

NIH STRATEGIC PLAN FOR AIDS RESEARCH RELATED TO RACIAL AND ETHNIC MINORITIES

THE NIH AIDS RESEARCH PROGRAM

The Role of the Institutes

Each NIH component supports HIV/AIDS-related research activities, consistent with its individual mission. The ICs whose research programs are most heavily concerned with HIV, AIDS, and their sequelae are the National Institute of Allergy and Infectious Diseases (NIAID), the National Cancer Institute (NCI), the National Institute on Drug Abuse (NIDA), the National Institute of Mental Health (NIMH), the National Center for Research Resources (NCRR), the National Heart, Lung, and Blood Institute (NHLBI), and the National Institute of Child Health and Human Development (NICHD). The Warren Grant Magnuson Clinical Center provides the infrastructure for intramural clinical studies sponsored by the ICs.

The Role of the Office of AIDS Research

OAR was established in 1988 by the Director of NIH and the Department of Health and Human Services (DHHS) Assistant Secretary of Health to coordinate the AIDS research effort across NIH and serve as a focal point for AIDS policy and budget development. The NIH Revitalization Act of 1993 (Public Law 103-43) gave broad new authorities to the office. OAR is responsible for the annual comprehensive planning and budgeting process for all NIH AIDS research and for preparation of a Presidential bypass budget. The law also requires OAR to evaluate the AIDS activities of each of the ICs, as well as provide for the periodic reevaluation of such activities. OAR maintains a discretionary fund, and the appropriations committees have provided OAR with transfer authority permitting it to move up to 3 percent of AIDS research funds among Institutes. The OAR monitors and fosters plans for NIH involvement in international AIDS research activities.

OAR has established and supported the efforts of five trans-NIH Coordinating Committees in the following areas: Natural History and Epidemiology, Etiology and Pathogenesis, Therapeutics, Vaccines, and Behavioral and Social Science. The Committees represent those Institutes with the most significant research portfolios in these areas. The Committees foster collaboration and coordination and assist in the development of the NIH Plan and budget for AIDS research. In addition, OAR established the Ad Hoc Minority Working Group in 1999. Composed of NIH staff and non-NIH scientists and experts, this group advises the OAR Director on needed research and research-related efforts specifically targeted to these populations.

OAR also established the Global AIDS Research Strategy Group to bring together all of Institutes and Centers of the NIH with international AIDS research portfolios, the Centers for Disease Control and Prevention, and the U.S. Agency for International Development, to facilitate international research efforts.

To carry out its activities, OAR depends upon the expert advice of several committees.

Each of these committees includes AIDS community representatives. The OAR Advisory Council (OARAC) is composed of non-Government experts from a broad array of disciplines, as well as AIDS community representatives. OARAC reviews the annual Plan and discretionary fund disbursements. A list of current OARAC members is included as Appendix A. OAR also has established the Prevention Science Working Group and the Therapeutics Research Working Group to provide advice in these critical scientific areas.

OAR directly supports several programs and initiatives. These include the Intramural AIDS Targeted Antiviral Program (IATAP) and the NIH AIDS Research Loan Repayment Program (LRP). In addition, OAR recognizes the critical need to ensure that research results are translated into effective prevention programs and into clinical practice. To accomplish this goal, OAR supports a number of activities to promote the distribution of research information to researchers, physicians, institutions, and communities.

LEGISLATIVE MANDATE

The Revitalization Act provided that the Director of the OAR shall “plan, coordinate and evaluate research and other activities conducted or supported” by NIH. The OAR Director “shall act as the primary Federal official with responsibility for overseeing all AIDS research conducted or supported by the National Institutes of Health” and shall

- “establish a comprehensive plan for the conduct and support of all AIDS activities of the agencies of the National Institutes of Health...;
- ensure that the Plan establishes priorities among the AIDS activities that such agencies are authorized to carry out;
- ensure that the Plan establishes objectives regarding such activities...;
- ensure that all amounts appropriated for such activities are expended in accordance with the Plan;
- review the Plan not less than annually and revise as appropriate...; and
- ensure that the Plan serves as a broad, binding statement of policies regarding AIDS activities of the agencies, but does not remove the responsibility of the heads of the agencies for the approval of specific programs or projects, or for other details of the daily administration of such activities, in accordance with the Plan.”

The law further mandates that the Plan provide for “basic research; ...applied research; research that is conducted by the agencies; ...research that is supported by the agencies; proposals developed pursuant to solicitations by the agencies and for proposals developed independently of such solicitations; and ...behavioral and social sciences research.”

The law also provides that the OAR Director develop the NIH AIDS budget for each fiscal year based upon “budget estimates...for carrying out the Plan for the fiscal year,” including a budget to be sent directly to the President and the Congress.

OVERVIEW OF THE PLAN

The Planning Process

OAR has established a unique and effective model for developing a consensus on scientific priorities for the annual comprehensive NIH Plan for HIV-Related Research. To develop the FY 2003 Plan, OAR sponsored a series of Planning Workshops to seek the input of non-NIH experts, including scientists from academia, foundations, and industry, and community representatives. These experts participated with NIH scientific and program staff in Planning Groups for Natural History and Epidemiology; Etiology and Pathogenesis; Therapeutics; Vaccines; Behavioral and Social Science; Microbicides; HIV Prevention Research; Racial and Ethnic Minorities; Women and Girls and HIV/AIDS Research and International Research Priorities. A list of participants in the Planning Group for Research Related to Racial and Ethnic Minorities is found in Appendix B. Participants in each Planning Group were asked to review and revise the objectives and strategies of the draft Plan, based on the state of the science, and to identify a set of priorities for their area. All groups were asked to address needs in the areas of information dissemination, training, infrastructure and capacity building related to their area. The resulting draft Plan was then provided to each Institute and Center Director and AIDS Coordinator for recommendations and comments. Finally, the Plan was reviewed by the Office of AIDS Research Advisory Council.

OAR continues to reassess the planning process and make refinements in order to better capture the broadest range of expertise and community participation and to facilitate the identification of specific scientific priorities. This year, new sections have been added to the Plan, focusing on Microbicides; HIV Prevention Research; and Women and Girls and HIV/AIDS Research.

Structure of the Plan

The Plan is divided into six Scientific Areas of Emphasis and six Areas of Special Emphasis. Scientific Areas of Emphasis are Natural History and Epidemiology; Etiology and Pathogenesis; Therapeutics; Vaccines; Behavioral and Social Science; and Microbicides. Areas of Special Emphasis, which cross-cut all of the scientific areas, are HIV Prevention Research; Racial and Ethnic Minorities; Women and Girls and HIV/AIDS Research; International Research; Training, Infrastructure, and Capacity Building; and Information Dissemination.

Scientific Issues and Priorities

This section provides a scientific overview and specific priorities identified by the planning groups for each area. These priorities narrowly define a few high-priority areas deemed most worthy of new or expanded funding, based on the current scientific knowledge, opportunities, and gaps. They will be used to guide the development of the FY 2003 AIDS budget and to adjust the FY 2002 AIDS budget as needed. It is expected that these priorities will change from year to year, and thus expenditures in these areas will not be tracked over time.

Objectives and Strategies

Objectives consist of a comprehensive list, in priority order, of the scientific questions to be addressed for each Scientific Area of Emphasis or Area of Special Interest. Under each Objective is a set of Strategies that provide examples of avenues and approaches that may be pursued.

Uses of the Plan

The Plan serves several purposes:

- As the framework for developing the NIH AIDS budget.
- For determining the use of NIH AIDS-designated dollars and for tracking and monitoring those expenditures. The Plan thus defines those research areas for which AIDS-designated funds may be allocated.
- As a document that provides information to the public, the scientific community, Congress, and the AIDS-affected communities about the NIH AIDS research agenda. OAR distributes the annual comprehensive Plan to a wide audience, and it appears on the OAR Web site: <http://www.nih.gov/od/oar/>.

STRATEGIC PLAN for AIDS RESEARCH RELATED to RACIAL and ETHNIC MINORITIES

Scientific Issues:

Significant gains have been made in the treatment of HIV infection, as well as in the elucidation of the complex mechanisms involved in the pathogenesis and pathophysiology of HIV infection. Despite these gains, for over two decades, HIV infection has continued an inexorable march across racial and ethnic minority communities in the United States. The increased number of treatment options, as well as the expanding number of clinical trials, has not significantly altered the course of HIV infection or transmission in these communities. Racial and ethnic minorities continue to dominate new AIDS cases, as well as new HIV infections. Many urban centers within the United States reflect HIV seroprevalence rates among racial and ethnic minorities that mimic those in the developing world.

The interplay of cultural, economic, political, individual, and societal factors in general, especially within racial and ethnic minority communities, requires comprehensive and innovative interventions. These interventions must include greater emphasis upon the training of minority scientists, as well as a long-term commitment to the production of skilled independent investigators. The demographics of the epidemic, in stark contrast to the demographics of both extramural and intramural NIH investigators, reveal a widening divide between those infected and those conducting research upon the infected.

However, race and ethnicity alone are insufficient to bridge the gap between the scientific

community and the communities most affected by HIV infection. Within these communities, the main routes of HIV infection—unprotected sexual intercourse and substance abuse—are inextricably linked to a range of underlying community and societal factors, as well as community norms and culture. Cultural competency, or the ability to see the world through the lens of a particular culture, not just cultural awareness, is a critical skill in understanding the context of the epidemic in racial and ethnic minority communities. In addition to understanding the cultural context of HIV infection, these skills can result in designing clinical research that will produce outcomes that have relevance for these communities. Focus groups have repeatedly demonstrated that research conducted with communities, rather than “for” or “on” communities is the only research that will be acceptable.

Participation of racial and ethnic minority communities in clinical research can only serve to broaden scientific knowledge about HIV infection. This would include identifying the impact, or lack thereof, of specific racial factors upon HIV pathogenesis, transmission, susceptibility, disease progression, and disease manifestation. The high rates of other co-morbid diseases in racial and ethnic minority communities, such as hepatitis C, also provide additional opportunities to determine the effect of these disease states upon not only HIV infection, but also upon treatment options for HIV infections, or the sequelae of treatment, such as metabolic abnormalities. To achieve this objective, recruitment and retention strategies for clinical studies must be appropriate for the target population. Partnerships between NIH-funded research institutions and institutions within the community, including community-based organizations, present an opportunity for unique collaborations and greater community participation. Through these partnerships the community and NIH can benefit from an exchange of ideas from research design to dissemination of research results.

Regardless of clinical study type or design, the infrastructure within racial and ethnic minority communities is variable and may not sustain interventions tested in a community and found to be effective. Recent revisions of the Declaration of Helsinki and National Bioethics Advisory Commission Ethical Guidelines remind us that research must leave a community “better off” than before the intervention was conducted. Research activities within racial and ethnic communities, as with any community, must recognize the value of the individuals and their unique contribution to their community and the wider society. Interventions that are effective, but not sustainable, represent a zero sum gain for the participating communities.

Under-representation of racial and ethnic minorities in clinical research, as well as in the scientific community that conducts that research, is the product of a complex interplay of a number of factors. With these factors ranging from racism and homophobia to mistrust and ignorance, the need for a new and innovative approach for increased minority representation across both the subject and investigator populations is clear. A detailed and objective interdisciplinary review of the successes and failures of the NIH research and training programs in racial and ethnic minority communities, with action steps linked to quantifiable outcomes, is essential.

Priority for Future Research:

- **Invest and expand funding in research infrastructure at minority institutions to increase capacity to support HIV/AIDS research.**

Creative strategies to increase the numbers of racial and ethnic minorities who participate in clinical research and behavioral intervention studies, without a parallel effort to increase the number of skilled, independent minority investigators, will change little in the ongoing health disparity in HIV infection. Community mistrust, only heightened by the consistent and ongoing paucity of minority investigators visible to the community, will continue to be a significant challenge. Minority investigators at all institutions face challenges; however, those at minority institutions face significant challenges, due in part to the unique missions and environments at these institutions. Ensuring adequate resources for partnership development between minority-level and established university-level and federal research institutions is key. Opportunities for faculty development, including the creation and support of partnerships between researchers at these institutions, would help foster collaboration. As minority investigators are developed and stimulated, the creation and funding of innovative pilot sabbatical and fellowship programs to ensure protected research time is necessary. Similarly, the identification and funding of senior visiting investigators for the purpose of enhancing the research capacity of minority investigators and institutions could serve as an additional catalyst at minority-predominant and minority-serving institutions. Finally, the development and funding of HIV/AIDS research networks in these same institutions may assist in the development of the critical mass needed to produce productive senior investigators.

Priority for Future Research:

- **Increase the number of funded minority investigators for greater efficacy in HIV research.**

In conjunction with infrastructure development, there are specific interventions necessary to expand the pool of minority investigators in HIV research. The development and expansion of short- and long-term local and national mentoring programs among racial and ethnic minorities is essential. There has been a consistent decline in the numbers of minorities selecting careers in the health sciences. To reverse such trends, there is a critical need to identify and develop strategies to recruit trainees and mentors at all levels, while providing economic and in-kind support. Innovative grant mechanisms and training workshops that support the transition from trainee to independent investigator are also needed. Enhancement and expansion of academic training programs that provide the theoretical as well as practical framework for the conduct of clinical and basic research are especially needed. As these investigators become independent and productive, there is an ongoing need for greater participation of minority investigators in the grant review process. Like the community from which it is culled, study sections in general reflect the demographics of the scientific community, and not the communities where the research they approve will be

conducted. This translation gap can be diminished by greater representation of minority scientists on study sections, as well as cultural awareness training of study section members. The increasing parallels between the domestic urban HIV epidemic and the pandemic in Africa and other developing nations will require a broader knowledge of the cultural impact of interventions to control and treat HIV infection. These parallels have, and will continue, to provide research opportunities for minority investigators.

Priority for Future Research:

- **Decrease the health disparities among racial and ethnic minorities to increase their health status to that of the majority population with respect to HIV infection.**

HIV is only one of many disease states for which significant disparities exist between racial and ethnic minorities and whites. The foundation for these disparities includes, but is not limited to: poverty, racism, homophobia, social apathy, and a profound mistrust of the health care and biomedical research establishment. This mistrust is rooted in not only historical lessons, such as Tuskegee, but also in the community experience of research that has not left any sustainable interventions in place. Upon completion of the trial or intervention, no identifiable or tangible benefit to the community has been realized. Minority communities will continue to decline research participation or cooperation until there is greater collaboration between the community and the scientific community, with attention to the sustainability of the intervention before *any* trial is begun.

Greater attention is also encouraged to the combined effects of societal factors upon the individual and community behavior with respect to HIV infection. The study of racial and ethnic differences with respect to HIV transmission, disease progression, and resistance to infection is also encouraged. The unique aspects of these communities, for example, the high rates of co-morbid disease states including diabetes, hepatitis C, sexually transmitted diseases, substance abuse and cardiovascular diseases, afford an opportunity to study interventions to reduce or eliminate the negative impact of these co-morbid diseases.

Barriers to accessing care and clinical trials are widespread within racial and ethnic minority communities. These barriers are at several levels, including individual, institutional, and community. A continued emphasis on studies that identify those factors that promote and impede early access to care, treatment, and clinical trials is important to determine effective interventions. The identification and study of these interventions to reduce or eliminate these barriers will be a fundamental step toward closing the gap between racial and ethnic minorities and whites. However, identification alone will be insufficient, hence sustaining the interventions that have proven effective will be necessary to ensure ongoing attention to these barriers.

Priority for Future Research:

- **Include racial and ethnic minorities in prevention, therapeutic, vaccine, and clinical trials in numbers that reflect the current incidence data.**

Given the barriers, mistrust, and challenges noted above, intensive efforts are justified for the recruitment and retention of racial and minority participants in clinical trials in numbers that reflect the demographics of the epidemic in real time. In order to achieve this goal, recruitment activities that are culturally appropriate for the specific target population will be necessary. Such interventions will need to include community-based education about basic and clinical research, including clinical trials. The conduct of clinical trials where individuals seek care and services will facilitate recruitment as well as retention.

Beyond recruitment and retention are the issues that unique race and/or gender characteristics may have an impact upon the outcomes in transmission, side effects, body composition changes, and treatment side effects. Racial and ethnic minorities must be recruited and retained in numbers sufficient to evaluate the presence or absence of such effects with adequate statistical power. The risks and benefits of alternative and complementary therapies used in conjunction with standard HIV therapies require further study, especially in racial and ethnic minority communities, given their place in the culture.

Priority for Future Research:

- **Develop, pilot, evaluate, and sustain effective interventions to prevent HIV transmission and its co-morbidities.**

The risk behaviors for HIV transmission, and the means of preventing such transmission, have been well known for over two decades. Yet despite this, HIV infection continues to spread rapidly throughout racial and ethnic minority communities. Effective, sustainable prevention messages are desperately needed in these communities, as well as an understanding of the impact of those factors that may interfere with prevention messages.

To better understand the impact of these factors, basic behavioral research is needed to effectively target the many sub-populations within racial and ethnic minority communities, including those who use illicit substances and those with multiple diagnoses (e.g., mental disorders and alcohol/drug abuse). Reduction or elimination of language barriers that limit participation in prevention research is also needed in communities where English is not the primary language. Any standardized scales to be used in these studies should have been validated in minority populations, especially given the cultural contexts within which risk behavior occurs. The role of the family and caregivers in HIV prevention in racial and ethnic minority communities needs to be explored.

There is a need for increased awareness of NIH HIV prevention activities at the community level, which can be achieved through closer collaboration between NIH and all other Department of Health and Human Services (DHHS) agencies charged with decreasing HIV transmission through public education. Such collaborations should include, but not be limited to, information dissemination and translation of research findings. These activities also need to include technology transfer of effective prevention programs to community-based organizations that reach at-risk groups among racial and ethnic minorities.

Priority for Future Research:

- **Promote and increase adherence to treatment regimens among racial and ethnic minorities.**

Effective drug treatment regimens identified in the controlled environment of a clinical trial do not perform as well in urban, inner city HIV clinics. Poor adherence is the major reason for this finding and is a reflection of a host of underlying economic, individual, and social factors. There is a need for the study of multilevel interventions, including the individual, peer, family, and community levels. Further studies of the impact of noncompliance in racial and ethnic minorities upon the emergence of drug-resistant HIV, multidrug-resistant tuberculosis, and disease progression are needed.

Increased support is recommended for basic science studies of the racial and ethnic differences in body composition and pharmacokinetics, and their potential role in suboptimal drug effects. The impact of drug side effects and cosmetic changes and their role in noncompliance also warrants further study, especially in racial and ethnic minority communities, where such changes can unmask underlying HIV infection. Finally, the

development of culturally appropriate and population-specific models of treatment acceptance and adherence is needed.

Scientific Objectives and Strategies

OBJECTIVE:

Invest and expand funding in research infrastructure at minority institutions to increase capacity to support HIV/AIDS research.

STRATEGIES:

- Ensure adequate resources for partnership development between minority institutions and established university level, and federal research institutions.
- Ensure information about training and recruitment opportunities is disseminated through a variety of traditional and non-traditional networks to reach the targeted population, with an ongoing evaluation of the effectiveness of these approaches.
- Ensure adequate training of minority researchers in the use of the Internet and information resources important for research.
- Ensure adequate telecommunications infrastructure at minority institutions to enable researchers to conduct their work.
- Develop and fund HIV/AIDS research networks in minority predominant and minority serving institutions.
- Create and fund innovative pilot sabbatical and fellowship programs to ensure protected research time.
- Identify and fund visiting senior investigators for the purpose of enhancing the research capacity of minority investigators and minority institutions.
- Create, support, and maintain equal partnerships between minority and majority researchers, as well as minority institutions.
- Emphasize long-term commitments, combining investments in research and training as in the model AIDS International Training and Research Program (AITRP). Such an approach is key to long-term sustainability and success.

OBJECTIVE:

Increase the number of funded minority investigators, for greater efficacy in HIV research.

STRATEGIES:

- Support the development and expansion of short and long term local and national mentorship programs among racial and ethnic minorities.
- Identify and develop strategies to recruit trainees and mentors at all levels, while providing economic and in-kind support, designed to enable continued participation of mentors in the mentor-trainee relationship.
- Increase awareness, as well as review the effectiveness of existing grant mechanisms and training workshops to support the transition from trainee to independent investigator.
 - Assure compliance, through the guidance given to study sections and yearly review of section performance, with NIH regulations for the inclusion of racial and ethnic minorities in research and training grants.
 - Create and implement cultural competency training for study section members, program staff, and investigators that is completed and updated on a biannual basis.
- Provide international research opportunities for minority investigators.
- Implement academic training programs that provide theoretical and practical framework for the conduct of clinical and basic science research for minority investigators.

OBJECTIVE:

Decrease health disparities among racial and ethnic minorities to increase their health status to that of the majority population.

STRATEGIES:

- Ensure that all clinical research addresses the ethical issues related to the feasibility of sustained access to therapeutic and prevention interventions after the research has concluded.
- Identify and study the effectiveness of various strategies to reduce or eliminate health disparities at the individual, institutional and community level.
 - Study the effectiveness of culturally appropriate interventions for primary and secondary prevention.

- Study the factors that promote and impede early access to care, treatment, and interventions.
- Study the combined effects of several factors, including but not limited to: poverty, racism, homophobia, and homelessness in creating the health disparities observed within racial/ethnic minorities (at the individual and community level).
 - Study the combined effects of societal factors on the individual and community behavior, with respect to HIV infection.
 - Study the biology of HIV infection among racial and ethnic minorities including vulnerability to HIV and opportunistic infections, transmission, disease progression, and resistance.
- Encourage and fund basic and clinical research to understand the influence of cultural, economic, biological, behavioral, gender, and age factors upon racial and ethnic minority health disparities in HIV/AIDS.
- Study the impact of other co-morbid diseases and management of symptoms including, but not limited to, tuberculosis, hepatitis B and C, mental illness, diabetes, substance abuse, and sexually transmitted diseases on health outcomes and access to care.
 - Study interventions to reduce or eliminate the negative impact of these co-morbid diseases.
 - Study the cost-effectiveness and replicability of the interventions.
- Study the differential responses to HIV and opportunistic infection therapy, including side effects among racial and ethnic minorities.

OBJECTIVE:

Include racial/ethnic minorities in prevention, therapeutic, vaccine and clinical trials in numbers that reflect the current incidence data.

STRATEGIES:

- Develop and fund recruitment activities that are culturally appropriate for the specific target population.
 - Provide community-based education about basic and clinical research, including clinical trials.
 - Conduct clinical trials where individuals seek medical care and services.

- Develop partnerships between NIH-funded research institutions and institutions in the targeted communities, including community-based organizations. Research infrastructure development within these community partners is an essential component of this partnership.
- Include community input from the initiation of study development to the dissemination of study results.
- Increase the emphasis upon study design and methods when planning and conducting studies that will better determine the impact of racial/ethnic/gender differences upon outcomes in transmission, side effects, body composition (e.g., pathogenesis, drug treatment, and clades).
- Conduct studies of the risks and benefits of complementary and alternative therapies that may be used in conjunction with standard HIV therapies.
- Encourage the use of ClinicalTrials.gov and the AIDS Clinical Trials Information Service as a tool to inform and promote and understanding of the clinical trials process, and current clinical trials in minority populations.

OBJECTIVE:

Develop, pilot, evaluate, and sustain prevention interventions to prevent HIV transmission and its co-morbidities.

STRATEGIES:

- Increase research to identify the specific mechanisms of transmission, and the critical factors that influence transmission, among racial/ethnic minorities.
 - Identify the significant factors (e.g., stigma, poverty, racism, sexism, violence, and homophobia) that interfere with prevention messages.
 - Fund research conducted with the multiply diagnosed HIV/AIDS infected population (e.g., mental disorders, alcohol/substance abuse, and medical disorders).
 - Develop and support innovative models to conduct outcome evaluations in racial/ethnic minority communities.
 - Ensure that any standardized scales to be used in studies that include racial and ethnic minorities have been validated in minority populations.
 - Increase community-level awareness of HIV prevention through closer collaborations between NIH and all other Department of Health and Human Services (DHHS) agencies charged with decreasing HIV transmission

through public education. Such collaboration should include, but not be limited to, information dissemination and translation of research findings.

- Reduce or eliminate language barriers which limit participation in prevention research in communities where English is not the primary language.
- Study the effect of nutrition and micronutrients on the impact of HIV and opportunistic infection therapies and their side effects.
- Support technology transfer of prevention programs to communities that reach at-risk groups among racial and ethnic minorities.
- Support research on the role of family and caregivers in prevention in minority communities.

OBJECTIVE:

Promote and increase adherence to treatment regimens among racial and ethnic minorities.

STRATEGIES:

- Increase support for basic science studies of metabolic, body composition and pharmacokinetic racial and ethnic differences and their potential role in sub-optimal drug effects.
- Study the short- and long-term effects of noncompliance in racial and ethnic minorities, including but not limited to, the emergence of drug-resistant HIV, multidrug resistant tuberculosis [MDR-TB], opportunistic infections [OIs], and disease progression.
- Study the effects of multilevel interventions (individual, peer, family, community) on adherence.
- Study racial and ethnic differences in adherence, and the gender-related issues and gender differences associated with the chronic noncompliance.
- Study new therapeutic regimens that would facilitate adherence.
- Develop culturally appropriate and population-specific models of treatment acceptance and adherence.
- Study of the impact of minor and severe side effects on adherence (e.g., the impact of cosmetic changes associated with antiretroviral therapy).

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RESEARCH RELATED to RACIAL and ETHNIC MINORITIES**

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