webb (2003) noted the following in a presentation to the Office of Human Rights and International Affairs by the NASW:
For many social workers, awareness of the complex reproductive health issues for women of color is a national initiative to eliminate ethnic and racial health disparities in reproductive health. The social work profession supports improvement in access to a full range of reproductive health services, with special interest in addressing underserved groups, including women of color.

Social workers seek to improve the quality of reproductive health care and services for all women by identifying barriers to health care access, increasing the availability of health coverage, and advocating to improve socioeconomic conditions, thereby furthering healthy outcomes. Additionally, social workers address the impact of the contributing systemic factors and advocate for their elimination.

The long-standing stigma of HIV
As resilient as the virus itself, there has been a damaging stigma surrounding HIV since its discovery in the early 1980s that has persisted for more than 30 years. Originally called the “gay disease,” mainstream Americans shunned those with HIV and felt they were far removed from the disease, which was equated with drug use, sexual orientation outside the norm and people involved in the sex trade. Even innocent children like Ryan White, who acquired the disease through infected blood transfusions for hemophilia, was made an outcast and not allowed to attend public school.

Fortunately, today we are better educated about the transmission of HIV – but those who have the disease still face ridicule and discrimination. Several laws have been passed to fight discrimination and protect the rights of those with HIV, but many negative, accusatory attitudes remain about those with HIV disease.

One stigma is the belief of some people that HIV is a plague sent from God to punish those who live outside the boundary of their interpretation of Christianity and its teachings. Others are fearful that they may contract the disease because they lack education about prevention and the transmission of HIV. The myths and misinformation surrounding the disease feed the stigma that leads to discrimination towards individuals with HIV. HIV is not synonymous with AIDS and death, though that is still the belief of many.

Compounding the stigma and discrimination is that HIV is disproportionately found among certain racial and ethnic or alternative lifestyle groups, the poor, homeless and elderly who already face discrimination because of color, country of origin, education level, language, sexual orientation, age and customs that differ from mainstream America.

The stigma occurs on a one-to-one basis, but it also invades larger social groups and communities, such as religious denominations, politicians, law enforcement personnel, legislators, military groups, school boards, social and community groups, employers, and other public facilities that may exclude and discriminate against those with HIV. These feelings are shared, spread, and affirmed when these like-minded individuals join together out of fear or ignorance and find strength in numbers or fall prey to the influences of group psychology.

As a result, people with HIV, who are already dealing with a serious illness, may turn inward and isolate themselves from others at the time they need support and understanding the most. Many people living with HIV are shunned by their own families and friends who fear they may contract the disease or are ashamed because of the stigma of HIV in their community. Those with HIV may deny they have the illness and refuse to be tested or seek treatment as a result of the prevailing stigma in their community, which will have devastating affects on their health, including the possible development of AIDS.

The NASW Code of Ethics (2008) includes sections on advocacy for social justice to address and eliminate the bias, prejudice, and discrimination faced by clients with HIV. It provides values, principles, and standards and states that social workers should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical disability (NASW, 2008).
The NASW policy on HIV and AIDS (2013) states, “The social work profession should take an active stand to mitigate the overwhelming psychological and social effects, including the inequality of access to health and mental health care and the lack of education and prevention in the United States and internationally.” The policy can be studied in its entirety at http://www.socialworkers.org/practice/hiv_aids/2009/102109.asp, but highlights are provided below:

The policy statement addresses the three goals of the National AIDS Strategy to reduce incidence, increase access, and decrease health disparities. Examples of supporting language include:

- Prevention strategies that focus on harm reduction, including publicly funded needle exchange programs.
- Client/consumer access to professional counseling focused on holistic services; addressing disparities through culturally competent and linguistically client/patient-centered services that includes the broadest range of services.
- Education of practitioners about evidence-based practices addressing prevention, testing, care and treatment.
- Continued public and private funding and advocacy for health and mental health services that address HIV/AIDS and related psychosocial issues in both national and international programming.

The International Federation of Social Workers’ International Policy on HIV/AIDS

The International Federation of Social Workers’ International Policy on HIV/AIDS provides information on the global, pandemic scope of the disease and affirms the commitment of social workers to fight the disease globally at all levels of society (IFSW, 2013).

It can be viewed in its entirety at http://ifsw.org/policies/hiv-and-aids/ and includes the following sections:

1. **Building partnerships** – IFSW acknowledges that partnerships – global, national and local – are vital to tackle the epidemic.
2. **Education and prevention** – IFSW recognizes that education is a key strategy in tackling the epidemic. Although initial education efforts have focused on safe-sex strategies, it has been shown that prevention efforts must begin at an early age, must be targeted, and must respect the unique needs of the populations at risk.
3. **Comprehensive care and treatment** – IFSW supports access to affordable services that are based on a continuum of care for people infected and affected by HIV/AIDS.
4. **Partnerships with people affected by HIV/AIDS** – IFSW supports the principle that people who are HIV-positive and those with AIDS are a vital resource for prevention, and they must be closely involved in any strategy used to tackle the epidemic.
5. **Research** – IFSW supports all research efforts that address health disparities.

**Protecting the right to privacy for individuals with HIV/AIDS**

The Office of Civil Rights works to enforce and protect the civil rights and health information privacy rights of people living with HIV, resulting in increased access to quality health care and reduced HIV-related discrimination, stigma and disparities (OCR, 2012). When discussing the laws and programs that govern the rights of individuals with HIV/AIDS, there are terms that must be defined. These terms are also found in the National Association of Social Work Code of Ethics, which will be covered in subsequent sections.

According to the OCR, part of the federal Department of Health and Human Services, the following definitions must be delineated when studying civil rights and privacy laws:

- **Privacy** refers to an individual’s right to control both access to and use of his or her health information.
- **Confidentiality** relates to the right of an individual to the protection of their health information during storage, transfer, and use to prevent unauthorized disclosure of that information to third parties.
- **Security** consists of the protections or safeguards put in place to secure protected health information (PHI). It requires that administrative, technical, and physical safeguards are developed and used.

There are several laws or acts that govern the privacy, confidentiality and security of all medical information, and protecting information about HIV/AIDS cases is especially critical to effective medical care for the client. Patients must have privacy to eliminate discrimination and the stigma that has surrounded this disease for decades. If individuals cannot trust that their health information and status will remain private and confidential, it will be unlikely that they will seek or follow the complex treatment programs and may not collaborate openly with the health care team.

**The Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

HIPAA is a comprehensive program that delineates the security of medical information and patient’s rights to privacy as well as specifying when, how and to whom information can be shared. It is available for study on the HHS.gov website and should be reviewed in detail by all members of the health care team, which includes those in social work with individuals with HIV.

A summary from the HHS.gov OCR website follows:

OCR also enforces the HIPAA Privacy and Security Rules, a set of federal standards to protect the privacy and security of patients’ medical records and other health information maintained by covered entities: health plans; most doctors, hospitals and many other health care providers; and health care clearinghouses. These standards provide patients with access to their medical records and with significant control over how their personal health information is used and disclosed. Persons with HIV/AIDS who believe that their health information privacy rights have been violated may file a complaint with OCR.

It is imperative that social workers understand the HIPAA Privacy Rule to help clients properly coordinate information sharing, ensure patient rights, and to protect themselves and their organization from violating patient rights.

The complexity of the HIV/AIDS cases are compounded by the fact that public health mandates require certain information to be shared, while at the same time protecting patients’ right
to privacy. Because the requirements for disclosure vary by state, social workers should contact their local jurisdiction for specifics.

The OCR offers the following explanation for guidance for those working with clients with HIV/AIDS.

There are instances in which you must reveal patient information to someone other than the patient. You are required to report the names of persons who have a positive HIV test to public health authorities for infectious disease surveillance. In some states, you are also required to report the names of partners of those who test positive for HIV. You may also share a patient’s medical information with the patient’s other medical providers to coordinate care and to manage HIV/AIDS as a chronic condition. The policies and regulations that have been put in place, see HIPAA, will allow you to share patient health information when necessary and appropriate, while maintaining the confidentiality, privacy, and security of this information. (HHS, OCR, 2012).

Section 504 and the Americans with Disabilities Act (ADA)

Social service agencies are among those that are governed under Section 504 and ADA. Under the Section 504 law, individuals with disabilities are defined as:

- Persons with a physical or mental impairment, which substantially limits one or more major life activities.
- People who have a history of, or who are regarded as having a physical or mental impairment that substantially limits one or more major life activities are also covered.
- Major life activities include caring for one’s self, walking, seeing, hearing, speaking, breathing, working, performing manual tasks, and learning. Some examples of impairments which may substantially limit major life activities, even with the help of medication or aids/devices, are: HIV/AIDS, alcoholism, blindness or visual impairment, cancer, deafness or hearing impairment, diabetes, drug addiction, heart disease, and mental illness.

The Office of Civil Rights also enforces these mandates that protect clients with HIV/AIDS because it meets the criteria for inclusion as a disability. ADA protects the individual against discrimination and exclusion from participation in a service or denial of a benefit.

The HHS.gov website gives the following summary as it pertains to HIV/AIDS:

If the individual with HIV meets the essential eligibility requirements for the service or benefit, the entity may be required to make a reasonable accommodation to enable the individual to participate. The ADA also protects other persons, such as family and friends, who are discriminated against because of their association with someone who has HIV. Examples of discriminatory acts toward individuals with HIV or AIDS include denying access to social services and/or medical treatment, or having services and/or treatment delayed solely because an individual has HIV or AIDS.

Section 504 of the Rehabilitation Act passed in 1973 is a federal law within the Department of Health and Human Services (DHHS) that protects individuals from discrimination based on their disability (DHHS, 2012). These organizations and employers include many hospitals, nursing homes, mental health centers and human service programs along with any employer, agency or organization that receives federal funding, including schools.

The HHS clarifies DHHS Section 504 regulation at 45 CFR Part 84 and defines who may qualify for protection under the law, which was expanded in 2008. Social workers should study the law to assist clients who may be facing discrimination because of their HIV/AIDS diagnosis.

Some highlights from DHHS are as follows:

- Organizations and employers are forbidden from excluding or denying individuals with disabilities an equal opportunity to receive program benefits and services.
- It defines the rights of individuals with disabilities to participate in and have access to program benefits and services.
- In addition to meeting the above definition, for purposes of receiving services, education or training, qualified individuals with disabilities are persons who meet normal and essential eligibility requirements.
- For purposes of employment, qualified individuals with disabilities are persons who, with reasonable accommodation, can perform the essential functions of the job for which they have applied or have been hired to perform.

Family and Medical Leave Act (FMLA)

The following information is from the Office of Personnel Management (OPM) of the U.S. government. An employee is entitled to use up to 12 weeks (480 hours) of sick leave each leave year to provide care for a family member with a serious health condition. The definition of family member covers a wide range of relationships, including spouse, parents, parents-in-law, children, brothers, sisters, grandparents, grandchildren, stepparents; stepchildren, foster parents, foster children, guardianship relationships, same sex and opposite sex domestic partners, and spouses or domestic partners of the aforementioned, as applicable.

Care of a family member includes psychological comfort and physical care, including being with the family member during a hospital stay or while being examined in a doctor’s office. Agencies may require an employee to provide a written statement from a health care provider certifying that:

1. The family member requires psychological comfort and/or physical care.
2. The family member would benefit from the employee’s care or presence.
3. The employee is needed to care for the family member for a specified period of time.

The ethics of social work and the client with HIV

The NASW Code of Ethics, revised in 2008, should serve as the guide for all social workers and students of social work, who should have knowledge of the code and apply to their daily practice.

The code does not mention HIV specifically, but the principals, standards and values apply directly because the mission of the social work profession is to “enhance human well-being and
help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. … Social workers promote social justice and social change with and on behalf of clients” (NASW, 2008).

Clearly, clients with HIV and their families embody the elements described in the mission statement. Social workers have a responsibility, as set forth in the code, to be “sensitive to cultural and ethnic diversity and strive to end discrimination, oppression, poverty and other forms of social injustice” – and that includes the stigma and discrimination towards individuals with HIV. One section in particular addresses work with diverse groups within a population and the requirement for multicultural competence within the social work profession.

The NASW Code of Ethics includes the following guidance and states that social workers should:

- Understand culture and its function in human behavior and society, recognizing the strength in all cultures.
- Have a knowledge base of their clients’ cultures and be able to demonstrate competence in the provision of services that are sensitive to clients’ cultures and to differences among people and cultural groups.
- Obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental and physical disability.

There are seldom “pure” cultures or groups, so social workers need to be flexible and aware of overlapping cultures and characteristics of social diversity and changing demographics. There are an infinite number of combinations and degrees of the characteristics listed in the section above that social workers may encounter in their practice. It is important that they have self-awareness to work through any bias or preconceived or stereotypic beliefs they may hold about the clients’ culture. If social workers do not feel they can be effective in their work with a particular client, they are obligated to refer that client to another professional (NASW, 2008).

Symptoms of HIV

Though HIV requires a medical diagnosis, the social worker needs to understand symptoms that may affect clients and their ability to participate in their care. Knowing about the disease will help the health care team to better prepare the client to make timely and effective care decisions and to anticipate and cope with complications of the disease.

HIV may lie dormant and go undetected for weeks or three to six months, which increases the chance that it will be spread unknowingly. Some individuals show symptoms soon after being infected, which may seem insignificant, much like the flu. These may include fever, sweating, stomach cramps, coughs, headaches, diarrhea, lethargy, weight loss, swollen glands, repeated infections, rashes, and difficulty with memory and other cognitive tasks. In other cases, it may take up to 10 years for more serious symptoms to appear, which makes it critical and for anyone who may be at risk to be tested for HIV as soon as they fear they may have been infected.

It is important for an individual with HIV to seek medical treatment immediately and be supported to continue treatment for a positive outcome to prevent AIDS. The “Home Access Express HIV-1 Test System” blood test is available and approved by the Food and Drug Administration (FDA) It is the only test approved by the FDA to be sold legally in the U.S. and can be purchased in a drug store. Tests that are advertised and sold online, on the street or from magazines are illegal, unreliable and should not be used.

Tests can be administered by private physicians, clinics or public health facilities. Additional information on HIV testing in a specific area can be found by visiting the website www.hivtest.org, and most states have public clinics that will provide tests confidentially and privately without requiring people to give their names. The CDC recommends all Americans ages 13 to 64 get tested at least once to know their HIV status to help prevent spreading the disease, and it is suggested that both partners be tested before commencing a new sexual relationship.

The Affordable Care Act (ACA) mandates insurance coverage of STI/HIV counseling and screenings, as well as contraception, without cost-sharing as part of the HIV/AIDS prevention program that is available for children through adults over 50 who are in high risk populations (ACA, 2012).

Closing the health care gap for prevention

Patient Protection and Affordable Care Act

This health care plan for all will be fully enacted in 2014 and will address the disparities in health care for the prevention and treatment of HIV/AIDS in all populations, including women, minorities, children, adolescents and the older populations.

The ACA determined eight areas of preventive care that must be covered without cost to women and all other population groups, regardless of income. The areas related to HIV/AIDS include:

- Well-woman visits: This includes an annual well-woman preventive care visit for adult women to obtain the recommended preventive services, and additional visits if women and their health care providers determine they are necessary. These visits will help women and their health care providers determine what preventive services are appropriate, and set up a plan to help women get the care they need to be healthy.
- HPV DNA testing: Women who are 30 or older have access to high-risk human papillomavirus (HPV) DNA testing every three years, regardless of Pap smear results. Early screening, detection, and treatment have been shown to help reduce the prevalence of cervical cancer.
- STI counseling: Sexually active women have access to annual counseling on sexually transmitted infections (STIs). These sessions have been shown to reduce risky behavior in patients, yet only 28 percent of women aged 18-44 years reported that they had discussed STIs with a doctor or nurse.
- HIV screening and counseling: Sexually active women have access to annual counseling on HIV. Women are at increased risk of contracting HIV/AIDS. From 1999 to
2003, the Centers for Disease Control and Prevention reported a 15 percent increase in AIDS cases among women, and a 1 percent increase among men.

- Contraception and contraceptive counseling: Women with reproductive capacity have access to all Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider. These recommendations do not include abortifacient drugs. Contraception has additional health benefits, such as reduced risk of cancer, HIV and improving the health of mothers and their children-to-be.
- HIV screening for children and adolescents in at risk populations or are sexually active.
- HIV screening for the older population.

**ACA community outreach to address HIV prevention**

**Capacity Building HIV Prevention Services for At-Risk Racial/Ethnic Minority Young Adults:** This program assists in building a comprehensive infrastructure for delivering and continuing quality HIV prevention services in colleges, universities, and community-level public and private non-profit organizations. The goal is to prevent the onset and transmission of HIV/AIDS among at-risk racial/ethnic minority young adults ages 18-24.

**Capacity Building Assistance to Improve the Delivery and Effectiveness of HIV Prevention**

This program funds community-based organizations (CBOs) and health departments to improve HIV prevention in racial/ethnic minority populations and subpopulations. Components of this capacity building assistance (CBA) program includes:

- Strengthening: organizational infrastructure, strategies, monitoring, and evaluation.
- Community access to and utilization of HIV prevention services.
- Quality and delivery of CBA services for HIV prevention.
- Provide consumer access to and utilization of CBA services for HIV prevention.
- Training, information dissemination, and technology transfer to CBOs, health departments, and community planning groups to strengthen HIV prevention for racial/ethnic minority populations and subpopulations at high risk for HIV.

**Substance abuse/HIV/hepatitis prevention programs on campuses of historically black colleges and universities (HBCUs)**

These programs support outreach strategies to carry out substance abuse/HIV/hepatitis prevention education and awareness activities, and distribute appropriate information and materials to HBCUs.

**Targeted Capacity Expansion Program for Substance Abuse Treatment and HIV/AIDS**

This program is designed to address gaps in substance abuse treatment services and to increase the ability of states, units of local government, American Indian/Alaska Native tribes and tribal organizations, and community and faith-based organizations to help specific populations or geographic areas with serious, emerging substance abuse problems and the transmission of HIV.

**National Network to Eliminate Disparities in Behavioral Health (NNED)**

The NNED supports the development of policies, practices, standards, and research to eliminate behavioral health disparities. This virtual online community of more than 600 community-based organizations and leaders addresses the behavioral health needs of diverse racial, ethnic, cultural, and sexual minority communities through training, technical assistance and information sharing opportunities. Community organizations and providers have opportunities to partner with researchers and participate in learning groups and communities of practice focused on issues and problems identified by the communities.

**Personal responsibility education**

Provides $75 million per year through FY 2014 for personal responsibility education grants to states for programs to educate adolescents on both abstinence and contraception for prevention of teenage pregnancy and sexually transmitted infections, including HIV/AIDS in high-risk, vulnerable, and culturally underrepresented populations. Funding is also available for:

- Innovative teen pregnancy prevention strategies and services to high-risk, vulnerable, and culturally underrepresented populations.
- Allotments to Indian tribes and tribal organizations.
- Research and evaluation, training, and technical assistance.

**Senior Support Network in Native American Communities**

Increases health care services to tribal members, particularly on programs geared towards elders. The project seeks to establish a coordinated case management system through which senior tribal members (age 60 or older) will have a single point of contact to learn about and be directed towards appropriate services.

**Medicaid reform**

ACA allows states to receive federal matching funds for covering additional low-income individuals and families under Medicaid for whom federal funds were not previously available. This will expand HIV prevention, screening and treatment for many underserved populations.

Under ACA reforms, Americans below 133 percent of the poverty level (approximately $14,000 for an individual and $29,000 for a family of four) will be eligible for Medicaid benefits. States will receive 100 percent federal funding for the first three years to support this expanded coverage, phasing to 90 percent federal funding in subsequent years.

This will help close the insurance gap that has excluded or limited access to health care for the prevention and treatment of HIV/AIDS.

**Social work in the integrated health systems**

According to the NASW, cultural competence in health care is defined as “the ability to provide care to patients with diverse beliefs and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs” (NARAL Pro-Choice America Foundation, 2003, p.29).

The difficulty, and in some cases failure, of health care organizations and programs to provide culturally competent health care to diverse racial and ethnic populations has been
identified as contributing factors to discrepancies in the delivery of quality health care (NASW, 2003).

For the social work profession, the importance of cultural competence practice is well documented in the National Association of Social Workers (NASW) policy statements, standards, and code of ethics (Webb, 2003). Webb noted that the social work profession has an opportunity to educate health care professionals and to collaborate and advocate for an improved culturally competent health care delivery system.

The development of accountable care organizations provides the perfect vehicle to begin this collaboration between the social work profession and the health care team.

Since 2012, ACA provides incentives for physicians and other physical and mental health care professionals to join together to form “accountable care organizations.” In these groups, doctors can better coordinate patient care and improve the quality, help prevent disease and illness, and reduce unnecessary hospital admissions. If accountable care organizations (ACO) provide high-quality care and reduce costs to the health care system, they can keep some of the money that they have helped save. (ACA, 2012).

ACOs serve as a health care provider for patients with chronic disease and are based on the following principles – the “three Ps”:

- Patient centered care.
- Performance measurement.
- Payment reform.

ACO members include hospitals, clinics and other care facilities, along with physicians, nurses, clinical social workers, and other physical and mental health care providers who work as a team. The team provides care for a certain number of patients, with the goal of achieving specific results for the patient. The team provides primary care to manage chronic illness and use prevention practices.

The Affordable Care Act involved the National Association for Social Work (NASW) in gaining support for ACA. In addition, social workers were given an important role in the ACA to serve as a member on the ACO community health care team. The Affordable Care Act authorizes federal grants for licensed clinical social workers (LCSW), who will play a critical role in ACOs, with high caseloads of individuals with co-occurring chronic conditions and mental and substance use disorders (NCBH, 2011).

According to the NASW, social workers have a number of skills that make them an important part of the ACO team. They advise social workers to become familiar with the ACO organizations in their state and determine their place in the home health care team.

The following are examples of positions for the clinical social worker in the ACO:

- Care coordinators, case managers, and patient educators.
- Behavioral health providers.
- Outreach specialists.
- Supervisors for ACO community health workers.
- Health care “neighbors” for continuum of care services.
- Participants in ACO governance structures.
- Advocates for vulnerable populations.
- Members of community health teams.

Clinical social workers have the training, skills, and experience to become an important member of the ACO in all of these areas and are encouraged to become involved in their communities when ACOs become fully functional in 2014 (NASW, 2010).

Prevention outreach and education

The only 100 percent effective means to prevent HIV is abstinence from sexual contact that results in the exchange of bodily fluids and avoidance of injectable drugs, and the use or sharing of drug paraphernalia. These methods have proven to be unsuccessful because of a lack of compliance.

The proper and consistent use of latex and polyurethane condoms can help minimize the risk of spreading HIV, although natural condoms are not as effective. The NIH reports that circumcision in males has been shown to decrease the risk of HIV transmission.

Another means of prevention is to require new sexual partners to be tested for HIV before commencing sexual relations. Less reliable is having a discussion about the partner’s sexual history, including same sex or multiple partners in the past as well as drug use or the possibility of shared needles. These discussions may not be reliable because the individuals may not fully disclose their history or may have been misled or misinformed about past sexual partners.

The CDC, NIH, and partners in the Affordable Care Act (ACA, 2010) have developed and administered a number of ongoing outreach programs for education, prevention and treatment.

CDC has addressed the HIV epidemic in following the guidelines of the 2010 National HIV/AIDS Strategy. This program works to reduce the number of new HIV cases, increase access to medical treatment and improve health outcomes to avoid the progression to AIDS (HHS, 2012). These programs are administered in metropolitan areas across the U.S. and in Puerto Rico as well as areas that have previously been underserved to eliminate health disparities.

In developing a national initiative to eliminate health disparities, the Department of Health and Human Services (HHS), through the Centers for Disease Control and Prevention (CDC), identified six focus areas that greatly impact the health status of racial and ethnic minority populations. Of these, three address reproductive health, including cervical cancer screening and management, infant mortality, and HIV/AIDS and STDs (HHS, 2012).

The CDC has developed a national community-based program called Racial and Ethnic Approaches to Community Health (REACH) 2010. REACH 2010 is the foundation of the CDC’s efforts to promote community-based organizations to administer programs to achieve a national initiative to eliminate ethnic and racial health disparities in reproductive health.

Examples of CDC’s programs for HIV prevention include:

- The Enhanced Comprehensive HIV Prevention Planning Project (ECHPP), which addresses HIV prevention in 12 metropolitan areas with the highest rate of AIDS. The ECHPP allows each site to create HIV prevention programs tailored to the specific needs of the population in that area.
The Expanded Testing Initiative (ETI), a large-scale HIV testing program for populations with a high rate of HIV diagnoses. CDC invested more than $100 million in ETI to test 2.7 million persons for HIV, resulting in 0.7 percent with newly identified HIV diagnoses and averting an estimated 3,381 new HIV infections. Research from this program noted that when people are educated and aware of HIV prevention measures, regardless of whether they are infected, they will take precautions to keep partners from becoming infected.

The Expanded and Integrated HIV Testing Initiative, which supports health departments in their effort to increase HIV testing opportunities, awareness of HIV status, and linkage to services for disproportionately affected populations. Primary focus is on African American and Hispanic men and women, men who have sex with men, and injection drug users, regardless of race or ethnicity. Components include HIV screening and counseling, testing, and referral; HIV screening in health care settings; and HIV counseling, testing, and referral in non-health care settings.

The High-Impact Prevention Funding program, which provides funds for state and local health departments in the geographic and population areas with the highest rates of disease. The CDC invests the most funds in areas where they are needed the most. The program goals seek to provide a rudimentary understanding of HIV, how to protect against and prevent HIV infection, promote and provide testing, and offer information for treatment options and access to care.

The CDC provides funding to every state to support behavioral interventions across the U.S. that address specific factors for prevention to stop the transmission of HIV. These include:

- **Take Charge.** Take the Test, a program that is part of Act Against AIDS (AAA) and works to promote HIV testing in African American women ages 18-34 who are at high risk for HIV.
- **Let’s Stop HIV Together,** also part of AAA that serves to increase awareness and crush the myths and the stigma surrounding HIV/AIDS.
- **Support for testing and prevention programs throughout all state and local health departments and community-based organizations,** to close gaps that lead to health disparity by serving previously undiagnosed African American women at high risk for HIV. Once these women are identified, they can be screened, tested and provided access and funding for preventative and medical care.
- **Fund for research in microbiology and prevention to develop medications that can be applied before sexual contact to prevent the spread of HIV.**
- **Support for ongoing clinical trials to fund a study on the use of preexposure prophylaxis (PrEP),** which is a daily dose of HIV drugs to prevent HIV infection for people at high risk.

**Treatment for HIV/AIDS**

According to the National Institute for Health, there are 31 antiretroviral drugs (ARVs) approved by the Food and Drug Administration (FDA) to treat HIV infection (NIH, 2009). These treatments work to suppress the virus, sometimes to undetectable levels, but to date there is no method to totally remove the virus and no cure.

The virus can be suppressed to the point that those with HIV can lead long and fairly normal lives. But those with HIV can transmit the virus and must remain vigilant and follow safe sexual and health practices. To remain healthy, they must continue to take the ARV drugs for life.

**HIV/AIDS antiretroviral drugs**

Antiretroviral drugs work by interfering with HIV cell development, growth and replication by interfering with the RNA and DNA, which are key building blocks of cell growth. To understand how these drugs work to fight HIV, it is important to have a basic understanding of these components.

- **RNA** – also called ribonucleic acid. This is the nucleic acid that is used in key metabolic processes for all steps of protein synthesis in all living cells. It transmits genetic information from DNA to the cytoplasm, carries the genetic information of many viruses, and controls certain chemical processes in the cell.
- **DNA** – Short for deoxyribonucleic acid. It is the nucleic acid that is the genetic material determining the makeup of all living cells and many viruses, and is found in the nucleus of the cell. It is capable of replication itself and carries the genetic material or code.


The antiretroviral medications are classified in five major classes. The National Institute on Health Institute on Aids provides the following information:

- **Reverse transcriptase (RT) inhibitors** – These drugs interfere with the part of the HIV lifecycle called reverse transcription (RT). At this point, the HIV enzyme RT works to convert HIV RNA to HIV DNA. RT inhibitor drugs block the HIV from replicating its own DNA, thus leaving the chain incomplete.
- **Nucleoside/nucleotide RT inhibitors** – These serve as faulty DNA building blocks as the HIV tries to replicate. When these faulty pieces are absorbed into the HIV DNA, the chain cannot be completed, thereby blocking HIV from replicating.
- **Non-nucleoside RT inhibitors** – These bind to RT, interfering with its ability to convert the HIV RNA into HIV DNA.
- **Protease inhibitors** – These serve to interfere with the protease enzyme that HIV must have to form infectious particles.
- **Fusion/entry inhibitors** interfere with the viruses’ ability to fuse with the cellular membrane, thereby blocking entry into the host cell.
- **Integrase inhibitors** block integrase, the enzyme HIV uses to integrate genetic material of the virus into its target host cell.
- **Multidrug combination products** combine drugs from more than one class into a single product. This is necessary to keep strains of the HIV virus from becoming resistant to certain ARVs that have been repeatedly used in treatment. The NIH has developed a combination of antiretroviral drugs known as highly active antiretroviral therapy.
(HAART), which combines drugs from at least two different antiretroviral drug classes

Other drugs are in development that would inhibit the HIV cells from assembling parts to mature. These drugs would work by interfering with HIV cells when they are developing a cell membrane and emerging from the human cell.

The ACA continues to provide increased funding for research into the prevention and treatment of HIV/AIDS, which will be fully implemented in 2014.

According to NIH, in some cases, antiretroviral drugs can cause serious side effects and medical complications, and monitoring patients for these complications and side effects is the responsibility of patients and their health care providers.

Social workers should consult with the health care team about the treatment plans for their clients with HIV and the possible side effects and complications of treatment. This is important to help clients with HIV become educated about the scope and sequence of their HIV, and to develop self-awareness, decision-making skills and plans to self-monitor their health during treatment.

Further training for social workers: The AIDS Spectrum Project

In 2012, the National Association of Social Workers (NASW) was called upon to respond to the HIV/AIDS pandemic. Evelyn P. Tomaszewski, senior policy associate, stated that globally, social workers are proactively providing critical services to individuals, families, and communities affected by HIV/AIDS in a wide range of community settings, including public, nonprofit, and for-profit organizations (Whitaker, Weismiller, & Clark, 2006).

Social workers not directly serving persons living with or affected by HIV/AIDS should have an understanding of their complex and unique challenges, because HIV is correlated with both substance use and other mental health concerns (Bing et al., 2000).

The National HIV/AIDS Strategy (NHAS) “takes deliberate steps to increase the number and diversity of available providers of clinical care and related services for people living with HIV” (NHAS 2010). Additionally, the NHAS stresses that persons living with HIV should be “linked to high-quality care that promotes adherence to HIV antiretroviral therapy.”

To ensure a comprehensive, effective professional response to this public health pandemic, the NHAS, in conjunction with NASW, provides social workers and allied health and mental health professionals with continuing education opportunities through the federally funded NASW HIV/AIDS Spectrum: Mental Health Training and Education of Social Workers Project (NHAS, NASW, 2010). The goal of the NASW HIV/AIDS Spectrum Project is to provide increased skills for professional practice with individuals, families and communities affected by HIV/AIDS.

It includes four core concepts:

- Addressing Ethical Dilemmas in an Era of Complex Practice Issues: HIV/AIDS as a Case Study.
- Providing Services in Complex Times: Working with Clients Living with HIV/AIDS and Co-occurring Mental Health Disorders.
- The Role of the Mental Health Provider in Medication Treatment Adherence: the ADHERE Model.

The project meets the NHAS goal of providing “specialized training to alleviate HIV workforce shortages,” and works to expand the ability of social workers and allied health and behavioral health professionals to meet the emerging needs of HIV in the 21st century (NASW, 2010). The website and contact information for this program is included in the reference section below.

Resources


AIDSinfo P.O. Box 6303 Rockville, MD 20849-6303; 800-448-0440 (toll-free) Monday to Friday, noon to 5 p.m. Eastern time, 888-480-3739 (TTY/TDD/toll-free); www.aidsinfo.nih.gov

Centers for Disease Control and Prevention (CDC) 1600 Clifton Road Atlanta, GA 30333; 800-232-4636 (toll-free/24 hours a day, seven days a week/English and Spanish), 888-232-6348 (TTY/toll-free), 800-CDC-INFO (800-232-4636); www.cdc.gov

CDC, ECHPP website (http://www.cdc.gov/hiv,strategy/ ecpp/index.htm).

CDC National Prevention Information Network P.O. Box 6003 Rockville, Maryland 20849-6003; 800-458-5231 (toll-free), 800-243-7012 (TTY/toll-free); www.cdcnpin.org

EEOC’s New ADA Regulation: What Does it Mean for People with HIV? http://aidsandthelaw.com/wp/?page_id=219

Ethics questions: office@naswil.org.


IDS.gov www.aids.gov


Training of Trainer Model: To schedule a workshop, visit www.socialworkers.org/practice/hiv_aids/default.asp
National HIV/AIDS Strategy: (http://www.whitehouse.gov/administration/eop/onap/nhas)

National Institute on Aging Information Center, P.O. Box 8057, Gaithersburg, MD 20898-8057; 800-222-2225 (toll-free), 800-222-4225 (TTY/toll-free); www.nia.nih.gov www.nia.nih.gov/espanol

National Institute of Allergy and Infectious Diseases 6610 Rockledge Drive, MSC, 6612 Bethesda, MD 20892-6612; 301-496-5717; 866-284-4107 (toll-free); 800-877-8339 (TDD/toll-free); www.niaid.nih.gov


NIHSeniorHealth, provided by the National Institute on Aging and the National Library of Medicine. This website is user-friendly and provides health information for adults over 50. (www.nihseniorhealth.gov)

Office for Civil Rights, U.S. Department of Health and Human Services, contact the office at ocrmail@hhs.gov; TDD 1-800-537-7697; hotlines at 1-800-368-1019 (voice) and 1-800-537-7697 (TDD); email: ocrmail@hhs.gov; website: http://www.hhs.gov/ocr

Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders, 305 7th Avenue, 6th Floor, New York, NY 10001; phone 212-741-2247; www.sageusa.org

SocialWorkers.org

UNAIDS.org


Women’s Preventive Services at: www.hrsa.gov/womensguidelines/

References


HIV: Implications For Social Work Practice Final examination questions

Choose the best answer for questions 1 through 10 and mark your answers online at SocialWork.EliteCME.com.

1. HAART is the acronym for which of the following?
   a. Highly effective anti-resistant therapy.
   b. Highly active antiretroviral therapy.
   c. Highly active AIDS resistant therapy.
   d. None of the above.

2. Which of these statements about the transmission of HIV/AIDS is a myth?
   a. You can catch HIV by being near someone with HIV.
   b. HIV cannot be spread through contact with saliva, sweat, tears, sneezes, clothes, drinking fountains, phones, swimming pools, hot tubs, chairs, toilet seats or shaking hands, hugging, or touching the person.
   c. Insect bites and stings cannot spread the HIV virus.
   d. Donating blood does not spread HIV.

3. Which of the following best describes young and adolescent girls and their risk for HIV?
   a. Young adolescent girls are biologically more susceptible to HIV infection.
   b. They are more likely to have older sexual and partners who use injecting drugs, thus increasing their potential exposure to HIV.
   c. Violence and the threat of violence, including young women and adolescents, interfere with their ability to protect themselves from HIV infection and to make smart decisions about sexual health.
   d. All of the above.

4. Which statement is NOT true about adolescents?
   a. Adolescents who sell sex or use drugs are at higher risk of HIV infection.
   b. Adolescents often engage in behaviors that put them at high risk for HIV.
   c. Age-appropriate sexuality education does not contribute to more responsible sexual behavior among participants.
   d. Sexual activity is initiated in early adolescence, before age 15.

5. Which of the following is NOT part of the HIPAA privacy rules covering people with HIV?
   a. The complexity of the HIV/AIDS cases is compounded by the fact that public health mandates require certain information to be shared.
   b. The requirements for disclosure vary by state; social workers should contact their local jurisdiction for specifics.
   c. There are never instances in which you must reveal patient information to someone other than the patient.
   d. You are required to report the names of persons who have a positive HIV test to public health authorities for infectious disease surveillance, and in some states, you are also required to report the names of partners.

6. Which of the following is NOT correct about Section 504 Law?
   a. Individuals with disabilities are defined as persons with a physical or mental impairment, which substantially limits one or more major life activities.
   b. Major life activities include caring for one’s self, walking, seeing, hearing, speaking, breathing, working, performing manual tasks, and learning.
   c. HIV/AIDS and drug addiction are not considered a disability under Section 504.
   d. Social service agencies are among those that are governed under Section 504 and the ADA.

7. Which of the following is NOT true about testing for HIV?
   a. Testing can only be done in a physician’s office.
   b. The Home Access Express HIV-1 Test System blood test is available and approved by the Food and Drug Administration (FDA).
   c. The Home Access Express HIV-1 Test System is the only test approved by the FDA to be sold legally in the U.S. and can be purchased in a drug store.
   d. Tests that are advertised and sold online, on the street or from magazines are illegal, unreliable and should not be used.

8. The Affordable Care Act (ACA) Community Outreach Programs for the prevention of HIV:
   a. Limits funding to nationally based organizations to improve HIV prevention in racial/ethnic minority populations.
   b. Funds substance abuse/HIV/hepatitis prevention programs on campuses of historically black colleges and universities.
   c. Does not allow direct funding aimed at ethnic minorities such as American Indians and Alaska natives.
   d. Specifically rejects funds for personal responsibility education grants to states.

9. Which of the following is NOT correct about accountable care organizations (ACO) and social work?
   a. ACOs include hospitals, clinics and other care facilities, along with physicians, nurses, clinical social workers, and other physical and mental health care providers who work as a team.
   b. The team provides care for a certain number of patients as a group.
   c. The team provides primary care to manage chronic illness and use prevention practices.
   d. The act charges NASW with providing grants or financial aid to licensed social workers to help with their role in the ACO.

10. CDC funding provided to states to support behavioral interventions for HIV prevention currently exclude which of the following?
    a. Programs to promote HIV testing in African/American women ages 18-34 who are at high risk for HIV.
    b. Free condom handouts at high schools.
    c. Funds for new research.
    d. Support for ongoing clinical trials on the use of preexposure prophylaxis.