APPENDIX

Comments on Health Disparities prepared for New Jersey State Legislators, September 19, 2002

Good Morning. My name is Diane R. Brown, and I am Executive Director of the newly established Institute for the Elimination of Health Disparities at the University of Medicine and Dentistry of New Jersey. I am honored to be here not only to present testimony on a very critical topic, but also to have the opportunity to visit my junior high alma mater. I have many fond memories of attending what was then called "VLD" or Vernon L. Davey Junior High School. I am delighted to see that it is still operating and focusing its mission on the arts.

The Institute at UMDNJ was established in recognition of the disparate health status and health care experienced by racial and ethnic minorities in New Jersey. Our mission is to be a broad based partnership dedicated to the elimination of health disparities through research, education, advocacy; and collaboration. Our focus is on the major urban areas where racial and ethnic populations are concentrated and where health disparities are the greatest. As we know, New Jersey is among the most diverse states in the nation with a non-minority population that approaches 28 percent, according to the 2000 census. So we know that health disparities are a critical issue for the welfare of New Jersey as a whole and will continue to be so for the near future. We at UMDNJ and the Institute for the Elimination of Health Disparities monitor these issues vigilantly because racial and health disparities do not appear to be going away. Rather, in some cases, they continue to get worse.

While health disparities exist for many conditions, the five leading threats to the health of minorities in New Jersey are:

AIDS

- The age-adjusted death rate from HIV/AIDS is 10 times higher in New Jersey's African Americans than in Whites.

- Incidence of the disease was 23 times greater among New Jersey African-American women ages 15 to 44 than their White counterparts.

- Among African-American men in the same age bracket, the incidence was 12.5 times higher.

- The AIDS incidence rate for New Jersey Latinos was three times that of their White counterparts, according to Division of AIDS Prevention and Control data.

Asthma

- New Jersey's African Americans are more than three times more likely than Whites to be hospitalized for asthma. The hospital admission rate for asthma among non-Latino Blacks is 472.6 per 100,000 population vs. 132.6 for non-Latino Whites.

- The hospital admission rate for asthma is 54.66 percent higher for Latinos than Whites in New Jersey. The Latino rate was 292.5 per 100,000 population in 1996, vs. 132.6 for non-Latino Whites.

- Asian/Pacific Islanders are 1.5 times more likely to die from asthma. Hospital admission rate for asthma among Asians is 225 per 100,000 children.

Cancer

- Black men are more than two times more likely than White men to die of prostate cancer. Their rate was 35.9 per 100,000 age-adjusted population vs. 14.2 for whites.*

·Black women are two times more likely (4.9 per 100,000) as Whites (2.2) to die from cervical cancer, despite similar rates of Pap testing used to diagnose this cancer.

Cancer has been the leading cause of death among New Jersey's Asian/Pacific Islander population followed by heart disease and stroke. This ranking was true for all major API groups except Asian Indians for whom heart disease was the leading cause.

The cervical cancer incidence rate for Latino women is 86 percent higher than the rate for non-Latino White women, and the cervical cancer mortality rate was 78 percent higher.

Diabetes

- Black New Jerseyans are two-and-a-half times more likely than Whites to die of diabetes. Blacks' death rate was 35.9 per 100,000 vs. a rate of 14.6 for Whites.

- Latino New Jerseyans' incidence of end-stage renal disease, a complication of diabetes, is about two times that of non-Latino Whites.

- Asian American/Pacific Islander women have higher rates of diabetes as a medical risk factor of pregnancy than women of any other race, and the rate of increase in this rate is greater than in other races.

Infant Mortality

- Black infants are more than three times at greater risk than White babies to die in the first year of life. According to available numbers, the Black, non-Latino, infant mortality rate was 15.1 deaths per 1,000 live births, compared with 4.4 for non-Latino Whites.

- Latino women have two times as many low-birth-weight babies than White women in New Jersey. Latino infants are at greater risk than White babies to die before their first birthday.

- The largest increase in infant mortality rates was among Asian American/Pacific Islanders at a rate of 6.4 percent. Asian American/Pacific Islander babies were of low birth weight at a rate that was higher than the White rate (7.2 percent vs. 6.3 percent), but lower than that of African Americans (13.7 percent).

These are just some of the disparities in health outcomes that racial and ethnic minorities in this state endure. As it would be impossible to cover all aspects of health disparities, I would like to indicate that additional documentation substantiating the depth and critical nature of health disparities are available from the recent report from the Institute of Medicine "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care"; the U.S. Department of Health and Human Services Healthy People 2010; Healthy New Jersey 2010: A Health Agenda for the First Decade of the New Millennium (HNJ2010); and reports from New Jersey's Office of Minority Health.

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Why do We Have Health Disparities? Why are the rates of morbidity and mortality disproportionately higher in minority populations than in the majority White population?

Although the causes are complex and include poverty, poor education, low paying service jobs lacking benefits, and racism among other factors, a significant factor is unequal health care. African Americans, Latinos and other minorities do not have access to, nor do they receive the same health care as Whites. Most of the health disparities could be reduced and significantly impacted by having equal access to *quality* health care. An unacceptably large number of minorities lack access to preventive health care and other services.

More than 158,000 Black New Jerseyans lacked health insurance in 1999, according to recent data from the New Jersey Department of Health and Senior Services (DHSS). This number increased to 263,482 in 2000, while the number of uninsured Whites decreased by nearly 38,000 people. Additionally, more than 31 percent of Latino state residents lacked health insurance coverage in 1998, compared with under 15 percent of non-Latino Whites and nearly 22 percent of non-Latino Blacks.

The uninsured represent a cost to the system of health care – and a cost that institutions are becoming less willing to absorb. Poor and sick minorities are viewed as contributing to the high costs of health care as hospitals and physicians state that they are not adequately reimbursed for charity care. When minorities, especially those of low income receive care, it may be fragmented and inadequate.

Even among minorities with health insurance, findings from recent studies indicate that minorities are less likely to receive the same quality of care as whites. They are less likely to receive innovative and high technology procedures.

Again, the causes of health disparities are complex and the reasons for unequal treatment are many. The differences in health care occur in the context of broader historic and contemporary social and economic inequality and persistent racial and ethnic discrimination that occur in all aspects of American life. Accordingly the remedies have to be multifaceted, wholistic and focused.

In moving forward toward the elimination of health disparities, we encourage you to consider the following:

- Support strategies that ensure that minorities, especially those of low income have access to quality health care. Specifically, promote incentives that ensure an

adequate supply of services to minority patients and that encourage providers to establish practices that address minority health needs in culturally competent wholistic ways.

- *Initiate or endorse legislation designed to foster healthy communities in* New Jersey, as health disparities are not just a health issue. They involve having quality education, adequate housing, safe neighborhoods, and employment with adequate health care benefits.

- Support the development and implementation of statewide awareness and educational campaigns to: 1) Raise levels of information and awareness about minority health disparities quality of life, and, 3) Encourage culturally competent health care practices and culturally- based interventions.

- Support research needed to plug some of the holes in our data, and the infrastructure for addressing health issues and healthcare needs.

Finally, in this very wealthy state of New Jersey located within this very wealthy nation, there is *no* legitimate reason for the existence of disparities in health status and health care in any segment of our population. Although we at UMDNJ are attempting to address these disparities, it is evident that it is going to take all of us working at various levels to make a difference.

Thank you for the opportunity to speak before you this morning.

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ST. JOSEPH'S
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Urban and Community Health

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Challenges Faced by Urban Hospitals in Providing Care to the State's Poor

Good afternoon. My name is Kenneth Morris, Jr. and I am the Director, Urban and Community Affairs at St. Joseph's Regional Medical Center in Paterson, NJ. I am here to discuss some of the particular needs and challenges of hospitals in providing health care to the State's poor, and some suggestions as to measures that the New Jersey State legislature may take to assist urban hospitals.

St. Joseph's Hospital and Medical Center is located in the middle of Paterson, the State's third largest city. Like many urban hospitals, its physical plant is somewhat dated in appearance, is surrounded by substandard housing and streets, and it does not have additional acreage because it is literally a part of the community around it. Yet St. Joseph's is a high-quality, academic-oriented medical center with virtually every medical and pediatric specialty, a trauma center, a children's hospital and teaching programs for medical students, nursing and a variety of other students. Most importantly, it serves the needs of its community in a high quality, comprehensive, caring and mission-oriented fashion. It is also the largest employer in Passaic County, employing almost 4000 persons, and one of the major economic anchors of Paterson.

Despite all of the wonderful contributions that St. Joseph's makes each day, we are faced with having to discontinue programs that directly impact the healthcare of New Jersey's poor. This is for a number of reasons. A part of it is because the hospital reflects the community it serves, and when the community does not have health insurance and is unable to pay its bills for health care, the hospital likewise does not have the resources that it would like to pay its vendors. Despite the fact that Paterson has a population of 147,000 people (1.8 percent of New Jersey's population), St. Joseph's cares for almost six percent of all of the charity care patients in the State of New Jersey, and cares for almost six percent of all of the Medicaid patients in the State of New Jersey. Medicaid reimbursement covers only a portion of the costs to a hospital of providing services, and New Jersey's charity care system reimburses only a percentage of the costs of providing services to documented charity care patients. St. Joseph's estimates that it loses over $20 million per year providing services to charity care patients. This is a function of both the fact that St. Joseph's is providing care for one of the State's poorest cities with a high percentage of charity care patients, and the fact that the charity care system in New Jersey is underfunded.

Another reason for the financial hardship being experienced by so many urban hospitals today is the medical malpractice insurance crisis in New Jersey. Although this is affecting all hospitals in New Jersey, urban hospitals are often particularly hard hit because they often have more difficulty obtaining physician coverage of high risk areas such as obstetrics than do suburban hospitals, where physicians are eager to cover the emergency room because it is a source of insured patients. Last year, St. Joseph's paid approximately $5.6 million for its liability insurance. This year, the Hospital is paying $8.5 million – an increase of $2.9 million, and a 51 percentage increase. These increases in payments for malpractice have to be taken from somewhere, and that may unfortunately be from the budget for programs that serve the community. As bad as the Hospital's situation is, we have a perinatologist who cares for most of our indigent patients, who if MIIX the malpractice insurance carrier for most of the State's physicians went under, was

unable to obtain malpractice insurance for less than $240,000 annually, an amount that would have left him with close to no income after taxes and malpractice insurance. This perinatologist had only one lawsuit in twenty years of practice, but he practices in an area where the statute of limitations allows him to be sued twenty three years after he first sees a patient, with no cap on damages.

Lastly, urban hospitals are hurting because of the change in State policy over the last several years that now allows almost any hospital to open virtually any service. This means that suburban hospitals are opening programs in the most profitable areas of medicine and attracting paying patients, leaving urban hospitals caring only for those patients unable to pay, rather than for a broader payer and patient mix. This dynamic has evolved over the past number of years. Previously, urban hospitals were allowed through the certificate of need laws to operate large programs in certain specialties that because there were no other local programs, attracted patients from a broad geographical range to the urban center of excellence. St. Joseph's open heart program, a recognized leader in this area, used to attract patients from a broad area, and was able to utilize this program to subsidize its clinics and other programs to assist the medically needy in the area. Now, with the change in certificate of need policy, nearby suburban hospitals have open-heart programs as well, and attract suburban patients who are more comfortable remaining in suburban settings, leaving St. Joseph's with a lesser payer mix.

The legislature can do a number of things to assist urban hospitals:
1. Recognize the impact on urban hospitals of state funding decisions such as removing people who receive General Assistance from the FamilyCare program. When 27,000 people who used to receive FamilyCare were removed from such, it meant hospitals were no longer reimbursed through the FamilyCare program for any hospital care provided. This decision by the State cost hospitals an estimated $75 million.

2. Recognize the need for additional charity care funding for urban hospitals. Hospitals in New Jersey provide approximately $ 624 million in documented charity care, yet are reimbursed only $ 381 million - a shortfall of $ 243 million. As mentioned, St. Joseph's pays over $20 million to take care of charity care patients.

3. Vote for tort reform in New Jersey. Hospitals' insurance premiums are increasing so dramatically that hospitals are looking at programs to cut to make up for the increase in insurance, and urban hospitals are having difficulty finding doctors to provide coverage in certain specialties. California, which implemented tort reform in 1975, is one of the lucky states that has had a long and continued period of stabilization of medical malpractice suits and damages. Although the number of malpractice cases seems to have stabilized, the amount of verdicts are ever rising, and the fear of doctors and insurance companies in being hit with a large verdict drives settlements in non-meritorious cases. Please vote for a cap of damages, and for measures that don't allow obstetricians and hospitals to be sued twenty three years after they deliver a baby

4.Support measures that would strengthen urban hospitals and their communities. It is important for all that people from a broad swatch of society continue to come into urban areas, utilizing not only the high quality hospitals that exist there, but patronizing the businesses there and keeping those employees with a paycheck.

Thank you for your attention.

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Our Market: Paterson and Passaic County

- Paterson is 3rd largest city in NJ with >150,000 people.
- 25% of population have incomes at 100% Federal Poverty Line; 50% have incomes at 200% of FPL.
- Average per capita income is $9,005 versus NJ's $18,436.
- Unemployment rate >9.8%.
- 17% Households supported by public assistance.
- Population is 49.4% Hispanic, 33.9% African American, 10% Arabic.
- Large immigrant and undocumented immigrant population.
- Estimates of the uninsured pool range from 20-30% of the population.
- 40% of Paterson's population resides in a designated health personnel shortage area.

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We serve a disproportionate percentage of the State's poor, while our competitors care for Medicare and the Insured.

2000 Numbers	Medicare (not Managed Care)	Commercial (inc.Medicaid Managed Care	Medicaid (not Managed Care)	Self-Pay/Charity Care
SJRMC	5754 1.2%	4538 3.86%		
SJWH	0.79%	0.69%	0.42%	0.52%
HUMC	3.20%	8.21%	1.76%	2.60%
Valley	3.45%	1.17%	0.55%	0.64%
Passaic General	1.46%	0.08%	0.65%	1.54%

(Percentage of all inpatients by payor type in the State)

St Joseph's Regional Medical Center

What are their healthcare needs?

- Hypertension, Diabetes, Asthma endemic
  - Undiagnosed and untreated, complex system failures, poor people wait until a crisis to seek care.
  - High incidence of End Stage Renal Disease
- Limited access to care for women and children
  - Paterson's large number of children (33,000) reflects the second highest birth rate/1000 in NJ (22.3/1000).
- Needs of the elderly growing as their numbers grow
  - Stroke is a primary cause of death
  - Cancer and Heart Disease are serious issues
- Paterson's incidence of TB, STD and HIV/AIDS are among highest in the state
  - New Jersey ranks first in the nation with regard to the rate of HIV infection amongst women
  - In greater Paterson area the rate of HIV infection among women exceeds that of the nation and the state, and is 31%.

SJRMC is the Primary Tertiary Care Safety Net Hospital for the Region

- Largest Medical Center in Passaic County, with 28,141 admissions in 2001 and a 26.2% market share.
- Largest ED in Northern NJ with 67,000 visits in 2001; 27,000 of those in the Pediatric ED.
- More than 66,000 clinic visits for specialty and primary care services.
- The largest Children's Hospital in Northern NJ with 4,365 pediatric admissions in 2001, excluding normal newborns.
- Over 900 babies in NICU—one of the top five NICU's in the country by Vermont-Oxford survey.
- Over 50,000 outpatient dialysis visits to more than 400 patients.

DISPARITIES IN HEALTH CARE FOR MINORITIES
Legislative Hearing
19 September 2002

Demographic Information

The City of East Orange is 3.9 miles. It has a population of approximately 74,000. This more nearly accurate number is not supported by the 2000 Census, as there is a substantial undocumented alien population. 94.2% of the population is African American or black. 28% of the households are below the poverty level of $15,000.00 per year. Approximately 8% of the population is unemployed. The City has a large immigrant population many of whom are undocumented and thereby, not eligible for most government funded services. The City of East Orange has the highest proportion of black residents in the sate of New Jersey.

Health Care Status

This is a community, which suffers from poverty and poor health. The residents are living in a high-risk, low-income community. Access to quality health care is limited because of financial hardship and the absence of insurance coverage.

There is one hospital located in the city (one of the few remaining independent hospitals in the state) and the services provided are limited. The hospital does not offer obstetrical services. This is cause for concern as about 1,167 babies are born to East Orange women each year. Of these babies, all but about six (home, emergency room, vehicle births) are born outside of the city. Until two years ago, the City of East Orange had the highest rate of infant mortality in the state. The East Orange Health Department secured funding from the New Jersey Department of Health and Senior Services to institute the Black Infant Mortality Reduction Program. Together with additional funding from Healthy Mothers Healthy Babies of Essex County, the infant mortality rate has been decreased. We no longer have the highest rate. A birthing hospital in East Orange would help make an even more significant impact on reducing these mortality numbers. Sick babies have to be taken to hospitals outside of the city for emergency room and in-patient hospital services.

The East Orange Department of Health provides services for uninsured residents. Limited and/or restricted resources limit our ability to meet the need. Currently, we provide immunizations for children, STD Screening and treatment, lead screening and treatment for

children, HIV/AIDS Counseling and Screening and TB surveillance and treatment. Periodic health fairs provide diabetes, cholesterol and hypertension screenings.

Diabetes, cancer and hypertension are three of the major chronic health problems that plague African Americans. Unfortunately, we are unable to provide medical followup and/or treatment for the uninsured population. A grant from the Susan G. Komen Breast Cancer Foundation has created the opportunity to provide free breast health education, clinical breast examinations and mammography screening for the uninsured/underinsured residents through collaborations with the East Orange General Hospital and the UMDNJ Mobile Mammography Van.

The demands for healthcare services have changed dramatically over the past decade. Increased population, increased incidence of chronic disease and the increased incidence of infectious disease have been major drivers escalating the cost of healthcare. Charity Care funds have provided limited coverage for physician visits and in-patient hospitalizations for those who meet the Charity Care requirements. This excludes the working poor and undocumented aliens. Further, Charity Care does not provide a prescription benefit.

Solutions

- The City would benefit from a general medical clinic to provide services for the uninsured. Increased funding would allow the Department of Health to establish this clinic and provide services for the substantial number of uninsured and undocumented residents. Additionally, collaboration with the East Orange General Hospital 's Pharmacy might provide a pharmaceutical program for the uninsured.

- The hospital needs sufficient funding to allow the restoration of much needed, in-patient services.

- Health Promotion/Education, Risk Reduction and Disease Prevention must be ongoing and practiced by all city health care providers. Collaborating community partners are essential to this endeavor.

Betty Lawson, RN
Acting Supervisor of Public Health Nursing
The City of East Orange, Department of Health and Human Services

Black and Latino Caucus Thursday September 16, 2002
Yvonne Wesley RN PhD
Vice President for Research and Development
Northern New Jersey Maternal / Child Health Consortium

Hello, my name is Dr. Yvonne Wesley. I am Vice President for Research and Development at the Northern New Jersey Maternal/Child Health Consortium. As many of you know, numerous studies have shown that race has an impact on health outcomes. Specifically, Black infants are 2.5 times more likely to die in the 1st year of life compared to their White counterparts. The largest portion of this disparity is due to the fact that 12% of pregnant Black women delivery prematurely regardless of their age, education, income or marital status.

A growing body of literature contributes the high rate of pre-term delivery to psycho-social factors. Most prominent among these factors is stress (Copper, et al., 1996, Wadhwa et al., 1996 and Sandman et al., 1997).

Based on the literature, the "***Reduce Stress for Baby's Best***" (RSBB) project was designed to decrease stress among pregnant Black women to prevent pre-term birth and low birth weight. Approximately 120 ~~eligible~~ women were recruited from the Northern region of New Jersey to participate.

Registered Nurses and Social Workers were trained as intervention specialists to provide free, one-on-one stress reduction sessions at approximately 15, 20 and 25 weeks gestation. Initial enrollment procedures

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included the completion of a demographics questionnaire and the Global Measure of Perceived Stress Scale.

The morning prior to the 1st intervention, the participants were asked to provide a saliva specimen for cortisol analysis, a biochemical marker of stress. The intervention sessions lasted 45 minutes and were guided by a Stress Management Workbook. Participants were encouraged to maintain a journal to process their feelings about their pregnancy and life events. They were also instructed to listen to a guided imagery audiotape, especially designed for the RSBB Project, at least once a week.

The morning after the 3rd intervention, the Perceive Stress Scale was completed again, and a second saliva sample was obtained from the participants. Long-term follow-up data was obtained including birth weight, gestational age at delivery and medical complications.

As of March 2002, 119 women were enrolled in the project. Thirty percent of the women dis-enrolled due to an inability to keep the three appointments. The remaining women were, on average, 26.3 years old (S.D.=5.5), with 13.4 years of education, and a mean annual income of $40K. On average, this was the third pregnancy for the participants and 63% of women were unmarried. The data shows that the women who had 3

visits experienced greater mean birth weights and gestational ages than those who dis-enrolled.

	Women with 3 visits N=44	Women with no visits N=17
Birth Weight in grams (S.D.)	3337g (623)	3253g (972)
Gestation at Delivery (S.D.)	39.1wks (2)	36.6wks (6.8)

Table 1.

Independent t-test analysis revealed a significant (p=.003) reduction in perceived stress scores and the mean post-intervention cortisol samples did not gain a significant increase relative to the pre-intervention saliva specimens.

To better understand why some pregnant Black women deliver prematurely, we need more community-based programs that systematically collect data, analyze the data and disseminate their results. We not longer need to compare races because most genetic scientists understand that race is a social construct. Therefore, we need to compare Blacks to one another to improve health outcomes among Blacks.

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CHAIRPERSON/CEO
Rev. J. Stanley Justice

Executive Director
Rev. Linda G. Ellerbe

Vision Statement
To provide the community with the knowledge, skills and services to lead happy, healthy and productive lives.

Address to the Black and Latino Caucus Special Hearing on HIV/AIDS September 19, 2002

Thank you for this opportunity to address the current status of HIV/AIDS in the minority community, in the state of New Jersey. Unfortunately, the news is not good. The minority community is in a health crisis in general (diabetes, hypertension, asthma, etc.) and being assailed in particular by HIV/AIDS.

I am privileged to direct a state wide HIV/AIDS community mobilization agency Project FAITH, which is Funded by the DOH and is part of the New Jersey Human Development Corporation. NJHDC also runs a family strengthening program which includes teaching on HIV, in some of our cities.- Project Rebuild.

While great efforts have been made in care and treatment and research efforts have been Herculean, the numbers of HIV infected and dying continue to rise, in our community.

The New Jersey DOH has identified 10 cities most severely impacted by HIV/AIDS. They are: Atlantic City, Camden, Trenton, Elizabeth, Asbury Park, Newark, East Orange, Irvington, Paterson, and Jersey City. (Please see the attached)

New Jersey Total Population: 8,414,350
African American Population: 1,144,352 13.6% Statewide
Latino Population: 1,119,109 13.3% Statewide
(based on the 2000 census report)

Total HIV Reported Cases 42,659 * .5% of total pop.
African American Population: 56% 23,477 (2.05 % of the AA pop.)
Latino Population 16% 6,911 (.62% of Latino pop.)
***Known dead 26,336**

New Jersey still ranks 5th in the nation of reported HIV/AIDS cases, (following NY, CA, FL,& TX) and has the dubious distinction of having one the largest %'s of cases caused by IDU (55% in AA men and 46% in Latino men, 49% and 35% respectively in women).

Unfortunately, non-communication about critical issues is inherent in our cultures. We must take leadership and begin to talk about the things that are killing us. Sex, sexuality, drugs, personal choices must be talked about openly. The repercussion of silence is death.

In my opinion, it is imperative that our leadership take certain immediate actions to:

1. Identify those who are infected. Everyone must know their status. HIV is asymptomatic for far too long. You can feel and look healthy while infecting other people. Infected persons need care and treatment.

2. Spread an emphatic emergency message in our communities of prevention and care and treatment. Teach HIV prevention in school, in houses of worship, in cultural clubs, in social settings. Make the message an " in your face" every where you go message.

3. Address the pertinent issues surrounding HIV- IDU, MSM; gay and DL, prison infection rates, teen pregnancy and sexuality.

Thank You,

Rev. Linda Ellerbe

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Project FAITH
Target Cities

IMPACT CITIES	HOT CITIES
Atlantic City	**Vineland/Millville** **Pleasantville**
Camden **Trenton**	
Elizabeth **Asbury Park**	**New Brunswick** **Perth Amboy** **Plainfield** **Long Branch/ Neptune**
Newark **East Orange** **Irvington** **Paterson** **Jersey City**	**Morristown/Dover** **Passaic** **Bayonne** **Hackensack/Teaneck**

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NJHDC Project FAITH

(Families Acquiring Information Together on HIV/AIDS)

presents

The African American Community Singing for AIDS Awareness

in

"THE REASON WHY WE SING" CONCERT SERIES

A Series of Gospel Concerts Across the State of New Jersey

Concert Locations, Dates & Times:

Atlantic City:
Vineland:

Camden:
Trenton:

Asbury Park:
Plainfield:

Newark:
Jersey City:
Paterson:

NO ADMISSION CHARGE
FREE WILL OFFERING

PLEASE CALL 1-866-HIV-TALK (448-8255) FOR MORE INFORMATION:

Project FAITH is funded by The New Jersey Department of Health and Senior Services, Division of AIDS Prevention and Control

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HOW TO BECOME A FAITH PARTNER OF NHDC PROJECT FAITH
(Families Acquiring Information Together on HIV/AIDS)

FAITH Partnership is for a term of one year. Organizations reassess and agree each year to remain in FAITH partners status.

To be FAITH Ministry Partner you agree to

1. Be an organized house of worship.

2. Complete the Annual FAITH Agreement.

Benefits of the FAITH Partnership

NJHDC Project FAITH is pleased to partner with houses of worship that are committed to the work of HIV ministry, and will provide the following:

1. **Affiliation with a state wide organization that has proven expertise in the mobilization of houses of worship in HIV/AIDS awareness.**

2. **Listing as a partner in local literature, selected press releases, and materials.**

3. **Ongoing technical assistance in developing and strengthening HIV/AIDS ministry in your community.**

4. **Certificate identifying your house of worship as a FAITH Partner for the year of partnership.**

5. **As appropriate, FREE HIV materials to enhance local efforts, including but not limited to Bulletin Covers, Bulletin Inserts, and HIV Literature.**

6. **Annual Partners Luncheon -**

Funded by The Department of Health and Senior Services
Division of AIDS Prevention and Control

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New Jersey Human Development Corporation

Project FAITH

(Families Acquiring Information on HIV/AIDS)

FAITH Partner Agreement

(please print clearly)

Name of House of Worship: _____

Address: _____

City: _____ **County:** _____ **State: NJ** **Zip Code:** _____

Telephone Number: _____ **Fax Number:** _____

E-mail Address: _____ **Website Address:** _____

Denomination: _____ **Membership #:** _____

Pastor's Name: _____

Address: _____

City: _____ **County:** _____ **State: NJ** **Zip Code:** _____

Telephone Number: _____ **Fax Number:** _____

E-mail Address: _____

HIV Ministry Coordinator's Name: _____

Address: _____

City: _____ **County:** _____ **State: NJ** **Zip Code:** _____

Telephone Number: _____ **Fax Number:** _____

E-mail Address: _____

Funded by The Department of Health and Senior Services
Division of AIDS Prevention and Control

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Do you currently have an HIV ministry? _____yes _____no
If yes, tell us about it.

_____

_____

_____

Areas of Interest for HIV Ministry: Circle (Circle all that apply)

Prison Ministry	Senior's Ministry	Health Ministry
Women's Ministry	Youth Ministry	Grief Ministry
Men's Ministry	Food Ministry	Support Group

Other: _____

In light of the pandemic of HIV/AIDS, that currently devastates our community, the people of God , called

_____ **wish to respond, in FAITH partnership with NJHDC Project FAITH.**
(name of house of worship)

The undersigned house of worship agrees to:

1. **Become a resource center, distributing provided/ pastor approved HIV literature and information.**
2. **Receive Free HIV Training - HIV Basic Facts.**
3. **Develop an HIV ministry that aligns with at least one of the Project FAITH designated areas.**
4. **Participate in the following:**
   a. **National Black HIV Awareness Day Feb 7**
   b. **The Balm in Gilead Black Church Week of Prayer for the Healing of AIDS March (The week beginning with the 1st Sunday)**
   c. **Annual HIV Testing awareness.(June 27.)**
   d. **World AIDS Day December 1**
5. **Complete the data forms and share samples of bulletins, programs, and events.**

_____

Pastor's Signature

Funded by The Department of Health and Senior Services
Division of AIDS Prevention and Control

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Project FAITH

Families Acquiring Information Together on HIV/AIDS

We Build Ministries !

Project FAITH is New Jersey's HIV Faith based, State funded, Community Mobilization Agency

Funded by the NJ DOH Div. of AIDS and Senior Services

We are the church's response to the HIV pandemic by providing:

FREE Training and Education
for clergy and ministry workers

FREE Technical Assistance
for ministry building

FREE HIV Literature

We bridge the gap between Faith Communities & HIV Service Providers

Let us assist you in moving from views and visions to Creating vital, vibrant ministry.

For information and assistance, please call:
The New Brunswick and North Central Jersey Region
Program Coordinator
Mr. Raymond Fleming

973-286-3705

or

1-866-HIV-TALK

Project FAITH is a certified partner of the Balm in Gilead
Funded by The New Jersey Department of Health and Senior Services, Division of AIDS Prevention and Control

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For information and assistance, please call:
The Newark and North Jersey Region
Program Coordinator
Ms. Eva Marie Flannory

973-286-3705

or

1-866-HIV-TALK

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For information and assistance, please call:
The Camden/Trenton and South Central Jersey Region
Program Coordinator
Rev. M. Lloyd Guyton

856-235-3152

or

1-866-HIV-TALK

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For information and assistance, please call:
The Atlantic City and South Jersey Region
Program Coordinator
Rev. Charles E. Wilkins

856-327-1247

or

1-866-HIV-TALK

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Project FAITH

Project FAITH

(Families Acquiring Information Together on HIV/AIDS)

We are here for you.

The New Jersey Human Development Corporation
(an AME 501c3 Corp.)
has responded to the AIDS Pandemic

We are your HIV/AIDS prevention, education, community mobilization agency.

Project FAITH offers you and your church:

FREE HIV Literature

FREE HIV/AIDS Basic Training

FREE Technical Assistance for Health Events

FREE HIV Workshops and Seminars & Films

FREE Help Building Your Ministry

Have questions? Need Assistance?
We can refer you to the proper agency. It's confidential.

Call us to find out about NJHDC's other program- Project Rebuild.

1-866-HIV-TALK (448-8255)

Help us break the silence. Save lives. Talk about HIV.

NJHDC- Project FAITH is Funded by the New Jersey Department of Health and Senior Services, Division of AIDS Prevention and Control

NJHDC

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HIV/AIDS AND INJECTION DRUG USE IN NEW JERSEY*

- **Among adult/adolescent males with HIV infection, the percentage linked to injection drug use decreased from 57% in 1993 to 46% in 1999.**
- **Among adult/adolescent females with HIV infection, the percentage linked to injection drug use decreased from 52% in 1993 to about 44% in 1999.**
- **Among adult/adolescent Whites with HIV infection, the percentage linked to injection drug use decreased from nearly 45% in 1993 to nearly 37% in 1999.**
- **Among adult/adolescent Blacks with HIV infection, the percentage linked to injection drug use decreased from 60% in 1993 to 49% in 1999.**
- **Among adult/adolescent Hispanics with HIV infection, the percentage linked to injection drug use decreased from 60% in 1993 to 45% in 1999.**
- **The statewide New Jersey HIV Prevention Community Planning Group has identified the reduction of HIV infections among injection drug users as New Jersey's highest HIV prevention priority.**

* *Data provided by the NJ Department of Health and Senior Services, Division of AIDS Prevention and Control; Surveillance data as of 12/31/99.*

You can get HIV...

- *from sharing needles, spoons, bottle caps, or whatever you use (your works) to inject drugs.*
- *from having unprotected sex with an HIV-infected person. And since most people with HIV look healthy, you may not know that your sexual partner is infected with HIV.*

You can give HIV to another person, if you are infected with HIV, and if...

- *you have unprotected sex with another person, male or female.*
- *you have unprotected sex with a woman and she passes it on to her unborn child.*
- *you share needles and works to inject drugs.*

You can reduce your risk for HIV infection...

- *by getting into a drug treatment program.*
- *by not sharing needles and works to inject drugs.*
- *by cleaning needles and/or works with bleach before using them.*
- *by using a latex condom correctly every time you have sex.*

You can reduce your unborn baby's risk for HIV...

- *by knowing if you are HIV positive as early in pregnancy as possible.*
- *by going for HIV testing.*
- *by going for prenatal care and keeping your appointments.*
- *by taking prescribed medications.*

New Jersey AIDS/STD Hotline
1-800-624-2377
or
New Jersey Substance Abuse Hotline
1-800-225-0196

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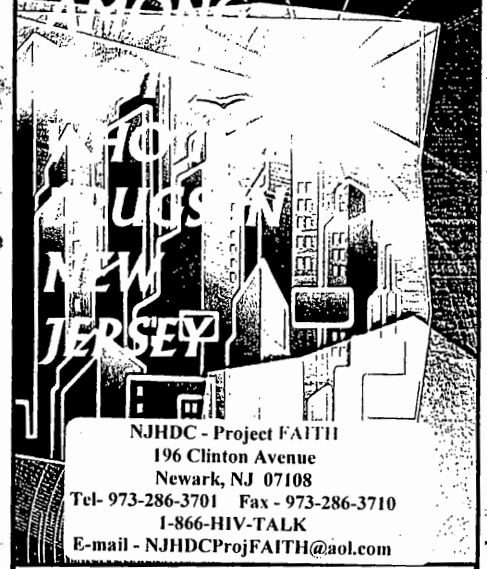
PREVENTING HIV INFECTION AMONG



NJHDC - Project FAITH
196 Clinton Avenue
Newark, NJ 07108
Tel- 973-286-3701 Fax - 973-286-3710
1-866-HIV-TALK
E-mail - NJHDCProjFAITH@aol.com

NEW JERSEY DEPARTMENT of HEALTH and SENIOR SERVICES

www.state.nj.us/health

Division of AIDS Prevention and Control

HIV PREVENTION PROJECTS STATEWIDE

Prevention projects targeting youth, women, and men who have sex with other men that include active injecting drug users and their sexual partners as part of their target populations are located in the following New Jersey cities:

Asbury Park	**Atlantic City**	**Bridgeton**
Camden	**Elizabeth**	**Glassboro**
Jersey City	**New Brunswick**	**Newark**
Passaic	**Paterson**	**Perth Amboy**
Plainfield	**Trenton**	**Vineland**

Prevention activities include:

- **intensive street and community outreach with links to HIV testing, treatment services, drug treatment, and other social services;**
- **intensive HIV prevention risk reduction/ health education group sessions that focus on information and skills needed to reduce HIV risk;**
- **intensive one-on-one HIV prevention case management counseling sessions to assist individuals in reducing their risk for HIV infection.**

PERINATAL HIV PREVENTION INITIATIVE

This intensive outreach effort uses mobile vans to link women who are injection drug users (IDU) and/or sex workers in Newark, Jersey City, and Paterson, to HIV prevention services and prenatal care.

For additional information about HIV prevention services statewide, and for referral to any of these HIV prevention projects, contact:

New Jersey AIDS/STD Hotline
1-800-624-2377

PREVENTION INCENTIVE PROGRAMS

Programs that provide incentives to active injecting drug users and their sexual partners to prevent HIV infection

The Health Incentive Program (HIP) for Women

- health education/risk reduction multi-sessions that provide women with the information and skills needed to reduce their risk for HIV infection;
- HIV risk reduction counseling and referral to HIV testing and treatment services;
- incentives provided to participants to encourage participation in educational sessions.

Patient Incentive Program (PIP) for Active Injecting Drug Users

- drug treatment services;
- health education/risk reduction multi-sessions that provide IDU with the information and skills needed to reduce their risk for HIV infection;
- HIV risk reduction counseling and referral to HIV testing and treatment services;
- incentives provided to participants to encourage participation in educational sessions.

For information about the locations and hours of operation of HIP and PIP projects statewide, contact the Counseling and Testing Services unit of the Division of AIDS Prevention and Control at (609) 984-6125.

HIV COUNSELING AND TESTING SERVICES

The New Jersey Department of Health and Senior Services funds 23 HIV counseling and testing sites statewide. Each site provides confidential HIV testing services, pre-test and post-test counseling, and partner counseling services, along with referral to HIV prevention and treatment services.

For information about the location and hours of operation for each of these HIV counseling and testing sites, contact
New Jersey AIDS/STD Hotline
1-800-624-2377

DRUG TREATMENT OPPORTUNITIES

A variety of substance abuse treatment services are available to injecting drug users in every New Jersey county. The Division of Addiction Services sponsors two 24-hour substance abuse hotlines, in English and Spanish, for information about drug and alcohol problems and substance abuse treatment resources:

ALA-call **1-800-225-0196**
NJ Substance Abuse Hotline **1-800-322-5525**

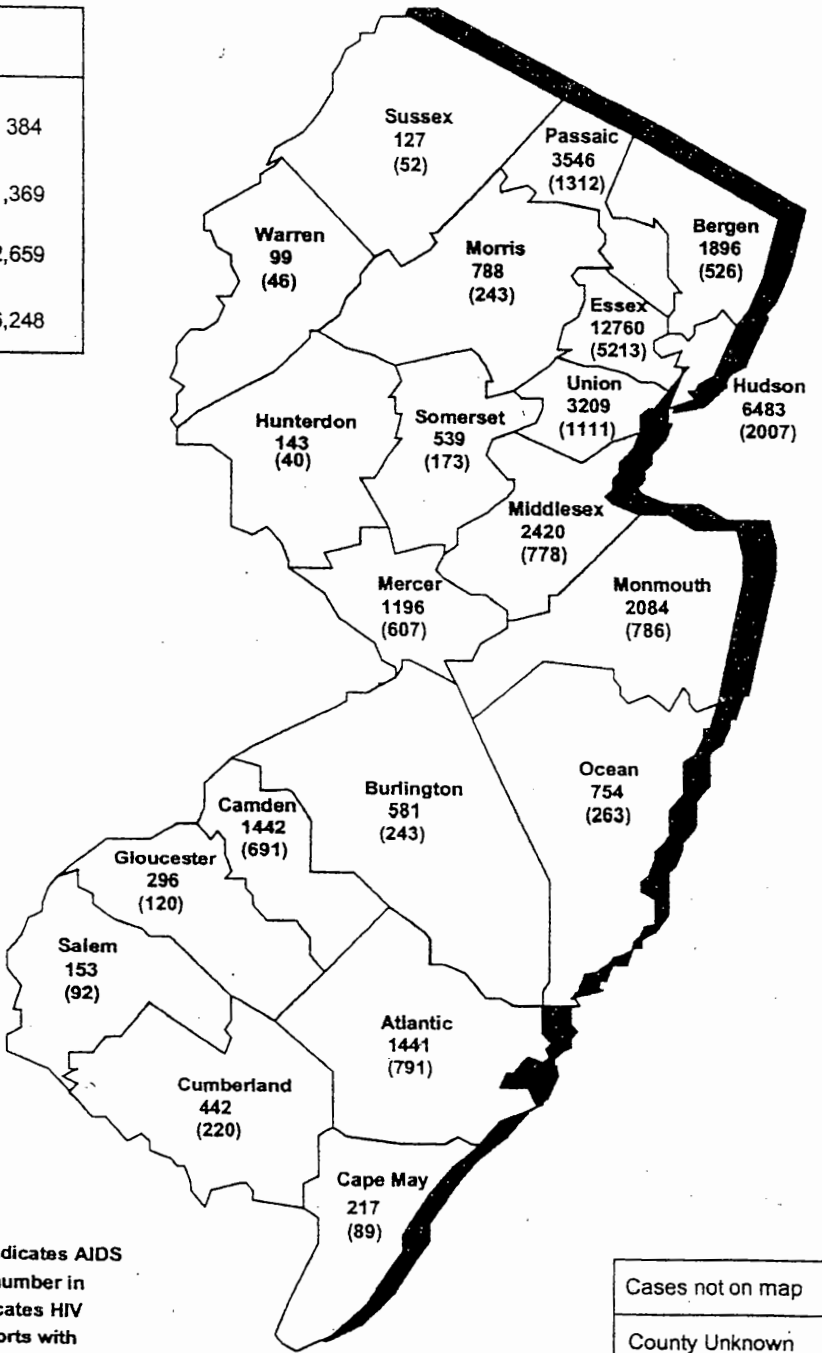
TREATMENT SERVICES FOR INJECTION DRUG USERS LIVING WITH HIV

A full range of HIV and drug treatment services are available to injecting drug users living with HIV in New Jersey. These services can be found at select drug treatment centers located throughout the State, and are funded by the Ryan White Care Act and by the Divisions of Addiction Services and AIDS Prevention and Control. For information, call the lead agency for the regional Title I or Title II service network in your area.

Atlantic and Cape May Counties	Atlantic City Medical Center 1-800-281-2437
Burlington, Camden, Gloucester, Salem Counties	South Jersey Council on AIDS (856) 453-2155
Cumberland County	Cumberland County Office of Planning and Development (856) 453-2155
Essex, Morris, Sussex, and Warren Counties	Newark Department of Human Services (973) 733-4402
Hudson County	Hudson County Department of Human Services (201) 271-4352
Mercer County	Family Guidance Center 1-800-550-6755
Middlesex, Somerset, and Hunterdon Counties	Middlesex County Health Department (732) 745-3149
Monmouth and Ocean Counties	VNA of Central Jersey 1-800-947-0020
Bergen and Passaic Counties	City of Paterson Department of Human Resources (973) 881-3395
Union County	Union County Department of Human Services (908) 558-2545

NEW JERSEY HIV/AIDS CASES
Reported as of September 30, 2001

HIV/AIDS Report Summary	
Current Quarter Increase - AIDS	384
Current Year Increase -AIDS	1,369
Cumulative Total AIDS	42,659
Cumulative Total HIV+ Only	16,248



Note: Top number indicates AIDS reports. Bottom number in parentheses indicates HIV unduplicated reports with identifiers.

Cases not on map	AIDS	HIV
County Unknown	2	47
Incarcerated at Diagnosis	2,041	798

NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF AIDS PREVENTION AND CONTROL
DATA AS OF DECEMBER 31, 2001
CUMULATIVE HIV REPORTS BY RACE AND MAJOR KNOWN MODES OF TRANSMISSION FOR SELECTED MUNICIBALITIES

CITY OF RESIDENSE AT HIV DIAGNOSIS	Race/Ethnicity												TOTAL			
	White Not Hispanic				Black Not Hispanic				Hispanic							
	Mode of exposure				Mode of exposure				Mode of exposure				Mode of exposure			
	MSM	IDU	HETE-RO	TOTAL	MSM	IDU	HETE-RO	TOTAL	MSM	IDU	HETE-RO	TOTAL	MSM	IDU	HETE-RO	TOTAL
	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#
ASBURY PARK	19	12	7	38	20	146	80	246	5	15	7	27	44	173	94	311
ATLANTIC CITY	35	52	11	98	57	330	72	459	27	66	14	107	119	448	97	664
CAMDEN	9	21	9	39	64	136	72	272	18	108	73	199	91	265	154	510
ELIZABETH	27	39	8	74	27	220	91	338	37	72	64	173	91	331	163	585
HACKENSACK	15	22	5	42	7	27	22	56	6	9	6	21	28	58	33	119
JERSEY CITY	72	122	36	230	184	430	281	895	94	221	134	449	350	773	451	1574
NEW BRUNSWICK	17	11	5	33	13	102	54	169	13	24	16	63	43	137	75	255
NEWARK	15	89	30	134	310	2146	1020	3476	77	405	181	663	402	2640	1231	4273
PASSAIC	7	12	6	25	6	74	31	111	20	41	34	95	33	127	71	231
PATERSON	10	71	18	99	62	391	198	651	54	177	104	335	126	639	320	1085
TRENTON	26	53	18	97	78	253	126	457	8	37	14	59	112	343	158	613
TOTAL	252	504	153	909	828	4255	2047	7130	359	1175	647	2181	1439	5934	2847	10220

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Table 1. New Jersey AIDS Cases Reported October 2000 - September 2001 and Cumulative Totals as of September 30, 2001 Age at Diagnosis, by Gender

Age Group	MALE				FEMALE				TOTAL				Females as Percent of Cumulative Age Group Totals
	October 2000 - September 2001		Cumulative Total		October 2000 - September 2001		Cumulative Total		October 2000 - September 2001		Cumulative Total		
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	
Under 5	4	0%	285	1%	0	0%	266	2%	4	0%	551	1%	48%
5-12	2	0%	88	0%	5	1%	99	1%	7	0%	187	0%	53%
13-19	11	1%	117	0%	7	1%	77	1%	18	1%	194	0%	40%
20-29	100	8%	3,752	12%	80	12%	2,143	18%	180	9%	5,895	14%	36%
30-39	457	35%	13,614	45%	275	41%	5,760	47%	732	37%	19,374	45%	30%
40-49	495	38%	9,159	30%	210	32%	2,833	23%	705	36%	11,992	28%	24%
Over 49	240	18%	3,480	11%	86	13%	986	8%	326	17%	4,466	10%	22%
Total	1,309	100%	30,495	100%	663	100%	12,164	100%	1,972	100%	42,659	100%	29%

Table 2. New Jersey Adult/Adolescent (1) AIDS Cases Reported October 2000 - September 2001 and Cumulative Totals as of September 30, 2001 Mode of Transmission, by Gender

Mode of Transmission (2)	MALE				FEMALE				TOTAL				Females as Percent of Cumulative Transmission Mode Totals
	October 2000 - September 2001		Cumulative Total		October 2000 - September 2001		Cumulative Total		October 2000 - September 2001		Cumulative Total		
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	
MSM (3)	329	25%	8,441	28%	0	0%	0	0%	329	17%	8,441	20%	0%
IDU (3)	374	29%	13,870	46%	174	26%	5,555	47%	548	28%	19,425	46%	29%
MSM/IDU	34	3%	1,576	5%	0	0%	0	0%	34	2%	1,576	4%	0%
Hemophilia	5	0%	174	1%	0	0%	2	0%	5	0%	176	0%	1%
Heterosexual	157	12%	1,963	7%	263	40%	3,948	33%	420	21%	5,911	14%	67%
Transfusion	11	1%	246	1%	11	2%	265	2%	22	1%	511	1%	52%
Other/Unknown	393	30%	3,852	13%	210	32%	2,029	17%	603	31%	5,881	14%	35%
Total	1,303	100%	30,122	100%	658	100%	11,799	100%	1,961	100%	41,921	100%	28%

(1) Includes all patients 13 years of age or older at time of diagnosis.
(2) Cases with more than one risk factor, other than the combinations listed in the tables, are tabulated only in the group listed first.
(3) MSM = Male sex with male. IDU = Injection drug use.

Table 3. New Jersey Pediatric AIDS Cases by Mode of Transmission Data as of September 30, 2001

Mode of Transmission (1)	MALE		FEMALE		TOTAL	
	No.	(%)	No.	(%)	No.	(%)
Hemophilia/Coagulation Disorder	11	3%	0	0%	11	1%
Mother With/At Risk of AIDS (2)	351	94%	351	96%	702	95%
Transfusion/Blood Components	7	2%	8	2%	15	2%
Other/Unknown	4	1%	6	2%	10	1%
Total (3)	373	100%	365	100%	738	100%

(1) Cases with more than one risk factor, other than the combinations listed in the tables, are tabulated only in the group listed first.
(2) Epidemiologic data suggest transmission from an infected mother to her fetus or infant during the perinatal period.
(3) Includes all patients under 13 years of age at time of diagnosis.

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Table 4. New Jersey Adult/Adolescent AIDS Cases Reported October 2000 - September 2001
Mode of Transmission by Gender and Racial/Ethnic Group
and Cumulative Totals as of September 30, 2001 (1)

MALE

Mode of Transmission (2)	White (Non-Hispanic)				African American (Non-Hispanic)				Hispanic			
	October 2000 - September 2001		Cumulative Total		October 2000 - September 2001		Cumulative Total		October 2000 - September 2001		Cumulative Total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
MSM	119	42%	4,244	47%	135	18%	2,755	18%	71	27%	1,384	26%
IDU	56	20%	2,897	32%	237	32%	8,554	55%	78	30%	2,386	46%
MSM/IDU	10	4%	474	5%	19	3%	834	5%	5	2%	263	5%
Hemophilia	3	1%	121	1%	2	0%	29	0%	0	0%	21	0%
Heterosexual	14	5%	315	3%	113	15%	1,236	8%	24	9%	391	7%
Transfusion	5	2%	146	2%	5	1%	69	0%	1	0%	25	0%
Other/Unknown	78	27%	834	9%	231	31%	2,197	14%	80	31%	764	15%
Subtotal	285	100%	9,031	100%	742	100%	15,674	100%	259	100%	5,234	100%

FEMALE

Mode of Transmission (2)	White (Non-Hispanic)				African American (Non-Hispanic)				Hispanic			
	October 2000 - September 2001		Cumulative Total		October 2000 - September 2001		Cumulative Total		October 2000 - September 2001		Cumulative Total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
IDU	24	26%	1,115	49%	121	27%	3,829	49%	28	25%	595	35%
Hemophilia	0	0%	2	0%	0	0%	0	0%	0	0%	0	0%
Heterosexual	33	36%	683	30%	179	41%	2,489	32%	47	41%	757	45%
Transfusion	1	1%	97	4%	7	2%	127	2%	2	2%	34	2%
Other/Unknown	34	37%	360	16%	134	30%	1,358	17%	37	32%	291	17%
Subtotal	92	100%	2,257	100%	441	100%	7,803	100%	114	100%	1,677	100%
Total (M & F)	377		11,288		1,183		23,477		373		6,911	

(1) Includes all patients 13 years of age or older at time of diagnosis
(2) Cases with more than one risk factor, other than the combinations listed in the tables, are tabulated only in the group listed first.
Note: Cases of other/unknown racial/ethnic groups are not listed in this table.

Table 5. AIDS Cases by State of Residence
Reported to CDC as of September 30, 2001

STATE OF RESIDENCE	CUMULATIVE TOTAL SINCE JUNE 1981					
	Adult/Adolescent		Children		Total	
	No.	(%)	No.	(%)	No.	(%)
New York	143,428	18%	2,275	25%	145,703	18%
California	122,077	15%	617	7%	122,694	15%
Florida	82,800	10%	1,422	16%	84,222	10%
Texas	55,618	7%	386	4%	56,004	7%
New Jersey	**42,697**	**5%**	**754**	**8%**	**43,451**	**5%**
Illinois	25,715	3%	272	3%	25,987	3%
Puerto Rico	25,417	3%	388	4%	25,805	3%
Pennsylvania	25,433	3%	334	4%	25,767	3%
Georgia	23,630	3%	212	2%	23,842	3%
Maryland	22,877	3%	309	3%	23,186	3%
Remainder of US	224,725	28%	2,066	23%	212,032	26%
Total	794,417	100%	9,035	100%	803,452	100%

HIV/AIDS Mode of Transmission

Figures 1, 2, and 3 reflect statistical adjustments for AIDS cases initially reported with "no identified risk" (NIR). NIR cases include persons whose risk category is incomplete or is under investigation, and persons for whom no transmission mode was identified. As the proportion of HIV/AIDS cases reported with no risk increases, adjusted estimates more accurately depict the distribution of cases by transmission category.

In the adjusted figures, AIDS cases reported with unknown risk are reallocated to other categories. The weights used to adjust NIR cases were computed by the Centers for Disease Control and Prevention. Weights are based on sex-, race-, and region-specific re-distributions of cumulative NIR cases diagnosed from 1990 through 1998 which have subsequently been reclassified.

Figure 1. Estimated Proportion of New Jersey Adult/Adolescent AIDS Cases Infected Through Heterosexual Sex by Gender and Year of Diagnosis 1986 - 1999

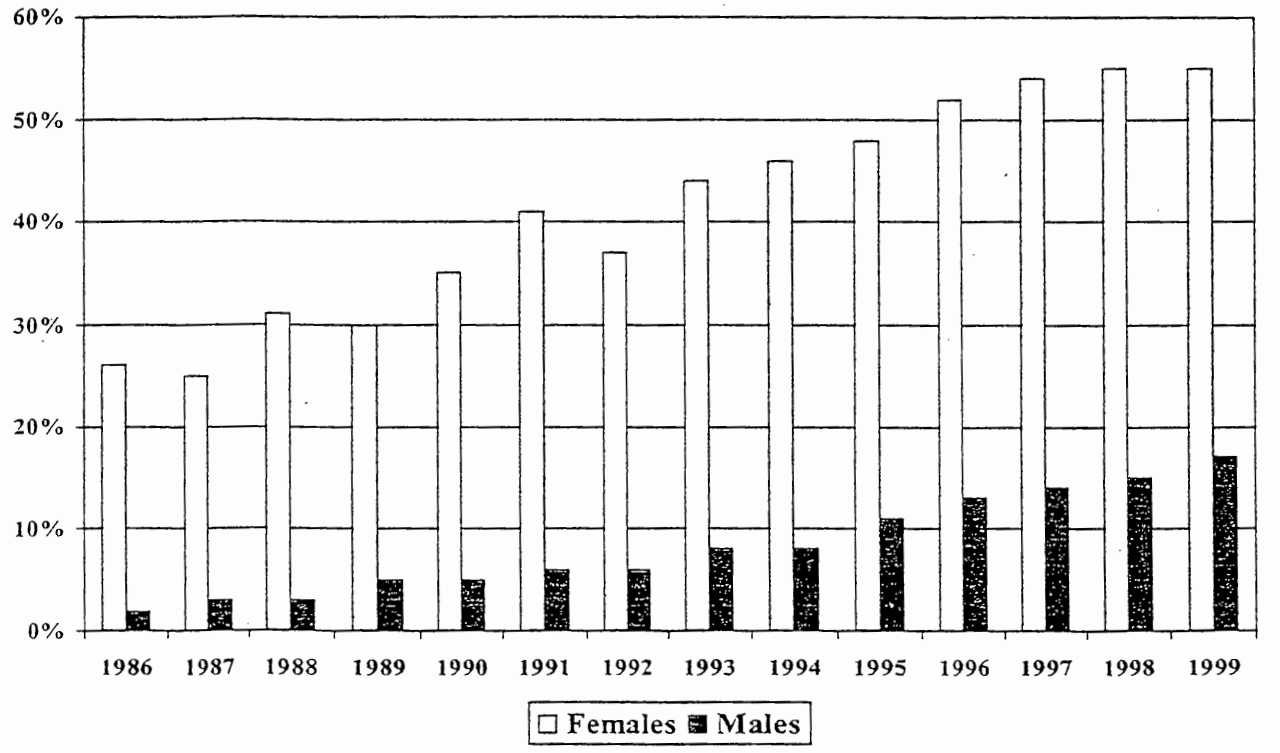

Figure 1 above depicts the estimated proportion of New Jersey adult/adolescent AIDS cases infected through heterosexual sex by year of AIDS diagnosis after NIR cases were redistributed. (See note on HIV/AIDS mode of transmission above). Figures 2 and 3 on page 5 depict the estimated numbers of New Jersey adult/adolescent AIDS cases by exposure category and year of AIDS diagnosis after NIR cases were redistributed.

Figure 1 shows that the proportion of men infected through heterosexual sex has increased tenfold since 1986, while the proportion of women infected through heterosexual sex has more than doubled in that same time period.

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Figure 2. Estimated Number of New Jersey Male Adult/Adolescent AIDS Cases by Mode of Transmission (see page 4) and Year of Diagnosis 1986 - 1999

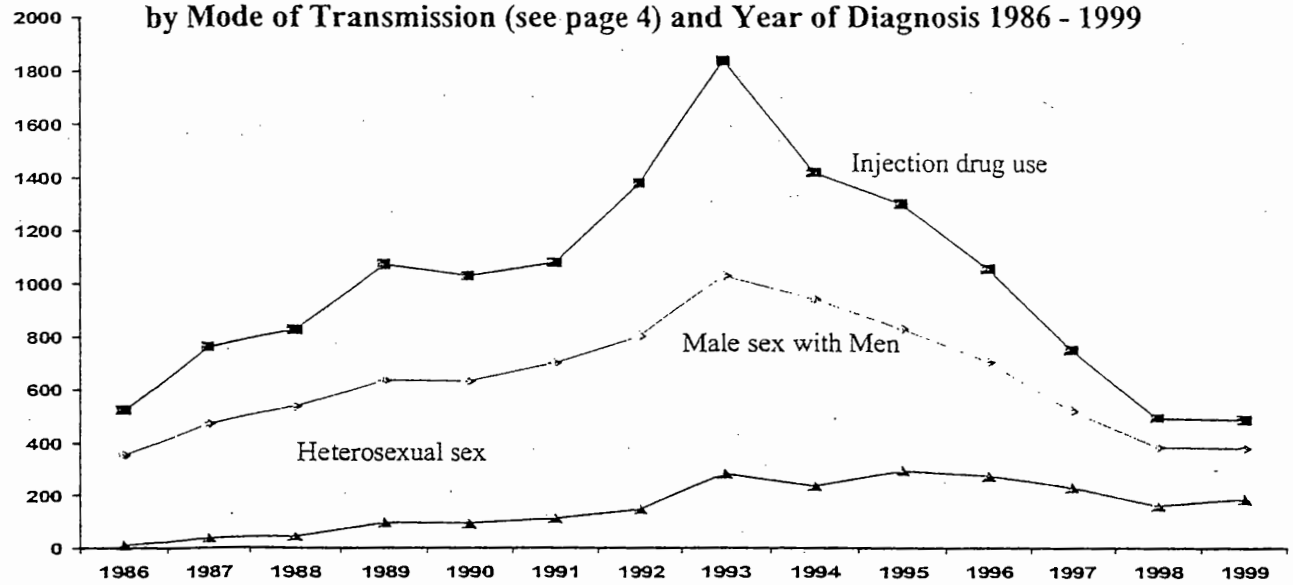

Figure 2 indicates that injection drug use remains the largest source of infection among men with adjusted modes of transmission. However, the number of men infected through injection drug use has steadily declined since peaking in 1993. Similarly, the number of men infected through male sex with men has also declined since 1993, although the decline has been less dramatic. On the other hand, the number of men infected through heterosexual sex has increased overall since 1986, and has remained relatively stable since 1993.

Figure 3. Estimated Number of New Jersey Female Adult/Adolescent AIDS Cases by Mode of Transmission (see page 4) and Year of Diagnosis 1986 - 1999

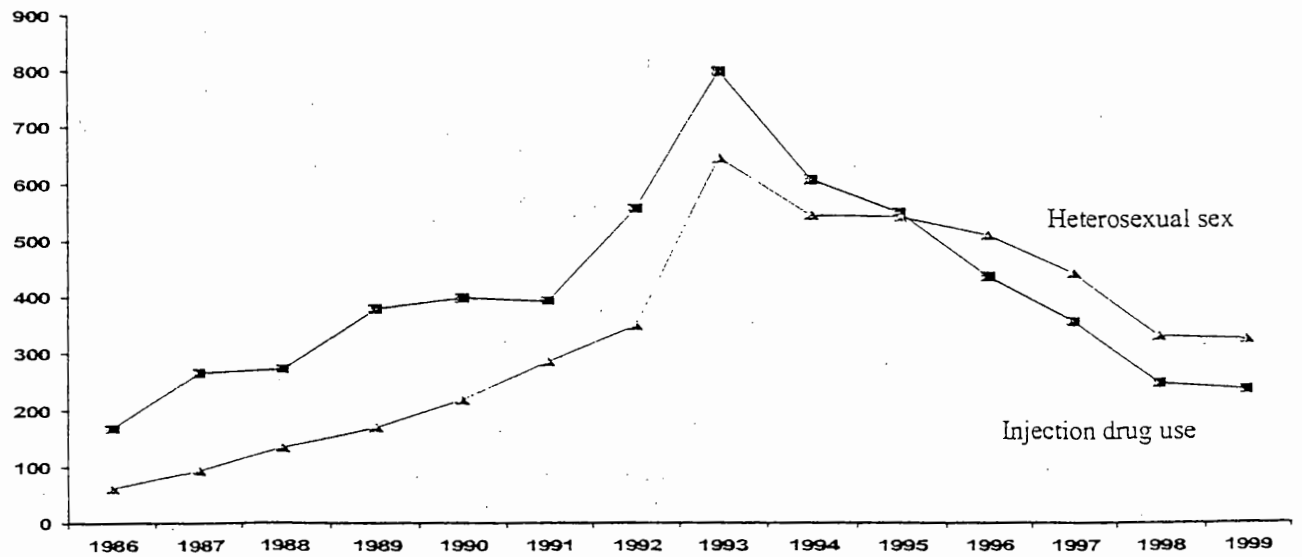

Figure 3 indicates that the number of women infected through heterosexual sex increased until 1993 along with the number of women infected through injection drug use. Because the number of women infected through injection drug use has decreased more sharply than the number of women infected through heterosexual sex since that time, heterosexual sex became the larger source of infection over injection drug use among women with adjusted modes of transmission in 1996.

Table 6. New Jersey AIDS Cases Reported October 2000 - September 2001 and Cumulative Totals by Racial/Ethnic Group and Gender as of September 30, 2001

	MALE				FEMALE				TOTAL				Females as %
	October 2000-September 2001		Cumulative Total		October 2000-September 2001		Cumulative Total		October 2000-September 2001		Cumulative Total		of Cumulative Racial/Ethnic
Adults/Adolescents (1)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	Group Totals
White	285	22%	9,031	30%	92	14%	2,257	19%	377	19%	11,288	27%	20%
Black	742	57%	15,674	52%	441	67%	7,803	66%	1,183	60%	23,477	56%	33%
Hispanic	259	20%	5,234	17%	114	17%	1,677	14%	373	19%	6,911	16%	24%
Asian/Pac. Isl.	10	1%	116	0%	8	1%	45	0%	18	1%	161	0%	28%
Other/Unknown	7	1%	67	0%	3	0%	17	0%	10	1%	84	0%	20%
Subtotal	1,303	100%	30,122	100%	658	100%	11,799	100%	1,961	100%	41,921	100%	28%
Known Dead*	142	11%	19,537	65%	46	7%	6,799	58%	188	10%	26,336	63%	26%

	MALE				FEMALE				TOTAL				Females as %
	October 2000-September 2001		Cumulative Total		October 2000-September 2001		Cumulative Total		October 2000-September 2001		Cumulative Total		of Cumulative Racial/Ethnic
Children (2)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	Group Totals
White	0	0%	59	16%	1	20%	59	16%	1	9%	118	16%	50%
Black	4	67%	239	64%	2	40%	241	66%	6	55%	480	65%	50%
Hispanic	2	33%	74	20%	2	40%	63	17%	4	36%	137	19%	46%
Other/Unknown	0	0%	1	0%	0	0%	2	1%	0	0%	3	0%	67%
Subtotal	6	100%	373	100%	5	100%	365	100%	11	100%	738	100%	49%
Known Dead*	0	0%	244	65%	1	20%	233	64%	1	9%	477	65%	49%
Grand Total	1,309		30,495		663		12,164		1,972		42,659		
Known Dead*	142	11%	19,781	65%	47	7%	7,032	58%	189	10%	26,813	63%	26%

(1) Includes all patients 13 years of age or older at time of diagnosis.
(2) Includes all patients under 13 years of age at time of diagnosis.
* Includes known deaths from all causes of persons with AIDS, whether or not cause of death is HIV/AIDS related.

New Jersey Persons Living with HIV/AIDS

Table 7. Racial/Ethnic Group by Gender as of September 30, 2001

	Adults/Adolescents (1)						Females	Children (2)						Females
	Male		Female		Total		as % of	Male		Female		Total		as % of
Race/Ethnicity	No.	(%)	No.	(%)	No.	(%)	row total	No.	(%)	No.	(%)	No.	(%)	row total
White	4,590	25%	1,797	17%	6387	22%	28%	81	11%	87	12%	168	12%	52%
Black	9,658	52%	6,554	64%	16212	56%	40%	504	70%	516	70%	1020	70%	51%
Hispanic	4,134	22%	1,792	17%	5926	20%	30%	129	18%	127	17%	256	18%	50%
Other/Unknown	332	2%	154	1%	486	2%	32%	5	1%	3	0%	8	1%	38%
Total	18,714	100%	10,297	100%	29,011	100%	35%	719	100%	733	100%	1,452	100%	50%

Table 8. Current Age by Gender as of September 30, 2001

Age Group	Male No	(%)	Female No.	(%)	Total No	(%)
Under 5	366	2%	365	3%	731	2%
5-12	353	2%	368	3%	721	2%
13-19	112	1%	108	1%	220	1%
20-29	838	4%	897	8%	1,735	6%
30-39	5,544	29%	3,841	35%	9,385	31%
40-49	8,217	42%	3,955	36%	12,172	40%
50-59	3,215	17%	1,167	11%	4,382	14%
Over 60	788	4%	329	3%	1,117	4%
Total	19,433	100%	11,030	100%	30,463	100%

(1) Includes all patients 13 years of age or older as of September 30, 2001.
(2) Includes all patients under 13 years of age as of September 30, 2001.

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HIV/AIDS
Healthcare Disparities Between Senior and The Younger Population
Presented by
Fairley H. Martin, Freeman-Martin Consultants
South Orange, New Jersey

Over the past five years my wife and I have been working as consultants for various educational and social services agencies (childcare to senior care). Most of our duties have been writing grants for funds to provide direct services. Some have been informational to direct clients to important community services for healthcare.

For the past two years we have been working with seniors services agencies and have had the opportunity to write many grants. Most of the grants that we have written to provide services to seniors have had a healthcare component. Some were for more direct health care services in the areas of HIV/AIDS, Hepatitis C, Tuberculosis, and Diabetes.

What disturbed us most during this process of securing health care funds for seniors was the reluctance of funding agencies and foundations to provide funding for senior healthcare initiatives. When my wife and the director of one of the agencies for which we worked met with one healthcare foundation's board to present an innovative proposal to direct eldery clients to healthcare sources for HIV/AIDS and Hepatitis C, one board member asked: "What's the point? They are going to die soon anyhow." In other words why are we wasting money on healthcare for seniors whose lives are almost over.

The point is all persons classified as elderly or seniors are not locked away where the community can be protected from whatever communicable disease they may have.

HIV/AIDS is one that comes to mind.

> *Over 10% of all new AIDS cases in the US occur in people over the age of 50. In the last few years, new AIDS cases rose faster in middle age and older people than in people under 40. While many of these AIDS cases are the result of HIV infection at a younger age, many are due to becoming infected after age 50.*
>
> *It is difficult to determine rates of HIV infection among older adults, as very few persons over the age of 50 at risk for HIV routinely get tested. Most older adults are first diagnosed with HIV at a late stage of infection-when they seek treatment for an HIV-related illness.*
>
> *Cases among older people may be under reported, as HIV symptoms and infections may coincide with other diseases associated with aging, and thus be overlooked. AIDS-related dementia is often misdiagnosed as Alzheimer's, and early HIV symptoms such as fatigue and weight loss may be dismissed as a normal part of aging.*

A common stereotype in the US is that older people don't have sex or use drugs. Very few HIV prevention efforts are aimed at people over 50, and most educational ad campaigns never show older adults, making them an invisible at-risk population. As a result, older people are generally less knowledgeable about HIV/AIDS than younger people and less aware of how to protect themselves against infection. This is especially true for older injecting drug users, who comprise over 16% of AIDS cases over 50.

Men who have sex with men form the largest group of AIDS cases among adults over 50. Older gay men tend to be invisible and ignored both in the gay community and in prevention. Among the HIV risk factors for older gay men are internalized homophobia, denial of risk, alcohol and other substance use, and anonymous sexual encounters.

Women comprise a greater percentage of all AIDS cases as age increases. While 6.1% of all AIDS cases among those aged 50-59 are women, the percentage of cases occurring among women rises to 13.2% for age 60-69 and 28.7% for those 65 and older. Normal aging changes such as a decrease in vaginal lubrication and thinning vaginal walls can put older women at higher risk for HIV infection during intercourse.

Few Americans over age 50 who are at risk for HIV infection either use condoms or get tested for HIV. In a national survey, at-risk people over 50 were one sixth as likely to use condoms and one fifth as likely to have been tested for HIV than at-risk people in their 20s. Factors that influence condom use in older persons are not known.

Doctors and nurses often do not consider HIV to be a risk for their older patients. A study of doctors in Texas found that most doctors rarely or never asked patients older than 50 years questions about HIV/AIDS or discussed risk factor reduction. Doctors were much more likely to rarely or never ask patients over 50 about HIV risk factors (40%) than they were to never or rarely ask patients under 30 (6.8%).

Many older people live in assisted living communities, where there is still great stigma attached to HIV/AIDS, often associated with homosexuality and/or substance abuse. Management may be resistant to providing HIV/AIDS educational materials or presentations in their facilities.

Cultural and generational issues need to be considered in crafting HIV prevention efforts. Older persons may not be comfortable disclosing their sexual behaviors or drug use to others. This can make it difficult to find older adults who attend support groups. Also, older adults may not view condom use as important or necessary, especially post-menopausal women who need not worry about pregnancy protection.

Unfortunately, few prevention programs exist that target adults over 50. Most programs for older adults offer support for HIV+ persons, or target clinicians and caregivers of older adults. Promising prevention programs incorporate generational concerns, target high-risk groups such as older gay men and older women (especially recent widows), and involve older adults in their design and as peer educators.

Senior HIV Intervention Project (SHIP) in Florida's Dade, Broward and Palm Beach Counties, trains older peer educators to present educational and safer sex seminars at retirement communities. Trained AIDS educators meet with health care professionals and aging services workers to help them understand the risk posed to seniors by HIV.

In six regional senior centers in Chicago, IL, a program used peer-led "study circles" to increase HIV awareness and knowledge. Participants viewed a video, "The Forgotten Tenth," and did their own research as to how HIV affects their lives physically, politically and economically. They then shared their knowledge at the next meetings. After the program many participants became AIDS educators.

An HIV education program for older adults was conducted at meal sites in Florida. Based on the Health Belief Model, the program included facts and statistics on older persons and HIV, condom use instruction, HIV testing information, and case studies of older persons with AIDS. After the session, participants reported a significant increase in knowledge about AIDS and perceived susceptibility to HIV.

(The Above Italicized Information was extracted from a Center for AIDS Prevention Report)

While HIV/AIDS is the example used to point up healthcare disparities between seniors and the young in this paper, the attitude of: "What's the point? They are going to die soon.", when applied to healthcare in general can have serious consequences for the general population and the Black and Latino communities especially.

American Cancer Society®

LEGISLATIVE HEARING ON DISPARITIES IN HEALTH CARE FOR MINORITIES

Testimony of American Cancer Society, Eastern Division

Good morning Chairwoman Weinberg, Assemblyman Edwards, and members of the Assembly Health and Human Services Committee. My name is Kristina Thomson, and I am the Director of the NJ Pain Initiative, a project of the American Cancer Society, Eastern Division. I am here today to testify on the disparate impact of cancer on the minority community.

I want to commend you for holding this hearing on such an important issue. Certain population groups face a disproportionate cancer burden, compared to the overall US population. The American Cancer Society is concerned about this issue and committed to helping overcome these disparities.

I would like to begin by providing you with some data on the disparities that exist. **African Americans** have the highest death rate for all cancer sites combined of any racial or ethnic group in the U.S. African American men have the highest incidence/mortality rates for prostate, colorectal and lung cancer. Prostate cancer rates for African American men are 50% higher, and they have twice the mortality rates than that of other social and ethnic groups.

While **Hispanics** experience substantially lower incidence and death rates from all cancers combined, and from the four most common cancers (female breast, prostate, colon-rectum, and lung), Hispanics have a higher burden of cancers of the stomach, liver and cervix. In fact, **Hispanics** experience the highest invasive cervical incidence rates of any group other than the Vietnamese, and twice the incidence rates of non-Hispanic White women. Breast cancer is the leading cause of cancer death among Hispanics.

Cancer has been the #1 killer of **Asian American** women since 1980. Smoking rates among Chinese men have risen and they are disproportionately impacted by lung cancer compared to other races. In addition, Chinese women have lower rates of breast and cervical cancer screening.

In addition, minorities with cancer often suffer more pain due to under medication by healthcare providers and lack of availability of appropriate resources in the community.

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Cancer Information 1.800.ACS.2345 www.cancer.org

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These are just a few examples of the disparate impact cancer has on minority populations. Clearly, many in the minority communities are not reaping the benefits of prevention, screening, improved treatment and support. The result of the challenges these populations face are fewer available culturally appropriate community health and information resources, uninformed or insensitive health care providers, lack of adequate insurance, and low usage of life saving tests, such as mammograms, Pap tests and colon cancer screenings. Cultural attitudes and beliefs may contribute to choices about available treatment options. For example, a recent survey of African American and Hispanic patients with cancer-related pain identified stoicism, and concerns about addiction and tolerance as the most common patient barriers to optimal pain control.

The American Cancer Society is committed to overcoming these health disparities. In fact, the Society has set a specific goal on this issue for the year 2015, and will work with underserved communities to achieve it. Our objective is *to eliminate the disparities in cancer burdens among population groups by reducing cancer incidence and death rates and improving quality of life in these groups to the average population.*

Towards that end, we have implemented programs to help achieve these goals. We are working community by community to insure that this goal is met. For example, the American Cancer Society has implemented the "Tell a Friend" program in Spanish—a program that encourages women to get mammograms and Pap smears according to our guidelines. The program will be implemented in cities like Jersey City, Paterson, Newark and Perth Amboy to reach the Hispanic populations in these cities.

In addition, the American Cancer Society is partnering with 100 Black Men and other community groups to promote "Let's Talk About It", a program that encourages African American men to get prostate cancer screenings. The program will be offered statewide in order to reach this population. These are just a few examples of programs the American Cancer Society is providing to reach these minority populations.

The NJ Pain Initiative, a project of the American Cancer Society, has worked feverishly to educate healthcare professionals throughout NJ about effective pain management and to dispel the myths associated with cultural bias and drug addiction.

At the American Cancer Society, we are also committed to effectively offering culturally sensitive support programs such as "Luzca Bien....Sientase Mejor", the Spanish language counterpart to the "Look Good...Feel Better" program. This group program teaches women undergoing treatment for cancer ways to manage side effects related to skin changes and hair loss. Our National Call Center, accessible at 800-ACS-2345, is available to the public 24 hours a day seven days a week to answer all questions and provide written material related to prevention, early detection, diagnosis, treatment and support services; Cancer Information Specialists offer this information in a variety of languages.

However, we clearly cannot achieve this objective on our own. We need to work with state and local governments to insure that these health disparities are reduced. A recent report issued in April, 2002 by the National Academy of Science's Institute of Medicine not only reiterates the conclusion that overwhelming evidence shows that health care disparities exist, but provides a number of recommendations to address these health disparities. Recommended interventions to combat inequities include (1) increasing public and professional awareness of disparities; (2) the promotion of consistent care through evidence-based medicine; (3) better patient education and empowerment; and (4) the integration of cross-cultural education into the training of all health professionals.

Promoting these recommendations are clear ways in which state government can help to reduce health care disparities, not just with cancer rates, but also with other diseases, which disproportionately impact minority communities. One state program that has focused on improving access to cancer screening tests among New Jersey's lower income minority population is the NJ Cancer Education and Early Detection or "CEED" program in the NJ Department of Health and Senior Services.

The CEED program was originally funded with money from the federal government to conduct breast and cervical cancer screenings for low-income uninsured women in New Jersey. Two years ago the program was expanded to also include prostate cancer screenings for men, and colorectal cancer screenings for both men and women.

In addition, NJ has also contributed $2.7 million during this budget year to fund this program—however, this funding has remained stagnant over the past few budget years. Although thousands of women have benefited from this screening program, the tight budget has severely limited the amount of prostate and colorectal cancer screenings completed. Further funding of this program, as well as promoting the other recommendations listed above will greatly increase awareness of and access to these life-saving screening tools.

Again, I thank you for the opportunity to testify today on this important issue. The staff and volunteers of the American Cancer Society look forward to helping you address this issue, so that more lives can be saved from this disease.

Dr. Dolores Ensley, D.C.
Chairperson of Gap Committee / NAACP Newark Branch

Eliminating Health Disparities

The first comprehensive report on health disparities came in 1985. By the Federal Department of Health and Human Services. "Its 2002, there is no significant change (NJPPRI) New Jersey Public Policy Research Institute".

Martha D. Hill director of the center for nursing research at John Hopkins University School of Nursing, states, " It cuts across all conditions of health and across the entire country."

Reasons attributed to health disparities.

- < Education
- < Knowledge of health options
- Lack of participation from patients
- Lack of minority doctors
- Communication/ Language barriers
- < Reimbursement from Insurance Companies, Medicare/Medicaid
- < Doctors Sensitive to cultural differences

"Racial bias and Classic negative racial stereotypes"
Stated by the Institute of Medicine.

My Recommendations.

- Relentless Teaching
- Incessant Perseverance
- Government Intervention

Civil right, equal employment opportunity, and segregation laws all needed government intervention. Health disparities are no exception.

We can no longer except coincidence as the perpetrator.

Mandatory Health Fair/Forum @ Every Middle School and High School once a year.

Phone: (973) 674-9936 Fax: (973) 674-7787

44x

Doctors, Clinics, and Hospitals / Emergency Rooms to give general posted options and standard protocols for diseases and disorders focused on prevention.

1. Cancer
2. Diabetes
3. Heart Disease and Stroke
4. Hiv/Aids
5. Homicide and Accidents
6. Immunizations
7. Infant Mortality
8. Substance Abuse

These focus areas are as listed by the state of Black Health in New Jersey.
"Prevention of the disease supersedes the cure"

Americans spend more money than any other country in the world. Yet America's health status fell short or ranking in the top five. Lets change our focus, prevention is what America must strive for in a proactive manner.

Areas of Focus

Love of self and family

1. Self- worth
2. Self – esteem
3. Self- confidence
4. Family values
5. Respecting one's health
6. Respecting family health

Nutrition

1. Importance of diet/exercise
2. Personal responsibity for your nutritional intake.
3. Patient and health care professionals must Taylor diet to embrace cultural differences.

Stress management/peer pressure

1. Identifing and channeling stress
2. Excepting self.

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Homicide/violence/suicide

1. Gangs
2. Pro/cons of Guns
3. Conflicts
4. Hope and self-worth

HIV/Aids

1. Prevention
2. Alternatives/choices
3. Facts/education on risks factors

Substance abuse

1. Prevention
2. Treatment

Respiratory disorders

1. Prevention
2. Risk factors

Infant mortality/ immunization

1. Prevention
2. Wellness

State of New Jersey
COMMISSION ON CANCER RESEARCH
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PO BOX 360
TRENTON, NEW JERSEY 08625-0360
(609) 633-6552 / FAX: (609) 633-6814

www.state.nj.us/health

STATEMENT OF
ANN MARIE HILL, EXECUTIVE DIRECTOR
BEFORE THE ASSEMBLY HEALTH AND HUMAN SERVICES MEETING
SEPTEMBER 19, 2002

Good morning, Ms. Chairman, I am Ann Marie Hill, Executive Director of the New Jersey Commission on Cancer .esearch. I appreciate the opportunity to appear before you today to discuss the problems relating to racial and ethnic disparities ı health care.

A large body of published research reveals that racial and ethnic minorities experience a lower quality of health services, ıd are less likely to receive even routine medical procedures than are white Americans. The sources of these disparities are ɔmplex, are rooted in historic and contemporary inequities, and involve many participants at several levels, including health /stems, their administrative and bureaucratic processes, utilization managers, healthcare professionals, and patients.

For instance, African American males experience cancer approximately 15% more than white men and have the highest verall rate of mortality from cancer. Death rates for preventable cancers such as cervical cancer are much higher among many hnic minorities. African American males have almost twice the death rate as white males and Asian-Pacific Islanders have high .tes of stomach, liver and gall bladder cancers. In summary, the medically underserved are likely to receive a lower quality of ısic clinical services even when variations in such factors as insurance status, income, age, co-morbid conditions, and symptom ɛpression are taken into account. Significantly, these differences are associated with greater mortality among these populations.

The New Jersey Commission on Cancer Research is strongly committed to a comprehensive research strategy that will ldress these disparities across the cancer control continuum from prevention to end of life care.

At the outset, the NJCCR in collaboration with the New Jersey Department of Health and Senior Services will offer a equest for Applications or RFA designed to foster the development of new research initiatives that will help identify, ıaracterize and evaluate reasons for the higher cancer rates among New Jersey ethnic minorities and under-served populations as ell as construct and test these strategies to reduce the burden of cancer within these populations.

The aim of these studies is to 1) bring advantages of state of the art cancer prevention, diagnosis, treatment and control to inority individuals within their communities through clinical trials; 2) facilitate greater participation among ethnic minorities in ncer prevention and control activities; 3) improve efficacy and efficiency of primary care health systems aimed at cancer ɔntrol; 4) evaluate practice patterns in underserved populations; 5) elucidate biologic, social or economic barriers to cancer care; evaluate adequacy of health promotion and prevention programs in ethnic minorities and medically underserved populations; d 7) identify innovative models aimed at improving compliance, outcomes or other positive impacts on discrepancies in cancer tes.

In addition, the NJCCR and the 100 Black Men of New Jersey have joined forces to launch a major education campaign ned at Improving Minority & Medically Underserved Participation and Access to Clinical Trials, called IMPACT. The IPACT Advisory board will work with New Jersey community leaders, research institutions, voluntary health care ganizations and faith based groups to assist statewide planning and program implementation, organize and train community ıders to provide education and outreach on clinical trials to their citizens, improve the cultural competency of researchers and ientists throughout New Jersey, and provide opportunities for dialogue and inclusion among scientists and community vocates to improve the clinical research process.

While these goals are ambitious, we are confident that working together we can improve these problems substantially and ɜure access to the best cancer care New Jersey has to offer.

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NJAFP
New Jersey Academy of Family Physicians

TO: Assembly Health and Human Service Committee

FROM: Claudine Leone
NJAFP - Director of Government Affairs

DATE: September 19, 2002

RE: Legislative Panel to Examine Disparities in Health Care for Minorities

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Please find attached the policy statement of the New Jersey Academy of Family Physicians on minority health care.

On behalf of the over 1,800 members of the Academy, thank you again for the opportunity to present the Academy's position.

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NEW JERSEY ACADEMY OF FAMILY PHYSICIANS

MINORITY HEALTH CARE POLICY STATEMENT

The New Jersey Academy of Family Physicians, consonant with its goal of excellence in health care for New Jerseyans and its role as a responsible public advocate on health care issues, reaffirms its commitment to the medically underserved of this state and urges each and every one of its members to become involved personally in improving the health of people from minority and socio-economically disadvantaged groups. The Academy supports the following:

(a) The cooperation between local family physicians and community health centers so that the resources of both can be most effectively channeled to those most in need of care.

(b) The promotion of health education in schools, churches and community groups to educate people about keeping healthy and appropriately utilizing health resources.

(c) The continuation of beneficial programs, which serve to promote health and disease prevention.

(d) The revision of rules and regulations pertaining to government funded medical assistance programs in order that private physicians may serve the patients of these programs and to encourage consolidation of benefits so that the patient may receive them from a single source.

(e) The development of reimbursement and other financial mechanisms, which recognize the economic disadvantage of medical practice in depressed areas and which compensate for this disadvantage, thus encouraging the establishment of private medical practices in these areas.

(f) The establishment of culturally specific outreach programs to encourage disenfranchised minority groups to seek appropriate preventive health care.

(g) The development of programs, which encourage voluntary provision of services by physicians and other health care professionals in underserved areas.

(h) The utilization of local family physicians by managed care organizations. Local family physicians generally have more cultural awareness of their community and their involvement reduces the possibility of racial prejudice affecting clinical judgment in medical care.

Contributing to the inadequate medical care of minority and disadvantaged groups of people is the small number of health professionals from these groups. The Academy recognizes that the intimate knowledge of patients' culture is extremely important in the art of medicine. Our national association, the American Academy of Family Physicians, is highly supportive of programs with the goal of increasing the number of qualified minority student applicants to medical schools and the number of qualified minority student admissions.

THE CITY OF ORANGE
29 NO. DAY STREET • ORANGE, NJ 07050
DEPARTMENT OF NURSING

September 19, 2002

As the Public Health Nurse Supervisor for the City of Orange Township I have been asked to address some of the health issues that affect the City of Orange as a community. The City of Orange is approximately 2.5 square miles and the estimated population size is 30,000.

The City of Orange Health Department, Nursing Division provides preventative services for the residents of Orange. Services include childhood immunizations, communicable disease control, tuberculosis control and senior health. These services are most often provided to the under/uninsured.

The Township of Orange has experienced a large increase in the immigrant population. There has been an increase of South American and Haitian immigrants. We are constantly asked to provide services for these families. Services most requested are childhood immunizations, adult immunizations, and comprehensive physical exams for families, older adult health care and filling prescriptions. Most of the services requested can be obtained at the Health Department or referred to community-based clinics. Other services frequently requested are blood pressure and diabetes management. Many of the families just arriving to this country are unfamiliar with the culture of our healthcare system and are intimidated by the providers as well as the paperwork involved.

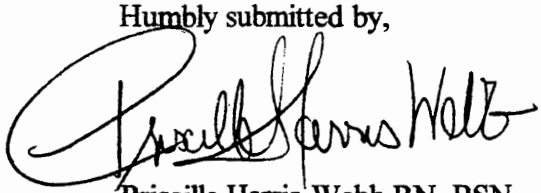
The increase of inquiries regarding filling prescriptions not only affects the immigrant population but also is increasing among the town residents. The age range of the largest group requesting prescription-filling services are from 35-60 years of age. There are very few programs that address this particular need. There are a few pharmaceutical companies that provide discounts but the cumbersome paper trail is often discouraging to the patient as well as their physicians.

Also there has been an increasing need for monitoring of diabetic clients. Some have difficulty with diet, medication regimen and follow-up blood work.

Although the Family Care Insurance Program exists in the State of New Jersey to provide insurance for the under/uninsured, clients complain that the wait is very long and find the application process difficult.

I am hoping that the health disparities that exist in urban areas within the State of New Jersey will be adequately addressed and rectified in the near future.

Humbly submitted by,



Priscilla Harris-Webb RN, BSN
Public Health Nurse Supervisor