

MA/NEHEC Monthly Health Disparities Update: November 2011

Editor's Note

Hello everyone. I'm Eric Brus, the director of HIV health promotion at the AIDS Action Committee of Massachusetts. For the past 16 years, I've been reviewing and summarizing research on the prevention and treatment of HIV, opportunistic illnesses, sexually transmitted infections, and related health conditions. Another important aspect of my work has been to track trends in the HIV/AIDS epidemic regionally, nationally, and globally – including patterns of health disparities by race/ethnicity, gender, age, and risk behavior.

This is the first in a series of *Monthly Healthy Disparities Updates* that I'll be distributing to HIV providers and researchers across New England. In these *Updates*, I will provide summaries of important health disparities news, as well as links to disparities resources that I hope will be both interesting and useful to you.

Since this is my first *Health Disparities Update*, I'd appreciate any feedback that you'd like to provide about the news and resources provided here. I'd also welcome your suggestions about the *Update's* format and any additional features you'd like to see in the future. You can contact me by email at: ebrus@aac.org.

If you know other people who might like to receive these *Updates*, please ask them to contact me, and I'll be happy to add them to the distribution list.

News Roundup

Summary of “Eliminating HIV/AIDS Health Disparities” Roundtable Discussion

Building on the momentum from last November's two-day conference, “The Forgotten Epidemic - HIV/AIDS: Crisis in Black America,” the Harvard University Center for AIDS Research (CFAR) hosted a roundtable discussion on November 14 entitled “Eliminating HIV/AIDS Health Disparities.”

The discussion focused on presentations by the following speakers:

Dr. Felton Earls (Professor of Human Behavior and Development at the Harvard School of Public Health) summarized the state of the U.S. HIV/AIDS epidemic among Black Americans – including disparities in HIV/AIDS diagnoses and deaths in the Black community. According to the [latest CDC data](#), in 2009:

- Black men accounted for 70% of the estimated new HIV infections among all Blacks. The estimated rate of new HIV infection for Black men was more than six and a half times as high as that of White men, and two and a half times as high as that of Latino men or Black women.
- Black men who have sex with men (MSM) represented an estimated 73% of new infections among all Black men, and 37% among all MSM. More new HIV infections occurred among young Black MSM (aged 13–29) than any other age and racial group of MSM. In addition, new HIV infections among young Black MSM increased by 48% from 2006–2009.
- Black women accounted for 30% of the estimated new HIV infections among all Blacks. Most (85%) Black women with HIV acquired HIV through heterosexual sex. The estimated rate of new HIV infections for Black women was more than 15 times as high as the rate for White women, and more than three times as high as that of Latina women.

Dr. Earls noted that, in the U.S., HIV/AIDS shifted from a predominantly White MSM epidemic to a predominantly Black epidemic in the mid-1990s – right about the time that highly active antiretroviral treatment (HAART) became available to treat HIV. This finding may be explained, at least in part, by disparities in access to HIV treatment, prevention, and other services.

Dr. Alexandria Shields (Director of the Harvard/MGH Center on Genomics, Vulnerable Populations, and Health Disparities) described the “Harvard Catalyst” program, which provides a consultation service for groups involved in health disparities research. She noted that Harvard provides pilot grants of \$50,000 for groups interested in pursuing health disparities research. You can check these links for more information about the [Harvard Catalyst program](#) and [their health disparities consulting](#).

The third speaker was *Dr. Rochelle Rollins* (Director, Division of Policy and Data of the Federal Office of Minority Health). Dr. Rollins’ presentation focused on two recent reports: “[National Stakeholder Strategy for Achieving Health Equity](#),” which “provides an overarching roadmap for eliminating health disparities through cooperative and strategic actions”; and “[A Nation Free of Disparities in Health and Health Care](#),” which is DHHS’s action plan to reduce racial and ethnic health disparities.

These two reports outline important initiatives of the [National Partnership for Action to End Health Disparities](#) (NPA). NPA is “is a public-private initiative that seeks to mobilize a nationwide, comprehensive, community-driven, and sustained approach to combating health disparities and to move the nation toward achieving health equity.”

As part of the National Stakeholder Strategy, a total of ten [Regional Health Equity Councils](#) (RHECs) have been established to “serve as leaders and catalysts for strengthening health equity actions” within their regions. For more information about initiatives in New England, you can contact the [RHEC for HHS Region 1](#).

Finally, *Karen Barretta, JD*, from HHS Office for Civil Rights, gave a brief overview of a project sponsored by the DHHS Office for Civil Rights entitled, “Stopping Discrimination Before It Starts: The Impact of Civil Rights Laws on Health Care Disparities – A Medical School Curriculum.”

If you have any questions about the Harvard roundtable, or would like copies of some of the speakers’ presentations, please email me at: ebrus@aac.org.

CDC/Hopkins Study Finds Major Disparities in HIV Death Rates by State

The journal *AIDS* recently published a study analyzing differences in HIV-related death rates during the period from 2001 through 2007 among the 37 U.S. states that had confidential name-based reporting of HIV infection for at least four years. (Of the six New England states, only Connecticut and New Hampshire met the criterion for inclusion in the analysis.)

The study authors (from CDC and Johns Hopkins School of Public Health) calculate and compare two different death rates for the 37 states: 1) the “conventional” HIV death rate; and 2) the HIV case-fatality rate.

The conventional HIV death rate is essentially the number of HIV deaths per year for each 100,000 of the state's entire population (both HIV-infected and uninfected). The conventional HIV death rate is heavily influenced by the prevalence of HIV (proportion of persons living with HIV) in each state. For example, states like New York with a relatively high HIV prevalence would be expected - all other factors being equal - to have a higher conventional HIV death rate than states like Wyoming, which have a relatively low HIV prevalence.

In contrast, the HIV case-fatality rate focuses only on each state's HIV-infected population and is a measure of the death rate per 1,000 HIV-infected person-years in that group. This case-fatality rate factors out state-to-state differences in HIV prevalence and looks instead at the rate at which HIV-infected persons in the state are dying. According to the authors, HIV case-fatality rates "are more useful [than conventional HIV death rates] for identifying determinants of the availability, utilization, timeliness, and quality of care for that population."

The following paragraph from the discussion section of the paper summarizes some of the authors' main findings:

“We identified significant interstate differences in US HIV case-fatality rates, with rates in many southern states being more than twice as great as those in other states even after adjusting for differences in racial/ethnic and age distributions. Substantial rank differences between case-fatality rates and conventional death rates in some states imply important differences in primary versus secondary and tertiary HIV prevention in these areas. For example, New York’s conventional HIV death rate was the third highest among the states examined, attributable in part to its high HIV prevalence. Its comparatively low case-fatality rate rank (30th out of the 37 states) suggests good secondary and tertiary prevention of HIV disease, which could be due in part to earlier screening or entry into care, better adherence to medical instructions, or better care, compared to many other states. In contrast, Wyoming has a relatively low conventional HIV death rate, ranking 36th, owing to its low HIV prevalence. However, its high HIV case-fatality rate rank (9th) suggests that services to those with HIV may be inadequate.”

It may be helpful to include the definitions of “secondary prevention” and “tertiary prevention” here:

Secondary prevention refers to “a level of preventive medicine that focuses on early diagnosis,

use of referral services, and rapid initiation of treatment to stop the progress of disease processes or a handicapping disability.” [from Mosby's Medical Dictionary]

Tertiary prevention “generally consists of the prevention of disease progression and attendant suffering after it is clinically obvious and a diagnosis established. This activity also includes the rehabilitation of disabling conditions.” [from Encyclopedia of Public Health]

Of the 37 included states, the 10 states with the highest HIV case-fatality rates (followed, in parentheses, by the associated death rates per 1,000 HIV-infected person-years) were:

- 1) Mississippi (32.9)
- 2) Louisiana (32.5)
- 3) Oklahoma (29.8)
- 4) North Carolina (28.8)
- 5) Tennessee (27.0)
- 6) Georgia (25.6)
- 7) South Carolina (25.2)
- 8) Alabama (25.0)
- 9) Wyoming (24.3)
- 10) Florida (24.2)

The 10 states with the lowest HIV case-fatality rates were:

- 1) Idaho (9.6)
- 2) Colorado (9.8)
- 3) Connecticut (12.2)
- 4) Utah (12.8)
- 5) Minnesota (13.5)
- 6) Wisconsin (13.9)
- 7) Alaska (14.0)
- 8) New York (14.7)
- 9) Missouri (15.0)
- 10) New Hampshire (15.0)

It's worth noting that the HIV case-fatality rates in the two highest states (Mississippi and Louisiana) are more than three times higher than those in the two lowest states (Idaho and Colorado) - a very striking disparity. Nine of the ten states with the highest HIV case-fatality rates were located in the South.

When the researchers considered the 37 states as a whole, they found that non-Hispanic Blacks had an HIV case-fatality rate about 1.4 times higher than Whites, while the rate for persons of Hispanic ethnicity was essentially equal to that of Whites. The researchers also found a significant association between age and risk of death: the HIV case-fatality rate increases about 35% for every 10 years of a person's age.

In their discussion section, the authors noted:

“The elimination of HIV-related health disparities is a national priority. Our study shows that state of residence should be considered as a geographic unit of analysis when assessing disparities, in addition to categorizations like sex, race/ethnicity, and transmission category. Our

findings also support earlier work identifying disparities in the southern US for earlier consequences of HIV infection, namely AIDS diagnosis. Examination of these rate disparities is a crucial step in addressing their causes, and can guide policymakers to consider area-level factors as well as individual factors when choosing interventions.”

For a news summary of the study, you can read the following article from aidsmeds.com:
[Death Rates Among People With HIV Vary Considerably From State to State, CDC Reports.](#)

Communities of Color Continue to Have Disproportionately High STD Rates

On November 17, CDC published its [2010 surveillance data for sexually transmitted diseases](#) (STDs). The CDC's summary report includes detailed national data for chlamydia, gonorrhea, syphilis, and selected other STDs. It also includes population-specific profiles on STDs in racial and ethnic minorities, women and infants, adolescents and young adults, men who have sex with men, and persons entering correctional facilities.

The National Coalition of STD Directors (NCSD) has issued a highly informative press summary of the report, which follows:

New STD Surveillance Data Shows Continuing Burden of Disease

Continued vital investments for testing and treatment needed

Washington, D.C. -- Today, the Centers for Disease Control and Prevention (CDC) released its 2010 sexually transmitted disease (STD) surveillance data. This annual report of statistics and trends for the three reportable sexually transmitted diseases in the United States shows that STDs rates in this country are still shockingly high, particularly in communities of color and among gay men and other men who have sex with men (MSM).

“This new data shows a persistence of the same trends that we have been seeing for years—that MSM and communities of color are continuing to bear a disproportionate share of the STDs in this country,” said William Smith, Executive Director of the National Coalition of STD Directors. “We should also not lose sight of a number of new additional studies this past year on the link between STDs and acquiring HIV. The 2010 STD data released today shows that we need to look closely at further investments in STD prevention as a means to prevent HIV as well,” continued Smith.

While the 2010 data shows that overall rates for syphilis went down compared to 2009, the first decrease in in ten years, rates among Hispanics went up just over 9% in the last year and MSM still account for two-thirds of the syphilis in this country. In addition, Black men continue to have the highest rates of syphilis in the U.S., with young (20-24) Black MSM seeing an increase of syphilis of a shocking 135% between 2006 and 2010. Co-infection of those with syphilis and HIV also continues; between 25-54% of those with primary or secondary syphilis were also HIV-positive.

“The good news is that there was a drop of 8.5% in the rate of Black men diagnosed with either primary or secondary syphilis in 2010 compared to the year prior,” said Smith. “While too early

to definitely assess the cause for this drop, there has been a distinct appeal for several years now to help address the explosion of syphilis among Black men, particularly among young Black MSM, and we must keep up efforts to prevent increasing rates of STDs and HIV among this group,” concluded Smith.

Rates for Chlamydia continued to increase over the last year, as they have for twenty years. This is in part due to increased testing which is increasingly identifying positive cases, of which there were more than 1.3 million reported in 2010. Black women continue to have the highest rates for Chlamydia, as well as gonorrhea. While there was only a small increase in the overall rates of gonorrhea, the rates of gonorrhea in Hispanics went up 12% compared to 2009.

Across all three diseases, communities of color and young people overall continue to be most affected, though even for all ages of Whites, increases were seen for all three diseases in 2010. Among Whites in 2010, rates of chlamydia increased by 7.5%, 9.2% for gonorrhea, and 3.6% for syphilis in 2010 compared to 2009.

“We hope the unacceptably high rates of STDs in this country continue to be clarion call for securing the sexual health of all people,” said Smith. “This means that state and federal investments in STD prevention remain a critical need in these times of tight budgets and that as healthcare reform continues to move ahead, that partners in every sector ensure that the safety net for these services continues to exist,” continued Smith.

Featured Health Resource

Updated CDC Web Page on the Health of American Indians/Alaska Natives

November is American Indian/Alaska Native Heritage month. To mark this event, CDC has updated its [web resources on the health of American Indians/Alaska Natives](#). According to CDC, heart disease and cancer are the leading causes of death for American Indians and Alaska Natives (AI/AN).

In addition, a variety of health disparities affect AI/AN communities, including disproportionately high prevalence for diabetes, suicide, teenage pregnancy, infant death, unintentional and motor vehicle injuries, chronic liver disease, and cirrhosis. CDC statistics also indicate that the rate of AIDS diagnoses is about 20% higher among American Indians/Alaska Natives than among Whites. For more information, you can visit the HIV Health Library’s [Native Americans, Alaskan Natives, and HIV](#) page.