Positive Communication

The quarterly newsletter of the HIV/AIDS Dietetic Practice Group

BIA in transgendered patients

Vol. 11, No. 1
Spring 2006

By Cade Fields-Gardner, MS, RD

Making a decision on how to evaluate the body composition of transgendered patients is difficult because very little information on this topic exists in the literature that registered dietitians (RDs) might use as evidence. The information presented here is not meant to be definitive, but rather to open the discussion based on concepts found in practice and research.

Several questions come to mind for consideration in our discussions:

1. How much like a reference man or reference woman is the transgendered individual?
2. What influence does hormone therapy or surgery have on body composition changes from baseline?
3. Does the dose or time of hormone treatment make a difference?
4. Will a single evaluation suffice or is trending from serial measures a more reasonable way to follow body composition?
5. How individualized should evaluations be?

Background on cross-sex hormone therapy and body measures

Body composition can be affected by hormone levels. Testosterone and estrogen replacement therapies are generally identified with increases in lean and fat masses, respectively. In men, estrogen therapy can increase subcutaneous and, to some degree, visceral fat tissues. Estrogen replacement therapy may work differently and can even improve lean tissue mass in women.

Generally, oral estrogen hormones are taken at high doses with or without anti-androgen medications by transgendered women, and high-dose testosterone injections are used for transgendered men. In a 1999 study that looked at fat distribution in transgendered adults on cross-sex hormone therapy, 20 male to female (MTF) and 17 female to male (FTM) transsexuals were evaluated at baseline and after 12 months of hormonal therapy (1). Significant differences were seen in anthropometry and body composition over the year period of time as summarized in Table 1.

In addition to these measures, thigh size (circumference and area) and abdomen circumference increased in MTFs, but was not significantly changed in FTMs. Visceral fat increased in both groups and abdominal area increased in MTFs. Muscle area increased in FTMs by 20% in the thigh, while it decreased in MTFs. Interestingly, while sex hormones changed over the 12-month period as expected, growth hormone levels decreased in FTMs and increased in MTFs.

While cross-sex hormone administration obviously affected both fat and muscle mass, the authors noted that baseline body composition and doses of

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sex hormones might affect hormone-driven body composition. Thus, a transgendered male is not likely to have a fully female body composition and vice versa. Another interesting finding is that even though testosterone levels dropped in MTFs, estrogen levels were not significantly changed in FTMs.

Translation of research to BIA evaluation

While we all may agree that this research and other research indicates that body composition changes are likely to occur in transgendered individuals, it is not likely that a transgendered female will have the expected body composition of a female, and a transgendered male will have the expected body composition of a male. The equations that are currently available to provide body composition estimates are only validated for men, women and a combination of both sexes. Whichever set of equations we deem appropriate for use in our clinical practice or for evaluating an individual, we must also make clinical judgments about how to set goals with each patient.

Body composition can be evaluated in many ways, including:

1. Minimum levels for survival
2. Minimum and range of levels required for normal (or as normal as possible) functions
3. Optimal level or goals set above functional levels (athletes and supermodels come to mind)

If we go the middle ground and choose "door No. 2," then we will have to evaluate body composition in conjunction with many other measures of well-being in order to decide what is an appropriate goal for our clients/patients.

Table 1. Transgenderd anthropometry and body composition over a year

Measure	MTF	FTM
Weight	↑	↑
Body mass index	↑	↑
Summary of skinfolds*	↑	↓
% body fat (skinfolds)	↑	↓
% body fat (skinfolds)	↑	↓
Visceral fat	↑	↑
Subcutaneous fat	↑	↓
Muscle area	↑	↑

*** Skinfolds included triceps, biceps, subscapular, suprailiac, and para-umbilical.**

There is a spreadsheet under discussion on the HIV/AIDS DPG e-mail list that was created by personnel at The Cutting Edge and has undergone several evolutions to address questions on how to evaluate results of BIA testing (2). This spreadsheet uses adequate levels for body function (door No. 2) and includes an estimate of goals for transgendered clients that are based on parallel exponential equations, validated for estimating fat-free mass and body-cell mass in fluid-shifted populations, specifically chronic HIV infection (3). The regression equations include men, women and both sexes. Because hormone-induced changes in body composition are not quite the same in transgendered sex as they are in the target sex, a combination of the two sexes was chosen for this spreadsheet.

We welcome submissions from our members. Please contact *Positive Communication* Editors Nicole Garfield, RD; Jacqui Brockman, RD; or Brenda Roche, RD; for further information.
The viewpoints and statements herein do not necessarily reflect policies and/or official positions of the American Dietetic Association. Opinions expressed are those of the individual authors.

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ISSN: 1096-7370.
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.

A comparison of results shows the limitations of this calculation for use in transgendered clients. (See Table 2.) These results may be expected with the transgendered client falling somewhere between male and female results. However, the body cell mass equation shows a different variation with levels lower for the "both sex" equation compared to measures taken on a female, especially when the person measured isn't within the bell curve's two standard deviations (an outlier with wasting or obesity). Using serial measures and trending results without setting a specific goal beyond what works for the individual according to other measures of well-being may have to suffice for the moment.

What is right and what is wrong and how do we standardize what we do in practice? Obviously, this topic requires more study. It may be difficult to come up with a set of equations that are appropriate in all cases for transgendered clients, partly because of the individualized response to hormones, differences in the types and levels of hormones given, and the amount of time that a person is taking hormones. It is, however, a discussion worth continuing with the dietetic practice group membership and others sharing our experiences. Discussing the reasoning behind our clinical judgments will be imperative until more solid evidence is available.

Table 2. Calculation limitations in transgendered patients

Measure	Male	Female	Both sexes
Height (inches)	65.0	65.0	65.0
Weight (pounds)	130	130	130
Sex (F, M, T)	m	f	t
Age (years)	40	40	40
Resistance (R)	550	550	550
Resistance (Xc)	65	65	65
Total body water (L)	35.5	34.1	34.0
FFM (pounds)	109.6	91.9	101.4
BCM (pounds)	55.3	44.5	42.1
ECT (pounds)	54.3	47.5	59.3
Fat (pounds)	20.4	38.1	28.6
Phase angle	6.74	6.74	6.74
Body mass index	21.7	21.7	21.7

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1. Elbers JMH, Asscheman H, Seidell JC, Gooren LJG. Effects of sex steroid hormones on regional fat depots as assessed by magnetic resonance imaging in transsexuals. *Am J Physiol Endocrinol Metab*. 1999;276:E317–E325. Available at http://ajpendo.physiology.org/cgi/content/full/276/2/E317.
2. The Cutting Edge, P.O. Box 922, Cary, IL 60013. The spreadsheet is available online at www.hi-r-ed.org in the appendix for the longer BIA course.
3. Kotler DP, Burastero S, Wang J, Pierson RN Jr. Prediction of body cell mass, fat-free mass, and total body water with bioelectrical impedance analysis: effects of race, sex, and disease. *Am J Clin Nutr*. 1996;64(3 Suppl):489S–497S.

Chair's message

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

Spring is in the air here in Baltimore, Md. I know it is officially spring, because baseball season has started. For those of you who know me, I am a baseball fan, although the thrill of going to opening day each year has faded.

Spring is also the time of year when I celebrate my anniversary at Chase Brexton Health Services, Inc. Now a federally qualified health center, which sub specializes HIV care. When I arrived on the scene 14 years ago, the organization provided HIV care only. Over the years, the staff has grown, and many staff members had no idea of the funerals we attended in those earlier days, or the complicated medication regimens that had all kinds of food implications when protease inhibitors first became available.

Imagine helping patients figure out when they could eat when their medications were:

- Crixivan every eight hours (not three times a day) on an empty stomach.
- ddI twice a day, also on an empty stomach, but not to be taken with Crixivan D4T twice a day, with or without food.
- Patients were getting up an hour early, just to take medication (ddI, usually), and then trying to go back to sleep for an hour, and then get up, so they could take the Crixivan, then get ready for the day and an hour later take the first d4T with breakfast.
- Lunch had to be over two hours before the next Crixivan dose, and then no afternoon snack for most patients.
- Dinner was normally a little later than normal, since the second ddI dose needed to be taken without food.
- And then, just to make life a little more complicated, evening snacks (if desired) were cut off two hours before the last dose of Crixivan.
- Along with this, patients were encouraged to drink extra fluids, since Crixivan (three tablets, three times a day back then) tended to cause kidney stones.

Medications have come a long way and dietetics professionals still have a role to play in medication adherence. In an up-coming issue of *Positive Communication*, an article will appear about the roles registered dietitians and dietetic technicians, registered play.

Also, thank you to everyone who voted this year in the dietetic practice group (DPG) elections. More than 60 HIV/AIDS DPG members voted, which is a huge increase from previous years!

2006-2007 HIV/AIDS DPG election results

By Theresa Gaffney, RD, LD

Thank you to all the candidates involved in the recent election and to all who voted. We had a terrific voter turnout, with nearly a 100% increase in ballots received over last year.

We are glad to announce our members and their newly elected positions:

- Chair-elect: Barbara Craven, PhD, RD, LD, (Washington D.C.)
- Secretary: Shelley Scott, RD, LDN, (Chicago, Ill.)
- Nominating Committee:
  - Chair—Ellyn Silverman, MPH, RD, (Long Beach, Calif.)
  - Waleska Rodriguez, MHScN, RD, LND, (San Juan, Puerto Rico)
  - Lisa Zullig, MS, RD, CDN, (New York, N.Y.)

The following is a message to the dietetic practice group (DPG) from Chair-elect Barbara Craven:

"I would like to thank you for your votes and support and I look forward to a great year in the DPG. The ADA (American Dietetic Association) is continually striving to define strategic direction in order to add value to its members and the profession. These goals also apply to the HIV/AIDS DPG members. But the DPG should have additional strategic direction focusing on the specialization of HIV. I believe that results come from setting priorities and goals. I would like the DPG to come to a consensus this year on its strategic direction, which will add value for members and the profession."

All five new officers will begin their tenure June 1, 2006. Barbara will serve for three years with her first year as chair-elect and the second and third years as chair and past chair, respectively. Shelley will serve as secretary for two years. Our new Nominating Committee will serve one year. The 2005-2006 Nominating Committee would like to extend a special welcome to Waleska, who will serve her first DPG position.

The Nominating Committee begins working immediately on planning for the next election. Positions open for 2007-2008 will be chair-elect, treasurer, and Nominating Committee. If you have any interest in one of these, or have an individual you would like to nominate, please contact Ellyn as early as this June.

As part of the 2005-2006 Nominating Committee, I can say that Marcy Fenton, MS, RD; Marge Morgan, MS, RD, CD; and I enjoyed our work together. With Marge and me in the Midwest and Marcy on the West Coast, we valued our diverse backgrounds and years of experience. One of our goals was to create a geographically diverse group of candidates. From the start, we were a cohesive trio and this helped us accomplish our mission with little fuss and much camaraderie. Thank you Marcy and Marge! May our incoming leaders have fruitful, positive experiences during their tenures.

Who me, volunteer? The unexpected benefits of getting involved

By Pam Charney, PhD, RD, CNSD
Consultant and author
HIV/AIDS DPG professional issues delegate
Mercer Island, Wash.

The mission statement of the HIV/AIDS Dietetic Practice Grou (DPG) is to be the "…advocate of the dietetics profession serving the public through the promotion of optimal nutrition, health and well being. The HIV/AIDS DPG enables members of the American Dietetic Association (ADA) to network and share information, collaborate, and advocate in order to positively impact people affected with HIV/AIDS."

To support this mission, the HIV/AIDS DPG has established four goals that include: information sharing, publication of a newsletter, keeping abreast of research developments, and advocating for the inclusion of nutrition into HIV disease management. As dietetics professionals working with those impacted by HIV/AIDS, what an amazing resource this group has proven to be! Can you imagine what would become of this practice group if no one volunteered to get involved and work towards meeting these goals? Think of the implications!

Without volunteer leaders, who would take responsibility for keeping our knowledge base up-to-date? There are literally hundreds, maybe thousands, of medical journals published. The amount of information now available on the Internet is simply astounding (do a simple web search using the term "HIV" and see what happens!). Who would ensure that the practice group publishes and mails a newsletter to the membership? Who would stay on top of legislative efforts and keep HIV/AIDS nutrition issues on the forefront of every legislative session? If not you, then who?

What are the benefits of ggetting involved? There is a popular saying: "If you aren't part of the solution, then you are part of the problem." All dietetics professionals have a unique skill set that can be used to drive the profession to higher levels. Sometimes when issues are identified by registered dietitians (RDs), it is much easier for some to complain rather than work towards a solution. Imagine if every RD and dietetic technician, registered (DTR) volunteered to improve the profession. ADA would be a formidable organization, indeed!

Committee members working together can learn new skills and share expertise. Throughout my 20-year career, I have been fortunate enough to learn many new skills; much of this learning would never have been made possible without my work as a volunteer. Professional volunteerism allows us to build networks that transcend practice and geographic boundaries. Many long-time volunteers can attest to the strong bonds that form from volunteer work.

Volunteering is hard work; there's no getting around that. It takes time and sometimes requires travel. Volunteering often lacks glamour. Committee work can sometimes unmask communication issues that have to be addressed before the work of the organization can continue. However, such hard work is well worth the effort involved. The interpersonal skills gained from volunteer work can be used in any situation.

How to get involved

More than 20 years ago, I had a clinical question. I contacted ADA and asked if there was someone who could answer my question. I was directed to one of the practice groups and given the name and phone number of a leader of that group. That person asked me to work on a subcommittee. My first project wasn't glamorous, and was a bit time consuming. We called a sample of previous DPG members to find out why they did not renew their memberships. Since working on this project, I have continued to serve the ADA in many different ways. I have been fortunate to be a DPG chair, Executive Committee member, coordinating cabinet member, and now serve as the professional issues delegate for the HIV/AIDS practice group. Additionally, I have been asked to serve on ADA's Standardized Language/ Nutrition Care Process Committee.

If you have a burning question, contact someone. If you think something needs to be fixed, contact someone. I have yet to find a group that says it has enough volunteers. Working with committees and projects leads to amazing opportunities to advance your own practice as well as the dietetics practice as a whole.

Public policy report

By Deane Edelman, MBA, DTR
Public Policy Committee co-chair

2006 Public Policy Workshop, 'The Tension Between Science and Politics', one of the best ever

This year's Public Policy Workshop, held March 14-16 in Washington, D.C., was outstanding. The program agenda was the best of all the workshops your Public Policy co-chair has attended. The theme was "The Tension Between Science and Politics." The speakers and sessions dealt with current, hot topics that often pit the science of dietetics against congressional legislation and government regulation.

Three top advocacy messages were presented for attendees to take to their members of Congress during the traditional Capitol Hill visits:

1. Secure federal funding to develop an evaluation tool to determine the effectiveness of the new wellness policies. These policies were mandated last year for the reauthorization of the Child Nutrition and Women, Infants and Children (WIC) Act for education agencies or school districts participating in the School Lunch or Breakfast programs.
2. Improve client access to nutrition screening, assessment and counseling, and strengthen the role of the registered dietitian in the Older Americans Act Nutrition Program, Meals on Wheels, which is the largest single component of the Older Americans Act. This is due for reauthorization this year.
3. Expand medical nutrition therapy (MNT) benefits in Medicare and amend the Ryan White CARE Act during the reauthorization process, which is now in progress, to name MNT as a core service.

While training the workshop participants on these issues, Ronald Smith, the American Dietetic Association's (ADA's) director of Government Relations drew attention to a Jan. 31, 2006 *New York Times* article entitled Where Science and Public Policy Intersect, Researchers Offer a Short Lesson on Basics. The article, written by Cornelia Dean, explains that "When scientific questions pervade legislation on issues like climate change and stem-cell research, there is growing concern that congressional misunderstanding can produce misguided policy.

To fight such misunderstanding, Rep. Sherwood Boehlert, R-N.Y., head of the House Science Committee, and others sponsored a Jan. 23 briefing "on how science works. More than 100 committee staff members, congressional aides and at least one senator, Jeff Bingaman (D-N.M.), crammed into a basement meeting room." This meeting indicates the subject struck a chord.

As if to underscore the importance of the Public Policy Workshop theme, "Mr. Boehlert said, 'everyone boasts that they are for science-based policy until the scientific consensus leads to an unwelcome conclusion, and then they want to go to Plan B'" (1).

We know of other dietetic practice group (DPG) members who attended the workshop: Margaret Swift, RD; Chair-elect Lucia Vining, MS, RD, LD; Secretary Lisa Zullig, MS, RD, LD; and Jennifer Carman, RD. Margaret also participated in a student orientation panel early in the workshop.

The following are summaries of several engaging sessions:

1. Dr. Paula Fitzgerald Bone, PhD; and Dr. Karen Russo France, PhD; of West Virginia University described their study on consumer understanding of the "strength of the evidence" statements the Food and Drug Administration (FDA) now puts on labels to accompany health claims for nutrients in foods and supplements. The statements are modeled on those developed by ADA to take the place of the "significant scientific agreement" standard that used to prevail for health claims. The conclusions of the study, with which Alison Kretser of the Grocery Manufacturers Association basically agreed, stated that consumers were either more confused than ever, or totally misinterpreted the language of these statements. The statements grading the evidence seemed to strengthen the claim in the minds of many consumers, but they are actually meant as disclaimers. Results were the same in an FDA-conducted study from last year. It was agreed that a better, simplified method is needed on labels to communicate to consumers the validity of health claims. The principle at play involves the protection of free speech on labels for manufacturers and marketers of products, balanced by the truth and accuracy of science. Thus, the "tension between science and politics."

2. The "Boomers or Bust" session featured former Congresswoman Barbara Kennelly of Connecticut, now president and chief executive officer of the National Committee to Preserve Social Security and Medicare. She gave a rousing speech on the mission of the Committee, which is to "protect, preserve, promote and ensure the financial security, health and the wellbeing of current and future generations of maturing Americans." The Committee does not support privatization of Social Security, and views Medicare Part D as a "complicated and meager prescription drug benefit, with glaring

flaws that will erode the value of what seniors receive, and could undermine the Medicare program itself." (2) Ms. Kennelly received a standing ovation at the conclusion of her talk.

She was followed by Dr. Sandra Schlicker, PhD, who described the registered dietitians' (RDs') successful strategy at the White House Conference on Aging last year. This strategy helped to elevate the main nutrition resolution and to insert nutrition concerns into many of the other resolutions during the breakout sessions for implementation planning. The "tension between science and politics," in the case of Older American programs, essentially boils down to the scarcity of resources available to implement actions demonstrated by science to be beneficial to those who are aging.

3. Dr. Scott Gottlieb, MD, associate commissioner for Medical and Science Affairs at the FDA, spoke about both food and drugs. He agreed that the statements ranking the strength of the evidence on label health claims need to be changed. He predicted other significant changes on food labels over the next 18 months, including: revisions in the "% Daily Value", the addition of "Calorie % Daily Value", larger print for calories, a definition of "low carbohydrate," and rules about "low carb" claims. He expects the FDA will do more work on drugs or supplements that prevent disease. He sees a need for better clinical trial designs in order to make more accurate prevention claims. Right now the trials are too expensive, too long and involve too many subjects.

4. Daryn Demeritt and Matt Robbins, public affairs consultants with Field Goals, Inc., gave an extremely useful session on the skills involved in grassroots lobbying. They discussed all the steps that precede sending a message to elected officials. This includes: forming and maintaining partnerships and networks; recruiting, educating, motivating, mobilizing, thanking, and rewarding your supporters; keeping supporters engaged between campaigns; cultivating legislative relationships before you have to ask for help; spending more time and commitment than money; and making known your expertise in dietetics by getting on boards and commissions.

Other addresses were given by Deputy Secretary of Agriculture Charles F. Conner; Karen Baldacci, RD, First Lady of the state of Maine; Sen. Tom Carper, D–Del., of the Senate Special Aging Committee; Sen. Richard Durbin, D–Ill. of Senate Appropriations Committee; and Rep. Fred Upton, R–Mich. of the House Energy and Commerce Committee.

Innovative breakout sessions were held on the first day of the workshop that covered the following:

- an introduction to policy and advocacy
- scope of practice
- the campaign to gain coverage and increase reimbursement
- a review of the complex web of regulation of dietetics and nutrition in the states (3)

States arranged the roundtable seating in the main hall for all remaining sessions.

2006 PPW: Taking it to the Hill

By Lisa Zullig, MS, RD, CDN

As a first-timer at the Public Policy Workshop, I found the sessions to be extremely informative and helpful. The information and training provided prepared me well for my first visits to Capitol Hill. These visits occurred on the third day of the conference after a morning of motivating addresses from Sen. Richard Durbin, D–Ill., Sen. Tom Carper, D–Del., and Rep. Fred Upton, R–Mich.

With the New York state delegation, I visited Sen. Hillary Clinton's, D–N.Y., and Sen. Chuck Schumer's, D–N.Y., offices. In meetings with legislative fellows or aides, we presented the current advocacy issues and provided real-life applications. As the designated Ryan White CARE Act point person, I stressed the importance of MNT for those served by RWCA grantees. After these visits, along with a student from Brooklyn College, I met with Rep. Major Owens', D–N.Y., chief of staff. Seeing that she was unaware, we first explained who RDs are and what makes the RD an expert in the nutrition field, before talking to her about the issues at hand. I felt that throughout all of our meetings we were met with genuine interest, were asked good questions, and our messages were well received.

Overall, my PPW experience was wonderful. In addition to attending instructive program sessions, I thoroughly enjoyed the Hill visits. In the advocacy sessions, I was reminded that elected officials work for us; voicing our opinions is crucial to the legislative process, and in doing so, making a personal connection with our legislators' offices can make a difference. Visiting them reinforced these points and inspired me to continue to be involved on the local and national levels.

References

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3. American Dietetic Assocition. *On the Pulse*. Friday, March 24, 2006.

An interview with Shannon Ward, MA, program development manager for the World Initiative for Soy in Human Health

By Cade Fields-Gardner, MS, RD, LD

Background

Shannon Ward, MA, holds a Bachelor's degree in international relations from the University of California, Los Angeles and a Master's degree in international policy from George Washington University in Washington, D.C. After receiving her Bachelor's degree she took a position teaching English in Slovakia. At that time the war in Bosnia was raging. She became familiar with and volunteered to work in refugee camps in Hungary that were set up for Bosnian refugees. She lived on the border between Slovakia and Hungary, and spent time in both countries. Shannon mentioned that she used to walk over the border and catch a train to where she wanted to go in Hungary. There is a large Hungarian population in the southern part of Slovakia, so many people living in the region have ties to both countries.

It was her introduction to working with war-affected and displaced and disaffected populations. After her time in Hungary, she joined the World Food Program and worked in Bosnia-Herzegovina, Liberia and Tanzania. Her next position was working with the American Red Cross in its International Services Section for activities in Central Europe.

It was during this time that she decided to seek her Master's degree in international policy, realizing that the field was becoming more competitive as more people became interested in international work. She chose international policy for its broader application and different perspectives allowing her to span across business concepts, such as micro-credit and business applications. She also recognized the benefit of having health-field experience in her chosen profession. Shannon's current position as the program development manager for the World Initiative for Soy in Human Health (WISHH) gives her the opportunity to identify and develop ideas that utilize her education and experience in food, health and development activities. Her interests and efforts are targeted to benefit populations receiving food or development aid, as well as supporting sustainable solutions in the business and industry setting.

Q: When and how do you think HIV/AIDS entered the minds and programming efforts of international organizations?

A: While there was an awareness of the issue of HIV/AIDS and its negative impact on development and other supportive activities, it wasn't until the late 1990s when more focus was put on HIV/AIDS in programming activities. Before that time we didn't have much discussion on how food security and HIV/AIDS were related. People living with and affected by HIV/AIDS were not specifically targeted by food distribution programs. Even in the 1990s, work I did had more emphasis on food distribution than in health.

In 1997 I went to work in Liberia, which was still war-torn following seven years of civil strife. Even now there are not good statistics about the impact of HIV in Liberia, and the priority then was on emergency programs addressing simple survival and transitional programs. Liberia recently held elections, and there is a resurgent hope that the country is now on the path to stability and an improved standard of living for its people, which will also assist in any efforts directed toward dealing with HIV/AIDS.

In 1999 I moved to Tanzania and was aware of some discussions about HIV-infected populations and activities in Uganda and South Africa. Still we talked about programs to address refugees, internally displaced or vulnerable populations due to limited economic assets, but not because of HIV infection. It wasn't until I returned to the United States in 2001 that I saw a focus on HIV/AIDS-affected people as a target population for assistance.

The focus and attention on HIV/AIDS was galvanized by the creation of the President's Emergency Plan for AIDS Relief (PEPFAR). With that funding support, a number of organizations that were interested or had done limited work in this arena now had the opportunity to do something on a grander scale. PEPFAR brought to the forefront the issue of HIV/AIDS in a way it had not been done before that time. More groups were asking how they could integrate the target of HIV-infected populations and issues into their food security efforts in order to benefit this population. More interest was placed on understanding the issues and integrating efforts of agriculture, micro-credit and rural development.

Q: How do you think HIV/AIDS has affected nutrition-related efforts of private volunteer organizations (PVOs) and other organizations?

A: Now there is a focus on synergy. There are a lot of ways that these organizations are working to learn how to best handle the issues and develop the programs to address HIV/AIDS. Organizations are having internal discussions with staff and others, looking at the experiences of other organizations and their lessons learned, discerning best practices, and other activities. For instance, best practices that have brought some success to efforts in Uganda and even some lessons learned from experiences in the United States are examined to see what might be successfully transferred and applied elsewhere.

Prior to consideration of which populations and issues to target, there are a series of activities a PVO will go through to determine its preferred direc-

tion. During the proposal development stages there is usually discussion in-house to see what funding is available, if there is the desire to integrate the various sectors that may impact nutrition, and what type of projects the donor may be interested in that fulfills the interest of the organization. The proposal may be generated from meetings with the in-house health, agriculture, food security and/or other teams to integrate sectors for a cost-effective program. Also, when an interest becomes a hot topic, such as HIV and AIDS, everyone is looking to get on the bandwagon. For those with an interest in international work to address HIV/AIDS, it is a good time to become involved.

There have been a number of challenges for organizations addressing this topic. Concerted efforts were made to realize the inter-connectedness of the sectors and the importance of addressing issues as a group or team rather than separately. For instance, if the health group were to address a health issue without involving water and sanitation where this is an issue, the group may not see that desired improvement in people's health. Therefore, there are benefits to meeting program objectives by taking an integrated approach.

There have also been challenges in budgets that were spread out over several different sectors with different funding sources. It can be difficult to coordinate and integrate each sector that could affect the outcomes of the others. I have not seen hesitation or resistance of organizations to make these changes to address HIV/AIDS. The issue is so huge and it impacts all sectors. I think that most people were generally open to the evolution of thought that integrating their efforts can benefit multiple sectors. In my experience, most of the responses to these challenges have been positive.

Q: What funding sources support work in the area of HIV/AIDS and nutrition?

A: There are many programs that have built-in possibilities. The U.S. Agency for International Development (USAID) coordinated PEPFAR efforts, and some U. S. Department of Agriculture (USDA) programs provide specific areas where nutrition may be addressed. We can look to organizations that include HIV/AIDS interventions in their broader programs, such as government programs that provide development assistance to developing countries. While they might have HIV-related programming, it could be that they also support nutrition. There are many organizations in Europe that address development, including the Department for International Development in the United Kingdom. In Japan there is the Japan International Cooperation Agency (www.jica.go.jp/english/). Government agencies in the Australian, Dutch, and Norwegian governments are also involved in international development efforts. The Global Fund (www.theglobalfund.org/en/) may not be involved specifically in food distribution, but it can include nutrition education efforts. There is also the Fight AIDS, Tuberculosis & Malaria program. Child Survival is another program that places an emphasis on nutrition and devastating diseases. The Asian Development Bank (www.adb.org), and other multilateral funding institutions have also issued statements about the importance of access to nutrition and related services.

In addition to these funding organizations, there are thousands of foundations with funds available. This can take quite a bit of searching, but it might be helpful to start with the Foundation Center (www.fdncenter.org) where a subscription can be obtained for access to its tremendous database (over 10,000 listngs!) to search for appropriate funding sources for both domestic and international work. This organization has offices in Washington, D.C. and New York, N.Y., but conducts training all over the country for topics such as proposal writing, fund seeking, compliance and other activities.

It is important to find out and match what the donors want. For instance, PEPFAR is looking at the numbers of people to whom to provide prevention, care and treatment services. The Centers for Disease Control and Prevention may be more interested in doing general research and operations research. Humanitarian donors may look at a direct feeding program. The Gates Foundation is supporting quite of bit of prevention efforts, and USAID is supporting a focus on prevention using the ABC concept (abstinence, be faithful, and condoms), among other things.

Much of the programming depends on what donors want. In some cases, the donors want to do something in a particular area, but may not be sure of what that program might look like. In those cases they may be more open to looking at a variety of program concepts. Most are open to new ideas, but getting the ideas funded may require an education plan and repeated contacts, especially with larger, more bureaucratic funders. Smaller funding organizations may find it easier to do smaller projects and pilot programming that allows a great deal of creativity. The process can take a long time and dedication on the part of those who pursue funding.

Q: Tell us about WISHH, the organization for which you are the program development manager.

A: WISHH was started in 2000 with the aim of increasing human consumption of soyfoods to improve human nutrition worldwide. WISHH works in a variety of sectors, including HIV/AIDS. We work with three primary goals in this area, including gaining knowledge and data to show the benefits of increased consumption of soy by people living with HIV infection, introducing soyfoods in projects that use food commodities to address the food-related issues surrounding HIV/AIDS, and working with the commercial sector to improve the nutrition composition of the foods that may be purchased or otherwise consumed by people with chronic HIV infection.

In the first area, WISHH is support-

(See WISHH, page 10)

(WISHH, from page 9)

ing projects to generate data on the benefits of soy consumption in the countries targeted. Generally we develop a partnership with a PVO or other organization, assist with designing the project, collect data in a baseline survey and objective nutrition-related measures, provide rations for a specified period of time, conduct a follow-up survey and objective nutrition-related measures, and compare results. We have completed such work in a number of countries and are now interested in moving on to more complex studies that will better demonstrate the benefit of high-quality protein for people living with HIV/AIDS.

Because WISHH is not providing the distribution services, we have to rely on ad hoc donations of products, and we have not been in the position to provide and study the effects of soyfoods on a longer-term basis. Most of our projects include a ration for a period of six to 12 months. We find that it is a challenge for both WISHH and partner organizations to address what will happen after the funding period is finished and how efforts are made toward sustainability.

The natural segue is to work with commercial-sector partners and private companies. We assist these partners to develop locally appropriate foods that may be purchased or otherwise obtained by people living with HIV/AIDS. This requires that the commercial partner and WISHH address the cultural acceptability, palatability, affordability and accessibility for targeted populations. In many cases, companies have targeted the high-end consumer. With our initial contact, some were most interested in developing products that could secure larger volume government and PVO contracts. However, many are realizing that with access to the Internet, media play, and other educational efforts, more consumers are looking for products that contribute to health improvement.

Our contacts with potential commercial partners have been met with varied feedback. Some companies are looking mostly to their own bottom line and less at their role in impacting their communities. In any case, most are open to creative ideas and innovation in product development. The idea of improving the nutritional value of their product line is received in a mostly positive way. The challenge is to make a product that is affordable while meeting nutrition needs and still profitable for the commercial partner. In all of the regions where we have commercial partners (East Africa, Southern Africa, and Central America), we see a consumer-driven demand for products that can improve their health.

Q: Do you have any additional comments to share?

A: It will be interesting to see where things are with food, nutrition and HIV/AIDS after the five years of PEPFAR funding are over in 2008. There is more pressure now on private sector organizations to deal with HIV to develop sustainable solutions for their workforces and the communities they affect, particularly in highly impacted countries. They must face it because their workforce is becoming ill and having a significant impact on profitability and even survival of companies. This can be directly linked to the impact on workers and their ability to physically and economically survive. I think that the private sector will play an increasingly large role in the efforts to confront the pandemic.

There are many advantages to working with the private sector to enhance development efforts that further benefit the private sector. Ultimately, if our commercial partners can make a product that makes a profit while better meeting nutrition needs of the consumer population, then it can become a sustainable solution.

Humanitarian efforts are generally not sustainable. However, many organizations involved in humanitarian efforts are adding components of sustainability to their projects. It is the "teach a person to fish" concept. These efforts include training toward the development of skills and talents of their beneficiaries so that the impact can live beyond the program life and funding. Well-rounded efforts toward a sustainable response include training to improve employability, education to improve the application of nutrition knowledge, and education on the prevention of transmission. It is important to demonstrate that type of success.

Publish your work in Pos Com!

Are you interested in writing articles for *Positive Communication*? HIV/AIDS DPG needs authors to provide *Pos Com* articles for the upcoming year. If you are interested in writing an article, contact Chair Karen Bellesky, RD, LD, at chair@hivaidsdpg.org.

Ethics Committee Continues To Educate Members

The following resources provide a wealth of information for members to use to increase their knowledge of the American Dietetic Association (ADA)/ Commission on Dietetic Registration (CDR) Code of Ethics and are available on the ADA Web site at www.eatright.org/codeofethics.

- Guidelines regarding the recommendation and sale of dietary supplements
- Ethics opinions: The committee may issue opinions on ethics issues under the code on its own initiative or in response to a member's or credentialed practitioner's request. These opinions will be available to members and credentialed practitioners to guide their conduct. Situations may be factual or hypothetical.
- Ethics in Action columns: The Ethics in Action column is designed to provide regular education for members on ethical practice.
- Code of Ethics "For Further Reading" List: The purpose of this list is to provide members with references related to the ethical practice of dietetics.
- Code of Ethics—*Trainers Guide*: The American Dietetic Association and Commission on Dietetic Registration joint Ethics Committee has developed a trainer's guide to help educators and leaders of the dietetics profession educate members and credentialed practitioners about the ADA/CDR Code of Ethics. More detailed information is included in the actual trainer's guide documents.
- Ethics Speakers Bureau: Developed to assist the affiliate dietetic associations and dietetic practice groups (DPGs) to identify qualified speakers and topics on ethical issues for member continuing professioan education programs.
- Food & Nutrition Conference & Expo 2005 Session Materials: Ethics and the ADA Scope of Dietetics Practice Framework—Practical Applications

The ADA and CDR have a voluntary, enforceable code of ethics. This code, entitled the Code of Ethics for the Profession of Dietetics, challenges all members—registered dietitians, and dietetic technicians, registered—to uphold ethical principles.

The Ethics Committee continues to educate members, credentialed practitioners, students and the public about the ethical principles contained in the Code. The Code of Ethics support by members and credentialed practitioners is vital to guiding the profession's actions and to strengthening its credibility.

Strengthen credibility through ethics

- The Ethics Committee has developed a wealth of resources for your use.
  - Ethics Speakers' Bureau
  - Ethics opinions
  - "For Further Reading" list
  - Code of Ethics—Trainer's Guide
- Support of the ADA/CDR Code of Ethics is vital to guiding the profession's actions and to strengthening our credibility.
- For more info about the Code of Ethics and resources, visit www.eatright.org/codeofethics

ADA has your CPE costs covered!

ADA's newest member benefit saves you time and money as you complete your continuing professional education (CPE) requirements. Beginning with the March 2005 issue, members can receive up to four units of CPE at no additional charge each month by reading specified *Journal* articles and taking the accompanying test.

Journal articles that meet your learning needs and are identified as approved for CPE credit are worth two CPEUs (continuing professional education units) each, and are classified by the Professional Development Portfolio (PDP) as "pre-approved, self-study."

At no cost, and in the convenience of your home or office, take advantage of a number of self-study *Journal* articles for your CPE needs.

Of course, for the Portfolio recertification process, the articles need to match the learning needs identified in your learning plan.

With 24 *Journal* articles to choose from annually and 120 articles in your five-year cycle, you're bound to find many that meet your particular needs.

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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