Positive Communication

The quarterly newsletter of the HIV/AIDS Dietetic Practice Group

Membership Update

Deane Edelman, MBA, DTR,
Alan Lee, RD, CDE, CDN, CFT,
and Joya Parenteau, RD
Alliance/Membership Committee

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Several conferences on the horizon

Hello colleagues and friends!

ANSA conference

Another fantastic Association of Nutrition Servies Agencies (ANSA) conference was held Sept. 15–17, 2005 in Washington, D.C. at the Loews L'Enfant Plaza Hotel. Participants shared wonderful information, made new connections, and old friendships were rekindled. Of particular note were the preconference institutes, "The Power of Collaboration—Advancing the Cause of Nutrition," sponsored by Kaiser Permanente, and "The Power of Collaboration— Community Coalitions," sponsored by Altria.

ANSA, Meals On Wheels Association of America (MOWAA) and the National Association of Nutrition and Aging Services Programs (NANASP) co-convened this special three-hour institute with representatives from other national organizations, funders and government agencies for whom nutrition is a core issue. We were joined by representatives from the American Dietetic Association, America's Second Harvest, Congressional Hunger Center, D.C. Central Kitchen, and Food Research and Action Center.

Representatives from major corporations and foundations that fund nutrition issues also attended, including Altria, Avon Foundation, Chicago AIDS Foundation, Harrah's, Kaiser Permanente, MAC AIDS Fund, MAZON: A Jewish Response to Hunger, and UPS Foundation.

The session's purpose was to brainstorm on how we can advance the cause of nutrition, and by the end, several key associations and companies had pledged their support and resources to ANSA. Also, four committees were formed:

1. Platform Committee— Develop a consistent and universal message about the value of nutrition that we can all agree to use.
2. Political Committee— Explore political avenues that will advance the cause of nutrition and the possible formation of a Political Action Committee.
3. Research Committee— Develop appropriate research partners who will document both the health outcomes and economic value of nutrition.
4. Leadership Committee— Identify ways that leadership within the field of nutrition services can be enhanced and developed.

If you are interested in joining any of the committees or learning more about them, please contact Frank Abdale at ANSA (FAbdale@ansanutrition.org).

The Nutrition Track had 11 sessions geared towards the nutrition professional.

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A DIETETIC PRACTICE GROUP OF
AMERICAN DIETETIC ASSOCIATION
Your link to nutrition and health.℠

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Some of the topics included senior nutrition and feeding programs, HIV nutrition from a global perspective, hepatitis C, renal disease, lipoatrophy, exercise and integrative medicine. Thanks goes to Alan Lee and Leah Stern, RD, for an outstanding job on developing a very educational Nutrition Track this year.

This year's confernce will be held in Aug. 23-25, 2006 in San Francisco, Calif., so check the ANSA Web site for NUTRITION TRACK program updates at www.ansanutrition.org.

Reminder—As a HIV/AIDS Dietetic Practice Group (DPG) member benefit – you are entitled to register for the ANSA conference at the member rate of $175, instead of $375. Taking advantage of this conference alone pays for your membership many times over.

Nutrition fact sheets

Thanks goes to the wonderful Nutrition Committee and members of the HIV/AIDS DPG for writing and reviewing 32 fact sheets that are available to anyone who visits the ANSA Web site at www.ansanutrition.org.

These fact sheets replace the existing set created over six years ago, and can be helpful for the health professional or agencies needing to provide nutrition education.

NORA discusses HIV among African-American men who have sex with men, and the campaign to end AIDS

On Monday, Sept. 12, 2005, the National Organizations Responding to AIDS (NORA) coalition, for which AIDS Action serves as the convener, held its bimonthly meeting at the American Public Health Association. The featured speakers for the meeting were Leo Rennie, HIV policy consultant, and Naomi Long, national coordinator for the Campaign to End AIDS.

Mr. Rennie spoke with NORA attendees about the community's mobilization efforts in response to data that was released by the Centers for Disease Control and Prevention (CDC) in June 2005. This data revealed an HIV prevalence of 46% among African-American men who have sex with men. Among these men, 67% were unaware of their HIV infection. The study, conducted as part of the CDC's National HIV Behavioral Surveillance System, presents data collected in 2004 in Baltimore, Md.; Los Angeles, Calif.; Miami, Fla.; New York, N.Y.; and San Francisco, Calif.

Mr. Rennie pointed out that although the results of the study are "off the charts," high HIV prevalence rates among this population have been documented for years. This continued trend, coupled with an insufficient government and community response to it, led Mr. Rennie and his colleagues to form the Black Gay Men's (BGM) Strategy Group in order to organize a response to this escalating public-health crisis.

Mr. Rennie shared with NORA members a document called BGM Strategy Group Recommendations to Address HIV Infection Rates Among Black men having sex with men. True to its title, the document makes recommendations to the federal government on how to respond to the high infection rates among black men who have sex with men. (See the Weekly Update, July 29, 2005, "African American Men's Health Briefing on HIV/AIDS" for the list of recommendations, available at www.aidsaction.org/communications/bweekly_updates/072905.htm) Explaining the need for such recommendations, the authors of the document wrote, "Neither CDC, HHS, nor the

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We welcome submissions from our members. Please contact *Positive Communication* Senior Editor Ginger Bouvier, RD, for further information.

A DIETETIC PRACTICE GROUP OF AMERICAN DIETETIC ASSOCIATION

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Subscriptions are available for people who are ineligible for ADA membership for $30. Contact Stuart Katsh, MS, RD, treasurer@hivaidsdpg.org or visit www.hivaidsdpg.org to order back issues.

Nutritionists In AIDS Care (NIAC) and the HIV/AIDS Dietetic Practice Group (DPG) of the American Dietetic Association (ADA) present

"5th Annual NIAC & HIV/AIDS DPG Conference: Putting It All Together – Nutrition and HIV Research, Science, and Practical Applications"

Saturday, March 25, 2006 Hunter College Brookdale Campus Ground Floor Auditorium East 25th Street and First Avenue New York, N.Y.

Program objectives

- The participant will understand the current concepts regarding the pathogenesis and management of metabolic complications in HIV such as lipodystrophy, HIV wasting syndrome and the importance of identifying causes of underlying conditions to implement effective interventions.
- The participant will be able to recognize the relationship between methadone on proper nutrition and creative strategies to manage HIV-associated side-effects.
- The participant will gain knowledge about advanced nutritional counseling skills, the concept of mindful eating, addressing client denial, and learn ways to motivate the unmotivated client.
- The participant will be able to discuss guidelines for nutrition co-management of HIV and renal compromise, including nutrition assessment, diet recommendations, and nutrition-related complications of end-stage renal disease and hemodialysis.

For more information, contact (e-mail will produce a faster response): Alan Lee at AlanLeeRD@yahoo.com or 212/229-2298; Jennifer Eliasi at JennEliasi@aol.com or 718/940-5935. For more information on GNYDA events, go to www.gnyda.org under the Calendar Of Events section.

8 a.m.—Continental breakfast and registration; company exhibits open

9 a.m.—Welcome address on behalf of NIAC and the HIV/AIDS DPG
Jenn Eliasi, MS, RD, CDN, HIV/AIDS DPG past-chair; Alan Lee, RD, CDN, CFT, NIAC co-chair

9:15 a.m.—Keynote address: "2006 HIV Nutrition and Medical Research Update"
Jul Gerrior, RD, research dietitian, Nutrition For Healthy Living Cohort, Tufts University, Boston, Mass.

Jül Gerrior, RD, is a research dietitian working with the Nutrition for Healthy Living Cohort (NFHL) study at Tufts University School of Medicine in Boston. She has been working in the nutrition and HIV arena for nearly 10 years and has both national and international experience on specific projects associated with nutritional status and HIV infection. She has recently been involved in training research teams in Vietnam and Argentina. Jül has been working with the NFHL cohort on identifying cardiovascular risk factors and interventing with diet, exercise, and pharmacologic studies aiming to reduce these metabolic and morphologic complications.

11:15 a.m.—Networking break and company exhibits open

11:45 a.m.—"Advanced Interviewing Skills: Motivational Counseling, Mindful Eating and Beyond"
Megrette Hammond, MEd, RD, CDE, director, Center For Mindful Eating, Portmouth, N.H.

Megrette Hammond, MEd, RD, CDE, LD, is the director of the Center for Mindful Eating, www.tcme.org, a non-profit organization dedicated to helping professionals implement aspects of mindful eating into new and existing programs. She is a writer and a professional speaker who has been lecturing on nutrition, eating disorders, counseling and diabetes throughout New England since 1996. Megrette has a masters in nutrition education from Framingham State College. She is the co-author of a recently published book called *Discover Mindful Eating: A Resource of Handouts for Health Professionals*, from DayOne publishing.

1 p.m.—Box lunch and company exhibits open

1:45 p.m.—"Innovative HAART Side-Effect Management and the Impact Of Methadone On Nutritional Status"
Guy Pujol, DMin., executive director, AIDS Treatment Initiative, Atlanta, Ga.

Guy Pujol, DMin., is the executive director of AIDS Treatment Initiatives (ATI), a buyers' club and treatment education organization in Atlanta, Ga. Guy holds a doctorate of ministry degree from Columbia Theological Seminary. Guy travels nationally, presenting programs on immunology and virology, complementary therapies, and side-effect management. He chairs the Nutrition Track for the United States Conference on AIDS (USCA).

3 p.m.—Networking break and company exhibits open

3:15 p.m.—"Double Jeopardy: Co-managing HIV and Renal Disease"
Mary Griffin, RD, HIV Primary Care Clinic, Arnot Ogden Medical Center, Elmira, N.Y.

In addition to nutrition counseling, Mary Griffin, RD, administers a food voucher program funded by the New York State Department of Health AIDS Institute that assists low-income people living with HIV/AIDS to purchase nutritious foods. Mary worked in an outpatient dialysis unit for two years prior to assuming a full-time position in HIV nutrition.

4:30 p.m.—Continuing professional eduction sign-up/ certificates of completion

Please visit www.gnyda.org for registration information.

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administration has met recently with representatives of this highly impacted population."

Mr. Rennie called on national HIV organizations to address this issue more directly. Continuing, he explained that national organizations will be key players in strategizing how to "integrate the information into broader conversations" which address public policy. He offered that the future CDC studies will look at other populations, such as Latino men and women and African-American women, and believes the findings will be similar.

He stressed that a response is needed now for Black MSM, adding that, as data from the CDC studies become available, the response should then be modified for the populations he had noted.

To read more about this CDC study, visit ww.cdc.gov/mmwr/preview/ mmwrhtml/mm5424a2.htm and www.cdc.gov/mmwr/preview/ mmwrhtml/mm5424a3.htm.

In closing, Mr. Rennie urged anyone doing HIV work to incorporate the CDC's findings into his or her efforts. He admitted that he does not have a comprehensive answer to the question of how this can be achieved. He did state, however, that stakeholders must begin talking about how to effectively incorporate new CDC data.

Naomi Long, the national coordinator for the Campaign to End AIDS (C2EA), followed Mr. Rennie's presentation. Ms. Long informed coalition members of the campaign and asked for their support in the form of organizational endorsements and direct involvement in campaign-related events.

Ms. Long explained that C2EA is a national effort to bring people living with HIV and their allies from across the country to Washington, D.C. to engage in HIV activism, advocating for the C2EA platform. Participants will also lobby their members of Congress.

People across the country traveled to Washington in caravans in early October and, along the way, participated in various community HIV-awareness events and spoke to the press about the C2EA platform. Among the community events were a country music festival in Vermont; a fashion show in Washington, D.C.; and an "AIDS-walk-type event" in Michigan. Travels culminated in Washington, D.C. on Nov. 5, 2005.

In closing, Ms. Long revealed that the campaign's D.C. activities were originally scheduled to take place four weeks earlier; however, organizers decided to reschedule them after Hurricane Katrina hit so that participants who had been affected by the hurricane would have more time to organize.

For more information on C2EA, including the campaign's platform, visit www.c2ea.org.

Chair's message

Karen Bellesky, RD, LD
2005-2006 HIV/AIDS DPG chair

As the winter issue is prepared to go to press and the dietetic practice group (DPG) elections are complete, I hope that many of you took advantage of the online voting system. The history of the last couple of years has shown that very few DPG members (less than 10%) actually vote. Leadership should not be determined by such a small number. If you do not like what you see on the ballot, you have the power to change the ballot by running for office or by nominating someone you think would be a strong candidate.

None of the current officers is unemployed; we all have jobs and lives outside of the DPG. Please consider getting involved. Pleas for member involvement are made each year, so that the DPG committees can remain strong. Over the next several months, please consider these questions: Where do your interests lie and which committee would be your best fit? If you are not sure what the committees do, you can contact the current chair of any committee. Contact information is listed on the Web site and on page 2 of *Positive Communication*.

The membership of this DPG has risen over the past year, which is great news. In order to keep membership up and the DPG as good as it is, active membership is needed. Please consider getting involved.

In order to best plan for the Member Meeting that typically occurs at the annual Food & Nutrition Conference & Expo (FNCE) or other national conferences, it is important that we know who is planning to attend. Please e-mail me directly if you plan on attending FNCE this September in Honolulu, Hawaii or ANSA (Association of Nutrition Services Agencies) this August in San Francisco, Calif. Contact me at kbellesky@chasebrexton.org.

Thank you for keeping the e-mail list active.

Keep current!

Log on to

www.hivaidsdpg.org

24 hours a day!

4th Annual NIAC and HIV/AIDS DPG Conference report

By Nicole Garfield, RD, and Brenda Roche, RD

On March 5, 2005, the Nutritionists in AIDS Care (NIAC) and the HIV/AIDS Dietetic Practice Group (DPG) of the American Dietetic Association (ADA) held the 4th Annual NIAC and HIV/AIDS DPG Conference at Hunter College in New York, N.Y. The following is a summary of the conference lectures.

Dispelling Fad Diet Myths

Presented by Cathy Nonas, MS, RD, CDE

Cathy Nonas is the director of diabetes and obesity programs at North General Hospital in Harlem, New York. She is also a practicing dietitian, researcher and diabetes educator. Cathy most recently published two books entitled, Managing Obesity: A Clinical Guide, (ADA, 2004), and Outwit Your Weight (Rodale Press, 2002).

Nonas began her discussion by reviewing a list of medical complications associated with obesity, as well as medical complications associated with weight loss. She said many of the complications associated with weight gain are due to upper-body obesity. Visceral fat causes insulin resistance and other metabolic problems. Nonas explained that the first goal of weight management is no further weight gain, followed by a reduction in weight, and finally maintaining a healthy weight. As an individual loses weight, however, fat mass as well as lean body mass is sacrificed. She advised that in order to reduce the risk of lean tissue loss, restrict the rate of weight loss to 1–2 pounds per week. Nonas emphasized the fact that it is important for HIV-positive individuals to lose weight at a slower rate than the general population to prevent the loss of lean body mass.

Nonas provided a list of medications that may promote weight gain. This includes antidepressants, corticosteroids, insulin, and B-adrenergic blockers. Nonas went on to profile a typical "dieter" who is confused by conflicting nutrition recommendations and frustrated by weight gain caused by antidepressants. Nonas recognized the frustrations of these dieters in her presentation and addressed the controversial low-carbohydrate versus low-fat fad diets. The data that was presented indicates there is a significant difference between low-carbohydrate and low-fat diets within the first six months (low-carbohydrate producing a greater weight loss initially). However, by the end of one year, both diets appear to produce the same effects.

Nonas stated that research has been unable to prove that one macronutrient is superior to another. She said it does not matter what type of calorie an individual is consuming; weight loss will occur only if this individual is in negative energy balance. In the same regard, a person in positive energy balance will store calories as fat, regardless of diet composition. A profile of the macronutrient composition of popular diets was presented along with a categorization of these diets. Nonas noted that most fad diets are moderate in composition apart from Atkins (which is 60% fat, 10% carbohydrate) and Ornish (which is 80% carbohydrate).

Nonas recommended visiting www.consumer.gov/weightloss to view nutrition information that was developed by consumer groups, governmental groups and nutritionists. She emphasized that it is very important for HIV-positive clients to be monitored by health-care professionals while following any of the diets that are featured on this Web site.

Of all eating plans that Nonas profiled, the type of diet that would appear to have the greatest results was portion controlled and easy to follow, such as Jared's Subway diet. Although this diet does not meet all nutritional requirements, it is repetitive, may involve no decision-making or cooking whatsoever, and desired weight loss is frequently achieved. In the end, however, Nonas cites data that indicates it does not matter what type of diet a person chooses to follow. After one year on any given diet, there is no statistical difference in overall weight loss among individuals studied.

Depression and nutrition

Presented by Dr. Satish Reddy

Dr. Satish Reddy is chair of the Department of Psychiatry at the Brooklyn Hospital Medical Center and assistant professor of clinical psychiatry and medicine at Weill Medical College of Cornell University in Ithaca, N.Y. Dr. Reddy presented a lecture on mental health and HIV nutrition. and the relationship between depression and nutrition.

Dr. Reddy began by highlighting the key points of his discussion. He stated that nutritional deficiencies can cause depression and some nutritional supplements may be used as part of the treatment for this disorder. A deficiency of omega-3 fatty acids, for example, can lead to depression and supplementation of this nutrient may be used in combination with traditional medications. In fact, according to Reddy, a variety of nutrients essential for the prevention of depression may be supplemented in combination with other medications for the treatment of depression.

According to Reddy, 8%–10% of the population is depressed. He stated that depression is the second leading cause of disability in the United States and is three times more likely in women due to serotonin deficiencies and fluctuating estrogen levels. Depression affects 4%–35% of the HIV-positive population. Biological abnormalities that lead to depression include serotonin, dopamine, epinephrine and nor epinephrine deficiencies.

Reddy went on to speak about the role of carbohydrates in depression. People who are depressed are usually more likely to crave carbohydrates because these foods stimulate serotonin

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production. Increased carbohydrate consumption may therefore be a mechanism for the body to regulate serotonin levels. This increase in carbohydrate metabolism, however, may lead to the depletion of B-complex vitamins resulting in a deficiency of nutrients that are essential for neurotransmitter synthesis.

Omega-3 fatty acids are supplied to our bodies from dietary sources such as fish oils and flax seed oils. Reddy explained that omega-3 fatty acids are anti-inflammatory agents that are associated with increased longevity when consumed in high doses. He discussed the biochemistry behind mood-enhancing nutrients and demonstrated that omega-3 fatty acids help improve neurotransmitter reception. An omega-3 fatty-acid deficiency is therefore associated with depression and bipolar disorder. Omega-3 fatty-acid supplementation along with antidepressants can be an effective form of treatment for depression. Reddy recommended 3 g. of omega-3 fatty acids per day (be sure to choose pharmaceutical grade fish oils to avoid mercury contamination).

Reddy also said that up to 35% of patients have folate deficiency. Folate plays a role in the synthesis of neurotransmitters and other important metabolic pathways in the body associated with regulating depression. Folate deficiency may result in a more severe state of depression. Supplementation of folate along with antidepressants may be a viable depression treatment. The recommended dosage for folate supplementation is 1 mg./day.

SAMe (S-adenosylmethionine) is a methyl donor in the brain that is a precursor for serotonin. Folate is a cofactor required for the production of SAMe. According to Reddy, a deficiency of folate results in low SAMe levels in the brain which may lead to depression. Supplementing with SAMe may help treat symptoms of depression. The recommended dosage is 200–800 mg. two times per day. However, this can become very costly. It is important to note that SAMe interacts with monoamine oxidase (MAO) inhibitors, and when used with selective serotonin reuptake inhibitors (SSRIs), may result in serotonin syndrome, or excess serotonin in the body.

Reddy explained that chromium decreases insulin resistance and increases transport of tryptophan, a precursor of serotonin, into the brain. It also increases nor epinephrine in the brain. Studies indicate that chromium supplementation may decrease symptoms of depression, overeating and fatigue in individuals who suffer from atypical depression. The recommended dietary allowance (RDA) for chromium is 120 mcg./day. However, levels of supplementation may need to reach 200 to 400 mcg./day to decrease symptoms of depression.

Carbohydrates contain tryptophan, a precursor to serotonin. Tryptophan was used in the past to treat depression by increasing serotonin levels in the brain before it was banned in the United States when the supply was found contaminated. Reddy warned that tryptophan use is not recommended at this time.

Reddy went on to discuss the use of St. John's wort in the treatment of depression. He said St. John's wort is likely to be approved by the Food and Drug Administration (FDA) as an antidepressant in the United States. This herbal supplement has little effect on weight gain and can be given safely in combination with other medications such as highly active antiretroviral therapy (HAART). He explained that he does not recommend St. John's wort at this time because the contents of this herbal supplement are not yet regulated by the FDA. However, once approved it could safely be used in combination with HIV medications.

Crystal methamphetamine and HIV infection; medical and nutritional aspects of an emerging epidemic

Presented by Dr. Antonio E. Urbina

Antonio Urbina, MD, specializes in HIV medicine and is the director of HIV education and training at the St. Vincent's Comprehensive HIV Center in Manhattan, N.Y. In addition to maintaining a clinical practice, Dr. Urbina also researches the interactions of party drugs and HIV medications, as well as the medical management of HIV disease.

Urbina began by defining crystal methamphetamine as a chemical that has stimulant properties. This drug can be snorted or dissolved in water and injected, smoked or inserted rectally into the body. Methamphetaine use is found in every city throughout the United States, especially in urban centers where men are having sex with men (MSM). Urbina said people taking methamphetamine do not eat. He explained that there is such a profound effect on appetite that users find creative ways to give themselves nutrition. Users have been known to not eat for up to three days, and in some cases, one week. This results in electrolyte imbalances, nutritional deficiencies and severe dehydration. Dehydration can result in the breakdown of muscle and the release of myoglobin, which can eventually lead to renal failure.

The oral health of methamphetamine users also suffers as a result of decreased saliva production. Urbina said saliva is important for the neutrality of acids and clearing away of food in the mouth. Methamphetamine use causes severe bruxism—the griding of the teeth—resulting in periodontal disease and bone erosion.

Urbina said methamphetamine stimulates the sympathetic nervous system and inhibits the parasympathetic nervous system. Over-activation of the sympathetic nervous system results in dilated pupils, inhibited saliva production, constricted blood vessels and increased blood pressure, open airways of lungs, accelerated heart rate, inhibited digestion, inhibited gall bladder and pancreatic secretions, increased liver stimulation, increased glucose production and release, ejaculation and inhibited erections.
Methamphetamine use also affects metabolism. Effects on metabolism include an increase in lipolysis and free fatty-acid production, increased insulin

levels, depleted protein stores, a breakdown of lean body mass, extraction of calcium from stores, and lowered resistance to infection, the latter being highly significant for HIV patients. Urbina stated that it is difficult to differentiate AIDS wasting syndrome from methamphetamine wasting.

Methamphetamine withdrawl results in insomnia, hyperphagia, carbohydrate cravings and an overall gain in fat mass. For the nutritional management of acute methamphetamine intoxication, Urbina recommended hydration, macro and micronutrient replacement (protein and multivitamin), and cardiovascular exercise and resistance training to increase lean body mass and help decrease insulin resistance.

Urbina noted that approximately 50%–60% of all new HIV infections are secondary to crystal methamphetamine use. Among the medical side effects associated with the use of this drug are impaired T cell functions. Urbina emphasized that all amphetamines are metabolized by CPY 2D6, an isoform of the P450 enzyme system. Three to 10% of the Caucasian population is deficient in this isoform. A potentially fatal drug-to-drug interaction can occur between methamphetamine and HIV medications when CPY 2D6 is inhibited. For example, Norvir (a protease inhibitor) is an inhibitor of CYP 2D6 and therefore amphetamines cannot be metabolized in the presence of this medication.

Urbina explained that methamphetamine use leads to a reduction in dopamine transporter levels. Studies suggest that HIV proteins are also toxic to dopamine neurons. Therefore, both HIV proteins and methamphetamines target dopamine neurons in the brain. Researchers have found that when cats infected with feline immunodeficiency virus are exposed to methamphetamine, there is a 15-fold increase in viral replication. Urbina suggests that HIV-positive patients abusing methamphetamine may be accelerating viral replication and HIV-related dementia.

Methamphetamine use may also diminish the rate of adherence among HIV-positive people on HAART. For example, "weekend warriors" are individuals who abuse club drugs on the weekend and stop using HIV medications during this time. This results in increased viral load and the possibility a new population of individuals likely to harbor drug-resistant strains of the virus. Drug-resistant variants to HIV may then be transmitted to sexual partners. Urbina notes that approximately 20% of all new HIV infections in New York City have some form of drug resistance.

Urbina said that non-occupational post exposure prophylaxis (nPEP) may help reduce the risk of HIV exposure by 80% in individuals exposed to the virus. He explained that HIV infection may be prevented in some cases by starting HIV medications within 72 hours of potential exposure for a 28-day period.

Urbina concluded by stating that methamphetamine use among MSM may increase the risk of HIV transmission. This drug may also affect the cardiovascular system and interact with HIV medications causing toxicity or death. In addition, dopamine depletion can result in memory loss and HIV-related dementia. Nutrition complications can result in severe dehydration and malnutrition similar to that of AIDS wasting syndrome.

Urbina recommended the following Web sites for more information:

- www.nida.nih.gov
  National Institute for Drug Abuse
- www.erowid.org
  pro-drug Web site
- www.hiv-druginteractions.org
  drug/herb/club-drug interaction charts

Nutrition counseling: the counseling they didn't tell you about

Presented by Paul Warren, LMSW

Paul Warren is the program manager of the Technical Assistance Program (TAP) at the National Development and Research Institutes, Inc.

Warren defined the purpose of this interactive presentation as a safe opportunity to explore the experiences and challenges of the work, consider skills that can be applied to enhance the counseling event, and develop self-care plans to protect counselors' emotional and physical health. Mr. Warren said that as HIV workers, it is imperative to have the tools to take care of ourselves to help prevent burnout.

The majority of the presentation was interactive with participants offering responses to questions about their practices. Reflection was a main theme. Warren conducted an exercise in reflection, asking if and why we reflect after counseling. Reflection is a way not only to improve counseling, but also to address and deal with the stress that is associated with counseling. The group then participated in an activity that compiled a list of challenges of this work. Challenges included nutrition not being a priority to clients/patients, getting clients/patients to dietitians as a source of nutrition supplements, poor communication among disciplines, not having enough time to fully educate clients/ patients, trust between RD and client, and reimbursement. This exercise's purpose was to lend support to colleagues, raise awareness, and practice reflection.

Warren briefly discussed interview dynamics, specifically transference dynamic. Transference was defined as the transfer of feelings from one situation into another. Transference occurs in client to counselor, as opposed to counter transference, which is from counselor to client. Hearing intense/ traumatic human stories impact those who listen. Counselors are at risk of developing vicarious trauma (VT), which occurs when experiences from work are adopted into personal life. VT is preventable and manageable. Warren provided a model for self-care to help deal with stress.

The ABC's of self care:

A = Awareness: self-aware, self-reflect.

B = Balance: don't let work become your life; maintain healthy boundaries, develop/maintain interests outside of work.

C = Connect: don't work in isolation; develop/maintain positive connections, reminders of rewarding life elements. Connect with your colleges to share

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challenges.

The lecture concluded with two requests from Warren:

1. Think of two things that we do to take care of ourselves.
2. Pick a new thing to do in the next week at least once, or pick an old thing you have not done in a while.

"Taking care of your self is a journey; take concrete steps."

Cultural competency: Caribbean and southern cuisine

Presented by Jamillah Hoy-Rosas, MPH, RD, CDN, and Kyle Shadix, CCC, MS, RD

Jamillah Hoy-Rosas works as a bilingual nutritionist at Betances Health Center in Manhattan, N.Y. Kyle Shadix is a full-time nutrition instructor at the Art Institute of NYC/NY Restaurant School. He also is a managing partner of Culinary Nutrition Consultants, Inc.

Hoy-Rosas began the lecture by defining cultural competence as "the design, implementation, and evaluation process that accounts for special issues for select population groups (ethnic and racial linguistics) as differing educational levels and physical abilities" (1).

Cultural competency is important for several reasons. The first is that ethnic diversity is growing rapidly in the United States. The 2000 U.S. census reports that 25% of the population is an ethnic subpopulation. These ethnic subpopulations are expected to increase to 47.5% by 2050 (2).

Secondly, a variety of health concerns are becoming more prevalent among ethnic populations. In 1997, 47% of persons diagnosed with AIDS were African-American, and 20% were Hispanic/Latinos (3).

Third, health-care providers are not prepared to work with a diverse patient population.

Finally, increased cultural competence can lead to increased customer service between health-care professionals and patients.

Several steps must be taken to become culturally competent:

- Recognize cultural biases in yourself.
- Learn about diverse cultures.
- Increase knowledge of cultural food preferences.
- Develop multicultural communication and counseling skills.
- Be respectful, cooperative and open-minded (4).

Hoy-Rosas then spoke about the Caribbean. The 2000 census counts people from the Bahamas, Barbados, Belize, Bermuda, British West Indies, Dutch West Indies, Haiti, Jamaica, Trinidad, Tobago and the U.S. Virgin Islands as Caribbean (4). According to the census, 22 million West Indians (another name for people from the Caribbean) live in the United States. There are at least 7,000 Caribbean islands, but not one specific Caribbean culture. Each island has its own culture and customs. Caribbean cuisine has been influenced by the cultures of many countries, including Africa, France, Spain, India and Holland.

Commonly used Caribbean foods include fresh fish and seafood, coconut, avocado, beans, cassava, greens, citrus fruits and many herbs and spices. Caribbean cuisine offers many nutritional benefits with the use of whole, unprocessed foods; lean protein; and healthy cooking methods. There are, however, negative characteristics such as high sodium content, large portions of starchy vegetables, many fried foods, and the tendency to over-cook vegetables.

Hoy-Rosas explained that food is a key aspect of Caribbean culture, and making nutrition recommendations that may take away from the flavor or experience of eating may be ill received. It is important to encourage healthy balanced meals that work with traditions. Counseling on appropriate serving size may make a big difference when counseling an overweight or diabetic patient. It may be necessary to dispel food myths and misconceptions.

Hoy-Rosas concluded her portion of the lecture with tips that should be practiced with patients/clients of any culture: Respect individuality; use culturally relevant food guide pyramids; support positive traditional dietary patterns; familiarize yourself with portion sizes, cost and preparation methods of food; encourage diet variety, including healthy American foods, especially whole grains; be aware of body images; and encourage exercise.

Chef Kyle Shadix continued the lecture by discussing the components of southern cuisine. Shadix explained that while Southern cuisine has many similarities, it varies from region to region. Therefore, it is important to familiarize yourself with the native terminology. As with Caribbean cuisine, Southern cuisine has deep roots and is a solid part of the culture. Southern cooks are very proud and typically do not want to make recipe/diet modifications that will take away from traditional taste.

Generally, Southern Americans do not make nutrition a priority. As RDs, it is our job to find comparable alternatives to high-fat recipes. Shadix recommended new trans fat-free Crisco as an alternative to lard or traditional shortening when baking. In addition to being high in fat, Southern cuisine is typically low in fiber, calcium, and fresh fruit, which should be addressed during counseling.

Shadix recommended expanding your knowledge of food by purchasing a copy of *The Food Lovers Companion*.

Shadix concluded his portion of the lecture with his own key points of cultural competency: Understand the culture of your clients, have good communication, ask about your own willingness to learn about other cultures, include your whole staff in cultural competency training, and be mindful of your own cultural biases.

For more information

- Cultural food pyramids—Southeast Michigan Dietetic Association www.semda.org/info/
- Sample reduced-calorie menus (Southern cuisine) www.nhlbi.nih.gov/health/public/heart/obesity/lose wt/southern.htm
- *The New Food Lovers Companion*, by

See NIAC, page 12)

Advocacy 101 (Second in a series): Keeping current with ADA issues

By Deane Edelman, MBA, DTR

Advocacy activities should take place only after information on the issue has been gathered and digested. It's fine to send messages to your legislators in response to the American Dietetic Association (ADA) or dietetic practice group (DPG) Action Alerts when you're told what to say, but for more in-depth or personal efforts, a more thorough knowledge of the issues is very important. You need to "know your stuff" when you visit your representatives, write letters to the editor, or conduct grassroots conversations with colleagues and community members.

Fortunately ADA has a goldmine of resources you will need in order to learn the current issues that are relevant to the dietetics profession in general, and to HIV dietitians in particular. You should begin by visting the ADA Web site at www.eatright.org, and clicking on the "Advocacy and the Profession" link (1).

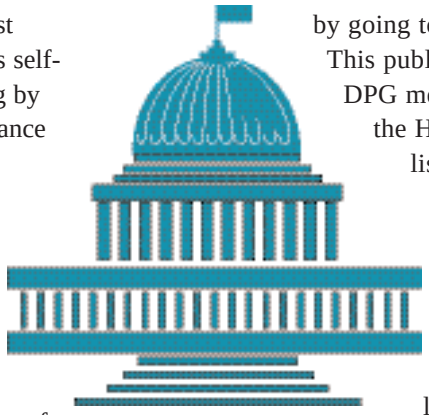
At the top of the menu on the left, you will see "Priority Areas." ADA's Board of Directors has approved seven public-policy priority issues for the Association. This list includes:

- Aging
- Child nutrition
- Food and food safety
- Health literacy and nutrition advancement
- Medical nutrition therapy and Medicare/Medicaid
- Nutrition monitoring and research
- Overweight/obesity/health weight management

ADA works proactively with its members, federal and state legislators, regulators and the media on these issues and the many subsidiary concerns that fall under the general categories.

There is an eighth priority area that focuses on state food, nutrition and health issues. Information on state issues is accessible in the "State Affairs" link, the third option on the menu. The following are discussions of the most prominent state issues contained in this link:

- State licensure of dietitians where it does not already exist
- Coverage of diabetes self-management training by state-regulated insurance carriers
- Medicaid
- Improving school nutrition at the state and local levels



Also review the link to the Final Report of the Task Force on State Nutrition, Food and Health Issues published in 2004.

There are 15 ADA Issue Briefs on federal and state topics, including the Ryan White CARE Act, complementary and alternative medicine, and the Older Americans Act. Visit the Web site to see additional ADA issue briefs at www.eatright.org/cps/rde/xchg/ada/hs.xsl/advocacy_1537_ENU_HTML.htm.

Further down the Advocacy menu are links to testimony, statements, and formal regulatory comments of the ADA. These are provided to various legislative committees and regulatory agencies that focus in on a range of food, nutrition and health legislation and proposed regulations. ADA's very thorough position papers often provide background for much of the testimony and comments. Read them at www.eatright.org.

The Advocacy section of www.eatright.org also contains numerous electronic and print publications available to keep you informed about public-policy issues. As ADA members you should automatically receive the *ADA Times* and the *Journal of the American Dietetic Association*, both of which contain public-policy articles.

On the Pulse is a special publication for public-policy issues. It is a weekly online newsletter informing ADA members of federal and state legislative and regulatory developments in ADA's priority areas.

You can subscribe to On the Pulse by going to www.eatright. org. This publication is forwarded to DPG members weekly through the HIV/AIDS DPG e-mail list.

ADA's public-policy structure provides you with many individuals who can assist in understanding the current issues, legislative and regulatory developments, along with the appropriate actions to take (2). First and foremost are the ADA staff members who make up the Government Relations and Nutrition Service, Coverage teams. Their offices are located in both Washington, D.C. and Chicago; they are the primary players working to influence food, nutrition and health policy at the federal, state and local levels. They also provide advocacy support and training for ADA's grassroots network, affiliates, and DPGs. Throughout the past year, two staff members within the Washington office, Mary Lee Watts and Ron Smith, have worked very closely with our DPG on Ryan White reauthorization. Their experience, contacts and activities performed on behalf of this issue have been invaluable.

Additional assistance is available from the following resources:

- The legislative network coordinator (LNC), the individual from each affiliate, organizes and mobilizes ADA members at the state level to track and respond to federal public-policy issues and is the primary link to ADA government affairs staff.
- The grassroots liaison (GRL) is the person(s) from the congressional

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(Advocacy, from page 9)

district who works to maintain contact with his or her own congressional representatives.

- The legislative chair and Legislative Committee consist of individuals appointed in most affiliates to oversee state issues important to their home state.
- Dietetic practice groups (DPGs). Some DPGs appoint a legislative chair or public policy chair to follow issues relevant to the practice area and mobilize DPG members. The HIV/AIDS DPG has been most active in this area.

More information on ADA's public policy structure can be found in the ADA policy initiatives and advocacy guide, *Food and Nutrition Matters: Effective Nutrition and Health Policy Begins with You*. Access it at www.eatright.org.

Perhaps the best way to keep current with the issues is to attend ADA's annual Public Policy Workshop in Washington, D.C. A dazzling array of guest speakers and ADA staff educate and train on ADA's current hot topics, and instruct how to approach Congress with these priorities. All interested members are invited to attend, particularly legislative chairs, LNCs, grassroots liaisons, and DPG public-policy chairs. For information on the March 14-16 2006 Public Policy Workshop, and for scholarship information to cover the registration fee, visit www.eatright.org.

Please feel free to contact the author of this article for more information. Contact Deane Edelman, MBA, DTR, at dfedelman@att.net or 202/333-0945.

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An inside view of nutrition efforts from the front line of the HIV/AIDS epidemic in Mozambique

By Lutz Mocker

Humana People to People is a program based in Denmark that produced the AIDS Development of People to People (ADPP) program. ADPP houses the Total Control of the Epidemic (TCE) program. As the project manager, I am responsible for tailoring and implementing the ADPP TCE program in Mozambique's Sofala district. The core value of the TCE program states that "Only people can liberate themselves from the HIV/AIDS epidemic."

Primarily, my work is to guide a team of leaders in six areas within the Sofala district to assure that the program is successful during its term of funding. My work requires me to understand the problems faced by people living with HIV/AIDS in this region, including poverty, food insecurity and malnutrition.

The TCE program is based on a military model that emphasizes decentralized saturation of the community. The house-to-house mobilization campaign covers 100,000 people in each TCE Area in an effort to educate and involve each and every person living within the community. Each TCE area is targeted for a three-year time period. At the same time, the team is charged with implementing a Food for Progress (FFP) program. This involves setting up small enterprises known as "TCE soy canteens" and distributing food to 2,900 households in the areas of high impact.

The goal of the soy canteen is to promote the improved nutritional value of foods for poor households using practical examples of food preparation and affordable meals. They provide a source of low-cost, nutritious meals within poor communities, utilizing a very structured program that includes intensive training and a tailored "operation manual." This allows us to promote nutrition concepts through simple income-generating projects. The soy canteen is a kitchen that is operated by a community-based organization that sells meals and food products to the community at affordable prices. Throughout the initial four TCE areas, we now have 50 soy canteens in place with an average of five trained people, called passionates, running them as small enterprises. In addition to producing meals to sell, they provide a certain number of meals each day to peole living with HIV infection, orphans and pregnant women free of charge. We expect that more than 1,065,000 meals will be served over the 31-month period of the program.

Soy canteens also provide tangible results and fuel the enthusiasm for mobilization in entire communities while further developing community volunteerism. Most of the materials used to construct the canteens were donated to the program free of charge. All of those involved in the TCE program have received comprehensive training on food handling and preparation, business practices, and other skills pertinent to the program.

Standards are established for hygiene, location, shape and outlook of the canteen. Monitoring and evaluation systems were established with a number of benchmarks and other indicators of impact set in place. Continuous trainings take place and the promotion of growth and partnerships are ongoing as a part of development efforts. While it is still too early to talk about the "big success", we can see the impact of the soy canteens. However, in some places we still struggle to convince people that the program is valuable, and we hope to see our experience translated into what is needed to generate additional interest.

Direct food distribution started in partnership with the World Initiative for Soy in Human Health (WISHH), which provided 20 metric tons of concentrated protein, 70 metric tons of defatted soy flour, and 217 tons of textured soy protein to the program. Each family receives a ration of each product through distributions that are subcontracted to ADPP Mozambique.

The food products are stored in a rented warehouse in the nearby city of Beira. From there it is transported by truck to each of the four TCE areas involved in the direct distribution program each month. This product is then distributed to the 2,900 families who were identified as in need of the direct feeding program. Each of four TCE areas have 50 field officers who are in charge of identifying 725 families for the direct feeding program.

In addition to the feeding program, each field officer, in cooperation with the management of TCE, has identified and trained three volunteers in home-based care and nutrition for people living with HIV infection. These volunteers are known as passionates and are responsible for monitoring the direct feeding program on a weekly basis. To accomplish this they ensure the correct use of soy products. They monitor and document improvements, problems and achievements. All of the beneficiaries of the direct feeding program have attended training on how to handle and prepare foods using the soy ingredients.

For the direct feeding program, specific nutritional monitors have been established. In addition to utilizing baseline surveys to determine available resources, food habits, quality of life, and objective nutrition measures, we plan a follow-up to determine program understanding, utilization, acceptability and impact on objective nutrition measures. The nutrition measures we use include height, weight, bioelectrical impedance analysis (BIA), and strength testing with hand grips.

We could not have accomplished the implementation of the TCE program without collaborating partners. We have active support and partnerships with the United States Department of Agriculture, the American Soybean Association/WISHH, World Vision, Planet AID, Inc., and ADPP Mozambique. These agencies help to implement the direct distribution of food in four of the TCE areas that cover 400,000 people. We work with the National AIDS Council using World Bank money to implement mobilization and education programs in one TCE area affecting 100,000 additional people. In Nampula we are working with the Irish Mining Company, KENMARE, to implement the TCE mobilization and education program in the district of Moma, the northern part of Mozambique. This will impact 50,000 people.

The programs in Mozambique developed to assist people living with HIV/AIDS are among the many efforts put forth by Humana People to People. More information on our programs and efforts is available on our Web site at www.humana.org.

Lutz Mocker is a German national who in 2001 first worked as a volunteer for Humana People to People/DAPP in Zimbabwe. Since February 2002 he has dedicated himself to working in response to HIV/AIDS and became the country coordinator responsible for the implementation of projects in Mozambique.

(NIAC, from page 8)

Sharon Tyler Herbst, Barron's Cooking Guide

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Join fellow HIV/AIDS DPG members online!

Perhaps one of the most tangible daily benefits of DPG membership is the electronic mailing list (EML), where members can post questions, get answers/ ideas/ suggestions, share links to current research and news reports, and discuss any topic related to HIV and nutrition.

Joining the HIV/AIDS DPG EML is easy! Go to **www.hivaidsdpg.org** and log into the "Members Only" area (using your ADA registration number). The second option in the Members area is the HIV/AIDS DPG EML, which will walk you through the signup process. (You can also modify your e-mail address from this screen.)

Be sure to reply to the e-mail message you get from Topica and you'll be added to the list.

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